NATIONAL AUDIT OFFICE

PERFORMANCE AUDIT REPORT ON THE HIV/AIDS PREVENTION, TREATMENT, CARE AND SUPPORT PROGRAMMES BY NATIONAL AIDS SECRETARIAT

JANUARY 2016

Independence Drive, Banjul, The Republic of The Gambia

Phone: (+220) 4228 289 Fax:(+220) 4224 192, Email: nao@gamnet.gm

LIST OF ACRONYMS

AAITG	Action Aid International, The Gambia
AIDS	Acquired Immune-Deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
CMS	Central Medical Stores
CSO	Civil Society Organisation
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
MoHSW	Ministry of Health & Social Welfare
NAS	National AIDS Secretariat
OIs	Opportunistic Infections
OVC	Orphans and vulnerable Children
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission of HIV/AIDS
RAO	Regional AIDS Offices
SR	Sub-recipient
VCT	Voluntary Counseling and Testing
VPP	Voluntary Pooled Procurement
WHO	World Health Organization

CONTENTS

LIST OF TABLES

LIST OF FIGURES

FORWARD

I am pleased to present to you my report on performance audit. The performance audit report concerns audit of HIV/AIDS Prevention, Treatment, Care and Support.

This report aims at providing our stakeholders (Members of Parliament, Central and Local Government Officials, Media, the Donor Community, Non-Governmental Organizations and the Civil Society etc.) with a summary of the findings arising from the performance audit conducted by my office as of November 2015.

Section 160 (2) (a) of the1997 constitution of the republic of The Gambia states that, The Auditor General "In the exercise of his or her functions under this Constitution or any other law, shall at all times carry out economic, efficient and effective examination to satisfy himself or herself that public funds are spent in such manner as to reduce waste, eliminate in- efficiency and maximize the benefits to be gained from the use of resources."

In order to meet the parliamentarians' expectations and the public at large, National Audit Office continually reviews its audit approaches to ensure that the audit coverage provides an effective and independent review of the performance and the accountability of public sector entities. Moreover, we seek to ensure that our audit coverage is well targeted and addresses priority areas so as to maximize our contribution in improving public administration. Hence, our work acts as a catalyst in improving efficient utilization of public resources.

I would like to acknowledge the professionalism and commitment of my staff in achieving our goals and undertaking the work associated in meeting our ambitious audit programs despite the fact that they have been working in very difficult conditions.

I hope that the National Assembly, the Media and the public at large will find the information in this report useful in holding the National Aids Secretariat for it stewardship of public funds.

Executive Summary

This Performance Audit on Prevention, Treatment, Care and Support programmes of the National AIDs Secretariat on HIV/AIDS was conducted in accordance with Section 160 (2) (a) of the1997 constitution of the Republic of The Gambia. This mandate is amplified by Chapter 75 (13) of the Finance and Audit Act, 1990 edition which requires the Auditor General to carry out audits for the purposes of establishing, economy, efficiency, and effectiveness in the operations of any Department, Ministry, Local Authority, Parastatals, and Government sub-vented Institutions.

National AIDs Secretariat was established in 2001 as an autonomous body to formulate a national HIV and AIDS policy to develop programmes for the implementation of the policy, direct, monitor and co-ordinate the programmes and activities in the fight against HIV and AIDS and other matters connected therewith.

National AIDS Secretariat is an organ of the National AIDS Council responsible for the implementation of the Council's mandates, policies and objectives.

The National AIDS Council is the oversight body to the NAS responsible of formulation of HIV and AIDS policy, provision of strategic direction, monitoring and evaluation of programme implementation, as well as advocacy on the global arena.

The audit was conducted in accordance with INTOSAI standards. These standards require that a performance audit should be planned in a manner which ensures that an audit of high quality is carried out in an economic, efficient and effective way and in a timely manner. Data collection methods, such as: Document reviews, Physical Observations, Analytical reviews and Interviews were used.The scope of the study was limited to NAS' programmes of Prevention, Treatment, Care and Support in the fight against HIV/AIDS in The Gambia

Key Findings

National AIDS Secretariat has registered significant progress in reducing the spread of HIV/AIDS by scaling up the programmes to many parts of the country, and making the service available to many .There are still challenges to overcome in order for the National AIDS Secretariat to achieve its overall objective in the prevention, treatment and care in the fight against HIV and AIDS. These challenges are; low coverage for Anti-Retroviral Therapy, Early Infant Diagnosis, Capacity Constrains, and Procurement associated problems, and lack of proper bonding and ensuring that those trained serve the government for a number of years before they can leave. If these problems are addressed, it will further consolidate gains registered in the prevention, treatment, and care for HIV and AIDS.

Early Infant Diagnosis

Through reviews of documents and interviews, the audit noted that Early Infant Diagnosis starts at 18 months, instead of between 4-6 weeks as required by the World Health Organization. As a result, infants with sign and symptoms suggestive of HIV infection to undergo screening for HIV will be missed.

The audit attributed this to lack of machines and re-agents necessary to conduct the test.

Training and Bonding of staff trained under Health System Strengthening

The Memorandum of Understanding signed between NAS and Ministry of Health indicated that the former shall provide training for staff and ensure that there is a mechanism in place for tracking and tracing those trained.

Even though there was evidence that those trained were bonded, however, we could not confirm whether they had successfully completed their course, and that they are still serving the government. This has reflected on the staffing situation in the health facilities. The understaffing of the health facilities was apparent during our visits to the facilities; we noted shortages of health personnel in all the categories of health facilities. Six (6) major health facilities should have a total of 294 staff, while the actual staff in post was 199, representing 32% under-capacity; while the minor health centres should have 256 nurses, but had 196 in post, representing 23% under-capacity.

This was as a result of both NAS and Ministry of Health's inability to enforce the terms and conditions stated in the MOU, which is to build appropriate skills and ensure that they serve the Ministry or places where such skills will be needed.

Capacity in the maintenance of CD4 Machine

Global fund provided five thousand euro (€5,000) for the training of biomedical technicians so that skills could be available in country to provide quality services for the maintenance of equipment necessary in confirming one's status. However, the team noted that no such training was conducted for the period under review. The team also noted that CD4 machines in both Basse and Bansang were broken. Samples from these facilities were taken to other places, thus causing considerable delays in service delivery.

The audit noted that training in this area could not be possible due to the following:

- Lack of capacity at the university of The Gambia to conduct such a specialized training
- The budgeted amount could not cater for overseas training

Procurement process and forecasting

According to Global Fund's Voluntary Pooled Procurement (VPP) strategy NAS is to ensure efficient, timely and reliable procurement and also stringent quality standard (B5/BP15). Procurement guidelines, further states that drugs procurement cycle, i.e. from determination of needs to final delivery should be between 6-9 months.

Through document reviews and interviews conducted, the team noted challenges relating to both procurement and forecasting of demands. There were shortages of drugs for treatment of HIV for all the nine (9) ART centres visited, more so for opportunistic infections and Nevarapine drugs. For instance, all the drugs from the procurement initiated on the 13 November 2014 by NAS they are yet to receive all the

drugs. After 10 months (August 2015, only antiretroviral drugs were received, while opportunistic infections drugs are yet to be received.

Low coverage for Anti-retroviral Drug

Audit noted that coverage for ART is limited to only three thousand five hundred and seventy one (3571) HIV Infected patients out of 20,107[1] representing 18% .This could be attributed to patient's refusal to be on treatment, denial for being positive.

National AIDS Council

National AIDS Secretariat Bill of 2011 gave powers to the National AIDS Council to formulate HIV and AIDS policy, and direct, monitor and coordinate national activities in the fight against HIV by meeting regularly to discuss issues relating to HIV.

During discussions with NAS employees and document reviews, we noted that no meeting was held as we were not provided with any minutes indicating decisions reached for the implementation of the strategic plan. This has led to issues surrounding challenges, success and constrains not being addressed in a timely manner.

We noted that the council is under the office of the president, and as such it was extremely difficult to convey meetings since the president is the chair to the council.

Conclusion

Despite low level of HIV (1.9%) prevalence in the country, National AIDS Secretariat still faces challenges in Prevention, Treatment Care and support for people living with HIV. These could be attributed to low coverage in terms of PMTCT in health facilities, coupled with capacity constraints, as a result of weak bonding system in ensuring that those trained serve the Ministry or in facilities where such skills will be needed. Similarly, low coverage for Anti-Retroviral Therapy is taking its toll on HIV patients, while Early Infant Diagnosis starts beyond the recommended timeframe set by the World Health Organisation (WHO) (4-6 weeks), thus depriving them Virological testing in confirming status, and if found to be would miss early initiation of ARV.

The budgeted amount for the training of Bio medic technicians for the periods under review were not utilized, even though such skills are limited in the country. The University of The Gambia was supposed to provide training, but due to capacity in this specialized area, training couldn't take off. Similarly, overseas training was also not possible. As a result no capacity was built in this critical area for the fight against HIV/AIDS, and thus NAS with global Fund support continues to out sources the services of a technician from outside. It is therefore, necessary to come up with a comprehensive plan that will address issues relating to this specialized training in order to ensure that capacity is available in country. This will greatly enhanced performance in the service delivery. Furthermore, regular meetings by the oversight

[1] UNAIDS Spectrum projection for the Gambia 2013

bodies should be held regularly to discuss issues relating to the strategic plan and overall implementation of policies regarding HIV in the country.

Recommendations

In order to curtail the spread of HIV, there is a need to start Early Infant Diagnosis at the recommended timeframe set by W.H.O of 4-6 months, as opposed to 18months.This will ensure that HIV infected infants are diagnosed as early as possible to save life. The treatment of those living with the disease entirely depends on the calibre of staff and the number that are available in the health facilities. Ministry of Heath should collaborate with NAS in ensuring that those who were trained under the Health Strengthen Programme to be posted in Health facilities were HIV services are available. The only way in ensuring that equipment for confirming one's HIV status is functioning properly is by training technicians to provide services in the event of breakdown.

Procurement should be initiated at the soonest possible time to avoid stock out, and provision should be made for drugs that are used by the general patients. Timely and accurate data should be available for consumption patterns. Implementation of HIV programmes entirely depends on the strategic decision reached, which calls for regular meetings for those charge with oversight functions.

CHAPTER 1

1.1 Introduction

The Gambia National Strategic Plan[2] for HIV and AIDS (NSP) covering June 2009-June2014wasprepared to guide the delivery of HIV services over a five year period. The strategies to be used were to ensure the involvement and participation of male, family members and communities in PMTCT of HIV, training of health workers among others.

The country has a generalised low HIV epidemic characterised by disparities in prevalence levels among the regions and pockets of high HIV prevalence concentrated among key population. Although the HIV epidemic is low, the national response needs to be scaled up and sustained to ensure that gains made are not reversed and the impact of the epidemic is reduced to the minimum. As of 2014, the national HIV prevalence rate in The Gambia is1.9%among age 15-49 of the general population[3].Source: (DHS+ 2013)

1.2 Motivation for the Audit

The first case of HIV and AIDS was diagnosed in The Gambia in 1986 but the disease still remains a formidable challenge for the country.

In The Gambia from 2011-2014, the HIV has shown an annual increase. For instance, in 2011, there were 18,886 infections (cumulative) while in 2012, there were 19,116showing 1.2% increase in new infections. On average between 2011 and 2014, the rate of infection rose by 1.6%[4]as seen on the table 1 below:

Table 1: Showing No. of people infected with HIV from 2011-2014

Year	Male	Female	Total	% increase in infection	%average increase
2011	7749	11,117	18,886	0.0	**1.6%**
2012	7793	11,354	19,116	1.2	
2013	7869	11647	19,516	2.1	
2014	8099	12,008	20,107	3.1	

Source: NAO analyses of NAS M&E report (2013)

[2] A guide for implementing the national response, as well as a resource mobilisation, allocation and accountability tool from 2009 to 2014

[3]National strategic plan for HIV 2015-2019

[4] NAS Monitoring and Evaluation report 2013

The HIV/AIDS prevalence among the age category or cohort of 15-49 in The Gambia is 1.9%[5].There are two types of HIV: HIV-1 and HIV-2. Both types are transmitted by sexual contact, through blood, and from mother to child, and they appear to cause clinically indistinguishable AIDS.

Worldwide, the predominant virus is HIV-1, and generally when people refer to HIV without specifying the type of virus they will be referring to HIV-1. The relatively uncommon HIV-2 type is concentrated in West Africa and is rarely found elsewhere. HIV prevalence varies by residence, region, education, employment and wealth quintile in The Gambia according to 2013 DHS+

HIV Prevalence rates in the Gambia have continued to rise despite the government intervention programmes on Prevention, Treatment, Care and support by NAS as evidenced from the table below

Table 2: Showing geographical distribution of HIV prevalence from 2011 - 2014

Region	Population	Prevalence	Estimated Infected Population
Mansakonko	82,361	2.9%	2,388
Brikama	699,704	2.5%	17,493
Janjabureh	126,910	2.1%	2,665
Kanifing	382,096	1.5%	5,731
Kuntaur	99,108	1.4%	1,388
Kerewan	221,054	1.3%	2,874
Basse	239,916	1.3%	3,119
Banjul	31,301	1.1%	344
Total	1,882,450	1.9%	36,002

Source: National Strategic Plan (2015-2019)

HIV has had a huge economic impact in The Gambia. For instance, the National Strategic Plan for 2015 – 2019 reported on a recent modelling exercise by that calculated the annual costs of scaling-up AIDS programmes to meet the current need to be between US$ 7 million and US$ 10 million. This represents a per capita cost of around US$ 6 to US$ 8 and 2.5 % of GDP.

[5]Strategic plan for 2015-2019

1.3 Audit Objective

The Overall Audit Objective for the study was to assess the performance of NAS's intervention programmes of prevention, treatment, care and support in the control of HIV/AIDS prevalence in the Gambia. The specific objectives were;

1. To determine the level of implementation of preventative measures by NAS in controlling the HIV/AIDS prevalence
2. To assess whether NAS defined the treatment regime for controlling the prevalence of HIV/AIDS and for those infected with HIV/AIDS
3. To assess whether NAS coordinated and monitored the care and support given to people living and affected by HIV/AIDS.

1.4 Audit Questions

The audit sought to answer the following questions;

1. To what extent has NAS implemented preventive measures to control the HIV/AIDS prevalence in the Gambia
2. Has NAS defined the treatment regime for controlling the prevalence of HIV/AIDS and for those infected with HIV/AIDS?
3. How NAS coordinates and monitors the care and support given to people living and affected by HIV/AIDS.

CHAPTER 2

2.0 Design of the Audit

2.1 Scope of the audit

The audit was carried out on Prevention, Treatment, and Care for HIV by National AIDS Secretariat (NAS) with the aim of ascertaining whether NAS is efficiently, economically, and effectively performing its role in ensuring that adequate measures were put in place in reducing the spread of HIV. The audit was conducted at the National AIDS Secretariat's Headquarters and selected Health facilities within the country. It covered operations in the following financial years i.e. 2011, 2012, 2013 and 2014.

2.2 Methodology

The methodology for this study was three-fold: we analysed documents from NAS; interviewed key staff of NAS; and administered questionnaires at Health Facility locations[6] where NAS operates

2.3 Interview and discussions

Six interviews were conducted during the audit in order to assess the operations of NAS and to corroborate information obtained from the other sources. We also held discussions with officers in charge of each of the 47 out of the 49 health facilities visited.

The team interviewed the following.

- Director of National AIDS Secretariat
- Deputy Director
- Programme Administrator
- Home Based Care Officer
- Procurement Specialist
- Care and Support Officer
- Monitoring and Evaluation Specialist

[6]West Coast Region; Lower River Region; Central River Region; Upper River Region; North Bank Region

2.4 Documents review

The team carried out detailed reviews of NAS's strategic and operational documents in order to obtain deeper understanding of its operations and strategies in the fight against HIV/AIDS.

Table 3: Documents reviewed

No.	Document Reviewed	Information obtained
1.	Annual work-plans and budgets	Information on achievements of NAS in regard to its activities. We also obtain information about what was not done during the period under review.
2.	Procurement and supply management plan.	This document shows plan for drugs to be procured and the way they should be distributed to various health facilities. It also helps NAS to monitor drugs, as well as when to place orders so that there wouldn't be drug shortages
3.	Strategic framework and action plan (2009-2014 and 2015-2019)	These documents set high level objectives and plans in combating the spread of HIV/AIDS
4.	Annual progress reports	These reports catalogue efforts being made in the fight against HIV/AIDS
5.	Monitoring & Evaluation plans.	This document was reviewed in order to assess the rate of implementation, challenges and areas of attention for corrective action in order to meet the aims and objectives of the organisation
6.	Questionnaire	This was administered in health facilities to assess the services being offered in terms of prevention, treatment, care and support.
7.	Memorandum of Understanding between ministry of health and NAS	To what extent have they carried the activities as per MOU

CHAPTER 3

3.1 Description of the Audit Area

The National AIDS Secretariat (NAS) was formed in 2001 in light of the changes in strategy in the fight against HIV/AIDS not only as a health-sector problem but one that poses a threat to national development. As a result of these changes in the approach to the epidemic, The Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Government of The Gambia, represented by the National AIDS Secretariat (NAS), signed a grant agreement on 26th August 2009, to complement The Gambia Government's efforts in the fight against HIV/AIDS.

The overall goal for NAS in relation to HIV/AIDS is to 'stabilize and reduce the prevalence of HIV/AIDS in The Gambia by providing quality treatment, care and support for people living with or affected by HIV to live a normal life, and also to take measures that will mitigate the impact of the epidemic.

3.2 Mandate

The mandate of NAS is provided for in the National AIDS Council and Secretariat Bill of 2011. According to the Bill[7], NAS is an Organ of the National AIDS Council responsible for implementation of the Councils mandate, objects and Policies.

3.3 Vision

The vision of the Gambia National AIDS Secretariat is to have an HIV/AIDS free society, with 100% level of awareness, characterized by behavioural change, manifested in safe blood supply, safe sex practices and equitable access to quality treatment, care and support for both the infected and the affected.

3.4 Mission

To control the spread of HIV/AIDS and mitigate its impact on all vulnerable groups, individuals, families, communities and the nation at large, through effective facilitation of the development and coordination of the implementation of a multi-sectoral, cost HIV/AIDS prevention, treatment, support and care programmes and policies in the Gambia in collaboration with local and International partners to realize an HIV/AIDS free society.

[7]Part III Section 10.2

3.5 Specific Objectives

NAS has the following specific objectives:

- ❖ Increase knowledge and skills for behaviour change to control the spread of HIV infection among the sexually active population (15 - 49 years) from 39% to 60%.
- ❖ Uptake of HIV voluntary counselling and testing (HCT) increased from 4% to 15% among sexually active population (15 to 49 years) by 2014.
- ❖ Uptake of ARV prophylaxis increased from 38% to 80% of pregnant women by end of 2014.
- ❖ At least 80% of PLHIV provided with clinical care, treatment and prevention of opportunistic infections including ART by 2014.
- ❖ At least 50% of PLHIV, orphans and vulnerable children provided with care and support.
- ❖ Support the coordination and implementation of the '' 3 Ones principles''.
- ❖ Training of nurses and health technicians and bio medic technicians.

3.6 The activities

The activities of NAS:

- To reduce the transmission of HIV from parent to child through the provision of services for the prevention of parent to child Transmission. (PPTCT)
- To improve access to and utilization of VCCT services
- To improve access to and utilization of ARVs.
- To strengthen and expand the national capacity to design ,implement monitor and evaluate HIV/AIDS programmes in Antiretroviral therapy (ART) in the country
- Syndromic management of sexually transmitted infections (STIs)
- Management of opportunistic infections (OIs)
- Nutritional support to HIV positive pregnant and lactating mothers and children

3.7 NAS Organisational Structure

NAS is governed by the National AIDS Council and is headed by a Director who is assisted by a Deputy Director and a team of professional staff. The professional staff includes Procurement Specialist, Monitoring and Evaluation Specialist, Care and Support Specialist, Global Fund Administrator, and an Accountant.

NAS is decentralized to the Regional and Municipal levels. The basic structures at these levels are Municipal and Regional AIDS Committees, respectively. Each of the committees is run by a Regional/ Municipal Coordinator, while the respective Governors/ Mayors serve as chairpersons.(See **Appendix A**)

3.8 Funding

The Government subvention to NAS is for Personnel Emoluments and Other Charges, while support from Global Fund is meant for HIV/AIDS drugs and any activity related to the prevention, treatment, care and support.The subvention from the government is not necessarily based on the budget submitted, but rather on the performance of the revenue, whereas that of the donor depends on the activities planned and implemented**.**

The table below shows breakdown of funding for NAS:

Table 4: Showing NAS funding from 2011-2013

FY	Donor(Global Fund) GMD		Government GMD	Total GMD
2011	143,704,850	(€3,547,392)	1,800,000	145,504,850
2012	110,083,537	(€2,730,160)	6,188,811	116,272,348
2013	245,571,234	(€5,306,206)	5,630,211	251,201,445
Sub Total	499,359,621	{ €11,583,758}	13,619,022	
Total funding for the period 2011-2013				**512,978,643.00**

(Source: NAS audited accounts and draftfrom 2011-2013)

3.9 Roles and Responsibilities of Key players

3.9.1 NATIONAL AIDS COUNCIL

The National AIDS Secretariat was established by the National AIDS Council and Secretarial Bill, 2011. The objective of the Council is to formulate HIV and AIDS Policy, direct, monitor and co-ordinate national activities in the fight against HIV and AIDS. The Council is chaired by H.E. the President, under whose Office the National AIDS Secretariat sits. The act specifies the roles/functions of the Council as follows:

- Formulate comprehensive National HIV and AIDS Polices and Strategies and establish programme priorities.
- Provide high level advocacy for HIV and AIDS preparation and control.
- Oversee the preparation and implementation of National HIV and AIDS strategy and Plan of action as well as the Multi-Sectoral HIV and AIDS national response activities.
- Create an enabling environment for political commitment to HIV and AIDS national response.
- Provide effective leadership in national planning, supervision and support of HIV and AIDS programmes.

- ❖ Develop strategies for mainstreaming of HIV and AIDS in all sectors and at all levels and to promote the principle of greater involvement of people living with HIV in all decision and policy making fora.
- ❖ Expand and Co-ordinate the national response to HIV and AIDS and to support people living with HIV and PLHIV Organisations in the country.
- ❖ Mobilise, control and manage resource available for the achievement of its objective and monitor their allocation and utilisation.
- ❖ Forster linkages among stakeholders.
- ❖ Promote issues relating to research, documentation and dissemination of messages on HIV and AIDS
- ❖ Monitor and evaluate HIV and AIDS programmes and to facilitate periodic review of HIV and AIDS policy, strategy and plan of Action.

3.9.2 DIRECTOR (see Appendix A)

The Director has overall responsibility for the management of the National AIDS Secretariat and ensures the smooth implementation of the Secretariat's policies and efficient management. Specifically, the Director is responsible for the following:

- ❖ The overall management and administration of the secretariat as well as evaluating the internal activities of the Secretariat.
- ❖ Exercise supervisory responsibility over the Deputy Director, the heads of Finance and Administration, Program Support, Policy Planning, Research and Monitoring and Evaluation.
- ❖ The Co-ordination, Preparation and Implementation of costed multi-sectoral plans for HIV AND AIDS national Response in line with the three ones principles.
- ❖ Recommend policies and procedures for the carrying out of the work of the Council.
- ❖ Co-ordinate the activities of all the regions of the Secretariat, including operational and financial management of the Secretariat.

3.9.3 DEPUTY DIRECTOR

The Deputy Director is responsible for ensuring effective inter-sectoral coordination and collaboration. He/she assists the Director in the implementations of the programmes, budget formulation, quarterly and annual progress reports preparations and any other function as may be directed by the Director.

3.9.4 PROGRAM ADMINISTRATOR

The Program Administrator has overall responsibility for the administration of the Global Fund grant activities and plays a key role in a team of professional staff of the NAS. He/she monitors the performance of all sub grantees and also serves as liaison officer between NAS and all other partners implementing Global Fund activities.

3.9.5 PROCUREMENT SPECIALIST

The Procurement Specialist ensures that a sound, effective and efficient procurement system is in place for effective project implementation. The Procurement Specialist also ensures the procurement of goods, services and works as per the project's procurement plan(s).

3.9.6 MONITORING & EVALUATION SPECIALIST

The Monitoring and Evaluation (M&E) Specialist assists the NAS in determining the impact of the multi-sectoral interventions in the prevention, care and support, management and co-ordination for HIV/AIDS infected and affected people. The M&E Specialist reviews monitoring reports, analyses them for impact evaluation and identify the causes of potential bottlenecks in the implementation of the project

3.9.7 FINANCIAL MANAGEMENT AGENT

The Global Funds (Donor funds) component of NAS's funds is managed by DT Associates. The firm is responsible for designing and implementing appropriate financial controls and treasury management to provide timely and reliable accounting information and reports essential for management of planning, implementation, accountability and evaluation of performance.

3.9.8 REGIONAL/MUNICIPAL AIDS COORDINATORS

A number of HIV/AIDS related activities are to be implemented by participating NGOs and other Civil Society Organizations (CSO) operating at the regional levels. The Regional AIDS Coordinators are responsible for the overall coordination of all activities relating to HIV/AIDS prevention, treatment, care and support within their respective regions/municipalities.

3.9.9 CARE AND SUPPORT OFFICER

The Care and Support Officer assists the National AIDS Secretariat in the development and scaling up of implementation of care models for HIV/AIDS. This involves, but not limited to: HIV counselling and testing in the context of care; opportunistic infection management (including prophylaxis); ARV administration use and safety; PLHIV support and palliative care (including home-based care); health worker safety protection and care; and monitoring and evaluation of the clinical outcomes of care and support.

3.10 Process Descriptions

3.10.1 Prevention process

3.10.1.1 Counselling and Testing

This is the first entry point for HIV prevention, treatment, care and support. This is part of the strategy to increase people's knowledge of their status. Individuals are taken through both pre-test and post-test counselling as a basic first step. During the pre-test counselling, the health care provider provides the individual with the following information:

- The reason why HIV counselling and testing is necessary and the benefits of having to test oneself;
- The availability of services in case of HIV positive test result, including antiretroviral treatment;
- The assurance of confidentiality of the test result;
- The person will volunteer to go for testing, whereby the blood sample will be taken to the laboratory to determine his /her status. There will be post-test counselling before the result is released to the person.

3.10.1.2*Prevention of Mother to Child Transmission (PMTCT)*

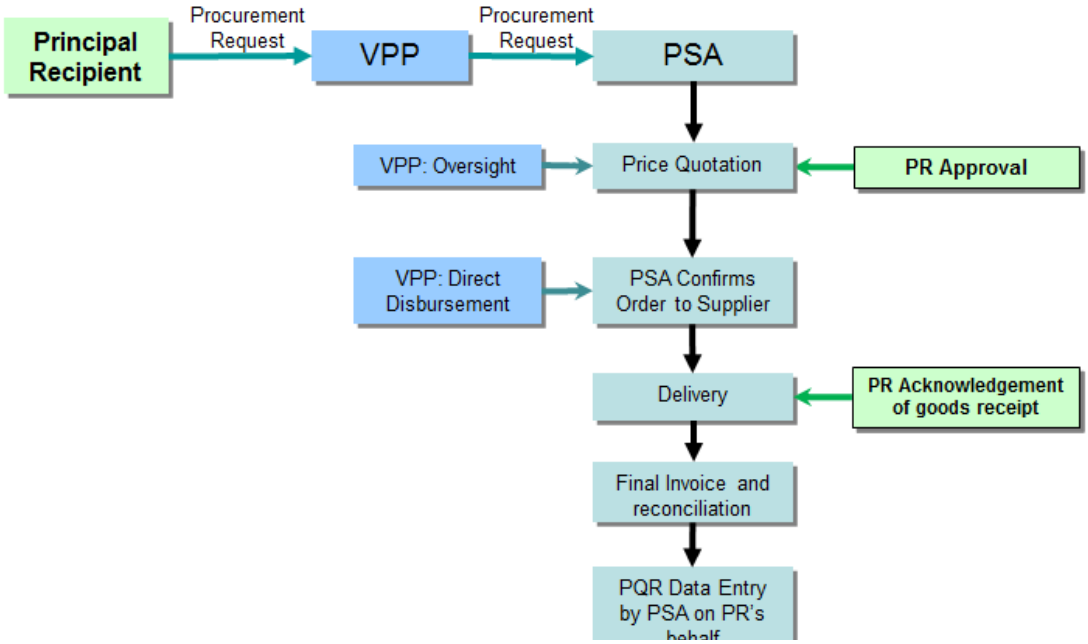
- Antenatal mothers are offered HIV testing on their first visit at the health centre they have registered;
- In the event that testing facility is not available at their registered health centre, they are referred to the nearest heath facility;
- Blood sample is obtained from the mother and taken to lab to determine their status;
- If the pregnant woman tests positive, and the CD4 count is 350 or below, ART is initiated as soon as possible;
- If the test result shows a CD4 count above 350, ARV prophylaxis is administered.

3.10.2 Treatment

3.10.2.1Procurement of Health Commodities

NAS procures health commodities (i.e. ARV medicines, ACTS, Rapid Diagnostic kits, etc.) through a Voluntary Pooled Procurement (VPP) mechanism initiated by the Global Fund. The procurement of such items involves some 8 process steps as indicated below:

Figure 1: Process flow showing Voluntary Pooled Procurement process steps



Source: NAS/Global Fund VPP procurement guidelines

Participation in the VPP Procurement Process – 8 Steps
Step 1: PR sends Request for Quotation with product specifications, quantities and desired delivery dates to PSS Team
Step 2: PSS Team screens Request for Quotation and sends to PSA
Step 3: PSA on behalf of the PR, invites bids from manufacturers/suppliers and submits Price Quotations to PR based on the bids
Step 4: PR reviews the Price Quotations and accepts (or declines) the Price Quotations and returns a signed copy to the PSA with copy to PSS Team
Step 5: PSA prepares Proforma Invoice; PSS Team prepares direct disbursement request and facilitates payment to PSA
Step 6: Upon receipt of payment, PSA confirms the order with supplier
Step 7: PSA provides periodic updates to the PR on expected delivery; coordinates the delivery process for the PR; PR confirms due receipt of goods to PSA
Step 8: PSA reconciles account and submits Final Invoice to PR; PSA enters data into Price and Quality Reporting system (PQR
(Source: NAS/Global Fund VPP procurement guidelines)

3.10.2.2 Distribution of Health Commodities

- All health commodities are centrally stored at the Central Medical Stores warehouses at Kotu, after the National Pharmaceutical Services certifies them;
- Health facilities within the Greater Banjul Area (GBA) send their requisitions to the Central Medical Stores; while facilities in the regions outside of GBA would send their requisitions to the respective regional medical stores;
- Drugs are issued based on the requisitions and the stores update the records to track the stock levels;
- Periodically Central Medical Stores shares stock distribution and consumption reports with the NAS.

3.10.3 Care and Support process

3.10.3.1 *Support and Care for PLHIV*

- HIV infected children and adults are routinely assessed for nutritional status, including weight and height at scheduled visits;
- Routine Vitamin A supplements are given to women 6-8 weeks after delivery and for children of 6-59 months;
- Nutritional support is offered in the form of rice, vegetable oil, sardines, beans and sugar; while a special Formula is prepared for children between 6-59 weeks;
- The support is given to PLHIV when they report to the treatment centers for either ART or for care through sub-recipients;
- Those who are seriously sick are cared by the Home Based Care officers through visits to provide them with the necessary assistance they may need.

3.10.3.2 Care for pregnant women

- HIV positive mothers are given routine iron and folate supplements during pregnancy and until six weeks after birth;
- Attention is given to mothers receiving ART to ensure that anemia is corrected;
- Insecticide treated bed-nets are supplied to pregnant women.

3.10.3.3 Support to orphans and vulnerable children

- The Care of HIV infected child considers the needs of the child and is necessary for comprehensive care and well-being of the child;
- Educational support is provided to all AIDS orphans and children, which includes school fees, text books, etc.;
- They are also provided with comprehensive care which includes antiretroviral therapy;
- They are provided with socio-economic and livelihood support in a form of income generating activities and micro credit schemes for their family.

A. Monitoring and Evaluation

- The M&E unit provides regular monitoring reports after collating reports from sub-recipients and regional coordinators;
- M&E unit undertakes field visits on quarterly basis to assess the performance of the partners in the implementation of planned programmes, and also provide training in areas where deviations arise;
- The M & E designs performance questionnaires in relation to key performance indicators and targets for each objective, and also reviews monitoring reports, and analyse them for impact evaluation.

B. Disbursement flow

- The NAS operates two Bank Accounts in respect of funds received from Global Fund as shown below:
  - Euro Account maintained at Central Bank of The Gambia.
  - Dalasi Account (Operational Account) maintained at Ecobank.
- All Funds requested from Global Fund are deposited into the Dollar account. The amount is later converted into local currency (Dalasi) at the rate ruling and then deposited into the local currency account (Operational Account) at Ecobank;
- All funds budgeted for the procurement of health products, equipment and pharmaceuticals are directly disbursed to the supplier by Global Fund through Voluntary Pool Procurement (VPP);
- Disbursements from Government of The Gambia are transferred, (on a monthly basis) to the NAS Subvention account maintained at the Central Bank;
- These funds are used only for payment of salaries and other recurrent expenditures.

C. Transfer of funds from NAS to sub-recipients

- Disbursements of funds from NAS to sub-recipients are based on work plan and budgets within the terms of the Memorandum of Understanding;
- Payments to sub-recipients are made from the Operational bank account to their respective banks.

CHAPTER 4

4.0 Detailed Findings

In this chapter, findings on the measures put in place in terms of prevention, treatment, care and support in the fight against HIV and AIDS by NAS are presented in reference to the audit objectives.

4.1 Prevention of Mother to Child Transmission of HIV/AIDS (PMTCT) Services

According to the National strategic framework of (2009-2014), NAS is to establish PMTCT services in all public, private and NGO health facilities conducting Reproductive Child Health Clinics and to extend such services at the outreach clinics.

It was noted during the field visits to the health facilities that PMTCT was not offered in all the health facilities as envisaged in the strategic plan. For instant, eighteen (18) out of forty nine (49) health facilities visited were providing PMTCT for Anti natal mothers visiting those facilities.

The percentage of pregnant women who are not tested for HIV is higher in the Western Region[8] (49%) followed by Upper River (18%) and Central River (16%) while in other region it is less than 10%. Children born to HIV positive mothers who did not receive HIV testing month 18 was also higher in Western Region (46%) followed by Central River (22%) and North Bank (12%). This implies that expectant mothers visiting those health facilities, and could not afford to visit other facilities where such services are available were denied the opportunity to administer ARV prophylaxis to mothers and their babies to prevent mother to child transmission, which can result to infection of babies if their mothers turn out to be infected with virus. *See Table 5: Showing health facilities offering PMTCT service as annex to this report*.

The reason for not extending the services was as a result of inadequate resources (financial, material and human).

Conclusion

Not all mothers have been given the opportunity to access PMTCT services in health facilities in The Gambia. Only eighteen (18) out of forty nine health facilities visited offered such a service. As a result pregnant women enrolled at health facilities without PMTCT, and could not afford going to the other health facilities where services are available will not have the opportunity to know their status, and even if they do and turn out to be positive, they will not have access to ART if they cannot afford the transport cost

[8]National strategic plan section iv page 14 of 2015-2019

Recommendation

Efforts should be intensify to ensure that this service is available at both minor and major health centres to reduce the spread of disease through Mother to child.

Management Response

PMTCT service is offered in 35 facilities, the programme has a scale-up plan because the establishment of PMTCT goes with huge resources needs, such as assessment and establishment, training of staff in PMTCT and the provision of health commodities, products, consumables and maintenance of the related equipment

Remember the implementing partners for the HIV response is not limited to the public health facilities alone, some NGOs such as HOC, CRS, BAFROW and GFPA to name a few.

Auditor's Further Comment

Audit recognizes the efforts of NAS in the scale-up plan for PMTCT services. However, efforts towards this plan should be fast tracked if benefits associated with PMCT are to be realized.

4.2 Storage of drugs

According to the standards set by the Ministry of Health and Social Welfare, drug stores should have adequate lightning, temperature, ventilation and humidity; all drugs should be placed on a raised platform.

Audit noted that health facilities were storing drugs in conditions not suitable for storage of drugs as recommended by the MoH&SW. Field visits to forty nine (49) health facilities revealed that only three (3) were following the guidelines on storage of drugs while the remaining (46) were not following the guideline.

For instance, 31 had poor ventilation, 15 had direct sunlight into their storage while 3 had their HIV drugs mixed with other drugs. As detailed in Table 6

According to management of these affected facilities, they could not follow the MoH&SW guidelines because neither the Ministry nor NAS have provided them with proper storage or renovated existing stores. This was attributed to low budgetary allocations to the sector as well as limited private intervention to supplement government's efforts.

Picture 1: Showing poor storage of drugs

Source: NAO photos taken on 29th/01/2015 at Fajikunda health facility in KMC and 7th/02/2015 at Fatoto health facility in URR

Conclusion

Not all the drugs for the treatment of HIV were stored under recommended conditions set by the Ministry. This can result to efficacy of drugs, thereby rendering them ineffective in the treatment of disease.

Recommendation

NAS should liaise with the Ministry of Health in order to ensure that drugs purchased for the treatment of HIV are stored in an environment that meets the standards set by the Ministry

Management Response

Please remember the stores do not belong to NAS, but the MoH&SW instead, so whatever NAS does just to compliment.

Auditor's Further Comment

Since drugs that are used for the treatment of HIV are purchased by NAS and stored by MoH&SW, there is a need for both parties to devise ways for proper storage of these drugs, in order to ensure their effectiveness in the treatment. If they are not stored as recommended by the MoH&SW it could seriously underpin the treatment programme.

4.3 Low coverage for Anti-Retroviral Therapy

World Health Organization's panel recommendation of May 2014, recommended Antiretroviral Therapy for all HIV infected individuals to reduce the risk of disease progression.

During our visit to the health facilities, we noted that only 10 out of the 49 facilities were providing Anti-Retroviral Therapy. Out of an estimated 20,107[9] HIV patients, only 3571 were provided with Anti-Retroviral Therapy, representing 18 % of coverage.

The provision of ART centers in each regional capital is a step in the right direction. There is still need for more centers in the remote areas to make it available to many. It was noted that there was a total of ten ART centers providing services at the regional level

According to the Management, they could not extend the services as a result of the following:

- Patient's refusal to be on treatment
- Denial for being positive
- Financial constrains
- Stigma associated with the disease often makes people reluctant to be on ART.

Conclusion

Not all HIV positive patients were provided with ART which implies that the amount of HIV in their bodies continues to rise thereby affecting their health.\

Recommendation

Anti-Retroviral Therapy should be accessible to HIV patients to make them healthy in order to contribute meaningfully to the society.

[9] UNAIDS Spectrum Projection for The Gambia - 2013

Management Response

Remember the availability of ART does not mean that every PLHIV would be on ART, it is optional for someone to accept taking ART, whiles all patients are offered; those in denial would always opt out

Secondly part of the period under review requires eligibility before one can be put on ART (CD4 count)

Auditor's Further Comment

Efforts should be intensified to increase the coverage for Anti-Retroviral Therapy, so as to reduce the risk of disease progression for those infected.

4.4 HIV Treatment

4.4.1 Early Infant Diagnosis

The World Health Organization (WHO) recommends that all HIV-exposed infants should undergo virological testing at 4-6 weeks of age or at the earliest opportunity.

Through review of documents and interviews, the team noted that Early Infant Diagnosis started at 18 months as opposed to the above WHO recommendation. This implies that NAS lost the opportunity to establish the HIV status of such infants within 4-6 weeks after birth.

The reason for not starting at 4-6 weeks could be attributed to lack of machines and re-agents necessary to do the test.

Conclusion

The timely initiation of ART in reducing the high morbidity and mortality that occurs among HIV- infected children is seriously undercut.

Recommendation

It is important for HIV-infected infants to be diagnosed as early as possible in order to undergo life-saving treatment before the virus take root.

Management Respond

HIV and especially EID is a very expensive venture, which requires huge resources (human, material and finance) to implement on a sustainable basis. Besides the government, the HIV programme has only one single donor which can't fill the gap at the moment

4.4.2 Training and bonding of Staff under Health System Strengthening

According to the Memorandum of Understanding (MoU) between the Ministry of Health and the National AIDS Secretariat, the former

"*Shall provide evidence of bonding for employees whose tuition fees to undertake training in any specialized areas are being paid by the Global Fund. The bonding will provide a mechanism of tracking and tracing the said staff at any given time of the period*."

We were provided with documentary evidence showing the number of staff who were trained and evidence of bonding by NAS. However, we could not also establish whether sponsored staff had successfully completed their programmes as no progress reports were presented to the audit team,

Even though training was provided, the staffing situation in most health facilities still remains dear and this is a cause for concern. For instance, the nursing staff requirements of 6 major health facilities (**See table 7 in the annex**) should have been 294, while the actual staff in post was 199 (32%). The same requirement for the minor health centres should have been 256 but had 196 in post, (23%). As a result, the World Health Organization's recommendation for Health Worker Density ratio of 2.25/1000 was not met, because Gambia had 1.03[10] per thousand.

Interviews with staff of NAS and MoH and documentary reviews attributed the reasons for failing to meet the WHO density ratio to the following:

- Low levels in Human Resource in Health (HRH)
- Inadequate capacities of training institutions
- Poor incentive package and ineffective HRH retention strategies
- Inadequate institutional capacities for HRH management
- Attrition of skilled health personnel
- Low remuneration package of health professions
- Lack of communication between the ministry and NAS on the status of those trained and where they are posted
- No information on transfers and resignations

The purpose of training of health personnel was to build capacity within the Ministry of Health. The bonding is to ensure that those trained serve the Ministry with their newly acquired skills and knowledge. A mechanism for reviewing training is in place to ensure that the trained staff are bonded, but it was never followed.

[10]Ministry of Health Information System

Table 8 below details trainings conducted under this programme.

Table 8: Number of staff trained through the programme

Name of School	Programme Name	No. Of Graduates
Gambia College, School of Nursing and Midwifery	General	33
School for Enrolled Nurses and Midwives, Bansang	General	20
School for Community Health Nurses and Midwifery	General	20
School for Community Health Nurses and Midwives, Mansakonko	Midwifery	40
University of The Gambia	Pharmacy Assistant	21
University of The Gambia	Pharmacy Technician	20
University of The Gambia	Laboratory Technician	20
Leeds Metropolitan University/UTG	MPHP	5
Total Number of Graduates		**223**

Source: Ministry of Health staffing norms, August 2014

Conclusion

In the absence of applying a strict bonding principles for staff benefiting from such trainings, it will be difficult to maintain the trained staff, and it will be difficult to maintain quality service delivery. Lack of progress reports could impede the ability of both the Ministry and NAS to monitor progress made by students- those excelling, failing or leaving the programme.

Recommendation

In order to build capacity through the Health Strengthening System, the Memorandum of Understanding between the parties should be applied consistently.

Management Response

Please be informed that the students are bonded at the level of the NAS for two years to work in the Gambia irrespective of the institution as GF policy dictate public private partnership and this bond documents are filed at NAS.

Auditor's Further Comment

Even though they were bonded at the level of NAS, there is no mechanism in place in tracking and tracing for those trained under the programme as envisaged in the

Memorandum of Understanding, so that where they work will be known to both NAS and MOH.

4.5 Lack of Capacity in the maintenance of Equipment (CD4 Machine)

Our reviews of NAS's financial records showed that Global Fund provided a total of five thousand Euros (€5,000 for each financial year) for the training of biomedical technicians for 2011, 2012, and 2013 financial years. The idea behind this was to build local capacity.

Our audit noted that NAS did not finance any training for the staff of MoH in this area during the period under review. We also noted that there was no technician in the country to service CD4 machines.This was evident during our treks, where we found that two machines (one in Basse and the other in Bansang) were not functioning due to technical problems. We were informed that samples from these facilities were sent to other facilities thus resulting to delays in the service delivery.

Management attributed their inability to fund such training programme to the following:

- The University of The Gambia which was supposed to conduct the training could not do so due to lack of capacity for such specialized training at the university.
- Overseas training was also not possible due to insufficient budgets

Conclusion

Lack of biomedical technicians could lead to interruption in the service delivery and by extension increased cost. This could also negatively impact on the centers' ability to provide CD4 services particularly given that only 10 health facilities had such machines throughout the country.

Recommendation

In order to ensure that the equipment are maintained properly and serves its useful life, there is a need to train Gambians on the maintenance of these machines.

.

Management Response

It was made clear to you that capacity in country was so limited to accomplish this specialised trainings in country, secondly the budget available at the time is insufficient to cater for overseas training in the area

Secondly the maintenance of the biomedical equipment's related to HIV work is out sourced to 'Sotel Med' the provider of the equipment for regular maintenance as agreed with the Global Fund.

4.6 Slow procurement process and forecasting

The aim of Global Fund's Voluntary Pooled Procurement (VPP)is to ensure a cost-effective and cost-efficient procurement process focusing on the three key principles of efficient, timely and reliable procurement and also stringent quality standards for

procured products. Also, the VPP guidelines set drugs procurement cycle, i.e. from determination of needs to final delivery between 6-9 months.

Through document reviews and interviews conducted, the audit noted challenges related to the procurement of drugs as a result of poor forecasting at the level of health facilities. For instance, at all the 9 ART centres, our visit found shortages, especially of Opportunistic Infection (OIs) drugs. Our findings noted slow procurement cycle for health commodities. The delays in the procurement of drugs is evident in the procurement of drugs initiated on the 13 November 2014 by NAS for which all the drugs are yet to be received. After 10 months (August 2015), only antiretroviral drugs were received, while opportunistic infections drugs are yet to be delivered.

The reason for slow procurement and forecasting could be attributed to the following

- Drugs are manufactured on order, and not produce for order
- Orders from Gambia are not given priority, because of our size
- Opportunistic Infection drugs are forecasted based on HIV patients, but at times it is given to general patients, leading to shortage
- Weak capacity in terms of data management in the health facilities

The shortages of the drug could lead to vulnerability to infection of other diseases that are associated with HIV because of weakened immune system.

Table 9: Availability of HIV drugs

HEALTH FACILITIES EXPERIENCED HIV DRUGS SHORTAGES		
NAME OF HEALTH FACILITY	**YES(√)**	**NO(×)**
Basse Major HC	√	
SerreKunda General Hospital	√	
Bansang Hospital	√	
Soma Major Health Centre	√	
AFPRC Gen. Hospital	√	
Faji-Kunda Health Centre	√	
SulaymanJunkung General Hospital	√	
Essau Health Centre	√	
Brikama Major Health Centre	Denied access or information.	

Source: NAO's analysis of health facilities experiencing drug shortages.

Conclusion

Audit noted that not all the drugs required for the treatment of HIV are available at the ART centres. As a result, some of the drugs required will not be available to patients thereby weaken their immune system, and making them vulnerable to other diseases.

Recommendation

In order to avoid stock-out, there is a need for an accurate and reliable data on the consumption patterns, and make early ordering of drugs.

Management Response

The programme has since addressed this problem in collaboration with the MoH&SW by instituting timely submission of consumption data.

4.7 The National AIDS Council

According to National AIDS Secretariat Bill of 2011, there shall be a National AIDS Council to formulate HIV and AIDS policy, and direct, monitor and coordinate national activities in the fight against HIV and AIDS by meeting regularly to discuss issues relating to HIV.

We sought to review the minutes of the Council's meetings with a view to finding out the policies and recommendations in the fight against the disease. Wewere not presented with minutes as evidence that regular meetings were held to highlight challenges, successes and constraints registered by the National AIDS Secretariat, especially the implementation of the strategic plan.

The National AIDS Council being under the office of the President, and chaired by the President himself makes it difficult to conduct meeting, due to other state functions he is deeply involved.

Conclusion

The National AIDS Council's ability to direct, monitor and co-ordinate national activities in the fight against HIV/IDS will be weaken in the absence of the important oversight role of a functioning National AIDS Council, more so, the rate of implementation of the strategic plan.

Recommendation

In order to ensure that the overall objective of HIV and AIDS programmes are achieved, there is a need for regular meetings to assess the rate of implementation in terms of the strategic plan, so that corrective measures can be taken to address issues in good time.

Management Response

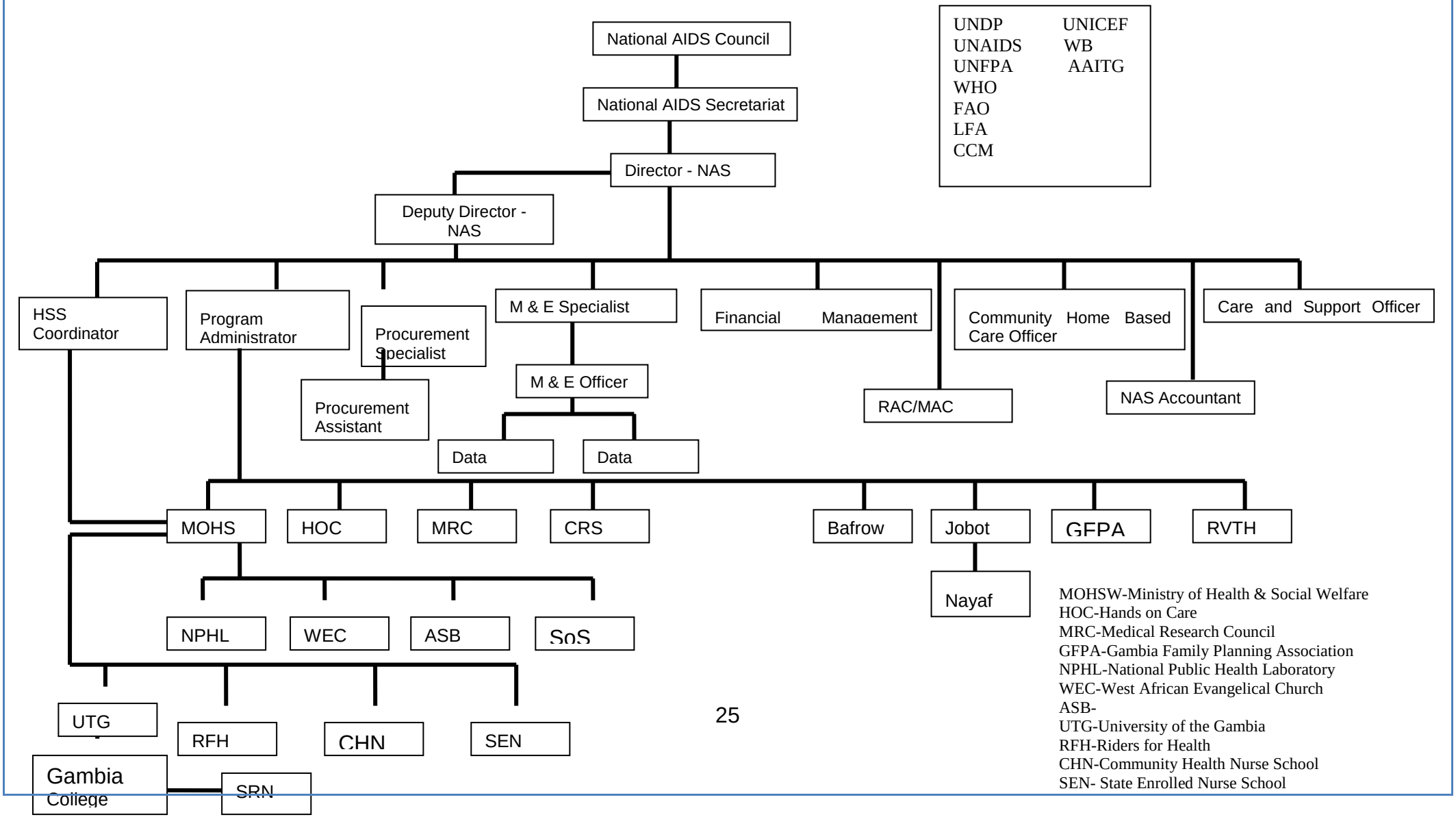
This response could only be found at the level of the NAC

Auditor's Further Comment

Audit maintains that National AIDS Secretariat is an organ of the National AIDS Council responsible for the implementation of the Council's mandates, policies and objectives, and this could not be done in the absence of regular meetings to discuss way forward.

APPENDIX A: NAS ORGANOGRAM

CURRENT ORGANISATIONAL CHART – NAS PROFESSIONAL STAFF



MOHSW-Ministry of Health & Social Welfare
HOC-Hands on Care
MRC-Medical Research Council
GFPA-Gambia Family Planning Association
NPHL-National Public Health Laboratory
WEC-West African Evangelical Church
ASB-
UTG-University of the Gambia
RFH-Riders for Health
CHN-Community Health Nurse School
SEN- State Enrolled Nurse School

APPENDIX B: THE PROBLEM TREE

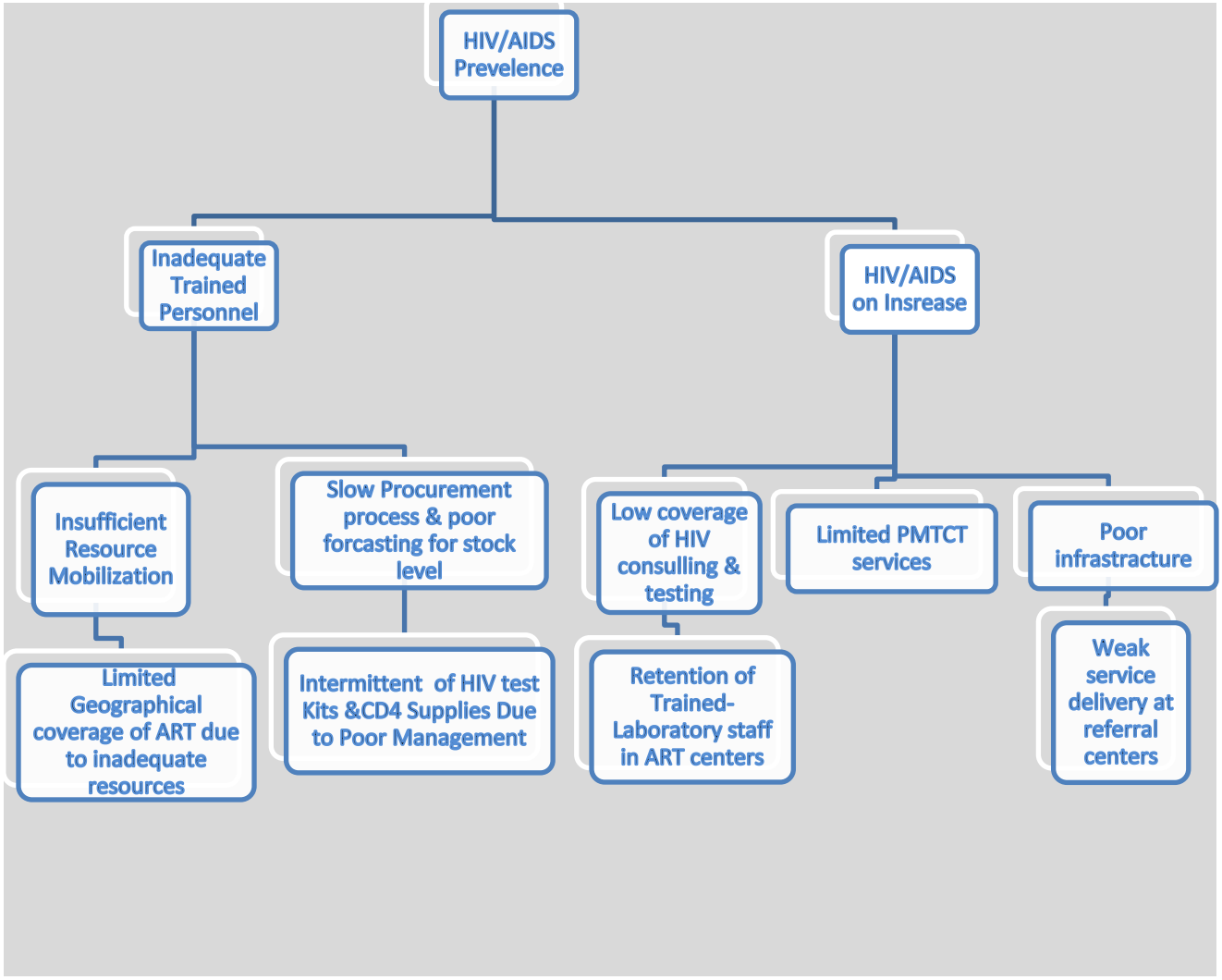


Table 5: Health Facilities Offering PMTCT Services

NAME OF HEALTH FACILITY	YES(√) OFFER PMTCT	NO(×) DO NOT OFFER PMTCT
Basse Major HC	√	
Diabugu	√	
Baja Kunda HC	√	
Gambissara	√	s
DembaKundaKuta 2		×
DembaKunda Koto 1		×
Numuyel Health Post		×
Bakadagi		×
Sotuma Sere		×
Garawol HC	√	
Koina HC		×
Fatoto HC		×
Yorobawol HC		×
FodayKunda HC	√	
Salikenni HC		×
Sara Kunda HC		×
NjabaKunda		×
Saaba HP	√	
Njawara Minor HC		×
Kerewan HC	√	
Kuntair		×
Kerr Cherno HC		×
NemaKuta HC		×
Albreda HC		×
EssauMjr. HC	√	
Sami KarantabaMnr. HC		×

Kaur	√	
Chamen		**×**
Kuntaur	√	
Janjabureh HC	√	
Brikamaba	√	
Kudang	√	
Njau HP		**×**
Dankunku		**×**
Bansang Hospital	√	
Ballangharr HP		**×**
Kiang Karantaba		**×**
Kwinella HC		**×**
KuliKunda		**×**
Pakaliba HP		**×**
Bureng HC		**×**
Jifferrong HP		**×**
Kaiaf HP		**×**
Soma Major HC	**×**	
NgayenSanjal		**×**
AFPRC General Hospital	√	
Pirang HC		**×**
Sibanor HC-(Private Owned)	**NA**	**NA**
REMIS HC (Private/German)		**×**
SulaymanJunkung General Hospital(SJGH)	√	
Serrekunda General Hospital	√	
Faji-KundaMjr. HC	√	
Bafrow Clinic-Churchill town (Private)		**×**
Ndogoro-Ba (Private)		**×**

Table 6: Health Facilities with stores that did not meet WHO standards

Name of Health Centers	Condition(Status)			Remark(s)
	Direct Sunlight	Poor Ventilation	Mixed with other drugs	
KuliKunda health post		√		Not enough space
Ballangharr health Post		√		Not enough space
Essau Health Center		√	√	
SarraKunda Health Center	√			High sun penetration
NjabaKunda		√		
Njawara Minor Health Center		√		Congested
Saaba Health Post		√		
Kuntair Health Center		√		
Kerr Cherno H/C		√		
NemaKunku Health Center		√		Very dark inside
Kerewan Health Center		√	√	
Albreda Health Center	√			
Salikenni health Center		√		
NgayenSanjall	√			
Jifferrong Health Post				
Kiang Karantaba	√	√		
Kaiaf Health Center	√			
Pakaliba Health Post		√		

Bureng	√			
Dongoroba Health Center(P)				
Kwinella Health Center	√	√		
Soma Major Health Center	Ok	Ok	√	
Diabugu Health Center				
Gambisara		√		
Sotuma Sere	√			
Baja Kunda Health Center		√		
Basse Major Health Center		√	√	Very tiny store with virtually no ventilation.
Pirang Health Center	√			
Bansang Hospital		√		
SulaymanJunkung Hospital	Ok	Ok	√	But Hiv drugs not separated from others, cartons of drugs place on the ground
Faji-Kunda Health Center				Hiv drugs not separated from others, cartons of drugs place on the ground
REMIS Health Center(P)	Ok	Ok		
SerreKunda Gen. Hospital	Ok	Ok	√	
Kuntaur Health Center	√			
Fatoto Health Center		√		

Garawol Health Center		√		Refrigerator not functioning
Numuyel Health Post	√	√		
DembaKundaKuta 2		√		Lack of refrigerator for cooling
DembaKundakoto 1		√		Lack of refrigerator for cooling
Bakadagi	√			
Sami KarantabaMnr. HC		√		
Kaur				
Chamen	√	√		
Janjabureh HC		√		
Brikamaba		√		
Kudang		√		
Njau HP	√			
Dankunku	√			
Koina HC		√		
Yorobawol HC		√		
FodayKunda HC		√		
Brikama Major Health Center				Denied access,
TOTAL	15	31	6	

Table 7:Staffing Requirement of Different Health Facilities (Categories)

Staffing Requirement of Different Health Facilities(Categories)												
Hospitals& Major Facilities-MF				Primary/Community Facility-VHS**P(1)**		Primary- Village Clinic**P(2)**			Secondary Minor HC-**S(A)**		**Secondary HC-S(B)**	
Name of Health Facility	Category or Type	No. of Medical Officer/ Doctors	Midwives /CHN	SRN/ RN	SEN	Lab.Tech/ Assistant	Pharmacist	CNA & Others	TOTALS	Ministry's Reqd. Norms	Difference	**Percent%**
Pirang HC	**S(A)**	NA	NA	2	1	-	-	2	5	**9**	4	
Faji-kunda	**MF**	1	13	2	5	5	-	18	44	**42**	+2	
Dankunku	**S(A)**	NA							8	**9**	1	
Brikamaba	**S(B)**								12	**13**	1	
Kudang	**S(B)**								12	**13**	1	
Janjabureh	**S(A)**								6	**9**	3	
Bansang	**H**	9	11	17	19	6	5	-	67	**75**	8	
Njau	**P(2)**								3	**4**	1	
Chamen	**S(B)**								5	**13**	8	
Kaur	**S(B)**								10	**13**	3	
Sami-karantaba	**S(A)**								8	**9**	1	
Gambisara	**S(A)**	5	-	1	-	-	-	-	6	**9**	3	
Demba-Kundakuta	**P(1)**								3	**2**	+1	
Demba-Kundakoto	**P(2)**								3	**4**	1	
Numuyel	**P(1)**								1	**2**	1	

Bakadagi	**P(1)**								1	**2**	1	
Sotuma	**P(1)**	NA	1	-	-	-	-	-	1	**2**	1	
Garawol	**S(A)**								5	**9**	4	
Koina	**S(A)**								5	**9**	4	
Fatoto	**S(B)**								10	**13**	3	
Essau	**MF**	3	6	10	8	3	2	14	46	**42**	+4	
NgayenSanjal	**S(A)**	NA	3	1	2	NA	NA	3	9	**9**	-	
Kerr Cherno	**S(B)**	NA	5	1	1	1	NA	3	11	**13**	2	
Kuntair	**S(B)**	NA	5	2	1	1	NA	5	14	**13**	+1	
Saaba	**P(1)**	NA	1	-	-	-	-	-	1	**2**	1	
Njawara HP	**P(1)**	NA	1	-	-	-	-	-	1	**2**	1	
NjabaKunda	**S(A)**	NA	3	1	-	-	-	3	7	**9**	2	
Sara Kunda	**P(1)**	NA	1	-	-	-	-	1	2	**2**	-	
Kuli-Kunda	**P(1)**	NA	1	-	-	-	-	-	1	**2**	1	
REMIS H/C	**P(2)**	NA	2	-	1	-	-	-	3	**4**	1	
Kwinella	**S(A)**	NA	4	-	1	1	-	2	8	**9**	1	
Dongoroba HC(P)	**S(B)**	NA	3	1	1	1	-	6	12	**13**	1	
Kaiaf HC	**S(A)**	NA	3	-	1	-	-	1	5	**9**	4	
Pakaliba	**P(2)**	NA	3	-	-	1	-	-	4	**4**	-	
Bureng	**S(B)**	NA	3	1	2	-	-	2	8	**13**	5	
Kiang-Karantaba	**S(A)**	NA	4	-	-	-	-	1	5	**9**	4	
Jifferrong	**P(2)**	NA	3	-	-	-	-	-	3	4	1	
Salikenni	**S(A)**	NA	1	1	-	-	-	4	6	9	3	
Kerewan	**S(B)**	NA	4	3	1	2	-	3	13	13	-	
KuntaurMjr	**MF**	1	3	6	1	2	-	3	16	42	26	
Bajakunda	**S(A)**	NA	3	1	-	-	-	2	6	9	3	

Serrekunda Gen. Hosp.	**H**	28	10	43	8	21	12	70	192	75	+117	
BasseMjr.	**MF**	1	18	3	13	4	2	2	43	42	+1	
Soma Mjr	**MF**	3	14	8	4	4	2	15	50	42	+8	
Sulayman Jun Hospital	**H**	NG	20	11	6	**NG**	**NG**	-	47	75	28	
NemaKunku	**P(2)**	NA							3	4	1	
AFPRC Gen	**H-Denied access.**											
Dongoroba	**S(B)**											
Brikama	**MF-Denied access**											
Total												
Secondary/Minor HC 'A' & 'B'									196	256	60	
Major Health Facilities									199	294	95	
General Hospitals									306	225	+81	

- **S(A)-Secondary Health Facility "A" category-(**14)
- **S(B)-Secondary Health Facility "B" category-**10
- **MF- Major Health facility-**5
- **H- General Hospitals-**3
- **P(1)- Primary Community Health Service clinic(VHS)-**8
- **P(2)-Primary Village clinics-**6