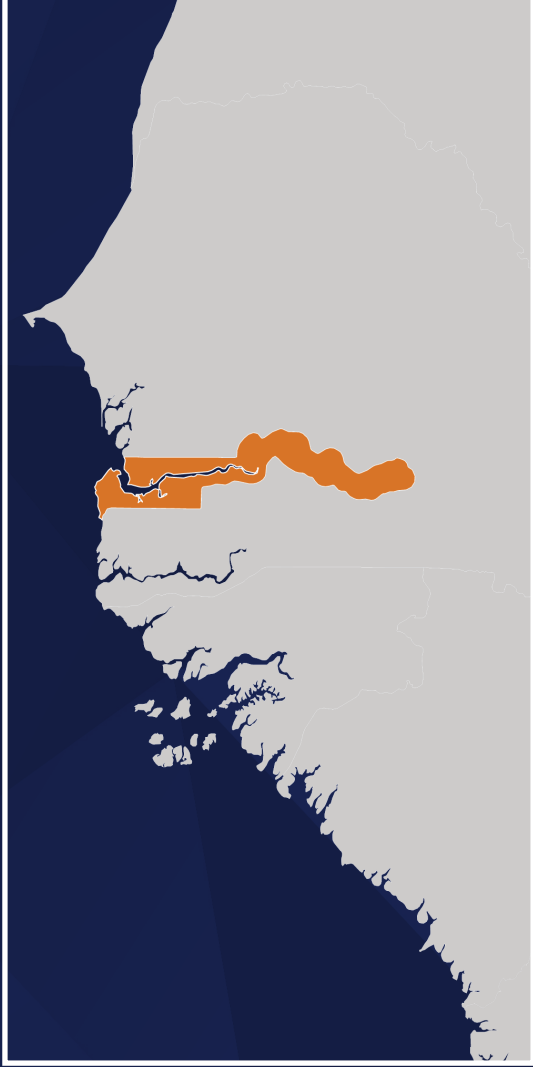


November 2019



ASSESSMENT OF THE HEALTH SYSTEM IN THE GAMBIA

Overview, Medical Products, Health Financing, and Governance Components



November 2019

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Abbreviations

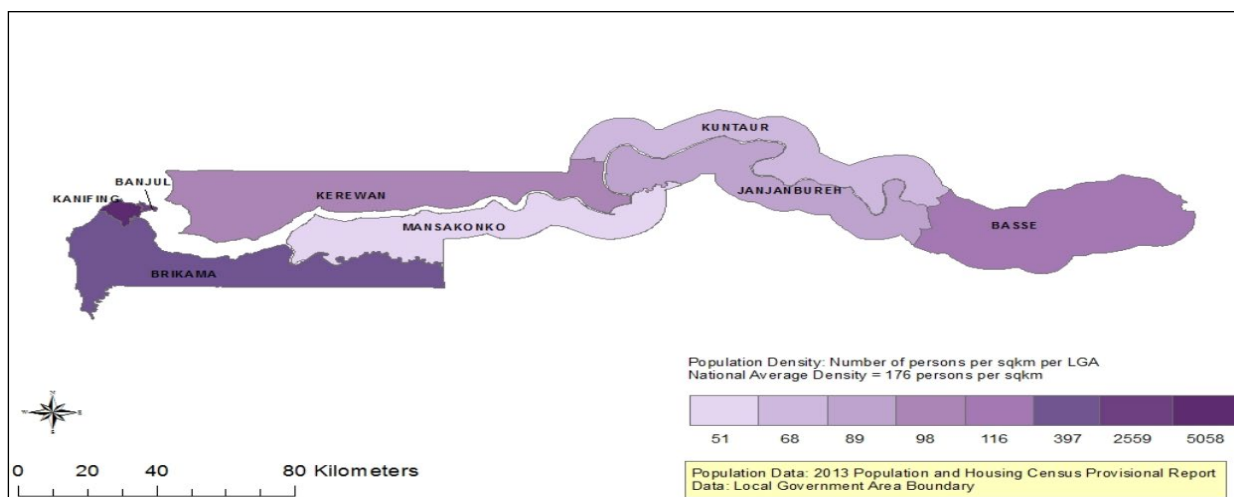
CMS	Central Medical Store
CSO	civil society organization
DHIS2	district health information system
GDP	gross domestic product
DRF	Drug Revolving Fund
EML	essential medicines list
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMD	Gambia dalasi
GPPA	Gambia Public Procurement Authority
JAR	joint annual review
LMIS	logistics management information system
MOH	Ministry of Health and Social Welfare
NGO	nongovernmental organization
NHA	National Health Account(s)
RHD	regional health director, regional health directorate
VEN	vital-essential-nonessential

1 Overview

1.1 Population and Geography

The Gambia is small, West African country fronting on the Atlantic Ocean and surrounded on three sides by Senegal (see Figure 1). It comprises 10,689 square kilometers of land, is home to an estimated 2.3 million people (UN, 2019), and has a density of 176 people per square kilometer (The Gambia, 2013).

Figure 1. Gambia Population Density by Local Government Area



Source: The Gambia, 2013.

With a total fertility rate of 5.6, a national modern contraceptive prevalence rate of just 8 percent of married couples of reproductive age (The Gambia Bureau of Statistics and ICF International, 2013) and a population growth rate at just over 3 percent per year, the country's population is expected to double in the 25 years. (See Table 1 for key population indicators.)

Population growth reduces the per capita impact of growth in the gross domestic product (GDP). This factor, coupled with high income inequality rate (at 0.47, The Gambia's Gini coefficient is one of the highest in the world), leads to high poverty rates in both rural (70 percent) and urban (32 percent) communities (The Gambia, 2017). Near-term prospects for slowing population growth are low. The unmet need for family planning (defined as those wanting to delay their next pregnancy or limit their fertility but not using a contraceptive method) is three and one-half times (22 percent of all married women of reproductive age) the met need (8 percent).

The Gambia also faces significant demographic challenges. The population is rapidly urbanizing with nearly 60 percent of the population living in urban areas (The Gambia, 2017). The country also faces significant migration challenges. Many well-educated Gambians migrated away from the country during the recent decades of political instability. By comparison, heavy in-migration from the southern region of Senegal into the southwest coastal region of Brikama has led to an annual population growth rate of 6 percent, more than double the national average (The Gambia, 2013). Other migrants travel from Senegal to other regions in The Gambia to access health services that are closer and cheaper than health services in the rural and more remote parts of Senegal.

Table 1. Population Indicators in The Gambia and Africa/W Africa Region

Indicator	Gambia		Sub-Saharan Africa
	Number ⁱ	Retrospective 10-year % change	Number
Population (millions)	2.04	+32%	927.4 ⁱⁱⁱ
Population growth rate	3.04%	-4.4%	2.6% ⁱⁱⁱ
Percent rural	39.8%	-13.5%	62% ⁱⁱⁱ
Percent urban	60.2%	+11.5%	38% ⁱⁱⁱ
Percent of population 0-14	45.5%	-1.9%	42% ⁱⁱⁱ
Percent of population 60+	3.7% ⁱⁱⁱ	-7.9%	5.0% ⁱⁱⁱ
Life expectancy at birth - females	62.3 ⁱⁱ	+4.7%	61.8 ^v
Life expectancy at birth - males	59.6 ⁱⁱ	+4.4%	58.3 ^v
Total fertility rate	5.8 ⁱⁱⁱ	-5.5%	4.9 ⁱⁱⁱ
Contraceptive prevalence	13% ⁱⁱⁱ	-31.9% ^{iv}	28% ⁱⁱⁱ
Unmet need for family planning	22% ⁱⁱⁱ	-30.4% ^{iv}	24% ⁱⁱⁱ

ⁱ World Bank, 2017a. All numbers pertain to 2016 except where noted.

ⁱⁱ World Bank, 2017a, Numbers pertain to 2015.

ⁱⁱⁱ WHO, 2016a; most data are for 2013. Notes: (a) The Gambia Demographic and Health Survey 2013 (DHS 2013) reports The Gambia's total fertility rate as 5.6. (b) The DHS 2013 reports contraceptive prevalence (any method) among currently married women aged 15 to 49 to be 9%. (c) Unmet need for family planning among women was reported in the DHS 2013 to be 25 percent compared to 22 percent in the WHO AAHS.

^{iv} Four-year change.

^v WHO, 2016a.

1.2 Macroeconomic Conditions

The country's macroeconomic environment exacerbates The Gambia's population challenges. Between 2005 and 2010, GDP growth rate averaged about 5 percent per year. Due to climate shocks, crop failures, poor fiscal management, and the political environment, GDP growth rates dropped sharply between 2010 and 2016. GDP growth for 2017 recovered to 4.6 percent (World Bank, 2019) and the Ministry of Finance and Economic Affairs (MOFEA) is optimistic that GDP growth will remain strong (see Table 2) (WHO, 2105; World Bank, 2018a).¹ However, as a result of high population growth, per capita income growth will not be as strong as overall GDP growth. To achieve the country's ambitious plan to accelerate growth (see *The Gambia National Development Plan (2018-2021)*), it will need to overcome several constraints. Forty-six percent of the working population are engaged in agriculture as its primary means for economic activity, generating just 20 percent of GDP (The Gambia, 2017). In rural areas, the agriculture sector employs more than 80 percent of the workforce. Raising domestic and international investment to spur growth, in accordance with national plans, will be challenging given the difficult investment climate. Seventy-six percent of non-agricultural workers are engaged in informal sector economic activity, resulting in a low taxable income base (World Bank, 2018).² While the percent of GDP captured by the national tax authority has increased considerably from a decade earlier, the rate fluctuates appreciably. The rate was 19.2 percent of GDP in 2017 and decreased to 14.8 percent in 2018 (IMF, 2019). Though showing signs of decline, total public debt in 2017 stood at 83 percent of GDP which further erodes the resource pool available for social investment (World Bank, 2019b). Much of the national debt is owed to domestic financial

¹ Interview in country office interview in Banjul, The Gambia.

² Data point for 2012.

institutions at high interest rates and only an estimated 2 percent of this debt is available for restructuring (World Bank interview). Private lending interest rates currently stand at about 17 percent. While this rate is a sharp decline from the 30 percent or higher rates at the end of the previous government's tenure, they are not considered to be conducive to private investment.

Table 2. Macroeconomic Indicators in The Gambia

Indicator	Gambia	
	Number ⁱ	10-year % change
GDP per capita (purchasing power parity: international \$, 2011) ³	1,555	+3.1%
Real GDP growth	6.6% ⁱⁱ	Constant, 2012-15 ^{vi}
GDP per capita growth (annual %)	2.2%	-39.0%
Poverty rate	55%	
Income share held by highest 20%	52.8% ⁱⁱⁱ	
Income share held by lowest 20%	4.8% ⁱⁱⁱ	
Inflation	6.8% ^{iv}	+231%
GINI coefficient	35.9 ^{iv}	-2.4%
GDP value added from agriculture	17.8%	-19.5%
Informal employment (% of non-agricultural workforce)	76.5% ^v	NA
Government consumption (% of GDP)	11.6%	48.2%
Country Policy and Institutional Assessment business regulatory environment score (1=low, 6=high)	3.5	0%
% of population using internet	18.5%	+198%

ⁱ World Bank, 2017a. All numbers pertain to 2016 except where noted.

ⁱⁱ 2018 dataset. Cited in World Bank, 2019b (<http://pubdocs.worldbank.org/en/214601492188159621/mpo-gmb.pdf>; data accessed September 25, 2019).

ⁱⁱⁱ World Bank, 2013.

^{iv} WHO, 2016a. Indicators for 2015.

^v World Bank, 2012.

^{vi} Real GDP growth from Table 12, Programme for Accelerated Growth and Employment 2012-2015 report.

1.3 Political Context

The Gambia is a constitutional democracy led by a president and a unicameral legislative body. The 2016 presidential election brought change and the promise of greater stability, after which Freedom House raised the country's political system from a rating of not free to partly free.⁴ However, important challenges remain. During that election, President Adama Barrow resigned from the United Democratic Party and led a seven-party coalition to unseat the previous president who held power for 22 years. The present administration solidified its political position by winning an outright majority of seats in the National Assembly in the May 2018 parliamentary elections. There are signs however, that this widespread optimism about the political transition may be giving way to a more reality-oriented perspective among Gambians on the prospects for fast-paced social and economic change.

³ An international dollar would buy in The Gambia a comparable amount of goods and services a U.S. dollar would buy in the United States.

⁴ Freedom House is a U.S.-based, government-funded nongovernmental organization that conducts research and advocacy on democracy, political freedom, and human rights.

The Gambia's 1997 constitution mandates that presidential elections be held once every five years. However, to unify a broad field of opposition parties to win the 2016 election, the coalition agreed to hold new presidential elections in 2019 after only a three-year term. Perspectives on the likely pace of change, both political and socioeconomic, are changing as new elections are now scheduled to follow the five-year cycle stipulated in the constitution instead of the three-year period originally promised. Perceptions about prospects for health sector strengthening and reform are changing as well.

High public expectations for quick social and economic improvements with the change in government have so far gone largely unmet as the government is challenged by the difficult macroeconomic constraints described above, a low tax revenue base, and high commercial interest rates. The country also faces challenging prospects for the domestic and foreign investments necessary to produce the jobs needed to meet ambitious economic development goals and social expectations.

Devolution is constitutionally enshrined; the country is divided into seven administrative regions. There are also seven health regions, four of which align with administrative regions. One administrative region contains two health regions and one health region includes two of the administrative regions. Each health region is headed by a regional health director (RHD) and a regional health team is responsible for the primary and secondary healthcare facilities in its region. However, health regions receive very few programmable resources and are almost entirely beholden to program level units at the central Ministry of Health (MOH) and external partner resources to finance health activities in their jurisdiction. (See Section 3: Health Financing.)

It is within this political and macroeconomic context that the country is ambitiously seeking to strengthen its health system.

1.4 Overarching Health Policy Framework

The Gambia's health sector is guided by the *Gambia National Health Sector Strategic Plan 2014-2020* and more than 20 other health policy documents. When the NHSSP was created, this strategic plan was linked to country's national development plan, *Vision 2020*, in place at the time.⁵ According to the NHSSP, the long-term health sector objective is "the provision of adequate, effective and affordable health care for all Gambians." The overall objective for 2014-20 is "to reduce inequalities in health care services and reverse the downward trend in health-related outcome indicators." An immediate objective is also articulated: "to improve the administration and management of health services, provide better infrastructure for Referral Hospitals and health facilities and the revitalization and extension of Primary Health Care services to all communities and having a well-motivated and trained staff and establishment of efficient procurement arrangements in order to ensure effective and efficient health services for all."

The strategic plan envisions achieving these goals and objectives "through supporting provision of equitable, affordable and quality health and related services at the highest attainable standards to all Gambians. It targets to attain a level and distribution of health at a level commensurate with that of a middle-income country." Activities are structured around seven service delivery outcomes and 21 systems investments. The term covered by the current NHSSP will conclude in 2020 and though official activities related to its replacement have not yet commenced, MOH leaders state that deliberations are underway regarding the structure and process of the next iteration of the plan. For the first time, in December 2017, the MOH led a health sector joint annual review of implementation progress

⁵ The recently produced *The Gambia National Development Plan 2018-2021* replaces *Vision 2020*.

for the NHSSP, setting the stage for the next multiyear strategic plan. Joint annual reviews are to be institutionalized and conducted every year going forward.

1.5 Health Financing Overview

Health financing policy and reform in The Gambia is guided by The Gambia National Health Financing Strategic Plan 2019-2024. At the macro level, health financing indicators in The Gambia present a mixed picture (Table 3).

Table 3. Health Financing Indicators in The Gambia and Sub-Saharan Africa

Indicator	Gambia	Sub-Saharan Africa	
	Number ⁱ	Number	10-year % change
Total health expenditures as a % of GDP	4.68%	6.0%	+3%
Percent of government budget allocated to health	7%	10.1%	-5%
General government expenditure on health as a percentage of total health expenditure	32.78%	43.3	+10%
Total health expenditures per capita (international \$)	\$118 ⁱⁱ	\$228	+42%
Out-of-pocket expenditures as a % of total health expenditures	24.42%	34.5%	+15%
External resources for health as a percentage of total health spending	36.45%	9.6%	+55%

ⁱ Source: Gambia Health Accounts (NHA): National Health Expenditures for Financial Year 2015. NHA Core Team, 2019. Note: alternate estimates for these health financing indicators include the 2019 World Development Indicators dataset; the two sources do not align. Disparities across sources exist for other health sector indicators; identifying and reducing such disparities is a subject of interest by the MOH.

ⁱⁱ World Bank, 2019. World Development Indicators 2019 dataset for the year 2014. Includes external partner resources contributed through government spending channels.

The government of The Gambia allocates a higher proportion of its total government spending to health than average among African nations. Though rising, out-of-pocket spending on health is 10 percentage points lower than the average in Africa. Total spending on health as a percent of GDP is higher than the Africa-wide average, though because The Gambia is one of Africa's poorest countries, this higher proportional spending masks a per capita spending level about half the Africa-wide average.

Health spending in the country is heavily dependent on external partner resources. Nearly half of the total reported expenditures on health and more than two-thirds of government spending on health is donor-derived. The Gambia is committed to universal health coverage. All Gambian residents have physical access to the country's publicly managed service delivery structure (see Section 1.7). User fees apply at the point of service and Gambian stakeholders interviewed for this assessment believe these fees are affordable for nearly all Gambians. At the same time, system deficiencies have encouraged rising out-of-pocket spending by consumers. One example is low availability of pharmaceutical products at health facilities, which drives consumers to private pharmacies even as user fees are intended to include pharmaceuticals. In addition, poorly equipped and maintained primary healthcare facilities drive consumers to higher levels of care, where they face higher costs, and to private providers, who require fees for service. Non-Gambia residents higher user fees. The Health Policy Plus (HP+) team was not able to identify any studies on the extent to which costs

affect access to health services nor any data regarding the proportion of households experiencing catastrophic or impoverishing health expenditures.

Data available from the most recent National Health Accounts (NHA 2015)) analysis report out-of-pocket costs to be 24 percent, low by international standards but a 5 percentage point increase from two years previously. If this figure is correct, it indicates that financial access to health services is relatively good. Health insurance coverage, which like the government system, can provide a pathway to universal health coverage, is very low in The Gambia; only about 4 percent of the population is covered by a health insurance scheme. A recent health financing assessment commissioned by the MOH and supported by the World Bank said increasing health insurance coverage should be investigated as a strategy for achieving universal health coverage.

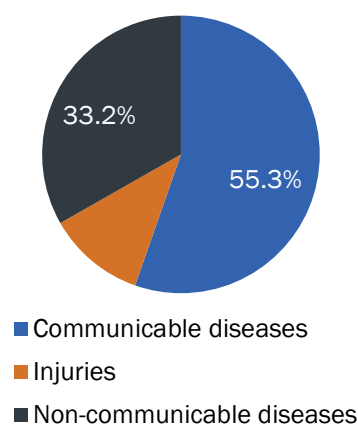
1.6 Epidemiology of The Gambia's Disease Burden

As with many countries in the region, The Gambia's epidemiological profile is in transition. Communicable diseases are still the most common cause of death (Figure 2), though noncommunicable diseases are thought to be under-diagnosed and underreported as a cause of illness and death. Among official data, communicable diseases have in the aggregate declined by 8.3 percent, now comprising 55 percent of all deaths (compared to 60 percent in 2010).

Tuberculosis incidence is notably declining. The proportion of all deaths caused by non-communicable diseases remained constant at 34 percent from 2010 to 2016, while injuries increased from 6 percent to 11 percent of all deaths, an increase in the proportion of 83 percent. Within non-communicable diseases, the relative contributions of a given disease appear to have remained largely constant over this period with the prevalence of hypertension, according to informants, the highest among non-communicable diseases.

The cause is not established for many deaths in The Gambia and actual disease distribution may differ from that based on reported deaths. The Medical Research Council maintains a cancer registry but it captures an unknown proportion of cases and the registry has not been used to estimate incidence or prevalence rates. Likewise, there are few diagnostic or treatment options for cardiovascular diseases and no incidence or prevalence information was identified by the HP+ team. Other major disease burden profile information is show in Table 4.

Figure 2. Epidemiological Profile of The Gambia (2016)



Source: WHO, 2018a.

Table 4. Disease Pattern Indicators in The Gambia and Sub-Saharan Africa

Indicator	Gambia		Sub-Saharan Africa
	Number ⁱ	Retrospective 10-year % change	Number ⁱ
HIV incidence rate (new HIV cases among 100,000 HIV-negative population ages 15-49)	64.3 ⁱⁱ	-50%	118 ⁱⁱ
HIV prevalence, total (% of population ages 15-49)	1.7%	-21.1% (from 2010)	NA
TB incidence rate (new TB cases per 100,000 population)	174 ⁱⁱⁱ	NA	254
TB prevalence, all forms (per 100,000 population)	128 ^{iv}	-74% (from 2013)	315
Malaria incidence rate (cases per 1,000 population)	25.3 ^v	-69.4% (since 2010)	240
Malaria prevalence	0.1% ⁱⁱ	NA	NA

ⁱ WHO, 2018b. All numbers pertain to 2016 except where noted.

ⁱⁱ Preliminary findings *Malaria Indicator Survey 2017*, draft report.

ⁱⁱⁱ WHO, 2018c.

^{iv} The Gambian Survey of Tuberculosis Prevalence. Medical Research Council Unit. The Gambia, April 2014.

^v *National Malaria Control Program DHIS2 Report 2017*.

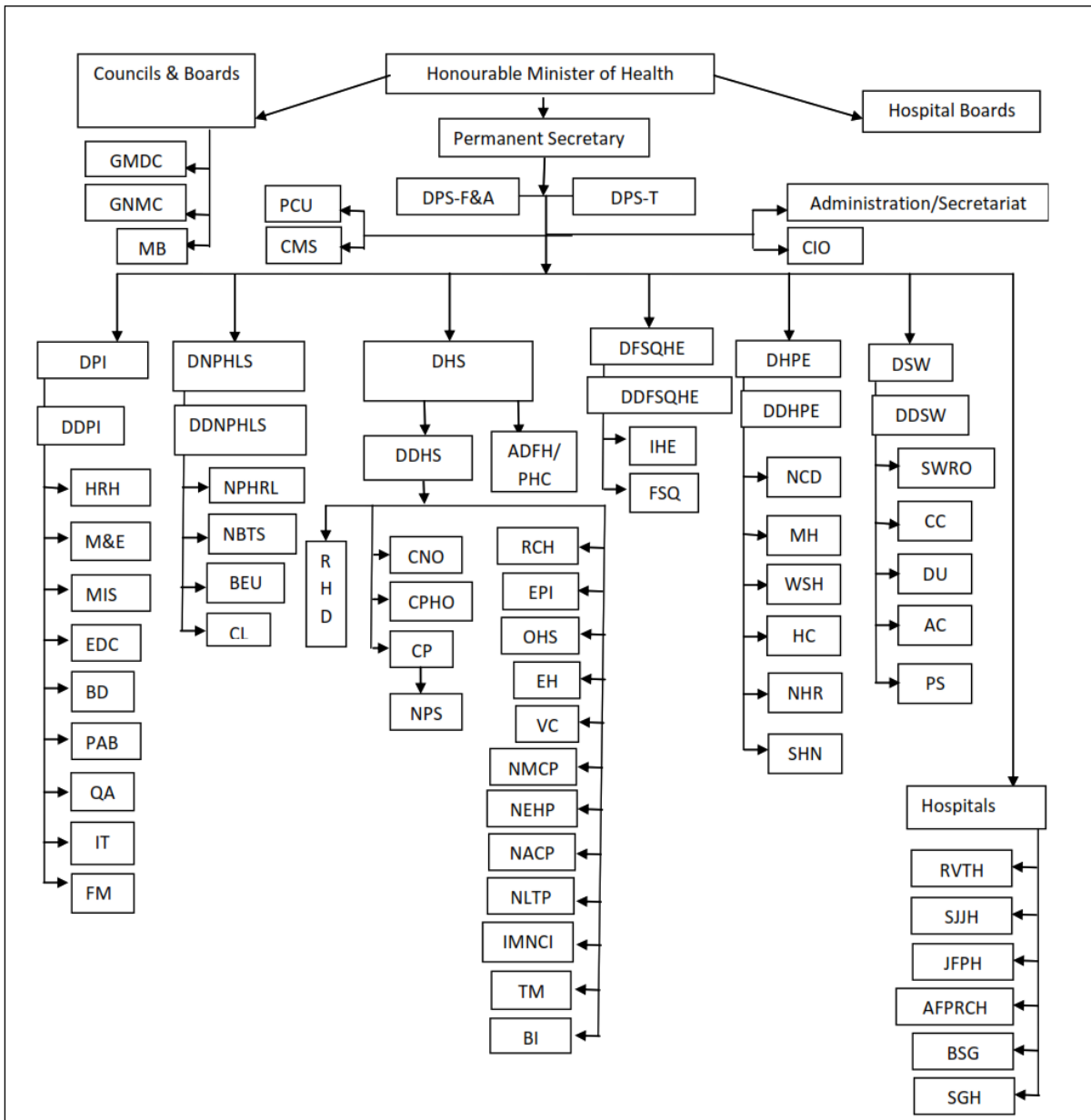
1.7 Organization of the Health Sector

National government health sector leadership resides in the MOH.⁶ This ministry comprises 10 directorates, including a Directorate of Social Welfare which operates relatively independently from the 10 health directorates. At the executive level, the ministry is led by a minister and a permanent secretary. Directors of each of the directorates report to the permanent secretary (Figure 3). The present structure is much changed from the 2001 “Changing for Good” health policy when there was only one director reporting to the permanent, the Director of Health Services (The Gambia, 2001). At that time, all other health units were subordinate to the Director of Health Services and all access to the MOH senior leadership (minister and permanent secretary) was channeled through the Director of Health Services. Functional responsibilities of the current MOH health directorates:

1. Directorate of Health Services
2. Directorate of Planning and Information
3. Directorate of Nursing Services
4. Directorate of Public Health Services
5. Directorate of Health Promotion and Information
6. Directorate of National Public Health Laboratory Services
7. Directorate of Human Resources for Health
8. Directorate of Health Research.
9. Directorate of Health Promotion and Education
10. Directorate of Food Standards Quality Hygiene Enforcement

⁶ Until early 2019, The Gambia’s MOH included the Directorate of Social Welfare, known as the MOH&SW. It has since been separated from the MOH into an independent government agency, the Department of Social Welfare, responsible for the provision of social welfare services to underprivileged and vulnerable groups in the country.

Figure 3. Organizational Structure of the MOH



Source: The Gambia, 2017b.

Regional health directorates (RHDs) are responsible for management and support of the seven regional health teams, which in turn are responsible for primary and secondary healthcare facilities and their staff in their respective regions.

Guided by the executive leadership of the MOH, the Health Services and Health Planning directorates play leading roles in setting direction, aligning other internal and external stakeholders with the direction, mobilizing and managing resources, setting standards, and monitoring implementation.

The current executive leadership reflects an increased commitment by the government of The Gambia to relieving what the current NHSSP expresses as the sector’s “most pressing constraint,” namely:

“...the ineffective management structure at the Ministry of Health and Social Welfare (MOH&SW). It has not helped matters that in

the recent past, frequent changes were made in the top management positions that hindered policy implementation, and weakened institutional memory (The Gambia, 2014a, ix).”

As noted in Section 1.3, the health sector is administered through seven health regions. Interviews with stakeholders in the two health regions visited by the HP+ team indicate leadership at this level in the health stewardship environment is severely hampered by capacity and financial resource constraints.

The service delivery structure is almost entirely owned and operated by the government of The Gambia. It is organized in three tiers (see Table 5).⁷ At the primary level, 634 primary healthcare village posts are clustered into circuits and services are delivered by village health workers and traditional birth attendants. They are managed by village development committees. Community health nurses supervise these circuits. The secondary level is composed of major and minor health centers and is complemented by a limited number of private, for-profit and nongovernmental organization (NGO) outpatient facilities, mostly concentrated in the greater Banjul area and West Coast regions. General, specialized and district hospitals comprise the tertiary level, including one teaching hospital. It is difficult to find information about the structure and use of the informal sector for healthcare, though it is clearly acknowledged to exist.⁸ Additional investigation is recommended given that many key informants for this assessment expressed the opinion that user fee structures for public sector health services are affordable for a large majority of the population and that given generally high trust in the formal system, use of the informal health sector is relatively low.⁹

Table 5. The Gambia’s Public Sector Service Delivery Structure

Facility Type	Public	Private
Tertiary level:		3
Teaching and specialty hospitals	2	
General hospitals	5	
District hospitals	4	
Secondary level:		36
Major health center	4	
Minor health center	49	
Community clinic	60	
Reproductive and child health center	3	
Primary level:		
Primary healthcare village health posts	634	
Service clinics ⁱ	11	

ⁱ Service clinics include those associated with military, police, fire and prison bases and facilities.

⁷ Different sources in the The Gambia cite different figures for the number of health facilities, by type. Key informants from the MOH reported that figures from the national health management information system are not in consistent with figures used by programs within MOH. This is one aspect of a broader challenge facing the MOH; discrepancies exist across many components of health information in the country.

⁸ The Gambia’s *National Health Financing Policy 2017-2030* (p. 5) acknowledges the informal health sector as follows: “For most communities, the first point of contact with health care services is the informal sector through traditional healers.”

⁹ Per multiple key informants interviewed among central MOH leadership, regional health directorate staff, and health facility staff.

According to key informants interviewed, nearly all of the population in The Gambia lives in close proximity to a fixed facility and most have reasonable road access though road travel to some communities is compromised during the rainy season. However, 28 percent of women responding to The Gambia Demographic and Health Survey 2013 reported that distance to a health facility was a barrier to accessing care. Moreover, only about 40 percent of rural villages have access to services by a community health worker.¹⁰ The few private sector facilities are concentrated in the greater Banjul area and along the West Coast where the population is concentrated and where there is more buying power among the population. Informants, particularly those in the coastal region visited, state that there are many more private clinics providing health services than are officially recorded. Poorly enforced clinic registration regulations prevent regional health authorities from keeping tabs on such clinics, most of which are established by charitable efforts. These do present challenges to regional health authorities, which are often expected to staff and supply such clinics when their charity resources cease to flow. (See Section 2 for a detailed assessment of the service delivery structure.)

1.8 Health Service Utilization

Service delivery statistics from The Gambia (see Table 6) present a mixed picture relative to sub-Saharan Africa. The statistics indicate a health services delivery system that performs on par with the sub-Saharan average for some services, with some areas that underperform relative to the average. Areas where The Gambia outperforms compared to the Africa regional average include prenatal care, childhood immunization, and access to improved water and sanitation. Areas where The Gambia underperforms relative to the Africa regional average include maternal mortality and antiretroviral therapy coverage among HIV-positive individuals. Three years into the current *Gambia National Health Sector Strategic Plan*, the MOH states that there are large gaps between expected and actual performance against targets. The most important contributing factor to this gap is said to be insufficient resources.¹¹ (See Section 3 for a detailed assessment of health financing in The Gambia.) Activities supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) were reported to be closest to meeting NHSSP targets due to international resource contributions that narrow gaps in domestic resources.

Several key informants, both at the central MOH level and at the two regional health offices visited by the HP+ team, reported that user statistics and health outcomes may be overstated in The Gambia due to the large (but not formally counted) cross-border migrants who use the country's public sector health services. Some service use by non-Gambians is a consequence of illness experienced by migrants who temporarily reside in The Gambia during family visits or during holiday seasons. Other use is by Senegalese who cross the border to use Gambian health services, which are of higher quality and lower cost compared to health services in Senegal's hinterland. According to informants at the MOH Disease Surveillance Unit, up to 15 percent of recorded service use in The Gambia's public sector health services network may be services provided to non-Gambian migrants.

Substantial progress has been made in registration of births. In 2013 (most recently available data), 72 percent of all births were registered, with near equivalency between registration of female and male newborns. This represents a nearly doubling compared to 8 years previously. Key informants at the MOH estimate that approximately 50 percent of deaths are registered. The main constraint on raising this figure is national policy that allows only a hospital medical examiner to assign cause of death. Bodies of deceased persons must therefore be transported to the few facilities with a medical examiner and this often

¹⁰ Data (2016) extracted by the MOH from The Gambia health management information system and provided to study team.

¹¹ World Bank, 2018a. Interview with Director of the MOH&SW Directorate of Health Services, March 1, 2018.

does not occur due to costs, transport limitations, and time requirements to perform religious traditions.

It is worth noting that discrepancies across data sources (among national sources, between national and international sources, and among international sources) are common. Understanding the reasons for these discrepancies and ameliorating them is an important health systems improvement need for the country.¹²

Table 6. Service Delivery Indicators in Gambia and Africa Region

Indicator	Gambia		Sub-Saharan Africa
	Number ⁱ	10-year % change	Number
Pregnant women receiving 4 or more prenatal care visits (%)	72% ⁱⁱ	+11.9% ^{ix}	48% ⁱⁱ
Births attended by skilled health staff (% of total)	54% ^v	+9.8% ^{ix}	54 ⁱⁱ
Maternal mortality ratio (modeled estimate, per 100,000 live births)	706 ^{iv} (433 ^{iv(b)})	-11.5%	542 ⁱⁱ
Neonatal mortality rate (per 1,000 live births)	21 ^v	-18.6%	28 ⁱⁱ
Infant mortality rate (per 1,000 live births)	34 ^v	-19.3%	55 ⁱⁱ
Under-5 mortality rate (per 1,000 live births)	61 ^v	-27.0%	81 ⁱⁱ
Exclusive breastfeeding (% of children under 6 months)	46.8% ⁱⁱⁱ	+14.7% ^{ix}	42% ⁱⁱ
Immunization, DPT (% of children ages 12-23 months)	95%	0%	77% ^{ii, ix}
Prevalence of stunting, height for age (% of children under 5)	25% ⁱⁱⁱ	-9.4% ^{ix}	NA
Children with fever receiving antimalarial drugs (% of children under age 5 with fever)	6.7% ⁱⁱⁱ	-89.4% ^{ix}	NA
Improved sanitation facilities (% of population with access)	58.9% ^{iv, vii}	-0.3%	33% ⁱⁱ
Improved water source (% of population with access)	90.2% ^{iv, viii}	+4.3%	66% ⁱⁱ
Antiretroviral therapy coverage (as a % of people diagnosed with HIV)	24% ^{iv}	+900%	30% ⁱⁱ
Tuberculosis treatment success rate (% of new cases)	82% ^{iv}	+41.4%	NA
Children under 5 sleeping under insecticide-treated bednets	33% ⁱⁱ	NA	NA

ⁱ World Bank, 2017a; World Development Indicators dataset. All numbers pertain to 2016 except where noted

ⁱⁱ WHO, 2016a

ⁱⁱⁱ World Bank, 2017a; World Development Indicators dataset, data for 2013

^{iv(a)} WHO, 2016a

^{iv(b)} Estimated in *The Gambia Demographic and Health Survey 2013* (p. 245) as the “direct estimates of maternal mortality rates for the seven years preceding the survey, by five-year age.” groups, The Gambia 2013

^v Source: MOH communication during health system assessment validation meetings, June 2019.

^{vi} female=37.9%, male=46.2%

^{vii} Urban=61.5%, rural=55%

^{viii} Urban=94.2%, rural=84.4%

^{ix} 8-year change

¹² See “*Gambia Health Information System (HIS) and M&E Assessment*” report, completed by Luke L. Bawo, consultant to the United Nations Population Fund in The Gambia, September 2018.

Health security and resilience. According to the MOH's *Health Sector Emergency Preparedness and Response Plan 2017-2019*, The Gambia is vulnerable to a number of natural hazards including floods, drought, disease outbreaks, fires, and storms (The Gambia, 2017c). This recently prepared policy and strategy document for health security provides guidance for policy development, coordination, and intra- and intersectoral collaboration for surveillance, planning, prevention, and response. It also lays out a plan for resource mobilization to finance these functions. The cross-sectoral National Steering Committee for Health Emergencies guides implementation of this plan and response to health emergencies. A new Public Health Emergency Operations Center has been constructed at the MOH campus but is not yet functional due to insufficient funds and staff to operationalize the facility.

The MOH is participating in regional training courses offered by the U.S. Centers for Disease Control and Prevention's Field Epidemiology Training Program designed to strengthen disease surveillance and outbreak management. To date, four Gambian cohorts have been trained (20-25 people per cohort). Two additional cohorts will soon graduate and return to The Gambia. All graduates to date have taken the course designed for frontline workers. No Gambian has yet to complete the intermediate and advanced level courses. This situation constrains The Gambia's internal ability to provide management and support for the frontline program graduates. Financing for participation is the main constraint. The Gambia has established a Field Epidemiology Training Program management unit with the Disease Control Unit in line with international recommendations. Though supported by the World Health Organization (WHO) and the World Bank, insufficient government funding constricts the program's functionality.

Research capacity. The Directorate for Health Research was established in 2014 when it was upgraded from a unit within the Directorate of Planning and Information. This directorate was established to provide leadership and technical support for the research needs within MOH and among the other research institutions in The Gambia. It has a well-articulated vision and structure though it is presently understaffed. Among the seven senior researcher positions, three are currently away in external training programs. There are no mid-level research staff within the directorate. It envisions a decentralized approach to supporting health research by starting topical research working groups within units of other directorates with the Directorate for Health Research providing mentorship and capacity building.

Beyond the Directorate for Health Research, health research capacity is limited. The Medical Research Council is among the most productive health research organizations in the country.¹³ Though much of its research is driven by an external agenda and most research is said to be led by expatriates and short-term external consultants, it is widely seen as the best positioned to assist the country in raising the capacity of the Gambian health research sector. The University of The Gambia Medical School and the National Nutrition Agency are also seen as important and productive health research institutions, though they too are in need of partnership support to further lift their capacity. Additional health research capacity exists in the Center for Innovations Against Malaria-Public Health Research and Development Center, the National Malaria Control Program, and the National AIDS Secretariat, though they are generally limited by inconsistent funding streams from the Global Fund. Other agencies with the potential to contribute to health research include the International Trypanotolerance Centre (which conducts research on sleeping sickness and roots in the agriculture and veterinary sciences) and the National Agricultural Research Institute, which conducts research on nutrition, food supply, and food security.

¹³ The Medical Research Council is a Gambian institution affiliated with the London School of Hygiene and Tropical Medicine.

Training capacity. Two higher education institutions in The Gambia prepare people for public health careers. The Gambia College offers a three-year diploma program in public health. Most graduates work in public health positions at health centers. The Gambia College graduates about 35 students per year. Diploma program graduates may also continue to the University of The Gambia's bachelor of science degree program. Most bachelor of sciences graduates become public health officers, take professional positions at the MOH, or go on to public health careers in NGOs or international agencies. The University of The Gambia also offers two master's degree programs at the School of Medicine's Department of Public and Environmental Health. The master of public health programs are new, having started four years ago. The program is broad-based, focused on health promotion and development, and designed for doctors, nurses, and social workers. The master of science, public health is a more technical program for those who have obtained a bachelor of sciences in environmental sciences. Output from these programs is largely dependent on outside organizational sponsorship for students. The MOH sponsors (i.e., provides financing for tuition and student living stipends) students to meet their internal needs for public health professionals, which the MOH determines to be approximately 70 graduates per year. The Medical Research Council recently has entered into an agreement with the University of The Gambia to sponsor an additional 35 students with all these graduates expected to be absorbed by the Medical Research Council to meet its self-assessed needs. National need is said to exceed the graduate output of these programs of The Gambia College and the University of The Gambia, but expansion is constrained by the limited capacity of the teaching staff capacity and financial dependence on external sponsorship for students.¹⁴ The University of The Gambia uses a small fund to sponsor a limited number of students to attend master's and Ph.D. programs outside the country. Recently, restrictions for such sponsorship have been placed on eligible locations, limited mostly to programs in West Africa and the United Kingdom, as very few students have returned to practice in The Gambia.

1.9 External Partners Support and Coordination

The Gambia International Health Partnership Plus Country Compact comprises 23 health development partners and 24 implementation partners (see Annex 1).¹⁵ Together, these partners provide close to half of all resources spent by the government of The Gambia (see Table 3). The Compact laid out a framework and a process to better align partner support with national health priorities as reflected in the health sector's guiding policy and strategy documents. It sought to establish:

- A joint funding arrangement to pool government and partner resources, preferably in a single fund, to finance implementation of the NHSSP's 2014-2020 strategies.
- Joint Working Arrangements as a mechanism for joint planning, financing, budgeting, procuring, implementing, and monitoring implementation of the NHSSP 2014-2020.
- A National Joint Interagency Coordination Committee to advise on policy, strategy, program and budget development.

According to a joint partners' interview for this assessment, this Compact did not receive the necessary cabinet approval from the government of The Gambia and was not operationalized

¹⁴ Key informants were not able to provide an estimate regarding total national need for public health professionals and this assessment team was not able to identify any formal or informal assessment of national need.

¹⁵ Compact between the Government of The Gambia and the development partners on accelerating the achievement of universal access to high-quality health care through the National Health Sector Strategic Plan 2014-2020 in the framework of International Health Partnership Plus (IHP+). Ministry of Health and Social Welfare, The Republic of the Gambia, March 2016.

(World Bank, 2018a).¹⁶ Each partner maintains an independent arrangement with the government of The Gambia with respect to planning and coordination of its activities. Among donors, the country coordinating mechanism is said to be the most effective inter-donor coordination mechanism operating in The Gambia now, though this mechanism only addresses Global Fund coordination needs at this time. The donors convene quarterly health sector review meetings. Donor representatives present at this assessment's joint donor partner interview stated that a process is underway to improve mechanisms for coordination with the government of The Gambia and that the MOH secretary general chairs the committee charged with this objective, with the country coordinating mechanism serving as the main platform at present. Most coordination currently takes place at the MOH program level and donors report finding it difficult to manage MOH program level outreach to donors. Engagement at higher leadership levels was described as in need of a better entry point. Current efforts to coordinate—among MOH programs, between MOH programs and donors, and among donors—do not result in improved, more efficient program implementation.

1.10 Summary

Population in The Gambia is growing and urbanizing rapidly. Population growth is especially high in the two coastal regions, with internal and external migration contributing significantly to growth in those regions. High growth and growth differentials will impact planning and resource distribution, both public and private. The country's health services system also faces substantial demand from cross-border populations, which adds stress on already burdened health services on the one hand, but also provides additional, much needed resources through a user fee structure that charges more to non-Gambians using the country's health services.

The macroeconomic fiscal environments, while improving, are likely in the short-term continue to constrain mobilization of new domestic resources for health needed to adapt to the needs of a rapidly changing population. Constructive recent changes in the political environment provide a backdrop conducive to advancing a health reform agenda, though some are concerned that social expectations for the pace and magnitude of change may outstrip what might be a more reasonable set of expectations. The overarching policy environment for the health sector is generally strong and is supported by an articulated and visionary national development framework and agenda. And the will of international partners is high to be a positive force contributing to advancement of the development and health reform agendas.

The picture for health financing is mixed; the burden of out-of-pocket spending for health is reported to be low by regional comparison but donor dependency for health financing is high. Risk pooling and strategic purchasing are much in the forefront of dialogue on health sector reform, though there is much distance to go to roll these out at the population level. Regionally, The Gambia compares reasonably well in terms of disease burden and the country has a well-articulated plan for managing health emergencies, though the plan is not currently well-financed. Geographic access to the service delivery infrastructure is good, though there are concerns about the quality of services provided at the largely public-sector dominated facility network. In each of this assessment report's component-specific sections, key challenges and opportunities will be summarized.

¹⁶ Joint donors' interview in Banjul, The Gambia.

2 Medical Products

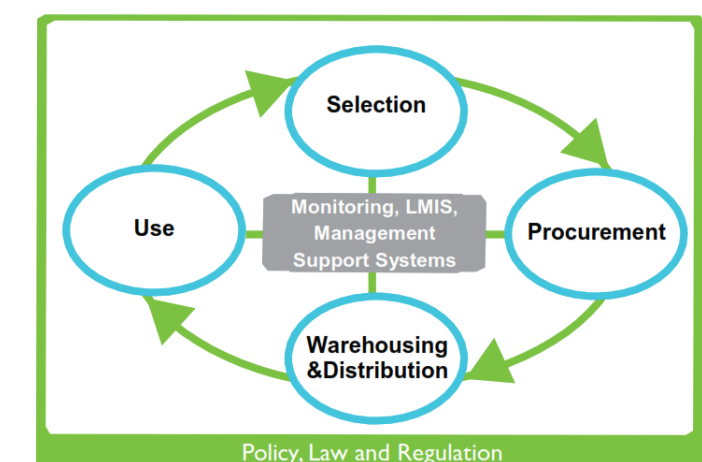
2.1 Overview of Medical Products

Equitable access to medical products and their scientifically sound and cost-effective use is an essential part of a well-functioning health system (WHO, 2007). Suboptimal management of medicines and medical products and other shortcomings are particularly important to examine because of the shortcomings' detrimental effects on overall health systems' performance and ability to achieve the goals of universal health coverage. Some public sector health systems have struggled to ensure access and appropriate use of medicines and medical products (Health Finance & Governance, 2017). This is well documented by evidence showing low availability of generic drugs in some countries, low levels of patient treatment according to standard treatment guidelines and weak adherence to treatment regimens (Bigdeli, et al. 2014; Holloway and van Dijk, 2011). Effective management of medicines and medical products that increases availability and appropriate use will directly contribute to the success of any public or private healthcare program or service.

A comprehensive set of logistics management activities are required to plan, implement, and control the efficient and effective flow and storage of medicines and medical products between the origin point and the consumption point to guarantee timely availability to and appropriate, safe, and cost-efficient use by patients. These activities are structured under interdependent components to make a continuous supply chain logistic system cycle in which each of the following four management functions are linked and contribute to the viability of the next: (a) product selection, (b) quantification/procurement, (c) storage/distribution, and (d) use. The non-logistics-related part completing the supply chain management system encompasses a core set of functions that comprise the management support system. The management support system includes monitoring through a logistics management information system (LMIS) focused on data collection, compilation, analysis and use; organization and human resource management; budgeting; and evaluation. These support functions are enabled and/or constrained by policies, laws, and regulations; and supported by good governance principles and practices.

Figure 4 provides a simplified framework of a supply chain management system for medical products, vaccines, and technologies. In practice, connections with other health system core functions add more complexity and challenges to how this supply chain management system operates within a broader country health system context. The logistics management functions such as selection, quantification/procurement, and storage/distribution are closely connected to health service delivery and include the provision of quality care and services that support appropriate use. The management support functions reflect the connections with the core health systems functions of leadership and governance, health systems financing, health information systems, and health workforce. This section analyzes how the medical products sector operates and is managed in The Gambia using the framework described below as a guide.

Figure 4. Framework for Managing Medical Products



Source: Health Finance & Governance, 2017. Medical Products module.

The Medical Products Industry in The Gambia

The Gambia has no internal/domestic pharmaceutical manufacturing industry and does not produce active pharmaceutical ingredients or manufacture drugs. With no manufacturing base, the country is completely reliant on foreign companies to supply the entire volume of the diverse set of products needed. The Medicine Control Agency, The Gambia Pharmacy Council, and the Department of National Pharmaceutical Services are responsible for regulation of pharmaceuticals, other medical products, and pharmacy practice standards and quality (The Gambia, 2014d, 24-25).

Management of Medicines and Medical Products Procurement, Storage, and Distribution

The Gambian public health supply chain system is managed by the MOH. The Gambian public health supply chain system is managed by the MOH. The Department of Medical and Health through its National Pharmaceutical Services Directorate coordinates and oversees the management of drug supplies for the whole country which involves product selection, procurement, storage, distribution and monitoring of use to ensure that products reach all health facilities and service delivery points spread across the country broken down as shown in Table 7 (The Gambia, 2017d, The Gambia, 2014a).¹⁷

Table 7. Health Facilities and Service Delivery Points Supplied by the Public Health Supply Chain System in The Gambia

Health Facility Type	WHR1	WHR2	NBWR	NBER	LRR	CRR	URR	Total
General and specialized hospitals	2	1	0	1	0	3	0	7
Major health centers and district hospitals	3	1	1	0	1	1	1	8
Minor health centers	5	4	4	6	5	7	10	41
NGO facilities and clinics	5	4	2	1	2	0	4	18
Private health facilities	6	9	0	0	1	2	5	23

¹⁷ List of health facilities.

Health Facility Type	WHR1	WHR2	NBWR	NBER	LRR	CRR	URR	Total
Community-managed facilities	7	9	6	5	4	8	1	40
Specialized reproductive and child health clinics	2	0	0	1	0	1	0	4
Reproductive and child health outreach clinics	13	24	32	31	34	62	61	257
Reproductive and child health base clinics sites	18	6	6	7	5	9	7	58
Primary healthcare key villages	3	12	13	9	8	17	12	74
Other primary healthcare villages	26	92	100	95	92	159	70	560
Service clinics	4	0	0	1	1	1	1	8
Total service delivery points	91	150	151	148	145	253	160	1,098

Source: Ministry of Health, Directorate of Health Services and National Pharmaceutical Services.

The MOH supply chain is divided into the following tiers:

- **Central Medical Store (CMS).** CMS procures and distributes medicines and other medical supplies to public health facilities including government hospitals.¹⁸ CMS uses a pooled procurement system to acquire the bulk of the supplies through tender processes. A smaller volume of items is processed as supplementary or emergency orders. Seven-hundred and sixteen items are currently being purchased by CMS and categorized into five groups. The purchasing groups are drugs, galenicals and X-ray consumables, medical and surgical items, dental products, and laboratory supplies. Located in Kotu near the capital city of Banjul and on one of the MOH campuses, CMS is the receipt point for drugs and other medical supplies, so all cleared shipments are delivered to CMS for verification prior to storage and distribution.
- **Government hospitals:** There are five general and four district hospitals in the country, plus one teaching and one specialty (eye) hospital.¹⁹ The general hospitals operate as autonomous institutions responsible for the management of their supplies. After clearing and verification of consignments, goods destined for hospitals are supplied by direct deliveries from CMS.
- **Regional Medical Stores:** Regional distribution of drugs and other medical supplies to facilities other than hospitals is supported by seven regional medical stores located in Brikama, Kanifing, Mansakonko, Bansang, Basse, Farafenni, and Essau.²⁰
- **Health centers:** Health centers receive supplies from CMS or the regional medical stores depending on the volume of or number of items requested in their orders.

Key actors in the distribution of medicines in The Gambia

The private health sector supply chain system includes a variety of actors including importers, wholesalers, retailers, licensed pharmacies, drug stores, supermarkets and health facilities. Table 8 provides a description of the supply chain actors.

¹⁸ List of health facilities.

¹⁹ List of health facilities.

²⁰ Crown Agents, 2017.

Table 8: Main Supply Chain Actors in The Gambia

Institution	Number	Description/Role
Public medical stores	1 central medical store, 7 regional medical stores	Procures, stores, and distributes medicines to all facilities providing government-supported health services
Private importers and wholesalers	14 (as of April 2018)	Procures and distributes medicines to public hospitals, private clinics, pharmacies, and other retail outlets.
Health facilities	459 (public, NGO, and private)	Provision of primary, secondary, and tertiary healthcare and medicine dispensing services to end user (majority are public facilities)
Community pharmacies	18 (as of March 2018)	Licensed to sell prescription and nonprescription medicines.
Drug stores	47 (as of March 2018)	Licensed to sell nonprescription medicines only.
Supermarkets	8 (as of March 2018)	Licensed to sell nonprescription medicines only.

According to the Gambia Pharmacy Council, The Gambia has 262 licensed pharmacy personnel—18 18 pharmacists, 23 pharmacy assistants, 84 dispensing assistants, and 137 nurse dispensers indicating a density of 1.3 10,000 habitants.²¹ Council members interviewed mentioned how dual practice is common in The Gambia pharmacy sector but not tracked nor formally reported. Information allowing a breakdown of licensed pharmacy personnel by employer (public and private) wasn't available to the team at the time of this assessment. It is important to note that even when available, these estimates might be inflated as they would double-count practicing pharmacy personnel working in both the public and private sector.

2.2 Pharmaceutical Policy, Laws, and Regulations

The Gambia adopted its first National Drug Policy in 1995 as a guide for action expressing and prioritizing the medium- to long-term goals set by the Gambian government for the pharmaceutical sector. The Department of National Pharmaceutical Services was established in 1996 as a division under the Directorate of Health Services with the mandate to implement the drug policy (The Gambia, 2007, 9). The policy, revised in July 2007 and published as the National Medicine Policy along with its strategic plan developed in 2009, laid the foundation to implement key reforms in the Gambian pharmaceutical sector. Key changes (Box 1) were considered achievements and attributed to successive implementation of the two policies toward the improvement in the availability and accessibility of medicines.

The Gambia National Medicine Policy closely follows the structure of WHO guidelines for drug policy development and implementation. It addresses legislation and regulation (import, distribution, and sale of pharmaceuticals); quality assurance; medicine selection; the essential medicine supply system (selection, procurement, storage, inventory control, and distribution of drugs, medical/surgical supplies, dental and laboratory supplies, local production, and disposal); rational use of medicine (drug information, prescribing, dispensing, and use); medicine financing and pricing; traditional medicines; research and development; human resource development; intersectoral and technical cooperation; and monitoring and evaluation. However, implementation of the 2007 National Medicine Policy

²¹ A breakdown of licensed pharmacy personnel by employer (public and private) was not available to the team at the time of the assessment.

is in need of strengthening; a starting point should be updating the policy, particularly with respect to effective enforcement.²²

Replacing 90-year-old legislation, the Medicines Act of 1984 and Medicines Regulation in 1986 provided the initial legal framework regulating the movement and distribution of pharmaceuticals for both human and veterinary use in The Gambia (Jallow, 1993; The Gambia, 2014b, 39). A review of this legislation in 2005 pointed out major weaknesses in the way pharmaceuticals were regulated (The Gambia, 2007, 12). Compliance with established norms for the business of pharmaceuticals and the professional practice of pharmacy was enforced by one legal structure deemed inadequate to provide such regulatory control (The Gambia, 2014c, 22). The Medicine and Related Products Act and the Pharmacy Council Act establishing the Medicine Control Agency and the Gambia Pharmacy Council were developed in 2014 from a recommendation in the 2005 review (The Gambia 2014c; The Gambia 2014b). The Medicine Control Agency was instituted as a body independent of the medicine supply system and fully accountable for the enforcement of pharmaceutical laws and regulations. It is funded by government budget support, registration fees paid by private sector suppliers and international partners' support. The Medicine Control Agency develops technical norms for management of pharmaceuticals including product registration, quality control, pharmacovigilance, marketing authorization. It is also responsible for warehouse inspection of pharmaceutical importers and wholesalers.

Despite the efforts made to maintain an up-to-date list of all registered pharmaceutical products available in the country, the Medicine Control Agency is a young institution facing several challenges. The quality of drug registration tracked by the indicators shown in Table 9 is affected not only by the shortage of technical staff but also by the limited technical capacity of current staff to conduct comprehensive reviews of medicine registration dossiers as well as to conduct quality sample tests for process auditing purposes. Furthermore, chronic backlogs of product registration applications seem to be exacerbated by the absence of a computer-assisted drug registration system (World Bank, 2018a). Low capacity coupled with a poorly equipped infrastructure for screening and sample/particle quality control testing and analysis have also been cited during interviews as major challenges making the execution by the Medicine Control Agency of key regulatory responsibilities pertaining to quality very limited. Drug quality sampling and testing for customs inspection for imported drug shipments, post-marketing surveillance, and pharmacovigilance are limited to visual and physical inspections.

Box 1. Key Reforms in the Gambian Pharmaceutical Sector Attributed to the National Medicine Policy and Its Strategic Plan

- Establishment of the National Pharmaceutical Services
- Construction and establishments of six regional medical stores
- Construction of new Central Medical Store warehouse and administration building
- Development and provision of the Standard Drug Treatment Manual and Essential Medicines List
- Training of health workers on rational use of drugs and the management of drugs at the health facility level

Source: Gambia National Health Strategic Plan 2014-2020

²² The Gambia National Medicine Policy Strategic Plan 2010-2015. Unpublished.

Table 9. Drug Registration Indicators

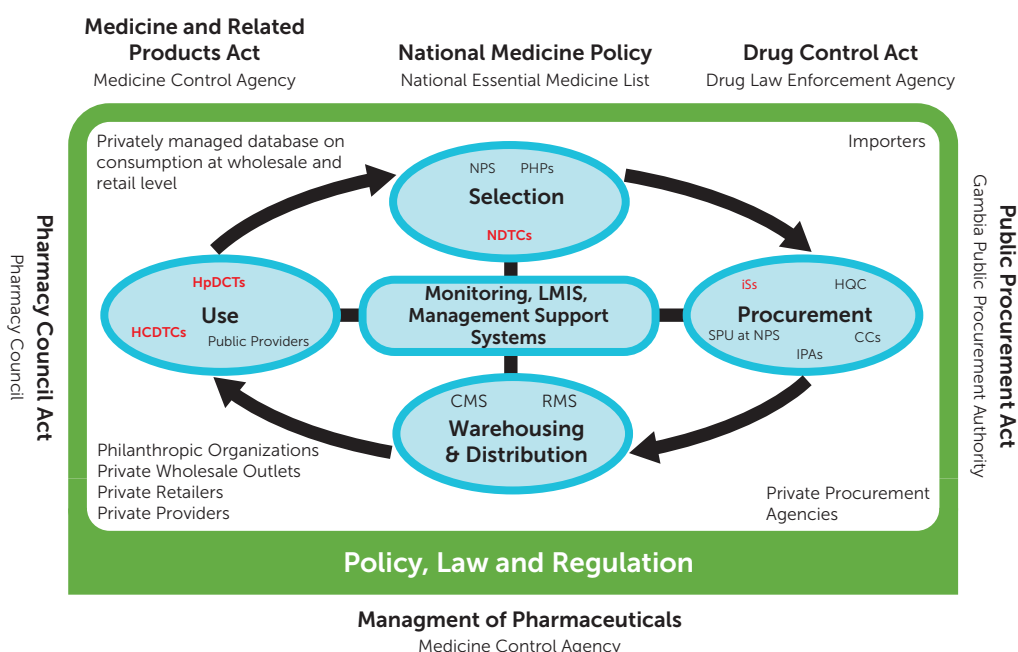
Value	Indicator Definition
107+	Estimated number of products registered
300	Cost of registration to company (US\$)
5 years	Initial registration duration
3-6 months	Time it takes Medicine Control Agency to perform initial registration
Up to 3 months	Time it takes Medicine Control Agency to renew registration if there ARE changes to product or packaging
Information not available	Time it takes Medicine Control Agency to renew registration if there ARE NO changes to product or packaging
Information not available	Estimated percentage of applications requiring some type of correction after initial submission
Information not available	Estimated percentage of companies that abandon the registration process after starting an initial application

The Gambia Pharmacy Council was founded to regulate the practice of the pharmacy profession. Even though the Pharmacy Council Act was issued in 2014, the Gambia Pharmacy Council was not operationalized until 2016 and implementation of activities truly began in 2017 with three part-time staff who transitioned to full-time as of February 2018 (World Bank, 2018a). The Gambia Pharmacy Council acts as the registering body for the pharmacy workforce and the licensing authority for both public and private pharmaceutical outlets for wholesale and retail of medicines and other medical supplies. It also prescribes and enforces practice standards. The Gambia Pharmacy Council also upholds conduct oversight and discipline among registered professionals such as pharmacists, pharmacy technicians, dispensing assistants, or operators of drug outlets.

Stakeholders interviewed reported that the functions and actions of the Medicine Control Agency and the Gambia Pharmacy Council frequently overlap. There is also overlap between each of these organizations and the Drug Law Enforcement Agency. The Drug Law Enforcement Agency is a government organization empowered by the 2003 Drug Control Act to register, manage, and regulate use and circulation of controlled drugs in The Gambia. The reason for empowering the DLEA with these responsibilities was reported to be low clarity in the respective acts on the mandate for product registration/marketing authorization versus wholesale and retail licensing.

This issue was later clarified with the creation of memoranda of understanding aimed at defining the scope of collaboration among the three entities and addressing the overlaps in responsibility. Application of these memoranda of agreement led to a division of roles. The Medicine Control Agency regulates product registration and marketing authorization. The Gambia Pharmacy Council regulates pharmaceutical dispensing and sales. The Drug Law Enforcement Agency directs enforcement when appropriate information on controlled/prohibited substances are provided by the Medicine Control Agency and the Gambia Pharmacy Council. Figure 6 provides a visual representation of the pharmaceutical sector and supply chain landscape in The Gambia.

Figure 6. Medicine and Medical Products Landscape in the Gambia



Source: Adapted from Health Finance & Governance, 2017, Medical Products module.

CCs: Contract Committees; IPAs: International Procurement Agencies; ISS: International Suppliers; HCDCs: Health Center Drug Therapeutic Committees; HpDTCs: Hospital Drug Therapeutic Committees; NDTCS: National Drug Therapeutic Committee; PHPs: Public Health Programs; SPU: Specialized Procurement Unit

Responsibility for inspection of premises in the private sector where medicines are sold, supplied, or dispensed is currently shared among the three regulatory bodies. The three regulatory bodies conduct joint inspections of the private sector entities. According to the Gambia Pharmacy Council, there are 82 registered private drug supply outlets and a national team of 19 inspectors based in Banjul and regional health offices. According to the Council, most inspectors work part-time and have a full-time employment in the private sector.

Between 2015 and 2018, 639 inspections of pharmaceutical premises took place across the country. As shown in Table 10, inspections were more frequent in West Coast Region 1, where the capital is located, than in other parts of the country, accounting for 47 percent of total inspections. With just 4 percent of total inspections, the North Bank West Region had the fewest inspections. Drugstores represent the most frequently inspected pharmaceutical location, accounting for 59 percent. No hospital storeroom inspection took place. Inspection information specific to public sector pharmaceutical premises was not available at the time of the assessment. It is not clear how pharmaceutical management and pharmacy service best practices and regulations are enforced in the public sector.

The country's drug policy need to be updated for several reasons. First, it has not been updated in 10 years and the update frequency recommended by WHO is five years. Second, there is a need to address overlaps in functions and the resulting confusion among the National Pharmaceutical Services, the Drug Law Enforcement Agency, and the newly established regulatory bodies, especially for the regulation of the public pharmaceutical sector; memoranda of understanding do not carry sufficient legitimacy to address the issues at stake. Third, clear guidance needs to be expressed regarding conflicts of interest between the individual performing inspection and pharmaceutical premises being inspected.

Table 10. Inspections by Pharmaceutical Location in the Last 36 Months

Location	URR	CRR	LRR	NBER	WCR1	NBWR	WCR2	Total
Pharmacy	10	0	0	5	38	0	5	58
Drugstore	45	32	28	35	120	22	92	374
Wholesalers	3	0	0	0	24	0	0	27
Pharmaceutical warehouses	0	0	0	0	16	0	0	16
Hospital storerooms	0	0	0	0	0	0	0	0
Private clinic storeroom	7	2	2	5	62	5	27	110
Supermarkets	0	0	0	0	36	0	0	36
Other types of facilities (markets, lumos (rural markets), ferry crossings)	5	3	3	3	2	0	2	18
Total	70	37	33	48	298	27	126	639

Source: Medicine Control Agency.

WCR1: West Coast Region 1.

NBWR: North Bank West Region.

2.3 Financing of the Medicines and Medical Products Sector

In The Gambia, public spending on drugs, according to 1999 and 2000 annual pharmaceutical budgets, averages US\$0.4 per capita unadjusted for inflation (World Bank, 2005, 42). More recently, according to the National Pharmaceutical Services, GMD 100 million, valued at US\$1.05 per capita, was spent on medicines by the MOH in fiscal year 2017. However, it wasn't possible to estimate with further precision the level of public funding for pharmaceuticals over the recent years as this assessment team was not able to obtain documents containing medicines budget information team to substantiate that the GMD 100 million and past spending amounts were in fact approved, received, allocated, and disbursed on drugs. It is not uncommon that autonomous administrative units such as hospitals in The Gambia or other countries experience significant variation between budget assigned by planning and budgeting structures at ministries of health and actual amounts received or disbursed. The potential consequences of lower-than-budgeted and delayed disbursements include delay of initiation of pooled procurement processes until funds are available, reduction in procurement volume, or changes in product selection.

In 2017, US\$4.9 million worth of medical products were purchased for The Gambia public health sector across the following programs: essential medicines (44 percent), HIV (29 percent), malaria (9 percent), tuberculosis (7 percent), maternal health (3 percent), child health and nutrition (8 percent). The main sources of public expenditure on drugs is attributed to the MOH (44 percent), the Global Fund (45 percent), UNICEF (8 percent), and the United Nations Population Fund (3 percent). Donations from private philanthropic organizations were not captured because they are difficult to track. During the interviews, stakeholders mentioned that donations are often supplied directly to the health facilities (mostly to philanthropically established facilities), rarely using the public supply chain system.²³

According to the World Bank's 2017 program document for emergency development policy financing, pharmaceutical procurement accounts for about 74.2 percent of total health

²³ Information allowing a breakdown of the distribution of public sector medical purchase by type of health facility ownership (public, private etc.) was not available to the team at the time of the assessment.

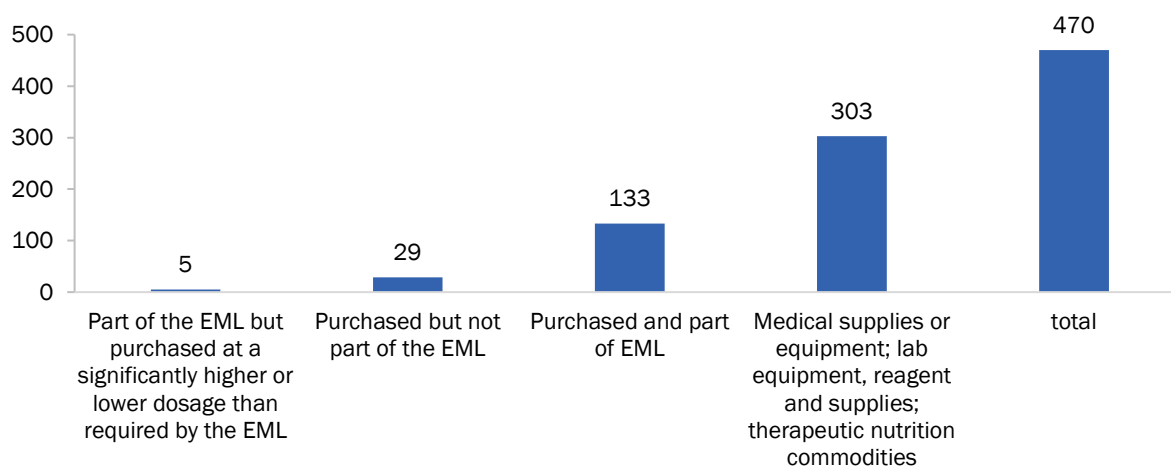
spending in The Gambia and has a value of \$87.60 per capita, using estimates from Table 3. This level of spending places a heavy financial burden on households to obtain healthcare (World Bank, 2017b).

2.4 Selection of Pharmaceuticals

Selection of medicines in the public sector is based on WHO-developed essential drugs concept, using the essential medicines list (EML) of The Gambia (Helling-Borda, 1983; WHO, 1990; WHO, 2002). The rationale behind essential medicines is that the list should be composed so as to maximize therapeutic efficiency given disease burden, service delivery systems, and resources. That is, a limited variety of carefully selected essential medicines can lead to improved health outcomes through better drug management at lower costs. The Gambia EML was first created in 1984 and last updated in 2016, according to the National Pharmaceutical Services. The quality of an EML is not determined only by the comprehensiveness of its content but also by how effectively it is used to guide the procurement process. The list of the medical products purchased by the MOH between February 2017 and February 2018 was obtained from the National Pharmaceutical Services to assess the quality of product selection. The items purchased were compared with all essential drugs on the EML to understand how closely drug procurement follows the EML.

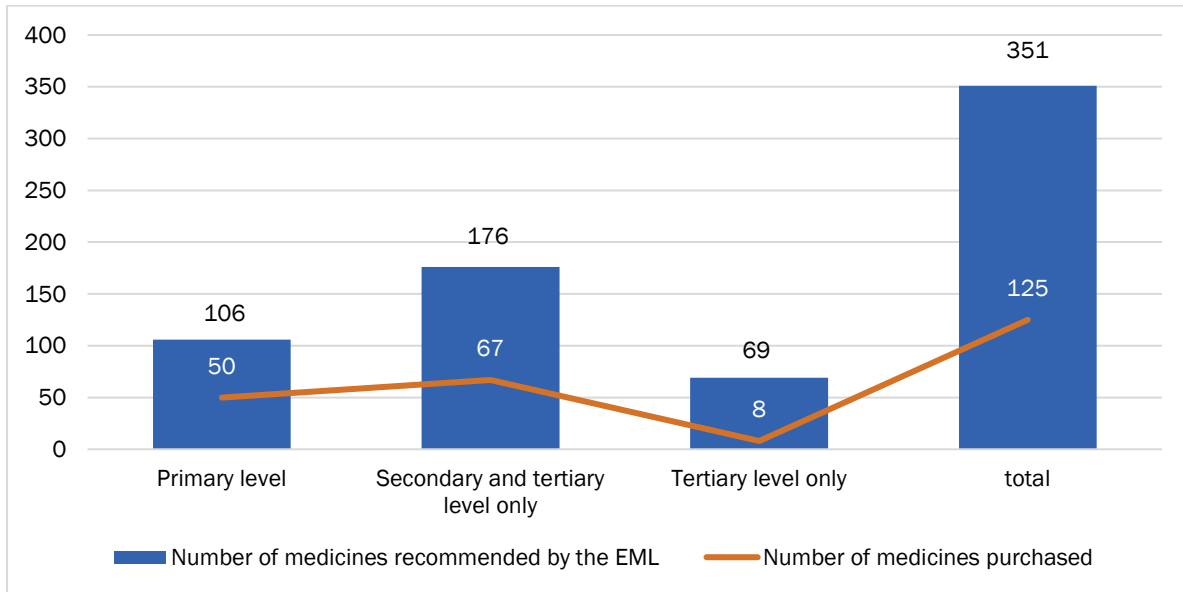
As shown in Figure 7, out of 470 items purchased during that period, 167 were medicines and 303 were non-pharmaceuticals (medical supplies or equipment; lab equipment, reagent and supplies; and therapeutic nutrition commodities). Among the pharmaceuticals purchased, 29 drugs were not part of the EML and five drugs that were part of the EML were purchased at a significantly higher or lower dosage than recommended.

Figure 7. Items Purchased by the National Pharmaceutical Services between February 2017 and February 2018



The comprehensiveness of the procurement of drugs in reference to the health sector needs was further explored using estimates of the number of medicines from the EML that are actually purchased for the public sector by level of care (Figure 8). The EML lists a total of 351 drugs. Of the 106 drugs recommended for use at the primary care level, 50 were purchased between February 2017 and 2018. Of 176 drugs recommended for secondary and tertiary care, 67 were purchased during the period. Of the 69 drugs recommended only for tertiary care, only eight were purchased. Of the specific pharmaceuticals suggested by the EML for the health post level, only seven were in stock at CMS and 13 were regularly purchased.

Figure 8. Use of The Gambia National Essential Medicines List in Product Selection by Level of Care



Looking at The Gambia's epidemiological profile, 72 out of 104 (69 percent) of medicines recommended across all three levels of care by the EML are used to treat communicable disease, non-communicable diseases and injuries. The distribution by therapeutic use of these 72 medicines can be considered as comparable to the country's disease burden highlighted in the overview section. Most of the 72 drugs are intended to treat communicable diseases only (53 percent), followed by drugs used to treat more than one condition type (29 percent), non-communicable diseases only (10 percent), and injuries only (8 percent). However, only 47 percent of these recommended therapeutic drugs were purchased between February 2017 and February 2018, with the largest share addressing communicable diseases only (50 percent), followed by drugs used for more than one type of condition (35 percent), drugs for non-communicable diseases only (9 percent), and for injuries only (6 percent).

Only a subset of all the items on the EML are purchased on a regular basis. Analysis of the products actually procured compared with the full range of items on the EML relevant for each level of care, it appears that selection favored lower levels of care. Overall, MOH procured only 36 percent of the products on the EML. However, it procured 47 and 38 percent of EML items appropriate for use at the primary and secondary care levels, respectively, while it procured just 12 percent of EML items appropriate at the tertiary care level. It appears that the selection process prioritized products used at the primary and secondary care level over those at the tertiary level. Key informants reported that the selection process takes into account budget constraints. Each year, once the final annual MOH budget is approved by the National Assembly and published, a team of MOH experts aligns product selection and quantification (see section 2.5w) with budget realities. The group employs the vital-essential-nonessential (VEN) principle following WHO recommendations. The VEN process also takes into account the fact that public hospitals have their own medicine budgets and considers consumer access to products in the private pharmacy market, though market information on product availability is poor. Key informants were not able to produce documentation for this process and it would be useful for the process to be systematically codified.

Limited funding isn't the only reason for low public procurement of essential medicines. Prescription practices and poor of diagnosis and treatment capacity in the public sector affect patient demand for medicines and can also impact selection. Provider-induced patterns of drug usage can dictate medicine procurement decisions. Non-prescribed—and

therefore non-used—medicines, although on the EML, are less likely to be purchased by the government. The importance of regulations controlling appropriate use of drugs enforced by national and facility-level drug therapeutic committees will be further discussed in subsequent sections.

2.5 Quantification and Procurement

Quantification of drugs and other health commodity (not including equipment) requirements is carried out once a year during a four- to five-week period. Quantification for mainstream essential medicines (for use in government health facilities) for fiscal year 2018 had not been completed as of the start of quarter two 2018 when data collection for this assessment began.

The Gambia's health system relies on dispensed-to-user data collected from health facility monthly reports. These reports record rates of health commodity consumption as completed by the officer in charge at the health-facility level. The facility-level reports are submitted to regional data managers at each regional health team's office and then compiled by the LMIS manager who sits at the CMS office. Drug quantity estimates are sent to suppliers and the National Pharmaceutical Services determines the final quantity of health commodities to procure based on the quotes received and the budget available for the fiscal year.

According to interviews, efforts are made to integrate the quantification process across MOH programs. Health commodities quantification methods for vertical programs are often program-specific, set up according to unique program needs and in consideration of donors and international agency requirements for donated products. Key informants noted that integration of information on expected donor contributions can be challenging. Donor contributions are subject to change even after commitments are made and sometimes with short notice, both with respect to timing and quantity of delivery.

Senior MOH officials reported that once each MOH program produces its annual quantification estimates, a cross-program meeting is held to compare needs and a consolidated quantification for each EML product is then produced. As noted above, a separate group uses a VEN-based method to consider product selection from among items on the full EML after knowing the final outcome of the annual MOH budget determination. It was not clear to this assessment team the degree to which the cross-program quantification exercise is synchronized, if at all, with the VEN-based process for product selection for procurement.

Medicines such as antiretroviral, tuberculosis medicines, malaria artemisinin-based combination therapies, contraceptives, and vaccines are quantified in consultation with development partners such as the Global Fund, the United Nations Population Fund, and the UNICEF. An ad-hoc committee is established to carry out the quantification process for government-financed essential drugs and to estimate the annual need for essential medicines. However, when final budget allocation decisions are made, past requisition levels and budget constraints generally hold more sway than past consumption and morbidity data. Interviewees suggested that forecasted demand of donor-funded products are more reliable than estimates for other essential medicines. This situation is a result of use of a consultative approach, which leads to greater involvement of program managers and better coordination between donors MOH during the quantitation process than prevails for the general MOH process. However, the assessment team could not confirm this assertion with the information available.

The National Pharmaceutical Services follows The Gambia Public Procurement Act of 2014 and uses a pooled procurement system for the purchase and supply management of medicines and medical supplies for public health facilities, including government hospitals. Public procurement methods allowed by regulations are enforced by the Gambia Public

Procurement Authority (GPPA). Under the act, the MOH is established as a procurement organization headed by the Permanent Secretary overseeing the National Pharmaceutical Services acting as a specialized procurement unit (see Box 2).

Box 2. Procurement Methods Used by the National Pharmaceutical Services

The following methods are available to the National Pharmaceutical Services for procurement of health products:

- Tendering. Open and restricted; formal procedure by which suppliers, national and/or international, are invited to bid for the sale of general goods. Bids could be open to all suppliers or restricted to a pool of interested suppliers approved in advance through a pre-qualification process.
- Direct or single procurement. For purchases under 1 million GMD, specialized procurement units are allowed to purchase directly from supplier (average lead time to complete the procurement was not provided).
- Quotation. Purchases of a certain amount require specialized procurement units to compare at least three price quotations obtained from local or foreign suppliers. Average lead time to complete the procurement wasn't provided.
- Framework agreement. Not part of the procurement manual's list of methods because it was introduced this current fiscal year by the National Pharmaceutical Services. It is a type of agreement governing the relationship between the MOH acting as the buyer with one or more suppliers that set out terms and conditions for making specific purchases (call-offs). Average lead time to complete the procurement once framework contracts are established was not provided.
- Excluded from requirements: According to the GPPA, under certain circumstances donor policies on procurement prevails. International donors such as the Global Fund, the United Nations Population Fund, or the United Nations Children's Fund are exempt from public procurement requirements and allowed to purchase directly from suppliers in accordance to their own internal procedures.

Sources: *Gambia Public Procurement Authority Act 2014*; *Procurement Manual for Pharmaceuticals and Other Health Products*, National Pharmaceutical Services, Ministry of Health and Social Welfare, Republic of The Gambia, May 2011; Interviews.

According to the World Bank supply chain assessment, three types of procurement are in use in The Gambia for procurement of health commodities (World Bank, 2016):

- Single source procurement through a bilateral arrangement with the government of Egypt.
- International competitive bidding through international suppliers such as UNIMED (UK), IMRES (Netherlands), the Arab Company for Drug Industries and Medical Appliances, and, more recently, a supplier based in Ghana.
- Procurement excluded from routine requirements such as the Global Fund Pooled Procurement Mechanism for Global Fund-funded products and procurement by the United Nations Population Fund, the United Nations Children's Fund for selected reproductive health, children's health products and vaccines; and by Catholic Relief Services for malaria bed nets.

Approximately 44 percent of medical products for the public sector were procured with government funding in 2017. The remainder of the medical products purchased for the public sector, particularly those funded through the United Nations Population Fund, the Global Fund, and UNICEF, are procured through international procurement agencies.

However, due to limited data availability, the assessment team cannot confirm whether government spending on essential medicines constitutes the largest portion of medicine procurement for the public sector. Without data on purchase volumes, it was not possible to estimate the proportion of need for each healthcare level actually purchased with fiscal year 2017 funds.

During interviews, it was communicated to the assessment team that until last fiscal year, direct purchase through a bilateral agreement with the government of Egypt was the main procurement method used by the MOH to acquire pharmaceuticals and other related products using government funds (including budget support from some development partners such as the World Bank). The National Pharmaceutical Services traditionally executed a bulk order of medicines and supplies once a year. Following the yearly order, the National Pharmaceutical Services receives the goods (medications) from one or various suppliers according to a pre-arranged delivery plan. In some cases, the entire order quantity is expected for delivery at once and in other instances staggered shipments are negotiated with the supplier (World Bank, 2016). If Central Medical Store experiences storage challenges once full order quantities are scheduled for delivery, the National Pharmaceutical Services can, at best, push a delivery back but cannot change the amount. Therefore, CMS is more a receiving task than a true procurement activity responsive to inventory-capacity constraints. The breakdown of deliveries is shown in Table 11.

Table 11. Deliveries to CMS, February 2017February 2018

Deliveries to CMS	MOH	Global Fund	United Nations Population Fund	UNICEF	Private philanthropic institutions	Total
Number of deliveries	5	120	8	17	0	150
Average/month	0.42	10	0.67	1.42	0	12.5
# of products delivered	Not available	Not available	Not available	Not available	Not available	Not available
Average delivery per product	Not available	Not available	Not available	Not available	Not available	Not available
Average # of products per delivery	Not available	Not available	Not available	Not available	Not available	Not available

CMS received 12.5 shipments on average per month in the 12 months previous to February 2018. The average number of products per shipment could not be determined because the data were not available to the assessment team.

It was less clear to this assessment team how in practice some procurement tasks are executed and evaluated (World Bank, 2016). Data tracking of procurement activities, contracts, and suppliers was not available to the assessment team. According to the GPPA, each procurement organization must complete and submit for subsequent review a supplier assessment form (Form 041) confirming that a procurement transaction has been successfully or unsuccessfully completed. The team did not have access to any of these forms and was unable to assess health commodity suppliers' performance for fiscal year 2016-2017. It is difficult to confirm whether a performance system is in place to monitor contracts or orders and working with suppliers. Systematic data on past performance of supplies are largely absent with the exception of information regarding whether suppliers met delivery deadlines.

Similarly, this team was not able to assess the reasonableness of commodity prices paid by the MOH for commodities in reference to International Reference Price, processing and lead times, order fulfillment rates, or other performance benchmarks. The assessment team learned through

key informant interviews that the National Pharmaceutical Services recently put a system in place to track the cost of items procured relative to the average international price paid but results were not yet available for as input into current procurement decisions. The consequences of national procurement system weaknesses for medical products can have negative repercussions on the supply chain. For instance, procurement of drugs in The Gambia is limited by budgetary constraints and currently relies on a small list of suppliers. Low negotiating power and low competition generally leads to higher, less competitive prices as compared to IRPs which reduces the volume of goods MOH can procure within its budget constraints. Higher prices paid by MOH also directly affects access to and availability of affordable medicine for the end-user. With limited resources for public financing of essential medicines, The Gambian government needs an efficient procurement process with regularly tracked performance metrics and timely communications to inform purchasing decision making.

The MOH has taken important steps (see Box 3) to improve procurement performance and is moving toward framework agreements with more stringent conditions (drafted as call-off terms and conditions) for suppliers to meet and subsequently be awarded call-off contracts. Based on the data shared by the MOH, more than US\$1.06 million of medicine and supplies have been spent in fiscal year 2017 by the government on medicine and supplies using framework contracts.²⁴ The benefit of using framework agreements is that they allow the supply of pharmaceuticals and related products to be secured over multiple delivery dates, meaning that the MOH does not have to hold excess stock of commodities and does not need to conduct an excessive number of rounds of competitive processes. Another significant benefit is that call-off contracts are often negotiated with pre-determined pricing, which can offer discounts for bulk ordering. However, careful management of call-off contracts is essential. With appropriate procedures, checkpoints and control systems can be put into place to act when deadlines are not met. Perhaps key informants encouraged the transition to framework contracts and noted the need to build capacity for this process.

Box 3. Key Procurement Reform Adopted by the Government of The Gambia for All Procurement of Drugs Using Government Funds

The government, acting through its MOH&SW, has issued Circular FIN 515/310/01/Temp (113-MD) dated April 24, 2017 mandating the use of an international competitive bidding framework for all procurement of drugs using government funds, and issued the technical specifications necessary to implement the framework and minimize disruptions in the supply of drugs to health facilities, including (i) the list of essential medicines and quantities to be procured and (ii) a list of accredited local suppliers for emergency procurement by health facilities.

Source: World Bank, 2017b, 24.

2.6 Storage and Distribution

Central Medical Store

Storage facilities in The Gambia include the Central Medical Store in Kotu (in the national capital area) and seven satellite regional medical stores with facilities in Brikama, Kanifing, Mansakonko, Bansang, Basse, Farafenni, and Essau. Under the management of the National Pharmaceutical Services, CMS is responsible for the storage and distribution of health commodities to hospitals and regional medical stores. Regional medical stores distribute supplies to health facilities such as health centers and clinics within their respective regions.

The CMS warehouse has seven storage rooms separated into two wings by a corridor. It holds 712 items in stock positions across eight product types in 224 locations (or slots). Most of the items are slow-moving lab and medical supply commodities representing 84 percent of

²⁴ Framework agreement between the MOH and Unlimited LLC (September 2017).

all stocked items, 88 percent of which have been in inventory for more than three years. It was not possible to retrieve the number of slots by product type to assess the storage space.

The storerooms were clean, and temperature and humidity levels were within the limits advised by WHO and the Medicine Control Agency. Temperature is routinely captured with thermometers; temperature recording charts are available and in use. At the time of data collection for this assessment, there was no energy backup to the city's power supply at night. According to CMS staff, nighttime power outages happen frequently and can last from less than an hour to the entire night, putting at risk the effectiveness and potency of temperature-controlled lifesaving medicines such as insulin or oxytocin stored in the cold room. MOH officials report that a generator recently has been purchased and installed.

Storage capacity at CMS was cited during the interviews as problematic; this observation was confirmed by a recent assessment commissioned by the Global Fund.²⁵ The assessment indicates that the volume occupied by stocked commodities is 69 percent above the cubic meter capacity for usable storage space.

Moreover, commodities were stocked in areas theoretically not considered as available storage space, such as the corridor and the receiving bay and dispatch area.²⁶ A large volume representing 24 percent of the warehouse total usable storage space is occupied by stacked products located in areas not designed as usable storage space. Over-stacked products that have been there for several months (according to interviewees) were observed in the corridor, receiving bay, and dispatch area (Photo 1) during the CMS visit. The warehouse assessment further revealed that the procurement volume of government-funded essential medicines for last fiscal year and Global Fund-financed commodities this current fiscal year were 2.88 times the CMS's usable storage capacity. This estimate excludes high-volume commodities procured by the United Nations Population Fund and UNICEF for which CMS staff are do not have enough visibility into the pipeline of future shipments. In some instances, CMS staff are only notified of a shipment delivery from these two donors when it is at customs and requires clearance.

Photo 1. Storage at CMS.



The combination of inability to estimate a definitive turnover rate and inflexibility in processing annual bulk orders contributes to issues in controlling inventory. Lack of timeliness of communication on procurement volume and supply planning can require unnecessary labor, lead to incorrect use of storage systems, and inappropriate racking arrangements that resulting in the CMS warehouse full of slow-moving products with no space for new inventory.

Basic processes such as first-to-expire first-out were used adequately in the CMS storerooms visited. However, insufficient storage space hinders stock rotation, making it difficult in some instances to apply first-to-expire first out. Quarterly stock reconciliations and stock-taking, carried out twice a year, are not frequent enough given the power supply challenges

²⁵ *Assessment of the National Medical Commodities Storage Design System-The Gambia*. Crown Agents. December 2017

²⁶ Assessment completed in February-March 2018; observations pertain to the preceding year.

faced by the warehouse. According to interviews, CMS distributes commodities during prolonged daytime power outages, which disrupts inventory movement tracking by mSupply, the warehouse inventory management software. The time lag between manual recording of all stock movement transactions and subsequent manual entry in mSupply increases the risk of misreporting and opportunities for product diversion. Every movement of a product or item within a warehouse is a chance to inadequately record or lose track of inventory, cause an error in the order, or create additional picking errors due to non-recorded location or slot changes.

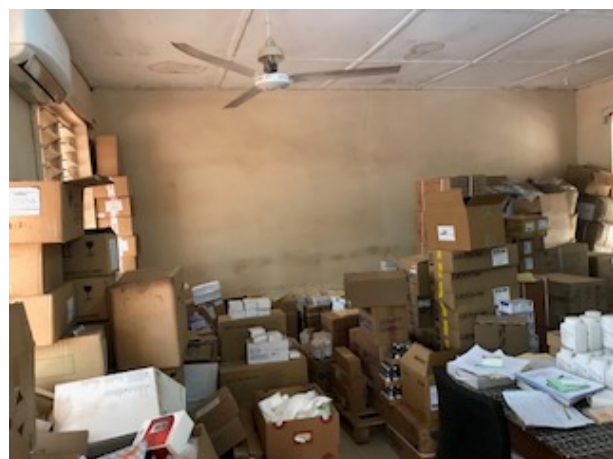
CMS uses three trucks to distribute drugs and medical supplies to seven regional medical stores, and seven general and five district hospitals. This limited fleet capacity requires detailed knowledge of rural road conditions, travel times, and available transport to optimize distribution. Interviews with several stakeholders did not provide any confirmation that a proper system is in place for drug route transport planning or delivery circuits. Drug route planning and delivery circuits are important elements to incorporate into the distribution system to ensure optimal use of resources. Given the size of The Gambia, all drop-off locations are within a day of CMS. Calculating travel time to fully supply the network, the amount of supplies to transport per route, and the trucks, drivers, and fuel needed all must be considered to improve efficiency in the CMS distribution system.

Regional Medical Stores

Interviews conducted at two Regional Medical Stores facilities indicated that a traditional pull/order process is used to plan distribution from CMS to the regions. Orders are sent by Regional Medical Stores to CMS every four months using a paper-based requisitioning system; delivery is expected about one week later. Order quantities are determined by health commodities monthly consumption reports. These reports are collected by the facilities and used to calculate an average monthly consumption rate by product through CHANEL, the inventory management software available in all regional medical stores. Consumption information is then compared to stock on hand and min/max inventory levels. When stock levels are low and will not last until the next resupply period, emergency orders are placed as supplementary requisitions. According to interviewees, supplementary requisitions are mostly caused by inadequate fill rate at service levels, for example, supply levels not matching amounts placed in the original orders. A mismatch between amounts ordered and shipped can stem from CMS due to low product availability. Interviewees noted that allocation and rationing decisions at CMS are not adequately communicated to Regional Medical Stores. Key informants said that attempts to push slow-moving, close-to-expiring commodities from CMS to the Regional Medical Stores is common. Close inspection at delivery is required to avoid having a high volume of expiries at Regional Medical Stores and to reduce the risk of receiving supplies that were not originally requested in the requisition forms.

Regional Medical Stores also face significant storage challenges. One of the regional medical stores visited was under rehabilitation and all the commodities have been stored for more than six months in an office (Photo 2). Storage conditions in this office were crowded, products were over-stacked, and the temperature was high at 39 degrees Celsius at the time of the visit,

Photo 2. Storage at a temporary regional medical store.



nine degrees above the room temperature recommended by WHO and the Medicine Control Agency. Rehabilitation work was expected to be completed in the two months following this assessment visit, according to staff.

The second level of distribution in The Gambia public supply chain is operated by the regional medical stores, supplying health commodities to 53 health centers and 107 clinics across all seven regions. This second-tier distribution is mainly passive, as the regional medical stores do not have the logistic capacity to transport commodities to the facilities. Some regions benefit from transport support available through the NGO Riders for Health which is contracted by the MOH to, among other things, distribute commodities. The Riders for Health transport service does not provide a systematic logistic network capable of rapid distribution of medical products. The contract with the MOH defining Riders for Health's scope of transport assistance to the medical product supply chain was not available for review by this assessment team. Key informants, however, noted that while CMS does participate in MOH meetings for the Riders' contract review, it does not have access to oversight and day-to-day monitoring of Riders' drug distribution planning and actual distribution. Health facilities often use their ambulances or maternal and child health trekking vehicles to collect drugs from the regional medical stores. Health facilities with only one or no functional ambulance use referral opportunities or other transportation to collect medical supplies at the regional medical stores. The ordering system used by the regional medical stores for distribution planning is in theory a pull system; it is adjusted in practice to be more of a mixed pull/push process. Requisitions sent by the facilities every two months to the regional medical stores are systematically compared with their reported monthly consumption and stock on hand for supply adjustments because the orders are deemed inaccurate by the regional medical stores. Stock on hand and corresponding shelf life are then checked to apply the first-to-expire first-out method, ensuring that the close-to-expiry products are included in the facilities' resupply amounts. Moreover, facilities face the same stock rationing issues described above for the CMS level at their distribution level. Health facilities should have a resupply interval of two months but in some cases, facilities can resupply several times in one month through supplementary requisitions. These frequent resupply intervals can also be explained by the following three scenarios: (a) facilities cannot store the amount of drugs they need for the supply period, (b) low fill rate due to rationing decisions at the regional level, (c) incorrect quantification of needs by Regional Medical Stores, and (d) inappropriate requisitioning or ordering by facilities.

The potential impact of item fill rate on the risk of stock-out and increased resupply intervals (with their additional costs) is an important issue to consider. Using a requisition order placed by a Regional Medical Store to CMS during the last quarter of fiscal year 2017, we analyzed the ordering and supply information of 194 items. The Regional Medical Stores reported 136 (70 percent of total) items for which the inventory stock on hand was equal to zero at the time of the requisition order submission. Furthermore, 76 out-of-stock items requested were not supplied at all. Among the 78 items supplied by CMS, only 24 had a 100 percent fill rate; the remaining items had an average fill rate of less than 17 percent.²⁷ Two items in the parenteral solution group were considered outliers as their quantity supplied represented respectively 20 and 30 times the amount requested. Based on these estimates, if a requisition is received for items that might be out of stock, or low on stock at the CMS, they are not shipped. However, according to Regional Medical Stores staff interviewed, the reasons behind this decision is not formally or systematically communicated. For unfilled items, the Regional Medical Stores do not systematically receive information on when stock is expected or notified when the items are restocked. The following scenario is entirely feasible: a regional medical store's unfilled item becomes available the week following the four months' requisition/order, and remains available for the next three months, but then is

²⁷ Delivery manifest or equivalent confirming the number of products received by item for the same corresponding period were requested but not provided. The assessment team had to rely on the amounts supplied reported by the CMS instead of the confirmed amounts received by the CRR RMS.

out of stock in the fourth month, when the Regional Medical Store next places an order. A page of the requisition form (Photo 3) provides an example illustrating the stock-out and low item fill rate issues discussed above.

Photo 3. Requisition form submitted to the CMS

CENTRAL MEDICAL STORES

COMBINED REQUISITION AND ISSUE NOTE

Date: 12/10/17 *Section: [Redacted]

The Following Items Required for a (3) Third Month Month Period

Signature of officer Authorized to Order: [Redacted]

Stores: [Redacted] *TO BE COMPLETED BY INDENTING OFFICER

C.M.S Stores Issue Note No. [Redacted]

RECEIVED ON: [Redacted]

issued by: [Redacted]

Date: 31/10/2017

Checked by: [Redacted] Date: [Redacted]

Item No.	Description (Please Type or Print Clearly)	Unit	Stock on Hand	No. Unit Required	Medical Stores Use Only		
					No. of Units Supplied	Quantity Received	Remarks
001	Antihaemorrhoidal Suppositories	100	0	50	—		
002	Tabs - Bisacodyl 5mg	1000	0	50	—		
003	Tabs - Hyoscine Butylbromide 10mg	1000	0	50	50		
004	Tabs - Magnesium Trisilicate 1000mg	1000	0	100	—		
005	Tabs - metoprolol succinate 10mg	100	0	200	—		
006	Caps - Omeprazole 20mg	14	0	2000	50		Low item fill rate
007	Tabs - Ranitidine 150mg	1000	0	50	—		
008	Tabs - Sulfasalazine 1000mg	1000	0	10	10		
009	Tabs - Zinc Sulphate 100mg	1000	0	10	—		
010	Tabs - Zolopramide 2mg	1000	0	50	—		
011	Tabs - Promethazine 25mg	1000	0	100	—		
012	Tabs - Carbimazole 5mg	1000	0	100	—		
013	Tabs - Acetylsalicylic Acid 75mg	1000	0	1000	50		Low item fill rates
014	Tabs - Amlodipine 5mg	100	0	50	—		

Received by: [Redacted] Designation: [Redacted] Signature: [Redacted]

Zero inventory stock on hand

Hospitals

Every four months hospitals place their health commodity orders to and receive their supplies directly from CMS. According to the World Bank, CMS deliveries to hospitals can vary from two to up to 10 deliveries per year. Hospitals may use their internal revenues to purchase commodities not available at CMS from private wholesalers or retailers. Maintaining adequate storage conditions at hospitals is a challenge and the storeroom of one of the general hospitals visited had no electricity for more than six consecutive hours. The recorded temperature in the refrigerator storing temperature-controlled lifesaving drugs, such as insulin and oxytocin, was read at 18 degrees Celsius, 10 degrees above the maximum of 8 degrees Celsius allowed by Medicine Control Agency guidelines. Insufficient storage capacity was also a challenge mentioned during the interviews. According to interviewees, slow-moving products mainly composed of medical and lab supplies are not well monitored and likely end up in the hospital storerooms where they would likely expire.

Based on the interviews conducted and, as pointed out by other assessments, it is difficult to identify the true causes of inefficiencies leading to stock-outs or waste, as there are many different factors.²⁸ These factors need to be identified to curb their detrimental effects to operations downstream in The Gambia public supply chain system. Questions include the following: Are facility-level stock-outs mainly caused by insufficient funds and/or other

²⁸ Yadav, Prashant. 2016 [August]. *Assessment of Procurement and Supply Chain of Reproductive, Maternal, Neonatal and Child Health and Nutrition (RMNCHN) Products in the Gambia*. Washington, D.C., World Bank [Unpublished].

problems in national-level procurement? Or is it an issue with stock-outs of products which are in stock at the national level? Or both? Stock-outs could be the result of inadequate requisitioning that could involve both regional medical stores and facilities, of central and regional suboptimal stock allocation/rationing decisions when products in stock are insufficient to meet demand from facilities, and of insufficient resources for transport at the regional level. Structures within the public supply chain system do not have a systematized or routine way to collect, report, analyze, understand, and ultimately act on what leads to the supply chain problems mentioned above. This issue will be discussed in the geographic access and LMIS sections.

2.7 Geographic Access

Geographic access to health commodities is critical to improving healthcare quality and outcome. Key indicators such as household distance to drug dispensing facilities are not followed according to the National Pharmaceutical Services. Geographic distribution of stock-out rates in the supply chain can also be used as an indicator to measure accessibility and availability of essential medicines (Health Finance & Governance, 2017; Section 3, Chapter 4, 33). However, current capacity for reporting on and analysis of health commodity stock-outs in The Gambia public sector health system is severely limited. Manual and electronic inventory control tools such as mSupply and CHANEL have been in use for many years with the support of international partners such as the Global Fund and the United Nations Population Fund. These systems have the capacity to track key supply chain indicators including stock-out. However, the assessment team was not able to evaluate stock-out data collected by the CMS in the last 12 months at any supply chain level because the information was not readily available and would take, according to the CMS, months to extract.²⁶ There is presently no standardized system to collect stock-out information from regional medical stores and from healthcare facilities. This indicates that geographic access isn't routinely tracked. Reporting and analysis of key medicine stock-out information distributed by type of products, location (urban vs. rural), geographic area, and facility type is critical to design targeted high impact interventions and build accountability among supply chain stakeholders. Systems need to be built and capacity strengthened to regularly analyze data from that system.

Some procurement decisions linked to product selection exacerbates inequity in medicine access. The decision to include a product in the procurement plan depends in part on its availability in the private market (World Bank, 2016). In other terms, the more likely a product is sold in the private market, the less likely it will be included in adequate quantity in the public procurement plan. This selection restricts access to medicines for poorer populations unable to afford drugs in private retail outlets. Interviews with representatives of two of the most frequented private pharmacies in the Banjul area confirmed that 70-80 percent of their clients entering the premises for prescription drug dispensing services have a medical prescription from a public facility provider.

2.8 Appropriate Use

Drugs are one of the most important drivers of health expenditure in either public or private sectors. Using a system of ongoing, methodical, criteria-based evaluations to support routine analysis and results dissemination for rational use of drugs will help ensure that medicines are used appropriately at the patient level. Appropriate use of drugs is key in reducing and controlling the costs of healthcare. Cost savings could be reinvested in other key areas of the health system that promote quality and equity of services. According to stakeholder interviews, rational use of drugs is a major issue in The Gambia. Common examples cited included giving an antibiotic for a course of 21 days as a result of a minor infection that requires just seven days of treatment or prescribing an antibiotic for a suspected viral infection. According to WHO, some of the commonly encountered patterns of irrational

prescribing include excessive use of injections, multiple drug prescriptions, excessive use of antibiotics for treating minor acute respiratory infections (mostly viral in origin), and the use of minerals and tonics for managing malnutrition (WHO, 1987). The Gambia Pharmacy Council has no control over drug dispensing at any level of care and is not formally part of the quantification committee. The Gambia Pharmacy Council should play a key role during the annual quantification process in determining adequate courses of action when evidence is presented showing that poor compliance to prescribing and dispensing standards is affecting drug usage/dispense-to-user consumption data. Proper regulations and bylaws have not yet been developed to adequately reflect the Gambia Pharmacy Council regulatory enforcement capacity.

There is no formal mechanism that brings together the four professional councils of pharmacy, medical and dental, nursing and midwifery, and public health. Crosscutting issues within their purview, including preventing irrational use of drugs at all levels of care, are not followed nor discussed. It was communicated through the interviews that the National Pharmaceutical Services intends to establish drug therapeutic committees at national and facility levels for appropriate drug usage tracking and enforcement. However, setting up drug usage control structures in the National Pharmaceutical Services overlaps with the Gambia Pharmacy Council's mandate and it is not clear how the scope of the NPS' role regarding medicine therapeutic committees will be clarified.

2.9 Monitoring, LMIS, and Management Support Systems

The Gambia uses a three-tier logistics management information system composed of paper-based and electronic inventory control tools. At the central level, CMS uses mSupply, a licensed software. At regional level, all Regional Medical Stores use CHANEL software provided by the United Nations Population Fund, a Windows-based software for managing health supplies in warehouses or service delivery points. Most hospitals and some health centers use CHANEL, while logistics management information in the remaining facilities is recorded via a paper-based system. Logistics information is collected as part of the health management information system through the district health information system (DHIS2), a cloud-based, open-source system for reporting, analysis and dissemination of data for all health programs. For The Gambia, DHIS2 it was designed to collect and process drug inventory, consumption, distribution data in addition to routine health services statistics.

Stockkeeping records are both paper based and electronic. At Regional Medical Stores and hospitals, the stockkeeper records information on the paper-based stock cards and a data entry clerk records information daily into CHANEL. CHANEL then generates monthly aggregated stock movement and drug usage data such as opening stock, stock received, stock balance and consumption rates. This information is manually entered by the data clerk in the DHIS2 and then automatically processed to provide regional stock levels for key health commodities. The data recording and processing by the facility level data clerks is supervised by data managers at the regional level. Data entered in DHIS2 are available in real time to the CMS LMIS manager and are updated monthly by Regional Medical Stores and hospitals.

Full visibility at central level on day-to-day stock flow operations downstream the supply chain has been cited as a key objective of the MOH. Supply chain staff in facilities without Channel and DHIS2 have a LMIS system entirely paper based. Monthly aggregates of key data points such as stock on hand, consumption, losses/adjustments must be calculated manually and sent to the Regional Medical Stores. Inadequate computerization and inconsistent internet connectivity at lower level or more remote health facilities will not provide that visibility but lead to poor stock monitoring and inaccurate stock levels making shortages longer to detect. Facility staff interviewed mentioned the main reasons behind poor/inaccurate reporting are inadequate supervision from Regional Medical Stores and CMS in addition to inadequate training on stock management human resource shortages.

Often a health provider is also the prescriber, dispenser, and the person in charge of completing stock cards at the same time.

According to the World Bank, 37 percent of health facilities in The Gambia reported stock-outs of tracer items in 2016 (World Bank, 2017b). This proportion could be underestimated. Low reporting capacity on and analysis of stock-out information, as previously mentioned, is further exacerbated by the widespread use of an inaccurate definition of stock-out. According to LMIS staff interviewed, the CMS and Regional Medical Stores revise the stock-out reported by facilities according to a definition, which was just recently aligned to WHO's definition, stating that the absence of a commodity at the point of dispensing should be considered as a stock-out after 14 consecutive days (Box 4).

Box 4. WHO Core Definition of Stock-Out

Stock-Out: the complete absence of the medicine, health product, or vaccine at the point of service delivery to the patient.

Source: WHO, 2016b, 10.

According to LMIS data shared with the assessment team, 72 percent of the commodities considered tracer items by the MOH are currently in stock at the CMS. Tracer items represent only 5.5 percent (39/712) of all distinct items in stock at the CMS warehouse. However, the remaining 94.5 percent is not closely followed and this poor monitoring has been cited as a main cause of understocking and overstocking and thus expiries. According to staff, although all items in the CMS warehouse are included in its electronic tracking system, the system is not as up-to-date for non-tracer items as it is for tracer items and CMS informants reported that they do not have the capacity to track or monitor all items stored in the warehouse.

Expiries

In addition to the storage challenges discussed above, shortcomings in central level inventory control and visibility over non-tracer goods can be considered as a potential cause of expiries at all levels of the supply chain. At the CMS level, all tracer and non-tracer commodities are included in the computerized CMS product tracking system. The system includes elements to monitor by batch and by expiration date. The system does not, however, adequately extend to monitoring supplies beyond CMS. As noted earlier, previous electricity and internet connectivity outages may have contributed to challenges in maintaining this system given that during outages, tracking must be recorded on paper and later inputted into the online system. Challenges associated with control and visibility of non-tracer commodities have also increased as result of expanded programs. Storage capacity has not increased commensurate with population growth and subsequent growth in demand for health services. Previous supply chain assessments have also pointed to the need for large-scale expansion of storage space though to date, neither resources nor plans for such expansion have been put in place., the assessment team will estimate the value of the 2017 expiries using a National Pharmaceutical Services listing and the WHO's international drug and medical products price databases.²⁹ Actual procurement prices for the expired items were not provided to the team, which would have allowed estimates of expiries value as a share of total procurement value of medical products for the public health sector.

²⁹ WHO international drug price indicator (2014), price estimates will be available in the final version of the report.

2.10 Key Findings and Recommendations for Strengthening The Gambia’s Medical Products Environment

Area	Key Findings	Recommendations
<p>Regulation</p>	<ul style="list-style-type: none"> • The National Medicine Policy has not been updated for more than 10 years and has several gaps to address in future iterations. It does not guide the sector on how to integrate key changes in the pharmaceutical sector (establishment of regulatory bodies, clarification of scope of the National Pharmaceutical Services as a directorate and coordination of rules with the Medicine Control Agency, the Gambia Pharmacy Council, and the Drug Law Enforcement Agency. Such rules mitigate conflict of interest between individuals conducting inspections and pharmaceutical premises being inspected, new procurement methods, etc.) • Inadequately regulated storage conditions in private premises due to conflict of interest, combined with the risk of provider- induced use of drugs for people who favor the private sector, either out of personal choice or due to public facility stock-out, can lead to potentially serious health problems. • The absence of a computer-assisted drug registration system at the Medicine Control Agency leads to a significant backlog of product registration applications processed on a paper-based system. • There is a shortage of technical staff and limitations in their technical capacity to conduct comprehensive reviews of medicine registration dossiers and quality sample tests for process auditing. • At the Medicine Control Agency, there is low capacity and equipment for screening. Sample and particle quality control testing and analysis have been cited during interviews as major challenges, making the execution of key regulatory responsibilities pertaining to quality very limited. 	<ul style="list-style-type: none"> • Update the national health policy to provide clear guidelines on (1) new procurement methods, (2) the scope of responsibilities between the National Pharmaceutical Services and newly established regulatory bodies, and (3) conflict of interest mitigation during pharmaceutical premise inspection. • Produce a strategic plan to operationalize the updated national health policy’s new procurement guidelines. • Explore low-cost opportunities to improve product registration operations such as the use of a free computerized system. SIAMED is a free software program for national drug regulatory bodies developed by WHO and the Pan-American Health Organization. Many countries have been trained on how to use this software, including Guatemala, South Africa, Tanzania, Uganda, Benin, Cameroon, Niger, and Tunisia.

Area	Key Findings	Recommendations
Selection of Pharmaceuticals	<ul style="list-style-type: none"> • Only a subset of all the items in the EML are purchased on a regular basis. The need to limit selection from among all items on the EML is mostly driven by insufficiency of budget resources. The MOH employs a VEN principle adapted from the WHO to make decisions about what to procure and what not to procure. • There is no standing medicines therapeutic committees to update the EML or to provide unbiased judgement on selection of medicines for procurement. • Selection of products for procurement is based on application of the VEN principle (adapted from a WHO-recommended process) and considers multiple dimensions to select items to be prioritized for procurement. The VEN process is applied annually after the MOH budget is finalized. 	<ul style="list-style-type: none"> • Closely monitor the impact on equity of decisions about product selection for each level of the service delivery system. Hold relevant structures accountable such as a national drug therapeutic committee or the National Pharmaceutical Services. • Produce terms of reference for a standing medicines therapeutic committee and appoint committee members at national and health facility levels; hold the committees accountable to meet on a defined, regular basis. • Encourage the National Pharmaceutical Services to support the EML development in a way that allows its implementation, at least for the short term, to focus on treatment medicines in an environment of limited funding. • Examine options for better integrating MOH and donor product selection and quantification processes, and for creating increased opportunities for cross-learning about product selection methods.
Financing	<ul style="list-style-type: none"> • Tracking medicines budgets is difficult. National Pharmaceutical Services has limited access to budget allocation decision making; National Pharmaceutical Services does maintain records of funds spent on product procurement. • The Drug Revolving Fund (DRF) was established with the intent to supplement MOH budgeted funds for medical products. In practice, it is not functioning as intended. 	<ul style="list-style-type: none"> • With the support of the Directorate of Planning, strengthen National Pharmaceutical Services' capacity to improve accessibility of public budgets and expenditures related to medicines to promote good governance. • Review the functioning of results-based financing and revise operations as needed to mobilize funds as intended for MOH medical products procurement.

Area	Key Findings	Recommendations
Quantification/ Procurement	<ul style="list-style-type: none"> • Cross-program integration of the MOH quantification process should be examined to identify areas for strengthening that would promote even greater procurement efficiency and savings. • Donor-led quantification is considered more accurate than government-led quantification for essential medicines. Quantification committee membership is ad-hoc and quantification is irregularly carried out. • Procurement performance tracking system for monitoring contracts or orders and selecting and working with suppliers is in need of strengthening. • There is poor transparency on supplier past performance. • Procurement management skills and capacity at National Pharmaceutical Services need to be strengthened especially in the context of the transition to an even more complex contract framework. 	<ul style="list-style-type: none"> • Strengthen National Pharmaceutical Services' capacity to improve and support the process of cross-program integration of the drug quantification process by MOH programs to reduce inefficiencies and potential wastage. • Examine options for better integration of MOH and donor product selection and quantification processes, and for increased opportunities for cross-learning. • Strengthen procurement process efficiency for medical products with regularly tracked performance metrics and timely communications to inform purchasing decision making. • Better incorporate past performance into supplier selection criteria. • Invest in building the National Pharmaceutical Services' management skills and capacity required to successfully transition to and execute framework contracts.

Area	Key Findings	Recommendations
Storage/ Distribution	<ul style="list-style-type: none"> • Severely insufficient storage capacity in the CMS warehouse is exacerbated by lower inventory visibility for non-tracer commodities as compared to tracer commodities. • Anticipated annual procurement volume from government and international partners is 2.88 times the warehouse's usable storage capacity. • Unpredictable electricity supply with long outage periods compromises storage conditions for and potency of lifesaving drugs. • CMS does not have the capacity to track and monitor all the items stored in the warehouse. • CMS staff do not have enough visibility into the pipeline of future shipments especially for products procured by the United Nations Population Fund and UNICEF. • The system for drug route transport planning or delivery circuits between the CMS and regional medical stores and hospitals is not under control of CMS. • The contract with the MOH defining Riders for Health's scope of transport assistance relative to medical product supply chain is unclear. • Low order fill rate for most items requisitioned by some Regional Medical Stores as unfilled item backorders are not followed up later when Regional Medical Stores' stock level would permit back orders to be filled. • There is no systematized or routine way to collect, report, analyze, understand, and ultimately act on some key drivers of supply chain inefficiencies such as inadequate requisitioning that could involve both regional medical stores and facilities; central and regional suboptimal stock allocation/rationing decisions when products in stock are insufficient to meet demand from facilities; and insufficient resources for transport at the regional level. • Very limited capacity for reporting on and analysis of stock-out despite having adequate paper-based and electronic tools to do so. 	<ul style="list-style-type: none"> • Properly maintain the new power back-up system to ensure that unpredictability of the power supply at the CMS warehouse no longer interferes with proper environmental control of stored products. • Strengthen CMS' capacity to have full inventory control of all commodities, not just tracers, to avoid stock-outs and wastage, and optimize its storage space. • Put a stock-out tracking system in place and institutionalize regular analysis of data from that system. • Follow short- and medium-term recommendations for storage space optimization and capacity increase from the Global Fund-funded storage capacity assessment report. • Strengthen CMS' capacity to timely create, track, and use a list of backorders of unfilled items to systematically send information to regional medical stores and facilities on when stock is expected or when the items are restocked. • Strengthen the national drug therapeutic committee's capacity to lead the development or revision of the criteria used to select tracer versus non-tracer commodities and its dissemination among all levels of the public supply chain in collaboration with the National Pharmaceutical Services, and the public health programs. • Until fully integrated under one quantification process across all funding sources, encourage donors and public health programs to timely share their respective supply plan with the CMS to avoid late notice of shipment arrivals that could affect storage availability for new inventory. • Clarify transport agreement between the Ministry of Health and Riders for Health regarding the provision of drug distribution logistics support from CMS to regional medical stores to health facilities. Revise Riders' contract terms to provide CMS greater access to and oversight of route planning and execution.

Area	Key Findings	Recommendations
<p>Appropriate Use</p>	<ul style="list-style-type: none"> • Roles and communication channels among the Gambia Pharmacy Council, Medicine Control Agency, National Pharmaceutical Services, and other professional councils are overlapping and often unclear. This affects the ability to address drug usage issues at health facilities such as compliance to rational drug use. • Compliance to rational drug use is not enforced at any level of care. • No agency is clearly designated for monitoring drug dispensing at any level of care; there is little routine monitoring of compliance with treatment standards and guidelines. • The Gambia Pharmacy Council is a regulatory body; it has no role in the quantification process. 	<ul style="list-style-type: none"> • Assess current roles and communication structures and guidelines for the Gambia Pharmacy Council, Medicine Control Agency, and National Pharmaceutical Services; revise as needed to rationalize and clarify roles and communication. • Put in place a routine monitoring system for compliance with national treatment standards and guidelines. • Encourage all four professional councils (pharmacy, medical and dental, nursing and midwifery, and public health) to discuss and timely act on cross-cutting issues within their purview, including preventing irrational use of drugs at all levels of care. Establishing responsibility for control and enforcement of drug-dispensing and prescribing practices in health facilities through drug therapeutic committees is essential. • Strengthen the Gambia Pharmacy Council's capacity to participate in annual quantification processes by determining adequate courses of action when evidence is presented showing that poor compliance with prescribing and dispensing standards is affecting drug usage and dispense-to-user consumption data.

Area	Key Findings	Recommendations
LMIS	<ul style="list-style-type: none"> • Systematic monitoring of consumption is limited to tracer drugs. • Hospital have improved their reporting to the national health management information system on drug consumption. However, periodic gaps in completeness, accuracy, and timeliness still occur. • Reporting capacity on and analysis of stock-out information across the entire supply chain system has been historically poor. The definition of “stock-out” was recently updated to comply with international standard. • Facility staff in charge of completing stock cards have inadequate training on stock management. • Facility staff are overburdened. Often, they are providers, prescribers, dispensers, and storekeepers at the same time. 	<ul style="list-style-type: none"> • Prioritize training on stock management for facilities without data clerks and a history of misreporting. • Prioritize for further supervision visits hospitals found to lapse in reporting consumption data. • Monitor dissemination and impact of the newly updated stock-out definition to ensure it leads to improvement in reporting of stock-outs. • Strengthen the LMIS unit’s technical capacity on and analysis of stock-out information. • Build a reporting mechanism on the definitions of stock-out developed by WHO with a standardized descriptive list of reasons of stock-outs. • Make the reporting of stock-out causes mandatory across all supply chain levels. • Develop, provide training on, and implement a comprehensive public health supply chain performance monitoring plan used for regular reporting to hold all actors accountable.

3 Health Financing

The objective of this component of the health system assessment is to assess the degree to which health financing systems are specifically designed to “provide all people with access to needed health services (including prevention, promotion, treatment, and rehabilitation) of sufficient quality to be effective; [and] ensure that the use of these services do not expose the user to financial hardship (WHO, 2000).” This objective is consistent with a commitment to universal health coverage.

With World Bank support, the government of The Gambia recently initiated a process to consider the feasibility of a national health insurance scheme in the context of a broader process of examining health financing sector needs. When this assessment was conducted, the MOH was developing terms of reference for that process and seeking a consultant to lead it.

3.1 Profile of Health Financing

Overview

Major financing for public sector health services in The Gambia relies on program-based budget allocations to the MOH from the National Treasury’s general tax revenue base. Additional resources are collected through a systematic set of user fees most of which are centralized to a Drug Revolving Fund (DRF) which are officially available to supplement the MOH’s pharmaceutical products budget. (See Section 3.3 for additional information about the DRF.) Few health resources, public or private, are channeled through risk-sharing pools such as health insurance schemes; less than 4 percent of the population is covered by a health insurance scheme. Use of private health services is low, estimated at less than 10 percent, and is mostly concentrated among populations in the economically more advanced Banjul capital area and the West Coast region.

According to the World Bank’s World Development Indicators 2019 database, in 2014, 15.3 percent of total government of The Gambia expenditures were spent on health, higher than the 15 percent Abuja target (see Table 12). However, according to the most recent National Health Accounts (NHA) data, this indicator by 2015 had declined to 7 percent of total government of The Gambia expenditures, a ten-year decline of more than 50 percent. According to the NHA, out-of-pocket expenditures on health have been trending up, rising from 17 percent in 2013 to 24 percent in for 2015. External sources comprised 36 percent of total health spending, of which 32 percent was contributed by international donor organizations.

On the measure of per capita spending on health, Gambia compares well to WHO’s \$112 estimate of the level of health spending needed in a low-income country to achieve the SDGs for health (Stenberg, 2017). The Gambia however falls well below the Africa regional average total health expenditures per capita.

The government of The Gambia strategy is provide universal healthcare access to all citizens by 2020 through seven health regions and in line with the Local Government Act of 2002.³⁰ Strategic objective 6 of the *Gambia National Health Sector Strategic Plan* is to have in place “an effective, efficient and sustainable financing mechanism by 2020 (The Gambia, 2014a, 80).” As is the case for the government of The Gambia in most sectors, reaching its health financing objectives will be challenged by the country’s poor macroeconomic conditions, inherited the current government from the preceding government which had been in place for more than two decades. National debt is at 105 percent of GDP, of which only about 2

³⁰ Local Government Act (Amendments) – Sections 1-23, The Gambia, NO.5 of 2002.

percent can be restructured (World Bank, 2018a). Bank lending rates for investment have been decreasing recently but they remain at about 17 percent. These macroeconomic issues will hamper achievement of the government’s ambitious economic development objectives and thwart GDP growth, thus limiting growth in public budgets.

Table 12. Health Financing Indicators in The Gambia and the Africa Region

Indicator	Gambia		WHO Africa Region	
	Number ^{1,2}	10-year % change	Number	10-year % change
Total health expenditures as a % of GDP	4.68%	+47.8%	6.0%	+3%
Percent of government budget allocated to health	7%	+17.3%	10.1%	-5%
General government expenditure on health as a percentage of total health expenditure	32.78%	+19%	43.3	+10%
Per capita total health expenditures (international \$)	\$118 ³	+73%	\$228	+42%
Out-of-pocket expenditures as a % of total health expenditures	24.42%	-16.9%	34.5%	+15%
Private insurance and private employer contributions	6.34% ⁴			
External resources for health as a % of total health spending	36.45%	+132%	9.6%	+55%

¹ Gambia Health Accounts (NHA): National Health Expenditures for Financial Year 2015. NHA Core Team, 2019. Alternate estimates for these health financing indicators include the 2019 World Development Indicators dataset; the two sources do not align. Disparities across sources exist for other health sector indicators; identifying and reducing such disparities is a subject of interest by the MOH.

² Total health expenditures are the sum of data rows 3, 5, 6, and 7.

³ World Development Indicators 2019 dataset for the year 2014.

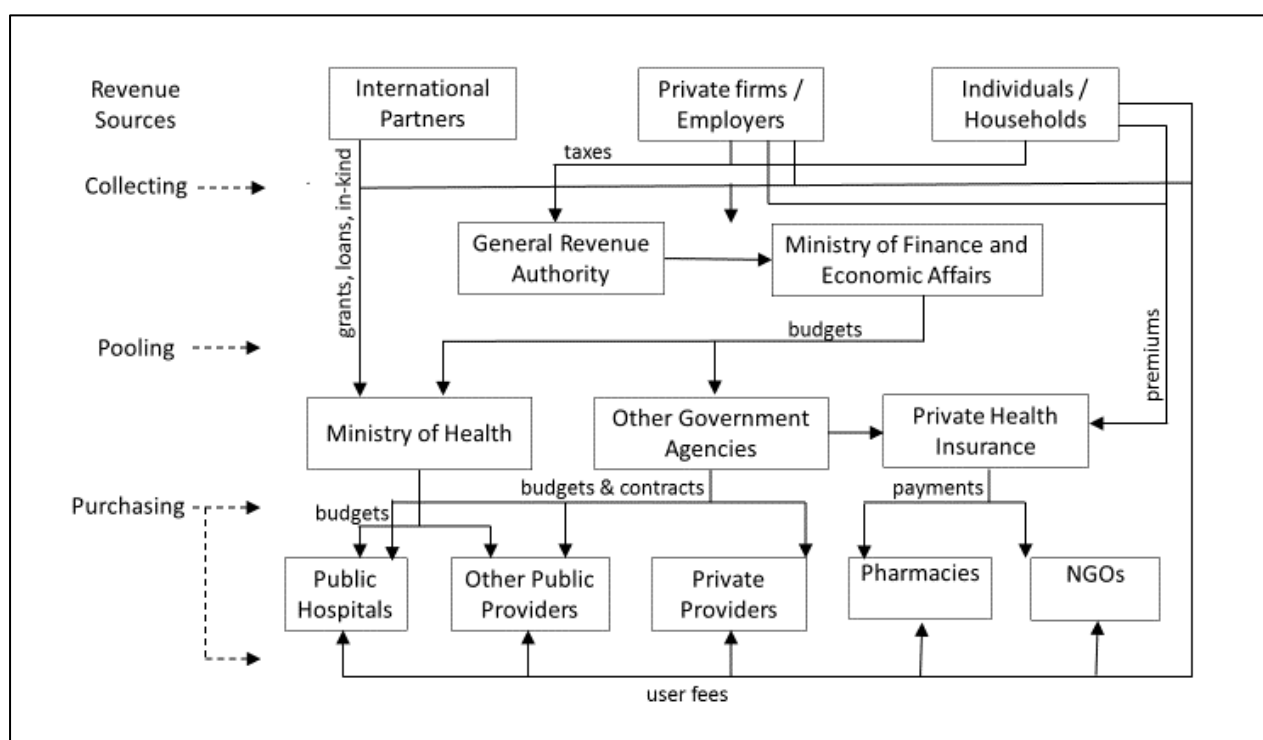
⁴ In The Gambia’s NHA 2015 report, private insurance and private employee contributions to health spending are presented as distinct from out-of-pocket expenditures.

Flow of Resources for Health

Figure 9 shows how funds flow through The Gambia’s health financing system. The three major sources are the following:

- Tax-based funds from the National Treasury, housed within the Ministry of Finance and Economic Affairs (MOFEA), flow to the MOH and other government agencies that operate health services (mostly police and military agencies, and prison health services). An estimated 33 percent of total health expenditures are sourced from tax-based funds. Salaries and emoluments for civil service health workers do not flow through the MOH; they are managed by the Personnel Management Office within MOFEA and are paid directly by the National Treasury.
- International partners provide a substantial proportion of total health expenditures, most of which flow through the MOH through a special account within the MOH and managed separately from the account through which National Treasury funds are channeled.
- Out-of-pocket spending by individuals and households account for the about one-fifth of total health expenditures, which flow through the system as user fees for public sector health services, direct payments to private healthcare providers and pharmacies, and to a limited degree, as premiums for private health insurance plans.

Figure 9. Health Financing Flowchart for The Gambia



Revenue collection

In order of importance, revenue collection sources are central government general taxation, multi- and bi-lateral international partners, and out-of-pocket expenditures (through user fees at public health facilities and payments to private healthcare providers and pharmacies). A small amount of revenue is collected from employers (mostly in the private sector) and individuals as health insurance premium payments. The Local Government Act of 2002 enacted decentralization and allows regional governments to raise their own resources. However, lacking a substantial tax base with their taxing authority eroding since enactment of the Act, regional governments' revenue-generating potential is low and few local resources are allocated to health.³¹

Resource pooling

Pooling is accomplished primarily through budget allocations to the MOH and other government agencies that provide health services (e.g., police and military agencies, and prisons) to defined populations. The NHSSP calls for pooling of international partner resources through a sector-wide approach. International partners have not, however, endorsed a sector-wide approach arrangement. Instead, some international partners—mostly multilateral agencies, including the Global Fund; Gavi, the Vaccine Alliance; the United Nations Children's Fund, the United Nations Population Fund, and WHO—channel funds through a separate MOH budget account that is disbursed under co-management terms by the MOH and contributing international partners. Bilateral international partners contribute a small percentage of resources for the health sector and most do not participate in this pooling arrangement. Most user fees collected at public health facilities are centralized to the national Drug Revolving Fund managed at the National Treasury. Some user fees, for instance those collected at public health facilities designated as a Bamako Initiative Health Center and those participating in a results-based financing initiative, are

³¹ Based on interviews in Lower River and Western 1 Health Regions and with officials at the Ministry of Community Development and local government, March 2018.

pooled and used at the health facility level. As noted earlier, only 4 percent of Gambians are covered by a health insurance scheme and pooling through insurance premium collection is minimal.³² In its *National Health Financing Policy 2017-2030*, the MOH acknowledges that, “[t]he contribution from direct out-of-pocket payments....for health goods and services do not go through any resource pooling and risk-sharing mechanism... there is no social health insurance in the Gambia (The Gambia, 2017d).” A new health financing strategic plan, the *Gambia National Health Financing Strategic Plan 2019-2024*, has been produced and validated, and is expected soon to be officially approved and adopted to guide ongoing health financing reforms.

Purchasing

Most health services are “purchased” through allocations fragmented across central government agency budget line items and programs which in sum fund services provided at health facilities. Civil service health worker services are likewise purchased through the MOFEA personnel management office through salary and emoluments payments. Funds for medical products and supplies are allocated to the Gambia Public Procurement Authority (GPPA) for purchasing. Facilities construction and maintenance budgets are allocated and managed separately. The MOH purchases some services through outsourcing contracts such as for distribution of drugs and supplies and for central MOH transportation needs. Under a results-based financing scheme, the MOH contracts with health facilities at the local level to provide population coverage for specific health services. The health facilities are paid by the National Nutrition Agency for achieved and verified results. As part of the results-based financing program, the MOH also contracts with the village development committee and the village support group to provide health information and education services. In the limited, private health insurance market, schemes (noted above) largely purchase services on a fee-for-service reimbursement basis.

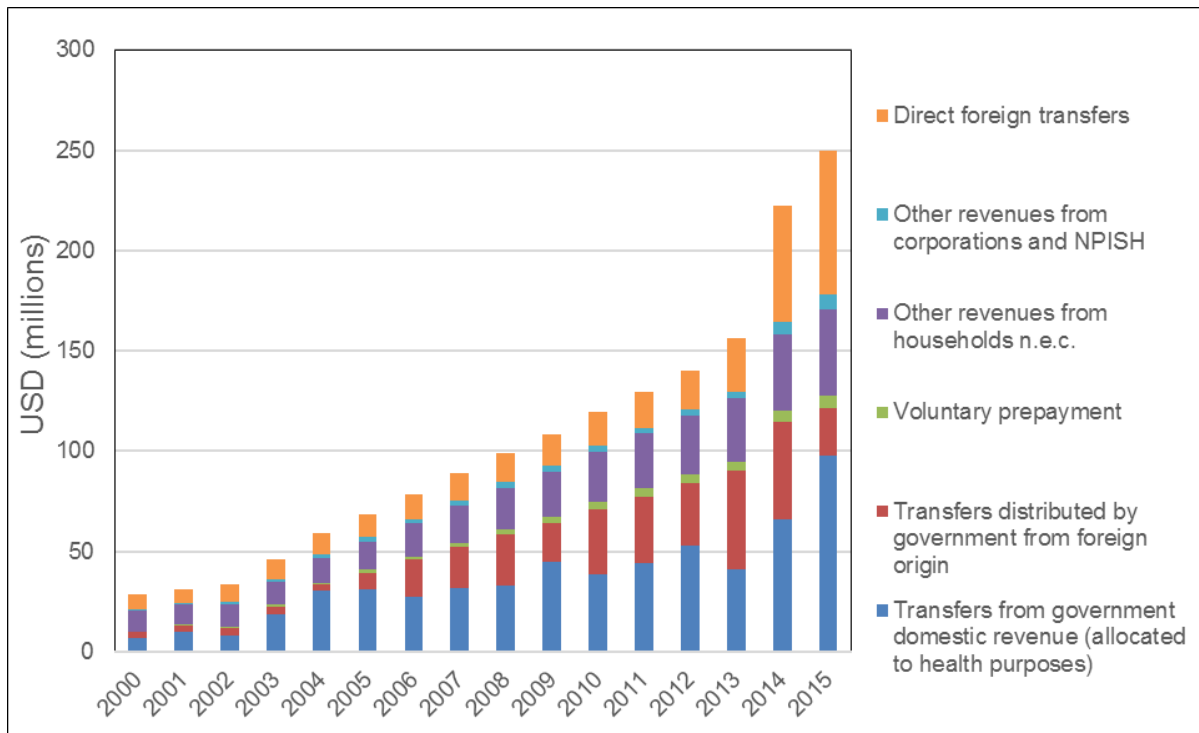
Each of these three financing dimensions is discussed in the sections below.

3.2 Amount and Sources of Financing

Health spending in The Gambia has been trending up, outperforming Africa regional averages (see Table 12). Figure 10 shows the continuous rise in total health spending since 2000. (See Annex 1 for equivalent figures in Gambian dalasi as provided to this assessment team.) The increase is observed across nearly all sources of funds. An exception is “voluntary prepayment,” which represents the small share of total spending derived from health insurance premiums paid; that source remains very small. While funds sourced from international partners also have continued to increase through 2015 (the period through which data were made available to this assessment team), there has been a notable shift in how partners have spent these funds. Before 2014, the share of internationally sourced funds spent through government channels generally outweighed the share spent through nongovernment channels. Beginning in 2014, an increasing share of internationally sourced funds was directed towards nongovernment channels.

³² Health Financing Unit staff also described the existence of self-financing insurance schemes. These are mostly state-owned enterprises that allocate funds from their operating budgets to reimburse private providers for services provided to their enrolled beneficiaries—employees and covered dependents.

Figure 10. Sources and Amount of Funds in The Gambia's Health Sector



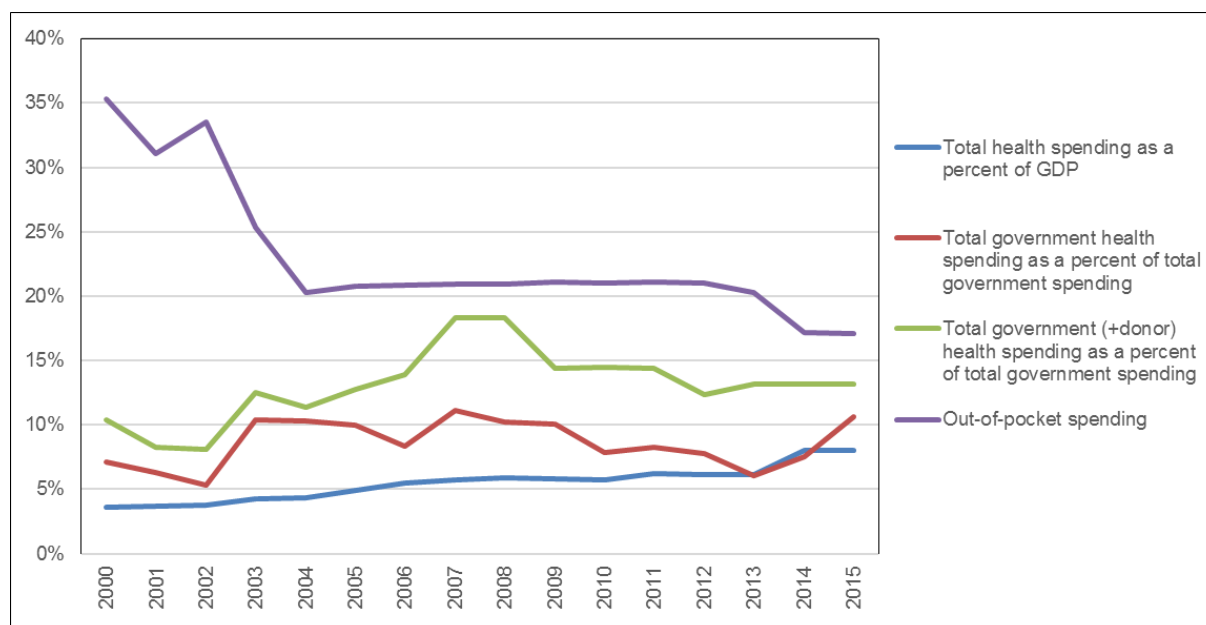
Source: Health Financing Unit, Directorate of Planning and Information, Ministry of Health and Social Welfare. Data provided May 2018. Figures converted from NGD to US\$ at each year's prevailing exchange rate.

Figure 11 compares government of The Gambia health spending to total government spending and to GDP. As a proportion of GDP, health spending rose steadily through 2008 when it reached almost 6 percent. It remained nearly level through 2013 when total health spending was still just 6.1 percent of GDP. It rose sharply in 2014 to 8 percent and remained at that level in 2015. Total government spending on health, excluding internationally sourced funds, as a proportion of total government spending shows an erratic pattern. It rose to and remained mostly above 10 percent between 2003 and 2009. In 2010 it fell considerably and hovered around 8 percent between 2010 and 2012, falling considerably again in 2013 to just 6 percent (a low not observed since 2002). It has since recovered, passing the 10 percent mark again in 2015. As a proportion of health spending channeled through the government of The Gambia, international partner funds have played an important though uneven role, falling from 31 percent in 2000 to just 9 percent in 2004. International partner funds rose steadily from 2005 to 2008 when they reached 45 percent of health funds channeled through the government of The Gambia. The share of government spending on health derived from international sources mostly remained high from 2008 forward, though it has fallen back to 19 percent in 2015.

Government spending in The Gambia on health from its own domestic budget resources began a six-year decline when international partner funding reached its peak in 2007-2008. Key informants for this assessment did not indicate whether the high level of international partner funding produced a displacement effect on government health spending. Regardless, international partner funding played an important role in maintaining the resource base for publicly funded health programs and services in The Gambia during the difficult years (2008 to 2013) of declining government allocations to health as a proportion to total government spending. At the end of the period shown (2015), government spending on health as a proportion of total government spending had returned to its previous high of over 10 percent and international partner contributions receded to 19 percent. As noted earlier, the balance in use of international partner funds has recently shifted from direct support to the public

sector through public budget channels to international partner-managed spending of its own resources (see Figure 10). The MOFEA reports that for 2017, health and education budgets were protected from budget austerity measures applied to nearly all other government agencies. According to MOFEA, official budget figures underestimate total government resources devoted to health because they do not include extra-budgetary allocations made for health emergencies.³³

Figure 11. Health Spending in The Gambia Compared to Total Government Spending and GDP



Source: Health Financing Unit, Directorate of Planning and Information, Ministry of Health and Social Welfare. Data provided May 2018.

Among key informants for this assessment, there was a consensus that despite the overall positive trends in public resources allocated to the health sector, the sector remains considerably underfunded. As evidence, they noted a cost analysis found that GMD 4.5 billion would be necessary for full implementation of the basic health care package in 2017. Comparing this figure against total government and international partner sourced health spending, the gap between the estimated basic health care package cost and available resources is more than 40 percent. Considering that only 20 percent of MOH funds are devoted to primary healthcare, the gap is likely larger (The Gambia, 2017b). The gap is closed by a combination of out-of-pocket spending and under-provision of services.

According to official figures, out-of-pocket health spending declined sharply between 2000 and 2004 from more than 35 percent to 20 percent of total health spending, then remained steady until 2013. It declined to 17 percent in 2014 and remained there in 2015. It is perhaps noteworthy that in 2015 the MOH sharply increased its schedule of user fees charged at public sector health facilities. This increase does not appear to have had a substantial impact on measured out-of-pocket spending, perhaps because the bulk of out-of-pocket spending by households occurs in response to drug shortages in public sector health facilities, requiring them to purchase medicines from private pharmacies, and only a small proportion is spent for user fees.

³³ MOFEA interview, March 1, 2018. These extra-budgetary allocations should be captured by National Health Accounts analyses; it is not clear whether the latest completed National Health Accounts (2013) includes these allocations and MOFEA did not provide an estimate of such allocations.

3.3 Pooling and Financial Protection

Resource Pooling

Government-mediated spending on health comprises more than two-thirds of total health spending. Government-mediated spending includes both domestically sourced funds (from tax revenue) and funds from international partners channeled through the MOH. No social insurance scheme exists (even for civil servants) and private health insurance constitutes less than 4 percent of all health spending in the country. Consequently, most resource pooling occurs in the form of budget allocations to government agencies managing the health system and providing services. Major pools for government resources are the following:

- **The MOH:** The MOH receives the largest share of government funds for health. Two major pools exist within the MOH. One pool comprises funds from government domestic revenue collection. These funds are transferred from the National Treasury through MOFEA to the main MOH budget account. The domestic resource pool is further sub-divided into five major program pools and in turn, each of these is further subdivided among the 10 health directorates (see Section 1) and their program units. Most hospitals also have separate subventions (spending account pools).³⁴ There is significant autonomy at this lowest program level in spending decision making. According to many informants for this assessment, there is little coordination and communication among programs.³⁵ Some informants say the small program unit pools contribute to low effectiveness of resource use (World Bank, 2018a). The second pool is also an account within the MOH; pool contains resources transferred from international partner organizations. It is managed separately from the domestic resources pool by joint decision-making authority by designated MOH leaders and by representatives from contributing international partners.

While government budget allocations for health have for the most part been trending up (see Figure 11), there is broad consensus that they fall far short of resource needs. One interviewee stated that, for example, the total amount budgeted in 2017 for pharmaceutical supplies (approximately US\$2.5 million) was far from sufficient to meet the funding needs. (This interviewee was, however, unaware of any estimates for what that total need would have been.) Products supplied for programs such as tuberculosis, HIV and malaria that have significant international partner support come closer to need. Another interviewee referenced a cost analysis completed for the basic health care package. That analysis estimated that full implementation of this package would have required a budget allocation to the MOH of GMD 4.5 billion (approximately US\$95.7 million) in 2017. Considering that total spending on health in 2015 (the latest year for which expenditures data was provided to this assessment team) was just GMD 3.2 billion and considering that the MOH estimated that it spends just 20 percent of its domestically sourced funds on primary healthcare, it is clear the gap is large.

- **Other government agencies:** These include the Department of State for Defense overseeing health services the Gambia National Army, National Guard, and the Navy and dependents; and the Ministry of the Interior overseeing some health services for the Gambia police force and dependents, and the Gambia prisons services. Information was not obtained on the size of these pools but given their limited services population reach, they are small.

³⁴ Not all officially designated hospitals have subvented budget pools. Interviews at the two health regions visited described major health centers that have recently been recategorized as hospitals but have not been afforded budget subventions as required by regulation.

³⁵ Interviews with technical advisory council members and regional health directorate heads in Western 1 and Lower River health regions.

- MOFEA's personnel management office: All resources for public sector health system employees' salaries and other emoluments (as for civil servants in all sectors and government agencies) are pooled in this agency and paid directly to staff by the National Treasury.
- Gambia Public Procurement Authority (GPPA): All resources for purchasing pharmaceutical products and other supplies and equipment for the public health sector are pooled in this agency, in compliance with regulations.
- National Drug Revolving Fund (DRF): Most fees paid by consumer for services received at public sector health facilities services are centralized to the DRF, which is housed at the National Treasury in the capital (Banjul). These funds are accounted for separately but comingled with general funds at the National Treasury. Officially, these funds are to be made available upon request from the MOH for pharmaceutical products procurement. According to one MOH informant, in 2017 the equivalent of US\$2.5 million was allocated from the DRF for this purpose. Officially, local governments are also entitled to access to DRF funds upon a formal request. However, most requests are reported to either be denied or ignored. MOH interviewees were unable to provide any accounting information about central DRF receipts or expenditures; this assessment team was informed that such reports are not routinely produced or circulated by the DRF managers. No DRF personnel were available to meet with this assessment team during its field data collection visit.
- Facility-based revolving funds: Any health center designated as a Bamako Initiative Health Center and health centers participating in the results-based financing initiative (managed by the National Nutrition Agency) are permitted to retain a portion of the user fees collected at their respective facilities. Hospitals retain all user fees collected at their respective facilities. Central-level MOH planners were unable to provide information about the magnitude or the use of these facility-based resource pools. Catchment area committees are supposed to oversee use of retained user fee revenue, but it is not clear how involved these committees are in planning and oversight for use of those funds. All other health facilities must transmit all user fees to the regional DRF manager, who in turn transmits funds aggregated across all health facilities in the region to the central DRF.
- Several stakeholders reported that there is a pool of funds set aside for healthcare services provided outside of The Gambia to Gambian citizens for services not available in The Gambia. Informants were unable to provide information or guidance to documents to ascertain who is eligible to tap this funds pool, the magnitude of the pool, or for what services the pool pays.

There is no social health insurance currently in The Gambia, though the current national health policy framework supports its introduction. In many countries, civil servants are among the first to be covered by social health insurance. In The Gambia, civil servants are entitled to seek services at public sector health facilities, on par with the rest of the population. Commercial insurance-based risk pooling schemes cover few Gambians; according to 2013 NHA data, expenditures through health insurance schemes comprised less than 5 percent of total health spending in the country.³⁶ The NHA 2013 data show separate expenditures pools for employer-based voluntary health insurance schemes (91 percent of health insurance expenditures), compulsory (both government and private) health insurance schemes (7 percent of total expenditures on health insurance), and government-based voluntary health insurance schemes (3 percent of the total).

³⁶ National Health Accounts 2013 Excel data file provided by MOH Directorate of Planning and Information, Health Financing Unit, May 2018.

Great Alliance is the dominant private company underwriting health insurance plans in The Gambia and only two or three other companies participate in that market. Minimum capital requirements for entering the insurance market are said to be difficult to meet and to maintain, thus presenting a barrier to entry of new firms into the insurance market. The pool of consumers able to pay premiums limits the size of potential risk pools, making health insurance a generally unattractive business market as well. The smaller compulsory and government-based voluntary insurance schemes mostly cover employees at parastatal organizations (such as the National Water and Electric Company).³⁷

Financial protection

Other than the very small private health insurance market, there are no formal mechanisms to protect Gambians from catastrophic health costs. Furthermore, no interviewees were able to identify analyses or data relevant to these topics. International researchers have described data from The Gambia on this topic as inadequate to assess catastrophic spending on healthcare (Wagstaff, 2018; WHO and World Bank, 2017a). Key informants interviewed for this assessment uniformly stated that the present system offers adequate financial protection to Gambians. Most cited what they consider to be affordable user fees that have been lowered in recent years, though further evidence was not cited. Interviewees also acknowledged that drug stock-outs were common in public sector health facilities (see Section 2, Medical Products) and that while out-of-pocket spending by households is not well documented, there is reason for caution in concluding that financial protection from health expenditures is satisfactory.

User fees

Though this assessment found no formal studies on the affordability of the current structure of user fees in place, and no interviewee was able to cite an evidence base on which user fee levels have been set, most interviewees stated the current structure and level is affordable even for poor Gambians. The basic consultation fee is GMD 25 (approximately US\$0.50); this fee entitles the user to the consultation as well as any medicine prescribed at no additional cost. This consultation fee is the same at health centers and hospitals (contributing perhaps to overuse of hospital outpatient clinics for primary healthcare services). While this fee entitles users to consultation and medicines, stock-outs are said to be common and there are no provisions for reimbursing users consequently required to purchase prescribed medicines from private pharmacies.³⁸

The picture on the left in Figure 12 shows a chart of user fees observed on wall of the inside of a client consulting room at a major health center (recently reclassified as a district hospital). It is transparent from the perspective of the comprehensiveness of the content. Its detail and placement in the health facility may pose challenges to the average client. The picture on the left provides information about user fees for a range of laboratory tests. The laboratory fee schedule was provided by staff at the DPI Health Financing Unit; it was not observed at the health facilities visited. As shown in both pictures, separate rates are clearly shown for Gambian and non-Gambian clients. Also noted on each schedule are some groups and services for which fees are waived. There are no formal exemptions from user fees based on ability to pay, though interviewees did state that health facilities have the discretion to waive them on a case-by-case basis. Two different interviewees stated that user fees were waived for as many as 5 percent of users based on an ad hoc assessment of the client's

³⁷ The National Water and Electric Company's health insurance scheme is self-financed; it does not contract with an external health insurance underwriter.

³⁸ Though interviewees were not able to provide information on the occurrence of drug stock-outs, they are said to be common and drug purchases from private pharmacies after consultations at public sector health facilities are said to contribute to a large proportion of out-of-pocket spending. No formal evidence was available either on the contribution of such pharmacy purchases to total out-of-pocket expenditures by consumers.

inability to pay the applicable fee; no interviewee was able to describe the criteria applied for such on-the-spot exemptions.

By national policy, maternal health services and services provided to children under age 5 are universally exempt from user fees at public sector health facilities, as are laboratory services for all children under age 15. Tuberculosis and HIV services are also exempt from user fees (services are largely financed by international partners).

Figure 12. User Fees for Public Sector Health Services in The Gambia

TEST	GAMBIAN	NON GAMBIAN
Hemoglobin	D50	D100
Packed Cell Volume (PVC)	D50	D100
WBC	D50	D100
Sickle Test	D50	D100
Blood Group	D50	D100
Urine dipstix	D50	D100
Urine Microscopy	D50	D100
Stool Microscopy	D50	D100
VDRL/RPR	D50	D100
Blood Glucose	D50	D100
Blood Grouping	D50	D100
Thick Blood Film	D50	D100
CROSSMATCH	D200	D400
BLOOD SUGAR	D50	D100

** NO CHARGES FOR GAMBIANS UNDER THE AGE OF 15YRS

Note: Exchange rate at the time of this assessment: GMD 47 = US\$1

Additionally, all military and police personnel, and their families, are exempted from all user fees for all services provided in public sector health facilities. This exemption is considered by many in the health sector to be inequitable; the exemption does not apply to any other civil servant. Extending such a blanket waiver to health workers and perhaps to all civil servants was said to be under consideration, though no formal policy dialogue or reform action was identified during this assessment. Similarly, according to key informants, there is no policy movement beyond informal discussions about extending the general waiver policy to poor households, even though close to half of The Gambia’s population is defined as poor.³⁹ One explanation given for slow movement on such changes to user fee exemption policy is the socially sensitive challenge of defining “immediate family” to which such exemptions would apply at the household or family level.

The practice of charging informal fees was acknowledged to occur by interviewees for this assessment, though none was able to identify any figures or information source on its extent. A 2015 impact evaluation found that household respondents reported charges being assessed for services to pregnant women and children under five despite the blanket exemption policy in place for these population groups (World Bank, 2015). In the context of frequent medicines stock-outs at public sector health facilities, it is reasonable to expect that some of these reported out-of-pocket expenses may be related to consumers’ need to fill prescriptions

³⁹ According to informants, the issue was raised at the December 2017 Joint Annual Health Sector Review convened by the MOH.

at private pharmacies. The user fee exemption policy does not include provisions for free consumer alternatives when stock-outs occur. During a health center site visit by this assessment team, one respondent reported that informal fee charging is more common for certain lower-frequency services such as ambulance transportation and autopsies for death certificates.

Out-of-pocket spending

The NHAs are the most often cited reference for out-of-pocket spending on healthcare, the most recent report in 2019 covered the year 2015. That analysis estimated such spending to be 24 percent of total health expenditures.⁴⁰ According to figures published in the MOH's *National Health Financing Policy 2017-2030*, this 2015 estimate was an increase from 9 percent in 2004 (The Gambia, 2017d). Some key informants for this assessment expressed skepticism about the NHA estimate. Interviewees stated that NHAs most likely underestimate out-of-pocket spending by half. Corroborating evidence that out-of-pocket spending is most likely much higher than NHA estimates is the existence of widespread stock-outs of medicines at public sector health facilities, requiring a high out-of-pocket spending. In one report on out-of-pocket spending reviewed by this assessment team, per capita spending on healthcare for a four-week period in 2014 was GMD 208.5 (Njie et al., 2014). This expenditure would have been nearly 15 percent of per capita income; thus, out-of-pocket spending on healthcare as a percentage of total health expenditures was likely more than the proportion reported in the NHA.⁴¹ Little additional evidence about out-of-pocket was identified by this assessment team. It is clear however, that reducing out-of-pocket spending is a public policy priority for the health sector (The Gambia, 2017d).

3.4 Purchasing

Public sector budgets

As noted earlier, most health services in The Gambia are purchased through MOH's annual program-based budgets. "Purchases" are inputs based on program-by-program budget build-ups during the government of The Gambia's annual budget development process (see Section 3.5). Services are paid by line items in each program's budget allocation. Other than for procurement of medical products, supplies, and capital expense items, there are no results or outputs-based payment provisions in the current MOH purchasing systems for health services. The exception is the results-based financing pilot underway through the National Nutrition Agency, described below.⁴² Additional services are similarly purchased for program inputs through off-budget supplemental funding allocated to the MOH for public health emergencies such as epidemic outbreaks.

Results-based financing

The Maternal and Child Nutrition and Health Results Project, supported by the World Bank, is the first results-based financing initiative implemented in The Gambia. This ongoing project is implemented by the National Nutrition Agency and it is the first effort to expand purchasing arrangements for public sector services beyond program-based budgeting. As indicated by the project title, this arrangement pertains only to maternal and child (under

⁴⁰ NHA 2015 data provided by the MOH Directorate of Public Information, June 2019.

⁴¹ This was computed as follows: annualized GMD 208.5 spending per capita for a four-week period equals GMD 2,710.5. Average per capita income in The Gambia in 2014 was reported to be GMD 18,131.55 in current local currency units (source: World Development Indicators database, 2017). $2,710.5/18,131.55 = 14.9$ percent.

⁴² The National Nutrition Agency was recently created as a semi-autonomous agency formed specifically from units within MOH and the Ministry of Agriculture to implement the Maternal and Child Nutrition and Health Results Project, supported by the World Bank.

age five) services. Other services provided by participating health facilities are not covered by this initiative. Incentive payments are made to both participating health facilities and to village support groups based on verified performance against pre-determined service delivery targets and for various health promotion community activities. Sixty percent of facility-based performance payments must be spent to improve facility conditions and to maintain adequate stocks of essential medicines and supplies. Forty percent is permitted to be spent for staff incentive payments.⁴³ At the time of this assessment, this results-based financing initiative was being implemented in nearly one-quarter of all health facilities in the project's five implementation regions (nearly 20 percent of all health facilities nationwide).⁴⁴ Project plans include further rollout to reach 600 facilities (one-third of all facilities nationwide). After two years of achieving facility and service quality improvement goals, participating facilities graduate and revert to MOH program-based budgeting for maternal and child health services. Thereafter, purchasing of maternal and child health services at graduated facilities reverts to the MOH program-based budgeting approach.

According to key informants interviewed for this assessment, including implementers at the National Nutrition Agency, the results-based financing initiative has shown promising results toward increasing access to and use of health facilities by the target population groups and improving health outcomes. Other than a World Bank document, the assessment team was unable to identify published evidence to confirm this widely expressed belief about the National Nutrition Agency's program (Medhin, 2016?). Some within the MOH are in favor of moving MOH purchasing arrangements away from program-based inputs budgets to results-based financing mechanisms. Though questions remain, there is consensus that results-based financing has improved the quality and readiness of health facilities, particularly health centers, and has restored trust among communities in the services rendered at those facilities. Interviewees said that results-based financing thus has the potential to increase the proportion of spending devoted to primary healthcare, a major goal of the MOH, and to contribute to the goal of shifting demand for primary healthcare services away from hospitals and back to the primary care level.

Other purchasing arrangements

There is limited use of contracting in the MOH's service delivery network. The notable use of contracting is for transportation services. Riders for Health is contracted to transport pharmaceuticals and medical supplies to the MOH network of health facilities; it also provides transportation services to MOH staff for attending meetings and other symposiums as required in their line of duty.

Private, commercial health insurance schemes in The Gambia purchase services on a fee-for-service basis. Health Financing Unit interviewees described numerous challenges to insurance-mediated purchasing arrangements, including control of benefits use by non-enrolled persons (usually extended family members not included on the scheme's "immediate family" enrollees list), over-provision and over-billing of services by providers, and ineffective claims verification. Some insurance schemes attempt to control costs by placing limits on the maximum value of benefits that can be claimed for an enrolled beneficiary and her/his family unit. The MOH Health Financing Unit staff have little knowledge of the benefits packages offered through these private insurance schemes

A substantial proportion of out-of-pocket spending by consumers is through direct purchase of health goods and services. It is estimated that less than 10 percent of all healthcare services provided in The Gambia are from private providers. However, given extensive

⁴³ Participating health facilities also continue to receive their usual inputs from the routine MOH budget arrangements.

⁴⁴ The results-based financing initiative is not implemented on the two better-off health regions, the national capital area of Banjul and the West Coast Region.

medical products stock-outs at public sector health facilities, consumers often purchase a large quantity of pharmaceutical supplies and medical products directly from private pharmacies.

This assessment team was unable to find evidence of the use of contracting for other MOH services and functions or for the use of vouchers for health services and we found little evidence of interest in these purchasing mechanisms at this time.

3.5 Public Sector Budget Process and Use

Ministry of Health

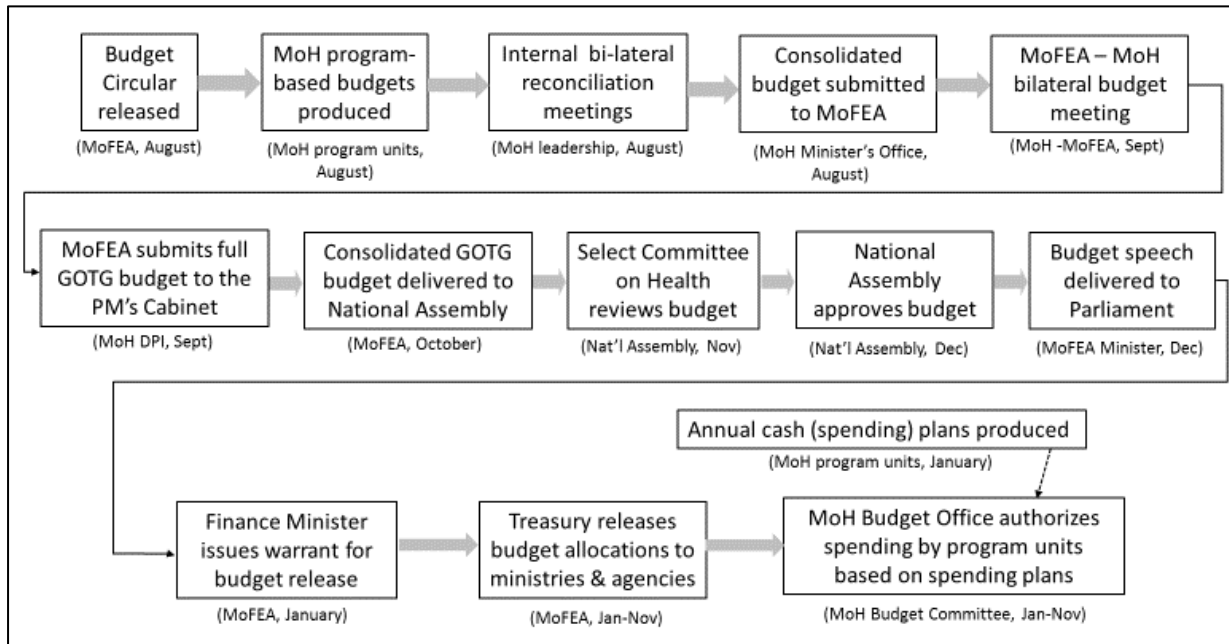
Figure 13 depicts the major steps in the MOH budget development and allocation cycle as described by the Directorate of Planning and Information Health Financing Unit. The MOH transitioned to program-based budgets in 2015. Its budget includes five main program areas: health promotion; family health; disease control; social welfare; and strategy, policy, and management. All directorates and their programs are grouped into one of these five budget program categories.

The budget process is launched in August each year by release of a budget call circular by the MOFEA to the minister and permanent secretary in each government agency. The circular sets operational and investment budget ceilings for each government agency, not including salaries and emoluments, which are managed by the personnel management office separately from agency budgets.

Within the MOH, the circular is forwarded from the permanent secretary's office to Directorate of Planning and Information. The Health Financing Unit within the directorate is responsible for internal coordination of the budget development process. The Health Financing Unit notifies heads of all directorates and programs and hospital chief executive officers of the need to begin the budgeting process.⁴⁵ Each entity is provided with the template for providing their program-based budgets and is given about two weeks to produce their budgets. The Health Financing Unit then compiles the budgets, comparing the total across all programs to the ministry's ceiling set by the circular. The Directorate of Planning and Information conducts "mini bilateral" meetings with all directorate and program heads and hospital chief executive officers to reconcile budgets with the MOH-wide ceiling. Negotiations consider MOH program and strategic priorities and these internal negotiations are generally completed in about two weeks.

⁴⁵ MOH hospitals are subvented organizational units. They produce their own budgets and are funded through transfers from the MOH budget office to bank accounts the hospitals manage.

Figure 13. MOH Budget Development and Allocation Cycle



The MOH permanent secretary submits the reconciled, consolidated budget to MOFEA around the end of August. The MOH defends its budget to MOFEA at a bilateral meeting within a week following submission. Adjustments are made as needed, after which the MOFEA submits a consolidated government budget to the Cabinet by mid-September. The Cabinet submits comments directly to MOFEA, which adjusts the budget as necessary prior to submitting the consolidated government budget to the National Assembly. The MOH does not have a role at this budget revision stage; changes based on Cabinet comments are made directly by MOFEA.

Upon Cabinet approval, MOFEA submits the consolidated government-wide budget to the National Assembly. The MOH component is reviewed by the National Assembly Select Committee on Health and any concerns or comments are raised during an open budget debate by the full National Assembly. The MOFEA revises budgets based on these comments; no formal input is sought from the MOH on this revision stage either. The MOFEA then resubmits the consolidated budget to the National Assembly for a vote which normally occurs in December. After the National Assembly votes to approve the budget, the MOFEA minister formally communicates the budget during the budget speech to the National Assembly, generally in the latter half of December. This step concludes the budget development process, after which the MOFEA minister instructs the accountant general to issue a warrant to the National Treasury to permit budget execution.

Based on the final MOH budget, the Directorate of Planning and Information oversees a budget analysis to identify program-specific and line-specific differences between what the MOH requested in its post-bilateral submission to MOFEA (as noted, MOH does not have access or input to budget revisions after this point) and the final budget approved by the National Assembly. Invariably, this analysis finds that the approved budget departs from MOH program and strategic priorities reflected in its own final budget submission to MOFEA.

Based on its budget analysis, the Directorate of Planning and Information requests a monthly cash plan from each directorate, program, and hospital. These cash plans are compiled by the Health Financing Unit. Funds are generally released by the National Treasury in monthly allotments to the MOFEA based on the MOH's annual cash plan which defines the monthly need for funds. Annual cash plans for each directorate,

program, and hospital are updated monthly based on prior year-to-date allocations and budget performance.

Upon execution of budget allocations, programs are permitted line-item flexibility for recurrent budgets. Reallocation of recurrent budgets across programs is restricted; such reallocations require MOFEA approval. While-line item flexibility is said to result in overall spending absorption rates routinely more than 90 percent, limits on cross-program flexibility is said to result in greater variation in absorption rates among programs. Absorption rates for salaries (managed by the personnel management office, outside of MOH) was reported to be close to 100 percent, raising the overall average. Absorption rates for capital budget allocations, where there is little line reallocation flexibility either within or across programs, was reported to be at best 50 percent MOH informants reported that the overall recurrent budget absorption rate, which is tracked monthly, to be about 50 percent as well; no precise figures were provided. It was not clear whether these performance rates were defined based on the approved budget or allocated fund levels as the denominator. Informants stated that the larger budget performance gap is between the budget approved by the National Assembly and funds released by the National Treasury. The gap between funds released and funds spent by MOH is said to be considerably less.

Regional health directorates

Each of the seven regional health directorates is headed by a director appointed by the prime minister's office; they report directly to the permanent secretary. Prior to the late 1990s, regional health directorates were subvented entities in the MOH budget structure and managed their own resource pool. Since then, their funding pool has eroded such that RHDs have no funds that they manage themselves. With elimination of direct subventions to RHDs, gradual retraction over the years of local government tax revenue collection authority, and a high degree of centralization of health facility user fee revenue through the Drug Revolving Fund, nearly all regional health funding is derived from various central MOH program budget pools. The central Directorate for Regional Health provides RHDs with operational material support (not funds, but rather materials such as vehicles and access to fuel depots, materials and supplies). Program units provide resources for program activities such as training and supervisory visits, and public health activities. There is no consensus among senior MOH officials interviewed for this assessment as to the need for or viability of re-establishing direct budgets for RHDs to manage as opposed to keeping the RHDs reliant on central inputs.

RHDs are required to submit annual workplans, though there is no provision to directly fund these workplans. Not having resources for implementation, RHDs respond to the workplan activities of the many central program units spread across the 10 central MOH health directorates. At present, poor regional financial planning and lack of management skills are commonly stated rationales among central ministry personnel for the highly centralized structure supporting health regions. Yet not having their own financial resources to manage erodes the regional skill base, resulting in a vicious cycle that is cited to justify the status quo. Interviewees in both health regions visited (Lower River and West Coast) , said that little effort is made to synchronize central MOH program and regional workplans and there is little incentive for central programs to do so. There is thus little programmatic autonomy or authority at the RHD level.

Public hospitals

Public hospitals are subvented organizations in The Gambia's public sector health system.⁴⁶ During this team's site visit to one hospital, neither the deputy chief executive officer nor the chief accountant was able to provide information on the hospitals most recent budget, nor were they able to provide information about user fee revenue.⁴⁷ Hospital leadership at the site visited told the assessment team that budget allocations from the MOH budget office are chronically insufficient and the hospital regularly deficit finances operations with overdrafts on its local bank account. Subsequent monthly allocations are used to balance out these bank overdrafts until the monthly allocation is insufficient to balance out the accumulated overdraft amount. At that point, the hospital seeks an emergency allocation from the MOH to pay the overdraft, after which a new overdraft cycle is initiated. Interviews with central MOH staff indicated that this hospital's budget situation is not unique. When asked about the source of central MOH funds used to balance out such hospital overdrafts, the respondent stated that the budget office decides on a case-by-case basis and that the funds may come from any "mainstream" MOH program budget depending on funds available at the time the need is raised.

3.6 Governance and Public Financial Management of the Health Financing System

As with MOH key informants, our MOFEA interviewee reported a high rate of budget allocation absorption by the MOH with small budget balances at the end of each fiscal year. MOH informants reported that public expenditures reviews are conducted on a quarterly basis by the MOH and annually by the MOFEA. This assessment team was not provided with any public expenditure review reports and was therefore not able to verify how often such reviews have been completed annually or quarterly. The MOFEA key informant did acknowledge that MOH budget and expenditure tracking and monitoring systems need strengthening. The MOFEA interviewee noted that there is a particular need to strengthen the tracking system's ability to reach down to the program level where most of the public budget spending occurs. In December 2017, The Gambia was selected as a Millennium Challenge Corporation threshold country. The selection criteria for threshold eligibility includes aspects of public financial management, indicating that at least one international agency considers The Gambia's public financial management performance to be improving.

Numerous informants for this assessment stated that current MOH structure presents considerable challenges to cross-program planning, coordination, and collaboration. Most agree that 10 health directorates and the large "proliferating and fragmented" number of programs under each directorate, coupled with non-technical leadership at the top of the structure, do not promote strong governance and lead to considerable inefficiency in resource use.⁴⁸ International partners estimate that 75 percent of MOH activities implemented were not included in workplans. Furthermore, many of these activities occur at the health region level. Regional health office staff in the two regions visited by the assessment team reported that most central program activities in their region were conducted with little advance notice and not at all in concert with RHD annual workplans.

⁴⁶ The notable exception are major health centers that have been recently redesignated as hospitals. This assessment team was informed of two instances in the RHDs visited of major health centers that have recently been redesignated as hospitals but which were not yet receiving subvention level budgets.

⁴⁷ By law, hospitals retain all user fee revenue raised at their facility and are permitted to use those funds to meet operational costs, and to purchase supplies, materials and drugs when allocations from approved subvention budgets fall short.

⁴⁸ The assessment team was unable to identify any studies or analyses that quantified the reported inefficiency.

During a group interview by this assessment team with representatives from international partner organizations, partners stated that poor access to MOH senior leadership coupled with poorly articulated plans drive them to work primarily with sub-directorate program units to implement their own workplans. MOH directorate leaders on the other hand stated that international partners do not seek out and coordinate their plans with MOH leadership, preferring to approach program units directly. The proposed Gambia International Health Partnership Plus Country Compact was intended to address some of the coordination issues.⁴⁹ The Compact was not signed by any of the 23 bilateral and multilateral international development partners, because, according to partners interviewed for this assessment, the MOH senior leadership was not successful in obtaining necessary Cabinet endorsement for the Compact.

In sum, senior MOH officials themselves describe the management environment within the MOH and between international partners and MOH as “chaotic” and inefficient

See Section 4 for additional assessment findings on health sector governance.

3.7 Research and Training

Key informants said that in general, research capacity in The Gambia is weak, particularly so for health financing. Beyond the MOH's health financing unit, there are few people with health financing research capacity and most of those are working for international partner agencies. Moreover, according to the MOH's Directorate for Health Research, most financing for health research is provided by international development partners; little domestic resources are allocated for health research and poor financing constrains development of human resource base for health research.⁵⁰

Capacity and research output are greater for health services and clinical research, however, much of this research is defined and led by external actors. Several interviewees expressed there to be low demand for research evidence in policy and planning processes and characterized that to be largely a function of the need to strengthen the culture, experience and capacity to interpret and use research output and low capacity and effort devoted to translating research into material that is digestible by policy makers and planners. Training programs at the University of The Gambia and The Gambia College integrate some research methods content into their public health curricula but research capacity among teaching staff is itself in need of strengthening.

The Directorate for Health Research was established within the MOH in 2014 when it separated off from the Directorate of Planning and Information. Four years later, the Directorate for Health Research remains understaffed (three of its four senior researchers are out of the country in degree training programs) and challenged in implementing its intended strategy of establishing topical research units in each MOH's other nine health directorates. Section 1 lists other research and training institutions and their relevance to health financing. Health financing research and analyses have to date included National Health Accounts reports (conducted by the MOH's Health Financing Unit), out-of-pocket expenditure studies (conducted by the National Nutrition Agency), costing plans (of the basic minimum health care package and other strategic plans), and budget and expenditures analyses. Beyond these, informants inside and out of the MOH were not able to identify or provide further health financing analyses and research.

⁴⁹ The Gambia International Health Partnership Plus Country Compact. MOH&SW, March 2016.

⁵⁰ Concept/Discussion Paper (Final Draft). Directorate of Health Research, MOH&SW, July 2016.

National Health Accounts

National Health Accounts analyses are a joint effort undertaken within the MOH led by the Health Financing Unit of the Directorate of Planning and Information. Other units involved include the directorate's Monitoring and Evaluation and Quality Assurance Program units, as well as the Program Management and Accounting units in the minister's office. Past National Health Accounts teams have included a health financing expert at the University of The Gambia (who has since left the university) and an NGO (Health Education, Promotion and Development Organization, assisting with mobilization of information from the health NGO sector). NHA teams have been supported with technical assistance from the health economist at WHO/The Gambia. Several analyses have been completed, the most recent covering 2013 expenditures.

Health financing experts in the Directorate of Planning and Information Health Financing Unit oversee National Health Accounts data collection and analysis. By their self-reports, challenges to completing high-quality National Health Accounts reports are insufficient financial resources to implement the process and challenges using the NHA tools, especially in managing the tools designed for data collection from international partner, commercial, and NGO sector actors. Apart from the quality of National Health Accounts 2013 output, though it is the most up-to-date available data, the results are too outdated for effective use in the health policy arena. The Health Financing Unit is currently completing analysis of 2017 data. Several interviewees for this assessment expect similar data quality concerns when results are released, again due to (1) capacity constraints in the Health Financing Unit and (2) challenges collecting data from non-MOH funding sources and funding users. Results for National Health Accounts 2015 are expected to be available in 2018; however, those results too will be outdated and less than optimal for policy formation.

Other health financing analyses

Budget analyses and public expenditures reviews are routinely conducted by the MOH Key informants for this assessment also identified a major cost analysis completed to estimate implementation costs for the Basic Maternal and Child Health Program. That costing analysis was completed by the MOH with support from international partners. According to key informants, implementation plans produced based on strategic plans are also routinely costed though no informants produced such costing reports. The Medical Research Council of The Gambia reportedly has conducted several cost-effectiveness analyses; results were said to have been published in international scientific journals. Health financing unit staff express interest in producing benefit-cost analyses and fiscal space analyses.

3.8 Recommendations

Numerous opportunities exist to build on the skills and motivation of Gambians inside the MOH and among other organizations in the country to strengthen the health financing environment. A major opportunity arises in the context of the new five-year health sector strategic plan development process that will commence in early 2019 under Directorate of Planning and Information leadership. This plan will be developed concurrently with the development of a new national development plan, which also present an opportunity to synchronize health sector plans with the broader national development agenda and to solidify health as a priority investment sector. Directorate-level MOH leadership acknowledges that better cognizance of financial resource constraints needs to be taken in account when producing the new national health sector strategic plan. Intensive support to health financing capacity building and hands-on support to mobilize health financing information and evidence to feed these strategic plan development processes is thus timely. Specific recommendations are presented in Section 3.9.

3.9 Key Findings and Recommendations for Strengthening The Gambia’s Health Financing Environment

No.	Key Findings	Recommendations
1	<p>Overall, total health expenditures have been rising. However, the composition of sources has shifted inconsistently over time, particularly international partner contributions. Such short-term shifts expose the country to challenges in predicting year-to-year needs and to risks of year-to-year financing shortfalls.</p>	<ul style="list-style-type: none"> • Complete an in-depth analysis of international partner funding and trends. Include in the analysis an assessment of how to increase the efficiency of international partner direct funding support to MOH programs. Strengthen international partner-government of The Gambia coordination and increasingly empower the government to lead planning on aligning and allocating these resources. Link results with fiscal space analysis and Resource Mobilization Plan development. • Strengthen the MOH’s Program Coordination Unit and position its capacity coordinate and align all funds, including support from international sources. • Conduct a fiscal space analysis to identify current and expected short- and mid-term resource pool changes and produce a Resource Mobilization Plan to guide domestic public and private, and international resource mobilization efforts. As part of the fiscal space analysis, place special emphasis on assessment of efficiency in current health resource use and quantify resource mobilization potential from narrowing efficiency gaps. • Conduct a benefit-cost analysis of the basic health care package to demonstrate the value of prioritizing health spending on primary healthcare.
2	<p>Evidence on current and potential private sector contributions to health is weak.</p>	<ul style="list-style-type: none"> • Conduct a comprehensive private sector assessment (to include traditional providers). Map the private sector’s geographic coverage and distribution and services provided. Profile its patrons (market segments). • Conduct a comprehensive and rigorous household health expenditures survey (separate from the context of a National Health Account) to provide a clear estimate and pattern of out-of-pocket spending on health, ameliorating disparities across current out-of-pocket estimates. • Examine the potential for public-private partnerships to close the gap between resources needed to fully fund the basic health care package and available public budget resources. • Support development of a stronger private sector regulatory framework, especially regarding licensing and quality monitoring that incentivizes responsible and responsive private sector expansion.

No.	Key Findings	Recommendations
3	<p>Only about 4 percent of The Gambia's population is covered by a risk-pooling scheme, though establishment of social health insurance has long been on the country's health reform agenda.</p>	<ul style="list-style-type: none"> • Support feasibility analyses for launching a national social health insurance scheme and for directly budgeting funds to be managed by a social health insurance agency to reimburse for services to beneficiaries. Include actuarial analyses of different benefits packages, highlighting short- and medium-term viability of enrolling low-income Gambians. (In the words of one key informant, "It is time to move beyond talk of generalities" in broadening the use of financing mechanisms beyond public budgets.) Assess expected impacts of social health insurance on financial protection among Gambians. • Examine alternative financing sources to expand resource pools, such as premiums to civil servants for social health insurance, social health insurance for private, formal sector employees, sin tax earmarks, and non-traditional sources. Specifically examine resource options to subsidize premiums for the poor and informal sector workers.
4	<p>Little information is publicly available about The Gambia's Drug Revolving Fund (DRF) with respect to resources mobilized from user fees and how those resources are used.</p>	<ul style="list-style-type: none"> • Conduct a formal audit of the Drug Revolving Fund, from the primary healthcare facility level to the central office at the National Treasury, to include identifying sources and uses of revenue and mapping the flow of funds into and out of the Drug Revolving Fund system. • Increase to number of staff within the central DRF administration with decision-making authority, thus eliminating bottlenecks originating from reliance on a single person's authority to make decisions and provide information. • Create a formal accountability framework for resource inflows (user fee tracking) and outflows (where the funds are spent, including administrative costs for the Drug Revolving Fund). Conduct an analysis of the Drug Revolving Fund policy and regulatory framework to identify reform needs to improve transparency and accountability at all levels.

No.	Key Findings	Recommendations
5	<p>Evidence is growing in The Gambia on the potential benefits of strategic purchasing for health services and there is growing interest among MOH leaders for increasing the use of results-based financing as a permanent purchasing arrangement for public sector provided health services.</p>	<ul style="list-style-type: none"> • Pilot the successful results-based financing initiative to priority health services beyond the maternal and child health services covered by the National Nutrition Agency initiative. Prior to institutionalizing results-based financing more broadly, assess MOH internal systems to support strategic purchasing. • Identify shifts necessary to support results-based financing and other strategic purchasing arrangements, and identify programmatic overlap, duplication, and inefficiency. • As a starting point for expansion, consider adapting the National Nutrition Agency's results-based financing design to smaller, more vulnerable communities where quality improvement needs are perhaps more compelling. (Selection criteria for the current results-based financing project participation excludes small and more vulnerable communities.) • Conduct a study of how Bamako initiative health facilities use their retained user fee revenues and take results into account for health financial planning. • Undertake an assessment of opportunities to expand use of contracting to promote resource use efficiency, for example to support information technology needs of the MOH, to support supply chain functions, and to deliver services, especially to currently underserved communities or poorly functioning health services.
6	<p>Important gaps exist in the evidence base on financial protection from catastrophic health expenditures for Gambians. Informal opinion is contradictory and evidence on drug stock-outs in public sector health facilities, household out-of-pocket spending, and application of user fee policies leaves room for concern.</p>	<ul style="list-style-type: none"> • Conduct a study of user fee policy implementation that analyzes consistency of policy and schedule application, incidence of waivers provided, formal and informal criteria used to determine for whom the waivers are provided, when and for what services the waivers are provided, and incidence and circumstances of informal fees paid by clients. • Conduct a study to quantify health services provided to cross-border migrants into Gambia. Determine the extent to which these non-Gambians pay the higher user fees that are supposed to be levied to non-Gambians and estimate the degree to which Gambian public budget resources are subsidizing care for non-Gambians. • Conduct a study to quantify the incidence and patterns of catastrophic spending by Gambian households on healthcare.

No.	Key Findings	Recommendations
7	<p>The public budget development and management processes are sound; some additional process revisions would strengthen them. Some suggested revisions are under the MOH's control, others are not.</p>	<ul style="list-style-type: none"> • Revise the budget development process so that MOH input is sought during budget revisions in response to Cabinet comments and then again based on National Assembly comments. • Revise budget management regulations to allow the MOH greater cross-program reallocation discretion based on under- and over-performance of program specific budget performance without requiring MOFEA approval. • Assess the current expenditure tracking system, revise and institutionalize it within the MOH Directorate of Planning and Information Health Financing Unit or another appropriate MOH unit to improve regular reporting and access to results.
8	<p>Regional health directorates are required to submit annual workplans but have few resources under their control for implementation which is contributing to frustration, demoralization, and difficulty addressing regional health sector needs and priorities.</p>	<ul style="list-style-type: none"> • Conduct regional-level health accounts analyses to map sources and uses of funds in each region. Use results to identify region-level health financing gaps and to delineate needs, options, and advantages for re-establishing direct funding to regional health directorates. • Twin re-institution of regional health directorate subventions with creation of a capacity building program to strengthen financial planning and management skills. To address central resource constraints, consider allowing a certain proportion of regional-level Drug Revolving Fund resources collected from health facility users to be retained by regional health directorates for programming use, with a requirement for regular regional Drug Revolving Fund accounts to be produced and made accessible to the public. • Require synchronization of central MOH program level workplans with regional health directorate workplans. This may be promoted by requiring that region-based activities organized by central MOH programs receive co-funding buy-in from respective regional health directorates. • Improve local government financial tracking systems and transparency in resource uses for Regional Council finances, local DRF offices, and MOH expenditures through its central level Directorate for Regional Health.
9	<p>The Gambia International Health Partnership Plus Country Compact, created in 2016, has not been formally adopted and government of The Gambia-International partner coordination is reported by both sides to need strengthening.</p>	<ul style="list-style-type: none"> • Update and formally adopt the 2016 Compact document as an initial step to strengthen coordination and efficiency in international partner and public budget resource use. Establish structures to strengthen national ownership and leadership over health sector resources and their use, align and harmonize objectives, strategies and activities, and establish mutual accountability mechanisms. • Invest in implementation of an advocacy strategy to ensure that the revised Compact receives the necessary Cabinet approval. Support continued strengthening of government of The Gambia public financial management mechanisms, particularly as it applies to the health sector to build confidence among international partners regarding use of their contributions. Strengthen systems components to improve program-level spending accountability where most of the public budget spending occurs.

No.	Key Findings	Recommendations
10	<p>Knowledge and understanding gaps about health financing were found at the central-, regional-, and health-facility levels. Some of these gaps can be attribute to the highly centralized approach to public budgeting and resource allocation.</p>	<ul style="list-style-type: none"> • Complete a top-to-bottom assessment of understanding of basic health financing principles, concepts, and practices, across all levels in the health system, including public and private sector actors. • Based on assessment results, design and implement a program to broaden and upgrade health financing knowledge and reform public financing systems to promote maintenance of the improved health financing knowledge and practice.
11	<p>Increased resources and skills development are needed to support health financing research and analysis.</p>	<ul style="list-style-type: none"> • Increase publicly budgeted resources explicitly earmarked for health financing research and capacity building, including for consumption and use of research and analysis outputs. • Identify and prioritize a list of health financing research gaps that need to be filled. These include but are not limited to the following: <ul style="list-style-type: none"> - Systematic analyses of the proportion of households who experience catastrophic or impoverishing out-of-pocket health expenditures. - Application of cost-effectiveness and benefit-cost analysis and how to use results for health policy decision making and planning. • Strengthen the capacity of researchers at the MOH Health Research Directorate to conduct health financing research and analysis. Strengthen links between the Health Research Directorate and the Directorate of Planning and Information's health financing unit; provide resources and incentives for the unit and the Health Research Directorate HFU and HRD to implement jointly analyses and research. • Quickly bring National Health Accounts analyses up to date by providing intense support to wrap-up analyses for any incomplete years up to 2018. Intensify National Health Accounts' capacity development to improve effectiveness of data collection. Per informants' advice, support should focus especially on methods to obtain information and data from commercial, NGO, and international partner organizations to strengthen the use of the National Health Accounts' tools and to improve the quality of its analytic outputs.

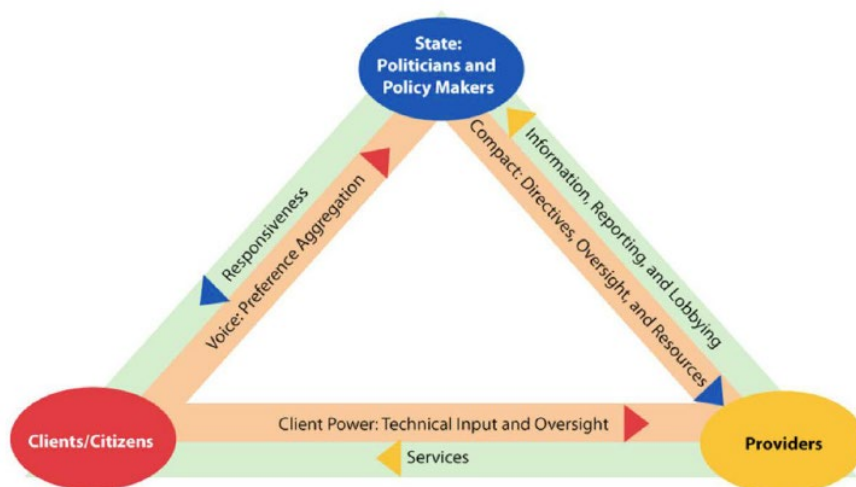
No.	Key Findings	Recommendations
12	<p>Increased support to the Health Financing Working Group may be an effective avenue to strengthening knowledge and advancement in the health financing domain in The Gambia.</p> <p>Note: The Health Financing Working Group is a broad-based group chaired by the director of MOH's Directorate of Planning and Information. Its members include representatives from international partner organizations, the government of The Gambia's National Treasury, the Office of the President, and CIAM (a nongovernmental public health research and development center).</p>	<ul style="list-style-type: none"> • Expand the Health Financing Working Group to include representatives from academic and private commercial and NGO service delivery organizations.

4 Governance

Health governance is subject to a variety of definitions and conceptualizations. The U.S. Agency for International Development defines governance as the “ability of government to develop an efficient, effective, and accountable public management process that is open to citizen participation and that strengthens rather than weakens a democratic system of government (Brinkerhoff and Bossert, 2008). WHO notes that governance involves “ensuring strategic policy frameworks exist and combined with effective oversight, coalition building, regulation, attention to system design and accountability (WHO, 2007).” The World Bank says that governance is “the traditions and institutions by which authority in a country is exercised. This includes the process by which governments are selected, monitored and replaced; the capacity of the government to effectively formulate and implement sound policies; and the respect of citizens and the state for the institutions that govern economic and social interactions among them (Kauffman et al., 2011).”

While these definitions outline some broad, and occasionally vague, definitions of governance, they also offer a window into dimensions considered to be important; democracy and citizen voice, accountability, institutions, policy development, and service oversight are critical analytic elements for assessing governance structures in the health system. To operationalize these elements, the tools and approaches used for this health systems assessment in The Gambia rely on a health governance framework developed by Brinkerhoff and Bossert. It proposes analyzing how three categories of actors (the state, health providers, and citizens organize themselves to address these elements. See Figure 14).

Figure 14. The Health Governance Framework



Source: Brinkerhoff and Bossert, 2008.

4.1 Overall Governance

Broad governance in The Gambia is characterized by declining scores across all six Worldwide Governance Indicators from 2006 to 2016 (Table 13) (Worldwide Governance Indicators, 2017). The political stability indicator suffered the largest decline from 2011 to 2016, with control of corruption not far behind. Voice and accountability and rule of law indicators declined significantly in the years preceding the 2016 election. These declines highlight the contentious relationship between the government in place at that time and journalists and the media, as well as significant executive control over the judiciary through direct presidential appointment of judges (The Gambia, 1997). With the new government

taking power in 2017, expectations for better governance are high, especially for a freer media.

Table 13. Worldwide Governance Indicators for The Gambia and (Sub-Saharan Africa)

Governance Indicator	2006	2011	2016
Voice and Accountability	24.04 (34)	13.62 (32)	13.79 (33)
Political Stability	44.44 (36)	47.39 (34)	27.62 (32)
Government Effectiveness	28.29 (27)	31.75 (27)	19.23 (26)
Regulatory Quality	39.71 (29)	42.65 (30)	31.73 (38)
Rule of Law	44.50 (31)	35.21 (30)	25.00 (30)
Control of Corruption	26.83 (32)	37.44 (32)	22.12 (31)

Source: Worldwide Governance Indicators, 2017.

Governance of the Gambian health sector is broadly characterized by many of the same issues measured by the Worldwide Governance Indicators including devolving power to local authorities, regulation of health providers and facilities, and ensuring citizen input into the health sector.

4.2 Compact: Policies, Directives, Oversight, and Resources

Health policies and strategies

Gambian health policy makers recognize the need to clarify roles and responsibilities both within the MOH and between the MOH and other parts of the Gambian government, especially local area councils. Currently, the health sector is guided by two foundational documents: the *National Health Policy (2012-2020)* and *The Gambia National Health Strategic Plan 2014-2020*. These foundational documents need to be fully aligned with the *National Development Plan 2018-2021*, which notes that the three most important health priorities are to “reduce maternal and newborn mortality, reduce the burden of communicable and non-communicable disease, and ensure the country has an appropriately skilled workforce.” The national health strategic plan includes two additional priority focus areas: data and infrastructure (see Box 5). As the Ministry of Finance takes financing direction from the national development plan rather than from sector-specific plans, it is likely that data and infrastructure will be underfunded compared to the other three priorities.

The *National Health Policy* sets a goal of reducing “morbidity and mortality to contribute significantly to quality of life in the population (The Gambia, 2012, 16).” It outlines 26 targets relating to maternal and child health, HIV, family planning, malaria, immunization, tropical diseases, decentralization, information systems, and policy development. While the policy is in force through 2020, most of the targets are set for achievement in 2015, in line with the United Nations’ Millennium Development Goals. Though the *National Health Policy* was supposed to be reviewed after 2015, interviewees noted that the review had not happened. The *National Health Policy* also describes pathways for achieving targets, including community empowerment, access to preventive measures, identification of health worker standards, and a commitment to equity.

The policy provides broad roles and responsibilities to five directorates which were in place at the time the policy was produced. These directorates are the Directorate of Health Services; the Directorate of Planning and Information, the Directorate of Food Standards, Quality and Hygiene Enforcement; the Directorate of National Public Health Laboratory Services; and the Directorate of Health Promotion and Education. These five directorates,

along with five new ones created in the last six years (the directorates of Nursing and Midwifery, Public Health, Human Resources, Research, and Pharmaceuticals) now form part of the Department of Health Services, while the Directorate of Food Standards, Quality and Hygiene Enforcement became part of the Directorate of Public Health. A separate Department of Social Welfare was folded into the MOH structure but was detached to create an independent agency in 2019. All central directorates report directly to the permanent secretary, with little clarity on roles and responsibilities.

Seven regional health directorates oversee health service delivery at the local level. In theory, the seven regional directorates report to the Directorate of Health Services, but one interviewee noted that “[the regional directorates] feel they should report directly to the permanent secretary to be at par with the other directorates. Almost everything goes through the permanent secretary and his deputy.” Interviewees felt that this structure is both unnecessarily centralized and directionless, as there is no overall technical lead for the regional health directorates. According to interviewees, the 10 central technical directorates do not have a coordination or reporting relationship with the regional health directorates, which report directly to the director of health services. The health strategic plan specifically notes that it aligns with the *National Health Policy* and aims to “ensure effective and efficient health service provision through the development of effective regulatory framework and Promoting effective coordination and partnership with all partners (The Gambia, 2014a, 97).” There are five key health priorities (Box 5). The 2017 joint annual review report for the health sector identified a number of strengths of the strategic plan, specifically its use of cost-effective strategies, identification of financial barriers, measurable milestones for success, and alignment with the national health policy.⁵¹ Identified weaknesses include targets tied to the Millennium Development Goals (which expired in 2015), weak analysis of contextual settings, and weak risk assessment/mitigation strategies related to strategic plan implementation.⁵²

Box 5. Health Priorities in The Gambia

1. Provide quality maternal, neonatal, infant and child health services
2. Carry out surveillance, prevention, control and management of communicable and non-communicable diseases
3. Improve knowledge and skills of healthcare providers at all levels
4. Build capacity of the health management information system and data management system within the health sector
5. Improve health infrastructure at primary, secondary and tertiary healthcare levels
6. Establish a national monitoring and evaluation coordinating body

Source: The Gambia. 2014a.

The national health strategic plan also notes that alignment with decentralization goals is critical and that the health sector must keep pace with the decentralization and local government reforms, which emphasizes an integrated management of government services, including health (The Gambia, 2014a, 13-14). According to interviewees, the implementation of the Local Government Act of 2002 is a common challenge across the entire government of The Gambia. Recent change in political leadership offers an opportunity to strengthen governmental commitment to decentralization and to better operationalize that commitment in the health sector.

⁵¹ World Health Organization (2015) Joint Assessment of Gambia’s National Health Strategic Plan (NHSP) 2014-2020

⁵² World Health Organization (2015) Joint Assessment of Gambia’s National Health Strategic Plan (NHSP) 2014-2020.

Legislation

More than 20 health policies are in place in The Gambia; most date from the 1980s and they provide broad powers to the MOH and the regulatory councils. Much of the policy and regulatory framework is in need of updating; interviewees for this assessment noted that this process is underway or planned to better address emerging priorities, including the commitment to achieving universal health coverage, regulating the health professions, and addressing financial and operational sustainability issues. See Table 14 for a partial list of major health-related legislation enacted or proposed in The Gambia.

A revision to the 1989 Public Health Act, recently drafted but not yet enacted, defines the health sector in The Gambia. This act outlines the responsibilities of the MOH, including establishing “health and sanitation district within any...area,” creating “health services institutions in any area,” regulating environmental health in residences and workplaces, and quarantining people suspected of having an infectious disease (The Gambia, 1989). Under this act, the MOH, under the direction of the minister of health and the director of health services, is the sole regulator of the health sector. Interviewees noted that the director of public health has organized a task force to review the 1989 Public Health Act, though that review has yet to be completed. In its final form, this act is intended to consolidate the law to address disease prevention and promote, safeguard, maintain and protect population health.

The Local Government Act (2002), though not health-specific, is another critical piece of legislation for the health sector. It outlines the government’s roles and responsibilities at the national level and for local area councils (see Box 6). The act also delineates funding mechanisms for each. Local area councils, in theory, receive funding from the Ministry of Community Development and are technically able to raise own-source revenue. Though these are de facto council responsibilities, in practice, regional health directorates, which report directly to the MOH, oversee health services at the subnational level. (See Section 1.3, Political Context, for more explanation of the structure of local government.)

Interviewees noted that there are many restrictions on how funding is raised and spent at the subnational level, as well as sharing requirements between the national and subnational governments. These arrangements constrict fiscal space for health at the regional and local levels. Additionally, interviewees said that little funding for health is actually released to the regions. Based on discussions with national-level informants, this challenge appears to be a fiscal flow problem from the treasury to the Ministry of Finance to the Ministry of Community Development. Funds raised at the local level, such as those raised through the Drug Revolving Fund and user fees, are mostly transferred to the national government, not retained by the local area council. While there are defined mechanisms for regions to seek a return of some of those centralized funds, access to those funds is severely limited. For a more detailed discussion of this issue, please see Section 3, Health Financing.

Box 6. Local Area Council Health Sector Responsibilities

- Promote and preserve health
- Manage major health centers, sub-dispensaries and all primary healthcare services
- Organize maternal and child health services
- Distribute pharmaceutical products and vaccines to health facilities
- Provide general hygiene and sanitation
- Create local public health committees
- Create a Department of Health Services

Source: The Gambia, 2014a, 12,

Table 14. Major Enacted and Proposed Health and Related Legislation

Legislation	Date Enacted	Status/Key Points
Medical and Dental Act	1988	<ul style="list-style-type: none"> Creates the Gambia Medical and Dental Council to regulate these professions Provides for training and registration of nurses and midwives
Public Health Act	1989	<ul style="list-style-type: none"> Environmental health and sanitation Outlines the structure of the health system Authorizes the MOH to direct health services
Nursing and Midwives Act	1989	<ul style="list-style-type: none"> Creates the Nurses and Midwives Council to regulate these professions Provides for training and registration of nurses and midwives
Local Government Act	2002	<ul style="list-style-type: none"> Describes the functions, powers, and duties of local authorities
Medical Services Act	(unknown)	<ul style="list-style-type: none"> Regulates service delivery
Pharmaceutical Act	2014	<ul style="list-style-type: none"> Creates the Pharmacy Council to regulate pharmaceutical professions and drug retail outlets.
Medicine and Related Products Act	2014	<ul style="list-style-type: none"> Regulates importation and sale of medicines
Tobacco Control Act	2016	<ul style="list-style-type: none"> Mandates regulation of tobacco industry
Public Health Council Act	2016	<ul style="list-style-type: none"> Register public health officers Provides guideline for the training of PHOs Sets standards for public health practice
Model Act	2016	<ul style="list-style-type: none"> Address stigma and discrimination and willful transmission of disease.
Mental Health Bill	2019	Under consideration by National Assembly.

In addition to legislation that provides general direction for the health sector, legislation is in place in The Gambia to regulate health professionals and pharmaceutical products (see Table 14). The national health strategic plan calls , for reviewing these laws to “ensure that all the enacted legal instruments will be harmonized and aligned to the current situation to eliminate the problems of divergence due to existence of several enacted legal instruments (The Gambia, 2014a, 97).” Interviewees noted that the Nursing and Midwives Act, specifically, is due for review, though no timeframe was provided.

Oversight and regulations

Regulation of the health sector, generally, is conducted by the MOH, as authorized by the Public Health Act (1989). Most of the authorized areas, however, relate to sanitation and business licensing, rather than service provision. Only one statement allows for the regulation of service providers. That regulation notes that the MOH may impose regulations on “the proper management and administration of any health service institution (The Gambia, 1989).” No specific licensing or accreditation provision for either public or private sector facilities exists. Health professions are regulated through three professional councils: the Medical and Dental Council, the Nurses and Midwives Council, and the Pharmacy Council. In 2016, the Parliament passed a Public and Environmental Health Bill, but the

Public and Environmental Health Council is not yet functional. The council is awaiting the appointment of a chairperson and a registrar. These councils register health professionals, establish codes of conduct, and set professional guidelines (The Gambia, 2014a, 96). They also have statutory mechanisms to review professional conduct and discipline providers.

Interviewees noted that the professional councils have technical capacity but do not have the leadership and resources to monitor and enforce professional standards. In theory, they are semi-autonomous from the MOH, but interviewees had noted that they had become politicized and disempowered under the previous government. For example, the Nurses and Midwives Council was, during the previous government, operating with only one appointee, rather than the statutory 24 members. Though there are now 24 members of the council, gender equity is a significant issue; only three of the 24 are women. Interviewees did note that the councils are improving under the new government, as they become better resourced and empowered to regulate health professionals.

Coordination

Coordination across the health sector, including among government, civil society, and donors, is a major challenge for The Gambia. Within the MOH, interviewees said that most coordination takes place at the program or activity level, rather than across health programs within the MOH. One interviewee estimated that 75 percent of MOH activities are unplanned, contributing to weak coordination. The same interviewee stated that there is no standing cross-program coordination mechanism within the MOH, and that decision-making authority essentially rests within each program.

There are, however, some examples of once-off national coordination mechanisms on which to build. In December 2017, the health sector's joint annual review forum provided program managers and heads of units, agencies, departments, and external health institutions the opportunity to report on priorities, progress, and challenges across the health system. Stakeholders recognized the need to formalize and institutionalize this review; some MOH, civil society, and United Nations agency stakeholders have advocated for it to become an annual process. Other efforts to improve health sector coordination have involved using sector-wide approaches to align donor funding to the health sector policy and strategic plan framework. The process can include building a common plan, budget, and evaluation framework.

In theory, coordination of the health sector at the regional level is governed by the regional health directorates under the authority of the Local Government Act (2002) (see Section 4.2, Legislation). However, interviewees thought that gaps and poor autonomy at the regional level currently hinder the regional health directorates' ability to fulfill this coordination role. Technical advisory committees are responsible for coordinating cross-sectoral development issues at the regional level. The governor heads the technical advisory committee, whose membership also includes regional line ministry heads of departments and regional NGOs. The technical advisory committee plans sector programs and provides technical advice to the Regional Governor and Area Council. Challenges to regional health directorates' ability to carry out this local coordination role also stem from independence of MOH program units with respect to their regional activities plans and the fact that regional health directorates are rarely consulted in decision making about MOH activities planned and conducted in their regions.

The national health strategic plan identifies several committees, created by the MOH in 2011, meant to include civil society in monitoring its implementation (see Box 7). However, interviewees could not identify which—if any—of the eight committees still met or are active. Based on our interviews, six of the eight committees have not been operational during the previous seven years and no longer provide a forum for engaging civil social organization (CSO) input into health sector decision making. Of the two remaining committees, the Hajj

Committee is functional, while the Regional Health Advisory Committee is now part of the Regional Technical Advisory Committee under the regional governor.

Technical working groups, in theory, exist for specific health areas and cross-cutting topics, and are outlined in the National Monitoring and Evaluation Plan for the national health strategic plan (The Gambia, 2015). However, no interviewee could give us a list of which technical working groups were created, existed, were active, or provided input into the policy process. In addition to government-led coordination mechanisms, interviewees felt that the Global Fund's country coordinating mechanism was a good example of coordination among government, development partners, and civil society, as these parties led a consultative and collaborative process that brought together various stakeholders (see Section 4.3, Voice and Preference Aggregation). Although a vice chair is from The Gambia Food and Nutrition Association, the country coordinating mechanism has limited civil society representation and its authority does not extend to national policy, only to Global Fund grants. The chair of the country coordinating mechanism is the permanent secretary of the MOFEA.

Box 7. Gambia National Strategic Health Plan MOH Coordination Mechanisms

- Resource Mobilization Committee
- Fellowship Committee
- Institutional Committee
- Bilateral Committee
- MOU Committee
- Project Management and Monitoring Committee
- Hajj Committee
- Regional Health Advisory Committee

Source: The Gambia, 2014a, 19.

The national health strategic plan notes that “poor coordination of donor funding, programmes and activities within the MOH&SW has led to duplication of resource allocation and utilization in some programme areas, leaving other critical areas under-resourced (The Gambia, 2014a, 99).” Due to the aforementioned gaps in coordination within the MOH, donors and international partners often work directly with MOH programs, as these programs directly implement activities at the regional level.

Though the national health strategic plan cites a health sector coordination mechanism, it is currently inactive, has outdated terms of reference, and does not meet regularly. In theory, International Health Partnership Plus Country Compact meetings were supposed to replace the health sector coordinating mechanism, however, neither the MOH nor development partners signed the Compact developed in 2014. (For more discussion of the Compact, see Section 1, External Partners Support Coordination.) The senior management team at the MOH is the default coordinating mechanism for external partners. Though the team engages external partners through ad hoc meetings, coordination is weakened by frequent turnover at the MOH leadership level. The health strategic plan notes that “[b]etween 2003 and 2013, the MOHSW has witnessed the appointment of 8 ministers of health, more than 10 permanent secretaries, 7 directors of planning, and 5 directors of health services.” Turnover also contributes to weak supervision and communication, and a heavily centralized management structure.

Multiple interviewees noted that the planning process did not empower the regional health directorates to oversee the health sector in their regions. They do create annual operating plans, but those plans are rarely reflected in the annual work plan developed by the MOH. Rather, the MOH creates a separate, centralized plan that is not synchronized with regional priorities. Instead, the MOH's annual operating plan reflects centralized data analysis, decision making, and funding, though interviewees noted that stakeholders provided input into annual operating plan development and review meetings. According to interviewees, funding decisions flow from the MOH's annual operating plan, rather than regional priorities. Regions do not have the resources or de facto authority to carry out their own

work plans. Activities at the regional level are often directed and implemented by central level programs, with the regional health directorates playing a supporting role.

4.3 Voice and Preference Aggregation

Overview of the civil society environment

Historically, citizen voice and participation in the Gambian health sector has been defined by “invited spaces” such as state-led forums, rather than “claimed spaces” such as social movements and community associations (Gaventa, 2006). A number of technical working groups, coordinating mechanisms, and planning processes have invited civil society to participate in the health sector, yet these tend to be government-led and managed for specific technical input into programs, projects, and/or activities, rather than serve as spaces for freewheeling discussion and debate about health sector priorities. In the later years of the previous government, CSOs self-censored to avoid running afoul of government restrictions on democratic space (Camara, 2017).

To continue operating without challenging government, CSOs have focused more on service provision, providing roughly 10 percent of health services, than on attempting to influence policy. They have been especially important in providing services to populations not easily reached by the mainstream government health system.⁵³ Decentralization has opened some opportunities for CSOs to operate outside Banjul.

The major civil society advocate in The Gambia is the Association of Non-Governmental Organizations. It was formed in 1983 as an umbrella organization for NGOs and currently represents about two-thirds of CSOs in The Gambia. Its role is to coordinate NGO activities, minimize conflict among NGOs, strengthen CSO capacity, and engage with the government across the various sectors in which their members operate. Unfortunately, due to time constraints our assessment team was not able to interview an association representative to learn about its current health advocacy work, its views on government transparency, or how it engages with the regional governments.

Mechanisms for participation

Though there is a need to continue strengthening and formalizing involvement of nongovernment stakeholders in health sector decision making, state-led forums for participation do exist at the national and subnational level. MOH interviewees for this assessment noted that since the change in the country’s political leadership, CSO and other nongovernment representatives are invited as a matter of routine to participate in health policy dialogue forums. One interviewee estimated that broad representation is achieved for about 70 percent of MOH-organized policy dialogue forums. The annual joint annual review forums are an example of the MOH’s success at engaging broad participation in policy and planning dialogue.

Interviewees also cited the development of the National Health Policy in 2012 as an example of a document that was created through a consultative process with key stakeholders, including civil society. A review of participation in the development of the 2017 Health Financing Strategy indicates very little civil society participation. Slots were set aside for CSOs to participate in regional consultation, the private sector had two representatives in the technical working group, and labor unions had a single representative in the steering committee (The Gambia, 2017d).

⁵³ *Civil Society Contribution Towards Achieving the MDGs In The Gambia*. 2005. Available at: <http://www.gbos.gov.gm/uploads/survey/MDG/CIVIL%20SOCIETY%20CONTRIBUTION%20TOWARDS%20ACHIEVING%20MDGS%20IN%20THE%20GAMBIA.pdf>.

At the regional level, technical advisory committees provide a forum for CSOs to advocate for health issues, while the regional health directorates have generally been open to CSO and citizen engagement. Technical advisory committees get citizen input through the participation of the cross-sectoral multidisciplinary facilitation team members, who aggregate community-level input from ward development committees in their region into reports for the technical advisory committee. The multidisciplinary team is composed of community workers such as community health nurses and helps to guide community-developed plans, though these plans are often poorly coordinated and project-oriented. Though neither the technical advisory committee nor the multidisciplinary team are health-specific, health issues are frequently part of their discussions. In theory, local area councils hold regular meetings open to the public to discuss sector plans, budgets, and activity progress. Interviewees were not aware that these meetings were open to the public and noted that citizens rarely attended, though they noted that biweekly council meetings were open to the public. There were few mechanisms for ensuring that citizens know about these meetings.

Advocacy

Given the years of political repression and weak democratic institutions prior to the 2017 political transition, it is unsurprising that civil society advocacy is nascent in The Gambia. The National Health Policy highlights advocacy in the context of generating demand for services, rather than policy development and reform, per se (The Gambia, 2014a). The association for coordinating NGOs, for its part, has advocated for more public-private partnerships in the health sector to increase private sector leverage and contracting out.⁵⁴

Though civil society is generally conceptualized as an intermediary for citizens to communicate with government, this role does not preclude citizens from communicating directly to government officials (Gaventa, 2004, 25-41). In The Gambia, interviewees felt that individual citizens did not have the skills or opportunity to advocate for health issues to either the national or local governments, citing poor awareness, literacy, and availability of forums. Given the recent opening in the political environment, there is an opportunity to inculcate a culture of citizen expression into government-citizen relationships. Interviewees said that local governments should improve citizen awareness of existing forums, such as the technical advisory committees and the catchment area committees (see Section 3.5.2, Citizen Oversight), empower citizens to engage with these forums, and build citizen capacity to identify and communicate health needs. Interviewees said citizens are becoming more involved in health advocacy and fund-raising, including efforts to build and set up clinics, and asking MOH to staff and manage those clinics. One interviewee from a regional health directorate noted this as a problem, as facilities are often built without guidelines, minimum equipment standards, licensing, or attention to sustainability, thus potentially sacrificing quality. The additional staff and drugs required to meet service delivery needs must also come from the region's existing, and limited, resources.

4.4 Transparency

Transparency is the ability of nongovernment stakeholders to access accurate information on the policy development process, availability and use of resources, service delivery quality and access, and health status information (Health Finance & Governance Project, 2017, Section 3, Module 7). From providing information on health services and responding to freedom of information or right to information requests to answering complaints and ensuring that

⁵⁴ A policy and regulations guiding establishment of public-private partnerships (PPPs) exist within the MOH. MOH's proposal to establish a PPP unit was not approved and the Directorate of Planning and Investment named a PPP focal person instead to guide PPP strategy and guideline development. In that strategy, CSOs will be included under the definition of "private" and eligible to participate in PPPs.

citizens are heard, this governance function is critical to ensuring state legitimacy. Though there is no freedom of information or right to information law in The Gambia, the Constitution does provide for freedom of speech and a free press (The Gambia, 1997, Section 207 and 208). The government does recognize the need for a freedom of information law, having held a consultation with the United Nations in 2017 to outline principles and content (Foroyaa, 2017).

In the health sector, the National Health Policy and national health strategic plan outline specific patient rights. The National Health Policy, for example, notes that “[p]atients have the right to accurate and easily understood information about his/her healthcare plan, healthcare professionals, and healthcare facilities. This must be done using a language understood by the patient so that he/she can make informed health care decisions” and that patients have the “right to considerate, respectful and non-discriminatory care from his/her health care provider(s) (The Gambia, 2012, 18).” The health strategic plan also references a patient’s bill of rights that improves confidence in the health system, ensures fairness, outlines a complaints mechanism, and encourages clients to become active in the system.

Despite these references to a patient’s bill of rights, no interviewees were able to identify existence of such a document nor were any able to speak to any content of such a bill of rights. Though the media occasionally do publicize specific examples of rights violations, there is no clear framework of what constitutes a violation and how a violation would be reported or addressed. One interviewee noted that health providers, especially doctors, are highly respected, and it is not considered appropriate to question them about care they provide. This same interviewee noted that the “audit culture” in The Gambia is weak, and that even upon the completion of audits, such as the maternal mortality audits, findings are rarely made available for public review and use. Despite weak transparency of patient’s rights, user fees appeared to be well codified and transparent, although somewhat complex. During site visits, user fee schedules were generally visible and outlined prices for a range of medical and dental services. While informal, or under the table, payments are said to exist, interviewees considered them to be sufficiently prevalent as to constitute a barrier to health service access. However, no corroborating formal evidence was identified that examined the extent and pattern of informal user fees in public healthcare facilities.

Data transparency and availability also have room for improvement. The MOH uses DHIS2 to collect monthly service data from health facilities. Interviewees noted that data completeness has improved markedly over the last five years and that the major challenges now are that capacity is low within the MOH to analyze, use, and disseminate DHIS2 data effectively. According to interviewees, the MOH provides general information on the health sector upon request, but it is not always specific, detailed, or in a useable format. In fact, the National Assembly Health Select Committee noted that it only received copies of DHIS2 outputs from the MOH, without any analysis. It also does not receive other critical information from the MOH, including revenue, expenditures, deliverables, challenges, and opportunities. MOH interviewees noted that the culture of data use in The Gambia is weak and demand for data and analysis of it is therefore also low. Consequently, investments to build data analysis and use capacity are also low.

Information on health budgets and expenditures is not easily obtained by stakeholders, both within the MOH and by the public. MOH publishes its annual budgets on its online, publicly accessible website. However, information on funds released to the MOH and its subvented units is less available and expenditures information is even less available. In part, these challenges are derived from the need for improved financial reporting performance and for clearer guidelines on financial reporting and on what is to be made publicly available and the periodicity of that reporting. At the subnational level, the Local Government Act requires that regional plans and budgets be publicized and shared with the public. In practice, regional plans and budgets remain mostly unavailable to the public.

The MOH posts much information, including annual plans and performance reviews, on official website. However, few people, even MOH staff, access that content. The reasons for this low frequency of accessing that content are unclear and the extent to which there is citizen demand for that information is also unclear. As noted, a culture of data use is weak in The Gambia and demand for data is low. It may also in part be a reflection of the timeliness of that content. For instance, 2013 is the most recent year for which MOH has made National Health Accounts information available detailing government and nongovernmental expenditures in the health sector (see Section 3, Health Financing). The MOH is attempting come more up to date on National Health Accounts analyses, though it expresses technical and financial challenges in doing so.

Most useful health information in The Gambia resides within programs and projects, such as that pertaining to the National Malaria Control Program, some of which is highly dependent on external partner funds. Projects generally provide a report on project results or disseminate studies or policies as appropriate. These reports often contain some information on quality and outcome measures. Interviewees noted that about half of donors, including the Global Fund and the World Bank, regularly publicize resource use and results, while United Nations' agency reports are less clear on outputs and results. According to interviewees, the Directorate of Planning and Information used to track donor spending but is no longer doing so due to insufficient staffing capacity.

While there are independent media in The Gambia, they do not have the capacity to conduct detailed investigations. Under the previous government, journalists practiced self-censorship to avoid running afoul of government sensitivities. Interviewees noted that journalists have started to play more of a watchdog role since the 2017 change in government, but this role is still nascent. Health reporting consists of reporting individual complaints of poor health services, covering highlights of government reports, or publicizing sensational political stories. For example, the 2013 National Health Accounts received a great deal of publicity in 2015 when it was disseminated, with newspapers printing entire sections.

4.5 Service Management and Oversight

This section addresses “the ability of individuals, communities, civil society organizations, and watchdog organizations to monitor and oversee the actions of health providers, ensuring that health services are high quality, transparent, and follow accepted norms (Health Finance & Governance Project, 2017, Section 3, Module 7).” As such, it focuses on the relationship between citizens and service providers, including citizen engagement and oversight of health services, incentives, and results-based service organization, rather than professional or technical oversight provided by the MOH, regional directorates, and professional associations.

Citizen oversight

The foundation for citizen oversight in the health sector is found in the National Health Policy, which calls for building “the capacity of communities to enhance their participation and involvement in health service delivery (The Gambia, 2012, 29).” To operationalize this directive, the MOH recently developed a primary health care road map that describes how to improve community oversight of health services. Specifically, the MOH works through existing village development committees to invest in the health sector and help all 1,891 settlements in The Gambia to become primary healthcare villages (The Gambia, 2017b, 81).

Village development committees are cross-sectoral committees that mobilize local, and project resources to invest in development projects across health, agriculture, education, and other sectors. In the health sector, village development committees are critical to the success of expanding primary healthcare services throughout The Gambia. The primary healthcare roadmap notes that “[a]ctive [village development committees] have been the hallmark of

[primary healthcare] expansion movement in The Gambia since the introduction of the strategy.” Village development committees are an important part of the primary healthcare strategy because they have strong community trust and engagement from community leaders, and they have been engaged in results-based financing in the health sector through the National Nutrition Agency’s Maternal, Neonatal, and Child Health Human Resources Project, supported by the World Bank (The Gambia, 2012, 48). This project has supported about 90 village development committees to become more involved in the health sector, including community mobilization, selecting community health workers (village health workers and other community development workers), and developing village support groups. An impact evaluation of the maternal, neonatal, and child health project should determine whether empowerment of village development committees to hold service providers accountable for outcomes improves health service indicators. Data were collected in 2018, but the results of the evaluation are not yet public.

The village development committee mechanism also faces challenges in its mandate to oversee primary healthcare services. The primary healthcare roadmap notes that only about 50 percent to 60 percent of village development committees are operational (The Gambia, 2012, 49). These committees are often not operational because of weak political and administrative support, political interference, and poor community representation.

Though village development committees are not directly involved in overseeing health services provided at facilities, representatives from these committees participate in catchment area committees, where such committees exist. In The Gambia, the MOH developed catchment area committees as part of the Bamako initiative to improve citizen engagement, ownership, and co-management of health facilities. Currently, 18 facilities in The Gambia are Bamako initiative facilities (The Gambia, 2012, 54). Catchment area committees meet quarterly and are responsible for ensuring community involvement in health facility management. These committees are made up of a variety of community leaders, including the district chief, a representative from the ward and from each village development committee in the catchment area, the officer-in-charge of the health facility, and the community health nurse. Catchment area committees, in theory, hold yearly community meetings, though in practice, they are rarely held and are poorly attended. Because catchment area committee members represent citizens, rather than having direct citizen participation in the committee, their usefulness in ensuring that citizen voices are heard at the community level is unclear. Interviewees noted that service quality was rarely discussed in committee meetings, but the maternal, neonatal, and child health project’s focus on results-based financing is shifting these discussions due to an increased focus on service quality metrics. In non-Bamako initiative communities, health management committees are expected to perform functions similar to those performed by catchment area committees, though the extent to which health management committees are operational across the country is unclear.

Complaints mechanisms

The National Health Policy notes that “[e]very patient shall have the right to a fair, fast, and objective review of any complaint he/she may have against any health plan, health care provider/personnel or health institution (The Gambia, 2012, 18-19).” However, this assessment was only able to identify informal complaint mechanisms. If a client has a complaint about health services, interviewees noted that the person would go to the officer-in-charge of the facility, the regional health directorate, or perhaps the health committee of the village development committee.

Media outlets are another opportunity for clients to register complaints. One interviewee claimed that the media will contact facilities to verify malpractice complaints; larger facilities have a public relations officer to handle these inquiries, while smaller ones are often handled by the officer-in-charge. This same interviewee noted that clients are skeptical about

prospects for getting a resolution without involving the media, thought that the media were independent, and that the MOH is more likely to respond to public, rather than private, complaints. Other interviewees felt that there was little investigation into complaints and that improved regulations and information-sharing were necessary.

Finally, the MOH recently commissioned a Facility-Based Client/Patient Satisfaction Survey in 30 public health facilities to gain a better understanding of how clients perceived services. Survey results showed that most clients were seen within 30 minutes of arriving at the facility, but that nearly a quarter reporting waiting over an hour. Satisfaction was generally high, with two-thirds reporting that providers were both respectful and helpful in explaining their diagnosis and treatment plan (The Gambia, 2018). There is no plan to routinely collect patient satisfaction data, but the survey does represent some commitment to understand patient needs. Before this survey, no client satisfaction data had ever been collected.

Service monitoring and supervision

In theory, regional health directorates supervise and monitor health facilities and posts in their regions. In practice, interviewees thought that though regional health directorates had strong technical capacity, but that their limited autonomy and limited access to financial resources rendered them unable to fulfil their mandated oversight, organization, and management functions. As a result, the national government continues to exercise de facto control over resources, roles, and responsibilities at health facilities. The regions work with vertical programs to conduct program-based oversight, rather than organizing integrated facility visits or working directly with MOH directorates. Each program, such as the malaria program and WHO's Expanded Programme on Immunization, has its own guidelines for supervision, and regions do not have guidelines for integrated supervision. National-level interviewees consistently said that regional autonomy is neither a priority nor a necessity, and that the regional health directorates received everything they needed from the national government.

In addition to program-level supervision, the National Health Policy also calls for the creation of clinical audit units in each health facility to “strengthen routine assessment of adherence to set standards and norms (The Gambia, 2012, 43).” However, interviewees made clear that these clinical audit units do not function as intended and likely were never created at the health-center level. As a result, no routine, integrated clinical audits are conducted in The Gambia.

At the same time, audits are occasionally conducted through specific programs. Maternal death audits are conducted with United Nations Population Fund and WHO funding, though such audits depend on the availability of external funding support and have not been institutionalized. The World Bank also provides supervision tools and checklists for maternal, neonatal, and child health services through the maternal, neonatal, and child health project and supported the Quality Assurance Unit in the MOH to train regional staff on the tools and conduct quarterly assessments. The Quality Assurance Unit does not have its own budget, however, and the supervision conducted under the maternal, neonatal, and child health project was not intended to be a comprehensive quality assurance mechanism.

Professional councils

Professional councils, such as the Medical and Dental Council, the Nurses and Midwives Council, and the Pharmacy Council, have a mandate to advise the MOH on health professions issues, register health providers, and protect citizens from malpractice as shown in Table 15. They help “the Ministry of Health to better organize the medical, dental, pharmaceutical, nursing and paramedical professions (The Gambia, 2012, 42-43).” To perform these roles, councils must be able to recognize qualifications, register health practitioners, manage problems relating to professional ethics, and revise professional

classifications according to qualification and specialization. In The Gambia, however, professional councils do not appear to have the capacity to fulfil their regulatory roles. Though legislation provides the statutory authority for regulation and licensing, interviewees said that the councils do not have the necessary technical or financial resources to enforce regulations on health providers and that health providers are often unaware of the relevant regulations for their profession. One interviewee noted that many nurses were practicing without having been licensed. However, the Nurses and Midwives Council does not have the ability to track down unlicensed nurses or enforce sanctions. On the positive side, councils have been reforming and strengthening under The Gambia’s new government, including reclaiming the ability to register and accredit providers, to act as an independent judge of provider competency, and to increase member representation on their respective councils. The Nurses and Midwives Council has brought on more than 20 new members; it used to be run by a single person. Similarly, the Medical and Dental Council was not empowered to register providers or assess whether providers were following protocols, standards, and codes of conduct, let alone investigate and adjudicate malpractice claims, under the previous government. Interviewees felt that this council is recovering from years of neglect, but that it would be some time before it is able to fully conduct its regulatory role.

For the most part, regional health teams are made up of health providers, who connect with their colleagues to gain provider perspective on annual operating plans. Associations, such as the Medical and Dental Association and the Gambia Public Health Association, should act as a voice for their members in national policy discussion. However, in general, they have very little access to the policy development process. They can get copies of policies after they are developed, but at that point, it is too late to influence the content of the policies. One exception to this generality, is that the public health association has been deeply involved in revising the Public Health Act with the MOH and WHO.

Table 15. Role of Professional Councils in Quality Assurance of Health Services

Medical and Dental Council	Nurses and Midwives Council	Pharmacy Council	Public Health Council (future)
<ul style="list-style-type: none"> • Registration of medical and dental officers • Regulation of medical and dental practices and ethics • Provide guidelines for training of medical officers • Establish clinical audit unit • Conduct periodic clinical audit exercise in all regions 	<ul style="list-style-type: none"> • Registration of nurses and midwives • Regulation of nursing and midwifery practices and ethics • Provide guidelines for training of nurses and midwives 	<ul style="list-style-type: none"> • Registration of pharmacists and other pharmaceutical cadres • Regulation of pharmacy practices and ethics • Provide guidelines for training of pharmacists, technicians and assistants 	<ul style="list-style-type: none"> • The Public Health Council shall be established by the act of parliament and its function shall be: • Registration of public health officers • Regulation of public health practices and ethics • Provide guideline for the training of public health officers • Set standards for public health practices

Source: The Gambia, 2012, 48.

4.6 Data Use for Governance

Routine data use and operational research

The health strategy plan calls for the MOH to “[e]nsure availability of relevant, accurate, accessible and timeline healthcare data for planning, coordination, monitoring and evaluation of the health care services.” In 2010, The Gambia has implemented the DHIS2

platform to collect service-level data from health facilities. Interviewees noted that the data collection function is working quite well, with 90 percent of facilities reporting in some regions. The quality of this data is improving as the MOH conducts quarterly verification visits to monitor timeliness, completeness, and accuracy. Due to error checks built into DHIS2, regions can verify when data is entered incorrectly and can check with facilities to ensure data are entered into DHIS2 correctly.

Although data collection and consolidation are quite functional in The Gambia, data analysis and use at all levels of the health systems is weak. Even though regions enter data monthly, service data does not inform facility supervision visits. As supervision visits are project-based and regions use project data instead for planning and decision making. The MOH compiles yearly service statistics from DHIS2 to share with key stakeholders. However, there is little evidence that the MOH or other stakeholders use this information to inform annual plans, health policies, or new directives. Regional health directorates have access to DHIS2 data through an open-source platform.

In theory, regional health directorates and the MOH consult DHIS2 statistics, stakeholders, and regular and periodic studies, such as the National Health Accounts, to develop annual operational plans. The MOH then consolidates regional annual operational plans into a single plan and includes information from the Human Resources Information System. Interviewees, however, noted that analysis of DHIS2 data is weak, hindering the usefulness of the data, though the MOH did use DHIS2 data to inform a commodity quantification exercise. Policy-relevant research is relatively rare, with the recent National Health Accounts being the most cited example, as it was used to cost the basic health care package of services. Interviewees cited few examples of operational research having been conducted, such as on quality of care metrics, household spending, or service provision and availability.

Private sector reporting

Private sector facilities are required to upload service statistics to the DHIS2 platform in the same way as public facilities. Interviewees noted that while private sector reporting had been poor in the past, since the MOH has been entering into memoranda of understanding with private facilities to provide services, reporting rates have improved. To incentivize reporting by private healthcare facilities, the MOH provides certain pharmaceutical products (e.g., family planning products and vaccinations) to those who report through DHIS2 uploads. In practice, these products often continue to flow to private facilities that fail to report.

Private facilities have an incentive to report statistics, as they only receive drug supplies if they submit monthly reports. Though some private facilities do not report, the private sector comprises less than 10 percent of facilities and their underreporting is not thought to be pose a major constraint on the quality and completeness of health statistics. Timeliness, accuracy, and completeness of reporting by public facilities bears more heavily on health statistics in the country.

Provider efforts to use evidence to influence the health system

Interviewees claimed that service providers occasionally use evidence to inform service provision or policy, but that their capacity to do so effectively is low. In instances where facilities use data, it is generally to advocate for more resources, including money, staff, and commodities, and improved programming, such as health promotion and community education.

4.7 Key Findings and Recommendations for Strengthening The Gambia's Health Governance Environment

No.	Key Findings	Recommendations
1	<p>The 10-directorate structure of the MOH with all reporting into a narrow base of frequently changing senior management appointees is widely perceived to need reorganization. Decisions on flow and use of public funds for health is highly centralized. This structure is perceived by some as not providing sufficient direction or oversight to programs and regions, and yet does not provide regions with sufficient tools for local empowerment of health management. (Section 4.2, Compact Policies, Directives, and Oversight; Health policies and strategies)</p>	<p>Appoint a high-level team and working group, facilitated by an external consultant, to determine a technically appropriate and politically acceptable MOH structure. Review terms of reference for senior management roles to provide clear lines of authority, oversight, and technical direction; address internal debates about the profusion of new directorates and provide regional health directorates with greater ability to manage programs and activities within their health regions.</p>
2	<p>Health services are not aligned with decentralization framework under the <i>Gambia National Health Sector Strategy Plan</i>. Roles and responsibilities of the national government and regional health directorates need clarification, including fiscal flows (Section 4.2, Compact Policies, Directives, and Oversight; Legislation)</p>	<p>Convene a committee of the Ministry of Community Development, MOH, local area council, and regional health directorate staff to conduct a functional assignment exercise for the MOH and regional health directorates to ensure alignment of functions, responsibilities, and resources.</p>
3	<p>Coordination of projects, donors, and funding streams at the national level is weak (Section 4.2. Compact Policies, Directives, and Oversight; Coordination).</p>	<p>Review, restructure, and staff the MOH's Program Coordination Unit to strengthen and operationalize is capacity to more strongly integrate and lead program and financial management coordination across the MOH and between MOH and external partners. Explicitly strengthen mechanisms to align programs and projects to policies and strategies and align across programs.</p>
4	<p>External support to CSOs (notably including the Association of Non-Governmental Organizations) has strengthened their ability to work with government. Civil society advocacy is strengthening and needs of continued encouragement and support to further strengthen its effectiveness to engage with government (Section 4.3. Voice and Preference Aggregation; Overview of the civil society environment and advocacy).</p>	<p>External support to other organizations should be provided, perhaps funneled through the association as an umbrella NGO to develop advocacy structures and mechanisms, including identifying messages, targets, messengers, communication processes, and evaluation measures.</p>

No.	Key Findings	Recommendations
5	<p>Weak data analysis and use hinders the ability of regional and national governments to create effective plans and strategies (Section 4.6. Data Use for Governance; Routine data use and operational research).</p>	<p>Require regional annual operating plans and the MOH's annual plan to include references to data (DHIS2 or otherwise) that support specific programming areas.</p> <p>Map and conduct a diagnostic assessment of disparities and irregularities among different data sources. Put in place corrective actions and institutionalize a process for monitoring data quality. Identify and remove disincentives at both technical and management levels throughout the health system to accurate, timely, and complete reporting through routine information systems.</p> <p>Support regional and MOH staff training on data analysis and dissemination and promote a culture of data use.</p>
6	<p>Regional annual operating plans are incorporated into national planning. However, on implementation, national programs do not adequately coordinate with regional plan implementation. National and regional implementation coordination is further constrained by insufficient funds for health region plan implementation (Section 4.2. Compact Policies, Directives, and Oversight; Coordination).</p>	<p>Create mechanisms for national level program involvement during regional annual operating plan development and vice versa. Situate oversight of this process within a newly strengthened program coordination unit (see Key Finding 3 above).</p> <p>Mandate that planning for use of external partner resources be included in this national-regional planning coordination program</p> <p>Provide directed funding to regional health authorities to carry out their annual operating plans and to finance coordination functions with national programs.</p>
7	<p>Availability of data on public financing for health, especially expenditures, is limited, particularly for citizens and civil society groups. Independent analysis of government health spending is challenging (Section 4.4. Transparency).</p>	<p>Budget information is more readily and regularly available through the MOH website. Develop "popular" versions of national health budgets for dissemination to citizens and/or civil society groups.</p> <p>Review and revise as needed existing systems for tracking budget release and expenditures data to improve regularity and comprehensiveness of it production; more regularly post this information along with budgets to the MOH website in CSV or other easy to use format.</p>
8	<p>Structures meant to improve citizen participation, such as catchment area committees and ward development committees, have spaces for elected or appointed citizen representatives, but not for average citizens, reducing the opportunity for citizen feedback or input (Section 4.5. Service Management and Oversight; Citizen oversight).</p>	<p>Include space for average citizens to participate in community and citizen feedback structures.</p>

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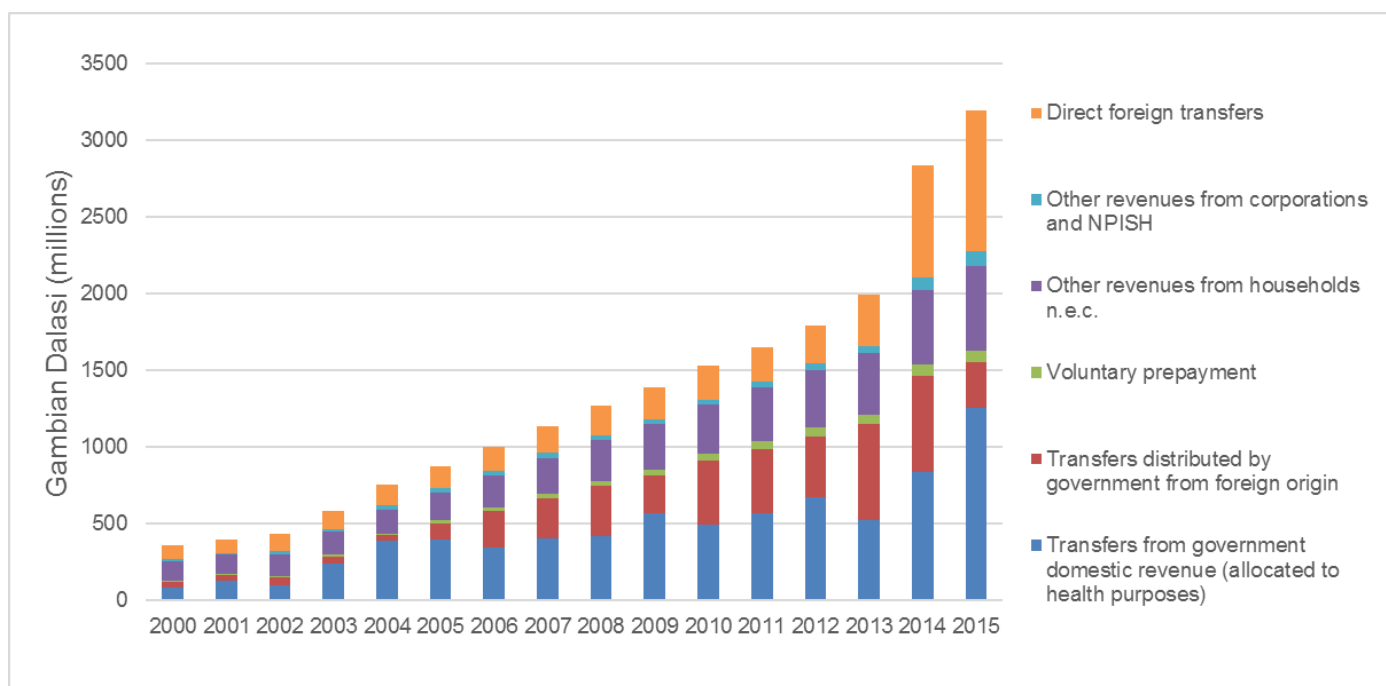
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Annex 1

Trends in Sources and Amount of Funds in The Gambia's Health Sector



Note: Equivalent to Figure 10, in actual GMD for year as reported in a dataset provided the Ministry of Health's Health Financing Unit, May 2018. Figure 10 shows values in US\$, converted from GMD figures at the currency exchange rate prevailing in June of the relevant year.

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