WHO COUNTRY COOPERATION STRATEGY

FEDERAL REPUBLIC OF THE GAMBIA

2002-2005

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ABBREVIATIONS

ADB	African Development Bank
APRC	Alliance for Patriotic Re-orientation and Construction
ARI	Acute respiratory infection
BCT	Blood Safety and Clinical Technology
CAH	Child and Adolescent Health
CCA	Common Country Assessment
CCS	Country Cooperation Strategy
CSD	Central Statistics Department
DOTS	Directly-observed treatment, short-course
DOSH	Department of State for Health and Social Welfare
EHO	Environmental Health Officer
EPI	Expanded Programme on Immunization
ERP	Economic Recovery Programme
FAWE	Federation of African Women in Education
FGM	Female genital mutilation
GFPA	Gambia Family Planning Association
HMIS	Health Management Information Systems
HIV	Human immunodeficiency virus
HSR	Health Systems Research
ICC	Inter-Agency Coordination Committee
IDB	Islamic Development Bank
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
NCD	Noncommunicable disease
NGO	Nongovernmental organization
NPO	National Professional Officer
PER	Public Expenditure Review
PHC	Primary health care

PHPNP	Participatory Health, Population and Nutrition Project
POW	Plan of work
PPA	Principal programme area
PRSP	Poverty Reduction Strategy Paper
RBM	Roll Back Malaria
STI	Sexually transmitted infection
TB	Tuberculosis
TBA	Traditional birth attendant
TRM	Traditional medicine
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDAF	United Nations Development Assistance Framework
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WHO/AFRO	WHO Regional Office for Africa

FOREWORD

In the year 2000, the Executive Board of the World Health Organization (WHO) approved a Corporate Strategy to guide the work of the WHO Secretariat. This Corporate Strategy emphasized the central role of countries in the work of WHO; hence, the global strategy was revised and adapted to the needs of each country. These measures constitute the basis for the WHO Country Cooperation Strategy (CCS).

The Country Cooperation Strategy describes WHO strategic priorities for each country in order to obtain an integrated response from the three levels: country office, regional office and headquarters. The CCS is a clear expression of the WHO country focus: the strategic agenda will guide cooperation between WHO and Member States for the medium term. The CCS will serve as a reference for WHO workplans and resource allocations, whether those resources are from countries, region, HQ or other sources such as collaborating centres.

The WHO Cooperation Strategy was developed through an extensive consultative process involving the Organization at all levels, the Ministry of Health, other government agencies, private sector and civil society organizations, training and research institutions, development partners and other key stakeholders in health. The process involved questioning, in-depth analysis of key health and development challenges of each country and consideration of the WHO comparative advantage.

I acknowledge the exhaustive process that has led to the formulation of this document, and I would like to thank the government and all stakeholders in health for their efforts and active participation. I have no doubt that the CCS process will help countries in their efforts to focus on priority health issues and coordinate the actions of different partners and stakeholders.

Our challenge now is to transform these strategies into concrete actions, with a view to improving WHO performance at country level as well as the health outcomes for populations in greatest need.

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1 INTRODUCTION

The purpose of the WHO Country Cooperation Strategy (CCS) is to improve the efficiency and effectiveness of the work of WHO in The Gambia, supporting government efforts to achieve the national health goals. It sets out the strategic directions and medium-term agenda of work in The Gambia for the entire WHO Secretariat at the Organization's three levels (headquarters, the Regional Office for Africa and the Country Office), covering the period 2002-2005.

The CCS was developed through a consultative process involving the WHO country team, national counterparts from the Department of State for Health and Social Welfare (DOSH) and staff from the WHO Regional Office for Africa (AFRO) and headquarters. 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, NGOs and other key stakeholders in health. Her Excellency the Vice-President, the Honourable Secretary of State for Health and Social Welfare and most of his senior staff, the senior staff of the Royal Victoria Hospital, the Medical Research Council of The Gambia, The Gambia Family Planning Association, Sight Savers International and all UN agencies represented in the country (UNDP, UNICEF and UNFPA) were consulted.

Through the CCS, WHO aims to be more responsive to the country's needs by being more selective and focused on the national health priorities. 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, fully taking into account the activities of other development partners.

In setting out the medium-term strategic agenda, the CCS has been inspired by the WHO Corporate Strategy,[1] the WHO African Region Strategic Framework 2002-2005,[2] the National Health Policy (2001), the strategic plan of the United Nations Development Assistance Framework (UNDAF),[3] the Common Country Assessment (CCA)[4] report and the Poverty Reduction Strategy Paper (PRSP).[5] 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 complementarity 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.

2 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. The Atlantic Ocean forms its western boundary. The country is divided into five administrative divisions (Western, Lower River, Central River, Upper River and North Bank Division) and two municipalities (Banjul and Kanifing).

2.1 Population trends

Based on the population growth rate of 4.2%, the 2001 population was projected at 1.44 million, of which 50.2% were females and 49.8% males (1993 Population Census). The high population growth rate has remained a source of great concern, leading to the establishment of a National Population Secretariat.

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. The census data indicated a total fertility rate of 6.1. These high rates have serious resource implications for health and other social services.

2.2 Governance

The Gambia has enjoyed relative peace and stability since independence in 1965. After the military take-over in 1994, there was a return to democratic rule in 1996. Presently, the government is taking several initiatives to improve the democratic process, which include:

- Establishment of an autonomous electoral office to introduce greater transparency and efficiency in the conduct of elections;
- Support to grassroots organizations engaged in civic and human rights advocacy and religious organizations engaged in moral and spiritual upliftment;
- School curricula changes to include civic education;
- Development of comprehensive decentralization programmes that aim at bringing the government closer to the people and encouraging community participation.

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. The preference

for a male child is dominant which has serious implications for gender equality. Also, harmful traditional practices such as female genital mutilation are common. Therefore, there is a need to empower women to participate fully in the socioeconomic development of The Gambia.

2.3 Socioeconomic situation

The Gambia is a predominantly agricultural country with a limited resource base. It is listed as one of the Least Developed Countries, with a real Gross Domestic Product per capita of US$ 456 (Central Statistics Department, 1998).[6]

Review of the past

By mid-1975, the economy was relatively strong compared to other sub-Sahara African countries. The per capita income grew by a steady rate of 4% per annum.

However, the world oil price shocks of the 1970s and 1980s, coupled with a 40% fall in the world market prices of groundnuts (which is the mainstay of The Gambia's economy), poor economic policies, drought and neglect of the investment sector saw a drastic decline in the economy. Foreign debt rose from US$ 158 million in 1979 to US$ 323 million in 1984. Foreign lenders and the International Monetary Fund (IMF) were about to declare the country ineligible for further drawing. This necessitated the introduction of the Economic Recovery Programme (ERP) in 1985. The ERP resulted in economic growth, appreciation of the currency, increase in the level of investment and booming of the tourism industry, which became a major source of income generation. However, the ERP resulted in social costs that largely affected the poor.

In 1994, the country experienced a military take-over which directly affected the tourism sector and brought about a reduction in donor support. After 1994, health services were expanded through the construction of hospitals and refurbishment and upgrading of some of the existing health facilities. One of the significant developments was the establishment of the Faculty of Medicine and Allied Health Sciences in the University of the The Gambia. Because of the diminishing multinational donor support, the country intensified resource mobilization from bilateral partners, leading to an increase in technical and financial assistance from Cuba, Taiwan, Libya, Kuwait, Nigeria and Egypt.

Current economic trends

A combination of factors such as poor economic performance, mounting debt and high fertility and population growth rates pose great challenges to government efforts to efficiently and effectively manage and sustain the economy. In addition, the country has a poor resource base since its economy depends mainly on groundnut

farming, trade and tourism. This has led the country to heavy dependence on foreign aid and grants for its development.

The Gambia is one of the poorest countries in the world and was ranked 161 out of 174 countries worldwide (HDR, 2000), with a Human Development Index of 0.398[7] and 64% of its population living below the poverty line (1998).[8] The recent Poverty Reduction Strategy Paper (PRSP II)[5] identifies strategies and calls for intersectoral action to reduce and eventually eliminate poverty in the country.

2.4 Health as part of wider development agenda

The government fully recognizes that health is a central long-term driver of economic growth. Health is clearly stated in government documents as one of the three development challenges facing the country, the other two being education and population. Rapid population growth has had a significant impact on the environment, leading to increased pressure on limited environmental resources such as firewood, resulting in increasing deforestation. It has also contributed to an increase in the level of urbanization, youth unemployment and underemployment and the attendant social problems such as drug and alcohol abuse. In the education sector, school attendance is below 50%, which is even lower among girls. The overall illiteracy rate is 74%,[7] but is substantially higher for females (85%). The overall human resource development remains a vital need in view of inadequate national capacity. Health challenges are linked to the broader population and education issues and are concerned with the need to:

- improve family health;
- control disease;
- promote awareness on environmental and public health issues;
- build institutional capacity across the health care system;
- develop and retain human resources;
- provide support services such as operational research, maintenance and logistics.

The health sector now recognizes poverty as the main underlying cause of ill-health. Poverty and health strongly impact on each other. The poor suffer disproportionately from ill-health and spend about one-third of their meagre income on seeking health care. In addition, loss of productivity through health-related problems is the biggest obstacle to poverty reduction and development. It is in recognition of this very clear assertion that the health sector has embarked on a new paradigm shift in its approach. Priority programme areas of work that are cost-effective and responsive to poverty reduction are currently being pursued.

2.5 Health profile

Significant improvements have been made in the health status of the population over the past three decades. Life expectancy at birth rose from 33 years in 1973 to 53 in 1993.[4,9]

The census results indicated that infant mortality was reduced by 50% from 167 per 1,000 live births in 1983 to 85 per 1,000 live births in 1993. The under-five mortality rate fell by 47% during the same period. These achievements can be attributed to the policies adopted by the government during the last 15 years.

While the health status of the Gambian citizens has improved significantly, serious public health problems still remain. These include infectious and parasitic diseases which result from persistent weaknesses in the public health services, especially environmental hygiene, nutrition and health education.

Malaria, acute respiratory infections, diarrhoeal diseases, helminthic infections and skin disorders are the leading causes of morbidity that drive the demand for public health and medical care services by both children and adults.[9,10] Together, these health conditions are responsible for over 50% of the outpatient and inpatient care delivered through the government's health care system.

The leading causes of inpatient deaths in children are: malaria, pneumonia, malnutrition, anaemia, neonatal sepsis, premature births, gastroenteritis, septicaemia and meningitis.[9,10] In adults, the leading causes of inpatient deaths are maternal deaths, pneumonia, cerebrovascular accidents, trauma, malaria, hypertension, anaemia, diabetes, heart failure and cancer.

Some natural disasters do occur in The Gambia; for example, floods and droughts. In addition, there are epidemics such as yellow fever and meningitis. Cancer, especially liver cancer, is secondary to hepatitis B infection which is prevalent in the country.

2.6 Health care delivery system

The public health service coverage is very high, reaching over 90% of the total population. 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, 36 health centres 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 such as herbalists, birth attendants, spiritualists, diviners and bonesetters. Therefore, the government is putting in place the necessary policies to integrate traditional medical practices into the formal health care system.

The public sector health service has over 1,500 beds, 211 doctors and dentists, 8 pharmacists, 655 nurses of which 261 are state registered nurses, 250 enrolled nurses and 144 community health nurses. Out of the total number of nurses, 243 have also been trained in midwifery. There are 112 public health officials and 47 laboratory and X-ray technicians. About 150 nurses are working in the private and NGO sectors.

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 divisions, with the Western Division having most of the resources. The health status and health services indicators for Banjul, Kanifing Municipality and Western Division are better than the national averages, while Upper River and Lower River divisions are substantially worse. Central River Division has indicators whose levels are in between the above two extremes.

2.7 Health policy[11]

The first health policy was formulated to cover the period 1994-2000. Subsequently, a five-year action plan (1999-2003)[12] was developed to implement the policy. In 2001, an updated policy called "Changing for Good"[11] was produced to incorporate new socioeconomic and health development challenges. The vision of the policy is the attainment of accessible quality health care for the Gambian population that would be a model in the African Region by the year 2020. It has as its mission provision of quality health care services within an enabling environment, delivered by appropriately and adequately trained, skilled and motivated personnel at all levels of care. This mission will be accomplished with the involvement of all stakeholders to ensure a healthy population.

The key guiding principles of the policy are: equity, health systems reform, and partnerships. Issues addressed in this policy are:

- essential care package;
- organization and management of health care services;
- human resource development;
- infrastructure and logistics;
- health information;

- referral systems;
- health 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 sector, professional associations, the Faculty of Medicine and others. A new five-year strategic plan will also be developed to support the implementation process. A framework for the formulation of the Strategic Plan has already been put in place to operationalize the policy.

Public expenditure reviews (PER)[6] are undertaken annually and are aimed at assessing the performance of the health department with regard to the implementation of the health policy. The PER also identifies achievements, failures and obstacles to implementation, as well as available opportunities. It serves as a strategic guide to the management of the health sector.

2.8 Health financing

During the period 1992-2000, the health recurrent budget showed an upward trend in both nominal and real terms. The recurrent health expenditure, as a share of the total government expenditure, ranged between 10.8% and 13.4%.[6] This represented real per capita recurrent expenditure of US$ 3.96 to US$ 5.91. In 2000, the recurrent expenditure on health as a proportion of the GDP reached 1.17%, which was slightly below the average in sub-Saharan Africa. In 2001, approximately 40% of the total health recurrent expenditure was directed towards primary and secondary health care. In 1998, the sources of funding of the health expenditure were as follows: government 46%, donors 28% and households 26%. The public expenditure per capita in the health sector in 2000 was US$ 6, which was just half of the WHO recommended standard required to provide minimum health care services.

To address this gap, a cost recovery programme was started in the early 1990s, which established the Drug Revolving Fund and the introduction of user fees as a form of health financing. The Bamako Initiative was introduced in 1993 as a further development on the cost recovery programme. One of the objectives of the five-year strategic goals of the health policy is to improve the management of available

financial resources in the health sector. Another is to centralize budgetary allocation to the divisions.

2.9 Health service management and public sector reform

The health sector management[9] is organized into three tiers, with a central level of five directorates. At the secondary level there are six health divisions. The third tier consists of community, private and traditional medicine systems. However, the management of resources for health care, both human and material, still remains centralized.

It has been agreed that one of the ways to overcome centralized decision-making is through structural changes at the Department of State for Health by devolving some monitoring, supervisory, administrative and management responsibilities to the newly-created Divisional Health Teams (DHTs). The DHTs comprise well-trained and experienced public health officers and nurses. Tools, checklists and planning manuals are also being developed to strengthen supervision, planning and gathering of information and indicators to monitor health programmes. These DHTs are working closely with Village Health Committees to promote health and increase community participation.

Since the adoption of the PHC approach by the country in 1979, a number of changes have taken place in health development as part of the health sector reform process. These include:

(a) restructuring of DOSH and creation of Divisional Health Teams;

(b) shifting financial and administrative functions from the Centre to Hospital Management Boards;

(c) increasing the proportion of outreach services to cover marginalized populations;

(d) creating and training new cadres of staff for special interventions (e.g. 'at risk' midwives and medical assistants);

(e) introducing user fees and the Bamako Initiative.

2.10 Health challenges and emerging issues

The government has identified health, education and population as its three main priorities. Despite some progress in improving the people's health status and development of the health infrastructure, which allows 90% of the population access to health services, the health status of The Gambia's population is still among the lowest in the African Region. In the face of the identified health problems and

challenges such as weak institutional capacity, especially relating to human resource availability, retention and development, the government needs to continue its efforts to address these issues. These limiting factors have adversely affected both the provision and quality of services.

In addition, the health system is now faced with other emerging issues, for instance, HIV/AIDS and noncommunicable diseases (NCDs), especially mental health and some others, which present additional challenges to the already overburdened health services.

Based on consultations during the CCS formulation process, the following key issues were identified:

Disease burden, maternal and child mortality

Maternal mortality

In 1990, The Gambia experienced one of the highest maternal mortality ratios (MMR) in the world, estimated to be 1,050 deaths per 100,000 live births.13 According to the preliminary findings of a recent survey (2001), the MMR had fallen to 703 per 100,000 live births. Despite several years of implementing the MCH programme, the MMR is still unacceptably high. The main causes of maternal mortality are antenatal and postnatal haemorrhage, pre-eclampsia, anaemia in pregnancy and postpartum sepsis. Lack of trained midwives further exacerbates the problem.

The low contraceptive prevalence rate of 12% (1990),[13] has contributed to the high fertility rate. There is also a high level of teenage pregnancy, which has become a major issue in The Gambia. The Reproductive Health Action Plan (2001) will help improve the knowledge of contraceptive issues and tackle the effects of some cultural beliefs that limit its widespread use and practice. The action plan addresses issues of Safe Motherhood, with the overall objective of reducing the high maternal mortality rate.

There is need for efforts to be directed at:

(a) upgrading the knowledge and skills of health personnel at the primary health care level, particularly in the area of obstetric care;

(b) improving national blood transfusion services;

(c) Sensitizing the general population on the importance of antenatal care and early bookings for delivery;

(d) Improving transport and communication to tackle obstetric emergencies.

Infant and child mortality

The infant mortality rate (IMR) has decreased from 167 in 1983 to 84 in 1993 per 1,000 live births,[14] while the under-five mortality rate declined from 260 to 135 per 1,000 live births during the same period. In 1998, the IMR was 64 per 1,000 live births[15] and the under-five mortality rate was 76/1,000. The major underlying causes of mortality in infants and children are acute respiratory infections (ARI), diarrhoeal diseases and malaria.

The government, in collaboration with WHO, UNFPA, the World Bank and UNICEF, has developed policies and established programmes such as EPI and ARI for the reduction and control of childhood diseases. The Gambia has had one of the most impressive Expanded Programme on Immunization (EPI) in Africa. Since 1998,[15] the rate of fully immunized children had averaged about 80%, but recently it dropped to 68%, mainly due to lack of vaccines and transport to undertake outreach services.

Expansion of selected PHC programmes through the outreach system to remote rural communities has been introduced as one of the strategies of combating these diseases.

The government has identified a national focal point for IMCI. Although still at an early stage, the programme has recently gained widespread support and participation from all stakeholders, especially bilateral, multilateral and NGO agencies. The introduction of the Bamako Initiative is aimed at making essential drugs available at the community level, which will also facilitate the introduction of the IMCI programme. This will be achieved through improved community involvement in health development and encouraging ownership of health programmes at the grassroots level.

In order for the IMCI and RBM initiatives to be successful in helping to reduce childhood mortality there is need to:

(a) establish effective integration of these programmes;

(b) undertake substantial training of health personnel;

(c) sensitize communities to increase their participation in the implementation of the programmes.

Malaria

Malaria is the leading cause of morbidity and mortality in The Gambia. It is also the main cause of workdays lost. It is estimated that about 20% of all outpatient consultations are due to malaria and it accounts for 6.3/1,000 deaths in infants and 10.7/1,000 deaths in children under five years. The burden is more severe among

pregnant women and children, especially in rural areas. The climate and environment favour the all-year-round transmission of the parasite.

Malaria is high on the agenda of the government. The country has recently developed a malaria control policy, which is in the process of being approved by the Cabinet. The Gambia is a focal point for malaria control at the sub-regional level as part of the 'Health for Peace' initiative. The country is benefiting from the Roll Back Malaria[16] funding to strengthen its capacity in the fight against the disease. To improve malaria control and prevention, there is need to:

(a) intensify resource mobilization for malaria control programmes;

(b) improve partnerships with communities and other stakeholders;

(c) increase the use of insecticide-treated nets for high-risk groups;

(d) increase the coverage of chemoprophylaxis;

(e) improve environmental hygiene management.

HIV/AIDS/STIs

Recent data from sentinel surveillance (2001) showed the prevalence rates for HIV1 and HIV2 as 1.2% and 0.9% respectively. The rate among pregnant women was recorded as 1.2%. During 1993-2001, sentinel surveillance data showed a two-fold increase in the number of HIV-infected persons.[17] It is estimated that at present there are about 8,000 adults in The Gambia who are infected with HIV1.

In line with the PHC approach, the DOSH integrated the National AIDS Control Programme into the existing health system. The government has formed a National AIDS Council chaired by the Head of State to promote intersectoral collaboration in the fight against the disease. Policies and guidelines on HIV and AIDS have also been developed.[18]

A study is being carried out to assess the social and cultural aspects that may be contributing positively to the relatively low prevalence. Efforts need to be made to arrest the further spread of HIV infection, especially among youths and other high-risk groups.

The high prevalence of STIs, especially among commercial sex workers, is contributing to the spread of HIV/AIDS. The treatment of STIs and the provision of condoms are two of the strategies being used by the government to prevent further spread of the virus. There is a need to intensify this programme.

Tuberculosis

In 1995, the number of TB cases detected was 930. This figure rose to 1527 cases in 1999.[9] The case detection rate is 65%. Although the directly-observed treatment, short-course (DOTS) coverage is countrywide, the high mobility of the population has seriously eroded the compliance rate.

With the advent of HIV/AIDS, about 8% of TB patients are also infected with the virus. The country has witnessed the re-emergence of TB affecting people of all ages. The poor living conditions of certain sections of the population, the influx of refugees, overcrowding and poor supervision of DOTS compliance due to staff shortages at the lower levels of the health system have exacerbated the situation.

Noncommunicable diseases[19]

Though The Gambia is still battling with poverty-related diseases, it is also experiencing an increase in the prevalence of noncommunicable diseases which are usually common among more affluent societies. Hypertension, diabetes and cancer now rank among the top 10 causes of mortality in adults in the country.

A study carried out in 1992 among the urban and rural populations of the country revealed that the prevalence rate of somatoform disorders among adults aged 15 and above was 7.5%, followed by mood disorders (6%) and anxiety-related disorders (5.2%). These three conditions together account for a prevalence rate of about 20%. The use of illicit drugs was noted to be high at an average of 5%, with rates as high as 10% in some parts of Western Division. There is a need to develop a mental health programme and ensure its integration into primary health care. The government has also initiated a social welfare policy, which will lead to the formulation of further policies for the elderly and the disabled.

Nutrition

In a multi-indicator cluster survey carried out in 2000 it was found that 19% and 17% of all under-five-year-olds were, respectively, stunted and overweight. Recent figures show that protein-energy malnutrition accounts for 9% of the overall inpatient deaths among children at the Royal Victoria Hospital. With regard to micronutrient deficiency, 64% of children under five showed a marginal deficiency and 9% showed serious vitamin A deficiency.

Iodine deficiency in the Divisions further inland is high, given the national average of 16.3%. Only 7.5% of households use iodized salt; therefore, there is a need for more widespread iodization of salt and its consumption. Vitamin A supplementation has been integrated into national immunization days (NIDs).

Health system challenges

Human resources development

One of the major obstacles facing the health sector is the shortage of health personnel at the primary and divisional levels. These shortages are increasingly having an impact on the health service delivery, which is compounded by the rapid expansion of health services through the construction of hospitals and upgrading of more health facilities and little possibility of staffing. Overall, only 18 doctors or less than 10% of the total number of doctors in the public sector are Gambian nationals. The attrition rate is high among nursing cadres, which is of great concern for the public health system.

A significant amount of braindrain is taking place, both internally to NGOs and the private sector and externally to other countries. This is as a result of relatively better wages, working conditions and incentives being offered outside the public sector. In addition, poor working environment such as lack of basic drugs and equipment contributes to the high attrition of medical and nursing staff.

Referral system

The referral systems are not fully functional due to inadequate staffing and lack of appropriate equipment. Only 20% of doctors work in secondary health facilities. As a result, many patients are referred to hospitals to receive appropriate care that should be delivered at the primary and secondary levels. The Royal Victoria Hospital, the major tertiary referral institution in the country, is already over-stretched and is unable to cope with increased demands. Inappropriate referrals, inadequate staffing and lack of equipment greatly hamper existing plans to transform the hospital into a teaching institution with the establishment of the medical school.

Health management information systems

The health information system is very weak. Health information is often scattered, inconsistent and uncoordinated and is not readily available for timely and effective decision-making. There is need to strengthen the capacity of the Epidemiology and Statistical Unit (ESU) to enable it to collect, analyse, interpret and disseminate quality information to decision-makers.

Laboratory services and quality assurance

There is lack of laboratory services at a number of health facilities in the country. Out of 40 health facilities only 28 have laboratories, of which only 12 are functional. In addition, there is a general lack of laboratory technicians. There is a need to train more laboratory technicians and technologists as a necessary accompaniment to the

upgrading of services and improving of routine diagnostic procedures. Expansion and upgrading of laboratory services should include the provision of incinerators for laboratory and clinical waste management, generators and solar systems to supply back-up electricity, especially in the Divisions. A quality assurance programme is necessary to ensure that health care standards are maintained.

Essential drugs and drug management system

Within the framework of the Essential Drugs Policy, there have been concerted efforts to improve the rational use of drugs at the dispensing level and the management of drugs at various levels of the health care delivery system through short-term training. Regional stores were created to facilitate access to drugs, especially by rural communities. This was part of the plan to provide a comprehensive national drug policy that also saw the establishment of a drug quality control laboratory.

The DOSH has embarked on strengthening the supervisory mechanisms at the peripheral level to complement the training. However, essential drugs are not always available in health facilities. The capacity for ensuring drug efficacy and safety is limited and the procurement procedures sometimes cause unnecessary delays.

Traditional medicine[20]

At the community level the first point of contact for seeking health care is usually the traditional healer. Some of the traditional methods of treatment have proven to be effective and need to be promoted, while others may be potentially harmful and therefore require further research. There would be benefits if traditional healers were adequately sensitized and utilized as the new village health workers or community health workers.

There is thus a need to integrate traditional and conventional health care systems and promote operational research in traditional medicine.

Health and the environment

The main environmental issues facing The Gambia are deforestation, waste management, rising sea levels and coastal erosion. There are frequent bush fires, which contribute to soil erosion and desertification. Waste management is a major problem, especially in urban areas, which emanates from indiscriminate disposal of household and small industry wastes, poor collection and inappropriate disposal practices. There is also limited laboratory control for food safety and quality.

The government has undertaken a number of intervention programmes through the Rural Water Supply Project, co-financed by the Gambian government, multilaterals and NGOs. A plan of action on health care waste management has just been developed. About 79% of the urban and 65% of the rural households have access to safe and convenient water, although divisional variations do occur.

Health promotion and advocacy

The Health Education Unit is weak and currently there is no health promotion policy. Low rates of literacy is a major constraint in transmitting health education messages to the public.

Currently, the government is in the process of formulating a health promotion policy and has translated major documents into local languages. Divisional health teams are given technical guidance by the Health Education Unit. There are a number of innovative health initiatives such as tobacco-free schools, legislation banning smoking in public places, and creation of an association of health journalists.

The involvement of parliamentarians in health promotion has been a positive step towards banning smoking in public. A WHO award was given to the parliamentarian who spearheaded anti-smoking legislation.

Partner coordination

The interests of donors have, to a large extent, compromised the strategic interests of the health sector, resulting in the creation of vertical health programmes and inefficient utilization of resources. There is need for the government to build partnerships and coordinate programmes that address the financing, delivery and management of health services.

This is particularly important in view of the proposed health investment package ('common basket') for the sector-wide approach in The Gambia. The strategy has been that each policy should have an investment programme to show what the government and other partners will support. This will strengthen partnerships, forge linkages with stakeholders and allow for more collaboration and coordination. All policies should be in line with the National Health Policy and in the wider context of The Gambia's Vision 2020.

There are two mechanisms for partner coordination, of which one is devoted to health and is chaired by the DOSH and the other by the UN Resident Coordinator.

3 DEVELOPMENT ASSISTANCE

Between 1994 and 1998, there was a drastic reduction in external assistance to almost half of the 1994 level. It was accompanied by the suspension of budgetary and financial support. These factors have severely affected The Gambia's capacity to improve access to, and the performance of, social services.

3.1 Aid flow

A significant share of the health expenditure incurred in the country comes from development partners. The percentage of the total budget declared as 'donor aid' considerably understates the overall magnitude of the external assistance. In the absence of a comprehensive account of the value of the aid flow, much of which reaches the country in kind rather than in cash, it is difficult to quantify the total amount.

Donor resources often flow in the form of technical assistance, supplies and equipment. In addition, limited information is collected on the contribution from NGOs who offer health services, yet this amount is significant in the broader context for indicating the total amount of funds for the health sector.

Despite allocation of considerable financial resources to the health sector by the government, high recurrent expenditures on health far outpace the funds allocated. This has a direct impact on the ability of the DOSH to run an effective and efficient system. Insufficient funds are spent on non-wage recurrent costs leading to periodic shortages of drugs and other essential supplies, weak logistic support systems such as maintenance of infrastructure, bio-medical equipment and transport. The flow of funds favours curative rather than preventive and promotive health care services.

3.2 Partners in health development

Following extensive consultations with all stakeholders within and outside the health sector, the DOSH, with technical support from WHO, developed a comprehensive 5-year Health Development Plan and a Technical Cooperation Programme (TCP).[21,22] Both these documents reflect current health priorities and provide a financing framework for funding health sector programmes within the plan period 1999-2003. Both documents were presented to development partners at the Social Sector Round Table Conference held in Geneva in June 1998. Although significant financial pledges were made, there was inadequate follow-up. It must be noted here that a track has not been kept of the aid flow to the health sector, and its importance has not been fully realized.

For poverty alleviation, micro-credit schemes for women in the informal sector are being funded. Financial and technical support has also been provided for the mainstreaming of the Poverty and Gender Programme (MPGP), working together with the Women's Bureau. (Partners: UNDP, DFID, FAO.)

The government is engaged in many activities such as the Bamako and Baby-Friendly initiatives and training of traditional birth attendants (TBAs) and traditional communicators. The Bamako Initiative currently focuses on operational issues at the community- and health-centre level. National advocacy for children's rights and the Family Life Education Initiative as well as the education of the girl child are given particular attention. (Partners: UNICEF, UNFPA, WHO, World Bank and NGOs, e.g. FAWE.)

As for infrastructure development, a number of health facilities have been built and equipped (Soma, Farafenni) while others are under construction (Serrekunda, Bwiam). Development of the road network is expected to improve the transport communication network between various health facilities especially in rural areas. (Partners: Islamic Development Bank, Kuwait Fund, Libya, Taiwan, Germany, Japan and DFID.)

On water and sanitation, various partners have worked with the government to provide safe water and adequate sanitation particularly targeting sub-urban and rural communities. (Partners: UNICEF, UNDP, WHO, DFID, Action-Aid.)

With regard to disease prevention and control, support has been provided to the Expanded Programme on Immunization (EPI) through vaccine procurement and supply and maintenance of cold chain equipment. This is essential as more than 50% of existing equipment in the country needs replacement.

Local partnerships for national immunization days for polio eradication have been strengthened. Oral rehydration salts (ORS) are provided as part of the diarrhoeal disease control programme. The Gambia has one of the best eye care programmes for the prevention of blindness targeting trachoma and cataracts for both urban and rural communities. (Partners: WHO, UNICEF, CCF, Rotary Club, Action-Aid, Sight Savers International-SSI.)

A number of partners are assisting the country to respond appropriately to the HIV/AIDS epidemic. This is being done by providing support to the National AIDS Control Programme for prevention and control activities. People living with HIV/AIDS are also assisted with care and support as well as to undertake income-generating projects. The national programme also focuses on the prevention of mother-to-child

transmission of HIV, protection of children's rights, especially orphans', and information, education and communication. Management of STIs is also a key intervention of the programme. (Partners: UNAIDS, WHO, UNDP, UNICEF, UNFPA, GFPA, MRC and others.)

In the areas of reproductive health, population and nutrition, development partners are supporting such initiatives as:

(a) safe motherhood and post-natal consultations;

(b) control of micronutrient deficiencies (vitamin A, iodine and iron);

(c) family planning;

(d) training related to the various sub-components of these programmes. (Partners: UNFPA, UNICEF, WHO, World Bank, GFPA, ADB.)

Health research is undertaken in key areas such as malaria, nutrition, HIV/AIDS, and tuberculosis. This research has a built-in element of service provision as well as capacity-building, with support provided by various partners (MRC, WHO, UNICEF, DFID, MH.)

Programmes such as strengthening health systems, health management and information systems (HMIS) as well as human resource development (HRD) continue to attract significant support. Improvement of records management at the Royal Victoria Hospital is currently being undertaken in collaboration with the National Records Directorate. Several expatriate doctors have been deployed to work in health facilities, while training of nationals of various cadres is being supported. (Partners: World Bank, WHO, Cuba, Nigeria, Taiwan, ADB, DFID.)

3.3 Partner coordination

One of the fundamental weaknesses of the health sector in The Gambia is its failure to ensure that resources are used in a coordinated manner towards the achievement of long-term health goals. Partner coordination is still a major challenge for the health sector. Inputs by different donors are influenced by specific mandates within which they operate. This has resulted in the creation of vertical and donor-dependent programmes that are largely fragmented.

In order to address the issue of coordination within the UN system in The Gambia, the UN agencies have developed a United Nations Development Assistance Framework (UNDAF), a harmonization strategy used by all UN agencies for development cooperation in The Gambia. Using the UNDAF approach, and based on the Common Country Assessment (CCA) report, a Country Strategic Note has been

developed to guide UN agencies in their cooperation efforts through various thematic groups, most of whom incorporate health issues including HIV/AIDS. At the beginning of 2002, there were thematic groups for HIV/AIDS, Governance and Economic Management, Food Security, the Environment and the Social Sector. Thematic groups hold regular monthly meetings to discuss issues of mutual interest and assess progress on agreed plans.

In an attempt to be more focused and effective, several operational modalities are emerging to reduce duplication and overlap between agencies. Such modalities include:

(a) promoting interagency coordination committees (ICCs) on selected public health challenges, e.g. the Polio Eradication Initiative, RBM, IMCI, HIV/AIDS, GAVI and the Global Health Funds (Partners: WHO, UNICEF, UNFPA, ADB/ WB, Rotary Club and others.)

(b) expanding their presence to divisional levels;

(c) establishing direct relationships with divisional health authorities, community-based organizations (CBOs) and NGOs (e.g. the HIV/AIDS Rapid Response Project of the Government and the World Bank).

These and other innovative approaches are likely to shape the way external agencies will work in the country in the future.

The National Health Policy Framework (2001) "Changing for Good", has set the goals, objectives and strategies for partnership. The process of translating the policy document into a five-year investment programme has started. This common programme will be jointly developed by all stakeholders and will eventually form the basis of building partnerships for the coordination of local and external resources for health. This partnership will be based on consensus on the strategic issues relating to the health sector. It is also anticipated that the common basket approach will form the basis of this collaboration. As part of the coordination strategy by the government, NGOs will continue to enter into memoranda of understanding (MOU) with the Department of State for Health and Social Welfare and will be encouraged to work through the existing institutional structures to avoid duplication.

4 WHO CURRENT COUNTRY PROGRAMME

During the long period after independence, WHO has developed close and long-lasting technical cooperation in the area of health with The Gambia, which was the first country to develop a primary health care programme in the WHO African Region (1979). Up to the present time, there has been a diversity of health issues and programmes aimed at addressing health challenges of the people.

4.1 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 other stakeholders and partners, with the back-up support of the WHO Regional Office for Africa and WHO headquarters. The WHO Country Office has a biennial budget exceeding US$ 4 million. This is composed of Regular budget and contributions from Other Sources. These funds are channelled to national programmes and projects through the Department of State for Health and Social Welfare in accordance with the established joint procedures. The WHO country team, composed of international and national experts, works in harmony to provide appropriate technical support to national efforts. The office presently has 25 technical and support staff.

4.2 WHO technical cooperation programmes

Presently, WHO operations are based on the Programme Budget and the Biennial Plan of Work for the period 2002-2003.[23,24] During the last biennium 2000-2001, the cooperation programme included WHO technical, financial and material support as described below.

Organization of health services

Organization of health services includes some core WHO programmes: (i) Strengthening of district health systems for improved delivery of PHC services, (ii) Development of human resources for health, (iii) health system research (HSR) and (iv) Health Management Information Systems (HMIS). During the 2001-2002 biennium the bulk of WHO human and financial resources were allocated to this programme area: it included five professionals (including the WR and Administrative Officer) and 43% of the overall budget for technical programmes. WHO assistance was provided through the Faculty of Medicine Allied Health Sciences of the University of The Gambia, award of fellowships, programme planning, development of monitoring indicators, assistance in conduct of surveys and studies, and establishment of a task force for health research. In addition, WHO was instrumental in the revision of the National Health Policy (2002).

Disease prevention, control and eradication

This programme area includes a wide range of activities aimed at supporting disease prevention and control measures in the country, including disease eradication or elimination initiatives. The latter cover poliomyelitis, leprosy, measles and neonatal tetanus, which received intensified support with a view to achieving the national and global targets set for their eradication or elimination. WHO support also includes surveillance activities for early detection and response to diseases of epidemic potential such as malaria, cerebrospinal meningitis, yellow fever, tuberculosis and HIV/AIDS. Other programmes covered are EPI, RBM and IMCI. Noncommunicable diseases such as diabetes and hypertension, which are showing an increasing trend in the country, were also covered. Due to the high priority attached to this programme area, the Country Office allocated 25% and 57% of its Regular and Other Sources budgets, respectively, as well as provided the services of three professional staff. Specific activities carried out during 2000-2001 included support to the establishment of a radio communication system at rural health facilities, training in integrated disease surveillance, conduct of studies on vector control, provision of support to measures for HIV prevention among youths and sex workers, establishment of a database on NCDs and others.

Reproductive health and child and adolescent health

This area incorporates Child and Adolescent Health (CAH), and Women's Health (WMH). In view of massive support to this programme from other sources (e.g. UNFPA) during 2000-2001, the Country Office allocated 7% of its budget and provided the services of a Family Health Adviser. WHO-supported activities included the Safe Motherhood initiative and its strategy development, project monitoring and evaluation and provision of TBA kits.

Health promotion; health and sustainable development

This programme area incorporates Health Promotion, Mental Health (MNH) and Substance Abuse, Sustainable Development (HSD) including Poverty Alleviation, Nutrition and Food Safety. During 2000-2001 the main thrust in this area was to support the programme on health promotion and community participation. A substantial proportion of the WHO Regular budget (13%) was allocated to this programme area for activities to be coordinated by a Health Information and Promotion Officer. Support was provided for translation into local languages and dissemination of IEC materials on epidemic-prone diseases at the community level. Seven major health centres and two training institutions received WHO Blue Trunk Libraries. Most of the activities were related to the Tobacco-Free Initiative involving schools, NGOs and parliamentarians. Essential budgetary and technical support was provided to develop a national mental health policy and strategic plan.

Health and the environment

This programme area is for the provision of support to government efforts in the implementation of the 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 2000-2001 biennium. A National Environmental Health Officer provides technical support to this programme, focusing on training and studies on water supply and sanitation and occupational and environmental health. Workshops were held to develop environmental legislation and policy as well as to review progress of the Africa 2000 Initiative. An essential National Vulnerability and Capacity Assessment survey was jointly organized with the government for emergency preparedness and response.

Essential drugs, traditional medicine and blood safety

This programme area incorporates Essential Drugs and Medicines, Traditional Medicine (TRM) and Blood Safety and Clinical Technology (BCT). The activities within this area are monitored on a shared basis by the WHO staff. During 2000-2001, support was provided through the Regular budget up to (6%) to develop operational manuals, conduct training and develop essential drugs management systems. Substantial efforts were made to carry out situation analyses of all components in this programme area.

Table 1 shows the allocation of WHO resources during the 2000-2001 and 2002-2003 biennia among the various principal programme areas.

Table 1: WHO country budget and staff distribution analysis

Programme Area	Professional Staff	Biennial budget 2000-2001		Biennial Budget 2002-2003	
		RB	Other Sources	RB	Other Sources
Organization of Health Services	5	43%	43%	65%	42%
Disease Prevention, Control and Eradication	3	25%	57%	6 %	39%
Reproductive Health and Adolescent Health	1	7%	-	7 %	6 %
Health Promotion; Health and Sustainable Development	1	13%	-	10%	8 %
Health and Environment	1	6 %	-	7 %	2 %
Essential Drugs, Traditional Medicine and Blood Safety	-	6 %	-	5 %	3 %
Total	**11**	**US$ 2 059 00 (100%)**	**US$ 467 000 (100%)**	**US$ 1 220 000 (100%)**	**US$ 2 059 720 (100%)**

4.3 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 and national capacity-building. Financial and technical support has also been provided towards the eradication and elimination of vaccine-preventable diseases, particularly poliomyelitis. Furthermore, with support from AFRO, a radio communication network consultancy has been concluded to link the primary, secondary and tertiary levels of the health system in the country. Financial support was also provided by AFRO for HIV/AIDS, mental health and other noncommunicable diseases programmes to supplement Country Office resources. Headquarters and AFRO undertook a number of technical support missions to the country, which included, among others, review and development of the Medical School curriculum, development of policies and strategic plans, assistance in the establishment of an integrated approach to diseases surveillance, introduction of new health initiatives, and review of progress of ongoing disease control and eradication programmes.

The Country Office is well-staffed with appropriate technical personnel, with the exception of an epidemiologist to assist the DOSH to strengthen its epidemiology unit.

5 WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been - and is still - undergoing changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges. This organizational change process has, as its broad frame, the WHO Corporate Strategy.[1]

5.1 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 and the Policy Framework for Technical Cooperation with Member Countries of the African Region outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

5.2 New emphases[1]

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

(a) adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;

(b) playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;

(c) triggering more effective action to improve health and to reduce inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;

(d) creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

5.3 Strategic directions[1]

On the basis of these new emphases, WHO has set out four strategic directions for its contribution to building healthy populations and combating ill-health. These

strategic directions, which are interrelated, provide a broad framework for the technical work of the Secretariat:

(a) reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;

(b) promoting healthy lifestyles and reducing risk factors to populations;

(c) developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;

(d) developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policy.

5.4 Core functions[1]

The typology of WHO core functions, presented below, is based on the comparative advantage of the Organization at all its levels:

(a) articulating consistent, ethical and evidence-based policy and advocacy positions;

(b) managing information, assessing trends and comparing performance of health systems; setting the agenda for and stimulating research and development;

(c) catalysing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;

(d) negotiating and sustaining national and global partnerships;

(e) setting, validating, monitoring and pursuing proper implementation of norms and standards;

(f) stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health-care management and service delivery.

5.5 Global and regional priorities[25]

In order to be more effective and efficient in its interventions, the Organization has selected a limited number of global priorities on which to focus over the four-year period (2002-2005). The global priorities selected on the basis of those criteria are: malaria, HIV/AIDS and TB; noncommunicable diseases (cancer, cardiovascular diseases and diabetes); tobacco; maternal health; food safety; mental health; safe blood; and health systems.

The WHO African Region[2] is facing enormous health challenges in relation to health. The WHO Regional Office for Africa has decided to focus its attention on 12 priorities closely related to the 11 global priorities, but adapted to the regional context. These 12 priorities are: HIV/AIDS; tuberculosis; malaria; maternal health; child and adolescent health; strengthening of health systems; blood safety; humanitarian and emergency action; health promotion; noncommunicable diseases control including mental health; and poverty and health.

5.6 Making WHO more effective at country level

The expression of WHO Corporate Strategy at country level will vary from country to country. Taking into consideration country-specific health and development challenges, the involvement of other external partners, WHO's current work in and with the country, and the global and regional policy frameworks, WHO will look at getting the balance right between its key functions at the country level. This means the Organization will act more as an adviser, a broker and a catalyst and will involve itself in routine implementation in case of specific, clearly identified initiatives, with a time-limited perspective. A working typology of WHO functions at country level has been developed based on the broader core functions presented above.

The specific functions at country level are:

(a) supporting routine long-term implementation;

(b) catalysing adoption of technical strategies and innovations; country-specific adaptation of guidelines; and seeding large-scale implementation;

(c) supporting research and development; policy experimentation; development of guidelines; stimulating monitoring of health sector performance; and trends assessment and anticipation;

(d) sharing information; generic policy options and positions; guidelines and standards; case studies of good practice; and advocacy;

(e) providing specific high-level policy and technical advice; serving as broker and arbiter; exercising influence on policy, action and spendings of government and development partners.

6 WHO STRATEGIC AGENDA FOR THE GAMBIA

In accordance with its Constitution, the WHO mission in The Gambia is to support its people 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 issues where WHO has the comparative advantage and has high technical capability and expertise, based on its three organizational levels.

Realizing that the government has developed policies which address major health issues, WHO will collaborate with the DOSH in implementing these policies and evaluating their impact on the health status of the country's population.

The issues identified in the strategic agenda are priority issues for the government and the people of The Gambia and WHO will support the government by advising it on policy 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'.

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 them impartial and highly reliable and evidence-based technical advice, incorporating experiences gained the African region and elsewhere. The Organization will play an advocacy role for health as well as assist the government in mobilizing resources for health. WHO will collaborate with other partners in the reduction of poverty within the framework of the UNDAF.

6.1 Functions

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

Supporting implementation of priority health programmes

The present trend of direct support to operations will continue for some time in programmes like Roll Back Malaria, polio eradication and HIV/AIDS, which need massive efforts from national and global partnerships. However, a gradual transition from direct support to technical and policy advice will take place over the next four years.

Catalysing the adoption of technical strategies and innovation

The Country Office will also support the DOSH in adapting technical guidelines and manuals.

Supporting research and development and stimulating improvement of health sector performance

The Country Office will assist the government in the strengthening of its health information management systems to undertake assessments of disease trends and forecasting.

Providing information and sharing knowledge among all levels of WHO

In order for the three levels of the WHO Secretariat to provide unified support to the country, there will be information-sharing among all levels.

Providing specific high-level policy and technical advice

WHO will serve as a broker and will try to influence policy formulation and implementation.

Six principal areas have been selected for support by WHO over the next four years. Within these areas, key issues have been identified on which the Organization will concentrate its efforts and resources for maximum impact.

6.2 Components of the strategic agenda

Organization of health services

This component includes some core WHO programmes, namely, strengthening of national and district health systems for improved delivery of PHC services, development of human resources for health, health systems research and health management information systems. WHO will address the main challenges and constraints in the health system such as weak and fragmented infrastructure, ineffective referral systems, critical shortages of health personnel, lack of motivation and inadequate remuneration for health staff.

WHO will assist the government with:

(a) Technical assistance to strengthen the Planning Directorate of the Department of State for Health and Social Welfare;

(b) Development of human resources and health research policies and plans;

(c) Technical assistance in the area of health sector reforms;

(d) Continued training of health personnel;

(e) Operational research in human resources management.

Disease prevention, control and eradication

This component entails supporting disease prevention and control measures in the country, including disease eradication and elimination initiatives. The latter cover poliomyelitis, leprosy, measles and neonatal tetanus, which will receive intensified support with a view to achieving the national and global targets set for their eradication or elimination. The integrated surveillance activities for early detection and response to diseases such as malaria, cerebrospinal meningitis, yellow fever, tuberculosis and HIV/AIDS will continue to receive the attention of WHO through programmes such as EPI, RBM and IMCI.

Childhood diseases, especially acute respiratory infections, diarrhoeal diseases and malaria, continue to pose serious health challenges. The threat of the HIV/AIDS pandemic to the country's population remains real. For the TB control programme, the priority now is sustained compliance with the DOTS therapy.

WHO will focus on the following interventions:

(a) Support to the introduction and implementation of the Integrated Disease Surveillance (IDS) system, including strengthening of laboratory diagnostic services;

(b) Support to the development and implementation of policies and strategic plans for malaria, HIV/AIDS and tuberculosis;

(c) Support to the continued efforts for polio eradication and the elimination of maternal and neonatal tetanus, measles, leprosy, lymphatic filariasis and dracunculiasis.

Reproductive health, maternal and child nutrition

This component incorporates Child and Adolescent Health (CAH) and Women's Health (WMH). It includes support for the Safe Motherhood Initiative, including strategy development, project monitoring and evaluation and provision of TBA kits. High maternal, child and infant mortality rates continue to be a cause for concern. Harmful traditional practices such as female genital mutilation (FGM) continue to be practised in the country. The high fertility rate coupled with increasing levels of teenage pregnancies have contributed to the high population growth rate, which presents additional challenges to health development with high maternal mortality.

Protein-energy malnutrition and micronutrient deficiencies are still high among children.

WHO will focus its efforts on the following:

(a) support for the implementation of the Reproductive Health policy and the Making Pregnancy Safer initiative;

(b) support for the development of an adolescent health strategy and implementation of IMCI in the country;

(c) advocacy for improved antenatal care, child and maternal nutrition and awareness-creation on the risks related to teenage pregnancy and FGM.

Health, environment and sustainable development

This component focuses on the provision of support to government efforts in the implementation of the environmental health policy as well as working with other UN agencies and development partners on issues pertaining to sustainable development and poverty alleviation. WHO's role is to address the health component of the poverty alleviation strategy, realizing that poverty is inextricably linked with health development.

The principal concerns in the area of health and the environment are waste disposal and poor waste management, inadequate food safety measures and limited access to safe drinking water and sanitation.

WHO will provide support for:

(a) the implementation of the environmental health policy with emphasis on healthy settings (schools, villages and cities);

(b) poverty alleviation efforts and sustainable development, focusing on micro-credit projects, with emphasis on creating opportunities for women.

Health promotion and noncommunicable diseases, including mental health and substance abuse

This component incorporates advocacy through health promotion for increased public awareness on the growing problems of mental health and substance abuse and implementation of the Tobacco-Free Initiative involving schools, NGOs, parliamentarians and communities. Noncommunicable diseases such as diabetes and hypertension, which are on the increase in the country, will also receive particular attention.

WHO will focus on the following:

(a) support for the finalization and implementation of policies and plans on mental health, social welfare, the elderly and the disabled as well as the establishment of a database on disability;

(b) development and implementation of a national health promotion policy with emphasis on community-based health promotion interventions, including Open Field days, to create awareness in communities on health issues;

(c) establishment of a website and acting as a reference and dissemination point for the most up-to-date health information in the country; working with the Association of Health Journalists to promote health through the mass media.

Essential drugs, traditional medicine and clinical technology

This component incorporates support to improving access to essential drugs of high quality, development of traditional medicine, improvement of standards on blood safety and clinical care. Essential drugs are not always available in health facilities. Lack of adequate capacity for ensuring drug efficacy and safety is a continuing problem and cumbersome systems of procurement often result in delays. Unregulated traditional medicinal practices need to be addressed. Blood transfusion services are not well developed and there are limited supplies at the National Blood Bank.

WHO will support DOSH in:

(a) improving access to and making rational use of essential drugs of high quality by providing support to the Chief Pharmacist and the drug regulatory authority;

(b) the strengthening of the national blood transfusion services with a focus on the quality assurance aspects of blood safety;

(c) developing and implementing a traditional medicine policy and strategic plan.

While implementing this strategy, 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 MRC and the Faculty of Medicine and Allied Health Sciences will also be strengthened in order to achieve the desired outcomes.

WHO will support DOSH 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.

7 IMPLEMENTING THE STRATEGY

The Country Cooperation Strategy sets out the strategic directions and medium-term agenda of the work of the entire WHO Secretariat in The Gambia. The WHO Proposed Programme Budget 2004-2005 will be reviewed accordingly to take the components of the agenda on board.[26] There is no doubt that the strategic shift described above will have certain implications for the Organization's work at its three levels.

7.1 WHO Country Office

The WHO Country Office will increase 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 new technical staff, especially an epidemiologist, to support disease surveillance programmes (Disease Control Programme officer - DCP).

WHO will support DOSH in exploring the recruitment possibilities 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: essential drugs, blood safety and traditional medicine; health planning; human resources policy and planning; laboratory services; and in other areas where the need may arise.

WHO will jointly review programmes with DOSH to identify areas where it can make the maximum impact. The Country Office will strategically focus on national health priorities by carrying out joint reviews with DOSH with a view to identifying priority areas for action.

WHO will need to build specific capacity for advocacy and resource mobilization in the areas of food safety and nutrition, disease elimination and eradication initiatives, medical equipment and communication systems and transport to respond to obstetric emergencies.

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

The Country Office will document results and demonstrate that WHO as an organization is making a difference in the health of the people of The Gambia. It will implement the strategy for the promotion of the WHO image through technical support for world health days, launching and disseminating the World Health Report, supporting Healthy Cities, Healthy Villages and Healthy Schools competitions 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 out of the CCS. As a starting point, AFRO will review and identify the implications of the Gambia CCS for the Regional Office.

A starting point would be to disseminate the findings of the Gambia CCS document to divisional directors and regional advisers in AFRO. This will create a better understanding among WHO staff of the country's health system and its problems and to improve the scope and quality of technical support provided to the country team.

Bearing in mind the need for additional resources to support the implementation of health issues arising out of the CCS, AFRO will use the document 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.

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

There is need to monitor the impact of the CCS, provide support to countries to implement the recommendations arising from this exercise, and to put in place a framework integrating CCS into the WHO managerial process.

7.3 WHO Headquarters

In line with the principle of "One WHO", WHO headquarters will work with AFRO to mobilize resources and provide technical support for the implementation of The Gambia CCS, and to document lessons arising out of the CCS process and its impact on WHO's work as a whole as well as in individual countries.

Headquarters will continue to provide uptodate technical information to countries, directly and through AFRO. It will provide sufficient packages of WHO publications for Blue Trunk Libraries and other technical materials.

Headquarters, in collaboration with AFRO, will explore the possibility of designating the Medical Research Council in The Gambia as a WHO collaborating centre for public health research.

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

8 CONCLUSION

This CCS will guide the annual plans and programmes of the WHO Country Office in The Gambia for the next four years. It is hoped that it will guide the support from all the three levels of the Organization and will lead to better coordination of the "One WHO" efforts. It is also hoped that this document will guide all partners in their resource mobilization efforts to support The Gambia achieve its stated health development agenda.

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