

2026

THE GAMBIA SYNTHESIS REPORT

Analysis of Reproductive, Maternal, Newborn, Child and
Adolescent Health Indicators for 2020-2025



Countdown to 2030 in partnership with The Gambia's Ministry of Health, Global Financing Facility,
WHO, WAHO & UNICEF

#CAM2026



Team Members

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KEY FINDINGS

1. Health Facility Data Quality Assessment: Numerators and Denominators

NUMERATORS: Routinely reported health facility data are an important data source for health indicators. The data are reported by health facilities on events such as immunizations given, or live births attended. As with any data, quality is an issue. Data are assessed for completeness of reporting by health facilities, extreme outliers and internal consistency. Appropriate adjustments are made to the data before using statistics.

Summary of reported health facility data quality, DHIS2, 2020-2025

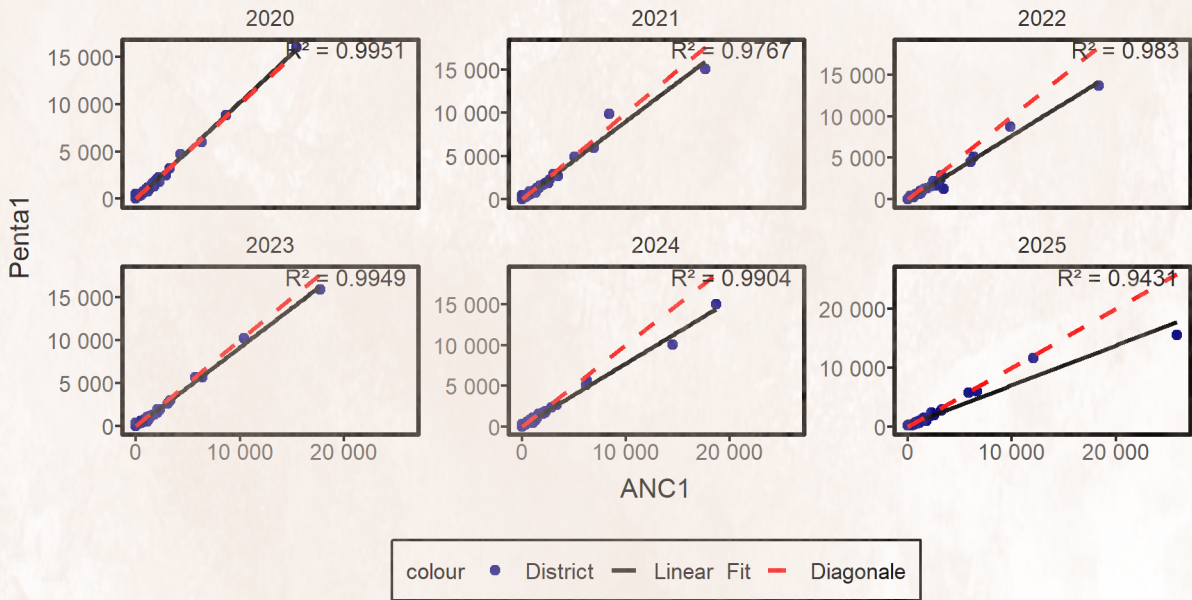
Data Quality Metrics		2020	2021	2022	2023	2024	2025
1. Completeness of monthly facility reporting (mean of ANC, delivery, immunization)							
1a	% of expected monthly facility reports (national)	85	78	79	86	91	98
1b	% of districts with completeness of facility reporting >= 90	59	50	50	68	70	95
1c	% of districts with no missing values for the 4 forms	96	99	95	98	99	100
2. Extreme outliers (mean of ANC, delivery, immunization)							
2a	% of monthly values that are not extreme outliers (national)	100	100	100	97	96	96
2b	% of districts with no extreme outliers in the year	92	90	87	80	79	77
3. Consistency of annual reporting							
3a	Ratio anc1/penta1	1.03	1.13	1.33	1.13	1.24	1.25
3b	Ratio penta1/penta3	1.09	1.01	1.07	1.00	1.02	1.03
3c	% district with anc1/penta1 in expected ranged	70	86	79	82	72	71
3d	% district with penta1/penta3 in expected ranged	70	35	79	32	48	67
4	Annual data quality score	82	77	81	78	79	86

Interpretations

- Data quality increased from moderate 77 in 2021 to strong 86 in 2025, mainly due to better reporting completeness.
- Drop in 2021 followed by steady recovery, with improvements closely linked to increased completeness of reporting.
- Despite high completeness, issues remain with outliers and data consistency, especially between indicators.
- Main inconsistency issue of ANC1 and Penta1 because ration increase from 1.03 to 1.25.
- ANC1/Penta1 data are not well aligned, likely due to reporting errors, over/under-reporting, or population differences at district level.

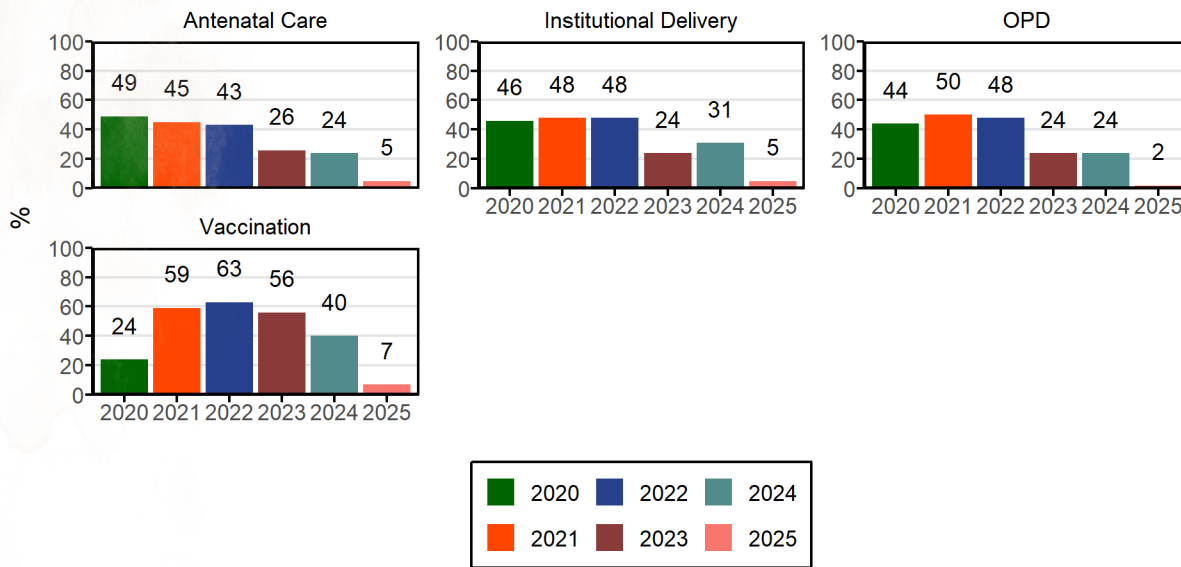
Numerator: facility data quality - example 1 Explain the observation on data quality (one bullet)

Comparison of numbers of ANC1 and Penta1 by year



There is a strong correlation between ANC1 and Penta1 each year, but the consistent deviation below the diagonal indicates systematic mismatch, suggesting higher reported ANC1 than Penta1.

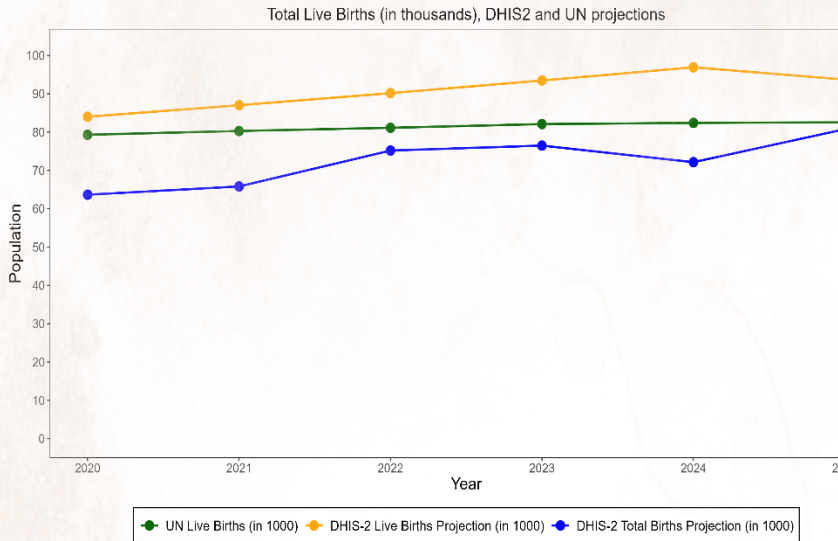
Percentage of districts with low reporting rate (< 90 %) by service and by year



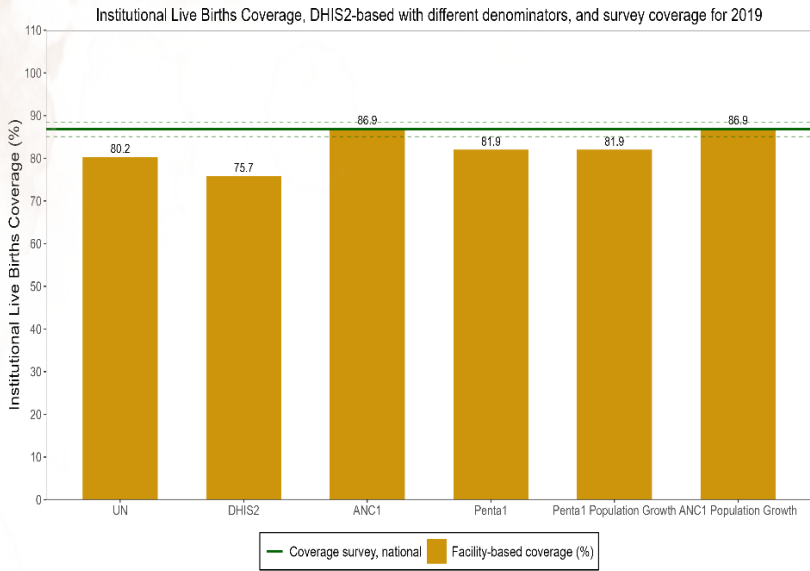
Low reporting rate (< 90 %)

DENOMINATORS: Service coverage is defined as the population who received the service (numerator) divided by the population who needed the services: (the denominator). We tested four options for denominator measures using institutional live births and Pent-3 immunization coverage (Figures 2c and 2d). The quality of the population projections in DHIS2 is assessed through consistency over time and comparison with the UN projections. Two denominators are also derived using near universal service such as ANC-1 and Penta-1. The most plausible is identified for use to generate other statistics.

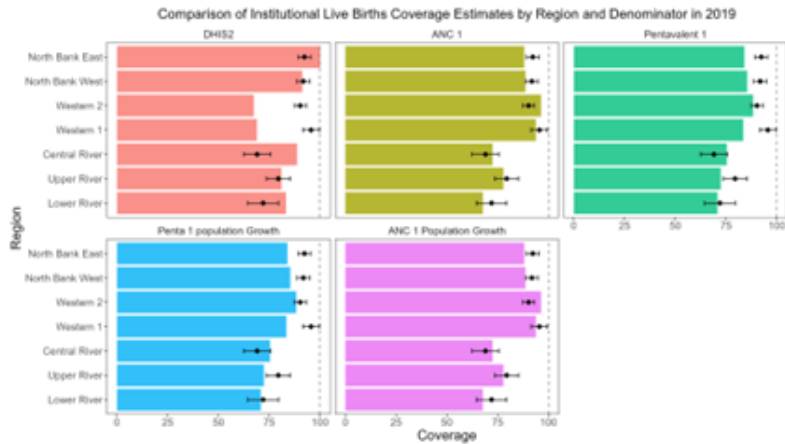
Total Livebirths



National Institutional Live Births



Subnational Institutional Live births



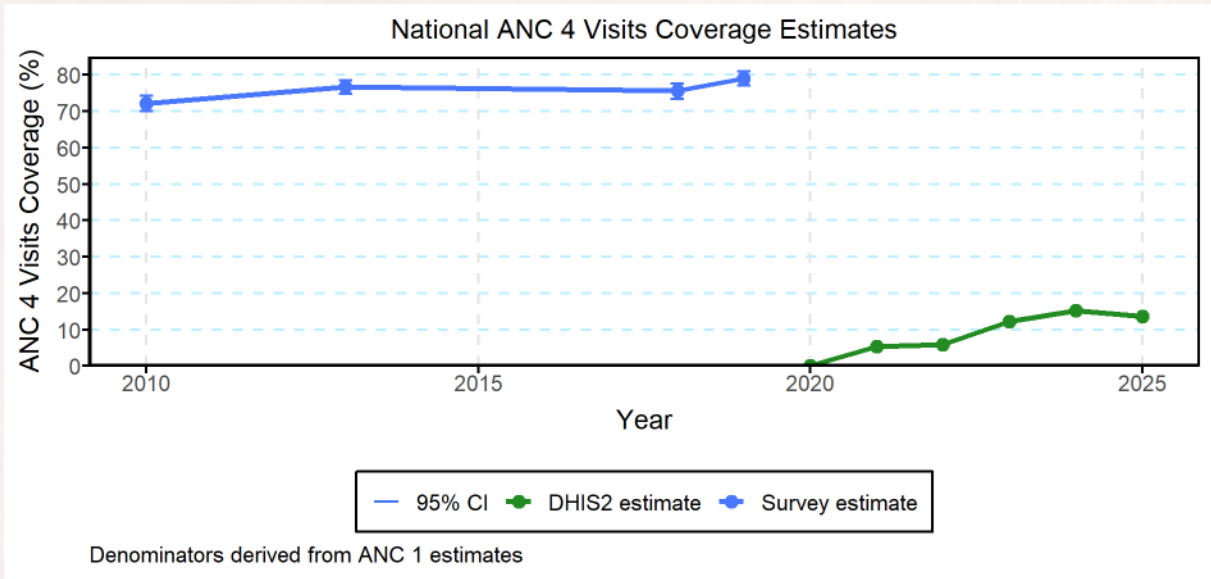
Interpretations

- DHIS2 projections are consistently higher than UN estimates, but both show a similar increasing trend over time, with DHIS2 total births fluctuating more.
- Coverage estimates vary by denominator, with ANC1 about 86.9% aligning closest to survey estimates, while DHIS2-based estimates are lower and underestimate coverage.
- Coverage varies across regions, and ANC1 and Penta1-based denominators produce estimates closer to expected levels, while DHIS2 denominators tend to show lower and more variable coverage

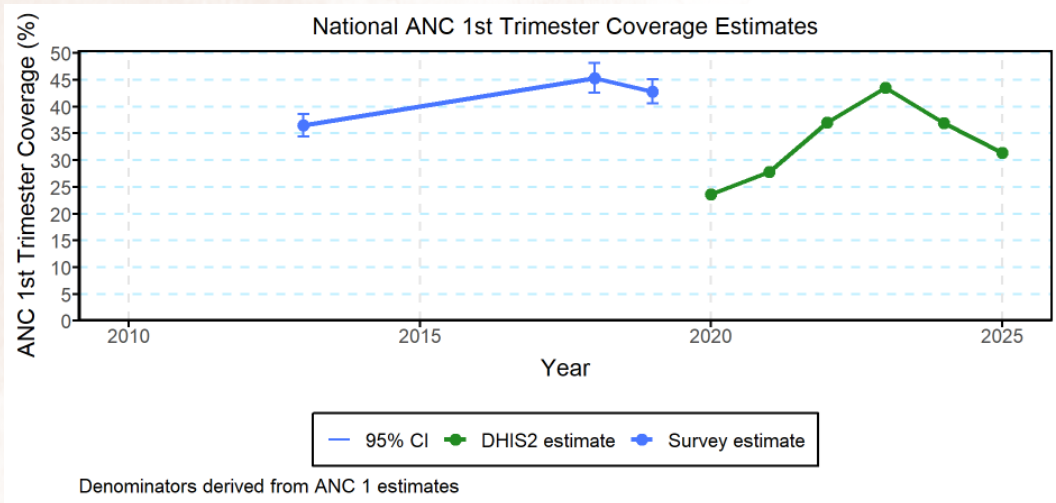
2. National Coverage Trends: Facility Data and Surveys

Antenatal care: ANC4, ANC early visit, first trimester of pregnancy

ANC 4



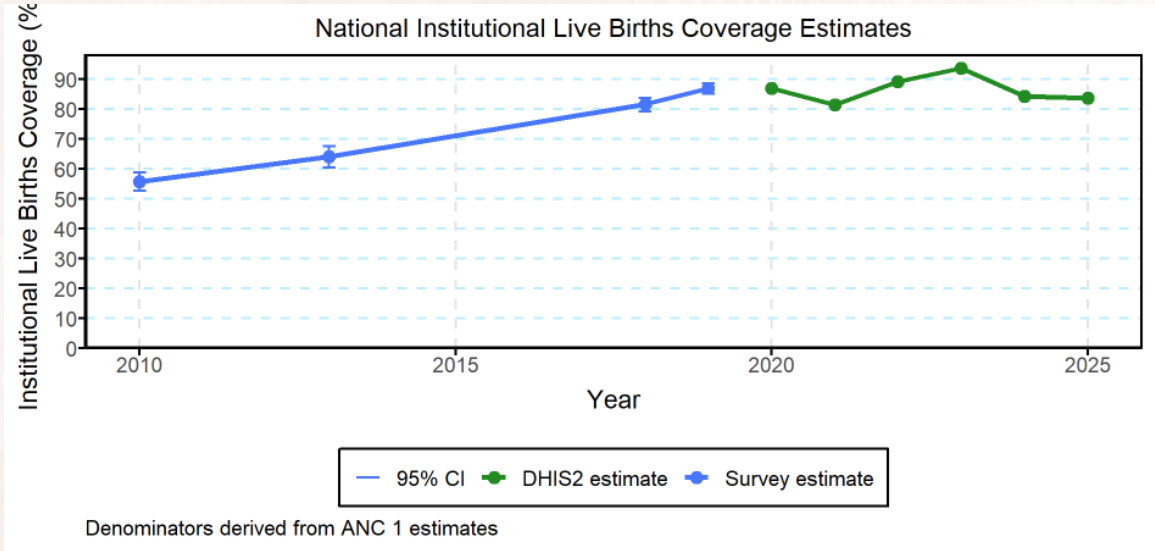
ANC early visit



Interpretations

- DHIS2 estimates show a gradual increase from about 0.13% (2020) to about 15% (2024) followed by a slight decline 14%(2025), which is a reasonable trend, but the overall levels are much lower than survey estimates from 72% to 79%.
- Facility (DHIS2) estimates are consistently lower than survey estimates.

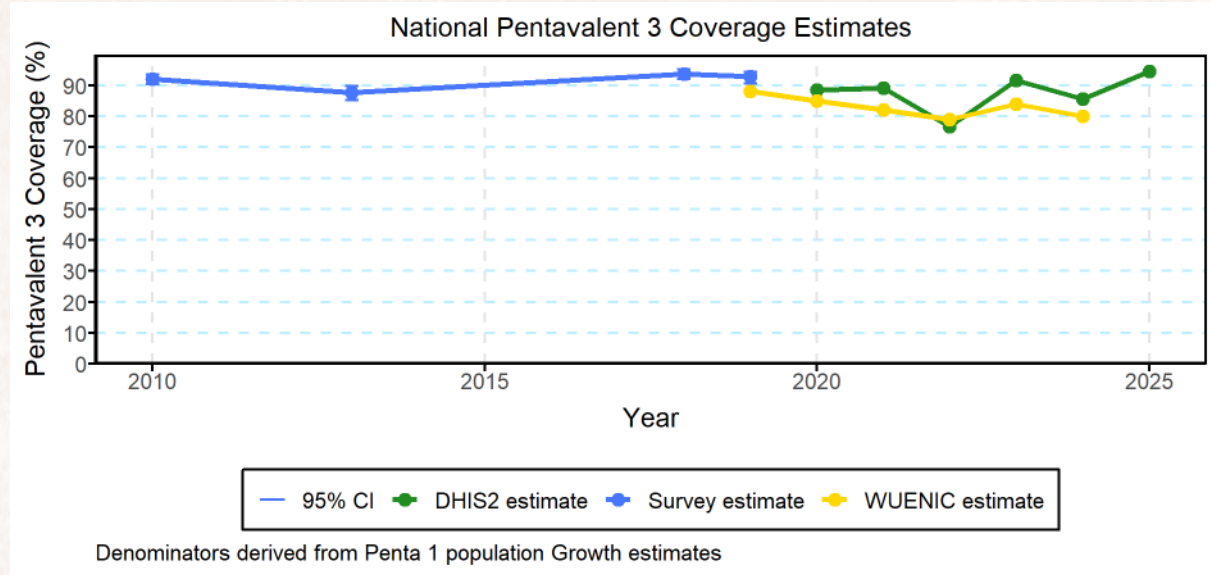
Institutional delivery



Interpretations

- The survey estimates ranged from approximately 56% to 87%, while the DHIS2 data showed an estimate of about 87% in 2020. The DHIS2 estimate subsequently declined to 81% in 2021, followed by a steady increase to 89% in 2022 and a peak of 94% in 2023. However, this improvement was not sustained, as the estimate declined to 84% in both 2024 and 2025.
- Overall, the data indicate considerable year-to-year variation, with an initial decline, followed by substantial improvement between 2021 and 2023, and a subsequent reduction in 2024–2025. The differences between the survey and DHIS2 estimates also suggest potential variation in measurement, reporting, or data sources, which should be considered when interpreting the observed trends.

Immunization: Penta 3, Measles 1

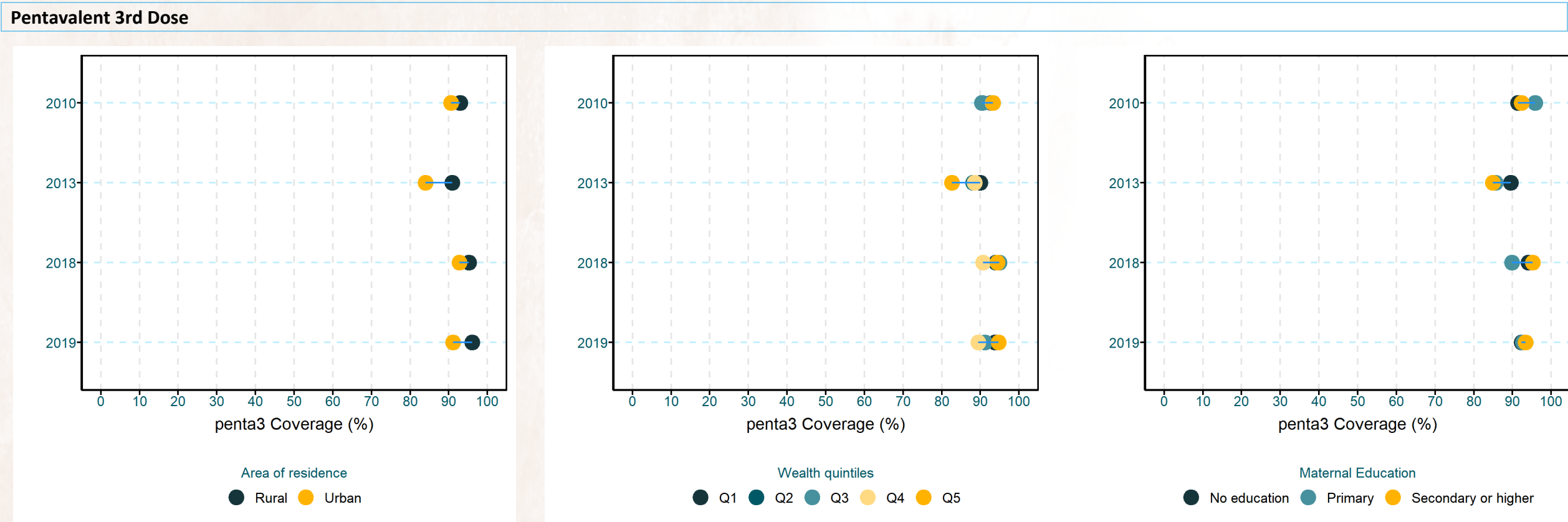
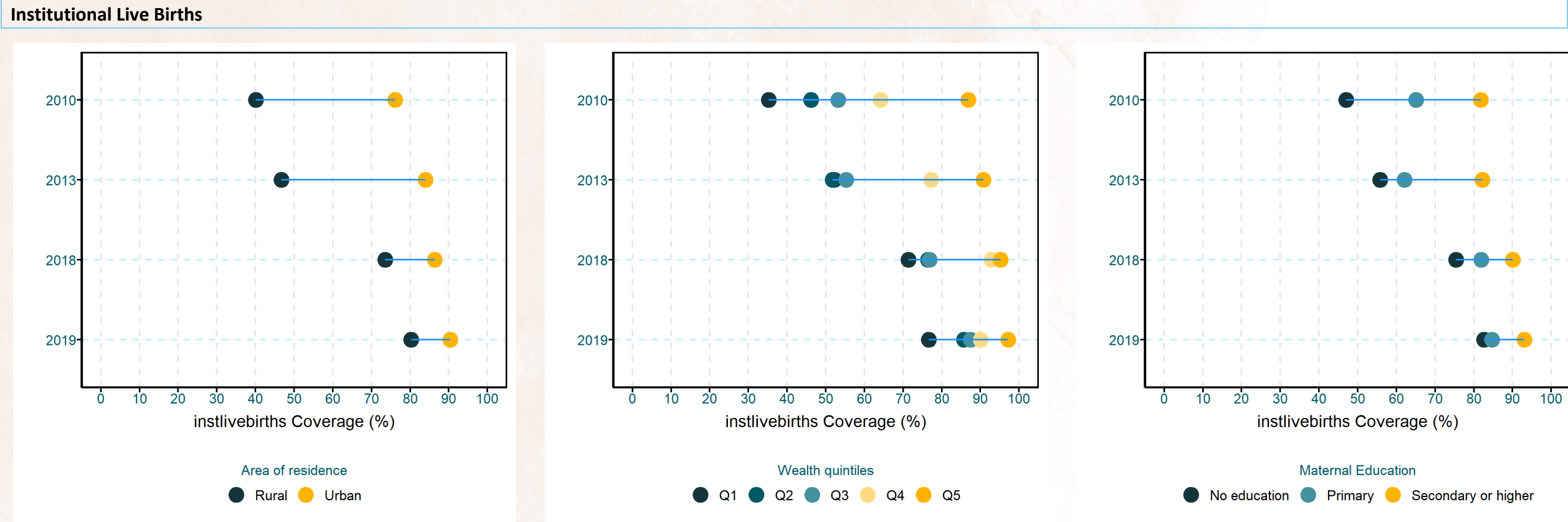


Interpretations

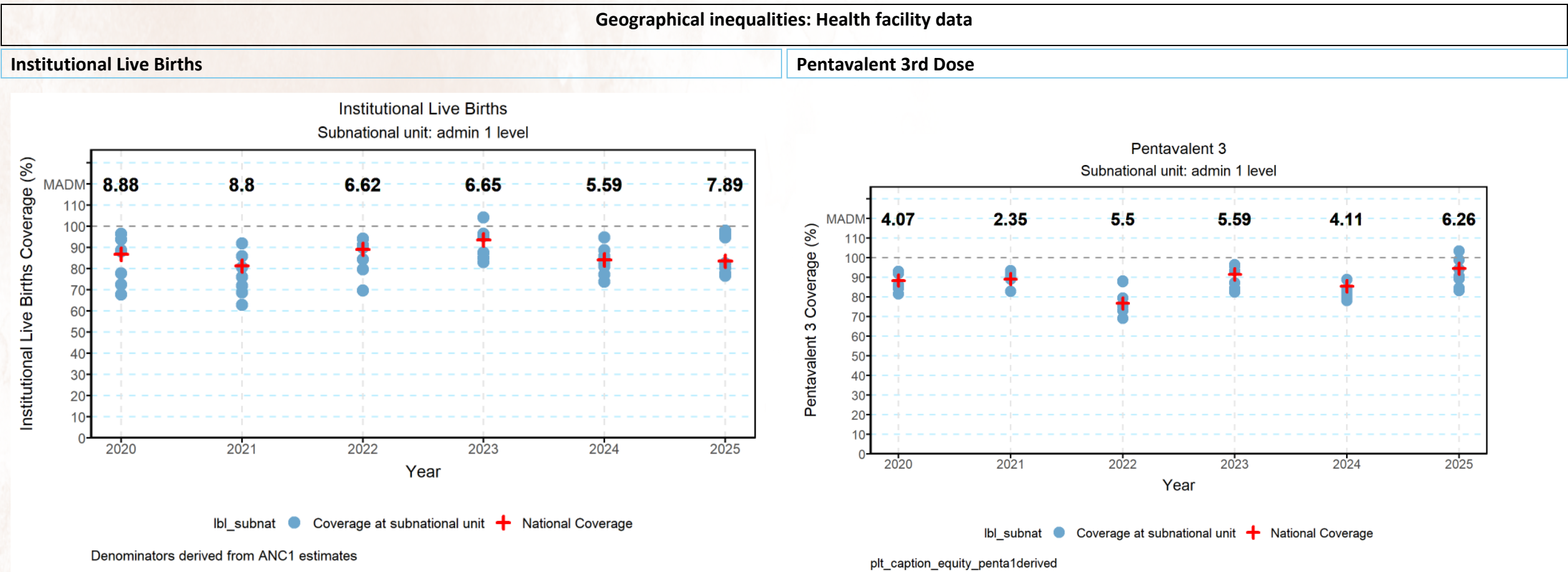
- Survey estimates remain high about 90%, while DHIS2 shows fluctuations and a dip around 2022, indicating instability.
- WUENIC estimates are consistently lower than survey but closer than DHIS2 in some yearsDHIS2
- . Coverage is generally near or below the 90% target, with fluctuations indicating mixed progress rather than a steady positive trend.
- Survey estimates remain relatively high about 95%, but DHIS2 shows large fluctuations, suggesting data quality or denominator issues.
- DHIS2 and WUENIC estimates do not consistently align with survey data, indicating inconsistency.
- Coverage is inconsistent relative to targets about 90%, with some years above and others well below, indicating no clear positive trend and possible reliability concerns.

3. Equity

Equity by wealth, education, rural-urban residence (from surveys)



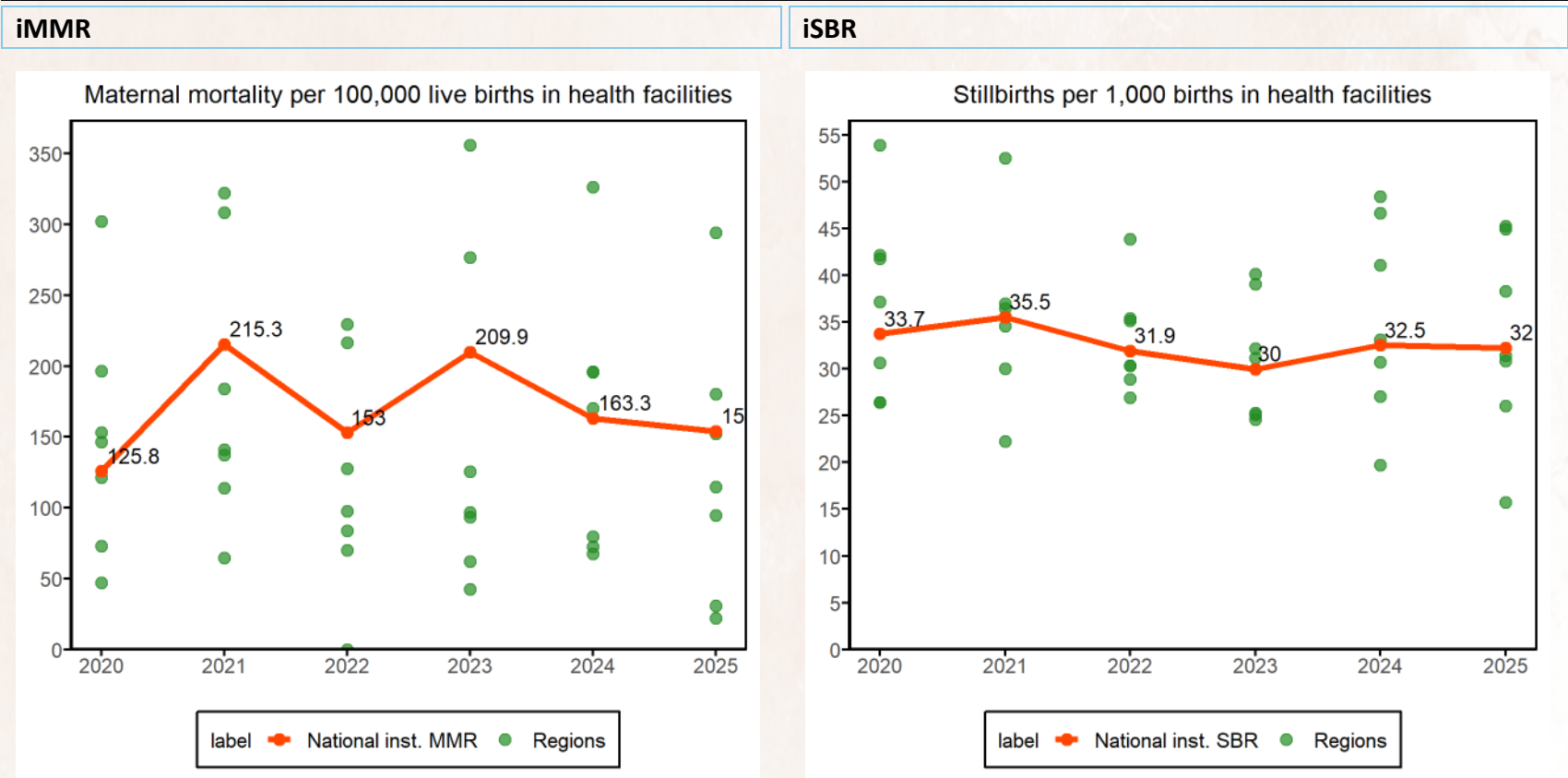
- Interpretations
- Coverage is consistently lowest among the poorest (Q1) and those with no education, and highest among the wealthiest (Q5) and more educated groups,
 - There is a linear gradient across both wealth quintiles and education levels (stepwise increase from poorest/least educated to richest/most educated).
 - While coverage is generally high across all groups, urban, wealthier (Q4–Q5), and more educated groups consistently maintain higher coverage.
 - The gaps between subgroups reduce somewhat over time especially by 2019, but differences remain, indicating partial improvement in equity without full convergence.
 - Target low-coverage groups (poorest and least educated) with outreach services, strengthen community-based maternal services in underserved areas, reduce financial and access barriers (transport, costs) and improve health education and awareness among disadvantaged populations



- Interpretations
- Institutional live births, the national coverage moved from 87% (2020) down to 81% (2021), then raise to a peak of 93% (2023), dropped to 84% (2024), and at 84% (2025). So overall an improvement from 2020 to 2025.
 - Penta3 the national coverage tracks a similar non-linear path: 88% (2020), 89% (2021) a notable drop to 77% (2022) raised to 92% (2023) dropped to 85% (2024) highest point of the coverage at 94% (2025). Penta3 ends the period stronger than it started, with 2022 standing out as a clear low point across the years.
 - Institutional births MADM This is a clear declining trend from 2020–2024 (inequality across regions shrinking, regions pulling in toward the national average), but then a sharp reversal in 2025 MADM jumps back up to nearly 2020 levels even though national coverage held steady.
 - Penta3 MADM: Here the pattern is almost the opposite shape: inequality was lowest in 2021 (tightest clustering, MADM 2.35), then rose through 2022–2023, eased slightly in 2024, and hit its highest point of the whole series in 2025 (MADM 6.26) consistent with the 2025 plot showing one region above the 100% .

4. Institutional Mortality

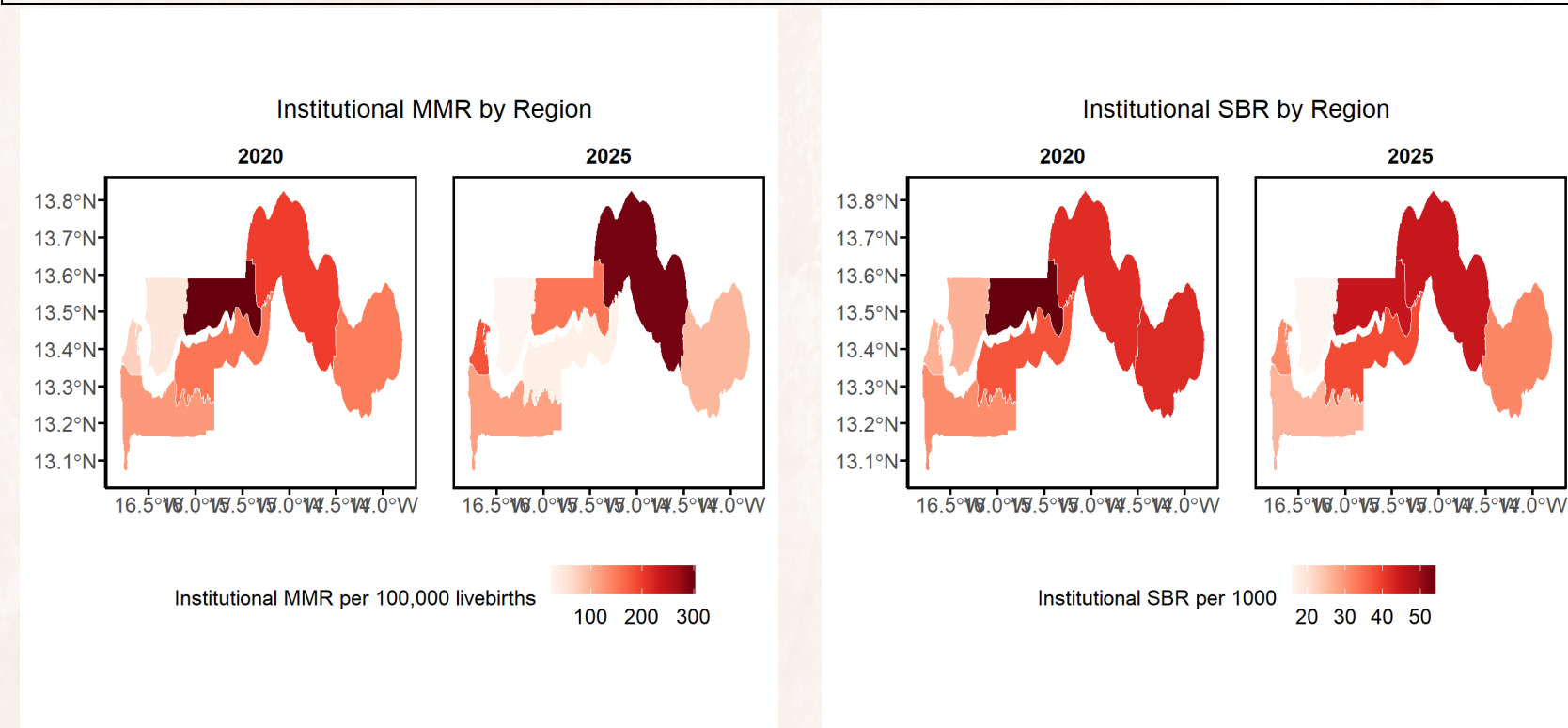
Institutional Mortality trends (iMMR, iSBR)



Interpretations

- The MMR shows fluctuating levels with no consistent downward trend, indicating instability over time.
- This pattern is not fully aligned with UN expectations.
- The SBR remains relatively stable over time with minor fluctuations, showing little overall change.
- This trend is generally plausible and closer to UN expectations, though it indicates limited progress in reduction.

Institutional Mortality by admin1 units

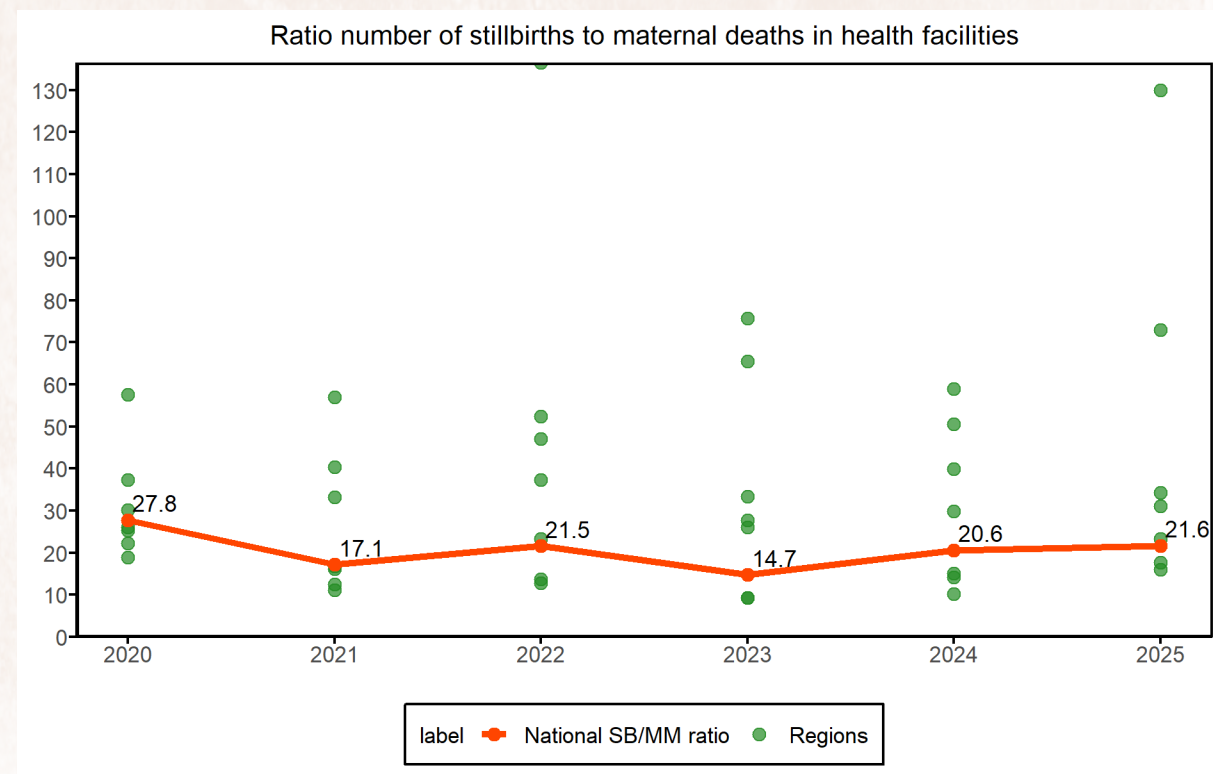


Interpretations

- The darkest shaded regions (≥ 300 per 100,000 live births in 2025) are concentrated in the central river and north bank regions in the map, indicating the top 3 highest-burden regions.
- The lightest shaded regions about 100 to 150 iMMR and about 20 to 30 SBR are located toward the western/southwestern parts, indicating the lowest-performing mortality values.
- Interpretation: This pattern is partly expected if higher mortality occurs in less-developed or hard-to-reach regions; however, the presence of very low mortality in some likely less-developed areas may suggest underreporting of deaths.

Data quality metrics

Ratio stillbirth to maternal deaths in the health facility data at national level



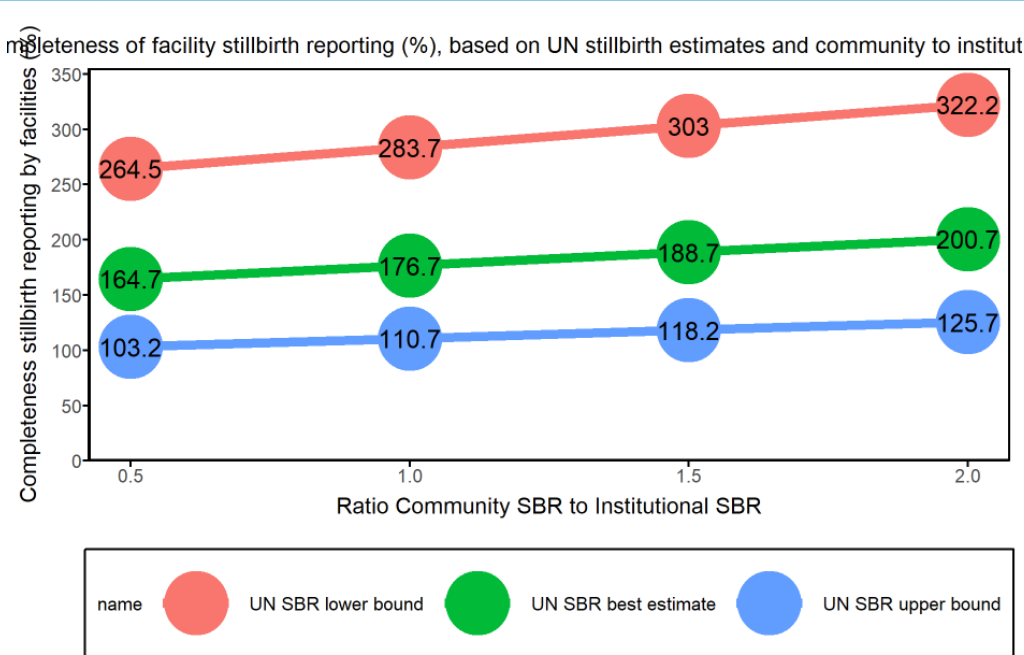
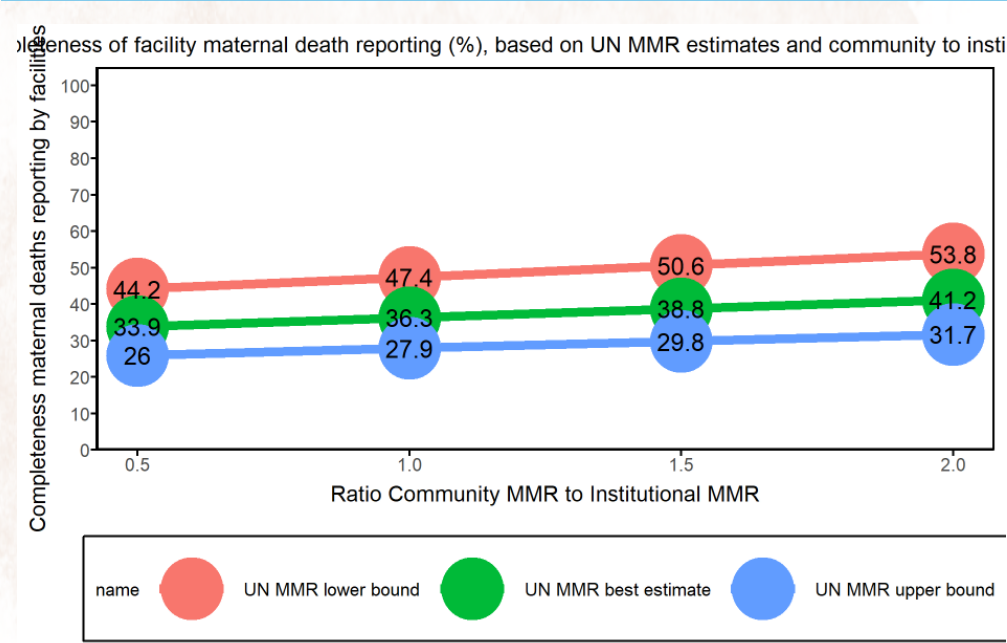
Interpretations

The national stillbirth to maternal death ratio is about 14.7 to 27.8, is mostly within the plausible range of 5–25, suggesting broadly acceptable reporting, though years above 25 (e.g., 2020) may indicate some underreporting of maternal deaths.

The top-performing regions show very high ratios (often above 50 or even >100), likely reflecting underreporting of maternal deaths, while the bottom-performing regions with ratios near or below 15 suggest either better balance in reporting or possible underreporting of stillbirths.

Since most values fall within or moderately above the expected range, reporting appears generally reasonable but with signs that maternal deaths may be more underreported than stillbirths in certain regions and years.

Estimated completeness of facility maternal death and stillbirth reporting

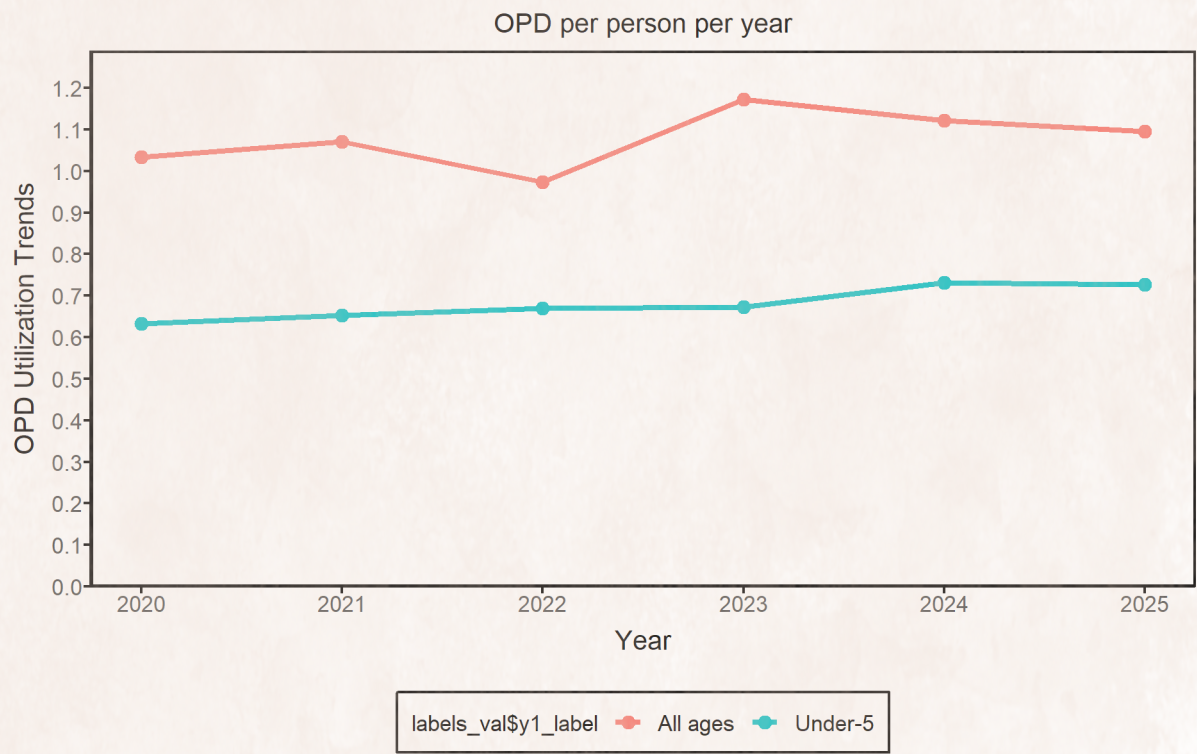


Interpretations

- Institutional maternal death reporting appears **incomplete 26% to 54%**, suggesting substantial underreporting of maternal deaths.
- Stillbirth reporting is **over 100%** indicating overestimation relative to population benchmarks
- Inconsistencies between reported facility data and assumed community-to-institutional ratios.

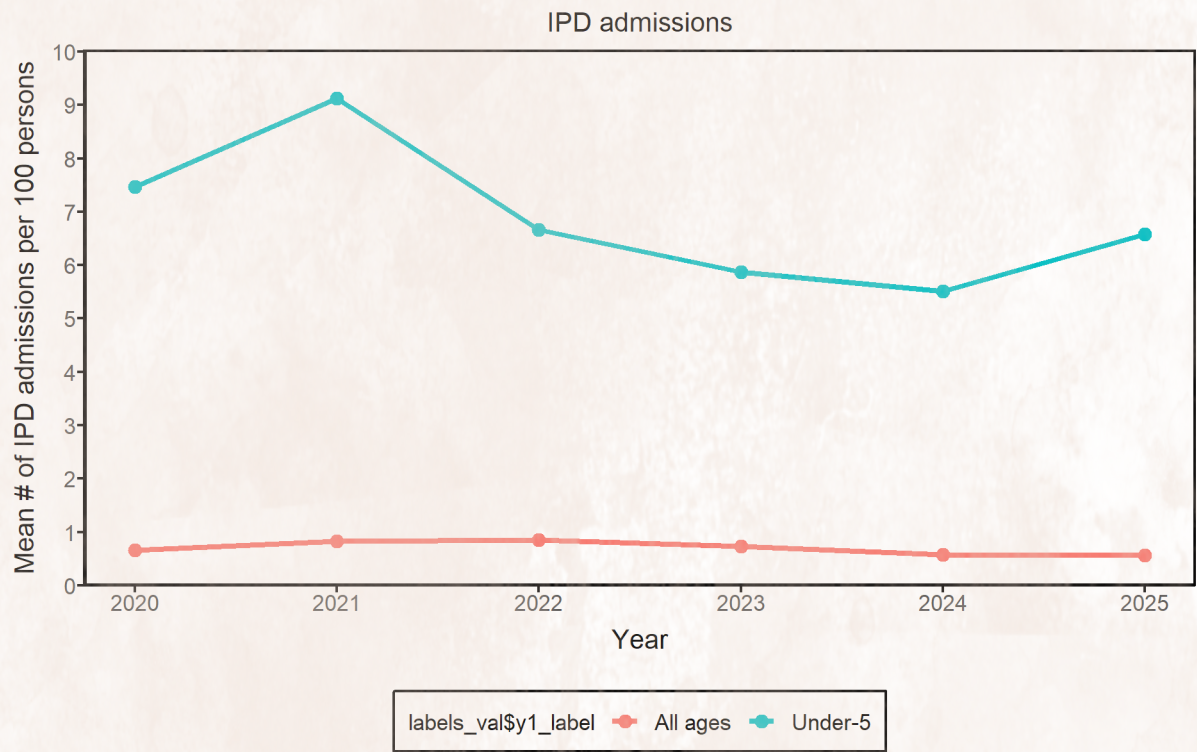
5. Curative Health Service Utilization for Sick Children

Outpatient and inpatient service utilization

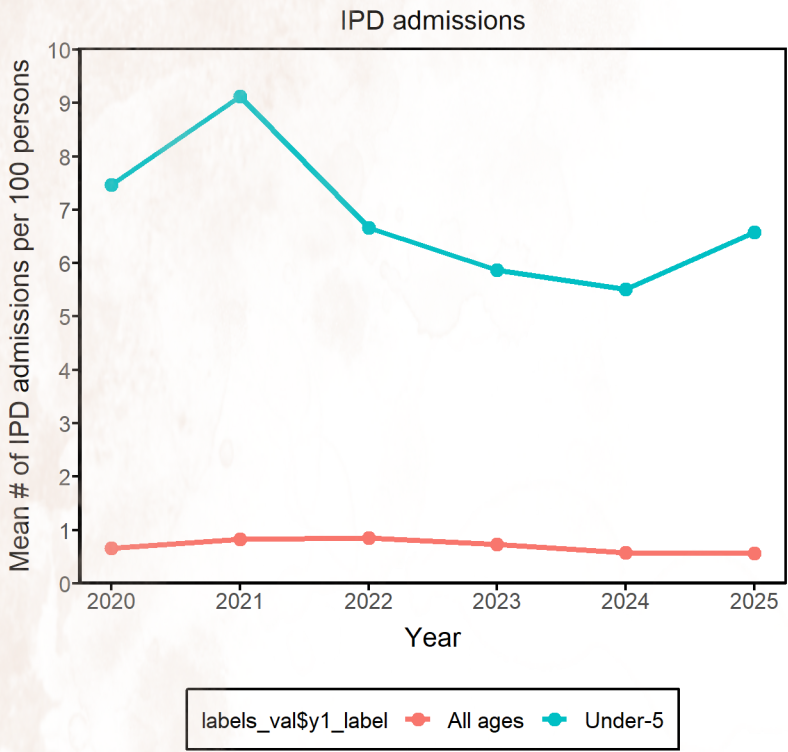
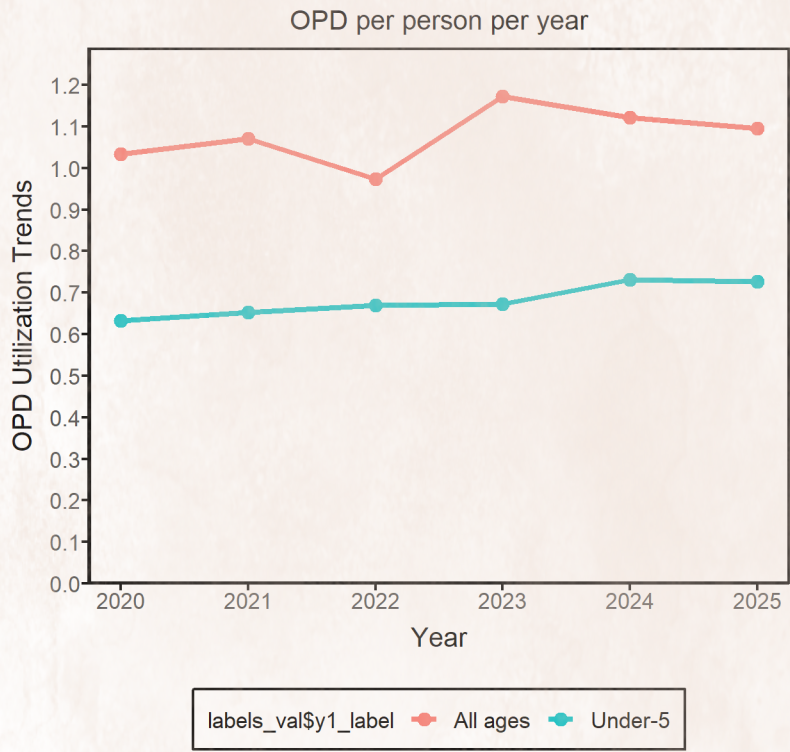


Interpretations

- In 2024, OPD visits per under-five child are about 0.73 per year, showing a gradual increase from about 0.63 (2020) but remaining below 1 visit per year, suggesting relatively low access to outpatient care.
- The OPD and IPD trends show moderate year-to-year consistency with no abrupt anomalies.
- OPD admissions for under-five children range roughly from about 5.5 to 9.1 per 100 children (2019–2024), showing a declining trend after 2021 but remaining well above the 2 per 100 thresholds.



Regional/provincial service utilization



Interpretations

- The Possible data issues include denominator inaccuracies (population estimates)
- Underreporting of visits/admissions in some areas, overreporting due to double counting or repeated visits.
- Inconsistencies in reporting completeness across facilities or years, which can distort OPD and IPD rates

6. Health System Progress and Performance

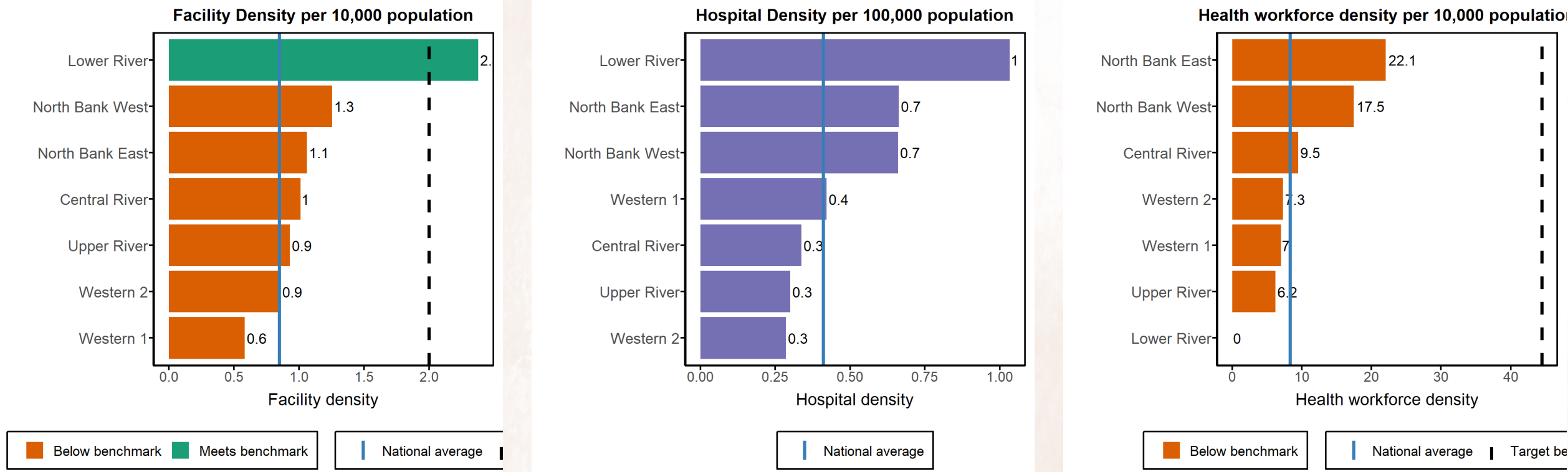
Health system inputs

2024		
Indicator	Value	Unit
Health infrastructure		
Health facility density	0.9	per 10,000
Share of facilities that are hospitals	4.8	%
Hospital density	0.4	per 100,000
Inpatient bed density	12.5	per 10,000
Health workforce		
Health workforce density	8.3	per 10,000
Skills mix ratio nurse-midwives per physician	17.2	
Role of private sector		
Share of Private facilities	14.1	%
Share of NGO facilities	8.5	%

Interpretations

- The data likely underestimate total system capacity, as private and NGO facilities (22.6% combined) are included but often incompletely captured in national reporting systems, meaning full private-sector contribution may not be fully reflected.
- Bed capacity is at 12.5 per 10,000, which is below the benchmark of 25 per 10,000.
- Health workforce is 8.3 per 10,000 which is below the benchmark of 23/100000and 45.5 per 100,000 for UHC.
- All key inputs (facilities, beds, workforce) are substantially below recommended benchmarks, indicating a low-capacity health system with significant constraints

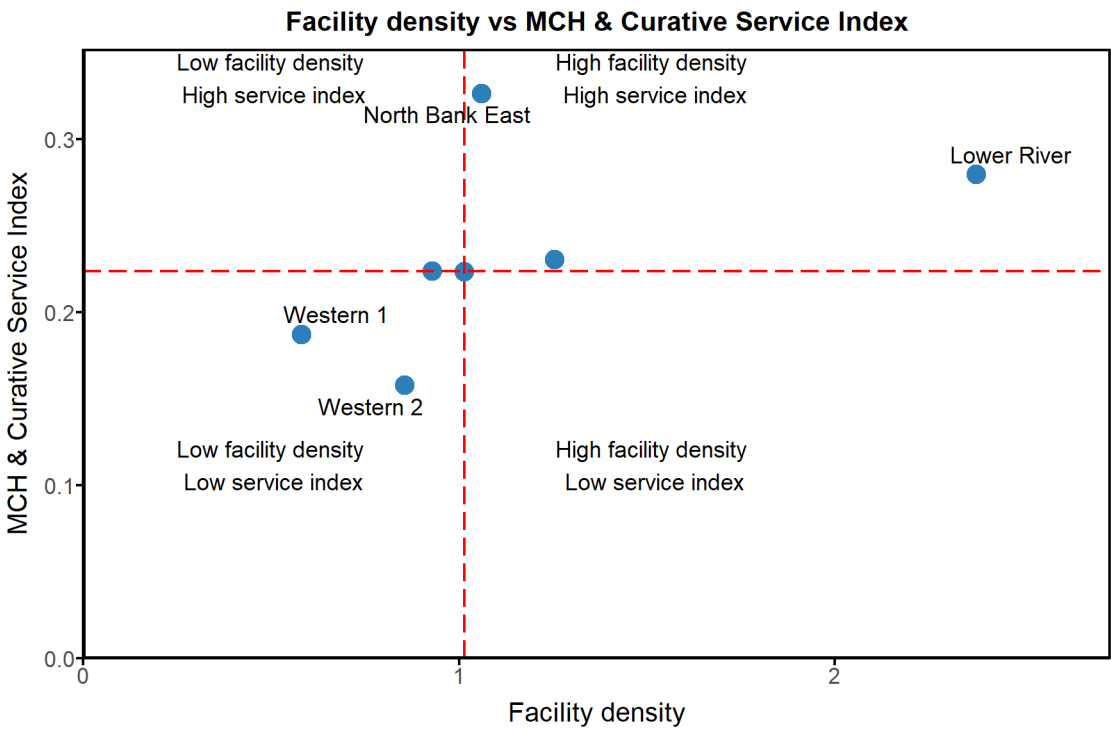
Health system inputs by region/province



Interpretations

- Facility density varies widely across admin1 units, ranging from 0.6 in Western 1 (lowest) to about 2.3 in Lower River (highest), with only Lower River meeting the benchmark, 2 per 10,000 while all other regions remain below it.
- Hospital density also shows disparities, with Lower River highest about 1.0 per 100,000) and Western 2, Upper River, and Central River lowest are 0.3), indicating uneven access to hospital-level care.
- Workforce density varies dramatically, from 0 in Lower River (lowest) to 22.1 in North Bank East (highest), with most regions far below the benchmark 44.5, highlighting major workforce inequities.
- The pattern is **not fully consistent across indicators**, as **Lower River leads in infrastructure but has zero reported workforce**, while **North Bank East performs best in workforce but not in facilities**, suggesting both real inequities and potential reporting gaps.

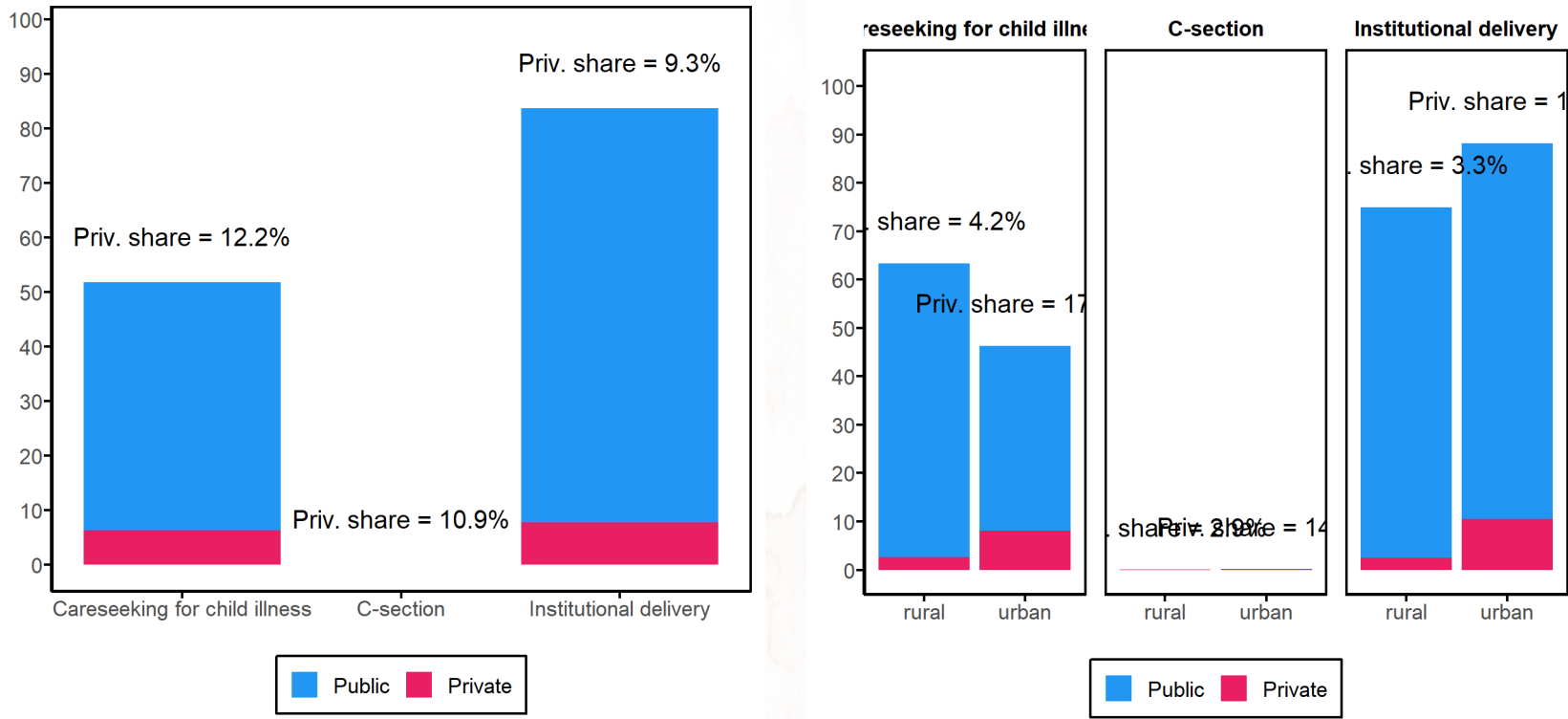
Health system outputs by inputs at the subnational level



Interpretations

- The pattern has good face validity, as regions with higher facility density tend to show better service performance (e.g., Lower River), while regions with lower facility density generally have lower service indices (e.g., Western 1 and Western 2).
- High facility density about 2.3 and relatively high service index about 0.28, indicating strong performance and expected alignment between inputs and outputs.
- North Bank East: is a moderate facility density about 1.) but high service index about 0.32, suggesting efficient use of available resources.
- Western 2 and western 1 are Low facility density and low service index about 0.15, reflecting both limited access and weak service delivery.

Private sector and RMNCAH services



Interpretations

- Care seeking for child illness about 12.2% has the highest private share, followed by C-section about 10.9%.
- Institutional delivery about 9.3% has the lowest private share
- There is a clear urban–rural gap, with higher private sector use in urban areas across all indicators
- Rural areas rely much more heavily on public services, reflecting better availability and access to private providers in urban settings.

Recommendations are as follows:

- Conduct supportive supervision and feedback loops to sustain high completeness.
- Expand use of electronic reporting systems to reduce manual errors.
- Build capacity in data validation and anomaly detection.
- Introduce dashboards that flag extreme values in real time for correction.
- Encourage district data teams to cross-check reports before submission.
- Conduct district-level data audits focusing on 2025 to identify sources of inconsistency.
- Strengthen routine data validation checks between ANC and immunization registers.
- Provide refresher training for data entry clerks on indicator definitions and reporting procedures.
- Implement automated cross-indicator validation rules in DHIS2.
- Introduce real-time dashboards showing correlation trends by district to prompt early corrective action.
- Invest in maternal health facilities and skilled birth attendants in rural areas.
- Improve transportation and referral systems to ensure timely access to institutional delivery services.
- Collaborate with community health workers to address cultural and logistical barriers that prevent rural women from delivering in health facilities.
- Maintain current immunization strategies, especially outreach and mobile clinics that reach rural populations.
- Continue monitoring for potential declines to ensure coverage remains above 90% nationally.
- Identify districts or communities with coverage below the national average and implement micro-planning to address logistical barriers.
- Strengthen community engagement and follow-up systems to ensure all children receive the full Penta3 series.
- Identify subnational units with coverage below the national average and provide focused interventions—such as improved facility access, community mobilization, and data verification.
- Conduct annual data quality reviews to understand causes of variability (e.g., reporting gaps, population estimates).
- Integrate equity indicators into routine monitoring to ensure all regions maintain consistent institutional delivery coverage.
- Conduct facility-level audits to identify causes of stillbirths and ensure accurate reporting.
- Implement focused interventions in regions with persistently high stillbirth rates — such as enhanced supervision, emergency obstetric training, and equipment upgrades.
- Use real-time dashboards to monitor regional performance and trigger rapid response support.
- Improve data linkage between community and facility reporting to capture all maternal deaths comprehensively.
- Train health workers and community health workers on timely and accurate death notification and cause-of-death classification.
- Introduce routine data audits and feedback mechanisms at district and facility levels to verify completeness.
- Enhance preventive and community health programs to maintain and further increase OPD utilization, especially for under-5s.
- Strengthen outreach and early care-seeking behavior to help sustain upward trends and reduce avoidable hospital admissions.
- Strengthen immunization, nutrition, and community case management to reduce severe illnesses requiring inpatient care among under-5s.
- Prioritize construction or upgrading of health posts and clinics in Western 1, Upper River, and Central River, where facility density is lowest.
- Use population-based planning to ensure equitable distribution of facilities, focusing on underserved and high-growth areas
- Improve transport and referral systems from low-density regions to nearby hospitals to ensure timely access to specialized care.
- Establish or expand district hospitals in Central River and Upper River to reduce regional disparities and ease pressure on Lower River facilities.
- Introduce incentives (housing, allowances, career development) to attract and retain staff in Lower River and Upper River.
- Expand health training institutions and accelerate recruitment to meet WHO’s recommended workforce density, ensuring balanced regional distribution.
- Prioritize Western 1 and Western 2 for facility expansion and equipment upgrades to improve access and service coverage.
- Conduct facility gap assessments to identify underserved communities and optimize resource allocation.
- Encourage public–private partnerships to expand service coverage and quality, especially in areas where public facilities are overstretched.
- Strengthen rural health infrastructure and incentives for private providers to operate in remote areas.

COUNTDOWN TO 2030

COUNTRY ANNUAL MEETING

CAM 2026



JUNE 2026