**Sami Medical College and Preventive Health Services in Gambia**

**Responding to unmet goals of global health targets:**

**Health for All by Year 2000**

“No child in the world will go to bed hungry by the year 2000.” This was one of the final statements at the closing of the Food Security Conference in Rome in 1974. According to the United Nations Development Programme, hunger now prevails among at least a quarter of the world's inhabitants.

1. Every day there are 30 000-40 000 child deaths in the world, most of these from diseases related to malnutrition.
2. This means that there are 12 to 14 million child deaths associated with hunger each year. Can we expect this figure to have improved by the year 2000?

The well-known phrase **“Health for all by the year 2000”** was coined at the United Nations Alma Ata conference in 1978. By 1996 only four years were left for hunger and disease to be defeated. Objectives are natural when setting targets and are often linked to a change of century or to a historically important date. But what is the use of wishful thinking far away from the bitter reality of widespread poverty? Gambia is not alone where targets are set to make political gains while reality pinches deeper and most painfully biting. There are always gaps between targets and what is achieved. Some of the unachieved targets undergo rollover while new plans and budgets raise greater hopes.

Cognisant of the fact that even best of plans by globally represented organisations still leave traces of undone tasks, Sami Medical College and Preventive Health Services is not seeking perfection. We strive to identify prevailing gaps, mobilise resources in collaboration with key stakeholders for most readily available remedial intervention. These gaps needed more vibrant solution approach.

Health service providers will be better by identifying factors responsible for trail of unmet goals. Our emergence as partners in this regard is fulfilling.

**Overall context of Health for all by Year 2000**

The goal of the World Health Organization in the 1980s is often mistaken for a slogan. It was resolved by the World Health Assembly in 1977 that the main social target of governments and of WHO should be attainment by all the world's people by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. This goal would be implemented by ensuring access to essential primary health care and reduction by finite amounts of the burden of disease, disability, and premature death. The goal was never achieved because of many obstacles, notably lack of political will to implement measures that would achieve it. The onset of the HIV/AIDS pandemic was an important aggravating factor.

**Problem Statement**

Service delivery and scope of outreach remain serious challenges for Gambian health sector. Part of the problem is lack of solution driven policy instruments. Remedial intervention is a felt-need requiring private sector involvement beyond treatment.

Existing private sector providers in Gambia’s health sector are largely motivated by commercial gains. In a population of low income with heavy dependency on sole bread winners, cost of medication is not sustainable.

Responding to demands of critical challenges requires solution driven intervention in diverse ways. Our call to duty is influenced by the need to provide sustainable remedies as key stakeholder in health service delivery. We target disadvantaged hard-to-reach and marginalised communities while striving to build the enabling human capital reserve needed in meeting varied health service delivery needs.

**Mission**

To deliver quality accessible integrated health service sustained by technically competent, trained and aspiring youth professionals with outreach coverage for hard-to-reach marginally disadvantaged communities, creating optimal satisfaction at lowest cost.

**Vision**

Championship in providing innovative result-oriented teaching and coaching health education for enhancing skill development of self-motivated nursing service and health professionals ensuring timely response to meet community health felt-needs .

**Motivation**

Establishment of Sami Medical College and Preventive Health Services emerged from a felt-need in finding sustainable response needed to cut down cost by preventive health maintenance approach.

**Core values**

Upholding highest ethical standards, we give respect to people and communities by preserving individual privacy in the provision of one-to-one personal health care with dignity.

**Scope**

Cutting down cost of health care and maintenance requires high priority in resource allocation. In Gambia the search for remedial response deepens as health challenges rise with a growing population relying on less equipped limited facilities around the country.

Against that background of scarcity and inadequacies entire health sector of Gambia requires preventive intervention with private sector involvement. Sami Medical College and Preventive Health Services is direct response on acute felt-needs for capacity building and outreach support to communities.

Overall functional objective and focus of this intervention is to fill gaps in health personnel capacity while providing remote communities with adequately trained health workers. It is also anticipated that training of more health service workers will serve as capacity generation with vast shared gains.

Those who prefer to continue serving remote localities will be meeting the felt-needs for deprived and disadvantage communities. Others may identify further capacity building prospects by enrolment in University of Gambia School of Medicine or choose further training abroad.

Through partnership cooperation and technical collaboration our mode of integration is both vertical and horizontal. As a medical college our trust lies on continued learning and promotion of best practice in provision of professional service.

Our cooperation with other stakeholders in the medical service sector takes cognisance of the need for integrated health care delivery.

While fulfilling our commitment to capacity building and providing much needed yet very scarce health services especially for deprived communities, we are also source of enrolment for universities and other colleges. Due to certain imposed limitations, we may not be able to provide training for those of our intakes who may identify better capacity building prospects.

We encourage those requiring higher professional standards to use our platform as primary springboard in reaching their goals local and abroad. Partnership cooperation and technical collaboration with various institutions provides the enabling environment for our students and field workers take advantage of vastly available opportunities.

By subscribing to medical journals we seek to be updated on prevailing best practice prospects of capacity building. Field staff in disadvantaged communities will be provided with upgrading courses to keep better informed and boost their capabilities.

**Gambia Health Sector Inadequacies and Gaps**

Sourcing government policy on health services of Gambia provides grounds to establish felt-needs. Close attention on government published health policy document reveals considerable gaps and inadequacies. Although problems are identified as contains in the document, there is lack of policy instruments needed to redress numerous listed matters affecting the health sector. What is meant to serve as instrumental policy ended up as compilation of facts and figures most fitting a situational report.

In the absence of properly constituted policy based on sound intervention strategies, health sector problems will further compound with no solution readily at hand.

Our capacity as key stakeholder in Gambia health sector gives occasion for Sami Medical College to fulfil the role of friendly critic where government regulations fall short addressing pertinent issues in their best outfit.

Apart from policy inadequacies Gambia health service delivery suffers from manpower deficiencies too. There is not only a situation of limited numbers in health worker proportion to the needy population. Capacity is also lacking visibly.

Sami Medical College and Preventive Health Services in Gambia emerged as outreach platform especially for marginalised sectors of society prone to preventive conditions. Our interest in health service delivery transcends narrow concerns.

**Unicef sourced health issues on Gambia**

Child mortality is declining in The Gambia, although not fast enough to reach MDG 4 by 2015. Infant mortality stands at 81 and under-five mortality at 109 per 1000 live births, according to the Multiple Indicator Cluster Survey (MICS) 2010. In 2010, under-five mortality rates in the rural areas were 36 per cent higher than those in urban areas due to contributing factors such as malaria, pneumonia, and diarrhoeal diseases which are the leading cause of child morbidity and mortality. The national maternal mortality rate has declined from 730 per 100,000 in 2001 to an estimated 360 per 100,000 deaths (WHO, UNICEF, UNFPA 2012 estimates), nonetheless, the country is unlikely to meet the MDG 5 target of 263 per 100,000. Nationally, 56.6 per cent of women were assisted at birth by a skilled health worker (MICS, 2010) while, in the impoverished Central River Region South, only 32 per cent of them were assisted at birth.

Most children are now immunized from diseases such as measles, meningitis and polio. According to the 2010 Multiple Indicator Cluster Survey, 87.4 per cent of children had all nine antigens as recommended in the first 12 months of life while 99 per cent of children aged 12-23 months received a Bacille de Calmette et Guérin (BCG) vaccination by the age of 12 months. The first dose of Diphtheria Petussis and Tetanus (DPT) was given to 96.5 per cent and the second and third doses were respectively given to 96.2 per cent and 89.3 per cent of children aged 12-23 months. Over 87 per cent of children were vaccinated against measles before their first birthday.

According to the 2010 MICS, 41.1 per cent of under-five children slept under a bednet the night before the survey interview, and 33.3 per cent of these bednets were impregnated with insecticide. About 71 per cent of the households reported to have at least one insecticide treated net or received indoor residual spray (IRS) in the last 12 months preceding the survey. Health seeking behaviour for prevention and management of pneumonia is on the rise because, of the 6 per cent of children age 0-59 months reported to have had symptoms of pneumonia during the two weeks preceding the survey, 68.8 per cent were taken to an appropriate health provider.

In terms of the knowledge, attitudes and practices of families and communities towards child and maternal health, the primary caregivers of the children have an important role to play in preventing and managing preventable diseases like diarrhoea and pneumonia. Evidence has shown that large scale communication focusing on the four key household behaviours of exclusive breast feeding, hand washing with soap at critical times, use of insecticide treated nets to prevent malaria and use of oral rehydration solution to treat diarrhoea can reduce child hood mortality by 40 per cent.

**Action**

UNICEF carries out its mission through a unique programme of cooperation jointly developed and agreed on with the government of The Gambia for a five-year period. This programme of cooperation, well informed by a situational analysis of women and children, guides our work within the country in support of the national development priorities. Our presence is visible in all high-level decision-making forums and is well positioned to directly influence major decisions made on policy design and development as well as downstream service delivery.

At the policy level, UNICEF influences decision-making through advocacy and sector-wide donor coordination processes. We provide technical support and contribute to shaping the development of various policies and plans on maternal and child health. In 2009, UNICEF was instrumental in developing the National Health Policy 2010 – 2020 and the Malaria Strategic Plan for 2010 – 2014. UNICEF is a key member of the Inter-agency Co-ordination Committee (ICC) for immunization and the Primary Health Care Working Party Group.

At the service delivery level, we support the village health service in our three intervention regions (Central River, Upper River and North Bank regions) by providing supplies of basic paediatric drugs for the management of common childhood diseases such as diarrhoea and pneumonia, which remain among the three top killers of children under five. Cold chain equipment have been expanded to maintain the quality of vaccines. Training activities to improve the capacity and skills of health staff, village health workers, village development committees and baby-friendly community initiatives (BFCI) groups are also supported. UNICEF actively participates and plays a lead role in national polio campaigns (integrated with Vitamin A and de-worming), reaching, on average, more than 95 per cent of all children under five years nationally.

At the grassroots level, we work with and support communities to improve the capacities of caregivers, mothers, families and communities for the adoption of essential care practices. This component supports the scaled-up use of communication for development to ensure the adoption of hand washing practices, household water treatment, use of insecticide treated nets for pregnant women and children under the age of five, preparation and use of oral rehydration salts for diarrhoeal cases, and promotion of exclusive breastfeeding for the first six months of life.

**Impact**

The health of the most vulnerable children and women will be improved through more access to supplies; routine and integrated supplemental immunization, vitamin A supplementation for children under the age of five and post-partum mothers; deworming; promotion of exclusive breastfeeding; use of insecticide treated nets to prevent malaria; oral rehydration solution to treat diarrhoea; hand washing with soap at critical times; and the consumption of iodized salt. At the same time, partners will be provided logistic support to enhance the services for children and women.

The provision of supplies and capacity building will not only allow for the treatment of childhood illness at community level and provide a comprehensive and cost effective system, but also contribute to the reduction of under-five mortality.

**Social inclusion**



Social Inclusion is at the heart of everything that UNICEF strives for across all programming; through working to ensure girls have the same access to education as boys, to targeting the hardest to reach communities in supporting primary health care or working on developing coherent and appropriate child protection strategies with government, or ensuring children’s rights are maintained during an emergency.  The work that UNICEF does in The Gambia aims to ensure that the rights and voices of children and women are being promoted and upheld in all aspects of poverty reduction.

**Issue**

In The Gambia, as in many other West African countries, social inclusion has been a significant challenge for UNICEF and its partners. Issues such as child marriage or poor educational attendance rates have been challenges to which UNICEF and the government have worked hard to meet. The Gambia, due to its comparative size, has the disadvantage of having meagre resources to address issues, where larger countries have taken advantage of their size to lever resources to address inequities. Data on social inequalities, for example, has been a constant challenge to making progress, as clear and reliable data on the situation of the most vulnerable children is unavailability. Lack of data impacts heavily on the ability of decision making and ensuring that efforts are being directed in the right manner. Consequently, many children are excluded from enjoying their rights. Further, the nascent nature of the country’s social protection programme and weak fiscal support has meant that existing programming has low coverage and only reaches a fraction of the poor. The social protection system in the county remains weak and fragmented with limited means of protection for the most vulnerable in the society especially in the event of life contingencies, livelihood shocks or severe deprivation. Social protection as a means to address social exclusion has had little exposure at policy level and, as a result, is constantly underfunded.

**Action**

The Social Policy Programme in The Gambia Country Office, which addresses elements of Social Inclusion, supports the Government of The Gambia to address a number of priority issues. These include support for the generation of quality and fully disaggregated data through conducting the Multiple Indicator Cluster Survey (MICS). The MICS is implemented every 3 years using the same methodology and provides the opportunity to monitor and assess progress in social sectors as well as highlight areas that require special attention. This support to data management and analysis supports evidence based decision making thus informing policies and programmes of government and their partners as well as providing baseline data and trend analysis for monitoring and evaluation purposes. To date, the country has conducted four rounds of the MICS with UNICEF support which have been key in developing other pro-poor policies in country.

With UNICEF’s support, and in response to the fragmented structure of the Social Protection system in The Gambia, UNICEF has supported the government in creating a platform to assist the development of a cohesive and comprehensive social protection system. Engaging with numerous influential stakeholders, the platform has driven the pro-poor social protection agenda, resulting to date in a number of outcomes, notably the production of strong evidence to advocate at the highest level for an integrated and equitable social protection programme. This lobbying has ensured that social inclusion, supported by the proposed national social protection systems, forms a key aspect of the countries high level development strategies where the rights of children and women are being championed as a key component of social development. A key component of this work was the development of the National Social Protection Policy. The policy provides the framework to accelerate and sustain pro-poor and inclusive economic growth, poverty reduction as well as expand the coverage of social protection into health, education and other key sectors where the main benefit are to the country’s most vulnerable and the marginalized. The policy provides the foundation at policy level that ensures roles and responsibilities across all society are known and allocated in working towards eliminating the worst forms of abuse, exploitation and neglect of children.

**Impact**

The Social Policy programme will address knowledge gaps to aid policy development and ensure coherent approaches to addressing structural inequities.  The social protection work being undertaken by UNICEF will also provide policy frameworks and programming to ensure that there is a ‘minimum package’ of social protection support to the weakest and most under-privileged children in the country.  The aim of the social protection package will be to target those children that are the most marginalized and those who have systemically been excluded from any forms of prior assistance. The development and strengthening of the Social protection Steering Committee, engaging senior government staff, will also work towards commitment to the strengthening of social inclusion and the fiscal space required at national budget level to adequately plan for financial allocation to the most vulnerable.

**WHO Health Focus on Gambia**

**Department of Public & Environmental Health, Gambia**

**Member profile**

The vision of the Department of Public & Environmental Health (DPEH) in Banjul, Gambia is the attainment of accessible quality health care for the Gambian population that would be a model in the Africa Region by the year 2020. It involves partners, donors, local and international agencies, interest groups and private sector in the Planning and Implementation of Health Services. The Gambia is located on the West African coast and extends about 400 km inland, with a population density of 97 persons per square kilometre. The public health service delivery system is three tier based on the primary health care strategy. Presently services are provided by 3 hospitals, 36 health facilities at the secondary level and 492 health posts at the primary level. Gambia's health sector has over the years been under great pressure due to a number of factors: the high population growth rate, inadequate financial and logistic support, shortage of adequately and appropriately trained health staff, high attrition rate and lack of efficient and effective referral system. Poverty and ignorance have led to inappropriate health seeking behaviours and contributed to ill health.

**Main activities**

The goals of DPEH are:

* to develop sustainable Essential Care Packages for all levels of the health care delivery system,
* to provide required resources for efficient delivery of the essential care package, and
* to implement delivery of essential care packages at all levels.

The current projects are:

* overall training for research methodologies in all health training institutions; and
* community-supported health interventions such as Bamako Initiative, Baby Friendly Community Initiative with proven health benefits should be scaled up and extended to national coverage.

Others will be reviewed to make them more relevant and effective. For the desired sustainability and continuity to be realised, the need for effective community involvement in the planning and implementation of these programmes is paramount.

**Links to the health workforce crisis**

The mission of DPEH is provision of quality health care services within an enabling environment, delivered by appropriately and adequately trained, skilled and motivated personnel at all levels of care with the involvement of all stakeholders to ensure a healthy population. DPEH works to decentralize responsibility, authority and resources to Hospitals, Divisional Health Management Teams, Basic Health Facilities and Village Development Committees. It looks to improve organization and management of the health care delivery system. A Human Resource Development Plan will be formulated that will address the whole range of personnel functions, i.e. recruitment, pre and in-service training, deployment, promotion, transfer, leave, grievances procedures, pay and non-monetary benefits.