



**REPUBLIC OF THE GAMBIA**  
**MINISTRY OF HEALTH AND SOCIAL**  
**WELFARE**

**NATIONAL MASTER PLAN**  
**FOR**  
**NEGLECTED TROPICAL DISEASES**  
**2015-2020**

**December 2014**

<b>LIST OF FIGURES .....</b>	<b>3</b>
<b>LIST OF TABLES .....</b>	<b>4</b>
<b>LIST OF ANNEXES.....</b>	<b>5</b>
<b>LIST OF ACRONYMS .....</b>	<b>6</b>
<b>FORWARD .....</b>	<b>9</b>
<b>ACKNOWLEDGMENT .....</b>	<b>10</b>
<b>LIST OF CONTRIBUTORS.....</b>	<b>11</b>
<b>INTRODUCTION .....</b>	<b>13</b>
<b>PART 1: SITUATIONAL ANALYSIS.....</b>	<b>15</b>
<b>PART 2: NTD STRATEGIC AGENDA.....</b>	<b>41</b>
<b>PART 3: OPERATIONAL FRAMEWORK .....</b>	<b>53</b>
<b>3.1 SCALING UP ACCESS TO NTD INTERVENTIONS, TREATMENT AND SERVICE DELIVERY</b>	
<b>CAPACITY .....</b>	<b>53</b>
<b>3.1.1 Scaling up preventive chemotherapy interventions .....</b>	<b>53</b>
<b>3.3 PHARCOVIGILANCE IN NTD CONTROL ACTIVITIES .....</b>	<b>60</b>
<b>3.4 STRENGTHENING CAPACITY AT NATIONAL LEVEL FOR NTD PROGRAMME MANAGEMENT AND</b>	
<b>IMPLEMENTATION .....</b>	<b>61</b>
<b>3.5 ENHANCING PLANNING FOR RESULTS, RESOURCE MOBILIZATION AND FINANCIAL</b>	
<b>SUSTAINABILITY .....</b>	<b>63</b>
<b>3.6 STRENGTHENING GOVERNMENT OWNERSHIP, ADVOCACY, COORDINATION AND</b>	
<b>PARTNERSHIPS .....</b>	<b>64</b>
<b>3.8. POST INTERVENTION SURVEILLANCE AND INTEGRATION WITHIN PRIMARY HEALTH CARE</b>	<b>66</b>
<b>BUDGET JUSTIFICATION AND ESTIMATES .....</b>	<b>68</b>
<b>ANNEXES.....</b>	<b>69</b>
<b>PART I SITUATION ANALYSIS .....</b>	<b>69</b>

## List of Figures

<b>Figure 1:</b> Administrative Structures of The Republic Of Gambia.....	16
<b>Figure 2:</b> Gambia Showing The Population Density. ....	18
<b>Figure 3:</b> Population Size And Growth Of The Gambia .....	18
<b>Figure 4:</b> Map of PC-NTD coendemicity in Gambia.....	34

## List of Tables

<b>Table1:</b> National Population Data, Schools,And Health Facilities At District Level .....	17
<b>Table 2.1:</b> LF Disease Distribution In The Country .....	29
<b>Table 2.2:</b> Trachoma Distribution In The Gambia.....	30
<b>Table 2.3:</b> Known Disease Distribution Of Urinary Schistosomiasis In The Gambia .....	30
<b>Table 2.4:</b> STH Distribution In The Gambia.....	31
<b>Table 2.5:</b> Number of dog bites per region from 2011 to 2014. Source, HMIS/MOH&SW.....	31
<b>Table 2.6:</b> Distribution Trends of Leprosy Cases According To Regions In The Gambia (2005- 2010) .....	32
<b>Table 3:</b> NTD Co-Enedmicity.....	33
<b>Table 4:</b> NTD Mapping Status.....	35
<b>Table 5.1:</b> Summary Of Intervention Information on Existing PCT-NTD Programmes.....	36
<b>Table 5.2:</b> Summary Of Intervention Information on Existing CM Programmes .....	36
<b>Table 6.1:</b> SWOT Analysis: STH / SCH / LF.....	38
<b>Table 6.2:</b> SWOT Analysis: Trachoma.....	38
<b>Table 6.3:</b> SWOT Analysis: Leprosy .....	39
<b>Table 6.4:</b> SWOT Analysis: Rabies.....	40
<b>Table 7:</b> Strategic Framework Summary.....	42
<b>Table 8:</b> Summary of NTD Disease Specific Goals and Objectives.....	44
<b>Table 9:</b> Types of Mass Drug Administration.....	54
<b>Table 10:</b> Activities For Strategic Priority 1- Scale Up Access To PCT Interventions.....	55
<b>Table 11:</b> Activities For Case Management Interventions.....	56
<b>Table 12:</b> Case Management And Chronic Care.....	57
<b>Table 13:</b> Intervention Packages For Transmission Control.....	58
<b>Table 14:</b> Activities For Disease Transmission Control.....	59
<b>Table 15:</b> Activities For Strengthening Pharmaco-Vigilance In NTD Programme.....	61
<b>Table 16:</b> Activities And Resources Needed For Strengthening Capacity For NTD Programme .....	62
<b>Table 17:</b> Scaling Up/Scaling Down Plan. ....	64
<b>Table 18:</b> Activities For Implementing Strategic Priority 1: .....	65
<b>Table19:</b> Activities For Implementing Strategic Priority 4: .....	66
<b>Table 20:</b> Activities For Surveillance And Sustainability.....	67

## List of Annexes

<b>Annex 1.1.</b>	Populations, Villages/Communities, Children, Schools, and Health Facilities .....	69
<b>Annex 1.2. :</b>	Distances Between Main Cities And District Headquarters of The Country.....	69
<b>Annex 1.3:</b>	Organisational Chart of The MOH &SW and The NTD National Programme.....	70
<b>Annex 1.4:</b>	Summary on Available Data Of PCT-NTD Distribution.....	71
<b>Annex 1.5:</b>	Summary on Available Data On CM-NTD Distribution.....	71
<b>Annex 1.6:</b>	Summary on Status Of Implementation of PCT- NTD Interventions In Districts.....	72
<b>Annex 1.7:</b>	Summary on Status Of Implementation of CM Interventions In Districts .....	73
<b>Annex 2. 1:</b>	Package of Preventive Chemotherapy (PCT) - Mass Drug Administration (Mda).....	74
<b>Annex 2.2:</b>	Package Of Case Management (CM) and Chronic Care.....	74
<b>Annex 2. 3:</b>	PCT Algorithm 1.....	75
<b>Annex 2.4:</b>	PCT Algorithm 2.....	75
<b>Annex 2.5:</b>	Algorithm For Co-Endemicity Of Cm-Ntds In Countries of the Who African Region.....	76
<b>Annex 2.6:</b>	Package Of Transmission Control - Vector/Reservoir Control.....	77
<b>Annex 2.7:</b>	Package Of Improvement of Environment, Supply Of Safe Drinking Water, Sanitation, .....	77
<b>Annex 2.8:</b>	What To Do” By District (Operational Unit) By Operational Package.....	78
<b>Annex 2.9:</b>	Drug Estimates And Logistics.....	79
<b>Annex 2.10:</b>	Drug Forecasting And Logistics.....	79
<b>Annex 2.11:</b>	Summary Of Progressive Scale Up And Phase Out Of PCT Interventions Package .....	80
<b>Annex 2.12:</b>	Results Framework For The WHO-HQ-AFRO-APOC Strategic Plan, 2010–2015 .....	81

## LIST OF ACRONYMS

CACs	Catchment Area Committees
CBI	Community Based Initiatives
CBOs	Community Based Organizations
CDCP	The Centre for Disease Control and Prevention Atlanta
CEO	Chief Executive Officer
CHNs	Community Health Nurses
CM-NTDs	Case Management- Neglected Tropical Diseases
CMDs	Chief Medical Directors
CRR	Central River Region
DHIS2	District Health Information System version 2
DHPE	Directorate of Health Promotion and Education
DHS	Directorate of Health Services
DRF	Drug Revolving Fund
DSW	Directorate of Social Welfare
EDC	Epidemiology and Disease Control
DPI	Directorate of Planning and Information
EPI	Expanded Program on Immunization
FSQHE	Directorate of Food Standards, Quality and Hygiene Enforcement
GAVI	Global Alliance on Vaccine and Immunization
GBoS	Gambia Bureau of Statistic
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, TB and Malaria
GRTS	Gambia Radio and Television Services
GHW	General Health Worker
HDI	Human Development Index
HIV/AIDs	Human Immune Deficiency Virus
HMIS	Health Management Information System
HMIS	The Health Information System
HND	Higher National Diploma
HRH	Human Resources for Health

ICT	Immunochromatography Test
ICC	Inter-Agency Coordinating Committee
IDM	Integrated Disease Management
IDSR	Integrated Disease Surveillance and Response
IDSR	Integrated Disease Surveillance and Response
IEC	Independent Electoral Commission
IEC/BCC	Information Education Communication/ Behaviour Change Communication
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IRS	Insecticide residual spray (IRS),
IVE	Ivermectin
IU	International Unit
KMC	Kanifing Municipal Council
LDCs	Least Developed Countries
LF	Lymphatic Filariasis
LEP	Leprosy
LGA	The Local Government Area
LMIS	Logistic Management Information
LRR	Lower River Region
MDA	Mass Drug Administration
M&E	Monitoring and Evaluation
MICS	Multiple Indicator Survey
MMR	Maternal Mortality Rate
MoBSE	Ministry of Basic and Secondary Education
MOFEA,	Ministry of Finance and Economic Affairs
MOHSW	Ministry of Health and Social Welfare
NaNA	National Nutrition Agency
NCD	Communicable and Non Communicable Diseases
NCG	National Consultative Group
NGO.	Non-Governmental Organisation
NPHLS	Directorate of National Public Health Laboratory Services

PAGE	Programme for Accelerated Growth and Employment
PC-NTDs.	Preventive Chemotherapy- Neglected Tropical Diseases
PEGEP	President Empowerment for Girls Education Program
PRSP	Poverty Reduction Strategy Paper
RBF	Result Based Financing
RCH	Reproductive & Child Health Services
RHD	Regional Health Director
SAFE	Surgery Antibiotics Face washing Environmental change
SDH	Social Determinant of Health Report
SMC	Senior Management Committee
STH	Soil Transmitted Helminths
TANGO	The Association of Non-Governmental Organizations
TAS	Transmission Assessment Survey
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TF	Follicular trachoma
THE	Total health Expenditure
TIPAC	Tool for Integrated Planning and Costing
TRA	Trachoma
TT	Trachoma Trichiasis
UNFPA	United Nation Population Fund
UNICEF	United Nation Children's Fund
URR	Upper River Region
UTG	University of the Gambia
WASH	Water access Sanitation and Hygiene
VHWs	Village Health Workers
VSGs	Village Support Groups
WCR	West Coast Region
WHO	World Health Organisation



## FORWARD

Neglected tropical diseases (NTDs) are a different group of diseases with distinct characteristics that thrive mainly among the poorest populations. There are 17 NTDs prioritized by WHO and are endemic in 149 countries and affect more than 1.4 billion people, costing developing economies billions of dollars every year. Many can be treated cost-effectively, yet they have been largely ignored on the global health policy agenda until recently. In May 2013, the 66th World Health Assembly adopted resolution WHA66.12 which calls for intensified, integrated measures and planned investments to improve the health and social well-being of affected populations. WHO is working with Member States to ensure implementation of WHA66.12.

In response to the global NTDs call for elimination, control and eradication of NTDs by 2020, the situational analysis of NTDs was conducted in The Gambia. This desk review revealed the need to map endemic NTDs, and the development of a programme master plan for the elimination, eradication, and control of NTDs such as lymphatic filariasis, trachoma, soil transmitted helminthes, schistosomiasis, leprosy and rabies. The major objective of this Master Plan is geared towards improving the quality of life and economic growth of the Gambians by reducing the burden of NTDs, through a well-coordinated national NTD control and elimination programme and to prevent the occurrence of new infections of all NTDs by 2020; in addition to initiating appropriate management of all existing cases. This plan will provide a tool that clearly articulates the strategies for joint planning, budgeting and resource mobilization for NTDs through sustainable integrated interventions in line with WHO guidelines.

The NTDs master plan was conducted in a consultative and multisectoral approach involving all stakeholders i.e. the relevant government ministries (Health, Education, Agriculture, Economics, Planning, Finance and Environment), NGOs, research institutions (MRC and CIAM) and the UN agencies. The entire process was transparent and open and allowed divergent views to reflect the perceptions of NTDs in The Gambia. This was of paramount importance, as the Ministry of Health provided leadership, while the necessary logistic support to guide the process was provided by WHO AFRO.

Ministry of Health & Social Welfare  
Gambia

## **ACKNOWLEDGMENT**

The Ministry of Health and Social Welfare provided the frame work on NTDs which many stakeholders used to produce a new five-year comprehensive strategic master plan. This plan is the National response to NTDs elimination, eradication and control, which will go into effect from 2015 -2020.

Many individuals have contributed immensely to the development of this NTDs master plan by providing time and technical expertise. In particular the following deserve special mention and appreciation for their contribution in the development of this NTDs strategic master plan: Dr. Samba Ceesay, Mr. Sana M. Sambou, Dr. Abdoulie Jack, Mr. Yaya Camara, Mr. Bakary Sanneh, and Dr. Shamila Jah from WHO Gambia

I wish to acknowledge the technical support and contributions of the WHO consultants- Dr.Sammy O. Sam-Wobo from Nigeria and Dr. Nicholas Tendogfor from Cameroun. We sincerely appreciate all the PARTNERS who had and are still supporting the Government of Gambia in their resolve to provide good and sustainable health system and service. Lastly, I wish to extend my sincere thanks and appreciation to the WHO Country Representative in The Gambia- Dr. Charles Sagoe-Moses for his support in securing the consultants through WHO to the EDC Team.

Hon. Minister  
Ministry of Health & Social Welfare  
The Gambia

## List of contributors

No	NAME	INSTITUTION
1	Dr. Samba Ceesay	Ministry of Health and Social Welfare
2	Yaya Camara	Epidemiology Disease Control
3	Sana M. Sambou	Epidemiology Disease Control
4	Bakary Sonko	Mental Health
5	Dr. Abdoulie Jack	Retired WHO Representative
6	Dr. Sammy O. Sam-Wobo	WHO Technical Consultant
7	Dr. Tendogfor Nicholas	WHO Technical Consultant
8	Dr. Shamila Jah	WHO Gambia
9	Alpha Jallow	NTD Focal Person, WHO Gambia
10	Lamin F. Manjang	Kwinella Health Centre
11	Pa Momodou C. Jaye	Retired Lab Scientist
12	Momodou Fatajo	Gambia Bureau of Statistics
13	Emmanuel Olabode	Edward Francis Small Teaching Hospital
14	Serign J Ceesay	Medical Research Council
15	Balla Jatta	Epidemiology Disease Control
16	Alieu Wurry	National Leprosy TB Programme
17	Sarjo Kanyi	National Eye Health Programme
18	Ebrima Bah	Directorate Public Health Research
19	Ebrima Joof	National Public Health Lab
20	Muhammed Saho	Directorate of Health Promotion & Education
21	Musa Jawara	Medical Research Council
22	Lamin Manneh	Epidemiology Disease Control
23	Fatou O. Sowe	Directorate of Health Promotion & Education
24	Tida C. Bojang	D.L.S/Ministry of Agriculture
25	Almea Matariock	Centers for Disease Control (CDC)
26	Ignatius Baldeh	National Public Health Lab
27	Abdoulie Camara	Epidemiology Disease Control
28	Iris Cassell	Ministry of Basic Senior Education, Lifeskills Edu. Unit
29	Fatoumata Jallow	Health Management Information System
30	Bakary Sanneh	National Public Health Lab
31	Karamba Keita	Regional Health Director/North Bank East
32	Karim Darboe	Regional Health Director/Lower River Region
33	Sheriffo MK Darboe	Regional Health Director/Western Region 1

34	Adama MB Sanneh	Epidemiology & Disease Control (Secretary)
35	Ebrima Keita	Environmental Health Unit
36	Abdoulie Juum	Regional Health Director/Upper River Region

## INTRODUCTION

Neglected tropical diseases (NTDs) is a group term that encompasses a group of parasitic, bacterial and viral infections collectively causing a disease burden comparable to that of malaria and HIV (Fenwick *et al.*, 2005; Hopkins *et al.*, 2008). Out of the 17 global NTDs, 14 are listed to occur in Sub-Saharan Africa. They include lymphatic filariasis (LF), schistosomiasis, soil transmitted helminthiases, leprosy, buruli ulcer, yaws and other treponematoses, onchocerciasis, dracunculiasis, blinding trachoma and human African trypanosomiasis (WHO, 2012a).

Worldwide, one billion people are estimated to be at risk of NTDs, and approximately 534,000 people die of the diseases annually (WHO, 2012a). NTDs are widespread in Africa, and are the world's most common infections of people living in poverty (Hotez and Kamath, 2009). Sub-Saharan Africa has a high prevalence of NTDs, accounting for approximately one-quarterhree major intestinal helminth infections (namely, ascariasis, trichuriasis, and hookworm infection), more than one-third of the LF, one-half of the trachoma, and all or most of the schistosomiasis, onchocerciasis, loiasis, and human African trypanosomiasis (HAT) (Hotez and Kamath, 2009; Hotez, 2014). The greatest burden of buruli ulcer lies in West and Sub-Saharan Africa, where it is a significant cause of disability among children and adults in subsistence agricultural communities (Huang and Johnson, 2014). Visceral leishmaniasis causes substantial morbidity in humans and leads to about 40,000 deaths annually (Ready, 2014). Due to the high morbidity and mortality that result from NTDs especially in poor communities, it is important to develop strategies to prevent and reduce their burden. In 2007, efforts to combat the diseases were redirected to shared commitment to support WHO's strategies, goals and targets after the first Global Partners Meeting (WHO, 2007). This move resulted in tremendous gain to public health, including scale up of control and eradication programmes and improved access to chemotherapeutic interventions for hundreds of millions of poor and marginalized individuals in an innovative and cost-effective way (WHO, 2012b).

Recently, there has been a growing momentum towards the control and/or eliminate of NTDs in the African region (WHO, 2012a), as a road map on NTDs was developed by WHO in 2012. The destination of the road map is the elimination or control of NTDs to levels at which they will no longer be considered as public health problems by 2015 and 2020 (WHO, 2012b).

Moreover, The Accra Urgent Call in 2012, the African Ministers of Health resolved to strengthen efforts to fight NTDs, and recently, the World Health Assembly adopted a resolution to scale up the control of NTDs. Currently, thirty-six countries in the WHO African Region have developed integrated national multi-year plans (NTD master plans) (WHO, 2013). Five of these countries (Burkina Faso, Ghana, Mali, Niger, and Uganda) have already started scale-up activities, since scaling up to national programmes is a goal of NTD control programmes (Hanson *et al.*, 2012).

In an attempt to meet this global objective of combating NTDs, The Gambia is developing an action plan for national neglected tropical diseases programmes. In any country, knowledge of local endemicity status of NTDs is essential for subsequent development of any implementation strategy. However, there is limited

information on the current status/endemicity of NTDs in The Gambia. For trachoma, its mapping has been carried out across the entire country except in one district (Kanifing), under the National Eye Health Programme. However, there is no specific programme for trachoma, or budgeted funding for its control in the country. The most recent research data on LF endemicity in the country is from a transmission assessment survey of primary school children conducted in 2013 by Epidemiology and Disease Control Unit of the Ministry of Health and Social Welfare (MOHSW) in collaboration with CDC. The data from this survey was not sufficient to provide reliable information on the prevalence of LF in The Gambia. Available information on Urinary Schistosomiasis was obtained from the Ph. D thesis of Dr. A. D. Jack (1989), which was based on a two-year longitudinal study on chemotherapy in 12 PHC villages, located in two regions which were then known as schisto-endemic areas in the country. This study is not only old, but was also limited in scope, as it covered only two regions. The only other data source was routine hospital reports, compiled monthly by the health facilities. Thus, the data available cannot provide reliable and adequate information on the endemicity of schistosomiasis in The Gambia. Soil-transmitted helminthiasis (STH) is the most neglected of the four PC-NTDs in The Gambia. It has not been captured under any division of the MOHSW and the only available data is from hospital routine examinations collated at the regional level. Furthermore for the CM-NTDs in the Gambia, document from NTDs and veterinary reports has shown pocket incidences of rabies and leprosy which are case management NTDs.

In the Gambia, there exist a parallel system in the management and control of some NTDs (i.e leprosy under the NTLP programme, and trachoma under the national eye care unit); but there is no control programme for schistosomiasis, STH, lymphatic filariasis, and rabies. Therefore, this NTD master plan will provide the platform for establishing and strengthening the control, elimination and reduction in the burden of NTDs in the Gambia.

## **PART 1: SITUATIONAL ANALYSIS**

### **1.1 Country Profile**

The Republic of Gambia is located on the West African Coast almost surrounded by the Republic of Senegal on the Northern, Southern and Eastern borders and the Atlantic Ocean on the Western borders. The Gambia is a small and narrow country whose borders mirror the meandering Gambia River. It lies between latitudes 13° and 14°N, and longitudes 13° and 17°W (figure 1).

The Gambia extends about 400 km inland forming a narrow enclave in the Republic of Senegal except for a short seaboard on the Atlantic Coastline as shown in the map below. The country is less than 48.2 km (30.0 miles) wide at its widest point, with a total area of 11,295 km<sup>2</sup> (4,361 sq mi). Approximately 1,300 km<sup>2</sup> (500 sq mi) (11.5%) of the Gambia's area is covered by water. It has a population of 1,882,450 people and with a population density of 176 persons per km<sup>2</sup> (GBOS, 2013), makes the country to be one of the highest densely populated countries in Africa, thus imposing extreme pressure on productive land and the provision of social services. In addition, the country has a tropical climate characterized by two seasons: rainy season (June-October) and dry season (November- May)

#### **1.1.1 ADMINISTRATIVE, DEMOGRAPHIC AND COMMUNITY STRUCTURES;**

The Gambia is divided into eight Local Government Areas, including the national capital, Banjul (figure 2). The Divisions of the Gambia were created by the Independent Electoral Commission in accordance with Article 192 of the National Constitution. The Local Government Areas or regions are further subdivided into 43 districts (GBoS, 2013). Administratively the country is divided into three tiers: the Central (National), Regional (Local Government Areas and Municipalities) and Districts. Within the districts are communities or villages. The regions are headed by Governors who are appointed by the President of the Republic, and the municipalities are headed by Mayors who are elected by democratic process. However there are two municipalities Banjul and Kanifing I ) and five Administrative regions ( West Coast Region (WCR), Lower River Region (LRR), Central River Region (CRR), North Bank Region (NBR) and Upper River Region (URR).



**Figure 1:**Administrative structures of the Republic of Gambia

The districts are headed by the Chiefs who are also appointed by the President. Each village or community has a community leader or village head known locally as 'Alkalo'. The 'Alkalo' is a customary position, inheritable and can be a male or female but can be appointed in certain situations by the Government.

The Gambian Population and Housing Census (2013) reported a total of 1,882,450 persons (approximately 1.9million). This count showed a 5.6 per cent increase in population size from the 2003 census. It further shows that overall, women constitute 51% of the total population whilst males constitute about 49%. About 42 per cent of the population is below 15 years of age, 24 per cent between 10 and 19 years old and 22 per cent are between 15 and 24. Only 3.4 percent of the population is 65 and over. Life expectancy at birth is projected at 5 years for both sexes (GPHC, 2013).

The major occupation in the rural areas of the country is farming, which is regarded as the woman's responsibility. The main crops include: groundnuts, rice, cassava and the vegetables (tomatoes, onions, etc). Tributaries and ponds serve as the major water sources for rice farming within the rural areas and the major source for the transmission of Schistosomiasis. Women in the rural areas use these tributaries and ponds for domestic chores (laundry, bathing, etc). There is a very high level of illiteracy amongst the women in the rural areas (MICS, 2010), some of whom had dropped out for early marriage as well as lack of the resources to continue their education. However, in order to address this issue, the government has introduced the PEGEP (President Empowerment for Girls Education Program) scholarship scheme for girls which has led to the high enrolment and retention rate for girls in school (MoBSE).

The women in The Gambia have very strong associations or groups within the communities, very strong social networks and are present at community meetings where major decisions are taken. They are said to have a very strong voice in the communities, making their involvement crucial to the success of any community-based program. They play key roles as Traditional Communicators using folk songs and tales to disseminate health information. They are also the key players in the Reproductive & Child Health Services



where they ensure that their children benefit from all available services. The women can, thus, be an important platform for the implementation of NTD projects in the communities.

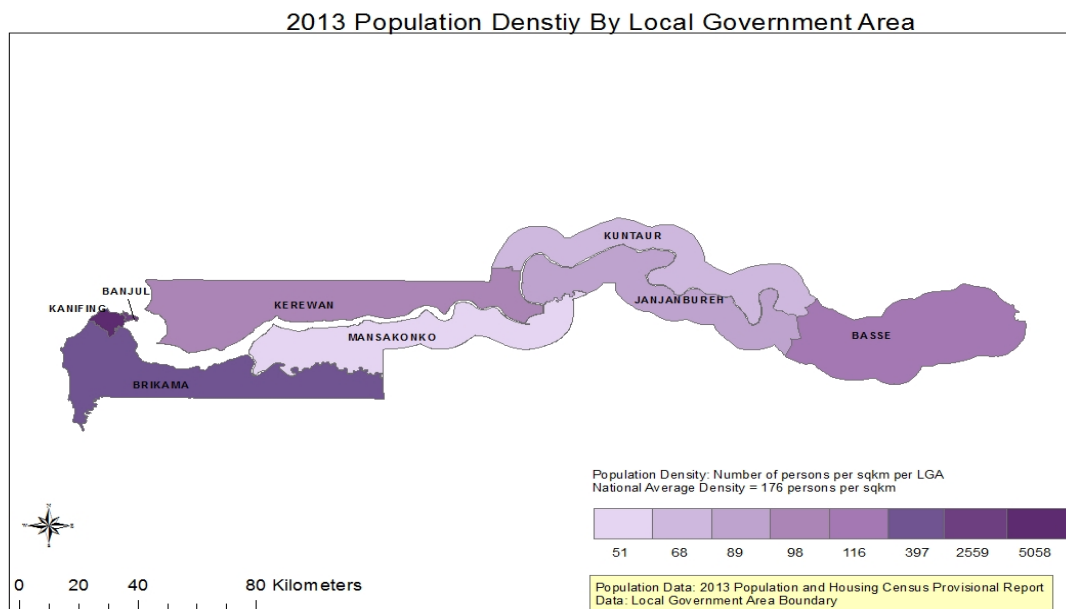
Gambia has a crude birth rate estimated at 46 per 1000 of the population while the total fertility rate is 5.4 births per woman (National Health Policy 2012). The high fertility rate has resulted in a very youthful population structure with nearly 44% of the population below the age of 15 years and 19% between the ages of 15 to 24 years. The implication of the Gambian age structure is that more than 63% of the youths are within the vulnerable groups for the PC-NTDs.

The National population data showing the schools and health facilities as provided by the Staff of the Ministry of Health & Social Welfare (MoHSW) is shown on table 1

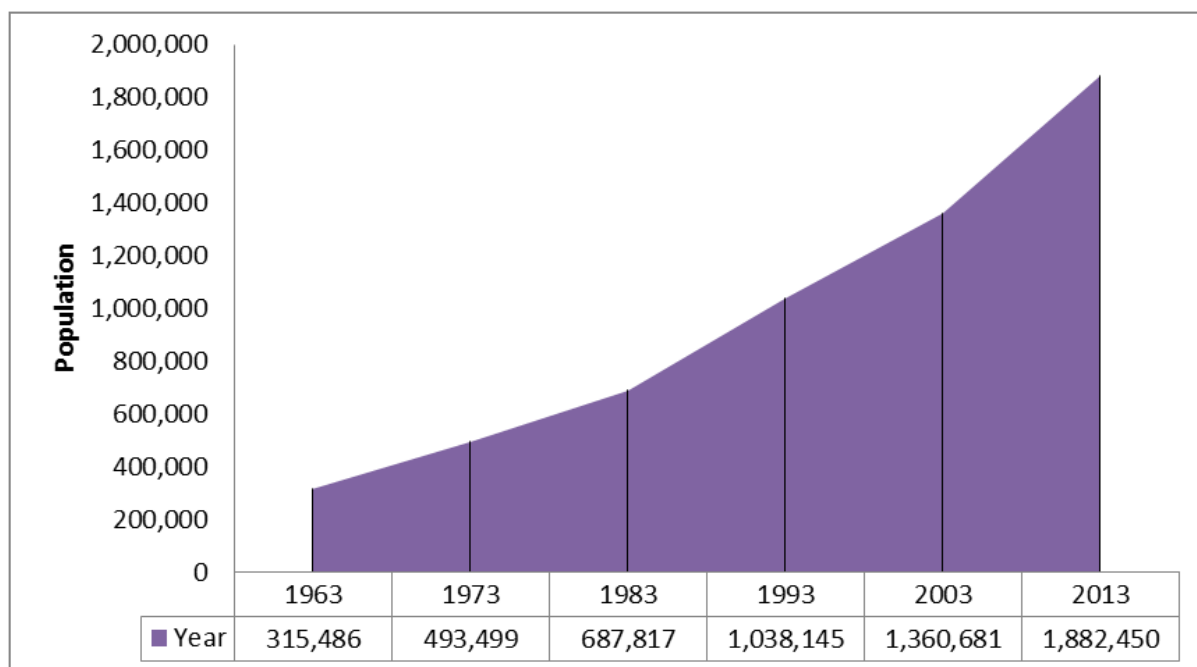
**Table1:** National population data, schools, and health facilities at district level

Region	No. of communities or villages	Total Population	< 5years	>5 - 14 years	No. of Primary schools	No. of peripheral Health facilities		
						Referral	Regional level	Health centres
West Coast A	345	699704	139938	107593	208	1	3	183
North Bank West	164	112970	22593	26954	64	0	1	150
North Bank East	178	79737	15946	25888	54	0	1	147
Lower River	153	82361	16470	22254	78	0	1	144
Central River	655	214853.175	45000	87037	128	0	2	248
Upper River	360	239916	47981	82871	118	0	1	159
West Coast B	21	413397	82678	81103	115	0	1	147
<b>Total</b>	<b>1876</b>	<b>1842938.18</b>	<b>370606</b>	<b>433700</b>	<b>765</b>	<b>1</b>	<b>11</b>	<b>1178</b>

The 2013 population and housing census report clearly indicated that the population of The Gambia has steadily grown since the commencement of a complete census in 1963, rising from less than a third of a million persons in 1963 to 1.4million persons in 2003 and now 1.9million (figures 3 & 4). The increase in population size has serious implications in the Nation's policy for all sectors particularly education, health, housing and agriculture. The consistent increase in population implies an increased demand on available services and infrastructure.



**Figure 2:** Gambia showing the Population density. *Source: GBoS, Population and Housing Census, 2013*



**Figure 3:** Population size and growth of The Gambia (Source: GBoS, Population and Housing Census, 2013)

### **1.1.2 Geographical Characteristics**

The Gambia is a small West African country surrounded on the three sides by the Republic of Senegal and on the fourth side by the Atlantic Ocean. It is the smallest country on mainland Africa, spanning only 10,680 km<sup>2</sup>. The country runs in an East-Westerly wind direction and lies between latitude 13° and 14° degrees north. The country varies in width from 28 to 50km and is flat, with an altitude not exceeding 50 metres. The River Gambia divides the country into two halves, North and South Banks.

The country lies in the Sahelian-Sudano Region and it has sahelian climate characterized by two seasons – a four month rainy season (mid June – mid October), with rainfall highest in August, and an eight-month dry season (SDH Report, 2013). Hot, humid weather predominates the rest of the year, with a rainy season from June to October; during this period, temperatures may rise as high as 43 °C (109.4 °F) but are usually low near the sea. Mean temperatures range from 23 °C (73.4 °F) in January to 27 °C (80.6 °F) in June along the coast, and from 24 °C (75.2 °F) in January to 32 °C (89.6 °F) in May inland. The average annual rainfall ranges from 920 mm (36.2 in) in the interior to 1,450 mm (57.1 in) along the coast ([http://en.wikipedia.org/wiki/Climate\\_in\\_the\\_Gambia](http://en.wikipedia.org/wiki/Climate_in_the_Gambia)).

### **1.1.3 Socioeconomic Situation And Indicators**

The Gambia is amongst the Least Developed Countries (LDCs) with Gross Domestic Product (GDP) per capita of US\$ 560 (IMF Staff report 2011). Agriculture forms the backbone of the economy with about 70% of the working population involved in the agricultural sector. With regard to GDP, the Service sector are the biggest contributor with 60%, while agriculture contributes 30%. The national economy is based mainly on agriculture, with groundnut as the main export crop. The recent upturn in performance of the economy has however been driven mainly by the service sector including tourism, telecommunication and construction.

The economy grew by 7.2% in 2007 over the preceding fiscal year; national revenue has been increasing progressively; inflation reducing to low single digit levels and was 2.3% as at end May 2007 (PRSP II, 2007). According to Ministry of Finance and Economic Affairs (MOFEA), the Gambia has been registering annual GDP growth rates of more than 5% (UNHDI, 2008-2011) during the current global economic crisis, and has maintained a stable macroeconomic environment that is increasingly threatened by a mounting debt burden. The Gambia is ranked 168 out of 187 countries in the 2011 UN Human Development Index (UNHDI), and the last poverty survey (2008) revealed that about 55% of the population lives below the poverty line.

The economy suffered a contraction of GDP to 4.3% in 2011 due to drought. This was due to a fall in crop production of around 45 per cent in that year, despite several non-agricultural sectors of the economy, such as tourism which has been performing well during 2011. The figures for 2012 shows a rebound in GDP growth of 5.3 per cent due to a recovery in crop production and strong growth in wholesale and retail trade, and construction. The services sector saw its total contribution drop 1.8 percentage from 16.3 per cent in 2011 to 14.5 per cent in 2012 (PAGE 2012).

#### **1.1.4 Transportation, Communications And Technology.**

As of 2002, the total number of roads by kilometer is 3,742 km with 723 km paved roads and 3,019 km unpaved roads.. There were 106,600 passenger cars and 142,300 commercial vehicles in use. The Gambia River not only provides important internal transport but is also an international commercial link. Oceangoing vessels can travel 240 km upstream. In 2004 there were 390 km of total waterways. Banjul, the principal port, receives about 300 ships annually. Ferries operate across the river and between Banjul and Barra ([http://en.wikipedia.org/wiki/Transport\\_in\\_the\\_Gambia](http://en.wikipedia.org/wiki/Transport_in_the_Gambia)). With the construction of major all-weather roads on both sides of the Gambia River, the waterway has become less significant for passenger traffic.

There are several GSM telephone companies in the Gambia which are involved in disseminating health and health related informations. Most of the health regions have community radios and, also the national radio and television services is very active in health information sharing with the Association of the Gambia Health Journalist which uses the electronic and print media respectively. The health regions also have traditional communicators who are actively involved in health communication and informations sharing. This plan envisaged that the NTDs operations can benefit from these existing information services to disseminate and enlighten the Gambian communities on NTDs.

### **1.2 HEALTH SYSTEM SITUATION ANALYSIS**

#### **1.2.1 Health system goals and priorities**

The current average life expectancy has been given as 58 years with infant mortality rate (IMR) estimated at 34 per 1000 live births; under-five's mortality rate at 50 per 1000 live births and Maternal mortality rate (MMR) given as 360 per 100,000 live births (Gambian Demographic and Health Survey 2013). The major causes of child mortality include: malaria, malnutrition, pneumonia, and diarrhoeal diseases. The maternal mortality rate has been attributed more to sepsis, haemorrhage and eclampsia (Maternal Neonatal Survey 2001). About 25% of Gambian children are chronically malnourished or stunted (height-for-age below – 2 SD), and 8% are severely stunted (Njie et al 2014). Stunted growth in children has been attributed to Soil transmitted helminthiasis (STH) especially *Ascaris lumbricoides* (Gambian Demographic and Health Survey 2013).

Due to the fact that STH does not have immediate fatal consequences, its public health importance in the Gambia has not been given a priority position. There is very little research data on the status of STH and STH has not been specifically identified under any unit or division of the MOHSW. Although STH has recently been included in routine laboratory investigations within the Gambian health system, there is as yet no established program for control, nor is there a budget line to fund the implementation of control strategies.

Trachoma has been captured under the National Eye Health Program as well as in the Gambia 2013 National Health Policy. Over the past five years trachoma programme has been focused mainly in the rural areas. The National Eye Health Programme has recognized the need to focus in the urban areas. The

Gambia is implementing the WHO endorsed SAFE strategy to eliminate trachoma in the Gambia. There is an existing leprosy intervention program country wide through The National Leprosy and Tuberculosis Control Programme in the Ministry of Health and Social Welfare. The programme is engaged in surveillance and case management country wide.

Lymphatic Filariasis and Schistosomiasis have been placed under the Epidemiology and Disease Control Unit of the Ministry of Health and Social Welfare (MOHSW). Data on these two diseases are scanty, incomplete or out-dated. As with the other NTDs, no specific control program is in existence and no specific budget has been earmarked to fund control strategies. The Centre for Disease Control and Prevention Atlanta (CDCP) has recently begun a technical collaboration with the Epidemiology and Disease Control Unit of the MOHSW in order to initiate the control of Lymphatic Filariasis. The CDCP sponsored 2013 Transmission Assessment Survey for Lymphatic Filariasis in 46 primary schools using ICT cards. Although limited in scope, this survey has provided the only recent data on Lf in Gambia.

The strategic priorities are in line with The National Health Policy, the PAGE, MDGs and Vision 2020 targets. These priorities are:

- a. Maternal, neonatal, infant and child health services
- b. Surveillance, prevention, control and management of communicable and Non communicable diseases (NCDs)
- c. Improve knowledge and skills of health care providers at all levels
- d. Build capacity of the Health Management Information System (HMIS) and data management system within the health sector

There are improved health infrastructures at primary, secondary and tertiary health care levels

### **1.2.2 Analysis of the overall health system**

Health care services are provided by 7 public hospitals at the tertiary level; 6 major health centres and 41 minor health centres at the secondary level; 40 community clinics and 634 Primary Health Villages at the primary level.

The public health system is complemented by over 60 other special private, NGO and community managed health facilities. Formal health services in The Gambia are delivered mostly in health facilities funded by the Government of The Gambia. These facilities are also supported by a number of donors and NGOs. NGOs and private practitioners also provide services though most of which are located in the Greater Banjul Area. In addition, there are large number of private pharmacies, drug stores for selling pharmaceutical products, and traditional healers that provide health services .

#### **1.2.2.1 Health Service Delivery**

The Gambia adopted the Primary Health Care (PHC) Strategy for health delivery in 1979. Primary health care is delivered through 3 levels of care:

- 1) The Primary Level – This provides the preventive and curative action through a network of health posts consisting of Volunteer Village Health Workers (VHWs) and Traditional Birth Attendants

(TBAs). The VHWs and TBAs are supervised by trained Community Health Nurses (CHNs). These work in community owned health centres and public health centres.

- 2) The Secondary Level – this level provides procedures as well as trained personnel to handle less complicated health issues. This level has a network of major and minor Health Centres and Clinics with more specialized staff and equipment located at districts or Local Government Areas.
- 3) The Tertiary Level – this level provides more specialized services and interventions and is planned to function as a referral service for the Secondary Level. This level of health care is found at the Central or National level.

The basic structure of the Primary Health Care system in Gambia has been well laid with the community fully entrenched in the system. In addition to a network of health posts consisting of the VHWs and TBAs, there are also strong organisations known as the Village Support Groups (VSGs) and the Community Based Organisations (CBOs). The VSGs and CBOs have a common understanding of the health issues in their respective communities. They provide health related services to their communities, including the purchase of medicines for the VHWs to use, participate in health talks and are the key players in the dissemination of health information. The VSGs are supervised by trained CHN to manage undernourished children in their respective communities. In a recently concluded study, the linkage of the VSG with the minor health facilities in the communities was found to be well-defined and cordial (Njie et al. 2014).

The VGS and CBO are very good platforms already in place for effective implementation and monitoring of Preventive Chemotherapy for Neglected Tropical Disease (PC-NTD) control project. These should be involved in the planning, implementation as well as monitoring of the PC-NTDs interventions to ensure community ownership in line with the Community Directed Intervention (CDI) approach. The VGS and CBO could be further trained in improved ways of mobilization of community members since they have their trust, and already understand their local issues. They could also be trained in record keeping so that accurate records of NTD activities can be available at this level.

The PHC at the primary level in Gambia is one of the most organized level of health care delivery. This situation can be used by the PC-NTD project for effective MDA implementation on completion of the mapping exercise. The advantageous coordination at the Primary level of Health delivery in Gambia can to some extent reduce the huge setback of the non-availability of the NTD program at the National level if properly utilized while efforts are made to bring the PC-NTDs to the priority list of the Country and be included in the National budget. The distribution of the population in line with the villages and health facilities is presented on tables 2 and 3.

Effective and efficient referral services from one level of health care to another (community to secondary and secondary to tertiary) are important in patient management and disease outcome. However, the current referral system still has major challenges. Some of the challenges include inadequate and ill equipped ambulances, intermittent shortage of fuel, inadequate feedback mechanism, inadequate referral protocol and guidelines and late referrals especially at community level. This situation is further compounded by limited (only receiving) telecommunication services within health facilities. A referral policy which will improve the referral system is required to enhance speedy and efficiency in safe evacuation of patients.

### **1.2.2. Health Workforce / Human Resources For Health**

The Human Resources for Health (HRH) situation in the Ministry has been very critical. The complexity and challenges associated with human resources such as high attrition rates, shortage of skilled health professionals (0.1 doctors/1000 populations, 0.11 registered nurses/1000, 0.18 enrolled nurses/1000, 0.04 registered nurse midwives/1000, 0.12 enrolled nurse midwives/1000 populations) (MOHSW, 2013), low morale among staff, deteriorating quality of care and other related problems has affected health care delivery at all levels of the health care delivery system (MOHSW, 2003).

The Directorate of Planning and Information through Human Resources for Health unit (now Directorate of Human Resources for Health) which was established in 2005 has registered number of achievements since its inception. These include: Provision of incentive packages (hard to reach, special skills, risk allowance, teaching allowance, on-call allowances, responsibility allowance) to MOHSW staff through advocacy, HRH Policy and strategic plan, Health systems strengthening project (accelerated training of health staff), establishment of HRIS data base, in-service training (management, IT, HR), Off-site provision – Leeds Metropolitan University, Introduction of masters programs in Public health and Community Health, introduction of the conversion course and upgrading the midwifery from certificate to diploma (HND), and expansion of health facilities.

In the face of the successes registered, the Directorate grapples with weak institutional and human capacity for HRH planning and management. There is still shortage of indigenous skill HRH including health training institutions, high attrition rate among trained and skilled staff, high dependency on expatriates, uneven distribution of health workers, remuneration packages which don't match the high cost of living, lack of clear guideline for staff promotion, posting guideline and fellowship awards (Training scheme and priorities), poor motivation and retention packages for staff, poor working environment and accommodation conditions (MOHSW 2005), inadequate infrastructure and teaching and learning aids for the health training institutions, weak linkages between MOHSW and Gambia College and UTG, non functional vehicle for the movement of students to and from practical experiences, unplanned/uncoordinated expansion of health facilities, poor working environment in terms of availability of essential tools for the service delivery, and inadequate private sector involvement in the production of health staff (MOHSW 2009). The human resource directorate is currently focusing on the service areas of Training and Development, Recruitment and Promotion, Distribution, Retention & Motivation, Planning & Management as well as Resource Mobilization for HRH.

### **1.2.3 Health Information:**

The Health Information System in The Gambia comprises five main service areas namely Health Management Information System (HMIS), Health research, Births and deaths registration, Information and communication technology and Integrated Disease Surveillance and Response (IDSR). These service areas focus on information generation, validation, analysis, dissemination and utilization for the purpose of effective and efficient planning and decision making process.

Health Management Information System is the programme responsible for collecting, analysing, storing and disseminating health data. Data generated health service delivery for the Ministry of Health are collected and punched into an open source software called District Health Information System version 2 (DHIS2) data can be punched offline but can only be used online in assigned user accounts that have restricted privileges for each user. The information can easily be accessed as they are punched. There are immediate, weekly, monthly and quarterly reporting of vital events such as cases of reportable and notifiable diseases including NTD (Schistosomiasis, Trachoma and lymphatic filariasis etc), as well as Epidemic Prone Diseases, and Vaccine Preventable Disease. Reporting the above events requires in addition to DHIS 2, the filling of investigation forms.

Key challenges faced by the HMIS include; inadequate number and skilled capacity to manage data at all levels, availability of parallel systems, duplication of efforts e.g. use of multiple software to manage the same system, weak reporting from some hospitals and private sector, inadequate functional ICT equipment at HMIS and regions, inadequate skilled ICT officers at all levels, poor power supply, inadequate financial support and poor internet connectivity.

#### **1.2.4 Medical Products:**

The Gambia adopted its first National drug policy in 1995 and was revised in July 2007 and a strategic plan developed in 2009. As a result the pharmaceutical sector in The Gambia registered a number of achievements that have contributed towards the improvement in the availability and accessibility of medicines in the country ranging from the establishment of National Pharmaceutical Services Unit, construction and establishments of six Regional Medical Stores, existing distribution system, construction of New Central Medical Stores warehouse and administration building under the World Bank (WB) project. In addition there is an existing LMIS and computerized inventory control system at Central Medical Stores and increase in skilled human resource. Furthermore there is an available infrastructure that needs to be developed into a Quality Control laboratory though not functional but limited tests are being conducted using the minilabs. Efforts to improve the management and utilization of pharmaceuticals had resulted in 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. A system to monitor safe use of these medicines and adverse drug reactions is in the process of being established.

Despite these achievements, there are still constraints and challenges as highlighted in the baseline survey of the WHO Pharmaceutical Sector assessment done in 2007 e.g. inadequate organizational structure, inadequate availability of essential medicines and vaccines, lack of sustainable medicines financing, inadequate logistics, inadequate medicines regulation (structure and processes), lack of a drug quality control lab and skilled human resources, irrational drug use and weakness in drug management, some of which are currently being addressed e.g. inadequate medicine legislation. A number of global and national challenges such as the HIV/AIDs pandemic, the re-emergence of TB, increase prevalence in non communicable diseases and the increasing medicines resistance to infectious diseases can also negatively impact on the pharmaceutical sector, as it obviously put further constraint to its limited resources, both



financial and technical. This is further aggravated by the problem of counterfeit, fake and substandard medicines, which is increasingly becoming a major concern within the sub-region and world-wide.

The Gambia government provides support for the provision of routine vaccines for immunization services and continues to meet its core financing obligation (5%) for the provision of new and under-used life saving vaccines. The provision of funds for supplementary immunisation activities and purchase of infant welfare cards as well as surveillance poses major challenge to effective implementation of EPI services.

### **1.2.5 Health Financing:**

In The Gambia, the main sources of financing health care are through the government, donors, NGO, and private out-of-pocket expenditures. Public sector financing of health has grown over the years but has mainly favoured investment in tertiary care. According to the first National Health Account Survey that was conducted in 2007 for the years 2002-2004 showed that the contribution of the Government to the health sector grew from 18% in 2002 to 24% of the total health expenditure in 2004. However, in the same period, the total health expenditure as a percentage of Gross Domestic Product (GDP) declined from 16.1% in 2002 to 13.9% in 2003 and rose slightly to 14.9% in 2004. The households, through direct out-of-pocket payments to health care providers were 12% in 2002, 11% in 2003 and 9% in 2004 to the total health expenditure.

The health sector has increasingly become dependent on donor funds from WHO, UNICEF, UNFPA and particularly the Global Fund for AIDS, TB and Malaria (GFATM). During the three year period, 2002-2004, over 66% of the total health funding came from donors including international health development partners. General Government expenditure on Health as percentage of General Government is still below the Abuja Declaration Targets of 15%.

As a supplement to the high government expenditure on health, user charges were introduced in 1988 and the proceeds are paid into a Drug Revolving Fund (DRF) account. These generated funds are used to complement the government's budget allocation for drugs. Despite this, health is seriously under-funded particularly at the primary and secondary levels. The health budget is also disproportionately distributed favouring the tertiary level and urban over rural areas with hospitals currently accounting for nearly half of the total government resources and expenditures. Strategies to equalize this imbalance include on-going advocacy to mobilize resources for health financing from traditional and non-traditional partners/donors and the strengthening of cost sharing mechanisms for all levels of health care delivery.

### **1.2.6 Achievements**

The Ministry of Health and Social Welfare has its draft Health Financing Policy since 2009 as a guide/tool to make funding available, ensure choice of cost-effective interventions, set appropriate financial incentives for providers, and ensure that all individuals have access to effective public health and personal health care. In addition, it has also conducted its first National Health Account in 2007 which provided information on Health budgets and expenditures nationally in terms of donors, government and out of pocket expenditures.

In line with attaining Universal Health Coverage, the Ministry has already conducted two feasibility studies on the introduction of National Health Insurance with the intention of starting with the formal sector (the civil

servants) as one of the studies highlighted as a recommendation. Moreover, through the support of the World Bank MoHSW in collaboration with NaNA has introduced Result Based Financing (RBF) as a pilot in the NBW region and upon successful implementation, this will be scaled up to other regions (NBE, CRR, and URR). These financing mechanisms are the most appropriate strategies that can help us achieve Universal Health Coverage.

In The Gambia, available statistics indicate that over 60% (NHA 2007 Report) of the total health funding comes from donors (international health development partners) raising high challenges of sustainability and predictability of funding to the sector. Although there is an impressive revenue collection system in place by the Gambia Revenue Authority, yet still funding to the health sector is still below the Abuja declaration of 15%.

Moreover, current funding for the health sector is less than optimal as available resources could still not provide the required quality services for the population due to so many reasons like high administrative cost especially from GLF component and in addition donor inputs are not well coordinated while issues of efficiency and equity in use of funds continue to be a challenge. Apart from the above issues, there are other challenges that the health sector is facing: Low capacities in resource mobilization at the various health facilities, low cost levied on user fees, inadequate data on health expenditure due to lack of regular studies of National Health Accounts and Public Expenditure Reviews and the delays in conducting the second round of National Health Account which suppose to give us current/true picture of the health financing situation of the country.

Since the Health Financing Policy is still not finalized, there is no holistic health financing mechanisms and legislation in place, no National Health Insurance Scheme and therefore there is inadequate health financing schemes in the country (only few private health insurance schemes). Inadequate trained Health Economists and health planners in the health sector to implement Health Financing Policy, in terms of putting proper system in place for health expenditure planning, execution, trekking and monitoring. Finally, cost of providing health care continues to rise due to increasing demand, changes in diagnostic and therapeutic technologies, inflation and currency fluctuations which are the biggest challenge worldwide.

#### **1.2.6 Leadership and Governance:**

##### *Leadership*

The Ministry of Health and Social Welfare is responsible for the management of the health sector, which includes: policy formulation and policy dialogue, resource mobilization, regulation, setting standards, health service delivery, quality assurance, capacity development and technical support, technical advice to other government line Ministries on matters of public health importance, provision of nationally coordinated programmes such as epidemiology and disease control, coordination of health research and monitoring and evaluation of the overall sector performance.

Due to on-going health system reforms, such as decentralization of health services, some of the functions of the central level management have been delegated to national semi autonomous institutions including

referral hospitals, specialist and general hospitals, professional councils, national drug authority and other regulatory bodies as well as local government authorities and research activities conducted by some research institutions.

The Ministry is headed by a Minister who is appointed by the President and head of state, and assisted by a Permanent Secretary, who serves as the Chief Administrator of the Ministry. The Permanent Secretary is also assisted by two deputy permanent secretaries; The Deputy Permanent Secretary technical assists the Permanent Secretary on technical operations of the ministry, while the deputy permanent secretary Administration and Finance assists the permanent secretary on administrative and financial matters.

The current organizational structure at the Ministry comprises of two departments namely; Medical and health department and Social welfare department.

The department of Medical and Health comprises of the following directorates:

- Directorate of Health Services (DHS)
- Directorate of Planning and Information (DPI)
- Directorate of Food Standards, Quality and Hygiene Enforcement (FSQHE)
- Directorate of National Public Health Laboratory Services (NPHLS)
- Directorate of Health Promotion and Education (HPE)

The Department of Social Welfare comprise one directorate which is the Directorate of Social Welfare (DSW). The public health sector covers 90% of the health facilities in the country, complemented by a few NGO and private sector run health facilities, mainly located in the Greater Banjul Area. Thus in the Gambia, the provision of healthcare is dominated by the Government facilities, with a minimum (subsidized) charge for accessing treatment under the basic care package at the three levels of health service delivery. The large majority of private health facilities are located in the Greater Banjul Area, making choice in health services delivery point in the rural community nonexistence.

## **Governance**

The central level is the decision-making point for the health sector's internal issues. The six directorates of the two departments plan, direct, manage and coordinate all Government health care activities countrywide through specialized units. The relationship between these directorates is neither vertical nor horizontal but interactive.

The country is divided into seven health regions each with a regional health team (RHT) headed by a Regional Health Director (RHD). The RHTs are responsible for the day-to-day administration, management and supervision of health services in their respective regions. They have overall responsibility for the primary and secondary health care facilities and their staff within their regions. The RHDs are assisted by the Regional Public Health Officer, Regional Public Health Nurse, Senior Administrative Officer and other support staff. The tertiary level, which comprises the hospitals and teaching hospital on the other hand, has semi-autonomous boards and headed by CEOs and CMDs respectively.

### **1.2.7 Challenges Health System Structure**

The following under-listed factors are Gambia's apparent challenges in the health care sector:

1. Neglect of the Primary care – about half of the National budget remains at the tertiary level while only 20% goes to the decentralized level. As a result, many public subsidies for health benefit the rich in the urban areas more than the poor in the rural areas.
2. Inadequate availability of Maternal and Child Health Nutrition and services – the health care delivery chain or system is weak with poor quality of care.
3. An absence of a comprehensive human resource strategy that enables recruiting, training, deploying, maintaining and monitoring sufficient numbers of providers in health facilities and communities. As a result, the health sector is experiencing high rates of attrition of skilled workers and inadequate distribution of providers.
4. Inadequate or inconsistent supplies of equipment, medicines, fuel, and commodities in both health facilities and in communities; electricity, clean water, cold storage capacity for blood, delivery kits, new growth reference charts, service manuals, consumables including birth control, transportation means for supervision as well as emergency evacuation and needs forecasting.
5. Socio-cultural barriers and limited community mobilization- the prevailing cultural practises result in a plethora of harmful practices, delayed treatment seeking and ineffective first contact with health personnel at the community level.
6. Uneven access to and utilization of nutrition and health services by socio-economic status, and by geographic regions with the urban and coastal regions faring better than rural and more remote regions, and under utilization of services by the adolescents.

These factors point to an operationally weakened and underfunded Primary Health Care system in the Gambia.

## 1.3 NTD SITUATION ANALYSIS

### 1.3.1 Epidemiology and burden of disease

#### 1.3.1.1 Lymphatic Filariasis (LF)

There is limited information on the prevalence of PC-NTDs in The Gambia. The latest information on LF which showed some level of endemicity was based on a survey conducted in 2013 (see Table 2.1 below). This was a transmission assessment survey funded by the CDCP Atlanta in collaboration with the Ministry of Health and Social Welfare (MoH&SW). The survey which was conducted by the Epidemiology and Disease Control Unit (EDC), MoH&SW, used ICT cards on children from 46 primary schools taken from various districts around the country. However the data provided was inadequate for analysis on the endemicity of (LF) in The Gambia. This information is summarized in table 2.1 below.

**Table 2.1:** LF disease distribution in the country

Region	Location/ Site/	Prevalence (numbers/ rate/proportion)	Study method	Year of survey and reference
CRR		0 (0)	ICT Card technique (School Age Children)	Year 2013 MoH unpublished
LRR		0.26 (1)		
NBRE		0.34 (1)		
NBRW		1.03 (3)		
UPR		0.24 (1)		
WCR1		0 (0)		
WCR 2		1.78 (8)		

#### 1.3.1.2 Trachoma

There is on-going activities under National Eye Health Program. The entire country apart from 1 district (Kanifing) an urban centre in the West Central region has been mapped for Trachoma. The National Eye Health Program (NEHP) has not only mapped the country for Trachoma but has also implemented fully the S & A components of the SAFE (i.e. Surgery, Antibiotics, Face washing and Environmental modification) strategy for Trachoma control. However there is the need to do more on the Face washing and the Environmental modification components of the SAFE strategy to further improve on Trachoma control, elimination and eradication in The Gambia. The 2012/2013 data from the NEHP is as presented in Table 2.2.

**Table 2.2:** Trachoma distribution in The Gambia

Region	Prevalence	Study method	Year of survey and reference
	(numbers/ rate/proportion)		
WCR	1.50%	Ocular examination (evert eyelid)	2012/2013 data from the NEHP
LRR	1.80%		
NBW	3.20%		
NBE	0.20%		
CRRN	0.60%		
CRRS	1.1%%		

### 1.3.1.3 Schistosomiasis

Information on Urinary Schistosomiasis was obtained mainly from the Ph.D thesis of Dr. A.D. Jack (1989), which was based on a two year longitudinal study of chemotherapy in 12 PHC villages, all of which were located in two regions which were then the known schisto-endemic parts of The Gambia (see Table 2.3 below). Although the data in this thesis may still be relevant, more recent information on the prevalence of Schistosomiasis is not available. Routine data collected via hospital sources and compiled monthly by the health facilities is also inadequate. Thus, the data available cannot give an accurate picture of the current endemicity of Schistosomiasis in The Gambia.

**Table 2.3:** Known disease distribution of urinary SCHISTOSOMIASIS in The Gambia (Jack , 1989)

Region	Villages	Estimated prevalence rates (%) (8-14 yrs)	Study methods	Year of survey and reference
URR	8	73.75	Urine filtration technique	Jack, 1989
	32	8.5	Urine Sedimentation by centrifugation	Ceesay et al., 2013 (Unpublished)
CRR	4	81.25		

### 1.3.1.4 Soil Transmitted Helminthiasis (STH)

STH is the most neglected of the four PC-NTDS in The Gambia. It has not been captured under any programme of the MoH&SW and the only data available was derived from hospital routine examinations which are collated at the Regional level only. This data does not in any way give a complete picture of the endemicity of STH in The Gambia. The available data is as presented in Table 2.4.

**Table 2.4:** STH distribution in the Gambia

Region	Prevalence (numbers/rate/prop ortion)	Total number	study method	Year of survey and reference
CRR	0.90%	2025	Wet preparations	Routine Data, 2013
LRR	1.20%	996		
NBER	0.70%	746		
NBWR	0.90%	979		
URR	0.30%	827		
WHR1	0.40%	3039		
WHR2	0.50%	1765		
Total	0.50%	9631		

### 1.3.1.5 Rabies

Rabies is a viral infection transmitted through the saliva of an infected animal. Rabies has been present in the Gambia for a long time. A Major contributing factor for rabies in the country is the increase in the stray dog population particularly in urban centers culminating in corresponding dog bites in both humans and animals. This situation is not abating but rather continues to expose lives to clinical cases of rabies.

Between 1970 and 1974, an average 72 cases of canine rabies were reported annually in the Gambia, between 2000 and 2004, public health officials reported 123 clinically confirmed human cases. In a study conducted in 2014 (Thomasa et al., 2014) of 49 cases of dog bites exposures, 6 were from rabies infected animals. Unfortunately, human rabies are rarely confirmed using laboratory diagnosis but rather on clinical diagnosis when the patient is in the advanced stage. Epidemiological studies on rabies have been constrained by the limited capacity of the Central Veterinary Laboratory for its surveillance, sampling and testing and hence continue to be of great challenge to the Veterinary services as a whole. The Central Veterinary Laboratory until now is very much dependant on the benevolence of other regional labs for the diagnosis of rabies which ultimately leaves a gap in the epidemiological data collection of rabies in the country.

**Table 2.5:** Number of dog bites per region from 2011 to 2014. Source, HMIS/MOH&SW

Dog bites by Region, 2011 to 2014				
Regions	2011	2012	2013	2014
CRR	132	541	154	56
URR	209	565	374	70
WR1	195	317	777	195
WR2	155	246	213	
LRR	47	75	41	37
NBWR	72	61	74	84
NDER	78	75	19	39
National	2899	3892	3665	481

### 1.3.1.6 Leprosy

The prevalence and incidence of leprosy in The Gambia is not known. So far, the most reliable indicators to monitor the extent and the trend of the leprosy disease burden is the registered prevalence of cases currently on treatment, and the notification of new cases. In 1993, there were 162 cases on register in 1993 with a prevalence rate of 1.57/10,000 and this decreased to 56 cases on register at end of 2010 with a national prevalence rate of 0.3/10,000). The reported national prevalence rate at end of 2010 (0.3/10,000) (56cases /1.7m) while the Case detection rate was 0.2/100,000 (38/1.7m) at end of 2010. Even though these figures show that leprosy is no more a major problem in The Gambia, leprosy scourge is not over until the last case is detected treated and declared cured.

In 2010, the MB proportion was 84 % among new cases detected (these are the highly infectious type of leprosy); the proportion of children among the new cases was 15.7%. This indicated some form of continuing transmission of the infection within the communities. The great majority of new leprosy cases were found in a few districts in 2 main regions in the Western Region and the Upper river region. Even though the leprosy number of cases seen annually is very low, as the registered prevalence (1/10,000 population), this does not mean however that leprosy is eradicated. On the contrary, it is more likely that many early leprosy cases are not detected due to low index of suspicion and skills among the health workers. The true incidence may be much higher than is currently reported. Table 2.5 below presents the trend in the distribution of leprosy in Gambia from 2005 to 2010.

**Table 2.6:** Distribution trends of Leprosy cases according to Regions in the Gambia (2005- 2010)

Region	2005	2006	2007	2008	2009	2010
West Coast Region	26	30	30	27	22	23
Lower River Region	0	0	0	0	0	0
North Bank Esat	3	2	3	2	0	2
North bank West	3	2	4	2	0	0
Central River	10	9	10	6	5	5
Upper River	13	12	14	10	7	8
Total	55	55	61	46	34	38

**Source:** The Gambia leprosy strategic The Gambia 5-Year National Leprosy Control Strategic Plan 2012-2017

### 1.3.2 PC-NTD co-endemicity

The co-endemicity of the PC-NTDs is very difficult to determine for the following reasons:

- i) Unavailability of reliable recent data. The only data from Schistosomiasis survey which could have been used to calculate co-endemicity is more than 25 years old and cannot be relied upon. There is no data on the distribution of STH.



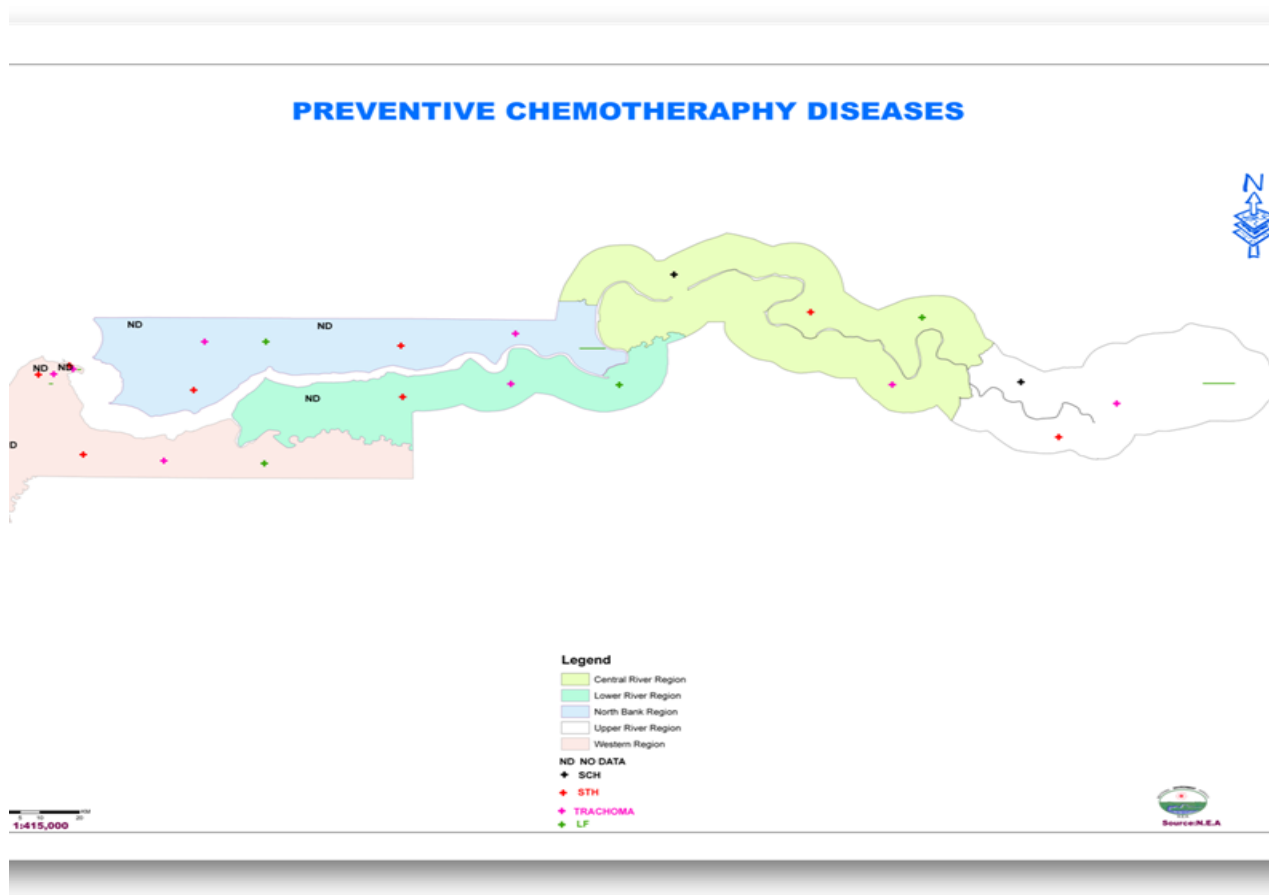
ii) Inconsistency in the study location. The only reliable data so far was from the Trachoma studies with an almost cross-country survey. The Schistosomiasis survey covered 2 regions only while the Lymphatic Filariasis survey did not cover all the regions. Secondly, the Trachoma survey gave the names of the communities and districts where the surveys were done while data from LF was only at the district level. Schistosomiasis was at village and District level for only 2 regions while STH was only on Regional basis. Calculating co-endemicity using regions with varying number of districts will not give an accurate picture of the co-endemicity of these NTDs. Table 3 summarises the current endemicity of the NTDs in Gambia.

**Table 3:** NTD Co-endemicity

Region	Diseases					
	Preventive Chemotherapy Diseases				Case management Diseases	
	SCH	STH	Trachoma	LF	LEP	Rabies
<b>WCR1</b>	ND	+	+	-	+	+
<b>WCR2</b>	ND	+	+	+	+	+
<b>LRR</b>	ND	+	+	+	+	+
<b>NBE</b>	ND	+	+	-	+	+
<b>NBW</b>	ND	+	+	+	-	+
<b>CRR</b>	+	+	+	+	+	+
<b>URR</b>	+	+	+	-	+	+

ND: No data available

**Figure 4:** Map of PC-NTD coendemicity in Gambia



### 1.3.3.1 NTD mapping status

The absence of reliable data on the occurrence of NTDs in The Gambia makes it imperative that all districts are mapped in order to ascertain the level of endemicity, particularly of Schistosomiasis, Soil Transmitted Helminths and Lymphatic Filariasis, occurring either singly or together. Trachoma needs to be mapped in only one district (Kanifing Municipal Council) and in the urban area of West Central Region. In this district, children from Senegal study in the schools in Gambia raising an issue of crossborder transmission. The mapping outcome will pave the way for the implementation of the Mass Drug Administration intervention leading to subsequent elimination of PC-NTDs from The Gambia. Table 4 below summarises the mapping situation of NTDs in The Gambia.

**Table 4:** NTD mapping status

Endemic NTD	Total number of Districts	No. of endemic districts	No. of districts mapped or known endemicity status	No. of districts remaining to be mapped or assessed for endemicity status
<b>SCH</b>	7	7	0	7
<b>STH</b>	7	7	0	7
<b>Trachoma</b>	7	6	6	1
<b>LF</b>	7	7	0	7

### 1.3.3 NTD programme implementation

This section outlines the past and on-going NTD control programmes for the PC-NTDs and CM-NTDs in the country. These interventions are summarized for PC-NTDs and CM-NTDs in tables 5.1 and 5.2 respectively.

#### Past and current NTDs intervention for PCT NTDs.

##### SCH, STH and LF.

The country has no past MDA implementation for STH, SCH and LF. For SCH and STH diagnosis is usually done in the health facility with treatment administered in a case by case strategy. Mapping of STH, SCH and LF is planned in the entire country in 2015 after which MDA can be organised in affected areas.

##### Trachoma

Apart from 1 district (Kanifing) and the urban centre in the West Central region, the entire country has been mapped for Trachoma. Mass drug administration of Azithromycin tablets as part of a Programme for Rapid Elimination of Trachoma (PRET) was carried out in 23 priority districts between 2007 and 2009. The National Eye Health Program (NEHP) has also implemented fully the S & A components of the SAFE (Surgery, Antibiotics, Face washing and Environmental modification) strategy for Trachoma control. The F and E component of the SAFE have to be implemented to further improve on Trachoma control, elimination and eradication in The Gambia.

##### Leprosy

The Gambia is a leprosy low endemic country. A lot has been achieved in leprosy control since the combination of the Leprosy and Tuberculosis control programme in 1984. The strategic plan of the programme plan is based on early case finding and adequate treatment of patients, public education on early signs and symptoms of leprosy, general Health Workers education on early signs and symptoms of leprosy to increase index of suspicions, increase in IEC/ACSM creation and awareness creation, contact

examination of all newly detected Leprosy patients, empowering all the skin disease units to suspect, diagnosis , treat or refer leprosy suspects for diagnosis/treatment and involving the communities in TBL services. The country achieved 100% MDT coverage in 1985 and successfully achieved the Leprosy Elimination target of less than 1 case per 10,000 in 1998 at National, Regional and District levels. However, new leprosy cases continued to be seen annually particularly from 2 regions; the Western Region and the Upper river region continue to be the 2 regions generating most of the leprosy cases reported.

## Rabies

Despite the high number of case of dog bites and exposures to rabies reported in the country, diagnosis and treatment of rabies has been ongoing in the country on a case by case management in health facilities. Due to lack of resources no active case finding has been organized in the country.

**Table 5.1:** Summary of intervention information on existing PCT-NTD programmes

NTD	Date programme started	Total districts targeted	No. of districts covered (geographical coverage*)	Total population in target district	No. (%) Covered	Key strategies used	Key partners
TRA	1986	34	34	800,000	ND	Survey	MRC, NEHP, LSTM
	1996	34	34	1,038,145	ND	Survey	MRC, NEHP, LSTM
	2010	43	43	1,300,681	ND	MDA	MRC, NEHP, LSTM
STH	ND	ND	ND	ND	ND	ND	ND
SCH	1989	3	3	ND	9917	Longitudinal Survey	LSHTM (PHD Thesis), MoH&SW, MRC
LF	1975/6	3	3	ND	6.80%	survey >15years	EDC/MOHSW
		3	3	ND	21.60%	ICT	
	1997-2000	1	1	ND	6%	ICT	EDC/MOHSW
	2013	43	43	188,660	3904 (2.07%)	ICT (TAS 6-7 years)	EDC/MOHSW

**Table 5.2:** Summary of intervention information on existing CM programmes

NTD	Date programme started	Total region targeted	No. of regions covered (geographical coverage*)	No. (%) Covered	Key strategies used	Key partners
Leprosy	1962	7	7	100	Active case finding and health facility treatment	WHO
Rabies	1989	1	1	10	Rabies Vaccination Campaign  Stray dog elimination	WHO  Government (MoHSW, Gambia Armed Forces, Ministry of Tourism)

### **1.3.3 Gaps and priorities**

#### **Trachoma**

With the exception of the urban region of the West central region and the district of Kanifing, Trachoma has been fully mapped in the country with the S and A component of the SAFE implemented. The major challenges today are to implement the F and E components of SAFE, complete mapping of Trachoma in some urban areas (West central region) and to address the transborder issues. In fact in some regions that are border with Senegal, students leave Senegal to study in Gambia and there is possibility of reinfection of area considered under control.

#### **STH, LF and SCH**

The endemicity of SCH, and STH is poorly known. This poor knowledge of the endemicity of these disease is favoured by the lack of an NTD control programme in the country as well as the lack of research activities on these diseases. There is need to carry out mapping of these NTDs in order to have a clear idea about their endemicity.

#### **Leprosy**

The Leprosy programme was established since 1985. This programme is overshadowed by the TB programme at all levels. There is no clear cut linkages between the leprosy community activities with the Health facilities. This programme also suffers from a lack of awareness campaigns, lack of funds for special case finding activities. There is also no leprosy training guidelines for general health workers (GHW)

#### **Rabies**

Epidemiological studies on rabies have been constrained by the limited capacity of the Central Veterinary Laboratory for its surveillance, sampling and testing. These obstacles constitute a major challenge to the Veterinary services. The Central Veterinary Laboratory is very much dependant on the benevolence of other regional labs for the diagnosis of rabies which ultimately leaves a gap in the epidemiological data collection of rabies in the country. There is a need to develop the human capacity in response to this endeavour.

SWOT and SWOT counteracting analysis were conducted. The findings are as presented on Tables 7.0 and 7.1. Lymphatic filariasis, Schistosomiasis and Soil Transmitted Helminthiasis in The Gambia did not have any strength because there are yet to be considered by the Government as priority diseases of public health importance. These are issues that need to be addressed urgently.

**Table 6.1: SWOT Analysis: STH / SCH / LF**

STRENGTHS	WEAKNESS	OPPORTUNITIES	THREATS
	Limited data on the endemicity of STH/SCH/LF		
	Inadequate trained staff	Identified as a priority diseases under the IDSR strategy Establishment of a Human Resource Directorate	High staff attrition
	Absence of a National STH/SCH/LF Control Programs	Availability of a harmonized routine data collection system Existence of a deworming program at the National Nutrition Agency(NaNA) Existence of a Water Sanitation and Hygiene unit under HPD for STH & SCH	Misconceptions about STH/SCH/LF control, treatment and care at National and sub-National levels
	There is no budget line for STH/SCH/LF control	Availability of a National Health Strategic Plan	Global economic recession
	Limited operational research activities	Establishment of public health research directorate to coordinate NTD research activities	
	Inadequate laboratory equipment and supplies		
	Inadequate drugs for STH/SCH control program	An existing PHC system capable of integrating STH/STH intervention	
	Low community awareness on prevention and control		

**Table 6.2: SWOT Analysis: TRACHOMA**

STRENGTHS	WEAKNESS	OPPORTUNITIES	THREATS
Available data on NTD	Inadequate Government Local Funding (GLF)	Funding from international agencies	Staff attrition at the primary level
National coverage	Minimal funds for NTD	Funding from foreign students	Global economic recession
Partnership is established		Establishment of a Human Resource Directorate	
PEC integrated with PHC			
Regional eye care center established (int.)			
Secondary eye care centers established (national)			
Training of ophthalmic nurses			

**Table 6.3: SWOT Analysis: LEPROSY**

STRENGTHS	WEAKNESS	OPPORTUNITIES	THREATS
MDT services introduced in 1985.	Compromised time management in the combined TB/Leprosy programme by staff at all levels	Joint planning of Training and Field supervision through TB funds	Patient recycling, Delayed Release From Treatment
Co-ordination mechanism established at national and sub national levels	Leprosy programme is overshadowed by the TB programme at all levels	Leveraging some TB budget and plan for some joint activities involving Leprosy programme	High staff attrition
Leprosy services integrated into PHC at village levels	No clear cut linkages of leprosy community activities with the Health facilities	Commemoration of World Leprosy day o 31ST Jan of every year	Global economic recession
MDT given free of charge	Lack of a curriculum for teaching GHWs on Leprosy topics, especially how to suspect early signs of leprosy.	Opportunity to combined some of the GF sponsored IEC, and ACSM TB activities at the village levels exists	
National and international training programmes offered to staff	No drugs for reactions		
Quality diagnostic services established	Diminished awareness campaigns on Leprosy		
National leprosy strategic plan developed	Lack of funds for special case finding activities		
Data capture to support the management and treatment of leprosy cases strengthened.			
Effective staff supervision in place			
Some donor support still available for leprosy control			
Training manuals and SOPs developed for leprosy staff			

**Table 6.4:** SWOT Analysis: **RABIES**

RABIES			
STRENGTHS	WEAKNESS	OPPORTUNITIES	THREATS
	No data on endemicity		
	No funding allocated for Rabies program		Global economic recession
	Inadequate trained staff	Establishment of a Human Resource Directorate	
	There is no budget line for STH/SCH/LF control		
	Limited operational research activities		
	Inadequate laboratory equipment and supplies		
	Low community awareness on prevention and control		



## PART 2: NTD STRATEGIC AGENDA

### 2.1 Overall NTD Programme Mission And Goals

**Vision:** To make The Gambia free of neglected tropical diseases by 2020.

**Mission:** To implement a cost effective, sustainable and intergrated strategy to control and eliminate NTDs.

**Goals:**

1. To improve quality of life and economic growth by reducing the burden of NTDs, through a well-coordinated national NTD control and elimination program
2. To prevent the occurrence of new infections of all NTDs by 2020 and initiate appropriate management of all existing cases

### 2.2 Guiding Principles And Strategic Priorities

The guiding principles for the preparartion of this NTD master plan were the following:

- **Inclusiveness:** a consultative and multisectoral approach involving all stakeholdres i.e. the relevant government ministries (Heallth, Education, Agriculture, Economics and Planning, Finance and Environment) NGOs (Sightsaver, HePDO etc), research institutions (MRC, CIAM) and the UN agencies.
- **Transparency:** the entire process was transparent and open and allowed divergent views to reflect the perceptions of NTDs in The Gambia
- **National ownership:** This was considered of paramount importance, with the ministry of health providing leadership and the necessary logistic support to guide the process.

The plan was informed by the situational analysis which depicted the current status of NTDs in The Gambia, reviewing existing information on the burden of these diseases and control programmes where they exist. This formed the basis for determining the strategic priorities for the period 2015 to 2020, outlined in table 7 below.

**Table 7:** Strategic framework summary

STRATEGIC PRIORITIES	STRATEGIC OBJECTIVES
Strengthen government ownership, advocacy, coordination and partnership	Establish and strengthen coordinating mechanisms for NTDs at national and sub-national (regional) levels in the Gambia
	Strengthen advocacy, visibility and profile of NTD elimination and eradication at all levels of Government.
	Establish and strengthen management and coordination mechanisms for effective operation of NTD control programme in the Gambia
	Strengthen and foster partnerships for the prevention, control, elimination and eradication of targeted NTD at national, district and community levels.
Enhance planning for results, resource mobilization and financial sustainability of National NTD Programmes	Establish integrated multi-year strategic plan and annual operational plans for the prevention, control, elimination and eradication of targeted NTDs.
	Enhance resource mobilization approaches and strategies at international, national, sub-national (regional) levels for NTD interventions.
	Establish and strengthen the integration of NTD programme and financial plans into sector-wide budget and financial mechanisms.
	Establish national NTD policies, guidelines and tools to support active policy and programme implementation.
Scale up access to interventions, treatment and system capacity	Establish, strengthen and scale up an integrated preventive chemotherapy, including access to Schistosomiasis, Soil-Transmitted Helminthiasis, Lymphatic Filariasis, Trachoma and Leprosy interventions
	Establish and strengthen case-management-based NTD interventions including integrated packages for LF, Leprosy, Trachoma (TT) and Rabies.
	Establish and strengthen integrated vector management for targeted NTDs.
	Strengthen the capacity of Epidemiology and Disease Control at national level for NTDs programme management and implementation.
	Accelerate implementation of disease burden assessment and integrated mapping of NTDs

Enhance NTD monitoring, evaluation, surveillance and operations research	Establish and strengthen the links between National Pharmaceutical Service and Epidemiology and Disease Control for monitoring of for NTD programme performance and outcome including monitoring of adverse drug reaction to NTD medicines and insecticides.
	Strengthen the IDSR and HMIS HIMS to ensure effective integration for data management and impact analysis for NTDs in the Gambia.
	Strengthen the surveillance of NTDs within PHC for Schistosomiasis, Leprosy, LF sequelae. Post surveillance for HAT, Guinea worm and baseline survey for dengue fever.
	Support operational research and documentation of evidence to guide innovative approaches to NTD program interventions

**Table 8:** Summary of NTD disease specific goals and objectives

NTD PROGRAMME AND GLOBAL GOAL	NATIONAL GOAL	OBJECTIVES	STRATEGIES	DELIVERY CHANNELS
<p>Lymphatic Filariasis Elimination.</p> <p><b>Goal:</b></p> <p>Elimination of LF as public health problem by 2020.</p>	To eliminate LF in the Gambia by 2020	<p>To Establish LF endemicity maps in the 8 Health Regions by 2015.</p> <p>To implement MDA in 100% of endemic Regions by 2016.</p> <p>To achieve 100% therapeutic coverage by the end of 2016.</p> <p>To reduce morbidity and disability due to LF by 25% (2016)</p> <p>Conducted first TAS activities in at least 50% of LF endemic regions districts by 2019</p> <p>To interrupt transmission of LF by 2020.</p>	<p>Mapping of LF</p> <p>Social mobilization.</p> <p>Mass drug administration</p> <p>Surgery, Disability management</p> <p>Vector control</p>	<p>Surveys</p> <p>Community</p> <p>Community</p> <p>Health facility</p> <p>Health Facility/Home-based care</p> <p>Indoor Residual spraying</p> <p>Aerial Spraying (Destroying breeding sites)</p>
<p>Schistosomiasis Elimination</p> <p><b>GOAL:</b></p> <p>Elimination of schistosomiasis by 2020</p>	Elimination of schistosomiasis by 2020	<p>To Establish Schistosomiasis endemicity maps in the 8 Health Regions by 2015</p> <p>To implement MDA in 100% MDA in endemic regions by 2016</p>	<p>Mapping</p> <p>Social Mobilization and Mass Drug Administration</p> <p>Vector control</p>	<p>Survey community (at risk populations e.g. school aged children)</p> <p>Community</p> <p>Mollusciding seasonal pools</p>

NTD PROGRAMME AND GLOBAL GOAL	NATIONAL GOAL	OBJECTIVES	STRATEGIES	DELIVERY CHANNELS
		To eliminate schistosomiasis in the Gambia by 2020	Water supply & Sanitation	and irrigation canals.  Community
Soil Transmitted Helminthiasis  <u><b>Goal:</b></u>  To reduce morbidity of Soil Transmitted Helminthiasis to a level where it is no longer a public health problem	Reduction of morbidity due to STH by 75% by 2020	Establish STH endemicity maps in the 7 Regions by 2015  Conduct school base treatment in 100% of schools in the endemic regions by 2015- 2016  STH burden reduced by 90% by 2020	Mapping  Preventive chemotherapy  Hygiene practices  Health education	Survey  School aged children  Community  Community
Trachoma Elimination  <u><b>Goal:</b></u>  Elimination as public health problem by 2020.	To Establish the Elimination of blinding Trachoma by 2020	To Establish trachoma endemicity maps in the remaining 2 Regions by 2016  To consolidate on the existing intervention structures for Trachoma elimination	SAFE strategy  SAFE strategy	Health facility/community
Leprosy Elimination  <u><b>Goal:</b></u>  Elimination as public health problem by 2020.	Elimination of leprosy as a public health problem by 2020	Sustain political commitment of Govt.  Enhance awareness efforts among the general public and health workers to improve case finding.  Increase access to good quality MDT MDA services for all patients needing treatment.  Improve community participation and support for leprosy	Advocacy  Health Education (Awareness creation)  Early detection and adequate treatment  Prevention of	NTD Programme  Surveys  Health facilities  Communities

NTD PROGRAMME AND GLOBAL GOAL	NATIONAL GOAL	OBJECTIVES	STRATEGIES	DELIVERY CHANNELS
		<p>activities</p> <p>Build capacity of health workers on all health facilities to leprosy case finding and management.</p> <p>Increase collaboration and support of all partners</p> <p>Strengthen the monitoring, evaluation and supervision of leprosy</p> <p>Ensure effective integration of Leprosy services and activities to TB component of the NLTBP and to general health services</p>	<p>disabilities</p> <p>Health Education</p> <p>Health Promotion and Education</p> <p>Health Promotion and Education</p> <p>Training in Mapping of Leprosy</p> <p>Advocacy</p>	<p>Communities</p> <p>Training workshops and surveys</p> <p>NTD Programme</p> <p>Epidemiological Surveys</p> <p>Health facilities</p>

## National Milestones

### LF elimination milestones, 2015-2020

Indicators	2015	2016	2017	2018	2019	2020
Completed mapping of LF and determined LF endemic areas and the population at risk	7/7(100%)					
Begun implementation of LF MDA in districts requiring LF MDA	7/7 (100%)					
Achieving 100% geographical coverage in LF endemic districts	7/7 (100%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	
Major urban areas with evidence of LF transmission under adequate MDA (Regional coverage more than 65%)	7(100%)	7 (100%)				
Conducted more than 5 rounds of MDA in all endemic IUs with regional/State coverage more than 65% and stopped MDA in at least 50% of LF endemic IUs under WHO criteria					7/7 (100%)	7/7 (100%)
Conducted first TAS activities in at least 50% of LF endemic IUs after at least 5 rounds of MDA				7/7(100%)		
Conducted and Passed at least 2 TAS activities in 75% of IUs					7 /7 (100%)	
Started passive surveillance and vector control activities in at least 75% of IUs.					7/7(100%)	7/7 (100%)
Present "the dossier " for in-country verification of absence of LF transmission						7/7 (100%)
Proportion and number of IUs where there is full coverage of morbidity- management services and access to basic care				7/7 (100%)	7/7 (100%)	7/7 (100%)
Proportion and number of IUs where 75% of hydrocele cases benefitted from appropriate surgery				7/7 (100%)	7/7 (100%)	7/7 (100%)

### SCH elimination milestones, 2015-2020

Indicators	2015	2016	2017	2018	2019	2020
Completed mapping of SCH and determined areas above intervention threshold and the Endemic population	7/7 (100%)					
Begun implementation of school-based/community-based treatments in Endemic districts	7/7 (100%)					
Achieving 100% geographical coverage in SCH Endemic subzones		7/7 (100%)				
Conducted 3-5 years of consecutive treatments in all Endemic subzones with zonal/national coverage more than 75%				7/7 (100%)		
Conducted first impact assessment activities in at least 50% of SCH Endemic districts after at least 3 years of consecutive treatments				7/7 (100%)	7/7 (100%)	
Endemic districts achieving moderate morbidity control		7/7 (100%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	
Endemic districts achieving advanced morbidity control			7/7 (100%)	7/7 (100%)	7/7 (100%)	
Endemic districts achieving elimination of transmission					7/7 (100%)	7/7 (100%)



### STH elimination milestones, 2015-2020

Indicators	2015	2016	2017	2018	2019	2020
Completed mapping of STH and determined areas above intervention threshold and the Endemic population	7/7 (100%)					
Begun implementation of school-based/community-based treatments in Endemic districts	7/7 (100%)					
Achieving 100% geographical coverage in STH Endemic districts	7/7 (100%)					
Conducted 3-5 years of consecutive treatments in all Endemic districts with regional coverage more than 75%				7 /7 (100%)	7/7 (100%)	
Conducted first impact assessment activities in at least 50% of STH Endemic subzones after at least 3 years of consecutive treatments				7/7 (100%)	7/7 (100%)	
Endemic districts achieving moderate morbidity control		7 /7 (100%)	/7 (100%)	7/ 7(100%)	7/7 (100%)	
Endemic districts achieving advanced morbidity control		7/7 (100%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	

### Trachoma elimination milestones, 2015-2020

Indicators	2015	2016	2017	2018	2019	2020
Completed mapping of trachoma and determined areas above intervention threshold and the target population	7/7 (100%)					
Begun implementation of community-based treatments in target districts	7/7 (100%)					
Achieved 100% geographical coverage in trachoma target districts	7/7 (100%)					
Conducted 3-5 rounds of treatments in all target districts with regional coverage more than 75%	7/7 (100%)	7/7 (100%)	7/7 (100%)			
Conducted first impact assessment activities in at least 50% of trachoma target subzones after at least 3 rounds of treatments			7/7 (100%)			
Started passive surveillance in at least 75% of IUs.		5/7 (72%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	
Proportion and number of target districts where there is full coverage of case-management services	7/7(100%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	
Target districts achieved elimination of blinding trachoma		5/7 (72%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	

**IDM control/elimination milestones, 2015-2020**

Indicators	2015	2016	2017	2018	2019	2020
Active Case detection in 100% of Highly endemic districts	7 (100%)	7 (100%)				
Passive case detection in 100% of other endemic districts	7 (100%)	7 (100%)				
Manage all patients in peripheral health facilities	14 (100%)	14 (100%)	14 (100%)			
Refer severe and complicated cases for management at district hospitals and reference centres	7 (100%)	7(100%)	7(100%)			
Achieved 100% geographical coverage of SAFE in trachoma target districts	3 (43%)	4 (57%)	7 (100%)	7(100%)		
Achieved 100% treatment coverage of identified leprosy cases	7 (100%)	7 (100%)	7 (100%)	7 (100%)		
Achieved 100% treatment coverage of identified cases for other CM-NTDs(Rabies)	3 (43%)	4 (57%)	7 (100%)	7 (100%)	7 (100%)	
Started passive surveillance in at least 50% of target districts for CM-NTDs targeted for elimination (Leprosy)	3/7 (43%)	4/7 (57%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	
Started sentinel site surveillance in at least 50% of target districts for CM-NTDs targeted for elimination (Leprosy)	3/7 (43%)	4/7 (57%)	7/7 (100%)	7/7 (100%)	7 /7 (100%)	
Target districts that sustained elimination of leprosy	0/7 (0%)	0/7 (0%)	3/7 (43%)	4/7 (57%)	7/7 (100%)	7/7 (100%)

# **PHASE milestones, 2015-2020**

	Indicators	2015	2016	2017	2018	2019	2020
1	Proportion and number of Endemic districts with adequate access to clean water for SCH control	2/7 (29%)	2/7 (29%)	2/7 (29%)	3/7 (43%)	4/7 (57%)	5/7 (72%)
2	Proportion and number of Endemic districts with adequate sanitation manipulation for SCH control	3\20 (43%)	7/7 (43%)	7/7 (100%)	7/7 (100%)	7/7 (100%)	7/7 (100%)
3	Proportion and number of Endemic districts with adequate*** environmental manipulation for SCH control	0/7 (0%)	1/7 (14%)	3/7 (43%)	4/7 (57%)	7/7 (100%)	7/7 (100%)
4	Proportion and number of Endemic districts with adequate access to clean water and health education for STH control	2/7 (29%)	3/7 (43%)	4/7 (57%)	7/7 (100%)	7/7 (100%)	7/7 (100%)
5	Proportion and number of Endemic districts with adequate sanitation for STH control	2/7 (29%)	3/7 (43%)	4/7 (57%)	7/7 (100%)	7/7 (100%)	7/7 (100%)
6	Proportion and number of Endemic districts with adequate environmental manipulation for STH control	0 (0%)	2/7 (29%)	3/7 (43%)	4/7 (57%)	7/7 (100%)	7/7 (100%)
7	Proportion and number of Endemic district that certify Open Defecation-free and Health Education for STH control	1/7 (14%)	2/7 (29%)	3/7 (43%)	4/7 (57%)	7/7 (100%)	7/7 (100%)

## **PART 3: OPERATIONAL FRAMEWORK**

After outlining the goals, specific objectives and activities of NTDs in part 2 of the master plan, this section describes how the planned activities will be implemented as well as the resources needed for the implementation.

### **3.1 SCALING UP ACCESS TO NTD INTERVENTIONS, TREATMENT AND SERVICE DELIVERY CAPACITY**

In prelude to the mapping of NTDs that will give a clearer picture of NTDs endemicity in the country this section gives a detail description of the activities for scaling up the NTD Program. The three main packages of interventions addressed were developed for the scaling up of NTD programme included Preventive chemotherapy, Case management/chronic case, Integrated vector management and other "PHASE"\* interventions for the targeted NTDs.

#### **3.1.1 Scaling up preventive chemotherapy interventions**

From the paucity of literature available in the country, it is envisaged that after aping of NTDs the most plausible NTD that will require Mass Drug Administration (MDA) will be Lymphatic Filariasis, STH, Schistosomiasis and Trachoma. The plan is to use Community and school based campaigns to address the sub zones that are mapped and found to be positive for these diseases. The type of MDAs to be implemented is detailed in table 9 and also in annexes 2.3 and 2.4. In addition to the implementing the proposed MDAs and scaling up the interventions various activities such as training, sensitization, supervision and drug administration will be conducted (Table 10).

**Table 9:** Types of mass drug administration

Cross-cutting MDA types	Delivery channels	Timing of treatments	Disease combination	Requirements	Target (regions)	Other mass disease control interventions
MDA2 (One annual round of DEC and albendazole) •	<ul style="list-style-type: none"> <li>Community-based campaigns</li> <li>School based campaign</li> </ul>	Annually	Lymphatic filariasis,	<ul style="list-style-type: none"> <li>Training of Trainers</li> <li>Training of health personnel;</li> <li>Training of community volunteers</li> </ul>	Forto Araata	Vitamin A campaigns ITN distribution
T1(One annual round of prizaquintel + Albendazole)		Annually	Schistosomiasis/STH	<ul style="list-style-type: none"> <li>Social mobilization of local administrators and village elders;</li> </ul>	All 7 regions	
T2 (one round of Praziquantel only)	<ul style="list-style-type: none"> <li>School based campaign</li> </ul>	Annually	Schistosomiasis	<ul style="list-style-type: none"> <li>Mass media</li> <li>Supervision</li> </ul>	All 7 regions	
MDA4 (One annual round of with azithromycin + Tetracycline eye ointment for under 2 children)	Community based	Annually	Trachoma		West coast region B	

**MDA4** = Azithromycin and TTC eye ointment for under 2 children

**T1**= Praziquantel + Albendazole

**T2** = Praziquantel only

**T3** = Albendazole or mebendazole only

**MDA2** = DEC + Albendazole

**Table 10:** Activities for strategic priority 1- Scale up Access to PCT interventions

<b>Strategic Objective 1:</b> Scale up an integrated preventive chemotherapy, including access to interventions for lymphatic filariasis, soil transmitted helminthiasis, schistosomiasis and trachoma and reach elimination by the mentioned diseases by 2020.			
<b>Activity</b>	<b>Detail ( sub-activities)</b>	<b>Time frame</b>	<b>Resources needed</b>
<b>Training</b>	Training of health workers at all the health regions	2015-2017	Personnel, meals, Transportation, stationery, Hire of Hall
	Training of teachers and cluster monitors	2015-2017	
	Training of community health workers (CHNs, VHWs, TBAs )	2015-2017	
<b>Community sensitization and mobilization</b>	Sensitization of Parent Teacher Associations/school management committees in schools	2015-2018	IEC materials, Per-diem, Food, logistics for chief, religious and opinion leaders, transportation/fuel
	Sensitization of local government authorities, community and religious leaders, drama groups, MDFTs, VSGs, TCs, RCVs	2015-2020	
<b>Distribution of medicines</b>	Data base for pupils and communities	2015-2020	Registers, stationery, personnel, communication cost, transportation, per-diem
	Supervision of data base for pupils and communities	2015-2020	
	Distribution of medicines from central medical store to the regional medical stores	2015-2020	
	Distribution of medicines from regional store to health facilities	2015-2020	

### 3.1.2 Scaling up NTD case management interventions

The NTDs in The Gambia that can be case managed include lymphatic filariasis, trachoma, leprosy and rabies. The detailed activities that are proposed for scale-up of detection and case management of CM-NTDs in The Gambia are described in tables 11 and 12 below.

**Table 11:** Activities for case management interventions

Strategic Objective 3.1. 2: Eradicate LF and eliminate trachoma, leprosy and rabies by 2020 by scaling up case management interventions.			
Activity	Sub-Activities	Time Frame	Resources needed
Training	1.Training of Trainers (TOTs) at central level	2015, 2017, 2019	Training modules, allowances, LCD Projector, Hall hire stationery, food and fuel
	2. Training of HWs at district level in case management	2015, 2017, 2019	
	iii. Special training on lymphoedema and hydrocele management	2015 - 2020	
	iv. Training on Identification, confirmation and management of leprosy cases	2015-2020	
	v. Training on Case management (CM) of schistosomiasis and rabies	2015-2020	
	i. Develop training guide on CM-NTDs	2015	Allowances, Hall hire, stationery. Transportation
	ii. Train CHWs on detection and morbidity management of CM-NTDs and referrals	2015-2020	
	Training of health workers and sensitization of communities on psychosocial support		
Surgery for Trachoma Trichiasis (Surgical camps)	TT surgical camps in 7 health regions	2015-2020	Allowances, transportation and disposable supplies
	Supportive supervision by the center during surgical camps	2015-2020	
Lymphoedema and hydrocele management	Lymphoedema and hydrocele management in all 7 health regions	2015-2020	
Leprosy, schistosomiasis and rabies management	Leprosy, schistosomiasis and rabies case management in all 7 health regions	2015-2020	Kits for leprosy, Microscopes, slides, haematocrit centrifuges, generators, lab reagents allowances, transportation
Laboratory equipments for Case detection	i. Training of Laboratory staff in all 7 health regions	2015-2020	
	ii. Procure lab equipment and reagents		
Provision of drugs	i. Procurement, clearance, delivery, storage and inventory management of drugs	2015-2020	Budget for procurement of IDM Drugs
Support supervision	i. Develop a support supervision tool/checklist		2015-2020
	ii. Conduct supportive supervision quarterly	Allowance, transportation	
Case finding	Active case finding of Trachiasis, Lymphodema, hydroceol and leprosy in 7 health regions	2015-2020	Personel,
Transmission assessment	Transmission assessment survey for LF	2018-2020	Allowance, transportation



**Table 12:** Case management and chronic care

<b>Cross-cutting interventions</b>	<b>NTDs targeted</b>	<b>Requirements</b>	<b>Other non-NTD opportunities for integration</b>
Hydrocele surgery (hydrocelectomies)  Trichiasis surgery	Lymphatic filariasis hydrocele,  Trachomatous Trichiasis (TT)	<ul style="list-style-type: none"> <li>• Training of Medical Doctors and nurses</li> <li>• Hospitals facilities or appropriate basic facilities with good surgical facilities</li> <li>• Follow up/supervision</li> </ul>	Capacity building for basic surgery at the regional level
-Daily hygienic washing of affected limbs.  -Exercise of affected limbs  -Application of antibiotic creams to affected limbs  - skin care	Elephantiasis/lymphedema  Leprosy disability	<ul style="list-style-type: none"> <li>• Washing kits (bucket, towel, soap, clean water, autoclave machines at local health facilities )</li> <li>• Procuring prosthesis for disability due to leprosy</li> <li>• Antibiotics/Vaseline creams</li> <li>• Training of first-line health/community workers, patients and family members</li> <li>• Social support clubs/groups</li> <li>• Follow up/ Supervision</li> </ul>	HIV/AIDS social support groups.  Diabetes support groups  Malaria home management  Community TB DOTs  Mental health support groups
Hospitalized treatment (rabies)  Self-administering MDT treatment (leprosy)	Leprosy, Rabies, Hydrocele	<ul style="list-style-type: none"> <li>• Specific drugs (tablets and injectables)</li> <li>• Hospitalization facilities</li> <li>• Close monitoring during treatment (in case of schistosomiasis or rabies)</li> <li>• Training of medical staff</li> <li>• Follow up/ supervision</li> <li>• Patient support (financial e.g. transportation to health facility)</li> <li>• Nutritional support</li> </ul>	Malaria home case management  Community TB DOTs  HIV/AIDS social support groups.  Community mental health team

### 3.1.3: Scaling up NTD transmission control interventions

**Table 13:** Intervention packages for Transmission control

Cross-cutting interventions	NTDs targeted	Requirements	Other non-NTD opportunities for integration
<p>Mosquito, snail and dogs control using:</p> <ul style="list-style-type: none"> <li>• insecticide treated nets (ITN)</li> <li>• In-door residual spraying (IRS)</li> <li>• Mollusciciding</li> <li>• Environmental management</li> <li>• Biological control</li> <li>• Health Education</li> <li>• Culling of rabid dogs</li> </ul>	<p>Lymphatic filariasis</p> <p>Schistosomiasis</p> <p>Rabies</p>	<ul style="list-style-type: none"> <li>• ITNs, and insecticide treated materials (ITM)</li> <li>• Insecticide chemicals</li> <li>• Larviciding and mollusciciding chemicals</li> <li>• Radio/TV, drama, flyers, posters, leaflets, sms, etc.</li> </ul>	<p>Malaria vector control</p>
<ul style="list-style-type: none"> <li>• Improved access and quality of water supply.</li> <li>• Improved sanitations facilities</li> <li>• Environmental management</li> <li>• Health Education</li> <li>• Personal Hygiene</li> </ul>	<p>Schistosomiasis</p> <p>Soil transmitted helminthes</p> <p>Trachoma</p>	<p>-Sinking bore-holes and pipe-borne water</p> <p>-Building of proper latrines</p> <p>-Health Education &amp; Promotion.</p>	<p>-Developmental programmes (e.g. water &amp; sanitation)</p> <p>-School health and Nutrition programmes</p> <p><u>Community Led Total Sanitation (CLTS)</u></p> <p>Environmental health</p>

**Table 14:** Activities for disease transmission control

<b>Strategic objective 3: Strengthening integrated vector management and other "PHASE" interventions for the targeted NTDs.</b>			
<b>Activity</b>	<b>Details (Sub-activities)</b>	<b>Timeframe</b>	<b>Resources needed</b>
1. Developing tools	Develop and finalize the integrated vector management policy	2015	Stationary, allowances, hall hire, transportation, technical assistance,
	i. Develop and finalize guidelines for integrated vector management	2015	
	ii. Development of training modules and IEC Materials (including radio, drama and TV spots)	2015	
2. Training	i. Training of National trainers	2015, 2017, 2019	Training modules, allowances, hall hire stationary, technical assistance
	ii. Training of central and regional level trainers	2015, 2017, 2019	
	iii. Training of Spray operators and WASH persons	2015 - 2020	
	iv. Training of health workers on specific NTD vectors	2015 - 2017	
3. Procurement of supplies	i. Procurement and distribution of integrated vector management supplies and equipments	2015 - 2018	Bed nets, Spray pumps, insecticides/larvicides, molluscicides personal protective gears
4. Communication and social mobilization on integrated vector management	Conduct Regional and district IEC/BCC activities	2015 - 2020	Personnel, meals, stationery, transportation, IEC materials
	ii. Regional and district Bed nets and IRS Advocacy meetings	2015 - 2020	
	iii. district and community leaders' sensitization meetings	2015 - 2020	
	iv. CHWs sensitization meetings	2015 - 2020	
	v. Media sensitization and advocacy	2015 - 2020	
	vi. Develop and air radio and television NTD messages	2015-2020	Air time,
	vii. Community mobilization for IVM	2015 - 2020	Transportation, allowances
	i. Conduct regional needs assessment for bed nets and IRS, larviciding and mollusciciding	2016 -2017	Transportation, allowances, communication, insecticides, molluscicides, bed nets
	ii. Micro planning and TOT workshop on IVM	2016 - 2020	
	iii. Baseline entomological and malacological studies	2015	

5. Conduct Operational Researches	iv. Baseline epidemiological studies	2015	
	v. Baseline KAP on sanitation and hygiene	2015	
	vi. Chemical exposure assessment of spray operators	2015 - 2020	
	vii. Post-IRS and ITNs entomological and malacological studies	2016 - 2020	
	viii. Post-IRS and ITNs epidemiological studies	2018 - 2020	
6. Other PHASE interventions	Conduct source reduction (filling and destroying breeding sites)	2015 - 2020	Transportation, allowances, equipment and supplies, communication
	Larviciding and mollusciciding of breeding sites	2015 - 2020	
	Health education on vector behavior, sanitation and environmental management	2015 - 2020	
	Support construction of pit latrines	2015-2020	Collaboration with environmental health division
7. Monitor and evaluate impact of on-going vector control interventions and PHASE activities	i. Monitor quality of ITNs, IRS, larvicides and molluscicides using bio-assay tests	2015 - 2020	Monitoring tools, transportation, allowances, equipment and supplies
	ii. Entomological and malacological evaluation studies	2018	Evaluation tools, transportation, allowances, equipment and supplies
	iii. Epidemiological evaluation studies	2018	
	iv. Latrine utilization surveys	2017	Survey tools, transportation, allowances, equipment and supplies
	v. KAP surveys on hygiene and sanitation	2017	
	vi. Conduct dissemination workshops	2017-2020	Stationery, allowances, transportation, airtime

- PHASE: Preventive chemotherapy, Health education, Access to safe drinking water, Sanitation and hygiene, and Environmental improvements

### 3.3 PHARCOVIGILANCE IN NTD CONTROL ACTIVITIES

In order to ensure that good quality of drugs are purchased, properly stored and delivered to the population with satisfactory reporting and management of adverse side effects, the national pharmaco-vigilance system will be strengthened. This section provide detail activities to strengthen pharmacovigilance in the country. These activities are summarised in table 15 below.

**Table 15:** Activities for strengthening pharmaco-vigilance in NTD programme.

<b>Strategic Objective 3.3.1: To strengthen the existing functional Pharmacovigilance(PV) to include NTD programme</b>			
<b>Activity</b>	<b>Details (Sub-activities)</b>	<b>Timeframe</b>	<b>Resources needed</b>
Sensitization on the role of pharmacovigilance in NTD Control	Train health professionals on Pharmacovigilance principles in the NTD programme.	2015 - 2018	Transportation, DSA, venues, refreshment, meals and stationery materials.
Monitoring and Evaluation of the Pharmacovigilance system	. Annual National workshop for the PV review	2015 - 2020	Transportation, allowance, and stationary
International meetings, trainings and conferences	Attend regional and international meetings and trainings on pharmacovigilance	2015 - 2020	Accommodation, airfare and DSA for participants
Workshop for integrated work plan	Annual National workshop for integrated work plan between Pharmacovigilance Unit and National NTD programme	2015 - 2019	Accommodation, transportation, DSA, Venues and stationary materials for the workshop participants
Quality Assurance (QA) of Medicines used for MDA in WHO prequalified Laboratories	Send batch samples of the medicines used for MDA in NTD Control to WHO accredited laboratory for quality test	2015 and 2017	Quality test fee & Transportation fee (DHL)
Conduct operational research on patient safety	Conduct Cohort study on medicines during MDA	2017, 2019	Develop pre and post questionnaires Recruit 10% of the population involved in MDA Airtime
Develop Risk Management and Risk minimization plan	Draft risk minimization plan during MDA	2015	Stationeries, DSA

### 3.4 STRENGTHENING CAPACITY AT NATIONAL LEVEL FOR NTD PROGRAMME MANAGEMENT AND IMPLEMENTATION

This section focuses on activities that will be implemented and the resources required to strengthen the management and operational capacities of the NTD programme staff at various levels. This is required to scale up and achieve elimination goals. The details are as presented in table 16. Table 17 shows the scaling up/down of IDM and PCT NTDS.

**Table 16:** Activities and resources needed for strengthening capacity for NTD programme

<b>Strategic objective 3.4.1: Strengthening capacity at national level for NTD programme management and implementation.</b>			
<b>Activity</b>	<b>Details (sub-activities)</b>	<b>Time frame</b>	<b>Resources needed</b>
Leadership and management training	Training of personnel	2015	Stationery Allowance
Procurement of office equipment and vehicles	Equip central and regional NTD offices with office equipment (Lap tops, furniture, LCDs, etc)	2015	Furniture (8 office sets), lap tops (8), desk tops(10), LCDs (2), Specifications Printers (10) and cartridges (24) Photocopiers (2) and toners (10) 2 vehicles (land cruisers)
Strengthening the capacity of Laboratory diagnosis	1. Training of Lab personnel on NTD diagnosis 2. Procurement of lab equipments and reagents	2015- 2018	Lab supplies and reagents
Strengthening data management system	Refresher trainings of data managers	2017	Allowance

**Table 17:** Scaling up/scaling down plan.

NTD	Total No. Region requiring MDA	Total at risk population	2015 No. regions and Total population to be treated	2016 No. regions and Total population to be treated	2017 No. regions and Total population to be treated	2018 No. regions and Total population to be treated	2019 No. regions and Total population to be treated	2020 No. regions and Total population to be treated
<b>PCT IMPLEMENTATION (MDA)</b>								
LF	5	5 (1628085)	5 (346663)	5 (366076)	5 (386576)	5 (386576)	5 (250000)	5 (1628085)
SCH	7	7(1842938)	7 (433700)	457987	7 (483634)	7 (510718)	7 (250000)	7(1842938)
STH	7	7(1842938)	7 (433700)	457987	7 (483634)	7 (510718)	7 (250000)	7(1842938)
TRA	4	4 (608728)	4(541417)	4 (541417)	4 (571736)	4 (571736)	4 (250000)	4 (608728)
<b>IDM IMPLEMENTATION</b>								
Leprosy	5	5 (433700)	5 (34)	5 (40)	5 (43)	(5) 39	(5) 37	(5) 41
Rabies	7	7(1882450)	7(200)	7(200)	7(150)	7(100)	7(50 )	0 (0)

**Note:** These figureare predictions based on the paucity of information available on NTDs endemicity. These figures may change after complete mapping of NTDs in the country

### 3.5 ENHANCING PLANNING FOR RESULTS, RESOURCE MOBILIZATION AND FINANCIAL SUSTAINABILITY

In order to ensure successful implementation of the NTD Master Plan it will be important to put in place good strategies to guarantee adequate resource mobilization for financial sustainability. Moreover a good accountability system for resource monitoring and control in a transparent manner based on justifiable evidence will be of prime importance. In this section, some key activities have been identified to enable the achievement of the four strategic objectives for enhancing planning for results, resource mobilization and financial sustainability of the NTDP. These activities are shown in table 17.

**Table 17:** Activities for implementing Strategic Priority 2: Enhance planning for results, resource mobilization, and financial sustainability of national NTD programmes.

<b>Strategic objective 3.5.1:</b> <i>To develop integrated multiyear strategic plan and gender-sensitive annual operational plans for the control, elimination and eradication of targeted NTDs</i>			
Activity	Details (sub-activities)	Time frame	Resources needed
1. Review and launch the new NTD master plan	i. Workshop to Revise the NTD Master plan	2014	Allowances, accommodation, hall rental, meals, stationaries.
	ii. Hold all NTDs stake holders meeting	2014	
<b>Strategic Objective 3.5.2:</b> <i>Enhance resource mobilization approaches and strategies at international, national and zonal levels for NTD interventions.</i>			
1. Develop an NTD resource mobilization strategy.	i. Hold meeting to develop resource mobilization strategy.	2015	Resource persons and participants, allowances, accommodation, hall rental, meals, assorted stationary, communication cost
2. Implementation of the resource mobilization strategy.	ii. Hold meeting with multi-lateral, bilateral and all NTD key stakeholders.	2015-2020	
	iii. Periodically update the resource mobilization strategy.	2015-2020	Personnel

### 3.6 STRENGTHENING GOVERNMENT OWNERSHIP, ADVOCACY, COORDINATION AND PARTNERSHIPS

NTD control strategies will be incorporated into the national and subnational health plan as well as into health service delivery in the facilities, education and other relevant areas. Community engagement and participation are critical to sustainability of the interventions. The NTD structure (Steering committees, task forces and secretariats) will review with stakeholders the progress. The media will be used to disseminate information on NTDs across the entire country. Table 18 list the activities that will be implemented to insure the achievements of the above strategic priorities. In order to insure



**Table 18:** Activities for implementing Strategic priority 1: Strengthen government ownership, advocacy, coordination, and partnership.

coordination, and partnership.

<b>Strategic objective 3.6.1:</b> <i>Strengthen coordination mechanism for the NTD control programme at national and sub-national levels</i>			
Activity	Details (sub-activities)	Time frame	Resources needed
1. Establish National coordination mechanisms	Establish NTD steering committees and secretariat at National level	2015	Personnel
	Hold quarterly meetings	2015-2020	Allowances, accommodation, hall rental, meals, stationary.
2. National Stakeholders NTD review meeting	All stakeholders meeting including MoH high officials and other line ministry high officials.	2015-2020	
<b>Strategic objective 3.6.2:</b> <i>Strengthen and foster partnerships for the control, elimination and eradication of targeted NTDs at national, sub zoba and community levels</i>			
Strengthening partnership	Organize advocacy meetings to involve more partners in NTD control	2015-2017	Personnel  Hall rental, meals, assorted stationary
<b>Strategic objective 3.6.3:</b> <i>Enhance high level reviews of NTD programme performance and the use of lessons learnt to enhance advocacy, awareness and effective implementation</i>			
1. Conduct annual review meeting.	i. Annual stakeholders meeting for reviewing program performance	2015 -2020	Allowances, accommodation, hall rental, meals, stationary.
	ii. Documentation of program performance and dissemination	2015 -2020	Personnel, stationery, communication cost, postal services, printing and dissemination

### 3.7 MONITORING & EVALUATION

Monitoring and evaluation activities are critical steps in tracking progress of programme implementation. The NTD Program will be monitored and evaluated periodically to collect data to ensure progress and achievements. Continuous supervision is required and programme evaluation will be conducted at midterm and at the end of the programme to assess performance in relation to the goals, objectives and set targets. Table 19 below describes the activities, sub-activities, time frame and resources needed to achieve the four strategic objectives.

**Table19:** Strategic priority 4: Enhance NTD monitoring and evaluation, surveillance and operation research.

<b>Strategic Objective 3.7.1:</b> <i>Develop and promote an integrated M&amp;E framework and improve monitoring of NTDs, within the context of national health information systems</i>			
<b>Activity</b>	<b>Details (sub-activities)</b>	<b>Time Frame</b>	<b>Resources Needed</b>
Develop an integrated NTD M&E framework	Develop an M&E tool	2015	Experts/honorarium, Stationeries, venues, DSA and Refreshment,
	Field testing of the tool	2015	Personnel, stationeries, Airtime, transportation costs,
Monitor drug management inventory and logistics	Supervisory visit on drug management, inventory and logistics	Quarterly	personnel, stationeries, transportation costs,
<b>Strategic Objective 3.7.2:</b> <i>Strengthen and foster partnership for the control, elimination and eradication of targeted NTDs at national, regional and communities.</i>			
Monitor the coordination and implementation activity of NTD unit	Develop checklist for monitoring indicators, conduct annual monitoring of activities against set indicators	2015-2019	Checklist, stationeries, DSA transportation costs, Airtime,
Monitoring resource use	Tracking of appropriate availability and use of resources; financial report	Annually	transportation costs, communication costs,
<b>Strategic Objective 3.7.3:</b> <i>Strengthen surveillance of NTDs and strengthen response and control of epidemic prone NTDs, in particular Dengue and Leishmaniasis, and other IDM NTDs</i>			
Strengthen cross border surveillance activities	Cross border advocacy, Identify joint sentinel sites for NTD surveillance; Joint community sensitization; joint supervision,	2017	transportation costs, communication costs, venues, DSA, refreshment,
<b>Strategic Objective 3.7.4:</b> <i>Establish integrated data management systems and support impact analysis for NTD in the WHO African Region as part of the global NTD data management system and global NTD plan</i>			
Strengthen integrated data management system (HMIS)	Develop and produce reporting forms, software, field test	2015	Trainings, field testing, Experts/honorarium, printing forms, stationeries, venues, DSA and Refreshment, transportation costs, software, communication costs,
	Identify and train NTD Data focal persons	2015	
Conduct impact assessment for NTDs	Develop integrated protocol for impact assessment;	2017	Experts/honorarium, Commodities, (Stationeries, venues, DSA and Refreshment, transportation costs, communication costs); survey cost; dissemination costs of results,
	Conduct treatment coverage impact survey, share best practices		
Reporting and submission of results to MoH and WHO/AFRO	Compile report and submit to MoH and WHO	2015-2020	Stationery

### 3.8. POST INTERVENTION SURVEILLANCE AND INTEGRATION WITHIN PRIMARY HEALTH CARE

The activities to be implemented and the resources needed are elaborated in table 20. Establishing a strong post-intervention surveillance within the health care system will help to keep in check the diseases thresholds. Surveillance activities will also be integrated into the national HMIS. The activities that will be implemented as part of the surveillance of each of the NTDs targeted in this plan are as summarized in Table 20.

**Table 20:** Activities for surveillance and sustainability

<b>Strategic objectives:3.8.1 Strengthen and sustain the surveillance of NTDs and the response and control epidemic –Prone IDM NTDs(leprosy, Rabies, etc)</b>			
<b>Activity</b>	<b>Details (Sub-activities)</b>	<b>Timeframe</b>	<b>Resources needed</b>
Capacity building	Review and update training manuals	2018	Personnel
Strengthen cross border collaboration	Meeting with NTD affected neighboring countries	2017-1018	Meeting cost (stationeries,Venues, DSA and refreshment transportation costs, Communication costs
Conduct supportive supervision	Identify sentinel sites for periodic spots checks	2016-2020	Allowances and refreshment, transportation cost, communication cost, printing cost

## BUDGET JUSTIFICATION AND ESTIMATES

### SUMMARY BUDGET PROJECTIONS FOR 2015 ACTIVITIES

#### 2015 Budget projections

Activities and Sub-activities	Total budget (USD)	Contribution		Gap (USD)
		Country	Partners	
<b>1. Coordination, Partnership &amp; Advocacy</b>	39,926	0	0	39,926
<b>2. Planning and Resource Mobilization</b>	63,273	0	0	63,273
<b>3. Scale-up Interventions</b>	-			
Mapping	322,104	0	0	322,104
Mass drug administration	-			
Drug (CM) supplies and procurement	-			
Morbidity management & disability prevention	-			
Vector control				
Infrastructure and capacity building	371,821	0	0	371,821
Laboratory equipment & support	-			
<b>Total 3</b>	<b>797124</b>			
<b>4. M&amp;E, Research</b>				
Monitoring and evaluation	119,462	0	0	119,462
Disease surveillance	-			
Operational research	-			
Program monitoring	-			
Data management	-			
<b>Total 4</b>	<b>119462</b>			
<b>GRAND TOTAL</b>	<b>916586</b>			<b>916586</b>

**Note:** The budget presented above is for the projected activities for 2015.

## ANNEXES

### PART I SITUATION ANALYSIS

**Annex 1.1.** Populations, Villages/communities, Children, Schools, and Health facilities per District and Province or Region

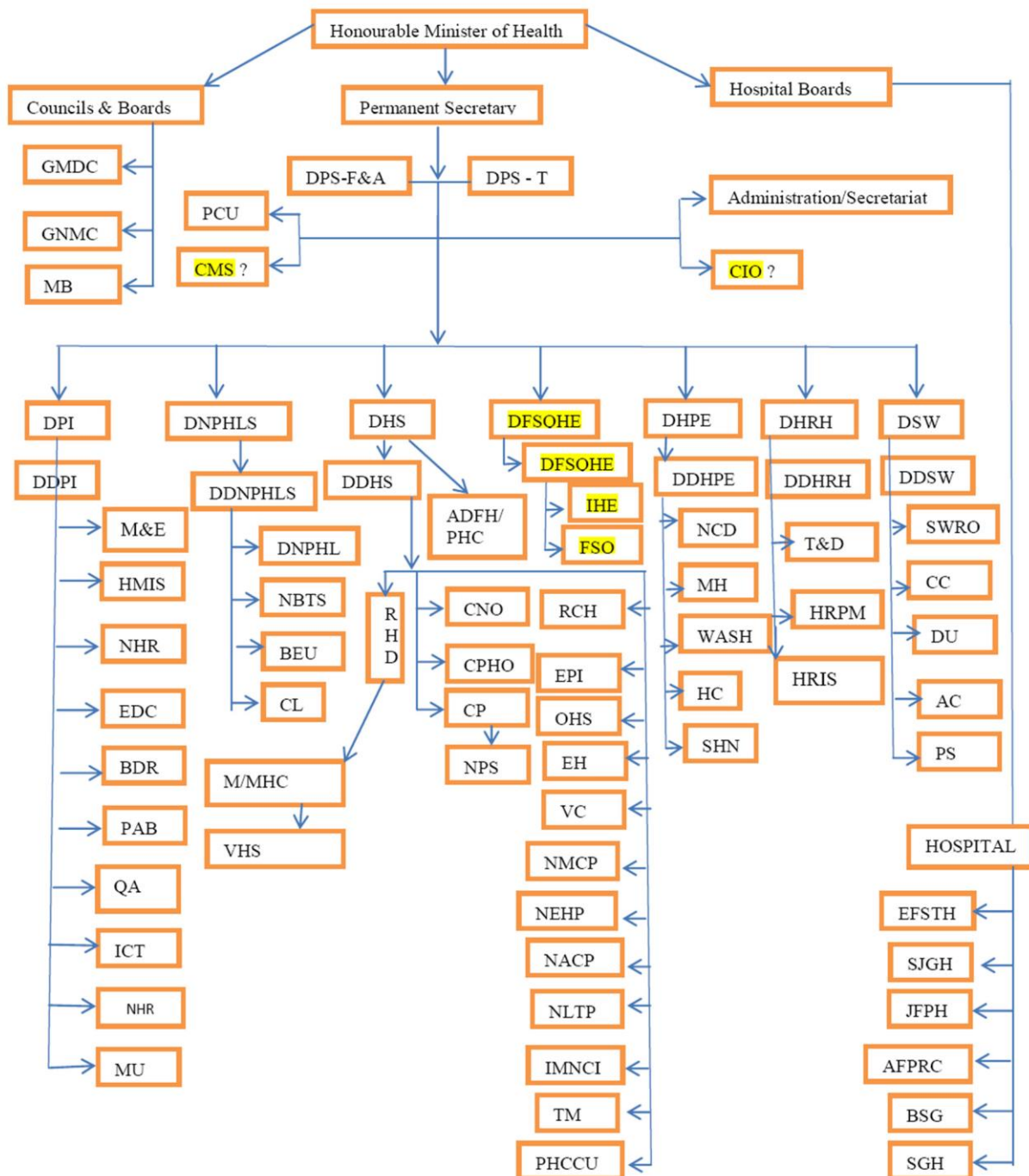
REGION	No. of communities or villages	Total Population	< 5years	>5 - 14 years	Primary schools No.	Peripheral Health facilities No.
<b>WEST COAST A</b>	345	699704	139938	107593	208	47
<b>NORTH BANK</b>						
<b>WEST</b>	164	112970	22593	26954	64	11
<b>NORTH BANK</b>						
<b>EAST</b>	178	79737	15946	25888	54	11
<b>LOWER RIVER</b>	153	82361	16470	22254	78	16
<b>CENTRAL RIVER</b>	655	214853.175	45000	87037	128	22
<b>UPPER RIVER</b>	360	239916	47981	82871	118	21
<b>WEST COAST B</b>	21	413397	82678	81103	115	21
<b>Total</b>	1876	1842938.18	370606	433700	765	149

**Annex 1.2. :** Distances between main cities and district headquarters of the country

**Banjul**

15	<b>Kanifing</b>					
40	25	<b>Brikama</b>				
200	185	145	<b>Mansakonko</b>			
60	75	100	70	<b>Kerewan</b>		
305	290	255	105	160	<b>Janjabureh</b>	
400	385	360	200	255	95	<b>Basse</b>

**Annex 1.3:** Organisational chart of the MoH&SW and the NTD National Programme



**Annex 1.4:** Summary on available data of PCT-NTD distribution

Region	LF	SCH	STH	Trachoma
West Coast Region A	ND	ND	ND	YES
North Bank West	ND	ND	ND	YES
North Bank East	ND	ND	ND	YES
Lower River Region	ND	ND	ND	YES
Central River Region	ND	ND	ND	YES
Upper river region	ND	ND	ND	YES
West coast region B	ND	ND	ND	ND

**Legend:**

**ND** (No data): if no information is available

**No:** Not endemic or below PCT intervention threshold

**Yes** or known **Prevalence rate** if endemic

\*Community is mainly for localised distribution of onchocerciasis and schistosomiasis.

In that case, state in bracket ( ) the number of endemic communities or villages within the District

**Annex 1.5:** Summary on available data on CM-NTD distribution

Province or region	Leprosy	Rabies
West Coast Region A	No	No
North Bank West	No	No
North Bank East	No	No
Lower River Region	No	No
Central River Region	No	No
Upper river region	No	No
West coast region B	No	No

**Legend:**

**ND** (No data): if no information is available

**No** for Not endemic or below elimination threshold

**Yes** or known **Prevalence rate** if endemic

**Annex 1.6:** Summary on status of implementation of PCT- NTD interventions in districts

Region	LF	SCH	STH	Trachoma
West Coast Region A	MAP	MAP	MAP	MAP
North Bank West	MAP	MAP	MAP	NO (SAFE)
North Bank East	MAP	MAP	MAP	NO (SAFE)
Lower River Region	MAP	MAP	MAP	NO (SAFE)
Central River Region	MAP	MAP	MAP	NO (SAFE)
Upper river region	MAP	MAP	MAP	NO (SAFE)
West coast region B	MAP	MAP	MAP	MAP

**Legend:**

**ND** (No data): if no information is available

**No**: if no intervention is required

**MAP**: if mapping is planned or on-going

**PCT (1),PCT (2) ...PCT (10)**: if MDA, CDTI or Targeted treatment is on-going. In bracket is the number of round being conducted. Examples: MDA1 (1) = 1<sup>st</sup> round of MDA1 (IVM+ALB), T2 (3) = 3<sup>rd</sup> round of T2 (PZQ in SAC), CDTI (7) = 7<sup>th</sup> round of IVM in communities for Onchocerciasis



**Annex 1.7:** Summary on status of implementation of CM interventions in districts

Region	Leprosy	Rabies
West Coast Region A	CM1	ACF
North Bank West	CM1	ACF
North Bank East	CM1	ACF
Lower River Region	CM1	ACF
Central River Region	CM1	ACF
Upper river region	CM1	ACF
West coast region B	CM1	ACF

**Legend:**

**ND** (No data): if no information is available

**No**: if no active case finding is required (elimination goal is achieved at district level)

**ACF**: if active case finding is planned or on-going for assessing the disease burden and treating

**CM1**: if routine case finding and treatment are on-going in peripheral health facilities

**CM2**: if routine case finding and treatment are on-going and reference to higher levels (hospitals) is organised for confirmation of diagnosis, treatment and prevention of complications and disabilities

## PART II: OPERATIONAL FRAMEWORK

### Annex 2. 1: Package of Preventive Chemotherapy (PCT) - Mass drug administration (MDA)

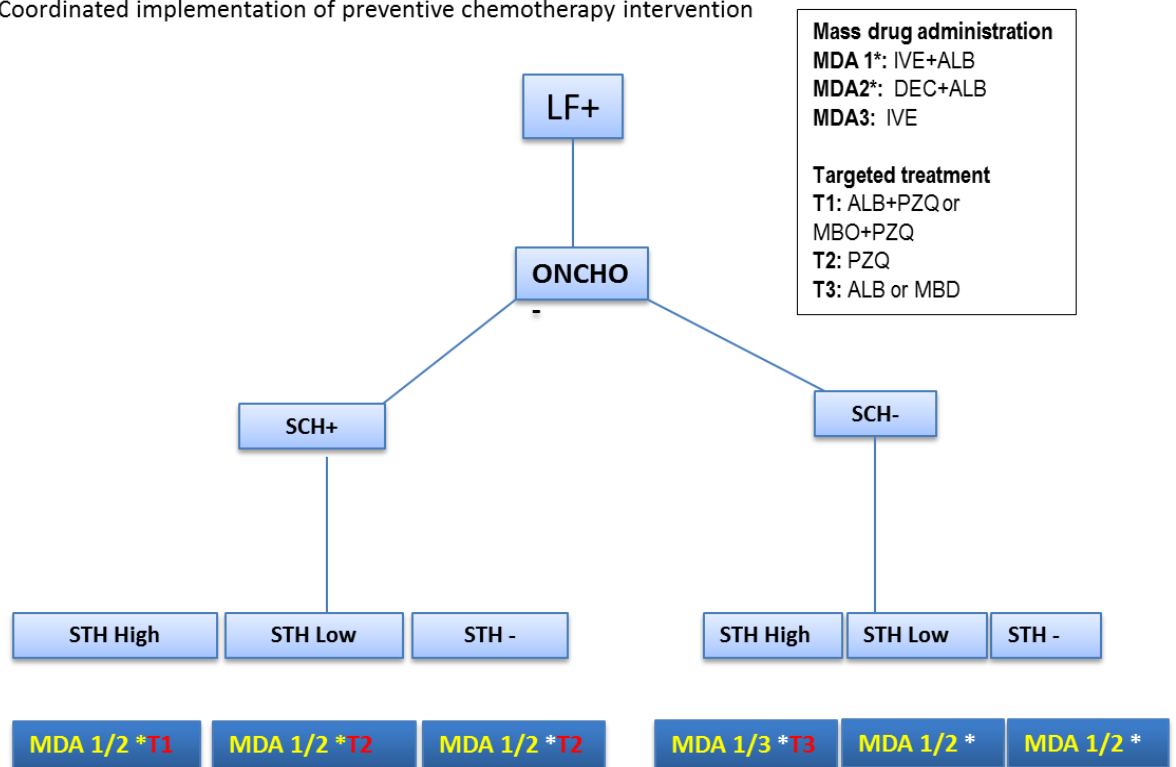
Activity		LF	SCH	STH	Trachoma
Programme coordination		X	X	X	X
Advocacy		X	X	X	X
Resource mobilization		X	X	X	X
Social mobilization		X	X	X	X
Training		X	X	X	X
Mapping		X	X	X	X
	School		X	X	X
	MDA campaign	X	X	X	X
	Child health day		X	X	X
	Immunization campaign		X	X	X
	Health and nutrition day	X	X	X	X
HSAM		X	X	X	X
M&E		X	X	X	X

### Annex 2.2: Package of Case management (CM) and chronic care

Key interventions	Leprosy	Complications LF	Trichiasis	Rabies
Advocacy/resource mobilization	X	X	X	X
Strengthening partnership	X	X	X	X
Intersectoral collaboration	X	X	X	X
Health promotion and Education	X	X	X	X
Capacity building	X	X	X	X
Mapping	X	X	X	X
Passive case finding	X	X	X	X
Active case finding	X	X	X	X
Medical treatment	X			X
Surgery	X	X	X	
Prevention of disability	X	X		
Integrated vector management/ reservoir control		X	X	X
Surveillance	X	X	X	X

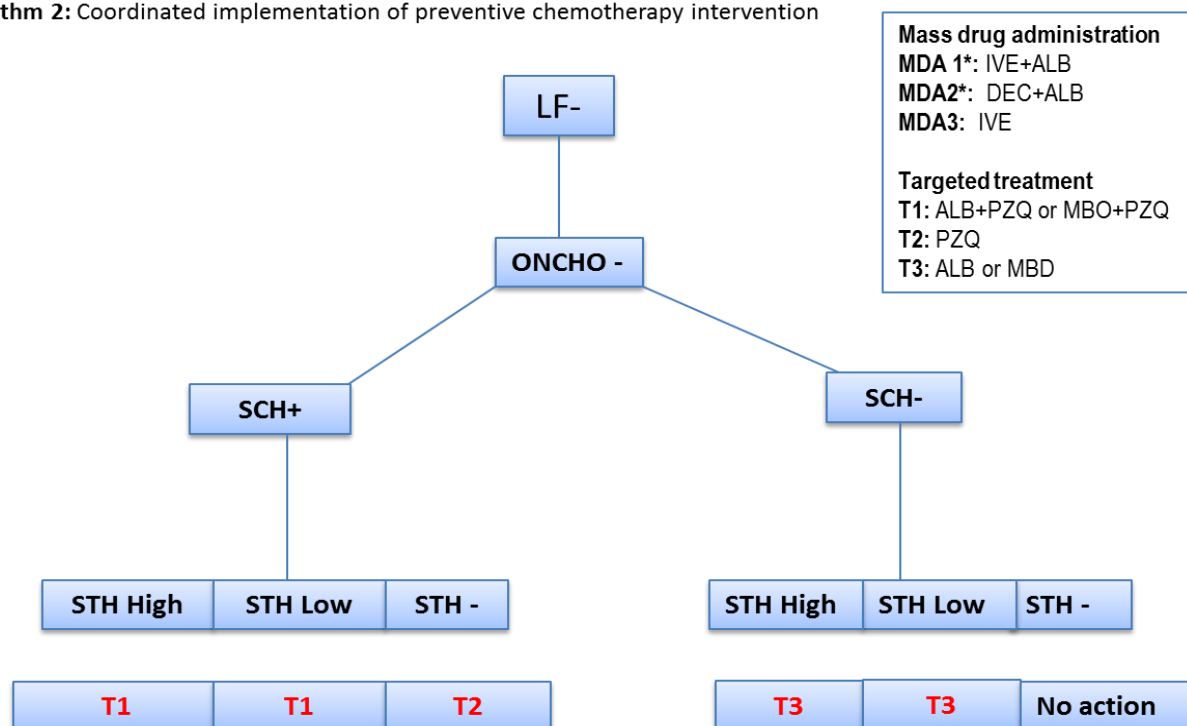
## Annex 2. 3: PCT algorithm 1

**Algorithm 1:** Coordinated implementation of preventive chemotherapy intervention

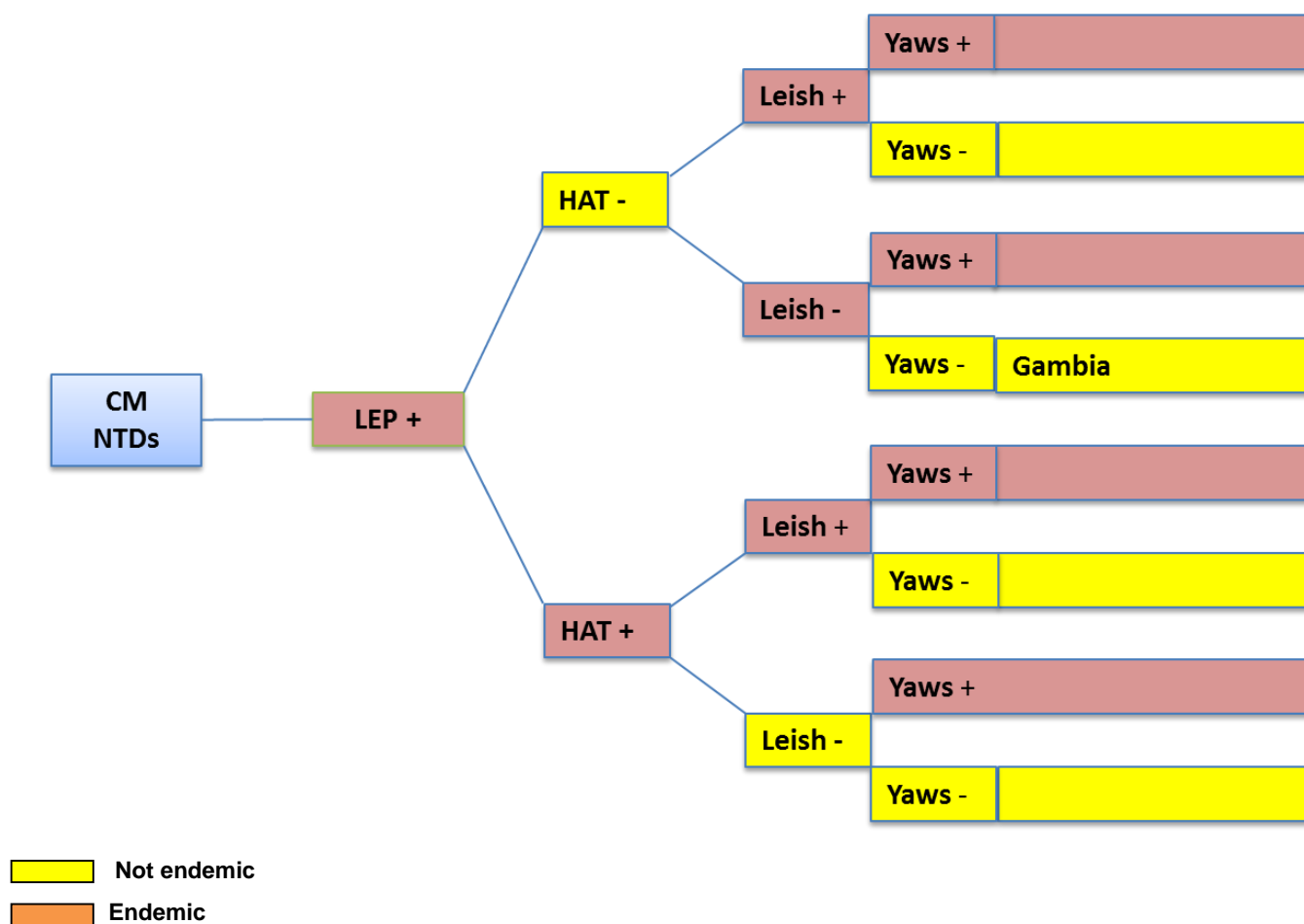


## Annex 2.4: PCT algorithm 2

**Algorithm 2:** Coordinated implementation of preventive chemotherapy intervention



**Annex 2.5:** Algorithm for Co-endemicity of CM-NTDs (Leprosy, Buruli ulcer, HAT, Leishmaniasis and yaws) in countries of the WHO African Region



**Annex 2.6:** Package of Transmission control - vector/reservoir control

Activity	Mosquitoes		Snail
	LF	Malaria	Schisto
ITN	X	X	
IRS	X	X	
Spaces spraying	X	X	
Larviciding	X	X	
Traps	X	X	X
Prevention/treatment of breeding sites	X	X	X

**Annex 2.7:** Package of Improvement of Environment, Supply of safe drinking water, sanitation, and operational research

Activity	LF	SCH	STH	TCH	LEP
Partnership for water supply improvement		X	X	X	
Partnership for sanitation improvement	X	X	X	X	X
Social mobilization	X	X	X	X	X
Health promotion	X	X	X	X	X
Operational research	X	X	X	X	X

**Annex 2.8: “WHAT to do” by district (operational unit) by operational package**

Region	PCT-NTDs		CM-NTDs		PCT & CM NTDs			NTDs Targeted for Elimination or Eradication	
	MAP	PCT	ACF	CM1+2	IVM	SWS	IoE	SURV	VERIF
West Coast Region A	X	X	X	X	X	X	X	X	X
North Bank West	X	X	X	X	X	X	X	X	X
North Bank East	X	X	X	X	X	X	X	X	X
Lower River Region	X	X	X	X	X	X	X	X	X
Central River Region	X	X	X	X	X	X	X	X	X
Upper river region	X	X	X	X	X	X	X	X	X
West coast region B	X	X	X	X	X	X	X	X	X

**Legend:**

**MAP** = Mapping;  
**PCT** = MDA, CDTI and Targeted Treatment;  
**ACF** = Active Case finding;  
**CM1+2** = Routine case finding and treatment in HF1 (peripheral) and HF2 (reference hospitals);  
**IVM** = Integrated Vector Management;  
**SSWS** = Sanitation and Safe drinking Water Supply;  
**IoE** = Improvement of Environment;  
**SURV** = Surveillance;  
**VERIF** = Verification

### Annex 2.9: Drug estimates and logistics

NTD programme	Drug	Source drug	Status of procurement (donated or purchased)	Minimum lead time before delivery	In-country consignee
LF	IVM	WHO/APOC	Donated	6 months	National programme
STH	Albendazole/Mebendazole	WHO	Donated	6 months	National programme
SCH	Praziquantel	WHO	Donated	6 months	National programme
Trachoma	Azithromycin	WHO, ITI, Cater Centre, Pfizer	Donated	6 months	National programme
LEPROSY	MDT blister packs	WHO, Novartis	Donated	6 months	National programme

### Annex 2.10: Drug forecasting and logistics

Drug	Source of drug	Status of procurement (donate/purchased)	Minimum Lead time before delivery	In-country Consignee
IVM	WHO	donated	6 months	National program
ALB	WHO	donated	6 months	National program
MEB	WHO	donated	6 months	National program
PZQ	WHO	donated	6 months	National program
AZI	WHO	donated	6 months	National program

- Complete the following table to describe how essential NTD drug supplies will be obtained.
- Identify sources of drugs (procured or donated)
- Describe management, logistics and monitoring system for delivering drugs to field distribution sites.

**Annex 2.11:** Summary of progressive scale up and phase out of PCT interventions package

	Status of interventions	Other PCT-NTD specific activities to be added
1	LFE Mass drug administration started	<p>Set up sentinel sites for STH impact evaluation</p> <p>Coordinate LF MDA with 2nd round of STH MDA, through school based approach, where prevalence is high (&gt;50%).</p> <p>Assess schistosomiasis endemicity, if endemic; coordinate LF MDA with praziquantel treatment jointly with 2nd round of STH MDA. If only schistosomiasis is endemic or STH prevalence is low (&lt;50%), coordinate with school based MDA for schistosomiasis.</p>
2	LF MDA planned	<p>-Map schistosomiasis and STH (also trachoma and onchocerciasis if applicable)</p> <p>-Collect baseline for LF, schistosomiasis and STH</p> <p>-Coordinate timing of delivery of MDA through community-based and school-based approaches appropriately.</p>
3	LF not mapped	<p>-Carry out integrated mapping with any of the five PCT diseases and Loa loa, where these are suspected. <i>Note: for some situations, LF mapping may need to be prioritized and carried out separately.</i></p> <p>-Where LF is endemic, to proceed as in 2 above.</p>
4	LF not endemic	-Proceed as in 2 above
5	LF MDA phasing out	<p>-Evaluate STH endemicity status and follow STH guidelines</p> <p>-where onchocerciasis is co-endemic, continue ivermectin distribution and follow guidelines for onchocerciasis control.</p>



**Annex 2.12:** Results framework for the WHO-HQ-AFRO-APOC Strategic Plan, 2010–2015

Strategic priorities	Strategic objectives	Core indicators
1 Strengthen advocacy, coordination and partnerships	<ul style="list-style-type: none"> <li>Strengthen coordination mechanisms for the NTD control programme at regional, national and subnational levels in the African Region;</li> <li>Strengthen and foster partnerships for the control, elimination and eradication of targeted NTDs at regional, national, district and community levels;</li> <li>Enhance high level reviews of NTD programme performance and the use of lessons learnt to enhance advocacy, awareness and effective implementation of targeted interventions;</li> <li>Strengthen advocacy, visibility and profile of NTD control elimination and eradication interventions at all levels in the African Region.</li> </ul>	<ul style="list-style-type: none"> <li>Minutes of high-level NTD coordination meetings in countries;</li> <li>Minutes of partnership events on NTDs;</li> <li>Number of high level advocacy events on NTDs;</li> <li>Number of partners involved in NTD programme.</li> </ul>
2 Enhance resource mobilization and planning for results in NTD control	<ul style="list-style-type: none"> <li>I. Support countries to develop integrated multiyear strategic plans and gender-sensitive annual operational plans for the control, elimination and eradication of targeted NTDs</li> <li>II. Enhance resource mobilization approaches and strategies at regional, national and sub-national levels for NTD interventions</li> <li>III. Strengthen the integration and linkages of NTD programme and financial plans into sector-wide and national budgetary and financing mechanisms</li> <li>IV. Support countries to develop and update national NTD policies and elaborate guidelines and tools to guide effective policy and programme implementation</li> </ul>	<ul style="list-style-type: none"> <li>Number of countries with updated national integrated NTD strategic plans;</li> <li>Number of NTD guidelines and NTD planning and implementation tools developed;</li> <li>Number of countries with adapted national guidelines and tools;</li> <li>Presence of NTD budget line;</li> <li>Total amount of financial resources available for NTD activities;</li> <li>Percentage of planned NTD funds received.</li> </ul>
3 Scale up access to interventions, treatment and NTD service delivery capacity, within the overall health system	<ul style="list-style-type: none"> <li>I. Scale up an integrated preventive chemotherapy, including access to interventions for lymphatic filariasis, soil transmitted helminthiasis, leprosy, rabies, schistosomiasis and trachoma;</li> <li>II. Scale up integrated case-management-based disease interventions, especially do the following: <ul style="list-style-type: none"> <li>a. Accelerate leprosy elimination activities;</li> <li>b. Intensify schistosomiasis eradication and surveillance activities in order to interrupt transmission in the two endemic zones (CRR and URR)</li> <li>c. Enhance Rabies control interventions in humans and dogs;</li> <li>d. Strengthen national programmes to control leprosy;</li> <li>e. Strengthen schistosomiasis control and human rabies prevention;</li> </ul> </li> <li>III. Strengthening integrated vector management for targeted NTDs.</li> <li>IV. Strengthen capacity at the national level for NTD programme management and implementation and accelerate implementation of disease burden assessments and integrated mapping of NTDs;</li> </ul>	<ul style="list-style-type: none"> <li>Number of countries with completed integrated mapping of NTDs;</li> <li>Drug administration coverage;</li> <li>National coverage;</li> <li>Parasitological prevalence;</li> <li>Percentage of disease-specific targets achieved.</li> </ul>
4 Enhance NTD monitoring and evaluation, surveillance and operations research	<ul style="list-style-type: none"> <li>Develop and promote an integrated NTD M&amp;E framework and improve monitoring of NTDs, within the context of national health information systems. This will include strengthening the reporting and response to severe adverse events (SAEs) by leveraging on-going efforts to strengthen pharmacovigilance systems in the African Region;</li> <li>Strengthen surveillance of NTDs and strengthen response and control of epidemic-prone NTDs, in</li> </ul>	<ul style="list-style-type: none"> <li>NTD data completeness and timeliness;</li> <li>Number of evaluation studies conducted and results disseminated;</li> <li>Number of operational research studies conducted and results disseminated;</li> <li>A functional data management</li> </ul>

Strategic priorities	Strategic objectives	Core indicators
	particular schistosomiasis and STH; .Support operational research, entomological interventions, documentation and evidence to guide innovative approaches to NTD programme interventions; .Establish integrated data management systems and support impact analysis for NTD in the WHO African Region as part of the global NTD data management system and global NTD plan.	system.

## Bibliography

1. Gambia Government, Maternal Neonatal Survey , 2001
2. Gambia Government, Poverty Reduction Strategy Paper II Report, 2007.
3. Gambia Bureau of Statistic, Multiple Indicator Survey, 2010
4. Gambia Ministry of Health and Social Welfare , National, Health Account Mini Report, NHA 2010
5. Gambia Government, Programme for Accelerated Growth and Employment Report, 2012
6. Gambia Ministry of Health and Social Welfare (2012). Nationwide latrine coverage survey and knowledge, attitude, behavior and practice (KABP) study on water, sanitation and hygiene (WASH)
7. Gambia Ministry of Health and Social Welfare, Health management information system Report, 2012
8. Gambia Ministry of Health and Social Welfare (2012). National Health Policy.
9. Gambia Bureau of Statistic, Demographic and Health Survey, 2013
10. Gambia Bureau of Statistic, Population and Housing Census, 2013
11. Gambia Ministry of Health and Social Welfare, Health Management Information System Report, 2013
12. Gambia Ministry of Health and Social Welfare, Lymphatic Filariasis Transmission Assessment Survey, 2013
13. Gambia Ministry of Health and Social Welfare, Social Determinants of Health Report, 2013.
14. Gambia Ministry of Health and Social Welfare, Summary Report of National trachoma prevalence survey, 2013.
15. Jack, A. D., (1989) ,Chemotherapy in the Control of Schistosoma Haematobium infections in The Gambia: A Primary Health Care Approach. Ph.D thesis, London School of Hygiene and Tropical Medicine.
16. Medical Research Institute, Prevalence of Schistosomiasis Among School Age Children Rural Gambia, 2013
17. Gambia Ministry of Health and Social Welfare (2014). Neglected Tropical Diseases Situational Analysis Report
18. Gambia Ministry of Health and Social Welfare, Health Sector Strategic Plan (NHSSP: 2015-2020), 2014.
19. Gambia Ministry of Health and Social Welfare (2012): The Gambia leprosy strategic The Gambia 5-Year National Leprosy Control Strategic Plan 2012-2017
20. Njie et al 2014. , (MOHSW, 2013 ) , , (MOHSW 2005), (MOHSW 2009).
21. WHO (2012) Guide for preparing a Master Plan for Neglected Tropical Diseases Programme in the African Region,
22. WHO (2013). Regional strategic plan for Neglected Tropical Diseases in the African region 2014-2020. WHO regional office for Africa.
23. WHO (2014). Guide for preparing master plan for national neglected tropical diseases programmes the African region. WHO regional office for Africa.
24. World Bank, International Monetary Fund Staff report, 2011