

# **JOINT EXTERNAL EVALUATION OF IHR CORE CAPACITIES**

of the  
**REPUBLIC OF THE GAMBIA**

Mission report:  
**September 24-29, 2017**



**World Health  
Organization**



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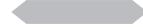
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# Abbreviations

<b>AFP</b>	Acute Flaccid Paralysis
<b>AHI</b>	Avian & Human Influenza
<b>AMR</b>	antimicrobial resistance
<b>BIA</b>	Banjul International Airport
<b>BSL</b>	biosafety level
<b>CDC</b>	US Centres for Disease Control and Prevention
<b>CVL</b>	Central Veterinary Laboratory
<b>DHIS2</b>	District Health Information System
<b>DLS</b>	Department of Livestock Services
<b>FAO</b>	Food and Agriculture Organization of the United Nations
<b>FETP</b>	Field epidemiology training programme
<b>FSQA</b>	Food Safety and Quality Authority
<b>GLASS</b>	Global Antimicrobial Surveillance System
<b>HCAI</b>	Health care-associated infection
<b>HSEPRP</b>	Health Sector Emergency Response Plan
<b>IAEA</b>	International Atomic Energy Agency
<b>IMS</b>	Incident Management System
<b>IDSR</b>	Integrated Disease Surveillance Response
<b>INFOSAN</b>	International Food Safety Authority Network
<b>IPC</b>	Infection Prevention and Control
<b>ITC</b>	International Trypanotolerance Centre
<b>JEE</b>	Joint External Evaluation
<b>MCM</b>	medical countermeasures
<b>MRC</b>	Medical Research Council
<b>MoHSW</b>	Ministry of Health and Social Welfare
<b>MOU</b>	Memorandum of Understanding
<b>NDMA</b>	National Disaster Management Agency
<b>NEA</b>	National Environmental Agency
<b>NFP</b>	National IHR Focal Point
<b>NHSP</b>	National Health Strategic Plan
<b>NPHL</b>	National Public Health Laboratory
<b>OIE</b>	World Organisation for Animal Health
<b>PHEOC</b>	Public Health Emergency Operation Centre



<b>POEs</b>	points of entry
<b>PVS</b>	pathway to veterinary services
<b>SOPs</b>	Standard Operating Procedures
<b>WAHIS</b>	World Animal Health Information System
<b>WALIC</b>	West African Livestock Innovation Centre
<b>WHO</b>	World Health Organization



# Executive summary

## Findings from the joint external evaluation

Despite the recent political changes in the country, the commitment by The Gambia to the JEE process was well noted.

The Gambia already has many pieces of legislation although these were enacted before the International Health Regulations (2005) (IHR) came into operation. Several issues were proposed to assist The Gambia make further progress.

- There is a need to review existing public health related laws and policies, in particular the review of the Public Health Act 1990; this is a critical piece of legislation to review in order to support the implementation of the IHR (2005).
- Development and enactment of legislation and guidelines for biosafety and biosecurity, a regulatory framework on the practice of medical laboratory services.
- The recruitment and retention of public health staff generally but particularly addressing shortages of veterinary staff.
- Establish an IHR National Focal Point and provide adequate resources for effective functioning.

The Gambia has had an Integrated Disease Surveillance Response (IDSR) implementation process in place since 2003 and has commenced the integration of IDSR into District Health Information System 2 DHIS2. The suggested next steps include:

- Linking laboratory data to syndromic surveillance as well as strengthening laboratory based surveillance.
- Coordination and information sharing between human health and animal health authorities.
- Establishment of in-country programmes for training medical laboratory scientists, laboratory technicians and other specialist public health professionals.
- Finalization and implementation of the National Health Laboratory Policy (which includes all One Health stakeholders).
- Establishment of the Laboratory Science Council as a priority to set standards for the registration and licensing of staff in public and private sectors laboratories.

The Gambia has a good number of points of entry (POEs), considering the size of the country and her relationship with her only terrestrial neighbour, Senegal. The designated PoEs include Banjul airport, seaport and ground crossings. The country has developed a Health Sector Emergency Preparedness and Response Plan (2017-2019). To achieve further improvements and to advance in the broad area of response, the country should:

- Update the National Public Health Emergency Preparedness and Response Plan and test the plan through simulation exercises and update as necessary.
- Allocate and release funds for public health contingencies and emergencies.
- Ensure that an all-hazard risk communication policy and plan is developed and operationalised by providing the required resources and adequate training for staff at all levels.
- Provide staffing at POEs to ensure that the country meets the IHR (2005) requirements.

The development of the JEE process together with other assessments opens the opportunity for The Gambia to take steps for improving health security and to meet obligations under the IHR (2005). It opens the door for joint working partnerships between relevant ministries and stakeholders. It allows for a shared understanding of the desired outcomes through the development of shared ideas, information and knowledge.

The concluding remarks for the government of The Gambia indicated that some work had already begun to address some of the priority actions recommended. The emphasis on capacity building was seen as being fundamental and the country is improving. Coordination of public health activities is already taking place. With the political will, The Gambia is also well placed to improve collaborative work within her public health emergency response by adopting a One Health approach.

# The Gambia scores

Technical areas	Indicators	Score
<b>National legislation, policy and financing</b>	P.1.1 Legislation, laws, regulations, administrative requirements, policies, or other government instruments in place are sufficient for implementation of IHR (2005)	2
	P.1.2 The State can demonstrate that it has adjusted and aligned its domestic legislation, policies and administrative arrangements to enable compliance with IHR (2005)	1
<b>IHR coordination, communication and advocacy</b>	P.2.1 A functional mechanism is established for the coordination and integration of relevant sectors in the implementation of IHR	1
<b>Antimicrobial resistance</b>	P.3.1 Antimicrobial resistance detection	1
	P.3.2 Surveillance of infections caused by antimicrobial-resistant pathogens	1
	P.3.3 Health care-associated infection (HCAI) prevention and control programmes	1
	P.3.4 Antimicrobial stewardship activities	1
<b>Zoonotic diseases</b>	P.4.1 Surveillance systems in place for priority zoonotic diseases/pathogens	1
	P.4.2 Veterinary or animal health workforce	1
	P.4.3 Mechanisms for responding to infectious and potential zoonotic diseases are established and functional	2
<b>Food safety</b>	P.5.1 Mechanisms for multisectoral collaboration are established to ensure rapid response to food safety emergencies and outbreaks of foodborne diseases	2
<b>Biosafety and biosecurity</b>	P.6.1 Whole-of-government biosafety and biosecurity system is in place for human, animal and agriculture facilities	1
	P.6.2 Biosafety and biosecurity training and practices	1
<b>Immunization</b>	P.7.1 Vaccine coverage (measles) as part of national programme	4
	P.7.2 National vaccine access and delivery	4
<b>National laboratory system</b>	D.1.1 Laboratory testing for detection of priority diseases	2
	D.1.2 Specimen referral and transport system	1
	D.1.3 Effective modern point-of-care and laboratory-based diagnostics	2
	D.1.4 Laboratory quality system	1
<b>Real-time surveillance</b>	D.2.1 Indicator- and event-based surveillance systems	3
	D.2.2 Interoperable, interconnected, electronic real-time reporting system	1
	D.2.3 Integration and analysis of surveillance data	2
	D.2.4 Syndromic surveillance systems	3
<b>Reporting</b>	D.3.1 System for efficient reporting to FAO, OIE and WHO	1
	D.3.2 Reporting network and protocols in country	2
<b>Workforce development</b>	D.4.1 Human resources available to implement IHR core capacity requirements	1
	D.4.2 FETP <sup>1</sup> or other applied epidemiology training programme in place	3
	D.4.3 Workforce strategy	3

<sup>1</sup> FETP: Field epidemiology training programme

<b>Preparedness</b>	R.1.1 National multi-hazard public health emergency preparedness and response plan is developed and implemented	<b>1</b>
	R.1.2 Priority public health risks and resources are mapped and utilized	<b>2</b>
<b>Emergency response operations</b>	R.2.1 Capacity to activate emergency operations	<b>2</b>
	R.2.2 EOC operating procedures and plans	<b>1</b>
	R.2.3 Emergency operations programme	<b>1</b>
	R.2.4 Case management procedures implemented for IHR relevant hazards.	<b>2</b>
<b>Linking public health and security authorities</b>	R.3.1 Public health and security authorities (e.g. law enforcement, border control, customs) are linked during a suspect or confirmed biological event	<b>1</b>
<b>Medical countermeasures and personnel deployment</b>	R.4.1 System in place for sending and receiving medical countermeasures during a public health emergency	<b>1</b>
	R.4.2 System in place for sending and receiving health personnel during a public health emergency	<b>1</b>
<b>Risk communication</b>	R.5.1 Risk communication systems (plans, mechanisms, etc.)	<b>2</b>
	R.5.2 Internal and partner communication and coordination	<b>3</b>
	R.5.3 Public communication	<b>3</b>
	R.5.4 Communication engagement with affected communities	<b>2</b>
	R.5.5 Dynamic listening and rumour management	<b>2</b>
<b>Points of entry</b>	PoE.1 Routine capacities established at points of entry	<b>1</b>
	PoE.2 Effective public health response at points of entry	<b>1</b>
<b>Chemical events</b>	CE.1 Mechanisms established and functioning for detecting and responding to chemical events or emergencies	<b>1</b>
	CE.2 Enabling environment in place for management of chemical events	<b>2</b>
<b>Radiation emergencies</b>	RE.1 Mechanisms established and functioning for detecting and responding to radiological and nuclear emergencies	<b>1</b>
	RE.2 Enabling environment in place for management of radiation emergencies	<b>2</b>

Scores: 1=No capacity; 2=Limited capacity; 3=Developed capacity; 4=Demonstrated capacity; 5=Sustainable capacity.

# PREVENT

## National legislation, policy and financing

### Introduction

The International Health Regulations (IHR) (2005) provide obligations and rights for State Parties. In some State Parties, implementation of the IHR (2005) may require new or modified legislation. Even if a new or revised legislation may not be specifically required, states may still choose to revise some regulations or other instruments in order to facilitate IHR implementation and maintenance in a more effective manner. Implementing legislation could serve to institutionalize and strengthen the role of IHR (2005) and operations within the State Party. It can also facilitate coordination among the different entities involved in their implementation. See detailed guidance on IHR (2005) implementation in national legislation at [http://www.who.int/ihr/legal\\_issues/legislation/en/index.html](http://www.who.int/ihr/legal_issues/legislation/en/index.html). In addition, policies that identify national structures and responsibilities as well as the allocation of adequate financial resources are also important.

### Target

*Adequate legal framework for State Parties to support and enable the implementation of all their obligations, and rights to comply with and implement the IHR (2005). New or modified legislation in some State Parties for implementation of the IHR (2005). Where new or revised legislation may not be specifically required under the State Party's legal system, States may revise some legislation, regulations or other instruments in order to facilitate their implementation and maintenance in a more efficient, effective or beneficial manner. State Parties ensure provision of adequate funding for IHR implementation through the national budget or other mechanism.*

### The Gambia's level of capabilities

The Gambia is a signatory to the IHR (2005). However, the IHR needs to be ratified (domesticated) to be part of The Gambia's national legislation as stipulated by the 1997 Constitution. The Gambia has several existing legislative frameworks, laws and policies focused on public health, including: the National Health Policy (2010-2020), the Public Health Act (1990), the Food Safety and Quality Act (2011), the Quarantine Act (1932), National Disaster Management Act (2008), the Medicines and Related Products Act (2014), the Pharmacy Act (2014), the National Environment Management Act (1994), the Health Sector Strategic Plan (2014-2020), and the Environmental Protection (Prevention of Dumping) Act (1988),

Under the Public Finance Act, the Minister of Finance is empowered to allocate a special fund to be used for health emergencies. In the health sector, The Gambia is striving to have a national compact using one coordination mechanism, one strategic plan, and one monitoring and evaluation plan. In addition, the country is developing a social protection scheme that includes access to a basic costed health package.

An IHR core capacity assessment was conducted in 2009 and a pathway to veterinary services (PVS) assessment and gap analysis was conducted in 2016. These assessments identified gaps which have been reviewed as part of the JEE process.

A few of the public health laws need to be reviewed and amended to incorporate new concepts and practices relating to the IHR and One Health. Moreover, many laws do not have a subsidiary legislation. To comply with the IHR (2005), The Gambia needs to accelerate the review of the Public Health Act, whose

purpose is to protect public and environmental Health. The current Act was enacted in 1990, repealing the previous Act of 1935.

## Recommendations for priority actions

- The IHR (2005) should be ratified and domesticated by expediting the legal processes required to ensure alignment with the country's constitution and laws.
- Conduct a comprehensive review of existing laws and policies to ensure that they are aligned and support the implementation of the IHR (2005). Based on this review, it is recommended that the country accelerates the amendment of the 1990 Public Health Act as well as other relevant extant legislation and regulations where necessary.
- Create and fund budget lines for IHR implementation and/or public health emergency core capacity building and management in all relevant sectors.

## Indicators and scores

### P.1.1 Legislation, laws, regulations, administrative requirements, policies or other government instruments in place are sufficient for implementation of IHR (2005) – Score 2

#### *Strengths/best practices*

- The Gambia has several pieces of legislation addressing various aspects of public health and health security, although most of the laws predate the IHR (2005).
- The Ministry of Health and Social Welfare and her relevant agencies in collaboration with stakeholders, have policies in place for the effective implementation of the IHR (2005).
- In case of any emergency, respective sectors may apply to the Ministry of Finance for funds.
- During the Ebola outbreak in West Africa, the government revitalized publicity campaigns on the need to abide by the health sanitary and hygiene measures.

#### *Areas that need strengthening and challenges*

- There is a need for comprehensive and detailed legislative instruments to support the application and enforcement of the respective Acts, preferably consolidated into one document for ease of reference
- There is a need for effective means of sharing information with and among respective stakeholders in case of health emergencies.
- At present, there is lack of comprehensive legislation that addresses the One Health approach. This will require harmonization of all health-related legislations. Although Section 108 and 112 of the National Disaster Management Act establishes the National Disaster Fund, at present, payment of administrative fees from the National Disaster Fund is not done, even though administrative fees are provided for in the Act. Therefore available resources are limited in case of a health emergency.

### P.1.2 The State can demonstrate that it has adjusted and aligned its domestic legislation, policies and administrative arrangements to enable compliance with the IHR (2005) – Score 1

#### *Strengths/best practices*

- There is significant political and technical commitment by the government of The Gambia to manage disasters and other health emergencies.
- The health sector has a robust health sector strategic plan (2014-2020) and this is available to all stakeholders.
- The Ministry of Health and Social Welfare, in collaboration with other stakeholders, undertakes relevant actions in response to health threats and disasters.

- The Gambia has a National Focal Point for health emergencies and disasters and all relevant stakeholders work with the National Focal Point in case of health emergencies and disasters.
- There is currently a practice restricting street vendors from selling food on the street during cholera or other food borne health emergencies.

#### ***Areas that need strengthening and challenges***

- There is a need for regular assessment of legislation and policies to demonstrate gaps in implementation of IHR (2005).
- The establishment of the National Focal Point should be published in the Gazette for public awareness.
- There is a need to create an enabling environment and enact comprehensive legislation to address "One Health" in The Gambia.
- It is critical to address financial gaps in funding available for routine public health activities and emergency response already funded from domestic and donor sources.

# IHR coordination, communication and advocacy

## Introduction

The effective implementation of the IHR requires multisectoral/multidisciplinary approaches through national partnerships for efficient and alert response systems. Coordination of nationwide resources, including the

designation of a national IHR focal point, which is a national centre for IHR communications, is a key requisite for IHR implementation.

### Target

*Multisectoral /multidisciplinary approaches through national partnerships that allow efficient, alert and responsive systems for effective implementation of the IHR (2005). Coordinate nationwide resources, including sustainable functioning of a national IHR focal point – a national centre for IHR (2005) communications which is a key requisite for IHR (2005) implementation – that is accessible at all times. State Parties provide WHO with contact details of national IHR focal points, continuously update and annually confirm them.*

## The Gambia level of capabilities

The IHR (2005) is being coordinated by an individual because the National IHR Focal Point (NFP) has not been established. The National IHR Focal Person is currently the Director of the Public Health Services. There is an existing national steering committee for the coordination of all public health emergencies between ministries and other stakeholders. The committee is multi sectoral and is multidisciplinary. However, there is a need for developing a coordination mechanism within the health services and between relevant sectors. Standard Operating Procedures (SOPs) to facilitate a multidisciplinary and multi-sectoral mechanism need to be updated based on the experience of the Ebola Virus Disease preparedness.

Information sharing between animal and human health surveillance is very limited. However, informal means of information sharing occurs when the need arises. There is inadequate implementation of the IHR (2005). National epidemic information updates are not regularly available and information sharing with stakeholders is on ad-hoc basis.

## Recommendations for priority actions

- Establish a functional IHR National Focal Point, provide human resources, equipment and IT support and training of the appropriate human resources on the roles and functions of the IHR NFP.
- Establish and make functional a multisectoral and multi-disciplinary national level coordination mechanism with clear composition, SOPs and roles and responsibilities for the members.
- Establish a robust communication and advocacy mechanism for regular information sharing within and between sectors.
- Test the functionality of the established system and mechanism using either real events - After Action Reviews or simulation exercises.

## Indicators and scores

### P.2.1 A functional mechanism established for the coordination and integration of relevant sectors in the implementation of IHR – Score 1

#### *Strengths/best practices*

- IHR core capacity assessment conducted in 2009.
- There is a designated IHR Focal Person.
- There is political commitment to IHR related activities.
- The existence of a National Multisectoral and Multidisciplinary Steering Committee on Public Health Emergencies.
- The existence of the National Disaster Management Agency (NDMA) that coordinates the response to all Emergencies and disasters.
- Use of IDSR guideline in the implementation of the IHR activities in the country.

#### *Areas that need strengthening and challenges*

- National IHR Focal Person needs to be trained and a national IHR focal point mechanism needs to be established.
- The need to establish operational communication between the IHR NFP and other relevant ministries.
- The Gambia needs to fully implement IHR (2005).
- Low awareness of IHR –related activities among stakeholders and communities.
- The need to fully equip Points of Entries both in terms of human resources and equipment.
- Evaluations of obligatory functions of NFP.

# Antimicrobial resistance

## Introduction

Bacteria and other microbes evolve in response to their environment and inevitably develop mechanisms to resist being killed by antimicrobial agents. For many decades, the problem was manageable as the growth of resistance was slow and the pharmaceutical industry continued to create new antibiotics.

Over the past decade, however, this problem has become a crisis. Antimicrobial resistance is evolving at an alarming rate and is outpacing the development of new countermeasures capable of thwarting infections in humans. This situation threatens patient care, economic growth, public health, agriculture, economic security and national security.

### Target

*Support work coordinated by FAO, OIE and WHO to develop an integrated global package of activities to combat antimicrobial resistance, spanning human, animal, agricultural, food and environmental aspects (i.e. a One Health approach). Each country has: (i) its own national comprehensive plan to combat antimicrobial resistance; (ii) strengthened surveillance and laboratory capacity at the national and international levels following international standards developed as per the framework of the Global Action Plan; and (iii) improved conservation of existing treatments and collaboration to support the sustainable development of new antibiotics, alternative treatments, preventive measures and rapid point-of-care diagnostics, including systems to preserve new antibiotics..*

## The Gambia level of capabilities

The country has an awareness of the need for interventions addressing antimicrobial resistance (AMR). Several initiatives have been undertaken to address AMR, however these initiatives do not follow the One Health approach. There is a published study which provides a baseline of health worker perspectives on antibiotic usage and stewardship. There are also draft guidelines for laboratory-based surveillance for AMR (developed in 2014), SOPs for AMR surveillance and ongoing ad-hoc surveillance being conducted at one tertiary hospital. There are facility level guidelines which address Infection Prevention and Control (IPC). Legislation includes the Pharmacy Council Act (2014) establishing the Pharmacy Council and the Medicines and Related Products Act (2014) that together replaced the Medicines Act (1984) to regulate the pharmacy profession separately from pharmaceutical products. The latter Act created the Medicines Control Agency and strengthens monitoring of the quality, safety and efficacy of medicines and newer therapeutic technologies (including medical devices). However, AMR is not specifically mentioned.

In addition, there is no existing national policy or strategy to guide the implementation of activities to achieve the benchmark required for the Global Action for AMR and qualify for enrolment in the Global Antimicrobial Surveillance System (GLASS).

There is keen interest within the National Public Health Laboratory (NPHL) system and political will which can ensure that The Gambia can soon become part of the global AMR initiative.

## Recommendations for priority actions

- Develop a national policy, guidelines and standard operating procedures (SOPs) which address Antimicrobial Stewardship and Healthcare Associated Infections with a One Health approach.

- Finalize the draft Infection Prevention and Control (IPC) policy and guidelines, broadening the scope in order to guide multisectoral action.
- Develop a comprehensive national action plan which will deliver an effective national AMR surveillance system as well as interventions addressing Health care Associated Infections and Antimicrobial stewardship.
- Implement a nationwide awareness campaign for AMR with targeted messaging for human and animal health care professionals, the agricultural sector and the public.
- Capacity building and provision of resources to ensure the laboratory services can deliver effective AMR Surveillance.

## Indicators and scores

### P.3.1 Antimicrobial resistance detection– Score 1

#### *Strengths/best practices*

- Existing draft technical guidelines for laboratory surveillance for AMR.
- Three laboratories (teaching hospital, National Public Health Laboratory (NPHL) and Medical Research Council (MRC)) are conducting detection/reporting on some priority pathogens and can be designated as sentinel sites.

#### *Areas that need strengthening/challenges*

- The current AMR initiatives are focused primarily on human health and have not been developed collaboratively with the other stakeholders in One Health.
- The NPHL is poorly resourced and unable to meet the GLASS national reference laboratory for AMR requirements without further investment.

### P.3.2 Surveillance of infections caused by antimicrobial-resistant pathogens– Score 1

#### *Strengths/best practices*

- One facility, Edward Francis Small Teaching Hospital, has commenced limited AMR surveillance in the country.
- The NPHL conducts tests for Multi-Drug Resistant Tuberculosis using GeneXpert technology along with four other hospitals; resistant specimens are referred for drug sensitivity testing.
- Some studies have been conducted to establish the prevalence of resistant bacteria (e.g. a Faecal carriage of multi-resistant pathogens in food handlers).

#### *Areas that need strengthening/challenges*

- The lack of a national action plan for AMR surveillance in humans and animals.
- Weak capacity and inadequate resources at the Central Veterinary Laboratory (CVL) to implement AMR surveillance in animals.
- Weak medical laboratory service infrastructure.

### P.3.3 Healthcare-associated infection (HCAI) prevention and control programmes– Score 1

#### *Strengths/best practices*

- There is a draft national guideline on Infection Prevention and Control as well as facility level standard operating procedures.

- Two hospitals have isolation facilities and have designated IPC focal persons.

#### ***Areas that need strengthening/challenges***

- Development and enforcement of national Infection Prevention and Control policy and a national action plan.
- Equip and establish isolation sites in all hospitals and major health facilities.
- Establish surveillance of at-risk groups for HCAI.
- Finalize and disseminate IPC SOPs and guidelines at the health facility level.
- Lack of operational research on the impact of HCAI on the Gambian Health care system.
- Poor awareness of the impact of Health Care Associated Infections in the Gambian Health care system.

#### **P.3.4 Antimicrobial stewardship activities– Score 1**

##### ***Strengths/best practices***

- Nationwide baseline survey conducted on the Knowledge, Attitude, and Practice of Healthcare workers in The Gambia.
- Pharmacy Registration Council established as the national regulatory agency ensuring quality, safety, and efficacy of antimicrobial agents.

##### ***Areas that need strengthening/challenges***

- Development of a national AMR stewardship plan.
- There is weak enforcement of regulations on antibiotic prescription for both human and animal health.
- Training and capacity building for human and animal health workers on rational use of antimicrobials.
- Development of behavioural change communication strategies and awareness campaigns to change the irrational use of antibiotics.
- Enforcement of restrictions on access to antimicrobial agents under the Medicines and Related Products Act (2014).

# Zoonotic diseases

## Introduction

Zoonotic diseases are communicable diseases that can spread between animals and humans. These diseases are caused by viruses, bacteria, parasites and fungi carried by animals, insects or inanimate vectors that aid in its transmission. Approximately 75% of recently emerging infectious diseases affecting humans are of animal origin; and approximately 60% of all human pathogens are zoonotic.

### Target

*Adopted measured behaviors, policies and/or practices that minimize the transmission of zoonotic diseases from animals into human populations.*

## The Gambia level of capabilities

Zoonotic diseases are likely to emerge in regions where the human population is dense and growing and biodiversity is high. The Gambia has a high population density and diverse ecosystems around the central Gambia River including seven national parks (in total, these constitute about 3.5 per cent of the country's total land area and are in less populated regions). There is no formal One-health policy in The Gambia although there is on-going work to establish a One Health platform.

The Gambia has operated with a narrower definition of zoonotic diseases; focusing on those diseases strictly transmitted only from animals to humans rather than shared infections. Thus, rabies was identified and prioritised by the Department of Livestock Services (DLS) in the country presentation. This also reflects historical collaboration with the Ministry of Health and Social Welfare (MoHSW) for a rabies control programme in animals (primarily dogs). The US Centres for Disease Control and Prevention (CDC) Prioritisation Tool could be used by the concerned Ministries to identify prioritized zoonotic diseases.

Other zoonotic diseases anecdotally present are bovine tuberculosis, Brucellosis (*Brucella abortus*), Anthrax, Rift Valley Fever, Cysticercosis and Fasciolosis. Multi-jurisdictional contingency preparedness and response plans exist, specifically:

- Integrated National Emergency Preparedness and Response Plan for Avian & Human Influenza (AHI) (2015-2019) originally written with FAO assistance in 2007 and updated in 2015 with the NDMA;
- The National Ebola virus Disease Preparedness and Response Plan, The Gambia(2014-2015) by the MoHSW;
- Health Sector Emergency Preparedness and Response Plan Related to All-Hazards 2017-2019 also by MoHSW.

Trypanosomiasis is present in The Gambia for which the International Trypanotolerance Centre (ITC) was created. ITC was officially renamed West African Livestock Innovation Centre (WALIC) in 2016. Although serologically positive, the trypanotolerant livestock breeds (of Ndama cattle, Djallonke sheep and West African Dwarf Goat) developed at WALIC do not exhibit clinical signs of the disease. The potential to collaborate with human public health in Trypanosomiasis disease has been identified. With respect to other common zoonoses, the ITC published an assessment which found a general "absence of Brucellosis and tuberculosis infection in cattle in The Gambia".

The DLS has a generic passive surveillance network only for livestock. Active surveillance has been dependent on external project funding such as occurred for avian influenza in 2008 in collaboration with

MoHSW and Department of Parks and Wildlife Management. Rift Valley Fever surveillance was conducted in 1988-90 and 2002-2011 collaboratively with MoHSW. DLS has monthly disease reporting system, the contents of the monthly reports are compiled into an annual report. There is no formal sharing of surveillance information with other Ministries. There are also no linkages between laboratories although laboratory confirmation of DLS disease reports is not common ( $\approx 15\%$ ). No zoonotic surveillance systems exists.

The last Livestock survey was done in 2016 awaiting results/report completion and prior to that, surveys were conducted in 2011/12 and 1993.

Severe veterinarian shortages exist in DLS with only 2 staffed veterinary positions in DLS. A recruitment programme is needed to attract students to a veterinary career in The Gambia. Retention of experienced veterinarians is essential with the creation of incentives to avoid the current "brain drain" due to more attractive positions in the private sector.

## Recommendations for priority actions

- Current Rabies vaccination scheme reflects historical MoHSW support of prioritized zoonotic diseases control programme.
- Generic epidemiological surveillance system network fed by DLS veterinary clinic paraprofessional staff can be supplemented with six recently re-established Regional laboratories.
- Multidisciplinary Preparedness and Response Plans (generic, Influenza and Ebola Virus) exist and can be used as templates for other diseases.
- Rapid Response Teams, Multidisciplinary Facilitation Teams and Technical Advisory Committees (exist and could be coordinated into a One Health approach).

## Indicators and scores

### P.4.1 Surveillance systems in place for priority zoonotic diseases/pathogens– Score 1

#### *Strengths/best practices*

- A generic epidemiological surveillance system and network exists in the DLS, incorporating six regional and one central veterinary laboratory. The human surveillance system was not presented and will be included in a following technical area (Real time surveillance).
- Comprehensive multidisciplinary preparedness and response plans already exist for highly pathogenic avian influenza, Ebola viruses and generic health sector emergencies.

#### *Areas that need strengthening/challenges*

- A DLS list of diseases exists (2017) but these diseases are not compulsorily notifiable (in legislation) as required by the OIE nor is there an agreed prioritized list of zoonotic diseases (including in wildlife) for The Gambia.
- With a passive surveillance system, there is no way to assess underreporting. Incentives to report (compensation) exist in legislation which are currently outdated and no longer routinely applied.
- Develop specific surveillance plans for priority zoonotic diseases and train DLS personnel at all levels and other stakeholders to implement them.
- No electronic laboratory information management system exists in animal health laboratories.
- Inadequate human and financial resources which weakens the DLS veterinary services.
- No linkage or exchange mechanism exists between public health and animal health surveillance

systems for information-sharing.

- No linkage or exchange mechanism exists between public health and animal health diagnostic laboratory systems for sharing specimens or diagnostic results.

#### **P.4.2 Veterinary or animal health workforce– Score 1**

##### ***Strengths/best practices***

- A relatively stable workforce of veterinary para-professionals exists at the national and regional level that can be trained to meet the capability required by PVS evaluations. Veterinary para-professionals (livestock assistants) have a two-year certificate level post-secondary school training course as well as in-service training by DLS.
- Regional laboratory infrastructure has been re-established, which had been gradually closed as the Pan African Rinderpest Campaign and the Pan African Control of Epizootics Program ceased ten years ago, but require equipment and diagnostic capability training.
- Rapid response teams, multidisciplinary facilitation teams, and technical advisory committees exist and could be coordinated into a One Health approach.

##### ***Areas that need strengthening/challenges***

- Only 2 veterinarians are staffed at DLS, out of the estimated 22 needed (PVS Gap Analysis 2012).
- Capacity building is needed in disease surveillance, laboratory, and specialist fields such as Veterinary Public Health, Epidemiology, and Biostatistics.
- There is an urgent need to recruit more veterinarians to enhance veterinary services at national and regional levels as well as retain those leaving for work in the private sector. Staff turnover is high.
- Only three veterinary paraprofessionals have been included in FETP which can be used to promote training on priority zoonotic diseases, improve awareness, encourage collaboration, and build synergies.

#### **P.4.3 Mechanisms for responding to infectious and potential zoonotic diseases established and functional– Score 2**

##### ***Strengths/best practices***

- A National policy, strategy, and plan for the response to zoonotic events is in place.
- The Highly Pathogenic Avian Influenza and Ebola Virus Disease Contingency plans, Health Sector Emergency Response Plan (HSEPRP) plan and all the broad stakeholder involvement in their development mechanism can be the basis to develop legislation, policies, SOPs and Guidelines for zoonotic diseases response mechanism and platforms

##### ***Areas that need strengthening/challenges***

- Current legislation, policies, SOPs and Guidelines development for priority zoonotic diseases response mechanisms and platforms need to be updated.
- Inadequate resource mobilization focused on zoonotic diseases.
- Training and simulation exercises on Avian Influenza and EVD contingency plans and National Health Sector Emergency Response Plan.
- There is a need to enhance the veterinary laboratory network to full functionality in order to diagnose and respond to potential zoonotic disease events.

# Food safety

## Introduction

Food- and water-borne diarrhoeal diseases are leading causes of illness and death, particularly in less developed countries. The rapid globalization of food production and trade has increased the potential likelihood of international incidents involving contaminated food. The identification of the source of an outbreak and its containment is critical for control. Risk management capacity with regard to control throughout the food chain continuum must be developed. If epidemiological analysis identifies food as the source of an event, based on a risk assessment, suitable risk management options that ensure the prevention of human cases (or further cases) need to be put in place.

### Target

*Surveillance and response capacity among State Parties for food- and water-borne disease risks or events by strengthening effective communication and collaboration among the sectors responsible for food safety, and safe water and sanitation.*

## The Gambia level of capabilities

The Food Safety and Quality Authority (FSQA) also serves as the focal point for the International Food Safety Authority Network (INFOSAN). Other agencies involved (on delegation bases authorised by the FSQ Act. 2011) in food safety in The Gambia includes the MoHSW (Directorate of Public Health Services), for inspection of food business establishments in North Bank, Central River, Lower River and Upper River Regions only. Ministry of Agriculture, DLS, for official post mortem inspection of animals slaughtered for food at abattoirs, slaughter houses and slaughter slab facilities countrywide, Ministry of Fisheries, Department of Fisheries, for official inspection of all fish processing vessels and landing sites countrywide.

The FSQA was established as the sole National Competent Authority with the mandate to control the safety and quality of all food and animal feed in The Gambia. The FSQA was set up by the Food Safety and Quality Act (2011). The 2011 Act repealed most parts of the Food Act (2005) which authorised five Ministries (MOHSW, Ministry of Agriculture, Ministry of Fisheries and Water Resources, Minister of Local Government and Lands, Ministry of Tourism and Culture) with specific aspects of food safety controls. There is an international movement to amalgamate all food regulatory functions to a single agency to ensure effective coordination across the food to fork continuum.

The FSQA has the mandate to institute structures and control mechanisms to ensure the safety and quality of food across the food chain. It is also responsible for assessing laboratory services in terms of technical capacity to carry out food and feed analysis for official control, promoting mutual recognition with foreign food safety authorities, and ensuring a risk based approach to inspection procedures. No domestic laboratories meet requirements of Section 53 of the Food Safety and Quality Act in The Gambia although a food quality laboratory has been set up by the Ministry of Fisheries and Water Resources & National Assembly Matters. All laboratory analyses of food to date have been only for export. Food safety sampling programmes for smoked fish, rice, groundnuts, meat, and other essential commodities for domestic consumption have not commenced because of lack of funding (there is a pending response from the Ministry of Finance for extra budgetary funding).

Although Memoranda of Understanding (MOUs) have been signed with several of the stakeholder Ministries which can provide a specified structured and formal system of reporting, information sharing mechanisms with delegated institutions has not been institutionalised. The lack of information sharing is threatening to compromise the main objective of a single accountable agency.

The field visit to the NPHL found investigations into the syndrome of “bloody diarrhoea” did not follow protocols in place and no food samples had been taken since the establishment of FSQA. Food borne illness investigation protocols need to be reviewed.

## Recommendations for priority actions

- Address incomplete sampling in current foodborne disease outbreak investigations for both the interim and long term by putting in place a proper coordination mechanism between all stakeholders. Establish an interagency coordination mechanism clarifying roles and responsibilities to ensure sustainable collaboration among all food safety stakeholders. Include delegated institutions to facilitate implementation of the food safety programme with clear communication links.
- Put in place a routine surveillance mechanism which can utilize upgraded national food testing laboratories that meet section 53 of Food Safety and Quality Act (ISO 17025 accreditation).
- Adopt and implement the national food safety policy.
- Capacity building for members of the independent Scientific Committee to conduct Risk Assessments.

## Indicators and scores

### P.5.1 Mechanisms for multisectoral collaboration established to ensure rapid response to food safety emergencies and outbreaks of foodborne diseases – Score 2

#### *Strengths/best practices*

- Regulatory framework for food safety control with dedicated budget.
- Availability/use of local and international standards through collaboration with The Gambia Standards Bureau.
- Food inspection protocols based on risk yield annual inspection plans, checklist and database.
- There is an Independent Stakeholder Consultative Forum that meets quarterly.
- A Scientific Affairs Directorate within the FSQA for risk profiling exists.
- Codex Contact and Sanitary & Phytosanitary measures Enquiry points with active international engagement are available.
- An INFOSAN Emergency Contact has been designated.
- Compliance of food business operators ensured by providing guidelines and sampling plans.

#### *Areas that need strengthening/challenges*

- Collaboration in food safety implementation by delegated institutions as MOUs are not being implemented.
- Improve collaboration and clarify roles, including information sharing, on foodborne disease occurrences and outbreaks.
- Enhance national surveillance system to capture foodborne outbreaks.
- Inadequate training in risk based inspection procedures due to lack of financial resources.
- Upgrade ports of entry inspection as facilities are currently inadequate to allow effective inspection protocols.
- Increase laboratory capacity to include foodborne outbreak testing for humans and suspect foods.
- Lack of ISO accredited laboratories that can be designated by FSQA.

# Biosafety and biosecurity

## Introduction

It is vital to work with pathogens in the laboratory to ensure that the global community possesses a robust set of tools – such as drugs, diagnostics, and vaccines – to counter the ever-evolving threat of infectious diseases.

Research with infectious agents is critical for the development and availability of public health and medical tools that are needed to detect, diagnose, recognize and respond to outbreaks of infectious diseases of both natural and deliberate origin. At the same time, the expansion of infrastructure and resources dedicated to work with infectious agents have raised concerns regarding the need to ensure proper biosafety and biosecurity to protect researchers and the community. Biosecurity is important in order to secure infectious agents against those who would deliberately misuse them to harm people, animals, plants or the environment.

### Target

*A whole-of-government national biosafety and biosecurity system with especially dangerous pathogens identified, held, secured and monitored in a minimal number of facilities according to best practices; biological risk management training and educational outreach conducted to promote a shared culture of responsibility, reduce dual-use risks, mitigate biological proliferation and deliberate use threats, and ensure safe transfer of biological agents; and country-specific biosafety and biosecurity legislation, laboratory licensing and pathogen control measures in place as appropriate.*

## The Gambia level of capabilities

Biosecurity and biosafety is underdeveloped in The Gambia especially within the public system. There seems to be disparities in biosafety and biosecurity training and facilities for laboratory workers within the public and private (notably the Medical Research Council).

There is limited awareness of international biosafety and biosecurity best practices for safe, secure, and responsible conduct of activities within the public health system. There are no elements of a comprehensive national biosafety and biosecurity system in place. Biological risk management training and educational outreach are not routinely conducted to promote a shared culture of responsibility, reduce dual use risks, and mitigate biological proliferation and deliberate use threats.

There is no system in place to identify, hold, secure, and monitor dangerous pathogens. There is no system in place for the safe transfer of biological agents, while country-specific biosafety and biosecurity legislation, laboratory licensing and pathogen control measures are non-existent. There is no record of a training needs assessment being conducted and therefore no comprehensive training or a common training curriculum available for implementation. The country does not have sustained academic training in institutions that train those who maintain or work with dangerous pathogens and toxins. In the human health laboratories, used samples are generally handled and treated as other types of clinical waste. National guidelines are in existence for health care waste, however, their implementation is generally weak. There are no plans incorporating elements from zoonotic disease pathogens in line with One Health strategy. In addition, The Gambia does not have a list of dangerous pathogens or toxins for control.

No external assessment of national laboratory facilities has been conducted. No funding is available for many of the line ministries dedicated for biosafety and biosecurity. The national veterinary laboratory has a

collaborating centre in Senegal (L'NERV). The NPHL is also collaborating with the Pasteur Institute in Dakar, Senegal. Post exposure prophylactic services exist in most public health facilities for HIV only.

While there seems to be an under-development of activities within the public laboratory system, the MRC, which is privately owned, seems to be operating at a really high level with compliance with international biosafety and biosecurity best practices. The MRC is a designated biosafety level (BSL) 3 level laboratory while the NPHL is a BSL 1. It appears there is minimal leverage from The Gambian government on the capacity and capabilities within the MRC. However, there are ongoing plans to upgrade the Tuberculosis laboratory to a BSL 3 level with donor funds.

## Recommendations for priority actions

- Develop and enact appropriate legislation and regulations on biosafety and biosecurity for regulation of dangerous pathogen and toxins.
- Establish a multi-sectoral national coordination (particularly leverage existing capacity at MRC), oversight and enforcement mechanism for response and control of dangerous pathogens.
- Provide adequate funding for the establishment of biosafety and biosecurity programmes and training of relevant human resources.

## Indicators and scores

### P.6.1 Whole-of-government biosafety and biosecurity system in place for human, animal and agriculture facilities– Score 1

#### *Strengths/best practices*

- Presence of a privately-owned BSL 3 level laboratory research institute in Banjul – the MRC.

#### *Areas that need strengthening/challenges*

- There is no mechanism for monitoring and developing an updated record and inventory of pathogens within facilities that store or process dangerous pathogens and toxins.
- There is no legislation or regulations on biosecurity
- The country has no regulatory body for licensing laboratories.
- No guidelines on laboratory biosafety in human and animal health.
- Regional laboratories do not have access controls to minimize potential inappropriate removal or release of biological agents.
- There is inadequate leadership and inadequate funding to support the sector, as well as partner-driven parallel programmes without collaboration or coordination.

### P.6.2 Biosafety and biosecurity training and practices– Score 1

#### *Strengths/best practices*

- There is a recognition by the relevant authorities about the lack of legislation and regulation focusing on biosecurity and biosafety as well as the will to address this gap.

#### *Areas that need strengthening/challenges*

- No specific agents have been identified for human and agricultural pathogens of concern.
- The Gambia needs to conduct a needs assessment and develop a curriculum for training relevant laboratory staff.

- Improve general awareness among the laboratory workforce of existing international biosafety and biosecurity best practices for safe, secure, and responsible conduct.
- Establish and secure adequate funds for sustained academic training institution or programmes that train and maintain or work with dangerous pathogens and toxins.
- Support trained staff to carry out exercises or drills on biological risk protocols.
- There is a need to identify a biological weapons convention focal point.
- Development and implementation of facility biosafety and biosecurity training and SOPs.

# Immunization

## Introduction

Immunizations are estimated to prevent more than two million deaths a year globally. Immunization is one of the most successful global health interventions and cost-effective ways to save lives and prevent disease.

### Target

*A national vaccine delivery system – with nationwide reach, effective distributions, access for marginalized populations, adequate cold chain and ongoing quality control – that is able to respond to new disease threats.*

## The Gambia level of capabilities

The Gambia has a National Expanded Programme on Immunization (EPI), established in 1979, which is responsible for the implementation and management of immunization services in the country. Activities are guided by the Comprehensive Multi-Year Plan for Immunization (cMYP) 2017 – 2021 which is aligned with the Global Vaccine Action Plan and Global Immunization Strategy.

The country has a functioning national vaccine delivery system – with nationwide reach, effective distribution, access for marginalized populations, adequate cold chain and ongoing quality control. The programme aims at reaching every child eligible for vaccination in the country. The Gambia's EPI programme (routine) delivers vaccines for 13 antigens including new vaccines.

A recent coverage survey indicated that approximately 97% of the country's 12-month-old population has received at least one dose of measles vaccine; this is followed by supplementary immunization campaigns. In addition, second measles vaccine dose was introduced in 2012 and uptake has progressively increased in the country, currently at 79%. Immunization campaign results are normally validated with post campaign evaluation.

The availability of a functional vaccine procurement and forecasting system means that there are no stock outs at the central level and rare stock outs at the district level. Procurement and forecasting is usually done with input from partners (Gavi, UNICEF, WHO) working within the immunization ecosystem. Vaccines are made available across all levels through a mixed push-pull system. Vaccines are pushed to regional stores and pulled by the health facilities from the respective regional stores with the exception of health facilities in the Western region which pull vaccines directly from the National vaccine store. All health facilities within the districts have functional solar-driven cold chain equipment. The Gambia has led the sub-region in best practices and achievements in immunisation coverage.

## Recommendations for priority actions

- Expansion of the coverage of vaccine storage equipment.
- Increase demand creation for routine immunization services.
- Strengthen the conduct and delivery of immunization outreach services across health facilities.
- Support the implementation of the immunization communication plan.

## Indicators and scores

### P.7.1 Vaccine coverage (measles) as part of national programme– Score 4

#### ***Strengths/best practices***

- 90% of the country's 12-month old population has received at least one dose of measles containing vaccine, as demonstrated by coverage surveys or administrative data. 80% of all sub-national (districts/provinces) units covered.
- Integration of immunization into Reproductive and Child Health.
- Development of country multi-year Plan aligned with the National Health Strategic Plan (NHSP).
- Linkages between the central level structure and the structures at the peripherals.
- Designated trained staff for immunization service delivery.
- Good partnership with donors to support immunization service delivery.
- Vaccine preventable disease surveillance integrated into the IDSR system.
- Use of electronic stock tracking tools to monitor vaccines and consumables.
- Involvement of partners, stakeholders, and regions in development of country plans.
- Periodic comprehensive EPI review to monitor and evaluate the programme.
- Bi-monthly meeting with immunization staff to provide feedback on immunization and surveillance performance.
- Undertaking Data Quality Assessment to maintain high coverage and improve quality of immunization data.

#### ***Areas that need strengthening/challenges***

- Improve the organization of outreach sites and implementation of outreach services.
- Institute surveillance of Adverse Events Following Immunization.
- Improve awareness on immunization services in the general population.
- Improving data management and use for timely action.
- Micro planning for activities to increase immunization demand and utilization and also conducting defaulter tracing in all regions.
- Finalization and update of the immunization policy and EPI.
- Zoonosis of national concern not included in the EPI plan.
- Limited intervention in operational research in immunization.
- Inadequate funding for cold chain and vaccine preventable disease surveillance.

### P.7.2 National vaccine access and delivery– Score 4

#### ***Strengths/best practices***

- Government procures traditional vaccines and meets the co-financing obligation for newly introduced vaccines.
- Annual vaccine forecast is developed with partners.
- All vaccines are procured through UNICEF Supply division.
- All public health facilities have functional solar-driven cold chain equipment.

- Walk- in cold room at national and in 5 regional cold stores.
- Electronic stock management tool to monitor vaccine stock and consumables.
- Availability of cold van to distribute vaccines to the regions quarterly.
- Expansion of outreach sites.
- Periodic conduct of the Effective Vaccine Management.
- Continuous temperature monitoring during storage and transportation.
- Quarterly preventive maintenance of cold chain equipment.
- Use of vaccine and stock management tools to prevent under and over-stocking.

#### ***Areas that need strengthening/challenges***

- Implementation of planned preventive maintenance of cold chain equipment including repairs especially old and obsolete equipment.
- Improving cold chain facility and capacity in some regions and major health facilities.
- Cold chain and vaccine management including reporting of immunization data from private clinics.
- Frequent power outage at the central cold store.
- Transport for Regional Health Directorates and surveillance officers.
- High cost of cold chain equipment spare parts.

# DETECT

## National laboratory system

### Introduction

Public health laboratories provide essential services including disease and outbreak detection, emergency response, environmental monitoring and disease surveillance. State and local public health laboratories can serve as a focal point for a national system, through their core functions for human, veterinary and food safety including disease prevention, control and surveillance; integrated data management; reference and specialized testing; laboratory oversight; emergency response; public health research; training and education; and partnerships and communication.

#### **Target**

*Real-time bio-surveillance with a national laboratory system and effective modern point-of-care and laboratory-based diagnostics.*

### The Gambia level of capabilities

The Directorate of Laboratory Services, within the Ministry of Health and Social Welfare, is at the centre of the National Public Health Laboratory System. This nascent directorate is evolving as the anchor for the National Laboratory System which includes clinical, reference and public health laboratories and the National Blood Transfusion Services and is currently responsible for reference testing, Quality Assurance (QA) and Continuous Professional Development.

There is one public health reference laboratory providing support for surveillance on priority diseases and coordination of the national laboratory network. The NPHL which serves as the reference laboratory for the following microbes: *Mycobacterium tuberculosis*, *Plasmodium* spp, HIV and Rotavirus, *Salmonella enteritidis* serotype typhi and *Shigella/Cholera*.

There are 52 clinical laboratories distributed throughout the country serving hospitals, major and minor health centres. There are currently 11 minor health centres without laboratory services. However, testing capability at these peripheral laboratories is mainly haematology and involving the use of rapid diagnostics for malaria and HIV.

There are several veterinary laboratories in the country, at national and regional levels. These laboratories include the National Agricultural Research Institute, the Central Veterinary laboratory, the Fisheries/Food Hygiene and Quality Control Laboratory. However, these laboratories are not all functional because of the lack of reagents and consumables, human resource constraints and inadequate infrastructure. There is no formal collaboration between the veterinary laboratories and none between these laboratories and the human health laboratories.

During public health emergencies/events, the NPHL located in Banjul receives specimens from the intermediate and peripheral levels and ships them to the Institute Pasteur Dakar and WHO Collaboration Laboratory located with the MRC. There is a system in place to transport specific disease specimens (Rota, Measles, Rubella, Yellow Fever, AFP) to national or regional reference laboratories from all the districts for advanced diagnostics. There is no standard system for routine specimen referral between facilities.

There is no established total quality management system for the laboratories. There is no national External Quality Assurance (EQA) scheme, however, the Global Fund for AIDS, TB and Malaria supports external

quality assurance (EQA) for HIV serology, TB, and malaria while the WHO supports EQA for rotavirus, measles, rubella, bacterial diagnosis, malaria, tuberculosis microscopy. There is no legislation, policy, or regulatory framework for the registration of premises and the licencing of laboratory scientists and technicians in the country.

## Recommendations for priority actions

- The process for the finalization of the National Health Laboratory Policy should be expedited through a collaborative system that includes all One Health stakeholders, which addresses the gaps in regulation, licensing, and quality assurance for laboratories in the country.
- The establishment of the Laboratory Science Council should be prioritized to set standards through the provision of frameworks for registration and licensing of laboratory staff and laboratories in the public and private sector.
- The NPHL should establish system for collaboration with private and research laboratories in the country, including Memoranda of Understanding, to strengthen the referral of samples and the conduct of specialized testing for priority diseases in the country.
- Establish a mechanism to link national animal and human reference laboratories and to mobilize sustainable financial resources.
- Strengthen the two national reference laboratories (for animal and human health sectors) and make them sustainable while establishing a functional national specimen referral and transportation system that is flexible and can be adapted to routine and outbreak situations.

## Indicators and scores

### D.1.1 Laboratory testing for detection of priority diseases– Score 2

#### *Strengths/best practices*

- A national diagnostic algorithm for HIV and TB, aligned to the WHO standards, is in place.
- Standardized SOPs for collection, packaging and transportation are available for diseases under surveillance.
- For the diseases under surveillance or during outbreaks, specimen referral is fully supported with the availability of a mobile laboratory.

#### *Areas that need strengthening/challenges*

- Most second and third tier laboratories do not have full hematology, biochemistry or microbiology services.
- The NPHL is close to the regional reference laboratory in Dakar Senegal, (although collaboration is limited and there is no formal MoU in place).
- Shipment of biological samples between countries to ensure that all tests can be conducted during outbreaks.
- Poor equipment maintenance culture, inadequate equipment, frequent stock out of laboratory reagents and consumables affect the functions of the laboratories.

### D.1.2 Specimen referral and transport system– Score 1

#### *Strengths/best practices*

- There is a system in place to transport specific disease specimens (Rota, Measles, Rubella, Yellow Fever, Acute Flaccid Paralysis, etc) to national or regional reference laboratories from all the districts for advanced diagnostics.

- Standardized SOPs for collection, packaging and transportation are available for diseases under surveillance.
- For the diseases under surveillance or during outbreaks, specimen referral is fully supported by MoHSW and partners.

#### ***Areas that need strengthening/challenges***

- Comprehensive systems for sample referral have to be put in place to increase the access to testing given the limited menus of tests (haematology, biochemistry or microbiology services) available in peripheral laboratories.
- Linkages between the National Public Health Laboratory and the regional reference laboratories (MRC, The Gambia & Dakar) need to be strengthened with formal agreements for specimen referral.
- National level protocols and policies need to be developed to enable safe shipment of biological samples within and outside the country to ensure that all tests can be conducted during outbreaks.

#### **D.1.3 Effective modern point-of-care and laboratory-based diagnostics– Score 2**

##### ***Strengths/best practices***

- Good collaboration between National AIDS Control Programme, National Malaria Control Programme and National TB Programmes, therefore malaria, TB and HIV and other diseases under surveillance have independent donor funded procurement but utilization of reagents/consumables are integrated at the laboratory level.

##### ***Areas that need strengthening/challenges***

- All media and reagents for performance of core laboratory tests are procured externally
- The country is heavily dependent on donor funding to procure laboratory equipment, reagents & consumables
- Rapid test kits should be deployed at the community level if possible in both public health and animal health sectors

#### **D.1.4 Laboratory quality system– Score 1**

##### ***Strengths/best practices***

- Both proficiency testing and re-checking of slides for TB and malaria are done routinely by the national public health reference laboratory.
- Refresher trainings for laboratory personnel is routinely undertaken.
- Monthly monitoring and supervision to all sites to ensure adherence to SOPs and early intervention to any challenges encountered has commenced.
- Good collaboration between National Aids Control Programme , National Malaria Control Programme and National Leprosy and Tuberculosis Programme respectively, contribute to improving the quality of laboratory systems.

##### ***Areas that need strengthening/challenges***

- Second and third tier laboratories are not performing IQC and EQA services.

# Real-time surveillance

## Introduction

The purpose of real-time surveillance is to advance the safety, security and resilience of the nation by leading an integrated bio-surveillance effort that facilitates early warning and situational awareness of biological events.

### **Target**

*Strengthened foundational indicator- and event-based surveillance systems that are able to detect events of significance for public health, animal health and health security; improved communication and collaboration across sectors and between sub-national, national and international levels of authority regarding surveillance of events of public health significance; improved country and intermediate level regional capacity to analyse and link data from and between strengthened, real-time surveillance systems, including interoperable, interconnected electronic reporting systems. This would include epidemiologic, clinical, laboratory, environmental testing, product safety and quality and bioinformatics data; and advancement in fulfilling the core capacity requirements for surveillance in accordance with the IHR and OIE standards.*

## The Gambia level of capabilities

The Gambia participates in a surveillance programme managed by the MoHSW. This has been implemented using the IDSR strategy since 2003. There is an IDSR technical guideline that provides the template for this strategy to be deployed in-country as stipulated by WHO AFRO. The guideline has been reviewed and upgraded twice (2008 and 2014) by the country to reflect current events in surveillance and as a response to improving resilience following the Ebola outbreak in 2014. The country has a list of 40 priority diseases, conditions, and events. Seven are notifiable immediately and 15 reportable weekly. Seven diseases have been targeted for elimination – Polio, Measles, Lassa Fever, neonatal Tetanus, Schistosomiasis, Trachoma, and Leprosy. The Gambia has been certified polio free by WHO in 2004 and certified Guinea worm free in 2009. A standard case definition is provided for all priority diseases. A minimum of 80% rate of timeliness and completeness is the minimum desirable target for each site and at all levels.

Ad hoc rumour monitoring is taking place but rumour logging is not adequately structured to allow for prompt capture of events of public health importance. Event-based surveillance is currently not operational. There is a dedicated hotline for reporting events. Community-based surveillance has been established at the peripheral levels. However, the functionality of these complimentary systems needs to be augmented to improve the indicator-based surveillance system.

Reporting is currently both paper-based and electronic. There is a regional health management office where the regional surveillance officer compiles all data from district surveillance officers. They further facilitate data entry into the electronic system using DHIS2 platform and submit weekly summary surveillance reports to the national surveillance officer. A weekly epidemiologic bulletin is produced and circulated widely.

At the regional level, data is validated following compilation by the Regional Surveillance Officer. Phone calls are made to facilitate data validation from reporting sites with joint monitoring visits conducted by the central level verification team to health facilities and Regional Health Directorates. Data validation is weak at all levels because it is not consistently done.

## Recommendations for priority actions

- Strengthen coordination between animal health and human health surveillance at all levels and use the One Health platform to improve information sharing.
- Build capacity for both human and animal health surveillance at all levels including provision of reporting tools.
- Strengthen electronic surveillance reporting platform that will be integrated, interoperable and interconnected with other systems.
- Strengthen the linkage between surveillance and laboratory data.
- Operationalize event-based surveillance.

## Indicators and scores

### D.2.1 Indicator- and event-based surveillance systems– Score 3

#### *Strengths/best practices*

- IDSR has been implemented since 2003 with revisions to cater for recent occurrences in surveillance.
- Indicator-based surveillance system is in place with diseases reported weekly and others reported immediately.
- Toll-free telephone lines are available for reporting of any health event, although they need to be supported to always function fully through provision of working space as well as funding.
- Production of weekly epidemiological surveillance bulletins.

#### *Areas that need strengthening/challenges*

- Scaling up community based surveillance to all districts.
- Operationalization of event-based surveillance.
- Training more health workers at all levels.
- Improving and strengthening animal health surveillance.
- Information sharing between sectors.
- Human and animal health surveillance at health facility and community level.

### D.2.2 Interoperable, interconnected, electronic real-time reporting system– Score 1

#### *Strengths/best practices*

- Surveillance reporting is both paper and electronic.
- Web-based electronic reporting from the regions to the central level.
- Data entry on the electronic platform from health regions.
- DHIS2 electronic support established.
- Areas that need strengthening/challenges
- The reporting systems are not interconnected and interoperable.
- Improved and coordinated data entry on electronic platforms from health facilities and regions to central level.
- There is neither linkage nor data sharing between the public health and animal health surveillance systems including environment.

- No mechanisms (e.g. One Health, zoonotic diseases office, staff, or logistics) exist to bridge the gaps observed in coordination of various stakeholders at human, animal and environmental health interface at all levels.

### **D.2.3 Integration and analysis of surveillance data– Score 2**

#### ***Strengths/best practices***

- Standardized case-based form that includes a laboratory component.
- National weekly surveillance bulletin for information sharing.
- Joint monitoring and supportive supervision.
- Data analysis is done but not frequently conducted at district, regional and national levels.

#### ***Areas that need strengthening/challenges***

- Data analysis needs to be routine and conducted by health workers and surveillance staff in animal and human health sectors.
- Strengthening capacity of public health and animal health staff to analyze data.

### **D.2.4 Syndromic surveillance systems– Score 3**

#### ***Strengths/best practices***

- Syndromic surveillance is deployed to report on Acute Flaccid Paralysis, Polio, Viral Haemorrhagic Fevers for example.
- Implementation of the Integrated Management of Neonatal Childhood Infections strategy across health facilities to facilitate reporting and treatment of infectious diseases.

#### ***Areas that need strengthening/challenges***

- Expand syndromic surveillance coverage to include private sector providers and tertiary/referral centres.
- Improve laboratory confirmation which is low due to logistical challenges (reagent stock-outs, specimen transport).
- Link laboratory data to syndromic surveillance and strengthen laboratory-based surveillance.
- Establish syndromic surveillance in animal sector.
- Establish documentation and archiving systems of surveillance reports across all levels and especially at National and regional levels.
- Regular validation as well as confirmation of suspected cases reporting through the surveillance system.

# Reporting

## Introduction

Health threats at the human–animal–ecosystem interface have increased over the past decades, as pathogens continue to evolve and adapt to new hosts and environments, imposing a burden on human and animal health systems. Collaborative multidisciplinary reporting on the health of humans, animals and ecosystems reduces the risk of diseases at the interfaces between them.

### Target

*Timely and accurate disease reporting according to WHO requirements and consistent coordination with FAO and OIE.*

## The Gambia level of capabilities

The Gambia has a directorate of Public Health Services which has been designated as responsible for reporting for the country. There is an IHR national focal person in the MoHSW who has the mandate to report to WHO. In the animal health sector, the OIE delegate is obligated to report through the World Animal Health Information System (WAHIS) on the country status of OIE listed diseases six monthly (presence/absence) and any outbreaks within 24 hours. Training is provided by the OIE to the WAHIS focal point. The FSQA has the authority on food safety. There is no formal mechanism to ensure the National IHR focal point or OIE focal points receive the information.

There is no formal mechanism to make decisions on reporting. However, weekly reports on human surveillance data are reported to WHO. Reports are ad hoc in the animal sector, although training is given.

The country reported that they have not experienced any public health emergency of international concern and have no formal process to report such incidents. There has been no recent exercise (or event) to test the country's systems for identifying and reporting on a potential public health emergency of international concern. However, the country has developed a plan and Early warning system that has a costed One Health approach.

## Recommendations for priority actions

- Conduct training of the IHR NFP and the OIE delegate and nominate candidates for WAHIS training.
- Strengthen the collaboration between human and animal health and FSQA.
- Formalize mechanisms for decision making and reporting using the current Early Warning and Reporting System in public health, animal health and food security authorities.

## Indicators and scores

### D.3.1 System for efficient reporting to FAO, OIE and WHO– Score 1

#### Strengths/best practices

- IHR focal person is identified for reporting.
- OIE provides training to the WAHIS focal point and an entry was made in February 2017.
- IDSR and Standard Operating Procedures (SOPs) utilised throughout the country.
- Bimonthly meetings on IDSR reporting held with stakeholders pending availability of funding

### ***Areas that need strengthening/challenges.***

- There is need for training of the IHR NFP and WAHIS focal points.
- Reporting from lower levels is not always timely for animal and human health.

### **D.3.2 Reporting network and protocols in country– Score 2**

#### ***Strengths/best practices***

- The country has developed a plan for Early warning system that has a One Health approach that is costed.

#### ***Areas that need strengthening/challenges***

- There are no mechanisms in place for public health, animal health and food security authorities to make decisions on reporting.
- Reporting processes and protocols are present under IDSR, but the country does not have protocols and/or SOPs for reporting to WHO.
- Legislation is not available to support reporting to WHO/FAO/OIE.

# Workforce development

## Introduction

Workforce development is important in order to develop a sustainable public health system over time by developing and maintaining a highly qualified public health workforce with appropriate technical training, scientific skills and subject-matter expertise.

### **Target**

*States Parties with skilled and competent health personnel for sustainable and functional public health surveillance and response at all levels of the health system and the effective implementation of the IHR (2005).*

## The Gambia level of capabilities

The health sector is clearly understaffed especially at the intermediate and peripheral levels and none of the cadres of health care workers has reached the WHO recommended health worker density threshold of 2.3/1000. There are also issues with distribution of health workers in the public health care system; with a mismatch in the staffing needs and health worker availability especially in rural and more remote locations. A high attrition of staff from the public health system has been reported, driven by brain drain and movement of trained staff into the private sector.

There are several health training institutions which have contributed to workforce training in the country. These include the degree awarding institutes under the University of The Gambia (Medical School, School of Nursing, and the School of Public Health); The Gambia College which offers certificate and Diploma courses through the Schools of Nursing and Midwifery and Public Health; and directly under the MoHSSW are the Schools of Community Health and state enrolled nurses.

The MoHSSW has put in place a programme for the accelerated training of nurses since 2006, and 7 cohorts of medical doctors trained at the University of The Gambia from 2007 have graduated. There is no laboratory training school in The Gambia, however, there are plans to address this.

The Basic Field Epidemiology Training Programme (FETP) commenced in 2016 and has trained over 100 front-liners; since then, public/environmental health officers in all districts who now function as district surveillance officers have benefitted from the frontline FETP training. These staff have been deployed to all the 42 districts across the country. At the national level, 4 personnel (2 physicians, 1 laboratory scientists and 1 veterinary laboratory scientist) have been trained to advanced level FETP, however, these individuals are yet to be deployed to appropriate posts.

The country has 2 veterinarians in the public sector, one of them has completed the advanced FETP, however, 69 veterinary technicians make up the bulk of the animal health workforce. Three veterinary technicians have benefitted from the basic FETP training. Unfortunately, no further funding is currently available to continue even the basic FETP training in the country.

The MoHSSW is responsible for managing the human resources for health in the country. The 15-year Human Resource Plans and Training Schedules for the Health Sector of The Gambia was developed in 2005, in response to the gaps in human resource for health. These gaps have remained a longstanding challenge for The Gambian health sector. The assessment of core capacities for surveillance and response in the Gambia, conducted in 2011 by WHO, recommended the provision of funding to build human resource

capacity to address the IHR (2005) and proposed the review of national policies to address this problem. The National Health Policy 2012-2020 aims to establish a vibrant and critical mass of human resources for health by 2020.

To achieve this goal, the country has developed a fully-costed and implementable Human Resources for Health Strategic Plan 2015-2019 which emphasizes the training and retention of nurses, public health officers, epidemiologists, doctors, pharmacists, medical laboratory scientists/technologists, statisticians, and demographers. Furthermore, Human Resource for Health (HRH) Directorate of the MOHSW has developed posting guidelines and a database to track distribution of the health care workers at the primary and intermediate care levels of the public health system.

## Recommendations for priority actions

- Implement the existing health workforce strategy which has quantified the public health workforce needs of the country, ensuring that the drivers of staff attrition are addressed and the retention of appropriate staff at all levels achieved.
- Develop and implement a sustainable plan for the frontline Field Epidemiology Training, and introduce the Intermediate Field Epidemiology Training in the country.
- Increase the access of One Health stakeholders to all levels of the FETP training and ensure access of appropriate staff to advance FETP training programmes in neighbouring countries.
- Introduce training programmes for medical laboratory scientists and technicians in the country to increase diagnostic capacity for epidemic prone diseases in the country.
- Strengthen integration of the FETP programme with the local schools of public health and ensure that the curriculum is updated appropriately.

## Indicators and scores

### D.4.1 Human resources available to implement IHR core capacity requirements– Score 1

#### *Strengths/best practices*

- Presence of the University of The Gambia and The Gambia College in training surveillance officers, nurses, medical doctors.
- Disease surveillance training programmes are available in the country.

#### *Areas that need strengthening/challenges*

- No in-country programme for training medical laboratory scientists, laboratory technicians, biostatisticians, and other specialist public health workforce.

### D.4.2 FETP or other applied epidemiology training programme in place– Score 3

#### *Strengths/best practices*

- Frontline FETP training currently undertaken in the country focused on district level staff
- There is a system for ongoing support and mentorship which has been provided to participants of frontline FETP, leading to improved quality of surveillance and other public health activities.
- The selection of trainees included public health officers, the security services, veterinary technicians, and physicians.

***Areas that need strengthening/challenges***

- Funding for frontline epidemiology training in the country has ended and because of the lack of further funding, there is a risk that the gains achieved in recent years may be reversed.
- Introduction of Intermediate level FETP training for public health workforce.
- Inclusion of animal health, medical laboratory and others in FETP.

**D.4.3 Workforce strategy– Score 3*****Strengths/best practices***

- The country has developed a costed Health Workforce strategic plan which addresses the public health staffing needs of the country.
- Through partner support, the country is providing transport refund for surveillance staff for cost incurred in sample transportation to the NPHL.

***Areas that need strengthening/challenges***

- Document and mitigate the root causes of staff attrition and address the inefficient placement of trained surveillance staff.
- Develop and implement a retention plan for surveillance officers and other public health staff.
- The National Steering Committee and the Technical Working Group need strengthening to operationalize the effective implementation of this strategy.

# RESPOND

## Preparedness

### Introduction

Preparedness includes the development and maintenance of national, intermediate and community/primary response level public health emergency response plans for relevant biological, chemical, radiological and nuclear hazards. Other components of preparedness include mapping of potential hazards, the identification and maintenance of available resources, including national stockpiles and the capacity to support operations at the intermediate and community/primary response levels during a public health emergency.

### Target

*Development and maintenance of national, intermediate (district) and local/primary level public health emergency response plans for relevant biological, chemical, radiological and nuclear hazards. This covers mapping of potential hazards, identification and maintenance of available resources, including national stockpiles and the capacity to support operations at the intermediate and local/primary levels during a public health emergency.*

### The Gambia level of capabilities

The Gambia has developed a Health Sector Emergency Preparedness and Response Plan but does not include some hazards in the IHR core capacities. In addition, Ebola Preparedness and Response plan was also developed in 2014. There is a need to revise the existing plan to make it all-hazards including radiological events, oil spill, chemical events, and other biohazards. National Disaster Management Act (2008) and National Disaster Management Policy also exist. National Disaster Management Programme Strategic Action Plan (2008 -2011), and the National and Regional contingency plans are available but need to be revised.

There is a multi-sector national Task Force and Regional Disaster Management Committees which are responsible for coordination of disaster management effort in The Gambia.

Hazard profiling of the common disasters in The Gambia was conducted in 2012. Disaster Risk Reduction/Country Capacity Assessment was also conducted in 2015 but there is a need to conduct a comprehensive all-hazards public health risk and resource mapping to strengthen IHR preparedness in the country.

### Recommendations for priority actions

- Update the national public health emergency preparedness plan to be all hazards including the missing components and test the plan using simulation exercises.
- Update the public health risks and resource mapping.
- Develop plans, SOPs, and guidelines for the implementation of the One-Health concept.
- Specific budget line for emergency preparedness and response from the national budget.
- Build capacity for multisectoral emergency preparedness at all levels.

## Indicators and scores

### R.1.1 National multi-hazard public health emergency preparedness and response plan developed and implemented– Score 1

#### *Strengths/best practices*

- The Gambia has health sector emergency preparedness and response plan (2017 – 2019)
- There is a multi-sector national Task Force and Regional Disaster Management Committees
- Developed Ebola Virus Disease Response Plan (2014-15).
- National and regional disaster contingency plans developed.

#### *Areas that need strengthening/challenges*

- National and Regional coordination.
- Surge capacity is not available to respond to public health emergencies of national and international concern.
- Training of the rapid response teams.
- Completion and functioning of the Emergency Operation Centre (EOC).
- Regular simulation exercises to build capacity and test the preparedness plan.

### R.1.2 Priority public health risks and resources mapped and utilized– Score 2

#### *Strengths/best practices*

- Disaster Risk Reduction/Country Capacity Assessment conducted in 2012.
- Hazard profiling conducted in 2015.

#### *Areas that need strengthening/challenges*

- All-hazards public health risks and resource mapping.
- Capacity building for all-hazard risk and resource mapping.
- No specific units for the different hazards.

# Emergency response operations

## Introduction

A public health emergency operations centre is a central location for coordinating operational information and resources for strategic management of public health emergencies and emergency exercises. Emergency operations centres provide communication and information tools and services, and a management system during a response to an emergency or emergency exercise. They also provide other essential functions to support decision-making and implementation, coordination and collaboration.

### **Target**

*Country with public health emergency operations centre (EOC) functioning according to minimum common standards; maintaining trained, functioning, multisectoral rapid response teams and "real-time" biosurveillance laboratory networks and information systems; as well as trained EOC staff capable of activating a coordinated emergency response within 120 minutes of the identification of a public health emergency.*

## The Gambia level of capabilities

The Gambia MoHSW coordinates a response to public health emergencies while the National Disaster Management Agency (NDMA) provides overall coordination for all disaster management. A structure for the Public Health Emergency Operation Centre (PHEOC) has been identified and is currently under construction with the aid of the Japanese Government. A National PHEOC plan has been developed and is awaiting validation. There is no functional multi-sectoral team for the operationalization of the PHEOC.

A National Task Force committee exists which is supported by sub-committees with various technical areas. However, the committee is not multisectoral or multi-disciplinary. Public and animal health work independently but they are represented in the national committee. The NDMA has a multi-sectoral Platform called National Platform for Disaster Risk Reduction. Regional Disaster Management Committees and Rapid Response Teams are in place in all the regions. There is a Hotline (1025) which is toll free to be used during emergencies or outbreak situations.

Training on Incident Management System (IMS) has been conducted for some of the PHEOC staff but there has been no public event to test the IMS function. The Emergency Operation Centre (EOC) plan describing the IMS structure is in place but still in draft form. Simulation exercises have not been conducted to test the Health Sector emergency preparedness and response plan. There is no surge capacity in place for emergency response, and expertise in areas like Disaster Risk Reduction is lacking. Case management guidelines for priority epidemic-prone diseases are available but no guideline for management of other public health hazards.

## Recommendations for priority actions

- Finalize the Public Health Emergency Operation Centre (PHEOC) plan and develop a strategic plan for operations.
- Develop SOPs for activation/deactivation of public health emergencies.
- Develop a training plan for the PHEOC and train PHEOC staff on emergency response at all levels.
- Conduct simulation exercises to test the plan.
- Complete PHEOC infrastructural development and equip and operationalize the PHEOC.

## Indicators and scores

### R.2.1 Capacity to activate emergency operations– Score 2

#### *Strengths/best practices*

- National and Regional Rapid Response Teams are in place and have been trained during Ebola outbreak.
- There is a plan in place for PHEOC activation and deactivation.

#### *Areas that need strengthening/challenges*

- No training programme yet developed for the PHEOC staff on emergency response operations.
- There is no surge staff in place for emergency response.
- There has been no public health event to activate the IMS.

### R.2.2 EOC operating procedures and plans– Score 1

#### *Strengths/best practices*

- There is PHEOC plan in place but still in draft form.
- Some PHEOC staff have been trained on IMS.
- There is a procedure in place for decision making at the National Task Force Level.
- An Incident Manager has been identified for the PHEOC.

#### *Areas that need strengthening/challenges*

- The PHEOC is still under construction.
- No SOPs in place for the PHEOC.
- The communication lines for the PHEOC are not fully functional.
- There is need to train dedicated staff on EOC management.

### R.2.3 Emergency operations programme– Score 1

#### *Strengths/best practices*

- Rapid Response Training conducted but specific to Ebola.
- NDMA has a multi-sectoral platform called National Platform for Disaster Risk Reduction.
- Available National Task Force committee for emergency response.
- Regional Disaster Management committees and Rapid Response Teams are available in all regions.

#### *Areas that need strengthening/challenges*

- No public health emergency operations exercise or activations conducted within the past year.
- No functional exercises that have been completed within the past year.
- No table-top simulation exercises and emergency activation within the last year.

### R.2.4 Case management procedures implemented for IHR relevant hazards– Score 2

#### *Strengths/best practices*

- Availability of case management guidelines for priority epidemic-prone diseases at all health system levels.

- Availability of SOPs for the management and transport of potentially infectious patients in the local level and point of entry.
- Availability of patient referral and transportation mechanism with some resources (designated ambulances, treatment centres and SOPs).

#### ***Areas that need strengthening/challenges***

- No case management guideline for other IHR related hazards.
- Capacity building for case management of all IHR related hazards at all levels.
- Inadequate number of the case management guidelines at the health facility level.

# Linking public health and security authorities

## Introduction

Public health emergencies pose special challenges for law enforcement, whether the threat is manmade (e.g. the anthrax terrorist attacks) or naturally occurring (e.g. flu pandemics). In a public health emergency, law enforcement will need to quickly coordinate its response with public health and medical officials.

### Target

*Country conducts a rapid, multisectoral response in case of a biological event of suspected or confirmed deliberate origin, including the capacity to link public health and law enforcement, and to provide and/or request effective and timely international assistance, such as to investigate alleged use events.*

## The Gambia level of capabilities

The Gambia is aware that effective multisectoral collaboration between security authorities and Public Health officers will enhance her compliance with the IHR (2005). The Gambia Armed Forces, Police, Civil Aviation Authority and the NDMA all support public health emergencies through internal security management, criminal investigations, human resource, logistics, mobilization and deployment in times of emergencies of public health concern. Also, these agencies and the Immigration service facilitate screening that focuses on prevention, preparedness, response, mitigation, and recovery from disasters/emergencies. However, there are no MoUs, and joint investigations or simulations have never been conducted together. In addition, there are no training materials for public health and law enforcement entities on these joint investigations. Military interventions during periods of emergencies area are adhoc. The Gambia is a signatory to the Interpol agreement and connected through the police headquarters. The Ministry of Interior and NGO Affairs is charged with interacting Interpol.

There is a Public Health Act (1990) which allows the government to detain/quarantine an individual who presents a public health risk. During the Ebola virus disease outbreak in West Africa in 2014, The Gambia Fire & Rescue Services conducted paramedic services, renovated, and built clinics and fire stations to support the public health sector.

## Recommendations for priority actions

- Review, revise and seek assent to Public Health Act 1990.
- Develop unique protocols and MOUs for security agencies and public health departments and clearly elaborate on the specific roles.
- Continuous capacity development on integration and working jointly with the relevant security authorities and those in public health to mitigate the normal turnover in positions and retirements.
- Develop and harmonize appropriate legal, policy instruments and operational package such as MOUs and SOPs to ensure multisectoral health preparedness and response.
- Establish reporting and information mechanisms including cross border collaboration.

## Indicators and scores

### R.3.1 Public health and security authorities (e.g. law enforcement, border control, customs) linked during a suspect or confirmed biological event– Score 1

#### *Strengths/best practices*

- There is legislation in place where public health authorities have the power to detain/quarantine individuals who present a public health risk.
- Enforcement agencies currently have and maintain a direct connection with international security community including the Interpol.
- The Gambian Armed Forces and the Police force support cross-border and internal security management and facilitate screening at PoEs
- The NDMA coordinates Disaster Management that focuses on prevention, preparedness, response, mitigation, and recovery from disasters/emergencies
- The Gambian Immigration Authority and the Civil Aviation Authority work closely together to support public health at the points of entry routinely and during disasters.

#### *Areas that need strengthening/challenges*

- Revision, passage, and assent of old laws and or bills needs to take place.
- Development of MoUs with all key stakeholders is critical to ensure that all roles and responsibilities are established.
- Training should be coordinated between agencies, including integrated capacity building and joint investigation activities.
- Involvement of public health experts in emergency response linked to the Biological and Toxins Weapons Convention.
- Improved routine sharing of informational reports between public health and security authorities

# Medical countermeasures and personnel deployment

## Introduction

Medical countermeasures are vital to national security and protect nations from potentially catastrophic infectious disease threats. Investments in medical countermeasures create opportunities to improve overall public health. In addition, it is important to have trained personnel who can be deployed in case of a public health emergency for response.

### Target

*National framework for transferring (sending and receiving) medical countermeasures, and public health and medical personnel from international partners during public health emergencies.*

### The Gambia level of capabilities

During the Ebola Virus Disease (EVD) outbreak in West Africa The Gambia established a multidisciplinary/multisectoral EVD Task Force to coordinate preparedness activities. Rapid Response Teams were constituted, trained, and equipped. A country road map, EVD Preparedness and Response Plan, Guidelines, and SOPs were developed. Technical expertise, medical countermeasures and funds were also mobilized. Treatment centre staff were identified, trained, and posted and several table top and functional simulation exercises were conducted on the use of medical countermeasures (MCM). Although The Gambia has some capacity for the containment of small local health emergencies, the supply pipeline is inadequate and faces major challenges in obtaining sufficient quantities of MCM in case of a large-scale emergency. There are no agreements in place with manufacturers or distributors to procure MCMs during a public health emergency. There is no plan in place that stipulates procedures and decision-making mechanisms related to sending and receiving MCM and public health personnel during a public health emergency. Furthermore, there is no framework to guide receiving and management of unsolicited donations. Moreover, the medicines policy and strategic plan needs review to address the issue of MCM.

### Recommendations for priority actions

- Develop policy, plan framework, SOPs, licensing procedures and guidelines for sending and/or receiving MCM and personnel deployment during public health emergencies.
- Establish mechanisms to facilitate rapid sending or receiving of MCM and personnel deployment during public health emergencies, by defining standards and establishing mechanisms for quality assurance of the MCM and personnel deployment that are sent or received.
- Establish protocols of cooperation with countries in the region to facilitate rapid sending or receiving of MCM and personnel deployment during public health emergencies.
- Conduct supply mapping to identify potential suppliers and establish strategic partnerships and agreements with potential manufacturers and other stakeholders to facilitate rapid receiving or sending of MCM.

## Indicators and scores

### R.4.1 System in place for sending and receiving medical countermeasures during a public health emergency– Score 1

#### *Strengths/best practices*

- Distribution of medical facilities within the country that can be used to distribute MCM.
- Availability of NDMA logistics (tents, ambulances) and active Red Cross logistics (Ambulances, tents, first aid).
- Availability of fleet management services and existence of a logistics management system (Central Medical Stores, Regional Medical Stores).
- Experience with receiving and re-integration of The Gambian refugees returning from Senegal after the political impasse (psychological support, vaccination, nutrition, clothing etc.).
- Experience and lessons learnt in mobilization, storage, and distribution of logistics during Ebola outbreak preparedness.
- Robust routine mobilization and distribution of immunization logistics, which can be used for vaccine preventable public health emergencies.

#### *Areas that need strengthening/challenges*

- Lack of policy, plan, framework, SOPs, licensing procedures and guidelines for sending or receiving MCM during public health emergencies.
- There are no agreements in place with manufacturers or distributors to procure MCM during public health emergencies.
- Inadequate mechanisms for the management of unsolicited donations.
- An outdated medicines policy and strategic plan.

### R.4.2 System in place for sending and receiving health personnel during a public health emergency– Score 1

#### *Strengths/best practices*

- Availability of human resource with knowledge and willingness to be deployed (teaching hospital, nursing schools, school of public health, red cross society).
- Fully functional Medical and Dental council and introduction of other health professional councils.
- Rapid mobilization of red cross volunteers for multiple roles.
- Deployment of personnel to the border regions to receive returning refugees.
- Deployment of additional personal to PoEs during the EVD outbreak.
- Deployment of multidisciplinary team during Ebola preparedness.

#### *Areas that need strengthening/challenges*

- Absence of policy, plan, frameworks, and SOPs, licensing procedures and guidelines for sending or receiving personnel during public health emergencies.
- There is no plan in place that identifies procedures and decision-making related to sending and receiving health personnel during a public health emergency.

# Risk communication

## Introduction

Risk communications should be a multilevel and multifaceted process which aims at helping stakeholders define risks, identify hazards, assess vulnerabilities and promote community resilience, thereby promoting the capacity to cope with an unfolding public health emergency. An essential part of risk communication is the dissemination of information to the public about health risks and events, such as disease outbreaks. For any communication about risk caused by a specific event to be effective, the social, religious, cultural, political and economic aspects associated with the event should be taken into account, including the voice of the affected population.

Communications of this kind promote the establishment of appropriate prevention and control action through community-based interventions at individual, family and community levels. Disseminating the information through appropriate channels is essential. Communication partners and stakeholders in the country need to be identified, and functional coordination and communication mechanisms should be established. In addition, the timely release of information and transparency in decision-making are essential for building trust between authorities, populations and partners. Emergency communications plans should be tested and updated as needed.

### **Target**

*State Parties use multilevel and multifaceted risk communication capacity. Real-time exchange of information, advice and opinions between experts and officials or people who face a threat or hazard (health or economic or social wellbeing) to their survival, so that informed decisions can be made to mitigate the effects of the threat or hazard and protective and preventive action can be taken. This includes a mix of communication and engagement strategies, such as media and social media communications, mass awareness campaigns, health promotion, social mobilization, stakeholder engagement and community engagement.*

### **The Gambia level of capabilities**

The Gambia MoHSW established the Directorate of Health Promotion and Education in June 2012 tasked with the responsibility of coordinating all communication related issues for the health sector in which Risk Communication is a key component. The National Health Promotion and Education Policy (2012-2020) was developed. In addition, there is a section on risk communication and community engagement in the National Health Sector Emergency Response Plan (2017-2019) and the National EVD Preparedness and Response plan (2014-2015). However, a comprehensive all-hazard risk communication policy and plan does not exist.

The Gambia has a National Communication Taskforce that coordinates communication interventions including risk communication. The country has 1 National Television and radio station, 13 private radio and 12 community radio stations that provide free airtime every week to the health sector for the dissemination of health information to the public. During public health emergencies extra airtime is provided by all media houses. A strong partnership also exists between the Directorate of Health Promotion and Education, Association of Health Journalists, Global System for Mobile communication companies and National Council of Seyfolu for information dissemination to the general public during public health emergencies. There is also good collaboration and engagement of community leaders in the public communication.

## Recommendations for priority actions

- Develop an all-hazard risk communication policy and plan.
- Expand and strengthen the existing coordination mechanism for risk communication at all levels to involve other sectors.
- Establish a systematic rumour management mechanism.

## Indicators and scores

### R.5.1 Risk communication systems (plans, mechanisms, etc.)– Score 2

#### *Strengths/best practices*

- Existence of the Directorate of Health Promotion and Education with structures at national and regional levels. The Directorate gives clearance for risk communication messages to be disseminated to the public.
- Existence of a diverse National Communication Taskforce responsible for the planning, coordination, monitoring and supervision of communication interventions on health and related matters.
- Multi-sectoral and coordinated approach towards social mobilization and community engagement for increased community action on health issues.
- Stakeholder engagement and participation in health events maximizes the use of available resource.

#### *Areas that need strengthening/challenges*

- Lack of a comprehensive Risk Communication policy and plan.
- There is need for a budget line for risk communication interventions.
- Capacity building on risk communication and community engagement at national, regional and district levels for health and other sector workers.

### R.5.2 Internal and partner communication and coordination– Score 3

#### *Strengths/best practices*

- Strong partnership exists between MoHSW and key stakeholders in risk communication for the dissemination of information to the public during public health emergencies.
- Strong partnership exists between religious leaders (Supreme Islamic Council and Christian Council); and traditional healers for information dissemination during public health emergencies.
- Creation of platform for effective dissemination of information before, during and after public health emergencies.

#### *Areas that need strengthening/challenges*

- Partnership building with Civil Society Organizations and private sector to invest in risk communication interventions.
- Absence of guidelines and protocols for partner engagements.
- Regular inter-sectoral meeting between partners.
- Revitalization of the call centre.

### R.5.3 Public communication– Score 3

#### *Strengths/best practices*

- Availability of the Directorate of Health Promotion and Education as the source of information dissemination during public health emergencies helps to avoid the spread of rumours.
- Director of Health Promotion and Education under the MoHSW designated as spokesperson that support risk communication activities before and during emergencies.
- Strong partnership exists between the MoHSW and media in creating awareness during public health emergencies.

#### *Areas that need strengthening/challenges*

- Establishment of a fully equipped media and call centre with functional internet facilities for effective media scanning and public information sharing.
- Capacity building for Association of Health Journalists members on health reporting.
- Capacity building of health promotion officers on script writing, newsletter production, video shooting, editing, production, and dissemination.
- Availability of a public- address system and a film van for the conduct of interactive community film shows especially in hard to reach areas.

### R.5.4 Communication engagement with affected communities– Score 2

#### *Strengths/best practices*

- Availability of Health Promotion and Education Officers at the regional level responsible for coordinating community engagement activities before, during and after public health emergencies.
- At district and community levels there are community interpersonal networks responsible for the implementation of community engagement activities including hard-to-reach populations.

#### *Areas that need strengthening/challenges*

- Capacity building of Regional Health Promotion and Education Officers on community engagement skills and participatory community action plan development.
- Capacity building of Interpersonal Communication Networks for effective community engagement.

### R.5.5 Dynamic listening and rumour management– Score 2

#### *Strengths/best practices*

- Availability of community-based surveillance system for the detection and reporting of rumours during public health emergencies.
- Ad hoc rumour monitoring and feedback mechanism.
- Call centre in place for the public to lodge rumours and for the health authorities to provide information to the public.

#### *Areas that need strengthening/challenges*

- Capacity development on crisis communication and rumour management for health promotion practitioners and other stakeholders.
- Capacity building on media scanning to detect, monitor and respond to rumours and misinformation during Public Health Emergencies.
- Keep the Call centre functional with all telephones working.

# OTHER IHR-RELATED HAZARDS AND POINTS OF ENTRY

## Points of entry (PoE)

### Introduction

All core capacities and potential hazards apply to "points of entry" and thus enable the effective application of health measures to prevent international spread of diseases. States Parties are required to maintain core capacities at designated international airports and ports (and where justified for public health reasons, a State Party may designate ground crossings), which will implement specific public health measures required to manage a variety of public health risks.

### Target

*States Parties designate and maintain core capacities at international airports and ports (and where justified for public health reasons, a State Party may designate ground crossings) that implement specific public health measures required to manage a variety of public health risks.*

### The Gambia level of capabilities

The Gambia Health Service recognizes 10 official points of entry including Banjul International Airport (BIA), the sea port at Banjul and eight ground crossings – the Sabi, Nyamanarr, Misira, Jiboro, Dasilammeh and Kartong border posts on the southern Gambian border, and Kerr Ali and Amdalai border posts on the north bank of The Gambia. All ten PoEs have designated MoHSW staff, and have some core capacities to implement specific public health measures to manage public health risks with the potential for international spread. An IHR core capacity assessment was conducted in 2011 identified the Port Health Division as the competent authority in the implementation of the IHR (2005) at the points of entry.

The country boasts of some trained (Environmental Health) personnel for entry screening of travellers, and the inspection of conveyances at the airport is done by the Environmental Health Unit.

Not all the designated points have specific space for the isolation of ill or suspected passengers, except the BIA which also has access to an ambulance service for the transport of ill travellers; the ground crossing points depend on regional/district hospital ambulances for transportation.

In The Gambia, travellers are checked for their vaccination certificates for proof of vaccination against yellow fever, however, not all visitors are checked (tourists are often allowed entry without the certificate because The Gambia's economy is heavily dependent on tourism).

The country does not have a specific public health emergency contingency plan for Points of Entry, but has a national public health response plan. There is a "draft Airport Public Health Emergency Response Plan for CAPSCA<sup>1</sup>", which is currently with the National Civil Aviation Authority.

The Gambia has some level of informal arrangement with Senegal for cross-border exchanges of health information with border officials. This allows for information sharing among border officials and keeps the

<sup>1</sup> Collaborative Arrangement for the Prevention and Management of Public Health Events in Civil Aviation

public health staff aware of public health events occurring on either side of The Gambian and Senegalese borders. Certification for animal health is done by the Plant Protection and Regulatory Service (Plant Quarantine), although some traditional food items are inspected and certified by the public health staff at the airport.

## Recommendations for priority actions

- Develop a strategic plan which includes posting of critical staff for permanent duties, for efficient public health services at PoEs to meet the core capacity requirements of the IHR (2005).
- Develop a Public Health Emergency Response Plan at PoEs with clear SOPs and guidelines for public health response.
- Develop MOUs with all stakeholders for public health emergencies at all designated PoEs.

## Indicators and scores

### PoE.1 Routine capacities established at points of entry– Score 1

#### *Strengths/best practices*

- The Gambia has 10 designated Points of Entry with space for port health services (largely entry screening).
- The BIA has official capacity (an ambulance service) to transfer ill travellers to the Banjulnding Health Centre for treatment.
- There is a strong goodwill from The Gambia Civil Aviation to support health and safety at the Banjul International Airport.
- There are some public health personnel for routine but selected entry screening of travellers at the seven designated PoEs.
- BIA has a thermal scanner for screening for arrivals. The ground crossing points have digital infra-red thermometers for fever detection.
- There is some collaboration between the port security officers, agricultural officers, food safety officers and their public health counterparts at the Banjul sea port.

#### *Areas that need strengthening/challenges*

- Training and posting of critical staff for permanent public health duties at the PoEs.
- Strengthen communication between public health staff and all stakeholders at the points of entry.
- Limited availability of ambulance services at PoEs.
- There are no structured vector control programmes at the PoEs except at the BIA where the Banjul Civil Aviation Authority conducts some form of vector control.
- Streamline food safety regulations with clear-cut roles and responsibilities among stakeholders at the PoEs.
- Designation of additional PoEs such as, Kerr Pateh, Kaur, Brikamaba etc.

### PoE.2 Effective public health response at points of entry– Score 1

#### *Strengths/best practices*

- The Gambia has a Public Health Act (1990) and some Quarantine Regulations (1932) which can be adopted in sync with the IHR.

- There are staff in all the designated border posts although some are not permanently stationed to carryout port health services.
- Though informal, there are systems in place to transfer ill travellers to designated health facilities in the districts for response.
- Adherence to infection prevention and control and practice of basic hygiene at all points of entry (Airport & Sea port).

#### ***Areas that need strengthening/challenges***

- Critical Staff should be trained and maintained to perform core public health duties at the PoEs.
- Develop and integrate PoEs contingency plans into the national public health emergency plan.
- Provision of personal protective equipment for staff at the PoEs.
- Strengthen communication lines for response and reporting of all health risks at the PoEs.

# Chemical events

## Introduction

Timely detection and effective response of potential chemical risks and/or events require collaboration with other sectors responsible for chemical safety, industries, transportation and safe disposal. This would entail that State Parties need to have surveillance and response capacity to manage chemical risk or events and effective communication and collaboration among the sectors responsible for safety.

### Target

*States Parties with surveillance and response capacity for chemical risks or events. This requires effective communication and collaboration among the sectors responsible for chemical safety, industries, transportation and safe disposal.*

## The Gambia level of capabilities

The capacity for detecting and responding to chemical events or emergencies in The Gambia is very limited. Although the country is a signatory to the various international chemical conventions and agreements, the National Environmental Agency responsible for chemical management, implementation has been rudimentary. There exists some national chemical legislation such as the Hazardous Chemicals and Pesticides Control and Management Act (1994) and the Hazardous Chemical Regulation Act (1999) but a chemical risk profile is not in place and there is no comprehensive and harmonized national policy or strategic plan to address chemical event surveillance, alert, detection, and response. The country has also established a multi-agency working group to coordinate chemical safety management, however, the roles and responsibilities of each stakeholder are not clearly defined, information exchange between them is limited and the scope of collaboration needs to be expanded.

The country is monitoring chemical usage and has sensitized chemical dealers to be registered for easy follow-up in case of chemical events. Furthermore, registration and licensing of chemical dealers and importers both at regional and central level have been undertaken. However, there is limited capacity of staff on chemical events and there is no systematic surveillance in place for chemical events, intoxication, and poisonings. There is also no laboratory capacity to confirm priority chemical events.

## Recommendations for priority actions

- Conduct a chemical safety assessment.
- Revise and consolidate existing legislation and policies and develop a comprehensive national strategic plan for chemical event surveillance, alert, detection and response.
- Strengthen mechanisms for multi-sectoral collaboration including information exchange and roles/responsibilities.
- Develop Guidelines or manuals on the surveillance, assessment, and management of chemical events.

## Indicators and scores

**CE.1 Mechanisms established and functioning for detecting and responding to chemical events or emergencies– Score 1**

### ***Strengths/best practices***

- Existence of some national policies and legislation for chemical event, surveillance, and response.
- Establishment of a multi-sectoral Working Group for chemical events.

### ***Areas that need strengthening/challenges***

- Clear definition of roles and responsibilities of all relevant sectors involved with chemicals.
- Establishment of a timely and systematic information exchange mechanism between relevant chemical agencies/departments.
- Development of guidelines or manuals on the surveillance, assessment and management of chemical events, intoxication and poisoning.
- Capacity building of staff in chemical agencies/departments on chemical events.
- Inadequate laboratory capacity to confirm priority chemical events.

## **CE.2 Enabling environment in place for management of chemical events– Score 2**

### ***Strengths/best practices***

- A number of national legislation for chemical event has been developed.
- There exists multi-sectoral working groups for national collaboration and coordination for chemical safety such as the Hazardous Chemical Committee and the Pesticides Technical Committee.

### ***Areas that need strengthening/challenges***

- Revision, consolidation and harmonization of existing legislation and policies on management of chemical events.
- Development of a comprehensive and harmonized national strategic plan for chemical event surveillance, alert, detection and response.

# Radiation emergencies

## Introduction

To counter radiological and nuclear emergencies, timely detection and an effective response towards potential radiological and nuclear hazards/events/emergencies are required in collaboration with sectors responsible for radiation emergency management.

### Target

*States Parties with surveillance and response capacity for radiological and nuclear hazards/events/emergencies. This requires effective communication and collaboration among the sectors responsible for radiological and nuclear emergency management.*

## The Gambia level of capabilities

The country is a signatory to the International Atomic Energy Agency (IAEA) and has tasked the Ministry of Defence and National Environmental Agency (NEA) with the responsibility of overseeing this area. The Gambia has finalized their Integrated Nuclear Security Support Plan in December, 2014. A radiation safety and security unit has been set up. The IHR Core capacity assessment conducted in 2011, outlined the 'nonexistence' of trained human and material resource capacity to respond to specific hazards including material, equipment, reagents, supplies and consumables to confirm radiological events. A multidisciplinary team constituted with the approval of the Office of the President, conducted an inventory of radiation sources in the country in 2016. While the occurrence of major radio-nuclear incidents has been rated as low risk in The Gambia, the country recognizes the importance of monitoring, occupational, iatrogenic, and environmental radiation.

## Recommendations for priority actions

- Complete and publish a comprehensive inventory of radiological sources in the country validated with the appropriate radio-nuclear risk assessments.
- Establish a coordinating mechanism and designate a national focal point for special hazards including radio-nuclear emergencies; which can coordinate the development of national protocols, guidelines, and SOPS.
- Develop a national policy for radiation emergencies and a radiation emergency response plan which leverages existing public health resources in the country and from other countries in the sub-region or globally.

## Indicators and scores

### RE.1 Mechanisms established and functioning for detecting and responding to radiological and nuclear emergencies– Score 1

#### Strengths/best practices

- The country was accepted as a member of IAEA in September 2016 and is a signatory to international radio-nuclear conventions.
- An ad-hoc multisectoral committee was constituted by the Office of the President in 2016 to address matters relating to radio-nuclear safety in the country.

### ***Areas that need strengthening/challenges***

- Development of a national policy, guidelines, and legislation to address radiation regulation and radio-nuclear emergencies in the country.
- Conducting a situational analysis to outline the specific requirements and needs of the country to meet the basic requirements for response and detection of radio-nuclear incidents.
- Provision of resources to support capacity building, the human and material resources needed to improve coordination, surveillance, and reporting of radio nuclear events

### **RE.2 Enabling environment in place for management of radiation emergencies– Score 2**

#### ***Strengths/best practices***

- The NEA has been identified as the agency with primary responsibility for radiation and surveillance/ monitoring.
- A national inventory of radioactive and radiation sources has been concluded and the gathered information will be uploaded into the Nuclear Security Information Management System.
- High level political leadership on nuclear and radiological matters (led by the Office of the President).

#### ***Areas that need strengthening/challenges***

- Improving linkages between agencies focused on nuclear and radiation issues to facilitate coordination and communication with the IHR Focal Point within the MoHSW.
- Improved awareness and sensitization of government agencies, stakeholders and public on nuclear and radiological risks.

# Appendix 1: JEE background

## Mission place and dates

Banjul, The Republic of The Gambia: 24-29 September 2017

## Mission team members:

- Dr. Ambrose Talisuna, World Health Organization Regional Office, Congo(team lead)
- Mohamed Mohamed, Director of Health Quality Assurance, Ministry of Health, Tanzania (team co-lead)
- Dr. Emmanuel Agogo, Ministry of Health, Nigeria
- Sonnah Zainab Bangura, Writer, WHO Consultant
- Dr. Marcel Boka, International Risk Assessment Expert, Food & Agriculture Organization of the United Nations., Republic of Guinea
- Dr. Olukayode Fasominu, Technical Advisor, Nigeria Centre for Disease Control
- Dr. Dorothy Geale, OIE Consultant, Canada
- Dr. Faiqa Ibrahim, World Health Organization, Regional Office, Congo
- Raphael Marfo, Head of Port Health, Ghana Health Services
- Dr. Emmanuel Musa, World health Organization Regional Office, Congo
- Dr. Mary Stephen, WHE Custer Lead, WHO Health Emergency Programme, WHO County Office, Nigeria

## Objective

To assess The Gambia's capacities and capabilities relevant to the 19 technical areas of the JEE tool for providing baseline data to support (host country's) efforts to reform and improve their public health security.

## The JEE process

The JEE process is a peer-to-peer review. The entire external evaluation, including discussions around the scores, the strengths, the areas that need strengthening, best practices, challenges and the priority actions should be collaborative, with JEE team members and host country experts seeking full agreement on all aspects of the final report findings and recommendations.

Should there be significant and irreconcilable disagreement between the external team members and the host country experts, or among the external, or among the host country experts, the JEE team lead will decide the outcome; this will be noted in the final report along with the justification for each party's position.

## Preparation and implementation of the mission

- The Ministry of Health & Social Welfare requested financial and technical support to commence the Joint External Evaluation Process in June 2017
- All the relevant stakeholders had an orientation meeting in August 2017
- An internal self-assessment exercise was held over several days in August 2017. During the internal self-assessment areas were identified for site visits
- The task force leading the internal preparation process analyzed the data accumulated and produced a draft report

- The draft report was circulated to all stakeholders including Members of the External Evaluation Team. Comments and inputs were incorporated and a final draft was validated at a validation meeting attended by all stakeholders and circulated to all parties involved in the JEE.
- The JEE process was conducted from 24-29 September 2017.
- Background documents were provided with the JEE team and meetings with the relevant stakeholders and field visits were conducted to validate the information collected.
- A consensus was reached with the nationals with regards to the scores and priority actions.
- A debriefing meeting with senior officials and national technical teams involved in the evaluation took place to present the outcome of the JEE best practices and priority actions.
- The press was invited to take pictures and publish the outcome of the JEE
- The Permanent Secretary and other senior members thanked the JEE team, technical staff and all stakeholders for their hard work and contribution. He acknowledged the importance of the priority actions and expressed the commitment of the Government to take on board the priorities identified using a systematic approach.

### **Limitations and assumptions**

- The evaluation was limited to one week, which limited the amount and depth of information that could be managed.
- It is assumed that the results of this evaluation will be publically available.
- The evaluation is not just an audit. Information provided by <host country> will not be independently verified but will be discussed and the evaluation rating mutually agreed to by the host country and the evaluation team. This is a peer-to-peer review.

### **Key host country institutions**

- Minister of Fisheries, Water Resources and National Assembly Matters
- Department of Livestock Services
- National Public Health Laboratory
- Directorate of Planning and Information, Ministry of Health
- Directorate of Health Promotion, Ministry of Health
- National public health facilities, Ministry of Health
- Health management information system, Ministry of Health
- Directorate of Public Health
- Public Utility Regulatory Authority
- National Agriculture Research Institute
- The Gambia Revenue Authority
- Epidemiology and Disease Control Unit, Ministry of health
- National Disaster Management Agency
- Medicine Control Agency
- World Health Organization
- Regional Health Directorate Western 1 and Central River Region
- The Gambia Immigration Department
- The Gambia Red Cross
- Plant Protection Services
- Directorate of Nursing And Midwifery

- The Gambia National Assembly
- Field Epidemiology Training Program
- Occupational Health And Safety Unit-Ministry of Health
- Environmental Health Unit-Ministry of Health
- Vector Control Unit-Ministry of Health
- Directorate of Health Research
- The Gambia Civil Aviation Authority
- The Gambia Fire and Rescue Services
- Food Safety and Quality Authority
- The Gambia College School of Nursing
- The Gambia College School of Public Health
- Food And Agricultural Organization
- UNICEF
- World Food Programme
- Joint Operation Centre
- Medical Research Council
- Blood Transfusion Services
- Medical & Dental Council
- National Pharmaceutical Services
- National Environment Agency
- Directorate of Human Resource for Health
- EPI
- ICT Unit
- National Assembly Health Select Committee

#### **Supporting documentation provided by host country**

#### **National legislation, policy and financing**

- National Health Policy (2012-2020)
- International Health Regulation 2005
- Public Health Act (1990)
- National Disaster Management Act (2008)
- Food Safety and Quality Act (2011)
- Quarantine Act (1932)
- The Medicines and Related Products Act. (2014)
- Public Finance Act (1990)
- National Environment Management Act (1994).
- Health Sector Strategic Plan. (2014-2020)
- Environmental Protection (Prevention of Dumping) Act (1988)

## IHR coordination, communication and advocacy

- Public Health Act 1996
- Food Act 2011
- OIE Reports (World Animal Health Information System - WAHIS)
- IHR reports to the World Health Assembly
- Legislation, protocols, or other policies related to reporting to WHO

## Antimicrobial resistance

- Knowledge, attitude and practice of health care workers on antibiotic resistance in The Gambia
- Draft Guide for establishing laboratory-based surveillance for antimicrobial resistance in The Gambia 2014
- The Gambia National Medicines Policy (2007)
- Prevalence of Highly Multi-Drug Resistant Salmonella Faecal Carriage Among Food Handlers in Lower Basic Schools in The Gambia International Journal of Nutrition and Food Sciences 2017; 6(1): 39-44
- Prevalence and risk factors of faecal carriage of Extended Spectrum ?-Lactamase producing Enterobacteriaceae amongst food handlers in Lower Basic Schools in West Coast region of The Gambia WHO publication Bakary Sanneh et al 2016, Ministry Of Health and Social Welfare National Public Health Laboratory 09-May-16
- OIE Annual report on the use of antimicrobial agents in animals BETTER UNDERSTANDING OF THE GLOBAL SITUATION November 2016 <http://www.oie.int/our-scientific-expertise/veterinary-products/antimicrobials/>
- Draft Standard Operating Procedure for Antimicrobial Resistant Surveillance Abou Kebbeh Haruna S. Jallow Ollimatou Sangnia (reviewed by Bakary Sanneh)
- STANDARD OPERATING PROCEDURES FOR MEDIA PREPARATION AND SELECTED BIOCHEMICAL TESTS FOR ANTIMICROBIAL RESISTANT SURVEILLANCE Abou Kebbeh Haruna S. Jallow Ollimatou Sangnia ( reviewed by Bakary Sanneh IgnatiousBaldeh Baba K. Fofana)
- Infection Control and Prevention Policy and Strategy
- Revised National Treatment Guideline
- WHOGFN EQA REPORT
- The Pharmacy Act (2014)
- The Medicines and Related Products Act (2014)
- Note these also need to be added to the list of Legislation in technical area #
- Surveillance data on AMR

## Zoonotic diseases

- Diseases of Animals Act 1944 as amended
- DLS List of Diseases 2017
- DLS data collection forms (11 forms)
- OIE PVS Evaluation Report of the Veterinary Services of The Gambia October 6-15, 2009
- PVS Gap Analysis Report The Gambia 29 May – 8 June 2012
- Veterinary Legislation Support Programme Report of the Veterinary Legislation Identification Mission of the Islamic Republic of The Gambia 2-6 May 2016.

- Final Report Review of the Livestock Sector with Respect to Smallholder Diary and Livestock and Meat Subsectors Development in West Africa The Gambia Commissioned by the Food and Agriculture Organization (FAO)\Integrated National Preparedness and Response Plan for Avian and Human Influenza (AHI) 2015-2019.

## Food safety

- Food Act 2005
- Food Safety and Quality Act 2011
- Food Inspection Manual
- Inspection check list
- Regulations developed from national and international standards
- FSQA SOPs
- Delegation MoUs
- Food safety guidelines (FSQA-GL 1 (2016); FSQA-GL 2 (2016); FSQA-GL 3 (2016); FSQA-GL 4 (2016); FSQA - GL 5 (2016))
- Microbiological sampling Plan (FSQA-SP 1 (2017))
- Internal Incident Response Protocol (FSQA/ IIRP 1 (2017))

## Biosafety and biosecurity

- OIE Country PVS report (also included for Prevent 2- Zoonoses)
- OIE Country PVS Gap Analysis report (also included for Prevent 2- Zoonoses)
- OIE Country PVS Laboratory Mission Report

## Immunization

- Comprehensive multi- year plan (cMYP, 2017-2021)
- Effective Vaccine Management Assessment (EVMA, 2014)
- WHO cold chain inventory tool (2017)
- Comprehensive EPI review report (2015)
- KABP study on immunization, 2015
- EPI communication plan (2014-2019)
- Draft national Immunization Policy
- Joint Reporting Form on Immunization 2013, 2014, 2015, 2016
- WHO and UNICEF estimates of national immunization coverage as of 3 July, 2017

## National laboratory system

- Draft National Laboratory Policy
- Documented list of top ten priority diseases and three core syndromes for targeted improvement of prevention, detection, and response
- Certificates of accreditation for national laboratories and/or EQA results within previous six months for core tests
- ASLM Specimen transport assessment report

## Real-time surveillance

- The Gambia IDSR strategy 2010
- WHO Guide to Establishing Event Based Surveillance [http://www.wpro.who.int/emerging\\_diseases/documents/docs/eventbasedsurv.pdf](http://www.wpro.who.int/emerging_diseases/documents/docs/eventbasedsurv.pdf)
- International Health Regulations (2005) Includes lists of disease that have "...demonstrated ability to cause serious public health impact" [http://whqlibdoc.who.int/publications/2008/9789241580410\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241580410_eng.pdf)
- OIE Terrestrial Animal Health Code - Section 1
- OIE Manual of Diagnostic Tests and Vaccines for Terrestrial Animals: <http://www.oie.int/en/international-standard-setting/terrestrial-manual/access-online/>

## Reporting

- OIE Reports (World Animal Health Information System - WAHIS)
- IHR reports to the World Health Assembly
- Legislation, protocols, or other policies related to reporting to WHO, OIE or FAO
- European Union Decision 1082/EU/2013, Early Warning and Response System

## Workforce development

- 15-Year Human Resource Plans and Training Schedules for the Health Sector of The The Gambia
- Assessment of Core Capacities for Surveillance and Response in The The Gambia 2011 – Preliminary Report
- Human Resources for Health Strategic Plan 2015-2019
- The National Health Policy 2012-2020
- GamNet Training Reports

## Preparedness

- Monitoring and Evaluation for Disaster Risk Reduction - <http://www.un-spider.org/risks-and-disasters/sendai-framework-drr>
- Sendai Framework for Disaster Risk Reduction 2015-2030
- Health Sector Emergency Preparedness and Response Plan 2017 – 2019
- Ebola Virus Disease Plan 2014
- NDMA 2009 DRR/CCA assessment Chapter 3: incorporated (hazard and vulnerability profiling), capacity assessment and mapping of its partners in 2012
- Country Capacity Assessment (CCA) Report (Nov. 2015)

## Emergency response operations

- National Health Sector Preparedness and Response plan
- Plan of Action: Establishment and Operationalization of the PHEOC The Gambia

## Linking public health and security authorities

- Public Health Act (1990)

## Medical countermeasures and personnel deployment

- Health Sector Emergency Preparedness Plan
- Logistics management and information system strategy

## Risk communication

- National Health Promotion and Education Policy 2013-2020 – September 2013
- National Ebola Virus Disease Preparedness and Response Plan. The Gambia (2014-2015)
- National Health Sector Emergency Preparedness and Response Plan (2016-2019)
- MenA Communication Plan 2013 – September 2013
- EVD Newsletter on the training of partners on risk communication and rumour management – October 2015
- MenAfriVac Daily Bulletin, The Gambia 2013 – December 2013
- Minutes of communication taskforce on EVD – September 2014
- Pandemic Influenza Preparedness (PIP) Emergency Risk Communication Certificate
- Epidemic and Emergency Risk Communication Certificate
- Comprehensive EVD CSM activity Report January-December 2015
- SMS message for Ebola, The Gambia (2014)
- List of TV and radio stations in The Gambia
- List of community drama groups in The Gambia

## Points of entry

- Public Health Act 1996
- Quarantine Act 1932
- The food act 2005
- Health Sector Strategic Plan
- CAPSCA plan

## Chemical events

- Hazardous Chemicals and Pesticides Control and Management Act (1994)
- Hazardous chemical regulation Act (1999)
- NEMA ACT
- Common Regulation for The Registration of Pesticides in CILSS Member States (December 1999)

## Radiation emergencies

- Proceedings of the sixtieth General Conference of the IAEA, September 2016
- Overview of IAEA, INSSP & NUSIMS in The Gambia by NEA



