COUNTRY HEALTH PROFILE

THE GAMBIA
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**LIST OF ABBREVIATIONS AND ACRONYMS**                                                                                                                                                    43  

ADB  African Development Bank
AFP               Acute Flaccid Paralysis
APRC              Alliance for Patriotic Re-orientation and Construction
ARI               Acute respiratory infection
BSc.              Bachelor of Science
DHT               Divisional Health Team
DOSH&SW           Department of State for Health & Social Welfare
DPI               Directorate of Planning and Information (DOSH&SW)
CDD               Control of Diarrhoeal Diseases
EPI               Expanded Programme on Immunization
EU                European Union
FGM               Female Genital Mutilation
GDP               Gross Domestic Product
GNP               Gross national Product
HIPC              Highly Indebted Poor Countries
HIV               Human Immunodeficiency Virus
HSR               Health Systems Research
HRH               Human Resource for Health
IDSR              Integrated Disease Surveillance and Response
IMCI              Integrated Management of Childhood Illnesses
IMF               International Monetary Fund
IMR               Infant Mortality Rate
MCH/FP            Maternal and Child Health/Family Planning
MMR               Maternal Mortality Rate
MRC               Medical Research Council
NCD               Noncommunicable Diseases
NGO               Nongovernmental Organization
NPO               National Professional Officer
PHC               Primary Health Care
PHOs              Public Health Officers
PHPNP             Participatory Health, Population and Nutrition Project
RVTH              Royal Victoria Teaching Hospital
SEN               State Enrolled Nurse
SRN               State Registered Nurse
SOS               Save Our Souls
SRN&M             State Registered Nurse and Midwife
STI               Sexually Transmitted Infection
TB                Tuberculosis
TBA               Traditional Birth Attendant
TRM               Traditional Medicine
UN                United Nations
UNDP              United Nation Development Programme
UNFPA             United Nations Population Fund
UNICEF            United Nations Children Funds
WB                World Bank
WEC               World Evangelical Crusade
WHO               World Health Organisation
WHO/AFRO          WHO Regional Office for Africa
I. GENERAL SITUATION AND TRENDS

The Country-Basic Data and Regional Indicators

1.1 General Context and Demography

1.1.1 Geographical Location

The Republic of The Gambia covers an area of approximately 10,690 Sq.Km. It is located on the bulge of West coast of the African continent between the latitudes 13.0N and 13.7N and longitudes 13.7W and 16.0W. It measures roughly 350 Km from East to West and has a width of between 24 and 48 Km, being widest to the West. Thus the Republic of The Gambia forms a narrow enclave into the Republic of Senegal and the Atlantic Ocean forms the Western boundary (see figure 1).

River Gambia is dominant geographical landmark and its tidal estuary cross the whole length of the country from East to West. The river including its swamps and creeks covers one third of the surface area of The Gambia or approximately 2075 Sq.Km.

The River has its source in the Futa Jalon Plateau in Guinea and flows across Senegal and The Gambia. The flow of the river is seasonal and tidal. During the dry season the flow is low and saline intrusion has been recorded 248 Km up stream. During the rainy season the saline interface is flushed down to 150 Km. Ocean going vessels of draught of up to 5.5 metres can reach Kantaur and smaller vessels reach Jajaburreh.

1.1.2 Topography

The land is mainly low lying and flat, varying from sea level at the coastal area to a maximum elevation of 36m in the interior. The country is covered with tropical forest, mangroves and savannah woodland along the river and the moist Western part. The rest of the country has Sudano – Sahelian type of vegetation characteristic of the drier Eastern part of the country.

1.1.3 Climate
The Gambia experiences Sahelian type of climate. There is a short rainy season between June and October followed by a long dry spell between November and June. During the dry season the Harmattan winds blow from the Sahara, giving a cool but dusty weather. Average annual rainfall increases from 800 mm in the East to 1,700 mm in the West. Along the coast, in the West the maximum temperature during the rainy season is about 32 degrees Centigrade with only slight variation. The daily minimum temperature ranges from 18 to 24 degrees.

In the interior temperature variations are more marked. The daily maximum may rise to 45 degree and minimum temperature can fall to 10 degrees during the dry season. The relative humidity is about 80% during the rainy season falling to less than 40% during the dry season. It is hot during the rainy season and the higher relative humidity make nights uncomfortable. On the contrary during the dry season the nights are cool leading to comfortable nights.

1.1.4 Communications

The Gambia can rightly boast of having one of the best Telecommunication systems in the continent. It is possible to have Direct Dialing Service to any part of the world and Telex and Facsimile system work efficiently. While the system was confined to the capital until recently, it is being extended the whole length of the country.

The Gambia has one of the biggest Tourist Industry on the continent, but air transport to link with the rest of the world is not so well developed. Tourists are served mostly by charter flights, which make many landings at Banjul International Airport. Charter flights are reduced after the tourist season (November to April). There are two airlines, which make direct scheduled flight to Europe. There are also about five Regional airlines, which fly into Banjul Airport. The Dakar Airport in Senegal is however about 3.5 hours by road from Banjul and could be used for travel purposes. For air Cargo purposes only Banjul Airport can be used and it appears that due to the limited number of airlines flying into Banjul Airport the freight charges are high.
Roads are of good standard on the whole, in that there is a hard surface road running the whole length on the country. Some of the roads are now tarred.

The country enjoys the courier services of DHL and letters and goods sometimes take a day or three to arrive at destinations.

1.1.5 History and Political background

Before the fifteenth Century, The Gambia formed a part of succeeding empires of Serrahulis and Mandinka groups. Various interests of groups of European came to the area now occupied by The Gambia for trade in ivory, slaves and hides, etc.

The British sent Captain Alexander Grant to occupy the fort on James Island as a base for suppression of slave trade. In 1816 Captain Grant founded a settlement at St Mary’s Island named Bathurst (Banjul) after the then Colonial Secretary.

The first Legislative Council was established in 1843. Further Constitutional changes took place in 1947, 1954 and 1960. In 1962 universal adult suffrage was introduced and in the general election that year the People’s Progressive Party (PPP) won the election and the party leader, Dr. D.K. Jawara, became the first Prime Minister.

The Gambia attained full internal self-government in October 1963 and independence on 18 February 1965. In 1970 the country became a Republic and President Alhaji. Sir Dawda Kairaba Jawara became the first State President, a post he held up until July 1994.

In 1994, after the Military take over there was a return to democratic rule in 1996 led by President Alhaji Dr. Yahya A.J.J. Jammeh.

1.1.6 Demography
The last Population Census was carried out in 2003\textsuperscript{1}. The total population was found to be 1,364,507 million of which 676,726 (49.8\%) were males and 687,781 were Females. The Capital, Banjul and the adjoining Municipality of Kanifing had a population of 715,397 (52\%).

1.1.7 Population Trends
From the provisional results of the 2003 population and housing census, 4\% of the population is under one year, 20\% under five years, 45\% under fifteen years and 55\% above fifteen years.

1.1.8 Geographical distribution of population from 2003 provisional census results.
According to the results of the 2003 census, the total population in the Western Division is 55\% while 5\% live in the Lower River Division, 13\% in the North Bank Division, 14\% in the Central River Division and 13\% in the Upper River Division.
Annual population growth rate for the period 1974 to 1983 (Report of 1983 Census) was 4.9\% and 3.4\% for the period 1984 to 1993 and 2.8\% for the period 1993 to 2003.\textsuperscript{2}
More than 52\% of the population is urban according to the 2003 census.
The life expectancy according to the World Bank estimates in 2003 is 52 years for males and 55 years for females.\textsuperscript{3}
The Crude Birth Rate has decreased from 50/1000 (1983 census) to about 46/1000 obtained from a survey in 1995. It is expected that this rate has decreased further due to high contraceptive prevalence rate experienced recently.

The Mortality trends show a more downward active movement with crude death rate of 30/1000 (1983 census) to the estimates derived from a survey in 1993, of 16/1000.\textsuperscript{4}

1.1.9 Regional and Other Cultural Beliefs
Ninety Five Percent of the population of The Gambia profess the Islam Religion. The remaining are of different Christian denominations.

\textsuperscript{1} 2003 Population and Housing census provisional result
\textsuperscript{2} 1983 Census, 1993 Census and 2003 Census Results, Central Statistics Department, The Gambia
\textsuperscript{3} World Bank 2003
\textsuperscript{4} Handbook of Statistics of The Gambia, Central Statistics Department – November 1993
Cultural Practices are important as determinants of health. Cultural beliefs and practices are also related to other issues, which are important in human ecology.

Each of the ethnic groups speak a language different from the other especially in the rural areas, but generally, however, Wolof (13.23%) and Mandinka (35.65%) forming the two main languages could be either spoken or understood by a majority of these groups. In urban areas these differences are less marked. The other major ethnic groups include the Fula (17.02%), Jola (9.38), Serahuli (7.3%), Serere (2.26%), Manjago (1.6%), Aku (0.73%) and Bambara (0.44%).

In rural areas families live in cluster of houses in a village. The typical African extended family culture is very conspicuous. Thus son’s families normally live in neighbouring house in close proximity in the village compound. The village compounds are congregation of houses built in one area often fenced out of farming and grazing areas.

Early marriages are common.

Female genital circumcision is practiced by all ethnic groups with exception of Wollofs, Manjagoes and Akus.

- Certain food taboos are known and related to different ethnic groups.
- Breastfeeding with colostrums is often not approved of and neonate may not be breast feed at birth.
- Certain ethnic groups practice sacrifice apparently to keep off bad spirits, etc.

1.1.10 Educational Related Issues

The current (2004) estimates for literacy rates for the adults 15 years and above was estimated at 35.5%. The rate is 44.5% and 26.9% for males and females respectively. The enrollment ratio for Lower Basic Education and Upper Basic Education including madrassa schools (Muslim Schools) is 75% and 72% respectively. More girls are now being enrolled in schools than before.

1.2 SOCIO-ECONOMIC SITUATION

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5 1983 Census, Central Statistics Department, The Gambia
The Gambia is a developing country figuring among the Least Developed Countries (LDCs). The GDP per capita has been put at 318 USD\(^5\). The GDP increased by 4% in 2002; by 8.8% in 2003; and is forecast to grow by 6% and 6.5% in 2004 and 2005 respectively. The inflation rate was quoted at 17% in 2003\(^7\) and is estimated to slow down to 16.7% at the end of December, 2004. As of end 2003 the country was estimated to have an external debt of 615 million USD. The exports totaled 102 million and imports totaled 116 in 2003. The figures are expected to be 114 million and 181 million for exports and imports respectively at the end of 2004. Figures for external debt ratio paid are not available.

The country is heavily dependent on rural subsistence agricultural production, especially groundnuts, to generate national income and foreign exchange. The 2004 groundnut harvest has increased considerably, because of good rains and more hectares under cultivation. It forms 32% of GDP.

Tourism has always been an important economic activity and has been improving over the years. Fishing as a source of foreign exchange and indeed for domestic consumption has become an important economic activity. The re-exporting business is also a very important economic activity.

The first 5-year Economic Development Plan 1975/76 to 1979/80 was aimed at development of the physical infrastructure and to create social services. The second plan 1980/81 to 1985/86 emphasized diversification of agricultural base. The present Internal and external imbalances at this period hindered satisfactory implementation of this plan. Economic Recovery Programme was prescribed to address balance of payment difficulties, which had set in, and to deal with structural constraints to economic development.

The Economic Recovery Programme involved:

i. Dismantling subsidies and market distortions – including distortions in foreign exchange, price of basic foodstuffs, fuel and process of farm produce

ii. Retrenchments in public sectors

iii. Removal of taxation anomalies

\(^{6}\) The Gambia, Economic report, UNDP, October, 2004

\(^{7}\) The Gambia, Economic report, UNDP, October, 2004
iv. Reducing Government expenditure
v. Enforcing performance target for parastatal institutions

The above measures proved a success to some extent. The success is now being followed by implementation of a Programme for Sustained Development (PSD) during the 1990s.

The Objectives of PSD are:

i. To achieve long-term expansion of the productive base of the economy.
ii. To support significant improvement in the living standard of the people.
iii. To turn the role of public sector towards encouraging and enabling private agents to invest in productive activities.

By 1991/92 Financial year Gross Domestic Growth was registering 4.0%. This was realized mostly through:

i. Re-export Trade
ii. Tourism
iii. Agriculture
   a. Fish Exports
   b. Horticultural Exports

The national currency, Dalasis had been floated and was holding on its own

A plan to explore for Oil deposits are in their early stages and some limited deposits seems to be in existence in the country

1.2.1 Economic Policy

In August 2004, parliament ratified the Government Budget Management and Accountability Bill, which seeks to clarify the roles of different government bodies in the formulation, implementation and management of the government budget. According to the bill, the Ministry of Finance is responsible for entering into any financial agreement on behalf of government, to collect revenue, to coordinate the management of external grants, to prepare and submit annual statements of government accounts to the auditor general and publish them. Banks are required to increase the minimum capital requirements for commercial banks operating in the country in an attempt to bolster the stability and quality of the banking system.

The current economic policy focuses on containing fiscal deficit and controlling the growth of domestic debt
The government has stated its intentions to privatize the state assets, boosting infrastructure development and streamlining the regulatory environment for business in order to facilitate the expansion of private sector activity.

According to the National Household Poverty Survey Report, 1998, 64% of the population lives below the poverty line. Women form the bulk of the poor, and the government has specifically targeted them for development. Women enjoy relatively free schooling, and the Department of Women Affairs under the office of the Vice-president, has a lot of programmes targeting their health and well-being. There are several income generating projects for women run by themselves all over the country. The Banjulding Women’s garden, supported by WHO, produces fruit vegetables and milk for the Greater Banjul Area market.

1.3 Environmental Health

Environmental Health challenges in The Gambia today would include solid waste management and good sanitation. According to recent information, about 88% of the population have got access to safe disposal of human excreta, most of which are VIP latrines. Nationally 85% of The Gambian population has got access to safe drinking water. According to the MIC Survey of 2000, 95% of urban dwellers and 75% of rural residence have access to safe drinking water.

The country has been operating a public health act, which is somewhat outdated. It was enacted in 1954 and reviewed in 2002. The act provides for public and environmental health. It specifically deals with issues related to the protection, preservation and promotion of health. It also addresses prevention and treatment of diseases and issues related to food, occupational health, port health, buildings, slaughter houses, notifiable diseases and control of stray animals. A new environmental health policy is being formulated. This draft policy deals with issues related to the following:

- Food hygiene and safety
- Pollution control
- Public Health pests

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8 Environmental Health Policy for The Gambia 2004 – 2014
• Quality of drinking water
• Collection and disposal of waste
• Building sanitation
• Vaccination and immunization
• Health and safety in workplaces
• Port sanitation
• Rural sanitation

1.4 Healthy Lifestyles, Food and Nutrition

Consumption of alcohol in The Gambia is very low and does not constitute a public health problem. However, tobacco smoking is a cause for concern. According to reports from the Department of State for Health and Social Welfare, the prevalence of cigarette smoking has been estimated at 23 per cent. From anecdotal observations substance abuse especially cannabis has been observed especially in tourist areas.

The legislation on food and specifically on imported foodstuff leaves much to be desired. Urgent action is needed to streamline the laws for ensuring safety of imported food. There are a lot of street food vendors in most towns and cities, which are largely unregulated. A draft food safety bill has been formulated and is passing through the approval stages in cabinet and parliament.

The Preliminary Report on Health Indicators 2001 of The Republic of The Gambia indicates that 18.8% of all newborns had a low birth weight (less than 2500gm). According to a survey conducted by the National Nutrition Agency (NaNA) only 13.7% of the children under five are within the expected weight for height. Children below five whose weight is below the 80th percentile have been found to be 2.7% according to NaNA.

The nationwide survey on the prevalence on Vitamin A and iron deficiency in women and children in The Gambia found that anemia due to iron deficiency is common among pregnant

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9 Environmental Health Policy for The Gambia 2004 – 2014
10 DOSH Preliminary Report for selected indicators 2001
11 NaNA Report for Rainy Season (August/September) 2000
12 NaNA Report for Rainy Season (August/September) 2000
women and is considered a major contributory factor to the high maternal mortality rate. Also, micronutrients study conducted in 2001 by NaNA in collaboration with MRC revealed that 73% of pregnant women showed moderate anemia and 5% showed high-risk anemia.\textsuperscript{13}

On the issue of non-communicable diseases, hypertension, diabetes mellitus and cancers now rank among the top ten causes of mortality in The Gambia.

2. COUNTRY HEALTH SITUATION

The Gambia is a developing country in the tropics, with tropical diseases predominating. Malaria, Acute Respiratory Tract Infections and Diarrhoea diseases ranked amongst the most important causes of morbidity and mortality. The infant mortality rate declined from 217/1000 in 1973 to 167/1000 live births in 1983 and to 84/1000 live births in 1993.\textsuperscript{14} The infant mortality rate has been found to be 84/1000 live births again in 2001.\textsuperscript{15} Although the health facility coverage is amongst the best in Africa (more than 80% of the population have access to health facilities),\textsuperscript{16} the staffing of these facilities is highly inadequate, and as a result the country has an unacceptably high maternal mortality rate (730/100,000 live births). It has however been decreasing over the years. In 1990 The Gambia experienced one of the highest maternal mortality ratios in the world, at 1050 maternal deaths/100,000 live births.\textsuperscript{17} Despite all these shortcomings the country has been able to maintain an immunization coverage of 80% above and is about to be certified as having eradicated the disease, by the Africa certification committee. The HIV prevalence rate is amongst the lowest among sub-Saharan Africa, although it has been increasing steadily over the years.

2.1 Mortality

Infant Mortality Rates (IMR) The official results of the 1993 Population Census shows a steady improvement over the years. The results indicate a drop in infant mortality rate to 90/1000, which compares to that of Africa of about 104/1000, The Gambia therefore registered a great improvement. The current estimate of 84/1000 live births is a further improvement on the

\textsuperscript{13} NaNA/MRC, Nationwide Survey on the prevalence of Vit.A and Iron Deficiency in Women and Children in The Gambia 2001
\textsuperscript{14} Vision 2020 2005 – 2009 Medium Term Plan
\textsuperscript{15} National Survey on Mortality and Contraceptive prevalence 2001
\textsuperscript{16} The Environmental Health Policy for The Gambia 2004 - 2014
\textsuperscript{17} Report of the Survey on National Mortality and Contraceptive prevalence December 2000
previous figure. It is important to note that 30 to 40% of the infant mortality in The Gambia is attributable to infant deaths peri-natally. Malaria, ARI and malnutrition and diarrhoeal diseases are important causes of infant mortality in The Gambia.

2.2 Morbidity

Malaria is the number one cause of morbidity and mortality in The Gambia. According to the report on selected health indicators 2001, the top seven causes of morbidity and mortality in under fives are, in that order, as follows:

- Malaria
- Pneumonia
- Anemia
- Malnutrition
- Sepsis
- Low Birth Weight
- Trauma and Burns

The most common causes of morbidity and mortality in the above fives, in 2001, are in that order:

- Malaria
- Pneumonia
- Hypertension/Stroke
- Heart Disease
- Tuberculosis
- Others including trauma due to Road traffic Accidents, and cancers)

According to the information obtained from the Ministry of Health, 40% of the total OPD consultation in 1999 was due to malaria, while acute respiratory tract infections is responsible for 25% of OPD visits.

2.2.1 Communicable Diseases

18 DOSH, Preliminary Health Indicators Report for 2001
Communicable Diseases of Public Health importance include:

i. Malaria
ii. Acute Respiratory Diseases
iii. Diarrheal Diseases
iv. Sexually Transmitted Infections including HIV/AIDS
v. Tuberculosis and Leprosy
vi. Meningitis

2.2.2 Malaria

The Eastern Region seems to have the majority of cases (see table 24). Most of the transmissions occur during the third and fourth quarter of the year, during and after the rainy seasons. All the causative parasite types, viz Plasmodium Falciparum, Vivax, Malaria and Ovale are known to be responsible for Malaria. Plasmodium Falciparum is however the main cause of Malaria in the country as well as the cause of the severe type. The vectors which transmit the parasite are Anopheles gambiae especially its sub-species A. Gambiae s.s. Other species include Anopheles melas in the West where the water is saline and A. arabiensis in the drier areas.

Control Strategies now applied include:
- Early diagnosis and treatment
- Use of impregnated bed-nets
- Environmental control in limited cases
- Active monitoring of development of resistance to insecticides (vector), and drugs (parasites).

2.2.3 Acute Respiratory Infections

Acute Respiratory Infections (ARI) is the second most common cause of morbidity and mortality in The Gambia. The main control measures include education to mothers to ensure that they begin to seek treatment for their children early, as well as staying in well-ventilated buildings, for prevention. Research work (by the British MRC) on vaccine against the main ARI causative agent, Haemophilus influenza, has been in progress in The Gambia for years. The vaccine has somewhat proved efficacious and is being marketed worldwide. A trial aimed at determining the efficacy of a vaccine against Streptococcus Pneumonia has just been concluded in the country.
2.2.4 Diarrheal Diseases

Diarrheal Diseases are leading causes of morbidity in the community and major cause of mortality in children under five years.

A survey carried out in 1993 by Ministry of Health using a sample of 1301 under five children showed that each child had an average episodes of the following diseases in that year:

<table>
<thead>
<tr>
<th>Illness</th>
<th>No. of episodes/child</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrheal Diseases</td>
<td>4.6</td>
</tr>
<tr>
<td>Acute Resp. Infection</td>
<td>3.4</td>
</tr>
<tr>
<td>Clinical Malaria</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Most episodes of diarrhea occur during the rainy season. The diarrhea is usually of bacterial origin. Diseases like dysentery (bloody diarrhea caused by Shigella) is common and other bacterial enteritis eg: typhoid do occur.

The dry season diarrhea is said to be a combination of bacterial infection but with a large mixture of viral infection. The situation is somewhat improving, as the large part of the population (>80%) has access to safe drinking water.

2.2.5 Sexually Transmitted Infections (STI) including HIV/AIDS

Sexually Transmitted Infections (STI) form an important group of major communicable diseases in the country. These are many, but those of greater concern are Gonorrhea, non-specific Urethritis, Syphilis, Chancroid, Lymphogranuloma venereum, lymphogranuloma inguinale and Trichomonitis vaginalis. Studies carried among antenatal clinic patients revealed a prevalence rate of 4.3% for syphilis. These groups of STIs are particularly important in that they may cause genital ulceration favouring HIV (Human immunodeficiency virus) infection which lead to AIDS.

The diagnoses of AIDS were first made in The Gambia in May 1986 and by December 1994 there were 327 reported AIDS cases, and an estimated 25,000 people infected with HIV. In 1988
and 1991, national sero-prevalence surveys carried out, revealed an increase in HIV I and II prevalence from 1.7% to 2.2% among the general population. While HIV/AIDS is not a major issue in the country at the present moment, the increasing prevalence of HIV over the years is worrisome. The HIV I prevalence was 0.9% in 2000 and has increased to 1.5% in 2003. The estimated prevalence among sex-workers is 40%.

2.2.6 Tuberculosis and Leprosy
Tuberculosis is showing a steady increase of new cases. One thousand nine hundred and eighty five (1985) cases of Tuberculosis have been reported in 2003. The increase is attributable to the increasing HIV prevalence in the country. Control measures in use are early diagnosis and effective treatment with the DOTS strategy. The Gambia is in the elimination phase of leprosy and active surveillance and treatment of cases is taking place.

2.2.7 Meningitis
Meningococcal meningitis is not an endemic disease in The Gambia. The Gambia being situated in the Sahelian zone experiences outbreaks of the disease during the dry season.

2.2.8 Non-communicable Diseases
Cardiovascular diseases including hypertension, Diabetes Mellitus, Cancers and Mental Health are among the most common non-communicable diseases in the country. It is being estimated that about 1% of the population is diabetic. Cancers, most notably liver and cervical cancers amongst the women are somewhat common in the country.

2.2.9 Malnutrition in children is a major public health problem. A 1998 national anthropometric study of children under five, indicated a 16.8% stunting, 6.8% wasting and 17.1% underweight.

2.2.10 Maternal Mortality Ratio
Maternal Mortality Ratio (MMR) have been a subject of much discussion in the country, but several reviews suggested that even though there were some changes, maternal mortality rate in The Gambia is still unacceptably high. A study in 1990 found the maternal mortality ratio to be 1050/100,000 live births. A recent study in 2001 found the MMR to have decreased to 730/100,000 live births. The Department of State for Health has put the further reduction of maternal mortality in the country as a central goal for its next medium term health plan.

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For pregnant or women in labour, the most important cause of morbidity and mortality in 2001 include in that order:

- Malaria
- Anemia
- Haemorrage
- Pre-Eclampsia
- Sepsis
- PID
- Ectopic Pregnancy
- Others

It is important to note that the contraceptive prevalence rate was put at 17.5%\(^{20}\) in 2001 as compared to 12% in 1990.

2.3 Comments on morbidity and mortality changes over the last ten years

It is worth noting that the same conditions were also noted as important causes of morbidity and mortality some ten years ago. Amongst the top causes of childhood morbidity some ten years ago were, skin diseases, abdominal pain and eye diseases\(^{21}\). The fact that these conditions are not anywhere near the top, suggests that some improvement must have occurred in the general health status of the population. The work of the Sight Savers International in the area of blindness prevention in the country, could also have contributed to the decline in the disappearance of eye diseases from the top diseases list.

Another important difference noted is the disappearance of acute diarrhoea and meningococcal meningitis from the list of the top causes of mortality in the children under five. The improved supply of safe drinking water to a large proportion of the population could be a factor in the dramatic reduction of the incidence of diarrhoeal diseases. The country has also been declared drancunculiasis free recently. This is a direct result of improved safe drinking water supply to the majority of the population.


\(^{21}\) WHO-Gambia Country Health Profile, 1995
There have been successful national vaccination campaigns against meningitis during the last decade. So, it is certain that this led to the disappearance of meningitis from the list of major causes of mortality in The Gambia.

2.4 Vaccine-preventable diseases

The Gambia is one of the countries that have maintained a high immunization coverage over the years, such that vaccine-preventable disease have been eliminated. The measles coverage has been consistently above 70% and in most cases 80% or more.

The African Regional Certification Commission recently reviewed accepted as adequate the Gambia’s documentation for polio eradication. This is testimony to the good efforts and resources being put into the EPI programme by government.

3. RESPONSE OF THE NATIONAL HEALTH SYSTEM

The Gambia is one of the countries with good national health policies and strategic plans over the years. Policies for specific issues and challenges and indeed programmes have been formulated, plans designed and implemented. The main challenges for the health system today include resources (human resources, finances, equipment and transport) to enable implementation of the policies. Lack of human resources for health is a serious constraint for the country. Financing of health services is a serious challenge for the country.

3.1 National Health policies and plans

In 1979 the Government of The Gambia adopted Primary Health Care philosophy as their guiding principle for the development of the health sector. Major activities were planned and implemented. The economic stagnation of the 1980’s referred to earlier have had devastating effect on the social Sectors all over Africa and The Gambia has not been spared.
With the economy improving a need exists to review existing Health Policy issues. A national Health Policy was accordingly launched in December 1994.

### 3.1.1 Objectives and Strategies of 1994 Health Policy

Ideals of PHC formed the guiding principle of the policy, with commitment of HFA by year 2000 and beyond.

The strategies were:

- To strengthen the secondary referral level for effective service delivery.
- To develop health prevention programmes to address emerging chronic diseases related to life style.
- To strengthen and enhance capacity building at the primary level so as to be able to address common diseases at the community level using cost effective PHC technologies.
- To enhance the ability of health manpower to continuously update formulated policy.
- To decentralize the authority for management and implementation of the health care system from the central level to the divisions and greater participation of communities in management of health system.

The current National Health Policy, titled “Changing for Good”, was formulated in 2001. The vision of the policy is the attainment of accessible quality health care for the Gambian population by the year 2020. It has as a mission provision of quality health care services within an enabling environment, delivered by appropriately trained, skilled and motivated personnel at all levels of care. The mission will be accomplished with the involvement of all stakeholders to ensure a healthy nation. The key guiding principles of the policy are: equity, health system reform and partnerships. Issues addressed in this policy include:

- Essential health package
- Organization and management of health care services
- Human resources development
- Infrastructure and logistics
- Health information (system)
- Referral systems
- Health care financing
- Legal framework
- Community participation
- Traditional medicine
- Partnerships

In order to monitor and evaluate the implementation of the policy, DOSH will ensure the creation of a health-monitoring unit and a health consultative forum, consisting of health and other government departments, donors, the private sectors, professional associations the Faculty of Medicine and others. A framework for the formulation of the Strategic Plan has already been put in place to operationalise the policy.

It is very re-assuring that aspects of almost all Millenium Development Goals are addressed in the policy. The Strategic plan has not yet been formulated, and the medium-term objectives could well be similar to some of the targets of the Millenium Goals.

As stated earlier, the main constraints for not adequately attaining the results of the policy include among others the shortage of human resources for health (almost all categories, partly due to lack of incentives, such as staff housing, limited promotion opportunities, very low salaries amongst others), inadequate financing of the health sector; insufficient supplies and shortages and non-repair of essential equipment. A lot of initiatives, including the training of additional health workers are under way

There is in existence other policies for specific programmes or areas in the health field. These include:
- The drugs policy
- The maintenance policy The National HIV/AIDS Control Programme policy and guidelines
- National reproductive Health policy
- National Nutrition policy
- National Population policy
- Health Management Information System policy
- Human Resources for Health policy (draft)
• Malaria policy
• Environmental Health policy (draft)

There is no national health policy on disasters, emergencies and humanitarian situations.

Some of these policies are in different stages of implementation while others are outdated (malaria – to change from Chloroquine to Artmesinine based treatment, HIV/AIDS – to provide for voluntary counseling and testing and anti retroviral treatment). The cross cutting issues (shortage of staff, poor financing of health services, limited supplies) are also responsible for the limited implementation of these policies.

3.2 ORGANISATION AND MANAGEMENT STRUCTURE OF THE NATIONAL HEALTH SYSTEM

The Department of State for Health and Social Welfare is one of the 13 Departments of State that oversee the administration of the country. A Cabinet Minister heads it. The objective of the Ministry is the provision of comprehensive Health Care Services, the Department of Social Welfare is to provide services and benefits to the least privileged members of society in order to ensure their survival within the system.

The day-to-day administration of the Department is under a Permanent Secretary assisted by two Deputy Permanent Secretaries, one for technical matters and the other one for administrative issues. There are four Directorates: The Director of Health Services, Director of Planning and Information, The Director of Support Services and a Director of Social Welfare providing the Permanent Secretary with the technical advice he requires. These directorates under the Chairmanship of Permanent Secretary of the Ministry form the top Management structure of the Ministry.

Health delivery systems have been decentralized according to the administrative divisions. There are six Divisional Health Management Teams (DHTs). These teams follow the existing administrative Divisions except for North Bank Division, which have two Divisional Health Teams, one for North Bank East and the other for North Bank West. The other divisions are:
Western, Lower River, Central River and Upper River Divisions. Each Divisional Health Team is composed of the following staff:

- Divisional Health Officer (formerly medical officer)
- Divisional Public Health Nurse
- Divisional Public Health Officer
- Divisional Pharmacy Technician
- Divisional Stores Officer
- Divisional Administrator
- Divisional Accountant
- Divisional Data Entry Clerk

The Divisional Health Management Teams oversee the health services through supporting the managers of health centers, clinics, dispensaries and outreach services (219)\(^2\) in those divisions. Presently, none of the DHTs is headed by medical officers due to the acute shortage of this category of health workers.

The Divisional Health Team was supposed to be headed by a Medical Officer and assisted by other personnel. Because of scarcity of indigenous doctors, most divisions are headed by divisional health officers, who are either State Registered Nurses or Public Health Officers. The Team operates from Divisional Health Centers from where they supervise all major and minor health centers, dispensaries and conduct outreach MCH services.

Some village health posts, (especially those for the 48 PHC villages) are staffed by Community Health Nurses (CHNs). The PHC Village posts are linked to village health posts through supervision of groups of Village Health Posts (VHPs) by the Community Health Nurse from the PHC villages. This last category of village health post is staffed by one Village Health Worker (VHW) and two Traditional Birth Attendants (TBA).

The decentralization of Health Management System to Divisional level through the establishment of Divisional Health Teams made the management of the Health System more

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\(^2\) Health Care Services in the Gambia, Margaret Grant, 2003
efficient. Currently most resources have been decentralized for management purposes from the central level to Divisional Health Teams. When the decentralization is fully implemented, it will include the decentralization of decision making (authority) on resource use. The Decentralization referred to earlier (still to become comprehensive) has practically moved the management of the implementation of the services to the Divisional level where the Divisional Commissioner coordinates all sectors thus ensuring collaboration by all sectors in the division.

3.2.1 Education

The relationship between health and education is well known. The Department of State for Education is responsible for the training of senior categories of health workers in the country. The department runs The Gambia College, with support of the Departments of Health and Agriculture for the training of Nurses, Public Health Officers and Agricultural Extension Workers. The University of the Gambia also has a Faculty of Medicine and Allied Health Sciences under which the Medical School, B Sc Public Health and B.Sc Nursing Schools resort. The first graduates of the Medical School are expected in 2005.

3.2.2 Organization of the Directorate of Health at the Central Level

The directorate of health, headed by a Director is organized along the following areas:

i. Family Health (RCH/FP, Adolescent Health, EPI, Nutrition and the).

ii. Disease Control (including malaria, IMCI, STI/AIDS and TB/Leprosy, traditional medicine and the Epidemiology and Statistics Unit).

iii. Health Promotion and Protection (including non-communicable diseases such as cardiovascular diseases, cancers (including liver cancer), road traffic accidents, eye care, oral health and environmental sanitation, health information system, hygiene).

iv. Training (including pre-service and in-service specialized training and post graduate training).

3.2.3 Health Planning Directorate

Health Planning is coordinated by the Directorate of Planning and Information of the Department. The Directorate collects information for planning purposes. Health planning is carried out with the information and participation of Divisional Health Teams. The Department is in the process of preparing a second five-year plan based on the National Health Policy titled
“Changing for Good”. Training including pre-service, in-service, specialized and post-graduate training resorts under this directorate.

3.2.4 Other directorates:
As referred to earlier in the text, the other two directorates are those for Social Welfare Services and of Administrative Support Services.

3.2.5 National Health Plan
As it stands, the major priorities of the five year National Health Plan (1999-2003)\textsuperscript{23} centers on:

- To institute an essential health package in such a way, so as to improve access to and ensure provision of essential care packages at all levels of health care delivery system
- To ensure an effective and efficient management of a decentralized Health
- To ensure appropriate and adequate human resources, for the health sector.
- To ensure continuous availability and accessibility to essential drugs, vaccines and other medical supplies
- To make available relevant information for effective planning, implementation, monitoring and evaluation of health services, on a timely basis.
- To ensure an effective and sustainable referral system at all levels
- To ensure a sustainable and adequate financing of health services
- To empower communities to be active partner in the management of their health
- To involve partners, (donors, local and international agencies, interest groups and private sector) in the planning and implementation of health services

3.2.6 Health Legislation
The public health act as well as all acts related to health are being reviewed currently and will replace the other existing acts.

Some of the acts of The Gambia which deal with Health issues are:

i. Act/Chapter 37 – Medical and Dental Practitioners Act

\textsuperscript{23} Five year National Health Development Plan, 1999-2003, The Gambia
The law establishes the Medical and Dental Councils and establishes procedures for registering medical and Dental Practitioners as well as setting up the set of ethics for these practitioners.

ii. Act/Chapter 38 - Nurses and Midwives
Similar to Chapter 37 the law deals with the Nursing profession.

iii. Act/Chapter 39 - Medical Services
Establishes Hospital Boards, which are autonomous and run the major hospitals in the country.

iv. Act/Chapter 40.01 - Medicines
The act makes provision for the control of manufacture, importation, sale and distribution of medical products.

v. Act/Chapter 40.02 - Dangerous Drugs
The act seeks to give Authorities power to more stringently control drugs which are habit forming.

vi. Act/Chapter 154 - Public Health
The act makes provision for public and environmental health. It establishes the Office of Director of Health Services and other proper offices for the purpose of preventing diseases and promotion of health.

vii. Act/Chapter 40.04 - Quarantine
Deals with epidemics of infectious diseases and gives Health Authorities power to take certain measures.

viii. Act/Chapter 40.05 - Lunatics Detention
This is an outmoded “mental health” act. It needs complete modification. The present act gives powers to detain mentally ill persons.

3.2.7 Inter-sectoral collaboration is ensured in the decentralized health delivery system through Divisional Co-ordination Committees, under the chairmanship of the Divisional Commissioner. Divisional Health Committee consists of Divisional selected members and sectoral functionaries represented at this level. Most sectors of Government are represented. There are also committees formed at the level of Health Units, called Catchment Area Committees, especially for the purpose of the implementation of the Bamako Initiative. This does not preclude Village Development Committees. In the latter cases not all Government sectors are represented.
The introduction of the Bamako Initiative and the formation of implementation committees at the village level have provided another opportunity for enhanced community participation and inter-sectoral collaboration. The Bamako Initiative is however, no more producing the desired results and there is a need to review its implementation in the country.

3.2.8 Private for Non-profit Health Sector

There are many NGOs participating in the provision of health care in The Gambia. Some are faith based, while some are local branches of international non-governmental organizations. It is stated that NGOs run about 15 health facilities in the Gambia. The World Evangelical Crusade (WEC) runs a health center at Sebanor, while the Methodist Mission runs a Mother and Child Health Clinic at Marakissa. The Hermann Gemmeir Save Our Souls (SOS) organization also runs a health center at its Headquarters in Bakoteh. The Ahmaddiya hospital, in the Greater Banjul Area is being run by the Ahmadiyya Muslim Jammat.

The Gambia Red Cross Society is also involved in rendering services that mitigate disasters and catastrophes. It also runs an ambulance service in the Greater Banjul Area. The Gambia experienced two disaster situations in recent years. These were: influx of refugees into the country from the neighbouring countries where there were civil strifes and the capsizing of a Senegalese boat along its coast stand out as major catastrophes. The number of refugees that entered the country was small initially and mingled with “relatives”. When numbers increased the Gambia Red Cross Society got involved in providing the necessary support.

A disaster preparedness plan does exist in the country.

3.2.9 Private Sector

The private health sector in The Gambia is concentrated mainly in the Western Area, where a number of private practitioners are located. A situation analysis on Human Resources for Health

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24 Description of Health Care system of the Gambia, Department of State for Health and Social Welfare
in The Gambia in 2003 revealed that 26% of all health staff (3383) work in the private sector. The private sector staff worked at the following categories of private sector facilities, clinics (4), drug stores (still unknown), health centers (4), hospitals (2), pharmaceutical wholesalers (4), pharmacies and five field research stations (all branches of the British MRC).

The household income and expenditure survey of 1998 indicated that the Gambians would be willing to pay D35 for the use of health services in the private sector. However, on average the Gambian spent D54 per capita in private clinics and D168 per capita in private hospitals in 1998.

3.2.10 Public Private Mix

The Government introduced a policy for the collaboration between the private and public health sectors in 1999, which permitted private doctors to use state facilities for private patients at a reasonable fee. Private patients are admitted to the private block of state hospitals.

The Medical staff of the MRC render medical services to state patients at no cost, for those patients who fall within the study group. It has been observed that the MRC provides its utilities such as electricity and fuel to some public hospitals at no cost to the state.

The Department of State for Health has outsourced the provision of transport for its activities to a private NGO called Riders for Health, where certain amount of fees is paid per kilometer for use of vehicles.

The Registrar of the Gambia Medical and Dental Council is a private practitioner doing this essential function mostly free of charge, for the country. There are no contractual arrangements between the public and the private sector with regards to the provision of health or medical services by private health providers to state patients.

3.2.11 Traditional Health Sector

25 Report on Policy Level retreat on HRH Situation Analysis and Policy
A Situational Analysis on traditional medicine was funded by WHO and conducted by DOSH around 2001. The traditional health sector was formally recognized and included in the Government policy in 2002. The Focal Person in the Department of Health was identified and appointed in 2003. The programme is provided for in the recurrent budget of 2003/04. There is not enough capacity in traditional medicine skills, especially for programme management, botany and research. The traditional medicine policy needs to be formulated. A 2004/2029 Plan of Action has been formulated. Its objectives include the following:

- To integrate the services of traditional healers in the health care delivery system.
- To promote traditional medicine in order to give it due recognition in the health care system.
- To increase public awareness of traditional medicine, i.e. its relevance in the management of diseases and the hazardous effects it is associated with.
- To put in place a regulatory mechanism that would be used to monitor activities and practices of healers as well as protect their intellectual property rights.
- To foster close collaboration between researchers and traditional healers so as to be able to validate most of the claims put forward by healers in providing cures for diseases.
- To foster collaboration with the Department of Agriculture and Forestry in the preservation of the nation’s flora and fauna.27

3.2.12 Integrated Disease Surveillance and Response (IDSR)

With support from the World Health Organization (WHO), the IDSR implementation was initiated in 2001. Significant milestones in the implementation process included the sensitization of key staff and stakeholders of the Department of State for Health (DOSH) and partners, situational analysis of the national surveillance and response system, preparation of a five-year IDSR plan covering 2002-2006, development of national IDSR technical guidelines and training materials as well as application of IDSR tools in the health system. The country has been engaged in the implementation of IDSR plans in the last two years. A reporting system has been put in place for monthly reporting on 21 epidemic prone diseases (Cholera, Diarrhoea with blood (Shigella), Measles, Meningitis, Plague, Viral hemorrhagic fevers, Yellow Fever, Acute

27 The National Traditional Medicine Programme 25 Years' Vision and Plan of Action, DOSH, Gambia
flaccid paralysis (AFP)/polio, Dracunculiasis, Leprosy, Neonatal Tetanus, Trachoma, Lymphatic Filariasis, Diarrhoea (under 5 years), Pneumonia in children less than 5 years of age, HIV/AIDS cases, Malaria, Anthrax, Schistosomiasis, Sexually Transmitted Infections (STIs) and Tuberculosis). Any sudden increase or outbreak of the target diseases is reported within 24 hours to the Divisional Health Team and to the central level for further assessment and support. The WHO Country Office is officially informed which in turn takes appropriate action including informing the WHO Africa Regional Office.

### 3.3 Physical Resources

#### 3.3.1 Infrastructure

The population of The Gambia is served by four major tertiary hospitals run by Government, and three privately operated hospitals. The public sector also operates more than 19 health centers and 22 clinics. There are also 48 key PHC villages run by Community Health Nurses under supervision of DHTs. These facilities are distributed equitably all over the country refer to table 3.

Apart from the health facilities mentioned above, there are 396 health posts plus 380 Primary Health Care Villages and staffed by Community Health Nurses and Village Health Workers. In addition there are 177 outreach stations for the health sector. According to the 2001 report of the Department of State for Health and Social Welfare, 100% of the population in urban areas live within 10 Km of a hospital or health facility, while the figure is 84.4% for the rural areas.

#### 3.3.2 Equipment

28 DOSH Health Information System 2001, The Gambia
Diagnostic equipment such as x-ray-, ultrasound- and anaesthetic machines, theatre tables and autoclaves are available at major health facilities, although their functionality have not been assessed. Cat scans are not yet available in the country.

Most major health facilities do have functional laboratories in place, or have easy access to laboratories run by the British MRC.

As quality of care is increasingly assuming importance, attention to procurement and maintenance of medical equipments will increase substantially.

**Equipment Purchasing**

**Procurement and Maintenance Policy**

Major equipment and large supplies are procured through the Government tender, which function resorts under the Department of State for Finance and Economic Affairs. Donors provide some of these equipment. However, some of the donated equipment do not meet the specifications for the Department. From discussions with the health authorities it emerged that there will be a national policy on donation of medical equipment.

The Gambia has formulated in 2001 an equipment maintenance policy for the fleet, maintenance of generators, boreholes and wells and medical equipment. The policy aims to address the issue of capacity building, mobilization of resources for maintenance, fleet and equipment management, monitoring the performance of the maintenance system and the establishment and running of a maintenance information, education and communication system. At the present time the execution of maintenance work in the health sector falls between two systems. At the tertiary level of health care, each hospital has its own maintenance team under the direct control of a Chief Executive Officer. Due to the intensity of the routine maintenance operations of the hospitals, the units have bigger budgets and a larger staff compliment. The secondary facilities are maintained by the maintenance teams located at Kanifing with satellite activities at Bansang. A sizable portion of maintenance work is contracted to private entities. For instance, the maintenance of motorcycles and cars are done by Riders for Health, a not for profit organization, based in the country and having garages close to bigger centres. The medical equipment
maintenance team is based in Banjul. The budget allocated for maintenance in 2004 is inadequate.

3.3.3 Medicines and Medical Supplies

The Gambia has been having a national drugs’ policy since 1994. This is complemented by the medicine’s act of 1994 and the drugs control act of 1993. The policy provides for the following:

- Supply of essential drugs.
- Quality assurance of medicines and
- Rational use of medicines

The policy provides for the national pharmaceutical administration. This administration coordinates and supervises the implementation of the drug policy. Some of the functions to be carried out by the national pharmaceutical services include:

- Essential drugs programme management
- Drug regulatory services
  - Registrations
  - Licensing
  - Inspection
- Information services
  - Drug information
  - Poisons information
  - Adverse drug reaction monitoring
  - Laboratory services
  - Drug quality control

The Department of State for Health is also responsible for training of sufficient number of pharmacist, pharmacy technicians and pharmacy assistants according to the policy.

Furthermore the policy provides for improvement of the career prospects of all personnel. Both the public and private sector have to abide by the policy including issues of procurement, distribution and quality assurance.  

The policy is being thoroughly implemented. The Department of State for Health issued in 1994 a list of essential drugs for the country. There is in existence a treatment manual to guide the use of medicines in the country. This treatment manual and The Gambia Essential Drug List is updated every two years and is used as a basis for supply and use of medicines in the public sector, for the training and supervision of health workers and for the promotion of local manufacture of drugs. For the public and private sectors, procurement of drugs, including donations is limited to items registered for use in the country as well as those drugs currently marketed in their country of origin. For drug distribution, only those medicines registered in the country are allowed to be distributed in the country. The Government pharmaceutical service is responsible for the procurement and distribution of drugs in the public health sector. A tender system is being used for procurement. Five licensed wholesalers are responsible for importing and distribution of drugs to license holders in the private sector, while the Government Medical Store procures through international tenders, for the public sector. There are no drug manufacturers in The Gambia as of now. The capacity for quality assurance is very limited and a quality assurance laboratory has been constructed but has yet to be operational\textsuperscript{30}.

Coverage of the population by essential medicines is good. The frequency of stock outs of essential medicines per year ranges between 15 to 20\%.\textsuperscript{31}

3.4 Human Resources for Health

The Department of State for Health has created a Unit for the coordination of the planning, management, monitoring and evaluation of human resources for health in 2004 following the launching of the HRH policy and a five year plan of action. The Unit is however, understaffed with only one person qualified in the management of human resources.

There is no medium or long-term plan for human resources for health as well as for their development and deployment. There are no norms and standards for staffing of the various levels of health facilities for the Ministry of Health. A World Bank funded and WHO executed

\textsuperscript{30} Personal communication, chief pharmacist, Department of State for Health, Dec. 2004
\textsuperscript{31} Personal communication, chief pharmacist, Department of State for Health, Dec. 2004
project for the development of the human resources for health plan as well as determination of staffing norms for the health sector will be implemented in the course of 2005.

The country is having a medical school for the training of medical doctors. Its first 15 graduates are expected in September 2005. It has a first year intake capacity of 20 students.

The Nursing Schools capacity is considered adequate for supplying the country with its nursing requirements. The country has a Nursing School, at Bansang, for training of enrolled nurse and midwives. The School of Nursing and Midwifery at Gambia College in Banjul trains, State Registered Nurses and Midwives. A school of nursing at Masankoko trains Community Health Nurses, a category of nurses specifically trained to operate at community level.

State registered nurses are becoming scarce due to migration to developing countries.

The Gambia also trains environmental health officers in-country. These officers form the backbone of the health delivery system in The Gambia.

The University of The Gambia offers degree courses for both registered nurses and environmental health officers. The training curriculum for the training of all the health workers in the country has been reoriented towards the primary health care approach.

For in-service training, the Department of State for Health, the Medical Nursing and Midwifery Association organize and conduct courses for various categories of health workers. The Department of State for Health also sends its Senior Managers for in-service training in Management. WHO is highly involved in the in-service training of health workers.

The HRH situational analysis carried out between end of 2002 and early 2003 highlighted a number of HRH issues that contribute in one way or another to poor performance of health system. Among these issues are weak institutional and human capacities for HRH planning and management, gross shortage of indigenous skilled HRH, which is made worse by very high attrition rate among skilled staff, leading to poor performance of the health systems and too much dependence on expatriate staff. While almost all nurses and environmental health officers in the country are Gambians only less than 10% of the Doctors are Gambians. The medical doctors in The
Gambia come from Nigeria, Cuba and Egypt. Various forms of staff mal-distribution exist. Remuneration packages, lack of clear guidelines for staff promotion, posting and transfer, poor working environment are among factors that contribute to low morale and negative work attitudes amongst health careworkers.

3.5 Health Care Financing

3.5.1 Budget for Public Health Sector

The revenue for the health expenditure is derived from households and from public revenue. The public revenue is collected from taxes on international trade, goods and services (companies) and personal income tax. Government also obtains loans and grants from international financial institutions, governments, international organizations and individuals in order to finance the budget. Domestic borrowing through treasury bills is also used for financing the budget. The use of the loans (external and domestic) led to an estimated external debt of US$490 million in 2002 and internal domestic debts of about US$111 million.

3.5.2 The amount of international aid received as a percentage of total national health expenditure

In 1990/91 Financial year the total Government expenditure for health was US$4.41 million for recurrent expenditure and US$0.19 million for Capital expenditure. The figures are US$6 million for the recurrent expenditure in 2003, and US$4.86 million for the development budget. This shows an increase in health expenditure of 136% in slightly more than 12 years. In addition the health sector received a total of US$1.33 million from the HIPC resources in 2003. The health sector enjoyed 11.78% of all public expenditures in 2003.

3.5.3 Percentage of gross national product spent on health

It was not possible to obtain the value of Gross National Product (GNP) therefore Gross Domestic Product (GDP) is used here instead. According to the Economist Intelligence Unit 2004, the GDP per capita for The Gambia for 2003 was US$334. Therefore, about 3% of the GDP is spent on health.

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32 Budget Speech 2003, Secretary of State and Finance and Economic Affairs, The Gambia
33 Budget Speech 2003, Secretary of State for Finance and Economic Affairs
In 2003, the proportion of the current public health budget (both recurrent and development) spent at the periphery i.e. at Primary Care Level and secondary level was 22.3%. The recurrent budget for the central level (planning, resources mobilization, coordination and supervision) plus subvention to the tertiary hospitals, amounted to about 28% of the total budget (recurrent and development). Six per cent of the total budget (recurrent and development) is devoted to pharmaceuticals. The development budget accounts for 42% of the total budget (recurrent and development). The rest of the budget is divided between the national laboratories, health training schools, maintenance of the physical infrastructure etc. This analysis did not disaggregate the budget according to management and services, only by level of the health system (primary and secondary level on the one hand and tertiary and central level on the other). The recurrent health expenditures for the years 1993 to 2001 were as follows:

3.5.4 Percentage Share of Recurrent Health Expenditure

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</thead>
<tbody>
<tr>
<td>Management</td>
<td>13.2%</td>
<td>12.5%</td>
<td>14.6%</td>
<td>13.7%</td>
<td>12.7%</td>
<td>11.9%</td>
<td>17.9%</td>
</tr>
<tr>
<td>Tertiary Care</td>
<td>44.9%</td>
<td>47.4%</td>
<td>42.2%</td>
<td>43.5%</td>
<td>47.1%</td>
<td>47.5%</td>
<td>44.2%</td>
</tr>
<tr>
<td>Primary and Secondary Care</td>
<td>39.1%</td>
<td>37.2%</td>
<td>40%</td>
<td>38.7%</td>
<td>36%</td>
<td>38.6%</td>
<td>36.2%</td>
</tr>
<tr>
<td>Training and Research</td>
<td>2.8%</td>
<td>2.9%</td>
<td>3.2%</td>
<td>4.1%</td>
<td>4.2%</td>
<td>2.0%</td>
<td>1.7%</td>
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</table>

The recurrent public health expenditure as a share of the total Government expenditure excluding debt services ranges between 10.8% and 13.4%. By the year 2000 the public health expenditure, measured in US$, were nearly US$6 per capita, which is just half of the WHO recommended level of US$12 per capita to provide a minimum health care service.

3.5.5 Health Expenditure in the Private Sector

This is largely unknown, as the private sector is not fully audited by the Auditor General’s Office. A situation analysis on Human Resources for Health in The Gambia in 2003 revealed that 26% of all health staff (3383) work in the private sector.\textsuperscript{34} However, the total expenditures of the

\textsuperscript{34} Report on Policy Level retreat on HRH Situation Analysis and Policy, The Gambia
population at the private health facilities are unknown. The national health account exercise, which was planned for 2003, was rescheduled due to financial constraints. It will be resumed early in 2005. Apart from using occidental practitioners, the majority of the population in the rural areas does make full use of Traditional Healers. The expenditure for the services of these practitioners is also not fully documented.

3.5.6 Cost Recovery
A cost recovery programme (policy) was introduced in 1988 and established a drug revolving fund and the introduction of user fees as a form of health financing. The Bamako Initiative (BI) was introduced in 1993 as a further development of the cost recovery programme.

A Gambian patient pay D5 for each outpatient visit, for registration at antenatal care clinic or for registration of a child at the RCH Clinic. Non-Gambians pay between D20 to D50 for the same services. Some patients suffering from certain diseases are exempted. Admission per week in a public ward cost D50 and D200 for non-Gambians. Admission to a private ward of a public hospital cost D750 per week. According to a household income and expenditure survey of 1998, Gambians will be willing to pay an average of D35 per consultation for better quality care and traditional healers or marabou charge D70 per consultation. The user fee system is likely to continue and full cost recovery from private patients will be used as a strategy for raising revenue and for cross subsidization.

3.5.7 External Financial Support to the health sector
i. A World Bank Project: Participatory Health, Population and Nutrition Project (PHPNP) has been designed to improve the quality of and access to family health services and the management of such services in the Gambia. It is a US$20 million project being executed over five years since 1998, but has continued into 2005.

It has four components:
- Reproductive Health Services: US$4.1 million
- Integrated Management of Childhood Illness: US$0.9 million

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• Nutrition Policy and Services for Women of Reproductive Age, Infants and Children: US$2 million
• Management and Implementation of Family Health Programme: US$9.3 million

ii) A 5-year project called Health Service Development Project, by the Africa Development Bank valued at US$10 million, ending December 2004, and aimed at:
   • Rehabilitating the physical infrastructure
   • Training of human resources for health

iii) A World Bank Project valued at US$15 million and ending in June 2005 is aimed at the prevention and treatment of HIV/AIDS

iv) A project titled Assistance to the Health Sector by the Islamic Development Bank valued at US$ 9 million has been used for various health interventions.

All of the above are low-interest loans or complete grants. The country’s health sector also benefited from various grants and in-kind assistance and support over the past few years. UN agencies have played a role in this regard. The following partners have contributed in one way or another to the health sector. INTERNATIONAL PARTNERS:

v) UNICEF
vi) UNDP
vii) WHO and the Global Fund against AIDS, TB and MALARIA
viii) UNFPA
viii) Italian Project: I BILATERAL COOP. STRENGTHENING P H C programmes
ix) The Netherlands- TB control
x) Catholic Relief Services (Nutrition, HIV/AIDS, malaria, Community Development)
x) Action Aid (MCH services and nutrition)
xii) Christian Children Fund (Nutrition, HIV/AIDS and malaria)
xiii) European Union (Infrastructure-roads and water installation), intercountry project on Integrated Diseases Surveillance
xiv) Republic of China on Taiwan (EPI equipment, and budget support to the health sector)
xvii) USA (EPI)
xviii) Cuban government (Human Resources for Health-Technical assistance)
xix) Nigeria (Human Resources for Health-Technical assistance)
xx) UK (Human Resources for Health-Technical assistance)
xxi) Egypt (Human Resources for Health-Technical assistance)
xxii) Japan (Solar panels for EPI refrigerators)
xxiii) Rotary International (National Immunisation Days)

LOCAL PARTNERS include Standard Chartered Bank, Trust Bank, Gamtel, Africel, Gamcel, Shell Marketing, Alliance Health Systems, The A J J Jammeh Foundation, to mention but a few.

3.6 Health Services Access and Utilization

The distance traveled or time taken to reach the nearest health facility is measure of physical access to health facilities. The average walking distance to and from a health facility is less than 50 minutes in The Gambia. Judging by this, one can safely state that the majority of Gambian population have geographic access to health care services.

Financial access has already been discussed under cost recovery (para 3.5.6). It is perhaps safe to say that financial constraints only excludes citizens from expensive private health care services and not the public health services.

According to the 1993 Household, Education and Health Survey Report and the 1998 National Household Poverty Survey Report, one in five of the extremely poor Gambian saw a medical doctor for consultations compared to one in three for the non-poor. Access to a medical doctor is now available to many communities especially in rural areas, due to the presence of Cuban and Nigerian medical doctors. However, the percentage of consultation with nurses has decreased over the years because of the reduction of the number of nurses available in the health center in the past few years. Increasingly patients are using the public health facilities rather than private ones.

The Gambia had 1.21 beds/1000 of the population, although the situation is less favourable in the North Bank West and Upper River Divisions.
The utilization of health care services has been increasing over the years. The outpatient consultation in the health divisions rose from 456,366 to 647,751 between 1996 to 2000. This is an 8.4% increase. The outpatient consultation at hospitals and basic health facilities rose from 602,716 to 957,919 over the same period. In-patient admission at hospitals and basic health facilities rose from 69704 to 103778 during the same period.

3.7 Monitoring and Evaluation of the Health System

The health system in The Gambia has got three management levels, the central level whose main function is policy formulation, resource mobilization, coordination, supervision and reporting, standards and norms setting and the divisional level for monitoring and reporting, and the implementation of the health programmes, interpretation of the policies with regard to addressing specific health issues, identifying and allocating resources to the lower levels, staff management and general support to the health facilities and community health services.

The management at the health facility level is responsible for the day to day supervision of the implementation of health programmes. Monitoring the use of resources and sourcing of these resources, supervising the services at community level and supporting the village health workers. Reporting is also one of the important function at this level.

There is in existence a health information system used mainly for monitoring the performance of the health care system. It is capable of producing monitoring reports on a regular basis. The health information system had been organized in such a way that the reports are useful for policy review, evaluation of health sector performance as well as monitor implementation of health plans.

Some of the important tools being used (in the health information system) to ensure communication of information between the levels are the Integrated Disease Surveillance and Response (IDSR) system that monitors some twenty-one epidemic prone diseases at all facilities on an ongoing basis. Some of these diseases are targeted for eradication and or elimination. This system is functioning rather well in the country. Another tool being utilize is the health management information system that monitors the workload in health facilities, the flow of
resources, the changes in the staffing patterns, the state of fixed assets (buildings) and the state of medical and non-medical equipment and other supplies.

For evaluation of the health system and its output and impacts, periodic (two years) surveys are held, e.g. the demographic and health surveys, the household income and expenditure surveys and others. Specific studies are conducted for certain issues, for instance, a study on the situation analysis of human resource for health, a study on the evaluation of availability, utilization and quality of emergency obstetric care in The Gambia and others. All these studies and research evaluate the state of the health system as well as its impact on the population.

The Medical Research Council (UK) based in Fajara carries out research in many areas including health services research. This provides useful information data bank for the Ministry of Health and NGOs.

Of particular importance is the existence of the British Medical Research Council in collaboration with government and WHO, which conducts research into the diseases that are of public health importance in the country, including malaria, TB, HIV/AIDS, diarrhea and ARI.

4. CONCLUSIONS

It is important to note that The Gambia has the national health policy and other relevant programme policies in place to direct its response to the various health issues, including communicable diseases, such as malaria, diarrhoeal diseases and others. Malnutrition and other non-communicable diseases such as hypertension, heart diseases and cancers are becoming common. Reproductive health issues such as maternal mortality are also priorities for the health sector. The country however is in need of various resources to implement the good policies. Human resources for health is probably one of the outstanding need amongst others. While strategies are in place to address most of the needs, financial and other resources are urgently needed to implement them.
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ANNEX I

Table 1. THE GENERAL ECONOMIC, SOCIAL AND POLITICAL CONTEXT OF HEALTH
1.1 THE COUNTRY – BASIC DATA AND REGIONAL INDICATORS

<table>
<thead>
<tr>
<th>ITEMS</th>
<th>UNIT OF MEASURE</th>
<th>MOST RECENT ESTIMATES</th>
<th>MOST RECENT ESTIMATES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>THE GAMBIA</td>
<td>AFRICA</td>
</tr>
<tr>
<td>GDP per Capita</td>
<td>US $ Million</td>
<td>340 *</td>
<td>1 364 507 *</td>
</tr>
<tr>
<td>Population</td>
<td>Annual %</td>
<td>2.77*</td>
<td></td>
</tr>
<tr>
<td>Urban Population</td>
<td>% of Population</td>
<td>55%*</td>
<td></td>
</tr>
<tr>
<td>Population Density</td>
<td>Population Per Sq. Km.</td>
<td>128 p.s..km*</td>
<td></td>
</tr>
<tr>
<td>Population Under 15 Years</td>
<td>% of Population</td>
<td>47%*</td>
<td></td>
</tr>
<tr>
<td>Males/Females Ratio</td>
<td>Number</td>
<td>98%*</td>
<td></td>
</tr>
<tr>
<td>Fertility</td>
<td>Births per Woman</td>
<td>5.55**</td>
<td></td>
</tr>
<tr>
<td>Unemployment Rate</td>
<td>% of Labour Force</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Female Labour Force</td>
<td>% of Labour Force</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>LIFE EXPECTANCY AT BIRTH</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>Years</td>
<td>52 yrs</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>Years</td>
<td>55 yrs</td>
<td></td>
</tr>
<tr>
<td>Crude Death Rate</td>
<td>Per thousand population</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Crude Birth Rate</td>
<td>Per thousand population</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Access to health Services</td>
<td>% of population</td>
<td>90%</td>
<td></td>
</tr>
<tr>
<td>Contraceptive Prevalence Rate</td>
<td>% currently using Persons</td>
<td>17.5%</td>
<td></td>
</tr>
<tr>
<td>Population Per Physician</td>
<td>Persons</td>
<td>6467</td>
<td></td>
</tr>
<tr>
<td>Population Per Hospital Bed</td>
<td>Per thousand live births</td>
<td>924</td>
<td></td>
</tr>
<tr>
<td>Under-5 Mortality Rate</td>
<td>Per thousand live births</td>
<td>110</td>
<td></td>
</tr>
<tr>
<td>Infant Mortality Rate</td>
<td>Per thousand live births</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>ORT Use</td>
<td>% of cases</td>
<td>83%</td>
<td></td>
</tr>
<tr>
<td>Immunization coverage</td>
<td>% of 1-2 years fully Immunized</td>
<td>13.7% (&gt;90 Centile)</td>
<td></td>
</tr>
</tbody>
</table>
Table 2: Key Macro-economic Objectives

<table>
<thead>
<tr>
<th>Indicator</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real GDP growth</td>
<td>3.2</td>
<td>6.0</td>
<td>7.0</td>
<td>7.1</td>
</tr>
<tr>
<td>Fiscal deficit (excluding grants, HIPC &amp;PRS)</td>
<td>8.01</td>
<td>2.7</td>
<td>5.9</td>
<td>4.8</td>
</tr>
<tr>
<td>As % of GDP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exports FOB in million USD</td>
<td>109</td>
<td>101</td>
<td>124</td>
<td>134</td>
</tr>
<tr>
<td>Current account deficit (excluding official transfers) as % of GDP</td>
<td>-16.1</td>
<td>12.3</td>
<td>14.6</td>
<td>14.5</td>
</tr>
<tr>
<td>Current Account deficit (including official transfers) as a % of GDP</td>
<td>-5.5</td>
<td>5.0</td>
<td>5.2</td>
<td>6.1</td>
</tr>
<tr>
<td>Gross official reserves as months of imports (incl. Transit)</td>
<td>4.2</td>
<td>5.2</td>
<td>4.4</td>
<td>4.8</td>
</tr>
<tr>
<td>Broad money growth</td>
<td>35.3</td>
<td>9.9</td>
<td>43.3</td>
<td>20.0</td>
</tr>
<tr>
<td>Inflation</td>
<td>8.6</td>
<td>4.0</td>
<td>18</td>
<td>14.5</td>
</tr>
</tbody>
</table>

Table 3: Distribution of Public and Private Health Facilities by Divisions

<table>
<thead>
<tr>
<th>Region</th>
<th>No. of Primary level facility</th>
<th>No. of Secondary level facility</th>
<th>No. of Tertiary level facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Western Division</td>
<td>Public 1</td>
<td>Private 3</td>
<td>7 (2 hospitals under construction)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Bank West</td>
<td>Public 3</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Private 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower River</td>
<td>Public 2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Division</td>
<td>Private</td>
<td>Public</td>
<td>Total</td>
</tr>
<tr>
<td>------------------</td>
<td>---------</td>
<td>--------</td>
<td>-------</td>
</tr>
<tr>
<td>North Bank East</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Central River Division</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upper River Division</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>26</td>
<td>27</td>
<td>7</td>
</tr>
</tbody>
</table>
Table 4: Summary of available HRH in the Health Sector (Public and Private) in Year 2003

<table>
<thead>
<tr>
<th>HRH Category</th>
<th>Total</th>
<th>Breakdown by sector</th>
</tr>
</thead>
</table>

---

46

DoSH&SW

Secretary of State for Health and Social Welfare

Permanent Secretary

Central Management Committee

Director of Health Services

Hospital Boards

Deputy Director of Health Services

Government and Private Hospitals

Chief Pharmacist

Chief Nursing Officer

Health Promotion and Protection

Disease Control

Family Health

Divisional Health Teams

Environmental Health

Mental Health

Vector Control

Eye Care

Oral Health

Food Hygiene

Health Education

Epidemiology

Lepry/TB

Malaria Control Unit

National AIDS Control

Non-Communicable Diseases

Epidemiology

IMCI

EPI

Basic Health Services

Village Health Services

Director of Social Welfare

Director of Support Services

Director of Planning and Information

Project Co-Ordinating Committee

Deputy Director

Project Manager

Financial Controller

Deputy Project Manager

Assistant

Human Resource Development

Policy Analysis and Budgeting

Research, Monitoring and Evaluation

Permanant Secretary

Secretary of State for Health and Social Welfare
<table>
<thead>
<tr>
<th>Position</th>
<th>Numbers</th>
<th>Public Sector</th>
<th>Private Sector (Profit &amp; Not for Profit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDs (General Physicians &amp; Specialists)</td>
<td>156</td>
<td>88</td>
<td>67</td>
</tr>
<tr>
<td>Dentists</td>
<td>7</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Dental Technologists/Assistants</td>
<td>18</td>
<td>16</td>
<td>2</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>18</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Pharmacy Technicians</td>
<td>4</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacist assistants/Dispensing Asst.</td>
<td>26</td>
<td>26</td>
<td>-</td>
</tr>
<tr>
<td>State Registered Nurses (SRN)</td>
<td>40</td>
<td>40</td>
<td>-</td>
</tr>
<tr>
<td>SRN with BSc Nursing</td>
<td>4</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>State Registered Nurse/ Midwives (SRN/M)</td>
<td>430</td>
<td>333</td>
<td>97</td>
</tr>
<tr>
<td>State Enrolled Nurses (SEN)</td>
<td>227</td>
<td>227</td>
<td>-</td>
</tr>
<tr>
<td>State Enrolled Nurses/Midwives (SEN/M)</td>
<td>106</td>
<td>38</td>
<td>68</td>
</tr>
<tr>
<td>State Enrolled Nurse/Ophthalmic (SEN/Ophth)</td>
<td>8</td>
<td>8</td>
<td>-</td>
</tr>
<tr>
<td>Community Health Nurses (CHN)</td>
<td>115</td>
<td>115</td>
<td>-</td>
</tr>
<tr>
<td>Community Health N/Midwives (CHN/M)</td>
<td>101</td>
<td>38</td>
<td>63</td>
</tr>
<tr>
<td>Community Health N/Ophthalmic CHN/Ophth</td>
<td>16</td>
<td>16</td>
<td>-</td>
</tr>
<tr>
<td>Public Health Officers (PHO)*</td>
<td>31</td>
<td>31</td>
<td>-</td>
</tr>
<tr>
<td>PHOs with BSc Public Health</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Physiotherapy Assistants</td>
<td>9</td>
<td>9</td>
<td>-</td>
</tr>
<tr>
<td>Nursing Auxiliary/Assistants/Attendants</td>
<td>578</td>
<td>524</td>
<td>54</td>
</tr>
<tr>
<td>Laboratory technologists/technicians</td>
<td>96</td>
<td>30</td>
<td>66</td>
</tr>
<tr>
<td>Radiographers</td>
<td>3</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Radiologist</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Radiology / x-ray Assistants.</td>
<td>19</td>
<td>1</td>
<td>18</td>
</tr>
<tr>
<td>Radiographer Assistants.</td>
<td>11</td>
<td>11</td>
<td>-</td>
</tr>
</tbody>
</table>
Others:
- Professionals at Central Level (various cadres) 80
- DHMT members 42
- Hospital Chief Exec. Officers (CEOs) & Deputy CEOs 5
- Tutors/Lecturers/Trainers in Local Health Training Institutes 44
- Others incl. Admin & support staff etc. 1,199

Community health workers\(^{36}\) 968

<table>
<thead>
<tr>
<th></th>
<th>36</th>
<th>968</th>
<th>-</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>4,365</td>
<td>3,506</td>
<td>859</td>
</tr>
<tr>
<td>TOTAL EMPLOYED</td>
<td>3,397</td>
<td>2,538</td>
<td>859</td>
</tr>
</tbody>
</table>

Distribution of Health Workers by Category

Table:---5--- Graph of numbers of health staff per division (public sector), 2003

\(^{36}\) Community Health Workers, including VHWs and TBAs are recognized, trained and supported by Government. However, they are not included in the nominal roles i.e. not salaried.
Table 6: Graph of health staff per 1,000 population per division, 2003

![Graph of health staff per 1,000 population per division, 2003](image)

Table 7: Medical Doctors, Pharmacists and Dental Surgeons in the 4 Referral Hospitals, 2003

<table>
<thead>
<tr>
<th>Category</th>
<th>AFPRC</th>
<th>Bansang</th>
<th>RVTH</th>
<th>SulJunk</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anaesthetist + registrars</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Consultants / Registrars (General Medicine)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Dental Surgeons / Sen DS / DS Specialist</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Medical Officers / House Officers</td>
<td>3</td>
<td>3</td>
<td>24</td>
<td>0</td>
<td>30</td>
</tr>
<tr>
<td>Obs / Gynecologist + registrars</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Ophthalmologist</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Paediatrician + registrars</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Pathologist / Haematologist</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Physicians + registrars</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Radiologist</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Surgeons / Orthop / Registrar / Urologist / Paed S</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Grand Total</td>
<td>9</td>
<td>18</td>
<td>44</td>
<td>3</td>
<td>74</td>
</tr>
</tbody>
</table>
### Table 8: Distribution of Nurses over 4 Hospitals, in 2003

<table>
<thead>
<tr>
<th>Category</th>
<th>AFPRC</th>
<th>Bansang</th>
<th>RVTH</th>
<th>SulJunk</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHN Nursing Officers / Staff nurses</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>SEN</td>
<td>49</td>
<td>53</td>
<td>193</td>
<td>12</td>
<td>307</td>
</tr>
<tr>
<td>Total</td>
<td>78</td>
<td>93</td>
<td>284</td>
<td>22</td>
<td>477</td>
</tr>
</tbody>
</table>

### Table 9: Staff in the Private Sector per Cadre, 2003

<table>
<thead>
<tr>
<th>Staff Cadre</th>
<th>Number employed in Private Sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>State Registered Nurses/Midwives (SRN/M)</td>
<td>97</td>
</tr>
<tr>
<td>State Enrolled Nurses/Midwives (SEN/M)</td>
<td>68</td>
</tr>
<tr>
<td>Community Health Nurses/Midwives (CHN/M)</td>
<td>63</td>
</tr>
<tr>
<td>Medical Doctors</td>
<td>67</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>5</td>
</tr>
<tr>
<td>Pharmacy Technicians</td>
<td>1</td>
</tr>
<tr>
<td>Dispensing Assistant</td>
<td>1</td>
</tr>
<tr>
<td>Lab Technicians/Technologists</td>
<td>66</td>
</tr>
<tr>
<td>Radiology/X-ray Assistants</td>
<td>18</td>
</tr>
<tr>
<td>Dental Technologists/Assistants</td>
<td>2</td>
</tr>
<tr>
<td>Nursing Auxiliary/Assistants</td>
<td>54</td>
</tr>
<tr>
<td>Other: Administrative/Support staff etc.</td>
<td>417</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>859</strong></td>
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</table>
### Table 10------Sectoral Allocation for 2003 Budget

#### Recurrent Expenditure

<table>
<thead>
<tr>
<th>Category</th>
<th>D Million</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOS Education</td>
<td>208.3</td>
<td>12.2</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>198.9</td>
<td>11.6</td>
</tr>
<tr>
<td>DOS Health</td>
<td>180.9</td>
<td>10.6</td>
</tr>
<tr>
<td>DOS Finance</td>
<td>101.3</td>
<td>5.9</td>
</tr>
<tr>
<td>DOS Foreign Affairs</td>
<td>87.7</td>
<td>5.1</td>
</tr>
<tr>
<td>Office of the President</td>
<td>68.5</td>
<td>4.0</td>
</tr>
<tr>
<td>DOS Interior</td>
<td>66.0</td>
<td>3.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>D Million</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOS Agriculture</td>
<td>53.1</td>
<td>3.1</td>
</tr>
<tr>
<td>DOS Defence</td>
<td>51.1</td>
<td>3.0</td>
</tr>
<tr>
<td>Debt Service Charges</td>
<td>539.9</td>
<td>31.6</td>
</tr>
<tr>
<td>Others*</td>
<td>151.7</td>
<td>8.9</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1707.3</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

#### Development Expenditure

<table>
<thead>
<tr>
<th>Category</th>
<th>D Million</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agriculture and Natural Resources</td>
<td>114.3</td>
<td>9.4</td>
</tr>
<tr>
<td>Industry and Employment</td>
<td>0.7</td>
<td>0.1</td>
</tr>
<tr>
<td>Public Utilities</td>
<td>16.6</td>
<td>1.4</td>
</tr>
<tr>
<td>Transport and Communication</td>
<td>600.6</td>
<td>49.3</td>
</tr>
<tr>
<td>Tourism, Trade and Finance</td>
<td>14.9</td>
<td>1.2</td>
</tr>
<tr>
<td>Education</td>
<td>112.0</td>
<td>9.2</td>
</tr>
<tr>
<td>Health and Social Welfare</td>
<td>146.7</td>
<td>12.0</td>
</tr>
<tr>
<td>Housing and Community Development</td>
<td>60.8</td>
<td>5.0</td>
</tr>
<tr>
<td>General Public Service</td>
<td>151.1</td>
<td>12.4</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1217.7</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>
### Table 11: Allocation of HIPC Resources 2003 in ’000 of Dalasis

<table>
<thead>
<tr>
<th>SECTOR</th>
<th>APPROVED ESTIMATES</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education</td>
<td>12,959.0</td>
<td>11.8</td>
</tr>
<tr>
<td>Health and Social Welfare</td>
<td>39,987.0</td>
<td>36.4</td>
</tr>
<tr>
<td>Agriculture and Natural Resources</td>
<td>15,334.0</td>
<td>14.0</td>
</tr>
<tr>
<td>Transport and Construction</td>
<td>11,600.0</td>
<td>10.6</td>
</tr>
<tr>
<td>Public Utilities</td>
<td>2,340.0</td>
<td>2.1</td>
</tr>
<tr>
<td>Justice</td>
<td>300.0</td>
<td>0.3</td>
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<tr>
<td>Local Government (Housing)</td>
<td>4,433.0</td>
<td>4.0</td>
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<tr>
<td>Judiciary</td>
<td>575.0</td>
<td>0.5</td>
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<tr>
<td>General Public Services</td>
<td>22,225.0</td>
<td>20.3</td>
</tr>
<tr>
<td>Of which Contingency</td>
<td>10,000.0</td>
<td>9.1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>109,753.0</td>
<td>100.0</td>
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</table>

### Table 12: Distribution of Department of State for Health and Social Welfare Recurrent and Development Budget for 2004 by Directorates, Management Levels and Levels of Implementation

<table>
<thead>
<tr>
<th>DEPARTMENT</th>
<th>AMOUNT GMD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RECURRENT BUDGET</strong></td>
<td></td>
</tr>
<tr>
<td>Office of the Secretary of State</td>
<td>91,058,060</td>
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<tr>
<td>Support Services</td>
<td>12,393,445</td>
</tr>
<tr>
<td>Directorate of Planning of Information</td>
<td>1,546,675</td>
</tr>
<tr>
<td>Birth Registration Control</td>
<td>168,394</td>
</tr>
<tr>
<td>Food Standards Control</td>
<td>99,481</td>
</tr>
<tr>
<td>Traditional Medicine Development</td>
<td>215,659</td>
</tr>
<tr>
<td>Maintenance Policy Monitoring</td>
<td>151,154</td>
</tr>
<tr>
<td>Maintenance Service Management</td>
<td>214,567</td>
</tr>
<tr>
<td>Maintenance Services Central Level</td>
<td>213,496</td>
</tr>
<tr>
<td>Directorate Basic Health Services</td>
<td>385,712</td>
</tr>
<tr>
<td>Epidemiologist and Disease Control</td>
<td>165,979</td>
</tr>
<tr>
<td>Malaria Control Programme</td>
<td>189,769</td>
</tr>
<tr>
<td>Mental Health Programme</td>
<td>94,231</td>
</tr>
<tr>
<td>Eye Care Programme</td>
<td>133,551</td>
</tr>
<tr>
<td>STD/HIV/AIDS Control Programme</td>
<td>173,769</td>
</tr>
<tr>
<td>Leprosy and Tuberculosis Control Programme</td>
<td>173,769</td>
</tr>
<tr>
<td>Reproductive and Child Health Programme</td>
<td>473,921</td>
</tr>
<tr>
<td>Department</td>
<td>Amount (GMD)</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Public Health Division</td>
<td>478,985</td>
</tr>
<tr>
<td>Health Education Promotion</td>
<td>219,366</td>
</tr>
<tr>
<td>Divisional Health Office KMC and BCC</td>
<td>619,915</td>
</tr>
<tr>
<td><strong>DEPARTMENT</strong></td>
<td><strong>AMOUNT GMD</strong></td>
</tr>
<tr>
<td>Divisional Health Office – Western Division</td>
<td>2,853,295</td>
</tr>
<tr>
<td>Divisional Health Office – LRD</td>
<td>941,810</td>
</tr>
<tr>
<td>Divisional Health Office – NBD</td>
<td>1,558,963</td>
</tr>
<tr>
<td>Divisional Health Office – CRD South</td>
<td>1,448,019</td>
</tr>
<tr>
<td>Divisional Health Office – CRD North</td>
<td>192,666</td>
</tr>
<tr>
<td>Divisional Health Office – URD</td>
<td>1,091,254</td>
</tr>
<tr>
<td>Banjul City Area</td>
<td>730,829</td>
</tr>
<tr>
<td>Kanifing Municipal Area</td>
<td>11,778,673</td>
</tr>
<tr>
<td>Western Division</td>
<td>20,322,257</td>
</tr>
<tr>
<td>Lower River Division</td>
<td>6,336,102</td>
</tr>
<tr>
<td>North Bank Division</td>
<td>11,232,164</td>
</tr>
<tr>
<td>Central River Division – South</td>
<td>6,434,654</td>
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<tr>
<td><strong>DEPARTMENT</strong></td>
<td><strong>RECURRENT BUDGET</strong></td>
</tr>
<tr>
<td>Central River Division – North</td>
<td>6,731,881</td>
</tr>
<tr>
<td>Upper River Division</td>
<td>13,348,059</td>
</tr>
<tr>
<td>Essential Drugs, Vaccines and other supplies</td>
<td>21,388,191</td>
</tr>
<tr>
<td>Schools Administration</td>
<td>350,000</td>
</tr>
<tr>
<td>SRN/SEN School - Bansang</td>
<td>1,256,933</td>
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<tr>
<td>CHN – Mansakonko</td>
<td>754,220</td>
</tr>
<tr>
<td>Medical and Dental Council</td>
<td>15,300</td>
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<tr>
<td>Nurses and Midwives Council</td>
<td>122,466</td>
</tr>
<tr>
<td>National Standard Laboratories</td>
<td>523,377</td>
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<tr>
<td>Directorate of Social Welfare</td>
<td>1,581,288</td>
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<tr>
<td>Orthopaedics and Prosthetic Unit</td>
<td>389,472</td>
</tr>
<tr>
<td>Divisional Social Welfare Office – BCC</td>
<td>51,849</td>
</tr>
<tr>
<td>Divisional Social Welfare Office – KMC</td>
<td>148,298</td>
</tr>
<tr>
<td>Divisional Social Welfare Office – Western Division</td>
<td>137,434</td>
</tr>
<tr>
<td>Divisional Social Welfare Office – Lower River Division</td>
<td>112,918</td>
</tr>
<tr>
<td>Divisional Social Welfare Office – CRD</td>
<td>113,716</td>
</tr>
<tr>
<td>Divisional Social Welfare Office – NBD</td>
<td>112,918</td>
</tr>
<tr>
<td>Divisional Social Welfare Office – URD</td>
<td>123,716</td>
</tr>
<tr>
<td><strong>DEPARTMENT</strong></td>
<td><strong>AMOUNT GMD</strong></td>
</tr>
<tr>
<td>Home for the Elderly</td>
<td>527,118</td>
</tr>
<tr>
<td>Project Description</td>
<td>Budget</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Bansang Hospital</td>
<td>400,000</td>
</tr>
<tr>
<td>Royal Victoria Teaching Hospital</td>
<td>4,500,000</td>
</tr>
<tr>
<td>Soma Health Center</td>
<td>150,000</td>
</tr>
<tr>
<td>Department of Social Welfare</td>
<td>319,000</td>
</tr>
<tr>
<td>Bwiam District Hospital</td>
<td>1,240,000</td>
</tr>
<tr>
<td>APRC General Hospital</td>
<td>650,000</td>
</tr>
<tr>
<td>Serrekunda Hospital</td>
<td>41,250,000</td>
</tr>
<tr>
<td>PHPNP</td>
<td>88,131,860</td>
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<tr>
<td>Health Services Capacity Building Project</td>
<td>27,129,740</td>
</tr>
<tr>
<td>Basic Health Services</td>
<td>700,000</td>
</tr>
<tr>
<td><strong>TOTAL BUDGET</strong></td>
<td><strong>386,350,338</strong></td>
</tr>
</tbody>
</table>