The Gambia

UNITED NATIONS POPULATION FUND (UNFPA)

MINISTRY OF HEALTH AND SOCIAL WELFARE

Reproductive and Child Health Unit

The Gambia

Reproductive Health Commodity Security Situation Analysis for The Gambia

Ministry of Health	UNFPA	GFPA	John Snow, Inc. (JSI)
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December 2010

John Snow, Inc.

UNFPA / John Snow, Inc. (JSI)

As an integral part of its reproductive health commodity security strategy, UNFPA strives to improve access to and use of reproductive health (RH) products in developing countries. To this end, UNFPA provides support and assistance in the procurement of RH products and to develop capacity at the country level in managing health systems for RH products. UNFPA applies effective approaches for delivering services in priority RH areas, including availability of and access to high quality RH products.

UNFPA's Commodity Management Branch (CMB), the headquarters division in charge of logistics management and procurement of RH products, along with the regional technical offices and with the technical assistance of JSI, is responsible for the identification of RHCS needs at the country level. CMB then provides technical assistance, capacity building, and RH products, including contraceptives, to its partners in developing countries.

John Snow, Inc. (JSI) is an American consulting firm specializing in public health and working to improve the health of individuals and communities around the world. Our technical staff, specializing in multiple areas, work in partnership with local experts, international and national organizations, and government officials in order to promote accessibility to high quality health care for women, men, and children around the world. Our main office is in Boston, Massachusetts, and there are also technical offices in Washington, D.C., Concord, New Hampshire, Denver, Colorado, and in more than 20 developing countries around the world. JSI Logistics Services is headquartered in Washington.

Recommended Citation

Hicks, Janne, Julia Byington. 2010. *The Gambia: Reproductive Health Commodity Security Situation Analysis*. Arlington, VA: John Snow, Inc./Logistics Services for the United Nations Population Fund (UNFPA).

Abstract

Reproductive health commodity security (RHCS) exists when every person is able to choose, obtain, and use quality contraceptives and/or other RH products every time he or she desires. The goal is thus to make sure that supply corresponds to demand.

The Gambia is engaged through its RH and HIV/AIDS programs in efforts to ensure the availability of RH products to correspond with demand. The country's current RHCS Strategy ends in 2010 and this along with extended stock-outs of contraceptives initatiated the Ministry of Health and UNFPA to undertake a situational analysis to understand the status of RHCS in the country.

This RHCS situational analysis provides information to strengthen interest in the efforts to improve RHCS. It provides information necessary for the development of a national strategic plan for contraceptives, and program linkages to obstetrical and neonatal health care, and HIV/AIDS commodity security.

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ACRONYMS

AFPRC	Armed Forces Provisional Ruling Council
AWARE/RH	Action for West African Regional Health Project/Reproductive Health
ART	antiretroviral therapy
ARV	antiretroviral
BAFROW	Foundation on Research for Women's Health
BCC	behavior change communications
CBD	community-based distribution
CHN	Community Health Nurse
CIF	cost, insurance, freight
CMS	Central Medical Supplies
COC	combined oral contraceptive
CRIN	Combined Requisition and Issue Note Book
CPR	contraceptive prevalence rate
CPT	contraceptive procurement table
CRR	Central River Region
CS	commodity security
DHS	Demographic and Health Survey
DoSFE	Department of State for Finance and Economics
DoSH	Department of State for Health and Social Welfare
EMs	Essential Medicines
EmOC	emergency obstetric care
FEFO	first expiry, first out
FP	family planning
GFATM	Global Fund to fight HIV/AIDS, Tuberculosis and Malaria
GFPA	Gambia Family Planning Association
GNI	gross national income
GoG	Government of The Gambia
HIV/AIDS	human immune deficiency virus/acquired immune deficiency syndrome
HV	Health Visitor
ICB	international competitive bidding
IEC	information, education and communication

IMF	International Monetary Fund
INGO	international nongovernmental organization
IMCI	Integrated Management of Childhood Infection
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JSI	John Snow, Inc.
LMIS	logistics management information system
LSAT	Logistics System Assessment Tool
M&E	monitoring and evaluation
MCH	maternal and child health
MMR	maternal mortality ratio
MOS	months of stock
MoU	memorandum of understanding
NAS	National AIDS Secretariat
NACP	National AIDS Control Programme
NBER	North Bank East Region
NBWR	North Bank West Region
NDA	National Drug Authority
NDQCL	National Drug Quality Control Laboratory
NEML	National Essential Medicines List
NGO	non-governmental organization
PHC	primary health care
PMTCT	prevention of mother to child transmission
POP	progestin-only pill
PRSP	Poverty Reduction Strategy Paper
QC	quality control
RDF	Revolving Drug Fund
RHCS	reproductive health commodity security
RHCSAT	Reproductive Health Commodity Security Assessment Tool
RHD	Reproductive Health Division
SDP	service delivery point
SPARHCS	Strategic Pathway to Reproductive Health Commodity Security
STG	standard treatment guideline
STI	sexually transmitted infection
TB	tuberculosis

TFR	total fertility rate
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
URR	Upper River Region
USD	United States Dollar
VAT	value added tax
VHW	Village Health Worker
WHO	World Health Organization
WR	Western Region

ACKNOWLEDGEMENTS

The authors would like to acknowledge a number of people who contributed to this situation analysis. From the Reproductive and Child Health Unit and National AIDS Control Programme of the Ministry of Health, special thanks go to Lamin Darbo, and Haddy Jagne; from Gambia Family Planning Association Momodou Njie, and from UNFPA Alhagie Kolley. We would like to thank all the people who met with us, answered our questions, showed us their facilities, drove us, and handled workshop arrangement, made copies, and printed documents. We hope that this report helps to strengthen reproductive health commodity security in The Gambia and goes some small way toward repaying the kindness and hospitality we received during our visit.

EXECUTIVE SUMMARY

INTRODUCTION

This situation analysis is an effort by the Reproductive and Child Health Unit (RCH Unit) of the Directorate of Basic Health of the Ministry of Health and Social Welfare (MOHSW) in conjunction with UNFPA to strengthen reproductive health commodity security (RHCS) in The Gambia. Previous assessments have found shortages of commodities and weaknesses in the systems meant to ensure those commodities are available and accessible.

Methodology and Scope

A team of consultants from John Snow, Inc. (JSI) was engaged by UNFPA and the MOHSW to carry out a three-week situation analysis, the findings of which would inform the preparation of a strategic plan for RHCS. The consultants, working with representatives of UNFPA and the MOHSW reviewed key documents pertaining to RHCS, met key stakeholders, carried out a central focus group workshop, and visited facilities in four of the six Regions. The assessment was based on the Reproductive Health Commodity Security Assessment Tool (RHCSAT), a tool developed by UNFPA and based on two preexisting tools: the Strategic Pathway to Reproductive Health Commodity Security (SPARHCS), a comprehensive methodology for RHCS; and the Logistics Systems Assessment Tool, for more detailed analysis of supply chains. The supply chain component focused on the public sector, and two supply chains were analyzed. These were the distribution of donated RH commodities – mainly contraceptives – through a vertical supply chain managed by the MOHSW; and the Central Medical Supplies (CMS) system, which distributes free essential medicines financed by the Government of The Gambia and Global Fund (GF). In terms of commodities, while the scope of this assessment was all RH commodities, the focus was on contraceptives. The assessment followed the SPARHCS framework and was thus comprehensive in terms of examining all the factors that impact RHCS, namely: client utilization and demand, commodities, commitment, finance, supply chain capacity, service delivery capacity, coordination, and context. The findings and key recommendations for each of these components are presented below.

FINDINGS

Findings and recommendations are included in the body of the report, organized by RHCS component. Some key findings are summarized here.

Context and Commitment

According to the 2003 census, the population is estimated at 1.36 million and had an annual growth rate of 2.7%. By the year 2011 it is estimated to reach 1.7 million. About 60% of the population lives in the rural area; and women constitute 51% of the total population. The crude birth rate is 46 per 1000 population while the total fertility rate is 5.4 births per woman. The high fertility level has resulted in a very youthful population structure. Nearly 44% of the population is below 15 years and 19% between the ages 15 to 24. Maternal mortality is very high at 730 and average life expectancy at birth is 64 years overall (DoSH 2007). The poverty level in The Gambia is high with 68% of the population in rural areas and 40% of the population in urban areas living in poverty. Urban poverty is high and on the rise. About 53% of the population of The Gambia resides in urban areas (DoSFE 2006).

Along with the growing youth population is an increase in teenage pregnancy, STIs, rape and sexual abuse of girls. Social stigma and to some extent religious views make if difficult for women, married or not, to use contraceptives to prevent and/or space pregnancies. The 2001 CPR rate was 17.5 percent, (13 percent modern methods) and it is projected to be approximately 26.5% in 2010. Unmet need was 25 percent in 2001 and maybe higher now.

Against this backdrop, the Gambian Government has put in place several policy documents and signed agreements favorable to reproductive health services. In 2005, UNFPA and the MOH undertook a similar reproductive health assessment which developed into a validated strategy for RHCS – The Gambia RHCS Plan 2006 -2010. As a result of this strategy, RH commodities are now included on the Essential Drugs List (EDL), several trainings were conducted on service delivery, and advocacy for acceptance of family planning has resulted in local leaders and decision-makers reflecting favorably on family planning. Moreover, indications are that the government will set aside two to three million Dalasi for purchase of reproductive health supplies in the country's 2011 budget.

However, the majority of objectives and activities in the Gambia RHCS strategy were not achieved due to lack of funding, attrition at MOH and in RCH Unit at all levels, lack of trained staff, and coordinated commitment by the government and stakeholders in the public and private sector. Policies are not disseminated and explained to the lower levels of the health system or to the public.

The RHCS committee that was active at the time the strategy was developed and validated has not met since 2007. While political commitment for RH is strong, advocacy and champions specifically for commodity security are minimal. It is not included in civil society or private sector dialogues; and strong action as a result of advocacy is lacking in terms of funding for improvement of services and commodity procurement, revitalization of the national RHCS committee, and generating demand for services through male and youth involvement.

Coordination

Several government and donor coordinating bodies and technical committees meet on a regular basis. However, there is no active coordinating body for RHCS activities. This has lead to inadequate supplies, duplication, and waste of donor resources. Part of the function of a RHCS committee is to coordinate donor support and shipment of commodities that are tied to programmed activities such as IEC/BCC campaigns, IUD and implant training and promotion, etc. A large quantity of female condoms was recently destroyed as they were not promoted; and, conversely, lack of trained personnel in IUD insertion has left the limited demand there is for IUDs unmet.

Linkages with Global Fund HIV/AIDS and malaria programming are mixed. The PMTCT program is well integrated with the RCH unit as with GF malaria activities of NMCP. However, sexually transmitted infection (STI) interventions are the responsibility of the National AIDS Control Programme (NACP) and not a high profile service of the government health clinics, which are primarily seen as a place where antenatal care/family planning/maternal and child health services are available. Voluntary Counseling and Testing (VCT) services are not always linked to STI treatment thus there is a large missed opportunity to reach Gambians who may be HIV positive.

Coordination and information sharing between levels of the health system and among regional levels is sporadic. While a meeting with all Regional Health Teams (RHT) is to take place quarterly, organization and funding for these meetings is not routinely available.

Finance

Financing for contraceptives in the Gambia is increasing but historically has been the main cause of ruptures in contraceptive supplies. Currently, the main donor for contraceptives is UNFPA. They also procure delivery kits and other RH supplies as needed. Since 2006, UNFPA has spent a total of USD 680,578 on contraceptive procurement for The Gambia.

IPPF used to provide contraceptives to the Gambia Family Planning Association (GFPA), but ceased in 2008 when GFPA was required to graduate from IPPF support. Currently, GFPA depends on MOH for their supplies. Also, due to lack of funding, GFPA no longer runs their social marketing program despite having the required infrastructure and expertise. Through the Global Fund Round 8, funding was earmarked to procure condoms for a two year period (Dec 2009-2011) under Action Aid. However, this is only about 30% of the estimated quantity of condoms required in that period for HIV/STI prevention alone.

Government run family planning services are free of charge and other RH services are highly subsidized. No cost-recovery scheme specifically for RH commodities and supplies is currently in place. Being part of the EDL for Gambia means that contraceptives can in theory be procured using government funding. However, past efforts by the RCH Unit to advocate for allocation of some of the essential drugs budget for contraceptive procurement have not been successful. Currently, the program is advocating for a dedicated budget line for contraceptives.

According to the contraceptive procurement table (CPT) exercise conducted in September 2010 by the USAID | DELIVER PROJECT, required funding to fill the estimated contraceptive need through 2012 is USD 413,700. The Gambia National RHCS plan 2006-2010 estimated needing USD 706,665 to implement the plan. Going forward, it will be important for key players to cost out needs to implement the next plan and mobilize resources to ensure it is fully funded.

Commodities

In general, the MOHSW through its National Pharmaceutical Services (NPS) Central Medical Stores (CMS) operates a standardized system of bi-monthly supply of essential drugs, equipment and other medical supplies to the regional stores of the six regional health teams responsible for the overall supervision of health services countrywide. Essential medicines including those for EmONC and those procured by the Global Fund for malaria, TB, and HIV/AIDS prevention and treatment are distributed through the CMS system. The RCH Unit centrally manages some RH commodities such as contraceptives, basic equipment for antenatal care and delivery including TBA kits, obstetric record card/registers and furniture for RCH outreach services.

Site visits to the four regions included the review of commodities available and reasons for stockouts. Most facilities visited had the following RH commodities available: male condoms, Depo, microgynon, oxytocin, magnesium sulfate, folate, antibiotics, and ergometron. To a lesser extent the following were available: female condoms, norigynon, IUDs, microlut, lo-femenal, overette, vaginal foaming tablets, PMTCT drugs, and hydralizine. A lack of requested quantities available at the next higher level and procurement problems were reported reasons for stockouts.

Identification and confirmation of necessary RH commodities for The Gambia was included as part of the workshop discussions with key informants. This list specific to the country's reproductive health program includes the 10 products recommended by WHO and UNFPA.

Client Utilization and Service Delivery

The RCH Unit offers a range of decentralized and integrated reproductive and child health services while sexually transmitted infections (STIs) management falls under the responsibility of the National AIDS Control Program. The most popular family planning methods are Depo, pills and condoms. There is general consensus that condom use is on the rise primarily for HIV prevention. The primary reasons for discontinuation of contraception include pregnancy (both desired and unwanted), spousal objection, religious/social/cultural, and side effects.

Although most clients go to the public sector, there are still issues such as frequent stockouts and quality of care at public sector health facilities, such as privacy and long waiting times. Frequent stockouts and supply to The Gambia is at a critical point and there has been product rationing from the central level. It was also found that public sector health facilities do not provide a conducive environment towards certain populations such as men, adolescents and commercial sex workers. Other barriers include a lack of written standard treatment guidelines (STG) and other written guidance available at lower level health facilities and there is not enough staff trained on IUD insertion.

BCC/IEC campaigns exist and vary among regions and are often conducted by regional health teams and village health teams. The high percentage of people who have heard of family planning methods as established by the 2001 survey is remarkable; however it has not necessary translated into significant uptake.

Logistics

The need for improved logistics systems has taken the forefront the past several months due to frequent and/or prolonged stock-outs of several contraceptive methods, rationing, and poor data management capabilities. The September quantification of contraceptives, efforts by NAS and CMS to assess the logistics systems for EMs, UNFPA and stakeholder concerns about commodity security, and RCH Unit requests have energized efforts to improve commodity security (especially for contraceptives) and improve the logistics system. Revisions to the CMS LMIS, HMIS, and contraceptive reporting systems are currently underway which will do much to improve reporting and forecasting of RH commodity needs. There was universal consensus to harmonize the CMS and RCH supply chains by merging supply chain management of contraceptives and other RH supplies into the CMS system.

Overall supply chain management for RCH Unit can be greatly strengthened, starting at the regional level through the introduction of standard procedures for logistics including preset stock levels, automated inventory management systems at all states, forms that capture essential logistics data such as consumption, stock on hand and losses and adjustments. These data should also be captured at the SDP level, though for the private sector this will be more difficult.

Given the weaknesses in the current supply chain for contraceptives and other donated RH supplies, and the relative strength of the CMS system, it makes sense to work towards increased integration of donated RH commodities with the CMS system. Integrating storage, distribution and inventory management would strengthen RHCS through stronger supply chain management and greater

efficiencies. It would improve coordination on forecasting and procurement with CMS. The RCH Unit would still have an important role to play in a more-integrated system, including product selection, forecasting, training, and supervision.

The existing supply chain can be strengthened while negotiation and planning for integrating the systems is taking place. Reporting forms for service data can be redesigned to capture essential logistics data, stock levels can be established, and the use of stockcards mandated. Procedures should be in writing, distributed and personnel should be trained as needed. An annual forecasting exercise at the central level for all partners involved in RHCS, linked to procurement planning and advocacy in the event of a funding gap should be one of the first steps in strengthening RHCS. The timing of this should coincide with funders' budget and procurement cycles.

CONCLUSION AND NEXT STEPS

As noted above, this situation analysis was intended to inform the development of a strategic plan to strengthen RHCS. The findings and recommendations of this report were presented to key stakeholders prior to the consultants' departure. During the debriefing on December 15, the consultants provided some priority recommendations which will have the greatest impact on improving RHCS in The Gambia. These include:

- Revitalization of the RHCS committee to coordinate immediate procurement needs, develop a RHCS plan, and to secure funding commitments.
- Continue to advocate for a budget line item for contraceptives and increased funding for RH commodities
- Integrate contraceptives into the CMS/NPS system
- Improve inventory management capacity through development of guidelines, in-service training and close monitoring and supervision
- Revision of forms to collect essential data items of consumption and losses and adjustments
- Hiring and training of data collectors
- Train more service providers in long acting FP methods – IUD and implants
- Expand advocacy efforts to increase demand and acceptance for SRH services and products
- Develop champions for RHCS by maintaining RCH's and others' focused advocacy and specialized technical oversight on the importance of RH supplies and services

At the close of the debriefing session, the Permanent Secretary confirmed her support for these recommendations and recognized the need for improvements to RHCS in The Gambia. Emphasis was put on the need to reestablish the RHCS committee to include donors, private sector, all MOHSW programs involved in RH, and NGOs. Secondly, she called for further discussion on the integration of contraceptives, delivery kits and other RH supplies into the CMS system. A suggestion was made that a regional study tour be conducted to model successful RHCS committees and integrated supply chains.

INTRODUCTION

The Gambia is a signatory to the 1994 International Conference on Population and Development Programme of Action (ICPD POA) and is thus committed towards achieving the POA's goals and targets and equally to the attainment of the Millennium Development Goals (MDGs). Following the ICPD conference, The Gambia shifted from Maternal and Child Health/Family planning to the delivery of broad based Reproductive Health Services. This resulted in the development of a revised national Reproductive Health Policy and Strategic Plan in 2006 and a subsequent one in 2009. A national RHCS plan for 2006 -2010 was developed with the support of AWARE/RH, DELIVER and POLICY Projects with financing by USAID West Africa and implemented under the overall coordination of the National RCH Unit.

PURPOSE AND OBJECTIVES

The purpose of the situational analysis was to assess the current situation and identify recommendations that will be used to update the 2006-2010 RHCS Strategy. The objectives of this situation analysis included the following:

- To strengthen participants' understanding of the concepts of reproductive health commodity security (RHCS);
- To collect information regarding the status of RHCS in the country;
- To provide recommendations for improving the situation that can be used in the development of the next national RHCS strategic or operational plan.

UNFPA is anticipating financial support of USD 1 million to strengthen the reproductive health program in The Gambia. Finding and recommendations from this assessment will help to define their program inputs for the coming year.

DATA COLLECTION

The methodology of the situational analysis constituted four parts. First, the international consultant team conducted a desk review of policies, strategies, surveys, and other documents of relevance to RHCS in The Gambia.[1] The team met with several stakeholders to brief them about the mission and discuss the stakeholder's role in RHCS. To understand the current situation of RHCS at the region and health facility levels, the consultant team and three local counterparts from the Ministry of Health and GFPA developed a questionnaire based on the Reproductive Commodity Security Assessment Tool (RHCSAT). The team was divided into two teams and visited a total of 12 sites including regional health teams/stores, major health centres, minor health centres, and hospitals in North Bank, Western and Lower River regions.

A two day focus group workshop was held to discuss the seven "C's" of the RHCS framework and validate the priority commodity list for RCH using the RHCSAT. Participants included central level stakeholders as well as the private sector, and two regional representatives. Lastly, a debriefing of findings was held on December 15, 2010 with major stakeholders including the Permanent Secretary

[1] A complete list of the documents reviewed can be found in the reference section

of the MOHSW, members of the RCH Unit, NACP, NAS, GFPA, and planning department of the MOHSW to validate findings and recommendations of the situational analysis.

The assessment tool was previously developed by UNFPA and JSI based on existing tools that have been well tested for RHCS situational analyses, including Strategic Pathway to Reproductive Health Commodity Security (SPARHCS), Logistics System Assessment Tool (LSAT) and Logistic Indicator Assessment Tool (LIAT). The tool contains questions relating to these seven core components of RHCS: context, coordination, commitment, capital, commodities, client demand and utilization, and capacity.

RHCS FRAMEWORK AND DIAGNOSTIC GUIDE

This assessment follows the SPARHCS diagnostic guide (Hare 2004) which is in turn based on the SPARHCS framework (Figure 1). The SPARHCS diagnostic guide can be used as an assessment tool to assess the current RHCS situation in a country, to identify key strengths and weaknesses, and to set priorities to prepare for strategic planning. The framework identifies the different elements that must be present in order to satisfy client demand for commodities – the center of the SPARHCS framework.

Figure 1: Reproductive Health Commodity Security Framework

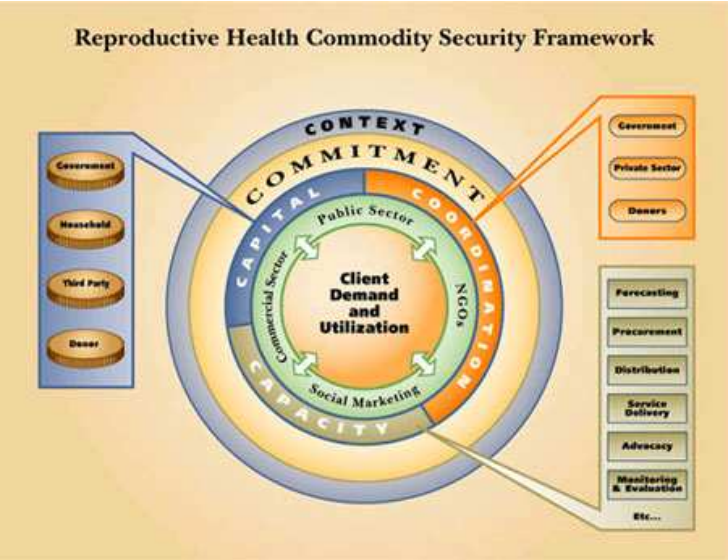


Figure 1 above depicts how six essential RHCS elements impact upon client demand and utilization of commodities. In every country, there is a **context** that affects the country's prospects for achieving RHCS, including national policies and regulations that bear on reproductive health and particularly on the availability of reproductive health supplies, and broader factors like social and economic conditions, political and religious concerns, and competing priorities. Within this context, **commitment**, evidenced in part by supportive policies, government leadership, and focused advocacy, is a fundamental underpinning for RHCS. It is the basis from which stakeholders invest the necessary **capital** (financing), **coordinate** for commodity security (CS), and develop necessary **capacities** to ensure CS. The boxes in the figure elaborate on each of these three components. **Coordination** involves government, the private sector, and donors to ensure more effective allocation of resources. Households, third parties (e.g., employers and insurers), governments, and donors are all sources of capital. Additionally, capacities must exist for a range of functions,

including policy; forecasting, procurement, and distribution; demand generation; service delivery; supervision, and monitoring and evaluation. Clients (youth, women and men), at the center of the figure, are the ultimate beneficiaries of RHCS as product users, and as shown by the double headed arrows, the drivers of the system through their demand.

ASSESSMENT LIMITATIONS

Due to the lack of recent health survey data, a current analysis of health trends was not available. Projections made by the Government of Gambia or other organizations were used for some health indicators if available.

ASSESSMENT FINDINGS

1. CONTEXT

The success of an RHCS strategy depends on a range of contextual factors affecting individuals' ability to choose, obtain and use RH supplies. To define the broader health, political, and economic environment as it affects RHCS, this section considers: policies and regulations that bear on the ability of public and private sector programs to secure and deliver reproductive health supplies; and basic demographic, health, and other development indicators.

SOCIO DEMOGRAPHIC AND HEALTH CONTEXT

The Gambia is situated in West Africa with an estimated population of 1.7 million. The Gambia is Africa's smallest mainland country and is divided into two municipalities and six regions. The country was previously a British colony until full independence was gained in 1965. The country serves as a Republic with the commonwealth and is a multi party democracy (DOSH 2007). The economy relies on agricultural and fishing, small scale manufacturing, tourism and trade. The GNI per capita is USD 440 (World Bank 2009) and 61.3% of the population is at the poverty line (World Bank 2003).

There are five main ethnic groups and approximately 90% of the population is Muslim. Gambian society is patriarchal in nature in that men earn most of the family's income and make the majority of decisions. Approximately 34% of women of reproductive age are in polygamous marriages and early marriage is common (Census 2003). It is generally believed that women are inferior to men, which is perpetuated by harmful social cultural practices against women, such as female genital mutilation. The 2001 maternal mortality survey (MMS) found that 23% of men currently do not use and do not intend to use contraception for religious reasons, indicating that some Gambians falsely interpret that Islam is against family planning. The 2001 survey also established that The Gambia is made up of a pronatalist society, and women and men desire as many children as "God wills." Low contraceptive usage can be attributed to these and other sociocultural and religious barriers and to inadequate access to high-quality services.

Although significant progress from the early 1990s to the early 2000s in the improvement of health indicators has been made, current health indicators are unknown due to a lack of recent survey data. From data collected in the 2001 MMS and 2003 census, the Gambian health context is characterized by high maternal mortality (730 deaths per 100,000 live births, MMS 2001), high total fertility (5.35, Census 2003), and frequent births. Contributing factors to the high maternal mortality ratio include: (a) the poor quality of care in prenatal and delivery services; (b) an inadequate high-risk referral system; and (c) delayed and/or inappropriate treatment of life-threatening complications of pregnancies and delivery (UNFPA 2006).

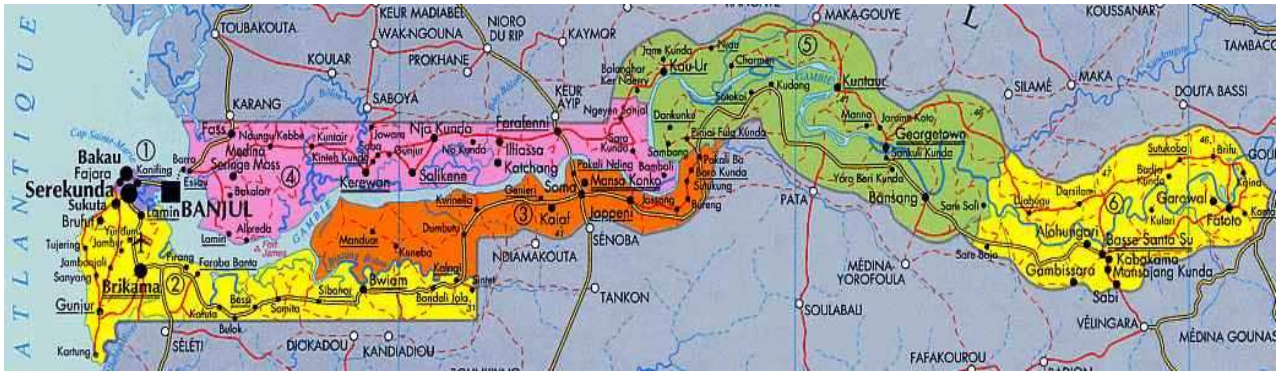
The 2003 census established the population growth rate at 2.7%, with a large amount of the population in their reproductive years. The contraceptive prevalence rate of 17.5% (13% modern, MMS 2001) and unmet need of 25% (MMS 2001) signify that FP is still not widely practiced. A total of 15% of single females have been pregnant once and over 65% of these pregnancies were unplanned. For those who do practice family planning, Depo-Provera injections and breast feeding

are the most popular forms of birth control followed by pills and condoms. A legal abortion is attainable, but two doctors must concur in order for a woman to have a therapeutic abortion (UNFPA, 2006).

The Gambia has a very youthful population with nearly 44% of the population is below 15 years and 19% between the ages 15 to 24. According to the 2003 census, nearly 41.5 per cent of those aged 15-24 are sexually active. Between 2000 and 2005, the adolescent fertility rate was estimated at 107.6 per 1000 births for women aged 15 – 19 (UN 2008). A study on adolescents cited cost and the lack of youth-friendly services as factors limiting the access of young people to condoms. The low awareness among youth about reproductive health issues, coupled with their limited access to youth-friendly services, exposes them to sexually transmitted infections, HIV/AIDS and unwanted pregnancies.

HIV/AIDS is a growing problem, and prevalence was 2% in 2001 (MMS 2001).

Figure 2: Map of The Gambia with regions



POLICY CONTEXT

Overall, The Gambia has a number of policies that are supportive and positive towards provision of RCH services which in turn provide support for RHCS. Further support for RHCS is evidenced by the inclusion of RH commodities including contraceptives on the essential drugs list. Some of the limitations found that RHCS is only specifically mentioned in the RH policy and it was found that policies are not widely disseminated to lower levels of the health system and the public. The Gambia's policies relevant to RHCS include but are not limited to:

The National Reproductive Health Policy
The National Population Policy
The HIV/AIDS Policy
The National Health Policy

The **National Reproductive Health** policy sets the tone of the document by confirming The Gambia as a signatory of the ICPD POA. As a signatory, the policy's vision, mission and goal demonstrate The Gambia's commitment to sexual and reproductive health rights for women, men and adolescents. The policy focuses on six priority components, namely: safe motherhood, family planning, youth and RH, RTI/STI, reproductive morbidity and gender. The provision of RH commodities and supplies are clearly outlined in several of the strategies. Capacity building for the

provision of service and for the policy's implementation is also reiterated throughout the document. These elements recognize that access to comprehensive commodities and services is a human right and contributes to a better quality of life and sustained economic growth for the country.

The **National Population Policy** affirms the need to slow the Gambia's population growth in order to meet its socioeconomic and environmental goals. Areas of concern include the high population growth rate, age structure and spatial distribution of the population which are causing overcrowding, pollution and environmental degradation. Although the policy does not specifically mention RHCS, many of its goals and objectives are in support of the provision of commodities and services, particularly: 1) promotion of and access to SRH and FP for all to reduce morbidity and mortality, 2) government provision of FP programs, 3) prevention of diseases and unsafe abortions, 4) strengthening of capacity to promote and implement the policy; amongst others. The policy's objectives also support RHCS by the call to ensure accessible and affordable FP information and services, target IEC/BCC to youth, promote a smaller desired family size and spacing, the prevention of unwanted pregnancies and abortions, and reduction of HIV/AIDS.

While one of the main components of the National RH Policy focuses on youth and RH, the **National Youth Policy** focuses on youth as a whole. Specific parts such as education and awareness raising, and interaction and networking call for the inclusion of SRH education complement the RH Policy. The GFPA is specifically mentioned as providing an open environment where youth can learn about SRH issues. Although not directly stated, the importance of achieving RHCS for The Gambia will be especially important for the country's youth.

The **National Health Policy** outlines The Gambia's health system, policies, principles, goals, vision and mission. The guiding principles call for health and gender equity, client satisfaction, skilled staff retention and circulation and partnerships for the entire health sector, amongst others. Specific RH health targets include: to reduce the prevalence of HIV/AIDS to .5% (HIV 1) and .1% (HIV2), reduce the TFR to 4.6 by 2015, to reduce the MMR to 150 by 2015 and to reduce the IMR to 28 by 2015. Health care program components on health care promotion and education, HIV/AIDS and STI management, and RH services including family planning, maternal and infant care all call for greater access and provision of services to achieve a better quality of life for Gambians. Although not specifically mentioned, RHCS is key to achieving these targets.

The objective to "ensure drugs, vaccines, medical supplies security and safety for the population" is undermined by the limitations of the country's logistics, infrastructure and information systems as recognized in the policy. One of the strategies to advocate for increased funding for vaccines should be revised to include RH commodities and supplies, as this is a priority for the country. Other strategies calling for the reform of the supply management system and encouragement of private sector provision of drugs to patients are in line with the recommendations of this report.

As in the other health policies, the **National HIV/AIDS Policy** calls for health service provision to reduce the impact of HIV/AIDS. The objectives of the policy make a clear connection to sexual and reproductive health by promoting safe sex and prevention and treatment of STIs. Again, like other policies, it does not specifically mention the need for commodity security. However, the policy is supportive towards RHCS as it calls for provision of services for prevention and treatment of HIV/AIDS, STIs, and OIs.

Context and Policy: Key Recommendations

- Ensure RHCS is specifically addressed in policy documents.
- Ensure validated policies are disseminated to all levels of service providers and to the public. This will help educate and reinforce intent for availability of quality reproductive health care.
- Conduct a comprehensive health survey to obtain status of current health indicators.
- Revise the national health policy with language advocating for increased funding across all RH program needs.

2. COMMITMENT

Commitment is evidenced in part by supportive policies, government leadership, and focused advocacy and is a fundamental underpinning for RHCS. It is the basis from which stakeholders invest the necessary capital (financing), coordinate for CS, and develop necessary capacities to ensure CS. While commitment to reproductive health in The Gambia has been demonstrated through various policies and strategies, mandates of donor agencies, and various coordinating bodies this has yet to be translated into adequate financing and programming. Gambia's Poverty Reduction Strategy Paper (PRSP) for 2007 - 2011 recognizes several policy actions taken over the last two decades:

> *The Gambia has demonstrated its commitment to address population matters in order to accelerate the pace of socio-economic development and ultimately improves the quality of life and raise the standard of living of all Gambians by adopting the Kilimanjaro Plan of Action (1984), the Dakar/Ngor Declarations on Population and Sustainable Development (1992), and the International Conference on Population and Development (ICPD) Programme of Action 1994. Hence theformulation of a National Population Policy in 1992 and revised in 1996 and 2003 in line with theICPD Programme of Action and Vision –2020 Incorporated and the MDGs. (IMF 2007)*

The revision of this policy in 2007 along with the development of the National Reproductive Health Policy 2007-2014) is a reaffirmation of Gambia Government's commitment in managing population and health resources in order to accelerate the pace of socio-economic development and ultimately improve the quality of life of Gambians.

Family planning/reproductive health services are addressed in the PRSP as a component of the health sectors action plan. However, there is no explicit language in the Health or Population sections addressing the need for RHCS as part of the strategy to improve service delivery, although the lack of it is recognized:

> *The low level of service utilization is associated with poor quality of care due to manpower shortage, periodic stock outs of essential drugs and contraceptives at the intermediate and peripheral levels, inadequate logistics and referral systems, also ineffective monitoring and supervision, as well as the attitudes of service providers.(IMF 2007)*

Advocacy efforts by MOH, religious leaders, political leaders, and opinion leaders are geared toward strengthening RHCS within the government. In August 2010, the World Health Organization Country Office and the MOHSW in collaboration with UNFPA embarked on a nation wide

advocacy campaign targeting the Technical Advisory Committees (TACs) at the Regional Governors Offices throughout the country. The campaign will run countrywide and target policy makers, parliamentarians, regional and district authorities, and communities.

> *The first leg of the exercise, targeting the TACs, has so far been successful bringing maternal and RH issues, particularly a budget line for reproductive health commodities and support for the reduction of maternal and newborn mortality, on the table at the regional level in a more open and participatory manner. Through this multi-sectoral framework, the MOHSW through its RCH Unit, the Health Education Unit, and the Regional Health Teams was able to collaborate with the WHO Country Team and GFPA and UNFPA and the regional and district authorities to discuss maternal and reproductive health issues in this manner. (WCO Gambia, 2010)*

As a result of this and other advocacy effort, Islamic and Christian leaders are increasingly involved in discussion and outreach promoting reproductive health care. However, strong action as a result of the advocacy is lacking in terms of funding and revitalization of the national RHCS committee, which has not been active since 2007. For example, while there is a budget for RCH commodities and supplies, contraceptives is not included, despite being included on the EDL since 2008.

Advocacy from the private sector is minimal and there are no champions from major employers or labor organizations. Thus, RH commodity issues are not included in broader health advocacy efforts and civil society dialogues. Such dialogues need to take place. Media coverage of population, family planning, and reproductive health issues focuses on raising awareness but is minimal due to lack of financing.

Commitment: Key Recommendations

- Continue to advocate for commitment to RH and in particular FP that results in translating policies and documents into finance and programme activities
- Develop and validate a new five year RHCS strategy and operational plan for The Gambia
- Advocate for more male and religious involvement in RH activities and BCC/IEC campaigns
- Increase advocacy efforts with the private sector to expand access to reproductive health commodities.

3. COORDINATION

> *"Donor coordination has been one of the main challenges facing the government of the Gambia in its development programmes across all sectors, including the health sector. With the development of a new health policy and master plan (2007–2020), the stage is set for better partner coordination in the health sector, as it is envisaged that all partners will buy into the policy and master plan. (WHO, 2009)*

Several government and donor coordinating bodies and technical committees meet on a regular basis. However, there is very little formal coordination on commodity security issues. This lack of coordination cuts across all levels: national, regional and local as well as between sectors and among stakeholders. Without coordination, decisions on forecasting, procurement, pricing, product selection, registration, and logistics system design and operations suffer; none of the partners,

sectors, or levels of the system has the complete picture. While relations are good between partners and there is informal coordination, this is very ad hoc and leaves major gaps.

In an effort to coordinate health activities and streamline operations for the MOHSW, the MOHSW has called on UN agencies to act as one agency – to speak with one voice and coordinate interaction with the MOHSW. To this end, a mapping study was recently conducted to help define roles, responsibilities, and objectives of the agencies and their interaction with the Ministry. Such exercises and documents such as the WHO Coordination Strategy for The Gambia will also direct synergies and aid cooperation.

The GFATM Country Coordinating Mechanism (CCM) proposed a dual-track financed Program including a Health System Strengthening component for GF Round 8. The two Principal Recipients are a) National AIDS Secretariat of the office of the President and b), and Action Aid the Gambia. NAS focuses on the treatment of AIDS and works in collaboration with the Ministry of Health and the University of the Gambia to reinforce the Health System, while Action Aid's main focus is on mass media, community prevention and on the home-based care. Their goal is to contribute to the halt and reverse the prevalence of HIV infection by providing universal access to high standards of prevention, treatment, care, and support. The target groups and strategies are similar the MOHSW's RH program. Common target group/beneficiaries include pregnant women and children, students, and Commercial sex workers (CSW). Common strategies include refurbishing sites to increase quality of care, youth friendly services, private sector participation, prevent and treat opportunistic infections including STIs. These commonalities must be explored further as significant opportunities exist for coordination of activities and managing of resources.

Another source to draw upon for coordination is the National Population Commission Secretariat (NPCS). NPCS is the focal point in the management of population programs and part of their mandate is to "foster functional linkages among sectoral departments, institutions, and agencies to harmonize the work of the NPC at national, regional, and district levels." The Secretariat's decentralized approach to working with local governments through Population Task Forces, Multidisciplinary Facilitation Teams, Ward Development Committee, etc. can greatly facilitate dissemination of policies and IEC/BCC messages, training, and monitoring of reproductive health programs.

Linkages with Global Fund HIV/AIDS and malaria programming are mixed. The PMTCT program is well integrated with the RCH unit as is the GF malaria activities of NMCP. However, sexually transmitted infection (STI) interventions are the responsibility of the National AIDS Control Programme (NACP). There is need for more integrated approach to address STIs and the need for proper linkages with Voluntary Counseling and Testing (VCT).

A central weakness of country's RHCS program is inadequate coordination – the national RHCS committee has not met regulary since 2007. From information provided during interviews, several factors contributed to the inactivity of the committee –

- loss of the AWARE RH Project, World Bank, and IPPF funding and expertise that were providing support to RH programs in early to mid 2000s,
- personnel changes in the MOHSW leadership and management levels with resulting differences in working styles and philosophies, and
- attrition at the MOHSW and RCH Unit resulting in loss of institutional memory

Coordination and information sharing between levels of the health system and among regional levels is sporadic. While a meeting with all Regional Health Teams (RHT) is to take place quarterly, organization and funding for these meetings is not routinely available. Historically, funding was available for meetings bringing together the Officers-in-Charge (OICs) and other health center nursing staff with their respective RHT. This was an opportunity for in-service training, sharing bestpractices, program updates, etc. This past year, funding was not available to continue these meetings.

Coordination: Key Recommendations

Create a Coordinating Committee for RHCS

- The creation of a committee to coordinate commodity security issues specific to reproductive health is a key first step to strengthening RHCS in The Gambia. The committee should include representatives of the various sectors and partners including the RCH Unit, UNFPA, NAS, Pharmacy Division, Planning Division, CMS, NACP, NMCP, NGOs, the commercial sector, etc. The committee should be the main coordinating body for RHCS and provide a venue for partners to exchange data and discuss common problems. The RCH unit with support from UNFPA should revitalize the RHCS committee and make it functional by:
  - organizing agenda ahead of time
  - disseminating notes with action points and persons responsible immediately after meetings
  - conducting monthly until purpose and needed outputs are well understood by committee members
  - rotating responsibility and venues as necessary
  - actively monitoring and assessing committee outputs and impact
- Conduct study tour to model structure and operations of successful RHCS committees.
- Strengthen lines of communication between UNFPA and MOHSW Permanent Secretary level to help ensure further coordination between RCH Unit, UNFPA and MOHSW at the management levels.
- Encourage, monitor and support coordination and in-service meetings between regions and central level, and between health service staff and their respective RHT. This will improve service delivery and commodity security through building capacity, reinforcement of policies and procedures, and sharing of best practices among other potential positive impacts.

Coordinate with GF Primary Recipients

- There are significant opportunities and benefits, for both RH and HIV/AIDS, for increased coordination between the RCH Unit, NACP, NAS and Action Aid. This parternship will increase experience in condom programming, which is needed to ensure full supply of dual purpose condoms are procured. NAS should be actively represented in any CS committee and likewise there should be a voice for RH in HIV/AIDS fora such as UN Technical Working Group and the GFATM Country Coordinating Mechanism.
- Build collaborative efforts with NACP to ensure that quality STI treatment is readily accessible for the public, especially men, youth, and commercial sex workers. Increase linkages with STI treatment and VCT programs to help target those at most risk for HIV infection. This will help ensure continued success in reaching Objective 2 of Round 8 GF grant calling for increase in VCT testing of sexually active population.
- Continue collaboration in PMTCT, ensuring FP is available in HIV/AIDS settings, that HIV/AIDS information and services are available in RH.

4. FINANCING (CAPITAL)

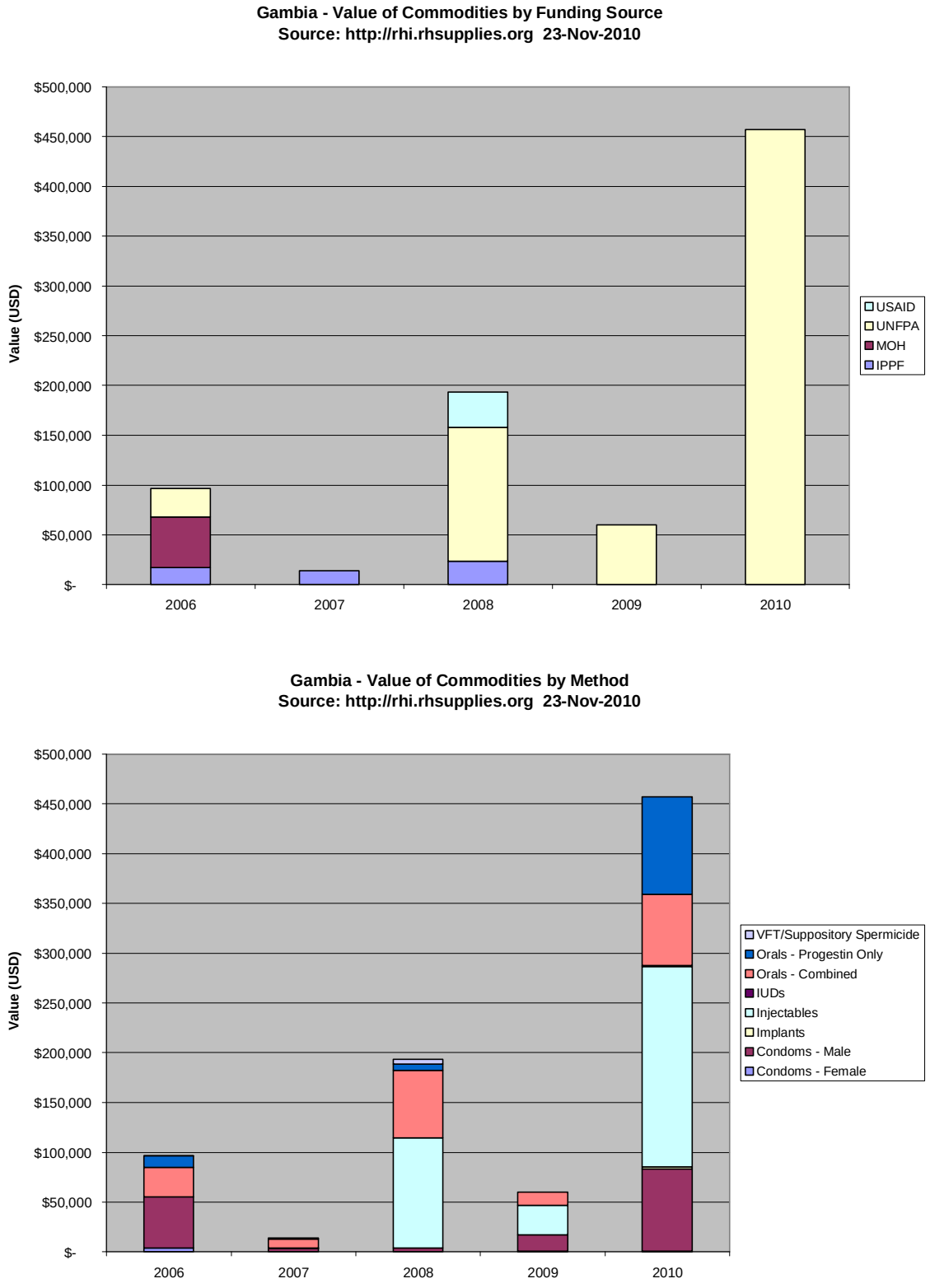
The Gambia is highly dependent on external aid to finance development projects in all the different sectors, more so in the priority sectors. The results of the first National Health Accounts (NHA) for the fiscal years 2002-2004 revealed that 67% of the financing to the health sector comes from the donors, with rest of the financing split between the government (21%) and households' out-of-pocket expenditure (12%) (WHO 2009).

There is currently no line item in the government budget for family planning commodities. However, a key objective in the country RHCS strategy is to "Sensitize key decision makers (finance, parliamentarians) to include a budget line for contraceptives in the health budget of the DOSH." In the next budget cycle all indications are that the government of The Gambia is including contraceptive procurement as a line in the health budget. This shows real commitment towards improving RHCS situation. While the final figure is not known or confirmed, an amount of 2-3 million Dalasi was suggested.

UNFPA, UNICEF and Global Fund are currently funding RH commodities. The Reproductive Health Interchange reports that donor funded contraceptive procurement since 2006 totals USD 821,386. As illustrated in figure 3, UNFPA is the main supplier of contraceptives to the public sector, which are distributed free through the government system, and UNFPA and UNICEF both provide funding for a number supplies and kits containing reproductive health commodities. Since 2006, UNFPA has procured USD 680,575 worth of contraceptives and was the sole public sector supplier in 2009 and 2010. Data from the RHI indicates that a total of USD 60,222 was spent on contraceptive procurement by UNFPA for the Gambia in 2009. However, this was only about 57% of the requirement as forecasted in the 2008 Contraceptive Procurement Tables (CPTs). In 2010 they purchased injectables, condoms, IUDs, implants, combined orals, and progestin only pills worth USD 457,056. Thus, 67% of their support occurred this year alone. The level of UNFPA's support from 2011-2012 for contraceptive procurement was not available at the time of this situational analysis.

IPPF used to provide contraceptives to the Gambia Family Planning Association (GFPA), but ceased in 2008 when GFPA was required to graduate from IPPF support. Currently, GFPA depends on MOH for their supplies (via UNFPA procurement). Also, due to lack of funding, GFPA no longer runs their social marketing program despite having the required infrastructure and expertise. USAID has not supplied methods since 2000 except for a shipment of injectables in 2008.

Figure 3: Value of Commodities by Funding Source and by Method



Since 2004, the GFATM has committed USD 98,655,882 to Gambia with over USD 67 million of this disbursed. The GFATM supports HIV/AIDS treatment, care and support (VCT, PMTCT,

Clinical ART, and Community, and Training/Capacity Building; for Malaria: Malaria Case Management, Intermittent Prevention Treatment (IPT), ITNs and IEC; and TB. (Global Fund, 2010) Condoms for HIV/AIDS are financed GFATM funds and distributed through the public sector as well as through NGOs such as Action Aid.

GF Round 8 began in December 2009 with USD 5,675,505 awarded to Action Aid, and USD 12,774,469 to NAS. According to the Grant Performance Report updated November 2010, NAS has spent over 1.078 million USD in pharmaceuticals (49%) and health products, commodities, and equipment (51%). This was used primarily for procurement of badly needed OI drugs, lab equipment, diagnostics tests, and ARVs that were nearly stocked out. As of October 2010 Grant Performance Report for Action Aid, this PR spent USD 40,048 on condom procurement.

There is no household or third party funding for family planning services. Workshop participants did indicate, however, that third party funding for health services is increasing and becoming available for government and some NGO employees.

The USAID | DELIVER PROJECT CPT analysis conducted in September 2010 estimates funding needed for contraceptive procurement to be USD163,892 in 2011 and USD 227,045 in 2011. The table below shows estimated commodity costs for the remainder of 2010 and for 2011 to 2012. The costs are based on USAID prices.

Table 1: Estimated Contraceptive Costs through 2012

Contraceptive	2010	2011	2012	Comments
Depo Provera	18,000	45,080	60,720	
Norigynon	0	0	0	Over stocked. No need for more supplies unless demand increases
Microgynon	0	46,200	59,640	
Microlut	0	0	0	Currently ordered quantities by UNFPA sufficient for 2011 & 2012
IUDs	0	0	270	
Implants	4,200	4,200	6,300	
Foaming tablets	546	555	573	
Male Condoms	0	67,857	99,542	
Female Condoms	0	0	0	Over stocked. No need for more supplies unless demand increases
Total	**USD 22,746**	**USD 163,892**	**USD 227,045**	

Finance: Key Recommendations

- Cost out reproductive health program components to identify funding gaps and mobilize financing of contraceptives, basic RH equipment, and improved service delivery.
- Leverage government, donor and private resources (UNFPA, Global Fund, WHO, UNICEF, USAID, NGO partners and private sector) for secure and continuous financial support for the full RH program. For example, of the USD 413,700 needed in contraceptive procurement, USD 167,000 is for condoms. If the National AIDS Secretariat (GF principle recipient) can provide the condom procurement as part of efforts to view condoms as having dual protection, then it will free up those funds for UNFPA to use on other RH program support.
- Conduct market segmentation and a price rationalization study (ability to pay) and use findings to help develop a strategy to expand role of private sector.

5. COMMODITES

In general, the MOHSW through its National Pharmaceutical Services (NPS) Central Medical Stores (CMS) operates a standardized system of bi-monthly supply of essential drugs, equipment and other medical supplies to the regional stores of the six regional health teams responsible for the overall supervision of health services countrywide. Essential medicines including those for EmONC and those procured by the GFATM prevention and treatment are distributed through the CMS system. The RCH Unit centrally manages some RH commodities such as contraceptives, basic equipment for antenatal care and delivery including TBA kits, obstetric record card/registers and furniture for RCH outreach services.

There is duty waiver for public sector commodities and GFPA. Private sector products are taxed. There are registration categories for service providers dispensing products. Condoms and pills are category "C" or can be sold over the counter. Injectables are category "B" or need a service provider trained in injection. IUDs are category "B" and "A" needing a trained service provider. Registration for RH commodities is reported to be relatively easy.

Identification and confirmation of necessary RH commodities for The Gambia was included as part of the workshop discussions with key informants. This list is specific to the country's reproductive health program includes the 10 products recommended by WHO and UNFPA.

Table 2: Reproductive Health Commodity List

Contraceptives and Condoms	Essential Medicines-EmONC	ANC/PMTCT	Supplies
• Male condoms (for dual purpose) • Injectables • Oral Pills: – Combined – Progestin only • Female condoms (for dual purpose) • Foaming Tablets • IUDs • Implants • Emergency contraception	• Oxytocin • Ergometrine • Magnesium Sulfate • Iron and Folate • Antihypertensive drugs • Antibiotics	• Iron and Folate • Tetanus toxoid • Sulfadoxine + Pyrimethamine • Nevirapine • Azidothymidine • STI diagnostic kits • Deworming tabs • ITNs	• HB estimation kits • Urinalysis kits • Syphilis test kits • C-section kits • Delivery kits • Pregnancy test kits • Examination gloves • Surgical gloves • Blood pressure machines, scales, tape measures, • Fetal monitoring device (fetoscopes, scanner) • HCT test kits • Disinfectants • Antiseptics • Vacuum extractors

CONTRACEPTIVES AND OTHER RH COMMODITIES AVAILABLE

Discussions with the RCH Unit and other stakeholders indicated that forecasting for contraceptives in The Gambia was conducted in 2008 with technical support from the AWARE RH Project. Further information provided in the contraceptive quantification exercise conducted in September 2010 indicates that the AWARE RH forecast was prepared using data collected from the six regions of the Gambia, GFPA store, and the RCH store. Pipeline software was used to develop the forecast. The exercise proposed quantities required in 2008, 2009 and 2010 and estimated the required funding and a funding gap analysis. There was no evidence that the forecast was used for procurement planning. There was also no evidence that the forecasts had been reviewed or updated.

This in conjunction with MOHSW staff turnover, limited donor funding, and lack of an active RHCS committee contributed to the limited availablility of RH commodities, primarily contraceptives. As figure 3 above illustrates, procurement of contraceptives was minimal, especially in 2007 and 2009. This trend is also shown through table 3 below. In 2000, USAID was the sole procurement source for contraceptives and amounts were small relative to the unmet need; 2006 shows a significant increase, especially in pills and condoms. However, it is still not enough for a full supply line. In 2010 efforts are made to correct these shortages with a big upswing of support from UNFPA.

Table 3: Source of contraceptives – 2000, 2006, 2010

Year	Funding Source	Method	Quantity
Jan-00 - Dec-00	USAID	Condoms - Male	348,000
	USAID	Injectables	6,400
	USAID	IUDs	600
	USAID	Orals - Combined	28,800
	USAID	Orals - Progestin Only	1,200

	USAID	VFT/Suppository Spermicide	57,600
Jan-06 - Dec-06	IPPF	Condoms - Female	5,000
	IPPF	Orals - Combined	39,000
	IPPF	Orals - Progestin Only	6,700
	IPPF	VFT/Suppository Spermicide	2,400
	MOH	Condoms - Male	1,872,000
	UNFPA	Orals - Combined	56,250
	UNFPA	Orals - Progestin Only	27,336
Jan-10 - Dec-10	UNFPA	Condoms - Male	2,694,672
	UNFPA	Implants	100
	UNFPA	Injectables	210,000
	UNFPA	IUDs	1,500
	UNFPA	Orals - Combined	215,100
	UNFPA	Orals - Progestin Only	215,100

The Gambia Family Planning Association provided implants in the past on a pilot basis and has expressed the intention to scale up. The MOHSW also expressed the desire to introduce implants as part of the contraceptive method mix. Whereas the requirements for implants were estimated, there is need to finalize in-country preparations for training providers in implant insertion to avoid supplies sitting around once received. Currently UNFPA plans to send implants to Gambia around the end of 2010.

There has been consistent reporting in documents and verbally that frequent stock-out and rationing is the norm. Site visits to the four regions included the review of commodities available and reasons for stockouts. Most facilities visited had the following RH commodities available: male condoms, Depo, microgynon, antibiotics, oxytocin, magnesium sulfate, folate, and ergometrine. To a lesser extent the following were available: female condoms, norigynon, IUDs, microlut, lo-femenal, overette, vaginal foaming tablets, PMTCT drugs, and hydralizine. A lack of requested quantities available at the next higher level and procurement problems were reported reasons for stockouts. Condoms, pills, Depo, oxytocin and antibiotics stocked out most frequently for an average period of 1-2 weeks with the exception of Depo. A global manufacturing problem led to a 3-4 month stockout of Depo. Some products, such as female condoms and vaginal foaming tablets expire due to lack of demand.

Key informants indicated that at one point this past year there were no contraceptives available in country. Some stated contraceptives were only in private sector pharmacies at elevated prices. Interviewees were very concerned about the spike in pregnancies as a result the Depo stock-out and other shortages. Norigynon and pills were substituted where available and as accepted by the clients.

CONTRACEPTIVE REQUIREMENTS

The contraceptive forecast conducted by the USAID | DELIVER PROJECT projected commodity needs through 2012 and was disseminated to USAID, UNFPA, MOH and the RCH Unit/MOH. The estimates are presented in table 4 below.

Table 4: Contraceptive Requirements through 2012

Contraceptive	Unit	2010	2011	2012	Comments
Depo Provera	Vials	20,000	49,000	66,000	80, 000 already ordered by UNFPA for remainder of 2010
Norigynon	Ampoule	0	0	0	Overstocked

Microgynon	cycle	0	165,000	213,000	200,000 already ordered by UNFPA for remainder of 2010
Microlut	Cycle	0	21,000	24,000	200,000 have been ordered by UNFPA for remainder of 2010. Proposal is for UNFPA to ship only the required 20,000 and schedule the rest for 2011 and 2012
IUDs	Piece	0	0	0	Over stocked
Implants	Set	200	200	300	UNFPA has ordered 100 for remainder of 2010
Foaming tablets	Tube	6,000	6100	6,300	Need to be ordered
Male Condoms	Piece	0	2,420,000	3,550,000	UNFPA has ordered for 1,008,000 for remainder of 2010
Female Condoms	Piece	0	0	0	Over stocked

Commodities: Key Recommendations

- Finalize list and prioritize commodities that must be covered 100% through available funding.
- Confirm Government and donor commitment to secure priority commodities at full supply.
- UNFPA, NAS and MOH to meet to discuss coordination of immediate procurement needs to avoid duplication.

6. CLIENT UTILIZATION AND DEMAND

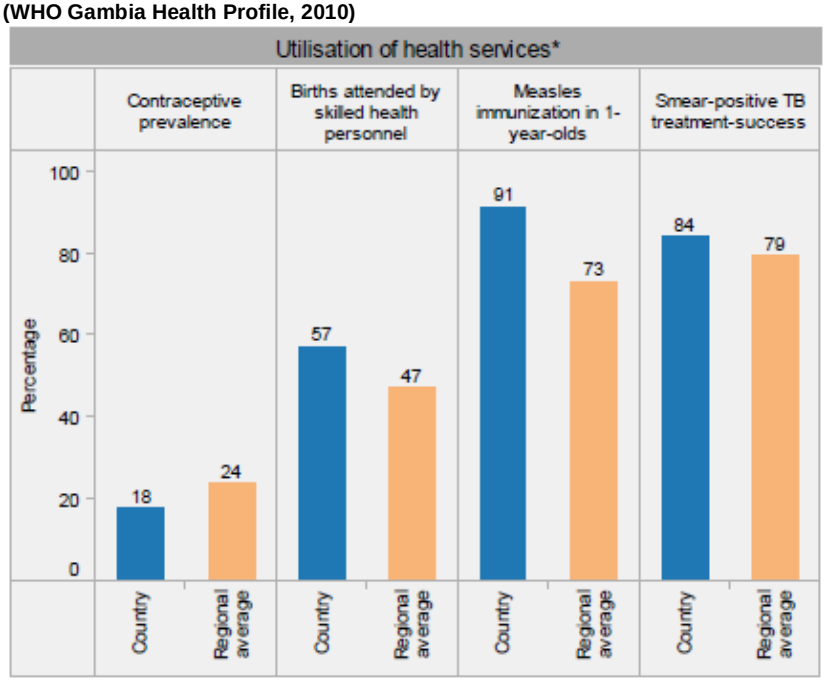
The RCH Unit offers a range of decentralized and integrated services in the public sector including: antenatal care, child birth and newborn care, postpartum care, family planning, prevention of mother to child transmission of HIV (PMTCT), malaria in pregnancy/intermittent preventive treatment (MIP/IPT), the integration of birth registration of children under-five and the integrated management of childhood infection (IMCI) strategy for the child health component of the RCH program. Sexually transmitted infections (STIs) management falls under the responsibility of the National AIDS Control Program. Services are free and delivered through:

* 6 Major Health Centres
* 12 Minor Health Centres
* 15 Dispensaries
* 4 Maternity Clinics
* 192 RCH Outreach/trekking Stations, and
* 450 PHC Villages

Private clinics, pharmacies and some NGO health facilities such as GFPA and BAFROW also offer RH services and are located primarily in the Western Region. GFPA has clinics in all regions of the country. The 2001 MMS survey reported that most clients obtain their supplies from the public sector, mostly because they cannot afford or are not willing to purchase services and commodities at NGO or private health facilities. Although most clients go to the public sector, there are still issues such as frequent stockouts and quality of care issues such as privacy, long waiting times, attitude of

service providers that need to be addressed. It was also found that public sector health facilities do not provide a welcoming environment towards certain populations such as men, adolescents, and commercial sex workers. These groups felt inhibited accessing clinic services that are stigmatized, for example, treatment for STIs and requests for contraceptives when it is known the person is unmarried or underage. Figure 4 below illustrates how this quality of care and RHCS issues reflect in country contraceptive use compared to other health interventions.

Figure 4: Utilization of Health Services
(WHO Gambia Health Profile, 2010)



As established in the introduction, the Gambia constitutes a male dominated society where men are primary decision makers and earners. Survey and site visit findings listed the following reasons for discontinuation of FP: pregnancy, spousal objection, religious/social cultural reasons, and side effects. Survey findings suggest that a higher percentage of men than women are against family planning due to religious/social cultural reasons. Surveys and information from key informant interviews also report suspicion of contraceptives by men, as they see contraception as a way a wife or wives can cheat on them. It was found many women preferred the injectable Depo because they could use the method without their husband's knowledge. Pills are another popular method for women, while male condoms are increasingly popular for men.

Survey findings and information from site visits also found that women and men desire large families or will have as many children as "God wills" even though 92.3% of married women and 88.4% of all women and 85.4% of married men and 83.2% of all men have heard of at least one method of contraception (MMS 2001). The high percentage of survey respondents who have heard of at least one family planning method as established by the 2001 survey is remarkable; however it has not necessary translated into significant uptake. These findings indicate that women and men may not have enough information to understand the benefits of contraception for spacing or limiting and/or believe it is prohibited to use contraception for religious/social cultural reasons.

BCC/IEC campaigns exist and vary among regions and the majority of people (60%) in the 2001 survey had heard of FP through the radio (MMS 2001). Campaigns are often conducted by regional health teams and village health workers. Without recent data, it is difficult to determine the current understanding and use of RH health commodities but key informants felt there was a definite increased awareness contraceptive use in certain areas and among men. The introduction of the local word "Fankanta" which means prevention, instead of "family planning" has helped men and women to understand and accept the purpose of birth control. BCC/IEC campaigns could additionally focus on how family planning benefits the family unit further acceptance. Condom use for prevention of STI and HIV was definitely on the upswing.

Table 5: Sources of Family Planning Information for Women and Men

Percent of distribution of women and men who have ever heard of FP by sources of methods according to residence	2001	
Urban	Women	Men
Public sector	82%	73.3%
GFPA	11.2%	13%
Commercial sector	6.7%	13.6%
Religious body	0.1%	0.1%
Rural	Women	Men
Public sector	87.2%	84.5%
GFPA	9.3%	10.3%
Commercial sector	3.4%	5.1%
Religious body	0.1%	0.1%

USE OF CONTRACEPTION

The CPR in 2001 was 17.5% with 13.4% constituting modern methods (MMS 2001) and an unmet need of 25% (MMS 2001). With an estimated increase of .5% - 1.5% per year, it is projected that the 2010 CPR is between 22% – 31% (RHCS Strategy 2006). The low uptake of family planning and high unmet need demonstrate that The Gambia must still continue to work towards increasing FP promotion messages and provision of services to not only to current clients, but to clients who would like to use FP, and groups who are unknowledgeable about FP, including men and adolescents.

Table 6: Contraceptive Prevalence

Contraceptive Prevalence	2001	Projected 2015**
All methods	**17.5%**	**31.5%**
BY METHOD		
Traditional methods	**4.1%**	**7.5%**
Modern methods	**13.4%**	**24%**
Pill	**6.5%**	**6.8%**
IUD	**1.4%**	**2.6%**
Injectables	**3.5%**	**6.6%**
Implants		
Male condom	**0.5***	**.9%**
Female condom		
Vaginal Foaming Tablets	**0.1%**	**.2%**

Emergency contraception	-	
Female sterilization.	**0.7%**	**1.3%**
Male sterilization	**0.2%**	**.2%**
BY AGE		
15-19	**6.9%**	
20-24	**17.4%**	
25-29	**17.8%**	
30-34	**19.6%**	
35-39	**21%**	
40-44	**18.9%**	
45-49	**11.5%**	
BY PARITY		
0	**33.3%**	
1	**37.9%**	
2	**34.8%**	
3+	**36.7%**	
BY SETTLEMENT		
PHC	**14.8%**	
Non-PHC	**18.9%**	
Urban	**19.5%**	
BY RESIDENCE		
Urban	**20%**	
Rural	**17%**	
BY EDUCATION		
No education	**14.5%**	
Primary	**20.3%**	
Secondary	**36.6%**	
Post - Secondary	**31.7%**	

* The survey did not differentiate between female and male condoms
** Projected CPR assuming 1% annual increase and constant method mix (RHCS Strategy 2006)

SERVICE PROVIDER STAFFING AND TECHNICAL CAPACITY

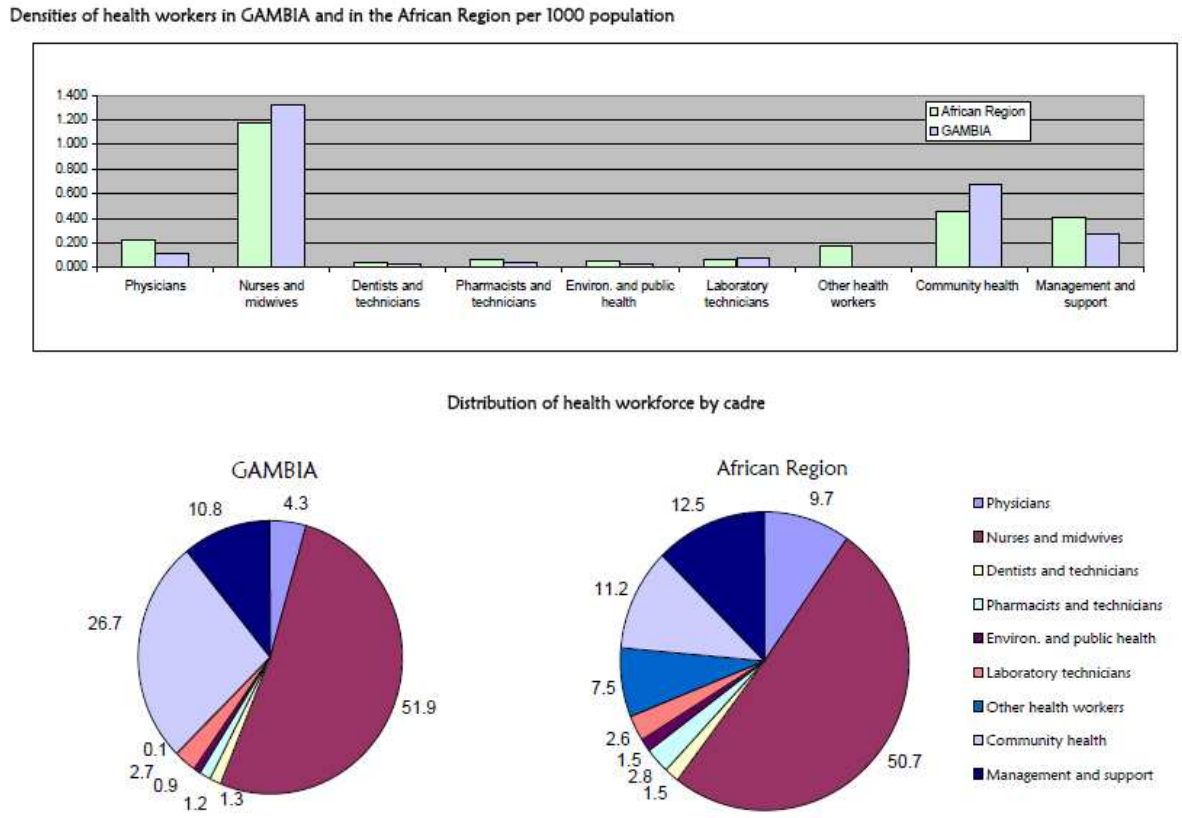
Health delivery systems in The Gambia are decentralized to the Regional level. RHTs oversee the health services through supporting the managers of health centers, clinics, dispensaries, and outreach services in those regions. Because of the scarcity of indigenous doctors, most regions are headed by regional health officers who are either state registered nurses or Public Health Officers. The team operates from Regional Centers from where they supervise all major and minor health centers, PHC teams, and conduct outreach RCH services. Supervision and monitoring visits are conducted monthly.

Enrolled Nurses, Midwives, and Community Health Workers (CHWs) staff major and minor health centers. CHWs, village health workers, and TBAs provide services at the village level. This includes distribution of contraceptives except those required higher level of skill – IUD and implants.

Human Resources for health is one of the outstanding gaps that needs to be addressed in order to improve RH care and RHCS. While almost all nurses and public health officers in the country are Gambians less than 10% of the doctors are Gambians. The medical doctors come from Nigeria, Cuba and Egypt and staff primarily tertiary level facilities. There are several nurse training facilities and in-service training for nurses is conducted. As indicated in figure 5 below, there is a good cadre

of nurses and midwives but physicians, lab technicians, pharmacisits, data entry staff and health program managers are scarce. This coupled with high attrition, transfer, poor working environment, and poor morale make adequate staffing near impossible.

Figure 5: Health Work Force in The Gambia
(Source: WHO Gambia Health Profile, 2006)



In discussion with key informants and information from site visits it was found that written guidance was generally not available for health facility staff use. Written guidance includes standard treatment guidelines, policies, universal safety procedures, etc. Much of this information is provided during trainings but staff "personalize" it, keeping it at home vs. at the facility for reference. In some cases, health facility employees were given more responsibility based on their experience and observations by supervisors rather than formal training certification.

Although the use of IUDs is not a widely known or used method, it was found that health facilities do not have enough staff trained on IUD insertion. If a health facility does not have the ability to provide IUD insertion, counseling on this method has the possibility of being omitted rather than referring the client to the closest available facility with the method available. It was however noted that many clients have difficulty in finding transportation to the nearest health facility. Lack of promotion of long acting and permanent methods coupled with lack of trained staff are barriers that will need to be overcome.

To help address this, new training and education programs through the University of The Gambia are offering new opportunities to Gambian youth for careers in the health sector. In fact, in was

recently reported that "17 medical students who have completed their studies at the School of Medicine and Allied Health Sciences of the University of The Gambia (UTG), were on Wednesday, 29th of December 2010 sworn in at a ceremony held at the Royal Victoria Teaching Hospital (RVTH) in Banjul." (Africa News, 2011) The MOHSW is also giving more incentives for higher eduction opportunities, training, and salary.

The GF Round 8 and previous grants have improved training opportunities and address capacity building. UNFPA, WHO and other donors also provide funds for in-service training. The first STI syndromic management training in several years was scheduled to be conducted in December 2010. EmONC training is conducted quarterly. A Manual for Training of Service Providers on the Prevention and Control of Malaria includes modules on Focused Antenatal Care, Records and Stock Management, and Monitoring Evaluation along with specifics on malaria. These are all excellent initiatives to improve service delivery.

Service Delivery: Key Recommendations

- Prioritize quality of care issues: privacy, service hours, provider attitude can all be improve with existing infrastructure to create a more open environment for all patients
- Explore ways of providing a range of sexual and RH services to underserved groups
- Train more staff on IUD insertion and promote long acting methods
- Expand BCC/IEC campaigns on the benefits of SRH targeting men and youth
- Disseminate Standard Treatment Guidelines
- STGs, currently being finalized, should be disseminated to state, locality and SDP facilities.

7. LOGISTICS

As mentioned earlier, there are two flows of RH commodities in The Gambia. EMs including those purchased by the Global Fund for HIV/AIDS, Malaria and TB are managed through the CMS. Contraceptives, delivery kits and equipment purchased by UNFPA are managed and stored by the RCH Unit in Banjul. The need for improved logistics systems has taken the forefront the past several months due to frequent and/or prolonged stock-outs of several contraceptive methods and poor data management capabilities. UNFPA and stakeholder concerns about commodity security and RCH Unit requests have energized efforts to improve commodity security (especially for contraceptives) and improve the logistics system. Revisions to the CMS LMIS, HMIS, and contraceptive reporting systems are currently underway which will do much to improve reporting and forecasting of RH commodity needs.

There was universal consensus to harmonize the CMS and RCH supply chains by merging supply chain management of contraceptives and other RH supplies into the CMS system. Some consistencies already exist as the Combined Requisition and Issues Notebook (CRIN) is used by all government and NGO groups to requisition commodities whether from CMS or RCH Unit. Also data collected for HMIS system is done through same data collection process and passed back up the system through the RHTs and then to the HMIS Unit of the Directorate of Planning, MOHSW.

The current operation of the two systems is illustrated in figure 5 showing the flow of commodities and information for the two supply chains, which at certain levels and/or sites comes together.

CENTRAL MEDICAL SUPPLIES

The National Pharmaceutical Services was established as a division under the Directorate of Health Services in 1996. Four major functions were identified: essential medicines supply, medicines legislation and regulation, medicines quality and control services, and planning and management. Under essential medicines supply, CMS is responsible for the selection, procurement, storage, and distribution of medical supplies and equipment for the public sector. It has a public mission – to ensure drug availability to all – and to do it sustainably and efficiently, at minimal cost.

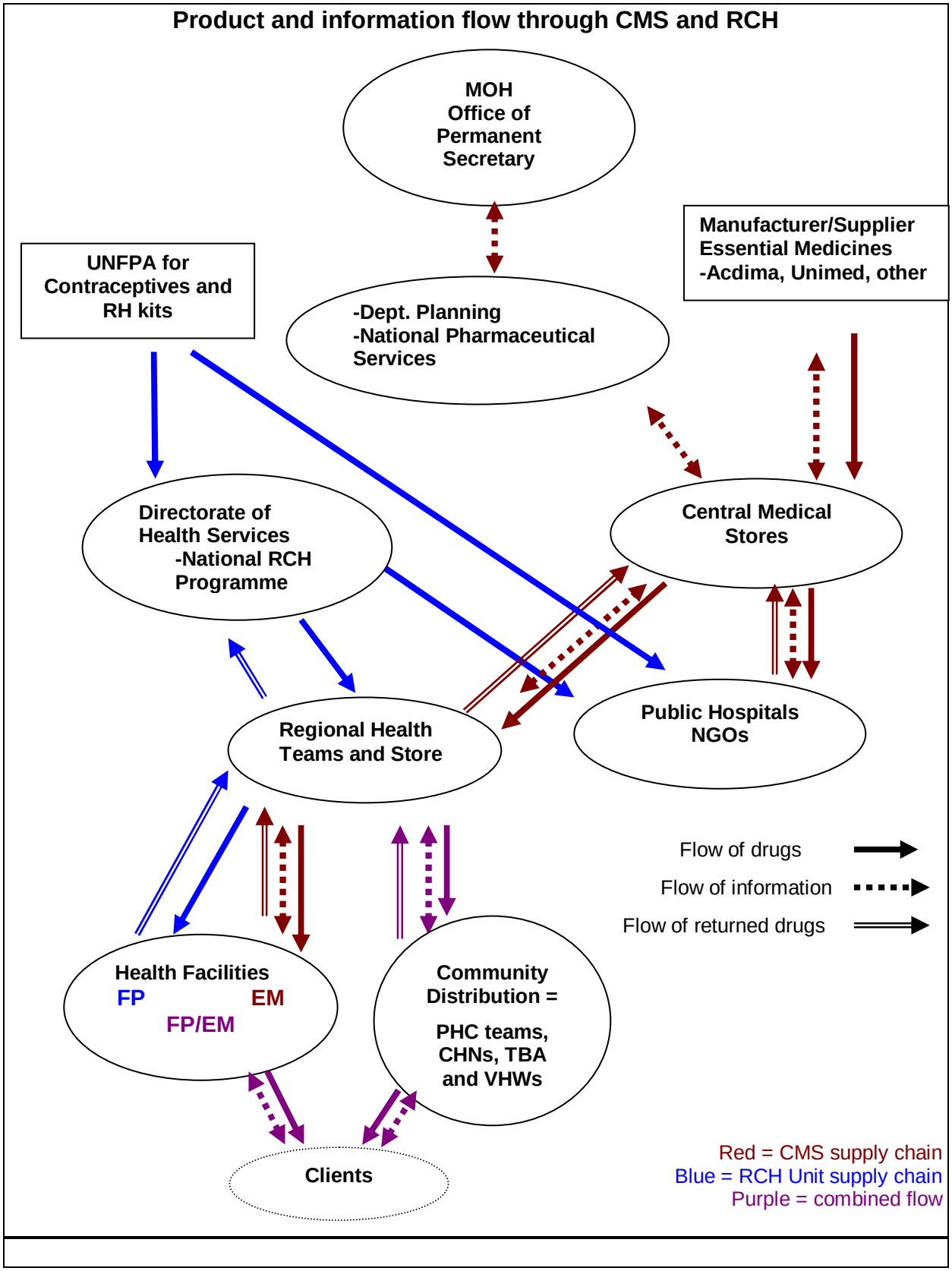
CMS purchases emergency obstetrics drugs, antibiotics, and other essential medicines either through direct sourcing or competitive bidding process. Direct sourcing is through a bilateral arrangement with the Government of Egypt. Procurement agents such as Acdima are used to facilitate the procurements. If prices are too high, CMS will seek alternative suppliers such as Unimed. Commodities for NMCP and NAS are done through an open competitive bidding process.

CMS prepares quantifications in September and October and sends estimated drug quantities to Acdima and Unimed. They send quotes back to CMS who will evaluate bids for cost, timing, quality, etc. Final budget amounts available for commodity procurement are available by this time. CMS uses this information to determine final quantities to procure. Requested procurements with costs are sent to the Ministry of Health for review. The Minister presents the total procurement amount to the cabinet for approval to spend the funds. Once the approval is granted, CMS (or their representative) contracts with the selected supplier for delivery of the drugs. CMS can procure only one time per year. If drugs stock-out, no further procurement can be done for the year using government funding. This doesn't happen regularly, but CMS admits that forecasting and quantification are not the best due to lack of consumption data.

LMIS and inventory control through the CMS is better managed through quarterly monitoring, more consistent use of tally cards, and correct use of forms such as the CRIN. Through GF Round 8 health systems strengthening funds managed by NAS, CMS is in the process of strengthening their LMIS, inventory, storage and distribution capabilities. They are revising their LMIS system given problems with automated software and information collected. In the short-term they have updated existing guidance and forms. In the longer-term they are contracting for installation of a new pharmaceutical inventory control software package, mSupply.

CMS operates a new central warehouse (opened in July 2007) located in Kotu, about 20 minutes south of Banjul and accessible by good, paved roads. The warehouse has multiple storage areas including cold storage and air conditioned bays. Use of pallets, shelving, forklifts, and first-to-expire, first-out (FEFO) was evident throughout.

Figure 6: CMS and RCH Pipeline



RCH LMIS and Inventory Control

For contraceptives managed through the RCH Unit, the system is a "pull" one where lower levels request re-supply when they determine they need it. Higher levels do not monitor stock at lower levels and there is no consistent flow of stock data from the health facilities back to regional and central levels. There is no forecasting according to standard methods. Min/max stock levels are not well known or understood. Respondents at regional stores and health centers said they used their judgment to determine when and how much to reorder based on their experience with commodity flow and immediate needs. Losses/adjustments and consumption data is not collected and thus not calculated into resupply needs. Stock outs have been frequent at lower levels and occur at all levels, including central stores.

For contraceptive requisition, the CRIN was not being used to its fullest advantage or at all. Neither the requisition nor the issues sections were completely filled out and final stock balance recorded, only the stock issued was recorded. For some transactions, the information on the CRIN did not accurately reflect where the order originated from. To make full use of the LMIS and tracking information, the OIC/pharmacist should complete the left side of the form with Unit, stock on hand (at regional level), and quantity needed. When stock is issued, the RCH storekeeper should complete the right hand side with stock on hand (at central level). Number of units supplied and stock balance. This way, the RCH Unit has an accurate accounting of stock on hand in the RCH warehouse, which can be compared with the stock cards. It also provides a monitoring tool for stock on hand at the regional level. Stock should not be issued to regional or SDP level unless the requisition section of the CRIN is correctly filled out.

HMIS

Extensive HMIS reporting is done on a monthly and quarterly basis using the MOHSW Health Facilities Quarterly Returns Form and reporting rates are high, approximately 90%. However, it is a time drain on staff at service delivery points to report service data and health centers are not often equipped with proper forms and/or organizational materials to ensure data is not lost. From the daily FP registers, RCH staff at the SDP complete monthly family planning visit forms; these are totaled and the number of new acceptors and revisits is sent to the OIC. OICs are required to complete monthly report forms, which include numbers of new acceptors along with many other health indicators to their RHT supervisor. Data entry clerks at the regional level then aggregate the data and reports to the regional RHT director, who in turn reports to the MOHSW Department of Planning's HMIS Unit.

The HMIS forms are not used for feedback to the regional teams but data is regularly posted to the website. An HMIS bulletin was done in previous years which reported on several health indicators. The last one distributed in March 2009 reported on such indictors as "total number of malaria cases reported by Region, total number of STI infection cases reported by Region, and total number of services provided by VHWs and TBAs." It was not done in 2010 due to technical problems. It is highly recommended that the HMIS Unit begin to report back service statistics to the RHTs, RCH Unit, NACP, and stakeholders on a quarterly basis. There is a wealth of data being collected that can be analyzed for trends and used to pin point priority program areas.

To improve the collection of consumption and stock-on-hand, the quarterly return form was recently revised to include family planning revisits and stock data for contraceptives. It does not include losses and adjustments, however. Training on this revised form was taking place at the time of the assessment and the HMIS Director estimated it would be rolled out in January 2011.

STORAGE

Contraceptives are not currently stored at CMS but at the RCH store located at the program offices in Banjul. In addition to storing contraceptives, the store is used for storing delivery kits, reproductive health equipment, and stationery for the program. At the time of the visit, the RCH store was found to be disorganized due to an on-going renovation exercise. A shipment of condoms and delivery kits were recently received and could not be properly organized (stack height, labeling) as there was not enough clear space. Some were stored outside the primary storage area (though still in secure area).

At the regional level contraceptives and medicines may or may not be stored in the same warehouse; at the health facilities observed, most contraceptives were kept in a separate location and managed by the OIC, not the storekeeper or pharmacist. Some regional stores were well organized; lighting was sufficient and had cold chain capacity. While most had AC, it was not available 100% of the time due to scheduled power outages that disrupt the electricity supply daily. For the most part, contraceptives were stored with EMs in the same storage areas. This was not the case for Western Region; however, the plan is to eventually move the contraceptives to the storage area at the Brikama medical center complex with other drug supply.

Storage conditions for all commodities were poor at the SDP level. They were crowded, dusty, and did not have AC. In their current configuration some stores would have trouble maintaining a full supply of commodities needed. At this level, the contraceptives are generally stored separately by the OIC, midwife, or community health nurse, usually near the consultation area. In one minor health center, Kwinella, the contraceptives and EMs were stored together.

DISTRIBUTION

The primary difficulty found with transport included space in vehicles and motorbikes to carry full supply of contraceptives and other needed RH commodities. The bulky condom cases are especially difficult. Frequent trips for resupply are made due to this lack of transport space and/or lack of stock.

Regions collect commodities from the RCH Unit warehouse in Banjul using utility vehicles. Normally the regional public health nurse will arrange to collect supplies using a regional vehicle when needed, or sometimes they will try to arrange collection through another means. From the regional level, RH personnel collect supplies by ambulance, motorbike, or whatever means available. Contraceptives are distributed with essential drugs but full supply will often not be carried due to space constraints on the vehicles. This is especially true for large cases of condoms. Usually, the local RH supervisor (usually a midwife or public health nurse) manages supplies for the PHC teams and village health workers (VHWs), storing them and distributing them as required.

It is worth noting that all regions are within a one day's drive of Banjul and can place an order at any time and receive supplies within a few days of placing an order or even sooner if it was an emergency. Distances are very manageable between health facilities and regional stores, which facilitates resupply as needed. In general there were no fixed distribution schedules for drugs. Generally, regions and SDPs order on a monthly basis but this is for convenience and in practice they can order whenever they want to.

INTEGRATION OF RCH UNIT AND CMS SUPPLY CHAIN

Given the weaknesses in the current supply chain for contraceptives and other donated RH supplies, and the relative strength of the CMS system coupled with the GF health systems strengthening resources, it makes sense to work towards increased integration of donated RH commodities with the CMS system. Integrating storage, distribution and inventory management would build up RHCS through stronger supply chain management and greater efficiencies. It would improve coordination on forecasting and procurement with CMS. The RCH Unit would still have an important role to play in a more-integrated system, including product selection, forecasting, training, and supervision.

The existing supply chain can be strengthened while negotiation and planning for integrating the systems is taking place. Reporting forms for service data can be redesigned to capture essential logistics data, stock levels can be established, and the use of stockcards mandated. Procedures should be in writing, distributed and personnel should be trained as needed. An annual forecasting exercise at the central level for all partners involved in RHCS, linked to procurement planning and advocacy in the event of a funding gap should be one of the first steps in strengthening RHCS. The timing of this should coincide with funders' budget and procurement cycles.

Logistics: Key Recommendations

- Build capacity in the following areas through revision and harmonization of existing logistics management information systems, training of trainers workshops, in-service training in and monitoring of:
  - the collection and use of logistics data for decision making at all levels of the system (central, regional and facility level)
  - quantification, procurement planning and monitoring for contraceptives
- Resolve PipeLine issues RCH Unit was having at time of the visit and ensure regular use to facilitate forecasting of contraceptive needs.
- Conduct joint quantification and forecasting exercises to maximize donor resources to ensure full supply of contraceptive and other RH commodities.
- To improve inventory control and LMIS
  - Include losses and adjustments on stock cards and HMIS Quarterly Returns Form
  - Report consumption data at time of requisition and quarterly reporting
  - Develop SOPs and guidance for inventory control system including standard max/min, emergency ordering, safety stock, etc. The min/max levels suggested by the USAID | DELIVER PROJECT consultant in September were condoms 3/6; other methods 6/9
  - Include check of stock-on-hand and note losses/adjustments and consumption against stock issued during monitoring visits
- National Pharmaceutical Supply/CMS is encouraged to offer regular technical support supervision to the RCH to strengthen their stores and inventory management.
- Department of Planning should move ahead with its plans to hire more data entry clerks to ensure date is recorded regularly, accurately, and submitted on time. Once compiled data should be provided back to the RHTs, RCH Unit, and partners to analyze trends, monitor progress towards meeting indicators, and identify problem areas.
- Develop a plan for integrating contraceptive supply chain into the CMS pipeline. Contraceptive supply management will then be part of full health systems strengthening initiative being undertaken through GF support resulting in improvements in information flow, transport, storage and monitoring.

RECOMMENDATIONS

Below are the key recommendations from this assessment and the stakeholder workshops. Note that these are taken directly from the assessment components sections.

Context and Policy:

- Ensure RHCS is specifically addressed in policy documents
- Ensure validated policies are disseminated to all levels of service providers and to the public
- Conduct a comprehensive health survey to obtain status of current health indicators
- Revise the national health policy with language advocating for increased funding across all RH program needs

Commitment:

- Continue to advocate for commitment to RH and in particular FP that results in translating policies and documents into finance and programme activities
- Develop and validate new five year RHCS strategy and operational plan for The Gambia
- Advocate for more male and religious involvement in RH activities and BCC/IEC campaigns
- Increase advocacy efforts with the private sector to expand access to reproductive health commodities.

Coordination:

- The revitalization of a committee with a mandate to coordinate commodity security issues specific to reproductive health is a key first step to strengthening RHCS in The Gambia. The committee should include representatives of the various sectors and partners including the RCH Unit, UNFPA, NAS, National Pharmacieuticals Services, Directorate of Planning , CMS, NACP, NMCP, NGOs,WHO, Action Aid, Representative of RHTs the commercial sector, etc. The committee should be the main coordinating body for RHCS and provide a venue for partners to exchange data and discuss common problems. The RCH unit with support from UNFPA should revitalize the RHCS committee.
- Conduct study tour to model structure and operations of successful RHCS committees.
- Strengthen lines of communication between UNFPA and MOHSW Permanent Secretary level to help ensure further coordination between RCH Unit, UNFPA and MOHSW at the management levels.
- Encourage, monitor and support coordination and in-service meetings between regions and central level, and between health service staff and their respective RHT. Coordinate with GF Primary Recipients so health systems strengthening in form of capacity building take place across the health sector and not just focused on malaria, TB and HIV/AIDs.
- Increase coordination between the RCH Unit, NACP, NAS and Action Aid
- Build collaborative efforts with NACP to ensure that quality STI treatment is readily accessible for the public, especially men, youth, and commercial sex workers.
- Increase linkages with STI treatment and VCT programs to help target those at most risk for HIV infection.

- Continue collaboration in PMTCT, ensuring FP is available in HIV/AIDS settings, that HIV/AIDS information and services are available in RH.

Finance:

- Cost out reproductive health program components to identify funding gaps and mobilize financing of contraceptives, basic RH equipment, and improved service delivery.
- Leverage government, donor and private resources (UNFPA, Global Fund, WHO, UNICEF, USAID, NGO partners and private sector) for secure and continuous financial support full RH program.
- Conduct market segmentation and a price rationalization study (ability to pay) and use findings to help develop strategy to expand role of private sector.

Commodities:

- Finalize list and prioritize commodities that must be covered 100% through available funding.
- Confirm Government and donor commitment to secure priority commodities at full supply.
- UNFPA, NAS and MOH to meet to discuss coordination of immediate procurement needs to avoid duplication.

Service Delivery:

- Prioritize quality of care issues: privacy, service hours, provider attitude can all be improve with existing infrastructure to create a more open environment for all patients
- Explore ways of providing a range of sexual and RH services to underserved groups
- Train more staff on IUD insertion and promote long acting methods
- Expand BCC/IEC campaigns on the benefits of SRH targeting men and youth
- Disseminate Standard Treatment Guidelines
- STGs, currently being finalized, should be disseminated to state, locality and SDP facilities.

Supply Chain:

- Build capacity in the following areas through revision and harmonization of existing logistics management information systems, training of trainers workshops, in-service training in and monitoring of:
  - the collection and use of logistics data for decision making at all levels of the system (central, regional and facility level)
  - quantification, procurement planning and monitoring for contraceptives
- Resolve PipeLine issues RCH Unit was having at time of the visit and ensure regular use to facilitate forecasting of contraceptive needs.
- Conduct joint quantification and forecasting exercises to maximize donor resources to ensure full supply of contraceptive and other RH commodities.
- To improve inventory control and LMIS
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  - Report consumption data at time of requisition and quarterly reporting
  - Develop SOPs and guidance for inventory control system including standard max/min, emergency ordering, safety stock, etc. The min/max levels suggested by the USAID | DELIVER PROJECT consultant in September were condoms 3/6; other methods 6/9
  - Include check of stock-on-hand and note losses/adjustments and consumption against stock issued during monitoring visits

- National Pharmaceutical Supply/CMS is encouraged to offer regular technical support supervision to the RCH to strengthen their stores and inventory management.
- Department of Planning should move ahead with its plans to hire more data entry clerks to ensure date is recorded regularly, accurately, and submitted on time. Once compiled data should be provided back to the RHTs, RCH Unit, and partners to analyze trends, monitor progress towards meeting indicators, and identify problem areas.
- Develop plan for integrating contraceptive supply chain into the CMS pipeline. Contraceptive supply management will then be part of full health systems strengthening initiative being undertaken through GF support resulting in improvements in information flow, transport, storage and monitoring.

CONCLUSIONS AND NEXT STEPS

This situation analysis is envisaged as the beginning of a process to strengthen RHCS in the The Gambia. Revitaliztion of RHCS coordinating committees at both central and then at regional levels are the vital next steps to strengthen the ability of all Gambian people to choose, obtain, and use quality RH commodities when and where they need them. The best way to strengthen the supply chain for RH commodities is to work towards the full integration of RH commodities into an improved national system for essential medicines while maintaining RHC Unit and others' focused advocacy and specialized technical oversight on the importance of RH supplies and quality of services.

An opportunity exists in The Gambia, with increased government revenues and donor support, and strengthened advocacy efforts to improve the RH situation for all Gambians. The Government of The Gambia should translate its declared commitment to RHCS into actions and financing through the National RH Strategy and the next RHCS Strategy for The Gambia.

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APPENDIX 1: SCHEDULE

Day	Activity
Sunday, November 28th	Consultants arrive in Banjul
Monday, November 29th	• Meeting with UNFPA and local team • Courtesy visits: WHO, NAS
Tuesday, November 30th	• Courtesy visit: UNAIDS • Review of questionnaire for site visits and workshop
Wednesday, December 1st	• Courtesy Visits: GFPA, NPS/CMS, RCH Unit • Preparation for site visits
Thursday, December 2nd	Site visits: • Team 1: Western Region, Lower River Region • Team 2: North Bank Region
Friday, December 3rd	• Site visit: West Coast Region • Data collation from site visits
Monday, December 6th	Courtesy visits: NMCP, West Coast Regional Health Team
Tuesday, December 7th	RHCS Workshop preparation
Wednesday, December 8th	RHCS Workshop
Thursday, December 9th	RHCS Workshop
Friday, December 10th	• Site visit: Brufut Minor Health Centre • Collation of workshop outputs
Monday, December 13th	Report writing
Tuesday, December 14th	• Courtesy visits: NACP, RCH Unit • Preparation of debriefing
Wednesday, December 15th	Debriefing
Thursday, December 16th	• Report writing • Consultants depart

APPENDIX 2: KEY CONTACTS

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	Fatou Gassama	Data entry clerk	
WHO	Bakary Jargo	Programme Officer Family Health	

CENTRAL LEVEL FOCUS GROUP MEETING

Name	Organization
1. Mrs. Haddy Jagne	NACP
2. Mrs. Haddy Gai	Banjul Pharmacy
3. Lamin Darbo	RCH, MCH
4. Mr. Momodou Njie	GPFA
5. Awa Janneh Lewis	GPFA
6. Juma Jallow	Regional Health Team, Western
7. Essa Marenah	RVTH
8. Ivan Coker	Regional Health Team, North Bank West
9. Maa Gomez	BAFROW
10. Alhagie Kolley	UNFPA
11. Momodou Darboe	RCH
12. Babanding Sabally	NPS
13. Lamin Badjie	NAS
14. Awa Dem	NPCS
15. Alieu Jammeh	NAS
16.	
17. David Paprocki	JSI Consultant
18. Julia Byington	JSI Consultant
19. Janne Hicks	JSI Consultant

SITE VISIT INTERVIEWS

Region\Name	Designation	Organization
Western Region		
1. Alieu Sonko	Officer-in-Charge	Brikama Health Center (Major)
2. Isatou Bojanj	Community Health Nurse, RCH	Brikama Health Center
3. Ebrima Sowe	Pharmacy Assistant	Brikama Health Center
4. Nyima Camara	Midwife/Care Nurse	Hands On Care, NGO
5. Alassan Tamba	Senior Pharmacy Assistant	Jammeh Foundation for Peace Community Hospital
6. Amie Njie	Nursing Officer	Jammeh Foundation for Peace Community Hospital

7. David Chiniodeh	Regsitered Nurse	Brufut Health Center (Minor)
8.		
Lower River Region		
9. Babajaleh Jallow	Lower River Regional Director	RHT, Monsokonko
10. Njankoba Jabbi	Regional Public Health Nurse	RHT, Monsokonko
11. Lamin Tunkara	Regional Store Keeper	RHT, Monsokonko
12. Babucaar Secka	Pharmacy Assistant	Soma Health Center (Major)
13. Basiru Drammeh	Officer-in-Charge	Soma Health Center (Major)
14. Jarjai Cham	Community Health Nurse, Midwife	Kwinella Health Center (Minor)
North Bank East		
15. Baboucarr Saine	Hospital Administrator	Farafenni Hospital
16. Buba Manjang	Regional Health Officer	Farafenni Regional Health Team
17. Amadou Jallow	Regional Nutrition Officer	Farafenni Regional Health Team
18. Ansmmana Manneh	Regional Health Nurse	Farafenni Regional Health Team
19. Ebrima Hydara	Senior Community Health Nurse	Farafenni Regional Health Team
20. Binta Sonko	Senior Community Health Nurse	Kerewan Minor Health Centre
21. Nyima Badjie	Senior Nurse and Midwife	Essau Major Health Centre
22. Fasecery Bass	Regional Nutrition Officer	Essau Regional Health Team

APPENDIX 3: FOCUS GROUP WORKSHOP

Ministry of Health

Reproductive and Child Health Unit

UNFPA/John Snow, Inc.

Situation Analysis for Reproductive Health Commodity Security
The Gambia
Workshop and Focus Group Discussion
December 8-9, 2010

I. Goals and Objectives

This workshop is one part of the situation analysis which involves a central-level workshop with key stakeholders in reproductive health.

Goals:

To strengthen participants' understanding of the concepts of reproductive health commodity security (RHCS);

To collect information regarding the status of RHCS in the country;

To provide recommendations for improving the situation that can be used in the development of a national RHCS strategic or operational plan.

Objectives

1. Explain purpose of situation analysis and provide brief update on findings to date.

2. Explain the concept of commodity security and the components of the commodity security framework.

3. Discuss and collect inputs for the following RHCS components:
    a. Commitment and Financing
    b. Policy, Advocacy and Coordination Mechanisms
    c. Commodities, Client Services, and Product Use
    d. Capacity and Logistics system

4. Identify gaps in available information from the components of the RH commodity security framework.

5. Determine key strengths and weaknesses.

6. Make recommendations for specific steps to improve the weaknesses identified.

Day 1: December 8, 2010

Time	Activities
9:00 – 9:45	Welcome and Introduction to the Workshop
9:45 – 10:15	Introduction to the Reproductive Health Commodity Security framework
10 :15 – 10 :45	Reproductive Health Commodity List
10 :45 – 11 :00	Coffee Break
11:00 – 11:15	Reproductive Health Commodity Security Situation Analysis Inputs Objectives of exercise and division into teams
11:15 – 13:00	Team Work – Answering of questions in the situation analysis tool – Identification of strengths, weaknesses and gaps in available information
13 :00 – 14 :00	Lunch
14 :00 – 14 :15	Team Work, continued – Prepare short presentations
14 :15 – 15 :45	Plenary session – presentation of group work and discussion
15 :45 – 16 :00	Summary and Conclusions from Day One

Situation Analysis for Reproductive Health Commodity Security
The Gambia
December 8-9, 2010

Day 2: December 9, 2010

Time	Activities
9 :00 – 9 :15	Summary from Day 1 and introduction to work for Day 2
9 :15 – 10 :00	Team review and status of National Reproductive Health Security Plan for The Gambia 2006 – 2010 Team work session**:** 1. Determine if the activities were completed 2. If completed, was the output achieved? 3. For activities not completed list the challenges and bottlenecks and whether activity is still relevant 4. Identify other activities outside of the strategy which have supported the CS pillar
10 :00 – 10 :30	Plenary – Groups present status of meeting objectives stated in RHCS Strategy
10 :30 – 10 :45	Coffee Break
10 :45 - 12 :30	**Prioritization and Recommendations** Team work : prioritization of weaknesses to be addressed or gaps in information that require supplemental research – Prioritization of weakness – Formulation of recommendations – Resources required – Preparation of short presentations
12 :30 – 13 :30	Lunch
13 :30 – 15 :30	Plenary: Presentations of group work and discussion of priorities and recommendations
15 :30 – 15 :45	Synthesis and Identification of immediate follow-up actions/points
15 :45 – 16 :00	Closing comments and appreciation