



**REPUBLIC OF THE GAMBIA**

**DEPARTMENT OF STATE FOR HEALTH**

**NATIONAL REPRODUCTIVE HEALTH POLICY**

**2007 - 2014**

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### FOREWORD

The Gambia endorsed the recommendations of the International Conference on Population and Development (ICPD 1994) Programme of Action into a broad-based Reproductive Health Implementation Programme because of the prevailing and unacceptable poor health indicators.

This Policy Document represents a common understanding between the Department of State for Health (DoSH) and its development Partners such as UNFPA, WHO, World Bank, UNICEF as well as several other Stakeholders at grass root community levels.

Cognisant of the need for evidence-based practice, the Policy has been developed by utilizing latest findings from several related baseline surveys with the blend of Stakeholders experiences and contributions during the Policy consultative process at all levels.

In addition a National RH Strategic Plan of Action and Guidelines have also been developed to assist Policy Makers, Directors, Programme Managers and Service Providers at all levels and other Stakeholders to move from Policy into appropriate and concerted action.

Government and Development partners are particularly encouraged to increase political commitment, financial resources and other mobilization efforts and co-ordination for the full implementation of this Policy in fulfilment of the ICPD POA '94 and in attaining the Health related Millennium Development Goals (MDGs) in Africa by 2015.

It is my ardent hope that all actors (Public, Private and NGO Sectors) in the field of reproductive and child health will be guided by this policy as well as the RCH Strategic Plan of Action to positively impact on the sexual and reproductive health and rights of all beneficiaries.

I thank you all.

Dr. Mariatou Jallow

Hon. Secretary of State for Health & Social Welfare

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**Acronyms and Abbreviations**

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	Ante-Natal Care
BCG	-	Bacillus Calmette Guérin
BCC	-	Behavioral Change Communication
BEmOC	-	Basic Emergency Obstetric Care
BHS	-	Basic Health Services
BLSS	-	Basic Life Support Skills
BP&CRP	-	Birth Preparedness and Complication Readiness Plan
CBD	-	Community Base Distributors
CEmOC	-	Comprehensive Emergency Obstetric Care
CIAM	-	Centre for Innovation Against Malaria
DPT	-	Diphtheria, Pertusis & Tetanus
EMCH	-	Emergency Maternal & Child Health
EMNCH	-	Emergency Maternal, Newborn & Child Health
EOC	-	Emergency Obstetric Care
EMNOC	-	Emergency Maternal Neonatal Obstetric Care
FGC	-	Female Genital Cutting
GFPA	-	Gambia Family Planning Association
HIV	-	Human Immune-Deficiency Virus
ICPD	-	International Conference on Population and Development

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ITN	-	Insecticide Treated Net
IUD	-	Intra-Uterine Device
LSS	-	Life Support Skills
MCH/FP	-	Maternal & Child Health and Family Planning
MDG	-	Millennium Development Goals
MICS	-	Multiple Indicator Cluster Survey
MMR	-	Maternal Mortality Ratio
MRC	-	Medical Research Council
MTCT	-	Mother to Child Transmission of HIV/AIDs
NGO	-	Non-Governmental Organisation
NPP	-	National Population Policy
NSS	-	National Sentinel Surveillance
PEM	-	Protein Energy Malnutrition
PHC	-	Primary Health Care
RH	-	Reproductive Health
PLWHA	-	People Living With HIV/AIDs
POA	-	Plan of Action
RCH	-	Reproductive & Child Health
RDC	-	Regional Development Committee
RHT	-	Regional Health Team
RTI	-	Reproductive Track Infection

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RVF	-	Recto Vaginal Fistula
RVTH	-	Royal Victoria Teaching Hospital
STI	-	Sexually Transmitted Infection
TBA	-	Traditional Birth Attendant
TFR	-	Total Fertility Rate
UNFPA	-	United Nation Population Fund
VCT	-	Voluntary Counselling and Testing
VVF	-	Vesico Vaginal Fistula
VHS	-	Village Health Services
WHO	-	World Health Organization



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CHAPTER 1

**BACKGROUND**

**Introduction**

As stated in the first National Reproductive Health Policy (2001-2006) of the Department of State for Health, the Gambia Government has since 1994 placed the health sector among its top development priorities to meet the health needs of its citizenry. Notably in September 1994, the Gambia government was signatory to the International Conference on Population and Development (ICPD) held in Cairo Egypt. At this conference, nations of the world reached an understanding on the key concepts of reproductive health and reproductive rights as rights for all men, women and adolescents.

This was a landmark event as it marked the beginning of a paradigm shift from the concept of Maternal and Child Health/ Family Planning (MCH/FP) to Reproductive Health in which The Gambia government was no exception. Subsequently, the DoSH through its former MCH /FP Programme, which was established in 1975, embarked on a series of research and evaluation activities along with its Partners for evidence based information to support the required shift. Between year 2000 and 2001 the country's first- ever National RH Policy and Strategic plan was formulated following a country-wide consultative process, and the policy was later endorsed by Cabinet in year 2002 for implementation.

*Following the expiration of the first RH Policy span in 2006, series of relevant research were conducted for evidence based information in support of the revision process and put in place the next Policy 2007 – 2014. Researches undertaken included the following: National evaluation of the first RH Policy, Plan and Services; update study on Adolescent/Youth Health with focus on Sexual and Reproductive Health, National Ante-Natal Coverage Survey; National Situational Analysis on Obstetric Fistula; IUCD, Female Condom and Male Involvement in RH among others.*

The definition of reproductive health adopted at the ICPD captures the essential characteristics that make reproductive health unique compared to other fields of

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health and marked the beginning of a new era globally. The goal set at ICPD was that by year 2015 the world would achieve universal access to reproductive health information and services.

**Definition of Reproductive Health-RH**

*“Reproductive health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes.*

*Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods for the regulation of fertility which are not against the law. In addition the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.*

*In line with the above definition of reproductive health, **reproductive health care** is defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases”*

**(ICPD POA: Paragraph 7.2).**

*“Bearing in mind the above definition, reproductive rights embraces certain human rights that are already recognised in national laws, international human rights documents and consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free from discrimination, coercion and violence, as expressed in human rights documents...”*

**(ICPD POA: Paragraph 7.3)**

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It is evident in the definition that the concept of reproductive health includes sexual health and extends before and beyond the reproductive years, recognises the needs and rights of individuals, and encompasses quality services and other appropriate interventions aimed at achieving reproductive well-being. As several global fora have reaffirmed, the ICPD agenda remains critical to sustainable development. At the United Nation General Assembly twenty-first special session of 1999 additional benchmark was added which is that by 2015, the proportion of all births assisted by skilled attendants should reach 90% globally. The centrality of reproductive health to the Millennium Development Goals (MDGs) has also been globally acknowledged.

The Gambia, realizing the importance of reproductive health to her national developmental aspirations and conscious of her obligations as a signatory of the ICPD Plan of Action (PoA) and a responsible member of the global community, remains committed to the ICPD goal of ensuring universal access to reproductive health by the year 2015.

### **JUSTIFICATION FOR THE REVISED REPRODUCTIVE HEALTH POLICY 2007-2014**

Following the expiration of the RH Policy & Strategic plan in 2006, The Department of State for Health & Social Welfare in year 2007, set in motion the actions to update the policy and plan of action for 2007 to 2014.

The revised policy builds on the platform of the achievements of the previous policy, addresses some of the limitations identified in the implementation of the old policy, integrates current perspectives on the reproductive health needs of the Gambian population, embraces recent *“Together, we can continue to improve the health & well-being of individuals, families and communities”*

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evidences on effective interventions, and aligns with the overall direction of current developmental focus in the health sector as well as the country as a whole. As part of the efforts to translate the new policy into concrete actions, a revised Plan of Action has been developed simultaneously. This will serve to affirm the commitment of the Gambian Government and peoples to the implementation of sexual and reproductive health in this country. In cognizance of the fact that RH is a “womb to tomb / life cycle approach” the policy also recognizes that several national policy documents have been developed to specifically respond to the needs in various areas that are part of RH. These include national strategies, plan of action, strategic framework, guidelines, and clinical protocols in areas such as Child Health including Prevention of Parent –to- Child Transmission of HIV, Nutrition, Malaria in Pregnancy, Immunization and Reproductive Health Commodity Security, HIV&AIDS, Syndromic management of STIs. Many of these documents remain pertinent to current reproductive health programming in the country. In the sense of integrated approach that reproductive health approach epitomizes, and to avoid re-inventing the wheel, this policy provides references to such key documents.

This policy has been developed to address the following:

- The unacceptably high rates of maternal, perinatal, neonatal and child morbidity and mortality;
- The increasing rates of infection with the human immune-deficiency virus (HIV) including MTCT and the prevalence of other STIs & RTIs;
- Increasing high-risk behavior of adolescents/youths leading to pre-marital sexual encounters, early marriage, unintended/unwanted pregnancies, unsafe abortions among others, and the health and social consequences such as PID, infertility and school dropout with subsequent negative intergenerational effects;

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- The persistence of harmful socio-cultural practices and family health values;
- The current fragmentation of reproductive health activities and the limited impact of existing programmes in reducing sexual and reproductive ill-health and improving reproductive health and well-being;
- The low level of male participation in reproductive and child health services;
- The low level of utilization of contraceptives including surgical and natural family planning services;
- Inadequate knowledge (and utilization) of routine services for reproductive morbidities i.e. fistulae, cancers of the reproductive system among others.

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## CHAPTER 2

### 2.0 CURRENT SITUATION OF REPRODUCTIVE HEALTH

Reproductive health issues like in many developing countries constitute a leading health challenge in The Gambia. While several interventions have been initiated by both the health sector and stakeholders, the country's reproductive health statistics have improved over the last decade by 30.5% reduction of MMR but the current levels remain unacceptably high. This section describes the current situation in The Gambia, and highlights the factors associated with lack of substantial progress.

#### 2.1 Situation Analysis

##### 2.1.1 Maternal Morbidity and Mortality

**Maternal mortality is defined as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental causes”.**

Maternal and Reproductive Health issues are a very high priority on The Gambia Government's development agenda. However, The Gambia is among the countries with unacceptably high maternal mortality ratio in Sub-Saharan Africa and faces numerous challenges in its efforts to realize the MDG targets on maternal mortality. The National MMS/CPR 2001 estimated maternal mortality at 730 per 100000 live births, indicating a decline of about 30.5 percent over the 1990 estimate of 1050 maternal deaths per 100,000 live births. There is further decline to 556 per 100,000 live births (Situational Analysis of Obstetric Fistula, The Gambia, 2007). The data suggest that maternal mortality is declining albeit slowly. The MDG target is a two-third reduction in maternal deaths between 1990 and 2015 and using the 1990 maternal mortality ratio of 1050 per 100,000, this

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works out to be 263 maternal deaths per 100,000 by 2015. Given that it took 11 years (1990 to 2001) to reduce by about 31 percent, it is unlikely that the country will be able to attain the MDG in the remaining time period of 7 years (*RCH Evaluation Report 2007/8*).

Many maternal deaths occur at a tender age. More than half of the maternal deaths occurred below 35 years of age and the risk of dying from maternity-related causes is about 1 in 23. This risk in rural areas is nearly twice as high than that in urban areas. The MMR in rural areas, whether in PHC or non-PHC villages, is still high. This is a cause for concern.

Access to high quality emergency obstetric and newborn care services 24 hours a day and 7 days a week is crucial in the reduction of maternal and newborn mortality and morbidity. However, there is gross unmet need (79%) for Emergency Obstetric Care (EmOC) in facilities in The Gambia as revealed by the survey on the availability, utilization and quality of EmOC services in The Gambia carried out in 2003. The survey also revealed a case fatality rate of 4.7% which is far above the maximum of 1%. These statistics are a pointer to inadequate and poor quality EmOC services in The Gambia.

This is as a result of a poorly functioning referral system especially at the community level including ill-equipped and inadequately staffed facilities. This is further aggravated by the paucity of skilled birth attendants in rural health facilities as a result of the on going staff attrition thus posing major challenge for the provision of Emergency Obstetric (EmOC) and Newborn services. Currently only two out of the six Major Health Centres are providing EmOC services.

The Antenatal care delivery, coverage and access in The Gambia survey (RCH–DoSH/CIAM, 2007), revealed that 99.2% used formal antenatal

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services; 67% received antenatal care at a health centre and 24% at an outreach post; 90% visited four or more times and 96% were satisfied or very satisfied with services received. It further revealed that 62% of women delivered their last baby at a health facility while 37% of women delivered at home. In line with the ICPD Programme of action 1999 recommended sets of milestones to achieve a 50% births by skilled attendants by 2010 and 60% by 2015 as stated in the DoSH, UNFPA & WHO National MCH/FP Evaluation Report 2001. However, this ICPD+5 set milestones have been exceeded by DoSH at 62% in 2007 contrary to the assertions indicated in the above MCH/FP Evaluation Report.

The Department of State for Health, in collaboration with the UNFPA and WHO, conducted a situational analysis on obstetric fistula in The Gambia in 2006. The analysis included a house hold survey to identify the magnitude of fistula. A total of 4,958 households were visited and 12,116 women were included in the study. The analysis revealed that the prevalence of fistula stand at 0.5/1000 women in reproductive age group totaling to 197 cases in The Gambia. Hence the need for promotive and preventive education, services and rehabilitation. In the absence of routine reconstructive surgery in the country, fistula patients have over the past benefited from surgical services provided through the RVTH/ UK Uro link covering 10-13 patients annually. Furthermore, the RCH-DoSH with support from Child Health Advocacy International (CAI-UK) and other Philanthropists linked by the RCH to the Department of Social Welfare are providing surgical and rehabilitative services to fistula patients.

#### **2.1.2 Child Morbidity and Mortality**

Until the late 1970's, childhood mortality rates in The Gambia (217/1000 LB, 1973 Census) were among the highest in the sub-region. Over the years however, major gains have been made in improving



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access to health services, particularly in the area of maternal, newborn and child health.

Estimates on infant and child mortality have largely been derived from censuses and surveys since the registration of births and deaths is incomplete and often such events are recorded late and cannot be used for statistical analysis. In spite of considerable achievements in terms of mortality decline during the past three decades, mortality levels in The Gambia remain among the highest in the sub-region. Perinatal mortality stands at 54.9 per 1000 Total births (live & deaths), Neonatal mortality declined from 60 per 1000 live birth in 1996 to 31.2 per 1,000 live births in 2001. (MMS/CPR 2001). Neonatal problems such as prematurity, low birth weight, hypothermia, birth asphyxia and infections contribute significantly to the high infant mortality rate. Similarly, the infant mortality rate has declined from 92 per 1000 live births in 1993 to 75 per 1000 live births in 2003. Although regional variations are slightly higher in parts of the North Bank Region; whereas under-fives mortality declined from 134 per 1000 live births in 2001 to 99 per 1000 live births in 2003 (National MMS/CPR 2001, Census Report 2003). The main causes of morbidity and mortality are malaria, diarrhea, and acute respiratory tract infection.

Forty percent (40%) of the total out-patient consultations in 1999 was due to malaria, while diarrhoeal diseases and acute respiratory tract infections constitute about 25%. Malaria causes about 4% of deaths in infants and 25% of deaths in children 1 – 4 years of age. According to a survey conducted by MRC, ninety-two percent (92%) of all malaria deaths occur at home. It is a leading cause of death of children under age five in The Gambia. It also contributes to anaemia in children and is a common cause of school absenteeism. (MRC, Greenwood & Pickering, 1999).

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Malnutrition among children continues to be a major public health problem in The Gambia. Children under 5 years are vulnerable due to poor feeding practices, inadequate care and increasing exposure to infections with poor environmental sanitation being a major contributing factor. Although breastfeeding is a universal practice, in The Gambia exclusive breastfeeding is practiced by 41% of mothers and the weaning diet is nutritionally inadequate, as well as unsafe, due to high level of bacterial contamination. Protein Energy Malnutrition (PEM), specifically marasmus, is more prevalent among children under 5 years of age (National Nutrition Policy 2000–2004). According to 2005/6 MICS III, one in five children under age five in The Gambia are moderately underweight (20.3 per cent) and 4% severely underweight. Almost a quarter of children (22 per cent) are moderately stunted or too short for their age. Six (6 %) are moderately wasted or too thin for their height. Overall, total vaccination coverage rate among Gambian children for all antigens is 55.3% and for single vaccines ranges from 82.4% for DPT 3 to 97.6% for BCG. Overall, the results indicate that there are no large differences in vaccination coverage among the other background characteristics except in household wealth quintiles where children from poorest households are more likely to be vaccinated with all antigens compared to children in the richest households (MICS III 2005/06)

### **2.1.3 Family Planning and Fertility Management**

The National MMS/CPR Report 2001 showed a wide gap between knowledge and use of contraceptive methods. The overall contraceptive prevalence rate among currently married women 15-49 years in 2001 was 17.5% of which 13.4% use modern methods. Comparatively, this is an increase of 46% in contraceptive use over the usage in 1990 when the contraceptive prevalence was 12%. Use of modern methods

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increased by 100%, from 6.7% in 1990 to 13.4% in 2001. The significant increases in the use of modern methods can mainly be accounted for in the use of pills and injections, over 90 and 100% respectively. Whilst the use of IUD and surgical contraception for women increased by 55 and 75% respectively, condom use among women increased the least, only 25% between 1990 and 2001. By contrast current use of condom was highest among men, from 20% in the 18 – 19 years; it peaked to 33 and 34% respectively in the 20 – 24 and 25 – 29 age groups respectively. Preliminary data from a survey conducted in 2008 to elicit source of contraception (condom for males were: pharmacy outlets (10%); Gambia Family Planning Association (GFPA) (7%); health facilities (4%); family planning community based distributors (4%); private doctors (2%); and youth peer counselors (0.6%). For Female adolescents, the main sources are: health facilities (6%); pharmacy (4.5%); GFPA (0.7%); family planning CBD (0.2%). (Gambia Social Marketing Management Programme year 2007)

The effect of contraceptive use on fertility levels in The Gambia remained the same over the period 1973 and 1983 with the TFR estimate put at 6.4. This showed a decline to 6.0 and 5.4 in 1993 and 2003 respectively. With this observed percentage decline in fertility in 2003, The Gambia has reached conventional 10 percentage margin beyond which, demographers consider the cause of fertility decline to be irreversible (Caldwell et al, 1992).

#### **2.1.4 Adolescent Sexuality and Reproductive Health**

Adolescent health is greatly affected by not only the inadequate provision of reproductive and sexual health services but to a major extent, by factors outside the control of the health system, such as religious and socio-cultural issues and values. The Gambia's culture and *"Together, we can continue to improve the health & well-being of individuals, families and communities"*

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traditions are such that parents rarely discussed with their adolescent children and in particular girls, on issues related to reproductive health. Young people need information about the physiological changes in their bodies and the implications of sexual activity in order to make more responsible and conscious decisions about their health. The opposing view is that, providing adolescents with information about their sexual and especially reproductive health services will encourage early sexual activity and promiscuity.

According to the National Health Policy Framework (2007-2020), rapid urbanization, increasing incidence of sexually transmitted infections (STIs) including HIV/AIDS in the young, the potential for drugs and substance use and abuse, the increasing cases of adolescent pregnancies usually unwanted and leading to unsafe abortion and its consequences, and baby dumping pose serious threats to the health of the adolescents. Ultimately, the National Population Policy (NPP 2006) has one of its aims as “equipping the youth with the knowledge on the importance of family planning and the right family size in order to enable them become responsible parents. The need to devise a comprehensive health programme for the youthful population need not be overemphasized, taking into account the rapid upsurge of this population group as they attain their reproductive life. Also of great importance is the risky behaviour characteristic of adolescents such as indulging in frequent and unpredictable sexual intercourse, sensitivities about confidentiality and thus not wishing their parents and relatives to know about their sexuality. They tend to have multiple sexual partners as they are not in lasting relationships at this age, and finally, they are easily influenced by their peers.

The 2006 national HIV sero-prevalence rate reported for age group 15-24 years also gives a frightening indication of the rapidity of HIV transmission occurring among adolescents. In The Gambia, girls traditionally marry too early (12-16yrs) and this result in early child birth and also bearing too many children. In addition, young girls are

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disproportionately affected by poor pregnancy outcomes, including maternal and neonatal morbidities and mortalities. Young girls are also more vulnerable than most population groups to harmful practices and sexual rights violation such as early marriage, sexual coercion, rape, incest and female genital cutting. Available data confirmed that 13% of pregnant women are teenagers and 10% of these women aged 15-24 years were unmarried compared to 3% above 24 years of age. The prevalence of HIV 1 in this age group based on sentinel surveillance increased from 0.8% in 2002 to 2.4% in 2006. There is no national available data on induced abortion among adolescents as this practice is illegal.

#### 2.1.5 HIV/AIDS/STI

The national sentinel surveillance result of 2001 among antenatal attendance in four health facilities showed that the prevalence of HIV 1 was 1.1% while that of HIV 2 was 0.9%. Comparing this figure with those of the prenatal study of 1993 – 2005, HIV 1, which is the most virulent sero-type, had almost doubled (0.7% - 1.2%) while HIV 2 had declined slightly from 1.1% - 0.9%) over a seven year period. HIV 1 prevalence reached its peak of 2.0% in 2004. However, according to a study conducted in 2005 (NSS), the estimated prevalence of HIV 1 has dropped to 1.1% while that of HIV 2 had declined to 0.6%. The Antenatal Sentinel Surveillance System was expanded to 8 sites in 2006 and continues to exclude the high risk groups which are young males, long distance bus and truck drivers and commercial sex workers. The sero-prevalence rate for HIV/AIDS is 2.8% in 2006. Nonetheless prevalence rate is now consistently higher in the urban areas and has also changed from being a concentrated one to a generalized epidemic. In 2006, two of the 8 surveillance sites; Serre-Kunda and Basse sites had

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striking increase of 1300% and 1270%. HIV 1 continued to drive the epidemic but it is worth noting that the rate of increase in HIV 1 prevalence between 2002 and 2006 was higher being 200% in the 15-24 year group compared to 63% in the over 24 years age group. Another source of infection is through the mother to child transmission.

The Gambian Government/MRC study estimates suggest that if current prevalence rates of 1.2% for HIV-1 and 0.9% for HIV-2 stay stable, the number of infected infants likely to be born to HIV positive mothers would increase from 202 to 250 between 2002 and 2007 (PPTCT 2003-2008). If the prevalence rates increase annually by 20% the corresponding number of infected infants over the same time period is estimated to increase to 562. For an annual increase in the prevalence rates of 50% the number of infected infants by 2007 is estimated at 1730. NAS to edit this section.

#### **2.1.6 Reproductive Cancers**

Breast and cervical cancer are the leading causes of cancer-related deaths among women while cancer of the prostate is the major cause of cancer-related deaths among men in Sub-Saharan Africa. Knowledge, availability and utilization of cancer screening services are low in The Gambia. Records from RVTH showed that 250 cervical cancer patients were recorded in 2005 and accounted for 5<sup>th</sup> cause of gynecological admissions. The DoSH through its National RCH Unit requested for technical and financial support from CAI-UK for the provision of Human Papilloma virus (HPV) Vaccine targeting girls early at the age of 9 to 13 years and the setting up of a cervical cancer screening programme. Henceforth, the DoSH and its RCH Unit have established Partnership with the University of Cardiff, Wales-UK to this effect. Meanwhile plans are underway to finalize the project proposal

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and funding modalities for phased implementation with relevant partners (e.g. RVTH, WHO).

**2.1.7 Harmful Socio-Cultural Practices and Reproductive Rights Violations**

A variety of harmful practices with negative implications for the reproductive health and rights of women, adolescents, and youths exist in The Gambia. The leading ones include child marriage, female genital cutting and domestic violence. Of women aged 15-49 years, 10% were married before age 15 years, 44% were in polygamous marriage, while 78% of women of the same age had one form or the other of FGC. Domestic violence is a common form of gender-based violence in the country, and still condone wife beating for reasons such as if she goes out without informing spouse, delay in food preparation or burn the food and refusal to have sex with spouse (**MICS III, 2005/06**).

**2.1.8 Household and Community Factors**

Poor reproductive health behaviours, including inadequate use of reproductive health services other than for ANC, are immediate factors that underlie the poor reproductive health status and outcomes in the Gambia. These behaviours are compounded by poor level of knowledge, socio-cultural beliefs and practices that are detrimental to reproductive health and well-being, and psycho-social, economic and environmental barriers to healthy RH behaviours. Poor reproductive health knowledge, for example, is associated with a variety of STI-related behaviours among adolescents. Misconceptions regarding

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danger signs in pregnancy are also associated with poor health seeking behaviour among poor rural-based mothers.

Myths and misconceptions on modern contraceptives, culturally-mediated health seeking decision-making pattern that curtails ability of women to independently seek health care, high premium on high fertility or male-child preference in traditional societies, and harmful traditional practices such as FGC and child marriage are reflections of negative socio-cultural beliefs and practices that are detrimental to reproductive health and well-being. Poverty could serve as an economic barrier to accessing and utilizing modern health services whereas environmental barriers such as difficult geographical terrains may also pose hindrances to using emergency obstetric services. In The Gambia, other major factors outside the reach of the health system that contribute to maternal and newborn morbidity and mortality include: the first two of the three delays that kills, i.e. the delay in deciding care at household level and delay in reaching care from community level to the nearest health facility; lack of birth preparedness and complication readiness plan for delivery and obstetric emergencies; passive male participation in RCH services including blood donation, partner management for STI's/HIV/AIDS and support for obstetric fistula; male opposition to use of FP services by women.



### CHAPTER 3

#### 3.0 POLICY FRAMEWORK, DECLARATIONS AND GUIDING PRINCIPLES

##### 3.1 POLICY FRAMEWORK

The Reproductive Health Policy is set within the framework of the Gambia National Health Policy, which upholds primary health care as the key to health development in The Gambia and further recognizes that the implementation of reproductive and child health should be in the context of primary health care. The following provisions of the national health policy are critical to the achievements of the RCH goal and targets:

- i) The Gambia operates a three tier national health care system: Primary and Secondary Health Care both managed by the Regional Health Teams and the Tertiary i.e. general / Teaching hospital managed by boards as semi autonomous;
- ii) The government has the responsibilities for the health of the people that shall be fulfilled by the provision of adequate health and social services. The citizens shall have the right and duty to participate individually and collectively in the planning, implementation, monitoring and evaluation of health services;
- iii) Health resources shall be equitably distributed giving preference to those at greater health risk and the under-served communities as a means of social justice and concern;

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- iv) Emphasis shall be placed on preventive and promotive measures which shall be integrated with curative and rehabilitation in a multi-disciplinary and multi-sectoral way;
- v) This RH Policy recognizes that services at all levels will be complemented by the Private and NGO health sectors as well as with component specific sectors/ organizations for the further promotion of sexual and reproductive health information and services.

### 3.2 POLICY DECLARATION

Whereas Government and People of The Gambia realize that women, men, children and adolescents have specific sexual and reproductive health needs that must be met and, past efforts to meet these needs have had limited impact in reducing sexual and reproductive ill-health of the vulnerable groups. The Government hereby adopts and undertakes to subscribe to this National Reproductive Health Policy with the following declaration:

- All tiers of Government hereby agree that the reproductive health of the people does not only contribute to better quality of life but is also essential for the sustained economic and social development of the nation.
- The people of The Gambia including young people shall participate individually and collectively in the planning, implementation and evaluation of their reproductive health care.

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- The Government and people of The Gambia affirm that the revised National Reproductive Health Policy and Strategic Plan of Action shall be complementary to the National Health Policy and its strategies to achieve health for all Gambians.
- To this end, the Department of State for Health shall:
  1. Support a sustainable framework to regulate and facilitate the implementation of the reproductive health policy, strategy and interventions;
  2. Promote the Reproductive Health Concept and the RCH minimum care package of services throughout the country using a multi-sectoral approach within the broader context of macro-economic policies as well as localizing the health – related MDGs;
  3. Review and update relevant policies, laws, strategies and programmes to encompass the broad spectrum of reproductive health issues in a coherent and integrated manner with particular attention to priority-setting;
  4. Ensure the availability of skilled attendants for the provision of basic essential obstetric care (BEmOC) during pregnancy, childbirth, newborn, postpartum and post-abortion care within a functioning healthcare setting.
  5. Ensure access to Comprehensive Emergency Obstetric and Newborn Care (CEmOC) twenty-four hours daily using the Emergency Maternal, Newborn and Child Health (EMCH) Strategy.

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6. Support country-wide expansion and consolidation of newborn and child survival strategies: e.g. the Integrated Management of Neonatal and Childhood Illnesses (IMNCI); Community Based Newborn Care; Baby Friendly Community Initiative; Immunization & Vitamin A / Deworming Initiative; Maternal Anaemia and Nutrition Initiative; Birth Registration.
7. Maintain free maternal, newborn and child health services.
8. Ensure the full implementation of The Reproductive Health Commodity Security (RHCS) Plan i.e. continuous availability of basic equipments, furniture for RCH base and outreach facilities, Family Planning commodities, information and capacity building at all levels; as well as inclusion of contraceptives in the DoSH essential drugs list.
9. Support the provision of adolescent/youth friendly sexual & reproductive health information and services.
10. Collaborate with the Departments of State for Education, Youth and Sports in the planning, implementation and Evaluation of Adolescent/Youth Health Issues.
11. Ensure the integration of relevant programme components and resources to increase public & provider awareness on RCH issues such as: Danger Signs in pregnancy, childbirth and postpartum; Maternal and Child Nutrition; Malaria in Pregnancy; STIs/HIV/AIDS/PMTCT/VCT.
12. Ensure that women and men as partners actively participate equally in RCH issues and that the RCH programme and services is gender sensitive and responsive through

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sensitization and training of service providers, particularly in the area of client-provider interaction and interpersonal communication skills.

13. Will work in partnership with key stakeholders on gender discrimination, harmful socio-cultural practices and gender based violence related to RH issues including the active involvement of men.

14. Advocate and ensure that other relevant components of RH such as infertility, menopause, andropause, fistulae and reproductive cancers are catered for in partnership with stakeholders.

15. Promote the collaboration between RCH and traditional medicine through community sensitization on the management of infertility, RH cancers & HIV/AIDS among others.

16. Support the implementation of the proposed HPV vaccine & cervical cancer screening programme in partnership with stakeholders.

17. Ensure continuous advocacy and IEC using standard RH IEC/BCC materials and guidelines for appropriate information dissemination and service delivery.

18. Promote quality assurance by ensuring an appropriate referral system, availability of essential services such as blood availability and transfusion, constant water and electricity supply, appropriately staffed facilities, continuous availability of basic and essential drugs and supplies among others.

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19. Spearhead resource mobilization efforts required for RCH services in partnership such as: financial, material, technical and human resource development as well as increase political commitment backed by budgetary allocation that will be used in a judicious and transparent manner.

20. Strengthen the institutional capacity of the National Health Management Information System in order to adequately address reproductive health needs. Quarterly collation and publication on reproductive and child health activities of all stakeholder institutions will be made and regular update of the RCH programme web site for information sharing.

21. Support the use of the revised monitoring tool for RCH services for implementation, reporting and planning of activities at all levels.

22. Promote and support research relevant to reproductive and child health issues in partnership with research institutions, community leaders and support the production, storage, retrieval, dissemination and use of relevant report/findings on reproductive health policy, programmes and activities.

## CHAPTER 4

### 4.0 Vision, Mission, Goal and Guiding Principle:

#### 4.1 VISION

**Improved reproductive health status of the Gambian population by the year 2014 and beyond to enable couples and individuals participate in the socio-economic development of the country.**

#### 4.2 MISSION

**Promotion and provision of comprehensive and sustainable sexual and reproductive health information and services through partnership.**

#### 4.3 GOAL

**To improve the quality of reproductive life of ALL persons living in the Gambia through promotion of sexual and reproductive health, and the prevention and reduction of morbidity and mortality associated with sexual and reproductive ill-health.**

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**4.4 GUIDING PRINCIPLES OF THE NATIONAL REPRODUCTIVE HEALTH POLICY**

Following on the above, the comprehensiveness, effectiveness and sustainability of the national reproductive health policy will be enhanced by incorporating the following:

- i. Good governance, peace and security;
- ii. Political commitment, national ownership and country leadership;
- iii. Enabling political, economic, legislative, cultural and media environment;
- iv. Effective decentralization of services to regional and community levels;
- v. Gender equity and equality in access to national resources;
- vi. Ethical considerations, confidentiality and culture-sensitivities;
- vii. Development/adaptation and use of appropriate terminologies, technologies and methodologies;
- viii. Effective preparation of young people for timely participation in the development of the nation with their involvement based on the national philosophy;
- ix. Effective partnerships among the key actors, including the informal and private sector, NGOs, civil society, communities and Development Partners;
- x. Men and women to take responsibility for their own sexual behavior, fertility, health and wellbeing as well as that of their partners and families;
- xi. Community participation and ownership of programmes;
- xii. Commitment to continuous evaluation based on regular research for effective health services and policy determination.



## CHAPTER 5

### 5.0 POLICY FOCUS, OBJECTIVES & STRATEGIES OF THE NATIONAL REPRODUCTIVE HEALTH POLICY

#### 5.1 POLICY FOCUS

As in the previous National RH Policy 2001-2006, this Policy will focus on six priority components to include current developments in the area of reproductive morbidity. These foci are priorities areas for The Gambia and most of which concur with the priorities identified by the World Health Organization in the recently developed global reproductive health strategy as the five core areas of reproductive health: improving antenatal, perinatal, newborn care and postpartum; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynecological morbidities; and promoting sexual health.

The six areas of strategic foci of the policy are:

- i. Safe motherhood : Improving Maternal, newborn and child health;
- ii. Adolescent/Youth : Healthy sexual development and sexuality;
- iii. HIV/STI/RTI/PMTCT: Ensuring infection-free sex and reproduction;
- iv. Family Planning: Providing quality family planning services to ensure desired and intended fertility, including prevention of mistimed and unwanted pregnancies;

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- v. Improve Gender, particularly male involvement and participation on RH issues, limit all forms of gender-based violence and harmful socio-cultural practices; and
- vi. Reproductive Morbidities.

**5.1 Policy Objectives and Targets:**

**5.1.1 Policy Objectives:**

*a. Improving maternal, newborn and child health:*

Objective 1: To reduce maternal morbidity and mortality due to pregnancy, childbirth and postpartum;

Objective 2: To reduce morbidity and mortality due to unsafe abortion;

Objective 3: To reduce perinatal and neonatal morbidity and mortality;

Objective 4. To reduce childhood morbidity and mortality;

*b. Healthy sexual development and sexuality:*

Objective 5: To increase knowledge of reproductive biology and promote responsible sexual behaviour among adolescents ;

*c. Ensuring infection-free sex and reproduction:*

Objective 6: To reduce the sexual transmission of HIV infection including PMTCT;

Objective 7: To reduce the incidence and prevalence of sexually transmitted Infections:

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*d. Providing quality family planning services to ensure desired and intended fertility, including prevention of mistimed and unwanted pregnancies:*

Objective 8: To reduce the level of unwanted pregnancies in all women of reproductive age;

Objective 9: To reduce the rate of primary and secondary infertility;

*e. Improve gender and male involvement:*

Objective 10: To increase the involvement of men in RH issues;

Objective 11: To reduce gender imbalance in all sexual and reproductive health issues;

Objective 12: To reduce female genital cutting and provide appropriate care for females who have already undergone genital cutting;

Objective 13: To reduce domestic and sexual violence and ensure proper management of victims;

*f. Reproductive morbidities:*

Objective 14: To reduce the incidence and prevalence of reproductive cancers;

Objective 15: To ensure improved management of menopause, andropause and other RH morbidities.

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**5.1.2 Policy Targets**

The targets are as follows:

- i. Reduce the maternal mortality ratio from 556 per 100,000 live births (LB) in 2006 to 250 per 100,000 LB by 2014;
- ii. Reduce the neonatal mortality rate from 31.2 per 1000 LB in 2001 to 20 per 1000 LB by 2014;
- iii. Reduce infant mortality rate from 75 per 1000 LB in 2003 to 28 per 1000 LB by 2014;
- iv. Increase access to qualitative maternal and child health services including post abortal care by 40%;
- v. Reduce prevalence of anaemia among women of reproductive age by 50%;
- vi. Ensure BLSS/LSS training for all relevant cadres of health care providers;
- vii. Reduce incidence of low birth weight from 17% to 10%;
- viii. Increase the practice of exclusive breastfeeding of babies for the first six months of life by 50%;
- ix. Increase the proportion of young people who have access to accurate and comprehensive health information and services by 50% by 2014;
- x. Reduce unwanted pregnancies, especially among adolescents, by 30% of the current level;
- xi. Increase the training of service providers on adolescents/youths health issues from 5.4% in 2007/08 to 50% in 2014;
- xii. Build partnership with communities and policy makers at all level on young peoples' SRH issues;
- xiii. Effectively manage at least 80% of the curable sexually transmitted diseases brought for treatment;

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- xiv. At least 80% of facilities providing antenatal and delivery care should undertake routine screening of pregnant women and effectively treat detected cases of syphilis and other STIs;
- xv. Halt the spread, and begin to reverse the spread of HIV/AIDS;
- xvi. Establish appropriate service such as VCT to pregnant women, appropriate treatment of neonates born to HIV positive mothers and counseling on infant feeding options in order to minimize the risk of MTCT;
- xvii. Reduce maternal deaths resulting from unsafe abortions to less than 5% of all maternal deaths;
- xviii. Increase the modern contraceptive prevalence rate by at least two percentage points per year;
  - ix. Train all family planning providers on current trends in family planning technology;
  - x. Reduce the prevalence of sexually transmitted infections by 50%;
  - xi. Increase the proportion of pregnant women who are screened and treated for syphilis and other STIs by 50%;
  - xii. Establish at least one voluntary counseling and confidential testing centre in every facility for HIV/AIDS;
- xiii. Train at least 60% of health care providers to care adequately for and protect the rights of people living with HIV/AIDS (PLWH/A) and people with other STIs;
- xiv. Increase male utilization of reproductive health services by 50%;
- xv. Promote male support for the utilization of reproductive health services by women;
- xvi. Increase male involvement in the promotion and upholding of reproductive rights of women;
- xvii. Reduce the incidence of obstetric fistula by 75% of the current rate;
- xviii. Limit all forms of gender-based violence and other practices that are harmful to the health of women and children;
- xix. Obtain baseline information on reproductive health issues;

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- xx. Increase public awareness on availability of HPV Vaccination & RH cancer screening services by 75% by 2014;
- xxi. Establish HPV Vaccination and cancer screening services from 0% to 50% of the Health Facilities by 2014;
- xxii. Train 50% of health service providers on RH cancer screening and management by 2014;
- xxiii. Promote screening programmes for early detection of breast, cervical and prostate cancer.

## 5.2 STRATEGIES

The following major strategic thrusts aim to support the attainment of the objectives of the revised national RH policy, thereby contributing to “ensuring the availability of and access to a full range of sexual and reproductive health information and quality services for all Gambians so as to enable them attain optimal sexual and reproductive health and wellbeing throughout their life cycle”.

The following strategies will be put in place to achieve the objectives and targets of the policy stated above:

- i. Strengthening health system capacity;
- ii. Promoting of healthy reproductive health behaviour;
- iii. Improving information base for priority-setting and evidence-based programming;
- iv. Advocacy and Social Mobilization;
- v. Strengthening coordination and partnerships; and
- vi. Strengthening monitoring, evaluation and accountability.

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Further details on the strategies and implementation of the RCH policy is provided in the National Reproductive and Child Health Strategic Framework and Plan of Action which has been developed along with the policy.

### 5.3 MONITORING AND EVALUATION OF RCH POLICY IMPLEMENTATION

Implementation of the RCH policy and the National Reproductive and Child Health Strategic Framework and Plan of Action require a core set of process indicators that will be used for its monitoring and evaluation. This will require strengthening of the country's Health Management Information System to ensure quality, reliability, consistency and accuracy of the data. A RHMIS within the RCH Unit will act as backup system to address this area. Sources of data for effective monitoring and evaluation include national, regional surveys, baseline and community surveys and a functioning routine data collecting system. Special effort will need to be put in place to also harness the data from the private sector which is gradually making its entry into various aspects of RCH programme especially in the urban areas. The following show the present data collection system in place in The Gambia:

1. Daily recording of data at service delivery points;
2. Monthly data collection and collation from Health facilities and Village health services;
3. Monitoring and supervision of service delivery points;
4. Quarterly collection and compilation of data at Regional and Central levels (RCH Unit and DPI of DoSH);
5. Quarterly monitoring of RCH activities by central level;
6. Monthly supervision at Regional level; and
7. Regular feed back at all levels.

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**SPECIFIC MONITORING AND EVALUATION:**

1. Gambia Demographic Health Survey (GDHS);
2. Multiple Indicator Cluster Survey (MICS);
3. Base line studies;
4. Mid term evaluation of policy implementation;
5. End of term evaluation of policy;
6. The national population and housing census;
7. Research: Operational research.



## CHAPTER 6

### INSTITUTIONAL FRAMEWORK FOR IMPLEMENTATION OF THE REPRODUCTIVE HEALTH POLICY

Reproductive Health services will be delivered throughout the existing three-tier level of the National Health Care delivery system of the government through the primary health care (PHC) approach i.e. Primary/Village Health Service (VHS) level, Secondary/Basic Health service (BHS) level and Tertiary/Hospital level respectively. Other community based structures and organizations will be utilized to increase access to adolescent/youth user-friendly services by stakeholders. This is in line with the national health policy for the integration of services.

Services at these levels will be complemented by the Private and NGO health sectors as well as with component-specific sectors/organizations for the further promotion of sexual and reproductive health information and services.

In addition, the National RCH Committee which is a multi-sectoral body constituted by provision of the first National RH policy will be strengthened to continue its oversight function in ensuring the full implementation of this RH Policy and Plan.

#### **Organization of the RCH Activities**

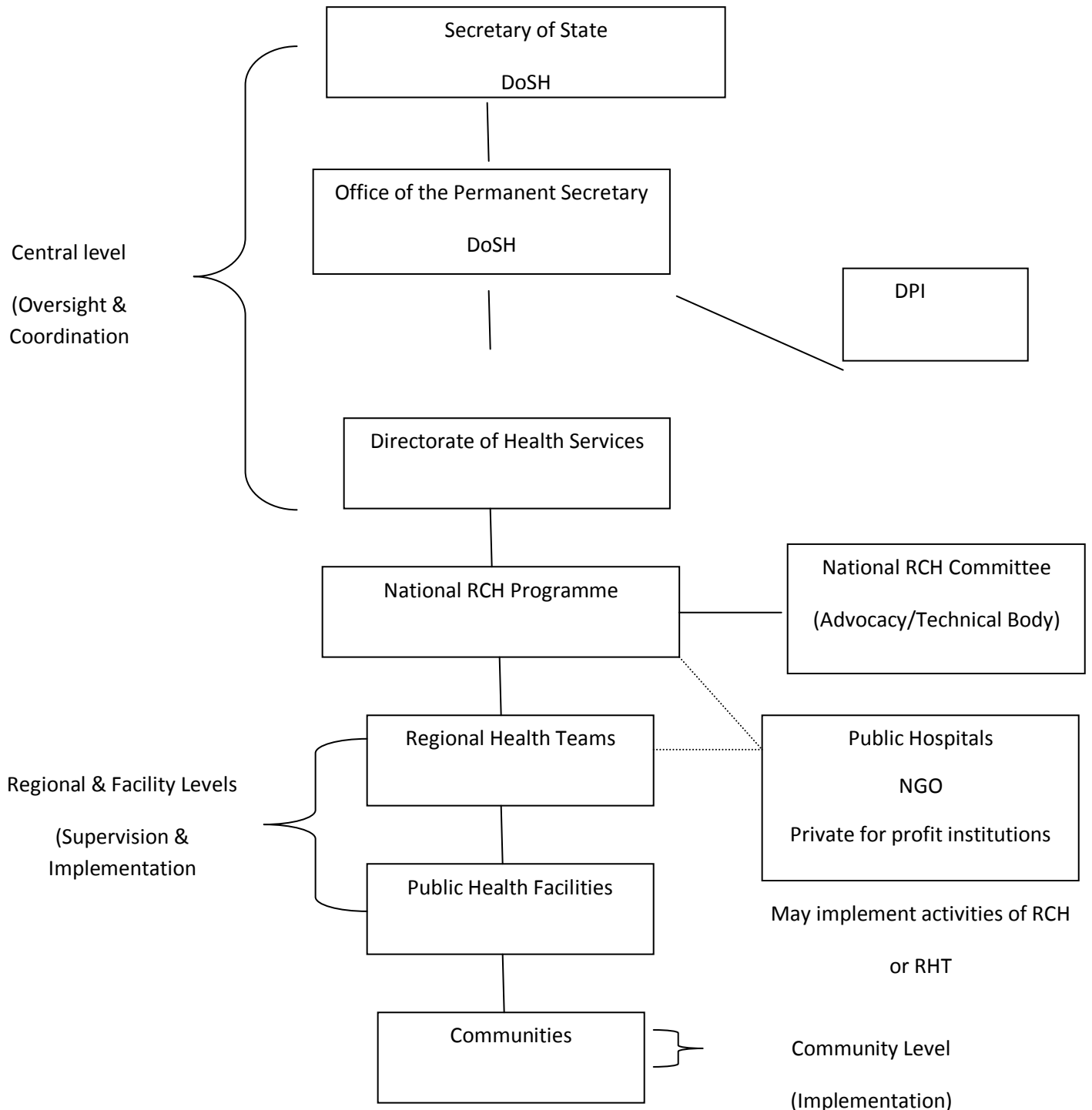
The implementation of the RCH program takes place at four levels namely: central, regional, health facility and community levels. Each of these levels (Figure 1) has functional structures and responsibilities.

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Figure 1: Organizational structures for implementation of RCH activities.



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**RESPONSIBILITIES OF THE NATIONAL RCH PROGRAMME:**

- i. Formulation of Policy and guidelines for implementation on RH activities;
- ii. Overall coordination of the implementation of RH activities;
- iii. Facilitate the timely and regular meetings of the National RCH Committee;
- iv. Preparation of quarterly and annual work plans from the Regional Health Teams work plans;
- v. Resource mobilization and distribution of RH tools, equipments and FP commodities;
- vi. Capacity building, needs assessment and training of RH service providers;
- vii. Advocacy and resource mobilization in support of RH services;
- viii. Coordination of RH Partners;
- ix. Conducting and supervising research activities in collaboration with Research Institutions;
- x. Quarterly monitoring & evaluation of RH services;
- xi. Provide regular supportive supervision to the RHTs and service providers;
- xii. Collect, collate and analyze RCH service data and provide timely feedback;
- xiii. Provide and disseminate relevant information on RCH.

**FUNCTIONS OF THE REGIONAL LEVEL (RHMT)**

- i. Planning and Implementation of RCH activities;
- ii. Coordination of RCH activities;

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- iii. Advocacy and sensitization on RCH program;
- iv. Monitoring and evaluation of RCH programs;
- v. Conduct of operational research on RCH issues;
- vi. Service Delivery at general hospital, major & minor health centers;
- vii. RCH Data Management at the regional level within the region.

### **FUNCTIONS AT DISTRICT LEVEL (Basic Health Facilities)**

#### ***Responsibility of the staff includes:***

- i. Planning and Implementation of activities;
- ii. Service delivery and Referral;
- iii. Social mobilization for RCH services;
- iv. Data Collection, analysis and utilization;
- v. Monitoring and Supervision.

### **FUNCTIONS OF THE COMMUNITY**

At community level, RCH services are provided by the Village Health Workers and TBAs.

- i. Service delivery and referral;
- ii. Community based distribution of FP commodities, ITNs and insecticides;
- iii. Social mobilization for RCH services;
- iv. Home visits;
- v. Village environmental sanitation.

### **FUNCTIONS OF THE MASS MEDIA**

- i. Increasing awareness on issues concerning RCH;
- ii. Dissemination of information;

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- iii. Include RCH issues in print and electronic media;
- iv. Provide media coverage of RCH activities;
- v. Create a sustained platform for public debate in support of the promotion and implementation of RCH issues.

**FUNCTIONS OF PROFESSIONAL GROUPS AND INSTITUTIONS**

- i. High quality Training to ensure professional competence of their graduands in RCH issues;
- ii. Monitoring and regulating the activities of their professionals to ensure efficient, effective quality RCH services of acceptable ethical standards;
- iii. Incorporating life saving skills into their curriculum to ensure that they are legally protected to practice the skills to reduce maternal and new born mortality;
- iv. Collaborating with Government to compliment its efforts in reducing maternal newborn and child mortality;
- v. Advocacy for maternal, newborn and child health issues.

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**ANNEX:**

**Relevant Policies developed by the Gambian Government:**

- i. National Health Policy;
- ii. National Population Policy;
- iii. Youth Policy;
- iv. National Population Policy (NPP 2006).