Reaching Out to the People



A Review of Progress towards Achieving the Millennium Development Goals at the Local Level in The Gambia

All Member States of the United Nations have pledged to meet the Millennium Development Goals by 2015

March 2005

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Review of Progress towards Achieving the Millennium Development Goals at the Local Level in The Gambia

Policy Analysis Unit of the Office of the President
Government of The Gambia, Banjul

March 2005

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The interpretations and views expressed in this report are those of the contributories alone and should not be attributed to the Government of The Gambia or the United Nations.

FOREWORD

The Millennium Declaration, which was adopted by 147 Heads of State and Governments (including The Gambia) at the Millennium Summit held in New York in September 2000, is a significant milestone in the annals of global development. The Millennium Development Goals (MDGs) are a key component of the Declaration and constitute the most comprehensive framework, or agenda, for achieving sustainable human development.

The MDGs are a symbol of an unprecedented global commitment to address the crucial needs of the least developed and developing countries. In addition, the MDGs also encompass a system for the effective monitoring of human development over time and across countries and regions. In this way, the MDGs provide clear, measurable yardsticks to assess progress towards improving human welfare around the world.

This report is the second that The Gambia has produced in fulfilment of its commitment to report on progress towards achieving the MDGs. The report was commissioned at the request of my Government, not only to demonstrate its commitment to the Millennium Declaration, but also to provide a key source of information to identify and focus on specific areas requiring attention, stronger partnerships and concerted action to attain the MDGs.

This report is especially important, and in many ways discernibly different from the previous report, in terms of both quality and coverage, and provides a more detailed, disaggregated assessment of progress towards the MDGs in each Local Government Area (LGA). The wide range of stakeholders who have participated actively in the consultation process, including local authorities, government technicians, representatives of civil society organisations and private sector operators, demonstrates my Government's intent to make the MDGs more meaningful and closer to "the reality of daily life" experienced by people in different parts of the country.

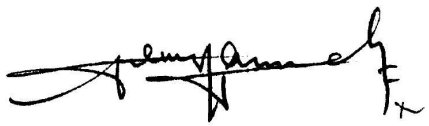
The report is also innovative in both design and content to make it easier to understand, which will greatly assist those charged with transforming the vision of the MDGs into reality. Progress made by the various LGAs and municipalities is measured against a set of common national MDG targets. This approach is important because it enables a more rational and demand-driven allocation of resources between those LGAs making the most progress towards achieving the MDGs and those that are not doing so well.

Another important feature of the report is that it provides an overview of how the MDGs are perceived around the country. This information comes from a series of consultations with representatives of the various local authorities, and their assessment of local capacities for data collection and analysis, report writing and information dissemination.

The report makes various recommendations on how to expedite the attainment of the MDGs in The Gambia, and the steps that need to be taken. The Government will incorporate and integrate the MDGs within The Gambia's Poverty Reduction Strategy (PRS) and national long-term development framework (Vision 2020) to highlight their relevance, strengthen national resolve and foster local ownership.

Finally, I am pleased to acknowledge the strong and consistent support provided by the UN System, especially the United Nations Development Programme (UNDP), and our other development partners, in my Government's endeavours to make progress towards achieving the MDGs and improve the lives of all Gambians. I also commend the co-ordinating role of the MDG secretariat located at the Policy Analysis Unit under my Office and all the Departments of State (Ministries) and their specialised units for their part in the various activities leading to the compilation and production of this report.

To our partners, I wish to remark that many challenges remain in achieving the MDGs, but we shall confront them together with a renewed sense of purpose, determination, and commitment to strengthen our partnership. We owe this to our people and the global community of nations working towards the attainment of the MDGs. In this way, we will, together, be able to make the world a better place for all.



Alhaji Dr. Yaya A. J. J. Jammeh
President, Republic of The Gambia

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LIST OF ABBREVIATIONS AND ACRONYMS

ACBF	African Capacity-Building Foundation
ACSD	Accelerated Child Survival and Development
AIDS	Acquired Immune Deficiency Syndrome
ALR	Adult Literacy Rate
ARV	Anti-Retro-Viral drugs
BCC	Banjul City Council
BFCI	Baby-Friendly Community Initiative
BI	Bamako Initiative
CEDAW	Convention for the Elimination of all forms of Discrimination Against Women
CIAM	Centre for Innovations Against Malaria
CRD	Central River Division
CSD	Central Statistics Department
CSO	Civil Society Organisation
DOSA	Department of State for Agriculture
DOSE	Department of State for Education
DOSFEA	Department of State for Finance and Economic Affairs
DOSFNRE	Department of State for Forestry, Natural Resources and Environment
DOSH	Department of State for Health
DOSJ	Department of State for Justice
DOTS	Directly Observed Treatment Short-course
DPWM	Department of Parks and Wildlife Management
DWR	Department of Water Resources
EC	European Commission
EPI	Expanded Programme on Immunisation
FD	Forestry Department
GAVI	Global Alliance on Vaccines and Immunisation
GBA	Greater Banjul Area
GCPDFS	Gambia Contraceptive Prevalence and Fertility Determinant Survey
GDP	Gross Domestic Product
GEAP	Gambia Environment Action Plan
GFMC	Gambia Forest Management Concept
GFSI	Girl-Friendly School Initiative
GICAP	Gambia Public/Private Sector and Civil Society Interface Capacity Building Project
GIS	Geographic Information System
HARRP	HIV/AIDS Rapid Response Project
HIV	Human Immuno-deficiency Virus
IBAS	Indigenous Business Advisory Service
ICT	Information and Communication Technologies
IM	Infant Mortality
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMR	Infant Mortality Rate
IT	Information Technology
ITN	Insecticide Treated Net
JSS	Junior Secondary School
KMC	Kanifing Municipal Council
KNVC	Royal Netherlands Tuberculosis Association

LBS	Lower Basic School
LGA	Local Government Area
LIF	Local Initiative Fund
LRD	Lower River Division
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MICS	Multiple-Indicator Cluster Survey
MM	Maternal Mortality
MMR	Maternal Mortality Ratio
NaNA	National Nutrition Agency
NAWEC	National Water and Electricity Company
NBD	North Bank Division
NEA	National Environment Agency
NNC	National Nutrition Council
NSMPNIMCP	National Survey on Maternal, Perinatal, Neonatal and Infant Mortality and Contraceptive Prevalence
ODA	Official Development Assistance
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
ProPAG	Pro-Poor Advocacy Group
PRSP	Poverty Reduction Strategy Paper
PTCT	Parent To Child Transmission
RCH	Reproductive and Child Health
RH	Reproductive Health
RVTH	Royal Victoria Teaching Hospital
SDF	Social Development Fund
SPA II	Strategy for Poverty Alleviation II
SSD	Sentinel Surveillance Data
SSHFC	Social Security and Housing Finance Corporation
SSS	Senior Secondary School
SWAP	Sector-Wide Approach
TB	Tuberculosis
TBA	Traditional Birth Attendant
U5MR	Under-5 Mortality Rate
UBS	Upper Basic School
UCI	Universal Childhood Immunisation
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
URD	Upper River Division
VCT	Voluntary Counselling and Testing
VHW	Village Health Worker
WATSAN	Water and Sanitation
WD	Western Division
WHO	World Health Organisation

THE GAMBIA'S MDG STATUS AT A GLANCE

Table 1: Summary of MDG Status in The Gambia by LGA

GOAL	TARGET	INDICATORS	LGA (DIVISION)/MUNICIPALITY and RANK						
			BCC	KMC	WD	NBD	LRD	CRD	URD
Goal 1:Eradicate Extreme Poverty and Hunger	Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than US$1 a day	Proportion of population below overall poverty line	1	2	3	5	5	4	5
		Proportion of population below food poverty line	2	1	3	5	5	4	7
	Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	Percentage of moderately under-weight under 5 children	1	2	3	5	4	7	6
		Percentage of severely under-weight under 5 children	1	2	4	3	6	7	5
Goal 2: Achieve Universal Primary Education	Target 3: Ensure that by 2015, Children everywhere boys and girls alike, will be able to complete a full course of primary schooling	Male NER	3	3	1	5	2	6	7
		Female NER	4	4	1	6	2	3	7
		Total NER	3	3	1	6	2	5	7
		Male ALR	4	4	2	3	1	6	7
		Female ALR	1	1	3	5	4	6	7
		Total ALR	2	2	4	5	1	6	7
Goal 3: Promote Gender Equality and Empower Women	Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	Ratio of girls to boys in primary education	2	2	6	7	2	1	5
		Ratio of girls to boys in lower secondary education	1	1	3	6	5	4	7
		Ratio of girls to boys in senior secondary education	1	1	3	7	5	6	4

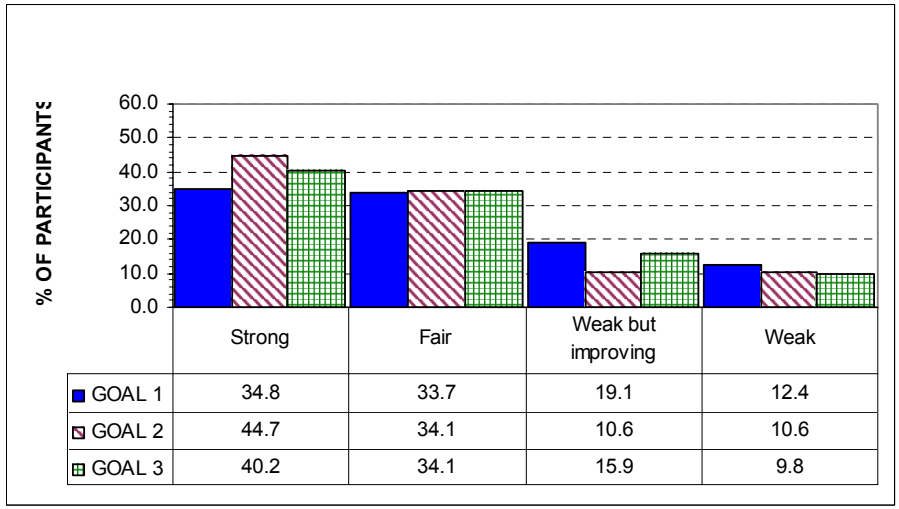
GOAL	TARGET	INDICATORS	LGA (DIVISION)/MUNICIPALITY and RANK						
			BCC	KMC	WD	NBD	LRD	CRD	URD
Goal 4: Reduce Child Mortality	Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	Under 5 mortality (per 1,000 births)	1	1	3	3	3	3	3
		Infant Mortality (per 1,000 births)	1	1	3	3	3	3	3
		Proportion of 1 year-old children immunised against measles	6	4	4	2	7	1	2
Goal 5: Improve Maternal Health	Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	Maternal Mortality (per 100,000 births)	1	1	3	3	3	3	3
		Proportion of births attended by skilled health personnel	1	2	3	4	5	7	6
Goal 6: Combat HIV/AIDS, Malaria, and other Diseases[1]	Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	Tuberculosis cases per 100,0000	7	6	4	3	1	2	5
Goal 7: Ensure Environmental Sustainability[2]	Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	Proportion (%) of population with access to unsafe water source	1	2	6	4	3	5	7
		Proportion (%) of population with unsanitary waste disposal	2	1	3	5	4	7	6
	Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	Proportion (%) of households with access to secure tenure	7	6	5	3	2	1	4

Table 2: Colour-Coded Ranking of Progress towards Achieving MDG Target

COLOUR/ RANK	NAME	SIGNIFICANCE
1	Green	Most progress toward LGA MDG target for year in question
2	Light Green	
3	Yellow	
4	Dark Yellow	
5	Gold	
6	Light Orange	
7	Red	Least progress toward LGA MDG target for the year in question

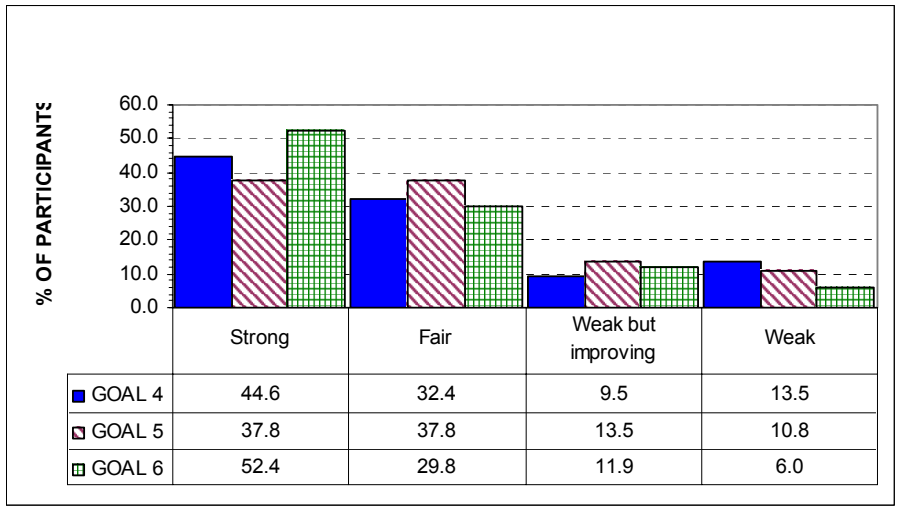
[1] Data for Target 7 are not available by LGA.
[2] Data for Target 9 are not available by LGA.

Figure 1: Supportiveness of Policy Environment to MDG 1, 2 & 3



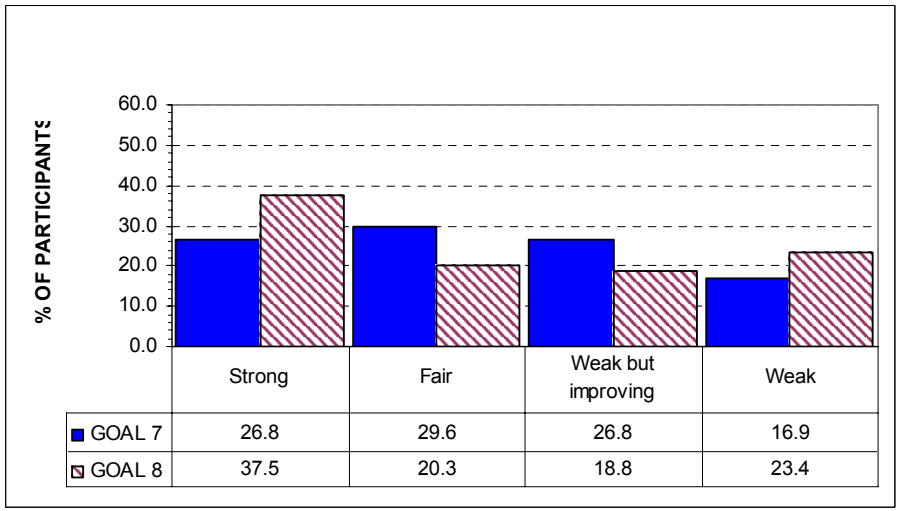
	Strong	Fair	Weak but improving	Weak
GOAL 1	34.8	33.7	19.1	12.4
GOAL 2	44.7	34.1	10.6	10.6
GOAL 3	40.2	34.1	15.9	9.8

Figure 2: Supportiveness of Policy Environment to MDG 4, 5 & 6



	Strong	Fair	Weak but improving	Weak
GOAL 4	44.6	32.4	9.5	13.5
GOAL 5	37.8	37.8	13.5	10.8
GOAL 6	52.4	29.8	11.9	6.0

Figure 3: Supportiveness of Policy Environment to MDG 7 & 8



	Strong	Fair	Weak but improving	Weak
GOAL 7	26.8	29.6	26.8	16.9
GOAL 8	37.5	20.3	18.8	23.4

THE GAMBIA'S PROGRESS TOWARDS ACHIEVING THE MDGs

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Target 1: Halve, between 1990 and 2015, the proportion of people whose income is less than US$1 a day

Indicators: proportion of population below overall poverty line; and proportion of population below food poverty line

National Status and Trends

Two measures of poverty are used in The Gambia: overall poverty[3] and food poverty[4] (also referred to as extreme poverty), as defined by the National Household Poverty Survey (GOTG, 2000). Extreme poverty increased markedly from 15% in 1992 and to 51% in 1998, the most recent years for which data is available, whilst overall poverty more than doubled to 69%.

Taking 1992 as the base year, the national MDG target is to reduce overall poverty by half to 15.5% by 2015. Assuming a uniform annual decrease, the overall poverty level should have fallen to 27% by 1998, but instead increased. so progress to meeting this national target was clearly off-track. It is important to recognise, however, that average national figures can often mask considerable variation at local level.

Local Variation

Disaggregated overall poverty figures for various Divisions, Local Government Authorities (LGAs)[5] and Municipalities in 1992 and 1998 demonstrate marked differences between urban and rural areas, as shown in Table 3 and Figure 4. Higher levels of overall poverty were found in rural LGAs than in urban area in both 1992 and 1998. Furthermore, no LGA or municipality achieved the 1998 National target, as shown in Table 3.

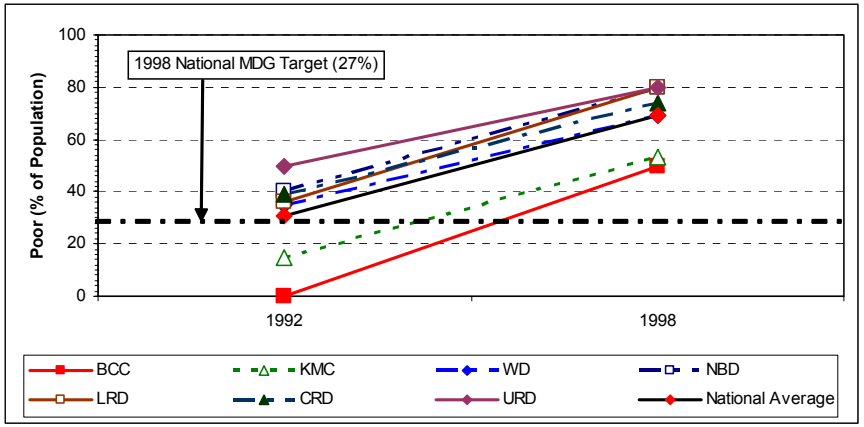
Although overall poverty levels increased in the urban areas of Banjul City Council (BCC) and Kanifing Municipal Council (KMC), they were the closest to the 1998 MDG targets on overall poverty.

Table 3: Overall Poverty Rates and MDG Targets

LGA/ Municipality	1992 %	1998 %	MDG Difference[6]	MDG Rank
BCC	0	50	-23	1
KMC	15	53	-26	2
WD	35	69	-42	3
NBD	36	80	-53	5
LRD	40	80	-53	5
CRD	39	74	-47	4
URD	50	80	-53	5
National Average	31	69		
2015 MDG Target	15			
1998 MDG Target	27			

Source: GOTG (2000). 1998 National household poverty survey report.

Figure 4: Overall Poverty Trends between 1992 and 1998



[3] Overall poverty is when the average annual household consumption per adult equivalent is less than the value of the overall poverty line.

[4] Food poverty is when the average annual household consumption per adult equivalent is less than the value of the food poverty line.

[5] Note: with the exception of CRD (which consists of two LGAs), all Divisional and LGA boundaries coincide, hence, the term "LGA" is used here to refer to administrative Divisions.

[6] Throughout this report, MDG differences are calculated as National MDG target minus actual value at the local level. The differences (whether positive or negative) are coloured red where the LGA has failed to meet the National MDG target.

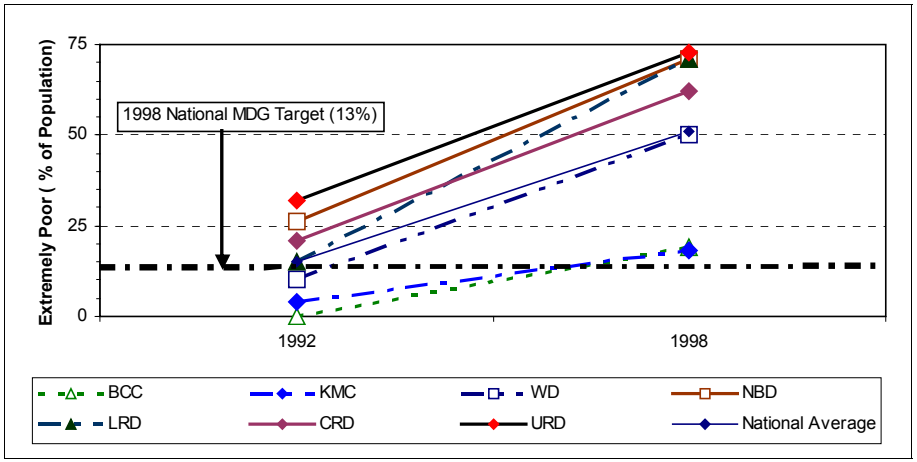
Levels of extreme poverty increased in all LGAs and municipalities between 1992 and 1998. None of the areas met the national MDG target of reducing extreme poverty to 13% by 1998. Highest levels of extreme food poverty were found in rural LGAs in both 1992 and 1998, as shown in Table 4 and Figure 5 and were particularly severe URD, NBD, LRD and CRD in 1998. Lower levels of extreme poverty occurred in urban areas of BCC and KMC.

Table 4: Extreme Poverty Rates Compared with MDG Targets

LGA/ Municipality	1992 %	1998 %	MDG Difference	MDG Rank
BCC	0	19	-6	2
KMC	4	18	-5	1
WD	10	50	-37	3
NBD	15	71	-58	5
LRD	26	71	-58	5
CRD	21	62	-49	4
URD	32	73	-60	7
National Average	15	51		
2015 MDG Target	7.5			
1998 MDG Target	13			

Source: GOTG (2000). 1998 National household poverty survey report.

Figure 5: Extreme Poverty Trends between 1992 and 1998

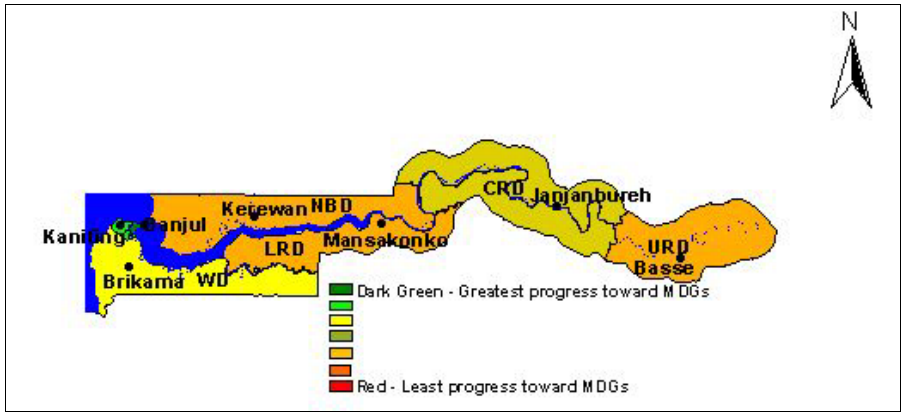


The reason for lower rates of extreme poverty in urban areas is likely to be the greater opportunities to earn money, so that people can afford to buy food even though they are poor. In contrast, people in rural LGAs have fewer opportunities to earn money and they are, thus, prone to being food-poor. Furthermore, the fact that many people in rural areas rely on farming, and groundnut farming in particular, makes them especially vulnerable to extreme poverty (GOTG, 2000). Remittances from aboard, however, can help to create employment and reduce poverty, and the evidence of these investments is ever more apparent with the construction of new houses, mosques, solar-powered lighting, boreholes etc..

The difference between the actual local and targeted national values of an MDG indicator for a given year provides an index of relative progress towards achieving that goal in different administrative areas. This MDG Difference value can then be ranked according to the degree of divergence from the national target, as shown in Table 3 and Table 4.

Thus, BCC made most progress towards reducing overall poverty, with the lowest rate of 50% in 1998, although still 23 points more (=worse) than the MDG target of 27% for that year. All other localities had overall poverty levels greater than the national target, even though NBD, LRD and URD tied last in terms of progress toward the 1998 targets for overall poverty.

Figure 6: MDG Difference Rankings for Overall Poverty

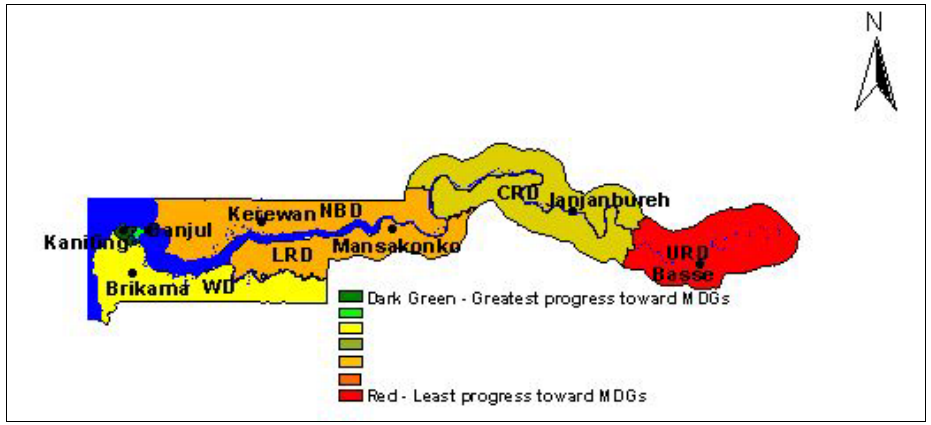


Colour-coded MDG difference rankings for overall poverty reduction are shown in Figure 6, based on the colour code indicated in Table 2. Thus, BCC is coloured dark green because it made most progress in reducing

overall poverty and LRD, NBD, and URD are coloured gold because they made least progress in reducing overall poverty, with other areas being assigned colours accordingly.

Area ranking positions were reversed with regard to reduction in extreme poverty, as indicted in the colour-coded map in Figure 7, with KMC 5 points below and URD 60 points below the national target for 1998.

Figure 7: MDG Difference Rankings for Food Poverty



Challenges

Despite generally adverse economic circumstances, Government has reaffirmed its commitment to fighting poverty, and is redoubling its efforts to fight poverty. Prospects are good for a significant reduction in poverty levels in The Gambia, but in this regard, the country still faces a variety of major challenges, including:

- Lack of resources to implement the Poverty Reduction Strategy Paper (PRSP). The failure of donors to deliver on pledges made at the 2002 Roundtable is especially regrettable;
- Inadequate ownership of PRSP, exemplified by the failure of various sectors to orient their programmes to conform to the PRSP and develop investment programmes to help fight poverty;
- Lack of human capacity (in terms of numbers and skills), which limits the absorption of development assistance and hampers the fight against poverty;
- Low agricultural productivity and output, resulting from a combination of low soil fertility, lack of inputs and prevalence of subsistence agriculture;
- Lack of funds/credit to finance agricultural development; and
- Lack of effective market outlets and marketing of agricultural products, which is especially serious for cash crops.

Policy Environment

There is no shortage of ideas on how to reduce poverty in The Gambia. Both Vision 2020 and Strategy for Poverty Alleviation II (SPA II) emphasise the importance of poverty alleviation for national development. Nevertheless, various policy issues remain outstanding, including:

- Extension of current cycle of PRSP implementation from 2005 to 2007, to provide more time for its objectives to be met;
- Revision of existing draft agricultural and natural resources policies to give greater emphasis to poverty reduction; and
- Completion of public expenditure reviews (PERs) of various sectors, especially agriculture.

Clearly, it will be some time before these issues are resolved, but it is encouraging to note that civil society organisations, especially the Pro Poor Advocacy Group (ProPAG), are becoming more involved in the process.

Priorities for Development Co-operation

The priorities for development assistance can be summarized as follows:

- Provide adequate resources and build capacity to implement SPA II;
- Promote the diversification of agriculture and transitioning from subsistence to more commercial and intensive farming to increase income and food security, and reduce poverty; and
- Support and strengthen the participation of civil society organisations and the private sector in the fight against poverty.

Target 2: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

Indicator: percentage of underweight under-fives

National Status and Trends

The percentage of underweight under-fives is one of two measures used to assess the MDG of reducing hunger; the other being the percentage of the population below the minimum level of dietary energy consumption.

Moderately and severely underweight children are defined as those whose weight for age is two standard deviations, or more, below the median for the reference population. Severely underweight children have a weight for age that is more than three standard deviations below the median for the reference population (CSD, 2000).

The proportion of moderately and severely underweight children under five years of age declined nationally from 20.9% in 1996 to 17.1% in 2000, as indicated in Table 5 and Figure 8. Taking 1996 as the base year and assuming a uniform decline to the MDG target of 10.45% by 2015, the national MDG target for 2000 was 18.7%. Nationally, therefore, The Gambia is well on track for meeting the 2015 MDG target.

However, children in urban areas fared much better than in rural areas, with the proportion of moderately and severely underweight children falling from 15.7% in 1996 to 9.4% in 2000, compared with a minor reduction from 22.1% to 21.2% in rural areas. Thus, whilst urban areas have already reached the 2015 MDG target, rural areas lag far behind.

A very similar pattern was evident for severely underweight under-fives, the proportion of which declined nationally from 5.3% in 1996 to 3.5% in 2000, as indicted in Table 6 and Figure 9. Using 1996 as the base year and assuming a uniform decline to the MDG target of 2.65% by 2015, the national MDG target for 2000 was 4.71%. Thus, at a national level, The Gambia is well on track for meeting the 2015 MDG target. Again there is a dichotomy between rural and urban areas, with urban areas already having exceeded the MDG target, with rural area far behind although, collectedly, they are on target to achieve the MDG by 2015.

Table 5: Moderate and Severe Underweight Under-Fives

LGA/ Municipality	1996 %	2000 %	MDG Difference	MDG Rank
BCC	26	6.2	12.5	1
KMC	14.4	9	9.7	2
WD	15.8	11.3	7.4	3
NBD	24	21.0	-2.3	5
LRD	18.6	19.1	-0.4	4
CRD	27.2	28	-9.3	7
URD	22.9	26.4	-7.7	6
Urban	15.7	9.4	9.3	
Rural	22.1	21.2	-2.5	
National Average	20.9	17.1		
2015 MDG Target	10.4			
2000 MDG Target	18.7			

Source: CSD (1998 and 2000).

Figure 8: Trends in Moderate and Severely Underweight Under-Fives

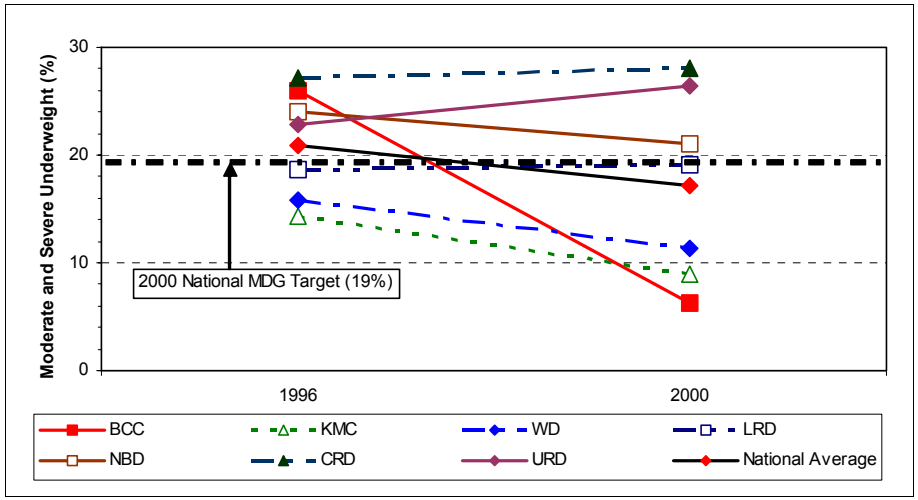
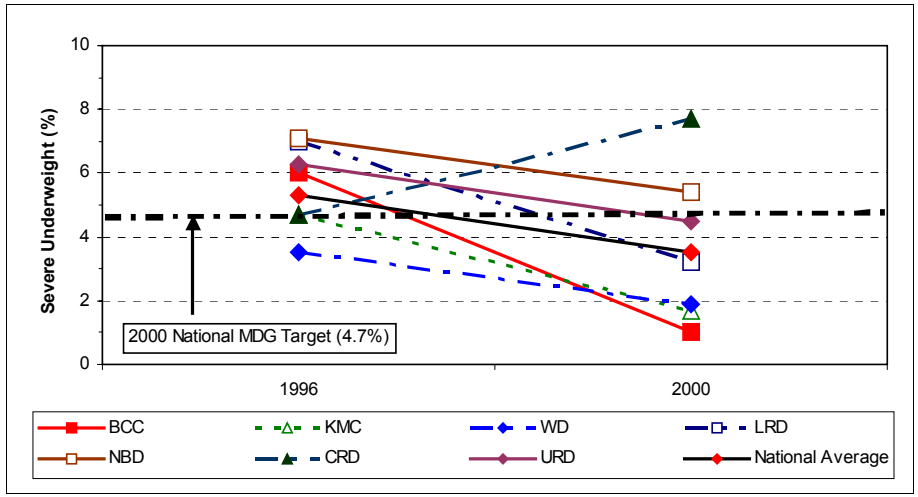


Table 6: Severely Underweight Under-Fives

LGA/ Municipality	1996 %	2000 %	MDG Difference	MDG Ranking
BCC	6	1.0	3.71	1
KMC	4.7	1.7	3.01	2
WD	3.5	1.9	2.81	3
LRD	7	3.2	1.51	4
NBD	7.1	5.4	-0.69	6
CRD	4.7	7.7	-2.99	7
URD	6.3	4.5	0.21	5
Urban	4.9	1.7	3.01	
Rural	5.4	4.5	0.21	
Average	5.3	3.5		
2015 MDG Target	2.6			
2000 MDG Target	4.7			

Source: CSD (1998 and 2000).

Figure 9: Trends in Severely Underweight Under-Fives



Local Variation

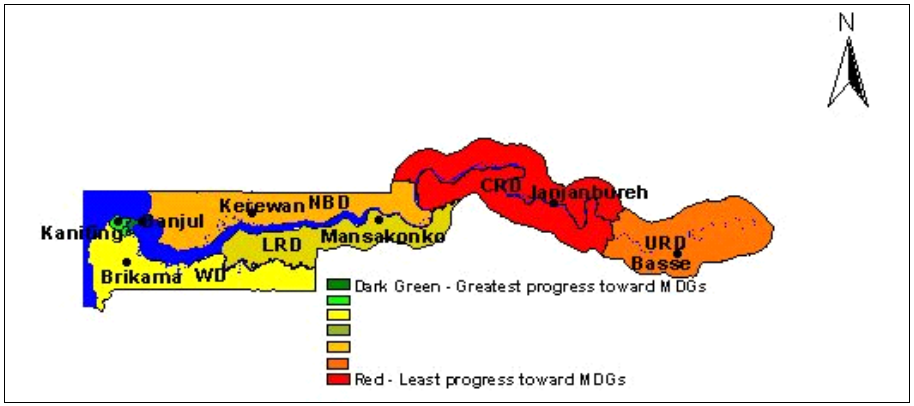
Moderately and severely underweight rates declined in BCC, KMC, WD and NBD, but increased in more rural LRD, CRD and URD, as shown in Table 5 and Figure 8. In 2000, lowest rates were found in BCC (6.2%) and KMC (9%). and highest rates were found in URD (26.4%), NBD (21.0%) and LRD (19.1%).

Severely underweight rates also declined in all areas except CRD, were it increased from 4.7 in 1996 to 7.7% in 2000, as indicted in Table 6 and Figure 9. In 2000, lowest rates were found in BCC (1.0%) and KMC (1.7%). and highest rates were found in CRD (7.7%) and NBD (5.4%).

The difference between the actual local and targeted national values of an MDG indicator for a given year provides an index of relative progress towards achieving that goal in different administrative areas. This MDG Difference value can then be ranked according to the degree of divergence from the national target, as shown in Table 5 and Table 6.

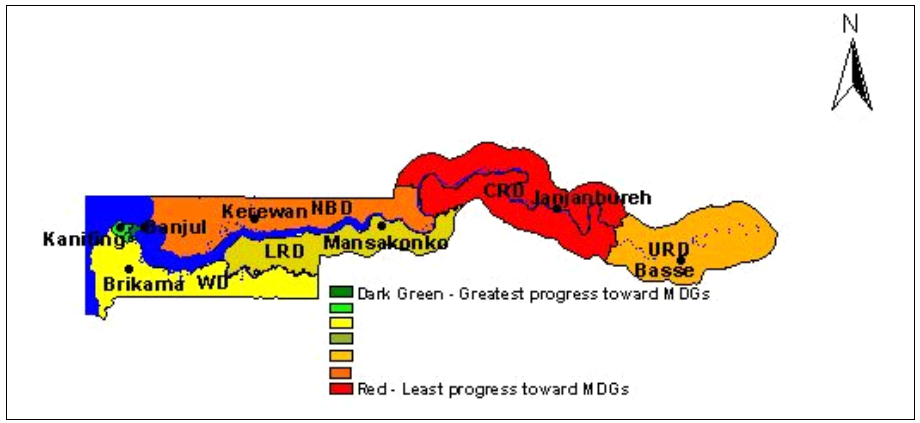
Thus, most progress in reducing moderately and severely underweight under-fives was made by BCC, KMC and WD, which were all well ahead of the national MDG target for 2000. Conversely, URD, NBD and LRD and CRD were all well behind the national 2000 MDG target for moderately underweight rates.

Figure 10: MDG Difference Rankings for Moderately and Severely Underweight Under-Fives



With regard to severely underweight under-fives, rates were again lowest in BCC, KMC and WD, which were all well ahead of target. LRD and URD were also just ahead of target, with NBD just behind and CRD a long way behind. Colour-coded MDG difference rankings for moderately and severely underweight under-fives, and severely under weight under-five are shown in Figure 10 and Figure 11, based on the colour code indicated in Table 2. The two maps are virtually identical except for the switch in colour code of NBD and URD.

Figure 11: MDG Difference Rankings for Severely Underweight Under-Fives



Challenges

The Gambia faces many challenges in the fight against hunger and malnutrition, and improving children's nutrition, including:

- Severe, widespread poverty - with more and more people getting poorer, it is a constant battle to get enough to eat, and to eat nutritiously;
- Poor infant feeding and hygienic practices;
- High infection loads caused by unsanitary conditions;
- Predominance of subsistence farming in rural areas and vulnerability to seasonal food insecurity;
- Obtaining cross-sectoral consensus and sustained collaboration to reduce hunger and improve nutrition;
- Inclusion of poverty and nutrition objectives in sectoral plans; and
- Lack of adequate and sustained financial and human resources to deliver the required services

Policy Environment

The importance of good nutrition has long been recognised by Government and is reflected in its National Nutrition Policy (2000–2004), which aims to meet the basic nutritional requirements of all Gambians and assure them of healthy and productive lives. Major achievements include:

- Establishment of a National Nutrition Council (NNC), with the Vice President as Chair and including various Secretaries of State;
- Establishment of the National Nutrition Agency (NaNA) in 2000 under the Office of the Vice President. NaNA is mandated to co-ordinate all nutrition activities in the country, and implement the national nutrition policy;
- Successful implementation of the Baby Friendly Community Initiative (BFCI) to promote community involvement in nutrition interventions;
- Establishment of a National Codex Committee to strengthen the National Food Control System; and
- Participatory formulation of a Food Bill, including enabling regulations, for food fortification (i.e. salt iodization) and promotion of breast feeding/ breast milk substitutes.

Priorities for Development Co-operation

- Improve nutrition service delivery;
- Support universal coverage of proven nutrition intervention programmes;
- Strengthen private sector and civil society participation through partnership;
- Strengthen the capacity of communities to plan, implement and manage nutrition interventions;
- Increase support to agricultural and rural development efforts to increase food security and alleviate poverty;
- Support programmes for improving infant feeding practices, hygienic practices and sanitary conditions;
- Provide adequate financial and human resources to deliver required services;
- Secure sustained and collaborative efforts of various sectors to reduce hunger, and improve nutrition.

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Target 3: Ensure that by 2015, Children everywhere boys and girls alike, will be able to complete a full course of primary schooling

Indicators: Net Enrolment Ratio in primary education (NER); proportion of pupils starting Grade 1 who reach Grade 5; and literacy rate of 15 to 24 year olds

National Status and Trends

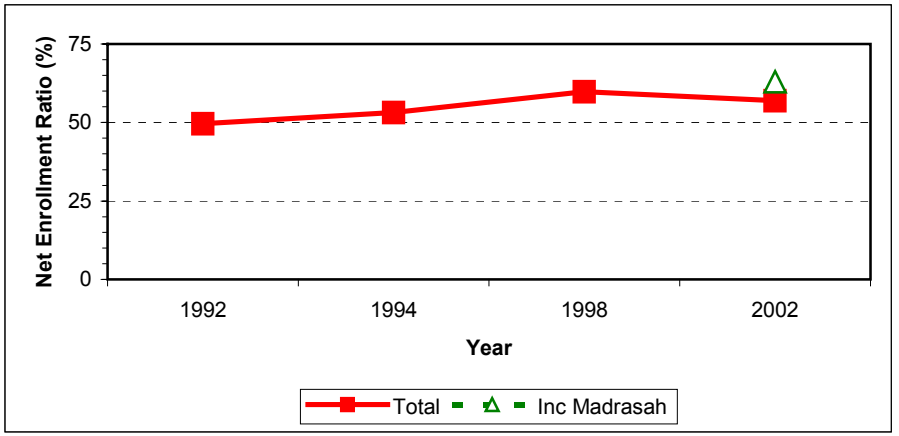
Formal education in The Gambia is based on a nine-year basic cycle (Grade 1–9), followed by three years of senior secondary schooling (Grade 10–12) and the tertiary level. Grades 1–6 of the basic cycle constitute the Lower Basic Cycle (primary level), while Grade 7–9 constitute the Upper Basic Cycle (lower secondary level). The Gambia also operates two parallel education systems. One is the conventional "Western" schooling and the other is the Madrasah[7] system.

The Gambia remains highly committed to developing its human resource base, with priority given to basic education for all. Significant progress has been made in providing access to education at all levels of the formal system, especially the primary level, which registered an annual average growth rate of 8% between 1990/91 and 1996/97 (compared with the target of 5%).

Net enrolment ratio (NER) is a measure of participation in primary education, as it is the enrolment of the official primary school age group (7 – 12 year olds) expressed as a percentage of the corresponding population. As shown in Figure 12, the NER increased from 1992 to 1998 and fell slightly to 57% in 2002, which may be due to rapid expansion of population in some areas over and above the corresponding increase in school facilities. Including Madrasah attendance, the 2002 NER was 63%.

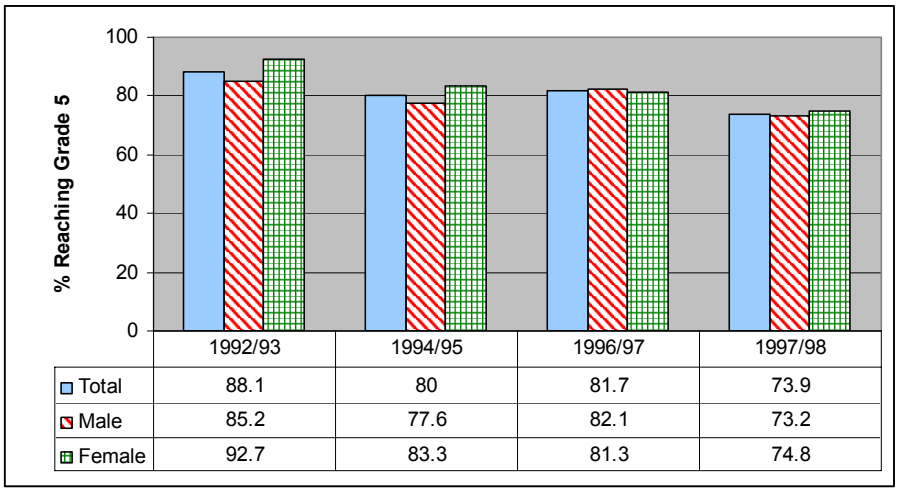
[7] Madrasah is an Arabic word, which means a school. In the Gambia, it refers to the formal schooling that uses Arabic as a medium of instruction. The system has been in operation for many years in The Gambia. The schools are operated by private individuals, communities and Islamic organisations, and are a result of the public demand for Islamic education. Efforts are being made to strengthen the teaching of English language (the official language) and other core subjects of the national curriculum in the Madrasahs. The system, however, lacks trained and qualified teachers, textbooks, facilities and equipment for the quality of education envisaged.

Figure 12: Net Enrolment Ratio in Primary Education



Sources: DOSE (November, 1999): EFA 2000 Assessment Report; DOSE Education Management Information System (EMIS).

Figure 13: Proportion of Pupils Starting Grade 1 Reaching Grade 5



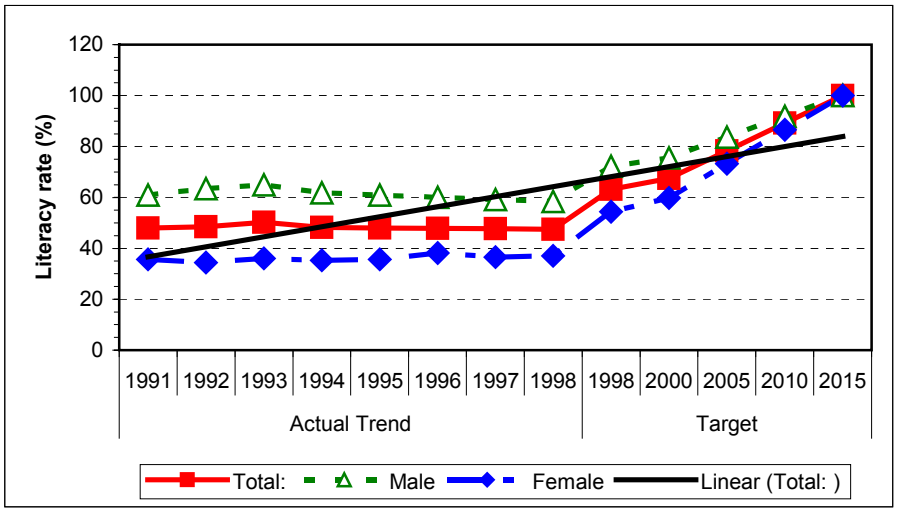
	1992/93	1994/95	1996/97	1997/98
Total	88.1	80	81.7	73.9
Male	85.2	77.6	82.1	73.2
Female	92.7	83.3	81.3	74.8

Sources: DOSE (November, 1999): "EFA 2000 Assessment Report"; and DOSE Education Management Information System (EMIS).

The proportion of pupils starting Grade 1 who reached Grade 5 was 73.9 % in 1997, compared to 88.1% in 1992. Figure 13 shows the trend, revealing that a significant proportion of pupils (boys and girls) are dropping out of school, indicating wastage and low internal efficiency of the system.

The national literacy rate was 47.5 % in 1998. The trend shown in Figure 14 reveals that unless the trend is reversed it is unlikely that a 100% literacy rate will be achieved by 2015. The new Education Policy (2004–2015) target is to halve the current rate of illiteracy (52.5%) by 2015, implying that the 2015 illiteracy target is about 26%, or a literacy rate of about 74%. As such, it is encouraging that the linear regression line in Figure 14 shows that literacy rates will reach about 80% by 2015.

Figure 14: Literacy Rate Trends and Targets



Local Variation

The Gambia is divided into six educational regions. Region 1 consists of the two urban municipalities, BCC and KMC. Region 5 (CRD) has two LGAs (Kuntaur and Janjangbureh Area Councils). The other regions (Region 2, 3, 4 and 6) correspond to the respective provincial administrative Divisions of the country. Table 7 shows NERs for boys and girls by LGAs, together with national MDG targets for 2001/02, MDG Differences and Rankings.

Table 7: Net Enrolment Ratios by LGA

Year	Gender	The Gambia	BCC/ KMC	WD	NBD	LRD	CRD	URD
1991/92	Total	46.3	64	50.4	40.1	64.8	34.1	20
	Male	54.2	69.7	66.1	51.3	66.8	43.7	25.3
	Female	38.5	58.9	33.9	28.5	39.6	24.1	14.4
1994/95	Total	65.0	76.2	82.8	61.4	80.1	46.6	34.0
	Male	74.6	84.2	91.8	73.8	98.9	56.5	42.9
	Female	55.3	69.3	73.5	48.8	59.9	36.5	24.5
1998/99	Total	59.8	57.3	73.6	49.9	72.9	55.6	43.9
	Male	64.2	62.2	78.2	57.4	77.7	58.9	49.2
	Female	55.4	53.1	69	42.5	67.9	52.3	38.3
2001/02	Total	60	58	76	52	66	55	43
	Male	62	62	80	57	68	54	45
	Female	57	55	73	47	65	56	41
MDG Target 2001/02	Total	69.6						
	Male	74.1						
	Female	65.2						
MDG Difference 2001/02	Total	9.6	11.6	-6.4	17.6	3.6	14.6	26.6
	Male	12.1	12.1	-5.9	17.1	6.1	20.1	29.1
	Female	8.2	10.2	-7.8	18.2	0.2	9.2	24.2
MDG Difference Ranking	Total		3	1	6	2	5	7
	Male		3	1	6	2	5	7
	Female		4	1	6	2	3	7

The difference between the actual local value and the national MDG target provides an index of progress towards achieving universal primary education in different areas. As shown in Table 7, WD made the greatest progress towards achieving universal primary education for both boys and girls, and was the only area to exceed the national MDG targets for 2001/02. LRD and BCC/KMC fell below target, with CRD, NBD and URD lagging much further behind. Colour-coded MDG difference rankings of the overall NERs for boys and girls combined and separately are shown in Figures 15, 16 and 17.

Figure 15: MDG Difference Rankings for Total NER

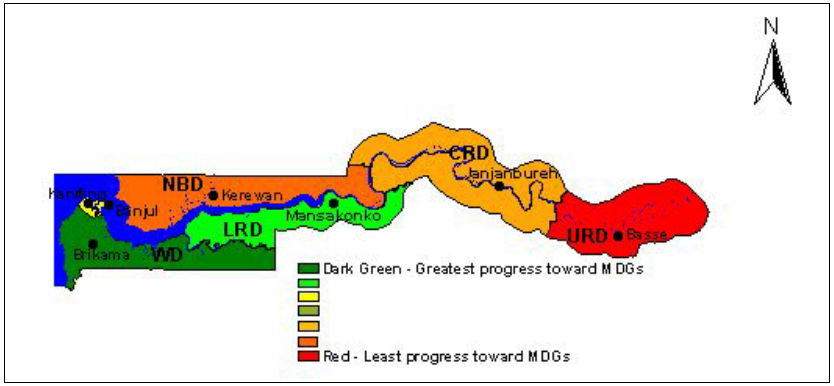


Figure 16: MDG Difference Rankings for Male NER

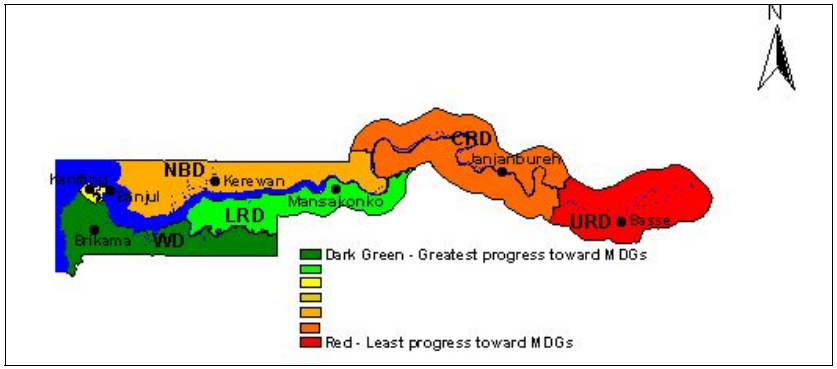
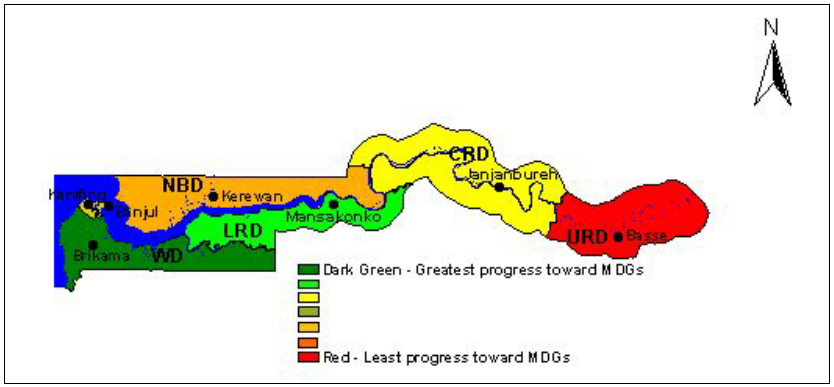
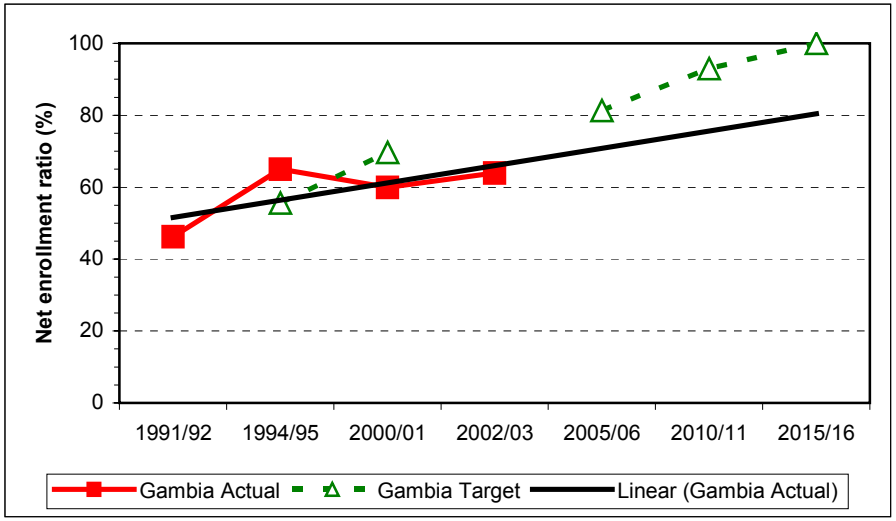


Figure 17: MDG Difference Rankings for Female NER



On current trends, The Gambia will have a net enrolment rate of 80% by 2015, and will thus fail to meet the MDG target of 100%, as shown in Figure 18. Urgent action is required to address this issue. Such measures will vary according to circumstances prevailing in each administrative area. However, recent efforts to incorporate Madrasahs in the educational system shows promise of expediting progress towards achieving the MDG in some areas.

Figure 18: National NER Trend and Targets



Figures 19 to 24 show actual NERs values and trends in each of the six educational regions since the early 1990s, together with targets to achieve universal primary education by 2015.

The alarming downward trend of NER in BCC/KMC (Figure 19) may be associated with the rapid growth of urban population, which has exceeded the capacity of school facilities in these areas.

In stark contrast to BCC/KMC, WD is set to achieve the MDG by 2010, as indicated in Figure 20.

Starting from a relatively low base, NER has increased in NBD (Figure 21) but will fall short of the MDG, unless urgent remedial action is taken.

Figure 19: NER Trend and Targets in BCC/KMC

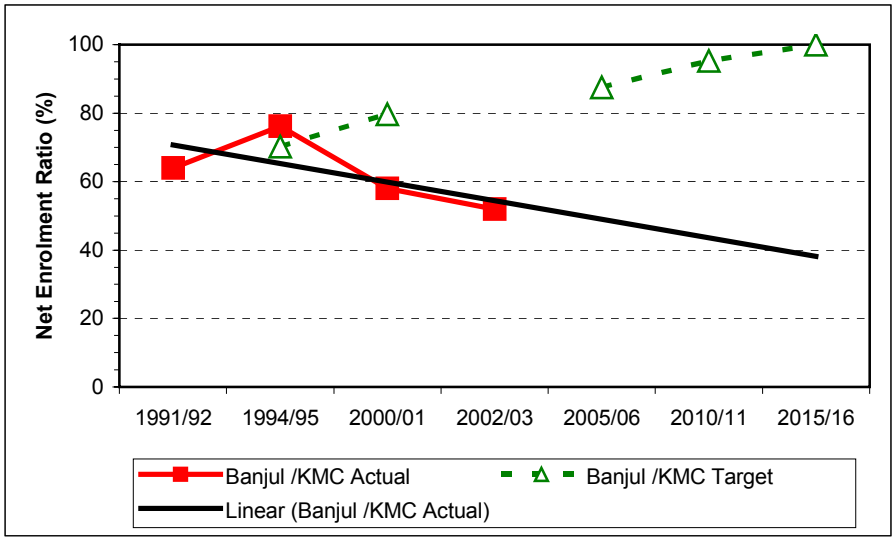


Figure 20: NER Trend and Targets in WD

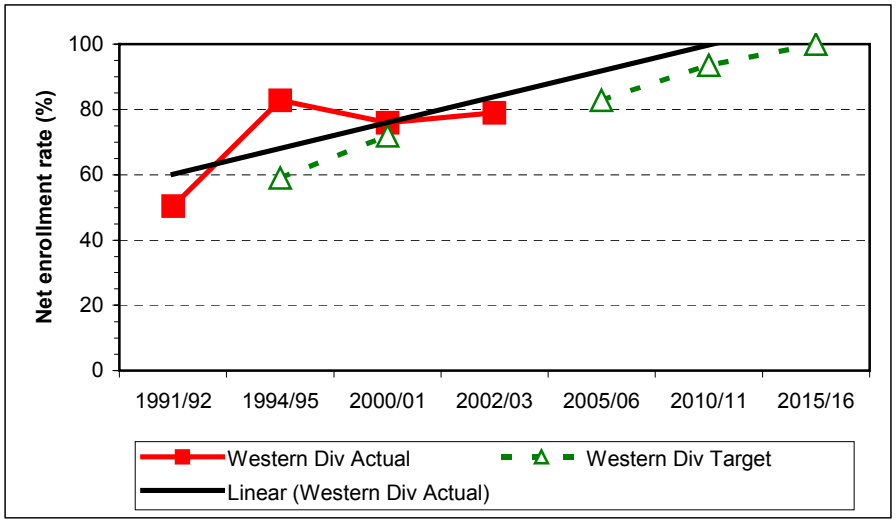


Figure 21: NER Trend and Targets in NBD

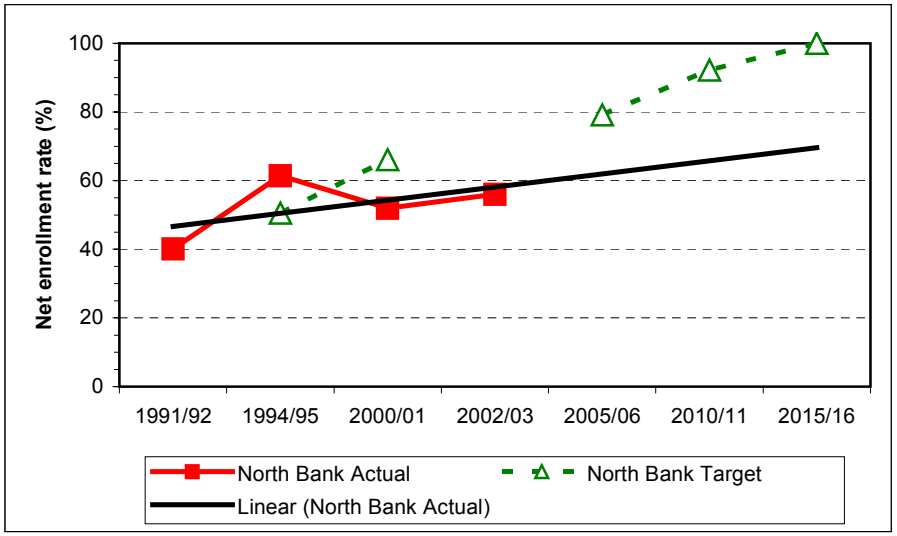


Figure 22: NER Trend and Targets in LRD

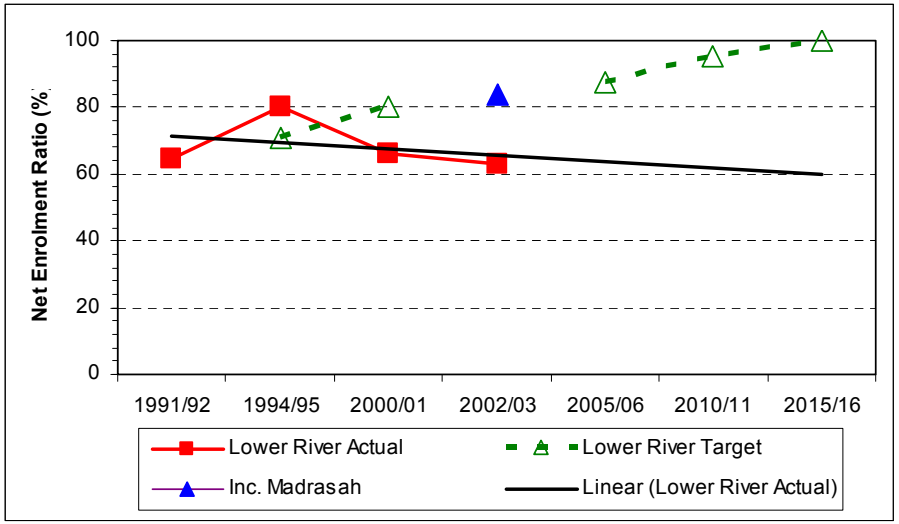


Figure 23: NER Trend and Targets for CRD

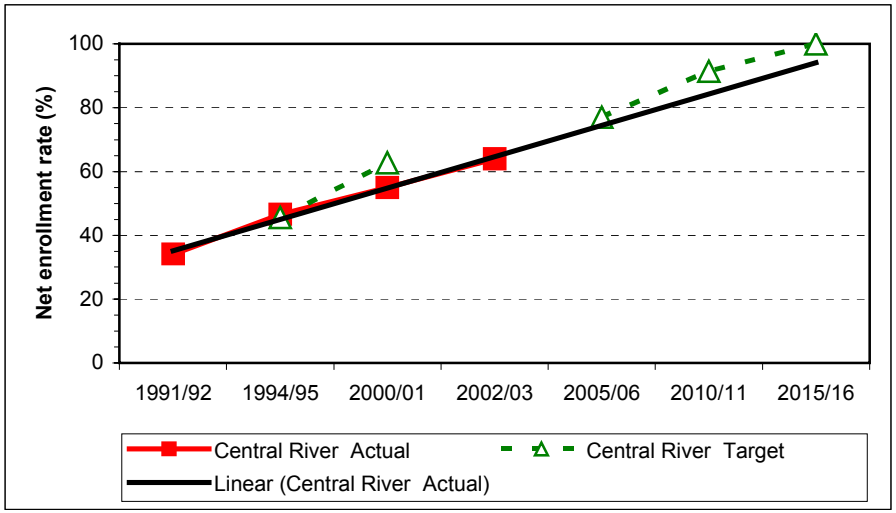


Figure 24: NER Trend and Targets for URD

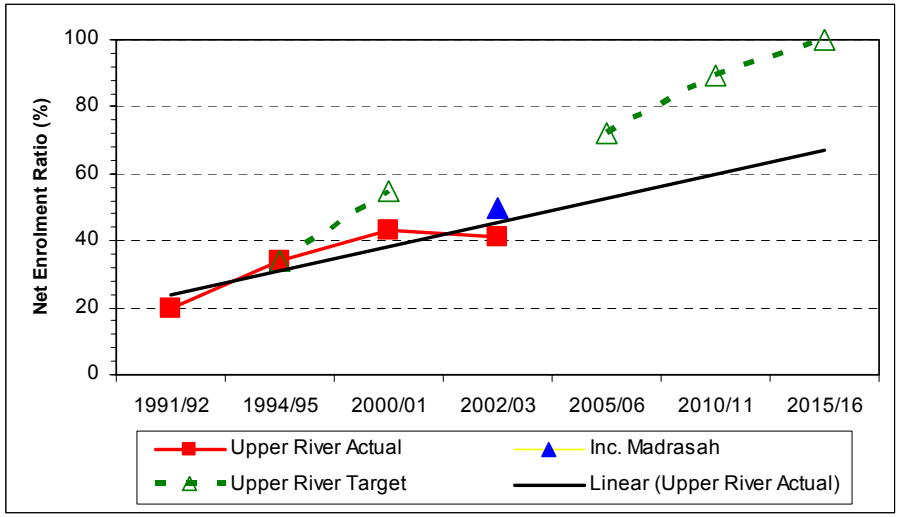


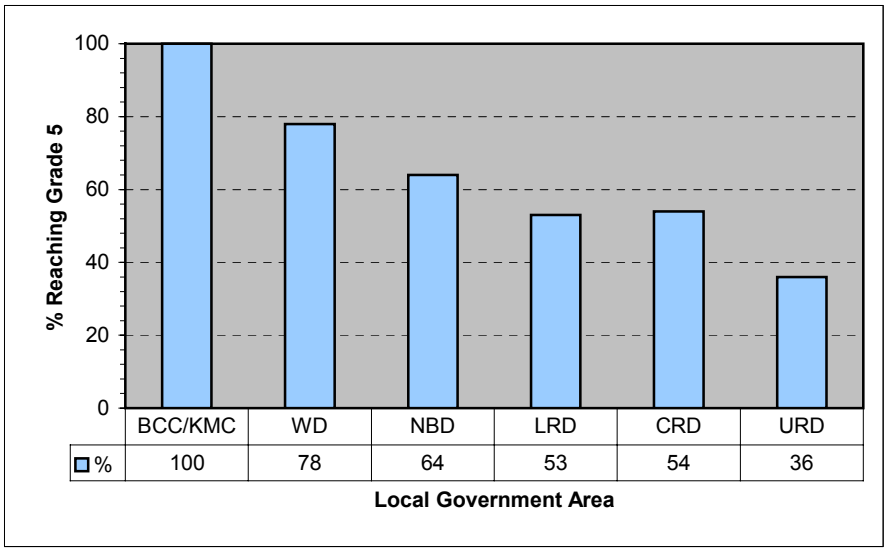
Figure 22 shows that NER declined in LRD between 1994 and 2002. Inclusion of Madrasah enrolment, however, increases 2002/03 NER from 63% to 84%, which, if strengthened and maintained, would achieve the MDG target.

Figure 23 shows that CRD is currently on track to achieve the MDG target, but this could be expedited with the incorporation of Madrasah enrolment.

Starting from a very low NER of 20% in 1991/92, URD made good initial progress through the 1990s, as shown in Figure 24, but this has not been sustained in 2000/01 an 2002/03. Inclusion of Madrasah enrolment would improve the situation, but even so, the MDG is unlikely to be met unless remedial action is taken.

With regard to the second indicator of this MDG, the proportion of pupils reaching Grade 5, Figure 25 relates to the cohort of pupils entering Grade 1 in 1996, who reached Grade 5 in 2001, which clearly demonstrates the contrast between the highest level of achievement in BCC/KMC (100%) and the lowest in URD (36%).

Figure 25: Proportion of Pupils Reaching Grade 5



Source: DOSE (1999): "EFA Assessment Report The Gambia".

Marked regional differences in adult literacy rates exist, ranging from 55.1% in BCC/KMC to 25% in URD, with an average of 47.5% for the whole country in 1998, as shown in Table 8. Male literacy rates are constantly higher than those for women in all areas, with highest levels of female literacy in BCC/KMC and WD, and lowest in CRD and URD.

The difference between the actual local value and the national MDG target provides an index of progress in raising levels of adult literacy in different areas, as shown in Table 8. Overall literacy levels are below their MDG targets in all areas. LRD and BCC/KMC are least behind, with URD and CRD furthest behind. Figures 27 to 28 show the LGA MDG Difference rankings for overall, male, and female literacy rates.

Table 8: Adult (15-24 Year-Olds) Literacy Rates

Year	Gender	The Gambia	BCC/ KMC	WD	NBD	LRD	CRD	URD
1991	Total	48	59.7	53.9	44.3	50.6	35.7	24.1
	Male	60.9	67.1	68	60.2	68.3	53.4	36.4
	Female	35.7	52.1	39.6	30.2	32.9	21.1	13.5
1994	Total	48.2	61.3	54.6	43.8	49	34.7	23.8
	Male	61.8	69.8	69.7	60	66.7	52	36.2
	Female	35.3	52.6	39.5	29.5	31.4	20	13.1
1998	Total	47.5	55.1	51.9	45.8	55.9	39	25
	Male	58.3	59.6	63.4	61.1	73.6	57.8	36.9
	Female	37.1	50.3	40.2	32.6	38.1	23.9	14.7
MDG Target 1998	Total	63.2						
	Male	72.3						
	Female	54.5						
MDG Difference 1998	Total	15.7	8.1	11.3	17.4	7.3	24.2	38.2
	Male	14.0	12.7	8.9	11.2	-1.3	14.5	35.4
	Female	17.4	4.2	14.3	21.9	16.4	30.6	39.8
MDG Difference Ranking 1998	Total		2	4	5	1	6	7
	Male		4	2	3	1	6	7
	Female		1	3	5	4	6	7

Source: DOSE (1999): "EFA Assessment Report The Gambia".

Figure 26: MDG Difference Rankings of Overall Literacy Rates

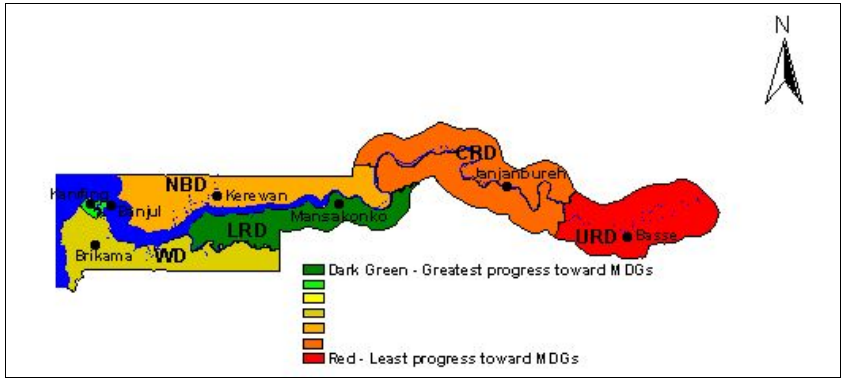


Figure 27: MDG Difference Rankings of Male Literacy Rates

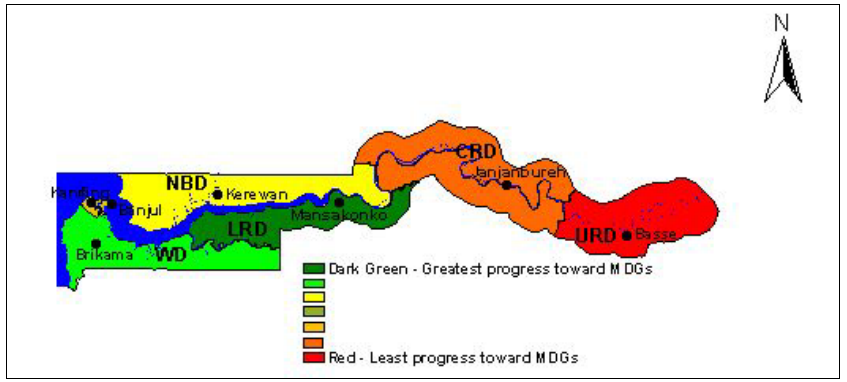
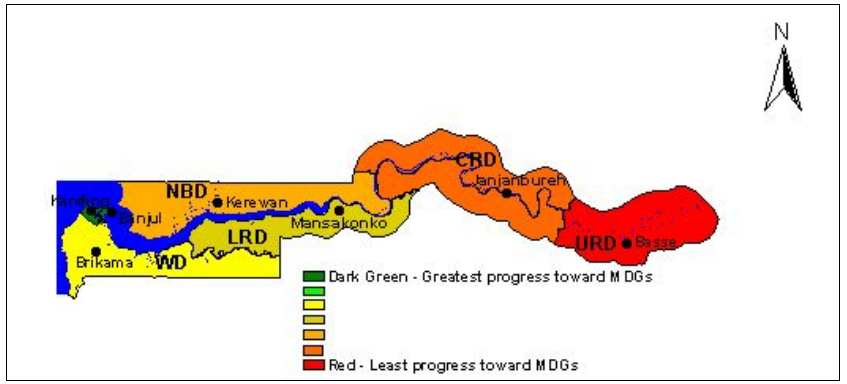


Figure 28: MDG Difference Rankings of Female Literacy Rates



Challenges

Important challenges for achieving the MDG include:

- The declining trend of net enrolment ratio, especially in BCC/KMC. This requires expeditious implementation of all aspects of the Decentralisation programme to encourage people to settle in rural areas;
- Ensuring capacity building of Madrasah education to enable the system to provide quality education to the large proportions of children they enrol;
- Reversing the trend of declining school completion rates, and promoting performance especially for girls in rural areas;
- Implementing appropriate measures to increase the supply of trained teachers and motivating them to serve in remote areas;
- Improving the quality of teaching and learning at all levels;
- Expanding senior secondary schools in rural areas, and tertiary and skill centres to provide marketable skills that will enable people to deal with the demands and challenges of life. Such initiatives will require consultations with the private sector on the types of skills required;
- School and classroom construction and rehabilitation programme;
- Addressing the direct costs of girls' education at senior secondary, tertiary and higher education levels;
- Developing a more gender sensitive curriculum and creating gender sensitive environments, as well as promoting community awareness of the benefits of both boys' and girls' education;
- Addressing the needs of the visually impaired, and other special needs students; and
- Minimizing the impact of HIV/AIDS on education, and adaptation of effective measures to enable the education sector to reduce the spread and the impact of HIV/AIDS pandemic.

Policy Environment

Various policy initiatives have had significant impacts in raising awareness of gender disparities to empower women. These include:

- An enabling policy environment resulting in the substantive increase in school facilities;
- Ongoing adult and non-formal education activities;
- Partnerships between government, NGOs, civil society, international and bilateral agencies;
- The willingness of Madrasah proprietors to include English language, core subjects and other life skills in the Madrasah curriculum. This is an important development because the Madrasah system enrols a significant proportion (15%) of school going age children;
- Many schools have been and are being established;
- Sponsorship/scholarship schemes especially for girls;
- Policy of having a nine-year, uninterrupted cycle of basic education;
- Expanded school facilities, especially the Lower and Upper Basic is increasing access to formal education;
- On-going awareness creation on the importance of education;
- Special unit at DOSE established for adult and non-formal education;
- Various NGOs and projects running literacy programmes; and
- Government, NGOs and private sector are participating in the provision of literacy all over the country.

Priorities for Development Co-operation

The challenges highlighted above require development co-operation to enable The Gambia to achieve the MDGs. The most pressing needs include:

- Capacity building for decentralised educational planning and management;
- Provision of staff quarters and other incentive packages for teachers to comfortably stay in rural settings;
- Capacity building for quality improvement in Madrasah, including curriculum development, teacher training, classroom construction and provision of teaching and learning materials;
- Reduction of the educational cost burden on parents;
- Curriculum revision, expansion and improvement of teacher training; and
- Establishment of educational standards, and monitoring and evaluation of standards at all levels.

GOAL 3: PROMOTE GENDER EQUALITY & EMPOWER WOMEN

Target 4: Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015

Indicators: ratio of girls to boys in primary education (gross enrolment – Lower Basic); ratio of girls to boys in lower secondary education –Upper Basic; ratio of boys to girls in senior secondary education; and ratio of literate female to men among 15 to 25- year-olds

National Status and Trends

The Government is committed to promoting gender equity and the empowerment of women to achieve their full participation in national development. High priority is given to implementing the Education Policy (2004-2015), based on the country's Poverty Reduction Strategy Paper (PRSP), and the fast-track, Education For All (EFA) initiative for timely achievement of the education MDGs.

The ratio of females to males in education is a measure of gender equity, as is the level of learning opportunities available to females compared to those available to males, both of which reflect the degree of women's empowerment. The MDG target is to eliminate gender disparity and an index value of unity at all levels and types of educational provisions. Thus, the closer the index is to 1, the closer the LGA or municipality is to achieving the MDG.

As shown in Table 9, The Gambia almost reached the Gender Parity Index target in primary level in 2002 with an index valued of 0.99, up from 0.74 in 1996. This success has been achieved through an expansion of primary education and various interventions to promote the enrolment of girls, including sponsorship schemes for girls, Girl Friendly School Initiative (GFSI) supported by UNICEF, and mother's clubs attached to schools.

The ratio of girls to boys at Upper Basic level; increased from 0.72 in 1996 to 0.80 in 2002 and from 0.44 to 0.60 at Senior Secondary School. These improvements relate to the expansion of secondary schools, especially in rural areas, and various measures aimed at reducing the burden, on parents, of the cost of educating girls. Although the enrolment of girls in primary education has increased, most do not move on to obtain secondary education.

Table 9: Trends in Gender Parity Index in Education and Literacy

Indicators	1996	1998	2002
Ratio of girls to boys in primary education – Lower Basic	0.74	0.85	0.99
Ratio of girls to boys in lower secondary education –Upper Basic	0.72	0.70	0.80
Ratio of boys to girls in senior secondary education	0.44	0.57	0.60
Ratio of literate female to male 15 to 25-year-olds	0.60	0.64	NA

NA = Not available

The female literacy rate amongst 15 to 25-year-olds, nationally, is much lower than for males, currently 37.1% and 58.4%, respectively, with even wider discrepancies at divisional level. Since, access to education and the ability to read and write are the essence of empowerment, these continuing disparities are of considerable concern.

Table 10 shows general improvements in net enrolment rates for both sexes at all levels between 1990/91 and 2002/03, except recently in Primary/Lower Basic, and the contribution of Madrasah enrolment in 2002/03. Disparities between male and female enrolment are clearly evident but are diminishing.

Table 10: Net Enrolment Rates by Level of Education and Gender

Level	Gender	1990/91	1994/95	1998/99	2002/03 Madrasah	
					Excl	Incl
Primary or Lower Basic	Total	45	53	61	57	63
	Female	37	46	56	57	65
	Male	53	61	66	57	60
Junior Secondary or Upper Basic	Total	9	10	23	31	35
	Female	7	10	20	29	31
	Male	12	11	26	31	39
Senior Secondary	Total	3	2	8	9.8	10.3
	Female	2	3	6	8.2	8.4
	Male	5	2	10	11.6	12.3

With regard to gender equity and empowerment in The Gambia, there have been remarkable improvements in the general well-being of women over the past decade. However, there are still some significant differences in areas of school performance and completion, literacy, decision-making and wage employment. Improvements in these strategic areas are required to expedite the empowerment process for women.

Local Variation

Since women form 49% of the Gambian population, their involvement in decision-making processes is crucial, as is their occupancy of managerial and political posts. With a few notable exceptions, however, female participation in political life is modest. Most Gambian women perceive themselves to be supporters rather than active participants in politics, and the National Assembly has only five female representatives, as opposed to 40 males.

Marked gender disparities are also evident at divisional level. There is no female Divisional Commissioner, or Chief, and at the local level, there are only five female village heads in the entire country[8]. Table 11 shows the gender representation in area and municipal councils. The indications are, however, that the situation will improve as more women are educated and gradually move into male dominated structures, such as chieftaincy, etc..

Table 11: Gender Representation of Councillors by LGA

Local Government Area	Number of Councillors		
	Male	Female	Total
BCC	8	4	12
KMC	20	1	21
Mansakonko Area Council	16	1	17
Kuntaur Area Council	11	2	13
Brikama Area Council	29	2	31
Janjanbureh Area Council	15	1	16
Kerewan Area Council	19	1	20
Basse Area Council	15	2	17
Total	133	14	147

[8] The Gambia NGO Report (2001). The Gambia National Report on Women: Report for the Beijing + 10 World Conference and Beyond.

Real empowerment of women also requires women to be gainfully employed to satisfy their financial and material well-being. Women form the bulk of the agricultural labour force in The Gambia, and the key issues that confront them are land and credit. While women can gain access to credit relatively easily, they receive smaller loans than men. In addition, men generally have control over land, probably because of inheritance rights in a patriarchal society.

Traditional stereo-types continue to dominate women's lives. Low levels of educational attainment appear to be correlated with low status. Women's low literacy levels and ignorance of policies and laws, and of the true teachings of Islam and Christianity continue to impede their progress. Thus, they are unable to claim their legitimate rights.

Divisional enrolment figures deviate from the traditional view that female enrolment is high in urban areas, and low in rural areas. Current figures indicate that WD has the highest female representation in education (73%), followed by LRD (65%). The enrolment rate in BCC and KMC is on the decline, as shown in Table 7. With regard to progress towards achieving the MDG, Figure 16 and Figure 17 show that WD ranks first, followed by LRD. The reasons for this dramatic turnaround can be traced back to the vigorous EFA Big Bang Campaign in rural areas and strenuous NGO activity, as well as rapid urban population growth.

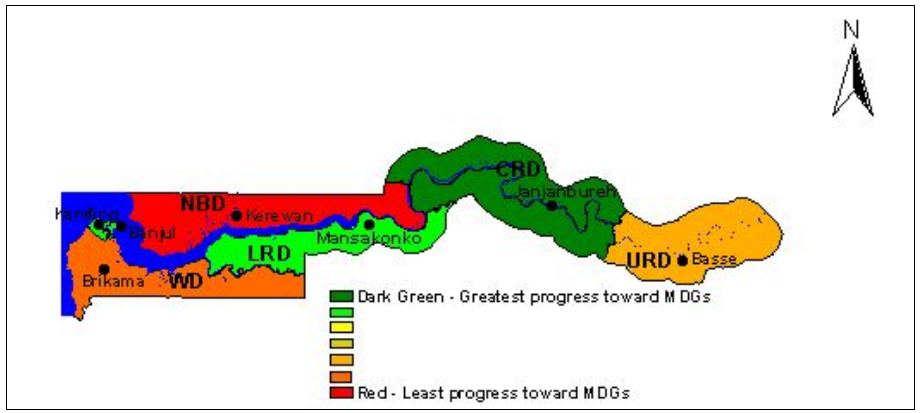
The variance in literacy rates in different LGAs and municipalities needs to be redressed, especially for women in rural areas. In addition, more targeted interventions are needed in education and access to substantive credit and land. LRD ranks first in terms of achieving male literacy, while BCC/KMC is progressing faster towards achieving the female literacy target (see Table 8, Figure 27 and Figure 28). Further mainstreaming of gender issues in the formulation and implementation of development policies will serve to enhance gender equity and empowerment.

Table 12 shows that gender parity at primary level has already been achieved at BCC/KMC, LRD and CRD, whilst other areas are very close to reaching that target. Only NBD is marginally below the MDG target for 2002. MDG difference rankings of the gender parity index at primary school level across the country are shown in Figure 29.

Table 12: Gender Parity Index at Primary School Level by LGA

Total	The Gambia	BCC/ KMC	WD	NBD	LRD	CRD	URD
1990	0.68	0.92	0.71	0.50	0.50	0.54	0.54
1994	0.74	0.95	0.78	0.65	0.56	0.62	0.54
1998	0.85	0.98	0.86	0.74	0.78	0.83	0.73
2002	0.98	1	0.96	0.93	1	1.07	0.97
MDG Target 2002	0.94						
MDG Difference	-0.04	-0.06	-0.02	0.01	-0.06	-0.13	-0.03
MDG Diff. Ranking		2	6	7	2	1	5

Figure 29: MDG Difference Rankings of Gender Parity Index at Primary School Level

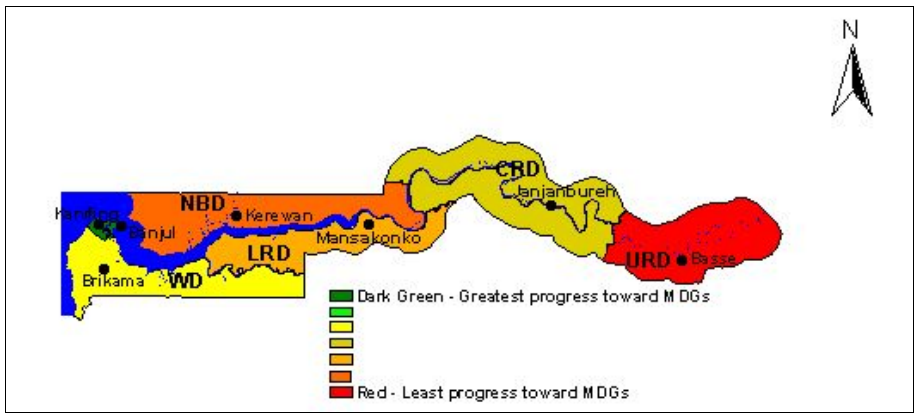


At junior secondary school level, BCC/KMC made the greatest progress, exceeding the MDG, target set for 2000, as shown in Table 13. WD fell just below target, with CRD, NBD and LRD substantially below target and URD way below target. MDG difference rankings of the gender parity index at junior secondary school level across the country are shown in Figure 30.

Table 13: Gender Parity Index in Junior Secondary Schools by LGA

Total	The Gambia	BCC/ KMC	WD	NBD	LRD	CRD	URD
1996	0.72	0.92	0.63	0.52	0.47	0.48	0.84
1998	0.70	0.86	0.71	0.55	0.44	0.49	0.44
2000	0.73	0.98	0.68	0.59	0.58	0.60	0.46
MDG Target 2000	0.84						
MDG Difference	0.11	-0.14	0.16	0.25	0.26	0.24	0.38
MDG Diff. Ranking		1	3	6	5	4	7

Figure 30: MDG Difference Rankings of Gender Parity Index at Junior Secondary School Level

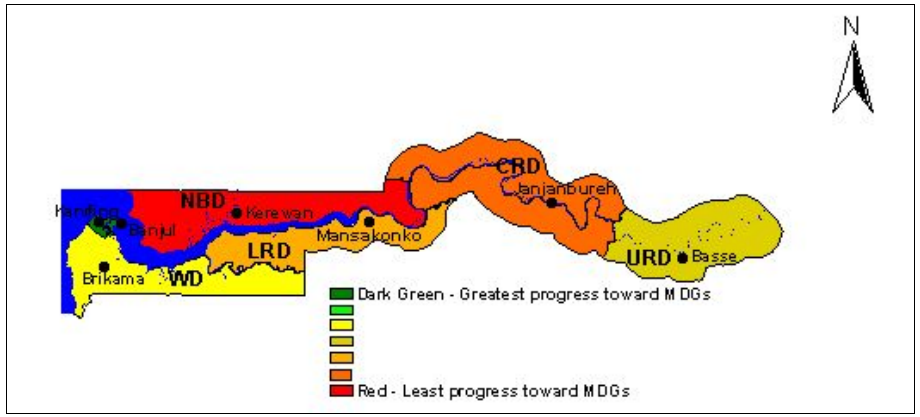


From an elevated starting point, BCC/KMC made good progress towards gender parity at Senior Secondary School (SSS) and reached the national MDG target for 2000, as shown in Table 14. WD, LRD, CRD and URD all improved their ratings to just below the national target for 2000. NBD was the only area in which gender parity index regressed. Colour-coded MDG Difference rankings are shown in Figure 31.

Table 14: Gender Parity Index in SSS (Grades 10-12) by LGA

Year	The Gambia	BCC/ KMC	WD	NBD	LRD	CRD	URD
1996	0.44	0.55	0.22	0.37	0.26	0.35	0.34
1998	0.57	0.65	0.54	0.35	0.68	0.32	0.42
2000	0.63	0.69	0.57	0.36	0.53	0.51	0.55
MDG Target 2000	0.69						
MDG Difference	0.06	0	0.12	0.33	0.16	0.18	0.14
MDG Diff. Ranking		1	3	7	5	6	4

Figure 31: MDG Difference Rankings of Gender Parity Index at Senior Secondary School



Policy Environment

Various policy initiatives have had significant impacts in raising awareness of gender disparities and the need to empower women. These include:

- National Policy on the Advancement of Gambian Women provides an overall framework to address women's development;
- Policy statements on gender equity and empowerment are embedded in the new Education Policy (2004-2015);
- Special unit for girls' education has been established at the Department of State for Education;
- Sponsorship/scholarship schemes especially for girls;
- Ratification of the Convention for the Elimination of all forms of Discrimination Against Women (CEDAW), and passage of similar bills;
- Programmes geared to the empowerment of women, include the loan schemes of the Indigenous Business Advisory Service (IBAS), Social Development Fund (SDF) and the Local Initiative Fund (LIF).

Challenges

Numerous socio-economic and cultural factors contribute to poor female performance in education as compared to boys, including:

- Poverty;
- Early marriage;
- Prostitution and girl child trafficking;
- Child labour and exploitation;
- Sex tourism and paedophilia;
- Parental preference of sending boy child to school; and
- Parental preference of Madrasah education for their girl child.

Current efforts and achievements in improving female education include:

- Scholarship trust fund;
- Take our daughters to work initiative;

- Construction of separate sanitary facilities and provision of separate toilets for girls and boys;
- Ongoing sensitisation on factors affecting female education;
- Girls clubs in schools;
- Mothers clubs in the most deprived regions;
- Female teachers associations;
- All girls conference; and
- Involvement of parents in school management.

The following measures and initiatives are required to ensure that women are included in the empowerment process:

- Reform of laws that govern women's lives, such as the discrepancies between the civil marriage act and customary law;
- Higher education, literacy and training;
- Employment in top decision-making positions and political life;
- Market opportunities for women in agriculture; and
- Increased access to land and credit.

Prospects in addressing gender empowerment issues include:

- Formation of gender action networks;
- Gender representation taken into consideration in recruitment process;
- Institutional mechanisms for advancement of Gambian women;
- NGO's that target women for improvement of their livelihood; and
- Availability of media coverage for publicity of empowerment issues.

Priorities for Development Co-operation

- Strengthen the Madrasah system and build capacity to ensure that more girls receive quality education;
- More scholarships for girls in senior secondary and tertiary institutions;
- Support building of senior secondary schools and skill centres in rural areas;
- Support NGOs, gender networks and other women's advocacy groups;
- Promote and enhance capacity for collection of gender disaggregated data;
- Appropriate technologies for women to improve productivity in agriculture;
- Identification and promoting of markets for the sale of produce; and
- Increased representation of women in top management positions and other key decision-making roles.

GOAL 4: REDUCING CHILD MORTALITY

Target 5: Reduce by two-thirds, between 1990 and 2015, the under five mortality rate

Indicators: under-five mortality rate; infant mortality rate; and proportion of 1 year-old children immunised against measles

National Status and Trends

National census reports for 1973, 1983 and 1993 show steep declines in both the under-five mortality rate (U5MR) and the infant mortality rate (IMR), from 320 to 135 per 1000 live births and from 217 to 84 per 1000 live births, respectively, as shown in Table 15 and Figure 32.

Although there are no quantitative MDG indicators for measles immunisation, the national coverage has been high, and the national target is to increase the coverage to 95% by 2006 according to the Expanded Programme on Immunisation (EPI) 2002-2006 Multi-Year Immunisation Plan.

Table 15: Summary of Child Mortality and Immunisation Indicators

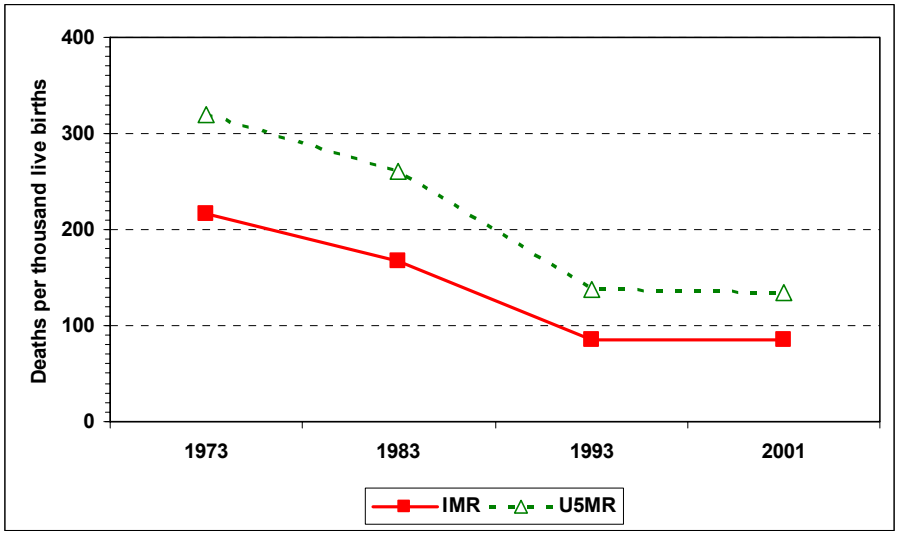
Indicator		1990	2000	2001	2002
Under-five mortality rate (per 1000 live births)	National Trend	135[a]	NA	135[b]	NA
	MDG Target		106	102	98
Infant mortality rate (per 1000 live births)	National Trend	84[a]	NA	84[b]	NA
	MDG Target		66	64	61
One-year-olds immunised against measles[c]	National Trend	87%[d]	92%	89%	93%

[a] Source: 1993 National Housing and Population Census;
[b] Source: Report on the National Survey on Maternal, Perinatal, Neonatal and Infant Mortality and Contraceptive Prevalence 2001;
[c] Source: EPI Coverage Surveys.% are for children 12 to 23 months
[d] 1991 EPI Coverage Survey

The very substantial reduction in child mortality during the 1970s and 1980s is attributed to a variety of factors, including: improvements in and expansion of health services, particularly Primary Health Care (PHC) services and introduction of the EPI in 1979; as well as improvements in other social services, e.g., family planning, environmental sanitation and availability of potable water.

These positive downward trends, however, were not sustained and there was no improvement in infant and under-five mortality rates during the 1990s, in spite of a highly successful immunisation programme: measles immunisation coverage nearly 90% or more in all LGAs.

Figure 32: Trends in Under 5 and Infant Mortality: 1973-2001



Sources: 1973, 1983, 1993: National Census Reports; 2001: Report on the National Survey on Maternal, Perinatal, Neonatal and Infant Mortality and Contraceptive Prevalence.

Local Variation

There is a significant disparity between urban and rural infant and under five mortality levels. The 1993 census provides baseline data on U5MR and IMR showing lowest mortality rates in urban areas (BCC and KMC) and highest in rural areas, especially LRD and URD (Table 16 and Table 17). The 2001 mortality and contraceptive study estimated U5MR to be 98 and 154 per 1000 live births in urban and rural areas, respectively; and the IMR to be 64 and 95 per 1000 live births in urban and rural areas, respectively. Differences were also observed between those villages with primary health care, 125 and 79 per 1000 live births, for U5MR and IMR, respectively, compared with 148 and 88 per 1000 live births in those without. Colour coded MDG difference rankings indicating relative progress in reducing U5MR and IMR are shown in Figure 33 and Figure 34.

Table 16: Under Five Mortality (per 1000 Live Births) by LGA

Year/Study	BCC	KMC	WD	LRD	NBD	CRD	URD	The Gambia
1993 Census	91	100	134	169	137	137	158	135
2001 Study	98	98	154	154	154	154	154	135
National Target 2001	102	102	102	102	102	102	102	102
MDG Difference	4	4	-52	-52	-52	-52	-52	-52
2015 MDG Target	45	45	45	102	45	45	45	45
MDG Rank	1	1	3	3	3	3	3	

Figure 33: MDG Difference Ranking for Under Five Mortality

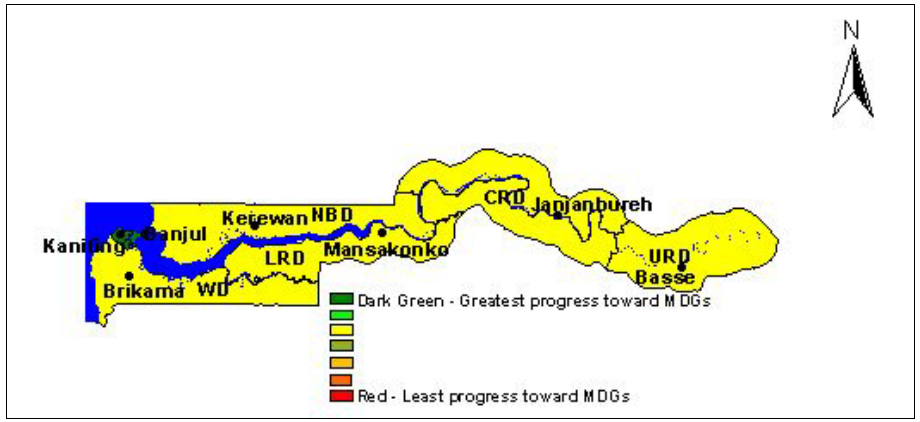
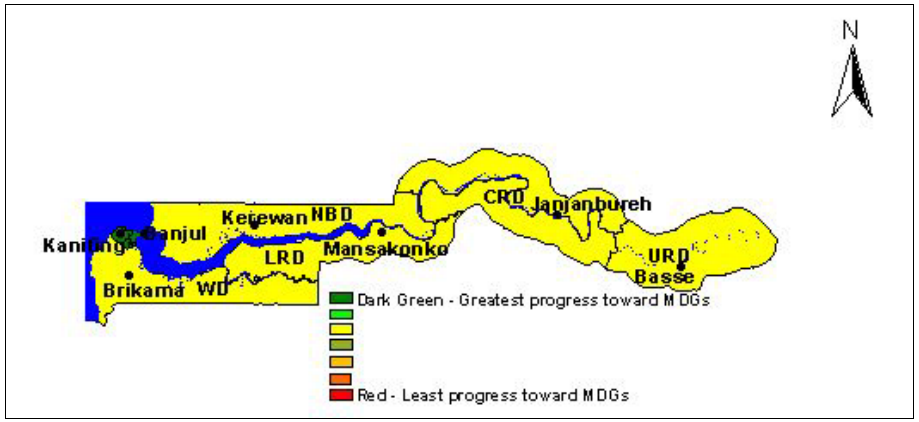


Table 17: Infant Mortality (per 1000 Live Births) by LGA

Year/Study	BCC	KMC	WD	LRD	NBD	CRD	URD	The Gambia
1993 Census	59	64	84	103	85	85	97	84
2001 Study	64	64	95	95	95	95	95	84
National Target 2001	64	64	64	64	64	64	64	64
MDG Difference	0	0	-31	-31	-31	-31	-31	-31
MDG Target 2015	28	28	28	28	28	28	28	28
MDG Rank	1	1	3	3	3	3	3	

Figure 34: MDG Difference Ranking for Infant Mortality



The Gambia's EPI programme is one of the success stories of the public health sector and was a major contributory factor in the steep decline in infant and under-five mortality. The country's drive to meet the 1990 goal of Universal Childhood Immunisation (UCI) employed extensive social mobilisation and health education campaigns to raise awareness of the importance of immunisation. Measles immunisation coverage exceeded 80% by 1990, and continues to be maintained at around 90% in most areas.

Figure 35: Measles Immunisation Ranking

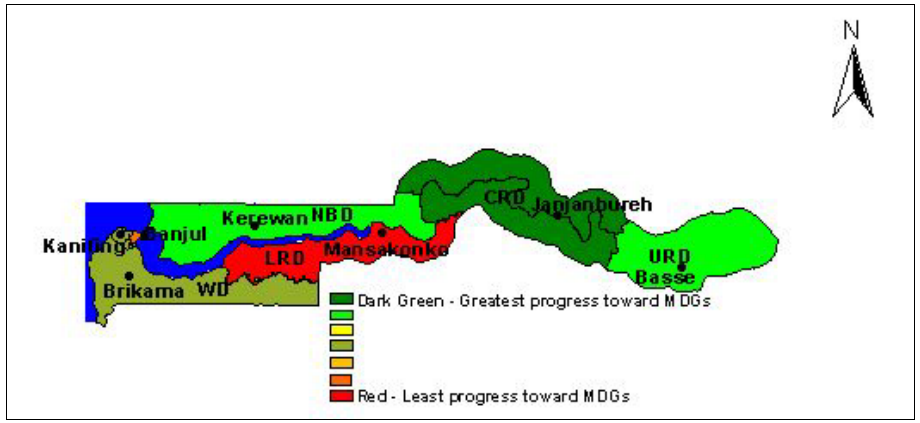


Table 18: Percentage of One-Year-Olds Immunised Against Measles

Year	BJL	KM	WD	LRD	NBD	CRD	URD	The Gambia
1990	84			89		93	83	89
1992	85			86		90	92	83
1993	85	86		77	86	93	89	87
1994	87	83		93	92	92	92	89
1995	92	91		94	92	91	87	91
1996	91	92		95	95	95	97	94
2000	83	87	89	81	87	91	87	88
2001	86	86		90	92	93	89	89
2002	90	91		89	96	97	96	93
MDG Rank	6	4	4	7	2	1	2	

Source: EPI surveys; except for 2000: MISC survey.

In spite of this high immunisation coverage, however, there are still sporadic outbreaks of measles, especially among those children less than nine months and in much older children. In 2003, The Gambia developed a National Measles Elimination Plan. The national objective is to reduce measles morbidity by 90% and measles mortality by 95%. Four main strategies are being used to reduce measles morbidity and mortality. These are:

- Improving the coverage and quality of routine immunisation services;
- Ensuring a second opportunity for measles immunisation – which is being conducted in the form of a National Measles Immunisation Campaign;
- Establishing an effective surveillance system for measles; and
- Improving case management, including Vitamin A supplementation.

A National Measles Immunisation Campaign was organised in December 2003 for children between the ages of nine months and fifteen years. A national coverage of 93% was achieved, with a minimum of 83% in WD, including Banjul, Kanifing Municipality, the Kombos and Fonis.

Challenges

There has been a serious setback in the prospects of meeting the MDG target of reducing under-five mortality by two-third by 2015. Although it is recognised that over 60% of all infant and under-five deaths are attributable to malaria, diarrhoeal diseases and acute respiratory tract infections, which are all underpinned by malnutrition, health programmes and interventions in the 1990s seem to have had little or no impact in reducing the U5MR or IMR. If significant improvements are not achieved soon, it seems highly unlikely that the 2015 target will be met. The challenges, therefore, are for a greater investment in the public health sector by government and its partners to ensure the following:

- Delivery of a quality health service;
- Revitalization of the Bamako Initiative (BI) and the PHC approach;
- Expansion of the Integrated Management of Childhood Illnesses (IMCI) programme;
- Addressing the chronic shortage of quality human resources; and
- Continuous and adequate supplies of essential drugs and equipment in the public health sector.

Policy Environment

In spite of these challenges, there is a fairly strong policy environment for reducing infant and under-five mortality, including:

- Provision of a virtually free child health services[9] for those under five at all government health centres and outreach clinics;
- Continuous expansion of MCH/EPI outreach services;
- Adoption of the IMCI strategy;
- Recent financial support secured from the Global Alliance on Vaccines and Immunisation (GAVI) to the EPI programme, and the Global Fund for HIV/AIDS and Malaria; and
- Availability of medical doctors in many of the key PHC Villages.

Priorities for Development Co-operation

Since over 60% of infant and child mortality are caused by malaria, diarrhoea, acute respiratory tract infections and malnutrition, priority should be given to combating these conditions. Government should work closely with all development partners, including NGOs and the private sector, towards the following objectives:

- Implement policies and strategies to reduce morbidity and mortality from malaria, diarrhoea, acute respiratory tract infections and malnutrition;
- Train and retain qualified personnel;
- Maintain existing high level of immunisation coverage;
- Ensure adequate supplies of essential drugs, promotion of insecticide treated nets (ITNs);
- Promote Baby-Friendly Community Initiative (BFCI);
- Strengthen and expand Primary Health Care; and
- Reinvigorate Bamako Initiative under the wider context of health financing.

[9] There is an initial registration fee of GMD5.00 (approx. 16 US cents) at first visit. Thereafter the child gets free services until the age of five.

GOAL 5: IMPROVING MATERNAL HEALTH

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio

Indicators: maternal mortality ratio; and proportion of births attended by skilled health personnel.

National Status and Trends

Available data indicates that maternal mortality, though still unacceptably high, is on the decline in The Gambia. The most recent estimate, derived from the National Survey on Maternal, Perinatal, Neonatal and Infant Mortality and Contraceptive Prevalence in 2001, is 730 maternal deaths per 100,000 live births, which indicates a 30% reduction since 1990 and a 75% decrease since 1983 (Table 19 and Figure 36).

Different methods were used in the 1990 and 2001 studies, but the decline nevertheless is consistent with the previous trend and appears to be genuine, although anecdotal evidence from two of the country's rural hospitals indicates otherwise.

Table 19: Summary of Maternal Health Indicators

Indicator		1983	1990	2000	2001
Maternal mortality ratio (per 100,000 live births)	National Trend	3,000[a]	1,050[b]	NA	730[c]
	MDG Target	-	-	735	704
Percentage of births attended by skilled health personnel	National Trend	NA	44 [d]	52[e]	53[c]
	MDG Target	-	-	-	-

Sources: [a] *1983 National Housing and Population Census.*
[b] *Report of the 1990 Maternal Mortality Survey.*
[c] *Report on the National Survey on Maternal, Perinatal, Neonatal and Infant Mortality and Contraceptive Prevalence 2001.*
[d] *1990 Gambia Contraceptive Prevalence and Fertility Determinants Survey (GCPFDS).*
[e] *2000 Multiple Indicator Cluster Survey (MICS2).*

Figure 36: Trend in Maternal Mortality

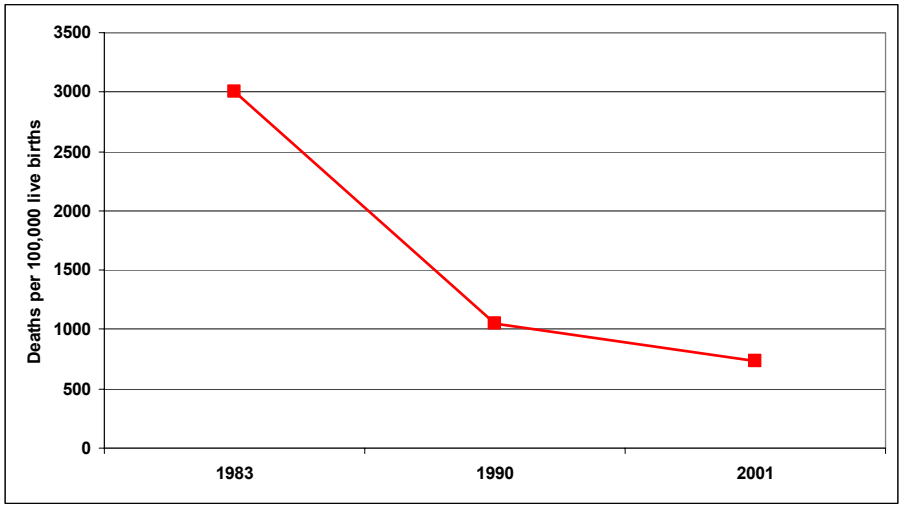
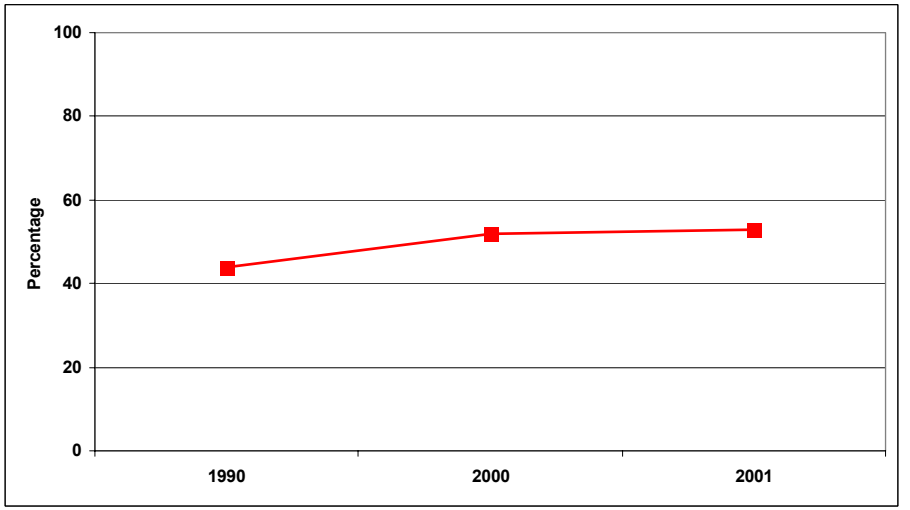


Figure 37: Proportion of Births Attended by Skilled Health Personnel



Data on births attended by skilled health personnel indicate only a modest increase from 44% to 53% (Table 19 and Figure 37). Skilled health personnel, in this context, refers to nurse midwives and doctors. Traditional Birth Attendants (TBAs) are not included in this category, although they perform up to two-thirds of deliveries in villages.

The prevalence of modern contraceptive use amongst currently married women almost doubled from 7% in 1990 to 13% in 2001 but is still very low.

Local Variation

There is evidence of significant disparities in maternal mortality between urban and areas. Detailed data on maternal mortality by LGA is not currently available. The National Survey on Maternal, Perinatal, Neonatal and Infant Mortality and Contraceptive Prevalence in 2001 gave an urban MMR of 495 per 100,000 live births, and an overall national MMR of 730 per 100,000 live births, as shown in Table 20, in which the urban MMR has been used for BCC and KMC and the national MMR has been used for the provincial LGAs. Comparison with the national MDG target for 2001 indicates that BCC and KMC are well ahead of target, and that provincial LGAs are behind target. A colour-coded MDG difference ranking of progress in reducing maternal mortality is shown in Figure 38.

The proportion of deliveries attended by nurse midwives and doctors is lowest in CRD, URD and LRD (Table 21 and Figure 39). These Divisions are the remotest in the country and are unappealing to most health professionals, who would not want to be deployed to remote, isolated posts. Under these circumstances the roles of the Traditional Birth Attendant (TBAs) need to be re-visited. TBAs are trained village midwives and conduct up to 60% of deliveries in their communities. They play an important role in improving maternal health services and the referral system, as evidenced in the 1990 MM study.

According to the 2001 study: 50% of the maternal deaths occurred when a woman was being cared for by her relatives; 31% when she was being cared for by a doctor; and 14% when she was being cared for by a nurse. The reasons for the very high number of maternal deaths during care by skilled personnel have not been fully established. An audit of the causes of maternal death would provide a sound basis for developing strategies to reduce maternal mortality.

Table 20: Maternal Mortality (per 100,000 Live Births) by LGA

Year	BCC	KMC	WD	LRD	NBD	CRD	URD	The Gambia
1990 MM Study	600	600	1080	820	820	1360	1360	1050
2001 Study	495	495	730	730	730	730	730	730
National MDG Target 2001	704	704	704	704	704	704	704	704
LGA Target 2001	402	402	724	549	549	911	911	704
MDG Difference	209	209	-26	-26	-26	-26	-26	-26
MDG Target 2015	150	150	270	205	205	340	340	263
MDG Rank	1	1	3	3	3	3	3	

Note: The 1990 Maternal Mortality Study provides information on MM by Health Region (Western, Central and Eastern); and by urban/rural and PHC/non-PHC settlements. LGA estimates are based on regional MMRs.

Figure 38: MDG Difference Ranking for Maternal Mortality

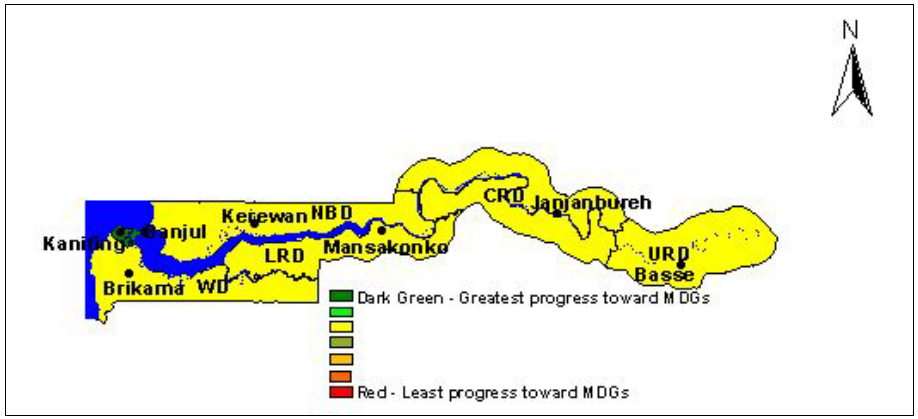
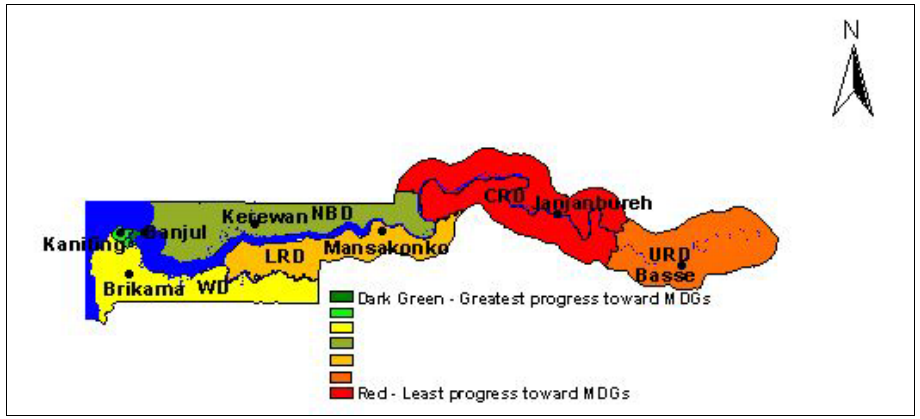


Table 21: Percentage of Births Attended by Skilled Health Personnel

Year	BCC	KMC	WD	LRD	NBD	CRD	URD	The Gambia
1990 GCPFDS	83	83	35	32	32	26	26	44
2000 MICS	83	82	55	44	46	31[a]	27	52
2001 NSMPNIMCP	92	88	57	38	47	30[a]	33	53
Rank	1	2	3	5	4	7	6	

[a] Weighted average of Janjanbureh and Kuntaur LGAs.

Figure 39: Proportion of Births Attended by Skilled Personnel Ranking



Challenges

The MDG of reducing MMR by two-thirds to 350 per 100,000 live births by 2015 is achievable, provided various challenges are overcome:

- Ensuring availability of adequately and appropriately trained staff, especially nurses and midwives, and stemming the high attrition rate among nurses;
- Ensuring timely antenatal referral;
- Inadequate financial and logistical support;
- Improving emergency obstetric care and services;
- Ensuring that major health centres are fully operational; and
- Ensuring availability of essential drugs and basic equipment.

Policy Environment

There is a strong policy environment for the continued decline in maternal mortality. Key contributory factors include:

- The renaming and restructuring of the Maternal and Child Health (MCH) Unit created in 1975 as the Reproductive and Child Health (RCH) Unit;
- The development of the first National Reproductive Health Policy in 2001, which is expected to provide direction for the implementation of an effective reproductive health (RH) service;
- The signing of Technical Corporation agreements with the Governments of Cuba, Egypt, Nigeria and Taiwan for the provision of human and financial resources for the health sector;
- The construction of Reproductive Health Clinics in major health centres; and
- Continuous expansion of MCH/EPI outreach services.

Priorities for Development Co-operation

The greatest threats to The Gambia's maternal health services, including obstetrical services, are the attrition and acute shortage of trained nurses and other qualified health practitioners; and the lack of necessary facilities at major health centres to provide either basic, or comprehensive, emergency obstetric care. Development co-operation priorities should focus on:

- Addressing these constraints by investing in human resource development and retention schemes, especially for nurse midwives, anaesthetists and trained laboratory staff;
- Supporting the provision of regular and constant medical supplies of drugs, and essential equipment;
- Strengthening the laboratory services at hospitals and major health centres;
- Improving the referral system;
- Revitalisation and continuity of TBA training and re-training programmes.

GOAL 6: COMBATING HIV/AIDS, MALARIA AND OTHER DISEASES

Target 7: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

Indicators: HIV prevalence among 15-24 year old pregnant women; condom use at last high-risk sex; percentage of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS; and ratio of school attendance of orphans to school attendance of non-orphans aged 10-14

National Status and Trends

The first case of HIV/AIDS was diagnosed in The Gambia in May 1986. A nationwide survey of 30,000 pregnant women in 1993-95 revealed prevalence rates of 0.6% for HIV-1 and 1.1% for HIV-2. The first generation of sentinel surveillance began in 2000-01 with a baseline survey in the catchments of four health centres: Serrekunda, Sibanor, Farafenni and Basse, which gave prevalences of 1.2% HIV-1 and 0.9% HIV-2.

Latest reports indicate that, cumulatively, over 3,000 cases have been confirmed and 1,400 died of the disease. There has been a steep rise in HIV-1, the main virus now driving the epidemic amongst 15 to 49 year old pregnant women, from 0.6% in 1993/5 to 2.1% in 2004, according to preliminary reports from the 2004 HIV/AIDS sentinel surveillance, as shown in Figure 40 and Table 22, although the latter figure still needs to be validated. The prevalence of HIV-2 seems to be on the decline.

The proportion of people with HIV/AIDS increases with age, as shown in Figure 41. Social stigma and discrimination against those with HIV/AIDS constrains prevention and control efforts.

Local Variation

Collection, analysis and interpretation of HIV/AIDS data is a complex and time-consuming process. Reliable data is only available from the six sentinel surveillance sites, which do not include Banjul, LRD and CRD-South. Preliminary analysis of 2004 data indicates that HIV-1 prevalence amongst 15 to 49 year old pregnant women has increased sharply at most sites, as shown in Table 23, reaching 2.8% in Sibanor and Basse.

Figure 40: HIV1 and HIV2 Prevalences in Pregnant Women 15-49 Years

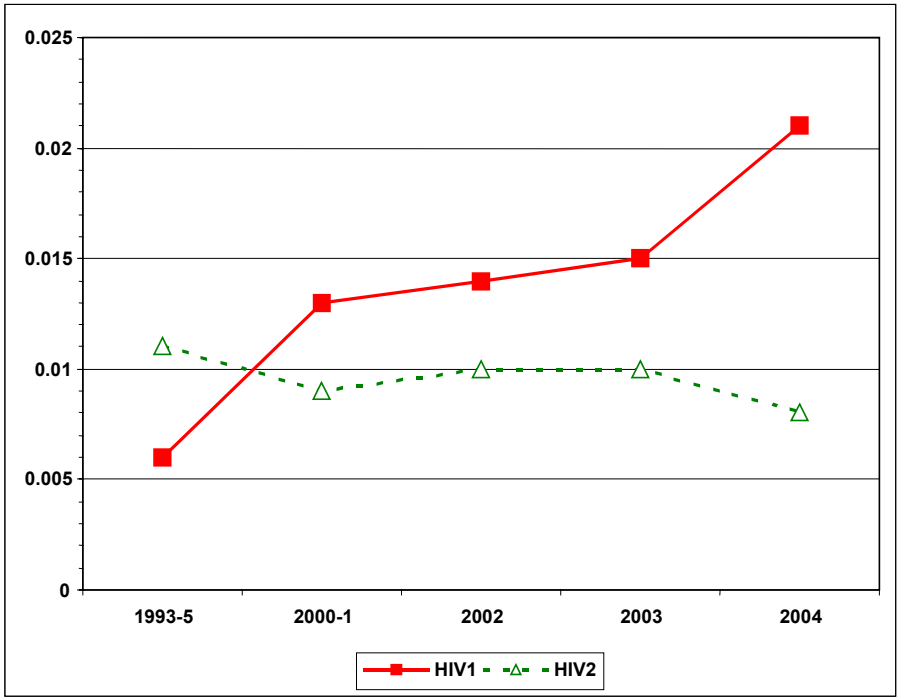


Table 22: Summary of HIV/AIDS Indicators

Indicator	1993-5	2000/1	2002	2003	2004
HIV-1 prevalence (%) among 15-49 year old pregnant women*	0.6	1.2	1.4	1.5	2.1
HIV-2 prevalence (%) among 15-49 year old pregnant women*	1.1	0.9	1.0	1.0	0.8
Condom use at last high-risk sex (among 15-24 year olds)**	NA	NA	62	NA	NA
Percentage of population aged 15-24 with comprehensive correct knowledge of HIV/AIDS**	NA	NA	37	NA	NA

*Sources: * Sentinel surveillance data; ** The Gambia 2002 Behavioural Surveillance Survey (BSS) on HIV/AIDS.*

Figure 41: HIV/AIDS Prevalence (%) by Age Group: 2000-2003

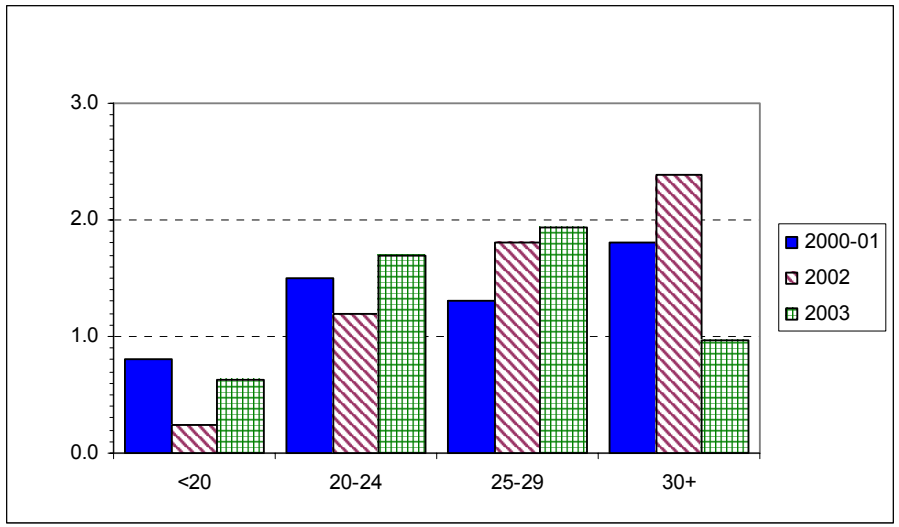


Table 23: HIV-1 Prevalence (%) in Pregnant Women by Sentinel Site

Year	Serre Kunda	Brikama	Sibanor	Farafenni	Kuntaur	Basse
1993-1995*	0.7	0.1	0.6	0.3	NA	1.0
2000-1 SSD**	1.0	NA	3.0	0.4	NA	1.4
2002 SSD**	0.2	2.4	3.4	0.0	0.6	0.3
2003 SSD**	2.4	0.8	2.8	0.7	1.2	0.8
2004 SSD**	2.2	2.0	2.8	1.8	1.0	2.8

** 1993-95 Gambia Government/MRC Antenatal Study.*
*** Source: Sentinel surveillance data.*

Knowledge about HIV/AIDS prevention and control was generally poor amongst respondents from sentinel sites, with Sibanor having the highest level (52%) and Basse the lowest (25%).

Condom usage at last high-risk sexual encounter was greatest at Serre Kunda (74%) and Sibanor (72%); and lowest at Brikama (48%).

Table 24: Condom Use and HIV/AIDS Knowledge in 15-24 Year-Olds

Indicator	Serre Kunda	Brikama	Sibanor	Farafenni	Kuntaur	Basse
% aged 15-24 with comprehensive correct knowledge	40	32	52	43	31	25
% of respondents using condoms at last high-risk sex	74	48	72	56	57	56

Source: The Gambia 2002 Behavioural Surveillance Survey on HIV/AIDS.

Challenges

Despite strenuous efforts to raise awareness and control the pandemic, the prospects of meeting the 2015 MDG target of halting and reversing the spread of HIV/AIDS in The Gambia appear very daunting. Several major challenges must be overcome to reinforce the fight against HIV/AIDS:

- Severe poverty leading to high-risk behaviour, especially amongst some women and girls, making them more vulnerable to HIV/AIDS;
- Need to obtain more reliable data on behavioural characteristics of high-risk groups, such as sex workers, uniformed services and truck drivers;
- Ensure that all health centres have the capacity to promote Voluntary Counselling and Testing (VCT), as a conduit to promote lasting behavioural change;
- Making Anti Retro-Viral (ARV) drugs available and accessible to People Living with HIV/AIDS (PLWHAs) who need them and creating support systems to maintain their provision;
- Ensure availability of drugs for opportunistic infections and proper nutrition for PLWHAs;
- Support health centres to implement home-based care;
- Create support and mitigation services and their availability and accessibility to individuals infected and affected by HIV/AIDS, including children and orphans;
- Continuity of aggressive and targeted HIV/AIDS awareness campaigns;
- Monitoring of patients on ARVs by health services; and
- Increased Government funding to fight HIV/AIDS, especially when HIV/AIDS Rapid Response Project (HARRP) and Global Fund financing ends.

Policy Environment

A very strong policy environment exists to combat HIV/AIDS, manifested by:

- Development of a national HIV/AIDS policy;
- Strong political leadership and support in the fight against HIV/AIDS, leading to the establishment of a National AIDS Council (NAC) chaired by the President; and a National AIDS Secretariat (NAS) under the Office of The President;
- Implementation of a World Bank funded HIV/AIDS Rapid Response Project (HARRP), currently being co-ordinated by NAS;
- Major interventions to increase awareness and knowledge, as well as the establishment of home-based care, PLWHA support groups, provision of Voluntary Counselling and Testing (VCT) services and prevention of maternal to child transmission of HIV/AIDS;
- Anti Retro-Viral (ARV) drugs are being introduced; and
- Additional funding is being secured from the Global Fund to fight AIDS and malaria.

Priorities for Development Co-operation

Priorities activities for support include:

- Setting up Voluntary Counselling Testing services in all major health centres;
- Ensuring the continuous availability of ARVs and drugs for opportunist infections for all PLWHAs;
- Increasing the number of sentinel sites to ensure a truly national coverage;
- Strengthening national efforts to sensitise all sectors of society;
- Scaling up prevention of Parent to Child Transmission (PTCT) services countrywide; and
- Promoting income generation for PLWHAs and high risk groups.

Target 8: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Malaria Indicators: prevalence and death rates associated with malaria; and proportion of population in malaria risk areas using effective malaria prevention and treatment measures

National Status and Trends

Malaria is the leading cause of morbidity and mortality in The Gambia, and is estimated to account for 40% of deaths in infants and a quarter of deaths in children aged five years and under. It is the most common disease treated in hospitals and health centres. Using fever as a proxy indicator of malaria, incidence of the disease does not appear to be declining, especially amongst infants, with 1.7 cases per child in 1999; nationally, and, according to a multi-indicator cluster survey (GOTG/UNICEF, 2000), 15% of under-fives had experienced fever within the previous two weeks.

Local Variation

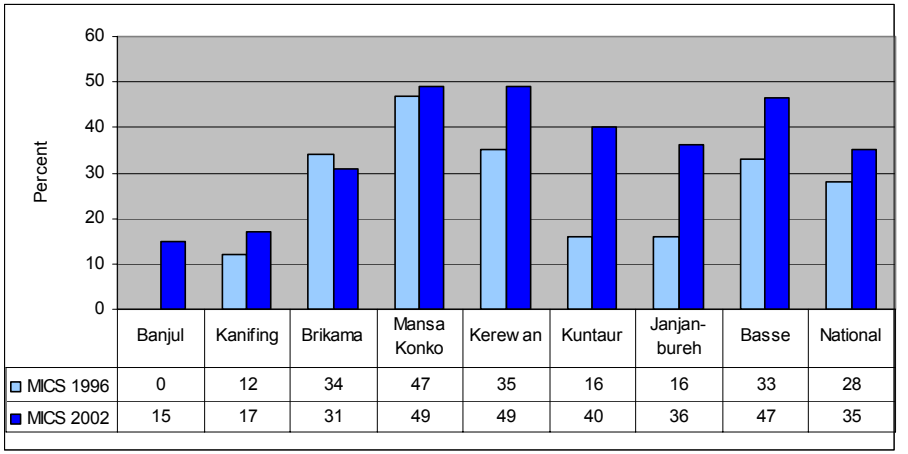
Fever incidence and disease control measures vary with location, as shown in Table 25. The proportion of under-fives who had had fever in the two weeks prior to survey was lowest in Banjul and Basse (7%) and highest in Brikama (21%) and Mansa Konko (19%).

Table 25: Malaria Treatment and Control for Under-Fives by LGA

Location	Fever in Previous 2 weeks %	Received Anti-Malarial Drugs %	Slept Under ITN %
Banjul	7.3	68.6	14.9
Kanifing	15.1	68.5	17.1
Brikama	21.1	57.9	30.8
Mansa Konko	19.1	40.6	49.1
Kerewan	14.1	40.6	49.0
Kuntaur	12.5	45.8	40.1
Janjanbureh	13.7	58.0	36.1
Basse	6.7	48.4	46.5
The Gambia	14.8	56.0	35.1

Source: GOTG/UNICEF (2000).

Figure 42: Percentage of Under-Fives Sleeping under ITNs



Source: GOTG/UNICEF (2000).

Use of anti-malarial drug treatment was highest in urban areas; whilst insecticide treated nets (ITNs) were most frequently used in rural areas Use of ITNs has increased in all areas, except Brikama, as indicated in Figure 42.

Challenges

The incidence of malaria can be reduced, but will require concerted action by all stakeholders. Major challenges to be overcome include:

- Improving environmental sanitation, especially drainage infrastructure;
- Increasing the utilization of ITNs;
- Ensuring regular supply and availability of anti-malarial drugs; and
- Increasing resistance to first line malaria drugs.

Policy Environment

There is strong political commitment to control malaria in The Gambia and a good supportive policy environment. A national policy and strategic plan to control malaria has been developed. Periodic "set-settal" ("Operation Clean the Nation") are mounted with active participation of the President.
The Gambia is participating in the World Health Organisation's (WHO) Roll Back Malaria programme. Funding has been secured from the Global Fund to fight Malaria, TB and HIV/AIDS. The British Medical Research Council

(MRC) has a facility in The Gambia with a strong focus on malaria. The Gates Foundation is supporting the Centre for Innovation Against Malaria (CIAM). The United Nations Children's Fund (UNICEF) is supporting the Accelerated Child Survival and Development (ACSD) project in LRD and CRD. The Government of Cuba is providing technical assistance in the fight against malaria and vector control activities.

Priorities for Development Co-operation

Priorities for development co-operation should focus on meeting the challenges identified earlier and strengthening health facilities in diagnosing and proper management of malaria cases.

Tuberculosis Indicators: Prevalence and death rates associated with tuberculosis; and proportion of tuberculosis cases detected and cured under direct observation treatment short-course (DOTS)

National Status and Trends

The Gambian tuberculosis (TB) control programme has used the Directly Observed Treatment Short-course (DOTS) strategy since 1985 and has achieved countrywide coverage through the Primary Health Care (PHC) programme, including community DOTS implemented by Village Health Workers (VHWs), with the financial and technical support of the Royal Netherlands Tuberculosis Association (KNCV). The programme includes the provision of diagnostic treatment services, provision of free drugs, registration and monitoring, supervision of services and continuing education of all health staff. These strategies are public oriented, vertically structured and had been largely donor driven.

The national incidence and prevalence of TB in The Gambia are unknown because there have been no comprehensive studies or tuberculin surveys conducted in conformity with WHO protocols. Nevertheless, data are routinely collected at specialised TB clinics and by NGO and private sector clinics. From this data, it is clear that the number of reported cases of tuberculosis has more than doubled over the past decade, from 900 in 1994 to 2,000 in 2003 (Figure 43). This increase is attributed both to improved surveillance and increased incidence as a secondary infection associated with the HIV-1.

Figure 43: TB Notification Rates in The Gambia

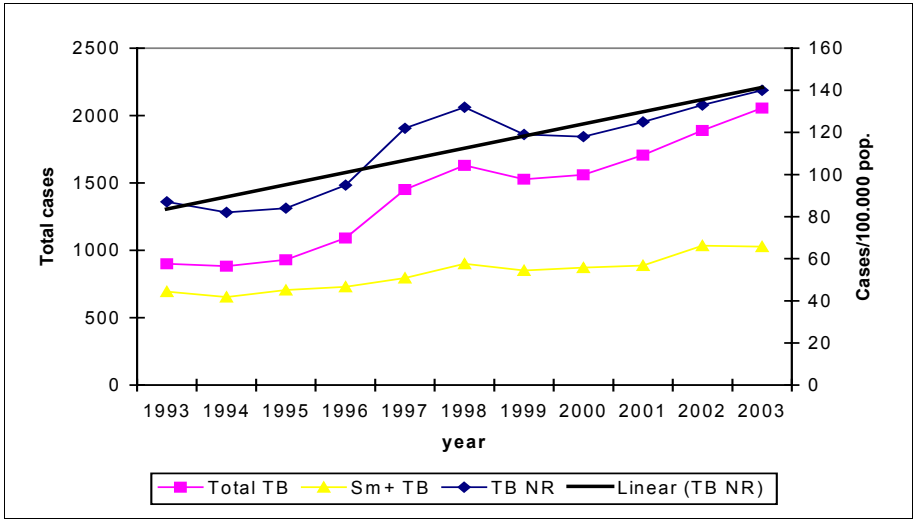


Figure adopted from: 1999-2003 Tripartite Agreement between the Gambia National Leprosy and Tuberculosis Control Programme, NSL and KNCV. End of evaluation report. 20–26th October 2003. KIT Royal Tropical Institute.

The epidemiology of the disease in The Gambia is influenced by urbanisation, HIV infection and the age and sex distribution in the population.

Urban TB

TB is concentrated around the urban areas in the western, most populated part of the country. Eighty percent of the 1,890 reported cases in 2002 came from Sere Kunda, RVH and Brikama health centres, with almost half (900) coming from Sere Kunda.

TB and HIV

There are no data on the impact of HIV on TB. However, TB patients have been tested for HIV in a few studies by the British Medical Research Council (MRC). The HIV prevalence of these highly selective groups of patients varied from 8-30%. The majority of TB in-patients at the Royal Victoria Teaching Hospital (RVTH) medical wards are tested for HIV and it is estimated that up to 50% of them are HIV positive.

Age and Sex Distribution

An age and sex analysis of 1,037 smear positive cases of TB in 2002 showed that twice as many males were HIV positive than females in all age groups and that incidence increased with age until the mid twenties and then declined.

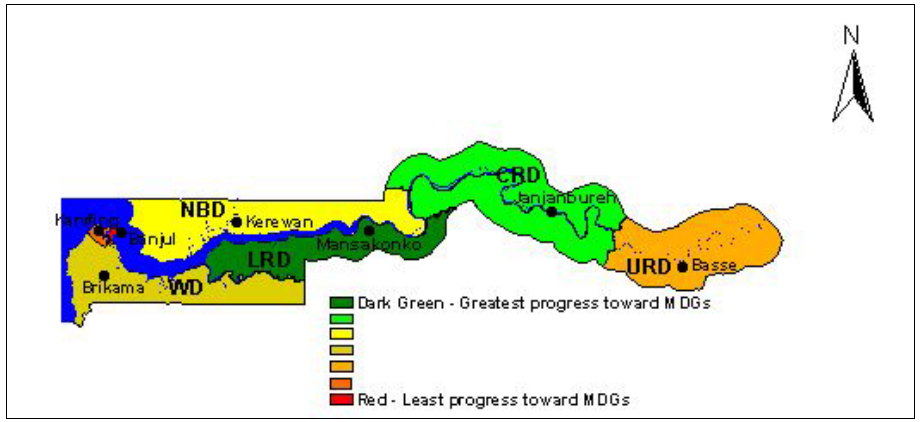
Local Variation

Urban areas of Banjul and Kanifing have by far the highest incidence of TB, well above the national average, as shown in Table 26 and Figure 44. With increasing urbanisation and the spread of HIV/AIDS, the incidence of TB in urban areas seems set to rise further. TB control personnel are currently limited to the major health centres and a few minor health centres.

Table 26: Tuberculosis Cases per 100,000

Year	Banjul	KM	WD	LRD	NBD	CRD	URD	The Gambia
1993	203	177	66	60	45	54	30	87
1999	201	114	32	32	59	33	23	119
2003	695	288	83	51	78	75	90	145
Rank	**7**	**6**	**4**	**1**	**3**	**2**	**5**	

Figure 44: Tuberculosis Cases per 100,000 Ranking



Challenges

Although DOTS coverage is high, the TB control programme still requires further strengthening. To reach the objectives of the DOTS expansion plan to detect 70% of cases and achieve an 85% cure rate, which are in line with the Global Stop TB Initiative, extra effort and inputs are required, including additional activities and additional financial resources for control operations. TB services need to be expanded in urban areas to cover all public health facilities and to follow up all smear-positive cases to ensure compliance with the DOTS treatment regime. The main problems are: case finding; late diagnosis; high defaulter rate; unsatisfactory treatment, reporting and recording; and insufficient human resources, in terms of capacity and number. Government support for human capacity and infrastructure is essential to sustain the TB control programme.

Policy Environment

Although a National Tuberculosis Committee, responsible for disease control policy and strategy development, has been established, the policy environment remains weak. A tuberculosis policy has yet to be formulated, donor support is dwindling and government funding is limited.

Priorities for Development Co-operation

Priority activities for the control of TB in The Gambia include:

- Development of a policy on TB;
- Advocacy to secure support for the national TB control efforts
- Training of TB control personnel;
- Provision of logistical support;
- Identification of infectious cases;
- Prevention of TB in children and people living with HIV/AIDS;
- Improvement in contact tracing on a wider scale;
- Supporting patients through directly observed treatment;
- Timely detection and quality treatment of cases;
- Control of drug resistance; and
- Systematic monitoring of performance in case management and strengthening the health system.

GOAL 7: ENSURE ENVIRONMENTAL SUSTAINABILITY

Target 9: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Indicators: proportion of land area covered by forest; and ratio of area protected to maintain biological diversity

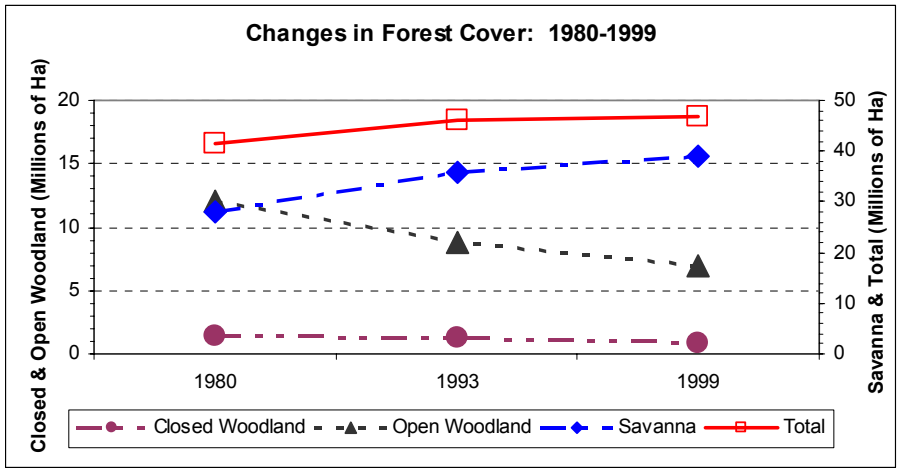
National Status and Trends

Natural vegetation in The Gambia is of the Guinea Savanna woodland type, which changes progressively into a more open Sudan Savanna vegetation towards the east (NEA, 1997). Although the country was endowed with extensive dense forests before Independence, a combination of population growth and increasing demand for agricultural land has resulted in extensive deforestation. Illegal extraction of timber and fuel wood has also contributed to the process. Consequently, the area of closed woodland has almost halved from 1.5 million ha in 1980 to 0.8 million ha in 1999, as indicated in Figure 45. Similarly, the area of open woodland declined from 12.09 million ha in 1980 to 7 million ha in 1999. Conversely, open Savanna vegetation has increased from 28 million ha in 1980 to 39.1 million ha in 1999.

Total woodland and savanna cover increased from 41.6 million ha in 1980, to 46.9 million ha in 1999, which was associated with declining groundnut production and increased community forestry (Sillah, 1999). It must be pointed out, however, that the increase in total forest cover was also accompanied by other changes, such as less dense forests, lower growth, undesirable grass species, and reduced species diversity.

Another important aspect in the expansion of forest area has been the formulation and implementation of various forest policy instruments and management plans. In particular, The Gambia Forest Management Concept (GFMC), Forest Policy (1995-2005) and the Forest Act (1998), which have helped halt and even reverse the decline of forest cover in some areas. Thus, a 3% degradation in forest cover in 1994 has been turned into a 1% increase within a decade (DOSFNRE, 2004).

Figure 45: Changes in Forest Cover in The Gambia: 1980-1999



Source: Forest cover data calculated from Sillah (1999).

The Gambia supports a rich diversity of plant and animal species. Wildlife/Biodiversity Policy aims to increase the extent of protection from 4.09% to 5% of the total land area by 2005. The Department of Parks and Wildlife Management (DPWM) manages seven protected areas in the country, and is co-operating with its counterpart institution in Senegal to manage the trans-border Sine Saloum Delta/Niumi National Park. These efforts, in conjunction with those of the Forestry Department, will help to maintain or increase forest cover and biological diversity in The Gambia.

Local Variation

There is considerable regional variation in the extent of forest land in The Gambia, as shown in Table 27 and Figure 46, the great majority of which is not managed or protected. CRD has the most forest, with 154,600ha, and NBD the least, with only 41,200ha. WD and CRD have the most community forests, with 6,203ha and 5,924ha, respectively, whilst NBD has the least, with only 230ha (Sillah, 1999).

Aerial photographic surveys were flown in 1999 and 2001 for different agencies and have been digitised into geographic information systems (GIS). Unfortunately, however, it has not been possible to obtain disaggregated information about how forest cover has changed over time in LGAs.

Table 27: Extent of Controlled and Un-Controlled Forests

LGA	Forested Land* (ha)	Controlled Management (ha)					No Management/Protection (ha)			
		Forest Parks	Community Forests	Private Forest	Total		Forest Parks	Forest Reserves	Total	
					ha	%			ha	%
WD	73,300	3,355	6,203	100	9,658	13.2	512	63,130	63,642	86.8
LRD	66,500	1,758	3,465	0	5,223	7.9	4,431	56,846	61,277	92.1
CRD	154,600	7,233	5,924	0	13,157	8.5	10,412	131,031	141,443	91.5
URD	113,200	858	1.565	0	2,423	2.1	2,178	108,599	11.,777	97.9
NBD	41,200	0	230	0	230	0.6	3,290	37,680	40,970	99.4
TOTAL	**448,80**	**13,204**	**17,387**	**100**	**30,691**	**6.8**	**20,823**	**397,286**	**418,109**	**93.2**

Source: Sillah (1999); * Excluding forested national parks/reserves and mangrove forests.

Challenges

Despite the great strides that have been made in forest conservation, increasing forest cover and management of protected areas in recent years, a variety of major challenges remain, including:

- Lack of political recognition of the importance of conserving natural resources;
- Overcoming attitudinal problems that still plague efforts to protect forest resources and ensure sound management;
- Limited human resource capacity and need for institutional strengthening;
- Management of land use conflicts, and finding an acceptable balance between agriculture and environmental and wildlife conservation;
- Controlling unauthorised use of forest resources;
- Controlling/preventing bush fires; and
- Advocacy for the conservation and sustainable use of natural resources and the prevention of bushfires. Senior political leaders (e.g. National Assembly members) should be encouraged to promote the benefits of conservation and bushfire prevention amongst their supporters and constituents.

Policy Environment

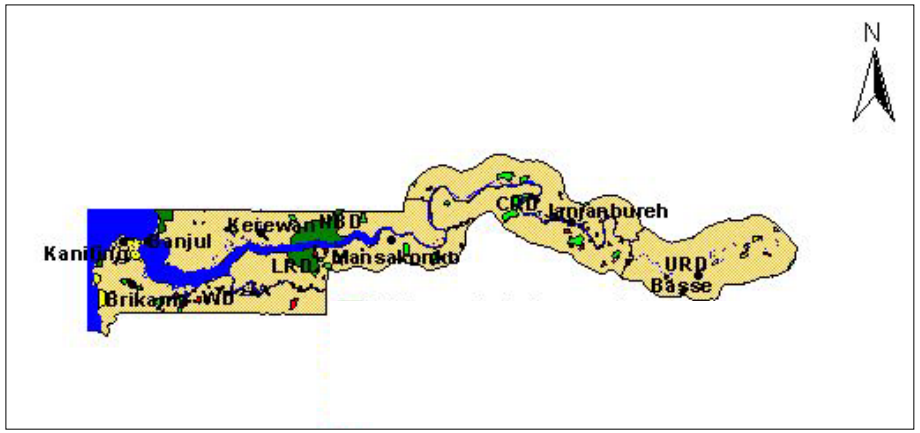
The Gambia has long been committed to environmental protection and biodiversity conservation, as demonstrated by various policies, laws and institutions responsible for environmental management.

The Abuko Nature Reserve was delineated as a water catchment area as far back as 1916 and given reserve status in 1968. The Department of Wildlife, now the Department of Parks and Wildlife Management (DPWM), was also established in 1968, and the Banjul Declaration on Wildlife Conservation was made in 1977.

The Gambia Environmental Action Plan (GEAP), which prioritised environmental concerns and requirements, was adopted in 1992. The National Environment Agency (NEA) was established in 1993 to liaise with all stakeholders and co-ordinate implementation of the GEAP.

National Forest Policy (1995-2005) was formulated and the Forest Bill (1998) was passed. Key objectives of Forest Policy were to maintain at least 30% of the total land area under forest cover and to bring at least 75% of that area under management. A National Forestry Action Plan (2000-2010) was prepared to achieve these objectives.

Figure 46: Forest Parks, Community Forests and State Parks



A National Biodiversity Strategy and Action Plan (NBSAP) was drawn up in 1998/1999 to promote the conservation and sustainable use of biodiversity in The Gambia. Current policy aims to increase the extent of protection from 4.09% to 5% of total land area by 2005. The 1977 Wildlife Act has been reviewed and the Wildlife/Biodiversity Bill was enacted in 2003.

Thus, the policy environment is conducive to achieving the MDG of ensuring environmental sustainability in The Gambia. Although various policies still need to be updated and fully implemented, a framework exists for integrating the principles of sustainable development into country policies and programmes and reversing the loss of environmental resources.

Priorities for Development Co-operation

Key areas for development co-operation in environmental sustainability are:

- Technical support for review and revision of forest policy;
- Renewal and extension of the participatory forest management project, when current German government assistance ends in 2005;
- Formulation and implementation of comprehensive integrated management programme for the north bank of the Gambia River;
- Formulation and implementation of a mangrove ecosystem conservation and management plan; and
- Capacity building and institutional strengthening.

Target 10: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation

Indicator: proportion of urban and rural population with sustainable access to an improved water source

National Status and Trends

Access to improved water sources has greatly improved in The Gambia over the past two decades. With an estimated 16% of the population not having access to safe drinking water in 2000, compared with 31% in 1996, the country has almost reached its national MDG target of halving this proportion by 2015, as shown in Table 28 and Figure 47. This remarkable achievement is attributable to the numerous water supply projects implemented across the country supported by various development partners.

Local Variation

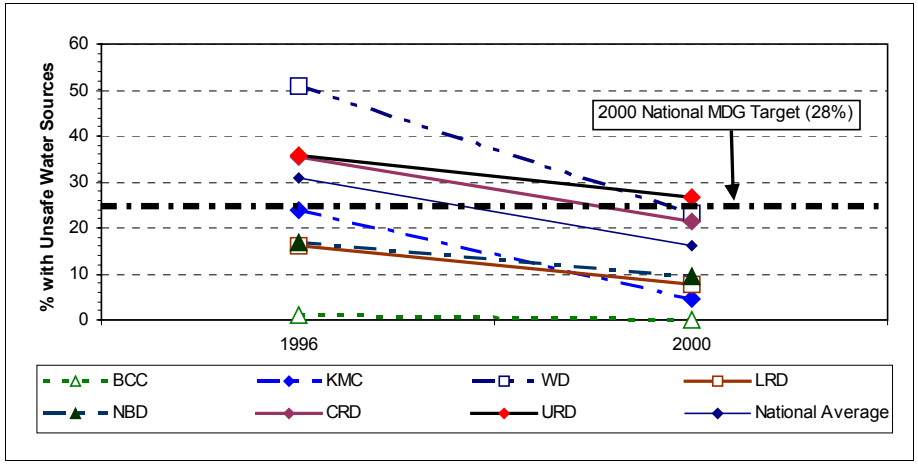
Marked regional differences in access to safe water sources are evident in Table 28, especially between urban and rural areas. No one in BCC and only 5% of people in KMC were unable to access safe drinking water in 2000, compared with 27% in URD and 23% in WD. Nevertheless, all areas achieved or exceed the national MDG target of 27.7% for 2000.

Table 28: Proportion of People with Unsafe Drinking Water Sources

LGA/ Municipality	1996 %	2000 %	MDG Difference	MDG Ranking
BCC	1	0	28	1
KMC	24	5	23	2
WD	51	23	5	6
NBD	17	10	18	4
LRD	16	8	20	3
CRD	36	22	6	5
URD	36	27	1	7
National Average	31	16		
2015 MDG Target	15.5			
2000 MDG Target	27.7			

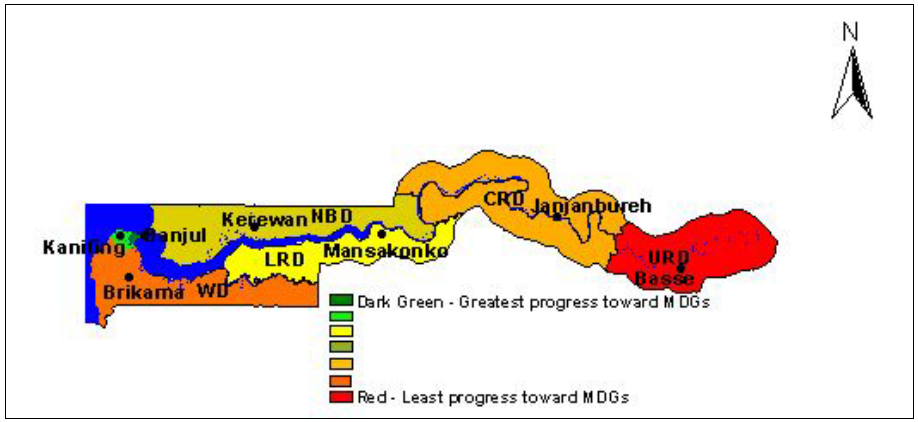
Source: GOTG (1998); CSD (2000).

Figure 47: Proportion of People with Unsafe Drinking Water Sources



Relative progress towards or exceeding the MDG target for 2000 is reflected in the MDG Difference in Table 28 and the colour-coded MDG Difference ranking in Figure 48. Clearly, BCC and KMC have made most progress, whilst URD, WD and CRD are well behind, reflecting a combination of greater investment in urban water supplies and reduced impact in rural regions.

Figure 48: MDG Difference Ranking of Proportion of People with Unsafe Water Sources



Challenges

The main challenges to sustaining access to improved water sources are:

- Institutional constraints: the Department of Water Resources (DWR) does not have the resources to fulfil its mandate of providing water to rural populations;
- Human resource constraints: shortage of adequately trained personnel and insufficient numbers of staff;
- Lack of material resources: difficulties in obtaining and maintaining equipment for drilling boreholes;
- Attitudinal problems in some communities: including reluctance to contribute to maintenance costs for hand pumps etc.;
- No clear institutional mandate for the provision of water in peri-urban areas: the National Water and Electricity Company (NAWEC) is responsible in urban areas and DWR is responsible in rural areas;
- Lack of proper co-ordination of activities: better co-ordination is required at both national and divisional levels;
- Lack of local government involvement in the provision of water supplies: institutional strengthening and capacity building required to promote decentralised provision and maintenance of safe drinking water sources.

Policy Environment

Despite the absence of a national water resources policy, the provision of safe drinking water sources has been a government priority, which has received substantial support from development partners, including UNDP, the European Commission (EC) and the Japan International Co-operation Agency (JICA). Huge investments have been made in water supply facilities, amounting to some D836 million between 1994 and 2004, with an estimated 288,000 beneficiaries - 68% of the target population (DOSFNR, 2004).

Government and development partners are expected to continue their support for improved access to safe water sources. Toward this end, the 1979 Water Act has recently been revised and is being reviewed by the Department of State for Justice (DOSJ). Further efforts are also to be made to finalise the formulation of a national water resources development strategy and a national water policy.

Priorities for Development Co-operation

Key priorities for development co-operation relate to capacity building, provision of equipment and extended coverage:

- Support the training and retention of more professional staff (especially civil engineers);
- Provide more solar pumps to villages that have outgrown previously installed hand-pump systems;
- Target LRD and CRD for improved rural water supplies, given that NBD and URD were the initial focus of activities;
- Support the provision of water supplies to peri-urban areas missed by urban and rural providers; and
- Support the provision of mini-solar systems to north bank regions of CRD and URD, where wells are too deep to sustain hand-pumps.

Target 11: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers

Indicators: proportion of population with access to improved sanitation, urban and rural; and proportion of households with access to secure tenure

National Status and Trends

The indicator used to measure progress toward the MDG target on access to improved sanitation is the percentage of population without access to sanitary waste disposal, which includes improved and traditional pit latrines, as well as flush toilets.

Nationally, this proportion has declined from 14.4% in 1993 to 12.1% in 2000 (CSD, 1996 and 2000) and The Gambia is, thus, on track to reach the MDG target of 7% by 2015, as shown in Table 29 and Figure 49.

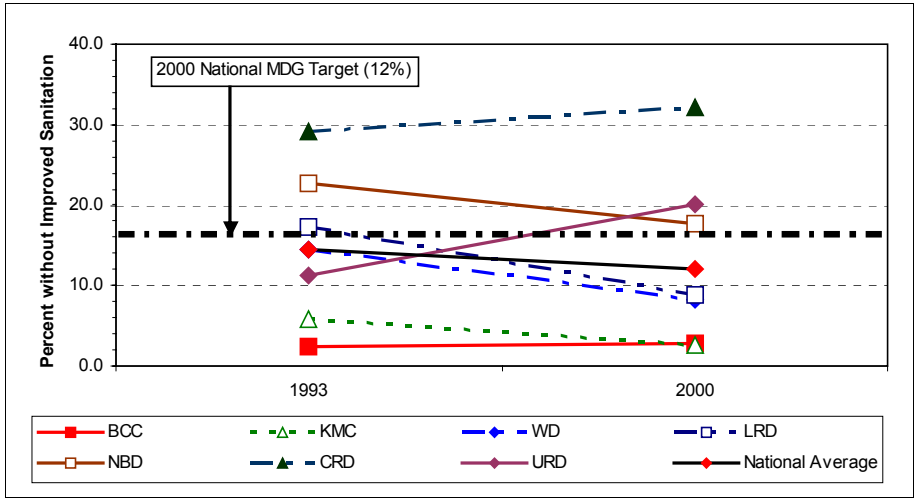
Marked differences exist between urban and rural areas, although sanitation has improved in both. In urban areas, the proportion of people without improved sanitation decreased from 6.2% in 1993 to 4.5% in 2000, compared with a decline from 21.4% to 17.0% in rural areas over the same period.

Table 29: Proportion of People without Improved Sanitation

LGA/ Municipality	1993 %	2000 %	MDG Difference	MDG Ranking
BCC	2.5	2.8	9.3	2
KMC	5.9	2.7	9.4	1
WD	14.4	8.3	3.8	3
NBD	22.7	17.7	-5.6	5
LRD	17.3	8.9	3.2	4
CRD	29.1	32.1	-20.0	7
URD	11.2	20.1	-8.0	6
Urban	6.2	4.5		
Rural	21.4	17.0		
National Average	14.4	12.1		
2015 MDG Target	7.2			
2000 MDG Target	12.1			

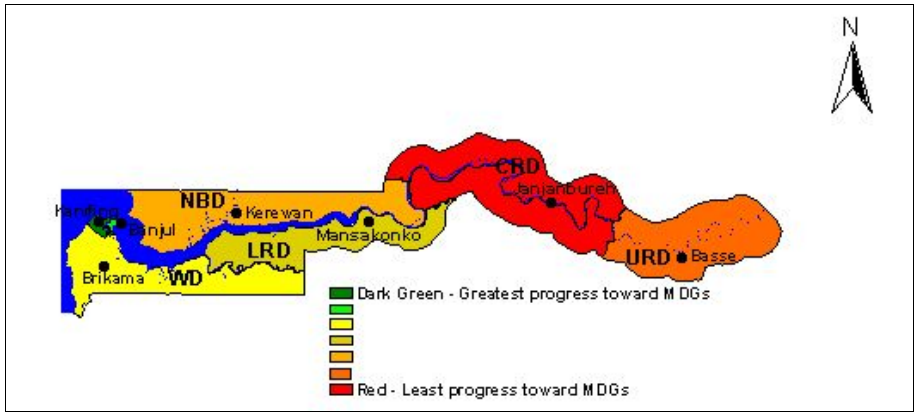
Source: CSD (1996); CSD (2000).

Figure 49: Proportion of People without Improved Sanitation



Preliminary results from the 2003 national census reflect a trend towards urbanization in The Gambia, with KMC and WD accounting for 52.4% of the total population in 2003 (CSD, 2004); up from 44.6% in 1993 (CSD 1996).

Figure 50: MDG Difference Rankings for Improved Sanitation



Tenure of housing is another indicator of environmental sustainability. The proportion of people with secure tenure of housing in The Gambia increased from 61% in 1993 to 64% in 1998, as shown in Table 30 and Figure 51. Nationally, however, The Gambia fell just below target for achieving a nominal 50% increase in secure tenure by 2015.

Home ownership was lowest in urban areas and highest in rural LGAs. Trends over time were mixed. Home ownership increased in BCC, KMC, LRD and CRD and fell in slightly in WD, DBD and URD.

Comparison of home ownership levels with the MDG target for 1998 highlights the differences between urban and rural areas and reflects the urbanisation process, with people moving away from relatively secure tenure in rural areas to rented accommodation and insecure tenure in and around urban areas.

Table 30: Proportion of Population with Secure Tenure of Housing

LGA/ Municipality	1993	1998	MDG Difference	MDG Ranking
BCC	23	27	-41.3	7
KMC	33	42	-26.3	6
WD	71	70	1.7	5
NBD	77	76	7.7	3
LRD	77	78	9.7	2
CRD	83	89	20.7	1
URD	79	75	6.7	4
National Average	61	64	-4.0	
2015 MDG Target	92*			
1998 MDG Target	68			

*Source, CSD (1996); GOTG (2000). * The MDG target for 2015 was calculated as a 50% increase of that in the 1993.*

Figure 51: Proportion of Population with Secure Tenure of Housing

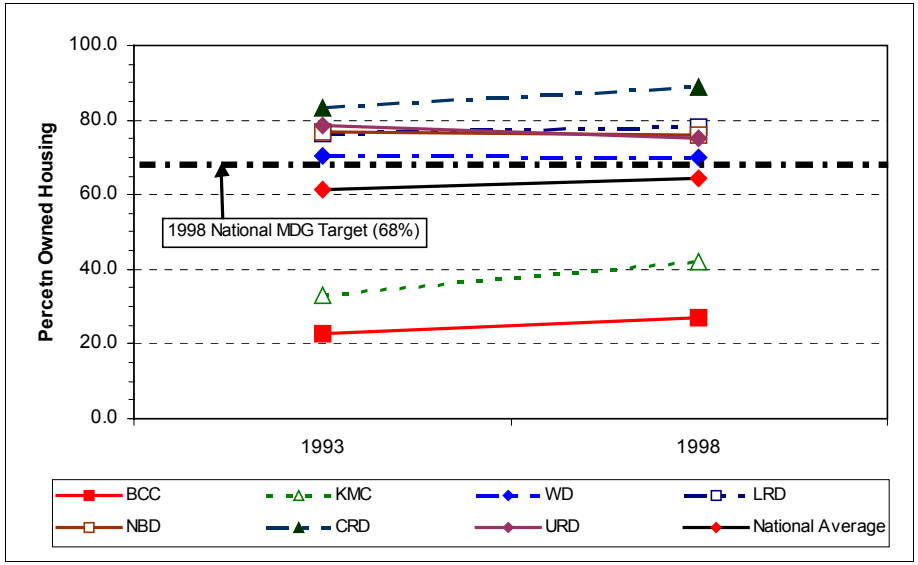
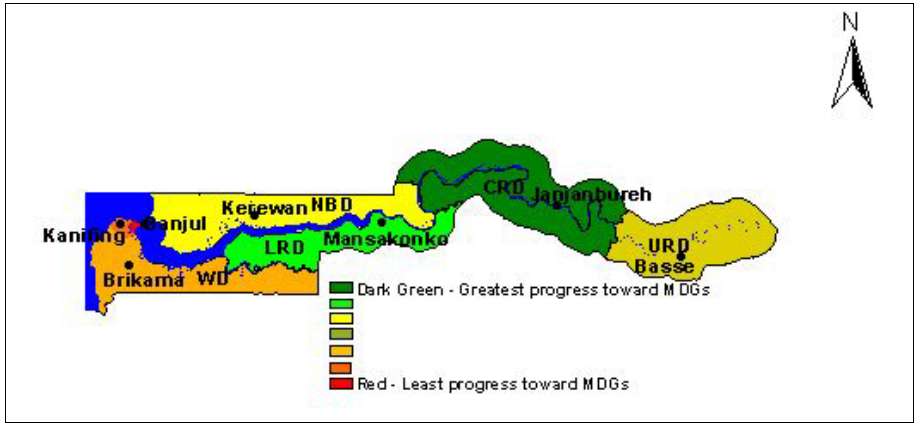


Figure 52: MDG Difference Rankings for Secure Tenure of Housing



Local Variation

Both indicators for monitoring improvements in the quality of life of slum-dwellers demonstrate marked contrasts between urban and rural areas in The Gambia, with urban areas having better sanitation and rural areas having greater security of tenure.

Relative progress towards improved sanitation in different parts of the country is indicated in Table 29 and the colour-coded MDG difference rankings shown in Table 2.

Relative progress towards achieving greater security of tenure in different parts of the country is indicated in Table 30 and the colour-coded MDG difference rankings shown in Figure 52.

Challenges

The main challenges in providing people with sanitary means of waste disposal and secure tenure of housing are:

- Increasing urbanisation;
- Increasing poverty;
- Inadequate facilities for collection and disposal of waste;
- Lack of control of pollution from small industries and informal enterprises;
- Inadequate monitoring and enforcement of environmental laws;
- Increasing cost of land and building materials, thus making home ownership more difficult to achieve; and
- Paucity of credit facilities and financing to increase home ownership.

Policy Environment

With increasing urbanisation and attendant problems of waste disposal, sanitation is becoming and increasingly important social issue, which is being addressed at various levels. For example, legislation has been passed to regulate the discharge of effluents and waste products from industries, and a new landfill site for the Greater Banjul Area (GBA) has been identified at Tambana to replace the Bakoteh dump site. US$1.4 million is to be spent cleaning up and rehabilitating the old site. Water and Sanitation (WATSAN) committees are still active in some Divisions and provide an institutional framework for dealing with waste and sanitation issues at local level.

With regard to housing, the Social Security and Housing Finance Corporation (SSHFC) continues to support the construction of affordable housing for Gambians. Work is already underway on the second phase of the Brusubi Housing Project, which will go some way towards satisfying demand for affordable housing in the GBA. Thus, elements of a sound policy environment are in place for providing sanitation facilities and affordable housing to people in The Gambia, but, as previously indicated, various challenges need to be overcome to consolidate achievements and extend the process.

Priorities for Development Co-operation

- Construction of waste disposal facilities and the new landfill site at Tambana;
- Build capacity for environmental regulation and enforcement;
- Promote environmental education and awareness programmes; and
- Support for poverty-reduction programmes.

GOAL 8: DEVELOPING A GLOBAL PARTNERSHIP FOR DEVELOPMENT

The Gambia is one of the smallest and poorest countries in Africa and, since achieving independence in 1965, has established long-standing relationships with many development partners. The perpetuation and strengthening of the global partnership for development is of vital importance to The Gambia and the future well-being of its people.

Status

The volume of Official Development Assistance (ODA) received by The Gambia has declined from $92.3 million in 1999 to $60.5 million in 2003 (GOTG, 2003; and UNDP, 2004). This reduction, however, is neither out of the ordinary, nor does it necessarily portray the complete picture. First, ODA flows can be very fickle, being influenced by various issues, not least of which is the state of bilateral relations with major donors. In addition, the lack of a mechanism for monitoring and tracking aid flows makes it difficult, if not impossible to obtain an accurate figure for ODA to The Gambia. Despite these uncertainties, there is no doubt that ODA contributes significantly to The Gambia's development, and is a key component of the country's development strategy.

Another key issue underlying The Gambia's development partnerships is its foreign debt. Recent economic problems have raised the importance of the issue and brought the matter to a head because of the increasing burden debt repayments place on the country's finances. For a poor country with few resources, The Gambia has a heavy burden of foreign debt, estimated at 105% of GDP in 1999 (GOTG, 2003).

In 2002, The Gambia received D80 million from the Heavily-Indebted Poor Countries (HIPC) initiative, 64% of which was spent on sectors directly related to the MDGs, namely education, health, employment and agriculture (GOTG, 2003). For this reason, it was especially unfortunate that the country failed to qualify for access to additional HIPC funds. The previous impasse, however, is being resolved, and the country is expected to be on track and able to access additional HIPC and other funds in the very near future.

Building a Stronger Partnership for Development

Given The Gambia's limited resources, the country is likely to remain dependant on development assistance for the foreseeable future. Such assistance should be based on sound principles of partnership that:

- Support national development objectives identified in Vision 2020 and the poverty reduction strategy (SPA II);
- Build on best practices and maximise the efficiency of resource-use by leveraging knowledge about what works, and adding value;
- Complement other development activities, rather than competing, contradicting, or duplicating them; and
- Are mutually-beneficial and ensure effective use of resources, transparency and accountability.

With regards to implementing development partnership programmes, a number of approaches can be adopted. Specifically, the programmes can be implemented along sectoral, regional, or institutional lines. Indeed, the Government is gradually adopting a Sector-Wide Approach (SWAP) to development assistance. SWAP is an integral part of Government's Aid Co-ordination Policy, which can be expected to gain more prominence in the future, with the establishment of an Aid Co-ordination Unit in DOSFEA.

The Unit should help to improve the targeting and monitoring of development interventions and reduce duplication of effort and the excessive concentration of activities in favoured areas to the detriment of others.

Development partnerships are formed between institutions, both national and international. At the national level, there is an urgent need to foster partnership with indigenous civil society organisations that are active in many sectors and regions. Such a focus on developing partnerships with local organisations is especially important and timely, given the rapid increase in the number of NGOs in The Gambia.

Similarly, Government should endeavour to build stronger and better partnerships with international organisations and agencies. Towards this end, further efforts are required to gain a better understanding of the aims, objectives and constituencies of these organisations, so that more fruitful and mutually-beneficial partnerships can be developed.

OVERALL ASSESSMENT AND RECOMMENDATIONS

The main objectives of this study were to assess data collection and analytical capability at local level, and review progress towards achieving the MDGs at local level.

Results obtained from Focus Group Discussions (FGDs) and individual interviews around the country indicate very limited capacity for data collection and analytical capacity, and very little awareness of the MDGs, the PRSP or the poverty monitoring system (PMS) at the local level. The first step in building local capacity, therefore, must be to embark on a campaign to increase awareness, and provide training, materials and financial resources to enable local authorities to collect and analyse data.

Progress towards achieving MDGs, or lack of it, was assessed using a set of standard indicators. For each indicator, a national MDG target was calculated both for 2015, and for the last year for which data was available. From this, it was possible to calculate MDG Differences (the difference between the value of an indicator and that of the MDG target) and assess how close each LGA or municipality was to meeting the national MDG target.

MDG Difference values provide an index of relative progress towards achieving the national MDG target, which was used to the rank the performance of each LGA and municipality. For ease of comparison, colour-coded, MDG Difference Rankings were displayed on administrative maps of the country to illustrate their geographical coverage.

Marked variation in progress towards achieving MDGs was evident in different parts of the country, and especially between rural and urban areas. In terns of overall poverty, BCC and KMC made most progress toward meeting national MDG target, while LRD, NBD, and URD made least progress. On the other hand, KMC came first with regards to provision of improved sanitation, while CRD came last on this issue. Similarly, mixed results were found for other MDG indicators.

No single LGA or municipality was universally successful or unsuccessful in meeting the targets for all goals. LGAs and municipalities should, therefore, be able learn from each other's experiences and practices, with those performing well in achieving a particular target providing a model of "best practice" for others to follow.

Challenges

Many constraints hamper attainment of the MDGs in The Gambia, as identified and discussed in the 2003 MDG Report (GOTG, 2003):

- Resource constraints;
- Poor agricultural performance;
- Debt burden;
- Data inadequacies;
- Low institutional capacity;
- Expanding the role of the private sector Civil Society Organisations (CSOs);
- Facilitating opportunities for public-private partnership; and
- Decentralisation.

Although identified in a national context, many of these constraints also apply at the local level, as confirmed by FGDs and individual interviews conducted during this study, especially with regard to institutional capacity and resource constraints.

Problems of low agricultural productivity persist and are compounded by difficulties in marketing agricultural products, especially groundnuts. The pursuit of poverty reduction and environmentally sustainable agricultural development becomes ever more problematic under such circumstances.

The debt relief issue is still very important for The Gambia and highly relevant to the attainment of the MDGs. In this regard, it is heartening that The Gambia is almost on track to comply with IMF criteria for eligibility for HIPC funds, which should soon be made available.

The study has highlighted the importance of good quality data. The FGDs and interviews all indicated a serious lack of data for many indicators. Furthermore, even where the data is available, bureaucratic and other institutional problems make it difficult, if not impossible, to obtain access.

There is a lack of institutional capacity at both national and local levels, which seriously hampers progress towards achieving the MDGs. Weak institutions are less able to utilise donor assistance and reduce the effectiveness of development partnerships.

There is no doubt that the private sector has an important role to play in efforts to achieve the MDGs in The Gambia. As foreseen in Vision 2020, the private sector is expected to be the driving force for economic development through employment and wealth creation. The role of the private sector in this regard, however, is limited by a multitude of factors, including lack of resources, ignorance and various institutional problems.

Despite these problems, the private sector must be encouraged to become more actively involved in achieving the MDGs. One way of doing this is by building public-private partnerships. The Gambia Public/Private Sector and Civil Society Interface Capacity Building Project (GICAP), funded by the African Capacity-building Foundation (ACBF), is a noteworthy example from which useful lessons can be learnt.

Decentralisation is a major objective of SPA II, but has yet to become fully effective. Many local authorities expressed a desire for greater financial and administrative autonomy from central government. It is their hope that such autonomy will provide them with the much-needed flexibility to plan and implement development programmes to achieve the MDGs.

The Way Ahead

The next steps in facilitating the MDG process in The Gambia should be:

- Localisation;
- Consultation;
- Prioritisation;
- Costing exercises;
- Resource mobilisation; and
- Capacity-building/data collection system for MDGs.

Efforts should be redoubled to increase ownership of the MDGs and SPA II at local level. Further sensitisation campaigns are required and an MDG/SPA II co-ordinator, or focal point, should be appointed for each LGA and municipality, as the National AIDS Secretariat (NAS) has done, so that local problems can be addressed and questions answered much more quickly.

The localisation effort should also involve providing local authorities with capacity and resources to collect data on the MDG and PMS indicators, analyse the data, and prepare MDG reports themselves. This will entail providing them the requisite training, equipment and materials.

Another important step in facilitating the MDG process in The Gambia is to consult widely with people around the country, especially local authorities and other stakeholders. This should not only promote a greater sense of ownership, but should also encourage the development of bankable projects, aimed at accelerating progress toward the MDGs.

An important outcome of the proposed consultations will be a prioritisation of the programmes and activities required to facilitate the achievement of the MDGs in The Gambia. Again, a consultative and participatory process would be the best way to prioritise the proposed programmes and activities in order to promote ownership and sustainability.

Once various projects and programmes have been agreed and prioritised, the next step should be to prepare costed proposals and action plans for their implementation and arrange for their submission to appropriate development partners for funding.

Finally, urgent action is required to ensure that The Gambia is eligible for selection as one of the dozen or so countries to be fast-tracked to achieving the MDGs as part of the Millennium Project (UN, 2005). Selection would not only bring an influx of resources for the benefit of the poorest and weakest members of society, but would also raise the country's profile as a showcase to the international community.

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