

PROJET ARIVA

APPUI AU RENFORCEMENT DE L'INDEPENDANCE VACCINALE EN AFRIQUE

UNION EUROPEENNE

ETUDE SUR LA SURVEILLANCE ET LE CONTROLE DES MALADIES TRANSMISSIBLES AUX NIVEAUX NATIONAL ET REGIONAL

Projet n° 8 ACP ROC 039 / TPS 096

Contrat n° 005/2002/MEF/ARIVA

Rapport de mission en Gambie

(17-28 septembre 2003)

CREDES
CONSULTANCE EN SANTÉ PUBLIQUE - PUBLIC HEALTH CONSULTING

CREDES – 53, Rue de Turbigo – 75003 PARIS – France
Tel. : (33) 01.42.74.11.10. – Fax. : (33) 01.42.74.11.20.
E-mail : credes@credes.net

This is a synthetic report drawn from the mission I made in the Gambia Republic in September 18-29, 2003, with the assistance of the focal point of Epidemiological Surveillance, Mr. Abdoulie CAMARA. Both Abdoulie and I worked at the central level. We visited the Royal Victoria Hospital and The Medical Research Council.

We made interview in the Ministry of health, in the Ministry of Finances and some international organizations that are financing or giving technical assistance to the Health information system

We would like to thank all people who are working in the health structures system and having great concern at our disposal to exchange experience in surveillance and disease control¹

We wish we would reach our objective to give orientation to provide technical, organizational and administrative supports for sustainable surveillance system program and response to epidemics for the country in the local level and regional area.

¹ Annex 1: List of persons met
Annex 2: List of organisms visited and mission order signed by The Premier General Secretary of The MOH
Annex 3: Agenda of visit and interview
Annex 4: References

1. THE GAMBIA: COUNTRY PROFILE²

1.1. Geographic profile

Sited on the Western Coast of Africa, The Gambia extends inland from the Atlantic for about 320 km, along the banks of the River Gambia, at widths varying from 24 to 48 km, covering an estimated area of 11,000 sq.km. Located in the Sahel region, it is surrounded on three sides (east, south, and north), by The Republic of Senegal, and on the west by the Atlantic Ocean. The country is also divided into 2 equal halves, namely the North and South banks, by the River Gambia, which runs from the Futa Jallon highlands in the Republic of Guinea to the Atlantic Ocean. It lies between latitudes 13 and 14 degrees North. The Gambia has a short rainy season, lasting from June to October, during which time rainfall ranges from 850 mm to 1200 mm. Over the last twenty years, The Gambia has been hit by a rapid rate of desertification and deforestation, partly due to excessive land use, the destruction of vegetation, erosion of beaches and increase in human livestock population.

1.2. Demographic profile and general indicators

According to the latest census of demographic statistics, The Gambia population is up to 1.4 million inhabitants. By year 2005, it will reach 1.7 million, with an annual growth rate of 4.2%. Almost 60% of the population lives in rural area; women represent 51% of the crude population. The density of the population is approximately 124 persons per square kilometer, the highest population density in the world. At the present trend, this population is expected to double in the next 16 to 17 years. This is a result of high fertility rate of 6.04 births per women and a low infant mortality rate about 84 per 1000 live births. (The average in the Sub Saharan countries is 91 per 1000 live birth).

The age distribution of the population shows a predominance of youths; nearly 45% per cent of the population is below 15 years old and 19% between the ages 15-24, according to the census of 1993.

Average life expectancy at birth is about 53 years, with 52 for male and 55 for female.

The crude birth rate is 46 per 1000. The Gambia has a crude mortality rate of 19 per 1000 in 1993 census.

The Infant Mortality Rate and Under-Five Mortality Rate declined from 217 and 290 per 1,000 respectively in 1973 to 167 and 260 per 1,000 live births in 1998. Infant's survival is highest in Banjul and Kanifing areas and lowest in the eastern part of the country

The leading causes of death are Malaria, Acute Respiratory Infection, Diarrhea, Malnutrition,

The maternal mortality rate is estimated at 7.3 per 1000 live births.

The Literacy rate of the population aged 10 and above has increased from 26% in 1985 to 37% in 1998. Males are more educated than female. Statistics shows that 54% of the male population aged 10 and above are educated as opposed to 26% female population.

The level of education is also low, boys spend less than 6 years in school and girls spend about 4 years in the education system.

But public educational expenditures are growing at an average rate of 9%. Basic education received 56% of education expenditure and secondary education received 10%. Development expenditure on education averaged 31% of the total budget between 1990 and 1996.

1.3. Lack of Income Opportunities

According to the Central Statistics Department's (CSD) 1992/93 Household Economic Survey, 29% of the population has an annual income below US\$150, and 48% fall below an annual income of US\$200. In rural area, 66% of the population have an annual per capita income of less than US\$200. The table below shows the poverty profile, under the International indicator of One US\$ a day.

The Gambia: % Contribution of Sectors to Gross Domestic Product at factor Coast.

² Main reference sources: (i) Human Resources For Health Situational Analysis Report, November 2002, (ii) Interim Strategy For Poverty Alleviation II (Interim – SPA II), October 5, 2000, (iii) Integrated Management of Childhood Illness (IMCI) Strategy Plan, 2004-2008, 21Th July, 2003

Sectors	1997	1998	1999
Agriculture	21.9	21.1	25.4
Industry	12.0	12.2	11.6
Services	66.1	66.7	63.0
GDP at Factor Coasts (Million Dalasis)	D554.3m	D574.8m	D619.2m
Indirect Tax (net) (Million Dalasis)	D84.9m	D87.1m	D84.7m
GDP at Constant Mkt.Prices (Million Dalasis)	D639.2m	D661.9m	D703.9m
Real GDP Growth rate	4.9%	3.6%	6.4%

Sources: CSD 1992/93 Household Economic Survey

1.4. Indicators and Predictors of health services

According to the analysis of some health indicators, some progress is made in some area, but The Gambia indicators remains low when compared to Sub-Saharan Africa countries.

	GNP per capita (US\$1997)	Life expectancy	Fertility rate	Infant mortality (Per 1000)	Male Primary enrolment	Female Primary enrolment	Illiteracy of pop. Aged 15+	Access to safe water (% of pop.)	Access to Sanitary Facilities
The Gambia	340	53	5.8	76	74	58	65	50	37%
Sub-Saharan Africa	510	55	5.4	92	n.a.	n.a.	40	47	n.a.

Sources: World Development Indicators

There is a high prevalence of endemic diseases, particularly malaria, diarrhea diseases, acute respiratory infections, leprosy, tuberculosis and sexual transmitted infections; an increase rate of HIV has also been noted with a preliminary estimate for the year 2000 of at least 3% for HIV-1.

Epidemics such as meningitis still continue to wreak havoc in the population. But there is no cholera since 1995 and no or yellow fever since 1978 according to ESU Unit report.

Malnutrition is a major public health problem in The Gambia because lack of household food security, access to health services and unhealthy environment. Children under five, pregnant or lactating women are particularly exposed to severe malnutrition. In rural area, more than 30% of young children are chronically malnourished.

However considerable effort and progress has been made in some aspects of the health, for example the Extend Immunization Program (EPI) with about 86.5 % coverage rate in DTC3 and 88.7% in measles in 2001. The implementation of Bamako initiative also made good performance.

Government, NGOs and private sectors provide health care services. Since adoption of a Primary Health Care Program (PHCP) in 1978, access to health care improved substantially; it is estimated that about 91.1% of the population now live within 10 km of a Hospital or Health Division or District. In rural area 84.4% live within 10 km and in urban area the rate is 100%.

Population accessed to immunization services within 5 km from a facility or outreach station providing vaccination is estimated about 99,6% of the population in 2001³

Health service utilization for outpatient visits at public facilities per capita is about 0.7 and for inpatient visits 8% of the total population in 2000.⁴

These low rates in service utilization are due to lack of health centers fully functional, a shortage of medical, nurse and inadequate staffing of all Divisional Health management Teams. Lack of income is also associated with low rate of admission in hospitals or health facilities.

³ Reference sources quoted from www.dosh.gm

1. Annexe5: Health Management Information System Hospital and Health Facilities Indicators, 2001
2. ⁴ Annex 6: Health Management Information System National Level Indicators, 2000

1.5. Health Policy and the Politics of Health Care

1.5.1 Health Care System / health Structure

A Secretary of State (SOS) heads the health service for Health and Social Welfare assisted by a Permanent Secretary, two Deputy Permanent Secretaries and Director of Health Services (DHS).

The health care system of The Gambia follows the primary health care strategy and is organized into three levels –primary, secondary, and tertiary. The primary levels provide for initial care and preventive action through a network of village health post, linked through key villages and staffed by Villages Health Workers (VHWs) and traditional Birth attendants (TBAs) supervised by Community Health Nurses (CHNs). This level is the first point of contact for people seeking health care. At this stage 492 health posts available including 16 dispensaries, 145 outreach stations. The secondary level, which provides for procedures less complicated than the tertiary, has a network of major and minor health centers, and dispensaries with more specialized staff and equipment. It provides for routine preventive and curative services and some medical, surgical and obstetrics interventions. This intermediate level is composed of 36 health centers. The tertiary level, with 4 Government referral hospitals, provides for more specialized services and interventions and is intended to function as a referral service for the secondary level. In addition there are 7 NGOs hospitals and 13 private clinics.

It is estimated that about 80% of the population lives within 7 km of a health facility and 80% of villages have a primary health care program.⁵

The Gambia is divided into 7 administrative divisions comprising five rural and two urban administrative areas (Kanifing and Banjul).

To achieve decentralization, the country is divided into 6 Health Divisions administered by Divisional Health Teams (DHTs). Western Health Division, Lower River Health Division, North Bank East Health Division, North Bank West Health Division, Central River Health Division, and Upper River Health Division.⁶ Divisions are subdivided into primary health care (PHC) villages and key villages. There are 490 Primary Health Care villages and 69 key villages.

1.5.2. National Health Policy

A new health policy has been developed “Changing for Good”⁷, in September 2001, based on the Primary Care approach.

Selected policy issues are⁸

- Essential Care Package
- Essential Care Package for primary care (Villages) Health Services
- Essential Care Package for Secondary health Services (Minor Health Centers)
- Essential Health care Package for Major health Centers and hospitals)
- Five-Year Strategic Goal: Human Resources Development
- Five year strategic Goal: Essential Drugs, Vaccines and other Medical supplies
- Five year Strategic Goal: Referral System
- Five-Year Strategic Goal: Health Financing
- Five-Year Strategic Goal: Community Participation
- Five-Year Strategic Goal: Partnerships

By adopting “Changing For Good”, The Department of State for Health is committing in his vision an attainment of accessible quality health care for Gambian population that would be a model in the Africa Region by the year 2020;

⁵ Quoted from (i) National TB Control Program, Strategic Plan for Tuberculosis control, THE GAMBIA 2003-2007 (ii) Health Management Information System Policy, 17/04/02. (iii) Human Resource For Health Situational Analysis Report, November 2002.

⁶ Annex 7: Average annual Growth and % Change in Population 1993-2003

⁷ Reference: Changing For Good, Health Policy Framework, Department of State for Health and Social Welfare, Banjul, THE GAMBIA

⁸ Annex 8: details about National Health Policy « Changing For Good »

In addition the mission statement in the new policy aims to provide quality of health care services within an enabling environment, delivered by appropriately and adequately trained, skilled and motivated personnel at all levels of care with the involvement of all stakeholders to ensure a health population.

1.5.3. Health Care Delivery System and Human resources⁹

1.5.3.1. Health Structures: Volume of facilities

Department of State for Health Facility beds						
Division or District	Facility Beds 1993	Facility Bed 2000	1993 Population (Census)	Beds per 1,000 Population in 1993	2000 Population (Projected)	Beds per 1,000 Population in 2000
Western Division	479	797	505,457	0.95	758,624	1.05
North Bank West	29	29	71,573	0.41	93,778	0.31
North Bank East	54	175	84,880	0.64	103,468	1.69
Lower River Division	48	52	65,146	0.74	73,131	0.71
Central River Division	214	240	156,021	1.37	181,193	1.32
Upper River Division	94	117	158,059	0.59	202,044	0.58
The Gambia	918	1,410	1,041,136	0.88	1,412,239	1.00

Because of the extensive overlap of facility use by the residents of Banjul and Kanifing Municipality, catchments area populations cannot be specified for each facility.

This table shows the number of facilities per 1,000 populations (Districts, Health Facilities) and the range of population per facility.

Catchment Area Population for facilities					
Division or district	Population 2001 (Projected)	Population Per Facility	Range of Population per Facility	Number of Facilities (include NGO but not private facilities)	
Banjul an Kanifing Municipality	477,238	68,177		Western Division	17
Western Division				Banjul and Kanifing	7
Kombos	326,692	46,670	40,787-55,195	Kombos	7
Foni	41,282	13,761	5,745-21,976	Foni	3
North Bank West	97,469	19,494	14,189-24,000		5
North Bank East	106,476	21,295	16,817-3		5
Lower River Division	73,131	14,626	7,611-35,05		5
Central River Division	185,107	18,511	9,019-45,364		10
Upper River Division	209,256	52,314	16,920-73,927		5
The Gambia	1,475,369	31,391	5,745-73,927		47

1.5.3.2. Human Resources. : Availability of volume of personnel

Department of State for Health Medical staff at hospital, Secondary Health Facilities and PHC Villages (including Technical Assistances)							
Division or District	Physicians	All Nurses	Midwives	2001 Population (Projected)	Physicians/1000 Population	All Nurses/1000 Population	Midwives/1000 Population
Western Division	85	326	142	803,930	0.11	0.41	
North Bank West	9	45	17	97,469	0.09	0.46	
North Bank East	29	84	19	106,476	0.27	0.79	
Lower River Division	14	46	17	74,349	0.19	0.62	
Central River Division	49	91	34	185,107	0.26	0.49	
Upper River Division	20	64	14	209,256	0.10	0.31	
The Gambia	206	656	243	1,478,587	0.14	0.44	

Number of personnel per 1,000 populations (Doctors, nurses, midwife). The number of physician per 1000 population is 0.2, among them 91% are expatriates and 81% of them are employed by the public sector.

⁹ References quoted from annex 5 and annex 6, Health Management Information System

The number of nurses and midwives per 1000 population is about 0.8, and 80% of them are used by the public sector. Village health worker represent only 0.3 per 1000 population.¹⁰

As a result, human resources are a big deal in the Gambia. The country needs physicians and specialists for better health care. Other major issues in human resources are motivation that deals with efficacy and efficiency at work. Employees are almost de-motivated and do not perform their work at a regular basis and at the required standard. This has a negative effect on quality of service and health status and social economic growth of the population.

Fortunately, many training courses in public health are offered in the Gambia.

- This is an overview of health training course in the Gambia
- State Registered Nursing Course
- Higher Diploma in Environmental Health Sciences (PHO)
- State enrolled Nurse Training Course
- Community Health Nursing Course
- Laboratory Technician Course
- Medical Doctor Course
- BSc Nursing Course
- BSc Public Health Course

1.5.3.3. Health Service Financing

Aggregate National Health Expenditures (1999, 2000, 2001, 2002)¹¹

Details of Expenditures	1999	2000	2001	2002
Personal Expenditures	21,708,690	25,413,050	30,901,410	33,285,470
Others Charges	51,181,790	65,850,720	79,452,730	100,350,810
Total Health Expenditures	78,890,450	91,263,766	110,345,144	133,636,281

The gross national product (GNP) per capita is amounting to 330 US\$ in 2000.

A variety of qualitative factors are believed to have contributed to the disproportionate growth in health care spending relative to the growth in GNP such as rising expectations about the value of health care services, government financing health care services

The annual growth gross domestic product rate (GDP) per capita is amounting to 3.4% between 1998-1999.

The National Health care expenditures reached 133,636,281 million Dalasis in 2002. During the last four years, health care expenditure grew at the substantially faster pace than did the overall economy, consuming an increasing percentage of gross national product. For example, the National health expenditures rose 69 percent from 1988 to 2002.

In 2000 year, NHE absorbed 3.4 percent of GDP, compared with 2.2 percent for the preceding year. The abnormally high increase in the share of GDP spent for health care in 2000 year, the second largest jump since 2002 year, is the result of slowdown in the general economy rather than an acceleration in the growth of health care costs.

Per capita health expenditures of 12 dollars in 2000 were almost four times as great as expenditures two years earlier.

In 2002, personnel health care expenditures accounted for 25 percent of the total amount of health expenditure. The best increase was in 2001 with 28%.

Public programs contributed 13.6 percent of the funding for health care. Partner's contribution is not available.

Government plays a major role in planning, directing, and financing health services in the Gambia.

¹⁰ Annex 6: Keys Health Indicators for The Gambia, Health Management Information Systems

¹¹ Annex: 9: Department of State for Health and Social Welfare: Details of Expenditure (Estimates of Recurrent Revenue and Expenditures with Development Expenditure, 2001,2002

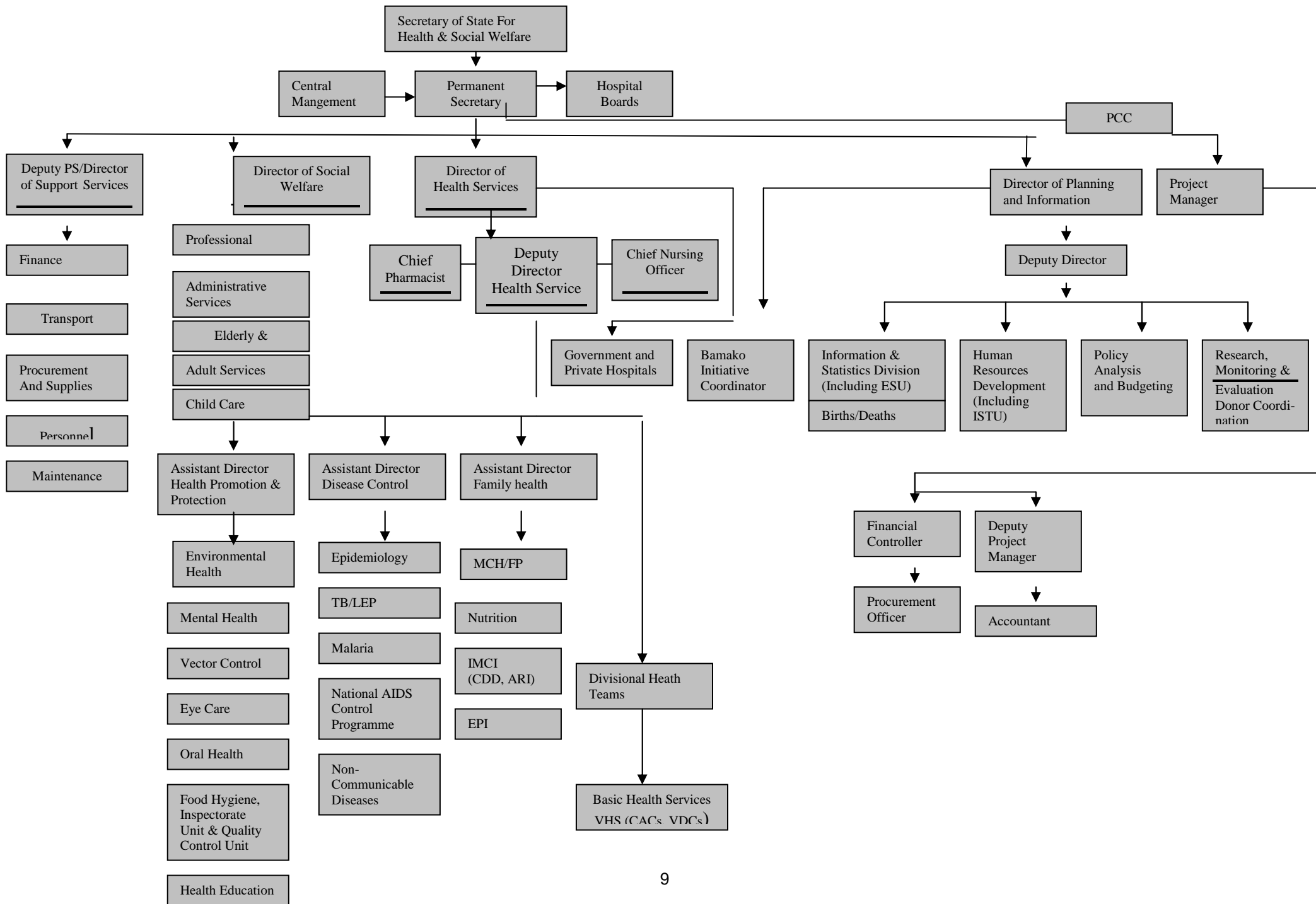
2. MANAGEMENT AND ORGANIZATION OF THE HEALTH SYSTEM

2.1. The Health Care System

The present diagram at the national level shows the organization of the health care system

- The permanent Secretary
- The Director of Health services
- The Director of Planning and Information (Include HMIS, HRD, Policy and Budget)
- The Director of Social Welfare
- The Deputy PS/Director of Support services
- The Program Units (Coordinated by Assistant Director Disease Control: ESU, TB/LEP, MAL, AIDS)
- The Program Units (Coordinated by Assistant Director Family Health IMCI, EPI, MCH)
- The Divisional Health Teams (Operational level) directly depends on Direction of Health Services
- Basic Health services (Community level)

2.1.1 Organization Chart



A Secretary of State (SOS) heads the Health service for Health and Social Welfare assisted by two Deputy Permanent Secretaries and a Director of Health Services (DHS).

The Gambia Institutes or Services in charge of Health Care	Health Institutes involved in surveillances activities and Response
The Secretary of State for Health and Social welfare	<input type="checkbox"/>
Vice President	<input type="checkbox"/>
School of Public Health	<input type="checkbox"/>
School of Nursing and Midwifery	<input type="checkbox"/>
Government and Private Hospital	<input type="checkbox"/>
University of The Gambia Faculty of Medicine	<input type="checkbox"/>
Medical Research Council	<input type="checkbox"/>
School of Community Health Nurses	<input type="checkbox"/>
School of Enrolled Nurses	<input type="checkbox"/>
School of Public Health	<input type="checkbox"/>

The Vice-President runs these committees and mobilizes resources for the circumstances.

Health Services Head Programs being interest to surveillance activities and response to epidemics.

Health Services/Programs	Routine	Early Warning	Response
Permanent Secretary			X
Director of Health Services	X	X	X
Director of Support Services			X
Assistant Direction of Health Promotion and Protection			X
Direction of Planning and Information System****	X	X	X
Division of Health Teams ***	X	X	
Assistant Director of Disease Control	X	X	X
Epidemiology and Statistics Unit (ESU) *	X	X	X
EPI **	X	X	X
Malaria Control Program	X	X	X
IMCI	X		
Information & Statistics Division (Epidemiology and Statistics Unit) ****	X		X
National AIDS Secretariat (NAS)	X		X
National AIDS Control Program	X		
TB/LEP	X		
Interagency Committee	X		X
Epidemic Preparedness Committee			X
Members of the Task Forces (HIV, EPI, BSS, IDSR, Meningitis Task Forces)	X	X	X
Laboratories	X	X	X

(*) Is part of Information and Statistics Division

(**) EPI is under The Family Health Office

(***) Division of Health team for basics health services is directly connected and supervised by Health Services Administration. Under Planning and Information Office but in practice, this ESU is under the Assistant Director of Disease control

2.1.2 Coordination mechanism between Institutions, Services and Programs in surveillance activities and response-Interactions between institutions, health staff and program managers

Although there are parallel surveillance system but Epidemiology Surveillance Unit (ESU) is responsible for the coordination and implementation of activities such as data collection, analysis and feedback. All these parallel programs rely on ESU for information generation from the field to the central level for planning and intervention purposes.

The main interaction institutional mechanism between actors or program is:

- The Epidemic Preparedness and Response Committee
- The Committee members meet regularly with this Epidemic Response Team whether or not they are an outbreak. Although members have other responsibilities they meet as often as needed to plan, implement, monitor and report on the epidemic response.
- National Epidemic Response Coordination Team (Page 103 IDSR Guideline)
- Technical IDSR Team (page103 Guide IDSR) Interagency Coordinating Committee
- Include partners who assist The SOS and Social Welfare. They have meetings on a regular basis according to their Schedule WHO is the only intervener for IDSR and put in financial resources but all program units take part in the IDSR process.
- Members Of Task Forces
- Members of task Forces have many responsibilities although their responsibilities are very well defined they encounter many difficulties because no early warning system is in place, no emergency stock available. The shortage of both qualitative and quantitative personnel hinders the quality of service delivery during emergency.

Health Management Information System overlaps all the Health Information System and collects from the field to the Division to the central level.

2.1.3. Roles and responsibilities of participants acting in surveillance

The roles and attributions of interveners in surveillance are well defined.

Sentinel Surveillance Task Force: assists the National Task force HIV/AIDS and Monitoring Evaluation specialist in the development of epidemiological map on HIV/AIDS and related diseases to facilitate information sharing at all level (National, Divisional, District, Village and Community level). The IDSR focal point is a member of Sentinel Surveillance Task Force and coordinates this sample collection from the sentinel sites and data entry, verification, analysis and feedback

EPI Task Force: Include the Polio Certification Committee and Polio Eradication Committee. The Polio Eradication Committee is responsible for reviewing cases; the Polio Certification Committee is responsible for the certification of The Gambia as a polio free country. Polio is one of the IDSR priority diseases targeted for elimination and eradication. Therefore the IDR Focal Point actively involved in AFP surveillance.

IDSR Task Force (IDSR Guideline Page 103)

Meningitis Task force: Is looking only on meningitis, resources mobilization for meningitis champagne.

Conflicts do not happen between task Forces and IDSR because role and responsibilities are clearly defined.

So mistake, misunderstanding, or error are not common because all Tasks Forces depends on the Director of Health services that manages the meeting.

The Chief Pharmacist directly depends on the Department of State for Health to purchase and manage drugs, reagents and materials.

Laboratories are under the Hospital, which directly connected to Permanent Secretary of health.

Other Factors of Success and Factors of constraint are:

Factors of Success	Factors of constraint
<ul style="list-style-type: none"> ▪ Political commitment ▪ Interagency Coordinating committee is active ▪ EPI Review is done ▪ IDSR Assessment in 2001 ▪ Five year EPI Strategic Plan 2003-2007 ▪ Five Year IDSR Strategic Plan 2002-2006 ▪ Existence of focal point IDSR in Division (Three per Health Division) ▪ Five year Strategic Plan for TB 2003-2007 ▪ Strategic Plan for HIV-AIDS from 2003-2008 ▪ Strategic Plan for Malaria 2002-2007 ▪ Annual Plan of Action for Department State for Health and Social Welfare (2003) ▪ Guidelines for IDSR 	<ul style="list-style-type: none"> ▪ Quantitative and qualitative human resources ▪ Shortage of material and equipment resources ▪ The IDSR and laboratories don't have budget line in the estimate ▪ Supervisory vehicles are lacking for ISDR and the Laboratory ▪ Poor office furniture for ESU

2.1.4. Official support mechanism

By and large official orders or decrees exist and clearly defined. Most of them are included in document reports.

2.2. Analysis

2.2.1. Strengths and Weaknesses

Strengths	Weaknesses
<ul style="list-style-type: none"> - A Management Health Information System that centralizes data collection - A network laboratories - Political commitment to enhance surveillance - Coordination mechanism between Institutions, Programs and agencies - Tasks Force Committees - Local schools for training in surveillance with health care package - New Health Policy framework - Human Resources For Health Situational analysis - Real annual growth Rate in health expenditures 	<ul style="list-style-type: none"> Some Parallel system of surveillance despite the implementation of IDSR Shortage of train for both quantitative and qualitative human resources Staff are overloaded Delay in the implementation of plan Parallel data collection activities by some Program Units and donor-sponsored programs are becoming a serious threat to the integrity an sustainability of the Heath Management Information System

2.2.2. Needs and Suggestions

2.2.2.1. Needs

There is still parallel surveillance system in the Department of State for Health & SW; therefore, there is a strong need for effective integration for IDSR to maximize the use of human, material and financial resources

There is a need to implement the Human Resources Development Plan as soon as possible
 There is a need to finalize and implement IDSR Strategic Plan

There is a need to create a budget line for the Integrated Disease Surveillance and Response.
There is an urgent need to train two ESU staff in Epidemiology

2.2.2.2. Suggestions

The IDSR Plan of Action be revised, finalized and sole to the donors
The staff capacity of the Epidemiology and Statistics Unit is very small and needed to be increased.

It is essential that DOSH and SW have a unified and truly interrelated system of data collection and storage rather than competing systems.

The staff collecting data in Primary Health Care villages and the health facilities is very few in number and seriously overtaxed with work.

Consequently multiple forms that duplicate information must be avoided to limit the burden of data collection and reporting for better coordination.

The Department of State for Health & SW has no national epidemiologist and therefore, the need to train at least two epidemiologists is paramount

The training need for the EPI staff is highly recommended, as there is a great need
All the surveillance components for the other programs units be surrendered to the ESU as the surveillance focal unit for the department

There is a great need for all the programs units to send all that they needed from the field to ESU so as to put them on one/two reporting tool to avoid duplication of efforts and waste of resources (both human, material and financial)

There is good laboratory networking system but the lack of vehicle to supervise and monitor their activities is a big set back to them

The extension of the National Laboratory will be a big achievement for the Department of State for Health & Social Welfare

There is a great need to boost the availability of vaccines, laboratory supplies and medicines
The human resource capacity of the Department of State for Health & SW is grossly inadequate and therefore, there is a great need for staff training

There is high attrition rate in the Department of State for Health & SW and therefore, there is a need for staff retention plan and implemented as soon as possible so as to maintain the quality service delivery system.

We suggest adding more IDSR focal points in the hospitals from two to at least three because they have other responsibilities.

Three data entry clerks be employed and stationed at the ESU to facilitate data entry of HMIS, IDSR, Sentinel Surveillance data and other epidemiological research data.

3. PLANNING SYSTEM OF SURVEILLANCE

3.1. The Integrated Disease Surveillance Status

3.1.1 Implementation stage of Interpreted Disease Surveillance and Response.

The Gambia has already realized a Five Year Strategic Plan for IDSR that needs to be financed by partners. This document was elaborated thanks to many reports generated by programs such as IDSR Assessment of National Communicable Disease Surveillance System and Epidemic Preparedness and Response in year 2001, Five year Strategic Plan for Tuberculosis in year 2003 Malaria Strategic Plan in year 2002, a Five year HIV- AIDS Strategic framework in year 2003, EPI Multiyear Action Plan in year 2001, EPI review in year 2001

The lessons learnt about these documents were reviewed to finalize the IDSR Strategic Plan of Action for disease surveillance.

3.1.2. Existing Document for planning use in the Department of State and Social Welfare

The main documents related to surveillance activities are:

- Expanded Program of Immunization Multi Year Action Plan 2001-2005L
- Annual Plan of Action 2003 for the Secretary of State for Health (SOS)
- Assessment of National Communicable Disease Surveillance System and Epidemic Preparedness and Response
- Strategic Plan for Tuberculosis control 2003-2007
- IMCI strategic Plan 2004-2008
- Malaria Strategic Plan of Action 2002-2007
- HIV-AIDS Strategic framework 2003-2008

3.1.3 Roles and responsibilities of actors in surveillance

The national level give according to issues and priorities the overall orientation strategic and aspects of planning disease surveillance and response. Each Division using the available means of the locality, and according to their needs, elaborate their micro-plan of action using the national conceptual strategic plan of disease surveillance.)

3.1.4. Planning Process

The Gambia achieves the following stages of implementation in the Integrated Disease Surveillance and Response process. Assessment, strategic plan, training and technical guideline for surveillance. However, disease surveillance still remains parallel and functions to its own strategic plan of action even though the Director of Health coordinates the planning process for any of these programs.

3.2. Analysis

3.2.1. Strengths and Weaknesses

Some problems encountered during the planning process can be specified as:

- Not enough time frame and human resources to deal with all aspects of the planning process although many programs take part of the planning process. The staff is over loaded with many responsibilities
- Other resources are not available such as vehicles, computer, laptops, supplies etc....
- The plan of action stresses more focus at the National level than the division level
- Only WHO intervene to give financial support to IDSR, as a result there is a lack of human resources, equipment, laboratory supplies and logistic support to handle all aspects of the planning process.)
- IDSR and the Laboratories do not have any line estimate in the regular national budget
- Planning aspects occult a budget line for emergency in case of epidemic and laboratories supplies.
- IDSR still runs as a parallel system to other programs

3.2.2. Needs and Suggestions

To improve the planning process, the health system of surveillance should:

- To create an environment to facilitate consultation between program units, the Health Management Information System and laboratories.
- To develop more training for senior and Middle level staff
- To advocate provision of specialized equipment and logistic support
- To create budget line for integrated disease surveillance and response
- To give the Epidemiology Surveillance Unit its real power for coordinating surveillance activities and response to diseases and put in place a mechanism to coordinate and evaluate all interventions in which it will include program units and partners.
- The integrated reports that are needed for the Integrated Disease Surveillance and Response process can be easily generated from the data collection in Health Information System without duplication of effort
- To reinforce and enhance the laboratory network for human resources and supplies

- To allocate more resources to the Divisions and to train the staff on emergency preparedness and response
- To put a task Force in place that monitors the trend of diseases.

4.THE MANAGEMENT HEALTH INFORMATION SYSTEM AND THE EARLY WARNING SYSTEM

4.1. At the central level

4.1.1. Human resources

4.1.1.1 Existing

The following table shows the number of personnel dealing with surveillance activities:

Qualification	Existing							Source of allowance	Needs							Gaps						
	EPI	ESU	TB/LE P	HIV-AIDS	LAB	HMIS	Ttl		EPI	ESU	TB/LE P	HIV-AIDS	LAB	HMIS	Ttl	EPI I	ESU	TB/LE P	HIV-AIDS	LAB	HMIS	Ttl
MPH	0	0	1	0	0	0	1	State	0	1	2	2	0	0	5	0	1	1	2	0	0	4
Epidemiologist	0	0	0	0	0	0	0	State	1	2	1	1	0	1	6	1	2	1	1	0	1	6
MD General Practicing	0	0	0	0	0	0	0	State	0	0	1	1	0	0	2	0	0	1	1	0	0	2
Microbiologist	0	0	0	0	2	0	2	State	0	0	2	2	6	0	10	0	0	2	2	4	0	8
Statistician	0	0	0	0	0	1	1	State	1	1	0	0	0	2	4	1	1	0	0	0	1	3
Tech. Labs	0	0	0	0	1	0	1	State	0	0	0	0	6	0	6	0	0	0	0	5	0	5
Computer scientist	0	0	0	0	0	1	1	State	0	1	0	0	0	1	2	0	1	0	0	0	1	2
Data Manager	1	0	0	0	1	1	3	State	1	1	1	0	1	2	5	0	1	0	0	0	1	4
Health Officer	0	0	0	0	0	0	0	State	1	1	1	1	0	1	5	1	1	1	1	0	1	5
Logistician	1	0	0	0	0	0	1	State	1	0	0	1	1	1	4	0	0	0	1	1	1	3
International TA	0	0	0	0	1	1	2	Partner	0	1	1	1	2	1	6	0	1	1	1	1	0	4
National consultant	0	0	0	0	0	0	0	State	0	0	0	1	1	1	3	0	0	0	1	1	1	3
Demographer	0	0	0	0	0	1	1	State	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Secretary	1	1	1	1	1	2	7	State	1	1	2	1	1	2	8	0	0	0	0	0	0	0
Drivers	2	1	2	2	0	1	8	State	2	2	2	2	1	2	11	0	1	0	0	1	1	3
Informatics Technician	0	0	0	0	0	1	1	State	0	0	0	0	0	1	1	0	0	0	0	0	0	0
Guardian	0	0	0	0	0	0	0	State	1	0	0	0	1	1	3	1	0	0	0	1	1	3
Total	5	2	4	3	6	9	29		9	11	13	13	20	16	81	4	9	7	10	14	9	55

4.1.1.2. Strengths and weaknesses

- There is a lack of human resources in the Government estimates and most of them aren't well trained to have the capacity to deal with surveillance.
- As a result the little staff are overloaded and then effectiveness becomes reduced in implementation process.
- Sometimes implementations are delayed because of staff commitment to other duties
- In addition some position have not been yet created in the estimate because of financial constraints.
- Critical shortage of skilled Human Resource for Health (HRH) in every level and in most health services. Skilled indigenous staff is rare in many programs. Activities are not well performed because of very low salaries that contribute to limited motivation and possible development of activities.
- Financial training resources are not available to improve the skill of actors
- Some position have not yet been created in the estimates
- There is no autonomy regarding human resource management.

But a strong political commitment motivates the Government to elaborate a plan of action for human resources in order to solve the gap between the existing and the needs. A situational analysis of the human resource for health in the Gambia was performed to identify issues and provisional proposals for a "Human Resource for Health Policy"¹²

Some strong points:

- A National Health policy "Changing for Good 2001" is in place
- The Department of State for Health (DOSH) is developing a strategic Plan 2002-2007 with a component on Human Resource Development.
- A mechanism is ongoing to decentralize health services and Human Resource for Health (HRH) management.
- Primary Health Care (PHC) is very well implemented and functioning well through training and support of Community Health Nurses (CHNs), Traditional Birth Attendants (TBAs) and Village Health Workers (VHWs).
- The local training on IDSR has really improved the case definition, reporting, follow up and sample collection, storage and transportation to the National Health Laboratory Services.

4.1.1.3 Needs and suggestions

Most of the needs and suggestions are well developed in the Human Resource for Health Situational Analysis Report.

- Joint supports are needed (Government, Donors, NGOs) in both financial and technical aspects to fulfill related activities;
- DOSH Strategic Plan of Action needs to be established and linked to the National Health Policy;
- There is a strong need to build human capacity in order to fill the gap and reduce the burden and transfer responsibilities to others.

The specific need for software in order to collect, process and analyze data fore epidemiological investigation are:

Qualification	Strength	Types Of software	Coast In USD	Comments
Medical Doctor, MPH	6	EPIINFO, SPSS Access	1500	2 months
Medical Doctor Epidemiologist	3	EPIINFO Access, Excel, SPSS	750	2 months
Statistician	3	EPIINFO	850	3 months
Microbiologist	6	Excel	1200	3 months
Computer scientist	2	DOS	2000	One year

¹² Human Resources for Health Situational analysis Report, Nov. 2002

Health Officer	4	Word	350	One year
Lab Tech	10	EPIINFO		
Data Manager	4	EPIINFO Access, SPSS, Excel	1000	3 months
Telecom/video/VHS	3	Excel, Access	900	One year
Logistician	3	EPIINFO Access	750.00	3 months

The others needs of training at the central level are:

Qualification	Strength	Type of training	Coast In USD	Comments
Microbiologist	2	MSC	250,000	1 year
Toxicologist	1	BSc	8,000	3 years
Tech. Labs	10	BSc	110,000	One year
Data Manager	3	Diploma/BSc	6,000	One year
Epidemiologist **	2	MSC in Epidemiology	150,000	2 years
Secretary	1	Certificate	200	1 year
Logistician	3	Diploma	4,000	One year
Medical doctor	1	BSc	6,000	3 years
Specialist Telecom/radio/VHS	2	BSc	6,000	3 years

** very urgent because there is no Epidemiologist in The Gambia

Most of the training needs can be organized in the Gambia according to the Human Resource for Health Situational Analysis Report.

State Registered Nursing Course (Higher National Diploma Course for Midwifery)
 Higher Diploma in environmental Health Sciences Public Health and Vector Control)
 State Enrolled Training Course (Midwifery and ophthalmology nursing)
 Community Health Nursing Course (Midwifery and ophthalmology nursing)
 Laboratory Technician Course (Certificate in Laboratory Science)
 Medical Doctor Course
 BSc Nursing Course (Community Health, Management Training, Research)
 BSc Public Health Course

Comments and views concerning the improvement of the training programs

Training institutions are under the Department of State for Education (DOSE) so we recommended giving a strong support for the Medical School to generate a more sustainable Human Resource to link public health sector to teaching staff.

4.1.2 Financial Resources

4.1.2.1 Existing !

The Five-year IDSR Plan of Action is already elaborated but does not have financial support; only WHO puts a little amount of money on it.

Source	Amount	Comments
State	15,000 USD	Not yet included in the National Budget
WHO	9000 USD	Regular Budget 2004-2005 for IDSR
UNICEF	441,000 USD	Measles campaign December 2003

Government or donors needs have not yet supplied procurement of materials and training. As a result IDSR is ruining slowly and the results have few outputs.

4.1.2.2. Strengths and weaknesses

Some strong points

Only WHO gives financial support to IDSR and provide vaccines

But we find many weaknesses: (i) Vaccine often are not available on time during epidemics (ii) delay in the implementation process (iii) there is no financial resources allocated to the Central, Divisional and Peripheral level (iv) Financial resources allotted to surveillance e are directly managed by MO/EPI WHO officer so many difficulties in timely receipt of financial resources to staff when funds are requested from WHO, (v) During epidemic many people are involved but resources are grossly inadequate, (vi) financial resources from the government are not directly managed by the Health Division or peripheral level.

4.1.2.3. Needs

- To Include IDSR in the estimates
- Long-term training for staff to improve their knowledge and skills (management for financial resources)
- -To Decentralize financial resources from DOSH to the Health Division
- To advocate donors to fund and implement IDSR
- To reinforce human capacity in qualitative and quantitative manners
- To propose incentive to health staff to retain them in the health sector
- To open an Account for the ESU for emergency purposes and for the effective implementation of IDS

4.1.3. Materials and Resources

4.1.3.1. Existing logistic equipment I

Equipment allocated to the Epidemiology and Statistic Unit at the central level are as follow:

Computer type	Existing number and software name							Source of Financing	Needs							Gaps						
	EPI	ESU	TB/LEP	HIV-AIDS	LAB	HMIS	Ttl		EPI	ESU	TB/LEP	HIV-AIDS	LAB	HMIS	Ttl	EPI	ESU	TB/LEP	HIV-AIDS	LAB	HMIS	Ttl
Laptop	2	1	0	0	2	2	7	WHO/Partner	3	3	1	1	0	2	10	1	2	1	1	0	0	5
Desktop	5	2	2	2	4	7	22		6	6	3	3	4	9	31	1	4	1	0	3	2	11
Software applied to ESU/HMIS/Lab	0	0	0	0	0	2	2			3 SPSS /EPIN FO/H M			1 SPSS	2 SPSS /EPII NFO	6	0	3				2	5
Printer	2	0	2	2	2	3	11	Partner	3	4	3	3	3	4	20	1	4	1	1	1	1	9
Photocopier	1	0	1	0	1	1	4	Partner	2	1**	1	1	1	1	7	1	1	0	1	0	0	3
Overhead Projector	0	0	0	0	1	0	1	Partner	1	1	1	1	1	1	6	1	1	1	1	0	1	5
Data show	0	0	0	0	1	0	1	Partner	1	1	1	1	1	1	6	1	1	1	1	0	1	5
Vehicles	2	1	1	0	0	0	1	Partner	3	2	0	1	1	2	2	1	1	0	1	1	2	2
Motorbike	0	0	0	0	0	0	0		7	8	0	0	1	0	16	7	8	0	0	1	0	16
Bicycle	0	0	0	0	0	0	0		0	1	0	0	1	1	3	0	1	0	0	1	1	3
International Phone line	0	0	0	0	0	0	0		1	1	1	1	1	1	6	1	1	1	1	1	1	6
Fax	0	1*	0	0	0	0	1	Partner	1	1	1	1	1	1	6	1	0	1	1	1	1	5
Mobile phone	0	0	0	0	0	0	0		1	2	1	1	2	1	8	1	2	1	1	2	1	8
Radio VHS	0	0	0	0	0	0	0		2	2	0	0	0	1	5	2	2	0	0	0	1	5
Internet	1	0	1	0	1	1	4	Partner	1	1	1	1	1	1	6	0	1	0	1	0	0	2
GPS	0	0	0	0	0	0	0		0	0	0	0	0	0	0	0	0	0	0	0	0	0

* The fax machine is only within the country (local)

** Giant photocopier for ESU

WHO or some partners such as World Bank make all investments

Interactions between services, programs and Divisions in management of resources for surveillance.

- There are no interaction mechanisms between programs to manage the budget for surveillance. No one is given the responsibility to manage budget equipment or materials. The Department of State manages the resources.
- There is no maintenance cost for equipment; no one is trained to deal with all these aspects.
- The laboratories are under the hospitals and therefore have no regular budget in the estimate.
- There is a scarcity of manpower and equipment. Personnel are not trained to take care of maintenance. Only partners allocate few resources for maintenance cost.
- Equipment do not survive a long time because of many users and lack of maintenance cost
- The reporting system is often delayed in term of timelessness and completeness.

The putting up of resources system to make all necessary arrangement and to place materials and equipment are also delayed.

We suggest :

- To train personnel (users) to take care of maintenance
- To attach maintenance cost to the equipment
- To put emergency funds to be managed by Directorate for Health Services for easy accessibility in epidemic situations
- To allocate special funds for the laboratories
- To put in place a conducive environment to reinforce the reporting system

Regarding laboratories

For laboratories difficulties are related to lack of hospital maintenance unit and biomedical engineer.

- The supply of material is often disturbed since it is allocated from abroad
- No line budget for the laboratories in the estimate
- The laboratory Network exists but does not function regularly properly because of lack of resources (vehicle, Fax and – 70oC freezers).
- The procurement of reagents and other supplies are done through the Central Medical Stores (CMS), which is responsible for distribution.
- Supervision activities are not often conducted at the Divisional and the peripheral levels

Some suggestions to improve activities for laboratories are:

- To put in place a logistic support for both transport and human resources at the Divisional and peripheral level;
- To make the necessary arrangement for laboratories to work well (supervision, equipment, phone, Fax)
- To put budget line for laboratories in the estimate;
- To give responsibility to the focal point laboratory Network to manage the stock of supply and maintenance cost.

.4.1.3.2. Maintenance of the equipments and material for laboratories

- The laboratories do not have any autonomy and no one is given the responsibility to manage any budget or resources. There is no maintenance cost available
- There is a lack of space, manpower and equipment eg –70°C refrigerator and office space
- No staff is trained to maintenance requirement. The Department of State is directly in charge of maintenance and restoring and renewal of stock or equipment. As a result the procedure of replacement last too long and have few impact in the equipment restoration.

Some suggestions for the laboratories

- To increase the staff in the laboratories both in quality and quantity.
- Need to purchase new equipment to replace the oldest ones
- To allocate financial resources for the laboratories

- To train personnel for restoring equipment and material
- To make the focal point of the laboratory Network responsible for managing the resources for easy accessibility.
- To advocate partners to support the Laboratory Network (The Medical Research Council)
- To equip the lab with reagents, consumables and other logistics support for epidemic preparedness.

4.1.3.3. Drug, vaccine, reagent and consumable management

	Acquisition	Stocking	Allotment
Drugs	CMS	Health Division PA	«CMSD/Health Division/Hospital/Major health Faculties
Vaccines	CMS	EPI cold Chain	
Reagents, consumables	CMS	Hospital, Laboratories, Health Division	

Drugs, vaccines and reagents Financing are provide by the following actors and donors:

	Drugs	Vaccines	Reagents	Consumables supplies
State	X	X	X	
WHO	X	X	X	X
EU				
MRC		X	X	X
UNICEF/GAVI		X	X	X

On the basis of lessons learnt from the last epidemics, the mechanism of supply drugs, vaccines and reagents management was the feature of:

- Lack of stocking supplies
- Management of resources at the central level (logistic, vaccines, drugs supplies) rests upon the Department of State for Health, which receive funds from WHO and other donors.
- Lack of human resources to handle the epidemics
- Vaccines were not available on time

The main difficulties are linked to shortage of equipments and logistics supplies. The circulation or movement of supplies between Division and the central level was very slow and delayed. In addition many problems were encountered in timely receipt of financial resources to staff. Consequently logistic supplies need to be improved.

4.1.3.4. Strengths and weaknesses

- Completeness and timeless of reporting still remains a constraint because of lack of communication devices at all level of the health system (Telephone, Fax and Internet)
- Resources mobilization, logistical support and strategies to implement plans of action is difficult to obtain from the government
- There are no specific resources for epidemics as a result implementation during epidemics or emergency situation is always delayed
- Shortage of reagents and other consumables in the laboratories
- Assessment of quality assurance is not included in the evaluation process
- The laboratory Network encounters many difficulties to manage confirmation and transportation of specimens between laboratories due to insufficient funds
- Supervisions activities for laboratories are not performed in a regular basis because of fund and human resources.
- Lack of maintenance cost for equipment
- Shortage of supplies in the Divisional and peripheral level

4.1.3.5. Needs and Suggestions

- To attach maintenance cost to equipments
- To train people to take care of equipment (maintenance)
- Implement the health information network (telephone, Fax and Internet) for completeness and timelessness of reporting.
- To create a budget line for laboratories to have autonomy to secure resource mobilization
- To settle assurance quality assessment for laboratories
- To put adequate funds in the budget line for logistic and resources, drugs, vaccines and other supplies
- To create budget line for emergency situation

4.1.3.6. Private sector Involvement in surveillance

Data and information from the private sector are not available during the interviews period. Private sector does not actively participate in the surveillance process because they're no demand from the public health system.

This situation needs to be improved:

- The Health Management Information System should consider the need of listing all structures in the private sector among the Health Division that intervene in surveillance and disease response.
- To establish coordination mechanism and connection to deal with surveillance activities between the private sector and the public health sector.
- To include the private sector in the Integrated Disease Surveillance and Response process. (Implementation, reporting, training, supervision and evaluation)

4.2. Health Division and Peripheral Level

4.2.1. Existing resources

The Gambia mission surveillance survey was not intends to visit any Health Division and the peripheral level of the health system. However, the interviewees raise many difficulties in the overall health system.

4.2.1.1. Human resources

- Retaining trained human staff. This is a challenge in the Department of Health
- The attrition rate of human resources is very high in the health surveillance system due to lack of motivation.

4.2.1.2. Financial Resources

- Funds from the Department of State for Health are not decentralized to the Health Divisions and the basic health facility levels.
- Funds are inadequate and do not fulfill the program needs
- There are no financial resources to handle and manage during epidemics.
- The health facilities do not have incentives and impress to take care of some minor problems at their level of responsibilities.

4.2.1.3. Materials and Equipments

- Limited resources and computers, printers and photocopiers
- No proper maintenance
- Lack of communication devices (Telephone, Fax and Internet)
- Lack of mean of supervision (Motorbike, vehicles)

4.2.1.4. Drugs, Vaccine, Reagents and consumables

- Shortage of medicine at the health Division and health facilities. Consumable are very minimal at the laboratories almost no reagents.
- Inadequate cold chain storage facilities and vaccines supplies

4.2.2. Needs and suggestions

4.2.2.1. Human resources

- Building staff capacities and staff motivation,
- Staff retention plan need to be developed and implemented
- To allocate adequate human resources to surveillance program, Health Division and health facilities.

4.2.2.2. Financial resources

- To allocate budget for health Divisions
- To allocate more drugs, vaccines and other supplies for EPI and laboratories
- To give incentives to the health facility staff to better invest in surveillance especially for the epidemic prone diseases.

4.2.2.3. Materials and equipments

- To supply stand-by generator to EPI for the cold chain and vaccine supplies
- To provide computers, printers to programs
- To furnish resources for proper maintenance

4.3. Sub-regional level

4.3.1. Existing resources /

The ESU staff find satisfaction dealing with human resources at the sub-regional level but suggest coordination meeting needed to be established between partners and the health staff to enhance the exchange of information and experience in the area of disease surveillance and response.

4.3.2. Difficulties

The main difficulties are the lack of sharing information between the staff, the powerless network and early warning system, and the attrition of capacity building of human resources.

In the financial aspect, there are no financial resources allocated to surveillance program except resources from **WHO**. Partners refrained from dealing with maintenance cost which remain biggest hindering factor. There is no emergency stock of medicines, vaccines, reagents and consumables in the sub-regional level, which can be easily accessed within 48 hours to stop epidemics.

4.3.3. Needs and suggestions

The IDSR focal points should develop meeting on six monthly bases and share experience with partners on surveillance activities

- There should be more donors and effective participation in surveillance activities.
- An emergency account should be opened which can be accessed within 24 hours.
- Donors should provide to programs some computers, printers and other devices for surveillance activities and funds for management and maintenance.
- It remains urgent to find special budget from States and partners for disease surveillance in the sub-regional level.
- To have an early warning system.
- ESU and laboratories need supplies for emergency situations (Regional storage of supplies).

5. STAGE OF INTEGRATED DISEASE SURVEILLANCE IMPLEMENTATION

5.1. Existing

5.1.1. Description of the implementation level of surveillance

The Gambia has already realized a Five Year Strategic Plan for IDSR that needs to be financed by partners. This document was elaborated thanks to many reports generated by programs such as IDSR Assessment of National Communicable Disease Surveillance System and Epidemic Preparedness and Response in year 2001, Five year Strategic Plan for Tuberculosis in year 2003 Malaria Strategic Plan in year 2002, a Five year HIV- AIDS Strategic framework in year 2003, EPI Multiyear Action Plan in year 2001, EPI review in year 2001; These documents were reviewed to elaborate and finalize the IDSR Strategic Plan of Action for disease surveillance in year 2002.

5.1.2. Partners and Donors

The following actors or agencies contributed to working out all these documents DOSH & SW, WHO, UNICEF, PHPNP

5.1.3. Budget and source of financing

Data collections were not available between DOSH and Partners.

5.2. Analysis

5.2.1. Strengths and weaknesses

Among strengths, a big deal of achievement is performed in capacity building reviews in the health surveillance system and the management health information and a network laboratory. A strong commitment in community-based surveillance exists. WHO and some donors are willing to funds programs. A real GDP annual growth rate and a satisfactory coordination between institutions, programs and agencies may allow to expect with a new health policy framework to bring about a spectacular progress in the IDSR plan of action.

However, some setbacks need attention in order to solve the problems during the IDSR implementation. There are no enough human, material and financial resources to fully implement IDSR. Only WHO is financing surveillance through the AFP budget.

5.2.2. Needs and suggestions

There should be enough human, material and financial resources so that there will be no delay in implementation and integrating the operational plan. We suggest selling the action plan to donors, to train more the personnel to motivate them

6. LESSONS LEARNT

6.1. Inventory of the actual health surveillance system

6.1.1. National capacity building of the warning system and response

The following actors intervene to coordinate surveillance action and response at the national level

Health Services/Programs	Routine	Early Warning	Response
Permanent Secretary			X
Director of Health Services	X	X	X
Director of Support Services			X
Assistant Direction of Health Promotion and Protection			X
Direction of Planning and Information System****	X	X	X
Division of Health Teams ***	X	X	
Assistant Director of Disease Control	X	X	
Epidemiology and Statistics Unit *	X		
EPI **	X	X	X
Malaria Control Program	X		
IMCI	X		
Information & Statistics Division (Epidemiology and Statistics Unit) ****	X		X
National Aids Secretariat (NAS)	X		X
National AIDS Control Program	X		
TB/LEP	X		
Interagency Committee	X		X
Epidemic Preparedness Committee			X
Members of the Task Forces (HIV, EPI, BSS, IDSR, Meningitis Task Forces)	X	X	X
Laboratories	X	X	X

6.1.2 Partnership with border countries

The Initiative of Peace between The Gambia, Senegal and Mauritania is a good opportunity for partnership in surveillance and disease control.

6.1.3 Institutional IDSR supports

The main IDSR sponsor WHO following by UNICEF and GAVI

6.1.4 Budget, source of financing

Funds from donors are not available.

6.2. Analysis

Tran border experience in disease surveillance is not very developed yet in the sub-African region. Coordination and support mechanism are very limited within countries. However opportunities exist within « Initiatives of Peace and Health between The Gambia, The Republic of Mauritania and Senegal. In addition West African region Monetary Union States (UEMOA) is performing an ongoing assessment to implement the health information system among member countries to facilitate information flows and forecast epidemic events in the sub-regions.

7. FINDINGS OF THE EPIDEMIOLOGICAL SURVEILLANCE AND RECOMMENDATIONS

7.1 Findings

- 1- There is still parallel surveillance system in the Department of State for Health & SW
- 2- Duplication of efforts both in human, material and financial resources
- 3- There is gross shortage of human resources both quantitative and qualitative
That the Epidemiology and Statistics Unit that is the Focal Unit for Surveillance has no control over the other parallel programs
- 4- The IDSR has still not been finalized and sole to the donors so as to get a proper funding which is crucial to its full implementation and success
- 5- The main funding agents are the Department of State for Health & SW and the WHO
There is an emergency preparedness budget within the estimate amounting to D400,000.00 but accessibility is always cumbersome
- 6- There is only one new computer in the ESU given by the State through the PHPNP and is without a printer and in many other programs and where there are, they are either too old or are not functioning properly
- 7- Maintenance cost of these equipment/materials is either not available or not sufficient
There are no trained personnel in the Department of State for Health & SW to take care of maintenance
- 8- The National Laboratory is very small
- 9- The lab is under staffed and has only few trained personnel.
- 10- There is a good laboratory networking system but there is no vehicle to conduct supervisory visits and coordinate the activities
- 11- Shortage of reagents, consumables and other materials is hindering the output of the lab
- 12- The storage facilities of the EPI is grossly inadequate and there is no standby generator in case of power failure
- 13- There is no national Epidemiologist and medical doctors for the IDSR
- 14- The attrition rate is very high and this is affecting the surveillance system
- 16- The incentives given to the staff who are involved in surveillance is relatively small
- 17- The Surveillance focal points in the hospitals is small
Government is the main financing body for the procurement of vaccines, medicines and consumables
- 18- Despite all these constrains The Gambia is still ahead of many countries in the Sub – region as far as surveillance is concerned
- 19- The following task forces are in place:
 - IDSR Task Force
 - Meningitis Task Force
 - National HIV/AIDS Task Force under which are the following Sub- Task Forces:
 - National Sentinel Surveillance Sub- Task Force
 - Behavioral Surveillance Survey (BSS) Sub – Task Force
 - IEC/BCC Sub- Task Force
 - Essential/Special Research Sub- Task Force
- 20 - Polio Expert Committee

7.2 Recommendations

- 1 - The IDSR Plan of Action be revised, finalized and sole to the donors
- 2 - The staff capacity of the Epidemiology and Statistics Unit is very small and needed to be increased
- 3 - There should be four (4) desk tops computers and two (2) lap top computers to enhance data entry of HMIS, IDSR, Sentinel Surveillance data and other epidemiological research data and analysis
- 4 - The Department of State for Health & SW has no national epidemiologist and therefore, the need to train at least two epidemiologists is paramount
- 5 -The office look is not all encouraging therefore, the furniture, cupboards and filling cabins should be looked as soon as possible to facilitate proper record keeping and improve the output of the staff
- 6 - There is a great need for a second vehicle for ESU as the only vehicle is almost old and is running all the surveillance activities (IDSR, Sentinel Surveillance of HIV, Epidemiological Researches) and other official duties
- 7- The EPI storage facilities needed to be expanded and standby generators available for their stores all over the country
- 8 - The training need for the EPI staff is highly recommended, as there is a great need
- 9 - All the surveillance components for the other programs units be surrendered to the ESU as the surveillance focal unit for the department for easy coordination and to maximize the use of resources
- 10 - There is a great need for all the programs units to send all that they needed from the field to ESU so as to put them on one/two reporting tool to avoid duplication of efforts and waste of resources (both human, material and financial)
- 11 - There is good laboratory networking system but the lack of vehicle to supervise and monitor their activities is a big set back to them
- 12 - The extension of the National Laboratory will be a big achievement for the Department of State for Health & SW
- 13 - There is a great need to boost the availability of vaccines, laboratory supplies and medicines
- 15 - The human resource capacity of the Department of State for Health & SW is grossly inadequate and therefore, the there is a great need for staff training
- 16 - There is high attrition rate in the Department of State for Health & SW and therefore, there is a need for staff retention plan and implemented as soon as possible so as to maintain the quality service delivery system
- 17 - The incentives given to the case investigators is relatively small and therefore, the need to increase it from D150.00 to D300.00 for the allowance and from D150.00 to D350.00 for fuel per month
- 18 - To add more IDSR focal points in the hospitals from two to at least three because they have other responsibilities
- 19 - three data entry clerks be employed and stationed at the ESU to facilitate data entry of HMIS, IDSR, Sentinel Surveillance data and other epidemiological research data
- 20 – Other donors to come in to complement WHO's effort in the battle against the communicable diseases