REPUBLIC OF THE GAMBIA
MINISTRY OF HEALTH AND SOCIAL WELFARE

NATIONAL REPRODUCTIVE, MATERNAL, NEONATAL, CHILD AND ADOLESCENT HEALTH (RMNCAH) POLICY

(2017-2026)

APRIL, 2017

BANJUL, THE GAMBIA

Preface

Reproductive and Sexual Health (SRH) is fundamental to individuals, couples and families, and the social and economic development of communities and nations. It is also an important factor in shaping how women, children and adolescents develop and maintain reproductive behavior and enjoy a meaningful life in a society. However, the burden of reproductive ill-health in terms of both life and economic losses are enormous in most low-income countries, including the Gambia. The Gambian government has recognized the slow progress made in improving reproductive and sexual health in general and maternal mortality reduction in particular over the past decades. The Government has also realized that the sustainable development of the nation would not be achieved without renewed commitment by the national as well as local leaders and partners towards the improvement of women, children and adolescents health.

Hence, the Government of the Gambia is committed to improve and maintain the reproductive health status of women, men, children, and the young people in the country. To materialize this and other health issues, the national Health Policy (2012-2020) and Health Sector Strategic Plan (2014-2020) have been prepared as a governing guide by putting reproductive health at the top priority. The period for the implementation of the previous Reproductive and Child Health (RCH) Policy (2007-2014) has already been ended. Therefore, the revision of the previous policy and the preparation of this 10-year Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Policy (2017-2026) is found to be imperative. In line with the existing and new high-impact interventions and the long-term vision of the country, the current policy consolidates the encouraging gains and accelerates progress to end all preventable maternal and child deaths.

The policy is highly aligned with the national health policy and health sector strategic plan as well the global Sustainable Development Goals (SDGs) and The Global Strategy on Women, Children and Adolescents Health (2016-2030). The strategic framework of the policy is also based on the concepts and principles of equity, quality and universal access to primary healthcare. This policy reaffirms the Government's commitment to take the momentum forward by setting targeted and measurable agenda. It builds on numerous past and ongoing initiatives and readily assimilates new and emerging developments, proven to serve the reproductive health needs of all the Gambians.

The implementation of this RMNCAH Policy (2017-2026) will be accompanied by two 5-year strategic plans where evidence based high impact interventions will be well integrated through partnership. The goal of the policy is therefore, built on the momentum occasioned by the SDGs to harness the multi-faceted support needed to meet the reproductive and sexual health needs of the culturally diverse Gambian population. The complementary role of NGOs, partners and other stakeholders will remain crucial in the actual execution of the activities of the policy and the strategic plans.

On behalf of the Ministry of Health and Social Welfare, I would like to take this opportunity to express my gratitude to all our partners in health and development for their continued support to apprehend success in our undertakings of the reproductive and child health programs in the Gambia and their contribution to the preparation of this policy. I would also like to urge the partners to sustain their continuous support and engagement, and use this RMNCAH policy as a guiding framework for their future endeavors to the realization of the sexual and reproductive health in the Gambia.

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Minister, Ministry of Health and Social Welfare of The Gambia

Acknowledgments

The Government of the Gambia is committed to the improvement of the reproductive health status of mothers, neonates, children, adolescents and youth. As part of this commitment, the first Reproductive and Child Health (RCH) Policy and Strategic Plan were developed and have been implemented for the periods from 2007-2014 to achieve the global and national goals and targets, particularly maternal, neonatal and child mortality reduction.

To accelerate the achievements gained in the past, respond to the challenges faced and meet the emerging needs of the women, children, adolescents and youth by ensuring the provisions of integrated and quality services, this revised Reproductive, Maternal, Neonatal and Adolescents Health (RMNCAH) Policy for the period from 2017-2026 is prepared.

The implementation of this RMNCAH policy will also serve as a vehicle for the achievement of the targets of the national health policy and the Health Sector Strategic plan of the country. For this purpose, the goals, objectives and targets of the policy are well aligned with the national health policy and strategic plan. In congruent with the global recommendations, other countries' experiences and the implementation of the last RCH Policy, top priority areas, key strategies and evidence based high-impact interventions were identified. Strengthening the health care system is also put at the center of the policy to ensure strong partners' coordination, sustainability and country ownership.

This RMNCAH Policy is revised by the active engagement of partners and stakeholders working in governmental and non-governmental organizations at various levels, including at the national, regional and facility level, including RCH Unit Staff, WHO, UNICEF and UNFPA by the support from an International consultant.

On behalf of the Reproductive and Child Health (RCH) Unit of the Ministry of Health and Social welfare of the Gambia, I would like to thank all the partners, stakeholders, the RCH Committee and the technical working group for their continued support in the implementation of the past RCH policy and active engagement in the revision and preparation of this RMNCAH policy. The continued and sustained support and engagement of all the partners and stakeholders in the implementation of the policy is paramount important for the realization of the achievement of the stated goal.

The RCH Unit would also like to extend its appreciation to the consultant, Dr. Gurmesa Tura, for his professional support and contribution in shaping the policy to be aligned with the global directions and the existing national health policy and strategic plan.

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Ministry of Health and Social Welfare of the Gambia

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Acronyms and abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Newborn Care
CBC	Community Birth Companions
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHN	Community Health Nurses
CMS	Central Medical Stores
CPR	Contraceptive Prevalence Rate
CRVS	Civil Registration and Vital Statistics
CSE	Comprehensive Sexuality Education
DHS	Demographic and Health Survey
EmONC	Emergency Obstetric and Newborn Care
FGM	Female Genital Mutilation
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunizations
GBOS	Gambian Bureau Of Statistics
GBV	Gender Based Violence
GDHS	Gambian Demographic and Health Survey
GDP	Gross Domestic Product
HC	Health Centre
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	Health system Strengthening
ICPD	International Conference on Population and Development
ICPD-PA	International Conference on Population and Development-Plan of Action
IEC	Information, Education and Communication
IMNCI	Integrated Management of Newborn and Childhood Illnesses
ITN	Insecticide Treated bed Net
IUCD	Intrauterine Contraceptive device
LDC	Least Developed Countries
LSCM	Logistics and Supply Chain Management
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MFSA	Ministry of Finance and Social Affairs
MICS	Multiple Cluster Indicator Survey
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal & Children Health
MNH	Maternal and Neonatal Health
MoHSW	Ministry of Health & Social Welfare
MRC	Medical Research Council
MTCT	Mother To Child Transmission
NGO	Non-Governmental Organization
NHA	National Health Account
PHC	Primary Health Care
PMTCT	Prevention of Mother To Child Transmission
PNC	Postnatal Care (PNC)
RCH	Reproductive and Child Health
RHCS	Reproductive Health Commodity Security
RHT	Regional Health Team
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
ROC	Reproductive Organ Cancer
SBCC	Social Behavior Change Communication
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive health
STI	Sexually transmitted infection
TFR	Total Fertility Rate
TWG	Technical Working Group
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
VHS	Village Health Service
VHW	Village Health Worker
WHO	World Health Organization

1. Introduction

Sexual and Reproductive Health (SRH) issues have been among the top priorities of The Gambian Government's agenda for many decades. These have been reflected by the adoption of the Alma-Ata Declaration on Primary Health Care (PHC, 1978), the International Conference on Population and Development (ICPD-PA, 1994) and The Millennium Development Goals (MDGs, 1990-2015). Despite these efforts, the Gambia is among the countries with high Maternal Mortality Ratio (MMR) (433 deaths per 100,000 live births) in the world. The neonatal (22 per 1000 live births), infant (34 per 1000 live births) and child mortality (54 per 1000 live births) rates are also remain high in the country (GBOS, 2014).

The country has high prevalence of malnutrition — stunting (24.5%), wasting (11.5%) and underweight (16.2%). With the Contraceptive Prevalence Rate (CPR) of about 9% and unmet need of 25%, the country has a crude birth rate of 40.5% and Total Fertility Rate (TFR) of 5.6. Sub-optimal access to quality maternal and child health cares, especially the Emergency Obstetric and Newborn Care (EmONC), are among the bottlenecks (GBOS, 2014).

Most of the global and national policies and strategies in the past give due emphasis to the Reproductive and Child Health and less emphasis to the adolescent health. Whereas, the updated Global Strategy, (2016-2030), includes adolescents; because, they are central to everything that any country want to achieve, and to the overall success of the 2030 Agenda.

The three overarching objectives of the updated Global Strategy — *Survive* (end preventable death), *Thrive* (ensure health and wellbeing) and *Transform* (expand enabling environments) — build on the momentum of Every Woman Every Child—no woman, child or adolescent should face a greater risk of preventable death because of where they live or who they are. These all need making the policy and the strategic plan inclusive of all segments of the population so that no one must left behind.

The last national Reproductive and Child Health (RCH) Policy was developed for the period of 2007-2014 and has already ended. Simultaneously, global and national developments have brought new evidence-based interventions to be included in the existing package of interventions. Thus it is imperative to revise the existing policy and develop a comprehensive national Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) policy for the years to come.

It is recommended that policies have to move from short-term to medium or long- term so that the impacts of the policy can be measured. This also minimizes costs of frequent policy development. Hence, this RMNCAH policy is developed for the coming 10 years (2017-2026). The revised policy has built on the evidence provided by an extensive situational analysis. The revision of the policy has been made in consultation with a wide range of individuals and institutional stakeholders at national and sub-national levels and has passed through several consultative meetings.

Based on the evidence form the situational analysis and the global directions, the policy has identified key priority areas, objectives and strategies for the coming ten years. The implementation of the policy will be guided by the detailed two successive 5-year RMNCAH strategic plans (2017-2021 and 2022-2026); where, the detail key high impact interventions will be included.

2. Background of The Gambia

2.1. Geography

The Gambia is located on the West African coast between Latitude of 130 and 140 North of the equator extending about 400 km inland. Its width varies from 24 to 28 kilometers and has a land area of 10,689 square kilometers. It is bordered on the North, South and East by the Republic of Senegal and on the West by the Atlantic Ocean. The country has a tropical climate characterized by two seasons: rainy season (June – October) and dry season (November-May) (Figure 1).

Fig. 1: Map of the Gambia

2.2. Demography

According to the Gambian Population and Housing Census (GBOS, 2013), the population was estimated to be 1,882,450, with annual growth rate of 3.3%. With the current trend, the population of the Gambia may reach about 4 million by 2040. About 60% of the population lives in the rural areas. About 44% of the population is below 15 years and 19% between the ages 15 to 24. The country has high family size with an average of 8.2 persons living per household. With a land area of 10,689km^2, the population density of the Gambia is about 176 persons per square kilometers.

2.3. Socio-economy

The Gambia is amongst the Least Developed Countries (LDCs) with Gross Domestic Product (GDP) per capita of US$ 427 (MoFEA, 2014, IMF, 2015). 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 recent upturn in performance of the economy has however been driven mainly by the service sector including tourism, telecommunication, construction, etc. The country has an overall age-dependency ratio of 0.85:1 and 94% of the economically active populations are employed. More than half (56.1%) of the economically active population had no formal education and the proportion was slightly higher for males (51.1%) than females (48.9%) (GBOS, 2013).

2.4. Healthcare Delivery System

The health care delivery system of the Gambia encompasses the Public Health Sector, the Private Health Sector and the Traditional Medicine as described below.

A. Public Health Sector

The public health sector's service delivery of the Gambia is organized into three tier system:

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

1. Primary Level: Village Health Services (VHS)

The VHS consists of the Community Birth Companions (CBCs) and the Village Health Workers (VHWs) who are often the first point of contact between individuals, families and communities within the health system. The CBCs provide care for pregnant women and identify and refer obstetric emergencies. The VHWs on the other hand are involved in health promotion and prevention measures, the treatment of minor ailments, and refer cases beyond their scope of management. The village health services are complemented by the Reproductive and Child Health (RCH) trekking visits from the health centres. The RCH package includes: antenatal care, child immunization, growth monitoring, registration of births and deaths and limited treatment for sick children.

2. Secondary Level

The secondary level consists of minor and major health centres:

- *Minor Health Centre*

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

- *Major Health Centres*

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

3. Tertiary Level

This includes general hospitals and teaching hospitals. The general hospitals serve as referral points for the Major health centres as they provide specialized services. The Teaching Hospital also serves as the referral hospital for the general hospitals.

B. Private Health Sector

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

3. Situation of RMNCAH in The Gambia

3.1. Impact analysis (morbidity and mortality)

3.1.1. Maternal morbidity and mortality

The Gambia subscribed to the 75% reduction of MMR by 2015. However, the reduction of MMR in the country has been very slow and remains among the top priority of the country for the post-2015 SDG agendas. Majority of maternal deaths in the country are as a result of avoidable direct obstetric complications, including hemorrhage (37%), hypertensive disorder of pregnancy (11%) and sepsis (11%) (WHO, *et al*, 2015). The main contributing factors include, inadequate access to CEmONC and BEmONC services, lack of trained human resources, transportation and low socio-economic status of the people. Addressing these challenges and improving availability and quality of CEmONC can contribute to at least 60% maternal mortality reduction in the country.

3.1.2. Child morbidity and mortality

Trends in infant and under-five mortality rates have shown a steady decrease in the Gambia. Under-five mortality had declined from about 109 per 1000 live births in 2010 (MICS 2010) to 54 per 1,000 live births in 2013. Similarly, infant mortality rate had declined from about 81 per 1,000 live births in 2010 (MICS 2010) to 34 deaths per 1,000 live births in 2013. As a result, the Gambia has achieved the MDG-4 target before the deadline (MFSA, 2014).

The neonatal mortality accounted for about 41% of the under-five mortality. This implies that more than 2 in 5 of under-five deaths occur during the first 28 days of life. Prematurity (34.8%), birth asphyxia (28.9%) and pneumonia (14.4%), account for about 78% of the neonatal deaths. Malaria (31.5%), pneumonia (16.6%) and diarrhea (13.7%), account for about 62% of post neonatal mortality. These causes are preventable or treatable, indicating that addressing the three causes alone effectively can avert about three-in-five of post neonatal mortality.

Inadequate access to quality pre-partum, intra-partum, and postpartum services for mothers and children, insufficiency of well qualified staff and poor treatment seeking behavior of the families due to distance and low socio-economic status are the major contributing factors for the high neonatal and a post neonatal mortality in the country (GBOS, 2014).

3.2. Process and outcome analysis (service coverage and gaps)

3.2.1. Fertility and Family planning

The Gambian government has been making several efforts together with the partners to increase the contraceptive prevalence rate, reduce unmet need for modern contraceptives and thereby reduce the total fertility rate. However, the TFR of the Gambia (5.6 births per woman) is one of the highest in the world. In the country, about 31% of women give birth by age 18 years and about half (49%) by the age of 20 years. Almost one in five (18%) of adolescent women age 15-19 years are already mothers or pregnant with their first child (GBOS, 2014). This high fertility is partly attributed to the low utilization of family planning methods as the CPR is about 9% unmet need is 25%. Moreover, about two-third (65.5%) rely on short term methods—injectables and pills accounting for 43.3% and 22.2% of the contraceptive method mix, respectively with very high discontinuation rate (GBOS, 2014). Socio-cultural factors, misconceptions, low male partner's acceptance, inadequate training of service providers are some of the barriers to the family planing service provisions in the country.

3.2.2. Maternal and Newborn Health (MNH)

Quality care during pregnancies, labor and child birth, and the postpartum period can significantly reduce maternal and neonatal morbidity and mortality. In the country, 86% of pregnant women receive ANC from a skilled provider with 78% receiving ANC4+ and 38% starting during the first trimester. About 63% of births are attended at health facility, with 57% being assisted by skilled birth attendants. There is also high unmet need for obstetric emergencies as delivery by C/S is about 2% in the country. Similarly 76% of mothers receive PNC in the first two days after delivery, but only 1% comes again for postnatal checkup between 3-42 days (GBOS, 2014).

Inadequate behavioral interventions, distance, socio-cultural, limited number of CEmONC facilities, and low number of trained human resources are among the major factors for the maternal health services use.

3.2.3. Post Abortion Care (PAC) Services

In The Gambia, abortion is illegal and punishable except in case of life threating conditions of the pregnancy. As a result, the health facilities provide post abortion care (treatment) to prevent complications and save the lives of the woman. This resulted in the paucity of reliable data on the national burden of abortion. But, in the HMIS 2015 report, about 1607 cases of post abortion were treated within a year (MoHSW, 2016). Many more might have been done underground and not reported to reflect the true magnitude.

Lack of adequate information on the complications of abortions and unwanted pregnancy before marriage are the major contributors. These point to the need for intensive behavior change interventions to reduce the prevalence of unwanted pregnancies thereby avoid unsafe abortions, particularly among adolescents. There is also a big gap in data for evidence based policy and strategy suggesting for the conduct of researches to have policy dialogs and better interventions.

3.2.4. Child Health and services

Despite the recent gains, the problem of child malnutrition is unsolved agenda in the Gambia, stunting (24.5%), wasting (11.5%) and underweight (16.2%) are high in the country. Besides, overall, 73% of children suffer from some level of anaemia (GBOS, 2014). In the country, 99% of children are breastfed at some point, but about 52% start within one hour of birth and 47% exclusively breastfeed, 55% start complimentary feeding timely (at 6-8 months) and 42% continue breast feeding up to 2 years (GBOS, 2014).

Full immunization coverage in the country is 68% among children aged 12-23, the coverage of specific antigens are very high: BCG (99%), polio 3 (90%), Pentavalent 3 (88%) and measles (88%) (GBOS, 2014).The HMIS 2015 also reported similar findings, where the immunization coverage for each vaccine is above 95% (MOHSW, 2015).

Shortage of trained staff on IMNCI case management skills, limited number of IMNCI guidelines in public health facilities, problems of laboratory supplies and other items such as 301 Heamocue Cuvettes are grossly inadequate.

3.2.5. Adolescent and Youth Sexual and Reproductive Health (AYSRH)

The WHO defines adolescents as people in the age range of 10-19 years and youth as people in the age range of 15-24 years, both together young people (10-24). The Gambian youth policy (2009-2018) considers young people as the population that falls in the age bracket of 13-30 years (Gambian Youth and Sports Affairs, 2009)

Young people constitute nearly half (47%) of the Gambia's population; thus their advancement including their health ranked high among national priorities. But, Adolescent and Youth (AY) Sexual and Reproductive Health (SRH) needs remain challenged with far-reaching social and economic consequences in the country for several years. The adolescent and youth survey conducted in 2000 in the Gambia indicated that 41.5% of youth aged 15-24 years were sexually active, with approximately 15% of sexually active females reporting the occurrence of at least one pregnancy with adolescent fertility rate of 88.1 per 1000 women aged 15-19. Furthermore, only 19.1% of 15-24 years had comprehensive knowledge on HIV and AIDS and the prevalence of condom use at the last high-risk sex is as low as 43.3%. Though, the HIV prevalence among 15-24 were relatively lower (0.3%), females were affected two-fold as compared to males (0.2% among males and 0.4% among females) (GBOS, 2014).

Therefore, it is of absolute need to expand the ASRH services and integrate adolescents and youth friendly services in a form of a "One stop shop" into the existing public health system. It is also important to collaborate with The Ministry of Education to revitalize age tailored, culturally sensitive, socially acceptable and legally sound Sexuality Education.

3.2.6. Sexually Transmitted infections (STIs), including HIV

Because of the silence and secrecy related to human sexuality, conducting researches and having reliable information on the prevalence of STIs is very challenging in many countries, including the Gambia. The existing very few reports, such as the GDHS-2013, show that the current magnitude is very significant. The self-reported prevalence of STIs and STI symptoms during 12 months before the GDHS-2013 survey was 8% among women and 3% among men. However, 27% of women and 26% men did not seek any treatment or advice either from public or private facilities (GBOS, 2014).

In response to the scourge posed by HIV/AIDS, the government of the Gambia has established a National AIDS Control Programme within the ministry of health as well as the National AIDS Secretariat under the Office of the President. The HIV/AIDS management (treatment, care and support) also continue to be provided free of cost throughout the country. As a result, the national adult (15-49) HIV prevalence rate became relatively lower compared to other countries within the region and it has declined from 2.8% in 2006 to 1.9% in 2013 (2.1% among women and 1.7% among men). However, HIV test uptake in the country is low with 39% of women and 19% of men aged 15-49 have ever been tested.
(GBOS, 2014).

About 72% of women and 54% men (15-49) know that HIV can transmit from mother to child by breastfeeding. Similarly, 66% of women and 49% of men know about special drugs that can be taken during pregnancy to reduce the risk of contracting HIV. However, about 65% of pregnant women were tested during ANC and about 54% received their results and post-test counseling (GBOS, 2014). Similarly, the HMIS 2015 report show low coverage of PMTCT, particularly significant dropout along the PMTCT continuum. In the year 2015, about 71,264 new ANC attendees were registered, from these 55,947 (78.5%) received pretest counseling, 55,623 (78.1%) tested for HIV and 55,014(77.2%) received their results and post-test counseling. The exposed infant prophylaxis (Cotrimoxazole at 2 months) drops

significantly— from 743 mothers starting ART to only 464 (62.5%). As the number of infants tested at 6 weeks (EID) were not reported, but only at 18 months, the status of test for exposed infants and the exact rate of MTCT is difficult to be estimated. Moreover, as the HMIS reports only the number of services given, but not the percentage, it is difficult to measure progresses in PMTCT and other services in general, which may need improvement in the future. According to Global fund Gambian AIDS progress report of 2014, the MTCT rate with breastfeeding at 18 months was 9.4% (Global Fund, 2014)

3.2.7. Reproductive Organ Cancers (ROCs)

Cervical cancer is the leading cause of cancer death for women in the Gambia. Though data are limited to know the community based prevalence and burden of cervical cancer, the facility based reports show that significant numbers of women get affected. According to Cancer register at Bafrow clinic, about 450 women were screened for cervical cancer between 2010 and 2015. According to the National Cancer Registry of the Gambian Medical Research Council (MRC), a total of 998 confirmed cases of cervical cancer were registered in the past between 2007 and 2016. Cervical cancer is also one of the common causes of death amongst women of reproductive age in the Gambia.

According to the National Cancer Registry of the Gambia, about 475 confirmed cases of breast cancer were also registered between 2007 and 2016. In Sharab clinic a total of 15 cases were registered and 10 were operated from 2013 to 2016 (National Cancer Register, 2017).

The major challenges to the implementation of the interventions for the prevention and treatment of ROCs include:

- Limited histopathology labs and other equipment.
- Limited materials for screening e.g. Mammogram machine.
- Weak coordination between the MOH&SW and private facilities involving in cancer management.
- Weak data management in many facilities dealing with cancer care.

3.2.8. Obstetric fistula

The Gambian Government has a strong stand of "*no women should suffer or die of obstetric fistula"* and has been discharging various efforts. However, though up-to-date data are very limited on the magnitude of obstetric fistula, the 2006 situational analysis identified about 197 women, with the prevalence of 0.5 fistula cases per 1000 women of reproductive age (SA, 2016).

Access to fistula repair in The Gambia is unevenly distributed across the country. Only two facilities out of the many facilities are offering fistula repair services (Sharab and Bafrow clinics), which are both private facilities and the cost is expensive. According to Facility Record of Bafrow clinic, a total of 150 fistula cases were repaired, rehabilitated and reintegration done at Bafrow clinic in Madinaba from 2010 to 2016. As per the Record of Sharab clinic, a total of 9 fistulae were repaired at Sharab clinic from 2013 to 2016. Low access to BEmOC and CEmOC facilities, and problems related to transport are the main challenges causing delays and leading to fistula. These suggest the need for increasing availability of functional theatres and obstetric specialists in every district hospital and major health centre; early and accurate diagnosis and surgical intervention, rehabilitation and reintegrated programs.

3.2.9. Gender, harmful traditional practices and male engagement

Economically, women are empowered greatly considering their involvement in both the formal and informal engagements in the Gambia. Yet, most of them are working in risky work environments and subjected to harassments and intimidations at all levels of work, especially in the formal sector where

some are denied pregnancy for a period, maternity leaves not fully paid and some denied of opportunities for not satisfying another's sexual desire.

Women have more access to RH services than men in the Gambia, which is due to the fact that women are seen to be responsible of RH issues in the family. With interventions from various stakeholders, women's autonomy in decision making especially in RH is improving. Except for FP, women have the autonomy to decide using every other RH service. Despite the legal instruments protecting women such as the women's act 2010, domestic and sexual offences acts 2013, gender based violence (GBV) and harmful traditional practices, including child marriage and female genital cutting is high in The Gambia.

Men support for RH service use is happening; but, not manifested in the way of accompanying them for the services. Key among the reasons are lack of information about RH for men, socio-cultural believes/misconceptions, health facilities are not male friendly and therefore men refrain from going there. Community conversation and dialogues by involving key community and religious leaders are crucial to enhance men engagement.

3.2.10. Reproductive health issues of people with special needs

The global strategy on women, children and adolescents health (2016-2030) recommends the provision of reproductive health services to everyone to ensure equity so that no one left behind. However, in most settings of the low-income countries, including the Gambia, specific interventions targeting people with special needs—such as people with physical as well as mental disabilities and people in the fragile emergency situations (refuge campus, displaced or hard to reach) are very scarce (WHO, 2015).

In such settings, women and adolescent girls in particular are vulnerable to exclusion, marginalization and exploitation, including sexual and gender-based violence. But, Humanitarian emergency responses have historically given insufficient attention to protecting women, children and adolescents, who in crises face increased risks of poor physical and mental health outcomes, harassment, assault and rape. These suggest the need for local, national and international actors across sectors, including health, to protect their rights, prevent gender-based violence and HIV/AIDS, and ensure the provision of essential sexual and reproductive health services (WHO, 2015).

3.2.11. Reproductive Health Commodity Security (RHCS)

Reproductive health commodity security refers to the situation in which all individuals can obtain and use affordable, quality reproductive health commodities/supplies of their choice whenever they need them. Access to a reliable supply of contraceptives, condoms, medicines and equipment is fundamental to all sexual and reproductive health programming (UNFPA 2010).

However, in most low income countries, including the Gambia, reproductive health commodities are more of donor dependent. The family planing commodities in the Gambia have been primarily supported by the UNFPA. In conjunction with MoHSW's staff turnover, limited donor funding and lack of active RHCS committee contributed to the unavailability of some of the RH commodities, including contraceptives. With increased government revenues, donor support, and strengthened advocacy, putting efforts in place to improve the RHCS situation in the Gambia is very crucial. Thus, the Government should translate its declared commitment to RHCS into actions through adequate financing (UNFPA, 2010).

3.3. Healthcare System Strengthening (HSS) —The 6 building blocks

3.3.1. Leadership and governance

The government of the Gambia has committed in improving reproductive and child health services in the country. This has been reflected by the establishment of Reproductive and Child Health (RCH) Unit, National RCH committee and articulation of the RMNCAH issues in to all the core and relevant documents of the MoHSW such as Health Policy and the health Sector Strategic Plan.

The past two successive RCH policy and strategic plans, development of guidelines such as Maternity Care, Family Planning, Referral, Maternal Death Review and Reproductive Health Commodity Security are also among the many endeavors. As a result of these efforts, RCH Services have been provided at all levels of the health system by both public and private sectors.

Weak coordination of partners and lack of institutional mechanism to review the performance of RCH programmes for better implementation are the major gaps among others. Additionally, the functionality of regional and national committees has been a main challenge. These can be improved by strengthening the coordination among all stakeholders and committees, allocation of funds to the committees for their operations and strengthening the monitoring, evaluation and supervision at all levels.

3.3.2. RMNCAH services delivery

There are 8 hospitals, 7 major health centers, 43 minor health centres, 43 community clinics (Health posts), 30 NGO clinics and 25 private clinics in the Gambia. However regional misdistribution exists as 5 of the 8 hospitals and 15 of the 25 private clinics are in the Western Higher River 1 (WHR 1) region.

The WHO recommends that there should be 1 CEmNOC and 4 BEmNOC facilities for every 500,000 population. For nearly two million projected population for 2017, 4 CEmONC and 16 BEmONC facilities are required as a minimum. With 8 hospitals and 2 of the major health centers are providing CEmONC services, the country has surpassed its target for CEmNOC, but falls short of its BEmNOC target as only 2 facilities fulfill for this. However, big regional distribution exists.

About 95% of facilities have electric supply, including generators and solar energy. All facilities have source of water supply, of which 88% are potable. Nationally, 70% of facilities have functioning motor vehicle ambulance while 12% had a functioning 3 or 4-wheel motor vehicle (EmONC Report, 2012). Though ambulance availability is high for health facilities, poor feeder road networks and shortage of fuel hamper smooth referral services. Additionally, lack of life saving equipments (e.g oxygen supply) in ambulances and a single driver for the ambulance, without health professional, also affect referral services.

3.3.3. RMNCAH Workforce

To provide quality maternal and child health services, the WHO recommends a health professional density of 23 (Doctors +Nurses + Midwifes) per 10,000 population. According to 2015 HMIS service statistics report, the Gambia has health professional density of 8.3 per 10,000 populations, which is almost about a third of the recommendation. Specifically, WHO recommends 1 Doctor per 10,000 populations. With about 198 Doctors, the Gambia has 1.1 doctors per 10,000 population; however, about three-quarter (148 of the 198 doctors) work only in the WHR 1 Region. The same regional disparities applies for nurses, midwifes, anesthetists and laboratory professionals.
Almost all facilities are understaffed because of the limited number of health professionals as a result of inadequate number/capacity of health training institutions to produce the required quantity and professional mix, weak motivation and retention mechanisms, including promotion, further education (upgrading or specialization) and part-time payments, and inadequate conducive accommodation, especially in rural areas.

3.3.4. RMNCAH Logistics and Supply Chain Management(LSCM) System

Significant efforts and resources have been invested in strengthening health infrastructure, logistics, supply, equipment and transport by the Gambian government and its partners over the past years. However, inadequate and inequitable distribution of health infrastructure, logistics, supplies and equipment across the country has continued to present major challenges to the health sector. As a result, stock-outs of some antibiotics, Oxytocin, Magnesium Sulfate and other RMNCAH medicines were the major problems. The main reasons for stock outs were insufficient funds and problems in procurement; stock allocation/rational decisions at Central Medical Stores (CMS) and regional stores.

There are also challenges in forecasting, procurement, distribution, storage and consumptions because of inadequate requisitioning by the regional stores; improper requisitioning by health centers; and lack of resources for transport at the regional level. These challenges could be overcome by a well-functioning health system that ensures equitable access to essential medicines, vaccines and technologies that are assured of quality, safety, efficacy and cost-effectiveness.

3.3.5. RMNCAH Financing

Healthcare services financing is a challenge all over the world; but, more pronounced in developing countries where government budgetary allocation to the health sector is less than optimal and health insurance schemes have limited coverage or non-existent. Though the Gambian government's general expenditure on health has significantly improved over the last ten years to 12.48% in 2013 (NHA, 2013), it is still below the Abuja declaration of 15%.

Moreover, the main health financing source, particularly RMNCAH, is through external donors, including bilateral and multilateral funding such as Global Fund and GAVI. In terms of procurement of contraceptives, this is solely undertaken by UNFPA. Biomedical equipment is normally procured by both donors and the government. Government revenue allocated via the national budget to various financing agents is the second biggest component. However with the high poverty level, the percentage of out-off pockets expenditure on health is about 21.2%, which many lead some households to fall into catastrophic health expenditure levels.

The RMNCAH care in the Gambia is provided almost free, since the introduction of a policy in 2007. But, some gaps in the implementation exist. In terms of cost recovery and exemption, only children under-fives, pregnant women and postpartum mothers are exempted from paying RMNCAH services. Nobody is exempted to pay because the person is poor. Any person with conditions such as TB, Leprosy and HIV and AIDS are exempted to pay. Hence, implementation of the free service policy for RMNCAH programs and looking for exemption mechanisms for the poor are needed.

3.3.6. Health Information, Monitoring and Evaluation system

Reliable and readily available health information is crucial for evidence based planning, monitoring and decision making for health service management. Such information has to come from sources that include, facility based recording and reporting as well as community based national and local surveys. As part of this, the Gambia has the Health Management Information system (HMIS), the Gambian Demographic and Health Survey and other diseases specific surveys and surveillances, including the MICS, MIS, RHCS, MMR surveys and EmONC assessment. There is also the introduction of Community Health Information System (CHIS).

Although the HMIS data are collected at facility level, they are reported to the regional level through paper based returns and entered in electronic data base called DHIS2 at regional level, which could have been done at the facility levels if trained staff available. Most of the HMIS indicators are reported in absolute numbers of service use and do not report coverage in terms of percentage either from the edible catchment population or institutional plan. As a result, it is difficult to comment on the level of achievement and change in trends over time.

Though the data have been used for decision making to some extent, there is need for capacity building in terms of data analysis and interpretation at all levels to improve local data use. In addition, minor limitations in providing complete HMIS data timely has been observed indicating areas of future improvement.

4. Policy framework and declarations

4.1. Policy framework

This Reproductive and Child Health (RMNCAH) Policy (2017-2026) is set within the framework of the Gambian National Health Policy, which upholds Primary Health Care (PHC) as the key to health development in The Gambia. The policy further recognizes that the implementation of the RMNCAH programs should be in the context of the primary health care.

The following provisions of the national health policy are critical to the achievements of the RMNCAH goal and targets:

I. The Gambia operates a three tier national health care system, where the Primary and Secondary level Health Cares both are managed by the Regional Health Teams and the Tertiary i.e. General/ Teaching Hospitals are managed by Boards as semi-autonomous;

II. The government has the responsibilities for the health of the people that shall be fulfilled by the provision of adequate health and social services. The citizens shall have the right and duty to participate individually and collectively in the planning, implementation, monitoring and evaluation of health services;

III. Health resources shall be equitably distributed giving preference to those at greater health risk and the under-served communities as a means of social justice and concern;

IV. Emphasis shall be placed on preventive and promotive measures which shall be integrated with curative and rehabilitation in a multi-disciplinary and multi-sectoral way;

This RMNCAH Policy recognizes that services at all levels will be complemented by the Private and NGO health sectors as well as with component specific sectors/ organizations for the further promotion of sexual and reproductive health information and services.

4.2. Policy declarations

Whereas the Government and People of The Gambia realize that women, men, children and adolescents have specific sexual and reproductive health needs that must be met and, past efforts to meet these needs have had limited impact in reducing sexual and reproductive ill-health of the vulnerable groups.

The Government hereby adopts and undertakes to subscribe to this National RMNCAH Policy with the following declaration:

- All tiers of the Government hereby agree that the reproductive health of the people does not only contribute to better quality of life but is also essential for the sustained economic and social development of the nation.
- The people of The Gambia, including young people, shall participate individually and collectively in the planning, implementation and evaluation of their reproductive health care.
- The Government and people of The Gambia affirm that the revised National RMNCAH Policy and Strategic Plan of Action shall be complementary to the National Health Policy and its strategies to achieve health for all Gambians.
- To this end, the Ministry of Health and Social Welfare (MoHSW):
    1. Support a sustainable framework to regulate and facilitate the implementation of this RMNCAH policy and the accompanying strategic plan.
    2. Promote the Reproductive Health Concept and the RMNCAH minimum of care packages of services throughout the country using a multi-sectoral approach within the broader context of macro-economic policies as well as localizing the health – related SDGs;
    3. Review and update relevant policies, laws, strategies and programmes to encompass the broad spectrum of reproductive health issues in a coherent and integrated manner with particular attention to priority-setting;
    4. Ensure the availability of skilled attendants for the provision of the Basic Emergency Obstetric and Newborn Care (BEmONC) during pregnancy, labour and delivery, postpartum (for mothers and newborn) and post-abortion care within a functioning healthcare setting.
    5. Ensure access to Comprehensive Emergency Obstetric and Newborn Care (CEmONC) twenty-four a daily and seven days a week as per the CEmONC implementation standards and guidelines.
    6. Support country-wide expansion and consolidation of newborn and child survival strategies: e.g. the Integrated Management of Neonatal and Childhood Illnesses (IMNCI); Community Based Newborn Care; Baby Friendly Community Initiative; Immunization and Vitamin A, Deworming Initiative; Maternal Anaemia and Nutrition Initiative and Birth Registration.
    7. Maintain free maternal, newborn, child and Adolescent health services.
    8. Ensure the full implementation of The Reproductive Health Commodity Security (RHCS) Plan i.e. continuous availability of basic equipments, furniture for RMNCAH base and outreach facilities, family planning commodities, information and capacity building at all levels; as well as inclusion of contraceptives in the MoHSW essential drugs list.
    9. Support the provision of age tailored adolescent and youth friendly sexual and reproductive health information and services.
    10. Collaborate with the Departments of State for Education, Youth and Sports in the planning, implementation and Evaluation of Adolescent and Youth Health interventions.
    11. Ensure the integration of relevant programme components and resources to increase public and provider awareness on RMNCAH issues such as: Danger Signs in pregnancy, childbirth and postpartum; Maternal and Child Nutrition; Malaria in Pregnancy and STIs/HIV/AIDS/PMTCT/VCT.

12. Ensure that women and men as partners actively participate equally in RMNCAH issues and that the programme and services are gender sensitive and responsive through sensitization and training of service providers, particularly in the area of client-provider interaction and interpersonal communication skills.
13. Work in partnership with key stakeholders on gender discrimination, harmful socio-cultural practices and gender based violence related to RH issues including the active involvement of men.
14. Advocate and ensure that other relevant components of RH such as infertility, menopause, andropause, fistulae and reproductive organ cancers are catered for in partnership with stakeholders.
15. Promote the collaboration between reproductive health and traditional medicine through community sensitization on the management of infertility, RH cancers and HIV/AIDS among others.
16. Support the implementation of the proposed HPV vaccine and cervical cancer screening programme in partnership with stakeholders.
17. Ensure continuous advocacy and IEC/SBCC using standard IEC/BCC/SBCC materials and guidelines for appropriate context specific and age tailored information dissemination and service delivery.
18. Promote quality assurance by ensuring an appropriate referral system, availability of essential services such as blood availability and transfusion, constant water and electricity supply, appropriately staffed facilities, continuous availability of basic and essential drugs and supplies among others.
19. Spearhead resource mobilization efforts required for RMNCAH services in partnership; such as: financial, material, technical and human resource development as well as increase political commitment backed by budgetary allocation that will be used in a judicious and transparent manner.
20. Strengthen the institutional capacity of the National Health Management Information System (HMIS) in order to adequately address reproductive health needs. Quarterly collation and publication on RMNCAH activities of all stakeholder institutions will be made and regular update of the programme web site for information sharing will be done.
21. Support the use of the updated monitoring tool for RMNCAH services for planing, implementation, reporting of activities at all levels.
22. Promote and support researches relevant to RMNCAH in partnership with researches institutions and support the production, storage, retrieval, dissemination and use of relevant report/findings on RMNCAH.

5. Vision, Mission, Goal and Guiding Principles

5.1. Vision

- Every woman, child and adolescent in the Gambia realizes their full reproductive health rights and well-being so as to participate fully in shaping sustainable and prosperous societies.

5.2. Mission

- Improve the reproductive health status of women, neonates, children, and adolescents of the Gambia through the promotion and provision of right based comprehensive, quality, affordable and sustainable sexual and reproductive health information and services through partnership.

5.3. Goal

- Improve the quality of reproductive life and wellbeing of mothers, newborns, children and adolescents of the Gambia by reducing morbidity and mortality associated with sexual and reproductive ill-health.

5.4. Guiding Principles

Following on the above policy framework and declarations, the comprehensiveness, effectiveness and sustainability of the national RMNCAH policy will be enhanced by incorporating the following guiding principles:

- ***Good governance and country ownership:*** Good governance, national ownership, country leadership and leadership commitment for the provisions of comprehensive and high quality RMNCAH services.
- ***Right based approach:*** Respect the rights of the individuals to information and education and emphasizes access to accurate information in order that they take full, free and informed decisions.
- **People-centred:** provide RMNCAH services, which are people-centred, confidential and not to discriminate against any individual on account of gender, or social background.
- ***Affordable, equitable and quality:*** RMNCAH services are provided in a manner that ensures affordability, equity in access and quality corresponding to the needs of each individual.
- **Gender responsive:** equity and equality in access to national resources and services by all people regardless of their sex or social status;
- ***Men involvement:*** Men and women to take responsibility for their own sexual behavior, fertility, health and wellbeing as well as that of their partners and families;
- ***Privacy and confidentiality:*** RMNCAH services ensure privacy of the individual, and sensitive and responsive to the socio-cultural circumstances of the individual.
- ***Evidence based:*** Evidence-based interventions, which lead to provision of good quality of RMNCAH services within a continuum of care along the life course.
- ***Consistent:*** The RMNCAH service provisions will be consistent with other related national policies, legal provisions and relevant international agreements and conventions.
- ***Sustainable and universal access:*** Health system strengthening based on PHC to ensure sustainability for achieving equity and universal access to comprehensive RMNCAH interventions.
- ***Partnership:*** strong partnership with relevant programmes and sectors, development partners and stakeholders in RMNCAH to optimize coordination and collaboration that promotes transparency and accountability in achieving the RMNCAH goals and to ensure community participation.
- ***Community engagement:*** active community participation and ownership of the RMNCAH programmes from planing to implantations and monitoring and evaluation.

6. Policy Priorities, Objectives, Targets and Strategies

6.1. Policy Priorities

Based on the global priorities, the previous policy, and the findings of the current extensive situational analysis, the following 10 focus areas are identified as policy priorities for the coming five years.

Priority 1: Improving Family Planning

Priority 2: Improving Maternal and Neonatal Health (MNH)

Priority 3: Improving Child Health (CH)

Priority 4: Improving Adolescent Sexual and Reproductive Health (ASRH)

Priority 5: Improving Prevention & Treatment of Sexually Transmitted Infections, including HIV

Priority 6: Improving the Prevention and Treatment of Reproductive Organ Cancers (ROCs)

Priority 7: Gender, Harmful Traditional Practices and Male Engagement

Priority 8: Improve access to RMNCAH services for people with special needs (people with disabilities or in fragile emergency situations)

Priority 9: Improve Reproductive Health Commodity Security (RHCS)

Priority 10: Health System Strengthening (HSS)

6.2. Policy Objectives

Based on the above identified key policy priorities, the following 10 policy objectives are set.

1. To reduce the magnitude of unwanted pregnancies and unmet need for contraceptives
2. To reduce maternal, perinatal and neonatal morbidity and mortality
3. To reduce childhood morbidity and mortality
4. To increase knowledge of reproductive biology and promote responsible sexual and reproductive health behavior among adolescents.
5. To reduce the incidence and prevalence of STIs and HIV among mother, children and adolescents
6. To reduce the incidence of common reproductive organ cancers
7. To reduce gender imbalances and harmful traditional practices and increase male engagement in RMNCAH programs
8. To improve access to RH service for people with special needs
9. To improve Reproductive Health Commodities' Security (RHCS)
10. To strengthen the health care system to provide quality RMNCAH services

6.3. Primary Targets

To measure the success of this policy, the key primary indicators listed below are identified based on county's priorities, the indicators of the global strategy and sustainable development goals. The targets for the 2026 are also set based on the current status by taking the global minimum recommendations in to account. The targets for the 2026 can be modified based on the mid-evaluation to be done at the end of the implementation of phase RMNCAH strategic plan (2017-2021). The details of baseline, midline and end-line targets are indicated under the monitoring and evaluation framework section.

I- Primary Impact Targets by 2026

1. Reduce maternal mortality ratio by 50% (from 433 to 215 per 100000 live births)
2. Reduce under-five mortality rate by 50% (from 54 to 27 per 1000 live births)
3. Reduce infant mortality rate by 50% from (from 34 to 17 per 1000 live births)
4. Reduce neonatal mortality rate by 50% (from 22 to 11 per 1000 live births)
5. Reduce total fertility rate per woman by 2 child (from 5.6 to 3.6)
6. Reduce the prevalence of malnutrition among children by 50%.
    a. Stunting by from 24.5% to 12%
    b. Wasting from 16.2% to 8%
    c. Underweight from 11.5% to 6%.
7. Reduce the rate of mother to child transmission (MTCT) of HIV by 50% (from 9.4% to <5%).

II- Primary Service Coverage Targets (Outputs and Outcomes) by 2026

1. Increase contraceptive prevalence rate from 9% to 35%
2. Reduce unmet need for modern contraceptives from 25% to 15%
3. Increase ANC4+ from 78% to 95%
4. Increase skilled care at birth from 57% to 95%
5. Increase PNC coverage from 76% to 95%
6. Increase coverage of ART for PMTCT (linked and Option B+) from 77% to 95%
7. Increase the coverage of fully immunized infants from 88% to 98%
8. Increase the HPV vaccine coverage to 75%

III- Primary Process and Input Targets (HSS) by 2026

1. All service delivery points will be equipped as per the standard and able to provide RMNCAH services as per the minimum packages.
2. All the service delivery points will have the required minimum human resources for the RMNCAH as per the national staffing norms.
3. Strong national and regional RMNCAH partners' coordination platform will be functioning.
4. All the service delivery points will have the necessary RMNCAH logistics, commodities, drugs and supplies as per their standard.
5. Strong national Monitoring and Evaluation unit will be functioning under the MOH&SW

6.4. Key Strategies

Priority 1: Improving Family Planning Services

Policy Objective 1: To reduce the magnitude of unwanted pregnancies and unmet need for contraceptives

Strategy 1.1: Provide quality FP information and services to reduce unwanted pregnancies and unmet need for contraceptives.

Strategy 1.2: Provide quality service for the prevention, investigation and treatment of infertility

Priority 2: Improving maternal and newborn Health

Policy Objective 2: To reduce maternal, perinatal and neonatal morbidity and mortality

Strategy 2.1: Provide quality ANC by improving access, quality and utilization of ANC services

Strategy 2.2: Provide quality skilled delivery and Postnatal Care (PNC) by improving access, quality and utilization.

Strategy 2.3: Provide comprehensive package of perinatal and neonatal care

Strategy 2.4: Provide quality Post Abortion Care (PAC) services for the prevention and treatment of complications as per the country's law.

Strategy 2.5: Provide quality services for the prevention and treatment of obstetric fistula

Strategy 2.6: Provide nutrition information and counseling for pregnant women.

Strategy 2.6: Provide quality services for menopausal women

Priority 3: Improving Child health

Policy Objective 3: To reduce childhood morbidity and mortality

Strategy 3.1: Improve the nutritional status of children by promoting comprehensive nutrition interventions

Strategy 3.2: Provide Quality Integrated Management of Newborn and Childhood Illnesses (IMNCI) for the prevention and treatment of common childhood health problems

Strategy 3.3: Provide quality Expanded Program of Immunization (EPI) services

Priority 4: Improving Adolescent and youth Sexual and Reproductive Health

Policy Objective 4.To increase knowledge of reproductive biology and promote responsible sexual and Reproductive health behavior among adolescents and youth.

Strategy 4.1: Provide comprehensive and quality Adolescent and youth Sexual and Reproductive Health (AY-SRH) information and services.

Priority 5: Improving the prevention and treatment of Sexually Transmitted Infections (STIs), including HIV.

Policy Objective 5: To reduce the incidence and prevalence of STIs and HIV among mother, children, adolescents and youth.

Strategy 5.1: Integrate STIs information, diagnosis and management in to the major RMNCAH programs

Strategy 5.2: Provide quality PMTCT services by integrating in to the main RMNCAH program

Priority 6: Improving the prevention and treatment of Reproductive Organ Cancers (ROCs)

Policy Objective 6: To reduce the incidence of Reproductive Organ Cancers (ROCs)

Strategy 6.1: Integrate ROCs screening and treatment into the major RMNCAH programs.

Priority 7: Gender, Harmful Traditional Practices and Male Engagement in RMNCAH programs.

Policy Objective 7: To reduce gender imbalances and HTP, and increase male engagement in RMNCAH programs

Strategy 7.1: Strengthen advocacy for gender equity/equality in SRH, prevention of gender based violence and HTP, and care of the victims.

Strategy 7.2: Enhance male engagement in the RMNCAH interventions programs

Priority 8: Improve access to RMNCAH service for people with special needs

Policy Objective 8: To improve access to RH service for people with special needs

Strategy 8.1: Design mechanisms to improve access and reach people with special needs (people with disability and in fragile emergency situations) with a package of RMNCAH services

Priority 9: Improve Reproductive Health Commodity Security (RHCS)

Policy Objective 9: To improve Reproductive Health Commodity Security (RHCS)

Strategy 8.1: Ensure Reproductive Health Commodity Security at all levels, including national and regional levels.

Priority 10: Health System Strengthening (HSS)

Policy Objective 10: To strengthen the health care system to provide quality RMNCAH services

Strategy 10.1: Improve leadership, governance and coordination of RMNCAH programs

Strategy 10.2: Strengthen the RMNCAH service delivery by building the capacity of health facilities

Strategy 10.3: Improve the human resources capacity for the quality RMNCAH service delivery

Strategy 10.4: Improve the logistics and supply chain management, including RMNCAH commodities' security

Strategy 10.5: Improve RMNCAH financing for the universal health coverage

Strategy10.6: Strengthen Health information management system including, monitoring and evaluation

7. Institutional framework

While implementing this policy, the RMNCAH services will be delivered throughout the existing three-tier level of the National Health Care delivery system through the primary health care (PHC) approach. This will involve the Primary (Village Health Service), Secondary (Basic Health service) and Tertiary (Hospital) levels of care. In line with the national health policy for the integration of services, other community based structures and organizations will also be utilized to increase access to RMNCAH services by all. Services at the public health sector will also be complemented by the Private and NGO health sectors as well as with component-specific sectors/organizations for the further promotion of sexual and reproductive health information and services**.** The National RMNCAH Committee will be strengthened and continue its oversight function in ensuring the full implementation of this RH Policy in the above mentioned sectors.

Organization of the RMNCAH Activities

The implementation of the RMNCAH program takes place at four levels namely: central, regional, health facility and community levels. Each of these levels has functional structures and responsibilities (Figure 7).

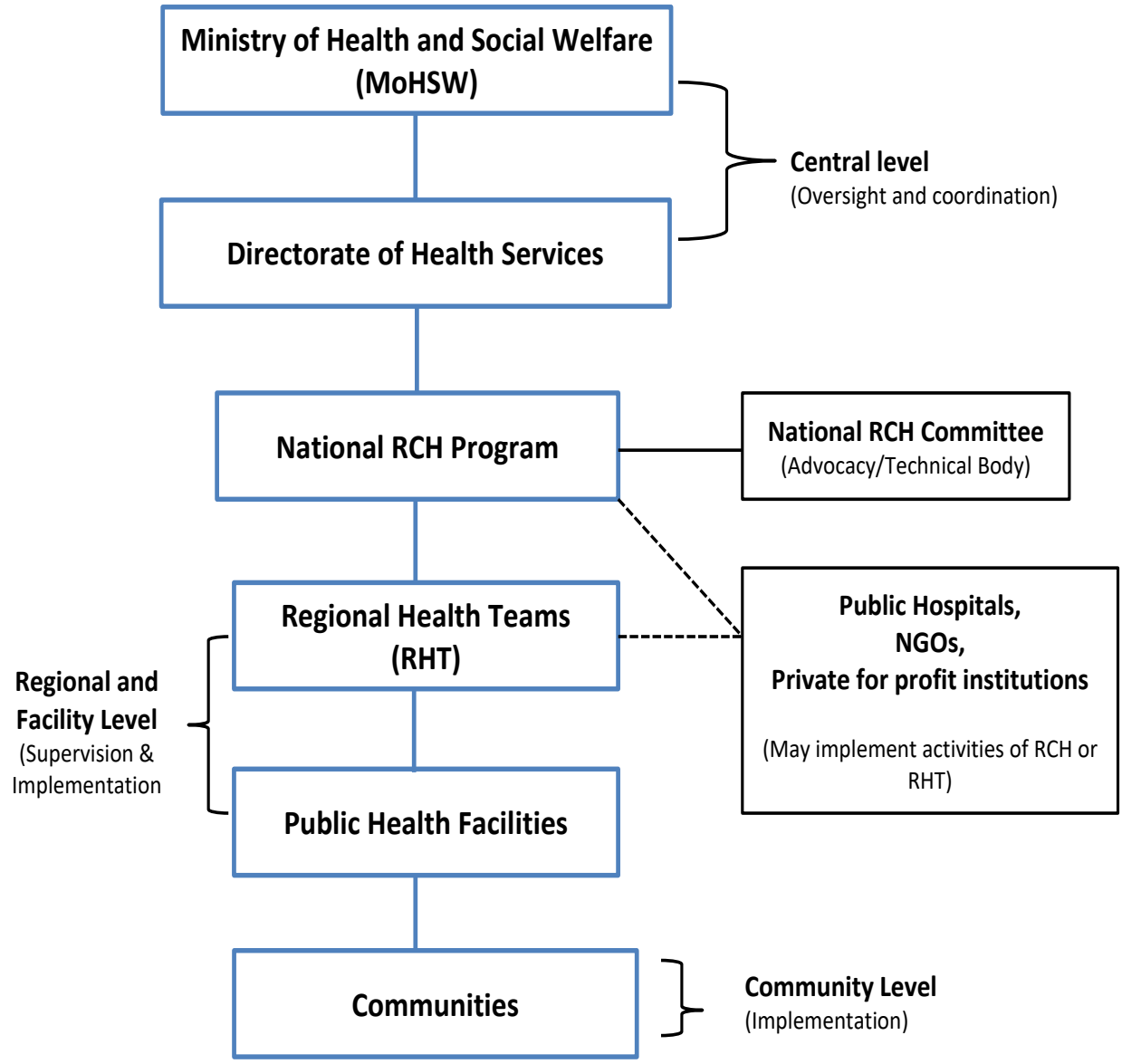

Fig. 7: Organization Structure for the implementation of RMNCAH Policy (Source: RMNCAH Policy 2007-2014)

- **Responsibilities of The National RMNCAH Unit:**
  - Formulation of policy, development of strategic plan and guidelines for implementation of the RMNCAH activities,
  - Overall coordination of RMNCAH partners and the implementation of RMNCAH policies and strategies
  - Advocacy for the engagement of all partners and stakeholders in the resources mobilization and implementation of this policy.
  - Facilitate the timely and regular meetings of the National RMNCAH Committee,
  - Preparation of quarterly and annual RMNCAH work plans and follow the timely development of Regional RMNCAH work plans
  - Quarterly and annual monitoring and evaluation of RMNCAH services delivery performance of the unit and all regions.
  - Resource mobilization for the implementation of RMNCAH interventions.
  - Facilitate the procurement and distribution of RMNCAH equipment, supplies, commodities, tools and other necessary logistics.
  - Needs assessment & building the capacity of health mangers and services providers at all levels.
  - Mentoring of lower level facilities and health professionals
  - Collect, collate and analyze RMNCAH service data and provide timely feedback
  - Conducting and supervising research activities in collaboration with Research Institutions;
  - Provide regular supportive supervision to the RHTs and service providers;
  - Provide and disseminate relevant information on RMNCAH.

- **Functions of the regional level (RHMT)**
  - Planning, coordination and implementation of RMNCAH activities;
  - Advocacy and sensitization on RMNCAH program actors;
  - Monitoring and evaluation of RMNCAH programs;
  - Encourage and support the Conduct of operational researches on RMNCAH issues;
  - Participate in ensuring quality service delivery at all levels
  - Facilitate and ensure the availability of logistics and supplies for RMNCAH
  - Data Management, including the HMIS at the regional level.

- **Functions of facilities**
  - Planning and Implementation of activities;
  - Service delivery and Referral as per the standard,
  - Social mobilization for RMNCAH services;
  - Data Collection, analysis and utilization;
  - Monitoring and Supervision.

- **Functions of the community**

At community level, RMNCAH services are provided by the Village Health Workers and Community Birth Companions (CBC)

  - Service delivery and referral as per their standards
  - Community based distribution of FP commodities, ITNs and insecticides and provision of child immunizations.
  - Social mobilization for RMNCAH services;
  - Home visits; Village environmental sanitation.

- **Functions of the mass media**

The RMNCAH unit of the MOHSW will collaborate with the existing mass media so that they will engage and perform the following activities:

- Increasing awareness on issues concerning RMNCAH;
- Dissemination of information;
- Include RMNCAH issues in print and electronic media;
- Provide media coverage of RMNCAH activities;
- Create a sustained platform for public debate in support of the promotion and implementation of RMNCAH issues.

- **Functions of professional associations, groups and institutions**

- High quality Training to ensure professional competence of their graduates in RMNCAH issues;
- Monitoring and regulating the activities of their professionals to ensure efficient, effective quality RMNCAH services of acceptable ethical standards;
- Incorporating life-saving skills into their curriculum to ensure that they are legally protected to practice the skills to reduce maternal and new born mortality;
- Collaborating with Government to complement its efforts in reducing maternal, newborn and child mortality;
- Advocacy for maternal, newborn and child health issues.

8. Monitoring and evaluation

The Implementation of this RMNCAH policy requires a core set of indicators that will be used for its monitoring and evaluation. This will require strengthening of the country's Health Management Information System to ensure quality, reliability, consistency and accuracy of the data. A RHMIS within the RCH Unit will act as backup system to address this area. Sources of data for effective monitoring and evaluation include national, regional surveys, baseline and community surveys and a functioning routine data collecting system. Special efforts also need to be put in place to harness the data from the private sector which is gradually making its entry into various aspects of RMNCAH programme.

The currently existing monitoring and evaluation systems, HMIS & CHIS, will be strengthened and used as primary data sources for the M & E of this policy.

1. Daily recording of data at service delivery points;
2. Monthly data collection and collation from health facilities and village health services;
3. Monitoring and supervision of service delivery points;
4. Quarterly collection and compilation of data at Regional and Central levels
5. Quarterly monitoring of RMNCAH activities by central level;
6. Monthly supervision at Regional level; and
7. Regular feedback at all levels.

In addition, the following specific surveys and procedures will be used as a source of data for monitoring and evaluation:

1. Gambia Demographic Health Survey (GDHS);
2. Multiple Indicator Cluster Survey (MICS);
3. Needs assessment or baseline studies;
4. Mid-term evaluation of policy implementation;
5. End-term evaluation of the policy;
6. The national population and housing census; and
7. Special program specific surveys (e.g EmONC assessment) and operational researches.

Table 3: Monitoring and Evaluation framework of the policy with core indicators and performance targets

S/N	Indicators	Baseline (2016)	Midline (2021)	End-line (2026)	Sources of data
1	**Impact Indicators**				
1.1	MMR (per 100000 live births)	433	315	215	DHS, CRVS
1.2	U5MR (Per 1000 live births)	54	44	34	DHS, CRVS, MICS
1.3	IMR (Per 1000 live births)	34	24	17	DHS, CRVS, MICS
1.4	NMR (Per 1000 live births)	22	15	11	DHS, CRVS, MICS
1.5	TFR (per woman)	5.6	4.6	3.6	DHS, CRVS, Census
1.6	Rate of MTCT of HIV (%)	9.4	5	<5	DHS, HMIS
2	**Outcome (coverage) Indicators**				
2.1	CPR any method (%)	9	25	35	DHS, HMIS, MICS
2.2	Unmet need for modern FP (%)	25	20	15	DHS, MICS
2.3	ANC (at least once) (%)	86	95	98	HMIS, DHS, MICS
2.4	ANC (at least 8 visits) (%)	N/A	50	75	HMIS, DHS, MICS
2.5	PMTCT (Option B+) coverage (%)	77	90	95	HMIS, DHS, MICS
2.6	Skilled care at birth (%)	57	80	95	HMIS, DHS, MICS
2.7	PNC coverage at least once (%)	76	90	95	HMIS, DHS, MICS
2.8	Full immunization of infants (%)	88	93	98	HMIS, DHS, MICS
2.9	Prevalence of stunting (%)	24.5	18	12	DHS, MICS
2.10	Prevalence of wasting (%)	16.2	12	8	DHS, MICS
2.11	Prevalence of underweight (%)	11.5	9	6	DHS, MICS
3	**Input and Process: Health System Strengthening Indicators**				
3.1	% Facilities equipped as per the national facility standards	N/A	100	100	Special Facility survey
3.2	# of CEmONC facilities	8	10	12	Special Facility survey
3.3	# of BEmONC facilities	2	10	20	Special Facility survey
3.4	% of facilities providing EmONC 24hours /7days	N/A	100	100	Special Facility survey
3.5	Facilities having 24 hours electricity and water supply	95%	100	100	Special Facility survey
3.6	Facilities having 24 hours functioning laboratories and drug supplies as per their standard				
3.7	% Facilities staffed as per the national staffing norms	N/A	100	100	Special Facility survey
3.8	Professional density (Doctors + Nurses + Midwifes) per 10,000 population	8.3	15	23	Special survey

11. Selected References

- Gambian Bureau of Statistics (GBOS) (2014). The Gambia Demographic and Health Survey 2013. Gambia Bureau of Statistics, Banjul, The Gambia; and ICF International, Rockville, Maryland USA. Available at: http://dhsprogram.com/pubs/pdf/FR289/FR289.pdf
- Gambian Bureau of Statistics (GBOS) (2013). The Gambian Population and Housing Census 2013. The Republic of The Gambia, Gambian Bureau of Statistics (GBOS); Banjul, Gambia. Available at http://www.gbos.gov.gm/2013.php
- International Monetary Fund (IMF) (2015). The Gambian Annual Progress Report-2014. IMF, Washington D.C., USA:
- Republic of The Gambia-Ministry of Health and Social Welfare (MoHSW) (2012). National Health Policy 2012-2020. Banjul, Gambia. MoHSW, Banjul, Gambia.
- Republic of The Gambia-Ministry of Health and Social Welfare (MoHSW) (2014). The Gambian National Health Sector Strategic Plan (2014-2020).
- Republic of The Gambia-Ministry of Health and Social Welfare (MoHSW) (2016). Service Statistics Report 2015: National Health Management Information (HMIS) 2015. MoHSW, Banjul, Gambia.
- UNFPA and MoHSW (2010). Reproductive Health Commodity Security Situation Analysis of The Gambia. Banjul, The Gambia, 2010.
- World Health Organization (WHO) -Every Woman Every Child (2015). The Global Strategy For Women's, Children's and Adolescents' Health (2016-2030): Survive, Thrive and Transform. WHO-Every Women Every Child, Geneva, Switzerland.
  Available at: http://www.who.int/life-course/partners/global-strategy/en/
- WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division (2015). Trends in maternal mortality: 1990 to 2015. Estimates by the UN-IAGME. WHO, Geneva, Switzerland.
  Available at: http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf

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