[The Gambia National Health Sector Strategic plan]

[2014-2020]

Contents

ACKNOWLEDGEMENT

This strategic plan has a long gestation and our local consultants and health experts, Dr. Hatib Njie, Dr. Kabir Cham, and Dr. Abdoulie Jack have given us advice and helpful comments. Our thanks also goes to all Directors both at central and regional levels, programme Managers and partners from other sectors that have in one way contributed significantly to make the document what it is.

A special acknowledgement goes to the Directorate of Planning and Information, especially the core planning and budget teams for their concerted effort and dedication and time spent to scrutinize all chapters included in this text. Providing us with invaluable comments and recommendations, this made it possible for the timely completion of this piece of work.

We would also like to acknowledge the hard work and patients of those who took the responsibility of proof reading all the chapters presented in the strategic plan, who have put great effort into the compilation of this work. Numerous others have been of great help particularly, our development partners in the UN system, specifically WHO and IHP+ for providing logistical and financial support for the realization of the laudable achievement. We cannot go without recognizing the invaluable services rendered by drivers and support staff in this process.

Our special thanks go to the leadership of the MOH&SW (Ministry of Health and Social Welfare), the Hon. Minister Omar Sey and his dynamic Permanent Secretary Dr. Makie Taal and his deputies for their moral support and continued guidance throughout the process.

Many thanks is also extended to His Excellency, The President of the Republic of The Gambia, Sheikh Professor Ahajie Dr Yahya A.J.J. Jammeh Babili Mansa, for his unflinching support to this process and to the Gambian health sector over the past twenty years affirming that “The Nations Health is His Priority”

EXECUTIVE SUMMARY

The Health Sector Strategic focus in The Gambia is anchored on the National Health Policy 2012-2020 which is linked to the country's development blue prints better known as VISION 2020 The Gambia Incorporated and PAGE. These aim to transform The Gambia into a globally competitive and prosperous country with a high quality of life by 2020, through transforming the country from a third world country into an industrialized, middle income country. Its actions are grounded in the principles of the 1997 constitution, specifically aiming to attain the right to health, and to decentralize health services management through a devolved system of Governance. This strategic focus has been defined in the Gambia Health Policy, which has elaborated the long term policy directions the Country intends to achieve in pursuit of the imperatives of the Vision 2020, and the 1997 constitution.

The long term objective for the health sector according to VISION 2020 is the provision of adequate, effective and affordable health care for all Gambians. The immediate objectives are to improve the administration and management of health services, provide better infrastructure for Referral Hospitals and health facilities and the extension of Primary Health Care services to all communities and having a well-motivated and trained staff and establishment of efficient procurement arrangements in order to ensure effective and efficient health services for all. **The policy aims to achieve this goal through supporting provision of** equitable, affordable and quality health and related services at the highest attainable standards to all Gambians. It targets to attain a level and distribution of health at a level commensurate with that of a middle income country, through attainment of specific health impact targets. The policy directions in the Gambia Health Policy are structured around seven Service Delivery outcomes, and twenty one System investment orientations.

This strategic plan provides the Health Sector Medium Term focus, objectives and priorities to enable it move towards attainment of the Gambia's Health Policy Directions. The Health Sector refers to all the Health and related sector actions needed to attain the Health Goals in The Gambia. It is not restricted to the actions of the Health Ministry, but includes all actions in other related sectors that have an impact on health. It will guide both

Regional and National Governments on the operational priorities they need to focus on in Health.

This Strategic Plan's overall goal is to reduce inequalities in health care services and reverse the downward trend in health-related outcome indicators. Recommendations from implementation of the seven Strategic Objectives of the NHSSP have guided prioritization of interventions for implementation during this strategic plan. These recommendations include the call for the sector to:

- Improve evidence based decision-making and resource allocation.
- Review and re-align the essential package for health.
- Review, and realign community-based services around expectations.
- Focus on strengthening of the referral system.
- Improve planning, and monitoring of quality of care, and service delivery.
- Operationalize the planning and review cycles and frameworks at all levels.
- Align Health Sector operations and services with 1997 constitution expectations.
- Strengthen the Health Information System to act as a resource for the sector.
- Update sector norms and standards.
- Establish systems to coordinate sector investments.
- Continue to strengthen Procurement and Supply Management systems
- Re-invigorate the sector partnership and coordination framework.
- Start to pro-actively, and regularly monitor technical and allocative efficiency in resource use by the Health Sector.
- Accelerate push towards systems to attain universal access to defined health service package.

The Gambia health sector has a three-tier system comprising the Primary, Secondary and the Tertiary levels. The primary level consists of the Village Health Services and Community clinics; the Secondary comprises the Minor and Major Health centres whilst the Tertiary consists of the General Hospitals and the Teaching Hospital. The Department of Social Welfare is responsible for the provision of social welfare services to the under-privileged and vulnerable groups in the country.

The Ministry of Health and Social Welfare (MOH & SW) is the main government institution responsible for healthcare delivery and provision of social welfare services in The Gambia. The health sector is managed at two levels, the central and regional levels.

Under the Ministry of Health and Social Welfare are six Directorates: Basic Health Services, Planning and Information, Social Welfare, Health Promotion and Education, National Public Health Laboratory and Human Resources for Health.

For the management at the regional levels, the country is classified into seven health regions each headed by a Regional Health Director (RHD). The Regional Health Teams are responsible for the primary and secondary healthcare facilities and their staff. At primary level there are 634 PHC village posts, which are clustered into circuits. The services at this level are delivered by village health workers, traditional birth attendants and other community volunteers. The Community Health Nurses based in key villages supervise clusters of primary healthcare villages. The secondary level is made up of 47 public health facilities and is complemented by private and NGOs service provision.

Although there are 4 general and 2 specialized public hospitals in The Gambia, the services they provide are inadequate due to capacity constraints. They are complemented by few private and NGO facilities all of which are located in the Greater Banjul Area whose services are unaffordable and inaccessible to the vast majority of Gambian populace. There are 3 Health Training Institutions producing professionals annually that feed the health system. They are: the School of Nursing and Midwifery, School of Public Health and the Faculty of Medicine and Allied Health Sciences at the University of The Gambia, which are all under the Ministry of Higher Education, Research, Science and Technology (MOHERST). The Enrolled Community Health Nurses and the Enrolled Nurses Schools are under the Ministry of Health and Social Welfare. Three of these schools (Nursing and Midwifery, Community Health Nurses and Enrolled Nurses) produce different categories of nurses such as Registered Nurses, Enrolled Nurses and Community Health Nurses respectively, at an average of 30 graduates per year. The Regional Ophthalmic Training Programme at the Regional Eye Care Centre trains Cataract Surgeons and Ophthalmic Nurses annually. The University of The Gambia, Faculty of Medicine and Allied Health Sciences was established in 1999. It has started producing graduates at BSc, MSc and MPH levels in Nursing and Public Health since 2003 and 2013 respectively. The first batch of Medical Doctors has graduated in 2006. As far as social welfare is concern, there also exist a training programme for social workers at certificate and diploma levels conducted at the SOS Regional Mothers' and Aunties' Training Centre and the University of The Gambia respectively. Although, there are constraints in the Health and Social Welfare Sectors, the most pressing is the ineffective management structure at the Ministry of Health and Social Welfare

(MOH&SW). It has not helped matters that in the recent past, frequent changes were made in the top management positions that hindered policy implementation, and weakened institutional memory. If this challenge is successfully overcome, then the rest of the constraints below will be effectively addressed:

- High attrition of skilled health and social workers,
- Inadequate skilled and competent health workers,
- Low staff production from health training institutions,
- Inadequate basic equipment, consumables and other logistics,
- Insufficient drugs and other medical supplies,
- Weak referral systems,
- Inadequate Infrastructure and ICT equipment,
- High incidence of malaria,
- Containing the spread of HIV/AIDS infection, the overall goal of which is to stabilize and reduce the prevalence of HIV/AIDS, provide treatment, care and support to people living with HIV/AIDS,
- Sustainability of Health Management Information System (HMIS),
- Inadequate facilities and services at the tertiary care level against the background of increasing population and poverty levels, and
- Maintaining the achievements made in the health sector.
- Limited human, financial and material resources to meet the growing demand of social welfare and child protection services at national, regional and community levels.

In view of the above and many other challenges facing the institution, the civil service reform strategy identified the health sector as one of the critical government institutions needing support to transform and strengthen how it is managed.

The strategic plan 2014 – 2020 takes its instructions from the health policy document, which aims at the attainment of the highest level of health delivery for the entire Gambian population by the year 2020 and the Social Welfare Policy document which aims to improve access to quality social welfare services at the local, institutional and national levels by 2020. The strategic plan is geared towards progressive reorientation of the health services to deliver quality healthcare as a means to achieving the envisaged socio-economic development of The Gambia, as enshrined in the PAGE and

vision 2020, The Gambia Incorporated, and in line with the Millennium Development Goal (MDGs) targets.

LIST OF ABBREVIATIONS

AFPRC	Armed Forces Provisional Ruling Council
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infections
ART	Anti – Retroviral Therapy
ARV	Anti-Retroviral (medicines)
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetrics and Neonatal Care
BHCP	Basic Health Care Package
BI	Bamako Initiative
CBR	Community Based Rehabilitation Programme
CEMoNC	Comprehensive Emergency Obstetrics and Neonatal Care
CHN	Community Health Nurse
CPR	Contraceptive Prevalence Rate
CRR	Central River Region
CSF	Cerebro Spinal Fluids
DRF	Drug Revolving Fund
DSW	Department of Social Welfare
EDC	Epidemiology and Disease Control
EFEM	External Factor Evaluation Matrix
EFSTH	Edward Francis Small Teaching Hospital
EMNCH	Emergency Maternal and Newborn Child Care
EMNOC	Emergency Maternal and Neonatal Obstetrics Care
EMOC	Emergency Obstetrics Care
EN	Enrolled Nurses
EPI	Expanded Program on Immunization
FP	Family Planning
GF	Global Fund
HCT	HIV Counselling and Testing
HCW	Health Care Workers
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health System Strengthening
ICPD	International Conference on Population and Development
ICT	Information and Communication Technology

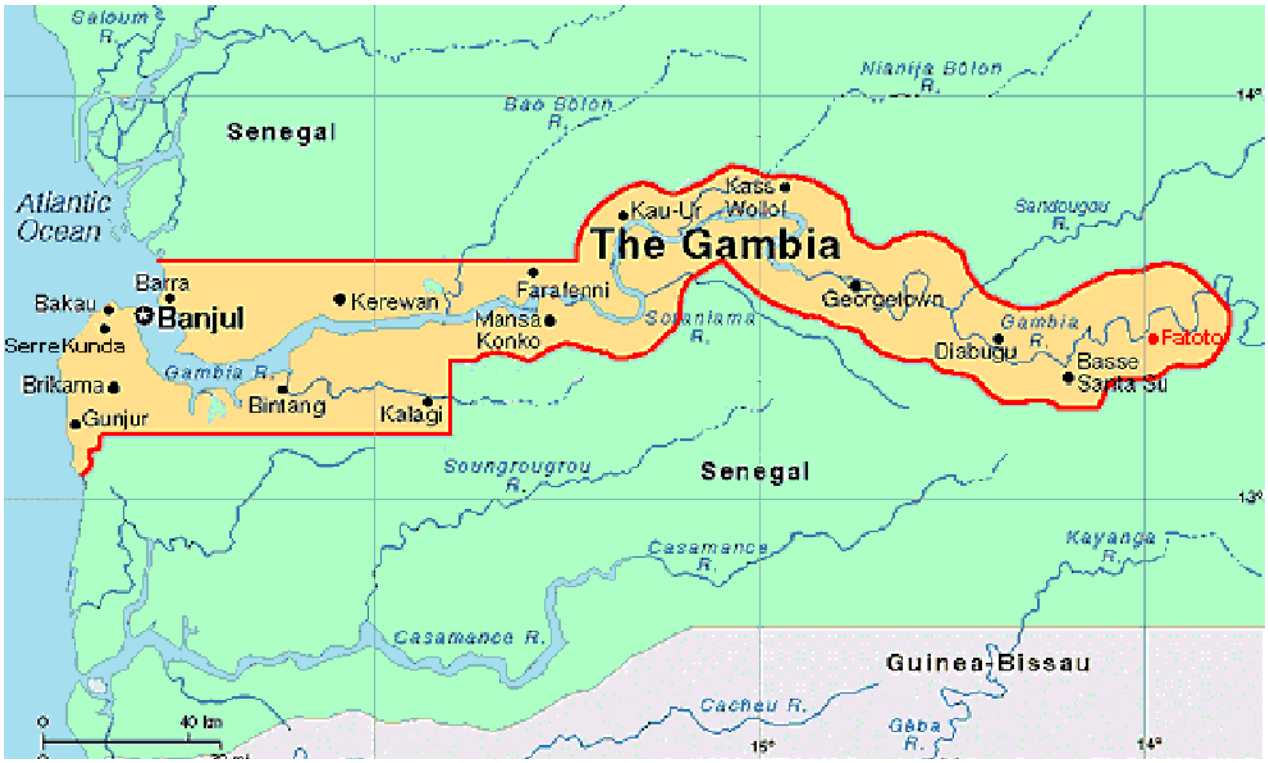
IDSR Integrated Disease Surveillance and Response
IEC Information, Education and Communication
IHP+ International Health Partnership+
IMNCI Integrated Management of Neonatal & Childhood Illness
IPT Intermittent Preventive Treatment
IRS Indoor Residual Spraying
ITN Insecticide Treated Net
LLINs Long Lasting Insecticidal Nets
LPED Local Production of Eye Drops
LRR Lower River Region
MAM Moderate Acute Malnutrition
MARPs Most At Risk Populations
MDFT Multi-Disciplinary Facilitation Team
MDGs Millennium Development Goals
MDR TB Multi Drug Resistant Tuberculosis
MICS Multiple Indicator Cluster Survey
MIS Malaria Indicator Survey
MOFEA Ministry of Finance and Economic Affairs
MOH&SW Ministry of Health and Social Welfare
MOHERST Ministry of Higher Education, Research, Science and Technology
MRC Medical Research Council
MTEF Medium Term Expenditure Framework
NBER North Bank East Region
NBWR North Bank West Region
NCDs Non-Communicable Diseases
NEA National Environment Agency
NEHP National Eye Health Programme
NGO Non-Governmental Organization
NSF National Strategic Framework
NTD Neglected Tropical Diseases
OPD Outpatient Department
OVC Orphans and Vulnerable Children
PHC Primary Health Care

CHAPTER 1: INTRODUCTION

1.1 BACKGROUND

The Gambia extends about 400 km inland forming a narrow enclave into the Republic of Senegal except for a short seaboard on the Atlantic Coastline as shown in the map below. It has a land area of 10,689km^2, with a population of 1,882,450 people. A population density of 176 persons per km^2 (Population and Housing Census, 2013), makes the country to be one of the highest densely populated countries in Africa, thus imposing extreme pressure on productive land and the provision of social services.

Figure 1: Map of the Gambia



1.1.2 Climate

The Gambia is situated on the West Coast of Africa between Latitude 13^0 and 14^0 North of the equator. It has a tropical climate characterized by two seasons; rainy season from June-October and dry season from November-May.

1.1.3 Economy

The Gambia is amongst the Least Developed Countries (LDCs) with Gross Domestic Product (GDP) per capita of US$ 560 (IMF Staff report 2011). Agriculture forms the backbone of the economy with nearly 70% of the working population are involved in the agricultural sector. However, it is the services sector that is the biggest contributor to GDP, at 60%, with agriculture contributing about 30%. The economy grew by 7.2% in 2007 over the preceding fiscal year; national revenue has been increasing progressively; inflation reducing to low single digit levels and was 2.3% as at end May 2007 (PRSP II, 2007). According to MOFEA, the Gambia has been registering annual GDP growth rates of more than 5% (2008-2011) during the current global economic crisis, and has maintained a stable macroeconomic environment that is increasingly threatened by a mounting debt burden. The Gambia is ranked 168 out of 187 countries in the 2011 UN Human Development Index and the last poverty survey (2008) revealed that about 55% of the population lives below the poverty line.

The national economy is based mainly on agriculture, with groundnut as the main export crop. The recent upturn in performance of the economy has however been driven mainly by the service sector including tourism, telecommunication, construction, etc.

The economy suffered a contraction of GDP to 4.3% in 2011 due to drought. This was due to a fall in crop production of around 45 per cent in that year, despite several non-agricultural sectors of the economy, such as tourism, performing well during 2011. The figures for 2012 show a rebound in GDP growth of 5.3 per cent due to a recovery in crop production and strong growth in wholesale and retail trade, and construction. The services sector saw its total contribution drop 1.8 percentage points from 16.3 per cent in 2011 to 14.5 per cent in 2012 (PAGE 2012).

1.1.4 Conceptual Framework of the GHSSP

The GHSSP is anchored on the National Health Policy 2012-2020, which is linked to the Country's Development Blue Print better known as VISION 2020 the Gambia Incorporated**.** The long-term objective for the health sector according to VISION

2020 is the provision of adequate, effective and affordable health care for all Gambians. The immediate objectives are to improve the administration and management of health services, provide better infrastructure for Referral Hospitals and health facilities and the extension of Primary Health Care services to all communities and having a well-motivated and trained staff. In addition establishment of efficient procurement arrangements in order to ensure effective and efficient health services for all.

It is common knowledge that all the MDGs are related to health either directly or indirectly. Despite all the linkages, the health sector is mainly responsible of MDGs 4, 5 and 6. The current status is as below:

Progress with regards to MDG 4, i.e. the reduction of child mortality is assessed against three main indicators such as under-five mortality rate, infant mortality rate and proportion of one-year old children immunized against measles.

The targets for MDG 5 (improve maternal health) are two:
1. To reduce by three quarters between 1990 and 2015 the maternal mortality ratio and secondly achieve by 2015 universal access to reproductive health. The indicators to track attainment of these targets are as follows: MMR and proportion of births attended by skilled health professionals, contraceptive prevalence rate, adolescent birth rate, antenatal coverage (at least one visit and at most four visits) and unmet need for family planning.

MDG 6 (combating HIV/AIDS, Malaria and other diseases) comprises of three targets namely;

1. Half halted by 2015 and begun to reverse the spread of HIV/AIDS,
2. Achieve by 2010 universal access to treatment for HIV/AIDS for those who need it,
3. Half halted and begun to reverse the incidence of malaria and other major diseases

Government takes the current levels of the core MDG indicators such as poverty, maternal, infant, and under-5 mortality rates as being unacceptably high. Therefore, these require accelerated action that would lead to the timely achievement of The Gambia's Millennium Development Goals (MDGs) related targets as reflected explicitly in key policy/strategy documents, notably, the National Health Policy, 2012-2020 (NHP) and the Gambia Programme for Accelerated Growth and Employment (PAGE), 2012-2015.

The Crude Birth Rate (CBR) is 40.5 per 1000 population (Gambia Demographic and Health Survey [GDHS], 2013) and the Crude Death Rate (CDR) is estimated at 9.24 per 1000 population (World Bank Report, 2010). The Infant Mortality Rate (IMR) is 34 per 1000 and Under-5 Mortality Rate (>5 MR) is reported at 54 per 1000 live births (GDHS, 2013), Maternal Mortality Ratio (MMR) is 433 per 100000 live births (GDHS 2013). 60% of the population lives in the rural area; and women constitute 50.5% of the total population. The high fertility level of 5.6 births per woman (GDHS, 2013) has resulted in a very youthful population structure. The annual population growth rate is 3.3% (GDHS, 2013). Nearly 44% of the population is below 15 years and 19% between the ages 15 to 24 years; whilst those aged 65 years and above account for about 3.4% of the population, (Multiple Indicator Cluster Survey [MICS], 2006).

The health sector despite remarkable achievements registered in the past 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, traditional beliefs and low awareness have led to inappropriate health seeking behaviours thus contributing to ill health.

Indicators of child and maternal mortality are improving, however more work need to be done in the following areas: poverty, low literacy, prevalence of communicable and non-communicable diseases such as Malaria, Diarrhoea, Pneumonia, Tuberculosis, Accidents, Hypertension, Cancers, and Pregnancy related conditions, 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.

Table 1: Demography and Health profile

No	Indicator	Rate/Rat	Source (Year)
1	Infant Mortality	34/1000	GDHS, 2013
2	Neonatal Mortality	22/1000	GDHS, 2013
3	Under Five Mortality	54/1000	GDHS 2013
4	Crude Birth Rate (CBR)	40.5/1000	DHS, 2013
5	Crude Death Rate	9.24/ 1000	(WB Report, 2010)
6	Growth Rate	3.3%	GBOS, 2013 (2013
7	Maternal Mortality	433/100000	GDHS, 2013
8	**Antenatal care**		
	a. At least once by skilled personnel	98.9%	GDHS,2013
	b. At least four times by a skilled personnel	77.6%	GDHS, 2013
9	Deliveries attended by skilled personnel	57%	GDHS, 2013
	Total fertility Rate (TFR)	5.6%	GDHS, 2013
	Contraceptive Prevalence	9%	GDHS, 2013
	Family planning Unmet need	24.9%	GDHS, 2013
11	HIV prevalence	1.9%	GDHS, 2013
12	Life expectancy (In years)	Males 62. 5 Females 65	GDHS, 2013
13	Literacy Rate	69.9%	GDHS, 2013
14	Poverty Index	61.2%	UNDP, 2011
15	GDP per capita	USD 428	MoFEA, 2014
16	Total Health expenditure per capita (USD)	USD28.08	NHA, 2013
17	Total government expenditure on health per capita (USD)	USD 7.89	NHA, 2013
18	Government expenditure on health as percent of general government expenditure	12.4%	NHA, 2013
19	General government expenditure on health as percent of total expenditure on	28%	NHA, 2013
20	Out of pocket expenditure on health as percentage of total health	21.21%	NHA, 2013
21	Malaria incidence	10% or	MOH&SW 2012
22	Professional Health workers per 10000 population	8.3/10000	MOH&SW 2012
23	Doctors per 10000 population	1.1/10000	MOH&SW 2012
24	Nurses per 10000 population	3.2/10000	MOH&SW 2012
25	Midwives per 10000 population	1.8/10000	MOH&SW 2012

HIV prevalence stands at 1.9% with the main route of transmission being through heterosexual contact. However, in children, the major mode of spread is by transmission from mother to child during pregnancy, delivery and through breast-

feeding. On the other hand, under-nutrition continues to be a major public health problem in the country, with 25% of children chronically malnourished or stunted and 8% severely stunted. 12% of the children were found to be wasted or acutely malnourished, with 4% severely wasted. 16% were found to be underweight, with 4% severely underweight (GDHS, 2013), aggravated by poverty, food deficit, rural-urban migration, environmental degradation, poor dietary habits, low literacy levels, poor sanitation, infections and a high population growth rate.

Like many developing countries, The Gambia is also experiencing the 'double burden of malnutrition' with the emergence of Diet-related Non-Communicable Diseases (NCDs) such as diabetes, hypertension, coronary heart disease, obesity, and some forms of cancers. With infectious diseases still a major public health burden, the increase in prevalence of diet-related non-communicable diseases poses a challenge for the allocation of scare resources and is exerting immense pressure on an already over-stretched health budget.

1.1.5 Achievements and Challenges of the Health Sector

Achievements

A five-year strategic plan 2010-2014 was developed but the institutional arrangement was not in place to steer and monitor its implementation. Notwithstanding the health sector has registered several achievements: For instance, there is high political commitment for TB control in the Gambia. Diagnosis and treatment of TB is provided free of charge to all irrespective of nationality. There has not been any stock-out of anti-TB drugs in The Gambia. With the support of Global Fund, NLTP has increased Directly Observed Treatment, Short Course (DOTS) centres as part of the scale up plan from 11 in 2006 to 36 centres in 2013 including the Mile 2 central prison for infection control measures. Diagnosis of new smear positive cases increased from 1306 cases in 2008 to 1429 cases in 2012. The proportion of new smear positive TB cases (**SS+**) in all notified cases has increased from a baseline of 52% in 2003 to almost 64% in 2012. According to the routine HIV surveillance report, HIV prevalence among TB patients is estimated at 16%. In 2012, 69% and 98% of TB/HIV co-infected patients were initiated on ART and CPT respectively. NLTP has succeeded in the procurement a GeneXpert that can test many samples for Drug Sensitivity Test (DST) and culture in a short period of time. TB prevalence survey was successfully conducted under the RD 9 TB grant, a second of its kind in Africa. Finally, defaulter rate declined from 14% in 2005 to 2%

in 2011 while treatment success rate increased from 86% in 2006 to 89% in 2012, exceeding the WHO target of at least 85%.

- The HIV prevalence rate is 1.57% for HIV1 and 0.26% for HIV2 (MOH&SW 2012) compared with 2.8% for HIV1 and 0.9% for HIV2 (MOH&SW 2006).
- There has been an increase in national coverage for penta-3-immunization of children from 96% in 2011 to 98 % in 2012 (MOH&SW2012).
- Several policy documents have been developed on Health Financing, Non Communicable Disease, Tobacco Control, Tuberculosis and HIV, Reproductive Child Health, Health Research, Human Resource for Health, Mental Health, Traditional Medicine, and Prevention of Mother to Child Transmission, Social Welfare, and Disability.
- The infant and under-five mortality rates were 98/1000 live births and 141/1000 live births in 2006 (MICS, 2006), which declined to 81/1000 and 109/1000 live births in 2010 respectively (MICS, 2010). These rates further declined to 34 and 54/1000 live births in 2013 respectively (GDHS, 2013).
- Maternal mortality ratio dropped from 1050/100000 live births in 1990 (MoH&SW 1990) to 730/100000 live births in 2001(MoH&SW 2001) and further reduced to 433/100 000 live births in 2013 (GDHS, 2013).
- The proportion of underweight children has increased from 17% in 2010 (MICS, 2010) to 22.6% in 2015 (SMART, 2015).
- Accelerated training of health workers started in 2006.
- Expansion of health and social welfare services at the regional level.
- Improved diagnostic and curative technology example CT scan, haemodialysis services
- An approved National Health Policy 2012-2020

Challenges

Over the years, significant achievements were registered by the Health and Social Welfare Sector as highlighted above. However, in recent past frequent changes in senior management has hindered policy implementation, which also has the potential for eroding the much-needed institutional memory.

In addition, there are limited human, financial and material resources to meet the growing demand of health and social welfare services at national, regional and community levels. High attrition rate of skilled health and social workers attributed to a number of factors such as poor working conditions and challenged personnel management (MOH&SW 2005). Furthermore, there is insufficient supply of drugs, basic equipment, consumables and other logistics including inadequate health and

ICT Infrastructure. This situation therefore hinders efforts to reduce the burden of communicable and non-communicable diseases.

Significant gains have been registered in the health service delivery system such as Expanded Programme on Immunization (EPI), Reproductive and Child Health (RCH). However, sustaining the gains in service management areas such as Health Management Information System (HMIS), Health Financing, and referral services remain a challenge to the health system in general. Below is a brief summary of some of the key areas requiring urgent actions for greater achievements in the health sector.

Human resource: Over the years, government has continually invested in the development of the human resource base for the health sector through the University of The Gambia (school of Medicine and Allied Health Sciences), the Gambia College (School Nursing and Midwifery), the School for Enrolled Nurse in Bansang and the School for Community Health Nurses in Mansakonko. Thus, more medical doctors, nurses, nurse midwives, pharmacists, public health officers and laboratory technicians are now providing invaluable health services to the Gambian Population. In addition, development partners such as the Global fund through the HIV/AIDS-Health System Strengthening (grant 8) has supported the training of nurses, laboratory technicians, pharmacy assistants and village health workers all geared towards improving health care delivery in The Gambia. Despite all these laudable initiaves and achievements, the physician population ratio estimated at 1.1 per 10,000 and the nurse/midwives - population estimated at 8.7 per 10,000 population in 2013 (WHS, 2015), underscore the urgent need for scaling-up training and retention of medical doctors, nurses and midwives in the health sector. In addition, the number of public/ environmental health officers increased from 100 in 2013 to 128 in 2014 (Human Resource for Health Directorate, 2014).

Budgeting: Government expenditure on health as percentage of total government expenditure in 2013 amounts to 12.5% and the total expenditure on health as percentage of GDP reported at 5.6% in 2013 (NHA, 2013). However, Government has steadily shown commitment in the budget apportioned to the health sector, notwithstanding the 15% allocation from the national budget, as pledged in the Abuja Declaration is still not achieved.

In addition, out-of-pocket expenditure as percentage of private expenditure on health estimated at 30.7% (NHA, 2013) continues to impact negatively on the livelihood of the ordinary Gambians resulting in catastrophic health expenditure.

Infrastructure: Whilst significant investment has been made in terms of availability of modern health care facilities across the country, diagnostic and rehabilitation services/facilities are limited and inequitably distributed. Similarly, adequate and skilled human resource to operate efficiently such services/machines also poses some challenges. In addition, ICT infrastructure and services are largely confined within the urban centres, but the low bandwidth and human resource capacity presents a challenge especially when plans are underway to introduce e-health services in the Ministry.

Drugs/consumables: Government through the health ministry has invested greatly in medical consumables including essential drugs. However, owing to the high demand vis-a Vis population growth continues to exert pressure on the availability of drugs, and as such drug shortages in health facilities are often being reported. For instance, an assessment of the health sector based on the PAGE mid-term evaluation report 2012-2013, revealed 17% and 15% of male and female respondents respectively reported that their main reason for dissatisfaction with the health sector was primarily due to drug stock-out.

1.1.6 Strategic Priorities of NHSSP

The strategic priorities are in line with The National Health Policy, the PAGE, MDGs and Vision 2020 targets. These priorities are:

1. Maternal, neonatal, infant and child health services
2. Surveillance, prevention, control and management of communicable and Non communicable diseases (NCDs)
3. Improve knowledge and skills of health care providers at all levels
4. Build capacity of the Health Management Information System (HMIS) and data management system within the health sector
5. Improve health infrastructure at primary, secondary and tertiary health care levels
6. Establishment of a National M& E coordinating body

VISION: Provision of quality and affordable Health Services for All By 2020

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

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

1.1.7 Guiding Principles

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 marginalized and underserved, irrespective of political national, ethnic or religious affiliations

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 utilization; prevention of gender based violence.

Ethics and Standards

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

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.

Cultural Identity

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

Health System Reforms

Devolution of political and managerial responsibilities, resources and authority in line with the Government decentralization policy coupled with sustained capacity building for the decentralized structures (institutions).

Skilled Staff Retention and Circulation

Attractive service conditions (package) to achieve job satisfaction to encourage a net inflow of skilled health care workers.

Partnerships

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

Evidence Based Health Care

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

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.

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.

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.

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.

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.

Respect and Non-Discrimination

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

Confidentiality of Health Information

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

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.

1.1.8 Strategic Objectives

1.1.8.1 Strategic Objectives

1. To provide high quality basic health care services that is affordable, available and accessible to all Gambian populace.
2. To reduce the burden of communicable and non-communicable diseases to a level that they cease to be a public health problem
3. To ensure the availability and retention of highly skilled and well-motivated HR for Gambian populace based on the health demands
4. To increase access to quality pharmaceutical, laboratory, radiology and blood transfusion services to all by 2020
5. To improve infrastructure and logistics requirements of the public health system for quality health care delivery
6. To establish an effective, efficient, equitable and sustainable health sector financing mechanism by 2020
7. To improve the effectiveness and efficiency of Health Information System for Planning and decision making to yield improved service delivery
8. To ensure effective and efficient health service provision through the development of effective regulatory framework and Promoting effective coordination and partnership with all partners

1.1.8.2 Key Targets and Indicators

- Reduce neonatal mortality rate from 22/1000 live births in 2013 to 15/1000 live births by 2020
- Redefine and implement the basic health care package for all levels by 2016
- Infant mortality rate reduced from 34/1000 in 2013 to 24/1000 by 2020,
- Under five Mortality rate reduced from 54/1000 in 2013 to 44/1000 by 2020,
- Maternal Mortality ratio reduced from 433/100000 in 2013 to 315/100000 by 2020,
- Provide cervical cancer screening and management to 50% of women of reproductive age by2020
- Increase the contraceptive prevalence rate from 9% to 25% by 2020
- Malaria incidence reduced by 50% by 2015
- To reduce HIV new infections from 1165 cases in 2014 to 579 by 2019 (i.e. by 50%)
- Increase case detection rate of new smear positive cases from 64% in 2012 (MOH&SW 2012) to 70% by 2017
- Increase the percentage of TB patients who had a HIV test from 83% in 2012 to 95% in 2017
- Reduce the burden of NCD risk factors from 24% in 2010 (MOH&SW 2010) to 20% by 2020
- Reduce morbidity due to other communicable diseases by 50% by 2020
- Increase government allocation to Health from 10.5% in 2013 to meet the Abuja declaration target of 15% by 2018
- Provide sustainable infrastructure and logistics conducive for the delivery of health services at all levels of the health care system by 2020
- Ensure availability of relevant, accurate, accessible and timely health care data for planning, coordination, monitoring and evaluation of the health care services
- To improve the ratio of critical health care workforce (Nurses, Midwives, Doctors, Public health Officers and Nurse Anaesthetics, pharmacists, lab technicians) to the population by 2020
- The ensure equitable distribution of health care professionals in urban and rural areas by 2020
- Percentage of vacancies filled annually
- Presence of staff appraisal system
- Presence of comprehensive incentive package for all health workers
- Availability of human resource data system

- Availability of well-functioning laboratory services in all hospitals and all major health centres by 2020
- Availability of functional radiology services in all hospitals and all major health centres by 2020
- Expand and strengthen Blood transfusion services to all hospitals and major health facilities by 2020
- Increase availability of essential medicines from 65% in 2014 to 85% by 2020
- Life Expectancy nationally increase from 63.4 years to 69 years by 2020
- Total Fertility Rate reduced from 5.6% in 2013 (GDHS, 2013) to 4.6% by 2020
- To fully incorporate E-Health in the health system by 2020

1.1.9 Decentralization of Health Service Delivery

The Gambia adopted the primary Health Care Approach (PHC) in 1979 following the Alma-Ata declaration in 1979. Subsequently a PHC Plan of Action from 1980/81 to 1985/86 was formulated, and this formed the basis for the National Health Policy. In an effort to decentralize the implementation of The Gambia's national Primary Health Care (PHC) programme in 1979, the MOH&SW established 3 Regional Health Teams (Western Region-Kanifing, Central Region-Mansakonko, and Eastern Region-Bansang).

These health administrative regions, headed by a Regional Medical Officer and his team of health Officers, Public Health Nurses, an administrator, an Accountant and other support staff, were fairly autonomous but with limited non formal support from other ministries working in the same geographical area. It must be noted that these three administrative regions were not coterminous with the local government administrative areas.

The Local Government Decentralization Act, 2002 gives enormous powers and autonomy to Local Area Councils and Local Services Commissions that form part of the Public Service to be responsible for Public and Environmental Health.

Under section 76 (1) of this Act, every Council shall be responsible for the promotion and preservation of health within its area of jurisdiction,

subject to national policy guidelines and such regulations as the Secretary of State for the time being responsible for the administration of the Public Health Act may prescribe. Subsection (2) of this section also empowers Council within its jurisdiction, to be responsible for:

(a) Major health centres, sub-dispensaries and all primary health care services;
(b) Maternal and child health services;
(c) Distribution of pharmaceutical products and vaccines to health facilities;
(d) General hygiene and sanitation.

Furthermore, the Local Government Decentralization Policy and Act, under section 77 (1) establishes the Local Public Health Committees. Sub section (2) of section 77 of the ACT gives powers to the members of a Local Public Health Committee to be appointed by the Council after consultation with the Director of Health Services and membership consists of:

(a) A Chairperson appointed by the Council,
(b) The Area Medical Officer;
(c) The senior public health officer;
(d) The public health nurse;
(e) Two women representing women groups;
(f) Two representatives of Organisations actively involved in the health sector;
(g) Two members who hold qualifications in health related fields; and
(h) Two prominent members of the community within the Local Government Area.

Notwithstanding, section 78 (1), enables the Council to establish a Department of Health Services to which shall be transferred the existing Divisional Health Teams for the purposes of performing its functions under this Act.

This complete devolution, which allows shifting of authority to the local councils, is considered the best form of decentralization as the local councils in this case have the statutory recognition of the right to make their budget arrangements. However, most of the local councils in The Gambia lack the tax base to raise adequate revenue, and the management capacity to run a health service, which also have implications for the health services within the context of the **WHO** concept of District Health Systems.

In 1991, the Government of The Gambia commissioned a UNDTCD/UNDP Mission to prepare a National Decentralization Action Plan including stages, time frame and sequences for implementing the proposed strategies within the existing regulations governing local government administration. Particular attention was paid to the financial issues of regulations, disbursement, procedures and control to improve local administration/management in The Gambia.

As a response to the Central government's commitment to implement a nation-wide decentralization programme (page 53 Report of The UNDTCD/UNDP Mission on Decentralization Strategies in The Gambia August 1991), the MOH&SW convened a two-day workshop (5th & 6th August 1992) to:

- Review the national strategy of decentralization with a particular focus on the health sector.
- Discuss the functionality of the Regional Health Teams.
- Discuss constraints and solutions for the implementation of the "Regional Health Team" concept
- Prepare and recommend an Action Plan for the establishment of the Regional health teams in each local government area review the existing job descriptions for the planned health staff in each Region.

The recommendations of the workshop were:

The concept of District Health System (DHS) in the Gambia emanated from the universal principle of PHC stated above, which emphasize popular participation on the part of local communities, accessibility to health services, utilization of local resources, involvement of the target population in planning and implementation, integration of preventive and curative services, rationalization of the health services (appropriate technology, financing and management) and inter-sectoral co-ordination.

Since the adoption of PHC a number of changes have taken place in health development as part of the global concept of Health Sector Reform. The changes include:

- The restructuring of the MoH&SW, this includes the creation of Regional Health Teams in 1993 and the process of shifting authority (decentralization) from the centre to facilitate decision making at the periphery;
- Establishment of new health facilities and more outreach stations; 80% of the population has access to health services

- Creation/training of new cadre of staff for special interventions;
- Introduction of user fees, and the Bamako Initiative;
- Increase in the number of donors and NGOs interested in health development.

The policy reforms envisaged under Health Policy Framework 2007-2020 and Health Master Plan 2007 -2020 (development of both documents technically and financially supported by WHO) is designed to follow the Decentralization and Local Government reforms process and The Local Government Act, 2002 which places great emphasis on an integrated approach to management of government services, including health in the regions. The devolution of authority, responsibility and resources to the regions is aimed at strengthening RHMTs through provision of adequate infrastructure, resource (i.e. personnel and finance) administrative support and management training.

Health service management and delivery have been decentralized to 7 Health Regions which would be coterminous with the administrative Regions except for the North Bank which by virtue of the River is divided into two regions and western region. For reasons of easier logistics and communications, the North Bank Region is divided into North Bank Western and North Bank Eastern segments, with the Kerewan tributary as dividing line. However, the present form of decentralization, which is a mixture of functional and prefectoral de-concentration does not encourage adequate decision-making (especially with resources) at regional level, and inter-sectoral co-ordination. For any meaningful decentralization the authority for decision-making and control over resources must be shifted from the centre to the periphery. The Government of the Gambia enacted the Local Government Act (LGA) for decentralization of services from the central to the regional level in 2002. The act was basically meant to bring both financial and administrative issues closer to the people aiming at providing equal opportunities to all citizens regardless of geographical location. Health care administration are provided at three levels namely: The senior management at the central level takes care of policy issues and overall coordination whereas the regional health teams are responsible for overall administration and monitoring of all health activities in their respective regions. These teams have to ensure that quality, effective and efficient services are provided at the third level which are the basic health services and village health services level

2.1 FUNCTIONS OF THE NATIONAL SYSTEM

The MOH&SW is responsible for the management of the health sector, which includes: policy formulation and policy dialogue, resource mobilization, regulation,

setting standards, health service delivery, quality assurance, capacity development and technical support, technical advice to other government line Ministries on matters of public health importance, provision of nationally coordinated programmes such as epidemiology and disease control, coordination of health research and monitoring and evaluation of the overall sector performance.

Due to on-going health system reforms, such as decentralization of health services, some of the functions of the central level management have been delegated to national semi autonomous institutions including referral hospitals, specialist and general hospitals, professional councils, national drug authority and other regulatory bodies as well as local government authorities and research activities conducted by some research institutions.

The Ministry is headed by a Minister who is appointed by the President and head of state, and assisted by a Permanent Secretary, who serves as the Chief Administrator of the Ministry. Two deputy permanent secretaries also assist the Permanent Secretary; The Deputy Permanent Secretary Technical assists the Permanent Secretary on technical operations of the Ministry, while the Deputy Permanent Secretary Administration and Finance assists the permanent secretary on administrative and financial matters.

2.2 ORGANIZATION OF THE GAMBIA NATIONAL HEALTH SYSTEM

The current organizational structure at the Ministry comprises of two departments namely; Medical and Health Department and Social Welfare Department.

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

- Directorate of Health Services (DHS)
- Directorate of Planning and Information (DPI)
- Directorate of National Public Health Laboratory Services (NPHLS)
- Directorate of Health Promotion and Education (DHPE)
- Directorate of Health Research (DHR)
- Directorate of Human Resources for Health (DHRH)
- Directorate of National Pharmaceutical Services (DNPS)

The Department of Social Welfare comprises of one directorate, which is the Directorate of Social Welfare (DSW). The public health sector covers 90% of the health facilities in the country, complemented by a few NGO and private sector run

health facilities, mainly located in the Greater Banjul Area. Thus, in the Gambia, the provision of healthcare is dominated by the Government facilities, with a minimum (subsidized) charge for accessing treatment under the basic care package at the three levels of health service delivery. The large majority of private health facilities are located in the Greater Banjul Area, making choice in health services delivery point in the rural community nonexistence.

2.3 GOVERNANCE

The central level is the decision-making point for the health sector's internal issues. The six directorates of the two departments plan, direct, manage and coordinate all Government health care activities countrywide through specialized units. The relationship between these directorates is neither vertical nor horizontal but iterative. The country is divided into seven health regions each with a regional health team (RHT), headed be a Regional Health Director (RHD). The RHTs are responsible for the day-to-day administration, management and supervision of health services in their respective regions. They have overall responsibility for the primary and secondary health care facilities and their staff within their regions. The Regional Public Health Officer, Regional Public Health Nurse, Senior Administrative Officer and other support staff, assists the RHDs. The tertiary level, which comprises the hospitals and teaching hospital on the other hand, has semi-autonomous boards and headed by CEOs and CMDs respectively.

The public health system is complemented by more than 60 private health facilities, NGO and community managed health facilities. Formal health services in The Gambia are delivered mostly in health facilities funded by the Government of The Gambia. These facilities are also supported by a number of donors and NGOs. NGOs and private practitioners also provide services though most of them are located in the Greater Banjul Area. In addition, there are a large number of private pharmacies, drug sellers, and traditional healers that deliver health services of some kind.

Table 2: Health facilities by type and region

Health Facility Type	W	WH	NBW	NBE	LRR	CR	URR	Total
Hospitals		1	0	1	0	1	1	7
Major Health Centres	1	1	1		1	1	1	6
Minor Health Centres	5	4	4	6	5	7	10	41
NGO Facilities and Clinics	5	4	2		12	0	4	18
Private Health Facilities	6	9	0	0		12	5	23
Community Managed Facilities	7	9	6	5	4	8	1	40
Specialized RCH Clinics	2	0	0		10		10	4
RCH Outreach Clinics	13	24	32	31	34	62	61	257
RCH Base clinics sites	18	6	6	7	5	9	7	58
Total RCH clinic sites	31	30	38	38	39	71	68	315
PHC Key Villages	3	12	13	9	8	17	12	74
Total PHC Villages	26	92	100	95	92	159	70	634
Service Clinics		40	0	1	1	1		18
Total Service Delivery Points	91	150	151	148	145	251	160	1096

Source: Health Service Statistics Report, 2012

2.4 THE REFERRAL SYSTEM

Activities within the private sector of the health care delivery service are regulated and monitored by the Directorate of Health Services, a function that the regulatory bodies should be involved. The relationship between MoH&SW and the private sector health facilities is cordial. The Government is the main provider of health services in the country.

The Government through its annual budgetary allocation to the health sector funds health care services. Donor partners such as UNICEF, WHO, UNDP, UNFPA, Global Fund, ADB etc. also give maximum support to the health sector through programmes and projects' support.

2.5 THE TIERS OF THE GAMBIA NATIONAL HEALTH SYSTEM

2.5.1 Tertiary health Care (Hospitals)

Currently there is one teaching and specialized hospital (Edward Francis Small Teaching Hospital) and five general public hospitals namely: Sheikh Zayed

Regional Eye Care Centre in Kanifing, Bansang Hospital in Central River Region, Armed Forces Provisional Ruling Council hospital in Farafenni, North Bank Region, Sulayman Junkung General Hospital in Bwiam, Serekunda General Hospital in Kanifing and Jammeh Foundation for Peace Hospital in Bundung.

They have semi-autonomous status, with hospital management boards, and are not generally supplied or supervised by the RHTs. They do, however, have some important responsibilities to the RHTs, including reporting diseases incidences, maternal deaths, and providing feedback on patients referred to them by the VHS and basic health facilities. The administration at the hospitals generally consists of the Chief Executive Officer and several administrative staff.

2.5.2 Basic Health Services

Basic Health Service is at the secondary level of the national health systems and it comprises of major and minor health facilities. The major health centre serves as the referral point for minor health centres for services such as: Family planning (prescribe contraceptives and follow-up users; perform surgical contraception for men and women), Maternal and child Health (Provide basic gynaecological services; manage normal and complicated deliveries (including C-section); counsel mothers on infant and child nutrition, audit maternal deaths; provide antenatal, postnatal care (in facility and through treks) Disease Management: (Diagnose and treat cases of diarrhoea/dehydration, ARI, malaria, HIV/AIDS, STIs, leprosy and TB; manage simple mental health cases), Minor Surgery, Radiology Services, and Laboratory Services and Referral (refer and transport serious illnesses and injuries, or cases needing specialist care, to the nearest public hospital). The standard bed capacity for major health centres ranges from 110-150 beds per 150,000 - 200,000 population.

The minor health facilities provide the following services: RCH services, FP services, Nutrition services, control of common endemic diseases, Health promotion and protection and provision of essential drugs and vaccines. A minor health facility has between 20–40 beds per 15000 population and should provide 70% of the basic health care package.

These BHS facilities provide the core outpatient (OPD) clinics and the Reproductive and Child Health (RCH) services. OPD clinics usually are held daily and treat children age five and above and all non-pregnant adults, as well as children less than five years and pregnant women. RCH clinics provide most of the health care to children under the age of five (Infant Welfare Clinic, IWC) and antenatal care for

pregnant women. RCH base clinics are held at the facility at least once per week. Trekking team visits a set schedule of outreach clinics in each health facility's catchments area. These trekking stations are visited at least once a month, depending on the catchment area population. The RCH team usually consists of a nurse midwife, health facility-based CHNs or CHN/midwives (with the addition of the VHS/CHN at some of the clinics), Community Nurse Attendant(s) (CNAs), an APHO for EPI activities and a Drug Revolving Fund (DRF) collector. The number of staff will vary with the size of the facility and the catchment area.

User fees were introduced in 1988 as part of the cost recovery programme. However, government introduced a policy for free maternal and child health services in 2007.

Growth monitoring of children under five, antenatal care, immunizations and family planning services are all provided through these RCH base and trekking clinics. Supervision of the RCH team is carried out by the basic health facility and, ultimately, by the RHT.

Eighteen facilities run by NGOs supplement the government-run facilities and are supervised by the RHT in whose jurisdiction they operate. The Medical Research Council (MRC) is British research organizations that provide clinical services at Fajara, Keneba, and Basse.

Twenty-three private health clinics and many pharmacies also diagnose and prescribe treatment, particularly in the urban area. These are not integrated into the government system, and provide services for fees paid by the patients.

2.5.3 Village Health Services (VHS)

Primary health care villages have been selected from those with a population of 400 and above or from those located in relatively isolated areas. In these villages, village health workers (VHWs) and traditional Birth attendants (TBAs) are selected by the Village Development Committee (VDC). They are given 6 (TBAs) to 8 (VHWs) weeks of formal training using a standardized curriculum at a designated place by the MOH&SW and partners. These workers are issued a start-up supply of medication and equipment (minimal) by Government. A fee of D 0.75($0.02) is charged for each patient seen. This money is paid to the VDC treasurer to be used for the purchase of additional drugs and supplies as needed. The VDC provides support to VHWs through in-kind contributions or voluntary labour in their farms.

The VHW functions as a primary health care provider for minor illnesses and injuries, serving males and females of all ages. In addition, the VHW functions as a community based health educator and adviser. The TBA, as their name implies, have been part of the culture long before the formal health care system was introduced. They function as trained birth attendants, as antenatal and postnatal advisers, family planning distributors and health educators. Both TBA and VHW are expected to refer serious cases to the local health facility.

The VHWs and TBAs are supervised and given continuing education by VHS/Community Health Nurses (VHS/CHN) who oversees circuits of 4 to 10 PHC villages. These VHS/CHNs in turn report through their nearest BHS facility and is supervised by the OIC of that facility and by the Regional Health Team. There are 634 PHC villages organized into 69 circuits. The CHNs were provided with motorcycles for supervisory VHS trekking. The VHS/CHNs are essential for the successful functioning of primary health care in The Gambia. Effective and efficient referral services from one level of health care to another (community to secondary and secondary to tertiary), are important in patient management and disease outcome. However, the current referral system still has major challenges. Some of the challenges include inadequate and ill equipped ambulances, intermittent shortage of fuel, 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 policy that will improve the referral system that enhances speedy and efficiency safe evacuation of patients with regards to the following:

- National ambulance services
- Skilled health professionals
- Referral policy

2.6 PARTNERSHIP IN HEALTH

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 utilization 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 health outcomes. Partnership will be based on consensus with partners on the strategic interest of the health sector and the common basket approach will form the basis for donor funding in health.

It is in the light of the aforementioned reasons that the national health policy provides a comprehensive framework for support to the sector, but is not sufficient alone to guarantee a coordinated approach to health sector development. The composition of stakeholders in the health sector is complex; there is a diverse range of partners who provide support in many different forms. Such an environment necessitates the need for partner coordination, which is deemed critical for the successful implementation of any National Health Sector Strategic Plan. In an attempt to strengthen the existing coordination mechanisms,

The Ministry of Health in 2011, established coordination mechanisms such as: The Resource Mobilization Committee, Fellowship Committee, Institutional Committee, Bilateral Committee, MOU Committee, Project Management and Monitoring Committee, Hajj Committee, and the Regional Health Advisory committee.

- Community
- Private
- NGO

Effective coordination is expected to address the following issues:

- Inadequate joint monitoring, review and evaluation systems;
- Numerous and parallel systems of accounting, procurement and management;
- Duplication of efforts;
- Inappropriately designed, uncoordinated projects;
- High transaction costs associated with individual one-on-one negotiations and consultations between government and partners;
- Inadequate information flow between government and partners.

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 organization.

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 MOH&SW 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 utilization 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 health outcomes. The health mapping exercise of 2001 defined the packages that were being implemented at the different levels of the health care delivery system. This was based on the reports of 3 documents, Health Sector Requirement Studies, 1995 (HSRS); the 1998 PER and the Report on extended Senior Management meeting, MoH&SW, December 1998 (MoH&SW SMM). The last review of the service delivery packages was based on the DOSH SMM report, where the packages were defined for PHC level, including RCH trekking sites, secondary level, distinguishing between minor and major health centre services; and tertiary level. Since then, no review of the service delivery packages has taken place, whilst the challenges of the health sector significantly changed with an increasing prevalence of Non communicable diseases, to cite an example.

Table: 3 Components of basic health care package at the various levels of the health care delivery system

PHC	Minor H/C	Major H/C	Hospitals
Maintain supply of essential drugs;	MCH/FP (including ob-stetric services, vaccinations and contracep-tives)	Out-patient services	All services provided by major health centres
Provide outpatient care, make home visits;	PHC	In patient	Specialized care usin More sophisticated equipment.
Carry out health education	Disease management	PHC	
conduct deliveries;	Referral of serious illness	Disease	
Identify and refer at-risk mothers	Eye care	MCH / FP (including obstetric-rice services, va and	
Provide care for minor ail- mint	Leprosy and Tuberculosis control	Minor surgery and laboratory services	
Prevention and promo-tin activities	Public Health services	Referral of serious illness	
MCH: very basic obstetric-call care; Out-patien	In patient	Eye care	
Referral to dispensaries or Pharmacy health centres.			
Health education (include-in nutrition education			
MCH (antenatal, postnatal care, Family Planning)			
Iinfant welfare care (includ-ing immunization)			
sometimes, dental servic-es			

Table 4: Minimum Health Care Package (Health Policy 2012)

VHS	Minor H/C	Major H/C	Regional Hospital	Teaching Hospital
Primary care service including:	Maternity care (antenatal, delivery and postpartum	All services provided at minor H/C level	All services provided at major H/C level	All services provided at regional hospital level
treatment of minor illnesses and referrals	Family Planning	Comprehensive emergency obstetric care (including theatre and blood transfusion services)	Specialist care and service	Specialist hospital services (in- and out-patient services)
environmental health & sanitation	STIs/RTIs/HIV/AIDS prevention and control	Functional theatre	Higher level referral services	Post-mortem and embalmment services
antenatal, delivery and postpartum care,	IMNCI	Comprehensive emergency new-born care	Specialized dental and eye care services	Overseas referral
home visits,	Immunization	In-patient services	Comprehensive laboratory	
community health promotion activities	Neonatal and child health	Pharmacy Services	Radiology services	
	Maternal and child nutrition	Basic Lab. services including HIV and TB Screening.		
	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			

Regarding the implementation of the minimum package of activities (MPA) as defined in 2001, certain discrepancies exist across the levels, in that at the lower level (PHC) there is higher implementation of the package than at higher levels (Major H/Cs). In addition, variance in implementation has also been observed at the same level. For instance 50% of major health centres are currently equipped to perform Comprehensive emergency obstetric care (including theatre and blood transfusion services). Basse, Brikama and Soma are currently functional in terms of EMOC services; however, within the last ten years the number of major health centres that provide EMOC services varies between different facilities.

Over the last ten years, the disease pattern has changed significantly with increasing prevalence of non- communicable diseases (Table 1: Disease Burden). The MPA as last defined has not accommodated the screening of cancers, testing for diabetes, haemodialysis, etc.

These deviations, among others underline the urgency to review and implement health care packages for different levels of the health care delivery system. This strategic plan is committed to providing basic health care to all Gambians, through the implementation of a Basic Health Care Package (BHCP). Considering the burden of disease in The Gambia and the need to enhance cost-effectiveness of interventions, the MOH&SW will define a Basic Health Care Package (BHCP) that aims at maximizing value for available resources by allocating them to interventions that realize the greatest benefits in improving the health of the population. The Basic Health Care Package (BHCP) will consist of the following priority interventions:

1. Reproductive and Child Health
2. Control and management of communicable diseases
3. Control and management of non-communicable diseases
4. Health Education and Promotion
5. Environmental Health and Safety;

These basic healthcare packages will be offered at the primary, secondary and tertiary level health facilities

3.1 MATERNAL, NEWBORN AND CHILD HEALTH

Preamble

Globally, the maternal mortality ratio has decreased by 45% between 1990 and 2013 (WHO, 2014). All MDG regions of the world have experienced considerable reductions in maternal mortality. Developing countries account for 99% (286,000) of the global maternal deaths with Sub Saharan Africa region alone accounting for 62% (179,000), followed by Southern Asia (69,000) (WHO, 2014).

The Maternal Mortality Ratio for The Gambia was estimated at 360/100,000 live births in 2010, down from 730/100000 live births in 2003, however MMR has surged up again currently estimated at 433 per 100,000 live births (DHS, 2013). Regarding gains registered on the skilful deliveries, the proportion of births attended by skilled health personnel has significantly improved from 42% in 1990 to 64% in 2013 (PAGE Mid-term evaluation Report, 2013The 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt was a landmark event in that it set the stage for Reproductive Health (RH) and Rights. The goal of the ICPD was proudly endorsed by delegates from over 179 countries including The Gambia (ICPD, 1994). Following the ICPD, The Gambia shifted approach from the provision of Maternal and Child Health Services to comprehensive Reproductive and child Health Services. Consequently, in 2000 the first National Reproductive and Child Health Policy and Strategic plan were formulated and endorsed by cabinet.

RCH services are provided at all levels (primary, secondary and tertiary) of the health system and focuses on 8 main components namely Safe motherhood, Child Health Family Planning, Adolescent/ Youth health, Gender Based Violence including male involvement and Harmful Traditional Practices, STI including HIV/AIDS, Reproductive morbidities, and Reproductive Health Commodity Security. Currently RCH services are provided at 256 outreach stations and their catchment areas, 41 Health Centres, 6 Major Health Centres, 6 general hospitals and 1 teaching hospital.

Achievements

In the Gambia, women and children consist of an important proportion of the population with over 50%. Over the years significant progress in both maternal and child health outcomes has been realized. Key to these successes is improved access to basic health care services across the country. It is documented that up to 85% of the population are within 5 kilometers reach of a primary health care facility. With

an RCH Policy (2007-2014) and Strategic Plan in place (period) and an impressive nationwide coverage of Reproductive Health Services (85% of the population live within 5 kilometers of a Reproductive health clinic), RCH indicators have over the years been improved. For example, MMR has reduced from 1050, 730 to 433 per 100,000 live births from 1990, 2001, and 2013 respectively (MMR & CPR study, 2001, GDHS 2013) whilst infant and under-five mortality rates decline from 98/1000 live births and 141/1000 live births in 2006 (MICS, 2006) to 81/1000 live birth and 109/1000 live births in 2010 respectively (GDHS, 2010). And these further decline to 34 and 54/1000 live births respectively (GDHS 2013).

Challenges

Access to high quality emergency obstetric and newborn care services 24 hours a day and 7 days a week is crucial in the reduction of maternal and newborn mortality and morbidity. However, there is gross unmet need (79%) for Emergency Obstetric Care (EMCOR 2003; state EmOC 2012 study) in facilities in The Gambia as revealed by the survey on the availability, utilization and quality of EmOC services in The Gambia carried out in 2003. The survey also revealed a case fatality rate of 4.7%, which is far above the maximum of 1%. These statistics are a pointer to inadequate and poor quality EmOC services in The Gambia.

This is as a result of a poorly functioning referral system especially at the community level including ill-equipped and inadequately staffed facilities. This is further aggravated by the paucity of skilled birth attendants in rural health facilities as a result of the ongoing staff attrition thus posing major challenge for the provision of Emergency Obstetric (EmOC) and Newborn services. Currently three out of the six Major Health Centres are providing EmOC services.

STRATEGIC OBJECTIVE 1: To provide high quality basic health care services that is affordable, available and accessible to all residents in the Gambia.

With this strategic objective, the Health Sector aims to provide high quality basic healthcare services that are affordable, available, accessible and responsive to client needs. This strategic objective has four main service areas, which include: Reproductive Health, essential surgical care package, Primary Health Care Services and Referral. The reproductive health has the following components: Maternal and newborn health care, child health, adolescent/youth health, family planning and reproductive morbidities.

SERVICE AREA:

- Reproductive Health
- Essential surgical care package
- Primary health care services
- Referral

3.1.1 Reproductive Health

- Maternal and newborn health care
- Family planning
- Adolescent/youth health
- Child Health
- Reproductive morbidities
- Gender, harmful traditional practices & male involvement in RH
- Reproductive Tract Infections
- Reproductive Health Commodity Security

Specific Objective 1: To reduce MMR by 25% (433/100,000 to 315/100,000LBs) by 2020

Strategy 1: Provide Pre-pregnancy care

Main Activities:

- Pre-pregnancy counselling in family planning clinics in major and minor health centres
- Conduct communication and social mobilization activities on pre-pregnancy services
- Establish and conduct School Health Programmes
- Conduct HPV immunization for girls age 9 -13 years

Strategy 2: Strengthen antenatal, Intra partum and postpartum care

Main Activities:

- Procure antenatal, intra-partum, post-partum care equipment and supplies
- Provide focused antenatal care, intra and post-partum care
- Develop, produce and distribute guidelines and tools on RCH
- Conduct operational research on MNH
- Train health care providers on the use of the guidelines and tools
- Conduct training to care providers on EmONC signal functions

Strategy 3: Strengthen minor health centers to provide basic EmONC services

Main Activities:

- Procurement of adequate equipment and supplies for EmONC services
- Conduct maternal Nutrition education and support
- Procure furniture for RCH clinics
- Conduct maternal morbidity and mortality reviews and meetings
- Provide maternal and new born lifesaving drugs
- Train health care providers on the signal functions
- Provide adequate skilled health professionals to conduct safe deliveries in all health facilities
- Advocate for Active community involvement and Male participation in RCH issues and services.

Specific Objective 2: To reduce neonatal mortality rate from 22/1000 LBs (2013) to 15/1000 by 2020

Strategy 1: Strengthen hospitals and major health centres to provide CEmONC

Main Activities:

- Procure high quality equipment, and supplies for CEmONC
- Procure furniture for RH services
- Develop, introduce and ensure the use of infection control policy, guidelines and protocols at all levels of care.
- Introduce and apply performance and quality improvement approaches (e.g. audits)
- Conduct maternal morbidity and mortality reviews and meetings
- Provide maternal and new born lifesaving drugs
- Integrate EmNOC signal functions in health training schools
- Train tutors on EmNOC signals functions
- In-service training of service providers on EMNCH
- Training of health care providers to specialized levels(pre- operative, Anaesthetics etc)
- Procure equipment for operating theatres and laboratories
- Expansion and refurbishment of existing structures to facilitate implementation of BEmNOC and CEmNOC
- Conduct biannual health meetings to include maternal and new born audits in both public and private health facilities involve in RCH service delivery
- Conduct advocacy meetings

Strategy 2: Health promotion and education

Main Activities:

- Development of a comprehensive Communication strategy on reproductive health Develop, produce and distribute communication support materials on RCH
- Build the capacities of health workers on Interpersonal Communication Skills for effective RH service delivery
- Conduct media campaign to create demand for RH services
- Community sensitization on danger signs during pregnancy, delivery and postpartum

Specific Objective 3: To increase the proportion of women who register in the first trimester of pregnancy from 13.3% to 80% by 2020.

Strategy 1: Strengthen Antenatal Care services at all levels

Main Activities:

- Training health care providers on focused antenatal care
- Introduce incentive package to promote early antenatal booking
- Community engagement and sensitization on the importance of early antenatal booking
- Provide equipment, drugs and other supplies for antenatal care services

Specific Objective 4: To increase skilled birth attendance from 57.2% to 80% by 2020

Strategy 1: Improving the provision of and access to quality maternal, new born health care

Main Activities:

- Training, recruitment, remuneration and appropriate deployment of skilled personnel
- Advocate for active community involvement and male participation in RCH issues and services

Strategy 2: Health Promotion and Education

Main Activities:

- Campaign to create demand for RH services
- Build the capacities of health workers on Interpersonal Communication Skills for effective RH service delivery
- Conduct in service meetings
  Family Planning

Specific Objective 5: To increase the Contraceptive Prevalence Rate (CPR) from 9% to 25% by 2020

Strategy 1: Strengthen Family Planning services at all levels

Main activities:

- Review and update the existing FP tools
- Train service providers on data management
- Procure adequate method mixed contraceptive commodities
- Train service providers on FP counselling
- Train Peer health educators on FP
- Train and retrain FP distributors in the communities
- Capacity building for service provider on FP technologies
- Provide adequate fund for FP commodities and supplies for sustainability
- Conduct research on CPR every five years

Strategy 2: Health promotion and education (BCC)

Main activities:

- Increase awareness for optimum utilization of modern FP methods
- Engage opinion and religious leaders on FP
- Encourage male involvement on FP services
- Create awareness on different contraceptive methods available
- Conduct Family Life education in schools

Reproductive Tract Infections

Specific Objective 1: To promote and enhance infection-free sexual and reproductive health

Strategy 1: Advocacy and promotion of positive sexual and reproductive health behaviour

Main Activities

- Provide a comprehensive sexual and reproductive health (SRH) service at all levels of care delivery.
- Introduce and roll-out adolescent-friendly SRH services
- Conduct public sensitization on the causes, prevention and management of RTIs.
- Promote the correct and consistent use of condoms and ensure availability
- Training of tutors and service providers on the syndromic management approach

Harmful Traditional Practices & Inadequate male involvement in SRH

Specific Objective 1: To Promote and Encourage Gender equity and equality

Strategies:

(i) Create awareness to enhance community participation on Gender equity and equality

(ii) Introduce male-friendly SRH services and facilities.

Main Activities

- Engage policymakers, parliamentarians, professional bodies and faith based organizations on SRH related gender issues.
- Engage religious and influential leaders on SRH-related issues.
- Sensitize men on participation in RCH services, gender-based violence and harmful socio- cultural practices related to SRH
- Engage print and electronic media to raise awareness on SRH.
- Design and redesign health facilities to promote male involvement in SRH.
- Training of service providers, health training institutions and schools, on gender-based violence and harmful socio-cultural practices related to RH Adolescent and youth Health

Adolescent/Youth Sexual and Reproductive Health

Specific Objective 1: To increase access to quality Sexual and Reproductive Health information and services for adolescent /youth

Strategy 1: Strengthen and expand adolescent/youth friendly centres and services

Main Activities:

- Increase access to quality adolescent/youth-friendly SRH information and services
- Establish functional youth friendly–facilities
- Train health service providers on adolescent-friendly SRH services.
- Utilize school health Programme platform to reach out to adolescents and youths
- Build and strengthen capacities of training institutions and service providers on SRH issues
- Advocate for active involvement and participation of parents, communities and religious leaders, policy makers in planning, implementation, monitoring and evaluation of adolescent/youths on SRH activities
- Promote dialogue between young people, adults and policy makers using appropriate channels of communication on adolescent/youth sexual and reproductive health needs

- Sensitize adolescent/youth on the availability and use of STIs/VCT/HIV/PMTCT services
- Orientate tutors on the updated SRH module of the pre-service training curriculum
- Conduct community sensitization for awareness creation on SRH issues and needs of the adolescent/youth at all levels

Child Health

Specific Objective 1: Reduce under five mortality from 54/1000 LBs to 44/1000 LBs by 2020

Strategy 1: Strengthen the IMNCI services at all levels of care

Main Activities:

- Health education and promotion on key positive household behaviours
- Review, IMNCI manuals and recording tools
- Orientation of communities on community IMNCI
- Operational research on Child Health
- Capacity building of service providers on IMNCI
- Procurement of equipment, medicines and supplies

Specific Objective 2: Reduce infant mortality from 34/1000 LBs in 2013 to 24/1000 LBs by 2020 Strategy: Strengthen the baby friendly health approach at community and health facility levels

Strategy 1: Strengthen health facilities to provide basic infant and comprehensive child health care

Main activities:

- Promote exclusive breastfeeding and initiation of EBF at health facility level.

  Food supplementation for IMAM
- Provide and promote the use of Oral Rehydration Salt at all levels
- Community education on timely introduction of complementary foods.
- Provide equipment, drugs and other supplies
- Promote exclusive breastfeeding at Health facility level
- Immunization
- Operational research on Child Health

Management of Post Abortion Complications

Specific Objective 1: To reduce the incidence of unintended pregnancies and unsafe abortion through investments in family planning services and post abortion care.

Strategy 1: Strengthen capacity in the health system to prevent and manage post abortion complications.

Main Activities:

- Develop norms, standards and guidelines on management of post abortion complications.
- Prevention and management of unwanted pregnancies.
- Train health staff on the management of post abortion complications
- Provision of adequate drugs and supplies for the management of post abortions complications.
- Train health staff on counselling on family planning, unwanted pregnancies and abortions.
- Increase in the use of effective contraceptive methods, results in reducing unintended pregnancies and consequently the incident of abortion.
- Provision of adequate and appropriate equipment, drugs and supplies in the management of post abortion complications.

Infertility

Specific Objective 1: To identify, detect and manage early infertility problems at all levels.

Strategy 1: Identifying and management of infertility/sub-fertility-related health problems, and risk factors at all levels.

Main Activities:

- Develop guidelines and protocols on diagnosis and management of infertility/subfertility.
- Train health staff on screening, diagnosis and management of infertility including HIV/STI screening and effective interventions before/after diagnosis and attending infertility interventions.
- Advocate, review and develop RH policy to adequately capture infertility issues and management.
- Research on infertility issues.
- Infertility services covering a comprehensive range of fertility.

Reproductive morbidities

Specific Objective 1: To provide screening and management of reproductive morbidities e.g. fistulae, cervical cancers, breast cancer, prostate cancer, menopause and infertility in suitable public health facilities by 2020

Strategy 1: Support the prevention, screening and management of reproductive morbidities

Main Activities:

- Train RH service providers on cervical and prostate cancers prevention, control and management
- Procure cervical cancer management equipment and supplies
- Provide cervical cancer screening and management services in all the regions
- Procure Breast cancer management equipment and supplies
- Provide Breast cancer screening, diagnosis and management services in all the regions
- Provide prostate cancer screening and management services in all the regions
- Procure prostate cancer management equipment and supplies
- Conduct base line assessment to gauge the prevalence reproductive cancers (cervical, breast and prostate)
- Develop, print and distribute guidelines and tools on reproductive morbidities
- Establish and equip fistulae management centre
- Provide HPV vaccine to 75% of girls age 9-13 years by 2020
- Health promotion and education on the causes, prevention and management of reproductive morbidity among men, women and young people

Reproductive Health Commodity Security

Specific Objective 1: To protect and promote quality reproductive health for all

Strategy 1: Sustained, uninterrupted access and use of commodities (contraceptives, condoms and other medical supplies) and basic equipment.

Main Activities:

- Train service providers on adequate and appropriate service delivery
- Procure adequate and quality commodities
- Integrate RH Commodities and supplies into the National Pharmaceutical Services
- Ensure adequate quality infrastructure for storage of commodities and supplies

Referral Services

Specific Objective 1: To improve the referral system at all levels of health care by 2020

Strategy 1: Strengthen the referral system at all levels

Main Activities:

- Procure fully equipped motor vehicle ambulances and river boats
- Provide communication facilities at all levels
- Update and provide referral protocols guidelines and standards
- Build the capacity of service providers on the referral service
- Conduct operational research on the current referral system

3.1.2. Essential Surgical Care Package

Specific Objective 1: To improve the essential surgical interventions in all hospitals and major health centres by 2020

Strategy 1: Strengthen essential surgical care interventions

Main Activities:

- Train doctors, anaesthetists, laboratory personnel, and nurses on the essential surgical care package
- Printing and distribution of essential surgical care documents
- Provide essential surgical equipment and supplies

3.1.3 Primary Health Care Services

Specific Objective 1: To revitalize primary health care services by 2020

Strategy 1: Strengthen and build capacity of CHWs at primary level

Main Activities:

- Orientation and sensitization of communities on PHC services
- Training of TBAs, VHWs, VSGs on danger signs during pregnancy, delivery and puerperium period for the mother and the new born
- Train and retrain VHWs, VDC and TBAs for expansion of PHC services
- Construct and refurbish village health posts
- Review BI strategy and implement recommendations
- Build capacities of VDCs, VSGs, on management for sustainability

Strategy 2: Strengthen service organization and management at community level to maximize effective coverage with minimum care package

Main Activities:

- Catchment area committee training for 74 existing PHC key villages
- Create incentives for CHWs
- Procurement of drugs and other esential supplies

3.2 PREVENTION AND CONTROL OF COMMUNICABLE DISEASES/CONDITIONS

3.2.1 Communicable Diseases

Preamble

Over the past years, there has been a noticeable progress towards the reduction of the communicable disease burden in The Gambia. Despite these achievements, communicable diseases still remain a major public health problem. Malaria, pneumonia, skin infections, diarrhoea are the leading causes of morbidity and mortality (MoH&SW 2012).

No national estimate of the incidence of Acute Respiratory Infections (ARI) is available although a number of localized surveys indicate the extent of the problem. A study conducted by MRC (2005) revealed that 14% of under-5 mortality was caused by ARI. Similarly, no national estimate of the incidence of Diarrhoeal disease exists in the country. Neglected Tropical Diseases (NTD) particularly Schistosomiasis are still prevalent in some areas of the country, since 2005, no case of Lymphatic Filariasis has been reported in the country and in June 2013 LF Transmission Assessment Survey did not identify any case or indication of transmission occurring however the final result of the study is yet to be released. There is inadequate data to establish the burden of Soil Transmitted Helminthiasis and no baseline study is conducted to that effect (MOH&SW 2013). More efforts towards the elimination and eventual eradication of these diseases are needed. Other diseases targeted for elimination are Measles, Polio and Neonatal Tetanus. Though immunization coverage continues to be impressive in The Gambia (90% MICS 2010), more efforts are needed to sustain the gains

Malaria in The Gambia is meso-endemic and transmission is higher during the rainy season. There are indications that effective interventions such as ITN, IPT, IRS and case management have shown improvements in the country. Achievements include decline in the incidence of malaria, high coverage of malarial program interventions, Long Lasting Insecticidal Nets (LLIN), Intermittent Preventive Treatment (IPTp) and development of National Malaria Control Policy Strategic Plan.

Despite the successes registered, utilization of interventions such as ITN (55.8%) and IPTp2 (61.7%) is suboptimal (MIS 2010). In addition, low government budgetary allocation to malaria control, weak coordination and management of Malaria Programme at regional level, low utilization of Long Lasting Insecticidal Treated Nets (LLINs) by households, low coverage for IRS and late booking at antenatal clinics continue to pose a challenge.

STRATEGIC OBJECTIVE 2a: To reduce the burden of communicable diseases to a level that they cease to be a public health problem.

This strategy looks at key interventions in addressing communicable diseases to a level they are not a major public health concern. These interventions include immunization, case management, food and water safety, integrated vector management, neglected tropical diseases, disease surveillance and response. It will also ensure communicable disease prevention services in marginalized populations.

SERVICE AREAS:

- Immunization
- Malaria Control and Preventive
- HIV/AIDS
- STI
- TB
- Eye Health
- Environmental Health
- Disease prevention and control
- Food and water safety
- Integrated vector management
- Neglected tropical diseases
- Integrated Disease Surveillance and Response
- Occupational Health and safety

3.2.2 EXPANDED PROGRAMME ON IMMUNIZATION

Preamble

Compared to other countries within the sub-region, The Gambia has a good track record of attaining and sustaining high immunization coverage due mainly to good access and service utilization. Furthermore, the Gambia has added hepatitis B (1990), Haemophilus Influenza Type B (1997), Pneumococcal vaccine (2009), Measles Second Dose (2012) and Rota (2013) to the traditional vaccines. Whilst

Meningitis types A (Men A) preventive campaign targeting 1- 29 years was conducted in November 2013. There are plans to introduce Human Papilloma Virus (HPV) vaccination for young girls at age 9 to prevent cervical cancer.

Achievements

The country achieved Polio free status in 2004. The pentavalent vaccine recently introduced has replaced DPT and Hepatitis B vaccines except for the first dose of Hepatitis B vaccine given at birth. The pentavalent vaccine contains, in addition to DPT, the Hepatitis B vaccine and a vaccine against Haemophillus Influenza Type B, or HIb and is supposed to be given according to the same schedule as DPT. Other achievements include good cold chain system (solarisation) and availability of Inter-Agency Coordinating committee, budget line for EPI in the national budget and funding partners.

Challenges

Though immunization coverage continues to be impressive in The Gambia, vaccine preventable diseases such as measles, TB, Diphtheria, Pertussis and Tetanus pose as important challenges for the health sector. In addition due to frequent staff movement and high attrition 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 levels, inadequate supervision at all levels, inadequate trained manpower, no budget line for supplementary immunizations, no cluster survey for the past 10 years to determine vaccination coverage, printing of Infant welfare cards and fuel for supplementary immunization activities have recently emerged as challenges for effective service delivery.

Specific Objective 1: To increase immunization coverage to at least 90% and to sustain 96% coverage for Penta 3 nationally by 2020

Strategy 1: Strengthen immunization services at all levels

Main activities:

- Procure and distribute vaccines, de-worming tablets and Vitamin A
- Conduct National Immunization Days (NIDs)
- Provide functional cold chain system
- Train HCWs on immunization services
- Strengthen Cold Chain Management
- Strengthen Supplementary Immunization Activities (SIAs)
- Conduct operational research on barriers to immunization
- Review and update the EPI policy and strategic plan

Strategy 2: Health promotion and education:

Main activities:

- Conduct communication & social mobilization
- Train HCWs on immunization
- Develop and operationalize EPI communication plan;
- Train health workers on communication skills and social mobilization for EPI
- Sensitize traditional communicators and community leaders on immunization

3.2.3 TUBERCULOSIS

Preamble

The incidence of TB (all forms) in 2012 was 128 per 100000 populations (GAMSTEP, 2013). TB control is showing remarkable improvement with critical indicators such as Case Notification, Case Detection and Treatment Success rate showing upward trends. Current case detection and treatment success rates among new smear positive cases are 64% and 90% respectively (MOH&SW 2012).

Achievements

The programme apart from the above also registered the following successes such as;

- Strong commitment and governance at all levels
- High case notification and treatment success rate exceeding WHO target of 85%
- TB prevalence survey conducted under the Round 9 TB grant second of its kind in Africa
- Robust Monitoring and Evaluation system in place
- Decentralization and coverage of the TB program
- Alignment and harmonization of funding and activities
- Involvement of community participation in TB control
- Effective drug procurement
- Existence of a National TB reference laboratory
- Integrated TB/HIV recording and reporting system
- Availability of Gene Xpert for culture and Drug Susceptibility Testing of MDR TB among the retreatment cases according to national TB treatment guideline and TB services available at the main central prison for infection control

- In addition there has never been any stock out of anti TB drug, 83% of TB patients were counselled and tested for HIV in 2012 (MOH&SW 2012).

Challenges

Despite the successes, the programme continues to face numerous challenges such as:

- High dependence on external funding especially from Global Fund.
- Lack of policy interventions to address cross boarder TB control and lack of clear strategy to target high-risk groups.
- There are no Multi Drug Resistant TB treatment guidelines and data collection tools,
- Lastly, TB (all forms of TB) in children continues to be grossly under diagnosed

Specific Objective: 1 Diagnose at least 70% of the total estimated incidence of new smear positive cases annually and cure at least 90% of new sputum smear positive patients by 2015

Strategy 1: Strengthen inter-sectorial coordination to address the synergistic challenges posed by TB/HIV

Main activities:

- Organize regular national, regional and facility coordinating committee meeting
- Develop and effective referral system to enhance access to care and support for TB and HIV patients
- Mobilize resource for TB-HIV collaborative activities
- Surveillance of HIV prevalence among TB patients
- Recruit and train medical health officers/health care workers on TB diagnosis
- Carry out joint TB/HIV planning and monitoring

Strategy 2: Support the implementation of advocacy, communication and social mobilization activities (ACSM)

Main activities:

- Commemorate World TB day at all levels annually
- Conduct Orientation seminar for Community and traditional leader
- Conduct School health education session with relevant partners annually
- Organize Open field day on TB, TB/HIV at Community level

- Conduct Radio and TV panel discussion on TB, TB/HIV issues
- Produce, print and distribute IEC materials
- Support the Regional Ex TB patients associations on stigma reduction campaigns
- Brief central NLTP and Child Fund staff on operational modalities of ACSM
- Sensitize all RHTs along with Regional Education Directorates on the NLTP; epidemiology and current situation of TB in the country; arrangements for supervision, monitoring and management of ACSM; roles and responsibilities of different actors
- Strengthen the regional communication taskforce
- Strengthen the regional MDFTs members
- Strengthen the regional peer health education groups
- Strengthen the School Health and Nutrition unit for TB-education
- Collaborate with DPI and support the M and E unit to develop all necessary ACSM tools and materials for supervision, monitoring, reporting and record keeping at various levels
- Conduct message development workshop on TB and related issues
- Conduct open field days (one Field Day in each health facility catchment area countrywide)
- Develop, produce and distribute communication and advocacy support materials
- **Strategy 3:** Scale up Directly Observed Treatment Short course (DOTS) equitably countrywide

Main activities:

- Develop Multi Drug Resistant (MDR) and extra-Drug Resistant (XDR) Tuberculosis manual
- print and distribute tuberculosis manual
- Study tour on MDR- TB case management
- Conduct step - down Training of Health Care Workers on MDR TB case management
- Procure and distribute MDR-TB drugs, equipment and furniture

3.2.4 HIV/AIDS

Preamble:

The epidemic response is over 30 years, yet still controlling HIV and AIDS remains a formidable challenge for the country. The response over the years witnesses renewed national and global commitment, and goals such as the Millennium Development

Goals (MDGs); the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) and the movement towards Universal Access (UA) to HIV prevention, treatment, care and support that require due attention, increased involvement of Non-governmental Organizations, Civil Society Organizations, private sector and people living with and/ or affected by HIV/AIDS.

The overall goal of the HIV response as captured in the National Strategic Framework 2009-2014 (NSF) and HIV policy (2007-2011) is to stabilize and reduce the prevalence of HIV/AIDS in the Gambia and provide treatment, care and support for people living with or affected by HIV/AIDS in a conducive environment that will mitigate the impact of the epidemic and ensure achievement of the socio-economic development of the Gambia as captured in Vision 2020.

Achievements

The country has a concentrated low-level mixed epidemic with a prevalence rate of 1.57% for HIV-1 and 0.26% for HIV-2 in 2012 (MOH&SW 2012). HIV/AIDS control is showing a downward trend regarding prevalence. Coverage and availability of critical HIV interventions has significantly improved. These are depicted as follows: 69% of HCT target (2012) achieved, 85% of 2012 target for counselling and testing of pregnant women achieved, ARV prophylaxis for positive women and their babies reached 149%, 3571 PLHIV on ARV representing 104% of 2012 target, treatment and prevention of Opportunistic Infections increased from 35% (2008) to 104% (2013), 180 HCWs graduated (HSS) from the health training institutions in 2012, All donated blood are screen for HIV, HIV policy and National Strategic Plan developed, HCT guidelines developed, Treatment guidelines, SOPs and Training Packages available, TB/ HIV policy developed and TB/HIV collaboration strengthened.

Challenges

Stigma and discrimination, unavailability of early infant diagnosis equipment, over dependence on external donors, inadequate nutritional support to PLHIVs on treatment, inadequate highly qualified bio-medical engineers for maintenance of equipment; intermittent shortage of HIV test kits and stock out of ARVs; limited services for other MARPs, cross border HIV/AIDS collaboration; limited access to ART services and human resources to provide HIV services pose challenges for the programme. The burden of STIs in the country is not known and management is still based on syndromic case management. There is limited availability of STI drugs in the public health system.

Specific Objective 1: To provide treatment, clinical care and support to at least 95% of people with advanced stage of HIV infection by 2020

Strategy 1: Expand and strengthen HIV/AIDS Counseling & Testing (HCT)

Main activities:

- Conduct Community VCT (outreach) services
- Development of Streamlining Tasks and Roles to Expand Treatment and Care for HIV (STRETCH) Manual
- Provide psychosocial support for people living with HIV

Strategy 2: Expand and strengthen Prevention of Mother to child transmission (PMTCT) services

Main activities:

- Development of Streamlining Tasks and Roles to Expand Treatment and Care for HIV (STRETCH) Manual
- To strengthen elimination of child transmission (eMTCT)
- Early infant diagnosis (EID)

Strategy 3: Support and expand Anti-Retroviral Therapy (ART)

Main activities:

- Procurement of ARVs and OI drugs
- Treatment and Care for HIV (STRETCH) Manual

Strategy4: Expand the care and support services for People Living with HIV (PLHIVs

Main activities:

- Train healthcare providers on Community Home base and Palliative care
- To provide nutritional support to PLHIV and OVC.
- Procurement of ARVs and OI drugs
- Support sentinel surveillance and research in HIV/AIDS

Strategy 5: Community system strengthening

Main activities:

- Conduct PEP sensitization for Health workers
- Intensify IEC/BCC interventions on HIV/AIDS
- Suggest another strategy and activities for addressing stigma and discrimination

3.2.5 STIs

Specific Objective 1: Increase STI diagnosis and effective treatment using syndrome management and/or Laboratory testing to more than 50% of primary point-of-care sites

Strategy 1: Strengthen STI case management at all levels

Main activities:

- Train/retrain healthcare providers annually on Syndromic Management of STIs (including Diagnosis & Management)
- Review and update STI Treatment Manual
- Establish mobile clinics for MARPS (including security forces) in each region
- Provide and distribute condoms
- Establish STI clinics targeted specifically for most at risk populations (MARPs)
- Suggested additional Strategy: Sensitize communities on STIs

Strategy 2: Support laboratories in all major health centres and hospitals for STI diagnosis and control

Main activities:

- Conduct STIs prevalence study
- Conduct sensitivity study on drugs use in the management of STIs
- Build capacity of laboratories of both major and minor health facilities for STI diagnosis and control

3.2.6 MALARIA

Preamble

The Malaria Control Unit (MCU) was created by the Ministry of Health in 1990 in recognition of the importance of malaria as a major public health problem in The Gambia. In1993, the Unit was placed under the Directorate of Basic Health Services to give it the attention it deserved. In1997/98, as part of an on-going health system reform process, the programme was restructured and strengthened through the provision of additional staff. Since then, the programme has evolved into a national structure for malaria control.

The first five-year malaria control strategic plan for the period 2002 to 2007 was developed in 2001. The plan outlined key interventions and formed the basis of malaria control and prevention services. This was revised in 2008, covering a seven-year, from 2008 – 2015. Significant progress has been made in the implementation of the plan. Funding opportunities for malaria control increased over the years leading to a significant increase in coverage in all key interventions.

The implementation of comprehensive malaria control strategies started in Western Health Region in 2004 with the commencement of support from the Global Fund. After successful implementation of malaria control activities in Western Health Region, activities were scaled up in the remaining health regions of the country in 2007 through the acquisition of additional Global Fund Grants. Following an increase in the size of the Global Fund grants for malaria, a Single Stream Funding (SSF) mechanism was developed by the GFATM where by all the malaria control programme grants were consolidated into a consolidated single stream funding (Malaria SSF Consolidated Grant).

Achievements

- National Malaria Policy, Strategic Plan and M&E plan are available, HR strategic plan 2012 -2016 updated and available
- Availability of guidelines and tools for supervision and monitoring;
- Existence of structures at all levels for the management and delivery of malaria control interventions;
- Allocation of funds to malaria in the recurrent budget;
- Increased funding from Global Fund
- Existence of integrated sector-wide Procurement and Supply chain Management (PSM)
- Availability of a range of tools (manuals, forms, guidelines,) and resources designed to facilitate and streamline PSM
- Existence of contracts committee at the Ministry of Health
- Existence of physical infrastructure at Central and regional levels for storage of medical commodities
- The National Health Policy, National Malaria Policy and National Malaria Control Strategy recognize vector control as a central component of malaria control.
- Positive community response to vector control measures
- There is capacity for parasitological diagnosis in all public sector health facilities.
- Case management is fully integrated in the national RCH services
- Staff at health facility and village health service levels trained in case management
- Up-to-date malaria treatment guidelines available
- Availability of capacity to conduct efficacy testing of anti-malarial medicines
- Malaria in Pregnancy (MIP) is fully integrated into RCH services

- MIP module Integrated into the curricula of Nurse training institutions
- Availability of data bank and information
- Partnership established within and outside MOH&SW
- Strong Operational research partnership

Challenges

- Malaria policy and strategic plan are not aligned with the Global Malaria Action Plan (GMAP) targets and strategic objectives;
- New WHO recommended strategies (SMC and IPTi) are not included in the malaria policy
- Lack of a business plan for implementation of strategies
- Resource mobilization is not explicitly featured in Health Master Plan 2007 to 2020;
- Limited capacity at regional and community levels for effective management of malaria control activities
- Inadequate staff motivation
- Inadequate budgetary allocation for malaria within the health sector budget;
- Limited human resource capacity at service delivery level
- Inadequate consumption data for forecasting and quantification of Non-adherence to standard treatment guidelines
- Inadequate transport facilities for distribution
- Weak pharmacovigilance system
- Ineffective system for monitoring the importation and use of antimalarials in the private sector
- Occassional stockout of medicines and commodities
- Limited national capacity for environmental control of vectors
- Low utilization of LLINs
- Larviciding is limited to Banjul city
- Parasitological diagnosis not optimally available at village health service level
- Adherence to the national treatment guidelines by the private sector is weak
- Weak coordination between RCH Unit and NMCP:
- IPTp service not delivered at some private clinics;
- Collaboration with the private sector is weak;
- The linkage with malaria and HIV-prevention is not featured in the malaria policy

- Limited operational research on the impact of IPTp on pregnancy outcomes
- Inadequate data on malaria mortality in pregnancy
- Late Antenatal Booking resulting to low uptake of IPTp 2
- Limited coordination of survey /studies within the National Statistical System (NSS)
- Limited capacity for handling and management of large surveys
- Non availability of epidemics preparedness plans
- Inadequate number and low skills of data entry clerks
- Limited capacity for data analysis and use
- Irregular data reporting from hospitals

Specific Objective 1: Increase and sustained the correct and consistent use of long lasting insecticidal nets to 85% by the population at risk by 2015 and maintained up to 2020.

Strategy 1: LLINs

Main activities

- Procure of LLINs
- Distribute of LLINs
- Promote consistent use of LLINs
- Monitoring and evaluating operations

Specific Objective 2: Achieve 80 % coverage for IRS in all regions by 2015 and maintained up to 2020.

Strategy 1: Indoor Residual Spraying

Main activities

- Procure and supply of IRS commodities
- Conduct Indoor Residual spraying
- Monitoring and evaluating IRS operations

Specific Objective 3: Reduce the incidence of infection caused by malaria parasite by 50% by 2015

Strategy 1: Treatment and case management

Main activities

- Ensuring access to ACT for the population at risk.
- Increasing access to ACTs at community level.

  Conduct service training of health workers including the private sector on malaria case management
- Strengthening pre service trainings on malaria case management
- Update the treatment guidelines for malaria case management

- Strengthen supervision for malaria case management.

Strategy 2: Quality assurance and quality control of laboratory diagnosis

Main activities

- Establish national QA&QC system for RDTs
- Strengthen QA&QC for slide microscopy
- Conduct efficacy studies

3.2.7 Integrated Vector Management

Specific Objective 1: Reduce the incidence of infection caused by vector borne diseases to zero by 2020

Strategy 1: Increase availability and access to LLINs and insecticides

Main Activities:

- Procure and distribute LLINs and IRS commodities and larvicides

Strategy 2: Increased coverage of IRS

Main Activities:

- Conducting IRS exercises
- Conducting vector resistance monitoring
- Conduct mapping of schistosomiasis endemic area

Strategy 3: Health education and promotion

Main Activities:

- Awareness creation and partnership on prevention and control of malaria
- Strengthen molecular laboratory for efficacy studies

3.2.8 Eye Health

The Gambia established a National Eye Care Programme (NECP) now known as **National Eye Health Programme (NEHP)** following a prevalence survey of Blindness and Eye Diseases in 1986. The leading causes of blindness were **Cataract 47%, Trachoma 17% and other Corneal** Opacities mainly associated with childhood measles or harmful traditional eye medicines **11%**.

Based on the fact that these conditions are either preventable and/or curable, and faced with shortage of trained personnel, the NEHP focused on the PHC approach i.e. making services affordable, accessible and appropriate. In addition, **a plan of action is developed for every five years to direct the implementation of the National eye health program with particular focus on**:

- Human Resources Development – e.g. Training of Paramedics and Community Ophthalmic Nurses Village Health Workers and Traditional Birth Attendants to function at community level.

- Cataract Campaign
- Trachoma control activities ‘’SAFE’ strategy is being fully implemented
- Information, Education and Communication
- Appropriate Technology – Construction and equipping secondary eye care Centres, and Local Production of Eye Drops.

The approach enable eye care providers function closer to the communities to the extent of performing eye lid surgery (for blinding Trachoma) right in the homes of the patient, thus relieving him/her from travelling to the Health facility and surgery fees. Outreach cataract surgeries were also conducted throughout the country by cataract surgeons.

A survey 10 years later in 1996 revealed 40% reduction in the prevalence of blindness. Trachoma, which was the leading cause of preventable blindness, was reduced from 17 % down to 5%. The NEHP has been implementing ‘’Vision 2020 The Right to Sight’ well before Vision 2020 was launched in 1999. As a proponent of Vision 2020 and a leading prevention of blindness programme, The Gambia NEHP is playing an active role in all its (Vision 2020) activities in Africa and the rest of the world.

NEHP worked with our neighbors to include the prevention of blindness in the Health for Peace Initiative. Health Ministers of the four countries (Senegal, Guinea Bissau, Guinea Conakry and The Gambia) unanimously nominated The Gambia to coordinate this component at a meeting held in Banjul from 16th – 17th August 2001.

Achievements

The incidence of blinding eye infections such as Trachoma is on the decline in the country. Currently Trachoma is no longer a public health problem and a survey to certify the country as trachoma-free has been conducted.

In addition expansion of secondary eye units country-wide, strengthened IEC/BCC activities, trained community groups (including Nyateros) on community eye health, reduced incidence of blinding trachoma and conducted community outreach surgeries are all achievements registered by the programme.

The “Post Health For Peace Initiative” (HFPI) project is a 5 year (January 2009 to December 2013) eye health project jointly funded by Sight savers and the European Commission and is being implemented in The Gambia, Senegal and Guinea Bissau.

The goal of the project is to reduce poverty in the three intervention countries through improved eye health services.

The project-implementing partners are:

The Ministries of Health of the Gambia, Senegal and Guinea Bissau, Sight savers works through the National Eye Health Programmes of these countries to implement the project.

- Helen Keller International, which is based in Dakar, Senegal, coordinates the Vitamin A supplementation with support from the nutrition agencies/units of the participating countries. Capacity building is also an achievement specifically the training of Ophthalmologists and other mid-level eye health workers including Cataract Surgeons, Ophthalmic Nurses, Community Ophthalmic Nurses, Re-fractionists and Local Production of Eye Drops (LPED) technicians and on-going refresher training programmes for mid-level eye health workers in the country, The building and refurbishment of 3 eye units in Brikama, Basse and Essau, and the construction of a Students' Hostel, Lecturers' Accommodation and private wards at Sheikh Zayed Regional Eye Care Centre.
- The procurement of ophthalmic equipment and consumables such as operating microscopes, slit lamps, cataract surgery sets, trichiasis surgery sets, and refraction kits.
- Support service delivery which includes screening of patients in schools and communities, on-going awareness raising activities on the prevention and management of prevailing eye conditions through community volunteers referred to as Nyateros, school teachers, radio stations, posters and other appropriate communication channels; free surgery camps to cater for patients unable to afford the surgery fees and providing vehicles and motorcycles to support outreach services.
- Supported advocacy efforts for The Government and other partners to allocate more resources to eye health care services. The commemoration of World Sight Day every year is aimed at supporting these advocacy efforts. The project creates opportunities for the eye health programmes of the intervention countries to share experience and best practices

Challenges

Inadequate human resources (e.g. staffing of Sheikh Zayed Regional Eye Care Centre by 2007 HFPI Resolution) at tertiary level, limited supplies of essential drugs and consumables, and limited funding to provide eye care services are challenges

faced over the years. Other challenges faced by the National Eye Health Programme include securing fellowship for one Ophthalmologist, lack of National Eye Health Policy and strategic plan, and NEHP Secretariat.

Childhood Blindness

General Objectives

- Early detection and prevention of blindness from cataract

and glaucoma

- **Main Activities**
- Strengthen school eye screening programme in formal and informal schools for early detection of children with visual impairment
- Reinforce itinerant teacher training to detect children with visual problems, and refer them to appropriate centres.
- Establish paediatric-oriented services and eye care teams at secondary level to provide services for postoperative care for children treated at the tertiary centre.
- Develop strategies for childhood blindness control.
- Develop paediatric specialist team for the tertiary centre.
- Establish Inter-sectorial collaboration with relevant stakeholders
- Institutionalize operational research and develop mechanisms for monitoring and evaluation.

Refractive Error Services

General Objectives

- To improve availability and affordability of refractive error services in collaboration with all stakeholders

Main Activities

- Create awareness on refractive error and available services at the community level.
- Strengthen school eye health screening programme and establish screening for pre -school children
- Establish vision centres in all the health regions
- Establish optical resource centre at the tertiary centre for maintenance of optical equipment and spectacles and warehousing of all optical supplies.

Diabetic Retinopathy

Main Activities

- Integrate blindness prevention strategies into national diabetes programs and ensure their incorporation into Non communicable chronic diseases programs of the Ministries of Health.
- Encourage strategies for prevention, early detection and effective treatment of diabetes and hypertension, which will prevent complications that lead to blindness.
- Develop public awareness programs to target groups that are at high risk.
- Establish referral systems from services for diabetics to the ophthalmologic services.
- Establish screening services using digital photography to detect and refer treatable diabetic retinopathy.
- Ensure laser treatment services for diabetic retinopathy are available, accessible and affordable.
- Perform a situation analysis of the management of diabetic retinopathy as a baseline for planning and advocacy.
- Develop education packages and training programs for the general public and health care providers.
- Develop continuing medical education programs for ophthalmologists and optometrists.
- Establish protocols and management guidelines
- Diabetes Associations playing a lead role in awareness raising and prevention of blindness due to diabetes.

Glaucoma

Main Activities

- Create awareness on Glaucoma through health talks, media campaign
- Set up Glaucoma screening services in each vision centre to identify and refer glaucoma cases to the tertiary centre
- Build capacity of Ophthalmologists in glaucoma management including retraining and updating on surgical skills
- Strengthen glaucoma services at the tertiary centre
- Ensure availability and accessibility of glaucoma drugs
- Encourage research on glaucoma prevention, early diagnosis and treatment

Strengthen the Tertiary Eye Care Services
Main Activities

- Train atleast 3 Ophthalmologists to complement the only ophthalmologist on ground
- Equip the Centre with more advanced equipment to take care of more complex cases hence reduce the rate of referrals abroad
- Develop subspecialty services to take care of more complex cases
- Provide Technical expertise and assistance for establishment of District level eye care services in HFPI countries
- To serve as centre for operational research
- To serve as centre for outreach services
- Strengthen the Regional Ophthalmic Training Programme

3.2.9 Environmental 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 MOH&SW, certainly some 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 cognizant 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.

Achievements

Availability of draft occupational health and safety policy (2007), Availability of Vector Control Officers at all regions., Availability of a draft Environmental Health Policy, The Unit spearheaded the implementation of "Operation Clean the Nation", Participated in drafting and enforcement of the National Environment Management Act (NEMA, 1994) and the anti- Littering regulations, Built a strong partnership with members of the National EIA Team, Factory Board and the Physical planning Board.

Challenges

The Environmental Health Policy is still a draft, limited resource allocation to environmental health, Occupational health and safety and vector control units of the ministry of health, No environmental health strategic plan, The creation of directorates is almost paralyzing Environmental health unit, Conflict in service delivery with other directorates.

Specific Objective 1: To reduce the prevalence of environmental health and safety related disease conditions by 30% by 2020

Strategie 1: Enforcement of environmental health related Acts

Main Activities

- Advocate for the enforcement of Public Health Act 1990
- Put a mechanism for the continuous review and update of the relevance of environmental and health safety regulations
- Build capacities of public health officers in the handling of enforcement of the ACTs

Strategy 2: Institute proper management of solid, gaseous and liquid wastes

Main Activities:

- Intensify compound and district inspection activities
- Provide adequate waste Management tools
- Mobilize communities to construct latrines
- Build capacities of waste collectors in waste management
- Develop management tools for proper monitoring and supervision
- Collaborate with relevant authorities /institutions on waste management

- Support the implementation of the Healthcare Waste Management Plan (HCWMP)

Strategy 3: Strengthen the environmental health unit

Main Activities:

- Build capacities of the environment health unit
- Build human resource capacity of environment health unit to monitor air and water pollution
- Strengthen communication and advocacy activities on environmental and safety related issues
- Commemorate world environment day
- Create awareness on environmental health and safety related issues

Strategy 4: Intensify vector control and occupational health and safety interventions

3.2.10 Food and Water Safety

Specific Objective 1: To reduce the incidence of food and water-borne diseases by 30% by 2020.

Strategy 1: Eliminate Open Defecation (OD) in the Gambia by 2020

Main activities:

- Sensitize communities on OD, hand washing and household water treatment
- Training of HCWS/Extension workers on CLTS and household water treatment
- Training of hygiene promoters on Water and Sanitation Hygiene (WASH)
- Capacity building of HCWs/ extension workers on Community Led Total Sanitation (CLTS)
- Embark on deworming campaign in schools
- Integrate food borne disease surveillance into IDSR

3.2.11 Disease Prevention and Control

Disease control in The Gambia is based on immediate reporting for all notifiable diseases made to Epidemiology and Disease Control through the RHTs. The other groups of diseases are called reportable diseases and they are reported monthly through the HMIS. Weekly reporting only ensued during epidemics and emergencies from all reporting units to the EDC.

The Epidemiology and Disease Control unit is responsible for disease control and the focal point for integrated disease surveillance and response (IDSR) implementation.

EDC coordinate surveillance activities with emphasis on all notifiable diseases and diseases of epidemic potential. It is responsible for coordinating data collection, collation, analysis, interpretation and provision of feedback to different levels.

Achievements

Many achievements have been registered by the programme such as the following: Established joint bimonthly monitoring and supervisory visit with EPI to all RHTs and allied public health facilities, Available trained health staff involved in surveillance, Sustainable support to sentinel studies and control trials on pneumonia and meningitis surveillance project, Instituted partner collaboration for management and support to programmes (Disaster, GF diseases control, Combating threats of potential epidemic diseases, Strengthening of data collection through provision of improved clinical registers to all reporting health facilities Available surveillance officers and or case investigators at all levels, Transmission Assessment Survey conducted in June 2013 to confirm the elimination of Lymphatic Filariasis in the Gambia, Bi-monthly meetings to share information and feedback from national and Regional surveillance.

Challenges

It is difficult to delineate surveillance activities in terms of the overall health information system and therefore surveillance of other diseases and events are spread between several units and programmes of the MOH&SW. This has created overlapping vertical surveillance systems. Furthermore lack of a disease control policy, limited trained health staff in surveillance especially for CSF sample collection, inadequate office space much more to cater for additional required staff, limited funds allocated for emergencies, no special budget line allocated for surveillance, limited human resource for coordination at programme level, absence of epidemiologist and biostatisticians at the EDC, substantial delays in getting access to timely funding for proposed activities on surveillance, lack of dedicated surveillance focal persons at hospital levels for early detection and coordination especially during epidemics and emergencies, high cost of communication involved in surveillance coordination and reporting, no motorbike for surveillance officers for follow-ups and related issues at central level, mobility for increasing case investigators, and maintaining bimonthly joint monitoring and supervision.

The major challenges includes but not limited to the following: limited funds for fuel and mobility constraints,

- Weak coordination and collaboration among stakeholders, low awareness levels among the general public on food hygiene, safety and quality issues, inadequate laboratory infrastructure to carry out credible chemical analysis, the lack of sample collection kits and Personnel protective equipment for use by the Inspectorate team, lack of a database on food safety control, lack of ICT equipment is a real setback for data generation and effective planning.

Specific Objective 1: To improve and expand disease prevention and control services by 2020

Strategy 1: Strengthen and expand disease prevention and control services

Main activities:

- Conduct assessment of infection prevention and control situation in all health care setting and implement the recommendations
- Develop infection control guidelines, protocols and standards
- Train HCWs on guidelines protocols and standards
- Procure infection prevention and control devices and products

Integrated Disease Surveillance and Response (IDSR)

Specific Objective 1: To reduce the prevalence of other communicable diseases by 70% by 2020

Strategy 1: Improve the capacity of health staff on integrated disease surveillance and response at all levels

Main Activities

- Review and upgrade the IDSR technical guideline
- Train health staff on the IDSR to improve on early case detection, investigation, management and reporting of national priority diseases for surveillance
- Harmonize data collection tools into National Health Information System
- Strengthen data management, reporting and feedback mechanism at central and regional levels
- Strengthen collection, handling & transportation of samples to national reference laboratory
- Build capacity of Regional Management Committees and health facility staff on Epidemic Preparedness and Response
- Develop and strengthen IHR core capacity for implementation
- Support diagnostic services
- Provide e-health facility for reporting (DHIS2 mobile application)

- Conduct supportive monitoring and supervision
- Organize bi-monthly meetings to share surveillance data and information with regions and hospital

Neglected Tropical Diseases

Specific Objective 1: To eliminate Neglected Tropical Diseases (NTDs)
Strategy 1: Strengthen Surveillance on Neglected Tropical Diseases
Main activities

- Conduct a baseline study on NTDs
- Develop and implement NTDs control plan

Strategy 2: Maintain the elimination of leprosy and trachoma
Main Activities

- Intensify trachoma surveillance
- Intensify leprosy case base surveillance
- Train health workers on the diagnosis of leprosy
- Distribute Multi Drug Therapies (MDTs)

Strategy 3: Elimination of schistosomiasis
Main activities:

- Conduct mapping of schisto- endemic area
- Conduct Mollusciding in endemic areas

3.3 *NON-COMMUNICABLE DISEASES (NCD)*

Preamble

In The Gambia there is anecdotal evidence that The Gambia is experiencing significant burden of non-communicable diseases/conditions such as diabetes, cancer, chronic respiratory infections, hypertension, road traffic crashes and mental disorders. This is due, in part, to a rapid change in lifestyles leading to reduced physical activity, changing diets and increased tobacco and alcohol use. This trend is even more noticeable today, affecting all societies, rich and poor. The Gambia is currently facing serious changes in life style characterized by the proliferation of modern supermarkets, fast food outlets, and increase in motor vehicle ownership. There is also a tendency for people to slowly but surely abandon their traditional diets and lifestyles and engage in risky lifestyles.

The Gambia in 2010 conducted the WHO STEPS survey to assess risk factors for NCDs in the general population. The survey revealed that: 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 being 3.3 and 5.0 respectively; about 22% of the adult population (males and females) have low level of physical activity, whilst nearly 59% of adults do not engage in rigorous physical activity; on average adults spend 231 minutes per day on sedentary activities; and 41.4% of adults never had their blood pressure tested; about 24.4% of the adult population has 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 and; about 39.5% of the adult population (33.7% for men and 45.3%) for women are considered overweight.

These diseases and conditions have serious implications for both the health service and the population. NCDs continue to cause significant morbidity and mortality, lower the quality of life, impair the economic growth of the country and place a heavy demand on the family and national budget. According to a WHO study in the Gambia in 2004, mortality due to non-communicable diseases of (1147/100000) far outnumbered that of communicable diseases (486/100000). In 2008, NCDs are estimated to account for 34% of all deaths in the Gambia.

Road traffic accidents, better described as road traffic crashes, are a growing public health problem worldwide. About 1.3 million people worldwide die each year as a result of road traffic crashes and up to 50 million more are injured. In the Gambia, a cumulative total of 7750 RTA cases were officially reported between 2000 and 2009 (provide recent data by NCD Unit). On average, 775 RTAs occurred annually during the period under review.Translated into months, an estimated 65 (64.58) RTAs were reported, on average, monthly during the same period under review.

Communities in the Gambia are faced with numerous mental, neurological and psychosocial disorders that undermined development. Based on the prevalence rate from the World mental health survey in 2004, it is estimated that approximately 27000 people in the Gambia (3% of the population aged 15 years and more) are suffering from severe mental disorders and a further 9100 (10% of the population aged 15 years and more) are suffering from moderate to mild mental disorders. This means that at least 118,000 people in the Gambia (13% of the adult population) are likely to be affected by mental disorders, which require varying degrees of treatment and care.

Successes for NCD Prevention and Control

Mindful of the need to protect non-smokers, The Gambia has legislated against public smoking through the enactment in 1998 of the Prohibition of Smoking (Public Places) Act.

To reduce demand on tobacco consumption, the Gambia has banned tobacco advertisement in the mass media through the 2003 Anti-tobacco advertisement Bill;

The Gambia also, unconditionally, ratified the WHO Framework Convention on Tobacco Control in 2007.

The MOH&SW also facilitated and supported the establishment in 2008 of a national coalition of nongovernmental organization for the implementation of the Framework Convention. The Ministry of Health and Social Welfare has established a multisectoral-working group on NCD prevention and control that comprises 30 stakeholders from different institutions.

Noting the complexities of NCDs and the fact that their prevention and control requires action at all levels of government and diverse sectors, The Gambia at this moment finalized a five-year integrated policy and action plan for NCD prevention and control and Tobacco control respectively.

Cognizant of its complexities and the fact that NCD prevention and control requires a comprehensive health promotion approach, the MOH&SW has established a Health Promotion Directorate which houses NCD and Mental Health Unit respectively. The Policy and creation of a Directorate are intended to give the "strategic push" needed for tackling NCDs and Mental Health through health promotion.

The Ministry of Health in collaboration with WHO Country Office and WHO Head Quarters, jointly conducted a needs assessment on the implementation of FCTC in The Gambia in September 2012 to identify the gaps. Based on the mission report, The Gambia has been identified to be among the beneficiaries for Gate Foundation Funds on Tobacco Control commencing 2014.

Challenges

- Limited capacities to effectively and efficiently manage NCDs both at technical and health care providers' level.

- Limited research to determine the prevalence of major NCDs conditions continues to an obstacle. Furthermore, political commitment and NGO involvement in NCDs prevention is limited. The Primary prevention is a major gap while treatment of major NCDs is not decentralized.
- In addition, there are no strategies for NCD prevention and control, Mental Health and Tobacco control. Similarly there is no budget line allocated for general NCD prevention and control within MOH&SW. Furthermore, there is limited funds and participation from donors/NGOs.
- Enforcing the legislations against public smoking, advertising and sponsoring is weak whereby exposing the community to environmental tobacco smoke as well as minors to tobacco use and its related effects.
- Limited and reliable data on major NCDs as baseline for major interventions.

STRATEGIC OBJECTIVE 2b: To reduce the burden of non-communicable diseases to a level that they cease to be a public health problem.

This strategy looks at key interventions in addressing non-communicable diseases to a level they are not a major public health concern. These include strategies to address tobacco use, unhealthy eating lifestyle, physical inactivity, alcohol and other harmful substances abuse. It will also ensure non-communicable disease prevention interventions directly address marginalized populations.

SERVICE AREAS:

- Major NCD risk factors
- Mental health
- Health promotion and Education
- Social determinants of health
- Accidents &Injuries
- Rehabilitation of persons with disabilities
- Prevention of violence & injuries
- Promotion of healthy ageing
- Physiotherapy

3.3.1 Health Promotion and Education

Preamble

Health promotion and education is a wide field. It involves behaviour change communication, advocacy and social mobilization. Some health issues are so complex that they can only be addressed through a comprehensive approach that combines behaviour change communication, advocacy and social mobilization. A

comprehensive approach to health promotion and education embraces actions directed at strengthening the skills and capacities of individuals to improve their health alongside actions directed towards changing social, environmental and economic conditions, which have an impact on health. The implementation of health promotion and education in The Gambia incorporates commitments and actions from WHO and other international conferences and declarations on health.

Achievements

The health promotion and education directorate since its inception in 2012 have made numerous achievements and has enjoyed high political commitment for Health Promotion and Education activities. The following are some of the major achievements registered thus far:

Significantly scaled up School Health, Nutrition Promotion and Mental Health programmes, Improved Water, Sanitation and Hygiene Promotion, Introduced Non-Communicable Disease Prevention and Control programme, developed national Tobacco control policy and strategic plan (2014 – 2018), reviewed and validated national Tobacco Control strategy, conduct communication and social mobilization activities for meningitis campaign (2013) in all the regions and trained thirty media practitioners on NCD prevention, control and monitoring. Formulation of a health promotion and education policy (2014 – 2020), availability of Health Promotion and educations officers at all health regions, availability of a functional National Multisectoral Working Group on Social Determinants of Health (SDH), capacities of Frontline communicators (hygiene promoters, traditional communicators and community drama groups) built on health information dissemination, existence of a strong partnership with the media (print and electronic), and development of an annual work plan.

Challenges

Alongside the successes registered, the Directorate is faced with the following challenges: weak or inadequate institutional human resource and community capacity for planning, designing, implementation, monitoring an evaluation of health promotion interventions; inadequate financing support for the Directorate, weak intra-sectoral collaboration within the MoH&SW for health promotion interventions, inadequate operational research on health promotion. ; Inadequate office space and equipment; lack of telephone line; fax and internet facilities; and inadequate funds to conduct monitoring and supervision of health promotion and education activities at all levels.

Specific Objective 1: To coordinate the implementation, monitoring and supervision of health promotion and education activities of MoH&SW by 2020

Strategy 1: Strengthen the health promotion and education component in priority health programmes

Main activities:

- Introduce guidelines for the integration of health promotion and education activities at programme level
- Develop and operationalize a comprehensive communication and social mobilization strategy for the MOH&SW;
- Train health workers on Interpersonal Communication skills on health issues
- Develop, produce and distribute communication support materials on health issues
- Procure vehicles, film van and communication equipment/gadgets

Specific objective 2: Promote the involvement of non- health public and private sectors in health development by 2020

Strategy 1: Increase public and private sector participation in Health Promotion and Education

Main activities:

- Undertake advocacy to increase the awareness and support for the use of health promotion and education, targeting both the health and non-health sectors and mobilizing new players for health
- Advocate with government and non-governmental agencies to support the implementation of health promotion and education and sharing of experiences
- Incorporate health promotion and education components into non-health and private sector interventions and programmes

Specific Objective 3: Promote the participation and involvement of the media in health issues by 2020

Strategy 1: Raise awareness on health issues

Main activities:

- Train journalist, editors and media executives on health reporting
- Support the Association of Health h Journalist in the production and documentation of health issues
- Conduct community film shows on various health issues at all levels
- Support the on-going weekly health programmes on radio and television
- Produce documentary for broadcasting

- Coordinate the commemoration of International Health Days
- Produce and print calendars on International Health Days and MoH&SW calendar of events
- Use of social media to educate the public
- Conduct mass media campaign on health issues

Specific Objective 4: Improve country capacity to design, implement and evaluate health promotion and education interventions by 2020

Strategy 1: Strengthen health promotion and education activities at all levels

Main activities:

- Develop a Strategy Plan for the implementation of the national health promotion and education policy (2013-2020)
- Train health promotion and education practitioners in designing health promotion and education approaches at all levels
- Develop Interpersonal Communication Training Manual for health workers
- Conduct training of trainers on Interpersonal Communication Skills
- Organize short and long-term training on health promotion and communication for Health Promotion Officers
- Develop monitoring tools and guidelines for frontline communicators at field level

3.3.2 Major NCD Risk Factors

Specific Objective 1: To reduce the use of tobacco among the general population, from 35% to 25% by
2020

Strategy 1: Provision of equitable services in the prevention and control of tobacco use.

Main activities:

- Advocate for the enactment of the national tobacco control policy
- Advocate for the Enforcement of the tobacco legislation
- Conduct sensitization meetings with law enforcement agencies
- Advocacy meetings with law makers, opinion leaders and civil society
- Enforce tobacco free workplace policies
- School health intervention programs
- Production of communication support materials
- Increase taxation on tobacco
- Conduct training of trainers on tobacco cessation and counselling

Specific Objective 2: To promote healthy eating lifestyle by 2020

Strategy 1: Strengthen Behavioural change communication at all levels

Main activity:

- Conduct sensitization meetings with law enforcement agencies

Strategy 2: Health education and promotion

Main activities:

- Conduct mass media campaign
- Support community and school gardening
- Conduct school health and nutrition program
- Open field days at community level
- Production of communication support materials
- Sensitization meetings with organized community structures
- Conduct interactive community film show

Specific Objective 3: To promote physical activity among the general population by 2020

Strategy 1: Health education and promotion

Main activities:

- Support physical activities in all institutions and communities
- Conduct mass media campaign
- Observe national MOVE for health

Specific Objective 4: To reduce alcohol and other harmful substance abuse, from 2% to1% by 2020

Strategy 1: Health education and promotion

Main activities:

- Provision of counselling centres
- Train peer health educators
- Conduct community sensitization programs
- Conduct mass media campaign
- Conduct nationwide baseline study on alcohol use

Specific Objective 5: To promote primary prevention and control of NCDs by 2020

Strategy 1: Strengthen primary prevention and control of NCDs

Main activities:

- Advocate for the enactment of the NCD policy
- Routine Screening for NCDs at all levels

- Training of all health care providers on NCDS management by 2020
- Provision of necessary equipment to manage NCDs at all levels
- Development of treatment guidelines for NCDs.
- Establish NCDs clinics in all major health centres
- Early detection of NCDs and reduction of disease related complications
- Procure of basic equipment for early detection and management of NCDs

Specific Objective 6: **To promote healthy eating lifestyle by 2020**

Strategy 1: Strengthen Behavioural Change Communication at all levels

Main activities:

- Conduct sensitization meetings with relevant stakeholders
- Support community and school gardening
- Conduct school health and nutrition program

3.3.3 Mental Health and Substance Abuse

Specific Objective 1: To provide equitable, affordable and accessible quality mental health services

by 2020

Strategy 1: Strengthening mental health services

Main activities:

- Adaption of the draft national mental health policy and strategic plan
- Build capacities of health care personnel to manage mental and behavioural disorders
- Increase awareness on the risk factors, effects and management of mental and behavioural disorders
- Upgrading the existing psychiatric facility.
- Creation of psychiatric units in all the hospitals
- Integration of mental health services in the primary health care delivery.
- Establishment of the mental health board
- Training of specialized health professionals
- Provision of biomedical equipment, medicines and medical supplies
- Providing adequate psychotropic medicines to the different facilities
- Mobilize resources for mental health interventions
- Conduct community outreach programs
- Review and update the current list of psychotropic medicines included in the National Essential Drugs List.

3.3.4 Accidents & Injuries

Specific Objective 1: To reduce the burden of accidents and injuries by 2020

Strategy 1: Health education and promotion

Main activities:

- Integration of occupational health and safety into the health communication strategic plan
- Safety education in workplaces
- Conduct mass media campaign
- School based injury prevention programmes
- Production of IEC materials

Strategy 2: Strengthen the occupational health and safety activities at all levels

Main activities:

- Review, updating and adaption of occupational health and safety policy
- A nationwide baseline survey on occupational health and safety
- Community outreach programs
- Advocacy meetings with law makers, opinion leaders and stakeholders
- Regular inspection of workplaces
- Research on the causes and prevention of major injuries and accidents
- Review and updating of the existing ACTs
- Advocate for the improvement of Enforcement of the road traffic Act, Injury Compensation Act, the Public Health Act, the factories Act, The NEMA and the Labour Act

3.3.5 Rehabilitation of Persons with Disabilities

Specific Objective 1: To provide rehabilitation care and services for all persons with disabilities

Strategy 1: Strengthen rehabilitation care and services

Main activities:

- Conduct early detection/screening for disability
- Reactivate existing community rehabilitation programs (CBR) for persons with disabilities

Specific Objective 2: **To reduce disability from 16% to 8% by 2020**

Strategy 1: Strengthen hospitals and major health centres to provide comprehensive disability care

Main Activities:

- Production of artificial limbs and assistive devices
- Provide psychosocial support to persons with disability
- Provision of home base care for persons with disability
- Provision of physiotherapy and speech services
- Provide training to specialized level on disability rehabilitation
- Provide specialized training for production of mobility aids
- Create advocacy awareness on draft disability bill for enactment

Specific Objective 3: To ensure all public infrastructures have disability access by 2020

Strategy 1: Strengthen and expand accessibility for disable person

Main activities:

- Community sensitization on accessibility of community facilities to disable persons
- Inclusion of disability access in all building plans

3.3.6 Physiotherapy

Preamble

Physiotherapy is a systematic method of assessing Musculoskeletal, Cardiovascular, Respiratory and Neurological disorders of function, including pain and those Psychosomatic origins, and treatment or prevention of those problems by natural methods based essentially on movement, manual therapy and physical agencies (Heat, Cold, Light, Electricity and assistive devices, such as walking aids and orthosis).

Ultimately, Physiotherapy aims to improve the quality of life and, where possible, restore the person to normal. A Physiotherapist is a member of the medical team who works with patients of all ages and conditions, and has a major role in health promotion. In order to restore function, a physiotherapist treats patients with acute and chronic musculoskeletal problems, undertakes respiratory care and cardiovascular rehabilitation, and treats patients with neurological disease or damage. Physiotherapists provide in-patients and out-patients and community-based services, and are normally based in districts, regional or consultant/Referral Hospitals.

Among the numerous health facilities across the country, there are only a few Physiotherapy service centres along the length and breadth of the country.

These centres are found in the following Hospitals:

- Bansang General Hospital
- Sulayman Junkung General Hospital in Bwiam
- AFPRC General Hospital in Farafenni

The Physiotherapy departments receive patients from both In-patients, out-patients within hospitals and also from those self-referred. With the increasing knowledge of the existence of the Physiotherapy services amongst the private clinics and the general public, the number of patients received from these sectors also remains on the rise.

It is a common knowledge, even without statistical backing, that the number of non-communicable diseases **(particularly Diabetes & Hypertension)** is on the rise in this country, and no clinician can completely manage their patients with either of these conditions without the direct or indirect involvement of the Physiotherapist. This same notion applies to other medical, surgical, Paediatrics and Obsteric and Gynaecological cases.

Achievements

Until recently, Physiotherapy services had been only limited in the country's only Referral and Teaching Hospital, EFSTH. Although Bansang has a complete Physiotherapy department with all the basic required Physiotherapy equipment, qualified personnel had remained an obstacle to the realization of their full potentials. This same phenomenon also applied to the rest, though Bansang remain second to the EFSTH in terms of the availability of these services.

However, following the introduction of the Health Technician Training Initiative (HTTI), the onset of which was spearheaded by the department of Planning (HSS component) of the MoH&SW and the National Aids Secretariat (NAS) in collaboration with the School of Medicine & Allied Health Sciences. The University of The Gambia is actively involved in the training of Physiotherapy personnel at Certificate level, thus, increasing the number of Physiotherapy Assistants (PTA) from five (5) countrywide to a total of twenty (20). I t is worth noting that as soon the PTAs training was completed another batch of ten (10), for a 2 year diploma level started and had successfully completed in February, 2014. These two batches would be placed in all the Hospitals across the country and provide much needed physiotherapy services to the general population.

It is worthwhile to report that the acquisition of the required tools (Physiotherapy Equipment) for the provision of Physiotherapy services in these health facilities were funded by NAS.

One of the key achievements of the Physiotherapy Society in The Gambia has been the acknowledgement and recognition by the MoH&SW and other sister institutions for

their role and contribution in health promotion and prevention of impairment and permanent disability among the general population.

Challenges

The main limitation of quality Physiotherapy services provision countrywide is the inadequate qualified personnel. There are only four trained Gambian Physiotherapists (3 at BSc level and 1 at MSc level). This is far below the need of a country with a population of nearly 2million.

Another major constraint is the uneven placement of services in the country. For example, Serekunda General Hospital and Brikama Major Health centre. These two health facilities are serving big catchment areas and therefore admit many patients that would normally require early Physiotherapy intervention in order to shorten their hospital stay. But due to the lack of Physiotherapy services, this could not be achieved.

Specific objective 1: To improve and expand Physiotherapy services at all major public health facilities

Strategy 1: Fully functional Physiotherapy services at all public hospitals and major health centres **Main Activities:**

- Upgrade service level from basic to comprehensive
- Procure equipment and consumables
- Provide specialized training on Physiotherapy to both undergraduate and graduate levels
- Support Physiotherapy training in the University of the Gambia

Strategy 2: Ensure quality Physiotherapy services

Main Activities:

- Establish a regulatory system for Physiotherapy services
- Promote public- private partnership for provision of quality Physiotherapy services

3.3.7 Prevention of Violence & Injuries

Specific Objective 1: To reduce the incidence of violence and injuries by 10% by 2020

Strategy 1: Strengthen the management of sexual and gender based violence

Main activities:

- Establishment of ONE STOP centre for victims and perpetrators of violence
- Build capacities of health care providers and professionals on management

of sexual violence and Standard Operation Procedures (SOP) on violence and injuries

- Increase knowledge and skill of health care providers on sexual abuse and violence
- Provide screening and psychosocial counselling and support for victims of violence and injuries

3.3.8 Promotion of Healthy Ageing

Specific Objective 1: To improve health care services for elderly persons by 2020
Strategy 1: Provision of NCD screening for the elderly

Main activities:

- Routine Screening of elderly for NCDs
- Provision of Oncology services
- Conduct a baseline need assessment on palliative care
- Increase awareness on palliative care
- Provision of palliative care to the elderly people

Strategy 2: Support home base care for the elderly
Main activities:

- Training of health care providers on healthy aging
- Support for family and care givers of the elderly
- Reduce severe malnutrition rate among the elderly

3.3.9 Social Determinants of Health

Specific objective 1: Create social and physical environments that promote good health for all by 2020

Strategy 1: Use of Health Impact Assessments to review needed, proposed, and existing social policies for their likely impact on health

Main activities:

- Strengthen the existing multi-sectoral Committee on Social Determinants of Health;
- Conduct situational analysis on Social Determinants of Health;
- Validate the situational report on Social Determinants of health;
- Support and sustain the multi-sectoral committee on social determinants of health;

Strategy 2: Application of a "health in all policies" strategy, which introduces improved health for all and the closing of health gaps as goals to be shared across all areas of government

Main activities:

- Use health promotion and education as a platform to put Health-In-All Policies by 2020
- Establish a national association or network of health promotion and education practitioners by 2020
- Support the participation in inter-country consultations and to form a health promotion and education partnerships;
- Conduct advocacy activities to raise awareness on the concept of putting Health-In-All Policies
- Orientate law-makers and decision makers on the concept of putting Health-In All Policies

CHAPTER 4

THE INTEGRATED SUPPORT SYSTEMS

4.1 HUMAN RESOURCES FOR HEALTH

Preamble

Human Resource (HR) issues have taken centre stage as the major challenge facing all organizations. As a strategic and differentiating resource, human resources are the most reliable means of achieving success. In view of this, it has become the desire of the MOH&SW to develop, attract and retain the best workforce. The Human Resources for Health (HRH) situation in the Ministry has been very critical. The complexity and challenges associated with human resources such as high attrition rates, shortage of skilled health professionals (0.1doctors/1000 populations, 0.11 registered nurses/1000 populations, 0.18 enrolled nurses/1000 populations, 0.04 registered nurse midwives/1000 populations, 0.12 enrolled nurse midwives/1000 populations) (MOH&SW, 2013) low morale among staff, deteriorating quality of care and other related problems has affected health care delivery at all levels of the health care delivery system (MOH&SW, 2003 the same applies here too) and need some attention. This situation has become more acute in recent years as a result of on-going massive movement of trained staff and the expansion of health care facilities leading to essential gaps in the delivery of health services.

Achievements

The Directorate of Planning and Information through Human Resources for Health unit (now Directorate of Human Resources for Health), which was established in 2005, has registered number of achievements since its inception. These include: provision of incentive packages (hard to reach, special skills, risk allowance, teaching allowance, on-call allowances, responsibility allowance) to MOH&SW staff through advocacy, HRH Policy and strategic plan, Health systems strengthening project (accelerated training of health staff), establishment of HRIS data base, in-service training (management, IT, HR), Off-site provision– Leeds Metropolitan University, Introduction of masters programs in Public health and Community Health, introduction of the conversion course and upgrading the midwifery from certificate to diploma (HND), and expansion of health facilities.

Challenges

In the face of the successes registered, the Directorate struggles with weak institutional and human capacity for HRH planning and management. There is gross shortage of indigenous skill HRH including health training institutions, high attrition rate among trained and skilled staff, high dependency on expatriates, uneven distribution of health workers, remuneration packages which is not at par with cost of living; lack of clear guideline for staff promotion, posting guideline and fellowship awards (training scheme and priorities), poor motivation and retention packages for staff, poor working environment and accommodation conditions (MOH&SW 2005), inadequate infrastructure and teaching and learning aids for the health training institutions, weak linkages between MOH&SW and Gambia College and UTG, non-functional vehicle for the movement of students to and from practical experiences, unplanned / uncoordinated expansion of health facilities, poor working environment in terms of availability of essential tools for the service delivery, and inadequate private sector involvement in the production of health staff (MOH&SW 2009).

STRATEGIC OBJECTIVE 3: To ensure the availability and retention of highly skilled and well-motivated Human Resource for Health based on the health demands

This strategic objective focuses on six service areas namely, training and development, recruitment and promotion, distribution, retention & motivation, planning & management and resource mobilization for human resources for health. With these, the health sector aims to resolve the problems it is facing such as shortages of skilled health professionals, high attrition, low staff morale, poor working conditions as well as improve on the staff performance.

SERVICE AREA:

~:• Training and Development
~:• Recruitment and Promotion
~:• Distribution
~:• Retention and Motivation
~:• Planning and Management
~:• Resource Mobilization for HRH

4.1.1 Training and Development

Specific Objective 1: To improve knowledge, skills and attitudes of health workers (nurses, midwives, doctors, pharmacists, laboratory technicians, Public health officers and other allied health care workers) in line with national health priorities by 2020

Strategy 1: Strengthen capacity of HRH at all levels

Main Activities:

- Reviewing the 15 year HR projections and comprehensive training plan
- Review curriculum plans for health training institutions

Specific Objective 2: To improve HRH planning at all levels by 2020 Strategy: Establish and operationalize comprehensive HRH plans

Strategy 1: Ensure coherent plans for HRH are developed

Main Activities:

- Develop guideline and policy for selecting the award of fellowships and training
- Review existing staffing norms
- Implement the 15 year HR projections and comprehensive training plan

Specific Objective 3: To support continuous professional development by 2020

Strategy 1: Harmonize and improve continuous professional development

Main Activities:

- Conduct training needs assessment at all levels in both private and public sectors including clinic setting
- Develop guidelines for in-service training
- Strengthen the in-service training unit
- Develop protocol to enhance competent staff to take teaching and research positions at all health training institutions.
- Develop schemes of service for cadres such as physiotherapy; radiology; and biomedical equipment technicians.

Strategy 2: Improve capacity for health training institutions

Main Activities:

- Provide teaching and learning materials
- Conduct training needs assessment in all health training institutions including clinical settings
- Monitor quality assurance in health training institutions and clinical settings
- Develop guidelines for quality assurance
- Train lecturers in all health training institutions and clinical settings based on the needs assessment

4.1.2 Recruitment and Promotion

Specific Objective 1: To establish mechanisms to manage recruitment and promotion at all levels for the public sector

Strategy 1: Improve staffing at all levels

Main Activities:

- Identify staffing needs at all levels
  Train ICT staff and other MOHSW staff on different specialization
- Develop guidelines for appointments/promotion
- Identify and fill in all vacant positions
- Develop and implement induction programmes for new staff
- Train ICT staff on different specialization

Strategy 2: Institutionalize and accelerate the use of performance management system at all levels

Main Activities:

- Develop M&E system for the performance appraisal
- Support RHMT and central level to develop plans for rolling out performance appraisal systems
- Train RHMTs and central level staff on performance appraisal systems
- Develop/review guidelines for performance appraisal at all levels

4.1.3 Distribution

Specific Objective 1: To establish a mechanism to manage and deploy staff at all levels by 2020

Strategy 1: Equitable distribution of staff at all levels

Main Activities:

- Develop and implement posting guidelines and policy
- Implement the staffing norm
- Develop a deployment plan
- Disseminate deployment and postings plans to staff concerned
- Establish a posting committee at all levels
- Increase number of trained staff per health facility by population size

4.1.4 Retention & Motivation

Specific Objective 1: To improve HRH performance management and reward systems by 2020

Strategy 1: Improve incentive package at all levels

Main Activities:

- Allocate 50% of basic salary as retention allowance for lower cadres of staff (grade six and below) and 40% for grade seven and above.
- Create a special hard-to-reach area allowance
- Provide performance-based rewards
- Advocate for free medical care for all health workers and their immediate family members

Strategy 2: Improve working environment at all levels for both private and public sector

Main Activities:

- Monitor staffing norms for both the public and private sectors
- Renovate and furnish existing staff quarters
- Provide essential equipment for service delivery at all levels.
- Build Staff quarters in 6 facilities in CRR and URR

4.1.5 Planning & Management

Specific Objective 1: To improve leadership and stewardship capacity in HRH by 2020

Strategy 1: Improve planning and management of HRH

Main Activities:

- Implement existing and developed schemes of service.
- Build capacity for HRH planning and management at all levels.
- Establish HRH Steering Committee and Technical Working Groups
- Integrate HRIS into the existing HMIS
- Build the capacity of the HRH Directorate
- Conduct periodic operational research

4.1.6 Resource Mobilization for Human Resource for Health (HRH)

Specific Objective 1: To improve management and planning of available HRH by 2020

Strategy 1: Improve resource mobilization, alternative financing, and partnership in HRH development

Main Activities:

- Develop resource mobilization plan for HRH
- Introduce cost sharing scheme for HRH production with partners
- Advocate for partner involvement in HRH production
- Organize donor conferences
- Coordinate donor support

4.2 *ESSENTIAL MEDICINES, VACCINES, AND OTHER HEALTH SUPPLIES*

Preamble

Essential medicines, vaccines, and other health supplies consist of pharmaceutical services, blood transfusion services, laboratory and radiology services. Blood transfusion requires safe, effective and appropriate practices for adequate care to patients in need. Issuing safe blood to patients involves complex processes of getting donations, ensuring proper screening, storing of blood and blood products, and ensuring rational use of blood. Although a national blood policy was approved in 2000 and a draft strategic plan was developed in 2006, the organization, structures and procedures in the policy have not been fully implemented. Currently, there are ten public health facilities (six hospitals and four health centres) that carry out blood transfusion, and one health centre that collects blood, screen and dispatch the screened blood to other hospitals. The screening of transfusion transmissible infections is carried out by the national laboratory services at each centre. The agents tested for are HIV, Syphilis, HBV and HCV. There is a need to strengthen laboratory capacity, policy guidance, and enhance recruitment and retention of safe blood donors. Therefore, the need to identify achievements and gaps in the service are paramount to reducing patient risks through unavailable/inappropriate transfusion practices.

The National Public Health Laboratories (NPHL) was established in 2009. Since its establishment, it has been actively involved in offering laboratory disease surveillance, quality control confirmatory tests, emergency and disease response. . There are 40 public facilities (peripheral laboratories) throughout the country manage and supervise by NPHL. Our main target is to develop NPHL to a research institution and to complement the clinical laboratory services offered at health facilities especially in the area of malaria microbiology, TB and HIV. NPHL has six functional laboratory units and one biomedical unit namely:

- Serology laboratory
- Food Chemistry Laboratory
- TB Laboratory
- Microbiology (Bacteriology) laboratory
- Parasitology Laboratory
- Molecular Biology Laboratory
- Biomedical Engineering Unit

Accurate diagnostic and appropriate patient management, effective, affordable and functional laboratory services are crucial in providing quality health service for all.

There are significant development in expansion of laboratory services in both public and private sectors even though there is no regulation to address the proliferation and expansion of private labs. The quality of laboratory services (Human and material resources) both in the public and private however needs to be strengthened and the adequate regulation established.

The scope of Radiological services is broad and therefore the demand keeps rising steadily in the Gambia. Radiological examinations are carried out 24 hours 7 days a week in all major Government hospitals and modern imaging modalities exist in hospitals

As accurate diagnostic and appropriate patient management, effective, affordable and functional radiology services are crucial in providing quality health service for all, other health facilities, staff and services therefore need to catch up with the steady rise in demand for radiological services.

The number of patients seen a day in the radiology at the main referral hospital is approximately 40 to 50. The examinations did include both plain radiography and special procedures.

Achievements

The Gambia adopted its first National drug policy in 1995 and was revised in July 2007 and a strategic plan developed in 2009. As a result the pharmaceutical sector in The Gambia registered a number of achievements that have contributed towards the improvement in the availability and accessibility of medicines in the country ranging from the establishment of National Pharmaceutical Services Unit, construction and establishments of six Regional Medical Stores, existing distribution system, construction of New Central Medical Stores warehouse and administration building under the World Bank (WB) project. In addition there is an existing LMIS and computerized inventory control system at Central Medical Stores and increase in skilled human resource. Furthermore there is an available infrastructure that needs to be developed into a Quality Control laboratory though not functional but limited tests are being conducted using the minilabs. Efforts to improve the management and utilization of pharmaceuticals had resulted in development and provision of the Standard Drug Treatment Manual and Essential Medicines List, training of Health Workers on Rational Use of Drugs and the Management of drugs at the health facility level. A system to monitor safe use of these medicines and adverse drug reactions is in the process of being established.

The national blood transfusion service programme under the national public health laboratory service directorate has a budget line established. The national blood transfusion policy and the draft strategic plan are currently being reviewed and validated but yet to be approved. Standard operating procedures have been developed and in used. Currently separation of blood into components (fresh frozen plasma and packed red cells) and exchange transmissions has started at the main referral hospital.

In addition, there are voluntary organizations and blood donors associations which are collaborating with the NBTS in the recruitment of voluntary blood donors.

The establishment of the National Public Health laboratories service Directorate and reference laboratories was a major achievement. The Directorate has a draft National Laboratory policy in place. NPHL has committed and dedicated staff and has registered high routine screening countrywide over the years. NPHL has a good quality assurance scheme and external quality control system in place for the public sector. It has improved its data management over the years with timely reporting of data and the expansion of laboratory services in all the regions of the country. NPHL successfully conducted Schistosomiasis study in collaboration with MRC in 2011, Coartem efficacy study in 2012 and Demographic Health survey with GBoS in 2013. The Serology laboratory has achieved partial accreditation in testing Measles and Rubella. NPHL in collaboration with the Global Fund and MOH&SW have trained more than 80 laboratory assistants and technicians. Training for Nurses, Public health officers and other health professionals had also been conducted. In 2013 there has been an expansion of laboratory services from 35 to 40.

Radiological services have progressed steadily through the past years. With the number of trained Radiographers being only 3 in the Gambia (two working for MRC), training of 19 Radiographic Assistants was successfully completed and 10 Radiographic technicians are currently on training, under Global Fund AIDS program through National Aids Secretariat (NAS). The University of The Gambia (UTG) currently runs the Programme.

Apart from training, some new imaging equipment was also acquired namely Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Digital Radiography equipment and imaging plates, and mobile x-ray machines for Ward radiography in EFSTH. Some staff members of the Radiology department of EFSTH have also benefitted from MRI applications training offered by the Republic China on Taiwan.

Challenges

The baseline survey of the WHO Pharmaceutical Sector assessment done in 2007 highlighted a number of challenges and constraints including inadequate organizational structure, inadequate availability of essential medicines and vaccines, lack of sustainable medicines financing, inadequate logistics, inadequate medicines regulation (structure and processes), lack of a drug quality control lab and skilled human resources, irrational drug use and weakness in drug management, some of which are currently being addressed e.g. inadequate medicine legislation. A number of global and national challenges such as the HIV/AIDs pandemic, the re-emergence of TB, increase prevalence in non communicable diseases and the increasing medicines resistance to infectious diseases can also negatively impact on the pharmaceutical sector, as it obviously put further constraint to its limited resources, both financial and technical. This is further aggravated by the problem of counterfeit, and substandard medicines, which is increasingly becoming a major concern within the sub-region and world-wide.

The Gambia government provides support for the provision of routine vaccines for immunization services and continues to meet its core-financing obligation (5%) for the provision of new and under-used lifesaving vaccines. The provision of funds for supplementary immunization activities and purchase of infant welfare cards as well as surveillance poses major challenge to effective implementation of EPI services.

Although the main referral hospital blood bank have been identified as the headquarters for the national blood transfusion services, lack of an independent national blood transfusion centre made coordination and supervision of the programme difficult in the past years. The lack of proper blood transfusion guidelines, regulatory mechanisms and limited quality management systems adversely affects the quality of blood given to patients. Acute shortage of qualified staff, lack of mobility to run the service across all levels and limited storage facilities has created a big gap to the service. There is a high reliance on relative donors due to the low public awareness of the service. There are no defined mechanisms to ensure sustainability of the service and lack of regulation of transfusion services in the private sector is a big challenge.

The NPHL is faced with a number of constraints and challenges, the draft national laboratory policy is yet to be validated and currently there is no laboratory strategic plan. These two key documents are essential in delivering quality laboratory services. Erratic electricity supply is a major risk factor in laboratory service delivery in NPHL and across the country. This affects the timely processing of specimen and reporting.

NPHL has inadequate laboratory equipment for sample processing. For the production of quality results special equipment and working tools should be provided to prevent delay in sample processing and reporting. Inadequate trained personnel also affect proper sample collection, processing and reporting.

This needs to be improved for the production of reliable and quality results. There are limited/ inadequate funds for laboratory service delivery in surveillances that could limit the coverage of laboratory service delivery and expansion. Shortages of test kits are one of the major challenges of the laboratory service, which could affect laboratory service delivery in the case of outbreaks.

Apart from CT, MRI and Ultrasound room in EFSTH, the main Radiology department, has always been a two-room department with equipment for plain Radiography. More rooms are needed to house other important imaging equipment such as Fluoroscopy (for examination of the alimentary track and interventional radiography), A/E equipment, orthopantomography (OPG) panoramic view of the dental layout), Angiography, (Radiological examination of the blood vessels) and mammography, Radiological examination of the female mammary gland (the breast). Female patients requiring mammography have to travel to Dakar to have it done. The cost, excluding transportation, feeding and accommodation can be expensive. In the Gambia, the cost was only D300.00 for both breasts. Currently, there is no mammography equipment and C arm x-ray machine, which are very important.

Ultrasound is vital in medical imaging. The current machines in EFSTH are old and out-dated. New ones are needed. The Radiology department of Sulayman Junkung General Hospital is yet to start functioning. An assessment of the department was carried out in October 2013.and Recommendations were made. The authorities are currently working on the recommendations, with the hope to commence radiological services soon.

Apart from the need for the important equipment mentioned above, capacity building is vital. We need more trained Radiographers (currently the course is not offered in the Gambia) as well as Radiologists. There is no Gambian Radiologist at the moment.

Officially trained biomedical engineers in Radiological equipment are also urgently needed. These are staff of the Biomedical Engineering department responsible for repair and servicing of hospital equipment. Some of them need to specialize in Radiological equipment.

Apart from the situation of the ultrasound machines in the EFSTH, challenges encountered are the same in all other hospitals nationwide, which include inadequate radiology consumables.

Table 5: An overview of radiological services nationwide

	Name of Hospital	No. of imaging machines	No. of staff	No of radiographer
1	Edward Francis Small Teaching Hospital (EFSTH)	5, two functional, 1 static 1 mobiles, 1 CT, 1 MRI, 4 ultrasound	1 radiographer, 4 assistants	1
2	Serrekunda hospital (SKH)	3, one static, 2 mobiles, 1 CT	2 technician 1 assistant	-
3	Sulayman Junkung Gen. Hospital (SJGH)	None yet	-	-
4	Farafenni General Hospital (FGH)	1 mobile, static and fluoro. Out of order	3	-
5	Bansang Hospital	1 mobile	3	-
6	Westfield Clinic	1 mobile	1	1
7	MRC Fajara	1 static	1 radiographer, 1 assistant	1
8	MRC Basse	1 static	2 assistants	-
9	Ahmadiyya Hospital		1 technician	-
10	Bijilo Medical Centre	1 mobile	1 technician	-
11	Afrimed Clinic	1 mobile	1 technician	-

Source: Radiology Unit EFSTH 2013

STRATEGIC OBJECTIVE 4: **Increase access to quality pharmaceutical services, laboratory, radiology and blood transfusion services to all by 2020**

This strategic objective will focus on improving and expanding on the following service areas namely, pharmaceutical, laboratory, radiology and blood transfusion services.

These services will be made available, accessible and affordable to health care seekers at all levels.

SERVICE AREA:

- Pharmaceutical Services
- National laboratory Services
- Radiology Services
- Blood transfusion Services

4.2.1 Pharmaceutical Services

Specific Objective 1: Ensure availability and access to quality pharmaceutical services by 2020

Strategy 1: Establish a sustained financing mechanism for continuous availability of essential medicines, vaccines, other medical supplies, laboratory and blood transfusion.

Main Activities:

- Advocate for and provide 100% of the estimated annual budget requirement
- Strengthen DRF structures for effective revenue collection (to supplement the budget for essential supplies (10 to 20%)
- Develop a plan for resource mobilization to reduce funding gap
- Establish an Interagency Coordinating Committee to monitor technical and efficient budgetary and resource allocation
- Promote collaboration between public and private sectors in the provision of essential drugs and other medical supplies
- Advocatefor10%incrementonroutineEPIbudgetlinetoaccommodateemergencyimmunization activities

Strategy 2: Improve the procurement and supply management system and promote rational use of medicines.

Main Activities:

- Create an effective integrated procurement and supply chain management system
- Strengthen the procurement, storage, distribution systems and rational use.
- Improve coordination, planning, monitoring and supervision of the supply chain
- Strengthen the LMIS system
- Develop, update, print and distribute policy documents for the procurement supply management system (including Standard Treatment Guidelines, Essential Drug List, National Formulary and SOPs)

Strategy 3: Strengthen the drug regulatory authority

Main Activities:

- Advocate for the approval of the draft bills (Pharmacy bill and Medicines and related products Act)
- Develop the necessary structure and tools for implementation of the Act

Strategy 4: Strengthen drug quality control lab.

Main Activities:

- Provide equipment and consumables for the quality control lab
- Identify and train staff for the quality control lab

4.2.2 Blood Transfusion Services

Specific Objective 1: Strengthen national blood transfusion services by 2020.

Strategy 1: Establish a national blood transfusion centre.

Main Activities:

- Construct a National Blood Transfusion Centre.
- Provide equipment, furniture and consumables for the centre
- Train staff on blood transfusion services

Strategy 2: Strengthen blood transfusion services at all hospitals and major health centres

Main Activities:

- Set up a National blood transfusion committee
- Improve information/data management systems
- Monitor quality control and quality assurance activities

Strategy 3: Reinforce nation-wide voluntary non-remunerated blood donation.

Main Activities:

- Provide resources for community outreach sensitization and donor bleeding
- Improve collaboration with Blood Donor Associations

Strategy 4: Achieve 90% voluntary non-remunerated blood donation through health Promotion and Education

Main Activities:

- Improve collaboration with Blood Donor Associations
- Conduct IEC activities on Blood Transfusion at all levels
- Conduct community film shows on blood donation
- Conduct radio and television programmes to raise awareness on blood donation
- Commemorate World Blood Donor Day

4.2.3 National Laboratory Services

Specific Objective 1: Strengthen National laboratory services by 2020.

Strategy 1: Establishment of fully functional laboratory services at all hospitals and major health centres

Main Activities:

- Upgrade service level from basic to comprehensive
- Provide equipment and consumables
- Train staff on laboratory services

Strategy 2: Ensure quality laboratory services

Main Activities:

- Establish a regulatory system for laboratory services
- Promote public- private partnership for provision of quality laboratory services
- Monitor quality control and quality assurance activities

4.2.4 National Radiology Services

Specific objective 1: To improve and expand Radiology services at all major public health facilities by 2020

Strategy 1: Establish fully functional radiology services at all public hospitals and major health centres

Main Activities:

- Upgrade service level from basic to comprehensive
- Provide equipment and consumables
- Train staff on radiology to both undergraduate and graduate levels
- Support radiology training in the University of the Gambia

Strategy 2: Ensure quality radiology services

Main Activities:

- Establish a regulatory system for radiology services
- Promote public- private partnership for provision of quality radiology services
- Monitor quality control and quality assurance activities

4.3 HEALTH INFRASTRUCTURE DEVELOPMENT AND MANAGEMENT (INCLUDING EQUIPMENT, MAINTENANCE AND TRANSPORT)

Preamble

Infrastructural development was sidelined in the MOH&SW for a number of years. Based on the organogram of the MoH&SW it is not clear which Directorate or Unit is responsible for Health Infrastructure Development and Management. The last staff quarters were constructed in 2005, which coincided with the construction of four health centres in

Albreda, Kafuta, Foday Kunda and Sarakunda under the World Bank (WB), Participatory Health Population Nutrition Project (PHPNP). Existing staff quarters remain dilapidated without regular maintenance, contributing to low staff morale and by extension, to high staff attrition rate especially in the rural areas.

Proposals for investment in infrastructure should be geared towards addressing and achieving equitable geographical access to health care. However, a number of facilities are yet to be built to improve access to health services. It is imperative that these health facilities are constructed to improve access to each level of healthcare.

Vehicles are utilized by various categories of facilities including hospitals, Major H/Cs and Minor H/ Cs, RHTs, programme units, the Ministry, Health Training Schools and maintenance units. The current transport fleet comprises of four-wheeled vehicles (ambulances, utility and others) and motorcycles. In 2002 the MoH&SW entered into a contract with Rider For Health (RFH) to manage their transport fleet. In 2008, a new contract (Transport Assess Management-TAM) was signed in which RFH purchase 36 ambulances, 27 trekking and supervisory vehicles and 60 motorcycles which they lease out to MoH&SW, as well as continuation of the 2002 contract (Demand Services-DS). As a result there have been major improvements in transport fleet management. Based on the population standards and using the minor health centre as unit of analysis (15,000 populations/per minor health facility) the health coverage per region is thus:

- Kanifing 18%,
- NBR 100%,
- LRR 60%,
- Banjul 100%,
- URR 67%,
- CRR 75%
- Western Region 30%. (MOH&SW, 2007)

Achievements

The MOH&SW has upgraded 12 dispensaries to minor health centres and constructed 4 new health centres between 2003 and 2007. In addition a new hospital was constructed in Kanifing that was operational in 2010. The commencement of the civil works under the IDB funded Health Facilities Expansion Project will see 7 health centres expanded and refurbished, 2 new health centres constructed, SEN training school in Bansang expanded and staff quarters built at AFPRC General Hospital.

In terms of transport there has been zero cancellation of RCH treks since 2010 due to lack of transport or fuel, which is attributed to the RFH TAM, programme. In October 2013, one 16,000 litres fuel tank vehicle, 11 pick-up trucks, 9 ambulances, 2 Uhuru X four wheel drive quad bikes (on trial), 1 RCH trekking vehicle and 60 motorcycles arrived in the country and were distributed country wide to improve service delivery. RFH have also constructed two workshops (Basse and Kerewan) and upgraded 3 workshops (Kanifing, Mansakonko and Bansang). They constructed a training-cum-resource centre in Kanifing.

Challenges

Poor maintenance of staff quarters and health facilities remain a big challenge to the public health sector. This is compounded by insufficient resources, inadequate and insufficiently trained maintenance workforce with inadequate tools and equipment. There is no coordination between the two Maintenance Units in the execution of their duties.

In transport system, the key challenges are, lack of coordination and management of the contract between MoH&SW and RFH, insufficient fuel allocation for routine services at all levels, inadequate servicing and maintenance of non-TAM vehicles, poorly equipped ambulances, inadequate trekking and utility vehicles for MoH&SW, shortages of spare parts and consumables.

STRATEGIC OBJECTIVE 5: To improve infrastructure and logistic requirements of the public health system for quality health care delivery.

The Gambia has a wide range of health facilities distributed all over the country provided by the government, faith based organizations, Non-Governmental Organizations and private institutions. Investment in infrastructure is geared towards addressing and achieving equitable geographical access to health care.

SERVICE AREA:

- Transport
- Infrastructure
- Biomedical Equipment

4.3.1 Transport

Specific Objective 1: To coordinate the procurement, operation, maintenance and replacement of vehicles and motorcycles in order to ensure a healthy fleet at all times by 2020

Strategy 1: Ensure maximum availability and management of vehicles and motorcycles **Main activities:**

- Develop a comprehensive vehicle inventory system as well as replacement and procurement plan
- Strengthen and maintain comprehensive vehicle maintenance workshops in all regions
- Review the MOU with RFH based on (costs benefit analysis)

4.3.2 Infrastructure

Specific Objective 1: To improve health infrastructure in all health regions by 2020

Specific Objective 2: To have well maintained and safe health facility structures (buildings) by 2020

Strategy 1: Ensure an effective maintenance system

Main Activities:

- Review and update the maintenance policy
- Recruit qualified building maintenance staff (welders, architects surveyors, carpenters, plumbers, electricians, masons, painters) should be captured in HR

Strategy 2: Strengthen the capacity of the maintenance unit
Main Activities:

- Provide equipment and working tools for the buildings maintenance unit.
- Establish a buildings maintenance workshop
- Train buildings maintenance unit staff should be captured in HR

Strategy 3: Develop a comprehensive Health Infrastructure Development and Management (HIDM) plan
Main Activities:

- GPS mapping of all existing health facilities public and non-public
- Inco-operate new facilities to be constructed over the planned period
- Develop a comprehensive maintenance plan
- Cost the capital investment plan (staff housing, health facilities, kitchens, incinerators, laundry areas, etc.)

- Establish a new unit to be called Health Infrastructure Development and Management (HIDM) Unit by integrating the maintenance unit and biomedical engineering unit
- Provide alternative energy source to facilitate health service delivery at all levels.

Strategy 4: Merge the Biomedical unit with maintenance unit to create a fully functional Health Infrastructure Development and Management (HIDM) Unit

Main Activities

- Provide appropriately qualified staff to run the service
- Provide required maintenance and biomedical repair tools

Specific Objective 3: To ensure the availability of biomedical equipment at all levels by 2020

Strategy 1: Provision of adequate biomedical equipment at all levels

Main Activities:

- Conduct a comprehensive assessment of biomedical equipment needs in the public health system.
- Procure quality biomedical equipment
- Develop a biomedical equipment replacement plan

Specific Objective 4: To have a well maintained inventory system for biomedical equipment by 2016

Strategy 1: Develop a comprehensive inventory system for Biomedical Equipment

Main Activities:

- Conduct quarterly update of inventory
- Provide resources for the inventory system (computers, software, engravers, etc.).

Specific Objective 5: To have a functional Biomedical equipment maintenance and management system by 2020

Strategy 1: Strengthen the Biomedical equipment management unit

Main Activities:

- Establish biomedical equipment management workshops in each region
- Train biomedical equipment management unit staff
- Recruit qualified Biomedical Engineers/Technicians and support staff
- Provide equipment and working tools for the biomedical equipment management unit

Specific Objective 6: **To refurbish / rehabilitate 5 health facilities in each health region by 2020**

Strategy 1: Ensure the Refurbishment and rehabilitation of health facilities

Main Activities:

- Review and update building requirements, standards and norms for the health system
- Conduct situation analysis of existing health facility needs
- Refurbish existing structures

Specific Objective 7: To provide a new office complex for the MoH&SW and food testing laboratory by 2020

Strategy 1: Ensure the building of a new MoH&SW office complex

Main Activity:

- Construct and furnish a new MoH&SW office complex

Specific Objective 8: To have a well maintained inventory system for physical infrastructure by 2016

Strategy 1: Develop a comprehensive inventory system for health assets

Main Activities:

- Provide resources for the inventory system (computers, software, engravers, etc.).
- Inventories all physical infrastructures (buildings, furniture, equipment),

4.4 HEALTH FINANCING

PREAMBLE

In The Gambia, the main sources of financing health care are through the government, donors, NGO, and private out-of-pocket expenditures. Public sector financing of health has grown over the years but has mainly favoured investment in tertiary care. According to the first National Health Account Survey that was conducted in 2007 for the years 2002-2004 showed that the contribution of the Government to the health sector grew direct out-of-pocket payments to health care providers were 12% in 2002, 11% in 2003 and 9% in 2004 to the total health expenditure. The total health expenditure as a percentage of Gross Domestic Product (GDP) was estimated at 5.6% in 2013.

The health sector has increasingly become dependent on donor funds from the Global Fund for AIDS, TB and Malaria (GFATM) and development partners such as, UNICEF, UNFPA and WHO. General Government expenditure on Health as percentage of General Government is still below the Abuja Declaration Target of 15%.

As a supplement to government expenditure on health, user charges were introduced in 1988 and the proceeds are paid into a Drug Revolving Fund (DRF) account. These generated funds are used to complement the government's budget allocation for drugs. Despite this, health is seriously under-funded particularly at the primary and secondary levels. The health budget is also disproportionately distributed favouring the tertiary level and urban over rural areas with hospitals currently accounting for nearly half of the total government resources and expenditures. Strategies to equalize this imbalance include ongoing advocacy to mobilize resources for health financing from traditional and non-traditional partners/ donors and the strengthening of cost sharing mechanisms for all levels of health care delivery.

In order to achieve progress in the critical service areas, there is need to create a comprehensive financing mechanism aimed at ensuring continuous availability of essential medicines, vaccines, other medical supplies, laboratory and blood transfusion. from 18% in 2002 to 24% of the total health expenditure in 2004. The households,

Table 6: Gambia - National Expenditure on Health (Gambian Dalasi)

Economic Indicators for	2003	2004	2005	2006	2007	2008	2009	2010	2013
Total health expenditure	5.8	6.3	6.2	5.9	5.3	5.2	6.1	5.7	5.6
General Government	2.9	3.6	3.4	3.3	2.5	2.5	3.3	3.4	3.6
Financing Sources measurement:									
External resources for health as % of total expenditure on health	21.0	19.6	55.2	63.5	42.8	39.5	25.4	41.2	35.7
Financing Agents measurement:									
General government expenditure on health	50.3	57.8	55.0	56.8	48.2	48.0	53.4	50.8	28.1
Private expenditure on health as % of total health expenditure	49.7	42.2	45.0	43.2	51.8	52.0	46.6	49.2	71.9
Out of pocket expenditure as % of total health expenditure	25.4	20.4	21.7	20.8	25.0	25.1	22.5	23.8	30.7
GGHE as % of General	12.9	11.7	11.3	11.3	11.3	11.3	11.3	11.3	12.5

Source: NHA, 2013 and World Health Statistics

Achievements

The MOH&SW has its draft Health Financing Policy since 2009 as a guide/tool to make funding available, ensure choice of cost-effective interventions, set appropriate financial incentives for providers, and ensure that all individuals have access to effective public health and personal health care. In addition, it has also conducted its first National Health Account in 2007 which provided information on Health budgets and expenditures nationally in terms of donors, government and out of pocket expenditures. Likewise the latest NHA conducted in 2013, has further

highlighted the gaps the health sector continuous to face in terms of financing requirements.

In line with attaining Universal Health Coverage, the Ministry has already conducted two feasibility studies on the introduction of National Health Insurance with the intention of starting with the formal sector (the civil servants) as one of the studies highlighted as a recommendation.

Moreover, through the support of the World Bank, MoH&SW in collaboration with NaNA has introduced Result Based Financing (RBF) as a pilot in the NBW region and upon successful implementation; this will be scaled up to other regions (NBE, CRR, and URR). These financing mechanisms are the most appropriate strategies that can help us achieve Universal Health Coverage.

Challenges

In The Gambia available statistics indicate that over 60% (NHA 2007 Report) of the total health funding comes from donors (international health development partners) raising high challenges of sustainability and predictability of funding to the sector.

Although there is an impressive revenue collection system in place by the Gambia Revenue Authority, the government allocation to the health sector is 10.5% of national budget in 2013, below the Abuja declaration of 15%.

Moreover, current funding for the health sector is less than optimal as available resources could still not provide the required quality services for the population due to so many reasons like high administrative cost especially from GLF component and in addition donor inputs are not well coordinated while issues of efficiency and equity in use of funds continue to be a challenge.

Apart from the above issues, there are other challenges that the health sector is facing: Weak revenue collection and low capacities in resource mobilization at the various health facilities, low cost levied on user fees, inadequate data on health expenditure due to lack of regular studies of National Health Accounts and Public Expenditure Reviews, which are supposed to give us the true picture of the health financing situation of the country.

Since the Health Financing Policy is not finalized, there is no holistic health financing mechanisms and legislation in place, no National Health Insurance Scheme and therefore there are inadequate health financing schemes in the country (only few private health insurance schemes). The health system has inadequate number of trained health economists and planners in the health sector to implement Health Financing Policy, in terms of putting proper system in place for health expenditure planning, execution, trekking and monitoring. Finally, cost of providing health care continues to rise due to increasing demand, changes in diagnostic and therapeutic technologies, inflation and currency fluctuations, which are the biggest challenge worldwide.

STRATEGIC OBJECTIVE 6: To establish an effective, efficient, and sustainable health sector financing mechanism by 2020

The purpose of health financing is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care. A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for the services.

The Gambia health sector will identify several modes of financing health services through the government either through sector wide approach (SWAp), taxation; user fees through out of pocket payments, external sources from bilateral, multilaterals, or philanthropic sources and will look into the introduction of health insurance, either social or private mechanisms.

SERVICE AREAS:

- Stewardship for health financing
- Revenue generation and collection
- Revenue Pooling
- Resource allocation and purchasing

4.4.1 Stewardship for Health Financing

Specific Objective 1: Development of a holistic health financing mechanism by 2016 to attain universal coverage

Strategy 1: Ensure required health financing policy and Acts are in place **Main Activities:**

- Review and validate the Health Financing Policy
- Develop and implement Operational Plan for Health Financing Policy

Strategy 2: Ensure Universal Health Coverage through the delivery of comprehensive basic healthcare packages to the population by 2018

Main Activities:

- Constitute a task force to review the existing basic package at all level of care
- Determine the cost of providing basic health care packages across various income groups
- Create a budget line for Results Based Financing (RBF) project
- Conduct study tours to learn best practices on Universal Health Coverage
- Define mechanisms for ensuring universal health coverage (e.g. Results Based Financing, Health Insurance)
- Incorporate National Health Account into health planning and budget circle

4.4.2 Revenue Generation and Collection

Specific Objective 1: Allocate 15% of government budget to Health by 2020 from 10.5% in 2013 to meet the Abuja Declaration Target

Strategy 1: Utilization of the MTEF process to gradually achieve the Abuja target **Main Activities:**

- Ensure the approved health budget is adequately executed
- Review and Implement MTEF by utilizing the Marginal Budgeting for Bottlenecks and making an investment case

Specific Objective 2: To institute other financing options to support government budget through the development of mixed prepayment mechanisms

Strategy 1: Use of tax-base and non-tax base financing of health care

Main Activities:

- Introduction of a Health Tax Policy and Act
- Advocate for innovative financing by allocating 3% of the levy on tobacco and tobacco products, alcohol and hazardous products
- Introduce National Health Insurance Scheme
- Establish health financing agency to manage risks, revenue collection and purchasing of health services
- Develop a resource mobilization plan

  Organize resource mobilization conference
- Advocate for the introduction of a service charge on GSM usage and bank transactions for contribution towards health financing

Specific Objective 3: Improve revenue collection mechanisms by 2020

Strategy 1: Strengthen resource mobilization

Main activities:

- Identify all revenue collecting source within the Ministry of Health
- Set up an efficient revenue collection mechanisms
- Phasing- out all non - accounting staff from collecting revenue at all levels
- Recruit accounts clerks for all public health facilities
- Develop adequate human resource capacity for revenue collection
- Monitor and supervise the collection of revenues in all public health facilities

4.4.3 Revenue Pooling

Specific Objective 1: To provide social safety nets to protect the poor against exorbitant health spending by 2020

Strategy 1: Establish social health revenue pooling scheme and equity fund to subsidize for out of pocket expenditure

Main activities:

- Pool health revenue generated funds into one basket
- Promote Community Based pre-financing Mechanisms (health insurance schemes)

4.4.4 Resource Allocation and Purchasing

Specific Objective 1: To achieve optimum utilization of resources to attain universal coverage by 2020

Strategy 1: Ensure resource allocation based on needs assessment and priority setting

Main activities:

- Develop a Resource Allocation Formula taken into account all resources available from all sources.
- Develop a monitoring framework to ensure accountability transparency and equitable resources utilization
- Strengthen the budget
- 'Resource allocation committee
- Use Drug Revolving Funds to support the procurement of essential drugs, reagents and other laboratory consumables

4.4.5 Resource Mobilization for Human Resource for Health (HRH)

Specific Objective 1: To improve management and planning of available HRH by 2020

Strategy 1: Improve resource mobilization, alternative financing, and partnership in HRH development

Main Activities:

- Develop resource mobilization plan for HRH
- Introduce cost sharing scheme for HRH production with partners
- Advocate for partner involvement in HRH production
- Organize donor conferences
- Coordinate donor support

4.5 HEALTH INFORMATION SYSTEM (HIS)

Preamble

The Health Information System in The Gambia comprises five main service areas namely Health Management Information System (HMIS), Health research, Births and deaths registration, Information and communication technology and Integrated Disease Surveillance and Response (IDSR). These service areas will focus on information generation, validation, analysis, dissemination and utilization for the purpose of effective and efficient planning and decision making process.

Health Management Information System is the umbrella programme for collecting, analysing, storing and disseminating health data of the Ministry of Health. Thus all service data should be harmonized and integrated into HMIS to facilitate easy flow and access to health information to producers and users of data. HMIS was established in 2000. With the support of University of Oslo Norway, HMIS started using an open source software called District Health Information System version 2 (DHIS2) in 2009/10 to manage its data. Since the establishment of this unit, a lot of

efforts went into ensuring that all the data collection systems within the ministry are integrated into HMIS.

Research issues have recently moved very high on the political agenda of the government of the Gambia and have thus gained greater national and international visibility. The aim is to reduce disease burden and poverty and to enhance socio-economic development and improve the quality of life. Evidence-based information is needed by policy makers and health managers to promote rational decision-making in policy and programmatic matters. Such information has to come from sources that include health research findings.

Births and Deaths registration started in the Gambia in 1880 then confined to the colonial city of Bathurst (now Banjul) and protectorate of George Town until 1965 when registrations was open to all Gambians. In 1996 it was decentralized and integrated into RCH in 2004. From inception to date it depends on manual system. The data collected from these processes can be used for producing key health indicators such as birth rates, fertility rates and mortality rates including (prenatal, neonatal, infant, etc.) but this is not possible with current system because of low coverage. Therefore births and deaths are registered for certification purposes. The MICS IV report 2010 indicated coverage as low as 51.5%. Although the act on births and deaths registration was reviewed in 1990, there is need to review it again to reflect current issues with the aim of improving timely and complete registrations of births and deaths in the country.

Achievements

Over the years HMIS unit achieved the following: development of HMIS policy and Strategic plan, deployment of VPN and internet connectivity in regions, programmes all hospitals and all the major health centres with the support of Global Fund Malaria Grant, recruited more data entry clerks, DHIS 2 hosted on line, conducted rapid assessment of DHIS2, increased in the number of facilities that report to HMIS, produced annual reports and quarterly bulletins.

In 2005 the MOH&SW set up a team to guide the process of developing a Health Research Policy. Consultative meetings were conducted between the members of the Team and health personnel in the public, private and non-governmental sectors.

Subsequently, the Directorate of Planning and Information continued with the consultative review process that culminated in the final version of the National Health Research Policy and Strategic Plan 2010 -2014.

In addition the following achievements were realized: annual national health research conference has been launched in October 2010, the first ever Demographic and Health Survey was conducted in collaboration with the Gambia Bureau of Statistics in 2013 and coordinate the M&E activities of the PAGE 2012 – 2015. Furthermore, Birth and Death registration programme registered the following achievements: Birth Registration (BR) Strategic Plan 2013 to 2017 developed, under five birth registrations is free, series of mini birth registration campaigns conducted.

Challenges

The legal framework that is required for integration is lacking giving rise to a situation where some programme units are still collecting and managing their data in a parallel fashion thus causing increasing workload on health workers. The following are key challenges faced by the HMIS: inadequate number and skilled capacity to manage data at all levels, availability of parallel systems, duplication of efforts e.g. use of multiple software to manage the same system, weak reporting from some hospitals and private sector, inadequate functional ICT equipment at HMIS and regions, inadequate skilled ICT officers at all levels, poor power supply, inadequate financial support and poor internet connectivity at HMIS unit. ICT system is in its infantry stage; therefore need expansion, capacity building for specialized IT staff and other service providers and provision of adequate tools and equipment.

The research programme has been faced with challenges affecting the implementation of Research programme over the years including; inadequate funding for research activities, inadequate research skills capacity, inadequate equipment and stationary and lack of mobility. Despite the above achievements registered, BR programme is experiencing the following challenges: BR system is not computerize, low birth and death registration coverage, inadequate archiving for birth and death registers, inadequate medical record system in the hospitals, decrease in coverage from 55.5% in 2005/6 to 52.5% in 2010, lack of civil registration and vital statistics system, lack of internet connection at BR, lack of telephone facilities.

Although the act on births and deaths registration was reviewed in 1990,there is need to review again to reflect current issues with the aim of improving timely and complete registrations of births and deaths in the country.

STRATEGIC OBJECTIVE 7: To improve the effectiveness and efficiency of Health Information System for Planning and decision making to yield improved service delivery by 2020

SERVICE AREA:

- HMIS
- Health research
- Births and deaths registration
- Information and communication technology
- IDSR

4.5.1 Health Management Information System (HMIS)

Specific Objective 1: **To strengthen HMIS at all levels by 2020**

Strategy 1: Strengthen staff development and motivation

Main activities:

- Implement HMIS Strategic plan
- Train and retrain HMIS staff at all levels
- Recruit personnel with relevant competencies required for effective HMIS

Strategy 2: Establish a functional coordination framework for HMIS

Main activities:

- Establish a mechanism to cater for adequate equipment and communication needs for HMIS
- Develop a coordination framework for HMIS and establish HMIS technical working group

Strategy 3: Expand and strengthen national application of DHIS 2 at all levels

Main activities:

- Capacities a core team on advance DHIS2
- Build capacity of all the programme managers, regional health teams and health facility staff on DHIS2
- Procure a backup server for DHIS 2

Strategy 4: Strengthen data quality assessment mechanisms

Main activities:

- Conduct periodic data verification (monthly at regional level and quarterly from HMIS) to service delivery areas
- Develop tools for data quality audit

Strategy 5: Integrate and harmonize all data collection tools within MOH&SW

Main activities:

- Conduct workshop to integrate and harmonize all the data collection tools of MOH&SW
- Print and distribute data collection tools to all health facilities
- Interlink all the open source databases of MOH&SW into DHIS 2
- Expand VPN with internet in minor health facilities

Strategy 5: Strengthen information sharing

Main activities

- Produce quarterly bulletins and annual service statistic reports.
- Conduct quarterly information sharing forums.
- Conduct awareness campaign on utilization of health data for planning and decision-making at all levels.

4.5.2 Health Research

Specific Objective 1: To establish structures for fully functional health research governance by 2016

Strategy 1: Secure a legal mandate for the National Health Research Council

Main activities:

- Review and update the health research policy and strategic plan.
- Develop an Act to legalize the mandate of the National Health Research Council.
- Enact the Act in Parliament

Strategy 2: Integrate existing structures into a National Health Research Council by 2020

Main activities:

- Set up National Health Research Council and its secretariat
- Set up sub-committees of the National Health Research Council
- Develop standard operating procedures (SOPs) and a work programme for the National Health Research Council

Specific Objective 2: To establish participatory health research planning and priority setting mechanisms by 2016

Strategy 1: Set up mechanisms and procedures for priority setting for health research **Main activities:**

- Explore existing procedures for setting health research priorities
- Develop and institutionalize best procedures for health research priority setting in The Gambia
- Develop 5 year health research agenda

Specific Objective 3: To establish mechanisms for dissemination and utilization of health research findings by 2016

Strategy 1: Develop and implement a communication plan **Main activities:**

- Develop a 5 year communication plan
- Organize regular conferences and meetings to disseminate and discuss research findings
- Develop policy briefs for decision and policy makers

- Make research publications available annually to stakeholders
- Advocate for the setting up of documentation centres in strategic locations.
- Develop a directory of health research

Specific Objective 4: To improve institutional and human resource capacity in health research in government and non-government sectors by 2020

Strategy 1: Strengthen capacity of health research institutions

Main activities:

- Undertake a national institutional mapping and research capacity needs assessment
- Train critical mass of health professionals in health research
- Strengthen collaboration between health training institutions and research unit

Specific Objective 5: To establish systematic procedures for attracting and maintaining public and private research partnerships nationally and internationally by 2020

Strategy 1: Promote and maintain a national and international research partnership building

Main activities:

- Participate in national and international meetings and conferences to network with other partners
- Provide / commission technical assistance for Gambian institutions involved in research partnerships nationally and internationally
- Identify opportunities for postgraduate training, exchange visits, attachments, study tours and joint research studies with other International research institutions.
- Develop advocacy materials such as leaflets, briefing notes and reports on the role, function and activities of the council. The institutional network available to stakeholders

Specific Objective 6: To establish accountable and transparent mechanisms for attracting and managing funding for health research by 2020

Strategy 1: Attract funding from multiple sources

Main activities:

- Develop a Financial Sustainability Plan.
- Develop briefing documents for inclusion in round table donor discussions.
- Advocate for a budget line for research within the MOH&SW

- Advocate for 2% of the national health budget & 5% of external health project aid to be allocated to health research in line with the Algiers Declaration Conduct annual spending assessment on health research

4.5.3 Births and Deaths Registration

Specific Objective 1: To expand and improve the birth and death registration service by 2020

Strategy 1: Strengthen birth and deaths registration services

Main activities:

- Review and update of the Births, Deaths, Marriage Registration Act (BDMRA) 1990
- Advocate and adopt proposed amendments of the BDMRA
- Develop a draft of the implementation methodology/procedures based on the Act and administrative structure of the county
- Include the approved procedures in the training manual for Registrars

Strategy 2: Health promotion and education

Main activities:

- Develop and implement a nationwide awareness campaign based on a clear communication framework and informed by the key communication strategies of BCC, social mobilization of actors and advocacy targeting the political and social leadership
- Conduct awareness campaign at all levels including community (orient print and electronic media and conduct live and radio theatre programs on national and community radio).
- Orient and mobilize regional authorities, TACs, District Chiefs, Alikalos, VDCs, Venerable Religious Authorities, National Celebrities and Regional Level NGOs.
- Conduct a national forum on Birth Registration.

Specific Objective 2: To ensure Commodities (Materials), Protection, Archiving and Inventory by 2020

Strategies: Identifying commodity needs of the system and ensure that it is funded on a regular basis, and set up a proper archiving system besides protecting registers, at all levels

Main activities:

- Assessment of material need of the system

- Development a proper inventory system
- Ministry to create a budget line for civil registration, (training and refresh training of civil registrars, gradual improvement of the infrastructure and data archiving)

Specific Objective 3: To institutionalize and expand the computerization of births and deaths at all levels by 2020

Strategies: Strengthen computerization of birth and death registration system

Main activities

- Integrate births and deaths registration systems into DHIS2
- Train data entry clerk and health workers on the use of integrated birth and death registration system

4.5.4 Information, Communication and Technology

Specific Objective 1: To expand information and communication technology infrastructure at all levels by 2020

Strategy 1: Strengthen ICT at all levels

Main activities:

- Develop an ICT policy and strategic plan.
- Develop guidelines for ICT utilization and the procurement of ICT materials
- Institutionalize the inventory of ICT assets of the ministry
- Continuously update and upgrade the MoH&SW website.
- Provide security mechanisms to protect health data from internal and external threats
- Provide internet connectivity to areas that are not connected
- Increase the Internet connection bandwidth at all levels

Strategy 2: Establish national e-health program

Main activities:

- Build the capacity of ICT personnel for e-health
- Conduct an assessment to determine the scope of ICT activities at all levels.
- Procure the required ICT equipment for e-health.
- Train health workers on e-health
- Conduct an assessment of all hospitals for telemedicine.
- Expand telemedicine application to all the hospitals
- Develop DHIS2 mobile application on specific programs
- Customize Open Medical Record System (OMRS)

4.6 PROCUREMENT AND SUPPLY CHAIN MANAGEMENT

Preamble

Procurement cuts across supply of essential goods and services to the Ministry of health in order to facilitate effective health service delivery. One of the major procurement components are the drug procurement and supply chain management system, which consist of four core areas namely procurement policies and procedures, drug management capacity, drug supply management and quality assurance.

The management of drug supplies which comprise the procurement, storage, distribution and monitoring on use, is the main activity of National Pharmaceutical Services, MOH&SW. The Central Medical Stores of MOH&SW is responsible for procurement and distribution of medicines and other medical supplies of the public health facilities including government hospitals in a pooled procurement system. The hospitals as autonomous institutions are responsible for the management of its supplies, while Central Medical Stores (CMS) are responsible for the supplies of the health centres.

The bulk of the supplies are procured through tender process, with limited quantities of items purchased as supplementary or emergency orders. There are presently 716 items being purchased by CMS stores, categorized into five groups' i.e. drugs, galenicals and X-Ray consumables, medical and surgical items, dental and laboratory supplies.

Constraints

There is no mechanism in place for tracking resource utilization and accountability. The checks and controls are fragmented and absent in some bilateral funding and in-kind assistance to the health sector.

A recent procurement audit by the Internal Audit directorate under the Ministry Finance and Economic Affairs for the period 2013-2015 (quarter 1) found that most of the sampled types of purchases and contracts over the period were identified as high risk, failing the controls and compliance tests for the MoHSW. The MoHSW has no procurement unit, which hinders the efficient management of procurement based on Gambia Public Procurement Authority regulations.

Strategic Objective: Improve the procurement and supply management system and promote rational use of medicines by 2020

Main Activities

- Integrate RH Commodities into the NHP services
- Ensure adequate quality infrastructure for storage of commodities and supply
- Develop, print and distribute guide lines and tools on RH
- Provide license software.
- Procure modern ICT tools
- Procure computers for healthcare systems at all levels

4.6.1 Storage

The storage facilities for drugs and other medical supplies for health facilities are the central medical stores in Kotu, four regional medical stores (Brikama, Mansakonko, Bansang and Basse). The Central Medical Stores (CMS) is the receipt point for drugs and other medical supplies, so all cleared consignments are delivered to the CMS for verification prior to storage and distribution.

The supplies for the hospitals are delivered directly to the hospitals after clearing and verification of consignments. Storage facilities in the hospitals are limited and bulky supplies such as IV fluids; gauze, syringes etc. are stored at the CMS. The storage facilities and conditions in the regional stores are also limited and the bulk stock is stored in the CMS. The supplies for EPI, including sterilizers, syringes and needles etc. are stored in the medical stores.

4.6.2 Infrastructure

While infrastructure at the CMS is very good, the storage infrastructure at the health facility level is inadequate and requires improvement. Store personnel do not have adequate capacity for appropriate inventory management and record keeping.

4.7 POLICY, PLANNING, PROGRAMMING AND MANAGEMENT

Preamble

The development of coherent policies and plans are crucial to bring about real and sustainable change in national health systems and for the achievement of the MOH&SW overall goal. Public health planning directs the assessment of the health needs of certain populations and communities, analyse, evaluate and advocate for programs and policies, and use this information to develop plans for effective health care delivery. Planning may entail conducting research projects and investigative

studies, compilation and documentation of data and information; formulate recommendations and reports related to specific public health issues. Furthermore, effective planning clearly articulates the needs and diverse focus areas of different public health divisions and professionals, as well as for securing funding and resources.

At the top of the programme management hierarchy is the Permanent Secretary, deputy Permanent Secretaries, Chief Pharmacist, Chief Nursing Officer, Chief Public Health Officer, Directors and Steering Committees. Their major responsibility is to provide overall stewardship and oversee the implementation of policies and strategies and to define the programmes in connection to the health sector's overall strategic plan. Their management activities include providing and interpreting policies, creating an enabling environment that foster sustainable momentum for the programmes and periodically reviewing programme progress and interim results to ensure alignment with the overall strategic vision. These individuals receive periodic summary reports, outlining detailed retirements of funds.

Achievements

Currently, MOH&SW's main thrust in the field of national health policy and strategies is to provide focused support in the development and/or reinforcement of national health sector plans for achievement of the goal set by the health sector. The Ministry through its Planning and Information Directorate has coordinated the development of various national health policies and plans notability among these are the revised health policy 2012-2020, "Health is Wealth", the National M & E Plan 2015-2020, the country Compact IHP+ as well as giving the necessary technical support in policy formulation at Programme level.

Challenges

All plans and policies should be integrated into a wider poverty reduction and development framework, e.g. Vision 2020, the National development Plan 2017-2020 and these should be developed through a transparent and democratic process, involving stakeholders, especially peoples' representatives, community leaders, international organizations, non-governmental organizations (NGOs) and civil society. The plans should address problems associated with the chronic under-financing of basic health needs by establishing budget priorities that reflect a commitment to achieving MOH&SW goals and targets at the earliest possible time.

Whilst numerous challenges are confronting the health sector, plans are under way to critically review or analyse both the internal and external aspects of the health system. The review or the analysis will look at the internal dynamics of the health system from various angles as well as the external conditions affecting health service provision such as macro-economic and socio-demographic context. The main aspects of the review or analysis of the health sector will include:

- Macro-economic and socio-demographic frameworks
- Access and equity issues in health
- Quality of health services
- External efficiency
- Cost and financing of health
- Managerial and institutional aspects

Programmes should be designed based on national documents and priorities such as the upcoming National Development Plan 2017-2020, VISION 2020 blue print and other National Health Policies and Strategies. Within programmes the responsibilities should be assigned to managers at different levels in the management hierarchy; the higher the level the more general the responsibilities. The major responsibility of the middle level programme managers or directors are to ensure that the activities achieve the outcome specified in the health policies and strategies. This involves setting and reviewing objectives, coordinating activities across programmes and overseeing integration and reuse of interim work products and results. This is to say that the programmes managers or directors need to spent more time on integrating activities , negotiating changes in plans, communication, leading high level sessions for programme plan and scheduled development, reviewing or approving programme plans for conforming to programme strategies, conducting periodic briefings or status updates etc.

Strategic Objective: Estabish a well coordinated and functional mechanism for the development of coherent nationl health sector policies, plans and strategies by 2020

Specific Objective 1: Ensure various Programme strategic plans and policies are completely aligned with the National Health Policy 2012-2020 and the NHSP 2014-2020

Strategy 1: Coordinate the development of all strategic plans and policies

Main Activities:

- Participate/monitor the development of Programme specific policies and strategic plans within MOH&SW

- Coordinate the development and review of national health policies ,strategic plans , M& E plans and operational plans

Specific Objective 2: Ensure the existence of a well harmonized and coordinated monitoring and supervisory mechanism for MoH&SW by 2020

Strategy 1: Establish and coordinate all monitoring and supervisory activities within MOH&SW

Main Activities:

- Monitor the implementation of the National Health Strategic plan and the National M&E plan
- Monitor the activities of other units, RHTS, Public Health Facilities and Hospitals
- Training of health workers and RHT members on M&E
- Training of staff on M&E
- Institutionalize and harmonize performance assessment at all levels
- Quarterly monitoring and review of the activities of MoH&SW operational Plan

Specific Objective 3: Ensure NHSP 2014 -2020 is alligned to the National Development Plan 2017-2020 and Vision 2020

Strategy 1: Ensure that the NHSP 2014-2020 is in synergy with national development goals and targets

Main Activities:

- Mainstream core health-related Sustainable Development Goals (SDGs) into MoH&SW annual Operational Plans in line with the NHSP 2014-2020
- Strengthen the availability of baseline data for reporting and tracking Sustainable Development Goals indicators and targets

Specific Objective 4: Ensure critical performance appraisal is institutionalized and maintained as per international norms and best practices by 2020

Strategy 1: Conduct Annual Health sector review

Main Activities:

- Organize annual health sector review
- Preparation of Annual Health Sector Performance Report

Specific Objective 5: Ensure the availability of comprehensive annual progress report of Directorate of Planning and Information (DPI) and shared within the MoH&SW for the duration of the NHSP 2014-2020

Strategy 1: Ensure timely and comprehensive annual activity report for DPI

Main Activities:

- Prepare annual DPI's report
- Validate and disseminate report to all relevant stakeholders

Specific Objective 6: Conduct comprehensive national health mapping

By 2020

Strategy 1: Audit and update list of all existing health facilities including services provided

Main activities

- Desk top review to establish baseline data
- Development of survey instrument and staff training
- Data collection and management
- Data analysis, Validation and dissemination of report to all stakeholders

4.7.1 Quality Control & Assurance

Specific Objective: To provide an effective quality control and assurance system which has the potential to improve quality health care services according to set standards at all levels of the health system by 2020

Strategy 1: Improve client/ patient-centered services

Main Activities:

- Establish a client/ patient complaints system in all health facilities.
- Introduce a customer care programme in all health facilities.
- Establish a system of accountability to clients in all facilities.
- Ensure that facilities have a system in place for informed consent for both invasive and non- invasive clinical procedures.

Strategy 2: Improve client/ patient and healthcare provider safety

Main Activities:

- Establish a client/ patient and healthcare provider safety committees in all tertiary facilities
- Advocate and encourage a non- punitive medical error reporting system in health facilities
- Establish standardised adverse event reporting system in all facilities.

- Strengthen Infection Prevention and Control practices in all clinical service delivery points (with focus on hand hygiene and sterilization).

Strategy 3: Improve clinical practice

Main Activities:

- Develop Quality control guideline for quality management and improvement in health service
- Establish quality management system in tertiary facilities and Regional Health Directorates
- Establish clinical audit systems in all regions and hospitals.
- Strengthen the referral system

Strategy 4: Improve management system for quality improvement

Main Activities

- Strengthen supportive supervision and monitoring in health facilities
- Collaborate with various programme units in the provision of quality health services
- Improve use of health information for quality improvement within an integrated HMIS
- Ensure that both public and private health facilities are accredited
- To develop a national Quality Control and Assurance strategy
- Collaborate with the various regulatory and professional bodies to ensure that all staff are license to practice and ensure continuous education programmes are in place for healthcare providers

Challenges

- Despite having many quality assurance programmes in health service delivery, most if not all is donor driven; disease specific or program oriented. There are weak mechanisms in place to coordinate quality improvement at central and regional levels. There is need therefore, for the MOH&SW to harmonize and coordinate quality improvement in health services at all levels

CHAPTER 5

LEGAL AND REGULATORY 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 out-dated 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. It is also vital not to lose sight of the importance of Traditional Medicine as an essential part of our health care delivery system.

The regulatory system in place has at its apex the MOH&SW headed by the Honourable Minister. The other regulatory bodies are:

The regulatory system in place has at its apex at the MOH&SW headed by the Minister. The other regulatory bodies are:

- The Medical and Dental Council.
- The Nurses and Midwives Council
- The Pharmacy Council
- The Public Health Council (Final stage of creation)
- Health Professionals' Councils and Associations
- Regulations governing the Private health and health related sectors
- Regulations governing Traditional and other Alternative Health Care Services
- Suspected lunatic act
- Children Act
- Traditional and alternative medicines Act
- Medicine and all related health products Act
- Pharmacy Act
- Disability Act

The national health policy has alluded to the need for the establishment of the Public Health Council as an additional regulatory body.

Achievements

A number of regulatory bodies are in place, established by different ACTS of Parliament. This has enhanced certain activities already in place such as registration of professionals, establishment of Codes of Conduct, Ethical rules,

and professional guidelines. A number of mechanisms in place for review of professional conducts and institution of disciplinary procedures within certain legal limits have ensured the availability of guidelines for professional training including review of training curricular, and mechanism for accreditation of training institutions.

The Ministry of Health has participated in the harmonization process of undergraduate and postgraduate training within the West Africa Health organization (WAHO). This harmonization process takes on board codes of ethics and conducts as enshrined under WAHO mandate, seeking to resolve the weak collaboration amongst Councils both locally and internationally.

Challenges

Most of the Acts of the various Councils are to a large extent out-dated. Thus, there is need to review these Acts in order to bring them up to date and at par with those of other sister councils within the sub-region and beyond. This will include the review of the process for the creation of Public Health Council. Whilst there are prospects in place to review the outdated "Acts" and regulations in order to be consistent with emerging trends, as well as opportunities to establish robust Continuous Professional Development (CPD) programs. However, limited financial support to the existing councils continues to be a major bottleneck in health sector regulation.

Strategic Objective: To ensure effective and efficient health service provision through the development of effective regulatory framework and Promoting effective coordination and partnership with all partners.

Two service areas have been identified for this strategic Objective: legal and regulatory framework and coordination and partnership. Legal and regulatory framework will be guided by the public health act, pharmacy act, nursing and midwifery act, medical and the dental act . The strategic objective will ensure that all the enacted legal instruments will be harmonized and aligned to the current situation to eliminate the problems of divergence due to existence of several enacted legal instruments.

SERVICE AREA:

- Legal and Regulatory Framework
- Coordination and Partnership

5.1 LEGAL AND REGULATORY FRAMEWORK

Specific Objective 1: Review and update at least 5 existing Acts and Regulations and formulate at least 2 new ones to reflect current realities in the health domain (Public Health Laboratory Act, Occupational Health and Safety Act by 2020.

Strategy 1: Advocacy and networking for reviewing of existing Acts, Regulations and the formulation of new Acts

Main Activities:

- Create a Health Professions Council (HPC)
- Transfer licenses and Regulation of premises to Councils
- Amend all existing Acts and Regulations
- Formulate new Acts
- Conduct public sensitization on all Acts and Regulations
- Implement and monitor all existing Acts and Regulations taking into consideration the amendments that will be made
- Develop mechanism for coordination of Councils activities
- Make Acts readily visible and accessible
- Conduct regular review and update of all Acts
- Conduct periodic M&E and provide reports

Strategy 2: Resource mobilization

Main Activities

- Convene a round table conference involving all stakeholders
- Prepare and present Profiles/Proposals to Partners for Funding

Specific Objective 2: Reactivate three existing councils (Medical and Dental Council, Nurses and Midwives and the Pharmacy council) and set up one new council (Traditional and Alternative Medicine Council for the protection of the public by 2020

Strategy 1: Strengthen all existing Councils and constitute new ones

Main Activities:

- Allocate a Budget line and a mechanism to ensure it accrues to Councils
- Provide Human and Material Resources to all Councils
- Develop Procedures for Council Operations

5.2 COORDINATION AND PARTNERSHIP FRAMEWORK

Preamble

Coordination and Partnerships will provide technical support to the MOH&SW to better engage current and emerging partners. This will facilitate dialogue and advocate for effective service delivery and the utilization of available resources to the health sector. For the effective implementation of any strategy there is the need to identify and coordinate all actors from central, regional and community level. If all relevant structures and policies are properly harnessed, a smooth and coherent implementation of strategies will achieve the desired goals and objectives.

With the advent of increased global convergence towards sector wide approaches for the coordination of development partners' support and intervention in the health sector, it has become more urgent to institute country led coordination processes in line with the principles of the 2005 Paris Declaration on Aid effectiveness. The Harmonization for Health in Africa initiative that emerged in 2006; and the International Health Partnership plus Initiative (IHP+) of 2007 are regional and global partnerships that promote development of a comprehensive national Health Strategic Plan for implementation by all health stakeholders as well as the creation of a country coordination Forum for relevant actors to guide the implementation of the strategic plan. The IHP+ supports the development of a country compact that will serve as the memorandum of understanding, outlining each health partner's role in the implementation of the plan, under the leadership of the Ministry of Health.

Achievements

The Ministry of Health finalized a new national Health Policy "Health is Wealth" (2012-2020) that was endorsed by cabinet in 2012, following a five year period of numerous attempts to update the 2001 health policy "Changing for Good". With the health Policy in place, the Gambia signed on to membership of the Global Compact of the IHP+ in May 2012 and officially launched the initiative at the country level in August 2012.

The creation of a national health sector coordinating committee was initiated during the latter stages of the finalization of the Health policy, with several meetings held and a draft TOR for the committee developed. Other reforms for coordinating and monitoring interventions in service delivery include the proposal to revitalize the primary healthcare programme through the establishment of a PHC steering committee and the rejuvenation of the quarterly primary health care working party meetings that involve the staff of the regional health management teams. A major challenge for the health sector in coordination continues to be how to consolidate these recent developments into a solid governance framework that will drive the implementation of this Health sector strategic plan.

The coordination structure at regional health management level has significantly developed since the introduction of regional health administration. The structures in place including the presence of the Technical Advisory Committee at the Regional level, and the MDFTs at district levels, has enabled the involvement of VDCs and other CBOs in health related issues at village levels. These structures have led to increased collaboration with other Ministries and NGOs. The existing coordination structure at regional health management level has enhanced the integration of health activities at service delivery points and improved supervision at regional level.

Challenges

The coordination and management of the health sector is one of the major challenges faced by the MOH&SW. Internal coordination without health partners has been at best, ad-hoc with irregular management meetings not based on formalized format (TOR of Committee, frequency of meetings, action points and follow-ups); and at worst absent with the lack of an official policy and coordinating structure for health sector management. The poor coordination of donor funding, programmes and activities within the MOH&SW has led to duplication of resource allocation and utilization in some programme areas, leaving other critical areas under-resourced.

At the Ministry of Health both inter and intra sectoral coordination is a major problem, which needs to be addressed. There is a weak coordination of the health sector by central level management, exacerbated by the frequent turnover of senior management staff. Between 2003 and 2013, the Ministry of Health has witnessed the appointment of 8 Ministers of Health, more than 10 Permanent Secretaries, 7 Directors of Planning, and 5 Directors of Health Services. This has contributed to the failure to establish a stable coordination framework, despite several attempts.

As a result, supervision of regional level service delivery by central level is irregular, heightening the weak supervisory feedback at both central and regional level. The issue of data flows from the central level to regional level and community level is inadequate, as illustrated by the MOUs signed at central level not being communicated at regional level.

A standardized operational plan at the regional level is unavailable, and where regional plans exist, there is inadequate information flow between central, regional and community levels. There are irregular Senior Management Meetings at central

level and policy decisions tend not to be properly disseminated to programme levels and regional and community based health workers.

The existing poor coordination mechanism has adversely affected the establishment of an effective regulatory framework for the health sector. The undesirable outcome from this situation is that the main constraints facing the health sector such as inadequate staffing at facilities, inadequate resources and equipment, high staff attrition rate coupled with the poor motivation scheme, remains largely unresolved.

In order to reverse the current situation, the NHSSP outlines the establishment of a comprehensive coordination framework that covers both inter and intra sector coordination, including the service delivery management at the lower levels. This is based on the premise that Health sector governance and administration is one of the 6 building blocks of a comprehensive health systems management. The strategic objective and specific objectives and outlined strategies seek to reform coordination, regulation and management of the health sector over the implementation period of the NHSSP.

STRATEGIC OBJECTIVE 8: To ensure effective and efficient health service provision through the development of effective regulatory framework and Promoting effective coordination and partnership with all partners

Specific objective 1: Establish a functional Health Sector Coordination Mechanism for The Gambia by 2015

Strategy 1: Strengthen intra and inter-sectoral collaboration

Main Activities

- Review and restructure the organizational structure of MOH&SW in line with the requirements of the national health strategic plan and policy.
- Establish a proactive internal management committee for Ministry of health
- Establish Health Sector Coordinating Groups
- Create budget lines ,allocate resources and disburse
- Institute annual health sector review
- Conduct periodic M&E and write reports to HPC, following its establishment

Specific objective 2: Broaden partnership in Health service delivery

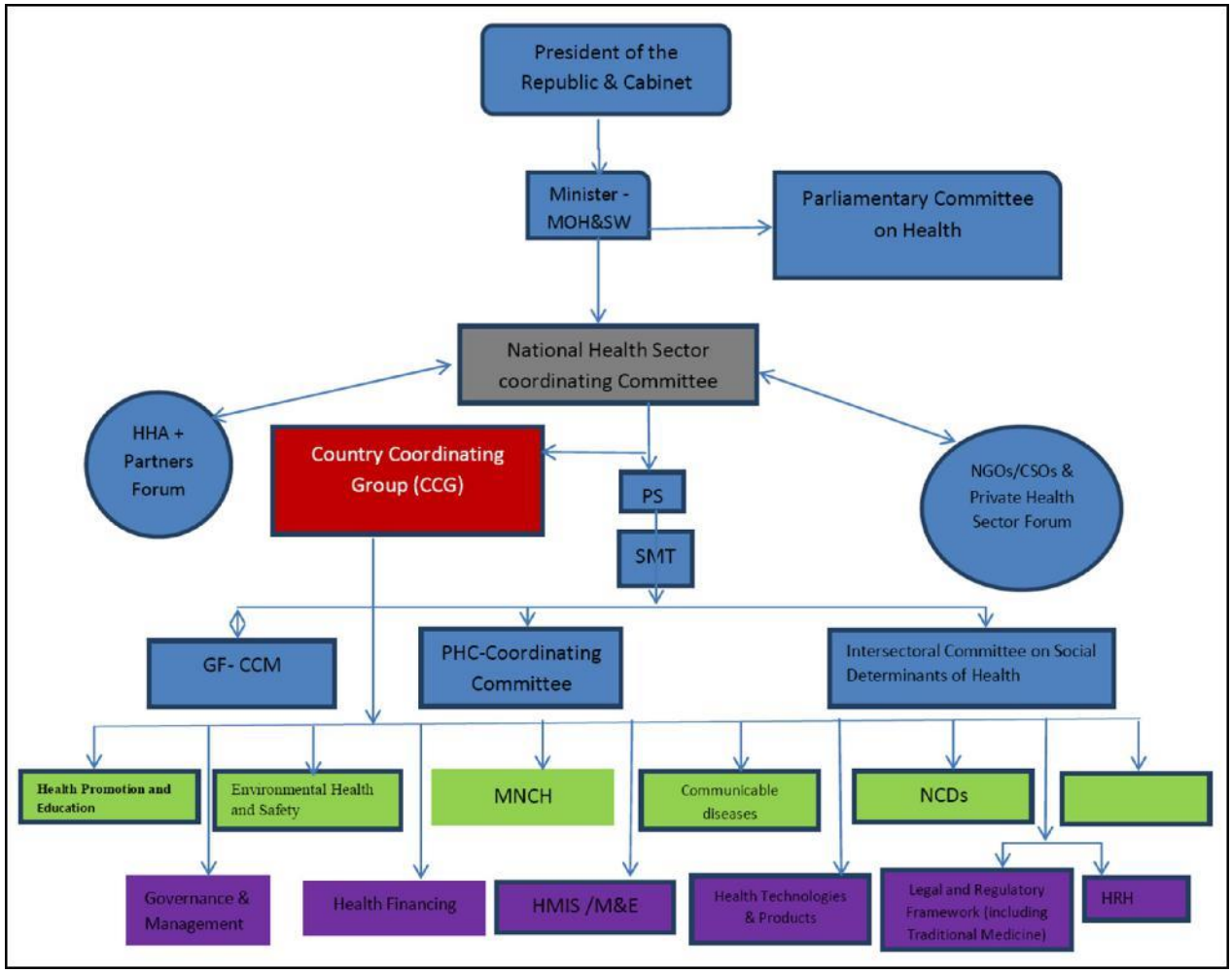
Strategy 1: Establishing a functional Health Partnership mechanism

Main Activities:

- Develop a Country Compact through the (IHP) Plus

- Develop MOUs with all relevant partners (NGO and Local Government)
- Sign performance contract agreement within MOH&SW and Local Government, NGO and Private Enterprises

Figure 4: Proposed Health Sector Coordination Mechanism for The Gambia


President of the Republic & Cabinet
Minister - MOH&SW
Parliamentary Committee on Health
National Health Sector coordinating Committee
HHA + Partners Forum
Country Coordinating Group (CCG)
PS
SMT
NGOs/CSOs & Private Health Sector Forum
GF- CCM
PHC-Coordinating Committee
Intersectoral Committee on Social Determinants of Health
Health Promotion and Education
Environmental Health and Safety
MNCH
Communicable diseases
NCDs
Governance & Management
Health Financing
HMIS /M&E
Health Technologies & Products
Legal and Regulatory Framework (including Traditional Medicine)
HRH

CHAPTER 6

MODALITIES FOR IMPLEMENTING THE GAMBIA HEALTH SECTOR STRATEGIC PLAN

Preamble:

For the effective implementation of any strategy there is the need to identify and coordinate all actors from central, regional and community level. If all relevant structures and policies are properly harnessed, a smooth and coherent implementation of strategies will achieve the desired goals and objectives. In view of this, the guiding pillars of the HSSP Implementation Strategy would be anchored on delivering the promise of accessible basic health care package grounded on the principles of equity, effective referral systems and active community participation for quality health care and client satisfaction. In addition, the concept of one National Health Plan, one integrated national health budget and one results monitoring framework.

6.1 MODALITIES FOR IMPLEMENTING THE GAMBIA HEALTH SECTOR STRATEGIC PLAN

6.1.1 HSSP Implementation Strategy

The overall strategy for implementing the NHSSP 2015-2020 is based on the following precepts:

- **Accelerating** action towards attaining improved health outcomes through effective delivery of the Gambia National Basic Health Care Package at **All** levels of the national health system
- Attaining **health equity**, not only in access to quality health care, but also in greatly improved **health status** of all the people resident in The Gambia
- Assuring effective **community ownership and participation** in all activities related to health
- Implementing the national policy and legislation on **Decentralization** of governance, including health service delivery
- Accelerating attainment of National Health Policy objectives on reforms in **health sector management at all levels**
- Strong **partnership** arrangements under effective national leadership and stewardship in accordance with the 2005 Paris Declaration and its subsequent High Level Forums on improving the effectiveness of development cooperation.

6.1.2 One National Health Plan, one integrated national health budget and one results monitoring framework

Coordination and Partnership aimed at galvanizing technical support to the MOH&SW for greater involvement and participation of the various actors for the health sector, which could in turn create that enabling environment for dialogue towards the judicious use of health resources for effective health service delivery. Recently, sector wide approaches have continued to shape funding requirements for the coordination of development partners' support and involvement in the health sector. To this end, the Harmonization for Health in Africa initiative in 2006; and the International Health Partnership plus Initiative (IHP+) 2007 are regional and global partnerships that promote development of a comprehensive national Health Strategic Plan for implementation by all health stakeholders as well as the creation of a country coordination Forum for relevant actors to guide the implementation of the strategic plan. The following are the various components for the establishments of one common basket funding and one coordinating mechanism for the health sector:

- This Health Sector Strategic Plan will be the main **guiding framework for ALL actors in health** development in The Gambia, irrespective of their status as signatories or not, to the Gambia IHP+ Country Compact.
- HSSP will be implemented through **3-year rolling plans and** detailed **Annual Operational Plans (AOPs)** that are consistent with the corresponding health sector 3-year rolling Medium Term Expenditure Framework and approved annual budget estimates respectively.
- Each 3-year rolling plan and MTEF will reflect two scenarios: (i) that am based on **actual commitments** of funding from Government, other predictable national resources available to the national health budget, and from the Health Development Partners (HDPs). Scenario (ii) will present a more optimistic, yet realistic reflection of the **highest priority needs** as defined in HSSP 2015-2020.
- The **Gambia IHP+ Country Compact** defines the fundamental principles and Common Working Arrangements for implementing the HSSP 2015-2020.
- One set of results monitoring framework for the IHP+ partnership will be selected from the overall HSSP Monitoring Framework for regular assessment of the performance of HSSP and its IHP+ partnership.

6.1.3 INTEGRATED DELIVERY OF THE BASIC HEALTH CARE PACKAGE

The Decentralized Health Care Delivery structures and institutions (Major and minor Health Centres, Primary Care Services) carry the heaviest responsibility for

delivery of BHCP. However, the Tertiary tier of services (Regional and National Referral Hospitals - including the Teaching Hospitals), share the burden of responsibility for delivery of the national Basic Health Care Package. Investments in the tertiary level must therefore be directly linked to hospital level delivery of and accountability for the basic Health Care Package.

The weighting of allocation to the various levels, and subsequently to each health facility will be influenced by considerations of equity, poverty reduction, and responsiveness to the Basic Health Care Package. These considerations will, also apply to **all** non- public sector facilities and institutions that receive funding and other support from the IHP+ Partnership.

Effective devolution of service delivery is a prerequisite for effective scaling up of the BHCP so as to attain universal coverage within the plan period. In collaboration with the Office of the President, the Ministry of Regional Administration and Lands, Ministry of Finance and Economic Affairs, the Personnel Management Office and the Regional, District and Community authorities (VDCs), MOH&SW will pursue vigorously, the re-establishment of the **Health Districts,** and as far as possible (in light of current financial and Human Resources for Health constraints), realign Regional and District health management structures to be co-terminus with the decentralized administrative structures, i.e. Municipalities, Regional Administration, Area Councils and VDCs, will be undertaken within Year 1 of HSSP implementation.

Accelerating the establishment and/or strengthening health service delivery to the most underserved areas – North URR, North CRR and Knifing Municipality will be accorded “first call status” for allocation of resources in the first two years of implementation.

The NHP requirements for Public-Private-Partnership for Health (PPPH) will be further strengthened and wherever appropriate support and or/funding will be provided to non-government organizations,

Institutions and facilities in their contribution to the attainment of universal coverage with the Minimum Health Care Package, as part of the devolution of service delivery, authority and responsibility, as well as progressive fiscal decentralization. In light with this, RHTs will be empowered to enter into **Results Based Financing type service level contracts with PPPH implementing partners.**

6.1.4 EFFECTIVE REFERRAL SYSTEM

The national Referral System will be strengthened by *inter alia*, establishing clear guidelines for referral, monitoring the effectiveness of the system, provision of adequate communications equipment and services including telephone land lines, mobile phones, internet service, other essential ICT needs, fully equipped ambulances, trekking and utility vehicles for All Hospitals and Major health Centres (and eventually to All Health Centres) as per the established standards and norms for service delivery.

6.1.5 QUALITY OF CARE AND CLIENT SATISFACTION

Standards and norms of service delivery for each level will be updated in line with HSSP expectations. Communities will be empowered to own and participate in their personal and their community's health. This will be achieved as part of the review/updating of the Health Mapping Report already available at the MOH&SW.

However, the overriding priority over the entire period of HSSP implementation will be on strengthening and consolidating **EXISTING HEALTH INFRASTRUCTURE** to enable them provide effective, integrated delivery of Basic Health Care Package. New facilities will only be established to fill proven gaps in access to services and therefore poorer health status indicators. In this regard, the full operationality of **ALL the Major Health Centres** will be restored within the first two years of HSSP implementation.

Initiatives already initiated by the MOH&SW in support of improved quality of care will be pursued and brought to scale. These include: training of Gambian Medical Officers to undertake **Essential Surgery and other common interventions**, unsupervised (WHO supported); the training of Teams (Medical Officers, Midwives, Nurse Anaesthetists and other personnel at Major Health Centre level to provide **Comprehensive Emergency Obstetric Care**, including the Caesarean Section, laparotomy for management of Ectopic pregnancy, and repair of ruptured uterus (supported MCAI, UK); using correct **hand washing** and **Maternity Cleanliness Champions Initiative** and **Clean delivery Kits** for health facilities as entry points for system-wide quality improvement (supported by Horizons Trust Gambia & Aberdeen University, UK Soapbox Collaborative; the NaNA managed Results Based Financing (RBF) initiative (WB funded); etc.

In collaboration with the health Professional Councils and Associations, a Service Quality Audit unit will be established in each health facility (including hospitals) within the first two years of HSSP implementation.

The Patients Charter will be revised and put into operation by the time of the Mid-term Review of HSSP.

6.1.6 SUPPORT/SUPERVISION AND MONITORING

In the quest for attainment of the highest levels of quality of care, a multi-disciplinary and intersectoral Supervisory and Mentoring Team will be established for each Health region. Clear guidelines for supervisory visits and tools such as supervisory check-lists will be developed for use within the second quarter of Year 1 of implementation.

Before the Mid Term Review of HSSP, decision will be taken as to the benefits or otherwise, of introducing the concept of a **District League Table** as an added incentive for improved performance.

The quarterly Technical Review missions will feed into the quarterly or biannual Country Coordinating Group (CCG) Meetings.

6.1.7 FRAMEWORK FOR IMPLEMENTING THE NHSSP 2014-2020

The structures and mechanisms that emerge from the development of **IHP+ Country Compact,** as well as the planned review of the entire health sector management structure so as to make it fit-for-purpose in the context of needs of HSSP.

6.1.8 MONITORING AND EVALUATION

Preamble

Monitoring and evaluation (M&E) is an action-oriented and pre-planned management tool that operates on adequate, relevant, reliable and timely data that is collected, compiled and analysed into information on programme/project objectives, targets and activities. The objectives of M&E are to improve the management and optimum use of resources for the health sector programmes and to make timely decisions to resolve constraints and/or problems of implementation.

Monitoring and evaluation of the implementation of the health sector strategic plan will be conducted through appropriate existing and new systems, procedures and mechanisms. The proposed monitoring and evaluation unit will be responsible for overall coordination of monitoring and evaluation activities. A separate national

monitoring and evaluation plan which is anchored on the vision, mission, objectives, and targets of the NHSSP, as well as on the three IHP+ principles of one strategy, one monitoring & evaluation framework and one coordinating mechanism has been developed to last the duration of the NHSSP. This plan will help in the implementation of the NHSSP 2014-2020, and will also support the implementation of the overall M&E system.

The development of a comprehensive M&E plan in itself is a major achievement and the intentional alignment of this plan with the NHSSP and the IHP+ speaks volumes in that no major challenges are foreseen to be encountered in the implementation of the plan. However, as with most M&E system implementation, we envisage minor hiccups such as untimely and incomplete HMIS data, inadequate data quality, inadequate infrastructure for timely reporting, inadequate HR capacity, and inadequate finances.

Going by the forgoing, the current M&E structure for the Ministry of Health and Social Welfare is fragmented as all programmes areas undertake their respective monitoring & evaluation activities despite the HMIS unit under the Directorate of Planning and Information tasked with overall monitoring and evaluation. However, with the coming into force the national health sector M&E Plan 2015-2020, a National M& E taskforce consisting of all relevant stakeholders will be constituted for the entire Ministry to be coordinated by the M&E unit under the Planning and Information Directorate.

6.1.9 GOAL/OVERALL OBJECTIVE OF THE M&E PLAN

The aim of Health Sector Performance Monitoring and Evaluation plan is to provide information that will enable tracking of progress to enhance the health sector's efficiency, and improve the quality and coverage of health services.

To establish a national harmonized mechanism for performance monitoring and impact evaluation with agreed upon sets of input, process, output, and outcome indicators for tracking implementation progress over the duration of the National Health Strategic Plan

To establish a system that is robust, comprehensive, fully integrated, harmonized and well-coordinated to guide monitoring of the implementation of the HSSIP and evaluate impact.

6.1.10 SPECIFIC OBJECTIVES OF THE M&E PLAN

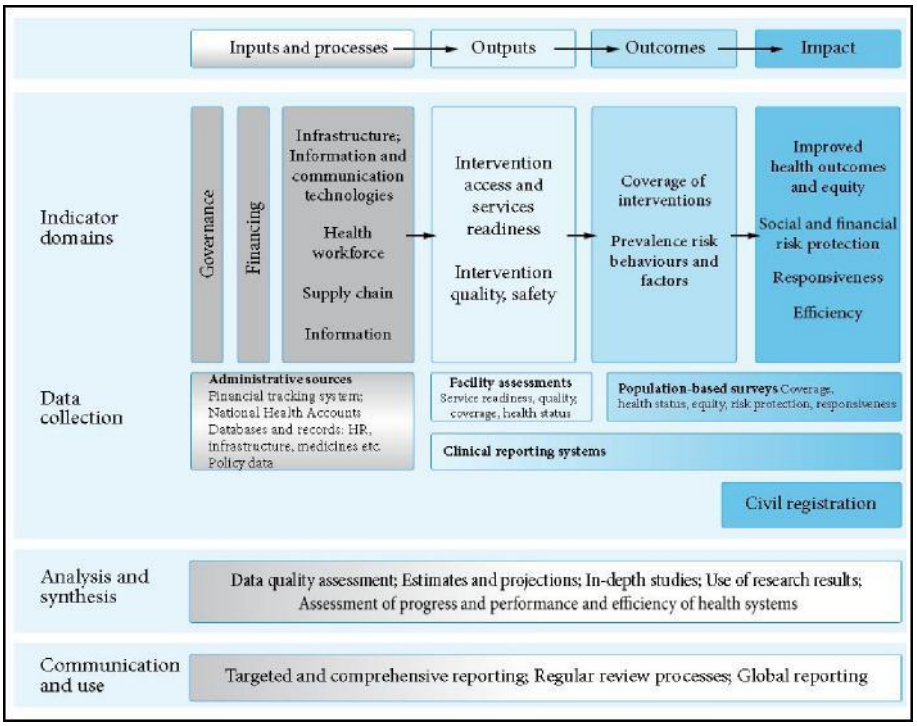
- To improve the quality of information, in terms of validity, accuracy, timeliness and completeness;
- To ensure that sector performance results are periodically analysed and disseminated to inform policy formulation and decision-making;
- To ensure a set of indicators, tools and the M&E system are adapted to monitor the quality of service delivery at national, district, health facility and community levels.
- To Evaluate the impact, effectiveness and cost-effectiveness health service delivery
- Improve information sharing and dissemination of information and the use of data for planning.
- To provide a health sector-wide framework for tracking progress and demonstrating results of over the medium term.
- To build technical capacity on M&E for regularly and systematically tracking of progress of implementation of the HSSIP.
- To facilitate MoH&SW and other stakeholders assess the health sector performance in accordance with the agreed objectives and performance indicators to support management for results (evidence based decision making),
- To improve compliance with government policies (accountability), and constructive engagement with stakeholders (policy dialogue).
- To facilitate continuous learning (document and share the challenges and lessons learnt) with in the health sector
- To promote the use of locally generated health information for effective planning and management.

6.1.11 INTERVENTIONS/STRATEGIES FOR M&E SYSTEMS STRENGTHENING

- Strengthen national technical capacity for monitoring and evaluation at all levels of the health system
- Harmonize M&E review, tools and methods among partners
- Strengthen logistics support for M&E systems
- Strengthen data quality assurance at all levels
- Gather and organize evidence-based information for improve health planning and management

- Improve Health information dissemination and use Improve National M&E system partnership with all stakeholders at all levels.

Figure 5: The Gambia National Health Strategy Plan



6.1.12 INDICATORS FOR MONITORING PROGRESS

The common M&E framework will guide the analysis of progress and performance toward the goals and targets of the GNHSSP. A key component of the GNHSSP monitoring and evaluation common framework is its Result Framework. This identifies the key indicators (Compiled M&E Appendix C) for monitoring progress using the logical framework approach.

Through the implementation of IHP+ country compact, the specific components will comprised of:

- The establishment of a unified, country-led data platform and procedures for collecting, analyzing and sharing data;
- Procedures for routinely assessing the performance of the health system in achieving its objectives are through:
- Demographic and Health Survey (DHS),
- Health Facility Surveys
- District Health Information System Version 2 (DHIS2),
- Household Surveys (MIS, MICS, IBBS and the BSS),
- Sentinel Surveillance
- Epidemiology and Disease Surveillance
- Formal mechanisms for periodically sharing performance results and revising targets and interventions will be through (HMIS Review Committee, JANS and National Health Research Conference).

6.1.13 INDICATORS, DATA SOURCES, AND REVIEW

Based upon the national sector performance indicators (**Compiled M&E Framework Appendix C**) and the log frames for each of the GHSSP components, a total of 83 **indicators** have been brought together from the primary data sources shown in **Table 7** below. Most of these sources are already well established within national priority health programmes of the Ministry of Health & Social Welfare.

Table 7: National sector indicators

Type	Data Source	Sum of Count of
Health Facility Survey	Health facility survey	3
	NHA	1
Household Survey	DHS	8
	HH Survey	2
MOH & SW Reports	MOHSW Reports	20
Routine Data	HMIS/DHIS2	6
	LMIS/M-supply	1
	CHANNEL	0
	iHRIS	24
	IFMIS	1
	IDSR	1
	LabMIS	2
	QA database	0
	Inventory Control System Database	14
Grand Total		83

The **HMIS (Health Management Information System)** is the primary source of routine data on health services provided through health centers, district hospitals, and referral services. The HMIS was substantially revised in 2011 to collect more relevant data. It has been built on a new web-based platform that should enhance data sharing and use. In addition, reporting formats have been introduced for all referral hospitals and private facilities, so coverage of reports should become even higher than it was in the past.

The **HRIS (Human Resource Information System)** was re-launched at the end of 2011, and the data are now maintained in a decentralized manner by hospital HR managers with support from the central level HR team. It now has active records of over 16,000 health professionals. This system is managed by the Directorate of Human Resource (DHR).

Logistics Management Information System (LMIS)

A Logistics Management Information System was established under the National Pharmaceutical Services (NPS) and funded under the Capacity Building Strengthening Plan of the Global Fund as per approved plan in 2011. This system was to strengthen the previously existing inventory control system of the NPS to further track supplies to the furthest level of the supply chain. Data generated at the field level is collected, compiled and sent to the RHT for verification and punching into the system. The electronic format of the data which is sent to the NPS always needs to be verified. This is done on a quarterly basis during our monitoring.

The consumption data is collected from the public, private; NGO and community managed/ owned health facilities by the primary data collectors. At the facility levels, registers are provided by the Ministry of Health to record all services that are being provided by the health workers.

CHANNEL

Since 2010 UNFPA through the RHCS program have been instrumental in the provision of training and tools to improve the LMIS system in the Gambia. This has led to the need for training of staff in the use of CHANNEL as 22 computers procured by UNFPA have been deployed to the health centres and regional stores immediately after the training.

The development of CHANNEL was undertaken in direct response for health supply management software that would be easy enough to use at warehouses and locations where computer usage is minimal and therefore capacity is not strong. It was developed to provide useful management reporting and also to be flexible and easily adaptable in a variety of country settings. The use of CHANNEL has proven to be useful and easy to use health supplies management software. The software is meant to automate the data collection and reporting requirements of the facilities at which it is used, and it is also meant to instruct and encourage good practices in logistics and supply management.

The Gambia Demographic and Health Survey (GDHS)

The first conducted Gambia Demographic and Health Survey **2013** is to provide current and reliable information on demographic and health indicators on the general population, adolescents, youth and the elderly by gender for use in Government

policy, planning, programming and decision-making. The GNHSSP planning process has greatly been informed by data derived from **GDHS, 2013.**

The **National Health Account (NHA)** framework, an internationally recognized methodology for comprehensively tracking spending within the health sector, will institutionalized to track the health spending within the health sector. The 2013 NHA study will soon be finalized and presented to the National Steering Committee on NHAs before being published.

The National Census 2013 will provide much-needed data for updating the denominators for calculating key service coverage indicators and better understanding the impact of certain equity and public health initiatives. Several of the disease control programs have scheduled surveys to collect data more frequently, particularly among high-risk populations and in highly endemic areas. These include the Malaria Indicator Survey, AIDS Indicator Survey, an HIV incidence survey and the Behavioral Surveillance Study (BSS) and IBBSS (Integrated Bio-Behavioral Surveillance Study).
The results of quarterly and annual data quality audit reports will be published on the MOH website and discussed during Joint Health Sector Reviews in order to maintain progress already made in this area.

PBF incentives for timely reporting have dramatically improved reporting rates and completeness, while the recent exercise to harmonize health facility registers and recording tools is expected to improve data accuracy.

In addition the Implementation of Results Based Financing (RBF), a World Bank (WB) Project by the MOH and NaNA which started off as a pilot in 2012 in the North Bank West Region will be scaled up in the other health Regions such North Bank East Region, Central River Region and Upper River Region in 2014.

In 2012, the Ministry of Health conducted and published the report on an investment case for the Health Sector using the **Marginal Budgeting Bottlenecks (MBB)** as an evidence-based planning and budgeting tool with support from UNICEF and partners.

The Gambia investment case as being proposed is ultimately intended to support preparation of the 2012-2015 National & Regional health sector investment case plan with its budget, inform Government as well as donor funding, and help national

and regional leaders to make informed choices or important decisions about adoption of new health strategies and resources allocation. Information derived from the invest case based on the different scenarios could effectively be used to inform the MTEF (2015-2017) in terms of cost projections.

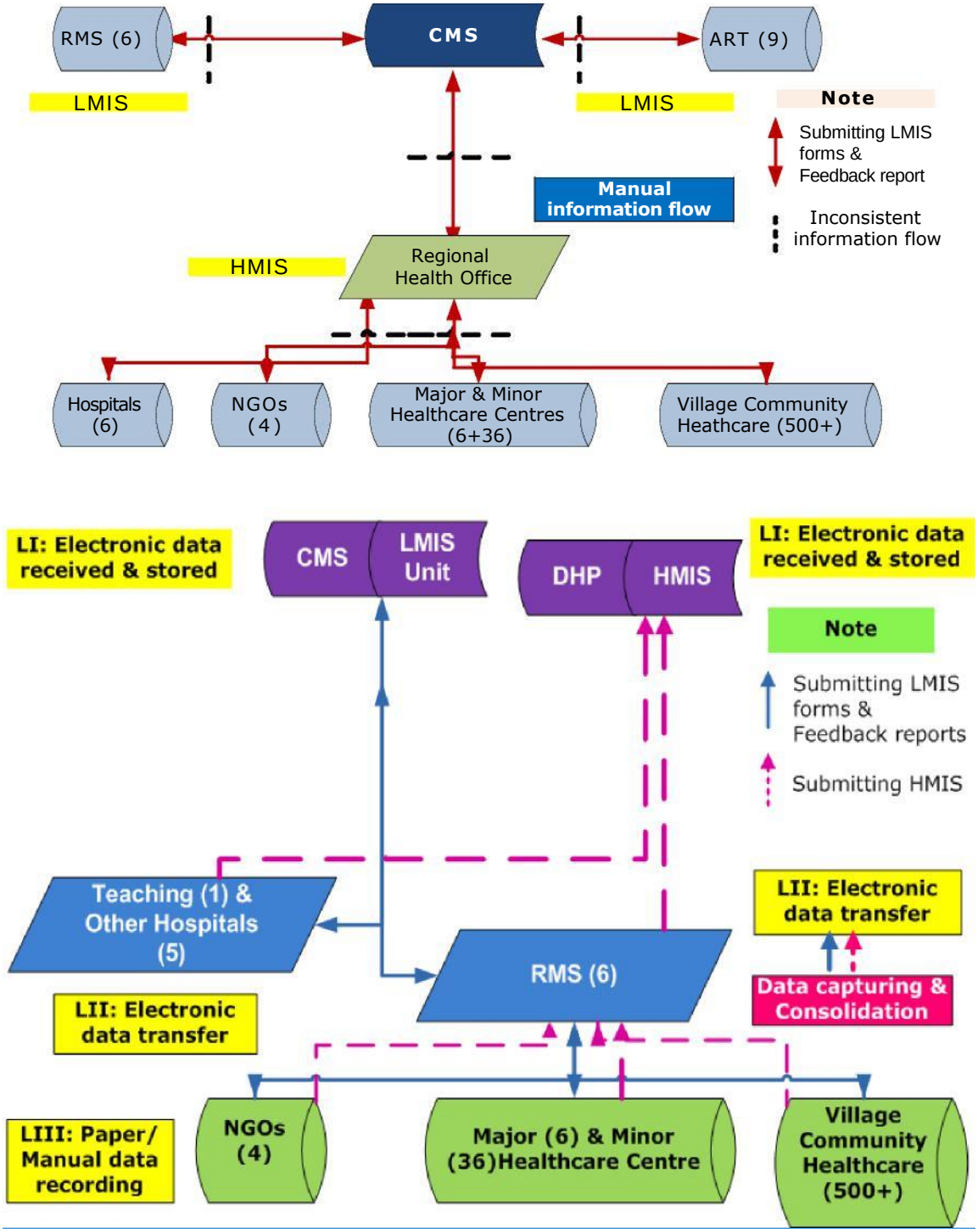
The purpose of the investment case is primarily to support us and partners to improve the use of evidence in developing national and regional health plans, and enhance the allocation efficiencies of health budgets through evidence-based costing and budgeting. A secondary goal, given the broad inter agency involvement in this effort, is to promote coordinated donor support towards the health- related MDGs.

6.1.14 Reporting, monitoring, and evaluation

There is clear need for a vibrant monitoring and evaluation plan and systems that allow for meaningful reporting, monitoring and evaluation of the different components of the health financing system, as well as the entire system as a whole. The role of M&E lies with the Directorate of Planning and Information of the Ministry of Health. As such, they will develop a comprehensive plan and will be responsible for undertaking the activities of this plan. A detailed M&E plan will be developed as part of the planned Health Strategic Plan. The M&E framework will includes output and outcome indicators of performance, against which the health system will be assessed annually over the GN HSSP 2014-2020

Process Mapping of Recommended LMIS

Figure 6: Recommended integration and flow of LMIS/HMIS data



Appendix A

CONSOLIDATED ANNUAL GHSSP 2014-2020

ESTIMATED COST IN US DOLLARS($)

Ref	Strategic Objectives:	2014	2015	2016	2017	2018	2019	2020	TOTAL
SOb1	To provide high quality basic health care services that is affordable, available and accessible to all Gambians	3,566,716.00	3,566,716.00	1,196,229.10	1,671,538.19	1,213,921.82	1,050,659.48	2,062,220.10	12,674,297.97
	To provide high quality basic health care services that is affordable, available and accessible to all Gambians	2,221,907.03	800,065.24	895,526.92	1,086,151.01	907,209.89	806,953.90	988,737.54	7,706,561.53
SOb 2.2	To reduce the burden of non communicable diseases to a level that they cease to be a public health problem	1,851,102.00	1,031,001.00	1,040,092.00	1,248,783.00	1,060,926.00	1,050,424.00	1,108,353.00	8,390,681.00
SOb 3	To ensure the availability and retention of highly skilled and well-motivated Human Resource for Health based on the health demands	712,259.20	182,261.00	185,831.00	459,069.46	188,382.00	183,791.00	322,923.00	2,234,516.66
SOb 4	To improve the effectiveness and efficiency of Health Information System for Planning and decision making to yield improved service delivery	1,242,679.00	193,782.60	197,521.40	324,358.60	200,134.40	195,472.80	335,684.00	2,689,634.80
SOb5	Increase access to quality pharmaceutical, laboratory, radiology and blood transfusion services to all by 2020	4,132,209.05	2,451,734.83	4,323,993.34	2,496,910.33	2,534,073.22	2,472,318.93	2,549,743.69	20,960,983.39
SOb6	To improve infrastructure and logistics requirements of the public health system for quality health care delivery	16,802,743.59	2,096,237.13	1,638,132.74	1,632,638.28	1,629,543.90	1,622,093.82	1,620,725.38	27,042,114.84
SOb7	To establish an effective, efficient, and sustainable health sector financing mechanism by	143,364.00	105,874.00	107,949.00	107,356.00	109,430.00	106,764.00	109,627.00	790,364.00
SOb8	To ensure effective and efficient health service provision through the development of effective regulatory framework and Promoting effective coordination and partnership with all partners	177,000.00	15,008.00	15,162.00	15,218.00	15,512.00	15,134.00	15,540.00	268,574.00
Sub-total Annual		30,849,979.87	10,442,679.80	9,600,439.50	9,042,032.87	7,859,133.23	7,503,611.93	9,113,553.71	82,757,728.19
Grand Total									$ 82,757,728.19

Appendix B

STRATEGIC OBJECTIVE 1:		**To provide high quality basic health care services that is affordable, available and accessible to all Gambians**								
						TIMEFRAMEWOR				
			2014	2015	2016	2017	2018	2019	2020	**Total**
						USD				
Specific		**Main Activities**								
To reduce MMR by 25% (433/100,000		Pre-pregnancy counselling in family planning clinics in major and minor health	15000	16080	16395	16305	16620	16215	16650	**$ 113,265.00**
		Conduct communication and social mobilization activities on pre-	13000	13936	14209	14131	14404	14053	14430	**$ 98,163.00**
		Establish and conduct School Health	18,000	19296	19674	19566	19944	19458	19980	**$ 135,918.00**
		Conduct HPV immunization for girls age 9 -13	700,000	0	0	0	0	0	0	**$ 700,000.00**
		Conduct operational research on	260,000	0	0	0	0		0	**$ 260,000.00**
		Develop, print and distribute guidelines and tools for MCH 2	7,250		7924.25	0	8033	0		**$ 23,207.25**
		Train health care providers on the use of the	25,650	27496.8	$ 28,035.45	$ 27,881.55	$	$	$	**$ 193,683.15**
		procurement of antenatal care equipment and supplies per	60,895	65279.44	66558.235	66192.865	67471.66	65827.49	67593.45	**$ 459,818.15**
		Procurement of adequate equipment and supplies for EMONC	260,000			282620	0	0	0	**$ 542,620.00**
		Conduct maternal Nutrition education and	10,000	10720	10930	10870	11080	10810	11100	**$ 75,510.00**

		Procure furniture for RCH clinics per annum	52,000	55744	56836	56524	57616	56212	57720	**$ 392,652.00**

DISAGGREGATED WORK PLANS

		Conduct maternal morbidity and mortality	33,850	36287.2	36998.05	36794.95	37505.8	36591.8	37573.5	**$ 255,601.35**
		Provide maternal and new born	256,410	274871.5	280256.1	278717.67	284102.2	277179.	284615.1	**$ 1,936,151.91**
		Train health care providers on the signal	6,500	6968	7104.5	7065.5	7202	7026.5	7215	**$ 49,081.50**
		Develop, produce and distribute guidelines and	3,282	0	0	0	0	0	0	**$ 3,282.00**
		Provision of focused antenatal care, intra and post-	100,000	107200	109300	108700	110800	108100	111000	**$ 755,100.00**
To reduce neonatal mortality rate		Procurement high quality equipment, and supplies for	260,000		284,180	0	288080	0	288600	**$ 1,120,860.00**
		Procure furniture for	30,680	32888.96	33,533	33349.16	33993.44	33165.0	34054.8	**$ 231,664.68**
		Conduct maternal morbidity and mortality	123,072	131,933	134,518	133,779	136,364	133,041	136,610	**$ 929,316.67**
		Provide maternal and new born	900,000	964,800	983,700	978,300	997,200	972,900	999,000	**$ 6,795,900.00**
		Integrate CEMoNC signal functions in health training	385	0	0	0	0	0	0	**$ 385.00**
		Train tutors on CEMoNC sig-	3,850	0	0	0	0	0	0	**$ 3,850.00**
		In-service training of service providers on	10,256	10994.43	11209.80	11148.272	11363.64	11086.7	11384.16	**$ 77,443.06**

		Training of health care providers to specialized levels(pre-operative	0	0	0	0	0	0	0	**$ -**
		Procure equipment for operating theatres and	51,600	0	0	56089.2	0	0	57276	**$ 164,965.20**

		Expansion and refurbishment of existing structures to facilitate implementation of	30,770	32985.44	33631.61	33446.99	34093.16	33262.37	34154.7	**$ 232,344.27**
		Conduct bi-annual health meetings to include maternal and new born audits in both public and private health	5,130	0	5607.09	0	5684.04	0	5694.3	**$ 22,115.43**
		Conduct advocacy	13,465	14434.4	14717.24	14636.45	14919.22	14555.	14946.15	**$ 101,674.22**
		Development of a comprehensive Communication strategy on reproductive	1,285	0	0	0	0	0	0	**$ 1,285.00**
		Build the capacities of health workers on Interpersonal Communication Skills for effective RH	6,500	6968	7104.5	7065.5	7202	7026.5	7215	**$ 49,081.50**
		Conduct media campaign to create demand for RH services	9,230	9894.56	10088.39	10033.01	10226.84	9977.6	10245.3	**$ 69,695.73**
		Community sensitization on danger signs during pregnancy,	5,000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**
		Develop, introduce and ensure the use of infection control policy, guidelines and protocols at	3,282	3518.304	3587.226	3567.534	3636.456	3547.842	3643.02	**$ 24,782.38**

		Introduce and apply performance and quality improvement	20,000	21440	21860	21740	22160	21620	22200	**$ 151,020.00**

		Develop, produce and distribute communication support materials on RCH	3,282	3518.30	3587.226	3567.534	3636.456	3547.8	3643.02	**$ 24,782.38**
		Community sensitization on danger signs during pregnancy	5,000	5360	5465	5435	5540	5405	22200	**$ 54,405.00**
To increase the proportion of women who register in the		Training health care providers on focused antenatal care	14,359	15392.8	15694.38	15608.23	15909.77	15522.	15938.49	**$ 108,424.81**
		Introduce incentive package to promote early antenatal booking	75,000	80400	81975	81525	83100	81075	83250	**$ 566,325.00**
		Community engagement and sensitization on the importance of early antenatal	1,538	1649.23	1681.538	1672.307	1704.615	1663.07	1707.692	**$ 11,616.92**
		Training, recruitment, renumeration and appropriate deployment of								**$ -**
To increase the Contraceptiv		Review , update, print and distribute the existing FP	5500	0	0	0	0	0	0	**$ 5,500.00**
		Procure adequate method mixed	51285	0	56054.50	0	56823.78	0	56926.35	**$ 221,089.64**
		capacity building for service provider on FP issues and	25000	0	27325	0	27700	0	27750	**$ 107,775.00**
		Conduct Family Life education in schools	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**

		Conduct research on CPR every five year	260,000	0	0	0	0	0	0	**$ 260,000.00**
		Engage opinion and religious leaders on FP	10,000	10720	10930	10870	11080	10810	11100	**$ 75,510.00**
		Encourage male involvement on FP services	12,000	12864	13116	13044	13296	12972	13320	**$**
To promote and enhance infection-free		Provide a comprehensive sexual and reproductive health (SRH) service at all levels of care delivery.	100000	107200	109300	108700	110800	108100	111000	**$ 755,100.00**
		Introduce and roll-out adoles-cent-friendly SRH services	65000	69680	71045	70655	72020	70265	72150	**$**
		Conduct public sensitization on the causes, prevention and management of RTIs	13500	14472	14755.5	14674.5	14958	14593.5	14985	**$**
		Promote the correct and consistent use of condoms and	150000	160800	163950	163050	166200	162150	166500	**$**
		Training of tutors and service providers on the syndromic	13,462	14430.76	14713.461	14632.692	14915.38	14551.9	14942.30	**$**
To Promote and		Engage policy makers, par-liamentarians, professional bodies and faith based organizations on SRH related gender	15000	16080	16395	16305	16620	16215	16650	**$ 113,265.0**
		Engage religious and influential leaders on SRH-related issues.	11000	11792	12023	11957	12188	11891	12210	**$**

		sensitize men on participation in RCH services, gender-based violence and harmful socio-cultural practices	15000	16080	16395	16305	16620	16215	16650	**$ 113.265.0**
		Engage print and electronic media to raise awareness on SRH.	10000	10720	10930	10870	11080	10810	11100	**$**
		Design and re-design health facilities to promote male								**$ -**

		Promote dialogue be-tween young people, adults and policy makers using appropriate channels of communica-	15000	16080	16395	16305	16620	16215	16650	**$ 113,265.00**
		Sensitize adolescent/ youth on the availability and use of	15000	16080	16395	16305	16620	16215	16650	**$ 113,265.00**
		Orientate tutors on the updated SRH module of the	1,000	0	0	0	0	0	0	**$ 1,000.00**
		Conduct community sensitization for awareness creation on SRH issues	15000	16080	16395	16305	16620	16215	16650	**$ 113,265.00**
To increase access to quality SRH		Increase access to qual-ity SRH youth –friendly in-formation and	5400	5788.8	5902.2	5869.8	5983.2	5837.4	5994	**$ 40,775.40**
		Advocate for more functional	0	0	0	0	0	0	0	**$ -**

		Build and strengthen capacities of training intuitions and	5128	5497.21	5604.904	5574.136	5681.824	5543.3	5692.08	**$ 38,721.53**
		Advocate for active involvement and participation of parents, communities and religious leaders, policy makers in	897	961.584	980.421	975.039	993.876	969.65	995.67	**$ 6,773.25**

		Promote dialogue between young people, adults and policy makers using appropriate channels of communica-	0	0	0	0	0	0	0	$ -
		Sensitize adolescent/ youth on the availability and use of	3585	3843.12	3918.405	3896.895	3972.18	3875.3	3979.35	**$ 27,070.34**
		Orientate tutors on the updated SRH module of the pre-service	800	857.6	874.4	869.6	886.4	864.8	888	**$ 6,040.80**
		Conduct community sensitization for awareness creation on SRH issues and	5385	5772.72	5885.805	5853.495	5966.58	5821.1	5977.35	**$ 40,662.14**
To Reduce under five mortality		Health education and promotion on key positive	0	0	0	0	0	0	0	$ -
		Review, update, print and distribute IMNCI manuals and recording tools	12,000	12864	13116	13044	13296	12972	13320	**$ 90,612.00**
		Conduct Operational research on	27,000				29916			**$ 56,916.00**
		Capacity building of service providers on	6,000	6,432	6,558	6,522	6,648	6,486	6,660	**$ 45,306.00**
		Procurement of equipment, medicines and								
To Reduce infant mortality		Promote exclusive breastfeeding and initiation of EBF at	92000	98624	100556	100004	101936	99452	102120	**$ 694,692.00**

		Strengthening of Immunization services and community education on	55,000	58960	60115	59785	60940	59455	61050	**$ 415,305.00**
		Food supple-mentation for	50,000	53600	54650	54350	55400	54050	55500	**$ 377,550.00**
		Provide and promote the use of Oral Rehydration Salt	45,000	48240	49185	48915	49860	48645	49950	**$ 339,795.00**
		Provide equipment, drugs and other supplies	57,000	61104	62301	61959	63156	61617	63270	**$ 430,407.00**
		Provide adequate under five and infant lifesaving drugs	75,000	80400	81975	81525	83100	81075	83250	**$ 566,325.00**
		Community education on timely intro-duction of	21,000	22512	22953	22827	23268	22701	23310	**$ 158,571.00**
To reduce the incidence of unintended pregnancies and unsafe abortion		Develop norms, standards and guidelines on management of post abortion com-plications	3,462	0	0	0	0	0	0	**$ 3,461.54**
		Preven-tion and management of	700,000	750400	765100	760900	775600	756700	777000	**$**
		Train health staff on the management of post abortion	50,000	0	54650	54350	55400	54050	55500	**$ 323,950.00**
		Provision of adequate drugs and supplies for the management of post abortions	65,000	69680	71045	70655	72020	70265	72150	**$ 490,815.00**
		Train health staff on counseling on family planning, unwanted pregnancies and	24,231	25975.3	26484.23	26338.84	26847.69	26193.4	26896.1	**$ 182,966.54**

		Increase in the use of effective contraceptive methods, results in reducing unintended pregnancies and consequently the incident of abortion.	50,000	53600	54650	54350	55400	54050	55500	**$ 377,550.00**
		Provision of adequate and appropriate equipment, drugs and supplies in the management of post abortion complications.								**$ -**
To identify, detect and manage early		Develop guidelines and protocols on diagnosis and management of infertility/	3,462	0	0	0	0	0	0	**$ 3,461.54**
		Train health staff on screening, diagnosis and management of infertility including HIV/ STI screening and effective interventions before/after diagnosis and attending	24,231	25975.38462	26484.23077	26338.84615	26847.69231	26193.46154	26896.15385	**$ 182,966.54**
		Advocate, review and develop RH policy to adequately capture infertility issues and	5,769							**$ 5,769.23**
		Research on infertility issues.	27,000							**$ 27,000.00**
		Infertility services covering a comprehensive range of fertility.								**$ -**

To provide HPV vaccine to 75% of girls age 9-13 years		Train RH service providers on cervical and prostate cancers prevention, control and management per annum	24,231	25975.38462	26484.23077	26338.84615	26847.69231	26193.46154	26896.15385	**$ 182,966.54**

To provide cervical cancer screening and		Procure cervical cancer management equipment and supplies every 2	45,000		49185		49860		49950	**$ 193,995.00**
To establish prostate cancer		Provide cervical cancer screening and management services in all the regions yearly	20,000	21440	21860	21740	22160	21620	22200	**$ 151,020.00**
		Procure prostate cancer management equipment and	60,000			65220			66600	**$ 191,820.00**
		Conduct base line assessment to gauge the prevalence reproductive cancers(cervical,	50,000	0	0	0	0	0	0	**$ 50,000.00**
		Develop, print and distribute guidelines and tools on reproductive	10,000	0	0	10870	0	0	11100	**$ 31,970.00**
		Establish and equip fistulae management	50,000	0	0	0	0	0	0	**$ 50,000.00**
		Conduct community sensitization on the causes, prevention and management of reproductive morbidity among men, women and	20,000	21440	21860	21740	22160	21620	22200	**$ 151,020.00**
		Provide Breast cancer screening, diagnosis and management	0	65,000	0	0	0	0	0	**$ 65,000.00**
To Protect and promote quality		Train service providers on adequate and appropriate	100,000	0	120000	0	0	0	0	**$ 220,000.00**

		Procure adequate and quality	200,000	150,000	170,000	180,000	165,000	195,00	150,000	**$**

To improve the referral system at all		Procure fully equipped motor vehicle ambulances and	0	1,000,00	0	0	0	0	0	**$**
		Update referral protocols guidelines and	5,000	0	0	5435	0	0	0	**$ 10,435.00**
		Build the capacity of the referral service	0	100,000	0	0	0	0	0	**$ 100,000.00**
		Conduct operational re-search on the current referral	15,000	0	0	16305	0	0	0	**$ 31,305.00**
To improve the essential surgical		Train doctors, anesthetists laboratory personnel, and nurses on the essential surgical	20,000	21440	21860	21740	22160	21620	22200	**$ 151,020.00**
		Developing, Printing and distribution of essential surgical	0	10,000	0	0	0	0	0	**$ 10,000.00**
		Provide essential surgical equipment and	60,000		64320		66480		66600	**$ 257,400.00**
To revitalize primary health care services		Orientation and sensitization of com-munities on PHC services	2500	2680	2732.5	2717.5	2770	2702.5	2775	**$ 18,877.50**
		Training of TBAs, VHWs, VSGs on danger signs during pregnancy delivery and puerperium period for the	0	15679	0	17043.073	0	0	0	**$ 32,722.07**
		Train and retrain VHWs and TBAs for expansion of	20542	0	0	22329.15	0	0	0	**$ 42,871.15**
		Construct and refurbish village health post	250,000	0	0	0	0	0	0	**$ 250,000.00**
		Review BI strategy and implement recommenda-	9876	0	0	0	0	0	0	**$ 9,876.00**

		Catchment area commit-tee training for 18 existing BI	38256	0	0	0	0	0	0	**$ 38,256.00**

		Create incentives for	30,000	32160	32790	32610	33240	32430	33300	**$ 226,530.00**
		Procurement of drugs and	42,857	45942.8	46842.85	46585.71	47485.71	46328.5	47571.4	**$ 323,614.29**
		Build capacities of VDCs, VSGs,	7633	0	0	0	0	0	0	**$ 7,633.00**
TOTAL			6847973	5535851	5116599.	4964134.	5089031.	4479442	5196528	**$**
Strategic Objective	**To reduce the burden of communicable diseases to a level that they cease to be a public health**									
Specific		**Main Activities**								
To increase immu nization coverage to at least 90%		Procureme nt and distribution of vaccines , deworming	410256. 4103	0	0	0	0	0	0	**$ 410,256.41**
		Conduct National Immunization	102564.	0	0	0	0	0	0	**$ 102,564.10**
		Provide functional	128205.	0	0	0	0	0	0	**$ 128,205.13**
		Training of HCWs on immunization	15384.6	16492.3	16815.38	16723.07	17046.15	16630.7	17076.9	**$ 116,169.23**
		strengthen Cold chain	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**$ -**
		Strengthen Supplementa-ry immuniza-	0	0	0	0	0	0		**$ -**
		Conduct communica-tion & social	0	76923.0						**$ 76,923.08**
		Ensure training of HCWs on	10256.4	10994.8	11210.25	11148.71	11364.10	11087.1	11384.6	**$ 77,446.15**
Reduce the incidence of infection caused by		Procurement and distribution of anti-	50,000	53600	54650	54350	55400	54050	55500	**$ 377,550.00**
		Training and retraining of HCWs on malaria case	0	65,000	0	0	0	0	0	**$ 65,000.00**

		Training and retraining of community health	650,000	696800	710450	0	0	0	721500	**$**

		Provide anti-malarial drugs and other	200,000	214400	218600	217400	221600	216200	222000	**$**
		Conducting therapeutic efficacy studies on	0	50,000	0	0	0	0	0	**$ 50,000.00**
		Conduct quality assurance / quality	0	0	25,000	0	0	0	0	**$ 25,000.00**
		Conduct quality assur-ance / quality control of lab diagnosis of		25,000	0	0	0	0		**$ 25,000.00**
To provide treatment, clinical care and support to at least 95% of		Conduct Community VCT (outreach)	5,755	6169.772308	6290.635385	6256.103077	6376.966154	6221.570769	6376.966154	**$ 43,447.40**
		Integrate and establish new VCT sites	3,956	4241.27	4324.356	4300.617	4383.702	4276.87	4391.615	**$ 29,874.85**
		Development of VCT training manual for HCWs includ-	9,991	0	0	0	0	0	0	**$ 9,991.03**
		Established wellness centres at hotspot area targeting key	1,949	0	0	0	0	0	0	**$ 1,948.72**
		Integrate VCT into PCH clinics	12,519	13420.6	13683.51	13608.40	13871.30	13533.2	13896.34	**$ 94,532.71**
		Sensitization of women and men on PMTCT	4,800	5145.6	5246.4	5217.6	5318.4	5188.8	5328	**$ 36,244.80**
		Establish the national molecular diagnostic	0	0	0	0	0	0	0	**$ -**

		Establish efficient referral system between ANC and ART sites and review	3,708	0	0	0	0	0	0	**$ 3,707.69**

		Build capacity of health care workers and health management	9,644	10338.2	10540.72	10482.86	10685.38	10424.9	10704.66	**$ 72,820.68**
		Equip selected ANC sites to provide ART	6,572	7044.96	7182.971	7143.541	7281.548	7104.11	7294.692	**$ 49,623.62**
		Strengthen existing	2,068	2216.84	2260.267	2247.860	2291.287	2235.45	2295.423	**$ 15,615.08**
		Development of Streamlining Task and Roles to Expand Treatment and Care for HIV (STRETCH)	10,159	0	0	0	0	0	0	**$ 10,159.49**
		Ensure uninterrupted supply of ARVs and drugs for	89743	96204	98089	97550	99435	97012	99614	**$ 677,647.00**
Increase STI diagnosis and effective treatment using syndrome		Expand ART sites to reach underserved	3,956	4241.271795	4324.35641	4300.617949	4383.702564	4276.879487	4391.615385	**$ 29,874.85**
		Strengthen the diagnostic capacities of the ART centres for timely availability of tests results and	32051			34839				**$ 66,890.00**
		Strengthen patient follow up to improve	1,926	2065.11	2105.566	2094.007	2134.462	2082.44	2138.315	**$ 14,546.32**
		Increase HIV treatment and care literacy	2,171	2326.78	2372.370	2359.347	2404.928	2346.32	2409.269	**$ 16,389.54**

		Train healthcare providers on Community Home base	9,008	9,008	9,008	9,008	9,008	9,008	9,008	**$ 63,053.85**
		Strengthen the support	1,422	1,422	1,422	1,422	1,422	1,422	1,422	**$ 9,950.77**

		Ensure regular supply of high quality food items to the patients	22,832	24476.09641	24955.57218	24818.5791	25298.05487	24681.58603	25343.71922	**$ 172,405.79**
		Increase the proportion of OVCs supported through ART sites	2595							**$ 2,595.00**
		Expand the support provided to OVCS to include child protection and	20512	21988	22419	22296	22727	22173	22768	**$ 154,883.00**
		Intensify IEC/BCC inter-ventions on	12,821	12,821	12,821	12,821	12,821	12,821	12,821	**$ 89,743.59**
		Protect and promote the rights of PLHIV	5,600	5,600	5,600	5,600	5,600	5,600	5,600	**$ 39,200.00**
		Conduct PEP sensitization for Health workers	9,231	9895.38	10089.23	10033.84	10227.69	9978.46	10246.15	**$ 69,701.54**
		Establish strong linkage between communities and health facilities	2,692	0	0	0	0	0	0	**$ 2,692.31**
		Strengthening linkage between the HMIS and the NACP Database to improve information flow to the national level in a timely and reliable manner. Upgrading of the NACP database to capture other relevant national HIV and AIDS	942	1010.153846	1029.942308	1024.288462	1044.076923	1018.634615	1045.961538	**$ 7,115.37**

		Develop a data quality assurance and audit mechanism and provide resources for supervision and data auditing at regional level and health facility levels	609	652.8205128	665.6089744	661.9551282	674.7435897	658.3012821	674.7435897	**$ 4,597.15**

		Improve dissemination of the M&E data and strategic information by ensuring dissemination reports on a quarterly basis and by advocating to enhance attendance and participation of target	1,827	1958.461538	1996.826923	1985.865385	2024.230769	1974.903846	2027.884615	**$ 13,795.10**
		Strengthen the capacity of the national M&E unit at NACP by recruitment of additional specialist for the M& E such as Statistical Analyst, Data	5390							**$ 5,390.00**
		Develop the capacity for conducting research and surveys especially the NSS and IBBS,	46,154	0	0	0	0	0	0	**$ 46,153.85**
		Support sentinel surveillance and research in HIV/AIDS	38,462	0	0	0	0	0	0	**$ 38,461.54**
		Conduct monitoring and	5,275	5654.8	5765.575	5733.925	5834.15	5702.2	5855.25	**$ 39,820.98**
		Train/retrain healthcare providers annually on Syndromic Management of STIs (including	8,635	9256.857436	9438.195128	9386.384359	9567.722051	9334.57359	9584.992308	**$ 65,203.85**
		Review and update of STI Treatment	2,692	0	0	0	0	0	0	**$ 2,692.31**

		Establish mobile clinics for MARPS (including	5,169	0	0	0	0	0	0	**$ 5,169.23**

		Provision and distribution of	3,106	3329.24	3394.465	3375.831	3441.050	3357.19	3447.261	**$ 23,450.70**
		Establish STI clinics targeted specifically for most at risk	2,962	0	0	0	0	0	0	**$ 2,961.54**
		Conduct STIs prevalence study	19253	20639	21043	20928	21332	20812	21370	**$ 145,377.00**
		Conduct sensitivity study on drugs use in the management	12823	0	0	0	0	0	0	**$ 12,823.00**
		Build capacity of laboratories of both major and minor health facilities	21174	22698	23143	23016	23460	22889	23503	**$ 159,883.00**
		Strengthen the capacity of the National AIDS Control Programme by recruitment of additional specialist, such as VCT coordinator, PMTCT coordinator, ART	11230	12038	12274	12207	12442	12139	12465	**$ 84,795.00**
		Improve the effectiveness and efficiency of the coordination	40,433	0	0	0	0	0	0	**$ 40,432.82**
		Ensure equitable distribution and delivery of	0	0	0	0	0	0	0	**$ -**
		Match and align development partners' programmes and support with national systems	0	0	0	0	0	0	0	**$ -**

		Strengthen greater partnerships and strategic alliances with development	1,346	1443.07	1471.346	1463.269	1491.538	1455.19	1494.230	**$ 10,164.81**
		Administration cost	24,981	26779.1	27303.75	27153.87	27678.46	27003.9	27728.42	**$ 188,628.24**

Diagnose at least 70% of the total estimated incidence of new smear		Develop and effective referral system to enhance access to care and support for TB	0	0	0	0	0	0	0	**$ -**
		mobilize resource for TB-HIV collaborative	0	0	0	0	0	0	0	**$ -**
		Recruit and train medical health officers/ health care workers on								
		Surveillance of HIV prevalence among TB	10,275	0	0	0	0	0	0	**$ 10,275.00**
		Carry out joint TB/HIV planning and	10,275		11230.57		11384.7		11405.25	**$ 44,295.53**
		Develop Multi Drug Resistant (MDR) and xtra-Drug Re-sistant (XDR)	0	0	0	0	0	0	0	**$ -**
		print and distribute of tuberculosis	0	0	0	0	0	0	0	**$ -**
		Study tour on MDR- TB case	0	0	0	0	0	0	0	**$ -**
		Step - down Training of Health Care Workers on	0	6300	6885.9	6848.1	6980.4	6810.3	6993	**$ 40,817.70**
		Procure and distribute MDR-TB drugs, equipment and	5000	0	0	0	0	0	0	**$ 5,000.00**
		Conduct open field	4900	5252.8	5355.7	5326.3	5429.2	5296.9	5439	**$ 36,999.90**
		Commemorate World TB day at all levels	20,000	20,000	20,000	20,000	20,000	20,000	20,000	**$ 140,000.00**
		Conduct Orientation seminar for Community and	5,000	5,000	5,000	5,000	5,000	5,000	5,000	**$ 35,000.00**

		Conduct School health education session with relevant partners	15,000	15,000	15,000	15,000	15,000	15,000	15,000	**$ 105,000.00**
		Organize Open field day on TB, TB/HIV at	20,000	18,000	18,000	18,000	15,000	15,000	15,000	**$ 119,000.00**
		Production, IEC materials	6,000	6,000	6,000	6,000	6,000	6,000	6,000	**$ 42,000.00**
		Support the Regional Ex TB patients associations on stigma reduction	4,500	4,500	4,500	4,000	4,000	4,000	4,000	**$ 29,500.00**
		Brief central NLTP and Child Fund staff on operational modalities of	1,000	1,000	1,000	1,000	1,000	1,000	1,000	**$ 7,000.00**
		Sensitize all RHTs along with Regional Education Directorates on the NLTP; epidemiology and current situation of TB in the country; arrangements for supervision, monitoring and management of	15,000	15,000	15,000	15,000	15,000	15,000	15,000	**$ 105,000.00**
		Strengthen the regional communication	15,000	15,000	15,000	15,000	15,000	15,000	15,000	**$ 105,000.00**
		Strengthen the regional MDFTs	8,000	8,000	8,000	8,000	8,000	8,000	8,000	**$ 56,000.00**
		Strengthen the regional peer health education	6,000	6,000	6,000	6,000	6,000	6,000	6,000	**$ 42,000.00**
		Strengthen the School Health and Nutrition unit for TB-education	30,000	20,000	15,000	10,000	5,000	2,500	2,500	**$ 85,000.00**

		Collaborate with DPI and support the M and E unit to develop all necessary ACSM tools and materials for supervision, monitoring, reporting and	7,500	7,500	5,000	0	0	0	0	**$ 20,000.00**
		Conduct message development workshop on TB and related issues	26,000	15,000	10,000	5,000	5,000	0	0	**$ 61,000.00**
		Conduct open field days (one Field Day in each health facility catchment area	12,307	12,307	12,307	12,307	12,307	12,307	12,307	**$ 86,149.00**
		Develop, produce and distribute communication and advocacy support materials	25,000	12,307	0	0	0	0	0	**$ 37,307.00**
Early detection and prevention of blind- ness		Strengthen school eye screening programme in formal and informal schools for early detection of children with visual impairment	15,000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 126,921.00**
STOP		Reinforce itin- erant teacher training to detect children with visual problems, and refer them to	20,000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 131,921.00**
		Establish paediatric ori- ented services and eye care teams at sec- ondary level to provide services for postoperative care for children	10,000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 121,921.00**

		Develop strategies for childhood blindness control	5000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 116,921.00**
				12,307	25,000	12,307	25,000	12,307	25,000	**$ 111,921.00**

		Establish Inter-sectoral collaboration with relevant	1500	12,307	25,000	12,307	25,000	12,307	25,000	**$ 113,421.00**
		Institutionalize operational research and develop mechanisms for monitoring and	1000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 112,921.00**
To improve availabil- ity and affordability of refractive		Create awareness on refractive error and available services at the	20000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 131,921.00**
		Strengthen school eye health screening programme and establish	10000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 121,921.00**
		Establish vi-sion centres in all the health	25,000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 136,921.00**
		Establish op-tical resource centre at the tertiary centre for main-tenance of optical equip-ment and	50,000	12,307	25,000	12,307	25,000	12,307	25,000	**$ 161,921.00**
				12,307	25,000	12,307	25,000	12,307	25,000	**$ 111,921.00**
To ensure that at least 80% of all straight forward cataract		Conduct free eye care screening and cataract	20000	12,307		12,307	25,000	12,307	25,000	**$ 106,921.00**

To reduce the burden of blindness due to cataract by ensuring that		Set up Regional cataract surgery targets after the conduct of surveys to determine the	12000	12864	13116	13044	13296	12972	13320	**$ 90,612.00**
		Train 4 more cataract surgeons and deploy them to	6000	0	0	0	0	0	0	**$ 6,000.00**

		Open 5 new outreach cataract sur-gery	0	100,000	0	0	0	0	0	**$ 100,000.00**
		Conduct routine twice weekly cata-ract surgery sessions in each second-ary eye unit and monthly outreach cataract surgery	12000	12864	13116	13044	13296	12972	13320	**$ 90,612.00**
		Train more Nyateros to identify and refer all cataract cases in their com-	9000	9648	9837	9783	9972	9729	9990	**$ 67,959.00**
		Conduct free mini cataract camps in each Region yearly to	6000	6432	6655.8	6522	6648	6486	6660	**$ 45,403.80**
		Ensure adequate supply of equipment, drugs and consumables for	14000	15008	15302	15218	15512	15134	15540	**$ 105,714.00**
		Monitor quality of outcome of cataract surgery	4000	4288	4372	4348	4432	4324	4440	**$ 30,204.00**
		Sensitise communities on the importance of early treatment and	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**
To reduce the frequency of en-		Advocate for the enforce-ment of public	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**
		Put a mech-anism for the continuous review and update of the relevance of environmental	8000	8576	8744	8696	8864	8648	8880	**$ 60,408.00**

		Build capacities of public health officers in the handling of	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**

		Construct latrines for the management of human waste	30,000	32160	32790	32610	33240	32430	33300	**$ 226,530.00**
		Intensify compound and district inspection	10000	10720	10930	10870	11080	10810	11100	**$ 75,510.00**
		Provide ad-equate waste Management	50,000	0	0	54350	0	0	55500	**$ 159,850.00**
		Build capacities of waste collectors in waste man	10000	10720	10930	10870	11080	10810	11100	**$ 75,510.00**
		Develop management tools for proper mon-itoring and	5000	5360	0	5435	0	5405	0	**$ 21,200.00**
		Build capacities of the environment	50000	53600	54650	54350	55400	54050	55500	**$ 377,550.00**
		Conduct public sensitization on vectors and vector borne diseases and occupational health and safety	30,000	32160	32790	32610	33240	32430	33300	**$ 226,530.00**
		Build human resource capacity of environment health unit to monitor air and water pollution	35,000	37520	38255	38045	38780	37835	38850	**$ 264,285.00**
		Strengthen communi-cation and advocacy activities on environmen-tal and safety related	30,000	32160	32790	32610	33240	32430	33300	**$ 226,530.00**
		Commem-orate world environment day	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**

		Collaborate with relevant institutions/ authorities example National Malaria Control Program(N-MCP),National Environment Agen-	25000	26800	27325	27175	27700	27025	27750	**$ 188,775.00**

		Provision of chemi-cals,spray-ers,protective gears and	50000	53600	54650	54350	55400	54050	55500	**$ 377,550.00**
		Conduct occupational health and safety	35000	37520	38255	38045	38780	37835	38850	**$ 264,285.00**
To improve and expand disease pre-		Conduct assessment of infection prevention and control situation in all health care setting and	35000	37520	38255	38045	38780	37835	38850	**$ 264,285.00**
		Develop in-fection control guidelines,	5000	5360	0	0	0	0	0	**$ 10,360.00**
		Train HCWs on guidelines protocols and	12000	12864	0	13296	0	12972	0	**$ 51,132.00**
		Procure infection prevention and control devices	49000	52528	0	13296	0	0	0	**$ 114,824.00**
To reduce the incidence of food and		sensitize communities on Open Def-ecation (OD), hand washing and	30,000.0	32160	32790	32610	33240	32430	33300	**$ 226,530.00**
		Training of HCWS/Exten-sion workers on CLTS	25,000.0	26800	27325	27175	27700	27025	27750	**$ 188,775.00**
		Training of hygiene promoters on Water and Sanitation Hygiene (WASH)	25,000.0	26800	27325	27175	27700	27025	27750	**$ 188,775.00**
		Enforce the food	30,000	32160	32790	32610	33240	32430	33300	**$ 226,530.00**
		Train and screen food handlers	12,000	12864	13116	13044	13296	12972	13320	**$ 90,612.00**
		Build capacities of food standard officers	60,000	0	0	0	0	0	0	**$ 60,000.00**
		Training of Health Workers on Better Training on Safer	25,000	26800	27325	27175	27700	27025	27750	**$ 188,775.00**
		Market surveillance and border inspections	10,000	5,000	5,000	5,000	5,000	5,000	5,000	**$ 40,000.00**

		Iodisation of salts in major	25,000	26800	27325	27175	27700	27025	27750	**$ 188,775.00**
		Sensitization of stake holders on salt	5,000	5,360	5,465	5,435	5,505	5,405	5,550	**$ 37,720.00**
Increase and sustain the correct and consistent use of long lasting insec-		Procure of LLINs	5400000	5,788,800	5,902,200	5,869,800	5,945,400	5,837,400	5,994,000	**$ 40,737,600.00**
		Distribute of LLINs	450,000	482,400	491,850	489,150	495,450	486,450	499,500	**$**
		Promote consistent use of	50,000	53,600	54,650	54,350	55,050	54,050	55,500	**$ 377,200.00**
		Monitoring and evaluating	25,000	26,800	27,325	27,175	27,525	27,025	27,750	**$ 188,600.00**
Achieve 80 % coverage for IRS in all regions by		Procure and supply of IRS commodities	256000	274,432	279,808	278,272	281,856	276,736	284,160	**$**
		Conducte In-door Residual	150,000	160,800	163,950	163,050	165,150	162,150	166,500	**$**
		Monitoring and evaluating IRS	50,000	53,600	54,650	54,350	55,050	54,050	55,500	**$ 377,200.00**
Reduce the incidence of infection caused by		Ensuring ac-cess to ACT for the population at risk.	25,000	26,800	27,325	27,175	27,525	27,025	27,750	**$ 188,600.00**
		Increasing access to ACTs at community level.	2,500,00	2,680,00	2,732,500	2,717,500	2,752,500	2,702,5	2,775,00	**$**
		Conduct ser-vice training of health workers including the private sector on malaria case	15,000	16,080	16,395	16,305	16,515	16,215	16,650	**$ 113,160.00**
		Strengthening pre service trainings on malaria case	35,000	37,520	38,255	38,045	38,535	37,835	38,850	**$ 264,040.00**

		Update the treatment guidelines for malaria case	10,000	10,720	10,930	10,870	11,010	10,810	11,100	**$ 75,440.00**

		Strengthen supervision for malaria case	8,000	8,576	8,744	8,696	8,808	8,648	8,880	**$ 60,352.00**
		Establish national QA&QC system for RDTs	28,000	30,016	30,604	30,436	30,828	30,268	31,080	**$ 211,232.00**
		Strengthen QA&QC for slide microscopy	25,000	26,800	27,325	27,175	27,525	27,025	27,750	**$ 188,600.00**
		Conduct efficacy studies	25,000	26,800	27,325	27,175	27,525	27,025	27,750	**$ 188,600.00**
		Strengthen molecular laboratory for efficacy studies	30,000	32,160	32,790	32,610	33,030	32,430	33,300	**$ 226,320.00**
To maintain the		Distribution of MDTs	25,000	26,800	27,325	27,175	27,525	27,025	27,750	**$ 188,600.00**
		Intensify leprosy case base	8,000	8,576	8,744	8,696	8,808	8,648	8,880	**$ 60,352.00**
To reduce the prev- alence of other communicable		Review and upgrade the IDSR technical guideline	$4,146.15	0	0	0	0	0	0	**$ 4,146.15**
		Train health staff on the IDSR to improve on early case detection, investigation, management and reporting of national priority	7422.21	7956.60912	8112.47553	8067.94227	8223.80868	8023.40901	8238.6531	**$ 56,045.11**
		Harmonize data collection tools into National Health	538.46	0	0	0	0	0	0	**$ 538.46**
		Strengthen data management , reporting and feedback mechanism at central and	2217.95	2377.6424	2424.21935	2410.91165	2457.4886	2397.60395	2461.9245	**$ 16,747.74**

		Strengthen collection, handling & transportation of samples to national	5128.21	5497.44112	5605.13353	5574.36427	5682.05668	5543.59501	5692.3131	**$ 38,723.11**

		Build capacity of Regional Management Committees and health facility staff on Epidemic	12820.510		14012.81	0	14205.12	0	14230.76	**$ 55,269.22**
		Develop and strengthen IHR core capacity for implementation	1923.08	2061.54	2101.926	2090.387	2130.772	2078.84	2134.618	**$ 14,521.18**
		Support diagnostic	2179.49	2336.41	2382.182	2369.105	2414.874	2356.02	2419.233	**$ 16,457.33**
		Provide e-health facility for reporting (DHIS2 mobile	6410.260	0	0	0	0	0	0	**$ 6,410.26**
		Conduct supportive monitoring and supervision	1299.72	1393.29	1420.593	1412.795	1440.089	1404.99	1442.689	**$ 9,814.19**
		Organize bi-monthly meetings to share surveil-lance data and information with regions and	2142.77	2297.04	2342.047	2329.190	2374.189	2316.33	2378.474	**$ 16,180.06**
TOTAL			1249129	1252710	12530444	11673439	11887695	114931	1274171	**$ 85,344,879.92**
Strategic Objective	**To reduce the burden of non communicable diseases to a level that they cease to be a public health problem**									
Specific		**Main Activ-ities**								
To reduce the use of tobacco among the general		Conduct sensitization meetings with law enforcement	20,000.0	21440	21860	21740	22160	21620	22200	**151,020.00**
		Advocacy meetings with law makers, opinion leaders	20,000.0	21440	21860	21740	22160	21620	22200	**151,020.00**
		Enforce tobacco free workplace policies	15,000.0	16080	16395	16305	16620	16215	16650	**113,265.00**
		School health intervention	30,000.0	32160	32790	32610	33240	32430	33300	**226,530.00**

		Production of communi-cation support materials	35,000.0	37520	38255	38045	38780	37835	38850	**264,285.00**
		Conduct mass media	25,000.0	26800	27325	27175	27700	27025	27750	**188,775.00**

		Conduct sensitization meetings at	15,000.0	16080	16395	16305	16620	16215	16650	**113,265.00**
		Sensitization meetings with organized community	25,000.0	26800	27325	27175	27700	27025	27750	**188,775.00**
To promote healthy										**0.00**
		Conduct sensitization meetings with law	20,000.0							**20,000.00**
		Support community and school	20,000.0							**20,000.00**
		Conduct school health and nutrition program	15,000.0							**15,000.00**
		Conduct mass media	20,000.0							**20,000.00**
		Open field days at com-	25,000.0							**25,000.00**
		Production of communica-tion support	15,000.0	16080	16395	16305	16620	16215	16650	**113,265.00**
		Sensitization meetings with organized community	20,000.0	20,000						**40,000.00**
		Conduct interactive community	20,000.0	21440	21860	21740	22160	21620	22200	**151,020.00**
To promote physical activity										**0.00**
		Dialogue with relevant	5,000	0	0	0	0	0	0	**5,000.00**
		Support physical activities in all institutions and	15,000.0	10,000.0	15,000.00	15,000.00	15,000.00	15,000.	15,000.0	**100,000.00**

		Conduct mass media	20,000.0	20,000.0	20,000.00	20,000.00	20,000.00	20,000.	20,000.0	**140,000.00**
		Observe national MOVE	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	5,000.0	5,000.00	**35,000.00**

To reduce alcohol and other harmful		Provision of counseling centers	10,000.0	10,000	0	0	0	0	0	**20,000.00**
		Train peer health edu-	20,000.0							**20,000.00**
		Conduct community sensitization	25,000.0	25,000.0	25,000.00	25,000.00	25,000.00	25,000.	25,000.0	**175,000.00**
To promote primary prevention										**0.00**
		Routine Screening for NCDs at all	30,000.0	30,000.0	30,000.00	30,000.00	30,000.00	30,000.	30,000.0	**210,000.00**
		Training of all health care providers on NCDS	25,000.0	25,000.0	25,000.00	25,000.00	25,000.00	25,000.	25,000.0	**175,000.00**
		Decentral- ization of NCD treatment	20,000.0	20,000.0		20,000.00			20,000.0	**80,000.00**
										0.00
		Development of treatment guidelines for	0.00	10000						**10,000.00**
		Establish NCDs clinics in all major	0.00	30000		15,000.00			10,000.0	**55,000.00**
		Early detection of NCDs and reduction of disease related	25,000.0	25,000.0	25,000.00	25,000.00	25,000.00	25,000.	25,000.0	**175,000.00**
		Procure of basic equip- ment for early detection and	20,000.0							**20,000.00**
To provide equitable access to		Build capac- ities of health care personnel to manage	15,000.0	15,000.0	15,000.00	15,000.00	15,000.00	15,000.	15,000.0	**105,000.00**

		Increase awareness on the risk factors, effects and management of mental and	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	**105,000.00**
		Upgrading the existing psychiatric	30,000.0	0.00	0.00	0.00	0.00	0.00	0.00	**30,000.00**

		Creation of psychiatric units in all the	25,000.0	0.00	25,000.00	0.00	25,000.00	25,000.	25,000.0	**125,000.00**
		Integration of mental health and substance abuse services in the primary	10,000.0	10,000.0	10,000.00	10,000.00	10,000.00	10,000.	10,000.0	**70,000.00**
		Establishment of the mental	5,000.00	5,000	5,000	5,000	5,000	5,000	5,000	**35,000.00**
		Provide specialized health professionals, biomedical equipment, medicines and	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
To reduce mental health disorders and substance		Create a multidisciplinary technical advisory committee on mental health and	5,000.00	5,000	5,000	5,000	5,000	5,000	5,000	**35,000.00**
		Provide biomedical equipment and medical	0.00	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**
To provide mental health and substance abuse		Providing adequate psychotropic medicines to the	40,000.0	40,000.0	40,000.00	40,000.00	40,000.00	40,000.	40,000.0	**280,000.00**
		Mobilize resources for mental health and substab-nce	10,000.0							**10,000.00**
		Conduct community outreach	15,000.0	15,000.0	15,000.00	15,000.00	15,000.00	15,000.	15,000.0	**105,000.00**
		Review and update the current list of psychotropic medicines included in the	10,000.0	0	0	0	0	0	0.00	**10,000.00**

		Develop treatment guidelines and protocol on management of mental health disorders and	10,000	0	0	0	0	0	0.00	**10,000.00**

		Produce and finalize the draft mental health and substance abuse policy	20,000.00	0	0	0	0	0	0.00	**20,000.00**
		Procure vehicle and other office equipment for the mental health and	80,000.00	0	0	10,000	0	10,000		**100,000.00**
		Orientation of traditional healers on mental health	10,000.00	10,000	10,000	10,000	15,000	15,000	20,000	**90,000.00**
		Training of specialized mental health and substance	150,000.	0	0	100,000	0		100,000.	**350,000.00**
To reduce the burden of		Safety education in	15,000.0	15,000.0	15,000.00	15,000.00	15,000.00	15,000.	15,000.0	**105,000.00**
		Conduct mass media	15,000.0	15,000.0	15,000.00	15,000.00	15,000.00	15,000.	15,000.0	**105,000.00**
		Community outreach	20,000.0	20,000.0	20,000.00	20,000.00	20,000.00	20,000.	20,000.0	**140,000.00**
		Advocacy meetings with law makers, opinion leaders	5,000.00	5,000.00	5,000.00	5,000.00	5,000.00	5,000.0	5,000.00	**35,000.00**
		Regular inspection of	10,000.0	10,000.0	10,000.00	10,000.00	10,000.00	10,000.	10,000.0	**70,000.00**
		Regular updating of	10,000.0							**10,000.00**
		Enforcement of the road traffic Act, injury compensation Act, the Public health Act, the	20,000.00	0.00	0.00	0.00	0.00	0.00	0.00	**20,000.00**
		Research on the causes and prevention of major injuries	35,000.0	0.00	0.00	0.00	35,000.00	0.00	0.00	**70,000.00**

To provide rehabili-tation care		Conduct ear-ly detection/ screening for	20,000.0	20,000.0	20,000.00	20,000.00	20,000.00	20,000.	20,000.0	**140,000.00**

		Conduct community rehabilitation programs (CBR)for	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	25,000.00	**175,000.00**
To reduce disability		Production of artificial limbs and assessive	50,000.0	50,000.0	50,000.0	50,000.00	50,000.0	50,000.	50,000.0	**350,000.00**
		Provide psychosocial support to persons with	40,000.0	40,000.0	40,000.0	40,000.00	40,000.0	40,000.	40,000.0	**280,000.00**
		Provision of home base care for persons with	25,000.0	25,000.0	25,000.0	25,000.00	25,000.0	25,000.	25,000.0	**175,000.00**
		Provide training to specialized level on	15,000.0	15,000.0	15,000.0	15,000.00	15,000.0	15,000.	15,000.0	**105,000.00**
		Provide specialized training for production of	15,000.0	15,000.0	15,000.0	15,000.00	15,000.0	15,000.	15,000.0	**105,000.00**
		Create advocacy awareness on draft disability	20,000.0	20,000.0	20,000.0	20,000.00	20,000.0	20,000.	20,000.0	**140,000.00**
To ensure that at least 80% of all straight forward cataract		Conduct free eye care screening and cataract	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	**140,000.00**
		Conduct Me-dia campaign on disability and rehabili-	10,000.0	10,000.0	10,000.0	10,000.00	10,000.0	10,000.	10,000.0	**70,000.00**
		Community sensitization on disability and rehabili-	20,000.0	20,000.0	20,000.0	20,000.00	20,000.0	20,000.	20,000.0	**140,000.00**
		Inclusion of disability access in all	10,000.0	0.00	0.00	0.00	0.00	0.00	0.00	**10,000.00**

To reduce the inci- dence of violence and		Establishment of ONE STOP centre for victims and	30,000.0	0.00	0.00	0.00	0.00	0.00	0.00	**30,000.00**

		Build capacities of health care providers and professionals on manage-ment of sexual violence and Standard	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	**140,000.00**
		Increase knowledge and skill of health care providers on	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	**105,000.00**
		Provide screening and psychosocial counselling and support for victims of	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	20,000.00	**140,000.00**
		Create awareness on injuries and	10,000.0	10,000.0	10,000.00	10,000.00	10,000.00	10,000.	10,000.0	**70,000.00**
		Advocacy and awareness on the domes-tic violence Bill	10,000.00	10,000.00	10,000.00	10,000.00	10,000.00	10,000.	10,000.00	**70,000.00**
		Increase awareness on sexual abuse	10,000.0	10,000.0	10,000.00	10,000.00	10,000.00	10,000.	10,000.0	**70,000.00**
To improve health care services for		Routine Screening of elderly for	30,000.00	30,000.00	30,000.00	30,000.00	30,000.00	30,000.	30,000.00	**210,000.00**
		Training of health care providers on	15,000.0	15,000.0	15,000.00	15,000.00	15,000.00	15,000.	15,000.0	**105,000.00**
		Support for family and care givers of	20,000.0	20,000.0	20,000.00	20,000.00	20,000.00	20,000.	20,000.0	**140,000.00**
		Reduce severe mal-nutrition rate among the	15,000.0							**15,000.00**
		Awareness creation on age friendly	15,000.0	15,000.0	15,000.00	15,000.00	15,000.00	15,000.	15,000.0	**105,000.00**
		Create awareness on the clinical management	15,000.00	15,000.00	15,000.00	15,000.00	15,000.00	15,000.	15,000.00	**105,000.00**

To improve and expand Physiother-apy services		Upgrade service level from basic to comprehen-sive	100, 000	0	0	0	0	0	0	**0.00**
		Procure equipment and consum-ables	275,000	12820.51282	14012.82051	13935.89744	14205.12821	13858.97436	14230.76923	**358,064.10**
		Provide specialized training on Physiotherapy to both un-dergraduate and	90000	0	0	99720	0	0	0	**189,720.00**
		Support Physiotherapy training in the University of	14102.5	15117.9	15414.10	15329.48	15625.64	15244.8	15653.8	**106,488.46**
		Establish a regulatory system for Physiotherapy	5 000	0	0	0	0	0	0	**0.00**
		Promote public- private partnership for provision of quality	5,000	5360	5465	5435	5540	5405	5550	**37,755.00**
		Strengthen quality control and quality assurance	7,000	7504	7651	7609	7756	7567	7770	**52,857.00**
To coordinate the implementation, monitoring and		Develop and operationalize a comprehensive communica-tion and social mobilization strategy for the Ministry of Health and Social Welfare	50,000	0	0	0	26,000	0		

		Train health workers on Interpersonal Communica-tion skills on	35,000	35,000	20,000	15,000	15,000	10,000		

		Procure vehicles, film van and communication equipment/ gadgets (video camera, still cameras, pro-jector, editing machine and software, tape	190,000	0	0	0	15,000	0		
		Develop, produce and distribute communica-tion support	100,000	0	0	100,000	0	0	0	
SPECIFIC OBJECTIVE										
Promote the involvement of non- health public and private sectors		Undertake advocacy to increase the awareness and support for the use of health promotion and education, targeting both the health and non-health	10,000	8,000	6,000	5,000	4,000	3,000	2,000	
		Advocate with government and non-gov-ernmental agencies to support the implementation of health	3,000	3,000	3,000	2,000	2,000	2,000	1,000	
		Incorporate health promotion and education components into non-health and private sector interventions and programmes	15,000	10,000	5,000	3,000	2,000	2,000	2,000	

Promote the participation and involvement of the media in health		Train journal-ist, editors and media executives on health reporting	20,000	20,000	20,000	20,000	20,000	20,000	20,000	

		Support the Association of Health Journalist in the production and documentation of	6,000	0	0	6,000	0	0	0	
		Conduct community film shows on various health issues at	4,500	4,500	4,000	4,000	3,500	3,500	3,000	
		Support the on-going weekly health programmes on	15,000	15,000	15,000	15,000	15,000	15,000	15,000	
		Produce documentary for	40,000	30,000	20,000	15,000	10,000	10,000	10,000	
		Coordinate the commemoration of International Health Days	15,000	15,000	15,000	15,000	15,000	15,000	15,000	
		Produce and print calendars on International Health Days and MoH&SW calendar of	10,000	10,000	10,000	10,000	10,000	10,000	10,000	
		Use of social media to educate the public	15,000	0	0	15,000	0	10,000	0	
		Conduct mass media campaign on health issues	30,000	25,000	20,000	20,000	20,000	20,000	15,000	
Improve country capacity to design, implement and evaluate health promotion	**education** inter-education	Develop a Strategic Plan for the implementation of the national health pro-motion and policy (2013-2020).	50,000	0	0	20,000	0	0	5,000	

		Train health promotion and education practitioners in designing health promotion and education approaches at all	25,000	0	25,000	0	25,000	0	25,000	

		Develop Interpersonal Communication Training Manual	12,000	0	0	0	0	0	0	
		Conduct training of trainers on Interpersonal Communication	60,000	0	60,000	0	60,000	0	30,000	
		Organize short and long-term training on health promotion and communication	0	50,000	0	0	50,000	0	0	
		Develop monitoring tools and guidelines for frontline communicators	8,000	0	0	0	0	0	0	
Specific Objective: Create social and physical environments that promote good health for all	Committee on	Strengthen the existing multi-sectoral Social Determinants of Health	15,000	10,000	10,000	10,000	10,000	10,000	10,000	
		Conduct situational analysis on Social Determinants of	25,000	0	0	0	0	0	0	
		Validate the situational report on Social Determinants of	8,000	0	0	0	0	0	0	
		Support and sustain the multi-sectoral committee on social determi-	15,000	15,000	15,000	15,000	15,000	15,000	15,000	
		Use health promotion and education as a platform to put Health-In-All	20,000	0	20,000	0	5,000	0	5,000	

		Establish a national association or network of health promotion and education practitioners by	35,000	0	0	0	3,000	0	0	
		Support the participation in inter-coun-try consulta-tions and to form a health promotion and education	30,000	0	10,000	10,000	5,000	5,000	0	
		Conduct advocacy ac-tivities to raise awareness on the concept of putting Health-In-All Policies	25,000	25,000	20,000	15,000	15,000	10,000	5,000	
		Orientate law-makers and decision makers on the concept of putting Health-In All	15,000	0	15,000	0	15,000	10,000	5,000	
TOTAL			2,927,60	1402142	1386002.	1606169.	1477386.	1255395	1410404.	**8,936,104.56**
Strategic Objective 3:	**To ensure the availability and retention of highly skilled and well-motivated Human Resource for Health**									
Specific		**Main Activ-ities**								
To improve knowl- edge, skills and attitudes of health		Reviewthe 15 year HR pro-jections and comprehen-sive training plan	13,400.00	0	0	0	0	0	0	**$ 13,400.00**
		Review curric-ulum plans for health training	16,400.0							**$ 16,400.00**
		Develop guideline and policy for selecting the award of	9,000.00	0	0	0	0	0	0	**$ 9,000.00**
		Review and implement the existing staff-ing	42,500.0							**$ 42,500.00**

		Implement the 15 year HR projections and comprehensive training plan	60,000.00	64320	65580	65220	66480	64860	66600	**$ 453,060.00**

To support contin- uous professional		Conduct training needs assessment at all levels in both private	40,000.00	0	0	0	0	0	0	**$ 40,000.00**
		Develop guidelines for in-service	3,200.00	0	0	0	0	0	0	**$ 3,200.00**
		Strengthen the HRH	25,600.0	27443.2	27980.8	27827.2	28364.8	27673.6	28416	**$ 193,305.60**
		Develop protocol to enhance com- petent staff to take teaching and research	12,350.00	0	0	0	0	0	0	**$ 12,350.00**
		Develop schemes of service for cadres such as physiotherapy; radiology; and	4,100.00	0	0	0	0	0	0	**$ 4,100.00**
		Support continuous development of health	132,307.	0	0	143818.4	0	0	0	**$ 276,126.15**
		Provide teaching and learning	75,300.0	80721.6	82302.9	81851.1	83432.4	81399.3	83583	**$ 568,590.30**
		Conduct training needs assessment in all health training institutions in-	12,000.00	0	0	0	0	0	0	**$ 12,000.00**
		Monitor quality assurance in health training institutions and	5,400.00	5788.8	5902.2	5869.8	5983.2	5837.4	5994	**$ 40,775.40**
		Develop guidelines for quality	6,923.08	0	0	0	0	0	0	**$ 6,923.08**
		Train lecturers in all health training institutions and clinical settings based on the	2,500.00	2680	2732.5	2717.5	2770	2702.5	2775	**$ 18,877.50**

		Support health professional development at the training	132,307.	0	0	143818.4	0	0	0	**$ 276,126.15**

		Construct 1 additional classroom block in SEN and	51,282.0	0	0	0	0	0	0	**$ 51,282.05**
		Renovate and furnish student dormitories at SEN school , CHN school and School of	38,461.54	0	0	0	0	0	0	**$ 38,461.54**
To establish mech- anisms to manage recruitment and		Identify staffing needs at all levels	4293.692308							**$ 4,293.69**
		Identify and fill vacant	0	0	0	0	0	0	0	**$ -**
		develop and implement induction programmes	1153.84							**$ 1,153.85**
		Develop M&E system for the performance	4807.69	0	0	0	0	0	0	**$ 4,807.69**
		Support RHMT and central level to develop plans for rolling out performance appraisal	16153.84615	0	0	0	0	0	0	**$ 16,153.85**
		Train RHMTs and central level staff on performance	4317.70	0	0	0	0	0	0	**$ 4,317.71**
		Develop/ review guide- lines for per- formance and	3461.53	0	0	0	0	0	0	**$ 3,461.54**
To establish a mechanism to manage and										**$ -**
		Develop and implement posting guidelines and	769.230	0	0	0	0	0	0	**$ 769.23**

		Establish a posting committee at	0	0	0	0	0	0	0	**$ -**
		Implement the staffing norm	0	0	0	0	0	0	0	**$ -**

		Develop a deployment plan	1000							**$ 1,000.00**
		Increase number of trained staff per health facility by population size	0	0	0	0	0	0	0	**$ -**
		Disseminate deployment and postings plans to staff concerned	256.4102	0	0	0	0	0	0	**$ 256.41**
		Allocate 50% of basic salary as retention allowance for lower cadres of staff (grade six and below)and 40% for grade seven and above(MoHSW to	0	0	0	0	0	0	0	**$ -**
		Create a special hard-to-reach area allowance (MoHSW to advocate to PMO for acceptance)	0	0	0	0	0	0	0	**$ -**
		Provide perfor-mance-based	25,000.0	26800	27325	27175	27700	27025	27750	**$ 188,775.00**
		Advocate for free medical care for all health workers and their im-mediate family	0	0	0	0	0	0	0	**$ -**
		Monitor staffing norms for both the public and pri-vate sectors	1221.435	1309.379	1335.029	1327.700	1353.350	1320.372	1355.793	**$ 9,223.06**
		Renovate and furnish existing staff quarters	1,647,00	1765584	0	0	0	178040	0	**$ 5,192,991.00**
		Provide essential equipment for service delivery	250,000	268000	273250	271750	277000	0	0	**$ 1,340,000.00**
		Build Staff quarters in 6 facilities in CRR	5,647,00	0			0	0	0	**$ 5,647,000.00**

To improve leader-ship and steward-				0			0	0	0	**$ -**
		Review existing schemes of	769.2307	0	0	0	0	0	0	**$ 769.23**

		Build capac-ity for HRH planning and management at	120000	0	0	132960	0	0	0	**$ 252,960.00**
		Establish HRH Steering Committee and Technical Working Groups	0	0	0	0	0	0	0	**$ -**
		Integrate HRIS into the existing HMIS	1500	0	0	0	0	0	0	**$ 1,500.00**
		Build the capacity of the HRH	25,000			27175	0	0	0	**$ 52,175.00**
		Conduct periodic operational research	27,500			29892.5		0	0	**$ 57,392.50**
To improve manage-ment and		Organize donor confer-ences	10000	10720	10930	10870	11080	10810	11100	**$ 75,510.00**
		Develop resource mobilization	576.923	0	0	0	0	0	0	**$ 576.92**
		Introduce cost sharing scheme for HRH pro-duction with partners	1000							**$ 1,000.00**
		Advocate for partner involvement in HRH pro-	1000							**$ 1,000.00**
		Coordinate donor support	500	536	546.5	543.5	554	540.5	555	**$ 3,775.50**
TOTAL			8,477,31	2253902	497884.9	972816.2	504717.7	2002575	228128.	**$**
Strategic Objective 4:	**Increase access to quality pharmaceutical, laboratory, radiology and blood transfusion services to all**									
Specific		**Main Activ-ities**								
Ensure availability and access										

		Advocate and provide for 100% of the estimated annual budget requirement by 2015 (for the	2,179,487	2336410.064	4206409.91	2369102.369	2414871.596	2356025.447	2419230.57	**$ 18,281,536.9**

		Strengthen DRF structures for effective revenue collection (to supplement the budget for essential supplies (10 to 20%) by	10000	0	0	10870	0	0	11100	**$ 31,970.00**
		Develop a plan for Resource mobilization to reduce funding Gap	12000	0	0	0	0	0	0	**$ 12,000.00**
		Establish an Interagency Coordinating Committee to monitor technical and efficient budgetary allocation and	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**
		Promote collaboration between pub-lic and private sectors in the provision of essential drugs and other medical supplies	0	0	0	0	0	0	0	**$ -**
		Advocate for 10% increment on routine EPI budget line to accommodate emergency immunization activities by	0	0	0	0	0	0	0	**$ -**
		Create an effective integrated procurement and supply chain manage-ment	900000	0	0	0	0		0	**$ 900,000.00**

		improve coordination, planning, monitoring and supervision of the supply	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**
		strengthen the LMIS system	12500	13400	13662.5	13587.5	13850	13512.	13875	**$ 94,387.50**

		Develop, update, print and distribute policy docu-ments for the procurement supply man-agement system (including Standard Treatment	0	2023	0	0	0	0	0	**$ 2,023.00**
		advocate for the approval of the draft bills (**Phar-macy bill, Medicines and**	0	0	0	0	0	0	0	**$ -**
		Develop the necessary structure and tools for im-	0	200,000	0	0	0	0	0	**$ 200,000.00**
		Strengthen the procure-ment, storage, distribution	0	5000	0	0	0	0	0	**$ 5,000.00**
		Mobilize, rationalize and allocate resources for training,	1,000,00							**$**
		Construct a National Blood Transfusion	$33,330.	$0.00	0	0	0	0	0	**$ 33,330.08**
		Train staff on blood transfu-								
		Provide equipment, furniture and	$22,294.	$0.00	0	0	0	0	0	**$ 22,294.50**
		Set up a National blood transfusion committee	$692.31	0	0	0	0	0	0	**$ 692.31**
		Improve information/ data manage-ment	1538.46	1649.23	1681.538	1672.307	1704.615	1664.61	1707.69	**$ 11,618.46**
		Strengthen quality control and quality	1923.07	2061.53	2101.923	2090.384	2130.769	2078.84	2134.61	**$ 14,521.15**

		Provide resources for community outreach sensitization and	$3,205.1	$3,435.9	$3,503.2	$3,483.97	$3,551.2	$3,464.	$3,557.6	**$ 24,201.92**

		Improve collaboration with Blood Donor Associ-	$1,282	$1,374.36	$1,401.28	$1,393.59	$1,420.513	$1,385.997	$1,423.08	**$ 9,680.77**
		Strengthen IEC activities on Blood Transfusion at all	$1,923.08	$2,061.5	$2,101.92	$2,090.38	$2,134.62	$2,078.846	$2,134.62	**$ 14,525.00**
		Upgrade service level from basic to comprehensive	809,864	0	0	0	0	0	0	**$ 809,864.00**
		Strengthen quality control and quality assurance	26,964	28905.4	29471.65	29309.86	29876.11	29148.04	29930.04	**$ 203,605.16**
		Establish a regulatory system for laboratory services	30,000	0	0	0	0	0	0	**$ 30,000.00**
		Promote public-private partnership for provision of quality laboratory	5,000	5,360	5,465	5,435	5,540	5,405	5,550	**$ 37,755.00**
		Upgrade service level from basic to comprehen-sive	150,000	0	0	0	0	0	0	**$ 150,000.00**
		Provide equip-ment and	211,000	226,192	230,623	229,357	233,788	228,091	234,210	**$**
		Train staff on radiology to both undergraduate and graduate	60,000	0	0	0	0	0	0	**$ 60,000.00**
		Support radiology training at the University of the Gambia	11282.05128	12094.35897	12331.28205	12263.58974	12500.51282	12195.89744	12523.07692	**$ 85,190.77**
		Establish a regulatory system for radiology services	30,000	0	0	0	0	0	0	**$ 30,000.00**
		Promote public-private partnership for provision of quality radiol-ogy	5,000	5,360	5,465	5,435	5,540	5,405	5,550	**$ 37,755.00**

		Strengthen quality control and quality assurance	26,964	28905.4	29471.65	29309.86	29876.11	29148.0	29930.04	**$ 203,605.16**
TOTAL			5,556,25	2884952	4554619.	2726270.	2767864.	2700413	2783956.	**$**

Strategic Objec	**To improve infrastructure and logistics requirements of the public health system for quality health**									
Specific		**Main Activ-ities**								
		Develop a comprehen-sive vehicle replacement	8,400	0	0	0	0	0	0	**$ 8,400.00**
		Procure vehi-cles (including trucks) and	260000	288,600	0	320346	0	355584	0	**$**
		Develop and maintain a comprehen-sive vehicle	744	798	813	809	824.352	804.26	825.84	**$ 5,617.94**
		Provide safe and adequate fuel storage facilities in all	60,000	60,000	30,000	0	0	0	0	**$ 150,000.00**
		Create comprehen-sive vehicle maintenance	90,000	0	135,000	0	0	0	0	**$ 225,000.00**
		Procure ade-quate fuel	500000	500000	500000	500000	500000	500000	500000	**$**
		Provide adequate and genuine spare parts (lubri-cants, filters,	100,000	107200	109300	108700	110800	108100	111000	**$ 755,100.00**
		Strength the coordination and manage-ment between	10,000	0	0	0	0	0	0	**$ 10,000.00**
		Construct ten new staff quarters in each health	0	800,000	800,000	800,000	400,000	0	0	**$**
		Provide household equipment for	0	200,000	200,000	200,000	100,000	0	0	**$ 700,000.00**
		GPS mapping of all existing facilities public and non public	8400	0	0	0	0	0	0	**$ 8,400.00**
		Inco-operate new facilities to be con-structed over	0	0	0	0	0	0	0	**$ -**

		Update the health mapping and establish criteria for pri-oritizing and	0	30,000	0	0	0	0	0	**$ 30,000.00**

		Cost the capital invest-ment plan (staff housing, health facili-ties, kitchens, incinerators	0	35,000	0	0	0	0	0	**$ 35,000.00**
		Develop a comprehensive mainte-nance	0	5000	0	0	0	0	0	**$ 5,000.00**
		Review and update building requirements, standards and norms for the	0	21,000	0	0	0	0	0	**$ 21,000.00**
		Conduct situation analysis of existing health facility needs		7350			7350			**$ 14,700.00**
		Refurbish existing	0	100000	109300	108700	110800	108100	111000	**$ 647,900.00**
To provide a new of-fice complex for the		Construct and equip a food testing	0	0	500,000	0	0	0	0	**$ 500,000.00**
		Construct a new fully furnished MoHSW office	0	4,750,00	0	0	0	0	0	**$**
		Recruit qual-ified building maintenance staff (welders, architects and surveyors, carpenters,	0	0	0	0	0	0	0	**$ -**
		Provide equipment and working tools for the	15000	0	0	16305	0	16215	16650	**$ 64,170.00**
		Establish a building maintenance	10000							**$ 10,000.00**
		Train main-tenance unit staff	12000	0	0	0	0	0	0	**$ 12,000.00**

		Provide resources for the inven-tory system (computers,		5,000			2,000			**$ 7,000.00**

		Inventorise all physical infrastructures (buildings,	1400	1500.8	1516.2	1521.8	1551.2	1513.4	1554	**$ 10,557.40**
		Conduct a comprehensive assessment of biomedical equipment needs in the	10000	0	0	0	0	0	0	**$ 10,000.00**
		Procure qual-ity biomedical	500000	250000	35000	30000	25000	20000	15000	**$ 875,000.00**
		Conduct quarterly trek-king to update	2800	4000	4000	4000	4000	4000	4000	**$ 26,800.00**
		Provide resources for the inven-tory system (computers,	0	0	0	0	0	0	0	**$ -**
		Establish biomedical equipment management	350000	70000	76510	76090	77560	75670	77700	**$ 803,530.00**
		Train biomedi-cal equipment management	0	30,000	0	0	33300	0	0	**$ 63,300.00**
		Recruit qualified Biomedical Engineers/ Technicians	0	0	0	0	0	0	0	**$ -**
TOTAL			1,938,74	726544	2501439.	2166471.	1373185.	1189986	837729.	**$**
Strategic Objec-	**To establish an effective, efficient, and sustainable health sector financing mechanism by 2020**									
Specific		**Main Activ-ities**								
Development of a holistic health fi-nancing mechanism		Review and validate the Health Financ-ing Policy	0	5000	0	0	0	0	0	**$ 5,000.00**
		Develop and implement Operational Plan for Health	0	6000	0	0	0	0	0	**$ 6,000.00**

		Constitute a task force to review the existing basic health care	0	400	0	0	0	0	0	**$ 400.00**

		Determine the cost of providing basic health care packages across	0	800						**$ 800.00**
		Support the implementation of Result Based Financing	0	36000	36500	37000	37500	38000	0	**$ 185,000.00**
		Conduct study tours to learn best practices on Universal Health Coverage	0		34000			36000		**$ 70,000.00**
		Define mech-anisms for ensuring universal health coverage (e,g Results Based Financing, Health Insurance)	0	0	0	0	0	0		**$ -**
		Incorporate National Health Account into health planning and budget circle	0	100000	110000	120000	130000	140000		**$ 600,000.00**
			50000	53600	54650	54350	55400	54050	55500	**$ 377,550.00**
Allocate 15% of government budget to Health by		Ensure the approved health budget is adequately executed	0	0	0	0	0	0	0	**$ -**
		Review and Implement MTEF by utilizing the Marginal Budgeting for Bottlenecks and	0	5000	5500	6000	6500	7000	0	**$ 30,000.00**

To institute other financing options to support government		Introduc-tion of a Health Tax Policy and Act	0	30000	0	0	0	0	0	**$ 30,000.00**

		Advocate for innovative financing by allocating 3% of the levy on tobacco and tobacco prod-	15000	16080	16395	16305	16620	16215	0	**$ 96,615.00**
		Introduce National Health Insurance		0	0	0	4000	0	0	**$ 4,000.00**
		Establish health financ-ing agency to manage risks, revenue collection and	0	0	0	0	5000	0	0	**$ 5,000.00**
		Develop a resource mobilization	0	6000	0	0	0	0	0	**$ 6,000.00**
		Organize resource mobilization			5000		5500		6000	**$ 16,500.00**
		Advocate for the intro-duction of a service charge on GSM usage and bank transac-tions for contribution	0	0	0	0	0	0	0	**$ -**
Improve revenue		Identify all revenue collecting source within the		600						**$ 600.00**
		Set up an efficient revenue collection		47500	7500	8175	8910.75	9712.7	10586.86	**$ 92,385.33**
		Phasing-out all non - accounting staff from collecting revenue at all	0	0	0	0	0	0	0	**$ -**
		Recruit accounts clerks for all public	0	0	0	0	0	0	0	**$ -**
		Develop adequate hu-man resource capacity for	0	15000		16350		17821.		**$ 49,171.50**

		Monitor and supervise the collection of revenues in all	0	6333	6903	7524	8201	8939	9744	**$ 47,644.00**

To Provide social safety nets to protect the		Pool health revenue generated funds into one basket	4000	4288	4372	4348	4432	4324	4440	**$ 30,204.00**
		Promotion of Commu-nity Based pre-financing	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**
To achieve optimum utilization of resources to		Develop a Resource Allo-cation Formula to include all resources	0	2307.69	0	0	0	0	0	**$ 2,307.69**
		Develop a monitoring framework to ensure accountability transparency	0	5128.20	0	0	0	0	0	**$ 5,128.21**
		Strengthen the resource allocation	0	1200	1308	1425.72	1554.034	1693.89	0	**$ 7,181.65**
		Use Drug Re-volving Funds to support the procurement of essential drugs, reagents and other	0	0	0	0	0	0		**$ -**
TOTAL SOB6			74000	346596.8974	287593	276912.72	289157.7848	339161.1154	91820.86208	**$ 1,705,242.38**
Strategic Objec-	**To improve the effectiveness and efficiency of Health Information System for Planning and decision making to yield improved service delivery**									
Specific		**Main Activ-ities**								
To strengthen HMIS at all		Train and re-tain HMIS staff	41538.4	44529.2	45401.53	45152.30	46024.61	44903.0	46107.69	**$ 313,656.92**
		Recruit relevant competencies	60000	0	0	65220	0	0	66600	**$ 191,820.00**
		Establish a mechanism to cater for adequate equipment and	500	500	0	0	0	0	0	**$ 1,000.00**

		Develop a coordination framework for HMIS and establish HMIS	0	333	0	0	0	0	0	**$ 333.00**

		Capacitise a core team on advance	0	8000	0	0	0	0	0	**$ 8,000.00**
		Build capacity of all the programme managers, regional health teams and health facility	4615	4947.692308	5044.615385	5016.923077	5113.846154	4989.230769	5123.076923	**$ 34,850.77**
		Procure a backup server	5,000	0	0	0	0	0	0	**$ 5,000.00**
		Conduct periodic data verification (monthly at regional level and quarterly	360.7179487	386.689641	394.2647179	392.1004103	399.6754872	389.9361026	400.3969231	**$ 2,723.78**
		Print and distribute data collection tools to all health	1000	0	0	1087	0	0	1110	**$ 3,197.00**
		Conduct workshop to integrate and harmonize all the data col-	3858.974359	0	0	0	0	0	0	**$ 3,858.97**
		Interlink all the open source databases of MOH&SW into	0	2500	0	0	0	0	0	**$ 2,500.00**
		Expand VPN with internet in minor health	0	2000	0	0	0	0	0	**$ 2,000.00**
			4358.974	4672.820	4764.358	4738.205	4829.743	4712.05	4838.461	**$ 32,914.62**
		Conduct quarterly information sharing	1000	1072	1093	1087	1108	1081	1110	**$ 7,551.00**
		Conduct awareness campaign on utilisation of health data for planning and decision	884.6153846	948.3076923	966.8846154	961.5769231	980.1538462	956.2692308	981.9230769	**$ 6,679.73**
		Develop 5 year e-health	6025.641	0	0	0	0	0	0	**$ 6,025.64**

		Develop DHIS2 mobile application on specific	2000	0	0	0	0	0	0	**$ 2,000.00**

To establish structures		Develop an Act to legalize the mandate of the National Health	10,000	0	0	0	0	0		**$ 10,000.00**
		Enact the Act in Parliament	0	0	0	0	0	0	0	
		Set up National Health Research Council and its	14600	0	0	0	0	0	0	**$ 14,600.00**
		Set up sub-committees of the National Health Research	11800	0	0	0	0	0	0	**$ 11,800.00**
		Develop standard operating procedures (SOPs) and a work programme for the National Health Research	12250	0	0	0	0	0	0	**$ 12,250.00**
To establish participatory health research										**$ -**
		Explore existing procedures for setting health research	500	0	0	0	0	0	0	**$ 500.00**
		Develop and institution-alize best procedures for health research priority setting in The	8750	9380	9563.75	9511.25	9695	9458.7	9712.5	**$ 66,071.25**
		Develop 5 year health research agenda annually	8750	9380	9563.75	9511.25	9695	9458.7	9712.5	**$ 66,071.25**
Specific Objective: To establish mechanisms for										**$ -**
		Develop a national health research communication	8750	0	0	0	0	0	0	**$ 8,750.00**

		Develop a 5 year commu-	6250	0	0	0	0	0	0	**$ 6,250.00**

		Organize regular conferences and meetings to disseminate and discuss research findings	15000	16080	16395	16305	16620	16215	16650	**$ 113,265.00**
		Develop policy briefs for decision and policy makers	750	804	819.75	815.25	831	810.75	832.5	**$ 5,663.25**
		Make research publications available annually to	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**
		Advocate for the setting up of documen-tation centres in	500	536	546.5	543.5	554	540.5	555	**$ 3,775.50**
		Develop a website for information	500	0	0	0	0	0	0	**$ 500.00**
To improve institu-tional and human resource capacity in										**$ -**
		Undertake a national institutional mapping and research capacity	11000	0	0	0	0	0	0	**$ 11,000.00**
		Advocate for training of critical mass of health professionals in research for	500	536	546.5	543.5	554	540.5	555	**$ 3,775.50**
		Set up and update train-	1000							**$ 1,000.00**
		Undertake resource mo-bilisation to secure funds for	2500	0	0	0	0	0	0	**$ 2,500.00**

		Advocate for the integration of health research training modules into curricula of health training	3150	3376.8	3442.95	3424.05	3490.2	3405.15	3496.5	**$ 23,785.65**

To establish sys-tematic procedures for attracting and maintaining public and										**$ -**
		Participate in national and international meetings and conferences to	4300	4609.6	4699.9	4674.1	4764.4	4648.3	4773	**$ 32,469.30**
		Provide / commission technical assistance for Gambian institutions involved in research	1000	1072	1093	1087	1108	1081		**$ 6,441.00**
		Identify op-portunities for post graduate training, ex-change visits, attachments, study tours and joint re-search studies with other International	36000	0	0	0	0	0	0	**$ 36,000.00**
		Develop advocacy materials such as leaflets, briefing notes and reports on the role, function and activities of the council. The institutional		1750	1876	1912.75	1902.25	1891.75	1942.5	**$ 11,275.25**
To establish accountable and transparent mecha-nisms for attracting										**$ -**

		Develop a Financial Sustainability	5250	0	0	0	0	0	0	**$ 5,250.00**

		Develop briefing documents for inclusion in round table	1050	1125.6	1147.65	1141.35	1163.4	1135.0	1165.5	**$ 7,928.55**
		Advocate for a budget line for research within the MOU&SW	1000	0	0	0	0	0	0	**$ 1,000.00**
		Advocate for 2% of the national health budget & 5% of external health project aid to be allocated to health research	1000	0	0	0	0	0	0	**$ 1,000.00**
		Conduct annual spending assessment on health research	52250	56012	0	56795.75	0	56482.		**$ 221,540.00**
		Review and update of the	7692	0	0	0		0	0	**$ 7,692.00**
		Conduct advocacy for adoption of the amendments	0	10,000	0	0	0	0	0	**$ 10,000.00**
		Develop a draft of the implementation methodology/ procedures based on the Act and	0	0	0	0	0	0	0	**$ -**
		Include the approved procedures in the training	2564	2564	0	0	0	0	0	**$ 5,128.00**

		Develop and implement a nationwide awareness campaign based on a clear communication framework and informed by the key communication strategies of BCC, social mobilization of	35897	35897	0	0	0	0	0	**$ 71,794.00**

		Conduct awareness campaign at all levels community dialogue on BR in selected communities Orient print and electronic media and conduct live and	25641	25641	0	0	0	0	0	**$ 51,282.00**
		Orient and mobilize regional au-thorities, TACs, District Chiefs, Alikalos, VDCs, Venerable Religious Authorities,	53846	53846	0	0	0	0	0	**$ 107,692.00**
		Conduct a national forum on Birth	3663	3926.73	4003.659	3981.681	4058.604	3959.7	4065.93	**$ 27,659.31**
To ensure Commodities (Materials), Pro-tection,										**$ -**
		Assessment of material need of the system – current and future – on a regular basis including cupboards,	2,500	2680	2732.5	2717.5	2770	2702.5	2775	**$ 18,877.50**
		Development a proper inventory								**$ -**

		Ministry to create a budget line for civil registration, (training and refresh training of civil registrars, gradual im-	0	0	0	0	0	0	0	$ -

		Develop a form for collecting information about children who are not yet 18 and require to								**$ -**
		Develop a public information campaign using various means of communication with special focus on the traditional means	17948							**$ 17,948.00**
		Register and issue birth cer-tificates upon								**$ -**
To institutionaliz e and expand the										**$ -**
		Integrate births and deaths registration systems into		2000						**$ 2,000.00**
		Train data entry clerk and health workers on the use of integrated birth and death registration	100000							**$ 100,000.00**
To expand informa-tion and communi-cation		Procure mod-ern ICT tools	2000							**$ 2,000.00**
		Develop an ICT policy and	7407	0	0	0	0	0	0	**$ 7,407.00**
		Develop guidelines for ICT utilization and the pro-	5550	0	0	0	0	0	0	**$ 5,550.00**

		Institution-alize the inventory of ICT assets of the ministry	4000	4288	4372	4348	4432	4324	4440	**$ 30,204.00**
		Upgrade the existing	7407	0	0	0	0	0	0	**$ 7,407.00**

		Provide security mechanisms to protect health data from internal and	15660	16787.5	17116.38	17022.42	17351.28	16928.	17382.6	**$ 118,248.66**
		Provide inter-net connec-tivity to areas that are not connected	20555	0	0	0	0	0	0	**$ 20,555.00**
		Increase the internet connection bandwidth at all	84444	0	0	0	0	0	0	**$ 84,444.00**
		Provide license software.	17037	18263.6	18621.44	18519.21	18876.99	18416.	18911.07	**$ 128,646.39**
		Procure computers for healthcare systems at all	98518	0	0	0	0	0	109354.9	**$ 207,872.98**
		Conduct an assessment of all hospitals for telemed icine	2666	0	0	0	0	0	0	**$ 2,666.00**
		Procure the required ICT equipment for	222350	0	0	0	0	0	0	**$ 222,350.00**
		Build the capacity of the ICT staff on	37036	0	0	0	0	0	0	**$ 37,036.00**
		Conduct an assessment to determine the scope of ICT activities at primary, secondary, tertiary and also	6,324	0	0	0	0	0	0	**$ 6,324.00**
Establish national e-		Conduct an assessment to determine the scope of ICT	2,000	0	0	2174	0	0	0	**$ 4,174.00**
		Procure the required ICT equipment for e-	0	100000	0	0	0	0	0	**$ 100,000.00**
		Build the capacity of ICT personnel for e-health	0	20,000	0	0	0	21620		**$ 41,620.00**
		Train health workers on e-	0	25,000	0	0	27700			**$ 52,700.00**

		Conduct an assessment of all hospitals for telemedicine	0	18,000	0	0	19944	0	0	**$ 37,944.00**

		Expand telemedicine application to all the hospitals	0	24,000	0	0	0	0	0	**$ 24,000.00**
		Develop DHIS2 mobile application on specific	0	15,000	0	0	0	0	0	**$ 15,000.00**
		Customize Open Medical Record System (OMRS)	0	1500	0	0	0	0	0	**$ 1,500.00**
To have a highly skilled ICT staff at										**$ -**
		Train ICT staff on different specialization	30,000	0	0	30,000	0	0	0	**$ 60,000.00**
To improve capacity for IDSR at all										**$ -**
		Train capacity of health staff on surveillance data collection management and	13461.52846	14430.76933	14713.46154	14632.69231	14915.38462	14551.92308	14942.30769	**$ 101,648.08**
		Integrate IDSR data collection tools into National Health Information System	0	0	0	0	0	0	0	**$ -**
		Train data entry clerks and health workers on the integrated IDSR	20,000	21440	21860	21740	22160	21620	22200	**$ 151,020.00**
			1200709	595176.	196243.8	350490.3	246581.5	272227.	375288.4	**$**
TOTAL										
Strategic Objec-	**To ensure effective and efficient health service provision through the development of effective regulatory framework and Promoting effective coordination and**									
Specific		**Main Activ-ities**								

: Update at least 5 existing Acts and Regulations (Medicine and Dental Council Act, Public		Create a Health Professions Council (HPC) as an umbrella professional regulatory body	6153.846154	6596.923077	6726.153846	6689.230769	6818.461538	6652.307692	6830.769231	**$ 46,467.69**
		Transfer licenses and Regulation of premises to Councils	0	0	0	0	0	0	0	**$ -**

		Amend all existing Acts and Regulations taking into consideration	60000	0	0	0	0	0	0	**$ 60,000.00**
		Implement and monitor all existing Acts and Regulations taking into consideration	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**
		Conduct public sensitization on all Acts	3000	0	0	0	0	0	0	**$ 3,000.00**
		Implement and monitor all existing Acts and Regulations taking into consideration	5000	0	0	0	0	0	0	**$ 5,000.00**
		Develop mechanism for coordination of Councils	4000	0	0	0	0	0	0	**$ 4,000.00**
Formulate at least 4 new ones to reflect current realities in the health domain (Public Health Laboratory		Formulate new Acts	1000	0	0	0	0	0	0	**$ 1,000.00**
Reactivate (3) existing councils (Medical and Dental Council, Nurses and Midwives and the		Allocate a Budget line and a mechanism to ensure it accrues to Councils	0	0	0	0	0	0	0	**$ -**
			0	0	0	0	0	0	0	**$ -**

		Provide Human and Material Resources to	3000	0	0	0	0	0	0	**$ 3,000.00**
			5,000	0	0	0	0	0	0	**$ 5,000.00**

		Develop Procedures for Council	0	0	0	0	0	0	0	$ -
			1000	0	0	0	0	0	0	**$ 1,000.00**
		Conduct periodic M&E and provide reports	0	0	0	0	0	0	0	$ -
		Develop a Country Compact Plan through the (IHP) Plus	50,000	0	0	0	0	0	0	**$ 50,000.00**
		Conduct periodic M&E	4,000	4288	4372	4348	4432	4324	4440	**$ 30,204.00**
Specific objective: Establish a func- tional		Establish Health Sector Coordinating Groups	1000	1072	1093	1087	1108	1081	1110	**$ 7,551.00**
		Create budget lines ,allocate resources and	0	0	0	0	0	0	0	$ -
		Institute annual health sector	2000	2144	2186	2174	2216	2162	2220	**$ 15,102.00**
		Conduct periodic M&E and write reports to HP-C,following its	2000	2144	2186	2174	2216	2162	2220	**$ 15,102.00**
Specific objective: broaden		Develop a Country Com-pact through the (IHP)	0	0	0	0	0	0	0	$ -
		Develop MOUs with all relevant partners(NGO and Local	0	0	0	0	0	0	0	$ -
		Sign performance contract agreement within MOHSW and Local Govern-ment,NGO and Private	0	0	0	0	0	0	0	$ -
		Conduct public sensitization on all Acts and Regulations	10000	0	0	0	0	0	0	**$ 10,000.00**
		Implement and monitor all existing Acts and Regulations	5000	5360	5465	5435	5540	5405	5550	**$ 37,755.00**

		Develop mechanism for coordination of Councils activities	3000	0	0	0	0	0	0	**$ 3,000.00**

		Make Acts readily visible and accessible	5000	0	0	0	0	0	0	**$ 5,000.00**
		Conduct periodic M&E and provide reports	4000	0	0	0	0	0	0	**$ 4,000.00**
		Prepare and present Pro-files/Proposals to Partners for	1000	0	0	0	0	0	0	**$ 1,000.00**
		Allocate a Budget line and a mecha-nism to ensure its accrues to Councils	0	0	0	0	0	0	0	**$ -**
		Provide Human and Material Resources to all Councils	0	0	0	0	0	0	0	**$ -**
		Develop Procedures for Council	3000	0	0	0	0	0	0	**$ 3,000.00**
		Develop MOUs	5,000	0	0	0	0	0	0	**$ 5,000.00**
		Sign performance contract agreement within MOHSW	0	0	0	0	0	0	0	**$ -**
		Establish Health Sector Coordinating	1000	0	0	0	0	0	0	**$ 1,000.00**
		Create budget lines ,allocate resources and disburse	0	0	0	0	0	0	0	**$ -**
		Develop a Country Compact Plan through the (IHP) Plus	50,000	0	0	0	0	0	0	**$ 50,000.00**
		Conduct periodic M&E	4,000	4288	4372	4348	4432	4324	4440	**$ 30,204.00**
TOTAL			243153.	31252.9	31865.15	31690.23	32302.46	31515.3	32360.7	**$ 434,140.69**

Appendix C

Annex: Organogram for the Minsitry of Health and Social Welfare