World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2013

GAMBIA

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ABBREVIATIONS

ACT	:	Artemisinin-based combination therapy
ADB	:	African Development Bank
AIDS	:	Acquired immune deficiency syndrome
APO	:	Associate professional officers
ART	:	Anti-retroviral therapy
CCA	:	Common Country Assessment
CCM	:	Country Coordinating Mechanism
CCS	:	Country Cooperation Strategy
DSHSW	:	Department of State for Health & Social Welfare
DOTS	:	Directly observed treatment short course
EmOC	:	Emergency obstetric care
EPI	:	Expanded Programme on Immunization
EU	:	European Union
FCTC	:	Framework Convention on Tobacco Control
FGM	:	Female genital mutilation
GAVI	:	Global Alliance for Vaccines and Immunization
GBOS	:	Gambia Bureau of Statistics
GDP	:	Gross domestic product
GF	:	Global Fund to Fight AIDS, Tuberculosis and Malaria
HARRP	:	HIV/AIDS Rapid Response Project
HHA	:	Harmonization for Health in Africa
HIV	:	Human immunodeficiency virus
HIPC	:	Highly Indebted Poor Countries
HMIS	:	Health Management Information System
HQ	:	Headquarters (of WHO)
HRH	:	Human resources for health
ICC	:	Inter-Agency Coordination Committee
IDB	:	Islamic Development Bank
IDSR	:	Integrated Disease Surveillance and Response
IEC	:	Information, education and communication
IHR	:	International Health Regulations
IMCI	:	Integrated management of childhood illnesses
IMF	:	International Monetary Fund
IMNCI	:	Integrated management of neonatal and childhood illnesses
IPT	:	Intermittent preventive treatment
IRS	:	Indoor residual spraying
IST	:	Intercountry Support Team (of WHO)

ITN	:	Insecticide-treated net
IVD	:	Immunization and Vaccine Development
MDG	:	Millennium Development Goal
MICS	:	Multiple Indicator Cluster Survey
MMR	:	Maternal mortality ratio
MTSP	:	Medium Term Strategic Plan
NaNA	:	National Nutrition Agency
NCD	:	Noncommunicable diseases
NEPAD	:	New Partnership for Africa's Development
NGO	:	Nongovernmental organization
NID	:	National Immunization Day
NHA	:	National Health Accounts
NMCP	:	National Malaria Control Programme
NPO	:	National professional officer
OS	:	Other Sources
PHC	:	Primary Health Care
PHPNP	:	Participatory Health, Population and Nutrition Project
PLWHA	:	People living with HIV/AIDS
PMTCT	:	Prevention of mother-to-child transmission (of HIV)
PRGF	:	Poverty Reduction and Growth Facility
PRSP	:	Poverty Reduction Strategy Paper
RB	:	Regular Budget
RBM	:	Roll Back Malaria
RH	:	Reproductive health
RHT	:	Regional Health Teams
SWAp	:	Sector-wide approach
TB	:	Tuberculosis
UN	:	United Nations
UNCT	:	United Nations Country Team
UNDAF	:	United Nations Development Assistance Framework
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children's Fund
VCT	:	Voluntary counseling and testing
WCO	:	WHO Country Office
WHO	:	World Health Organization

EXECUTIVE SUMMARY

The purpose of the WHO Country Cooperation Strategy (CCS) is to improve the efficiency and effectiveness of the work of WHO in the Gambia in supporting government efforts to achieve national health goals. This 2nd CSS sets out the strategic directions and medium-term agenda of work for the entire WHO Secretariat in the Gambia, covering the 6-year period 2008–2013.

Following an evaluation of the first CCS, the 2nd generation CCS was developed through a consultative process conducted by the WHO country team and national counterparts from the Department of State for Health and Social Welfare (DSHSW). It is based on a systematic assessment of the country's health priorities and extensive discussions with government departments, development partners, nongovernmental organizations (NGOs), private health care providers and other key stakeholders in health, with input from the other levels of WHO.

While the health status of Gambian citizens has improved significantly, important public health problems and challenges still remain. Malaria, acute respiratory infections, diarrhoeal diseases, noncommunicable diseases, and poor maternal, neonatal and child health services are the leading causes of morbidity and mortality.

A 2003 census in the Gambia estimated infant mortality rate to be 75/1000 live births, while the 2006 UNICEF Multiple Indicator Cluster Survey (MICS) puts the figure at 90/1000 live births. The 2001 maternal mortality ratio (MMR) survey showed some decline in the MMR to 730 per 100 000 live births, down from 1 050 per 100 000 live births in 1990.

Based on consultations as well as reports from the Department of State for Health during the CCS formulation process, the following health problems were identified: high maternal and child mortality ratios, high disease burden (malaria, tuberculosis, and HIV/AIDS), an increasing prevalence of noncommunicable diseases, and malnutrition. The main health challenges identified include development and retention of human resources for health (HRH), strengthening referral systems, health management information systems, mainstreaming traditional medicine, improving laboratory and blood transfusion services, health and the environment, health promotion, managing the essential medicine system and overall health systems strengthening.

The Gambia is highly dependent on external aid to finance development projects in all the different sectors, more so in the priority sectors. The results of the first National Health Accounts (NHA) for the fiscal years 2002-2004 revealed that 67% of the financing to the health sector comes from the donors, with rest of the financing split between the government (21%) and households' out-of-pocket expenditure (12%).

Donor coordination has been one of the main challenges facing the government of the Gambia in its development programmes across all sectors, including the health sector. With the development of a new health policy and master plan (2007–2020), the stage is set for better partner coordination in the health sector, as it is envisaged that all partners will buy into the policy and master plan. A biennial operational health plan will form the basis for the introduction of the sector-wide approach (SWAp) mechanism.

Key issues have been identified on which WHO will focus its efforts and resources for maximum impact. These areas cover:

(i) Health systems strengthening;

(ii) Health promotion, disease prevention, control and eradication;

(iii) Reproductive health, and maternal and child nutrition; and

(iv) Health, environment and sustainable development and emergency response.

The strategic objectives formulated to address the key issues in these areas are:

- To improve the health care delivery system in the country;
- To reduce morbidity and mortality due to communicable and noncommunicable diseases and conditions, and strengthen health-promotion capacity at all levels;
- To improve maternal health and reduce neonatal and childhood morbidity and mortality; and
- To contribute to the improvement in the general standards of health of the population and address health consequences of emergencies.

Under each of these strategic objectives, WHO has outlined a number of strategies that will be implemented during the 6-year period of the CCS. While implementing these strategies, WHO will carry out activities in partnership with the DSHSW, relevant departments in the government, other health development partners, and NGOs involved in the health sector, taking into account its own comparative advantages.

The WHO Country Office will continue to increase its role as a broker and advocate for health, and technical assistance will be intensified in areas where there is a critical shortage of national expertise. The WHO Regional Office for Africa will create an enabling environment that will facilitate organizational change and institutional development issues arising from the CCS. With regards to the need for additional resources to support the implementation of the agenda of the CCS, and in accordance with the principle of "One WHO", WHO headquarters will work with the Regional Office to mobilize resources and provide technical support for the implementation of the Gambia CCS, and to document lessons arising from the approach and its impact on WHO's work as a whole. The monitoring of the implementation of the CCS will be through semi-annual monitoring, midterm review, and biennial evaluation of the programme budget.

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

SECTION 1

INTRODUCTION

The purpose of this WHO Country Cooperation Strategy (CCS) is to improve the efficiency and effectiveness of the work of WHO in the Gambia in supporting government efforts to achieve the national health goals. It sets out the strategic directions and medium-term agenda of work for the entire WHO Secretariat at the Organization's three levels (Headquarters, the Regional Office for Africa and the Country Office) in the Gambia, covering the 6-year period 2008–2013.

The CCS was developed through a consultative process conducted by the WHO country team and national counterparts from the Department of State for Health and Social Welfare (DSHSW). It is based on a systematic assessment of the country's health priorities and is a product of extensive discussions with government departments, development partners, nongovernmental organizations (NGOs), private health care providers and other key stakeholders in health and other levels of WHO. These include Her Excellency the Vice-President; Honorable Secretaries of State and/or their senior staff; program unit heads of Health and Social Welfare; senior staff of the Royal Victoria Teaching Hospital; the Dean of the Faculty of Medicine and Allied Health Sciences of the University at the Gambia; and the Principals of the Schools of Nursing and Public Health. Other partners consulted include the Medical Research Council of the Gambia, the Registrar of the Gambia Medical and Dental Council, the U.S. Embassy, the Nigerian High Commission, and all UN agencies represented in the country.

Through the CCS, WHO aims to be more responsive to the country's needs by being more selective and focused on national health priorities, whilst taking into consideration WHO's policy directives. The Organization aims to provide an optimum balance between the needs and expectations of the country on the one hand and the comparative advantage of WHO on the other, whilst simultaneously taking into account the activities of other development partners.

In setting out the medium-term strategic agenda, the CCS has been inspired by the following documents: the Common Country Assessment (CCA) report (2006), the United Nations Development Assistance Framework (UNDAF, 2007–2011), the WHO Medium Term Strategic Plan (2008–2013), the WHO African Region Strategic Framework (2005–2009), the 2nd Poverty Reduction Strategy Paper (PRSP II, 2007–2011), the recently formulated National Health Policy and Strategic Plan (2007–2020), and the various policies guiding national programmes. It provides a framework for the Organization to address the health component of the Millennium Development Goals (MDGs) in the Gambia.

WHO will work to maximize synergies and achieve optimum complementarities with all stakeholders and development partners, in line with the strategies developed in this document. Thus, the CCS provides general guidelines for WHO operations in the Gambia for the medium term, and will influence the work of the organization at all its levels.

SECTION 2

COUNTRY HEALTH AND DEVELOPMENT CHALLENGES

The Gambia is located in West Africa, and has a surface area of 10 690 sq km. It forms a narrow enclave into the Republic of Senegal, with the Atlantic Ocean forming its western boundary. The country is divided into five administrative regions (Western, Lower River, Central River, Upper River and North Bank) and two municipalities (Banjul and Kanifing).

2.1 POPULATION TRENDS

The Gambia's population was estimated to be 1.364 million in 2003, of which 50.2% were female and 49.8% male. The population growth rate is 2.74%[1], with a crude birth rate of 46 per 1000 population and a total fertility rate of 5.4 births per woman. According to the 2003 census, nearly 44% of the population is below 15 years and 19% is between the ages 15 to 24. The youthfulness of the population (63% below 24 years) has profound implications for the nature of health services to be provided. Average life expectancy at birth is 64 years overall. The Gambia is one of the most densely populated countries in Africa, with 135 persons per sq km, 26% of whom live in urban areas.

2.2 SOCIOECONOMIC SITUATION AND GOVERNANCE

The Gambia is a small Least Developed Country (LDC) with a gross domestic product (GDP) per capita of US$320 (2005). Although 80% of the total population is involved in the agricultural sector, services are the biggest contributor to the GDP, at 60%. Whilst the Gambia's ranking on the UNDP's Human Development Index improved to 155 out of 177 countries (2006), the 2003 National Household Survey estimated that 61.2% of the population is classified as "poor". This high poverty rate implies a high level of disease vulnerability on the population and has serious implications for public health services delivery.

The Gambia has enjoyed relative peace and stability since independence in 1965. After a military takeover in 1994, there was a return to democratic rule in 1996. Despite adherence to democratic principles over the years, the status of women in the society has not changed appreciably, although the government has taken positive steps to include women in key positions in public service. In general, the social and reproductive rights of women are not well recognized in the society. Harmful traditional practices such as female genital mutilation/cutting (FGM) are still common. Therefore, there is a need to empower women to participate fully in the socioeconomic development of the Gambia.

[1] 2003 National Population and Housing Census.

2.3 HEALTH PROFILE

The leading causes of morbidity in children are malaria, acute respiratory infections, diarrhoeal diseases, helminthic infections and skin disorders. In adults, malaria, respiratory conditions, skin disorders, cardiovascular diseases (including hypertension), diabetes, cancers and trauma are the common diseases/conditions. Inaccessible and inadequate maternal health care services are responsible for increased maternal morbidity and mortality. These health conditions are responsible for over 75% of the out-patient and in-patient care delivered through the government's health care system.

The leading causes of in-patient deaths in children are malaria, pneumonia, malnutrition, anaemia, neonatal sepsis, premature birth, gastroenteritis, septicaemia and meningitis. In adults, the leading causes of in-patient deaths are maternal deaths, pneumonia, cerebrovascular accidents, trauma (especially following road traffic injuries), malaria, hypertension, anaemia, diabetes, heart failure and cancer.

Natural disasters, such as floods and droughts, do occur in the Gambia. In addition, there have been epidemics of diseases such as yellow fever, meningitis and cholera. Cancer, and especially liver cancer, is secondary to hepatitis B infection whose prevalence in the Gambia is estimated at 90%, with a chronic carrier rate of 15%.

2.4 HEALTH CARE DELIVERY SYSTEM

The government is the major provider of health services in the Gambia. The public health care system has three tiers, based on the primary health care strategy. Presently, services are provided by four hospitals at the tertiary level, 38 health centers at the secondary level and 492 health posts at the primary level. The system is complemented by 34 private and NGO clinics. For most communities, the first point of contact with health care services is the informal sector through traditional healers.

The public-sector health system has 167 medical doctors, 13 pharmacists, 819 nurses (of which 373 are state registered nurses), 227 enrolled nurses and 115 community health nurses. Out of the total number of nurses 409 have also been trained in midwifery (2005 HRH Situation Analysis). Private and NGO health facilities employ 67 medical doctors (general physicians and specialists), 5 pharmacists and about 228 nurses..

In the Gambia the majority of health facilities and personnel are located in urban areas, resulting in inequitable access to care. There are also disparities among regions, with the Western Region having most of the resources.

2.5 HEALTH POLICY

The Primary Health Care (PHC) approach has been the guiding strategy for healthcare delivery since the late 1970s. The new Health Policy and Master Plan (2007–2020), "Health is Wealth," seeks to promote, maintain and protect the health of the population, thus strengthening the linkage between health and economic productivity. The means to achieving this is to improve the delivery of health services, with a specific focus on the attainment of the health-related objectives of Vision 2020 and those of the MDGs.

The key guiding principles of the Health Policy are equity (including gender equity); ethics and quality; skilled staff retention and circulation; health systems reform; and

partnerships. The Policy defines areas of intervention, and aims at bringing about significant improvement in the following areas:

- **Legislations governing health practices:** Acts such as the Public Health Act (1990), the Lunatic Act (1914), Medical and Dental Professions Act as well as the Nursing Profession Act are outdated and not responsive to new developments;
- **Public health programmes and clinical care delivery**, through the basic health care package, environmental health and safety, health education and promotion, expanded programme on immunization, disease control, reproductive and child health, nutrition, basic clinical (secondary) and tertiary care;
- **Health systems strengthening and capacity building**, through organization and management of health care services, human resources development, infrastructure and logistics, health information, health financing and partnerships;
- **Technical support services** for essential drugs, vaccines and other medical supplies, blood transfusion services, radiology services and referral systems; and
- **Community participation and traditional medicine**.

The completion of the Health Master Plan has led to the preparation of a two-year Operational Health Plan, which will result in the introduction of the Sector-Wide Approach (SWAp) mechanism for better coordination of partner support.

2.6 HEALTH FINANCING

The Gambia finalized its first National Health Accounts (NHA) in 2007. The results revealed that the per capita total health expenditure was D895 in 2002, D1026 in 2003 and D1203 in 2004. This ranges between $ 33 and $ 40, which is within the range of the WHO Commission for Macroeconomics and Health (CMH) recommendation of US$ 34 per capita expenditure for health needed for an essential package of health services. The challenge for the Gambia lies in the development of an appropriate and effective health financing policy.

2.7 HEALTH SERVICE MANAGEMENT

The health sector's management is organized into three tiers, with a central level of three directorates. At the secondary level, there are six regional health management teams. The third tier consists of officers in charge of major and minor health centres and village health workers. The fundamental challenge here is the effective decentralization of management responsibilities, especially the administrative functions to the Regional Health Teams (RHTs) and integration of traditional medicine into the mainstream health care delivery system.

2.8 HEALTH CHALLENGES AND EMERGING ISSUES

Based on consultations as well as reports of the Department of State for Health during the CCS formulation process, the following key issues were identified:

2.8.1 High Maternal and Child Mortality Ratios

The maternal mortality ratio (MMR) in the Gambia declined from 1 050 deaths per 100 000 live births in 1990 to 730 per 100 000 live births in 2001 but this is still unacceptably

high. Delivery at a health care facility is estimated at 52% of all births (2001 MMR survey). The main causes of maternal mortality are haemorrhage, eclampsia, anaemia, malaria in pregnancy and postpartum sepsis. Poor maternal nutrition contributes to complications during pregnancy and delivery, and shortage of skilled birth attendants further exacerbates the problem. The continuing low contraceptive usage (17.5% in 2001), has contributed to the high fertility rate of 5.9 (2003) and subsequent high maternal mortality ratios. There is also a high level of teenage pregnancy, which has become a major issue in the Gambia. Obstetric fistula in women is an important morbidity issue in the country (prevalence rate of 0.5/1000 for women in the reproductive age group 15–49). Inadequate equipment and supplies in most major health centres also contribute to poor obstetric care.

2.8.2 High Neonatal, Infant and Child Morbidity and Mortality

According to the Maternal Mortality and Contraceptive Prevalence study (2001), perinatal and neonatal mortality rates are 31.2 and 54.9 per 1000 live births respectively. Infant mortality rate (IMR) has increased slightly from 84 in 1993 to 93 in 2005 per 1000 live births, while the under-five mortality rate declined slightly from 135 to 131 per 1000 live births during the same period (MICS, 2005-2006). The coverage of integrated management of neonatal and childhood illnesses (IMNCI) in the country is still low, at about 48%, and there is need to integrate with other interventions such as Roll Back Malaria (RBM), and to scale it up.

The Gambia has one of the most successful Expanded Programme on Immunization (EPI) in Africa. However, the challenges of maintaining the high coverage rate and the introduction of new vaccines still remain. Expansion of selected PHC programmes (e.g. EPI) through an outreach system to remote rural communities has been introduced as one of the strategies for combating these childhood diseases, but transportation remains a challenge.

2.8.3 High Disease Burden

The Gambia is now faced with emerging and re-emerging diseases such as HIV/AIDS, cholera, and other communicable diseases such as malaria, tuberculosis and meningitis. Due to its geographical location, the country is also facing threat from diseases such as yellow fever, avian influenza, and polio. Noncommunicable diseases (NCDs) especially cardiovascular diseases, hypertension, diabetes, mental and neurological disorders, and cancers are becoming diseases of public health importance, which presents additional challenges to the already overburdened health care delivery system.

Most of the elements in the first CCS's Strategic Agenda dealing communicable diseases prevention, control and eradication were implemented, and only some of the programmes need consolidation, such as polio eradication and the elimination of neonatal tetanus, measles, lymphatic filariasis and leprosy. The integrated disease surveillance and response (IDSR) system has been implemented as per the 1st CCS (2002–2005), but needs review to include International Health Regulations (IHR) (2005).

2.8.3.1 Malaria

Malaria is the leading cause of morbidity and mortality in the Gambia. It is estimated that about 20% of all outpatient consultations are due to malaria, which accounts for 6.3 per 1000 deaths in infants and 10.7 per 1000 deaths in children aged under 5 years[2]. The burden is more severe among pregnant women and children, especially in rural areas. The Gambia's

[2] Malaria Situation Analysis (2002)

climate and environment favour the year-round transmission of malaria and as a result, the disease is endemic in the country. Malaria is high on the agenda of the government. The Malaria Drug Policy has been reviewed as a result of high resistance to chloroquine, and a new policy for malaria treatment with artemisinin-based combination therapy (ACT) was adopted and implemented from October 2007.

In order to improve malaria control and prevention, there is need to:

(a) Increase the use of insecticide-treated nets;
(b) Improve environmental management;
(c) Expand intermittent preventive treatment (IPT) countrywide;
(d) Monitor drug resistance;
(e) Improve partnerships with communities and other stakeholders;
(f) Intensify resource mobilization for malaria control programmes;
(g) Introduce new interventions such as indoor residual spraying (IRS);
(h) Conduct research into new intervention methods.

2.8.3.2 HIV and AIDS

The Gambia is one of the West African countries with a low prevalence of HIV. National estimates put the prevalence at 2.8 percent for HIV-1 and 0.6 percent for HIV-2 (HSS, 2006), with a cumulative estimated mortality of 2000. As of June 2007, there were about 500 people on antiretroviral therapy (ART) in the Gambia, way below the estimated 1800 people who may need it. The overall goal of the HIV/AIDS strategy is to stabilize and reduce the prevalence of HIV/AIDS in the Gambia. The main approaches to the reduction of HIV/AIDS prevalence include:

- Disseminating comprehensive and correct knowledge of HIV transmission and prevention and the application of such knowledge in lifestyles (behavior change);
- Reducing stigma and discrimination;
- Promoting condom use;
- Promoting and scaling up voluntary counseling and testing (VCT), prevention of mother-to-child transmission (PMTCT) and anti-retroviral therapy (ART);
- Care and support for people living with HIV/AIDS (PLWHA) and orphans;
- Increasing the number of health workers trained in VCT, PMTCT and ART;
- Monitoring the trend of HIV prevalence;
- Ensuring the availability of drugs and relevant equipment, and equipment maintenance;
- Improving the management of the programme, including the review of the National HIV/AIDS Strategic Plan.

2.8.3.3 Tuberculosis

Tuberculosis is a major public health problem in the Gambia. The number of all TB cases reported has been increasing steadily from 900 in 1994 to 1,963 in 2004. The case notification rate for 2004 was 140/100,000 for all forms of TB. The proportion of patients with smear-positive sputum has increased from 65% in 2005 to 70% in 2007. The case detection rate is 77%, which is above the WHO target of 75% and the cure rate is 82%,

surpassing the WHO target of 80%.[3] However, there are many challenges for the national TB programme, which include the following:

- Strengthening the TB programme management, including capacity building for data management and supervision at all levels;
- Reducing the defaulter rate;
- Improving the management of drugs supply;
- Improving record management for directly observed treatment short course (DOTS) at the primary health care level;
- Strengthening the referral system for TB patients at all levels;
- Reducing stigma and discrimination against TB patients;
- Increasing collaboration between TB and HIV/AIDS programmes. This includes testing of all TB patients for HIV/AIDS and vice versa;
- Monitoring multi-drug resistance TB;
- Strengthening the integration of TB surveillance into the IDSR.

2.8.3.4 Noncommunicable Diseases (NCDs)

The most common NCDs in the Gambia are hypertension (prevalence rate of 9.5% of adult population), diabetes (1.4% and 8.6% for rural and urban population respectively)[4] and cancers (9.4/100 000 for cervical cancer and, respectively, 19.2/100,000 for liver cancer in men and 5.9/100 000 in women)[5]. Road traffic injuries have now become an important public health problem, with a yearly average of about 1000 road traffic crashes.[6] Mental health disorders are also common, with a prevalence of about 20%. The challenges for NCDs include:

- Conducting a situation analysis of risk factors;
- Developing and implementing a policy and strategic plan for NCDs;
- Implementing the national mental health policy and strategic plan;
- Integrating mental health care services into primary health care;
- Reviewing the 1914 Lunatic Act;
- Management of mental illnesses in communities.

2.8.4 Nutrition

The 2005-2006 Multi-Indicator Cluster Survey found that 22% and 20% of all under-five-year-olds were stunted or underweight, respectively. In 2000, 64% of children under five showed a marginal deficiency and 9% showed serious vitamin A deficiency. In 2005, 80% of children under five received high-dose vitamin A supplementation while 78% of mothers received vitamin A supplementation within eight weeks of delivery. Iodine deficiency is still a problem in the regions further inland, as only 7.5% of households use iodized salt.

2.8.5 Health system challenges

[3] TB Quarterly report (June 2007).
[4] Situation Analysis of NCDs in the Gambia (2001).
[5] Gambia Hepatitis Intervention Study (2005).
[6] Gambia Police Force Annual Report (2004).

2.8.5.1 Human Resources for Health

One of the major obstacles facing the health sector is the shortage of health personnel at all levels of the health care delivery system. The doctor population ratio of 1: 6132, the nurse population ratio of 1:1554 and the trained midwife population ratio of 1:3325 are below the 1:1000 standard ratios for developing countries[7]. The high attrition rate and slow production of new human resources for health (HRH) are responsible for the shortage of health personnel. As a consequence, there is a high reliance on foreign health professionals. As at June 2003, out of the 99 medical doctors (clinicians) in the public health sector, almost 80% were expatriates, mainly from Cuba, Nigeria and Egypt. In 2003, the attrition rate among health professionals in general was estimated at between 30–50%. The rates are higher for some cadres, including State Registered Nurses, medical doctors, public health officers (PHOs) and laboratory technicians. Poor conditions of service and work environment are among the factors leading to such high attrition.

The strategic agenda with regard to HRH of the first CCS was implemented, including the formulation of the HRH Policy and Strategic Plan in 2004. The HRH policy needs to be implemented if considerable success in health care delivery and all other main objectives of the sector are to be met. Although the overall implementation rate has been poor, significant achievements include the introduction of an accelerated training programme of nurses and PHOs that helped improve the availability of HRH in critical areas; introduction of a hardship allowance for remote areas and the creation of a Human Resources Development unit.

2.8.5.2 Referral Systems

The referral systems are not fully functional, due to inadequate staffing and lack of appropriate equipment and transport. Challenges include ensuring the availability of the basic clinical care package at the first referral point (major health centres), availability of adequate number of ambulances and their maintenance, early referrals, safe evacuation methods and ensuring the availability of effective communication systems.

2.8.5.3 Health Management Information Systems

The health information system in the Gambia is weak and fragmented. The IDSR system functions with the assistance of the WHO. Health information is often scattered, inconsistent and uncoordinated and is not readily available for timely and effective decision-making. The implementation of the International Health Regulations (IHR) (2005) requires the health information system to detect disease outbreaks early and to report any such to WHO in a timely manner. Work needs to be done to improve the availability of health status data and indicators, disaggregated at the district level, and this will require greater collaboration between the DSHSW, the Gambia Bureau of Statistics (GBOS) and partners.

2.8.5.4 Laboratory Services and Quality Assurance

There is a need to develop a laboratory policy for the Gambia. A number of health facilities in the country lack laboratory services. More than 50% of the public health facilities do not have functioning laboratories. In addition, there is a general lack of laboratory technicians. A quality assurance programme is necessary to ensure that health care standards are maintained.

[7] HRH Situation Analysis report (2005).

2.8.5.5 Essential Medicine Management System

A situation analysis of the pharmaceutical services revealed that there has been irrational use of medicines, their inadequate supply, an inadequate regulatory system, limited quality control and shortage of human resources. Within the framework of the 2007 National Medicines Policy, four areas have been identified as needing attention. These are essential medicine supply, medicines legislation and regulation, medicines quality control services and planning and management, including human resource development.

2.8.5.6 Traditional Medicine

At the community level, the first point of contact for seeking health care is usually the traditional healer. There would be benefit if traditional healers were adequately sensitized and utilized. There is also a need for research into the efficacy and safety of traditional medicines and treatments and the registering/patenting of intellectual property rights of traditional medical practices and medicines.

2.8.6 Health and Environment

One of the main environmental issues facing the Gambia is waste management, especially in urban areas. This is exacerbated by indiscriminate disposal of wastes from households and small industries, poor collection and inappropriate disposal practices. A 2006 study supported by the Global Alliance for Vaccines and Immunization (GAVI) revealed poor management of health care waste in the Gambia.

The 2005/2006 Multiple Indicator Cluster Survey (MICS) estimated that 85% of the population has access to safe drinking water, with 91% of urban and 81% of rural households having access to safe water. While 84% of the population has access to sanitary means of excreta disposal, regional variations do occur. In areas where the water table is high, traditional wells may become a source of water-borne infections.

2.8.7 Health Promotion and Tobacco

The capacity for health education and promotion is generally weak at all levels, and currently there is no health promotion policy. This, together with the low literacy among the population (43%) has seriously constrained the development, implementation, coordination and evaluation of health education promotion interventions. The ratified WHO Framework Convention on Tobacco Control (FCTC) will serve as a major instrument and guidance for tobacco control in the Gambia in the coming years.

2.9 UNFINISHED AGENDA FROM THE 1ST CCS – CHALLENGES AND GAPS

From the review of the first CCS, it was found that substantial strategic inventions in the 6 programme areas were implemented. However, the implementation of the 2002–2005 CCS has also revealed the following gaps:

- Under **Health, Environment and Sustainable Development**, poverty alleviation projects have not taken off;
- Under **Health Promotion and Noncommunicable Diseases**, the development of a Disability Policy, a Health Promotion Policy, and the establishment of a WHO Country Office website were not achieved;

- With regard to **Essential Drugs, Traditional Medicine and Clinical Technology**, the strengthening of the national blood transfusion services was not achieved. A traditional medicine policy was drafted but a strategic plan was not formulated;
- There was inadequate advocacy on the risks related to teenage pregnancy and FGM.

Some of these gaps will be carried over to the 2nd-Generation CCS and others may not be pursued because of altered circumstances. For instance, because of UN reforms and division of labour within the UN, the lead agency for poverty alleviation at the country level is now UNDP. The key lesson here is that despite the progress made in improving the people's health status and development of the health infrastructure, which now allows 85% of the population access to health services, there still exist numerous challenges and gaps in health service delivery. The persistence of high infant and child morbidity and mortality, mainly due to acute respiratory infections, malnutrition and malaria; adult morbidity and mortality caused by an unacceptably high maternal mortality ratio and the increasing prevalence of non-communicable diseases such as diabetes, hypertension and cancers indicate that the Gambia faces daunting challenges in disease control. The gaps in the health system that demand the most attention are to do with service delivery at the district level, through the strengthening of primary health care; improving the referral system; sustaining adequate HRH and reinforcing the regulatory framework with appropriate reforms in public health.

SECTION 3

DEVELOPMENT ASSISTANCE AND PARTNERSHIPS

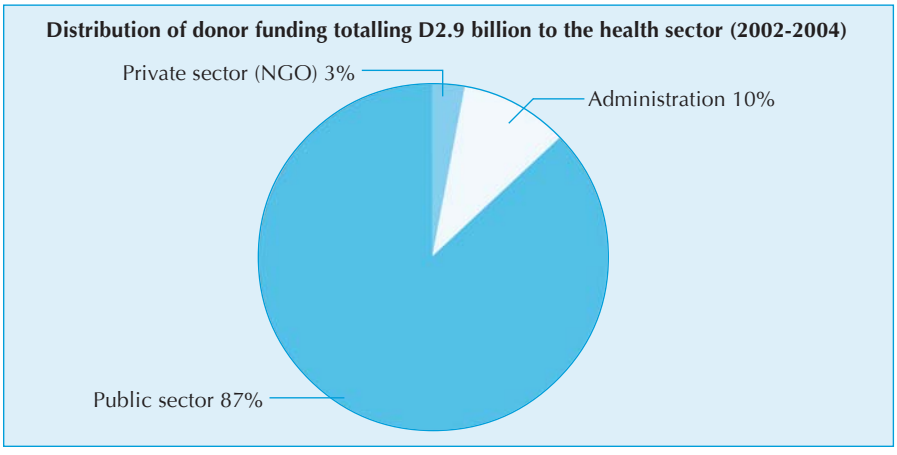
The Gambia is highly dependent on external aid to finance development projects in all sectors, more so in priority ones. Over the years, the level of external debt has risen significantly, to $665 million in 2006, thereby creating a heavy debt servicing burden on the national budget (over 40% of the national budget is spent on debt servicing). In 2000, a Debt Sustainability Analysis carried out by Debt Relief International and the national authorities revealed that the Gambia was eligible for debt relief under the Highly Indebted Poor Countries (HIPC) initiative.

However, accessing debt relief proved quite difficult due to the country's inability to meet all the conditions set by the Bretton Woods institutions for reaching HIPC completion point. One of the main conditions was to successfully conclude a review of the Poverty Reduction Growth Facility (PRGF) programme for achieving macroeconomic stability negotiated with the IMF in 2000. Following many start-stop processes between 2000 and 2005, in 2007 the Gambian authorities completed a successful review of a PRGF programme negotiated in 2006, and the country reached the completion point for the Enhanced HIPC initiative[8]. Debt relief will enable the country to access significant levels of new funding for development projects in the 3 priority sectors, which include Health.

3.1 AID FLOW

The results of the first National Health Accounts (NHA) for the fiscal years 2002–2004 revealed that 67% of the financing for the health sector comes from donors, with rest split between the government (21%) and households' out-of-pocket expenditure (12%).

Figure 1: **Aid flow in the health sector, 2002–2004 (Source: NHA exercise)**



[8] IMF First Review of the PRGF (2007) and IMF Press Release 07/302.

During the 3 years from 2002–2004, of the total health expenditure of D4.3 billion [in US$?] nearly D2.9 billion (67%) came from donor funds. About D2.5 billion (87%) of this funding consisted of multilateral, bilateral and UN Agency grants to the health sector, and went to the public sector. As Figure 1 above shows, 3% (D85 million) of donor aid to the health sector represented private provision of health care (mainly by NGOs). The remaining 10% of the aid to health went towards administration and support to health care provision (including the WHO country office operations).

3.2 PARTNERS IN HEALTH DEVELOPMENT

As the government has always identified health as a priority sector (along with education and agriculture), a number of development loans have been acquired to improve the health sector. The World Bank-funded Participatory Health, Population and Nutrition Project (PHPNP) was a US$18 million project that lasted for 8 years and focused on improving health care provision through health system strengthening. In 2001, the negotiation of a $15 million HIV/AIDS Rapid Response Project (HARRP) with the World Bank led to the establishment of a National AIDS Council and National AIDS Secretariat (NAS), and the development of a National Strategic Plan on HIV/AIDS, for the prevention, treatment of HIV/AIDS and care and support for PLWHA.

Although WHO is the leading partner in health, a number of development partners have also been supporting the Gambia's effort in overall health development, including UNFPA (sexual and reproductive health), UNAIDS (HIV/AIDS), UNDP (poverty reduction), UNICEF (child survival, HIV/AIDS, water and sanitation), EU (water), and the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria. Local partners such as Gambia Family Planning Association (reproductive health), Action Aid–The Gambia (malaria and HIV/AIDS), Red Cross (humanitarian action in emergencies and social mobilization for health), the Medical Research Council (health research), Christian Children's Fund (nutrition, avian influenza and malaria), Sight Savers International, Methodist Mission and WEC Mission (basic health services) have also been supporting the health sector through various programmes.

The African Development Bank (ADB) has been instrumental in funding infrastructure development for the health sector in the Gambia. A component of the Participatory Health, Population and Nutrition (PHPN) project on the upgrading and refurbishment of thirteen minor and major health centres was supported ADB. In this regard, ADB launched the $10 million Health Services Development Project in 2003 (UA 7 million). The project supported the construction of a warehouse complex for the Central Medical Stores and the National Health Laboratory, as well as the expansion and rehabilitation of 6 health centres across the country. During 2004 and 2005, the project provided bio-medical equipment, hospital furniture and ambulances to each of the rehabilitated health centres. The ADB has also provided support for a deworming project, which was implemented in association with the Department of State for Education.

The Islamic Development Bank (IDB) financed the construction of amajor Health Centre in Soma that was completed in 2003, and the construction of the Serrekunda Hospital, completed in 2006 at a cost of D42 million (US$).

In addition, the significant development of the road network that is still ongoing will improve the transport communication network between various health facilities especially

in rural areas. This was funded by a number of multilateral donors that include the ADB, IDB, Kuwaiti Fund and the EU.

In the area of bilateral cooperation, Cuba has been assisting the health sector in the Gambia with the provision of technical assistance in the form of medical personnel (doctors and nurses as well as lecturers for the medical school at the University of the Gambia). Although the Gambia government is responsible for the basic recurrent expenses of the health personnel, the services provided have been very useful. The number of Cuban doctors has increased from 150 in 1995 to 244 in 2005 and this has, along with Nigerian and Egyptian technical assistance, significantly strengthened service delivery at primary, secondary and tertiary levels of care.

The Taiwanese Fund from the Republic of China on Taiwan has also facilitated capacity-building and institutional strengthening at all levels of health care. Between 2002 and 2004, the total contribution to the health sector from the Fund was D62.3 million, equivalent to $2.4 million. Among the other bilateral partners of the Gambia who contributed to the development of the health sector in the last five years were the Italian Government with a $1.4 million grant for strengthening primary health care in the North Bank region, as well as Germany, USA and UK.

3.3 PARTNER COORDINATION

Existing donor coordination mechanisms in the health sector include those for programmes such as the Inter-Agency Coordination Committee (ICC) for EPI, the Country Coordinating Mechanism (CCM) for the Global Fund programmes, the Health Sector Partner Coordination Meeting (HSPCM), which started in 2007, and the National Codex Committee for Food Safety and Standard. The HSPCM will be institutionalized to become the major coordination body in the health sector.

With the development of a new health policy—"Health is Wealth"—and Master Plan (2007–2020), the stage is set for better partner coordination in the health sector. It is envisaged that all partners will buy in to the policy and master plan, to implement parts of or all of the plan (through sector-wide approaches, SWAps). In this regard, diverse stakeholders in health may contribute towards the implementation of programmes in whole or in part, while others may contribute towards a common basket of funding for the health sector or give direct budgetary support. In 2008, the DSHSW will develop a financing policy that will guide funding of the sector so as to direct donor intervention to the priority areas in health care service delivery. This is line with the Paris Declaration on Aid Effectiveness, which provides for country ownership of donor support, alignment of this donor support to country priorities and harmonization of donor support to avoid duplication.

The UN Country Team (UNCT) is the overall coordinating body for UN support to the country. In addition, there are coordination mechanisms known as theme groups, whose membership include almost all UN agencies. The WHO is a member of the Social Services, HIV/AIDS, Health and Environment, and Poverty and Food Theme Groups. Some are in the process of developing joint support programmes directed at relevant sectors. With the establishment of the Harmonization for Health in Africa (HHA) by the Regional Director's team in Africa chaired by WHO, an opportunity has been created to coordinate technical support for health programmes in-country through the UN Theme Groups. WHO will facilitate the access to this service at the country level.

Furthermore, the Government of the Gambia initiated commendable reforms during 2006 to improve planning, donor coordination and policy implementation at the national level. With the assistance of UNDP, a national planning commission was established to improve coordinated planning and financing, and monitoring and evaluation of government projects and programmes. In the same vein a new Aid Coordination and Central Projects Management Directorate has been created at the Department of State for Finance and Economic Affairs. The new directorate is charged with the responsibility of tracking the flow of funds in government.

SECTION 4

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been — and is still — undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States address key health and development challenges, and the achievement of the health-related MDGs. The organizational change process has, as its broad frame, the WHO Corporate Strategy[9].

4.1 GOAL AND MISSION

The mission of WHO remains "the attainment by all peoples, of the highest possible level of health" (Article 1 of WHO Constitution). The corporate strategy, the 11th General Programme of Work, 2006-2015[10] and the Strategic Orientations for WHO Action in the African Region, 2005–2009[11] outline key features through which WHO intends to make the greatest possible contribution to health. The organization aims at strengthening its technical and policy leadership in health matters, as well as its management capacity to address the needs of Member States, including the achievement of the MDGs.

4.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions, which are based on its comparative advantage[12], these are:

1. Providing leadership in matters critical to health and engaging in partnership where joint action is needed;
2. Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
3. Setting norms and standards, and promoting and monitoring their implementation;
4. Articulating ethical and evidence-based policy options;
5. Providing technical support, catalysing change, and building sustainable institutional capacity;
6. Monitoring the health situation and assessing health trends.

[9] WHO EB 105/3 A corporate strategy for the WHO Secretariat.
[10] 11th General Programme of Work 2006-2015. A Global Health Agenda.
[11] Strategic Orientations for WHO Action in the African Region 2005-2009.
[12] 11th General Programme of Work 2006-2015. A Global Health Agenda.

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas.

These include:

1. Investing in health to reduce poverty;
2. Building individual and global health security;
3. Promoting universal coverage, gender equality, and health-related human rights;
4. Tackling the determinants of health;
5. Strengthening health systems and equitable access;
6. Harnessing knowledge, science and technology; and
7. Strengthening governance, leadership and accountability.

In addition, the Director General of WHO has proposed a six-point agenda as follows:

(i) Health Development;
(ii) Health Security;
(iii) Health Systems;
(iv) Evidence for Strategies;
(v) Partnership; and
(vi) Improving the Performance of WHO. She has, in addition, indicated that the success of the Organisation should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

WHO's Global Priority Areas are outlined in the 11th General Programme of Work[13].

They include:

1. Providing support to countries in moving towards universal coverage with effective public health interventions;
2. Strengthening global health security;
3. Generating and sustaining action across sectors to modify the behavioural, social, economic and environmental determinants of health;
4. Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and
5. Strengthening WHO's leadership at the global and regional levels, and supporting the work of governance at the country level.

[13] 11th General Programme of work 2006–2015. A Global Health Agenda

4.5 REGIONAL PRIORITY AREAS

Regional priorities take into account the global documents and the resolutions of the WHO governing bodies, the health-related MDGs, the NEPAD health strategy, resolutions on health adopted by Heads of State of the African Union and the organizational strategic objectives which are outlined in the Medium Term Strategic Plan (MTSP) 2008–2013[14]. These regional priorities have been expressed in the "Strategic Orientations of WHO Action in the African Region, 2005–2009". They include prevention and control of communicable and noncommunicable diseases, child survival and maternal health, emergency and humanitarian action, health promotion and policy making for health in development and other determinants of health. Other priorities cover health and environment, food safety and nutrition, health systems (policy, service delivery, financing, technologies and laboratories), governance and partnerships, and management and infrastructure.

The WHO Regional Office for Africa is committed to supporting countries attain the health-related MDG goals and tackle their human resource challenges. In collaboration with other Agencies, the challenge of how to assist countries source relevant financing will be addressed under the leadership of the countries themselves. To meet these added challenges, one of the important priorities of the Regional Office is that of decentralisation and the installation of Intercountry Support Teams to further support countries in their own decentralisation process, so that communities may benefit maximally from the technical support availed to them.

To effectively address the priorities, the Regional Office is guided by the following strategic orientations[15]:

1. Strengthening the WHO Country Offices;
2. Improving and expanding partnerships for health;
3. Supporting the planning and management of district health systems;
4. Promoting the scaling up of essential health interventions related to priority health problems; and
5. Enhancing awareness and responses to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT THE COUNTRY LEVEL

The outcome of the expression of WHO's cooperate strategy at the country level will vary among countries, depending on country-specific contexts and health challenges. But building on WHO's mandate and its comparative advantage, the six critical core functions of the Organisation outlined in section 4.2 may be adjusted to suit each individual country's needs.

[14] Medium Term Strategic Plan 2008-2013, Strategic Direction 2008-2013, P.4, Paragraph 28.
[15] Strategic Orientations for WHO Action in the African Region 2005-2009, P. 7.

SECTION 5

CURRENT WHO COOPERATION

Over the years, WHO has developed close and long-lasting technical cooperation with countries in the area of health. The Gambia was one of the first countries in the WHO African Region to develop and implement the primary health care strategy (1979). In this regard, WHO has been supporting the country to address issues and challenges within the primary health care context.

5.1 COUNTRY OFFICE OPERATIONS

The WHO Country Office in the Gambia has evolved into an essential partner in health, sharing its financial and technical resources with government, other stakeholders and partners, with the support from the WHO Regional Office for Africa and WHO Headquarters.

The Country Office's biennial budget for 2006–2007 was US$ 4.3 million. This was composed of Regular Budget and contributions from "Other Sources". These funds were used to support national programmes and projects through the DSHSW, in accordance with the agreed plan of action. The WHO country team of 8 professional staff works in harmony to provide appropriate technical support for achieving national health objectives. The office currently has 23 technical and support staff.

5.2 WHO TECHNICAL COOPERATION PROGRAMMES

WHO's operations are based on the Programme Budget and the Biennial Plan of Work. During the current and previous biennia, the cooperation programme included WHO technical, financial and material support as described below.

5.2.1 Organization of Health Services

Organization of Health Services includes programmes such as Health Systems Strengthening for Improved Service Delivery, Human Resources for Health, Health Financing, Health System Research, and Health Management Information Systems (HMIS). During the 2004–2005 and 2006–2007 biennia, the bulk of WHO human and financial resources were allocated to these programme areas, representing about 73% of the regular budget. The funds were utilized for human resources development, including the award of fellowships, the preparation of the 1st National Health Accounts (NHA), and as well as support to the implementation of critical operational processes necessary to strengthen planning and decision-making in the health sector. The National Health Policy (2002) and Strategic Plan were also revised with WHO assistance during this period. All the objectives in this component from the 1st CCS were achieved, but there is a need to build on these achievements in order to address new challenges.

5.2.2 Disease Prevention, Control and Eradication

This programme area includes a wide range of activities aimed at supporting disease prevention and control measures, including disease elimination and/or eradication initiatives. Diseases targeted for elimination are leprosy, measles and neonatal tetanus. WHO supports the eradication of poliomyelitis, and the country attained a polio-free status in 2004.

WHO support also includes surveillance activities for early detection and response to diseases of epidemic potential such as cerebrospinal meningitis, yellow fever, tuberculosis and HIV/AIDS. Other programmes covered under disease control are EPI, National Malaria Control Programme (NMCP) and IMNCI. Noncommunicable diseases such as diabetes mellitus and hypertension, which are increasing in the country, are also covered.

Due to the high priority attached to this programme area, the Country Office allocated 19% and 62% of its Regular and "Other Sources" budget, respectively, as well as provided the services of two professional staff members. Specific activities carried out during the period under review included support for training in integrated disease surveillance; management of cholera outbreaks, National Immunization Days (NIDs); review of the Expanded Programme on Immunization (EPI) and the development of the multi-year EPI plan (2007–2011); the mass bed-net treatment campaigns and mass de-worming exercises in schools. Most of the objectives envisaged under the 1st CCS were achieved for this component. There is a need, however, to consolidate the gains made in the following programmes: EPI, eradication of polio, elimination of neonatal tetanus, measles and leprosy, as well as integrating the International Health Regulations (IHR, 2005) into Integrated Disease Surveillance and Response (IDSR).

5.2.3 Reproductive Health and Child and Adolescent Health

This area incorporates Child and Adolescent Health, and Women's Health. The Country Office allocated 7% of its regular budget and 20% of funds from other sources (e.g. UNFPA), and provided the services of a Family Health Adviser. WHO-supported activities included the Making Pregnancy Safer initiative, formulation and implementation of the Gambia Specific Road Map to Accelerate the Reduction of Child and Maternal Illnesses and Deaths; Strategic Plan for Adolescent Health, and the training of Cuban collaborators in IMNCI. Advocacy and mobilization of resources for skilled attendants during pregnancy, childbirth and post-delivery is being conducted in collaboration with other stakeholders. However, advocacy on the risks related to teenage pregnancy and FGM was not adequately addressed as planned in the first CCS.

5.2.4 Health Promotion; Health and Sustainable Development

This programme area incorporates Health Promotion, Mental Health and Substance Abuse, Sustainable Development (including poverty alleviation), Nutrition and Food Safety. During the period, the main thrust in this area was to support the programme on health promotion and community participation in health programmes. A substantial proportion of the WHO regular budget (10%) was allocated to this programme area for activities to be coordinated by a Health Information and Promotion Officer. Support was provided for the development and dissemination of IEC materials on various health issues, training of health and non-health workers (members of the association of health journalists and media proprietors) in health education, and the establishment and promotion of tobacco-free schools. Financial and technical support was also provided for the development of a National Mental Health Policy and Strategic Plan as well as public sensitization on the ratification of the WHO Framework Convention on Tobacco Control. Most of the above targets were achieved as per the first CCS, except for the development of a disability policy, a health promotion policy, and the establishment of a WHO Country Office website.

5.2.5 Health and the Environment

This programme area is concerned with the provision of support to government efforts in the implementation of environmental health policies as well as improving emergency preparedness and response. The funding of this package was up to 6% of the WHO country budget during the period under review. A National Environmental Health Officer provides technical support to this programme, focusing on:

(i) training on waste management;

(ii) supporting environmental health and sanitation measures (including the construction of one incinerator in each of the 6 health regions, under "Operation Clean The Nation"),

(iii) as well as the development of a draft Occupational Health And Safety Policy.

(iv) Support was provided for the revision of the Public Health Act, the development of an environmental health legislation and policy (draft), strengthening of the National Codex Committee and the implementation of the Food Act. However, poverty alleviation activities, including micro-financing, have not taken off as envisaged in the first CCS.

5.2.6 Essential Medicines, Traditional Medicine and Blood Safety

This programme area incorporates Essential Medicines, Traditional Medicine, and Blood Safety and Clinical Technology. The activities within this area are monitored jointly by two national programme officers. During 2006–2007, support was provided to revise the National Medicine Policy and to implement some components of the new policy. The National Blood Transfusion Policy was revised and a Strategic Plan developed. However, the envisaged strengthening of the national blood transfusion services, with focus on quality assurance, was not achieved. A Traditional Medicine Policy was drafted but a strategic plan was not formulated.

Table 1 shows the allocation of WHO resources among the various principal programme areas during the 2004–2005 and 2006–2007 biennia.

Table 1: WHO country budget and staff distribution analysis

Program Area	Professional Staff	Biennial Budget 2004– 2005		Biennial Budget2006– 2007	
		Regular Budget (RB)	Other Sources (OS)	RB	OS
Organization of Health Services	4	78.06%	11.30%	68.48%	12.90%
Disease Prevention, Control and Eradication	2	6.94%	69.11%	18.98%	61.96%
Reproductive and Adolescent Health	1	3.74%	10.49%	3.44%	9.76%
Health Promotion; Health and Sustainable	1	4.75%	3.19%	5.51%	2.58%
Health and Environment Development	1	3.31%	1.56%	3.05%	1.00%
Essential Drugs, Traditional Medicine and Blood Safety	–	3.20%	4.35%	0.54%	11.81%
Total	**8**	**US $1 873 000**	**US $2 505 400**	**US $2 034 000**	**US $2 293000**

5.3 WHO REGIONAL OFFICE AND HEADQUARTERS SUPPORT

Support from the WHO Regional Office for Africa and Headquarters to the Gambia has been in the areas of policy and technical advice, research and development, information-sharing, national capacity-building and programme evaluation. Financial and technical support has also been provided towards the eradication (and elimination) of vaccine-preventable diseases, particularly poliomyelitis; the development of a road map for the reduction of maternal and newborn mortality; the assessment of EPI equipment; the management of clinical health care waste, including injection safety assessment; as well as the development of a proposal for the GFATM.

Financial support was also provided by the WHO Regional Office for Africa for HIV/AIDS, mental health, road safety and the ratification of the WHO Framework Convention on Tobacco Control.

Headquarters and the Regional Office undertook a number of technical support missions to the country, which included, among others, development of policies and strategic plans, introduction of new health initiatives, and review of progress of ongoing disease control.

SECTION 6

STRATEGIC AGENDA: PRIORITIES AGREED FOR WHO COUNTRY COOPERATION

In accordance with its Constitution, WHO will support the people of the Gambia to attain the highest possible level of health. In pursuing this goal, the efforts and resources of the WHO Country Office will be directed towards addressing issues where WHO has a comparative advantage and high technical capability and expertise, based on its three organizational levels.

WHO will collaborate with the DSHSW and partners in implementing these policies and evaluating their impact on the health status of the country's population, realizing that the government has either developed or is in the process of developing policies on major health issues.

The issues identified in the strategic agenda are priority issues for the government and the people of the Gambia. WHO will support the government by advising it on policy development and implementation frameworks, including monitoring and evaluation of programmes and adjusting health gains, as the country moves towards the realization of the goals of Vision 2020.

The current National Health Policy states that the government will utilise the primary health care approach as a cornerstone for health delivery; WHO will support this strategy.

WHO will continue to collaborate and cooperate with all other partners in health and act as an honest broker between the government and external partners, giving impartial and highly reliable, evidence-based technical advice, incorporating experience gained in the African Region and elsewhere. The Organization will play an advocacy role for health, as well as assist the government in mobilizing resources for the health sector. WHO will collaborate with other partners and stakeholders in the reduction of poverty within the framework of UNDAF.

6.1 FUNCTIONS OF WHO COUNTRY OFFICE

In accordance with the WHO strategic directions and guiding principles, the WHO Country Office will carry out the following functions:

- Support the implementation of priority health programmes;
- Catalyse the adoption of technical strategies and innovation;
- Support research and development and stimulate the improvement of the health sector's performance;
- Provide information and share knowledge among all levels of WHO;
- Provide specific high-level policy and technical advice.

Three principal strategic priorities have been selected for support by WHO over the next 6 years. Within these areas, four key issues have been identified as the main focus areas on which the Organization will direct its efforts and resources for maximum impact.

6.2 COMPONENTS OF THE STRATEGIC AGENDA: THE STRATEGIC PRIORITIES

6.2.1 Health Systems Strengthening

The major issues undermining health service delivery in the Gambia are weak management systems, a critical shortage of trained health personnel, poorly motivated staff and high staff attrition. Other challenges identified in the Health Policy and Master Plan include an inadequate health financing system, weak health management information system (HMIS), poor infrastructure (including poorly equipped laboratories), and a weak referral system. Other issues are inadequate capacity for drug quality control, weak blood transfusion services and the unregulated traditional medicinal practices. The intervention of WHO in the Gambia in this area is concerned with health systems strengthening for effective healthcare delivery.

Objective:

To improve the health care delivery system in the country.

Main focus:

(a) Support the training of healthcare workers in priority areas in order to improve healthcare delivery to reduce morbidity and mortality rates;

(b) Advocate for the implementation of the HRH Policy and Strategic Plan, including the retention of skilled health personnel;

(c) Strengthen the functional capacity of the public health system at all levels, including the provision of technical assistance and support to the provision of operational logistics;

(d) Promote evidence-based decision-making in the planning and management of health services delivery by supporting the strengthening of the Health Management Information System and Research;

(e) Support the development and implementation of a sustainable health financing mechanism utilising the SWAps and other appropriate mechanisms;

(f) Support the review of legislation governing health practices;

(g) Support the monitoring and evaluation of intervention programmes;

(h) Support the development and implementation of a National Laboratory Policy;

(i) Support the continuous functioning of the Drug Quality Control Laboratory;

(j) Support the updating of the National Essential Medicine List;

(k) Support the improvement of the National Drug Regulatory Authority's capacity in the registration and licensing of drugs and vaccines;

(l) Support the strengthening of the National Blood Transfusion Services with a focus on the quality assurance aspects of blood safety;

(m) Support the implementation of the National Traditional Medicine Policy and Strategic Plan;

(n) Promote research in traditional medicine, conservation of medicinal plants, development of local production of traditional medicines and the protection of intellectual property rights and knowledge.

6.2.2 Health Promotion, Disease Prevention, Control and Eradication

This component entails supporting disease prevention and control in the country, including measures for disease elimination and eradication initiatives. The integrated disease surveillance activities for early detection and response to epidemic-prone diseases will continue to receive the attention of WHO through programmes such as EPI, and Epidemic Alert and Response, including the implementation of International Health Regulations (IHR, 2005). Childhood diseases continue to pose serious health challenges; WHO shall continue to support the country address these conditions through strategies such as IMNCI and the EPI programme.

This component also incorporates advocacy, increasing community awareness and participation for the reduction of the growing threat of noncommunicable diseases (NCDs), which include mental and neurological disorders, cardiovascular diseases, hypertension, diabetes, cancers and injuries. Emphasis will be placed on broader intersectoral involvement in the reduction of risk factors for NCDs, and the prevention and control of other priority health problems through appropriate health-promotion initiatives.

Objective

To reduce morbidity and mortality due to communicable and noncommunicable diseases and conditions, and to strengthen health-promotion capacity at all levels.

Main focus:

(a) Support the continued implementation and monitoring of the Integrated Disease Surveillance and Response (IDSR) system, including strengthening of laboratory diagnostic services;

(b) Support the country's epidemic alert and response mechanism and its capacity for the implementation of the IHRs (2005);

(c) Support the development or review and implementation of national policies and strategic plans for malaria; HIV/AIDS and tuberculosis;

(d) Support the continued efforts for polio eradication and the elimination of maternal and neonatal tetanus, measles, leprosy and lymphatic filariasis;

(e) Support the maintenance of the high immunisation coverage achieved;

(f) Support the implementation of a Mental Health Policy and Strategic Plan;

(g) Support the conduct of a WHO Stepwise Survey on the prevalence of NCD risk factors and the development and implementation of an NCD policy;

(h) Support the development and implementation of a National Health Promotion Policy and Strategic Plan;

(i) Support the implementation of the ratified WHO FCTC;

(j) Support the development and implementation of a National Road Safety Strategy.

6.2.3 Sexual and Reproductive Health: Maternal, Newborn, Child, Adolescent Health and Nutrition

This component focuses on the improvement of the health of mothers, children and neonates towards the achievement of MDGs 4 and 5, in line with the WHO Medium Term

Strategic Plan, and the WHO Regional Office for Africa's Strategic Orientations, The National Health Master Plan, and the Country-Specific Road Map for the Acceleration of the Reduction of Maternal and Newborn Deaths.

Objective:

To improve health and reduce maternal, neonatal and childhood morbidity and mortality.

Main focus:

(a) Mobilize resources for the implementation of the Country-Specific Road Map to accelerate the reduction of maternal and newborn deaths;

(b) Support the re-commissioning of the major health facilities for the provision of basic and comprehensive emergency obstetric care (EmOC) services and improve the referral system for complicated obstetric cases;

(c) Support capacity building for skilled attendants during pregnancy, childbirth and post-delivery, and advocate for their motivation and retention;

(d) Advocacy for improved antenatal care, delivery and postpartum care, and adolescent health and sexual health, including awareness-creation on the risks related to teenage pregnancy and FGM, and undertake joint endeavours with partners in the "End Fistula Campaign";

(e) Advocate for the sensitization of the general public on the risks associated with early pregnancy and the importance of early attendance for antenatal care, skilled birth attendants and male involvement and participation in all reproductive health issues;

(f) Advocate for the strengthening of the national blood transfusion services;

(g) Support the National Nutrition Agency (NaNA) in the coordination and implementation of the Food Act and Codex Alimentarius, including advocacy for addressing protein energy malnutrition and improved child and maternal nutrition;

(h) Support the expansion of the IMNCI strategy in all six Health Regions of the country and the implementation of other child survival strategies such as infant and young child feeding and key IMNCI community practices;

(i) Support the availability and continuous supply of the necessary EPI vaccines and train health workers on the introduction and utilization of new EPI vaccines;

(j) Support other initiatives to promote maternal and child health in partnership with local and international stakeholders in health to achieve improved hospital care, encompassing supply chains management of drugs and vaccines.

6.2.4 Health, Environment and Sustainable Development, and Emergencies

The key determinants of health (water and sanitation, food and nutrition, housing, education and income) need to be addressed in order to attain and maintain the optimal level of health in the population. This component therefore, focuses on the implementation of activities that will lead to the reduction of the incidence of diseases and environmental conditions that adversely impact the above key determinants.

The principal concerns in the area of health and the environment are waste management, food safety practices and water quality and safety (including storage). Although access to sanitary facilities is high (84%, according to MICS, 2006), there is need to improve on their quality.

This component will also address issues of health emergencies that arise during and after major disasters such as floods, droughts, and displacements of people.

Objective

To contribute to the improvement in the general standards of health of the population and address health consequences of emergencies.

Main focus:

(a) Support the development and implementation of the national environmental health policy, with emphasis on the provision of a sustainable waste management system;

(b) Advocate for the implementation of the Anti-litter Law;

(c) Support the implementation of the policy on occupational health and safety;

(d) Advocate for good housing, household food security, adult literacy and women's economic empowerment;

(e) Support the formulation and implementation of health-specific emergency preparedness and response plans;

(f) Monitor water quality, especially in rural areas, and improve the management of human and household waste;

(g) Support the implementation of the Health Care Waste Management Plan.

While implementing these strategies, WHO will carry out activities in partnership with bilateral, multilateral and international agencies, taking into account its own comparative advantage. In doing so, WHO will work jointly with DOSH, relevant departments in the government, and NGOs involved in the health sector. Collaboration with national institutions such as the Faculty of Medicine and Allied Health Sciences, and the schools of Nursing and Public Health will also be promoted in order to achieve the desired objectives.

WHO will support the DSHSW to coordinate the work of other partners in the health sector, in particular, to draw up and update the profiles of donors active in this sector.

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA

The 2nd Country Cooperation Strategy (2008–2013) sets out strategic directions and a medium-term agenda of the work of the WHO Secretariat in the Gambia. The Proposed Programme Budget 2008–2009 and subsequent two programme budgets will be based on the strategic agenda as outlined in this document. The implementation of the CCS is expected to have implications for the Organization's work at its three levels: Country Office, Regional Office, and Headquarters.

7.1 WHO COUNTRY OFFICE

The WHO Country Office will continue to expand its role as a broker and advocate for health. It will maintain a balance of highly experienced National Professional Officers (NPOs) and international experts. WHO will assist the country by providing the services of technical experts, where and when necessary. Existing programme officers will be re-oriented to become functional in new areas contained in the CCS.

WHO will support the DSHSW in exploring the recruitment of UN Volunteers and Associate Professional Officers (APOs) in order to strengthen programme implementation. Technical assistance will be intensified in areas where there is a critical shortage of national expertise, such as essential medicines; blood safety; traditional medicine; health planning; human resources for health management; laboratory services; emergency preparedness and response; midwifery training and practice; noncommunicable diseases, and other priority areas as needed. WHO will jointly review programmes with the DSHSW to identify areas where the Organization can have the maximum impact.

WHO will need to build specific capacity for advocacy and resource mobilization in the areas of food safety and nutrition, disease elimination and eradication, emergencies and mental health. In the area of obstetric emergencies, skilled personnel, medical equipment, communication systems and transport need to be provided. Another area that needs attention is staff development in communication skills such as report writing and public speaking.

WHO will continue to play an active role in the review and implementation of UNDAF by participating in the UN Thematic Groups and Interagency Coordinating Committees (ICCs), thereby strengthening collaboration with partners, minimizing possible overlap of efforts and opening up new avenues for resource mobilization at the national level.

The Country Office will document results, including best practices, to demonstrate that WHO is making a difference in the health of the people of the Gambia. It will implement the strategy for the promotion of WHO's image through advocacy and support for International Health Days, launching and disseminating annual World Health Reports, supporting health-promoting initiatives and disseminating information on major health events in the world.

7.2 WHO REGIONAL OFFICE

The WHO Regional Office for Africa will create an enabling environment that will facilitate organizational change and institutional development issues arising from the CCS. As a starting point, the Regional Office will review and identify the implications of the Gambia CCS to its work.

The Regional Office will disseminate the Gambia CCS document to divisional directors and regional advisers. This will create a better understanding among staff of the country's health system and its challenges, and improve the scope and quality of technical support provided to the country team.

In view of the additional resources needed to support the implementation of the agenda of the CCS, the Regional Office will use the CSS to mobilize financial and technical resources for the Country Office. For this purpose, the CCS document will be disseminated to key donors and stakeholders in health.

Adequate technical backstopping will be provided by the Regional Office to the Country Office, to support the implementation of the CSS agenda in a timely manner.

The Regional Office will seek to increase allocation of resources to the Country Office in line with the priority areas identified in the CCS. The Regional Office's decentralization of financial responsibilities has facilitated the work of the Country Office; this needs to be sustained.

7.3 WHO HEADQUARTERS

In accordance with the principle of "One WHO", WHO headquarters will work with the Regional Office to mobilize resources and provide technical support for the implementation of the Gambia CCS, and to document lessons arising from the approach and its impact on WHO's work as a whole as well as in individual countries.

Headquarters will continue to provide up-to-date technical information to countries, directly and through the Regional Office for Africa. It will provide sufficient quantities of WHO publications and other technical materials.

Finally, headquarters will review the CCS document and use it as a basis for revisiting the WHO reform agenda.

7.4 MONITORING AND EVALUATION

The monitoring of the implementation of the CCS will be conducted through semi-annual monitoring, midterm review, and biennial evaluation of the programme budget.

The monitoring and evaluation reports of national health programmes supported by WHO and other partners will be used to complement the standard reports described above. The results of other national evaluation exercises such as censuses, surveys and research will also be used to evaluate the impact of the CCS.

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