REPUBLIC OF THE GAMBIA

COUNTRY PROGRESS REPORT
The Gambia

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Contents

Acronyms

AAITG	ActionAid The Gambia
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Anti Retroviral Therapy
CBOs	Community Based Organizations
CSOs	Civil Society Organizations
CHBC	Community Home Based Care
GARP	Global AIDS Response Progress Reporting
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HARRP	HIV/AIDS Rapid Response Project
HIV	Human Immuno-deficiency Virus
IBBSS	Integrated Biological and Behavioural Surveillance Survey
MARPs	Most-At-Risk Populations
M&E	Monitoring and Evaluation
MERG	Monitoring and Evaluation Reference Group
MoH	Ministry of Health
MRC	Medical Research Council
NACP	National AIDS Control Programme
NAS	National AIDS Secretariat
NGO	Non-Governmental Organization
NSF	National Strategic Framework
OI	Opportunistic Infections
OVC	Orphans and vulnerable children
PAGE	Programme for Accelerated Growth and Employment
PMTCT	Prevention of Mother to Child Transmission
PLHIV	People Living with HIV/AIDS
PRSP	Poverty Reduction Strategy Paper
RAC	Regional AIDS Co-ordinator
RCH	Reproductive and Child Health
STIs	Sexually transmitted Infections
TB	Tuberculosis
TWG	Thematic Working Groups
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNDP	United Nations Development Programme
UNGASS	United Nations General Assembly Special Session
VCT	Voluntary Counselling and Testing

VPP	Voluntary Pooled Procurement
WHO	World Health Organization

I. INTRODUCTION

In June 2011 Heads of State and Government and representatives of States and Governments assembled at the United Nations to review progress achieved in realizing the 2001 Declaration of Commitment on HIV/AIDS and the 2006 Political Declaration on HIV/AIDS. The aim was to guide and intensify the global response to HIV and AIDS by promoting continued political commitment and engagement of leaders in a comprehensive response at community, local, national, regional and international levels to halt and reverse the HIV epidemic and mitigate its impact. The High Level Meeting also approved the new UNAIDS strategy-Getting to Zero 2011-2015 (Zero new Infections, Zero AIDS related deaths, Zero Stigma and discrimination)

The leaders expressed serious concern regarding in inability of the majority of low- and middle-income countries to meet their universal access to HIV treatment targets despite the major achievement of expansion in providing access to antiretroviral treatment. Concern was expressed that the number of new HIV infections is outpacing the number of people starting HIV treatment by a factor of two to one.

The leaders committed themselves to redouble efforts to achieve, by 2015, universal access to HIV prevention, treatment, care and support as a critical step towards ending the global HIV epidemic, with a view to achieving Millennium Development Goal 6, in particular to halt and begin to reverse by 2015 the spread of HIV.

II. STATUS AT A GLANCE

A. The Inclusiveness of the Stakeholders in the Report Writing Process

The 2011 country UNGASS report followed a participatory process. The National AIDS Secretariat (NAS) provided the leadership supported by the UNAIDS Country Office and the MERG which comprised members from international and national non-governmental organizations (NGOs), organizations of people living with HIV (PLHIV), UN System representatives and government sectors. A national workshop was held during which current available data was reviewed. The NCPI was also completed during the workshop.

B. The Status of the Epidemic;

The first case of HIV in The Gambia was diagnosed in May 1986. As at 1999, a cumulative total of 810 cases were reported, 54.4% being HIV-1, 39.5% HIV-2 and 6.7% dual positive.

The 1993/95 Medical Research Council (MRC) and Ministry of Health (MoH) study of 29,670 women conducted nationwide showed that 168 (0.6%) were positive for HIV1, 336 (1.1%) were positive for HIV-2 and 16 (0.1%) were dual positive (HIV-1 + HIV-2). The May 2000-August 2001 sentinel surveillance showed a prevalence rate of 1.2% for HIV1 and 0.9% for HIV2. Since the mid-90s HIV-1 overtook HIV-2 as the main virus that was driving the epidemic. The 1993-1995 study has revealed that the risk of transmission from mother to child is 25% for HIV-1 and 4% for HIV-2. Heterosexual transmission, however, continues to be the main mode of spread of HIV in the country. An Integrated Biological and Behavioural Surveillance Survey (IBBSS) has been conducted among MARPs and preliminary data has shown that prevalence in this cohort is much higher than in the general population.

According to the most recent National Sentinel Surveillance (NSS) study conducted among 6120 antenatal women in 12 health facilities (3 hospitals and 9 health centres) in 2011, the prevalence of HIV-1 is estimated at 1.65% and HIV-2 at 0.07%. Over the years the prevalence within the antenatal women has been fluctuating from 1.4% for HIV-1 in 2002 and peaking at 2.8% in 2006 and showing a sustained decline for the subsequent years 2007, 2008 and 2011. In 2008 a qualitative assessment on most-at-risk populations was conducted by the National AIDS Secretariat (NAS) in collaboration with UNAIDS and UNDP. The goal of the assessment was to document evidence needed for targeting and designing interventions for most-at-risk populations (MARPs) in The Gambia to reduce the incidence of HIV. In recent months a sero-prevalence study among two sub-groups of the MARPs has been conducted.

C. Policy and Programmatic Response

The Gambian response to the HIV and AIDS pandemic has always been guided by national policies and strategic plans. Initially it was health focused, with the setting up of a National AIDS Control Programme (NACP) in 1987 under the Ministry of Health. The first national policy and guidelines on HIV/AIDS was developed in 1995. It had two goals:

- To prevent and control the spread of HIV/AIDS in The Gambia
- Reduce the social and personal consequences of HIV infection both to the person already infected with the virus and to those who have developed AIDS

The 1995 policy had the following 6 major component areas:

1. Prevention of transmission through sexual intercourse;
2. Prevention of transmission through blood;
3. Care and Social support for HIV infected persons;
4. Programme Planning and Management;
5. Programme Monitoring and Evaluation;

6. AIDS/HIV/STD Epidemiological Surveillance

In November 2000 The Gambian Development Forum on HIV and AIDS was held. In his address to the forum, The President highlighted the urgency of a multi-sectoral and coordinated action in response to the epidemic. In July 2001 the Gambian government signed a credit agreement for over US$15 million with the World Bank (WB) to implement an HIV/AIDS Rapid Response Project (HARRP). The HARRP triggered the establishment of a National AIDS Council under the Office of The President and chaired by The President and a secretariat responsible for co-ordinating the national response, the National AIDS Secretariat (NAS). The objective of the HARRP was to assist The Gambia government in stemming the potential rapid growth of the HIV/AIDS epidemic through a multi-sectoral response, specifically by:

- Maintaining the current low level of the HIV/AIDS epidemic;
- Reducing the spread and mitigating its effect;
- Increasing access to preventive services as well as care and support services for those infected and affected by HIV/AIDS.

The HARRP witnessed the decentralization of HIV and AIDS programmes and activities to regional, district and community levels, with funds being provided to community based organizations (CBOs) and non-governmental organizations (NGOs). Divisional and municipal structures were created headed by co-ordinators and supported by AIDS committees. The main source of funding for many local NGOs and CSOs was from the Community and Civil Society Initiative component of the World Bank HARRP. With the closure of the project and without any guaranteed funding from other sources, most of the civil society organizations do not have funding to continue implementing HIV/AIDS programmes.

A national strategic framework 2003 – 2008 was developed in June 2003 which articulated the strategic plan of the country to respond to the HIV and AIDS epidemic. The framework governed and coordinated all HIV related activities and programmes in the public, private and NGO sectors and in civil society at large. It comprised the following sections:

1. Prevention of HIV;
2. Voluntary Counselling and Testing;
3. Treatment care and support;
4. Mitigation;
5. Cross-cutting issues;
6. Coordination;
7. Monitoring and evaluation;
8. Financing and resource mobilization for HIV/AIDS.

In 2004 The Gambia successfully secured a grant for its HIV and AIDS response under the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). The goal of the programme,

captured in the HIV/AIDS National Strategic Plan of The Gambia is to stabilise and reduce the prevalence of HIV/AIDS in the Gambia and provide treatment, care and support for people living with or affected by HIV/AIDS in a conducive environment that will mitigate the impact of the epidemic and ensure the achievement of the socio-economic development of the Gambia as captured in the vision 2020. The Global Fund support bridged the gap on treatment, care and support not covered by the HARRP.

In 2006 the HIV/AIDS policy guidelines were revised to cover the period 2007-2011. The goal of the policy was to provide a framework for action to stabilise and reduce the prevalence of HIV/AIDS in The Gambia and to provide equitable treatment care and support for people infected and affected by HIV/AIDS in a conducive and favourable environment, that will mitigate the impact of the epidemic and ensure the achievement of the socio-economic development of the Gambia as captured in the vision 2020

A review of The Gambia's national HIV and AIDS response conducted in 2008 revealed that the 2003-2008 NSF has not been very operational, being particularly hampered by the lack of a formal approval by Government and the NAC throughout the five year period. This made it difficult to coordinate or manage stakeholder activities that are not funded through the NAS in accordance with the Strategic Framework. The review also highlighted that with the end of the HARRP the regional HIV/AIDS response structures created by the project, such as the position of the Divisional AIDS Co-ordinators, were terminated, whilst the Divisional AIDS Committees were inactive or dormant. The review further noted that there has been a significant expansion of VCT and PMTCT services and a steady increase in the uptake of these services, provision of nutritional and educational support to orphans and vulnerable children (OVC) as well as a scale-up of comprehensive HIV treatment and care services as well as a significant emergence of PLHIV support groups.

In 2008 a new GFATM round 8 funding was secured for HIV and AIDS. The aim is to accelerate access to prevention, treatment, care and support services.

D. Overview of GARP Indicator Data

Targets	Indicator		Percent
Target 1: Reduce sexual transmission of HIV by 50 per cent by 2015			
General population	1.1	1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	All 15-24 yrs: 28.1% Males: 31.9% Females: 23.9%
	1.2`	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	All 15-24 yrs: 2.8% Males: 3.9% Females: 1.5%
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	All 15-49 yrs: 80.0% Males: 81.5% Females: 78.3%
	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	All 15-49 yrs: 15.1% Males: 19.1% Females: 10.5%
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	All 15-49 yrs: 16.7% Males: 15.4% Females: 18.1%
	1.6	Percentage of young people aged 15-24 who are living with HIV	1.4%
Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes	Not Available (NA)
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client	96.7% (Female sex workers only)
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	65.4% (Female sex workers only)
	1.10	Percentage of sex workers who are living with HIV	NA
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention programmes	NA
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	45.5%
	1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	20.0%
	1.14	Percentage of men who have sex with men who are living with HIV	NA
Target 2: Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015			
	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	NA
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	NA
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	NA
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	NA
	2.5	Percentage of people who inject drugs who are living with HIV	NA

Targets	Indicator		Percent
Target 3: Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths			
	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	68.5%
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	NA
	3.3	Mother-to-child transmission of HIV (modelled)	NA
Target 4: Have 15 million people living with HIV on antiretroviral treatment by 2015			
	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy	84.)%
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	81.9%
Target 5: Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015			
	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	NA
Target 6: Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries			
	6.1	Domestic and international AIDS spending by categories and financing sources	NA
Target 7: Critical Enablers and Synergies with Development Sectors			
	7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)	See NCPI tool
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	NA
	7.3	Current school attendance among orphans and non-orphans aged 10–14	NA
		Proportion of the poorest households who received external economic support in the last 3 months	NA

III. OVERVIEW OF THE HIV EPIDEMIC

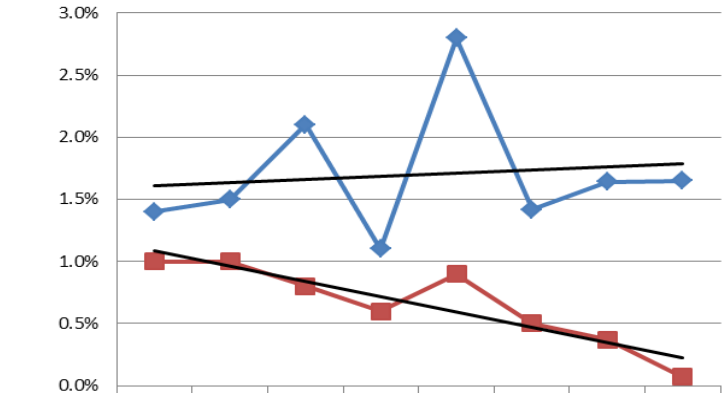
Table 1: Prevalence of HIV-1 and HIV-2 among antenatal women by sentinel site, 2002 to 2011

Sentinel Site	Indicator	Yr. 2002	Yr. 2003	Yr. 2004	Yr. 2005	Yr. 2006	Yr. 2007	Yr. 2008	Yr. 2011
Serre Kunda	Sample	500	503	501	498	498	378	502	512
	HIV-1	1 (0.2%)	12 (2.4%)	11 (2.2%)	5 (1.0%)	14 (2.8%)	10 (2.65%)	4 (0.80%)	5 (1.0%)
	HIV-2	2 (0.4%)	6 (1.2%)	7 (1.4%)	3 (0.6%)	0 (0.0%)	3 (0.79%)	1 (0.20%)	0 (0%)
Brikama	Sample	500	505	500	499	499	495	497	514
	HIV-1	12 (2.4%)	4 (0.8%)	10 (2.0%)	13 (2.6%)	24 (4.8%)	6 (1.21%)	13 (2.62%)	13 (2.5%)
	HIV-2	5 (1.0%)	3 (0.6%)	2 (0.4%)	3 (0.6%)	10 (2.0%)	4 (0.81%)	2 (0.40%)	1 (0.2%)
Sibanor	Sample	500	502	502	500	496	334	331	504
	HIV-1	17 (3.4%)	14 (2.8%)	14 (2.8%)	11 (2.2%)	21 (4.2%)	8 (2.4%)	12 (3.63%)	11 (2.2%)
	HIV-2	10 (2.0%)	15 (3.0%)	7 (1.4%)	4 (0.8)	12 (2.4%)	1 (0.3%)	2 (0.60%)	1 (0.2%)
Farafenni	Sample	346	446	488	486	489	499	500	514
	HIV-1	0 (0%)	3 (0.7%)	9 (1.8%)	2 (0.4%)	12 (2.5%)	2 (0.4%)	7 (1.40%)	6 (1.2%)
	HIV-2	5 (1.4%)	1 (0.2%)	4 (0.8%)	1 (0.2%)	1 (0.2%)	1 (0.2%)	0 (0.0%)	1 (0.2%)
Kuntaur	Sample	159	498	402	446	424	398	485	515
	HIV-1	1 (0.6%)	6 (1.2%)	4 (1.0%)	4 (0.9%)	1 (0.2%)	10 (2.51%)	6 (1.24%)	9 (1.7%)
	HIV-2	1 (0.6%)	4 (0.8%)	0 (0%)	5 (1.1%)	1 (0.2%)	-	1 (0.20%)	0 (0%)
Basse	Sample	312	504	505	528	444	359	462	504
	HIV-1	1 (0.3%)	4 (0.8%)	14 (2.8%)	7 (1.3%)	18 (4.1%)	5 (1.39%)	6 (1.30%)	5 (1.0%)
	HIV-2	0 (0%)	2 (0.4%)	4 (0.8%)	3 (0.6%)	6 (1.4%)	-	2 (0.43%	0
Essau	Sample				543	407	404	414	512
	HIV-1				0 (0%)	13 (3.2%)	1 (0.25%)	5 (1.21%)	11 (2.1%)
	HIV-2				0 (0%)	4 (1.0%)	-	3 (0.72%)	0 (0%)
Soma	Sample				529	424	270	498	512
	HIV-1				1 (0.2%)	6 (1.4%)	3 (1.1%)	7 (1.41%)	3 (0.6%)
	HIV-2				6 (1.1%)	1 (0.2%)	4 (1.48%)	1 (0.20%)	2 (0.4%)
Banjul	Sample					458	450	336	513
	HIV-1					7 (1.5%)	6 (1.33%)	6 (1.79%)	10 (1.9%)
	HIV-2					2 (0.4%)	5 (1.11%)	3 (0.89%)	0 (0%)
Gunjur	Sample								508
	HIV-1								5 (1.0%)
	HIV-2								0 (0%)
Faji Kunda	Sample								514
	HIV-1								14 (2.7%)
	HIV-2								0 (0%)
Bansang	Sample								511
	HIV-1								9 (1.8%)
	HIV-2								0 (0%)
Total	Sample	2317	2955	2898	4029	4139	3587	4025	6120
	HIV-1	32 (1.4%)	43 (1.5%)	62 (2.1%)	43 (1.1%)	116 (2.8%)	51 (1.42%)	66 (1.64%)	101 (1.65%)
	HIV-2	23 (1.0%)	31 (1.0%)	24 (0.8%)	25 (0.6%)	37 (0.9%)	18 (0.5%)	15 (0.37%)	4 (0.07 %)
15-24	Sample	1180	1424	1347	1849	1847	1560	1803	2714
	HIV-1	10 (0.8%)	19 (1.3%)	27 (2.0%)	10 (0.5%)	44 (2.4%)	19 (1.21)	35 (1.94%)	38 (1.40%)
	HIV-2	7 (0.6%)	11 (0.8%)	5 (0.4%)	6 (0.3%)	13 (0.7%)	3 (0.19)	2 (0.11%)	1 (0.04%)

Source: National AIDS Secretariat, 2012

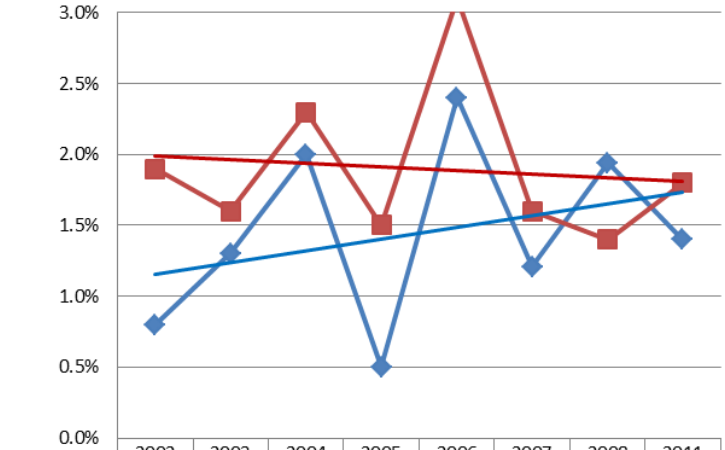
According to UNAIDS and WHO, countries should collect prevalence information from populations that are more or less representative of the general population, such as pregnant women, as well as populations considered to be at high risk of infection and transmission, regardless of the state of the HIV epidemic. Conducting serosurveys among pregnant women is a core surveillance activity in concentrated and generalized epidemics and an additional surveillance activity in low-level epidemics. Pregnant women considered a good proxy for the general population and they are also fairly easy to access using antenatal clinic (ANC) services. Blood is drawn for routine testing and a portion of it is used for HIV testing. In The Gambia, over 90% of pregnant women use ANC services during their pregnancies.

Figure 1: Prevalence (in percentages) of HIV-1 and HIV-2 among antenatal women 15-49 years, 2002 to 2011



	2002	2003	2004	2005	2006	2007	2008	2011
HIV-1	1.40%	1.50%	2.10%	1.10%	2.80%	1.42%	1.64%	1.65%
HIV-2	1.00%	1.00%	0.80%	0.60%	0.90%	0.50%	0.37%	0.07%

Figure 2: Prevalence (in percentages) of HIV-1 among antenatal women, by age group, 2002 to 2011



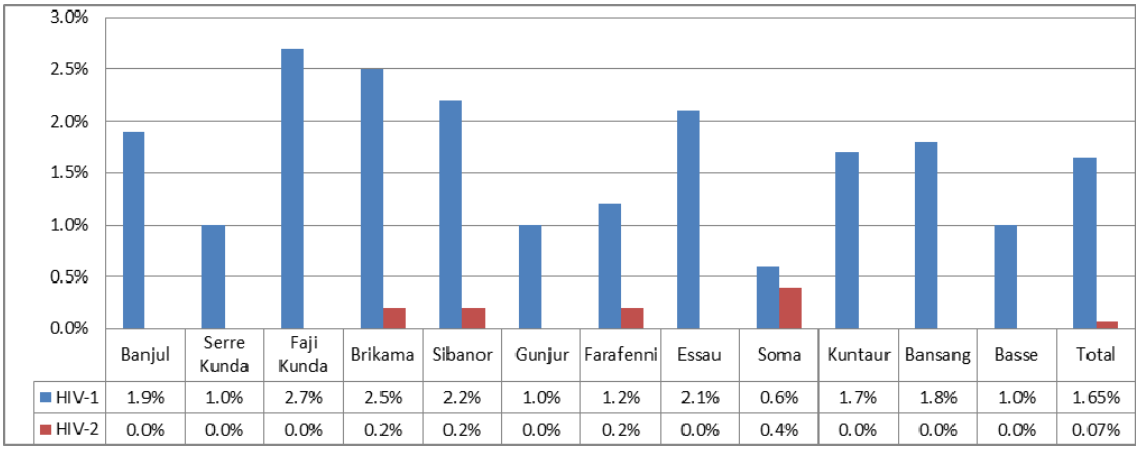
	2002	2003	2004	2005	2006	2007	2008	2011
15-24	0.80%	1.30%	2.00%	0.50%	2.40%	1.21%	1.94%	1.40%
25-49	1.90%	1.60%	2.30%	1.50%	3.10%	1.60%	1.40%	1.80%

The NSS was started in The Gambia in 2000/2001 in four sites: Serrekunda, Sibanor, Farafenni and Basse health centres. The number of sites has been increasing over the years and in 2011 the total number of sites increased to 12. With these additions all 8 local government areas of the country are now covered, including the city of Banjul. Prevalence data is available annually up to 2011 with the exception of 2009 and 2010.

At the start of the epidemic in 1986, HIV-2 was more prevalent. The number of sites has been increasing over the years and in 2011 the total number of sites increased to 12. Preliminary results from the 2011 sentinel surveillance indicate 1.65% prevalence for HIV-1 and 0.07% for HIV-2. The trend of the epidemic, as can be seen in Figure 1, seems to be stabilizing for HIV-1. It may take a few more years of NSS data to genuinely indicate a stabilization of HIV-1. HIV-2, however, seems definitely to be declining from 1.0% in 2002 to 0.07% in 2011.

As can be seen in Figure 2, prevalence of HIV-1 is higher in older women 25-49 years compared to younger women, 15-24 years. Prevalence in older women was consistently higher except for 2008. A trend analysis of the data, however, seems to indicate that the prevalence is declining in the older women's group and increasing in the younger women, 15-24 years.

Figure 3: Prevalence of HIV-1 and HIV-2 by sentinel site, 2011



	Banjul	Serre Kunda	Faji Kunda	Brikama	Sibanor	Gunjur	Farafenni	Essau	Soma	Kuntaur	Bansang	Basse	Total
HIV-1	1.9%	1.0%	2.7%	2.5%	2.2%	1.0%	1.2%	2.1%	0.6%	1.7%	1.8%	1.0%	1.65%
HIV-2	0.0%	0.0%	0.0%	0.2%	0.2%	0.0%	0.2%	0.0%	0.4%	0.0%	0.0%	0.0%	0.07%

In 2011, HIV-1 prevalence by sentinel site was highest in Faji Kunda and Brikama and lowest in Soma, see Figure 3. Seven of the 12 sites had prevalence higher than the national weighted average. The difference between Faji Kunda (2.7%) and Serre Kunda (1.0%) is worth noting. Both are within the Kanifing Municipality, within 2 kilometres of each other, yet there is a significant difference in their HIV-1 prevalence.

In 8 of the 12 sentinel sites HIV-2 has not been seen among pregnant women whose bloods were tested. Among the4 sites in which HIV-2 have been reported 2 are located in the West Coast Region, 1 in North Bank Region and the other in Lower River Region.

In addition to the NSS, HIV prevalence is also captured from routine hospital and health centre voluntary counselling and testing (VCT) and PMTCT services. In 2010 a total of 23,973 women were tested for HIV in health facilities offering PMTCT services. Out of this 481 (2.0%) were HIV positive. Also in 2010, 21,734 persons (10,182 males and 11,552 females) were tested at health facilities offering VCT services. Out of this 2,043 (9.4%) were

HIV positive, 700 (6.9%) males and 1,343 (11.6%) females. Similarly in 2011, 41,160 women were tested for HIV in health facilities offering PMTCT services. Out of this 660 (1.6%) were HIV positive. Also in 2011, 35,309 persons were tested at health facilities offering VCT services. Out of this 2,992 (8.3%) were HIV positive. Persons going for VCT can never be used as proxy for the general population.

IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

The national response to the HIV and AIDS epidemic is currently being guided by the National Strategic Framework (NSF) 2009-2014. The NSF was developed in partnership with stakeholders including civil society, international and local NGOs, the UN System and government. The following were prioritised as fundamental principles to guide the implementation of this NSF: Result Based Management of HIV response, evidence based planning, application of Gender and Human rights principles, operationalization of the Three Ones, working towards universal access, upholding MIPA, efforts by all stakeholders to support to the NSF and harmonise their work and finally working towards achievement of HIV-related commitment at all levels. The main NSF intervention areas are:

i. Strategic Information: This programme area focuses on strengthening monitoring and evaluation (M&E) systems. During the first two years of the NSF (Phase 1), strategic studies will be conducted in order to inform and sharpen evidence-based strategies in all the programme areas. The key studies will include: a population based sero-prevalence survey including a sero-HIV prevalence among pre-survey high risk groups, a formative Assessment of Social Behaviour Change Intervention in selected geographical sites, a situation analysis of women and men's vulnerability to HIV, a rapid assessment of men and boys involvement in HIV/AIDS, updating the situation analysis of OVC and a rapid assessment of quality of Care in PMTCT. The Gambia will strengthen the national HIV/AIDS M&E systems in order to effectively track progress towards the implementation of this NSF and other Global commitments.

ii. Prevention: The new NSF represents a major departure from the previous NSF because of increased focus on evidence and results based programming. Prevention efforts for Phase 1 will be tailored to current appreciation of the epidemic (concentrated epidemic among MARPs, low generalised prevalence and regional variations in prevalence) and potential drivers. The prevention strategy will thus emphasise the tailoring of interventions to the specific drivers and proximate risk behaviours exhibited by sub-populations in the various regions. Prevention has five

programme interventions areas: 1) The Social Behavioural Change Interventions (SBCI), 2) The MARPs Prevention efforts, will focus on intensive prevention interventions and research support to regions with significant MARPs and the general populations in their environs, 3) VCT: The thrust of the VCT will include greater concentration of such services in MARPs areas focussing on girl and boy adolescents and adult male and female. VCT services will be provided with pre- and post-test counselling for positives and negatives and support groups for enhanced behaviour change. Referral for treatment of S/RH and HIV will be central to overall VCT services. Advocacy for the general population for VCT will also be scaled up, 4) Coverage of PMTCT services will be improved. Other areas of focus will include: enhancing the capacities of health personnel in relevant skills, improvement of laboratory equipment and advocacy for PMTCT services to the general population. 5) Blood Safety: The overall thrust is to use effective practices designed to protect healthcare workers, patients and rape survivors.

iii. Treatment Care and Support: For a relatively low HIV prevalence country, there is a strong rationale and evidence for using Treatment, Care and Support to PLHIV as an important aspect of both improving the wellbeing and welfare of PLHIV and as a potent tool for reduction of both stigma and HIV transmission. The overall strategy for this programme is to provide quality complementary services in a well coordinated fashion. Provider-initiated testing and counselling complements targeted community VCT activities and acts as an entry-point to holistic care. The care of PLHIV (which include clinical and Community Home Based Care –CHBC, and Nutrition Assessment, Counselling and Care) is a service that will be provided alongside the management of TB/HIV co-infections and the provision of ART services. The emphasis will be on the early initiation of ART as cost is no longer a tenable justification for delaying therapy.

iv. Impact Mitigation: As with other programme interventions, a strategic study on the situation of orphans and vulnerable children (OVC) will be conducted during the Phase 1 of the NSF. Impact Mitigation will have three broad programme intervention areas. Support to OVC will include increased access to education, social support, food and nutrition and psychosocial support services. The socio-economic support to PLHIV and their families will include implementation of sustainable livelihood programmes, improved access to food and nutrition, building the capacity of PLHIV coordination bodies and other services. The overall strategy for food and nutrition support is to strengthen the policy environment for HIV and AIDS and nutrition while implementing well-crafted strategies to ensure improved nutrition to all PLHIV in The Gambia.

v. Response Management: The main thrust of Response Management is overall coordination of the NSF while ensuring that at least 80% of the NSF results and set

targets are achieved. Against a backdrop of capacity challenges, the Response Management will give attention to NAS institutional strengthening and capacity enhancement for strategic stakeholders such as civil society organisations, private and public sector. The NAS will work on establishment and strengthening of its financial management systems and monitoring effective utilisation of HIV and AIDS resources by multi-sectoral stakeholders. The Gambia will put in place effective advocacy strategies in order to enhance achievement of set results by addressing pertinent HIV and AIDS issues identified by stakeholders. Overall coordination of the national HIV response through enhancing coordination competencies of the NAS and Thematic Working Groups (TWGs) at both central and regional levels will be given special attention. Community systems strengthening will be an integral part of improving effective HIV responses at the sub-national levels. Greater attention will be given to increased community participation in the national response, strengthening strategic community structures and systems and enhancing HIV programming competencies of CBOs and CSOs.

vi. Gender and HIV/AIDS: The gender and HIV programme will have 3 main programme interventions. 1) *Gender Competencies of Multi-sectoral Stakeholders*: Capacity enhancement will focus on the following: design and implementation of gender responsive HIV and AIDS programmes using the mentorship approach and gender training through workshops, enhancing capacity of strategic stakeholders in collection and analysis of sex-disaggregated data including utilisation of gender analysis reports to inform effective HIV programming and mainstreaming of gender and HIV/AIDS issues into key policy framework, research and evaluations. 2) *Vulnerability of Women and Girls*: The Gambia will work towards a better appreciation of the vulnerabilities of girls and women to HIV risks and design tailor-made HIV interventions to reduce the risks of HIV infection. 3) *Men and Boys vulnerability to and Involvement in HIV programmes*: Relevant studies will be conducted in order to inform the design of tailor-made, male responsive HIV interventions.

The recently developed Programme for Accelerated Growth and Employment (PAGE) 2012-2015 highlights 3 key HIV intervention areas. These are:

1. Build capacity of staff in HIV research, M&E and surveillance
2. Conduct HIV population survey (male and female) aged 15-49 years
3. Conduct gender analysis study of male and female vulnerability (children, adolescents, adults) to HIV and AIDS

The programme areas in PAGE underline the need for evidence-based and results-based management response framework. PAGE 2012-2015, the successor to the Poverty

Reduction Strategy Paper of the Government of The Gambia is aimed to operationalize the strategic Vision 2020 for the country's development path including addressing poverty. The goal of the PAGE is to significantly increase, by 2015, the welfare of The Gambia's population. Under the fifth pillar of the PAGE, reinforcing social cohesion and cross-cutting interventions, the government has committed to work in ten areas, one of them being HIV/AIDS (area ix). Several other areas under the fifth pillar of the strategy are also linked to HIV/AIDS such as social protection, child protection and disability, food security, gender equality and empowerment, nutrition, and sound population management. The third pillar of PAGE, "Strengthening human capital stock and enhancing access to social services", under which strategies will be implemented to improve access, equity, quality and equality and financing of education, health, water and sanitation are also essential for an effective national AIDS response.

V. BEST PRACTICES

A. Outreach PMTCT

Health centres and hospitals in The Gambia run Reproductive and Child Health (RCH) clinics. These clinics offer both infant and child welfare services, and antenatal and family planning services. Most RCH teams conduct outreach clinics in designated villages within their catchment areas, visiting them once or twice a month. Communities close to these outreach clinics know which days the RCH team from the health centre or hospital will be visiting to offer services. It is estimated that close to 60% of all immunizations are done at outreach clinics, showing the extent and utilization of these facilities. Outreach PMTCT involves RCH teams in those health centres and hospitals conducting PMTCT services at these outreach stations each time RCH clinics are held there. This service is contributing to increasing access to PMTCT services and bringing it to the doorsteps of the communities, especially those in rural and remote parts of the country. In 2010 and 2011, out of the 23,973 and 41,160 HIV tests conducted, 1,745 (7.3%) and 5,152 (12.5%) respectively, were done at the outreach.

B. Outreach VCT

Services similar to outreach PMTCT are also being offered for VCT by some of those health centres and hospitals that conduct outreach RCH clinics. As stated earlier this is contributing significantly to increasing the utilization and uptake of VCT at community level. In 2010 and 2011, out of the 22,335 and 36,098 HIV tests conducted, 7,687 (34.4%) and 12,712 (35.2%), respectively, were done at the outreach.

BAFROW, a national NGO, is conducting a mobile VCT service. This involves moving from one community to another to conduct VCT.

C. The Mentoring Approach

According to WHO, clinical mentorship is a system of practical training and consultation that fosters on-going professional development to yield sustainable high-quality clinical care outcomes. A clinical mentor in the antiretroviral therapy context is a clinician with substantial expertise in antiretroviral therapy and opportunistic infections who can provide on-going mentoring to less-experienced HIV clinical providers by responding to questions, reviewing clinical cases, providing feedback and assisting in case management. This mentoring occurs during site visits as well as via on-going phone and e-mail consultations. Clinical mentoring is critical to building successful district networks of trained health care workers for HIV care and treatment in resource-constrained settings. A central level mentoring team has been created that goes on a monthly basis to ART centres to work with care teams and to prepare patients for eligibility. Care teams have found this approach extremely useful.

D. Database of Trained Personnel

The NAS has conducted several training programmes for health workers over the years. A database has now been created to keep track of persons trained, area of training, period trained and location. This tool will help in avoiding individuals attending the same training repeatedly (unless it is a refresher course) just because one has been redeployed to a different health centre or hospital. Training programmes now have a pre- and post-training evaluation to assess whether knowledge and skills acquired are being utilised and/or has it made any difference.

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

A. Progress made on key challenges reported in the 2010 UNGASS country report

Capacity Limitation: Over the past 2 years the NAS has made significant strides in building capacity though the health systems strengthening programme. NAS is currently sponsoring students in all the nurse training institutions. It has been working with the University of The Gambia to set up a health technicians' training programme. The initial set up materials, equipment, books, teaching aids and provision of lecturers were provided by NAS. In

addition NAS is sponsoring nearly 30 Masters students enrolled in the Leeds Metropolitan University public health programme.

Stigma and Discrimination: This continues to be a challenge. NAS and AAITG are developing a stigma and discrimination strategy document to address the issues.

Coordination of the National Response: Some improvement have been realised in the coordination of the response. There is greater information sharing and reporting. However the NAS is still unable to track all resources channelled towards HIV and AIDS programmes and activities.

Expanding and scaling up access to HIV services: There are now 45 VCT centres, 31 PMTCT centres and 10 ART centres. Ten VCT centres (Baja Kunda health centre, Diabugu health centre, Fatoto health centre, Brikamaba health centre, St. Lazarus clinic in Fulla Bantang, Gunjur health centre, Gambia Armed Forces Clinic, Gambia Police Force Clinic in Banjul, Afrimed Clinic, Ahmadiya Hospital); 5 PMTCT centres (Baja Kunda health centre, Diabugu health centre, Fatoto health centre, Brikamaba health centre, and Gunjur health centre); and 2 ART centres (Soma health centre and SOS Clinic) were added during the reporting period.

ART Uptake: ART uptake has increase significantly, although the survival rate, according to the Impact Study, dropped from 86% to 82% in the 2009 cohort. There is a need to investigate changes in survival rates for subsequent impact studies with a view to understanding the factors causing or affecting the survival of PLHIV.

HIV and TB Collaboration: Progress has been registered in the collaboration between the 2 disease programmes. The GFATM is supporting collaboration mechanisms between the 2 programmes, especially in indicators reporting. The HIV and TB collaboration policy provided by WHO has been reviewed and adapted for the country. The policy will be validated within the coming months.

Mainstreaming of HIV: This remains a challenge due largely to the limited budgetary support for HIV and AIDS activities within the public sector.

B. Challenges Faced During the 2010-2011 Reporting Period

The following are some of the key challenges faced during the 2010-2011 reporting period:

Funding challenge: The new NSF 2009-2014 has been costed. Whilst the GFATM is the major source of funding there are still gaps therefore cannot meet all activities in spite of the limited funding provided by government and the other development partners. The Gambia's approved funding under GFATM round 8 has been reduced by 45%; whilst the application for round 11 is postponed.

Resource mobilization: Linked to the funding challenge is resource mobilization to adequately respond to the HIV epidemic. There is only one main donor, providing over 90% of the funds

Voluntary Pooled Procurement (VPP): VPP was established by GFATM procurement assistance to its grant recipients. The challenge, however, is that VPP is not responsive to emergency or urgently needed supplies. This may probably be due to the size of the country, and the quantity of the orders, which are always small compared to most other countries.

Supply chain management: The main challenge is in getting timely data on supplies and consumption patterns. m-Supply software for pharmaceutical inventory management has been installed at 14 facilities but these are yet to be fully operational

Nutrition Support for PLHIV: Nutrition plays a vital role in the immune system of all people, including PLHIV. Good nutrition strengthens the immune system, while HIV infection and poor nutrition have a cumulative effect in damaging it. PLHIV are more vulnerable to malnutrition than the general population and nutritional status is a good predictor of their mortality risk. Good nutrition enhances ones ability to fight opportunistic infections and promotes effectiveness of drug treatment. Increase in patient load limits food supplies provided per patient.

Support to Orphans and Vulnerable Children (OVC): The GFATM HIV program provides nutritional support to 62% (5070 OVC), out of a total of 8147 registered OVC. A maximum of 4 children per PLHIV family receive support. There is a big funding gap to cater for all eligible children per PLHIV family. There is an additional 500 children being supported under UNICEF at CaDO in Basse.

Opportunistic Infections (OIs) and Sexually transmitted Infections (STI) drugs: Drugs for OIs and STIs are procured by the GFATM and the Gambia government. The GFATM procurement targets 50% of PLHIV, whilst the government one is supposed to target both the other 50% PLHIV and the rest of the general population who present with similar disease conditions whether or not they are HIV positive. The GFATM and government purchased drugs are pooled into one central supply management system, occasionally causing shortages in supplies of OI and STI drugs for PLHIV.

Early Infant Diagnosis: The primary goal of early infant diagnosis is to identify the HIV-infected child during the first months of life prior to the development of clinical disease. It provides a critical opportunity to strengthen follow-up of HIV-exposed children, assure early access to ARV treatment for infected children, and provide reassuring information to families of uninfected children. The Gambia's health services can only test for HIV in children from 18 months.

VII. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

For this reporting period the GFATM is the single largest development partner providing support to the national response, contributing over 90% of financial resources. The current GFATM round 8 funding is led by 2 principal recipients the NAS being a government agency, and ActionAid Internation The Gambia, being an NGO. Other development partners commiting resources to the national response include the UN Sytem (mainly UNAIDS, UNDP, WHO, UNICEF).

VIII. MONITORING AND EVALUATION ENVIRONMENT

Overview of the Current Monitoring and Evaluation (M&E) System

Within the context of the "Three Ones", the NAS has the mandate to coordinate the national HIV M&E system in The Gambia. For the NSF 2009-2014, the M&E focus is to strengthen HIV surveillance systems, and conduct urgent studies and research to support strategic information needs. This sets the stage for the significant role that M&E should be playing and the need for documented evidence to support the national response. The M&E unit of the NAS is composed of an M&E Specialist supported by 2 M&E officers. In addition to this central team the Regional AIDS Co-ordinators (RACs) have M&E functions at the regional and community levels.

In 2011 the M&E unit of the NAS conducted an Impact Study to determine the survival of people living with HIV and AIDS (PLHIV) initiating anti-retroviral therapy from January 2007 to March 2010. Data for the study was collected from records and registers in health centres and hospitals. Such secondary data is available for a range of HIV services. The M&E unit should be conducting studies using these secondary data sources. Findings from these studies can feed into the pool of evidence need for planning and programming for the national response.

Challenges Faced in the Implementation of a Comprehensive M&E System and Remedial Actions Planned to Overcome the Challenges

The key challenges being faced by the NAS M&E unit include the following:

a. Being unable to conduct population based surveys. This is largely due to gaps in funding for the national response. NAS to identify type of population surveys to be conducted and request for financial assistance from its development partners, including the UN System.

b. No M&E training in the past 2 years for NAS and health staff. There is on-the-job training during quarterly M&E supervisory visits to health centres and hospitals. NAS to seek for funding to contract formal in-country M&E training for their key central and regional level staff; and to conduct step down training for health staff.

c. High turnover of health staff in health centres. This affects the periodic reports to be submitted to the NAS by health centres. NAS should meet with the Ministry of Health (MoH) to discuss staff deployments and durations of postings. A recommended minimum duration of posting for health staff involved in HIV work can be agreed with the MoH.

d. Limited epidemiological skills in the M&E unit. The NAS should request for technical assistance in the form of an epidemiologist attached to their M&E unit for between 6-12 months, with a possibility of extension. This will provide the much needed skill an expertise and transfer of such expertise to the staff of the unit and the RACs.

e. Keeping up to date records of the ever increasing number of HIV patients seen at health centres and hospitals. NAS should consider migrating from a paper based record keeping in health centres to an electronic system. This new system can be piloted in 2-3 facilities initially before expanded to cover all centres.

f. The Monitoring and Evaluation Reference Group (MERG) not meeting frequently. The MERG team is an important part of the NAS M&E structure. It comprises members from government, civil society, and the UN System. Recently a new chairman and secretary have been selected. It is hoped that this will improve on the regularity and frequency of meetings and their oversight function.

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ANNEXES

Annex 1: Letter from the Director of The Gambia National AIDS Secretariat

National HIV/AIDS Secretariat (NAS)

Office of the President

2nd Floor, FIB Building

Kairaba Avenue

Tel: 4395895/4395875 Fax: 4395834

31st March 2012

Dear Sir/Madam,

RE: SUBMISSION OF THE 2012 GLOBAL AIDS RESPONSE PROGRESS (GARP) REPORTING

I wish to make reference to the above mentioned subject matter and I am pleased to submit both the narrative and online reporting regarding the Global AIDS Response Progress (GARP) reporting.

The NAS will be available to provide further clarification if the need arises. Once again, I count on your usual support.

Sincerely yours

Mr. Alieu Jammeh
Director - NAS

Cc: Focal Point – GARP Reporting
Consultant

Annex 2: Monitoring and Evaluation Reference Group Members

Name	Institution	Email
Lamin Camara	UNAIDS	CamaraL@unaids.org
Nuha Ceesay	UNAIDS	Ceesayn@unaids.org
Kebba M.S. Gibba	WHO	gibbak@gm.afro.who.int
Robert Ninson	NAS	mande@nas.gm
Mariam Khan-Senghore	UNICEF	mkhansenghore@unicef.org
Haddy Mboge - Barrow	NAS KMC/BCC	mackmcbcc@yahoo.co.uk
Alpha Sey	Gambia Family Planning Association	seyalpha@yahoo.co.uk
Dawda Joof	ActionAid International	dawda.joof@actionaid.org
Kebba Sima	ActionAid International	kebba.Sima@actionaid.org
Fanta Bai Secka	Department of Social Welfare	baisecka24@hotmail.com
Musu Komma - Bah	Gambia Bureau of Statistics	musukommabah@yahoo.co.uk
Benard Gomez	Hands On Care	bengommez@hotmail.com
Alhagie Sowe	MoH Epidemiology Disease Control	sowealha@yahoo.com
Halimatou Jesurobo	MoH NACP	hjesuorobo@hotmail.com
Malick Gai	MoH NMCP	gaimalick@gmail.com
Alagie Kolley	UNFPA	kolley@unfpa.org
Alieu Jammeh	NAS	alieujammeh2001@yahoo.co.uk
Major Seedy Touray	Gambia Armed Forces	Touray_seedy@hotmail.com
Mamodou Bah	MoH NPHL	do_bah@yahoo.com
Dr. Makie Taal	MoH NPH	makietaal@hotmail.com
Pa Ousman Bah	MoH NACP	podmbah23@yahoo.com
Alieu Jammeh	MoH NACP	Abs.jammeh@gmail.com
Karafa Manneh	CRS	kmanneh@gm.waro.crs.org
Dodou Jallow	GAMNASS	gamnassthegambia@yahoo.com
Abdoulie Camara	MoH Epidemiology Disease Control	abdouliecamara273@hotmail.com
Lamin Badjie	NAS	badjiebassen@gmail.com
Ousman Njie	NAS	obnjie@yahoo.com