REPUBLIC OF THE GAMBIA

LEVEL OF ACHIEVEMENT OF THE MILLENNIUM DEVELOPMENT GOALS (MDGs) IN THE GAMBIA

MDG Status Report, 2007

National Planning Commission
August 2008

FOREWARD

The Millennium Declaration, which was adopted at the Millennium Summit in New York in September 2000, is a significant milestone in the agenda to promote global peace and development. The Gambia was among the 147 States and Governments that adopted the Declaration and the eight smart, measurable, achievable and realistic goals and targets of what has become known as the Millennium Development Goals (MDGs).

This report is the third The Gambia has produced in fulfillment of a commitment placed on countries to provide periodic account of MDG progress or the lack of it at national and sub-national levels. The Report was commissioned at my Government's request to demonstrate our commitment to the sorts of policy and programme gaps that concerted efforts and action as well as renewed partnership would be required in order to accelerate the implementation and achievement of MDGs in The Gambia.

The Report followed the same pattern as that adopted in 2005, of accounting for MDGs progress on the basis of a comparison between national averages and those observed in each of the Local Government Areas of the country. This way, we are able to identify disparities where they exist in the level, standard, or sophistication of development and which Region or Locality therefore requires the biggest push in terms of resources allocation and partnership.

In the period since the last report, significant strides have been taken to deepen the country's absorptive and responsive capacities for meaningful growth and socio-economic advancement to take place. Notably, these include the creation of a National Planning Commission with the mandate to prioritize national planning and coordination in accordance with the MDGs, the poverty reduction goals of PRSP II, and the Vision 2020 development blueprint. My Government applauds the support of the development partners in this drive, including in particular the support by the United Nations Agencies. We have also put in place an Aid Coordination Unit in an attempt to foster the harmonization of donor procedures and practices, and the targeting and reporting of resources in a more coordinated or unified manner. Although there are countless challenges that we confront, and despite achieving slow progress in some MDG targets including the poverty targets as alluded to in the report, we remain steadfast in our resolve to bring about development to the doorstep of every Gambian household before the 2015 deadline. The role of the United Nations, other multilateral and well-meaning bilateral friends of The Gambia in helping us achieve this, cannot be over-emphasized.

I wish to acknowledge with gratitude, the strong and consistent support that The Gambia has been receiving from the UN System towards achieving the MDGs. I wish to commend in particular, the coordinating role of the MDGs secretariat now located at the recently established National Planning Commission and, the Policy Analysis Unit under my office.

To our partners, which notably also include NGOs, Civil Society and Faith Based Organizations, I wish to remark that while there certainly are many challenges to achieving all of the MDGs, there certainly is no other way to regard the MDGs than appreciating the fact that they represent a hope for the hundreds of millions of poor and largely marginalized people across the world that yearn for a better world than that they found and live in.

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

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LIST OF ABBREVIATIONS AND ACRONYMS

AfDB	African Development Bank
AfDF	African Development Fund
ARV	Anti-Retroviral
BCC	Banjul City Council
BFCI	Baby Friendly Community Initiative
CBG	Central Bank of The Gambia
CIAM	Centre for Innovation Against Malaria
CO_2	Carbon dioxide
CPR	Contraceptive Prevalence Rate
CRR	Central River Region
CRR-N	Central River Region-North
CRR-S	Central River Region -South
DoSCIT	Department of State for Communication, Information and Technology
DoSFEA	Department of State for Finance and Economic Affairs
DoSH	Department of State for Health
DoSTIE	Department of State for Trade, Industry and Employment
DOTS	Directly Observed Treatment Short-course
DSA	Debt Sustainability Analysis
ECOWAS	Economic Community of West African States
EDF	European Development Fund
EEZ	Exclusive Economic Zone
EMCH	Emergency, Maternal and Child Health
EMIS	Education Management Information System
EPI	Expanded Programme of Immunization
EU	European Union
FAO	Food and Agricultural Organization
GBoS	Gambia Bureau of Statistics
GEAP	Gambia Environmental Action Plan
GHG	Green House Gases
GoTG	Government of The Gambia
HARRP	HIV/AIDS Rapid Response Project
HIPC	Heavily Indebted Poor Countries
HIS	Health Information System
HMIS	Health Management Information System
IDA	International Development Agency
IEC	Information, Education and Communication
IMF	International Monetary Fund
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IT	Information Technology
ITNs	Insecticide Treated Nets
JICA	Japan International Co-operation Agency
KMC	Kanifing Municipal Council
KNCV	Royal Netherlands Tuberculosis Association
LGA	Local Government Area
LLN	Long Lasting Nets
LRR	Lower River Region
MDG	Millennium Development Goals
MDGR	Millennium Development Goal Report

MDR	Multi-Drug Resistant
MDRI	Multilateral Donor Relief Initiative
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate/Ratio
MRC	Medical Research Council
NAC	National AIDS Council
NaNA	National Nutrition Agency
NAPA	National Adaptation Plan of Action
NAS	National AIDS Secretariat
NAWEC	National Water and Electricity Company
NBR	North Bank Region
NEA	National Environment Agency
NER	Net Enrolment Ratio
NGO	Non-Governmental Organization
NPV	Net Present Value
NNC	National Nutrition Council
ODA	Official Development Assistance
ODS	Ozone Depleting Substances
OP	Office of the President
PAU	Policy Analysis Unit
PDU	Public Debt Unit
PER	Public Expenditure Review
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
PTCT	Parent to Child Transmission
RCH	Reproductive and Child Health
RVTH	Royal Victoria Hospital Teaching Hospital
SCC	Short Course Chemotherapy
SoS	Secretary of State
SPA	Strategy for Poverty Alleviation
TB	Tuberculosis
UNDP	United Nations Development Programme
UNEP	United Nations Environmental Programme
UNICEF	United Nations Children's Fund
URR	Upper River Region
VCT	Voluntary Counselling and Testing
WATSAN	Water and Sanitation Project
WHO	World Health Organization
WR	Western Region
XDR	Extra Drug Resistant

EXECUTIVE SUMMARY

The Millennium Development Goals (MDGs) became the global development framework following the Millennium Conference and Declaration in 2000. A total of 8 goals, 18 targets[1] and 48 indicators were identified to measure progress from 1990-2015. The implementation of the MDGs began in earnest by most developing countries in Africa, Asia and Latin America in 2001.

In addition to integrating the MDGs on all aspects of national development, countries are obliged to monitor progress towards achieving the MDGs. The Gambia is committed to the attainment of the MDGs and has put in place a monitoring mechanism to measure progress. To date, two progress reports have been prepared and submitted; one in 2003 and another in 2005. Thus, this is the third report on the implementation status of the MDGs.

Using data from the 2003 Integrated Household Survey, the round three of the Multiple Indicator Cluster Survey (MICS III), 2005/2006, the 2003 Census as well as sector specific data on education and health, the report presents an assessment of The Gambia's progress towards achieving the MDGs. The findings at national level are as follows:

Goal 1: Targets on poverty and hunger have not been attained and the country is unlikely to attain the income related poverty targets; however it is likely that the nutrition targets will be realized by 2015

Goal 2; targets on proportion of pupils starting grade 1 who reach last grade of primary has been attained. The country is on track to attaining net enrolment in primary and secondary education as literacy among 15-24 year olds.

Goal 3 (gender parity in primary and lower basic has been attained and parity at senior secondary is within reach)

Goal 4 (proportion of 1 year old children immunized against measles has been attained).

Goal 6 (proportion of under-fives sleeping under ITNs is on track). Country is on course to meet both the Abuja and MDG targets of .80% of children sleeping under ITNs

Goal 7 (proportion of population using improved drinking water source has been attained)

Goal 8 (partnership for development). Completion point under the enhanced HIPC Initiative has been reached and the country is eligible for debt relief under the HIPC to the tune of US$66.6 million and under MDRI to the tune of approximately US$373.5 million in nominal terms over the next 43 years (IMF Press Release No. 07/302, December 20, 2007.

Although The Gambia has made significant strides, much more needs to be done to achieve the MDGs in its entirety. The country is not on track to reducing maternal mortality from its present rate of 730 per 100,000 live births to the MDG target of 263 per 100,000 births by 2015. Similarly, the country is not on track to attaining infant and child mortality targets. Concerted efforts are also needed to halt and reverse the trend of HIV/AIDS. Given the political commitment and leadership, there is no doubt that there will be further successes in attaining the MDGs.

Finally, the report has identified some major challenges in terms of data resources, policy orientation and priorities for development co-operation. Appropriate recommendations have been made on all these issues. It is hoped that the report, in addition to stimulating further discussions on the MDGs with development partners with a view to strategise for better results, will serve as a useful tool for resource mobilization for The Gambia's development efforts.

[1] Revised in 2007 to 21 targets and 52 indicators

LITERATURE REVIEW

Table 1: Summary of MDG Status by Region, The Gambia MDG Status at a Glance 2007

Target	Indicators	MDG Target	MDG Status 2007								
			National	BCC	KMC	WR	NBR	LRR	CRR-North	CRR-South	URR
Goal 1: Eradicate Extreme Poverty and Hunger											
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day	1.1. Proportion of population below $1 purchasing power parity (PPP) per day	15%	58%	7.6%	37.6%	56.7%	69.8%	62.6%	94%	75.7%	67.9%
	1.2. Poverty gap ratio		25.1%	0.8%	6.8%	13.7%	21.6%	10%	30.5%	14.4%	15%
	1.3. Share of poorest quintile in national consumption	8%	8.8%								
Target 1.B: Achieve full and Productive employment and decent work for all, including women and young people	1.4. Growth rate of gross domestic product (GDP) per person employed	NA	NA								
	1.5. Employment-to-population ratio		0.38	0.38	0.32	0.29	0.37	0.38	0.45	0.40	0.40
	1.6. Proportion of employed people living below $1 (PPP) per day	NA	NA								
	1.7. Proportion of own-account and contributing family workers in total employment		0.79	0.51	0.48	0.69	0.89	0.88	0.95	0.93	0.94
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8. Prevalence of underweight children under 5 years of age	2.65%	3.9%	5%	1.7%	2.8%	5.2%	6.1%	7.2%	3.8%	5%
	1.9. Proportion of population below minimum level of dietary energy consumption	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Goal 2: Achieve Universal Primary Education											
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1. Net enrolment ratio in primary education	100%	64%	85%	85%	70%	57%	65%	53%	53%	39%
	2.2. Proportion of pupils starting grade 1 who reach last grade of primary	100%	96%	96.8%	97.7%	99.5%	100%	96.0%	91.6%	87.9%	95.0%
	2.3. Literacy rate of 15-24 year-olds, women and men	72%	62.9%	75.1%	70.6%	69.7%	59.8%	69.3%	45.4%	62.9%	49.5%
Goal 3: Promote Gender Equality and Empower Women											
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of	3.1. Ratios of girls to boys in primary, secondary and tertiary education	1.0	1.06	0.99	0.99	1.03	1.09	1.13	1.30	1.30	1.11
	3.2. Share of women in wage employment in the non-agricultural sector	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Target	Indicators	MDG Target	MDG Status 2007								
			National	BCC	KMC	WR	NBR	LRR	CRR-North	CRR-South	URR
education no later than 2015	3.3. Proportion of seats held by women in national parliament	33%	6.25%								
Goal 4: Reduce Child Mortality											
Target 4.A: Reduce by two thirds, between 1990and 2015, the under-5 mortality rate	4.1. Under-5 Mortality Rate	67.5	99	41	61	93	109	137	134	128	110
	4.2. Infant mortality rate	42	75	36	51	71	81	96	94	92	82
	4.3. Proportion of 1-year-old children immunized against measles	100`%	92.4%	91%	89%	92%	93%	99%	96%	93%	93%
Goal 5: Improve Maternal Health											
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1. Maternal mortality ratio	263	556	NA	NA	NA	NA	NA	NA	NA	NA
	5.2. Proportion of births attended by skilled health personnel	63	56.8	94.7	84.7	59.8	44.8	40.8	29.3	34.5	32.9
	5.3. Contraceptive Prevalence Rate		13.4%	NA	NA	NA	NA	NA	NA	NA	NA
Target 5.B: Achieve, by 2015, universal access to Reproductive Health	5.4. Adolescent birth rate	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	5.5. Antenatal care coverage (at least one visit and at least four visits)	100%	99.3%	100%	98.5%	99.5%	99.8%	97.8%	99.5%	99.7%	99.5%
	5.6. Unmet need for family planning		30%	NA	NA	NA	NA	NA	NA	NA	NA
Goal 6: Combat HIV/AIDS, Malaria and Other Diseases											
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1. HIV prevalence among population aged15-24 years	0.3	2.8HIV 1 0.9HIV 2	NA	NA	NA	NA	NA	NA	NA	NA
	6.2. Condom use at last high-risk sex		54.3	53.8	46.9	48.0	73.7	85.4	50.0	73.3	79.0
	6.3. Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS		39.1	37.4	40.9	50.1	46.8	32.9	32.1	24.4	23.2
	6.4. Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years		.87	NA	NA	NA	NA	NA	NA	NA	NA
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5. Proportion of population with advanced HIV infection with access to antiretroviral drugs		NA	NA	NA	NA	NA	NA	NA	NA	NA
Target 6.C: Have halted by 2015 and	6.6. Incidence and death rates associated with malaria	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Target	Indicators	MDG Target	MDG Status 2007								
			National	BCC	KMC	WR	NBR	LRR	CRR-North	CRR-South	URR
begun to reverse the incidence of malaria and other major diseases	6.7. Proportion of children under 5 sleeping under insecticide-treated bed nets and proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	80	49.0 ITN 52.4 Anti malarial	28.6 28.0	30.4 54.7	56.2 65.0	56.9 52.0	76.4 Nil	66.6 43.9	67.7 69.2	58.5 32.6
	6.8. Incidence, prevalence and death rates associated with tuberculosis	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
	6.9. Proportion of tuberculosis cases detected and cured under directly observed treatment short course	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Goal 7: Ensure Environmental sustainability											
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1. Proportion of land area covered by forest	40%	45%	NA	NA	NA	NA	NA	NA	NA	NA
	7.2. Carbon dioxide emissions: total per capita and per $1 GDP (PPP) and consumption of ozone-depleting substances	.18	4.42	NA	NA	NA	NA	NA	NA	NA	NA
	7.3. Proportion of fish stocks within safe biological limits		74.1%	NA	NA	NA	NA	NA	NA	NA	NA
	7.4. Proportion of total water resources used	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.5. Proportion of terrestrial and marine areas protected	10%	4.09%	NA	NA	NA	NA	NA	NA	NA	NA
	7.6. Proportion of species threatened with extinction	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.7. Proportion of population using an improved drinking water source	85%	85.2%	100[2]	91.0	79.2	89.1	82.6	83.4	81.7	87.6
	7.8. Proportion of population using an improved sanitation facility	92%	84.2%	96..6	95.8	94.0	86.2	65.5	77.1	30.7	86.4

[2] Source: 2003 Census

Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum-dwellers	7.9. Proportion of urban population living in slums	NA	59.2	NA	NA	NA	NA	NA	NA	NA	NA
Goal 8: Develop a Global Partnership for Development											
Debt Sustainability	8.11. Debt relief committed under HIPC and Multilateral Debt Relief Initiatives		$66.6 m (HIPC) $373.5m[3] (MDRI)	NA	NA	NA	NA	NA	NA	NA	NA
	8.12. Debt service as a percentage of exports of goods and services			NA	NA	NA	NA	NA	NA	NA	NA
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13. Proportion of population with access to affordable essential drugs on a sustainable basis	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14. Telephone lines per 100 population		4.83	NA	NA	NA	NA	NA	NA	NA	NA
	8.15. Cellular subscribers per 100 population		41.9	NA	NA	NA	NA	NA	NA	NA	NA
	8.16. Internet users per 100 population		4.37	NA	NA	NA	NA	NA	NA	NA	NA

[3] Source: IMF Press Release (No. 07/302, dated December 20, 2007). The Gambia is eligible for debt relief under the MDRI in nominal terms over next 43 years

GOAL 1: ERADICATE EXTREME POVERTY AND HUNGER

Introduction

This Goal on Eradicating Poverty and Hunger contains three targets; income poverty, employment and hunger. Nine indicators are used to measure progress against the targets and as shown in Table 1.0 below, achievement of the targets in this goal are mixed; there is high level of achievement in some areas whilst in others little progress has been made.

Table 1.0: Summary Status of Indicators for MDG 1

Target	Indicators	1990	Current Status (2007)	MDG Target
Target 1.A: Halve, between 1990 and 2015, the proportion of people whose income is less than $1 a day	1.1. Proportion of population below $1 purchasing power parity (PPP) per day (Poverty Head Count Index)	31%	58% (2003)	15%
	1.2. Poverty gap ratio	22.9	25.1 (2003)	
	1.3. Share of poorest quintile in national consumption	4%	8.8% (2003)	8%
Target 1.B: Achieve full and Productive employment and decent work for all, including women and young people	1.4. Growth rate of gross domestic product (GDP) per person employed			
	1.5. Employment-to-population ratio	0.33	0.38	
	1.6. Proportion of employed people living below $1 (PPP) per day			
	1.7. Proportion of own-account and contributing family workers in total employment	0.77 (1993)	0.79 (2003)	
Target 1.C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger	1.8. Prevalence of underweight children under 5 years of age	Moderate: 20.3% (1996) Severe: 5.3% (1996)	20.9 % (2005) 3.9% (2005)	10.2% 2.65%
	1.9. Proportion of population below minimum level of dietary energy consumption			

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

Status and Trends

Three poverty studies have been conducted in the country so far with each study using a different methodology. However, in all the studies, overall poverty and food poverty were used to estimate the head count index. In the first poverty study conducted in 1992, 31 per cent of the population were poor overall and 33.1 per cent of the population in the urban areas and 54 per cent in the urban areas were food poor. The second poverty study, conducted in 1998, showed overall poverty significantly increasing from 31 per cent in 1992 to 69 per cent. The study also showed a widening disparity between urban and rural populations with

60 per cent of the rural population being poor compared to only 13 per cent of those living the urban areas. The third poverty study carried out in 2003, put the poverty head count index at 58 per cent, indicating a downward trend in poverty. However the likelihood of being 'poor' is much higher in rural households; 34 per cent for Banjul and Kanifing combined, 56 per cent in other urban areas and 67.8 per cent for predominantly rural areas.

Regional Disparities

Similar to the results of both 1992 and 1998, overall poverty levels in 2003 were also higher in the regions that are predominantly rural compared to the urban settlements in the Greater Banjul Area (i. e. Banjul and Kanifing). The head count index declined from 69 per cent in 1998 to 58 per cent in 2003 and overall poverty levels decreased in all the regions except CRR, North and South. In 2003, CRR (North and South) had the highest poverty rates compared to NBR, LRR and URR, which had the highest rates in 1998.

Table 1.1: Overall Poverty Rates and MDG Targets by Region, 1992-2003

Region/Municipality	1992	1998	2003	Difference with MDG target
	%	%	%	
Banjul	0.0	50.0	7.6	-7.4
Kanifing	15.0	53.0	37.6	22.6
Western Region	35.0	69.0	56.7	41.7
Lower River Region	40.0	80.0	62.6	47.6
North Bank Region	36.0	80.0	69.8	54.8
Central River Region-N	39.0	74.0	94.	79.9
Central River Region-S			75.7	60.7
Upper River Region	50.0	80.0	67.9	52.9
National Average	31.0	69.0	58.0	
MDG Target	15			

Source: GoTG (2000), 1998; Census 2003 & Integrated Household Survey (IHS), 2003

Overall, poverty levels have been on the rise in the country since 1992; from 31 per cent of households to 58 per cent in 2003 but poverty is generally a rural phenomenon, being much higher in the rural areas than the urban areas. Predominantly urban areas (i.e. Banjul and Kanifing) have lower levels of extreme poverty (0.8 and 6.8) than in the rural areas ranging from (10 and 30.5 per cent in LRR and CRR-North respectively). Extreme poverty is lower in the urban areas because there are better employment opportunities; both formal and informal. In the rural areas, most people depend on agriculture; mainly groundnut production, for their livelihood.

Rural dwellers are therefore more vulnerable due to limited access to loans and agricultural inputs, irregular rains, frequent crop losses and low producer price of groundnut at the world market and the situation is further compounded by the current rise in food prices at the global level.

Table 1.3 presents the total household consumption by quintiles. In 1998 the share of the poorest quintile was 4 per cent compared to 8.8 per cent in 2003, showing a 120 per cent increase in the share of the poorest quintile. However, the share of the richest quintiles

dropped by 32 per cent in 2003. In general, all the quintiles increased their shares of total household consumption in 2003.

Table 1.2: Extreme Poverty Rates Compared with MDG Targets

Municipality/Region	1992	1998	2003 Poverty Severity	MDG Difference
	%	%	%	
Banjul	0.0	19.0	0.8	-6.7
Kanifing	4.0	18.0	6.8	-0.7
Western Region	10.0	50.0	13.7	6.2
Lower River Region	26.0	71.0	10.0	2.5
North Bank Region	15.0	71.0	21.6	14.1
Central River Region-N	21.0	62.0	30.5	23
Central River Region-S			14.4	6.9
Upper River Region	32.0	73.0	15.0	7.5
National Average	15.0	51.0	25.1	
2015 MDG Target	7.5			

Source: GoTG (2000), 1998; Census 2003 & Integrated Household Survey (IHS), 2003

Thus, the 2003 data suggest significant reduction in disparities in total household consumption by quintiles in The Gambia. The poverty gap in 1998 and 2003 was 22.9 and 25.1 per cent respectively and the total national consumption that should be re-allocated to eliminate poverty increased slightly by 2.2 per cent.

Table 1.3: Household total Consumption by Quintiles, 1998 and 2003

Quintiles	1998	2003
1st. Quintile (Poorest)	4.0	8.8
2nd. Quintile (Second)	7.6	13.6
3rd. Quintile (Middle)	12.1	18.0
4th. Quintile (Fourth)	20.3	21.6
5th. Quintile (Richest)	56.0	38.0

Source: HIS, 2003/04; National Household Poverty Survey (NHPS), 1998

Given the poverty trends in recent years and the current situation in the country, it is very unlikely that the country will achieve the achieve the MDG target of reducing poverty to 15 per cent i.e. halving the 1990 poverty value by 2015. As shown in Table 1.1 above, the head count Index needs to be reduced by a further 43 percentage points from now to 2015.

Challenges

The Gambia government is committed to reducing poverty and this is manifested by its commitments during the past few years to SPA I & II and the recent PRSP II and other sectoral strategies. However, there are some major challenges facing government's efforts in the fight against poverty. These include:

- The need for increased resources to implement the PRSP II. It is hoped that pledges made by the development partners at the 2008 Roundtable Conference will be honoured so that the government initiatives in the fight against poverty will be implemented

- Inadequate institutional capacity in the priority PRSP sectors especially Agriculture, which hinders the formulation and implementation programme policies and strategies.

- Low agricultural productivity and output resulting from low and decreasing soil fertility, lack of inputs and markets and the lack of credit/finance for agricultural development

Policy Environment

In The Gambia, there are several policies aimed at reducing poverty the most notable being the PRSPs I & II. In addition, there are the sectoral policies of the Departments of State for Education and Health as well as a National Strategy for Food Security. All these policies emphasise the importance of reducing poverty and attaining faster economic growth, a pre–requisite for sustainable poverty reduction.

Priorities for Development Cooperation

The priorities for development assistance are:

- Provision of adequate resources; both internal and external, and building the capacities of institutions to implement PRSP II

- Promoting diversification of agriculture from subsistence to commercial so as to increase income and ensure food security thereby reducing poverty particularly in the rural areas

- Build the capacity of local communities, civil society organisations and the private sector so that they can play an active role in the fight against poverty.

- Move away from a project approach to programme approach in the PRSP priority sectors to ensure that issues are addressed holistically and mainstreamed into the fight against poverty.

- Establish performance mechanisms for all the sectors involved in the implementation of the PRSP to monitor progress towards the achievements of the targets

Target 1B: Achieve full and productive employment and decent work for all, including women and young people

One of the major issues here is that information is available only from the censuses hence information is available only for 1993 and 2003. As shown in Table 1.4 and Figure 1.4, the proportion of the population employed as a ratio of the total population by Region and type of Residence in 1993 and 2003. The data show that the proportion employed in 2003 is higher in the predominantly rural areas; ranging from 29.3 per cent in the Western Region to 45.6 per cent in CRR-North. The higher proportion in the predominantly rural areas could be attributed to the fact that, most people in the rural areas are engaged in agriculture and persons engaged in any form of agricultural activity are considered as employed. Only Kanifing and the Western Region had proportions that are lower than the national average (31.7 per cent and 29.3 per cent respectively). At the national level, the proportion of the population employed had increased during the intercensal period from 33.5 per cent in 1993 to 37.6 per cent in 2003. Among the Regions, it is only in the Western Region where there

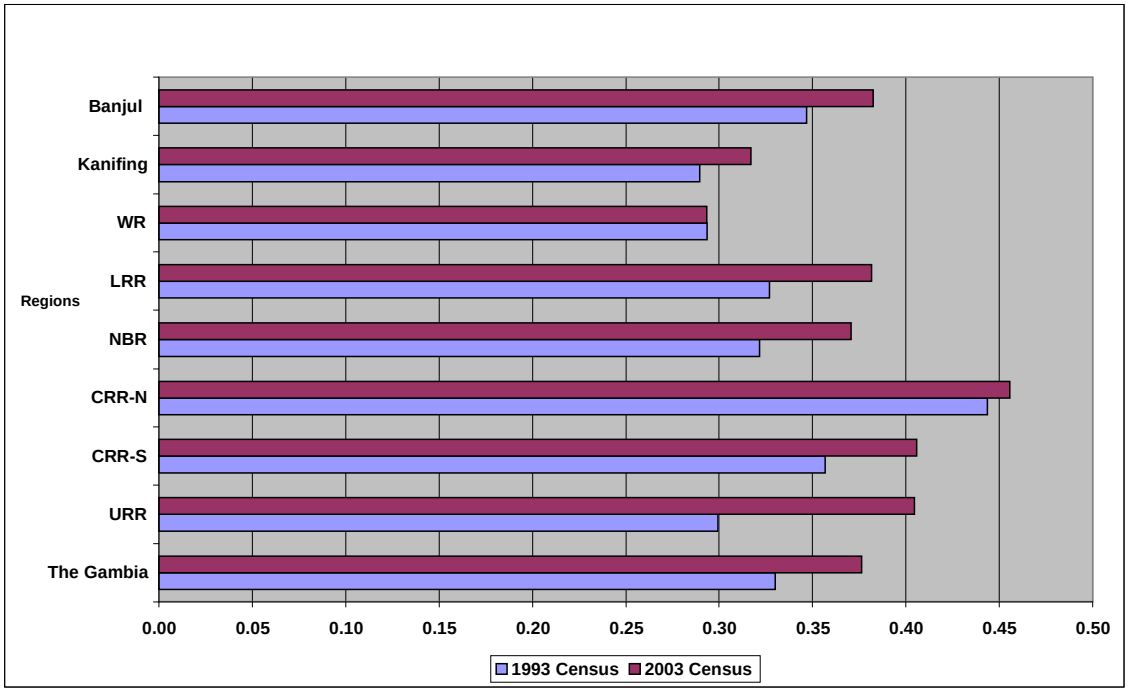
was no change in the number of people employed as ratio to the total population between 1993 and 2003.

Table 1.4: Proportion of the population employed as a ratio of total population by Region and type of Residence, 1993 and 2003 Censuses

Residence/Region		1993 Census	2003 Census
Residence	Urban	0.2943721	0.3077017
	Rural	0.3306008	0.3904777
Region	Banjul	0.3468317	0.3824833
	Kanifing	0.2895221	0.3170373
	Western Region	0.2935505	0.2932808
	Lower River Region	0.3269272	0.3814189
	North Bank Region	0.321471	0.3706117
	Central River Region (North)	0.4436067	0.4555334
	Central River Region (South)	0.3566354	0.4057213
	Upper River Region	0.2992603	0.4046231
The Gambia	**TOTAL**	**0.3347256**	**0.3763387**

Source: Census 1993 & 2003

Figure 1.4: Employment to Population Ratio by Regions, 1993 and 2003 Census



Data on employed persons as own account workers and unpaid family workers show that these categories of employees are also found more in the Regions that are predominantly rural. The CRR-North, which had the highest poverty rate in 2003 also had the highest number of own account workers and unpaid family workers, about 96 per cent. Kanifing had the lowest proportion with about 49 per cent (Table 1.5 and Figure 1.5 below). The high prevalence of these type of employees in the rural areas can be attributed to the fact that

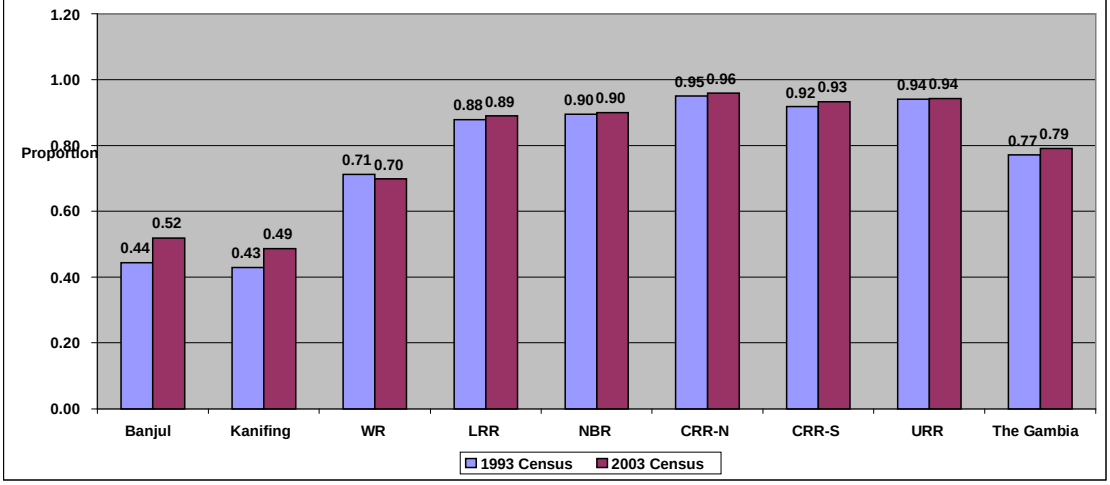
agriculture is the main occupation in the rural areas where family members assist in the farms and are mostly not paid and thus, classified as unpaid family workers. Own account workers, who are mostly self-employed, are found in the informal sector which is more common in the urban setting compared to the rural. Although the ratio of own account workers is highest in the rural, the percentage increase is higher in the urban than in the rural areas during the inter-censal period (50.2 per cent in 1993 to 56.8 in 2003 compared to 88.7 per cent to 92.3 per cent).

Table 1.5: Proportion of own-account and contributing family workers in total employment 1993 and 2003 Censuses

Residence/Region		1993	2003
Residence	**Urban**	**0.502662**	**0.568534**
	Rural	**0.887383**	**0.923216**
Region	Banjul	0.444608	0.518859
	Kanifing	0.429702	0.486737
	Western Region	0.712076	0.698562
	Lower River Region	0.878820	0.889987
	North Bank Region	0.895402	0.899424
	Central River Region -North	0.950325	0.959559
	Central River Region -South	0.918445	0.932612
	Upper River Region	0.941238	0.942824
The Gambia	**TOTAL**	**0.771327**	**0.791071**

Source: Census 1993 & 2003

Figure 1.5: Proportion of own account and contributing family workers to total employment by region



Target 1C: Halve, between 1990 and 2015, the proportion of people who suffer from hunger

The prevalence of underweight children among under-fives is a proxy indicator that is used to measure the extent of hunger and according to Multiple Indicator Cluster Survey (MICS) III of 2005/06 methodology, children whose weight for height is more than two standard deviations below the median of the reference period are classified as *moderately or severely wasted*, while those who fall more than three standard deviations below the median are *severely wasted.* The proportion moderate and severely underweight children fluctuated in recent years; it declined from 20.9 per cent in 1996 to 17.1 per cent in 2000 but increased to 20.3 per cent in 2005.

Children in urban areas are less likely to be underweight compared to their counterparts in the rural settlements as was observed in 1996, 2000 and 2005. The high prevalence of underweight children in the rural areas could be attributed to the fact that households in the rural areas tend to be poorer than those in the urban areas and therefore some families may not be able to provide minimum level of dietary energy consumption for their children.

Regional Disparities

As shown in Table 1.6, in the ten year period between 1996 and 2005, the proportion of moderately and severely underweight children increased in all the Regions of the country except Upper River Region, where the proportion actually decreased. Overall, the current prevalence is about 10 percentage points higher than the MDG target, though there is a wide variation between rural and urban areas and also between regions. The prevalence of moderately malnourished children in urban areas is just 4 percentage points above the MDG target whilst in the rural areas it is 13 percentage points away and in some specific regions e.g. Central River region, it is almost 17 percentage points above the target. Thus quite a lot of effort will be required to achieve the MDG targets in the rural areas (table 1.6) below.

Table 1.6: Percentage of Moderate Underweight Under-Five-Children by Region and Type of Residence

Region/Municipality	1996	2000	2005	MDG Difference
Banjul	26.0	6.2	17.5	7.1
Kanifing	14.4	9.0	13.5	3.1
Western Region	15.8	11.3	16.8	6.4
Lower River Region	24.0	21.0	27.0	16.6
North Bank Region	18.6	19.1	23.7	13.3
Central River Region-North	27.2	28.0	27.3	16.9
Central River Region-South			26.1	15.7
Upper River Region	22.9	26.4	23.5	13.1
National Average	20.9	17.1	20.3	9.9
Urban	**15.7**	**9.4**	**14.7**	**4.3**
Rural	**22.1**	**21.2**	**23.4**	**13.0**
2015 MDG Target	**10.4**			

Source: 1996 MICS, 2000 MICS II, 2005 MICS III

For severely underweight children, the national average declined from 5.4 per cent in 1996 to 3.5 in 2000 but increased slightly to 3.9 per cent in 2005. Children in rural areas are more severely underweight than their urban counterparts (4.8 per cent compared to 2.2 per cent) and similar to the case of moderately under weighed, the proportion of severely under weighed children increased in all the Regions except Kanifing, where the proportion remained the same between 2000 and 2005. Banjul had the highest increase in severely under weighed children, Kanifing had the least proportion of severely underweight children and LRR had the highest proportion. As shown in Table 1.7 below, The MDG targets have almost been realized in the Urban areas; Kanifing has already achieved the MDG target, whilst the rural regions still lag behind, in particular LRR and CRR North.

Table 1.7: Percentage of Severely Underweight Under-Five Children by Region and type of Residence

Municipality/Region	**1996**	**2000**	**2005**	**MDG Difference**
Banjul	6.0	1.0	5.0	2.4
Kanifing	4.7	1.7	1.7	0.9
Western Region	3.5	1.9	2.8	0.2
Lower River Region	7.0	3.2	6.1	3.5
Lower River Region	7.1	5.4	5.2	2.6
Central River Region-N	4.7	7.7	7.2	4.6
Central River Region-S			3.8	1.2
Upper River Region	6.3	4.5	5	2.4
National Average	5.3	3.5	3.9	
Urban	**4.9**	**1.7**	**2.2**	**0.4**
Rural	**5.4**	**4.5**	**4.8**	**2.2**
2015 MDG Target	**2.6**			

Source: 1996 MICS, 2000 MICS II, 2005 MICS III

Challenges

Although The Gambia government has been pursuing policies that address health and nutrition needs of the population, the government is faced with many challenges in the fight against hunger and malnutrition. These challenges include:

- Increasing levels of poverty; although the head account index has dropped from 69 per cent in 1998 to 58 per cent in 2003, poverty is still endemic.
- Poor infant and young child feeding and hygiene practices
- High food contamination that is caused by high infectious rates among infant and children
- Predominance of subsistence farming in the rural areas; farmers are usually caught in a vicious circle of risk aversion, low productivity and income which makes them vulnerable to seasonal food insecurity
- Non-inclusion of nutrition objectives in sectoral policies

- Lack of adequate financial and human resources to deliver the required nutritional services

Policy Environment

The importance of nutrition has long been recognised by the Government of The Gambia and is reflected in the National Nutrition Policy (2000–2004) which is aimed at attaining basic nutritional requirements for all Gambians. The policy also addressed issues that could impact on children's life such as protecting, promoting and supporting breastfeeding, caring for the socio–economically deprived and nutritionally vulnerable and improving food security at national, community and household levels.

Priorities for Development Co-operation

- Strengthen private sector and civil society participation in the delivery of nutritional services
- Strengthen the capacity of communities to plan, implement, and manage nutritional interventions
- Increase support to agricultural and rural development efforts so as to increase food security and alleviate poverty particularly in the rural areas
- Support programmes to improve feeding and hygiene practices and sanitary conditions
- Provide adequate financial and human resources to deliver the required services
- Collaboration with various sectors to reduce hunger and improve nutrition

GOAL 2: ACHIEVE UNIVERSAL PRIMARY EDUCATION

Introduction

The education sector in The Gambia has over the recent past experienced significant reforms which as indicated in the Education Policy (2004–2015) were mainly aimed at responding to changing needs and circumstances, guided by perspectives and experiences derived from both national and international contexts. Some of these changes resulted in a nine-year basic cycle followed by three years of senior secondary schooling. Over the years, there has been a new phenomenon in the form of Madrassas (Arabic and Islamic schools), which provide education at primary and secondary school levels. Since Madrassas have increasingly served as alternative options to a number of people who are largely apprehensive of Western education, Government has integrated them as part of the formal education system. Thus, Madrassas have significantly contributed to the rapid improvements in enrolment observed in the country in the recent past.

The 2004-2015 Education Policy of The Gambia seeks to ensure the right to quality education for all and guides policy direction towards the attainment of the MDGs. Over the years, major strides have been made in The Gambia towards improving access to all levels of education. Educational facilities have been decentralized with the establishment of facilities across the country. Initiatives such as the Girls Scholarship Trust Fund have been put in place to promote girls' education with the ultimate objective of bridging the gap in enrolment between boys and girls.

Table 2.0: Summary Status of Indicators for MDG 2

Target	Indicators	1990	Current status 2007	MDG Target
Target 2.A: Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	2.1 Net enrolment ratio in primary education	**46.3%** (1991)	**64%**	**100%**
	2.2 Proportion of pupils starting grade 1 who reach last grade of primary	88.1% (1992)	96.6% (2006)	100%
	2.3 Literacy rate of 15-24 year-olds, women and men	48% (1991)	62.9% (2003)	72%

Source: EMIS, 2007, MICS 2005/6, Census 2003

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

Indicator 2.1: Net enrolment ratio in primary education

Status and Trends

Overall, Data on Net Enrolment Ratios (NER) show significant improvements in enrolment during the past 15 years. Whereas the NER for both sexes was estimated at 46.3 per cent in 1991/92, in 2006/07 the ratio increased to 64 per cent. In 1991/92, male NER was 54.2 per cent compared to 38.5 per cent for females and in 2006/07 the corresponding estimates were 62 per cent for males and 66 per cent for females, respectively. Thus the gender gap in enrolment at the national level has narrowed over the years and females were at par with their male counterparts by 2002/03; thereafter, female enrolments were slightly higher than that of

males for subsequent years. A review of enrolment ratios across the Regions, showed a wider gender gap in predominantly rural Regions in the early 1990s but the gap narrowed by the 2001/02.

The rapid improvements in girls' enrolment may be attributed to concerted efforts at improving access to education throughout the country with specific measures targeted at improvement of girls' education. Madrassa education has also immensely contributed to improvements in enrolment. Although a significant proportion of children remain out of school, trends in net enrolment ratios are indicative of the potential for the country to meet the MDG target by 2015.

Table 2.1: Net Enrolment Rates by Region and Gender, 1991/92-2006/07 Academic years

Year	Gender	Banjul/ Kanifing	Western Region	North Bank	Lower River	Central River	Upper River	The Gambia
1991/92	Total	64.0	50.4	40.1	64.8	34.1	20.0	46.3
	Male	69.7	66.1	51.3	66.8	43.7	25.3	54.2
	Female	58.9	33.9	28.5	39.6	24.1	14.4	38.5
1994/95	Total	76.2	82.8	61.4	80.1	46.6	34.0	65.0
	Male	84.2	91.8	73.8	98.9	56.5	42.9	75.6
	Female	69.3	73.5	48.8	59.9	36.5	24.5	55.3
1998/99	Total	57.3	73.6	49.9	72.9	55.6	43.9	59.8
	Male	62.2	78.2	57.4	77.7	58.9	49.2	64.2
	Female	53.1	69.0	42.5	67.9	52.3	38.3	55.4
2001/02	Total	58.0	76.0	52.0	66.0	55.0	43.0	60.0
	Male	62.0	80.0	57.0	68.0	54.0	45.0	62.0
	Female	55.0	73.0	47.0	65.0	56.0	41.0	57.0
2002/03	Total	58.0	79.0	55.0	70.0	60.0	46.0	61.0
	Male	62.0	81.0	57.0	67.0	56.0	46.0	60.0
	Female	54.0	77.0	54.0	74.0	65.0	47.0	61.0
2003/04	Total	47.0	71.0	50.0	66.0	54.0	40.0	62.0
	Male	49.0	72.0	51.0	64.0	48.0	39.0	60.0
	Female	44.0	69.0	49.0	68.0	60.0	40.0	63.0
2004/05	Total	49.0	60.0	52.0	63.0	51.0	36.0	61.0
	Male	52.0	59.0	54.0	59.0	44.0	35.0	59.0
	Female	47.0	60.0	50.0	67.0	59.0	37.0	64.0
2005/06	Total	79.0	71.0	64.0	66.0	54.0	39.0	64.0
	Male	79.0	70.0	63.0	63.0	46.0	37.0	62.0
	Female	78.0	72.0	65.0	69.0	62.0	40.0	66.0
2006/07	Total	85.0	70.0	57.0	65.0	53.0	39.0	64.0
	Male	86.0	69.0	55.0	61.0	46.0	37.0	62.0
	Female	85.0	71.0	60.0	69.0	60.0	41.0	66.0

Source:

Indicator 2.2: Proportion of Pupils Starting Grade 1 who Reach Last Grade of Primary

Regional Disparities

Data on the proportion of children enrolling in Grade 1 who eventually reach to Grade 5 shows that in 1992, 88.1 per cent of such children reached Grade 5 compared to 73.9 per cent in 1997, 96.6 per cent in 2000 and 96.6 per cent in 2006 though recent figures seem to suggest that transition rates to Grade 5 have stagnated, overall. Across the sexes, however

figures for 2000 and 2006 show that rates have improved for males but declined for females. Similarly, transition rates for the same period across the regions suggest slight improvements in Kanifing, Western and Upper River Regions; and declines in Banjul, Lower River, Central River, North and South. The transition rate stagnated in the North Bank Region over the period at 100 per cent. Thus the Gambia is on track to attaining this MDG both at the regional and national levels by 2015.

Table 2.2: Percentage of children entering first grade of primary school who eventually reach grade 5, 2000 and 2006

	2000	**2006**
Gender		
Male	96.4	98.1
Female	97.0	95.2
Region		
Banjul	98.2	96.8
Kanifing	96.5	97.7
Western Region	98.1	99.5
Lower River Region	96.3	96.0
North Bank Region	100.0	100.0
Central River Region (North)	94.0	91.6
Central River Region (South)	98.0	87.9
Upper River Region	88.0	95.0
Urban	**96.9**	**98.1**
Rural	**96.5**	**95.7**
The Gambia	**96.6**	**96.6**

Source: MICSII and MICSIII, 2000 and 2005/6

Indicator 2.3: Literacy Rate of 15-24 Years-Old, Women and Men

In addition to those who acquire literacy skills through the formal education system (i.e. Western and Madrassah), a good proportion of individuals acquire literacy skills from the informal sector. It is common for people who have never attended formal education to acquire literacy skills in the process of undergoing religious education be it Islamic or Christian. There has also been non-formal education programmes implemented by the Department of State for Education which targeted out of school youth and adults who did not attend formal school. Such programmes have contributed significantly to literacy in the local languages using the Roman script.

Literacy levels improved over the period 1991–2003. Overall, the literacy rate in 1991 was estimated at 48 per cent gradually increasing to 48.2 per cent in 1994 and then rose to 62.9 per cent in 2003. Disparities have been observed in literacy levels across the Regions ranging from 59.7 per cent in Banjul and Kanifing to 24.1 per cent in the Upper River in 1991. Similar disparities have been observed across the Regions over the years. Literacy levels are highest in Banjul/Kanifing and the Western Region compared to the rest of the regions with levels declining as one move towards the eastern part of the country.

Considerable gains have been made in improving literacy rates across the sexes. Although female literacy rates remain below male rates, female rates have improved much more than their male counterparts. Female literacy has improved from 35.7 per cent in 1991 to 52.5 per cent in 2003. Across all the Regions, the gender gap in literacy rates has declined

significantly over the years. Notwithstanding the gains in literacy over the years, the levels generally remain low.

Table 2.3: Literacy Rate of 15-24 Year Old, Women and Men, 1991 to 2003

Year	Gender	Banjul/ Kanifing		WD	NBR	LRR	CRR		URR	The Gambia
1991	Total	59.7		53.9	44.3	50.6	35.7		24.1	48.0
	Male	67.1		68.0	60.2	68.3	53.4		36.4	60.9
	Female	52.1		39.6	30.2	32.9	21.1		13.5	35.7
1994	Total	61.3		54.6	43.8	49.0	34.7		23.8	48.2
	Male	69.8		69.7	60.0	66.7	52.0		36.2	61.8
	Female	52.6		39.5	29.5	31.4	20.0		13.1	35.3
1998	Total	55.1		51.9	45.8	55.9	39.0		25.0	47.5
	Male	59.6		63.4	61.1	73.6	57.8		36.9	58.3
	Female	50.3		40.2	32.6	38.1	23.9		14.7	37.1
		Banjul	Kanifing				CRR-North	CRR-South		
2003	Total	75.1	70.6	69.7	59.8	69.3	45.4	62.9	49.5	41.8
	Male	80.7	78.4	79.0	74.5	85.8	60.1	73.9	62.7	56.4
	Female	69.6	63.2	60.5	47.2	54.4	32.4	52.5	37.6	28.1

Source: 2003 Population & Housing Census

Challenges

Despite the gains in improving enrolment, the shortfall in the attainment of universal enrolment is a pointer to the need for further improvements. The following are major challenges that require attention;

- Improvement of educational facilities for the disabled (i.e. visually impaired, physically and mentally impaired);
- With increased enrolment in Madrassah, there is need to ensure that quality education is provided in such facilities to ensure relevance and maintenance of standards;
- Retention of girls in school beyond primary level
- Improvement in overall quality of teaching and learning in primary schools

Policy Environment

Cognisant of the need to improve primary school enrolment rates, the Government of the Gambia with support from the donor community and NGOs have put in place policies and programmes geared towards improving access and creating a conducive learning environment. These initiatives include the following;

- Mainstreaming of Madrassas into the national education system which has provided alternative educational opportunities;
- Partnership between government, international and bilateral agencies in the promotion of access to education, particularly in promoting girls' education
- The establishment of schools in many parts of the country with a view to making education more accessible;
- Broadening of the Madrassa syllabus to include English language and other taught subjects.

GOAL 3: PROMOTE GENDER EQUALITY AND EMPOWER WOMEN

Introduction

The Government of the Gambia is committed to the ideals of gender equity, particularly in education. The Education Policy (2004-2015) promotes girls' education and aims to reduce gender disparity in enrolment and the direct costs of girls' education at senior secondary and tertiary educational levels. Under the policy, a scholarship trust fund has been created to get more girls to school. The Policy also recommends more gender sensitive curriculum and environment and the continuous promotion of community awareness on the benefits of both boys and girls' education. With support from UNICEF, Mothers' Clubs have been created in the three programme intervention regions of Lower, Central and Upper River to advocate and to sensitise parents to send their girl-child to school. The Mothers' Clubs are composed of dedicated women who travel from village to village and conduct door-to-door campaigns on girls' education. The Clubs work closely with the schools' head teachers and the parents' teachers associations (PTAs

Thus, the gross enrolment rates (GER) for girls have increased significantly over the years and in some rural schools girls now outnumber boys. In the UNICEF intervention Regions, GER for girls increased, on average, from 69 per cent in 2000/2001 to 81 per cent in 2002/2003. In addition to the Mothers' Clubs, the Department of State for Education also embarked on a nationwide sensitization programme called the "Big Bang". This was aimed at bridging the gender gap in enrolment and has immensely contributed to the increased sensitization of the populace on the importance of girls' education, hence their positive impact on enrolment, particularly, for girls.

Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015

Status and Trends

Table 3.0: Summary Status of Indicators for MDG 3

Target	Indicators	1990	Current status (2007)	MDG Target (2015)
Target 3.A: Eliminate gender disparity in primary and secondary education, preferably by 2005, and in all levels of education no later than 2015	3.1 Ratios of girls to boys in primary, secondary and tertiary education	Primary- 0.74 L/Secondary- 0.72 S/Secondary- 0.44	1.06 (2006) 1.00 (2006) 0.83 (2006)	1.0 1.0 1.0
	3.2 Share of women in wage employment in the non-agricultural sector	N/A	N/A	N/A
	3.3. Proportion of seats held by women in national parliament	Parliament Local Councils	6.25% 13.91%	33% 33%

Source: EMIS 2007, Independent Electoral Commission (IEC) 2008

The gender gap as measured by the gender parity index widens more at the senior secondary school level. Over the decade 1996-2006, the gender gap narrowed at all levels with parity being attained at lower basic school and upper basic levels respectively in 2003 and 2006. However, despite the significant gains in reducing the gender gap at senior secondary level,

parity is yet to be achieved at this level. This can be attributed to the persistence of negative practices such as early marriage which continue to curtail gains in educational achievements for girls in particular (Table 3.1 below)

Regarding parity in literacy between the sexes, this seem to be narrowing with the index declining from 0.60 in 1996 to 0.64 in 1998 and 0.71 in 2003 (Table 3.1). This trend can largely be attributed to significant improvements in female enrolment rates. The country has already achieved the MDG targets for primary and lower secondary education and is on target to reaching the target for upper secondary education.

Table 3.1: Trends in Gender Parity Index in Lower, Upper, Secondary Education and by Literacy: 1996 to 2006

Indicator	1996	1998	2002	2003	2004	2005	2006	MDG Difference
Ratio of girls to boys in primary education – Lower Basic	0.74	0.85	0.99	1.05	1.08	1.06	1.06	-0.06
Ratio of girls to boys in Lower secondary education – Upper Basic	0.72	0.70	0.80	0.93	0.90	0.94	1.00	0.00
Ratio of girls to boys in Senior Secondary education –	0.44	0.57	0.60	0.90	0.67	0.80	0.83	0.17
Ratio of Literate Female to Male 15 to 25 years-olds	0.60	0.64	NA	0.71	NA	NA	NA	
MDG Target: 1.00								

Source: EMIS 2007, Census 2003

Gender parity in school

A review of the data on gender parity at primary school level suggests marked improvements across the Regions (Table 3.2) particularly in Regions where girls' enrolment levels have been generally low for many years. In particular, the CRR and URR have registered marked improvements in gender parity in primary school. These Regions achieved gender parity as early as in 2002 whilst the Western, North Bank and Banjul/Kanifing that enjoyed much higher enrolment rates for many years are either yet to achieve parity or only achieved it around 2005. Parity at the national level was achieved in 2003, a year when most of the predominantly rural regions also achieved gender parity at this level of education.

Table 3.2: Gender Parity Index at Primary School Level by Region, 1990-2006

Year	The Gambia	Banjul/ Kanifing	WR	NBR	LRR	CRR	URR
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	1.00	0.96	0.93	1.00	1.07	0.97
2003	1.05	0.90	0.96	0.96	1.06	1.25	1.03
2004	1.08	0.90	0.97	0.93	1.14	1.34	1.06
2005	1.06	0.99	1.03	1.03	1.10	1.35	1.08
2006	1.06	0.99	1.03	1.09	1.13	1.30	1.11
MDG Target	1.00						

Source: EMIS 2007

However, negative socio-cultural practices such as early marriage continue to impede efforts aimed at the attainment of gender parity in enrolment. Such practice particularly affect girls at the secondary school level and has over the years significantly contributed to gender disparities in enrolment both at the Junior and Senior Secondary School levels.

Whereas disparity in enrolment rates between the sexes in Banjul and Kanifing at the Junior Secondary school level has been quite low over the years, the gap has been wide in the predominantly rural regions. Gender parity at the national level was only achieved in 2006. LRR and CRR achieved parity in 2005 whilst North Bank and Upper River regions are yet to achieve parity at the Junior secondary Level. Improvements in gender parity at this level of education can largely be attributed to initiatives such as the Girls' Scholarship Trust Fund and similar initiatives that have been motivating factors for the retention of girls in school, particularly at the secondary level.

Table 3.3: Gender Parity Index in Junior Secondary Schools by Region, 1996-2006

Year	Banjul/ Kanifing	WR	NBR	LRR	CRR [4]	URR	The Gambia
1996	0.92	0.63	0.52	0.47	0.48	0.84	0.72
1998	0.86	0.71	0.55	0.44	0.49	0.44	0.70
2000	0.98	0.68	0.59	0.58	0.60	0.46	0.73
2001	0.93	0.85	0.67	0.75	0.70	0.62	0.82
2002	0.94	0.93	0.83	0.82	0.79	0.79	0.85
2003	0.95	0.91	0.88	0.90	0.92	0.64	0.93
2004	0.92	0.88	0.77	0.71	0.83	0.83	0.90
2005	0.94	0.97	0.88	1.03	1.00	0.81	0.94
2006	1.03	0.91	0.88	1.11	1.15	0.81	1.00
MDG Target	1.00						

Source: EMIS 2007

At the senior secondary school level trends similar to that of the junior secondary school have been observed. Banjul and Kanifing are performing better than the rest of the regions although there have been improvements in parity across the regions. Despite significant improvements in gender parity at secondary level of education parity is yet to be achieved Tables 3.3 and 3.4).

Table 3.4: Gender Parity Index in Senior Secondary Schools (Grades 10-12) by Region, 1996-2006

Year	The Gambia	Banjul/ Kanifing	WR	NBR	LRR	CRR[5]	URR
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
2001	0.80	0.81	0.75	0.33	0.75	0.50	0.50
2002	0.71	0.79	1.00	0.36	0.60	0.50	0.80
2003	0.90	0.89	0.86	0.86	1.00	0.67	0.60
2004	0.67	0.66	1.00	0.42	1.00	0.40	0.75
2005	0.80	0.73	1.11	1.00	1.17	0.75	0.83
2006	0.83	0.75	0.88	1.08	0.86	0.64	1.00

[4] Refers to both CRR – North and South
[5] Refers to both CRR – North and South

Source: EMIS 2007

Representation in Councils

Women constitute about 51 per cent of the population according to the 2003 Population and Housing Census results. The majority of the women are found in the rural areas and are mostly engaged in agriculture and the declining performance of the agricultural sector in the recent past, this has impacted negatively on the earnings of women.

Traditionally, Gambian women have not assumed lead roles in national politics despite their involvement in politics. Women's role in politics has for long been relegated to providing support to male candidates and for many years now the majority of females occupying political office are either nominated or appointed but not elected.

In response to advocates for the empowerment of women and the global campaign for women to take up their rightful positions in society, governments and individuals have increasingly promoted the active involvement of women in politics. In the Gambia, such campaigns seem to be paying off with an increasing number of women taking up political office. Currently, the Vice President and Secretary of State for Women Affairs, Secretary of State for Tourism and Culture, Secretary of State for Basic and Secondary Education, Secretary of State for Communication, Secretary of State for Justice and the Head of the Civil Service are all females. Also, the speaker of the National Assembly is a female. At the level of the National assembly, there is one female nominated member and 2 elected members compared to 48 male members of the National Assembly but at the divisional level, there is no female Governor or District Chief, although there are few village heads.

Table 3.5 below shows the number of male and female councillors by Local Government Area. Of all the councils, it is only in the Banjul City Council (BCC), where the gender gap in representation is not wide. Kerewan Area Council, which had 1 female Councillor in the past five years, currently does not have any female representative in its Council. For the other Councils, the number of male representatives far outnumbers the females. Overall, there are more males (86%) than females in the Municipalities and the Area Councils; an indication that women are still highly under-represented at decision making levels. Despite the important roles women play in national development, traditional beliefs and practices relating to the segregation of roles by gender still exist. Male dominance in decision making in The Gambia largely explains the poor representation of women in political office.

Table 3.5: Number of Elected Council Members by Sex and Local Government Area

Local Government Area	Number of Councillors		
	Male	Female	Total
Banjul City Council	5	4	9
Kanifing Municipal Council	14	4	18
Brikama Area Council	21	3	24
Mansakonko Area Council	11	1	12
Kerewan Area Council	16	0	16
Kuntaur Area Council	9	1	10
Janjanbureh Area Council	11	1	12
Basse Area Council	12	2	14
Total	99 (86%)	16(14%)	115

Source: Independent Electoral Commission (IEC)

Challenges

Data on gender parity in secondary school are indicative of disparities in educational attainment between the sexes across the country. The data show that gender parity has been attained at the level of primary school but there are disparities in gender parity between primary and secondary school levels, an indication of lower transition rates for girls than boys from primary to secondary school. This phenomenon can mainly be attributed to socio-cultural beliefs and practices that negatively impact on retention of girls beyond primary school. Some of these beliefs and practices relate to the following;

- Early marriage, particularly in rural areas;
- Parental preference of boys education to girls education;
- Parental preference of Madrassah education for their daughters;
- High educational costs

GOAL 4: REDUCE CHILD MORTALITY

Introduction

Until the late 1970s, childhood mortality rates in The Gambia were among the highest in the sub-region. This could be associated with a combination of factors such as low immunization coverage, poor access to health services and low nutritional status at the time. Nutritional status, particularly of children, has in the past been adversely affected by food taboos and feeding practices that affected the nutritional status of children. Over the years however, major gains have been made in improving access to health services, particularly in the area of maternal, newborn and child health.

Estimates of infant and child mortality have largely been derived from censuses and surveys since the registration of births and deaths is incomplete and often, such events are recorded late and cannot be used for statistical purposes.

Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate

Table 4.0: Summary Status of Indicators

Targets	Indicators	1990	Current Status (2007)	MDG Target (2015)
Target 4.A: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	4.1 Under-five Mortality Rate	135 (1993)	99 (2003)	45
	4.2 Infant Mortality Rate	84 (1993)	75 (2003)	28
	4.3. Proportion of 1 year-old children immunised against measles	87 (1991)	92.4 (2006)	29

Source: EPI Coverage Surveys, 1991; Censuses 1993 & 2003; MICS 2005/2006

Status and Trends

Available data point to improvements in child survival over the census periods. Mortality estimates derived from the 1973 and 1983 censuses showed infant mortality rates of 217 and 167 deaths per 1000 live births respectively. Under-five mortality rates for the same period were estimated at 320 and 260 deaths per 1000 live births. Estimates of childhood mortality as presented in the Table 4.1 below show considerable improvements over the past two decades. Whereas both under-five and infant mortality estimates for the period 1990-2001 showed stagnation, the estimates obtained from the 2003 census showed remarkable improvements in both indicators. Under-five mortality rate improved from 135 deaths per 1000 live births in 1993 to 99 deaths per 1000 live birth in 2003 and infant mortality improved from 84 per 1000 to 75 per 1000 live births for the same period. Although The Gambia has made significant progress over the years in reducing both infant and under-five mortality, it is not on track to attaining the MDG target of reducing under-five and infant mortality respectively to 45 and 28 deaths per 1,000 live births by 2015 (see Table 4.0 above).

Testimony of improved access to health services, particularly maternal and child health is evident in the high national coverage rates of immunisation in The Gambia. Coverage of measles immunization in 1990 was estimated at 87 per cent slightly improving for subsequent years with the proportion ranging from 89-93 per cent (Table 4.1)

Table 4.1: Summary of Child Mortality and Measles Immunisation Coverage

Indicator		**1990**	**2000**	**2001**	**2002**	**2003**	**2006**
Under-five mortality rate (per 1000 live births)	National trend	135 (1993)	NA	135	NA	99	**NA**
	MDG Target	45	106	102	98		
Infant mortality rate (per 1000 live births)	National trend	84 (1993)	NA	84	NA	75	**NA**
	MDG Target	28	66	64	61		
One-year-olds immunized against measles	National trend	87 (1991)	92	89	93	NA	92.4
	MDG Target	29					

Source: EPI Coverage Surveys, 1991; Census, 1993 & Maternal, Peri-natal, Neonatal, Infant Mortality and Contraceptive Prevalence Survey, 2001

Regional Disparities

Improvements in childhood survival at the national level also mirror regional improvements in survival. Estimates available for various periods indicate substantial variations across the Regions. Estimates based on the 1993 Census showed that under-five mortality ranged between 91 deaths per 1000 live births in Banjul to 169 in the Lower River Region. Under-five mortality rates for the period 1993-2003 showed significant improvements across the regions. Notwithstanding these improvements, the LRR continue to trail behind the other regions with Banjul, Kanifing and Western Region registering the lowest rates of mortality (Table 4.2).

Table 4.2: Under-five Mortality (per 1000 live births) by Region, 1993 and 2003 Census

Year	**Banjul**	**Kanifing**	**WR**	**NBR**	**LRR**	**CRR**		**URR**	**The Gambia**
1993 Census	91	100	134	137	169	137		158	135
2001 Survey	98	98	154	154	154	154		154	135
2003 Census	41	61	93	109	137	CRRN 134	CRRS 128	110	99
National Target	102	102	102	102	102	102		102	102

Source: 1993 and 2003 Population and Housing Census

As was observed with the under-five mortality rates, infant mortality showed similar trends over the period under review with the LRR recording the highest rates and Banjul, Kanifing and Brikama registering the lowest rates. In general, all regions registered considerable improvements in infant survival (Table 4.3 below).

Table 4.3: Infant Mortality (per 1000 live births) by Region, 1993 and 2003 Census

Year	Banjul	Kanifing	WR	NBR	LRR	CRR		URR	The Gambia
1993 Census	59	64	84	85	103	85		97	84
2001 Survey	64	64	95	95	95	95		95	84
2003 Census	36	51	71	81	96	CRRN 94	CRRS 92	82	75
National Target	64	64	64	64	64	64	64	64	64

Source: 1993 and 2003 Censuses and Maternal, Peri-natal, Neonatal, Infant Mortality and Contraceptive Prevalence Survey, 2001

Measles Immunization Coverage

Improvements in infant and child survival in The Gambia have often been associated with the high immunization coverage. Whilst the high coverage rates can partly be associated with a rigorous sensitization campaign which was aimed at educating the public on the importance of immunization, improved access to maternal and child health services have significantly contributed to the gains of the EPI programme.

Coverage of one-year old children immunized against measles in the Gambia has been impressive since the early 1990s in all the regions. In 1990, immunization coverage against measles was as high as 93 per cent in CRR, 83 per cent in URR and 89 per cent in NBR and LRR combined. It is particularly interesting that coverage rates for measles are slightly higher in predominantly rural regions than Banjul and Kanifing, where access to health services are relatively much better. Across the regions, immunization coverage improved slightly over the period 1990-2006 (Table 4.4). Despite the gains in improved coverage of measles immunization, the target of universal coverage is yet to be achieved. The most recent figures show that LRR and CRR North are closer to hitting the target of universal coverage of measles immunization than any other region. Whereas the high immunization coverage rates point to the need for concerted efforts to consolidate the gains, there is need to further improve coverage rates to achieve universal coverage. Nonetheless, The Gambia is on track to attaining the MDG target for immunization by 2015.

Table 4.4: Percentage of One-Year-Olds Immunized Against Measles, 1990-2006

Year	Banjul	Kanifing	WR	NBR	LRR	CRR		URR	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
2006	91	89	92	93	99	CRRN 96	CRRS 93	93	92

Source: EPI Coverage Surveys 1990´1996, 2001 and 2002; MICS II 2000 and MICS III, 2005/2006

Challenges

Despite the significant gains in reduction of infant and childhood mortality, levels observed in the Gambia remain among the highest in the World. The observed levels can be associated with a number of factors and challenges that impede rapid decline in levels of mortality. These relate to the following;

- Differential access to quality health services across the country;
- Sustenance of adequate supply of essential drugs and equipment in the public health sector;
- Retention of trained manpower in the public health sector;
- Maintenance of an efficient cold chain for the storage and transportation of drugs
- Non-functionality of the Primary Health Care (PHC) system
- Difficulty of maintaining health personnel in the rural areas

GOAL 5: IMPROVE MATERNAL HEALTH

Introduction

Maternal and Reproductive health issues are a very high priority on The Gambia Government's development agenda. However, The Gambia has one of highest maternal mortality rates in sub-Saharan Africa and faces numerous challenges in its efforts to realise the MDG targets on maternal mortality. Data on maternal mortality are generally problematic because of their small sample sizes. A 2001 national survey estimated maternal mortality at 730 per 100,000 live births, indicating a decline of about 30.5 per cent over the 1990 estimate of 1,050 maternal deaths per 100,000 live births. The data suggest that maternal mortality is declining albeit slowly. The MDG target is a three-quarters reduction in maternal deaths between 1990 and 2015 and using the1990 maternal mortality ratio of 1,050 per 100,000, this works out to 263 maternal deaths per 100,000 by 2015 (Table 5.0 and Figure 5.1 below). Given that it took 11 years (1990 to 2001) to reduce by about 31 per cent, it is unlikely that the country will be able to attain the MDG in the remaining time period of 7 years.

Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio

Table 5.0: Summary Status of Indicators

Targets	Indicators	1990	Current Status 2007	MDG Target
Target 5.A: Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio	5.1 Maternal Mortality Ratio	1050	730 (2001)	263
	5.2 Proportion of births attended by skilled health personnel	42	57 (2006)	63
Target 5.B: Achieve, by 2015, universal access to reproductive health	5.3 Contraceptive Prevalence Rate	6.7%	13.4% (2001)	
	Adolescent (15-19 years) Birth Rate per 1,000	167 (1993)	103 (2003)	
	5.4 Antenatal care coverage (at least one visit and at least four visits)		96% (2001)	
	5.5 Unmet need for Family Planning	30%		

Source: Fertility Determinants and Contraceptive Prevalence Survey, 1990; 1993 Census and Maternal, Peri-natal, Neonatal, Infant Mortality and Contraceptive Prevalence Survey, 2001

Status and Trends

The percentage of births attended by skilled health personnel increased from 52 per cent in 2000 to 57 per cent in 2006; an increase of about 10 per cent within six years (Table 5.1 and Figure 5.2 below). The increase in births attended by skilled health personnel is quite

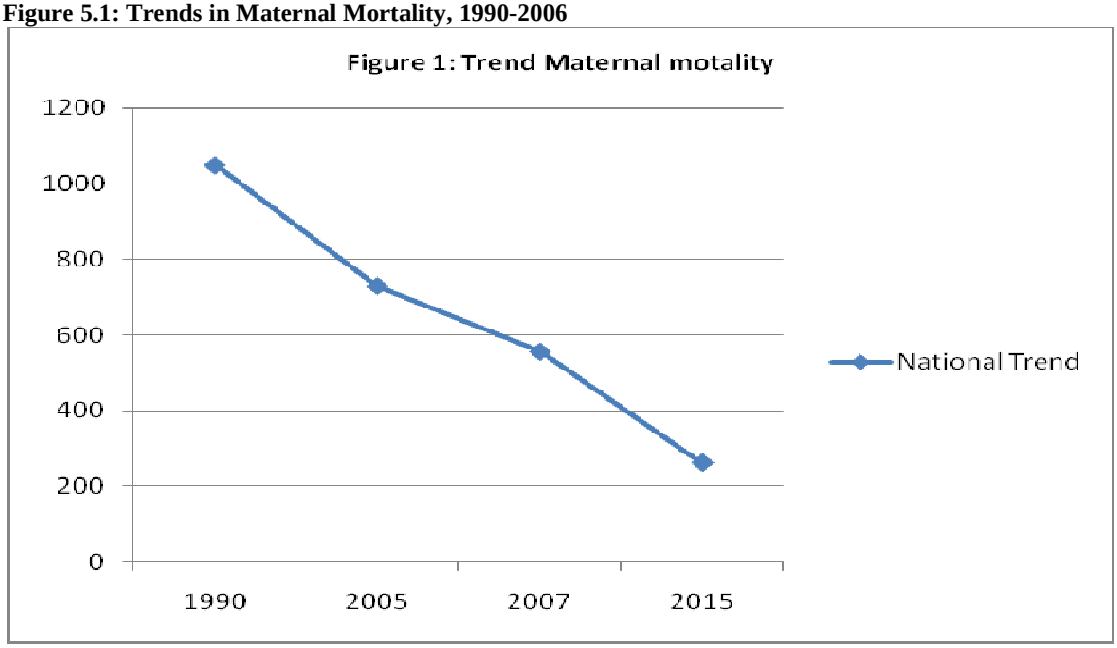
encouraging, however, if the 10 percent increase of 2000 and 2006 trend continues, the country is not likely to attain the MDG target of 90 per cent by 2015 i.e. in seven years time.

Table 5.1: Summary of Maternal Health Indicators, 1990-2007

Indicator		1990	2005	2007
Maternal Mortality Ratio (per 100, 000 live births)	National Trend	1050	730 (2001)	
	MDG Target	525	735	735
Percentage of births attended by skilled health personnel	National Trend	42	52 (2000)	57 (2006)
	MDG Target	44	52	

Source: Maternal and Mortality Survey (MMR Study 1990 DOSH), MMR and Contraceptive Prevalence Rate CPR) Survey 2001, National Survey on Obstetric Fistula 2006, 2001 and 2005 National Survey on Maternal Perinatal, Neonatal and Infant Mortality and Contraceptive Prevalence Survey and the Multiple Indicator Cluster Surveys (MICSII) and (MICSIII)

Figure 5.1: Trends in Maternal Mortality, 1990-2006



Regional Disparities

Disaggregated data by region from the 1990 Maternal Survey is presented in Table 5.2. CRR and URR had the highest maternal deaths of 1,360 per 100,000 live births followed by the WR with 1,080 maternal deaths per 100,000 live births. As expected, the urban areas of Banjul and Kanifing had the lowest maternal deaths each of 600 per 100,000 live births. The lower rates of maternal deaths in the urban areas compared to the mostly rural regions can be attributed to better access to health services, better nutritional status and appropriate and timely referrals. The combined impact of these services led to reduction in maternal morbidity caused by anaemia and malaria that normally affect pregnant women both at national and regional levels. It is worth noting that the more recent 2001 Maternal Survey was not disaggregated by region due to small sample size. Thus, it is not possible to do a comparative regional analysis of the 2001 survey.

Figure 5.2: Proportions of births attended by skilled health personnel, 1990-2015

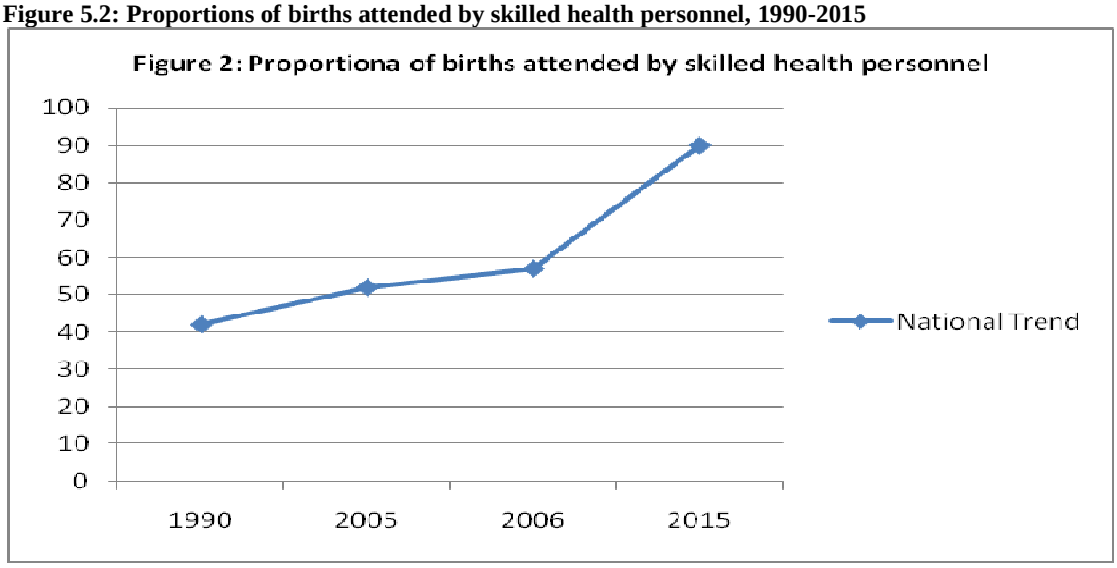


Table 5.2: Maternal Mortality (per 100, 000 Live Births) by Region

Year	BCC	KMC	WR	LRR	NBR	CRR	URR	The Gambia
1990 MM Study	600	600	1080	820	820	1360	1360	1050
2001 MPNIMCP Survey	495	495	730	730	730	730	730	730
MDG Difference								
MDG Target 2015	150	150	270	205	205	340	340	263

Source: , Maternal, Perinatal, Neonatal and Infant Mortality and Contraceptive Prevalence Survey, 2001 and the LGA Estimates based on the Regional Maternal Mortality Regional figures

Table 5.3 shows the regional distribution of the percentage of births attended by skilled health personnel. According to the data, the percentage of births attended by skilled health personnel in 2006 were highest in the urban regions of Banjul and Kanifing respectively with 95 and 83 per cent, followed by the WR, 65 per cent. Besides, the CRR, which has 50 per cent of its births attended by skilled health personnel, all the other rural regions had less than 50 per cent of their birth attended by skilled personnel. The URR had the lowest with only 26 per cent of births attended by skilled health personnel.

It is noteworthy that births attended by skilled health personnel had actually declined by 11 and 4 percentage points respectively in NBR and LRR between MICS II in 2000 and MICS III in 2005/6. Nationally, only 57 per cent of births were attended by skilled health personnel. This partly explains why maternal mortality is very high in The Gambia. The reason for the low rates of births attended by skilled health personnel can be explained by declines in the number of skilled health personnel in the rural areas, the loss of these skilled health workers to either the private sector mostly in the urban areas coupled with the high attrition of skilled health personnel, particularly nurses for well paid jobs overseas in the United Kingdom and\or to the United States.

Table 5.3: Percentage of Births Attended by skilled Health Personnel by Region

Year	Banjul	Kanifing	WR	LRR	NBR	CRR	URR	The Gambia
1990 GCPFDS	83	83	35	32	32	26	26	44
2000 MIC II	83	82	55	44	48	31	27	52
2006 MIC III	95	83	65	40	37	50	26	57

Source: Gambia Contraceptive Prevalence and Fertility Determinants Survey (GCPFDS), 1990; Multiple Indicator Cluster Study (MICS II & III), 2000 and 2005/6

The Gambia's contraceptive prevalence rates remains very low. According to Table 5.4, contraceptive prevalence (modern and traditional) increased from 11.7 per cent in 1990 to 17.4 per cent in 2001. Interestingly, unmet need for family planning is estimated at 30 per cent. It would be noted that availability of data on contraceptive is a major constraint as the latest information on contraceptive prevalence dates back to 2001 thus, affecting reproductive health planning.

Table 5.4: Percentage of Contraceptive Methods Used, Unmet Need for Family Planning and Antenatal Care (ANC) Coverage

Indicator	FP Method	1990	1993	2001	2003
Contraceptive Prevalence Rate (CPR)	Modern	6.7%	-	13.4%	
	Traditional	5.0%	-	4.1%	
Adolescent (15-19) years Birth Rate per 1,000		-	167	-	103
Antenatal care coverage (at least one visit and at least four visits)		-	-	96%	
Unmet need for Family Planning		-	-	30%	

Source: GCPFD Survey, 1990; Censuses 1993 and 2003 and GFPA

Table 5.4 also shows that adolescents' births to women aged 15-19 years have declined by 38 per cent i.e. from 167 births per 1000 adolescents in 1993 to 103 births per 1000 adolescents in 2003. This significant decline in adolescents' births is the major driving force in The Gambia's fertility decline in 2003. Increases in girls' education and age at first marriage coupled with urbanization are the major contributing factors to the decline in adolescents' births. Overall, the antenatal care (ANC) coverage of at least one visit and at least four visits was 96 per cent in 2001. This indicates that the utilization and access to reproductive and child health (RCH) services in all health facilities in the country is on the increase (Table 5.4 above).

Table 5.5 presents regional breakdowns of adolescents' births as percentage of total fertility in 1993 and 2003. All the regions have witnessed significant declines in adolescents' births between 1993 and 2003. Comparatively, the KMC and WR witnessed the largest decline with 38.5 and 35.7 per cent respectively and Banjul, the capital, has the least proportion of

births to adolescents of 9 and 7 per cent respectively for 1993 and 2003. This indicates the importance of urbanization as a major factor in fertility decline.

Table 5.5: Adolescents (15-19) births as percentage of total fertility by Region, 1993 and 2003 Census

Regions/LGA	1993	2003
Banjul	9	7
Kanifing Municipal Council (KMC)	13	8
Western Region (WR)	14	9
Lower River Region (LRR)	15	11
North Bank Region (NBR)	14	10
Central River Region (North) CRR-N	15	10
Central River Region (South) CRR-S	16	11
Upper River Region (URR)	16	13
The Gambia	**14**	**10**

Source: 1993 and 2003 Population and Housing Census

Challenges

- Scarcity of trained Human resources; Doctors/Nurse/Midwives especially in the rural health facilities; including both availability and retention of health care personnel
- Inadequate data to assess the MDG indicators
- Lack of resources to conduct assessments for some of the key indicators of Maternal Mortality and Reproductive and Child Care
- Weak referral system especially in rural areas
- Poor equipment and non-functioning of operation theatres to deal with maternal and newborn emergencies
- Low budget allocations to activities and services to improve the maternal mortality ratio (MMR) and the national RCH Programme
- Improving the socio-economic and nutrition level of women
- Availability of adequate infrastructure in health facilities including staff quarters
- Availability of adequate essential and emergency drugs and ambulances for RCH outreach services

Policy Environment

- Favourable health policy with the strategic goal of providing an important framework to address maternal and other health issues
- Implementations of prioritised strategies e. g. emergency maternal and child health (EMCH), integrated management of neonatal childhood illnesses (IMNCI) and information communication and education (IEC) to address the immediate needs of RCH.
- Strengthen Technical Cooperation agreement with the government of Cuba, Egypt, Nigeria and Taiwan and other development partners for provision of both human and financial resources to the health sector
- Pronounced budgetary measures to address the resource needs of DoSH for RCH Programmes
- Provision of adequate health infrastructure and expanding RCH/EPI outreach

Priorities for Development Assistance

- Support to strengthening the health planning, monitoring system and management at both national and regional levels
- Creation of incentives to retain trained health personnel and mechanisms to prevent brain drain
- Provision of equipments and material resources to the health facilities especially the referral centres and the required personnel to effectively deliver the services needed
- Provision of resources to assess Maternal Mortality and Reproductive and Child Care
- Provision of financial support for the Information Education and Communication (IEC) campaigns increase community awareness levels on malaria, sanitation, prevention of acute diseases and preventive services available at health facilities
- Strengthening bilateral relationship between The Gambia government and its development partners for effective health service delivery

GOAL 6: COMBATING HIV/AIDS AND OTHER DISEASES

Introduction

Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS

HIV/AIDS was first observed and diagnosed as an epidemic in the Gambia, in 1986 and the country has since recognised the pandemic as a developmental issue and addressed it using a holistic approach. Thus, the first National AIDS Forum, which was a multi-sectoral response to the epidemic, was convened in November 2000. Response to HIV/AIDS has since been mainly supported by the Government of the Gambia, WHO, World Bank, UNAIDS, UNFPA, the Global Fund and UNDP. Table 6.0 gives a summary status of the indicators.

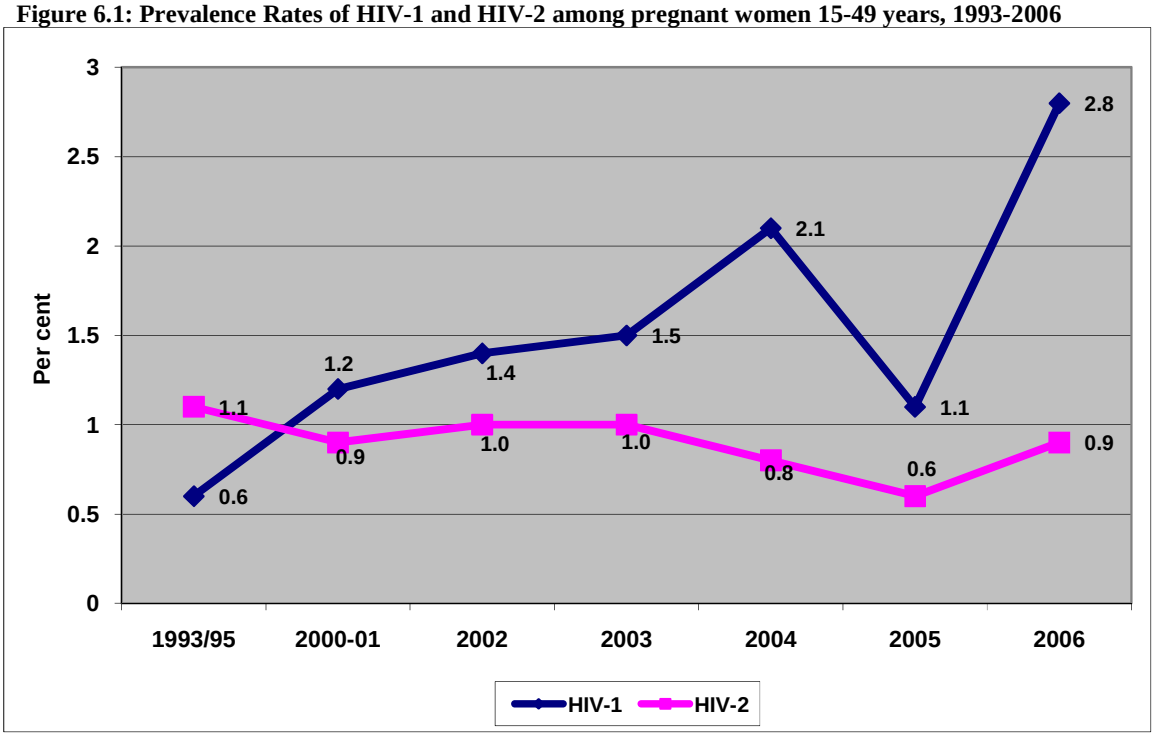
Table 6.0: Summary Status of Indicators

Target	Indicators	1990	Current Status (2007)	MDG Target (2015)
Target 6.A: Have halted by 2015 and begun to reverse the spread of HIV/AIDS	6.1 HIV prevalence among population aged 15-24 years	HIV-1: 0.6 HIV-II: 1.1	2.8 0.9	
	6.2 Condom use at last high-risk sex	N/A	54.3	
	6.3 Proportion of population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS	N/A	39.1	
	6.4 Ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years	N/A	0.87 (2006)	
Target 6.B: Achieve, by 2010, universal access to treatment for HIV/AIDS for all those who need it	6.5 Proportion of population with advanced HIV infection with access to antiretroviral drugs			
Target 6.C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	6.6 Incidence and death rates associated with malaria			
	6.7 Proportion of children under 5 sleeping under insecticide-treated bed nets and Proportion of children under 5 with fever who are treated with appropriate anti-malarial drugs	ITNs Anti-malarial	49 62.6	80 80
	6.8 Incidence, prevalence and death rates associated with tuberculosis			
	6.9 Proportion of tuberculosis cases detected and cured under directly observed treatment short course			

Status and Trends

The first nationwide survey of 30,000 pregnant women in 1993-1995 revealed prevalence rates of 0.6 per cent for HIV-1 and 1.1 per cent for HIV-2. The first generation of sentinel surveillance among pregnant women began in 2000-01 with a baseline survey in the catchments of four health centres: Serekunda, Sibanor, Farafenni and Basse. A prevalence rate of 2 per cent HIV-1 and 0.9 per cent HIV-2.were respectively found.

Figure 6.1: Prevalence Rates of HIV-1 and HIV-2 among pregnant women 15-49 years, 1993-2006



Source: The Gambia, 2006 Sentinel Surveillance Data

The results of the 2004 sentinel survey indicated a significant increase in HIV/AIDS prevalence with 2.1 per cent of HIV-1 whilst HIV-2 has been declining steadily with 0.8 per cent within the same period. The 2005 results indicated that the prevalence rate has decreased to 1.1 per cent for HIV-1 and 0.6 for HIV-2. This trend took a reverse direction with an alarming increase of 2.8 per cent prevalence rate in 2006 for HIV-1 and 0.9 per cent of HIV-2 with geographical variations in reported HIV-1 prevalence rates (Figure 6.1 above and Table 6.1 below). The highest rates recorded were from rural communities of Brikama, Sibanor, Basse and Essau where the prevalence was 4.8 per cent, 4.2 per cent, 4.1 and 3.2 per cent respectively (Table 6.2 below). Possible reasons for these high rates include the influx of refugees from conflict areas in neighbouring countries in addition to cultural/traditional practices, low condom use and poverty among others.

Table 6.1 HIV/AIDS Indicators, 1993/5-2006

Indicator	1993-5	2000-01	2002	2003	2004	2005	2006
HIV-1 Prevalence (%) among 15-49 Year old Pregnant Women	0.6	1.2	1.4	1.5	2.1	1.1	2.8
HIV-2 Prevalence (%) among 15-49 year old Pregnant Women	1.1	0.9	1.0	1.0	0.8	0.6	0.9
Condom use at last high-risk sex (among 15-24 year olds)	NA	NA	62	73.7	NA	NA	54.3
Percentage of Population aged 15-24 with comprehensive correct know of HIV/AIDS	NA	NA	37	NA	NA	48.8	39.1

Sources: * Sentinel Surveillance data; ** The Gambia 2003 Behavioural Surveillance Survey (BSS) on HIV/AIDS and (MICS III, 2005/2006 Report)

Regional Disparities

Data on HIV/AIDS is only available from the sentinel surveillance sites and in order to improve national coverage and estimates, sentinel surveillance sites have been increased from six to nine to include Banjul, Soma and Essau. A preliminary analysis of the 2006 data indicates that HIV-1 prevalence among the population aged 15-24 years is now 2.4 per cent, the highest recorded in 2006. For HIV-2, the highest was recorded in 2003 with 0.8 per cent. However, HIV-2 has since been decreasing steadily during 2004 and 2005 with 0.4 and 0.3 per cent respectively but increased to 0.7 per cent in 2006 (Figure 6.1 above)

Table 6.2: HIV-1 Prevalence (%) in Pregnant Women by Sentinel Site, 1993/95-2006

Year	Banjul	S/kunda	Brikama	Sibanor	Soma	Farafenni	Essau	K/taur	Basse	The Gambia
1993-95	NA	0.7	0.1	0.6	NA	0.3	NA	Na	1.0	0.6
2000-01	NA	1.0	NA	3.0	NA	0.4	NA	NA	1.4	1.3
2002	NA	0.2	2.4	3.4	NA	0.0	NA	0.6	0.3	1.4
2003	NA	2.4	0.8	2.8	NA	0.7	NA	1.2	0.8	1.5
2004	NA	2.2	2.0	2.8	NA	1.8	NA	1.0	2.8	2.1
2005	NA	1.0	2.6	2.2	0.2	0.4	0.0	0.9	1.3	1.1
2006	1.5	2.8	4.8	4.2	1.4	2.5	3.2	0.2	4.1	2.8

Source: The Gambia 2006 Sentinel Surveillance Survey on HIV

Condom use at last high-risk sexual encounter among young women aged 15-24, was 54.3 percent at the national level. At the Regional level, LRR registered the highest proportion 85.4 percent followed by the URR with 79 per cent while NBR and CRR-South recorded almost equal proportions of 73.7 and 73.3 percent respectively. Kanifing has the lowest at 46.9 percent (Table 6.3). There were no significant differentials in the use of condom at last high-risk sex in the rural area, 55 per cent, compared to urban at 53.8 per cent (MICS-III, 2005/2006 Report).

Data on comprehensive knowledge of HIV/AIDS by residence indicates that a high proportion of urban residence 41.9 per cent have a comprehensive knowledge about HIV/AIDS transmission as opposed to 37.1 per cent in the rural areas (MICS-III, 2005/2006 Report).

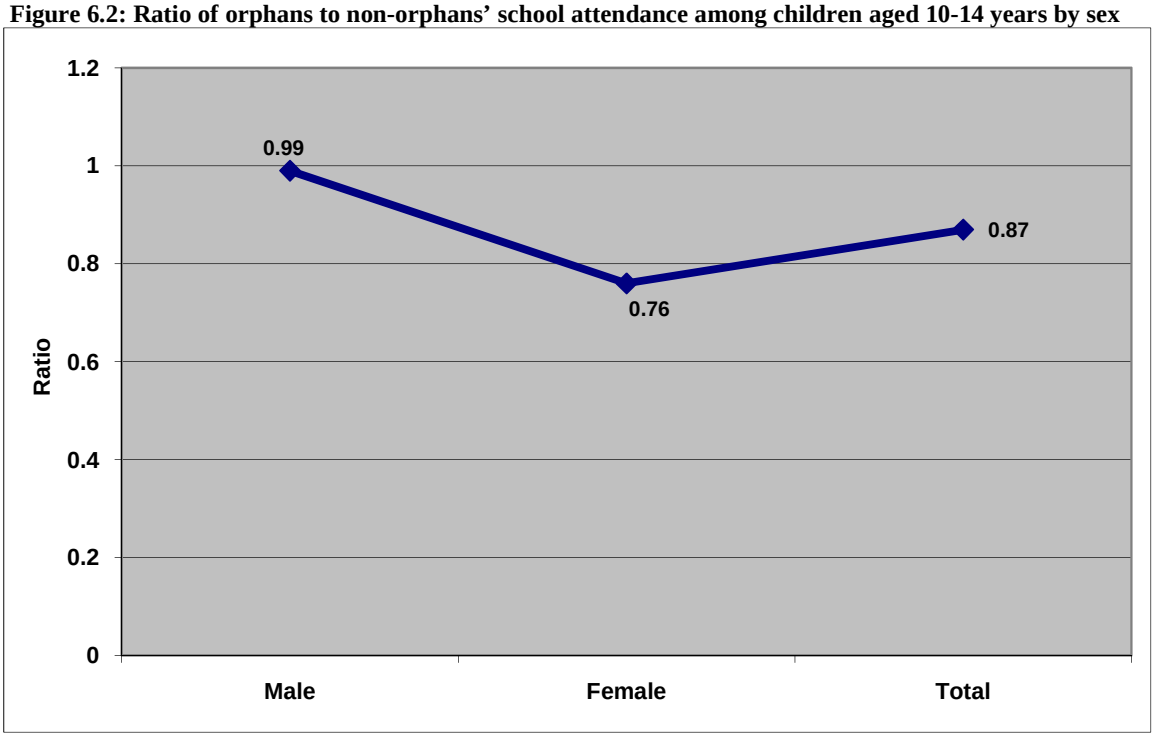
Table 6-3: Condom use and HIV/AIDS Knowledge among 15-24 Year Olds

Indicator	Banjul	Kanifing	Western Region	LRR	NBR	CRR-N	URR	The Gambia
% aged 15-24 with comprehensive correct knowledge	37.4	40.9	50.1	32.9	46.8	32.1	23.2	39.1
% of respondents using condoms at last high-risk sex	53.8	46.9	48	85.4	73.7	50	79	54.3

Source: Multiple Indicator Cluster Survey (MICS-III), 2005/2006 Report.

The ratio of school attendance of orphans to school attendance of non-orphans aged 10-14 years, seeks to analyse the relationship of a child being orphaned and attending school by gender. The data shows an overall ratio of 0.87. This does not show significant difference with non-orphans attending school (Figure 6.2 below) also there is no significant differential in school attendance among orphan or non-orphan children of different sexes (MICS-III, 2005/2006 Report).

Figure 6.2: Ratio of orphans to non-orphans' school attendance among children aged 10-14 years by sex



Source: MICS, 2005/2006 Report

Challenges

The initial response of the programme was on IEC with the assumption that an effective IEC programme will eventually result in the control and stabilization of the epidemic. However, the current focus is on treatment, care and support through VCT, PPTCT and ARV provision to curb the prevalence rate. Behavioural Change Communication (BCC) is now given prominence in the current response. Since the disease was discovered, only one nationwide

survey was conducted in 1993-1995 but this is not adequate for a thorough understanding of the epidemic and its drivers. Currently, most of the information on HIV/AIDS is obtained from sentinel surveillances and clinical records from urban and peri-urban areas. These are limited in scope and depth to enable the planners and policy makers to understand the epidemic better with a view to plan and formulate appropriate policies to fight against the disease. However, in spite of the remarkable gains registered in the national response to HIV/AIDS there is still an apparent gap between knowledge and behaviour change as well as insufficient knowledge of the key drivers of the epidemic.

Despite strenuous and concerted 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 slim. Several major challenges must be overcome to reinforce the response against HIV/AIDS and these include:

- Thorough understanding of the epidemic and the key drivers and their locations;
- Reduce stigma and discrimination against People Living with HIV/AIDS;
- Eliminating abject poverty which leads to high-risk behaviour, especially amongst some women and girls, making them more vulnerable to HIV/AIDS;
- Availability of reliable and timely data on behavioural characteristics of high-risk groups, such as sex-workers, uniformed services and truck drivers;
- Ensuring that all health facilities have the capacity to provide Voluntary Counselling and Testing (VCT), as a conduit to promote lasting behavioural change;
- Making Anti-Retroviral (ARV) drugs available and accessible to eligible People Living with HIV/AIDS (PLWHA) and creating support systems to maintain their provision;
- Ensuring availability of drugs for opportunistic infections and proper nutrition for PLWHA;
- Strengthening and supporting implementation of home-based care services;
- Strengthening care and support services and making it available and accessible to individuals infected and affected by HIV/AIDS, including children and orphans to mitigate the impact of HIV and AIDS;
- Supporting the implementation of the Behavioural Change communication strategy;
- Monitoring of patients on ARVs by health services for early initiation of PLWHA on ARVs;
- Strengthening the national Monitoring and Evaluation framework for HIV and AIDS multi sectoral response;
- Encouraging male involvement in HIV and AIDS response; and
- Increasing Government funding to fight HIV/AIDS.

Policy Environment

A very strong policy environment exists to combat HIV/AIDS which includes the existence of a national HIV/AIDS policy and the 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 National AIDS Secretariat (NAS) under the Office of The President. Also a Global Fund Round 3 HIV/AIDS Grant is currently being implemented and co-ordinated by NAS and there are major interventions to increase prevention programmes as well as establish home-based care, PLHIV support groups, provision of Voluntary Counselling and Testing (VCT) services and prevention of parent to child transmission of HIV/AIDS, Anti-Retroviral therapy are being provided.

Priorities for Development Co-operation

- Expanding and scaling up Voluntary Counselling, Testing services;
- Ensuring the continuous availability of ARVs and opportunistic infection drugs for all eligible PLWHA;
- Conducting a Demographic and Health Survey plus (DHS+) to provide a more robust estimate of HIV/AIDS prevalence rates;
- Conduct of ethnographic studies
- Increase in the number of sentinel sites to ensure a truly national coverage;
- Strengthening national efforts to sensitise all sectors of society and mainstreaming HIV and AIDS into all sectoral policies;
- Accelerating HIV and AIDS prevention programmes through behavioural change communication (BCC)
- Expanding and scaling up prevention of Parent to Child Transmission (PTCT) services countrywide;
- Promoting income generation for PLWHA and other high-risk groups, and
- Implementation of the "Three Ones" principles

Target 6 C: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

Status and Trends

Malaria is the leading cause of morbidity in The Gambia, and according to data derived from health facility reports; malaria is estimated to account for about 44 per cent of total deaths in the country and 47 per cent in infants and children under-five. Malaria is also the most common disease treated in hospitals and health centres. According to MICS-III, 2006, 8.4 per cent of children under-five had experience fever within the previous two weeks whilst 62.6 per cent received ant-malarial drugs and about 50 per cent slept under ITNs.

Regional Disparities

Fever incidence and disease control measures vary within the Regions/Municipality, as shown in Table 6.4. The proportion of under-fives who had fever in the last two weeks prior to survey was lowest in LRR and CRR-South 3.4 and 6.5 per cent respectively. The highest was reported in Banjul (15.6 per cent) and CRR North (11.2 per cent).

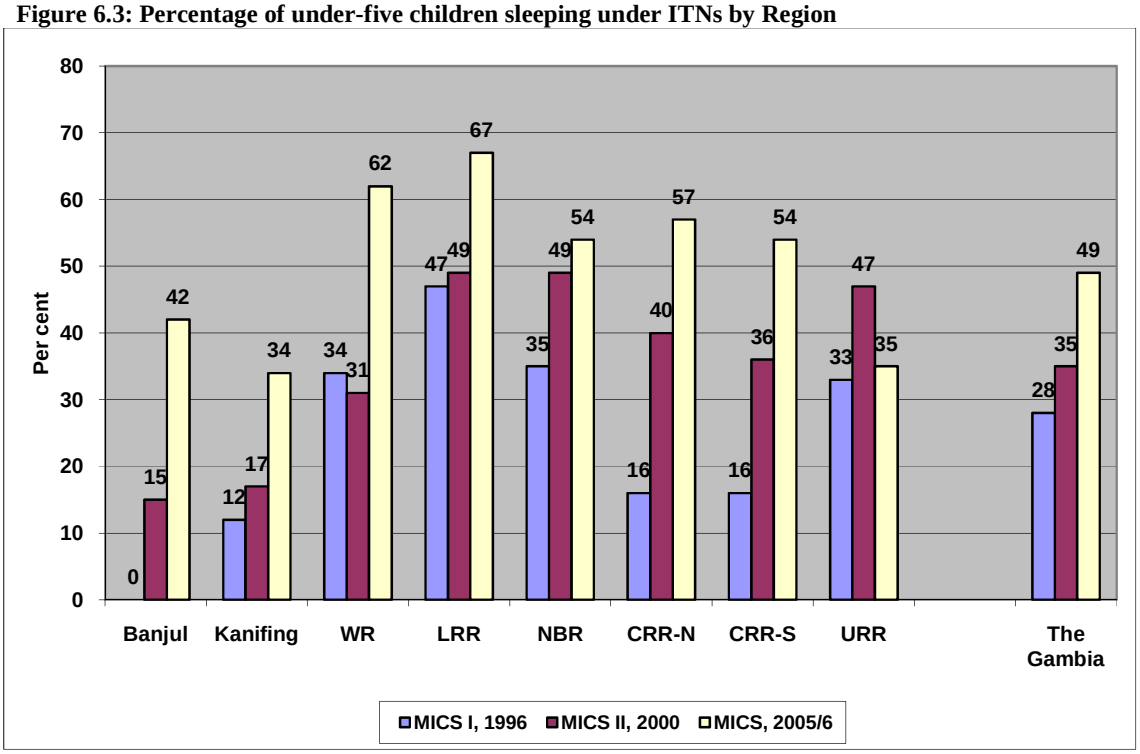
Table 6.4: Malaria Treatment and Control for Under-Fives by Region, 2005/2006

Municipality/Region	Fever in previous 2 weeks %	Received Anti-Malarial Drugs %	Sleep Under ITNs %
Banjul	15.6	28	42.5
Kanifing	9	60.2	34.3
Western Region	7.7	66.9	62.3
Lower River Region	3.4	NA	66.6
North Bank Region	9.7	65.1	54.0
Central River Region -North	11.2	64.3	56.8
Central River Region - South	6.5	79.6	54.0
Upper River Region	7.9	56.8	35.0
The Gambia	8.4	62.6	49.0

Source: MICS III Report, 2007

The use of anti-malarial drug treatment was highest in rural areas; as well as insecticide treated nets (ITNs) were most frequently used in rural areas. According to the MICS III results, the use of ITNs has increased in all the Regions, except the URR (Figure 6.3.below)

Figure 6.3: Percentage of under-five children sleeping under ITNs by Region

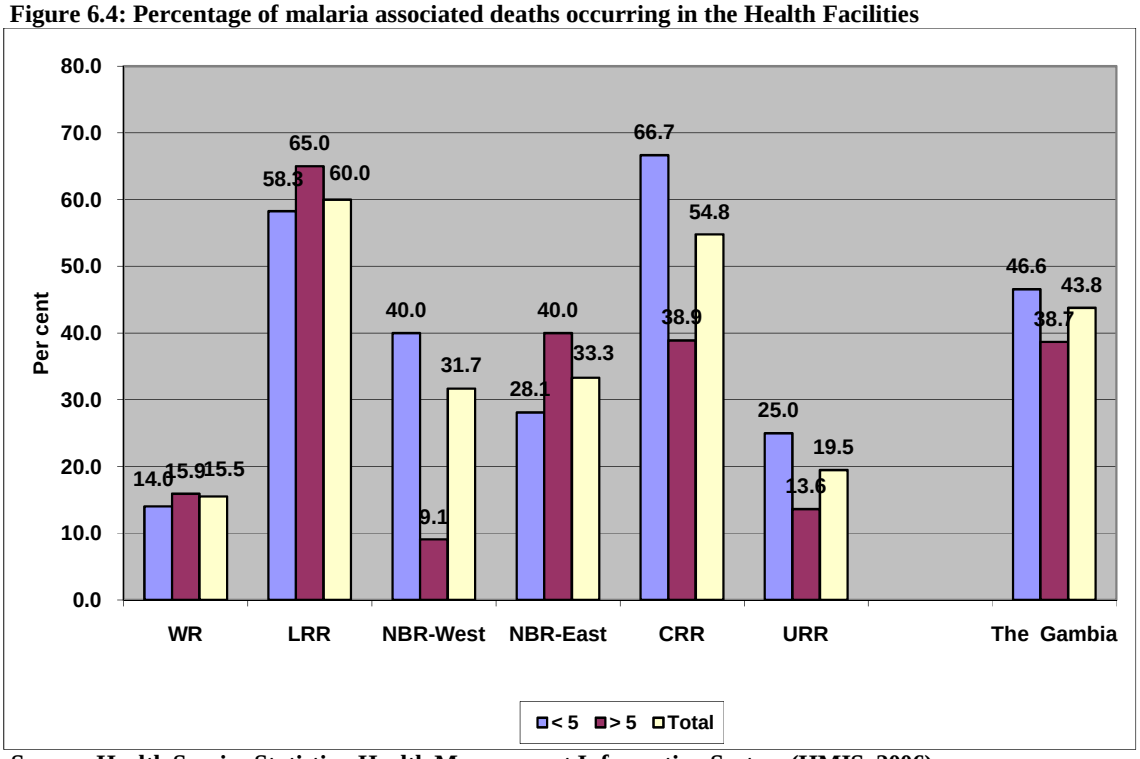


Source: MICS-I, II & III, Reports

Figure 6.4 below provides data on malaria associated deaths occurring in Health Facilities in the country. Generally, malaria associated deaths are lowest in the Western Region, which comprises Banjul, Kanifing and Brikama. Malaria associated deaths among under-five children are highest in CRR, about 67 per cent followed by LRR, 58 per cent. According to the 2003 poverty study, the two regions (CRR and LRR) were identified as the poorest.

Overall, malaria associated deaths are highest among children under-five, about 47 per cent compared to 39 per cent of those aged 5 and above.

Figure 6.4: Percentage of malaria associated deaths occurring in the Health Facilities



Source: Health Service Statistics, Health Management Information System (HMIS, 2006)

Challenges

The incidence of malaria can be reduced, but will require concerted action by all stakeholders. Major challenges to 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 also been developed. In addition, a nationwide "Operation Clean the Nation"(known as ¨'set settal' in local parlance) is conducted in the last Saturday of each month with the active participation of the President, cabinet ministers and senior government officials. This exercise has helped to increase awareness on the importance of environmental cleanliness in the overall fight against malaria.

The Gambia is participating in the World Health Organization'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) through the Accelerated Child Survival and Development (ACSD) project is providing long lasting nets (LLNs) to newborn babies and their mothers and popularising the use of ITNs in its area of intervention in URR and

KMC. 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.

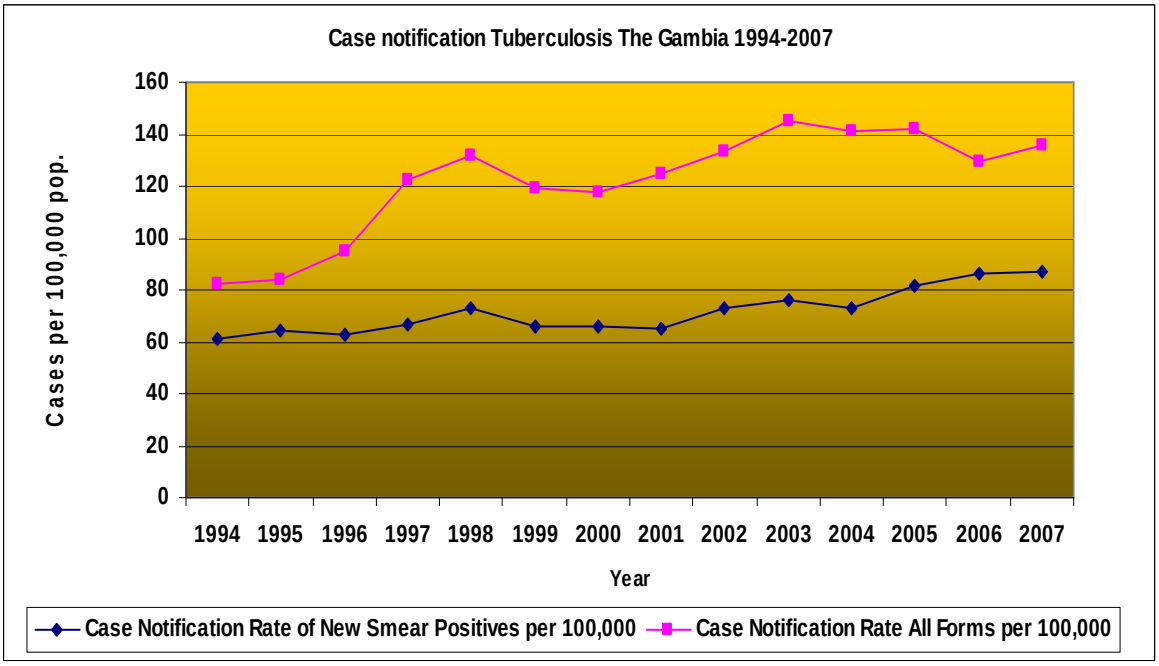
Tuberculosis

The Gambia 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). These efforts have been complemented by the approval of the Global Fund TB Component Grant Round 5 of 2005, which is being implemented countrywide since May 2006. 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.

Status and Trends

The incidence and prevalence of TB in The Gambia is unknown because there were no comprehensive studies or tuberculin surveys conducted in conformity with WHO protocols. Nevertheless, data is routinely collected at specialised public sector TB clinics and by NGO and private sectors. Figure 6.5 below shows that the case notification rate per 100.000 populations of new smear positive TB cases and TB of All forms increased significantly over the past decade.

Figure 6.5: Case Notification of Tuberculosis per 100,000 population in The Gambia, 1994-2007



The rate of new smear positive cases increased from 61 per 100,000 in 1994 to 87 per 100,000 in 2007. Similarly, the rate for All forms of TB (New sputum Smear positive, New Smear negative, Extra-pulmonary TB, Relapse, Failure and Return After Default) also increased (Figure 6.5 below). This increase attributed to both improved surveillance and increased incidence as a secondary infection associated with the HIV-1.

Table 6.5: Percentage distribution of treatment of new smear positive cases enrolled on SCC 1988-2007

Year	Cured	Success	Treatment Completed	Failure	Died	Defaulted	Transferred
1988-1992	68	71	3	1	5	17	6
1993-1995	66	73	7	1	5	12	10
1996	72	80	8	1	7	10	2
1997	70	74	4	3	6	14	3
1998	69	73	4	3	5	14	4
1999	65	71	6	2	8	15	4
2000	65	73	8	1	6	14	6
2001	65	71	6	2	6	16	5
2002	67	74	7	3	5	11	7
2003	67	75	8	1	4	14	6
2004	76	86	10	2	6	4	2
2005	82	87	6	1	7	3	1
2006	83	86	3	1	8	3	1
2007	80	85	5	3	7	4	2
National	70	76	6	2	6	11	5

Source: National Leprosy and TB Programme (NLTP), 1988-2007

Figure 6.6: TB Treatment Outcomes 1988-2006, National Leprosy and TB Programme, 1988-2006

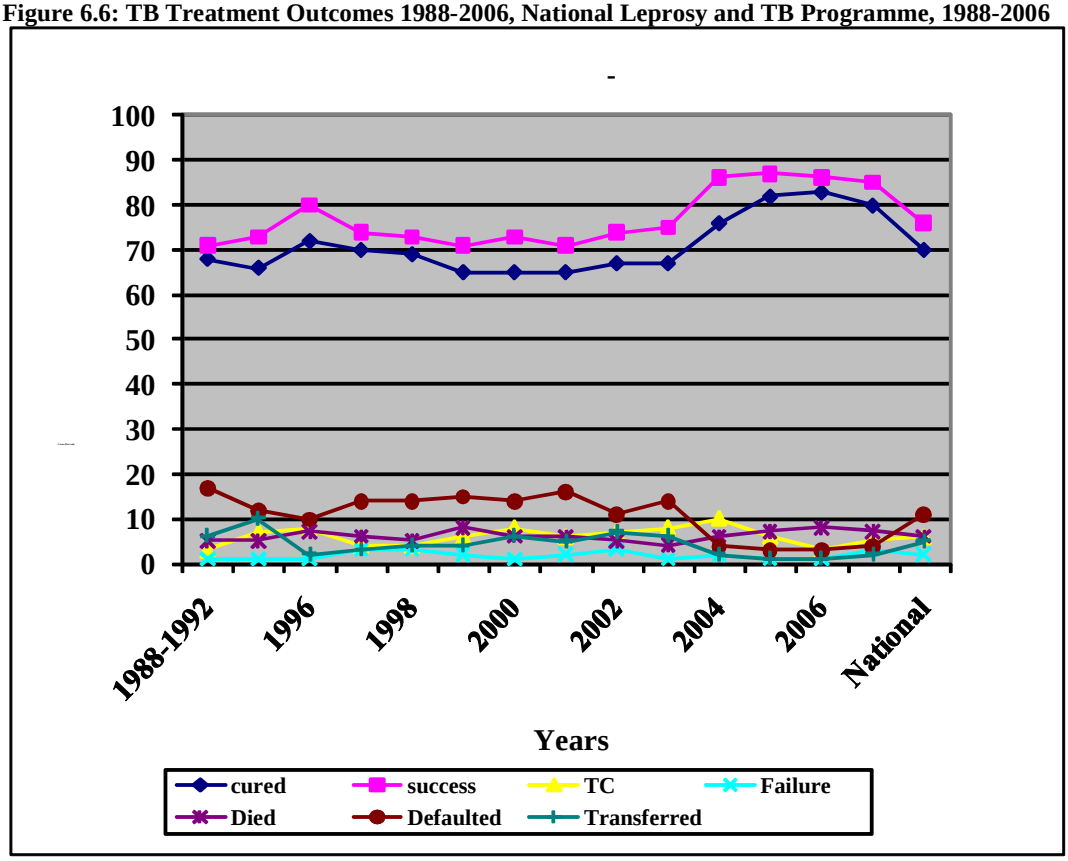
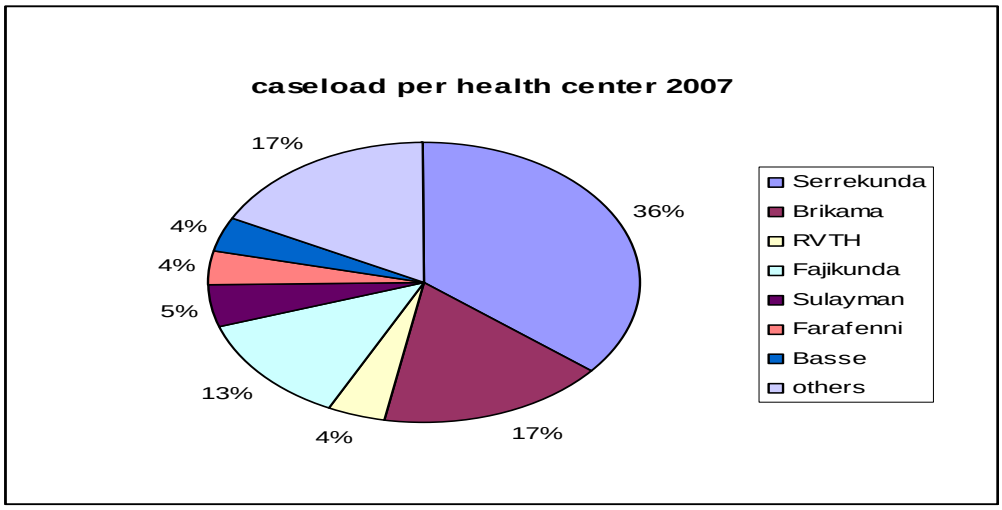


Table 6.5 and Figure 6.6 below show the percentage distribution of Short Course Chemotherapy (SCC) treatment outcomes of TB cases from 1988 to 2007. According to the data, there is high success rate of 76 per cent. This is mainly due to high coverage of TB treatment in the country. Success rate is a combination of treatment completed and cured. Only 6 per cent died, with 2 and 11 per cent failure and default respectively. The epidemiology of tuberculosis (TB) in The Gambia is influenced by urbanisation, HIV infection and the age sex distribution in the population.

Urban TB

Tuberculosis (TB) caseload and notifications differ strongly between regions. The Western Region (WR), which comprises of Serekunda, Brikama, RVTH, Faji Kunda and Sulayman Junkung Health Centres diagnoses 75 per cent of all notified cases (Figure 6.7 below) but it is not clear if all these cases are all residents of the WR or if a number of the patients come from rural areas to WR for diagnosis and treatment. It is also evident that most cases in the WR are found within settlements that are conducive to the spread of TB, such as military barracks, slum dwellings, and crowded housing. Therefore activities geared towards increased case finding in the Western Region should focus primarily on areas with clustering of TB cases.

Figure 6.7: TB Caseloads by Centre and Region, 2007



Source: National Leprosy and TB Programme, 2008

TB and HIV

Integrated voluntary TB/HIV counseling and testing services (VCT) are available at all diagnostic and treatment centres. At the Brikama Anti-Retroviral Treatment (ART) Centr,e TB/HIV co-infection was estimated at 37 per cent. In 2007, 14 per cent of tested male and 24 per cent of female TB patients were HIV positive. A total of 937 patients were tested for HIV in 2007, about 50 per cent of total TB cases in 2007. As data is only reported in quarterly notification reports, this is probably an underestimate as those who agree to be tested later are not captured (Figure 6.7 below). An age and sex analysis of 1,220 smear positive cases of TB in 2007 shows that 20 per cent as many males were HIV positive compared to 32 per cent females in all age groups and incidence increased with age.

Regional Disparities

Within the Western Region, Serekunda, Brikama and Fajikunda are the three main Health Centres where screening of people in waiting areas could yield additional suspects. Serekunda and Brikama experienced a decline in sputum smear positive (ss+) notifications and an increase in sputum smear negative (ss-) and Extra-pulmonary (EP) cases (Tables 6.5 and 6.6).

Table 6.5: Brikama Notifications, 2005-2007

Notification Rate Patients	2005	2006	2007
SS+	170	181	158
SS-	68	85	95
EP	15	20	34
Total new patients	253	286	287
Re-treatment	17	7	23
Total	270	293	310

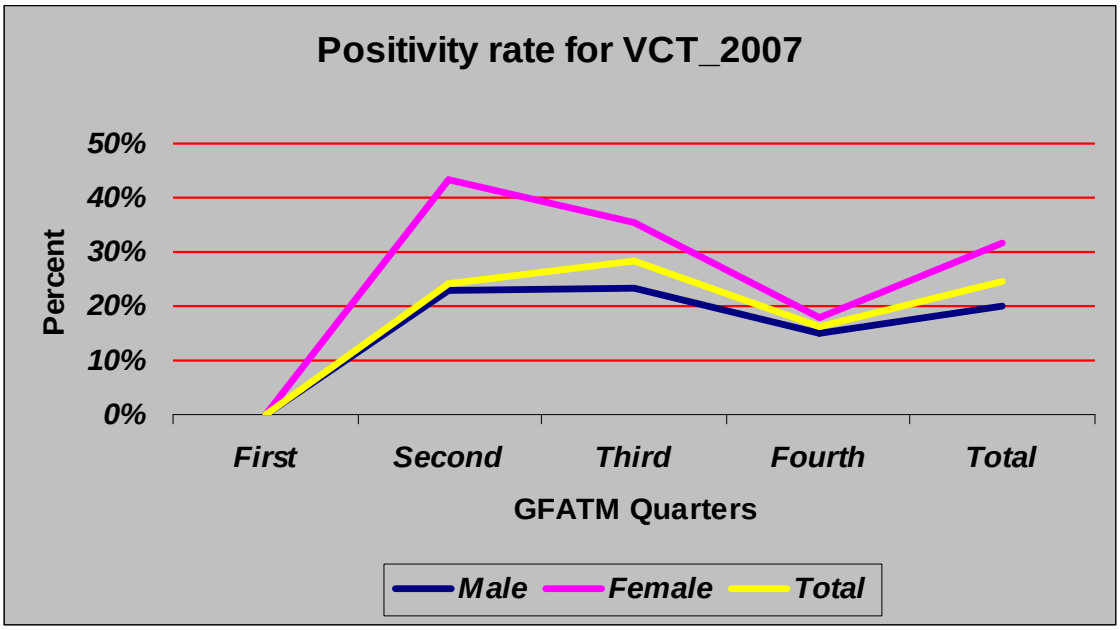
Source: National Leprosy and TB Programme, 2008

Table 6.6: Serekunda Notifications, 2005-2007

Notification Rate Patients	2005	2006	2007
SS+	576	487	400
SS-	336	202	222
EP	43	54	34
Total new patients	955	743	656
Re-treatment	3	18	33
Total	958	761	689

Source: National Leprosy and TB Programme, 2008

Figure 6.8: Positivity Rate for Voluntary Counseling and Testing (VCT) in The Gambia, 2007



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 per cent of cases and achieve an 85 per cent cure rate, which are in line with the Global Stop TB initiative, extra effort and inputs are required, including additional activities and financial resources for control operations. Tuberculosis services need to be expanded in urban areas to cover all public health facilities including the private sector and to follow up all smear-positive cases to ensure compliance with the DOTS treatment regime. The main problems are as follows:

- health seeking behaviour with late presentation to health facilities by patients;
- barrier to access diagnostic and treatment centres in remote/underserved parts of the country due to lack of or inadequate public transport in addition to high transport costs;
- lack of capacity to diagnose smear negative and extra-pulmonary TB in rural health facilities due to the lack of trained staff, and diagnostic facilities such as chest radiography and culture case finding; late diagnosis; defaulting during treatment; reporting and recording.

- Government support for human capacity and infrastructure is also essential to sustain the TB control programme.
- Aggressive IEC campaign is required for the acceptance of the new line of drugs (ACT and Cortem).

Policy Environment

The National Tuberculosis Committee remains weak and has now been reconstituted by TB/HIV Coordination bodies at national and regional levels. This body is responsible for disease control policy and strategy development for both Tuberculosis and HIV/AIDS epidemic. Discussions are underway to formulate a TB/HIV policy at the level of the Coordinating body.

Priorities for Development Co-operation

- Development of a policy on TB and TB/HIV;
- 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 (Multi-Drug Resistant (MDR TB) and (Extra Drug Resistant (X DR TB);
- Systematic monitoring of performance in case of management and strengthening the health system.

Goal 7: Ensure Environmental Sustainability

Introduction

Ensuring Environmental Sustainability is the seventh Goal of the MDGs. It comprises of four targets and nine indicators. This is the only Goal that does not have quantifiable targets for 2015 against most of its indicators. Only two indicators i.e. proportion of population using an improved water source and proportion of population using improved sanitation facility have quantifiable targets for 2015. Table 7.0 below provides a summary status of indicators on environmental sustainability in The Gambia.

Table7.0: Summary Status of Indicators for MDG 7

Targets	Indicators	1990	Current Status (2007)	MDG Target (2015)
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	7.1 Proportion of land area covered by forest	40.7%	45%	
	7.2 CO_2 emissions, total, per capita and per $1 GDP (PPP), and consumption of ozone-depleting substances	0.2 (2003)	4.42	
	7.3 Proportion of fish stocks within safe biological limits	88.8%	74.1%	
	7.4 Proportion of total water resources used	Not Available	Not Available	
Target 7.B: Reduce biodiversity loss, achieving, by 2010, a significant reduction in the rate of loss	7.5 Proportion of terrestrial and marine areas protected	3.7%	4.09%	
	7.6 Proportion of species threatened with extinction	Not Available	Not Available	
Target 7.C: Halve, by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation	7.7 Proportion of population using an improved drinking water source	69%	85.1%	85%
	7.8 Proportion of population using an improved sanitation facility	80%	84%	92%
Target 7.D: By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	7.9 Proportion of urban population living in slums[6]	Not Applicable	59.2%	

[6] This is measured by the following proxy indicators: (1) lack of access to improved water supply; (2) Lack of access to improved sanitation; (3) Overcrowding (three or more persons per room), and, (4) Dwellings made of non-durable materials

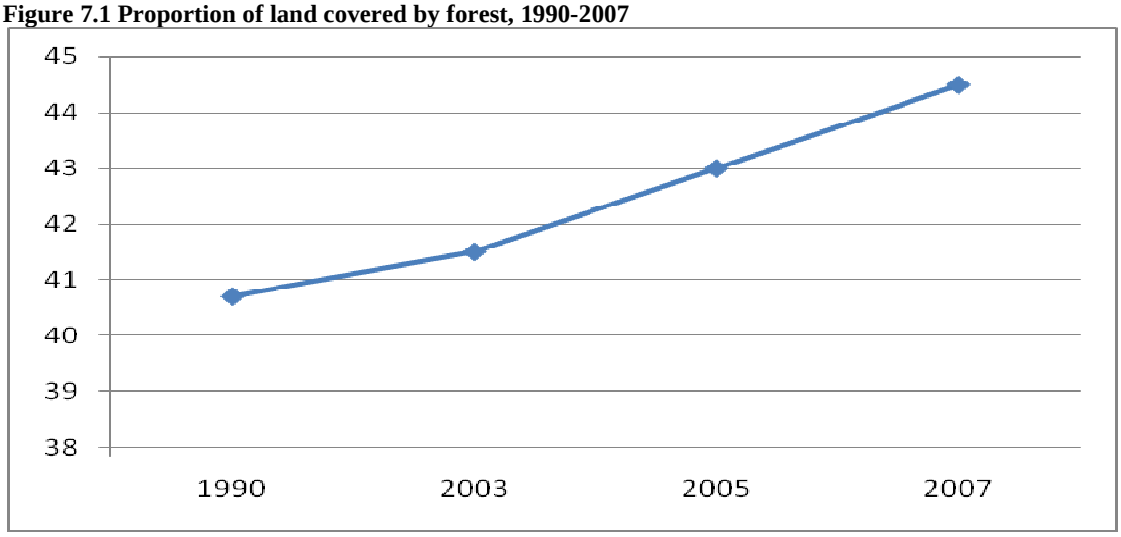
Target 7.A: Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources

Status and Trends

The Gambia's natural vegetation is of the Guinea Savannah woodland type but this is reported to be changing rapidly to the Sudan Savannah type (NEA 1997) due to increase in population and consequently a pressure on the natural vegetation coupled with increased demand in land for agricultural purpose, massive deforestation occurred in the years after independence. With concerted efforts as early as 1977, the country has been making strides to combat lost of vegetation and forest cover.

As indicated in Figure7.1 below, there has been a steady increase in the proportion of land area covered by forest. From a baseline of 40.7 per cent in 1990, the percentage of total land area covered by forests now stands at 45 per cent compared to 41.5 and 43 per cent respectively in 2003 and 2005 (Gambia Government, 2005). According to Sillah (1999), cited in the Localized MDG Report, 2005, the increase in forest cover is a result of decline in groundnut production and increase in community forestry. Another key factor in the increase of forest cover is the introduction of the Gambia Community Forestry Management Concept, the revised Forest Policy and the enforcement of the Forest Act of 1998.

Figure 7.1 Proportion of land covered by forest, 1990-2007



Source: 2005 MDG Report and Department of Forestry Statistics

Regional Disparities

Based on the findings (Sillah, 1999) cited in the 2005 MDG Report, local and regional disparities exist with regards to forest cover in the country. Most of the forests are not protected or properly managed. Central River Region has the highest forest cover and North Bank Region has the lowest per capita forest cover (Sillah, 199), cited in the 2005 MDG Report.

Challenges

Notwithstanding the gains made in reversing the lost of natural forest cover and improvement in the proportion of land area covered by forest, challenges still exist that require urgent attention. As outlined in the revised Forest Policy, 2007, these include:

- Undesirable community practices and attitudes that hinder proper management of forest resources
- Ensuring sustainable use of land and managing a balance between agriculture, conservation and wildlife.
- Controlling bush fires
- Proper management and control of forest products.
- Inadequate funding to sustain the gains of the donor-funded projects
- Limited capacity at the Forestry Department
- Alternative energy resources

Policy Environment

The Gambia has been concerned with environmental management and biodiversity issues as early as 1977. This is stipulated in the Banjul Declaration on Wildlife Conservation of 1977. A ten-year National Forestry Policy (1995-2005) was formulated and a Forest Bill passed in 1998. The key objectives of the Forest Policy are to maintain at least 30 per cent of the total land area under forest cover and 75 per cent of that under management. To implement this, a ten-year National Forestry Action Plan (2001–2010) was prepared and is currently being implemented. It is also worth noting that the National Forestry Policy (1995 – 2005) has been revised since 2007 to cover (2006-2016) to be aligned to the Agriculture and natural Resource Policy and is currently waiting for cabinet approval.

Priorities for Development Cooperation

- Funding and technical support to implement the revised National Forest Policy
- Capacity building and institutional strengthening
- Implementation of the comprehensive Forestry Action Plan for the North Bank Region

Carbon dioxide (CO_2) Emissions

Status and Trends

Environmental management in The Gambia is treated as a crosscutting issue. The country is currently implementing the second Gambia Environmental Action Plan (GEAP II). The total CO_2 emission by 2001 was 216,018 Tonnes representing 0.2 per capita emission (UNEP 2004). This has risen to 4.42 per capita by 2005 and is reported to be the same as of 2007 (Gambia Green House Gas (GHG) Inventory 2007). The same study indicated that about 60 per cent of total emissions of Co_2 are from transport.

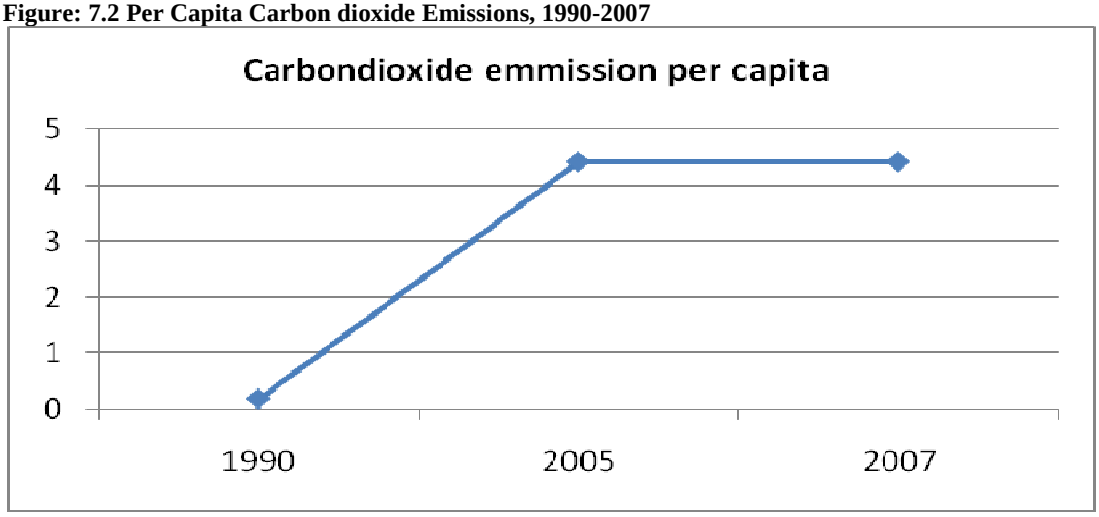
Figure 7.2 below shows the rise in carbon dioxide (CO_2) emissions from 0.18 per capita in 1990 to 4.42 per capita in 2005 and 2007 respectively. The significant rise in CO_2 emissions indicate the upsurge in industrial related activities over the period including the rise in the number of cars and other vehicles, which are the largest emitter of GHG in the country.

Although The Gambia continues to be classified as a carbon sink (i. e. not a net emitter of CO_2), the continuous and significant rise in CO_2 emissions should be a cause for concern.

Challenges

- Effectively mainstreaming environmental issues in economic policy management.
- Expansion of environmental education.
- Responding to the needs for Adaptation.
- Contributing to poverty reduction through sound environmental management practices.
- Strengthening communities' management of natural resources.
- Implementing environmental regulations particularly those relating to waste management and importation of banned substances.

Figure: 7.2 Per Capita Carbon dioxide Emissions, 1990-2007



Source: NEA (calculation from GHG Inventory report of 2001 and 2007)

Policy Environment

The Gambia made significant policy pronouncements and regulations over the years to ensure environmental sustainability. The National Environment Agency was established in 1993 to implement the country's first National Environmental Plan (GEAP I). This is under the auspices of the National Environmental Council chaired by the President. Currently the country is implementing the second Environmental Action Plan (GEAP II). The ratification of the international environmental conventions and the formulation of action plans to implement them is a basis for action to reverse environmental losses at the national level. As early as 1994, The Gambia started the phasing out of ozone depleting substances (ODS) and developed an ODS regulation in 2000 to ban the importation of all controlled substances. In 2007, The Gambia enacted an anti-littering regulation as part of the National Environmental Management Act.

Priorities for Development Assistance

- Financial and Technical Assistance to implement the National Adaptation Plan of Action (NAPA)
- Formulation of legal and policy frameworks to address possible barriers to the implementation of the NAPA.

- Promotion of renewable energy (biomass and charcoal saving stoves).

To cope with current environmental stresses, the country has just concluded preparing a National Adaptation Plan of Action (NAPA) that is prepared to ensure that the country adapts to current environmental pressures.

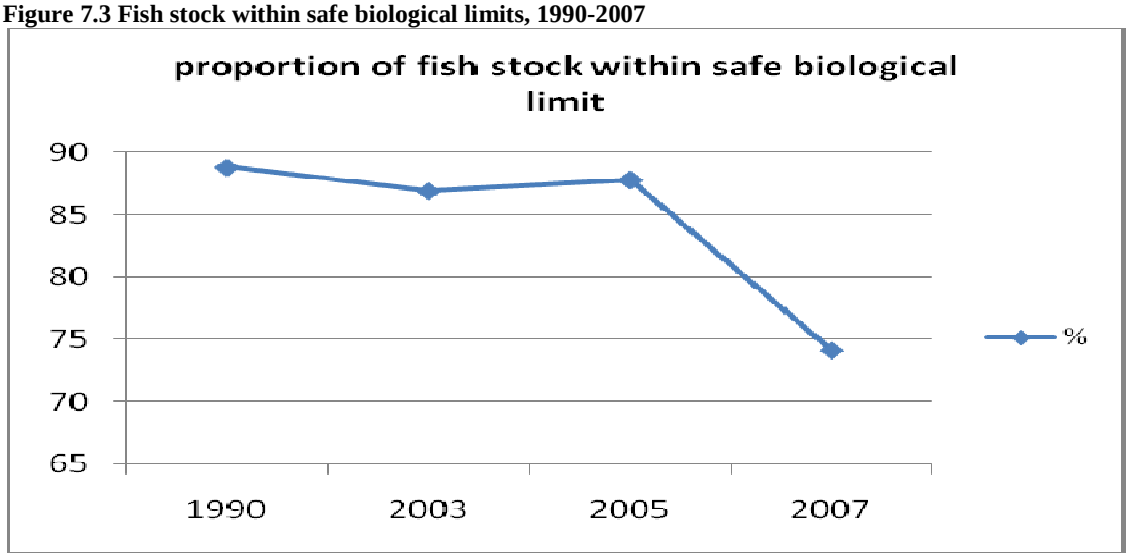
Fisheries

Status and Trends

Fisheries in The Gambia is characterised by marine waters, brackish waters and fresh water regimes. The country has an approximate continental shelf of 4000km^2 and an Exclusive Economic Zone (EEZ) of 10500km^2 (FAO 1964). There are over 500 marine species which are classified as demersals[7] and pelagic[8]. Data are based on the biomass estimates of both demersals and pelagic from 1986 to 1995 and the corresponding catches for the same period and only biomass metric tons on pelagic between 1995 and 2005 and the corresponding catches.

Figure 7.3 below shows the proportion of fish stock within safe biological limit. The proportion of fish stock within safe biological limits has been steadily declining over the years at an average rate of 2 per cent between 2003 and 2005 and an alarming annual rate of 7 per cent between 2005 and 2007. The decline affects the demersal stock more than the pelagic.

Figure 7.3 Fish stock within safe biological limits, 1990-2007



Source: Fisheries Department Statistics Unit

Challenges

Despite the Government's continuous efforts to rip maximum benefits from the country's fisheries on a sustainable manner, considerable challenges exist. These are:

[7] Deep water fish
[8] Shallow water fish

- A comparably low participation of Gambians in marine artisanal fishing, thereby preventing communities from deriving maximum benefits from government interventions in the sector.
- Under exploitation of the off-shore pelagic stock due to lack of appropriate fishing technology, high cost of fuel and the commercially low value of these species.
- Rapid decline of species due to over fishing, particularly of a commercial nature
- Underdeveloped inland fisheries.
- Complete regulation and control of processing activities to reduce post harvest losses.

Policy Environment

The Fisheries sector in The Gambia contributes significantly to national development objectives related to food security, employment, improved incomes and foreign exchange earnings. The sector provides employment to an estimated 140,000 people (Fisheries Department 2005) and it is also the main source of first class protein for majority of the population. The Gambia Government through the Department of State for Fisheries and Water Resources has just concluded reviewing and amending the Fisheries Act of 1991 and Fisheries Regulations of 1995 to incorporate the Food and Agricultural Organisation's Code of Conduct for Responsible Fisheries. The revised Fisheries Policy is anchored on the following guiding principles:

Conservation and Sustainable Resource Use: This is to pursue ecosystem preservation and environmental quality goals by focusing on awareness creation and education.

Global Responsibility: This is meant to acknowledge the trans-boundary and global nature of most fisheries problems and resolve to work cooperatively with regional and international partners to strengthen environmental conservation strategies.

Responsible Fisheries Management: This is to ensure that there exists a national fisheries policy consistent with the FAO Code of Conduct for Responsible Fisheries and also become an integral component of all economic, industrial and social policies.

Priorities for Development Cooperation

- Strengthening national fisheries planning for economic development.
- Maintenance and enhancement of fisheries ecosystem.
- Greater cooperation with international organisations for global protection of marine and fresh water ecosystem.
- Training facilities and research in fisheries matters.
- Development of aqua-culture

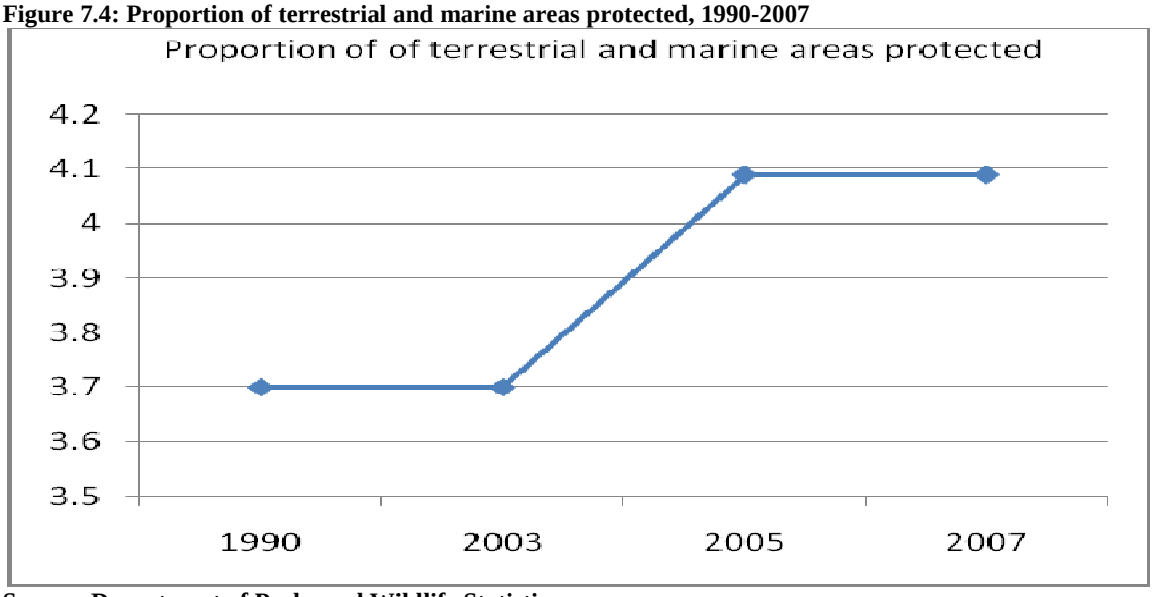
Target 7 B: Reduce Biodiversity loss, achieving by 2010 a significant reduction in the rate of loss

Status and Trends

The proportion of terrestrial and marine areas under protection rose from 3.7 per cent in 1990 to 4.09 per cent in 2007 (Figure 7.4 below). However, with a national target of 10 per cent protection, it is very much unlikely that the country will meet the target it sets for itself in

2015. Meeting the national target of 10 per cent by 2015 will require at least an annual 1 per cent percentage point increase in the protected areas. This looks an uphill task as the Department of Parks and Wildlife is currently under funded and has limited capacity both in terms of human and other necessary resources coupled with other environmental pressures on terrestrial and marine biodiversity.

Figure 7.4: Proportion of terrestrial and marine areas protected, 1990-2007



Source: Department of Parks and Wildlife Statistics

Challenges

- Management of land use conflicts, particularly striking a balance between agriculture and wildlife.
- Limited human resource capacity and the need for institutional strengthening of the Department of Parks and Wildlife.

Policy Environment

The Gambia's long commitment to environmental protection has been demonstrated through various policies, laws and institutions for environmental management and biodiversity. The Department of Parks and Wildlife Management was established as early as 1968 following the designation of Abuko as a Nature Reserve, coupled with a declaration on wildlife conservation in 1977 (Banjul Declaration). In 1998/99, the country formulated a National Biodiversity Strategy and Action Plan to promote the conservation and sustainable use of biodiversity in The Gambia. Following the review of the 1977 Wildlife Act, a Wildlife/Biodiversity Act was enacted in 2000. The country is currently managing seven protected areas through the Department of Parks and Wildlife Management. The department is also co-managing the trans-border Sine Saloum Delta/Niumi National Park with its counterparts in Senegal.

Priorities for Development Co-operation

- Capacity building and institutional strengthening of the Department of Parks and Wildlife Management

- Formulation and implementation of a mangrove ecosystem conservation and management plan

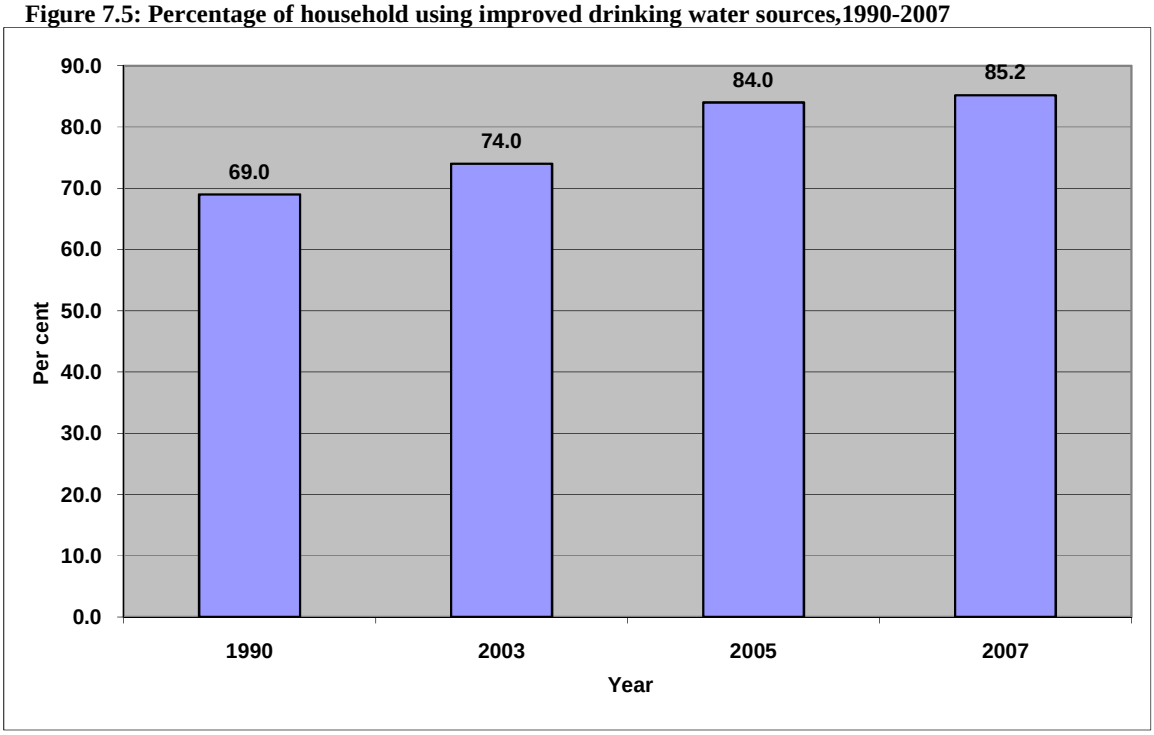
Target 7 C. Halve by 2015, the proportion of people without sustainable access to safe drinking water and basic sanitation.

Access to Safe Drinking Water

Status and Trends

Access to improved water sources has greatly improved in The Gambia over the past decades. An estimated 69 per cent of the population had access to safe sources of drinking water in 1990. The country has reached its MDGs target with up to 85.2 per cent of the population with access to safe sources of drinking water in 2007 (see Figure 7.5 below).

Figure 7.5: Percentage of household using improved drinking water sources,1990-2007



Source: MDGs Reports of 2003/2005 & GBoS 2007

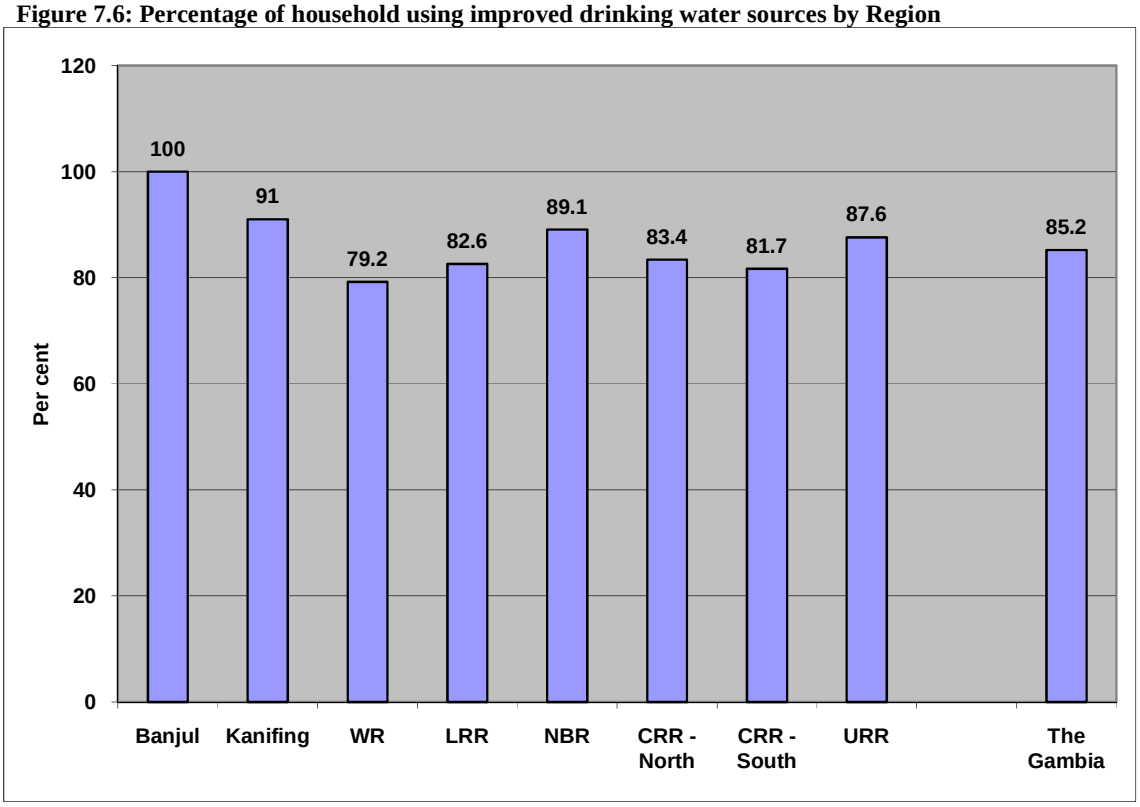
This remarkable achievement is attributed to the government's resolve to provide safe drinking water to the whole population, coupled with the numerous water supply projects implemented across the country supported by various development partners such as the EU, UNICEF, JICA and the Saudi Government..

Regional Disparities

Access to safe drinking water has improved in all regions in the country, although disparities still exist among the Regions. All households in Banjul have access to safe water sources and in the Kanifing municipality 9 out of 10 households have access to safe drinking water. Households in WR have the least access to safe drinking water among all the regions as 21 per cent of the households' still lack access to safe drinking water (Figure 7.6). The Western

Region (WR), LRR CRR-North and South are yet to attain the MDG target of 85 per cent of households using improved water sources (Figure 7.6). It is likely that these regions will attain the MDG target by 2015.

Figure 7.6: Percentage of household using improved drinking water sources by Region



Source: GBoS (Census 2003 & MICSIII 2007)

Challenges

- Improving management capacity of communities on a gender sensitive manner for sustainable management of water infrastructure.
- Maintaining adequate supply of safe drinking water to match growing population growth particularly in peri-urban centres.
- Formulation and implementation of legal and institutional frameworks that addresses the competing water demands for human consumption and agricultural purposes.

Policy Environment

The provision of safe drinking water has been a top government priority throughout the years. This effort has been strongly supported by development partners over the years. The country has just finished formulating its first Natural Water Policy as part the Natural Resource Policy. Over the years partners such as the UNDP, ECA and the Japan International Co-operation Agency (JICA) have invested heavily in the water sector. This investment has continued as the country is currently implementing a rural and peri-urban water project as part of the European Development Fund grant (EDF 9).

Priorities for Development Co-operation

Priorities for development co-operation should include provision of solar reticulation system for villages that have grown in population and can no more be sustained by the use of hand pump well, support for the training and retention of professional staff and financial and technical support to assess ground water resources in terms of quality.

Access to improved Sanitation

Status and Trends

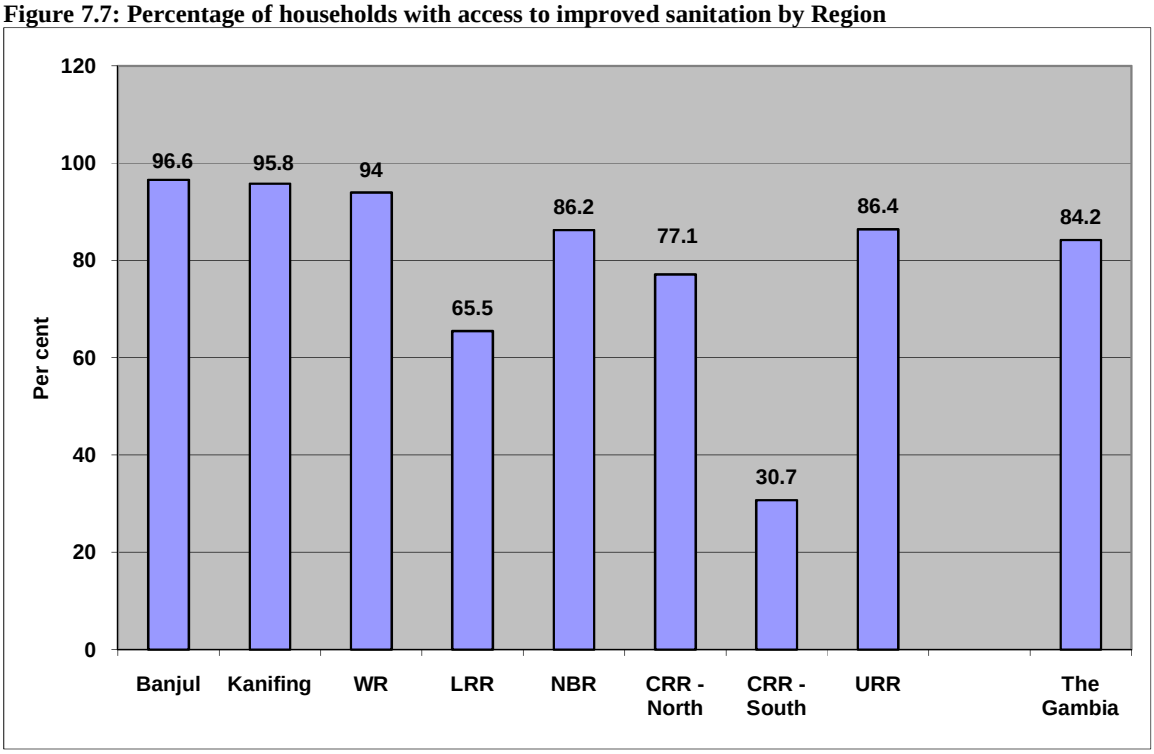
Eighty-four per cent of the population of The Gambia lives in households with access to sanitary means of excreta disposal (GBoS 2007). Nationally, access to improved sanitation increased from 80 per cent in 1990 to 84 per cent in 2007. At this rate of increase, The Gambia is poised to attaining the MDG target of 92 per cent by 2015.

Regional Disparities

The proportion of people using improved sanitation facilities is higher in urban areas as Banjul, Kanifing and Western Region (WR) record 96.4 per cent, 95.8 per cent and 94 per cent respectively. Residents of CRR-South have the least access to improved sanitation facilities as only 30.7 per cent of the population in this region uses improved sanitation facilities. (Figure7.7). The proportion of the population using improved sanitation facilities has remain relatively high and has been within the range of 80 per cent since 1990.

However, it should be noted that the definition of this indicator in The Gambia is based on means of excreta disposal and all the studies carried out including the 2005/06 Multiple Indicator Cluster Survey include traditional pit latrines that are not ventilated. If this mean of excreta disposal is excluded, the proportion of the population using improved means of sanitation is expected to be lower than what is reported. According to Figure 7.7, Banjul, Kanifing and WR have attained the MDG target. The NBR, URR and CRR-North are on track to attaining the MDG target, while CRR- South and LRR are not likely to reach the target of 92 per cent of population using an improved sanitation facility.

Figure 7.7: Percentage of households with access to improved sanitation by Region



Source: GBoS, MICSIII, 2007

Challenges

These include changes on customs and personal habits of communities on hygiene and proper waste disposal, effective and efficient waste management systems, clear institutional mandates for sanitation, susceptibility of flooding in certain areas within the urban.

Policy Environment

Sanitation issues are now of national priority to The Gambia and over the years the country has implemented various projects, prominent among them is the Water and Sanitation Project (WATSAN). This was implemented through DCD with the aim of introducing low technology but hygienic means of excreta disposal toilets throughout the country. With regard to waste management, the country has for the past four years introduced a nationwide monthly cleaning exercise to ensure environmental sanitation. In 2007, an Anti littering regulation was enacted to ensure proper environmental practices. Waste management, part of which is the role of the local councils and municipalities has been revived and there are periodic waste collection exercises by the two urban councils (BCC and KMC). Priorities for Development Cooperation include technical and financial support to institute sustainable waste management strategies and private sector investment in waste management.

Slum Housing

This indicator was initially measured as percentage of people with access to secure tenure of accommodation and in 2003, it was reported to be 65 per cent of households (MDGR,2003).

According to MICS III 2005/6 59.2 per cent of the urban population live in slums[9] (GBOS 2007). This is quite a significant figure given the fact that over 50 per cent of the country's population live in urban settlements.

Challenges

The major challenges of urban housing in the country are rapid urbanisation as a result of rural urban drift, rising urban poverty, limited capacity to implement housing regulations and limited capacity of utility services to match with rapid urbanisation

Policy Environment

The country has formulated housing regulations under the auspices of the physical planning and Housing Department but building and housing issues are entirely handled by the private sector in the country. The National Water and Electricity Company (NAWEC) remains the sole provider in the country, its capacity has been recently boosted but it still lacks the capacity to adequately meet the demand of utility services in the entire country. The Gambia government has recently created a Department of State for Energy and Public Utility Regulatory Authority to regulate utility service provision in the country.

Priorities for Development Cooperation include finance and technical capacity to formulate and implement housing regulations and technical support for research on alternative low technology and efficient construction materials.

[9] This is measured by the following proxy indicators: (1) lack of access to improved water supply; (2) Lack of access to improved sanitation; (3) Overcrowding (three or more persons per room), and, (4) Dwellings made of non-durable materials

GOAL 8: DEVELOPING A GLOBAL PARTNERSHIP FOR DEVELOPMENT

Introduction

Considering that no country can tackle development single-handedly, Goal 8 is about developing a global partnership for development in general and for attaining the MDGs in particular. Thus, issues of good governance, trade and tariff, ODA, HIPC and debt sustainability and private sector partnership in the realisation of the MDGs are addressed under this goal.. According to the 2007 revision of the MDG targets and indicators, Goal 8 has 6 targets and 16 indicators. However, due to data constraints only targets 8 D and 8 F are addressed in this report (See Table 8.0 below).

Table 8.0: Summary Status of Indicators

Targets	Indicators	1990	Current Status (2007)	2008	MDG Target
Target 8 D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term	8.11. Debt relief committed under HIPC and Multilateral Debt Relief Initiatives	N/A	Qualified for debt relief Dec. 2007		
	8.12. Debt service as a percentage of exports of goods and services				
Target 8.E: In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries	8.13. Proportion of population with access to affordable essential drugs on a sustainable basis	NA	NA	NA	NA
Target 8.F: In cooperation with the private sector, make available the benefits of new technologies, especially information and communications	8.14. Telephone lines per 100 population	2.89 (2005)	3.93	4.83	
	8.15. Cellular subscribers per 100 population	16.28 (2005)	38.0	41.9	
	8.16. Internet users per 100 population	3.22 (2005)	3.47	4.37	

Source: DoSTIE, DoSCIT, 2007 & 2008

Target 8 D: Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term

Status and Trends

The Gambia's total external trade has slightly improved in 2007 after a slight decline in the previous years. The year 2007 recorded 8 per cent increase, from D7.8 billion in 2006 to D8.2 billion in 2007. Import values in 2007 stood at D7.95 billion and this represent 96.8 per cent of total external trade. However, the total export amounted to D332.8 million. These

developments have led to a trade deficit of 7.61 billion resulting in a decline of 15 per cent relative to 2006 (Table 8.1).

Table 8.1: Summary of the Gambia External Trade (in D'000), 2004-2007

Trade	2004	2005	2006	2007	% Change
Total trade	7646000	7633832	7599039	8207241	8.00%
Imports	7105000	7422502	7277284	7945367	9.18%
Domestic exports	342000	201039	288198	312167	8.32%
Re-exports	199000	10291	33552	20603	-38.59%
Total exports	542000	211330	321750	332771	3.43%
Total balance	-6563000	-7211172	-6599539	-7612596	-15.35%

Source: Gambia Bureau of Statistics: (2007 Annual Trade Review of The Gambia)

The major trading partners of The Gambia have been Cote d'Ivoire, Germany, and Denmark to name a few. However, over the years, this trade partnership has undergone a sharp increase from some of the main importing countries such as Cote d'Ivoire, and Germany with a slight increase for Singapore and Spain (GBoS, 2007). The import by major importing countries for 2005 and 2006 is shown on Table 8.1 above.

The total direction of imports from blocks of exporting countries such as the European Union (EU), Asia, America and others indicate a positive change for the EU, America, and others while a negative change for ECOWAS and Asia as shown on Table 8.2.

Table 8.2: Direction of exports by Region (in D'000)

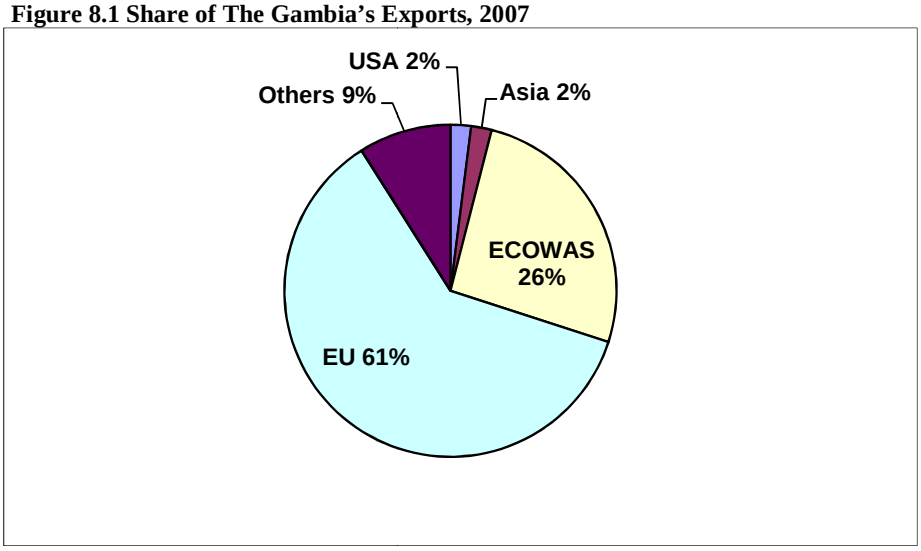
Region	2006	2007	% change
EU	195665	200217	2.3
ECOWAS	105631	87776	-16.9
Asia	7959	7087	-10.9
America	5707	7267	27.3
Others	6788	30442	348.4
Total	323756	334796	3.4

Source: Gambia Bureau of Statistics 2007

The exports trade value for 2007 increased from D323.8 million in 2006 to D334.8 million in 2007. This gives an increment of 3.4 per cent. The share of exports to the EU remained at 61 per cent both in 2006 and in 2007. The exports to ECOWAS markets dropped by 16.9 per cent in 2007 compared to 2006 (Table 8.2). A summary of exports to Asian and the Americas remained marginal. The share of Gambia's exports in 2007 is shown in Figure 8.1 below

The share of Gambia's exports to the EU in 2007 remained high at 61 per cent. The main exports to the EU are Fish and fisheries products (33 per cent), groundnuts related products (24 per cent) and vegetables and fruits (18 per cent). These products constituted 76 per cent of exports to the EU and 45 per cent of total exports in 2007 (DoSTIE, 2007).

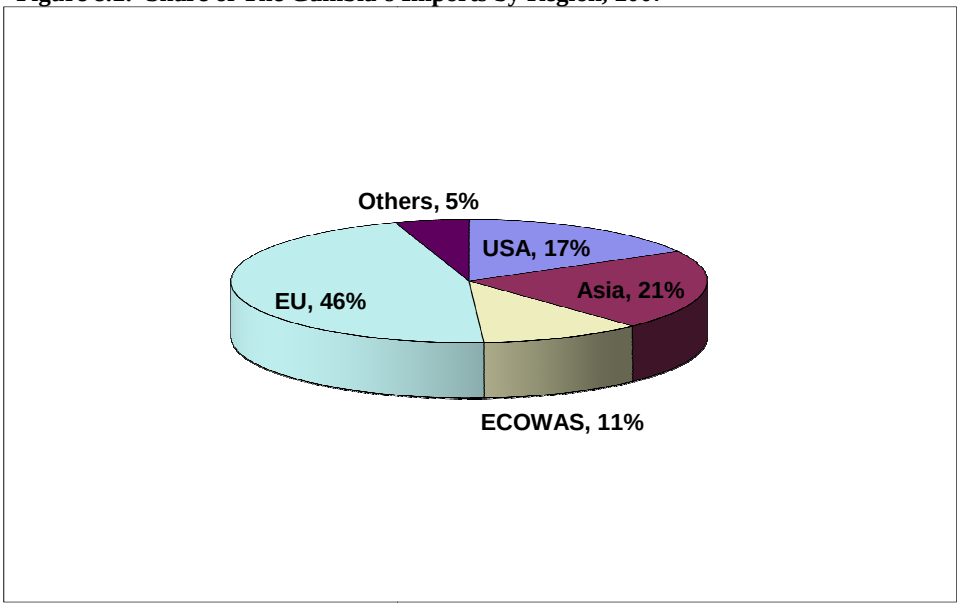
Figure 8.1 Share of The Gambia's Exports, 2007



Source: Department of State for Industry and Employment 2007

In a similar trend, the direction of the imports in 2007 indicated that Europe continued to be Gambia's major trading partner representing 46 per cent of total imports. The percentage for other trading partners compared to Europe was Asia (21 per cent), America (17 per cent), ECOWAS (11 per cent) and others (5 per cent) as shown on Figure 8.2. The main source of trade comes from Denmark 13 per cent, Germany 18 per cent, and United Kingdom 17 per cent and Netherlands 12 per cent. These four countries provided 78 per cent of the total imports from the EU and 36 per cent of total exports. In other regions such as Asia, China was the main source of Gambia's imports in 2007. Its trade accounted for 51 per cent of total imports from Asia while in the ECOWAS region; Cote d'Ivoire and Senegal were the main sources of Gambia's imports.

Figure 8.2: Share of The Gambia's Imports by Region, 2007



Source: Department of State for Trade, Industry and Employment, 2007

The volume of Official Development Assistance (ODA) received by the Gambia has declined from $92.3 million in 1999 to $60.5 million 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 influence 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 flow makes it difficult, if not impossible to obtain an accurate figure for ODA to the Gambia. Despite these shortcomings, there is no doubt that ODA contributes significantly to The Gambia's development, and is a key component of the country's development strategy (GoTG, 2005).

The institutional framework of debt management is provided in the government budget management and accountability Act. (2004). The Secretary of State for Finance and Economic Affairs (DoSFEA) is the only authority entitled to borrow from legal entities or to enter into a guarantee or indemnity with third parties. The Public Debt Unit (PDU) of DoSFEA is responsible for managing, recording, and reporting on external debts, while the Central Bank of The Gambia (CBG) borrows in the domestic market by issuing treasury bills. The Central Bank of The Gambia (CBG) is also responsible for making payments to external creditors upon receipt of instructions from DoSFEA.

The Net Present Value (NPV) of the Gambia's external debt at the end of 2007, after full delivery of the assistance committed under the enhanced HIPC Initiative at the decision point, is estimated at US$347 million, equivalent to 236 percent of exports, as compared with a decision point projection of 137 per cent. As the delivery of full HIPC initiative relief by the Paris Club creditors will entail the cancellation of all of their claims, the Paris Club will not be in a position to provide "beyond HIPC" relief to The Gambia. As explained in the discussion on topping-up, the significant deterioration of the NPV of debt-to-exports ratio was mainly due to poor export performance, higher new borrowing compared with the decision point projections, and adverse changes in the discount rates and exchange rates (IMF Country Report No. 08/109, 2008).

Partnership for Development

All assistances to The Gambia must be based on sound principles but flexible enough to allow implementation of the programme plans. Therefore, all partners should be aware and to support the country's development agenda such as:

- The Gambia's vision 2020 and the poverty reduction strategy (PRSP II) as a development agenda:
- Maximize resource use while applying the principles of best practice that are socially friendly and environmentally sound:
- Avoid negative competition, unnecessary duplications of efforts and encourage complementary work
- Mutually benefitting, transparent and accountability to all parties.
- Open and accountable donor agreements and financing
- Exploring other alternatives towards energy and food needs for the country because they absorb most of the funds received by the state

The above mentioned partnership needs openness and institutional discipline so that sectors can work effectively. This kind of inter-sector partnership is not new in the country. Indeed,

the Government has already established an Aid Co-ordination Policy Unit at DoSFEA and with support from OP this unit will bear positive results.

The Government of The Gambia is aware of the need for ensuring an enabling environment for business partners in the area of Information Technology (IT). As a result, the Department of State for Communication and Information Technology (DoSCIT) came up with a coherent local partnership with institutions in order to improve the communication vacuum existing in the country. The partnership between Gamtel, Africel and Comium resulted to the telephone line increment from 2.89 per 100 population in 2005 to 3.93 per 100 population in 2007 with a projection to 2011 using 2005 as a base line as shown on Table 8.3 (DoSCIT, 2007).

Table 8.3: Telecommunication per 100 population, 2005-2008

Expected outcomes	**Indicator**	**Baseline 2005**	**2007**	**2008**
Greater coverage and affordability penetration and bridging the urban and rural divide in ICT utilization	Tele-density per 100 population	2.89	3.93	4.83
	Mobile users per 100 population	16.28	38.00	41.90
	Internet users per 100 population	3.22	3.47	4.37
	PC per 100	**1.51**	**2.35**	3.3

Source: DoSCIT, PRSP Report 2008

The quantity of mobile telephone has been difficult to establish because there is no centralized data available to capture its distribution at DoSCIT. The institutions as mobile telephone service provider issues SIM cards to buyers without keeping records to show what has been distributed. This problem has been expressed by DoSCIT as their major constraint on line follow-up.

Challenges

Some challenges for The Gambia to achieve MDG 8 are:

- Resource constraints
- Huge debt burden
- Limited institutional capacity
- Supporting private and civil organizations
- Stalled decentralisation process
- Accountability
- Transparency

Agriculture remains the country's priority for self sufficiency in food production and development. However, the country remains dependent on outside support for most of its farming implements and materials for production. With shortage and untimely supply of resources coupled with difficulties in getting the right partner in marketing the agriculture products, especially groundnuts is a major constraint on the economy and most of the development plans.

Debt relief is very important to the Gambia for it to meet targets of the MDGs. Developments with the global partnership have shown that The Gambia is on track on the IMF criteria for eligibility for HIPC funds.

The study has highlighted the importance of good quality data for developing projects and programmes that will impact positively in meeting the MDG goals. Furthermore, even where data are available, bureaucratic and other institutional problems make it difficult to access the data.

Frequent change of staff, inadequate information and limited institutional capacity at both national and local level negatively affect the programme planning and implementation of the country's development agenda. It is obvious that with weak institutions, effective use of donor assistance will become meaningless unless institutional capacity is adequately built.

The role of the private sector and civic organizations for partnership towards the country's MDG programme cannot be over emphasized. In the field of communication, trade and agriculture the private sector should be the catalyst for economic development by creating the necessary job opportunities for the people. Currently, The Gambia seems to make a positive impact because of the enabling environment given to the private sector.

Decentralisation, transparency and accountability at all levels of partnership in the country should be encouraged for greater financial and administrative autonomy from central government. This will allow flexibility, timely implementation of programme plans to achieve the MDGs particularly Goal 8

CONCLUSIONS AND RECOMMENDATIONS

The Gambia's status vis-a-vis the Millennium Development Goals is mixed; there is significant progress in some areas whilst in others, progress has been slow and the country is not likely to meet the targets by 2015 unless there are accelerated efforts both in term of resource availability and programme implementation.

With respect to goal 1 on eradicating poverty, the target of reducing poverty to 15 per cent is unlikely to be achieved given that the prevalence of poverty is still very high (58 per cent in 2003). However good progress has been registered in the area of reducing hunger; the targets for reduction in prevalence of underweight children are most likely to be achieved before 2015. With respect to goal 2 on universal primary education; the MDG targets have almost been achieved, primary school completion rate is 96.6 per cent and literacy rate is 62.9 per cent, the MDG target for literacy is 72 per cent. With respect to goal 3 on gender equality and women empowerment the country has already surpassed the targets for gender parity in primary school, thanks to the efforts of H.E. the Presidents in enhancing girls' education.

For Goal 4 on reducing children Mortality, the country is off track with respect to reduction of under 5 and Infant Mortality butt immunization targets have almost been achieved; currently it is 92.4 per cent against a targets of 100 per cent. Achievements with respect to Goals 5, Improving Maternal Mortality are mixed; Maternal Mortality still remains high 556 per 100,000 live births and the target is to reduce it to 263, but target for births attended by skilled health personnel have almost been achieved; 57 per cent currently, compared to a target of 63 per cent. Also Antenatal coverage target has almost been achieved; 96 per cent currently and the target is 100 per cent by 2015.

With respect to Goal 6; combating HIV/AIDS and other diseases, the prevalence of HIV/AIDS continues to be low (below 3 per cent) whilst condom use and comprehensive knowledge of HIV/AIDS continue to increase. Use of insecticide nets and malaria treatment for under-fives are quite high; in fact The Gambia has one of the highest coverage rates in the world.

Progress on targets for environmental sustainability; Goal 7, has also been quite impressive especially with respect to forest cover and access to clean water and sanitation. The country is on target to achieve these targets but progress on other targets such as CO2 emission has been slow; in fact Co2 emission has been increasing instead of decreasing. On Goal 8; Partnership for development, the country reached HIPC completion point in December 2007 and currently benefiting from debt relief from HIPC and MDRI. There is good progress towards meeting the other targets such tele-density which is quite high, and the use of internet is also on the rise. Thus overall, the country faces problems in achieving the MDGs but mainly with income poverty related indicators, progress with non income poverty is much better.

The Assessment of level of achievement of the Millennium Development Goals was undertaken in order to determine the status of each of the indicators of the MDGs; both existing and the new or revised indicators and targets introduced recently. A number of challenges were encountered in the process the main one being the availability of data to assess the status of the indicators. For every goal, there were problems with data for the indicators contained within it. The time frame for the assessment was 2007 but information for 2007 was not available for almost all the indicators. As a result of this difficulty faced data used in the assessment was as old as 2003; five years ago. This is the case for the

poverty information for which the latest data available was the 2003 Integrated Household Survey as well as many of the health indicators for which the latest information available was the 2003 Population and Housing Census. Another major data challenge was the availability of data dating back to 1990 for the newly introduced MDG targets.

The lack of readily available updated information to assess the status of the MDGs is of major concern and needs to be addressed immediately by updating the poverty profile as well as updating demographic and health information of the country. This will require enhancing statistical capacities to carry out data collection and analysis in relevant government institutions in particular, the Gambia Bureau of Statistics. Other institutions that would need statistical capacity strengthening are the Department of State for Health and Social Welfare for health and Demographic statistics and the Department of State for Trade, Industry and Employment for labour statistics.

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