REPUBLIC OF THE GAMBIA

The Gambia Global AIDS Response Progress Report

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UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

List of Acronyms

AAITG	ActionAid International The Gambia
AIDS	Acquired Immune Deficiency Syndrome
ARV	Anti-retroviral drugs
BSS	Behavioural Surveillance Survey
CRR	Central River Region
CSO	Civil Society Organization
DHS	Demographic and Health Survey
GARPR	Global AIDS Response Progress Reporting
GDHS	Gambia Demographic and Health Survey
HARRP	HIV/AIDS Rapid Response Project
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IBBS	Integrated Bio Behavioural Survey
IEC	Information, Education and Communication
LGA	Local Government Areas
LRR	Lower River Region
M&E	Monitoring and Evaluation
MARP	Most At Risk Population
MERG	Monitoring and Evaluation Reference Group
MoHSW	Ministry of Health and Social Welfare
NACP	National AIDS Control Programme
NAS	National AIDS Secretariat
NAYCOF	National Youth Conference and Festival
NBER	North Bank East Region
NBWR	North Bank West Region
NGO	Non-Governmental Organization
NSF	National Strategic Framework
NSP	National Strategic Plan

OAFLAA	Organization of African First Ladies Against AIDS
PEP	Post Exposure Prophylaxis
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-To-Child Transmission
PR	Principal Recipient
RHT	Regional Health Team
STI	Sexually Transmissible Infections
TB	Tuberculosis
UAT	Unlinked Anonymous Testing
UN	United Nations
UNAIDS	United Nations Joint Programme on AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
URR	Upper River Region
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WHR1	Western Health Region 1
WHR2	Western Health Region 2

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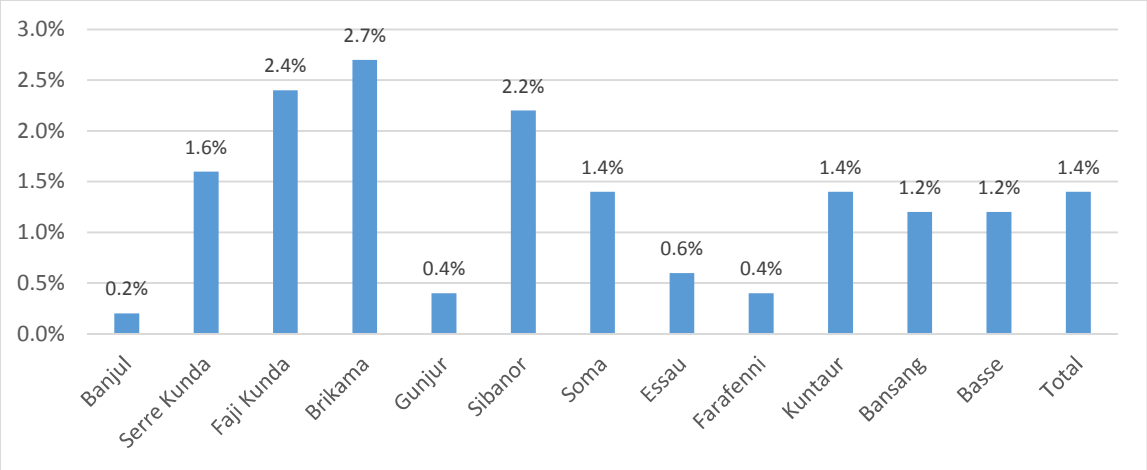
I. Status at a Glance

a) The Inclusiveness of the Stakeholders in the Report Writing Process

The Gambia's Global AIDS Response Progress Reporting (GARPR) for 2014 was led by the National AIDS Secretariat (NAS), supported by the UNAIDS country office. NAS is the national institution mandated to coordinate the HIV and AIDS response in the country. An in-depth interview tool was developed and administered among key stakeholders in the HIV and AIDS national response, among them are Non-Governmental Organizations (NGOs) and Civil Society Organizations (CSOs), including organizations of people living with HIV; UN organizations; and government sector institutions. Data on indicators presented in this report are from secondary sources such as studies and programme reports. These include the 2014 preliminary Behavioural Surveillance Survey (BSS) among 15-49 year-olds in the general population, the 2014 preliminary national HIV Sentinel Surveillance among antenatal women, the 2013 Gambia Demographic and Health Survey (GDHS), the 2011 Integrated Bio-Behavioural Survey (IBBS) among key populations, and 2014 programme monitoring data and reports. The national Monitoring and Evaluation Reference Group (MERG) which comprised members from institutions and organizations engaged in the HIV response, reviewed the draft narrative report and data table.

b) The Status of the Epidemic

Figure 1: HIV prevalence by site, 2014 HIV Sentinel Surveillance



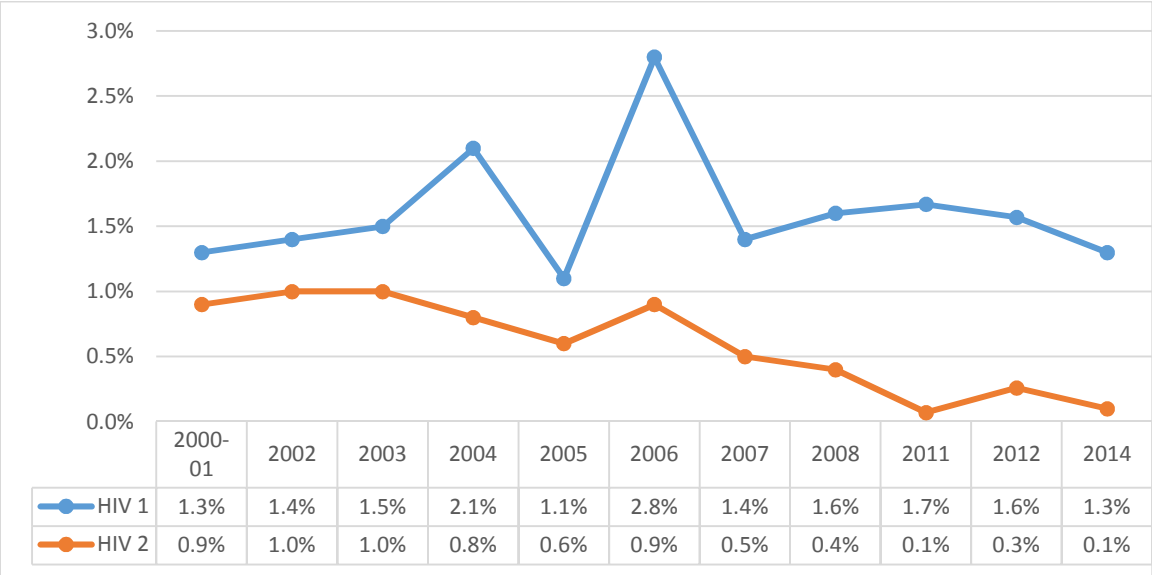
Source: National AIDS Control Programme (NACP), Ministry of Health and Social Welfare

According to the 2014 preliminary National HIV Sentinel Surveillance, the HIV prevalence in The Gambia is estimated at 1.4% (88 out of 6120) among antenatal women 15-49 years. This, according to WHO, is a generalized HIV epidemic. There are however disparities in prevalence rates among the regions and pockets of high HIV prevalence concentrated among key populations. HIV prevalence was highest in Brikama, 2.7%; followed by Faji Kunda, 2.4%; Sibanor, 2.2%; and Serre Kunda 1.6%; all 4 of them being above the national estimate. HIV prevalence was lowest in Banjul, 0.2%, Gunjur and Farafenni, 0.4% each; and Essau, 0.6%. Overall, the HIV prevalence was below the national estimate in 6 of the 12 sentinel sites, see Figure 1. The sample size for the NSS is 500 per sentinel site.

(i) Trend in HIV prevalence 2000/2001-2014, using NSS data

The first NSS in The Gambia was conducted between 2000/2001 in four sites, Serrekunda, Sibanor, Farafenni and Basse Health Centres. The number of sites has since then increased to 12 in 2011. With these additions all 8 local government areas of the country are now covered, including the city of Banjul.

Figure 2: HIV prevalence according to National Sentinel Surveillance studies, 2000/2001-2014



	2000-01	2002	2003	2004	2005	2006	2007	2008	2011	2012	2014
HIV 1	1.3%	1.4%	1.5%	2.1%	1.1%	2.8%	1.4%	1.6%	1.7%	1.6%	1.3%
HIV 2	0.9%	1.0%	1.0%	0.8%	0.6%	0.9%	0.5%	0.4%	0.1%	0.3%	0.1%

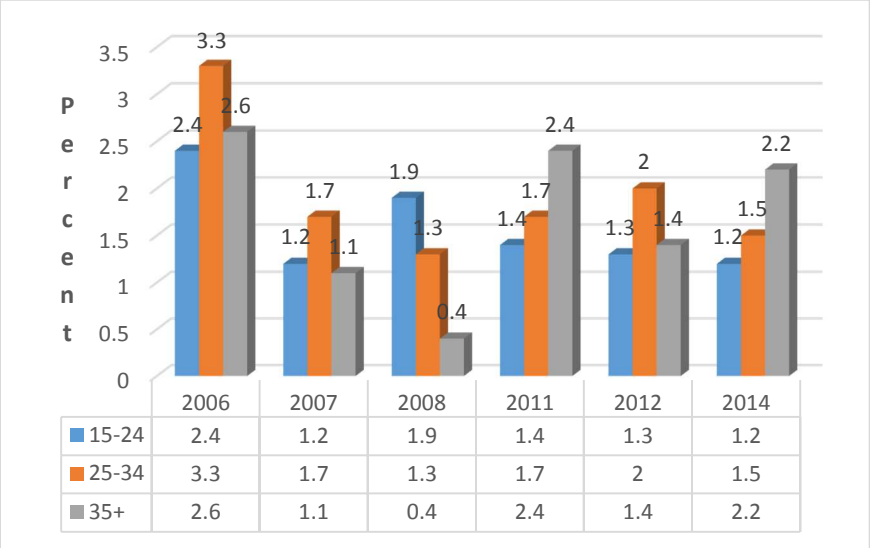
Source: NACP

The first case of HIV was diagnosed in The Gambia May 1986. At the start of the epidemic HIV2 was the predominant virus. But HIV1 has, from 2000/2001, been the main virus driving

the epidemic. Since 1986 the prevalence has been on the increase, with HIV1 reaching a peak of 2.8% in 2006. After two decades HIV1 seems to be stabilising and may even be on the decline as the 2014 seems to suggest. HIV2, on the other hand seems to have stabilised between 2000/2001 and 2006, with the trend seemingly on the decline, see Figure 2.

(ii) HIV prevalence by age group, using NSS data

Figure 3: HIV prevalence by age group and year of National HIV Sentinel Surveillance



	2006	2007	2008	2011	2012	2014
15-24	2.4	1.2	1.9	1.4	1.3	1.2
25-34	3.3	1.7	1.3	1.7	2	1.5
35+	2.6	1.1	0.4	2.4	1.4	2.2

The NSS does not seem to suggest which age group among pregnant women is most affected by HIV. According to the preliminary 2014 NSS results, HIV prevalence is highest among pregnant women 35 years and above, 2.2%, followed by those aged 25-34 years, 1.5%. Pregnant women aged 15-24 years had the lowest HIV prevalence, 1.2%, in the 2014 NSS. The 2011 NSS findings mirrors that observed in 2014. In 2012, however, HIV prevalence was highest among pregnant women 25-34 years. As can be seen in Figure 3, there is no clear trend or pattern on HIV prevalence by age group among pregnant women.

(iii) HIV prevalence in 2013, using DHS data

In 2013 the first ever Demographic and Health Survey (DHS) was conducted in The Gambia. The total sample size was 7,739 respondents aged 15-49 years in the general population. HIV prevalence, according to the DHS was 1.9% among those 15-49 years in the general population. The prevalence was higher among females, 2.1%; compared to males, 1.7%. HIV prevalence in the local government areas (LGAs) was highest among females in Mansa Konko, 3.8%; followed by Janjanbureh, 2.8%, and Brikama 2.6%. Basse LGA had the lowest

prevalence among females, 0.2%. Among males, Basse LGA had the highest prevalence, 3.0%; followed by Brikama 2.4%, and Mansa Konko, 1.5%. HIV status by residence showed prevalence to be higher in urban males, 2.4%, compared to rural males, 1.8%. For females the story is completely the opposite, HIV prevalence was much higher among rural that urban females, 2.3% and 1.3%, respectively. Findings from the 2013 DHS also revealed HIV prevalence to be higher among the employed than the non-employed, again for both males and females. Similarly HIV prevalence was highest among those with no formal education followed by those with only primary education. Those with secondary or higher education had the lowest HIV prevalence, see Table 1.

Table 1: HIV prevalence by socioeconomic characteristics

Percentage of HIV positive among women and men age 15-49 who were tested, by socioeconomic characteristics, The Gambia 2013

Background characteristic	Women		Men			
	Percentage HIV positive[1]	Number	Percentage HIV positive[1]	Number	Percentage HIV positive[1]	Number
Residence						
Urban	2.4	2,291	1.3	2,150	1.9	4,441
Rural	1.8	1,798	2.3	1,300	2.0	3,098
Region						
Banjul	2.0	89	0.2	83	1.1	171
Kanifing	2.3	979	0.5	825	1.5	1,804
Brikama	2.6	1,362	2.4	1,403	2.5	2,765
Mansakonko	3.8	195	1.5	136	2.9	331
Kerewan	1.7	455	0.8	311	1.3	766
Kuntaur	1.4	216	1.3	138	1.4	353
Janjanbureh	2.8	291	1.3	231	2.1	521
Basse	0.2	503	3.0	323	1.3	826
Employment (last 12 months)						
Not employed	1.8	1,979	0.3	989	1.3	2,969
Employed	2.4	2,109	2.2	2,460	2.3	4,569
Missing	-	1	-	0	-	1
Education						
No education	2.6	1,907	3.0	1,040	2.7	2,947
Primary	2.4	569	1.3	464	1.9	1,033
Secondary or higher	1.5	1,613	1.0	1,945	1.2	3,558
Wealth quintile						
Lowest	2.8	685	3.2	506	3.0	1,190
Second	1.5	804	1.4	602	1.5	1,406
Middle	2.8	703	2.8	549	2.8	1,252
Fourth	2.2	891	0.7	912	1.4	1,802
Highest	1.7	1,007	1.2	881	1.5	1,888
Total 15-49	**2.1**	**4,089**	**1.7**	**3,450**	**1.9**	**7,539**

[1] HIV positive refers only to individuals infected with HIV-1, including those infected with both HIV-1 and HIV-2. Individuals infected with HIV-2 only were not counted as HIV positive when calculating the numerator of the percentages.

Source: GDHS 2013

(iv) HIV prevalence among key populations

In 2011 an integrated bio-behavioural surveillance (IBBS) was conducted among two key populations, Female Sex Workers (FSWs) and Other Key Populations. Findings from the study reveal that HIV prevalence among FSWs in The Gambia is 15.9%, which is nearly ten times more than the 2012 NSS figure among pregnant women, 1.6%; and more than eight times the 2013 DHS figure, 1.9%. The table below shows the behavioural factors exposing female sex workers to HIV infection.

Table 2: IBSS Indicators for Female Sex Workers

Indicator	**Percent**
Knowledge of HIV prevention methods	63.9
No incorrect beliefs about AIDS	38.8
Have received HIV prevention information in the past year	65.8
Tested for HIV in past year at least once	75.6
Source of information on HIV prevention:	
Media	43.7
Peer educator	22.2
Health facility	12.0
Friend	10.1
Have participated in talks or meetings related to HIV in the past year	32.9
Used condom at last sex with regular client in the last 30 days	96.0
Used condom at last sex with new client in the last 30 days	97.0
Used condom at last sex with non-paying partner in the last 30 days	44.2
Having had sex without a condom in the past 6 months	29.3

Source: Integrated Bio-Behaviour Survey of Most at Risk Populations in The Gambia, 2012

The Other Key Populations have a high HIV prevalence, 9.8%; high levels of self-reported unprotected anal intercourse, low rates of use of water-based lubricants, low levels of knowledge of high-risk sexual behaviours, and high levels of human rights violations. The figure below shows the sexual behaviour among the Other Key Populations.

Table 3: IBBS indicators for Other Key Populations

Indicator	Percent
Knowledge of HIV prevention	50.9
No incorrect beliefs about AIDS transmission	62.1
Concurrency of both male and female partners in the last 12 months	30.2
Number of male partners in last 12 months	
less than 5	88.7
5 or more	11.3
Number of female partners in last 12 months	
Less than 3	92.0
3 or more	7.9
Condom use at last sex with	
Regular male partner	66.2
Non-regular male partner	55.8
Any female partner	60.9
Always condom use	
With male partners	9.5
With female partners	9.0
As a result of sexual orientation or practice:	
Lost employment	6.5
Afraid to seek healthcare services	11.2
Denied healthcare services	4.4
Felt healthcare workers unable to meet needs	14.2
Heard healthcare workers gossiping	9.9
Felt legal discrimination	3.9
Have been beaten up	9.8
Have been tortured	11.8
Tested for HIV without consent	6.9
Yes to any of the above HR abuses	33.5

Source: Integrated Bio-Behavioural Survey of Most at Risk Populations in The Gambia, 2012

c) The Policy and Programmatic Response

In 2014 The Gambia's national response to HIV was guided by the National Strategic Framework (NSF) 2009-2014. This framework set out the priority interventions for HIV prevention, treatment, care and support; socio-economic impact mitigation, gender mainstreaming, as well as the mechanism for coordination and management of the response. In the same year a new National Strategic Plan (NSP) 2015-2019 was developed to replace the NSF 2009-2014.

The NSF 2009-2014 was the third multi-year policy document developed to direct the national HIV response. In 1995, the first Policies and Guidelines on HIV and AIDS was formulated.

There were two goals 1) To prevent and control the spread of HIV/AIDS in The Gambia, and 2) 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 six components:

i) Prevention of transmission through sexual intercourse;
ii) Prevention of transmission through blood;
iii) Care and Social support for HIV infected persons;
iv) Programme Planning and Management;
v) Programme Monitoring and Evaluation;
vi) AIDS/HIV/STD Epidemiological Surveillance

In 2000 The Gambia received support from the World Bank to implement an HIV/AIDS Rapid Response Project (HARRP). In November of the same year The Gambia 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. The HARRP project facilitated the establishment of a National AIDS Council under the Office of The President and chaired by H.E.; 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:

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

In 2003 a National Strategic Framework 2003-2008 was developed 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:

i) Prevention of HIV;
ii) Voluntary Counselling and Testing;
iii) Treatment, care and support;

iv) Mitigation;

v) Cross-cutting issues;

vi) Coordination;

vii) Monitoring and evaluation;

viii) Financing and resource mobilization for HIV/AIDS.

In 2004 The Gambia successfully secured funding for its HIV and AIDS response under the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) Round 3 grants. The Round 3 grant focused on treatment, care and support; complementing the World Bank HARRP project which focused on HIV prevention and awareness raising. In 2008, another round of funding was secured from GFATM Round 8 for the national HIV response.

In 2014 the NSF was reviewed and replaced by a new National Strategic Plan (NSP) 2015-2019. This new NSP emphasizes programmatic prioritization and lists the following key guiding principles:

i) Evidence-based planning

ii) Integrated service delivery

iii) Improved allocative efficiency

iv) Cost efficiency and effectiveness

v) Human rights based programming

vi) Gender responsive programming

Table 4: The new NSP 2015-2019 outlines the following impact targets to be achieved

No	Impact indicator	Baseline		Target
		Value	**Source and year**	**2018**
1	Percentage of young women and men aged 15-24 years who are HIV infected (GARPR 1.6, UNAIDS #844, GF HIV-12)	All: 0.3% Female:0.4% Male:0.2%	DHS 2013	All: 0.2% Female:0.3% Male:0.1
2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (GARPR 4.2, UNAIDS #860, GF HIV-16)	86%	ART survival Study, 2013	92%
3	Estimated percentage of child infections from HIV-infected women delivering in the past 12 months (GARPR 3.3, UNAIDS #858, GF HIV-17)	9.67%	Spectrum file	3.10%
4	AIDS related mortality (UNAIDS #887, GF HIV-11)	12%	ART survival Study, 2013	6.0%

d) Indicator Data in an Overview Table.

Table 5: 2014 indicator data table

Indicators	Males			Females			Total		
	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent
Target 1. Reduce sexual transmission of HIV by 50% by 2015									
1.1 Young people: Knowledge about HIV prevention:									
15-24 yrs	358	1214	29.5	344	1223	28.1	702	2437	28.8
15-19 yrs	162	598	27.1	181	701	25.8	343	1299	26.4
20-24 yrs	196	616	31.8	163	522	31.2	359	1138	31.5
(i) Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?									
15-24 years	955	1214	78.7	1020	1223	83.4	1975	2437	81.0
15-19 yrs	450	598	75.3	569	701	81.2	1019	1299	78.4
20-24 yrs	505	616	82.0	451	522	86.4	956	1138	84.0
(ii) Can a person reduce the risk of getting HIV by using a condom every time they have sex?									
15-24 years	936	1214	77.1	801	1223	65.5	1737	2437	71.3
15-19 yrs	446	598	74.6	423	701	60.3	869	1299	66.9
20-24 yrs	490	616	79.5	378	522	72.4	868	1138	76.3

Indicators	Males			Females			Total		
	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent
(iii) Can a healthy-looking person have HIV?									
15-24 years	824	1214	67.9	884	1223	72.3	1708	2437	70.1
15-19 yrs	398	598	66.6	505	701	72.0	903	1299	69.5
20-24 yrs	426	616	69.2	379	522	72.6	805	1138	70.7
(iv) Can a person get HIV from mosquito bites?									
15-24 years	808	1214	66.6	758	1223	62.0	1566	2437	64.3
15-19 yrs	405	598	67.7	415	701	59.2	820	1299	63.1
20-24 yrs	403	616	65.4	343	522	65.7	746	1138	65.6
(v) Can a person get HIV by sharing food with someone who is infected?									
15-24 years	695	1214	57.2	729	1223	59.6	1424	2437	58.4
15-19 yrs	311	598	52.0	385	701	54.9	696	1299	53.6
20-24 yrs	384	616	62.3	344	522	65.9	728	1138	64.0
1.2 Sex before the age of 15									
15-24 years	33	1214	2.7	40	1223	3.3	73	2437	3.0
15-19 yrs	23	598	3.8	16	701	2.3	39	1299	3.0
20-24 yrs	10	616	1.6	24	522	4.6	34	1138	3.0

Indicators	Males			Females			Total		
	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent
1.3 Multiple sexual partnerships									
15-49 years	192	2384	8.1	32	2416	1.3	224	4800	4.7
15-19 yrs	11	598	1.8	2	701	0.3	13	1299	1.0
20-24 yrs	20	616	3.2	8	522	1.5	28	1138	2.5
25-49 yrs	161	1170	13.8	22	1193	1.8	183	2363	7.7
1.4 Condom use at last sex among people with multiple sexual partnerships									
15-49 years	50	192	26.0	7	32	21.9	57	224	25.4
15-19 yrs	6	11	54.5	1	2	50.0	7	13	53.8
20-24 yrs	13	20	65.0	3	8	37.5	16	28	57.1
25-49 yrs	31	161	19.3	3	22	13.6	34	183	18.6
1.5 HIV testing in the general population									
15-49 years	249	2384	10.4	483	2416	20.0	732	4800	15.3
15-19 yrs	44	598	7.4	41	701	5.8	85	1299	6.5
20-24 yrs	55	616	8.9	96	522	18.4	151	1138	13.3
25-49 yrs	150	1170	12.8	346	1193	29.0	496	2363	21.0

Indicators	Males			Females			Total		
	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent
1.6 HIV prevalence in young people, from antenatal clinic attendees									
15-19 yrs				6	822	0.7			
20-24 yrs				24	1725	1.4			
15-24 yrs				30	2548	1.2			
Target 3. Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths									
3.1 Prevention of Mother-to-Child Transmission									
Numerator Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery: 810									
1. Newly initiated on ART during the current pregnancy: 39									
2. Already on ART before the current pregnancy: 166									
3. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B): 605									
4. Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A or WHO 2006 guidelines): 0									
3.1a Prevention of mother-to-child transmission during breastfeeding: **Numerator**: Number of women living with HIV who were breastfeeding who received antiretroviral medicine for herself or her child to reduce the risk of mother-to-child transmission during breastfeeding during the past 12 months: 605 in 2014									
3.2 Early infant diagnosis **Numerator**: Number of infants who received an HIV test within two months of birth, during the reporting period. Infants tested should only be counted once: 91 Test result – Positive: 0									

Test result – Negative: 91 Test result – Indeterminate: 0 Test result – Rejected by laboratory: 0 Test result – Other: 0
Numerator: Number of infants who received an HIV test within two months of birth, during the reporting period. Infants tested should only be counted once
3.7 Percentage of infants born to HIV-infected women provided with antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks
Percentage (%): Percentage of infants born to HIV-infected women (HIV-exposed infants) who received antiretroviral prophylaxis to reduce the risk of early mother-to-child- transmission in the first 6 weeks (i.e. early postpartum transmission around 6 weeks of age) Note. Ideally countries should capture the percentage of infants who received ARV prophylaxis. If this is not possible then countries should record the percentage of infants who were started on or provided with ARV prophylaxis. 52.0%
Numerator : Number of infants born to HIV-infected women who received antiretroviral prophylaxis to reduce early mother-to-child transmission (early postpartum, in the first 6 weeks): 405
Denominator : Estimated number of HIV-infected pregnant women giving birth: 779
3.9 Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth
Percentage (%): Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth: 52.1%
Numerator : Number of infants born to HIV-infected women started on CTX prophylaxis within two months of birth: 406
Denominator : Estimated number of HIV-infected pregnant women giving birth: 779
3.10 Distribution of Outcomes of HIV-Exposed Infants
3.10.1 Number of infants born to HIV positive mothers (“HIV-exposed infants”) born in 2013 (or latest data available): 421 Reporting year: 2013

3.10.2 Number of infants, born in 2013 (or latest data available) to HIV positive mothers, classified as indeterminate (i.e.: all lost to follow up, death before definitive diagnosis, indeterminate lab results):
Reporting year: 2013

3.10.3 Number of infants born in 2013 (or latest data available) to HIV positive mothers that are diagnosed as positive for HIV: 34
Reporting year: 2013

3.10.4 Number of infants born to HIV positive mothers in 2013 (or latest data available) that are diagnosed as negative for HIV: 172
Reporting year: 2013

3.11 Number of pregnant women attending ANC at least once during the reporting period: 86000

Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

4.1 HIV treatment: antiretroviral therapy: Currently on ART (2014) 4586; Males: 1279; Females: 3307

Target 5. Reduce tuberculosis deaths in people living with HIV by 50% by 2015

5.1 Co-Management of Tuberculosis and HIV Treatment: 205

Indicators	**Males**			**Females**			**Total**		
	Numerator	**Denominator**	**Percent**	**Numerator**	**Denominator**	**Percent**	**Numerator**	**Denominator**	**Percent**
Target 7: Eliminating gender inequalities									
7.1 Prevalence of recent intimate partner violence									
15-49 years				107	1307	8.2			
15-19 yrs				3	92	3.3			
20-24 yrs				19	254	7.5			
25-49 yrs				85	961	8.8			

Indicators	Males			Females			Total		
	Numerator	Denominator	Percent	Numerator	Denominator	Percent	Numerator	Denominator	Percent
Target 8: Eliminating stigma and discrimination									
8.1 Discriminatory attitudes towards people living with HIV									
15-49 years	1756	2325	75.5	1686	2340	72.1	3442	4665	73.8
15-19 yrs	530	582	91.1	558	681	81.9	1088	1263	86.1
20-24 yrs	519	597	86.9	372	517	72.0	891	1114	80.0
25-49 yrs	707	1146	61.7	756	1142	66.2	1463	2288	63.9

II. Overview of the AIDS Epidemic

It is nearly 29 years ago that the first AIDS case was recorded in The Gambia. From that single case in May 1986, the country has seen a continued rise in HIV prevalence. In 2014, a National HIV Sentinel Surveillance (NSS) study was conducted among pregnant women attending clinic in 12 health facilities across the country. Out of 6,120 blood samples collected 79 (1.3%) were positive for HIV1 and 9 (0.1%) for HIV2. None had dual (HIV1 and HIV2) infection. Conducting serosurveys among pregnant women is a core surveillance activity in concentrated and generalized epidemics and an additional surveillance activity in low-level epidemics. According to UNAIDS and WHO (2003), antenatal clinics provide ready access to pregnant women who represent a cross-section of sexually active women from the general population who are not using contraceptive methods. In addition, blood collected for routine antenatal diagnostic tests (e.g., syphilis) can be made available for unlinked anonymous testing (UAT). In The Gambia, over 90% of pregnant women access ANC services (The National Strategic Plan for Elimination of Mother to Child Transmission of HIV (eMTCT-HIV) 2013 – 2015)

a) Findings from the 2014 Behavioural Surveillance Survey on HIV

HIV and AIDS Awareness: In 2014, a Behavioural Surveillance Survey on HIV was also conducted. The 2014 BSS showed that overall, about 97.2% of the 4800 respondents have heard of HIV. About 97.5% of male respondents and 96.7% of female respondents have heard of HIV and AIDS. There was no clear trend in the differences between sexes.

Knowledge of HIV prevention: Comprehensive knowledge about HIV prevention as defined by the GARPR guidelines combines identifying consistent condom use, mutually monogamy between HIV negative partners and rejecting the misconceptions about HIV transmission and prevention. This indicator has increased slightly among those 15-49 years in the general population, from 25% in 2010 to 26% in 2012 and 29% in 2014. Among young people, 15-24 years, comprehensive knowledge decreased slightly from 28% in 2010 to 25% in 2012 and increased again to 28.8% in 2014. Whilst most respondents have constantly heard of HIV and AIDS over the years, the frequency of comprehensive knowledge of HIV prevention has

consistently been low in the general population; and even lower among youths 15-24. Knowledge is an important prerequisite for behaviour change.

Misconceptions, or incorrect beliefs, about HIV transmission and prevention can be a disincentive to behaviour change. Misconceptions could also be a reflection of the success or otherwise of IEC programmes and strategies. In the 2014 BSS, 61.7% of all respondents between 15-49 years had incorrect beliefs based on the responses on the two misconception statements: HIV is transmitted through the bite of a mosquito and sharing meal with an HIV infected person.

HIV Testing: HIV counselling and testing (HCT) is the crucial bridge to HIV treatment, care, and support. HTC helps people to learn their HIV status, access treatment, learn how to prevent transmission, and gain the support services needed. HIV testing within the past year, among those 15-49 years was 16% in the general population with most (94.1% - 732 out of 778) of them going back for their results.

Exposure to IEC interventions: In 2014 just over half of all respondents 15-49 years heard about HIV and AIDS from the radio. In the 2012 BSS, approximately 66% males and 57% females heard about HIV and AIDS from the radio compared to 70.2% and 57.6%, respectively in 2010; and 90.5% and 86.9%, respectively in 2005. Exposure to HIV and AIDS messages through the radio is on the decline.

Stigma and discrimination: Accepting attitudes, a combination of seven attitude-related questions, have reduced to 18% in 2014, from 26% in 2012 and 22% in 2010. The older one is the more accepting attitudes one has towards PLHIVs. This was observed for both males and females. Previously it has been shown that the main issue for all groups is willingness to buy food from an HIV+ shopkeeper or food seller. Most respondents have been unable to accept this.

b) Programme Indicators

HIV counselling and testing: The number of sites offering HIV counselling and testing services remain the same for 2013 and 2014, 45. In 2014, however, a total of 43,713 persons were tested for HIV and received their results, up by 22% from 2013. There was a decrease on those testing positive in 2014, 7.5% (3274 out of 43713 who were tested and returned for

their results) comparted to 2013, in which 8.2% tested positive (2,944 out of 35,729 who were tested and returned for their results).

Table 6: Selected programme indicators, 2013 and 2014

Programmatic Area	Indicator	2013	2014
HCT	No. of VCT sites	45	45
	No. tested and received results	35729	43713
	No. tested positive	2944	3274
PMTCT	No. of PMTCT sites	32	32
	No. of pregnant women tested and received results	50233	52065
	No. of pregnant women tested positive	773	728
	No. of HIV+ pregnant women receiving complete course of ARV prophylaxis	729	605
TB/HIV	No. of HIV+ persons screened for TB	2802	3487
	TB sites	78	78
Nutritional Support	No. of PLHIVs provided with nutritional support	4374	5231
ART	No. of ART sites	10	10
	No. patients currently on treatment	4006	4586
	Adults	3708	4206
	Children	298	380

Prevention of mother-to-child transmission (PMTCT): In both 2013 and 2014 only 32 health facilities were offering PMTCT services. Nearly 4% more pregnant women were tested for HIV and received their results in 2014 compared to 2013. However there was a slight decrease in the number of HIV positive cases among those pregnant women, from 1.5% (773 out of 50,233) in 2013 to 1.4% (728 out of 52,065) in 2014. The percentage of HIV+ pregnant women receiving complete course of ARV prophylaxis decreased between 2013 and 2014 from 94.3% (729 out of 773) to 83.1% (605 out of 728).

TB/HIV: The number of health facilities offering TB services was far more than HCT and PMTCT sites. In 2014 a total of 3,487 HIV positive persons were tested for tuberculosis, up from 2,802 in 2013.

Nutritional Support: The number of PLHIV receiving nutritional support increased by almost 20%, from 4,374 in 2013 to 5,231 in 2014.

ART: The number of ART sites still remain at 10, nationally. The number of HIV positive persons on ART, however, continue to increase. In 2013, 4,006 PLHIVs were on ART compared to 4,586 in 2014, an increase of 14.5%.

III. National Response to the AIDS Epidemic

The national response to HIV is coordinated at national, regional and community levels through active engagement of sectoral, regional and community structures. The National AIDS Council (NAC) is supposed to provide overall strategic and policy leadership and oversight to the national response to HIV. NAC was formed in 2002 and is composed of representatives of Government, PLHIV, Civil Society, Private Sector, development partners and academic and research institutions. The President is the Chairperson and the focal point officially designated in his Office is the Minister of Health and Social Welfare.

The National AIDS Secretariat (NAS) is an administrative structure of NAC responsible for day-to-day coordination and management of the national response. NAS has established multi-sectoral committees and taskforces providing a platform for stakeholder participation in coordination of the response. These include the ARV Steering Committee, National PMTCT Coordinating Committee, National PMTCT Technical Working Group, National Monitoring & Evaluation Reference Group (MERG), Regional AIDS Committees, National Orphans and Vulnerable Children committee, Inter-Grant Coordinating Committee and National HIV Training Taskforce.

Regional and Municipal Coordination Committees provide leadership and coordinate the national response at decentralised levels. In total, six RACs and one MAC (Banjul City Council and Kanifing Municipality) have been established. Membership of these committees includes local representatives of the government and the civil society.

The Gambia national response to HIV is guided by national policy and strategic plans. The year 2014 saw the development of a new National Strategic Plan (NSP) 2015-2019. In 2014 the old NSF 2009-2014 continued to guide the national response to HIV and AIDS. The old 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 were:

i. ***Strategic Information***: This programme area focused on strengthening monitoring and evaluation (M&E) systems. During the period of the NSF, strategic studies were conducted in order to inform and sharpen evidence-based strategies in all the programme areas. The key studies included the Integrated Bio-Behavioural Survey of Most At Risk Populations, a Stigma Index Study which lead to the development of a Stigma Reduction Strategy, the first Demographic and Health Survey, and the fifth Behavioural Surveillance Survey. The Gambia strengthened the national HIV/AIDS M&E systems in order to effectively track progress towards the implementation of the NSF and other global commitments.

ii. ***Prevention***: The NSF 2009-2014 represented a major departure from the previous NSF because of increased focus on evidence and results based programming. Prevention efforts for Phase 1 was 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 emphasised the tailoring of interventions to the specific drivers and proximate risk behaviours exhibited by sub-populations in the various regions. Prevention had five programme interventions areas: 1) The Social Behavioural Change Interventions (SBCI), 2) The MARPs Prevention efforts, which was to focus on intensive prevention interventions, including treatment of STIs and provision of condoms, and research support to regions with significant MARPs and the general populations in their environs, 3) VCT: The thrust of the VCT included greater concentration of such services in MARPs areas focussing on girl and boy adolescents and adult male and female. VCT services was provided with pre- and post-test counselling for positives and negatives and support groups for enhanced behaviour change. Referral for SRH services and HIV was central to overall VCT services. Advocacy for the general population for VCT was to be scaled up, 4) Coverage of PMTCT services was to be improved. Other areas of focus included: enhancing the capacities of health personnel in relevant skills, improvement of laboratory equipment and advocacy for PMTCT services to the general population. 5) Universal Precaution, Blood Safety and Post Exposure Prophylaxis (PEP): The overall

thrust was to minimize the risk of exposure to HIV and other disease conditions for healthcare workers, patients and the general public in the healthcare setting; post-exposure prophylaxis management; participation in external quality assessment schemes for HIV screening; and awareness raising among males, females and communities regarding risks associated with rape, and the challenges and potential benefits of PEP.

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 was 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 included clinical and Community Home Based Care –CHBC, and Nutrition Assessment, Counselling and Care) is a service that was to be provided alongside the management of TB/HIV co-infections and the provision of ART services. The emphasis was on the early initiation of ART as cost was 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) was to be conducted during the Phase 1 of the NSF. Impact Mitigation had three broad programme intervention areas. Support to OVC including increased access to education, social support, food and nutrition and psychosocial support services. The socio-economic support to PLHIV and their families including implementation of sustainable livelihood programmes, such as income generation activities, improved access to food and nutrition, building the capacity of PLHIV coordination bodies and other services. The overall strategy for food and nutrition support was 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 was overall coordination of the NSF while ensuring that at least 80% of the NSF results and set targets were achieved. Against a backdrop of capacity challenges, the Response Management gave attention to NAS institutional strengthening and capacity enhancement for strategic stakeholders such as civil society organisations, private and public sector. The NAS was to 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 to 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 enhanced coordination competencies of the NAS and Thematic Working Groups (TWGs) at both central and regional levels to be given special attention. Community systems strengthening was to be an integral part of improving effective HIV responses at the sub-national levels. Greater attention to 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 had 3 main programme interventions. 1) *Gender Competencies of Multi-sectoral Stakeholders*: Capacity enhancement focused 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 to 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 to be conducted in order to inform the design of tailor-made, male responsive HIV interventions.

IV. Best practices

Political leadership

- Launching of the Early Infant Diagnosis (EID) programme by the First Lady of The Gambia in April 2014 as part of Organization of African First Ladies against AIDS (OAFLAA) activities. The launching ceremony was graced by Vice President and Minister of Women's Affairs Dr Isatou Nije-Saidy, Cabinet Ministers and other senior government officials.
- The National Assembly's Select Committee on Health sensitized on the proposed HIV Bill for easy passage

Supportive policy environment

- The partnership between the NAS, MoHSW (public), NGOs and other civil society actors in the national HIV/AIDS response. For example, ActionAid International The Gambia (AAITG) is a Global Fund co-PR with the NAS. AAITG is spearheading HIV prevention strategies and interventions. Similarly, Hands on Care, an NGO, is the institution taking care of the largest cohort of HIV and AIDS patients in The Gambia. This strong partnerships encourages open and honest participation of all partners in the processes and procedures of project implementation
- HIV related services are integrated into the existing healthcare delivery system. At the primary level, TBAs and VHWs have been sensitized to promote the utilization of PMTCT/HCT/ART services, referrals and also support adherence to ART.
- The activities of CSOs together with PLHIV support groups have sensitized and mobilized communities and these have helped to create demand for HIV services and linkages between the health and community systems.

Prevention programmes

- Networking with other partners in the HIV prevention activities
- HIV services showcased at trade fairs and the National Youth Conference and Festival (NAYCOF). HCT have been conducted during trade fairs by Business Coalition Against HIV and AIDS (BUCAHA) and JOBOT Laboratories; and at NAYCOF activities.

- Outreach services for both PMTCT and HCT enabled providers to access hard-to-reach communities.
- Provider initiated HIV counselling and testing (PICT) among outpatient department (OPD) clients is being carried out at public health facilities.
- The CSOs undertake community mobilization and sensitization activities using participatory methods, and leveraging community structures and leadership to create demand for health services especially HIV prevention, treatment, care and support services and also foster male involvement in community programmes

  The 'Kabilo' strategy represents an integrated participatory approach for social mobilization on issues of community health. The strategy effectively addresses health issues in promoting positive health behaviours at the household level. The 'Kabilo' approach was first used in The Gambia by Save The Children Federation USA and the Ministry of Health and Social Welfare. Based on the major findings, it was concluded that the use of the 'Kabilo' approach will not only increase awareness and promote positive behavioural change but also encourages the use of local community structures. Using the local traditional structures therefore can augment the process of behavioural change as well as increase the sense of ownership amongst community members. Societies Tackling AIDS through Rights (STAR) and Stepping Stone are other participatory approaches to HIV prevention also being used in the HIV response in The Gambia.

Care, treatment and/or support programmes

- Community home-based care services are also part of the continuum of services and these are delivered mainly by CSOs in partnership with families, PLHIV support groups and volunteers.
- Establishment of a female society representing a network of HIV positive women.

Monitoring and evaluation

- Integrating NAS M&E database into the Ministry of Health HMIS database (DHIS2). Previously there were parallel reporting systems. The NAS used to have a standalone database, which has now been integrated into the DHIS2.

V. Major challenges and remedial actions

a) Progress made on key challenges reported in the 2013 Country Progress Report

Table 7: Progress made on key challenges in 2012

Key Challenge in 2012	Progress made
1. Funding challenge and resource mobilization	These still continue to be challenges up to 2014. The national HIV response is funded almost entirely by GFATM, with some contribution from the UN System. Government contribution to the HIV response is staff and the public health infrastructure, including health facilities, office space, and medicinal products, equipment and materials procured using budgetary allocations
2. Voluntary Pooled Procurement (VPP)	There has not been any challenge regarding the VPP in 2014
3. Supply chain management	Getting data on supplies and consumption patterns remain challenging. The m-Supply software for pharmaceutical inventory management installed in health facilities are still not fully operational
4. Nutrition Support for PLHIV	Increase in patient load continues to limit food supplies being provided per patient.
5. Support to Orphans and Vulnerable Children (OVC)	There continues to be funding gap to provide for all eligible children per PLHIV family.
6. Drugs for opportunistic infections (OIs) and sexually transmissible Infections (STI)	There are still occasional stock-outs of drugs for OIs and STIs
7. Early Infant Diagnosis	EID was officially launched by the First Lady in April2014. A total of 91 babies were tested between October and December 2014

b) Challenges faced throughout the reporting period

The following issues are key obstacles that hindered the national HIV response in The Gambia:

- The National AIDS Council, the body responsible for oversight to monitor the national HIV/AIDS response has not been functional for many years.
- Human Resources for the HIV response: Inadequate health related human resources to respond effectively to HIV/AIDS. High turnover of staff in some organizations contributing to the national response. Inadequate inequitably distributed skilled human resource capacity to run clinics
- Funding for the HIV response: High dependence on external funding and weak

mobilization efforts for domestic resources. This has led to inadequate financial resources to invest in a comprehensive response to HIV and AIDS. Currently GFATM is the main funder of the response providing over 90% of the financial resources. Some of the partners to the response do not have access to funding other than GFATM. Delays experienced in receiving project funds affected the timely implementation of their planned activities and payment of staff salaries.

- Unfavourable social, legal and political environment with regards to key populations thus making programme implementation with those groups difficult. Double stigma experienced by key populations. Unfriendly PLHIV health care services.
- Stigma and discrimination still remain a huge problem. Educated PLHIVs unwilling to disclose their status due to stigma and discrimination. Stigmatization and discrimination of the PLHIV and the key populations which often constrains them for accessing services. Lack of disclosure to partners due to fear of stigma may affect the intake of medication on time. Out of an estimated 10,000 PLHIV on care and treatment there are only 3000 enrolled with support societies.
- Limited involvement of other government line ministries and other non-government sectors in the national response. The active involvement of other sectors in the national HIV response is virtually missing. There are few, if any, workplace HIV and AIDS interventions
- Translating HIV and AIDS knowledge into behaviour change continues to be challenging.
- Early Infant Diagnosis has been successfully piloted. Funding not, however, available to roll it out nationally.
- HIV and AIDS M&E: Activities are still largely GF focused with non-GF supported activities not being captured
- Weak TB/HIV coordination

c) Concrete remedial actions that are planned to ensure achievement of agreed targets

The National AIDS Council (NAC): It is envisaged that the long awaited HIV and AIDS Control Act will be passed in 2015. This Act may trigger the re-activation of the NAC.

Human Resources for the HIV response: The MoHSW with the support of the GF under the HSS component of Round 8 HIV grant and in collaboration with the University of the Gambia trained a host of health care providers. To ensure that these training efforts yield the intended benefit the MoHSW would need to create good working conditions/policies to retain the much needed trained staff. In addition the development and implementation of Task Shifting in health service delivery stipulated in the NSP should be piloted without delay. Another related issue is the inadequate human resource both in terms of numbers and technical capacity to maintain and repair bio-medical equipment such as CD4 machines. NAS should solicit technical assistance from international partners to address this issue through capacity building/training.

Funding for the HIV response: There is the need to diversify funding sources. A Resource Mobilisation Strategy and Plan should be developed and implemented. Such an effort should target both domestic and international sources.

Unfavourable social, legal and political environment: Programme implementation targeting key populations should make best use of experience form other countries in the sub region. Innovative approaches are needed to provide services to key populations. Due to the sensitive and emotive nature of the key populations issues discrete dialogue and advocacy is required to avoid confrontation which may affect or impact negatively on gains made so far.

Stigma and discrimination: Stigma and discrimination are still big issues as is evident in the 2014 BSS report. There is a clear need for a solid Stigma and Discrimination Strategy and Action Plan. Such a plan should be preceded and informed by a comprehensive situational analysis of interventions in this regard. It should be noted that isolated radio/TV programmes and open field days may not be very effective. A solid Stigma and Discrimination Strategy and Action Plan should be developed, implemented, and monitored and evaluated.

Limited involvement of other government line ministries and other non-government sectors: All sectors are affected by HIV and AIDS. All institutions and organizations should therefore be actively involved in their various work settings to address this important socio-economic and human problem. This will make available to the response added human, financial and material resources and also importantly collective ownership of the response.

Translating HIV and AIDS knowledge into behaviour change: NAS and its partners to roll out behaviour change interventions in all regions and communities, including the Kabilo Approach, Stepping Stones and STAR.

Early Infant Diagnosis: NAS and the MoHSW to use the Office of the First Lady and UNICEF to mobilise resources for EID

HIV and AIDS M&E: NAS M&E unit to focus on the national M&E framework, which has listed indicators to be monitored from the NSF.

Weak TB/HIV coordination: Reinstate joint supervision and monitoring by the 2 programmes at central level. Integrate the 2 services in health facilities. Sharing of programme data.

VI. Support from the country's development partners

a) Key support received from development partners

The Gambia's national HIV response is funded by development partners. Key among the partners is Global Fund. They continue to provide over 90% of HIV funding. GFATM funding has been used to procure HIV and OI drugs; laboratory equipment, materials and consumables, including test kits and reagents; transport, including ambulances, delivery trucks, supervision and monitoring vehicles; and motorcycles; pre-service and in-service training for health workers; payment of incentives for health workers; etc. The generation of relevant data from studies and surveys to inform programming has been supported mainly by the GFATM, e.g., NSS, BSS, IBSS, ART Survival Study, including the cost of the first ever DHS to be conducted in The Gambia in 2013.

The institutions under the UN System have also provided technical and limited financial support. These include funding from:

- UNAIDS through OAFLAA Gambia Chapter to start EID, training of staff, procurement of test kits
- UNICEF for scaling up of EID, monitoring and supervision visits, transport refunds for mothers bringing babies for HIV testing,
- UNFPA for male and female condoms, maternal live saving drugs, HIV test-kits and Medical equipment. UNFPA also provided technical and financial support on Family Planning awareness to PLHIVs and contributed to capacity building on HIV/AIDS prevention for young people and also support World AIDS Day commemoration activities.
- UNAIDS for the development of the National Strategic Plan 2015-2019.
- WFP for the development of a nutrition manual for PLHIV
- WHO for technical support
- UNDP for NSP development, and World AIDS Day commemorations

In addition, the following other partners provided financial and/or technical assistance to the national HIV response:

- US government for HIV programmes under the Gambia National Army
- AAITG (Technical and financial support)
- CRS HQ (Technical and financial support)
- NASO (Financial and in-kind support)
- ENDA Santa (Financial and in-kind support)
- GAMWORKS for supporting PLHIVs on skills development projects
- ITPC (International Treatment Preparedness Coalition)
- Capacity Development and institutional strengthening of NAS , Support Groups, Networks, NGOs and CSOs
- UNDP, UNAIDS, WHO – Mock TRP, UNICEF – PMTCT Bottle neck analysis,

b) Actions that need to be taken by development partners to ensure achievement of targets

The following actions are required to ensure achievement of national targets:

- Increase funding to HIV and AIDS. The HIV funding from the UN agencies remains scanty. To make a huge impact, there has always been an expressed need for the UN Country Office to ensure a single HIV basket funding.
- Support in the area of resource mobilisation to ensure that the NSP targets are met. Currently the Global Fund is the main donor funding the operations of the response. Additional support is needed to address the financing gap in order to meet the targets set in the National Strategic Plan 2015-2019
- Support the NAS to develop a Technical Assistance Plan to articulate the technical capacity needs with regards to the optimal implementation of the National HIV and AIDS Strategic Plan. Such a plan will engender better coordination of TAs.
- Development Partners should advocate as well as collectively provide the much needed oversight in the national response, for example through joint meetings and supervisory visits and periodic programme implementation updates. This will provide good guidance in the implementation of the NSP as well as improve donor/partner coordination.
- Support through continuous advocacy the fight against stigma and discrimination with regards to HIV and AIDS.
- Include poverty reduction initiatives in the national response to HIV and AIDS
- Health System Strengthening in particular ensure availability of services for PLHIVs in public health facilities (e.g. establishment of ' Point of Care and capacity building for health care workers and strengthening of supply gain management mechanism
- More investment is needed into the HIV program and strengthening of the capacity of the health system, more staff needs training especially in specialised areas of health, inject more incentives as a retention package without this the

system will continue to lose the train skill health care workers to the developed world.

VII. Monitoring and evaluation environment

a) Overview of the Current Monitoring and Evaluation System

Monitoring and evaluation (M&E) of the national HIV response is under the purview of the NAS. Under the NSF 2009-2014, the M&E focus is to strengthen HIV surveillance systems, and conduct 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 an M&E Officer and two Data Managers. In addition to this central team the Regional AIDS Co-ordinators (RACs) have M&E functions at the regional and community levels. Some of the partners to the national HIV response do have M&E units and/or do carry out M&E functions. There is an HIV and AIDS M&E Reference Group (MERG) that meets quarterly. The MERG consists of M&E experts from stakeholders and it provides technical support to NAS on M&E issues.

In 2014, 2 studies were conducted – a Behavioural Sentinel Surveillance (BSS) and National HIV Sentinel Survey (NSS). As part of the new NSP 2015-2019 developed in 2014, an M&E Plan was developed. The purpose of the national HIV M&E system described in the plan is to provide timely, high quality data.

In addition, the following have been noted:

- Current M&E system is functional but need to be improved
- Over the years, efforts to strengthen capacity in monitoring and evaluation have ensured that the HIV M&E system is able to produce regular reports about the performance of the national response to HIV and AIDS
- Sustaining the capacity building in Health Information Systems and M&E so that all investments into the national response can be adequately evaluated with quality assured data systems

- The M&E indicators have been harmonized and the data collection systems have been integrated into the national HMIS
- The M&E Team meets the basic requirements for coordinating activities
- The team has a wealth of knowledge on database for reporting
- The team has a good understanding of indicators and how to collate them from the source
- The team has the ability to analyze data and write report

b) Challenges faced in the implementation of a comprehensive M&E system and remedial actions planned to overcome the challenges

This M&E Plan does not introduce a new system but seeks to remedy weaknesses in the existing system. The final version of the M&E Plan was reviewed and approved by the national Monitoring and Evaluation Reference Group (MERG).

The principal shortcoming relates to inadequate implementation of the M&E component of the "*Three Ones*" principle. In summary, although there has always been "*one AIDS action framework*" and "*one national AIDS coordinating authority*", the National AIDS Secretariat only routinely receives data on interventions it is funding. In the past seven years, this funding has been almost exclusively courtesy of the *Global Fund to Fight AIDS, Tuberculosis and Malaria*. Therefore, the HIV M&E system has essentially functioned as a grant reporting system.

The main weaknesses and the planned remedial actions have been organized into three broad categories based on the *UNAIDS 12 Components Monitoring and Evaluation System* and are shown in the table below.

Table 8: Weaknesses in the National HIV M&E system and planned remedial actions

Components of M&E System	Main weaknesses	Remedial actions
A: People, partnerships and planning		
1. Organisational structures with HIV M&E functions 2. Human capacity for HIV M&E 3. Partnerships to plan, coordinate, and manage the HIV M&E system 4. National multisectoral HIV M&E Plan 5. Annual costed national HIV M&E work plan 6. Advocacy, communications, and culture for HIV M&E	• Limited number of personnel with adequate knowledge and skills in monitoring and evaluation. • Limited capacity to design, conduct and report operational research.	• Develop national training/ learning curriculum and full set of training/learning modules for M&E and operational research. • Train master trainers capable of delivering the curriculums. • Establish database of trainers in M&E and operational research.
B: Collecting, verifying, and analysing data		
7. Routine HIV programme monitoring 8. Surveys and surveillance 9. National and sub-national HIV databases 10. Supportive supervision and data auditing 11. HIV evaluation and research	Primary data collection tools (registers) do not capture all of the data that is required for complete reporting on indicators in the NSP performance framework.	Review and revise registers and reporting forms to ensure they include all variables required for complete reporting.
	Respondents in the Behavioural Surveillance Survey (BSS) are drawn from the catchment population of HIV sentinel surveillance sites and, therefore, are not representative of the general population.	Modify the Behavioural Surveillance Survey so that: (a) the sample of respondents is representative of the general population; (b) survey participants include all relevant population groups e.g. pregnant women; (c) questionnaire collects data based on the definitions of indicators in the NSP performance framework; (d) reduce duplication by removing KAP from the BSS since these are surveyed in Integrated Bio-Behavioural Survey of key affected populations; (e) it collects data on household wealth; and (f) includes HIV testing during the 2018 survey if DHS will not be conducted.
	The formulation of several questions in the BSS questionnaire is not consistent with the definitions of the relevant indicators in the NSP performance framework.	
	The BSS collects information on key affected populations. This amounts to duplication since the same information, and more, is collected during the Integrated Bio-Behavioural Survey of key affected populations.	
	There is uncertainty about sustainability of Demographic & Health Survey.	
	Data generated from activities that are not conducted by health facilities are not routinely reported to the National AIDS Secretariat, for instance, peer health education of in-school youths, among others.	Expand the national DHIS 2 database to include data for all indicators (impact, outcome, output) in the NSP performance framework and require all stakeholders to report through the DHIS 2 system.
	Inadequate clarity about how monitoring and supervision visits conducted by regional teams, the National AIDS Control Programme and the National	Develop objectives and an integrated schedule for monitoring and supervision visits to enhance complementarity and minimize duplication.

Components of M&E System	Main weaknesses	Remedial actions
	AIDS Secretariat complement rather than duplicate one another.	
	Inadequate characterization of implementation bottlenecks and determinants of individual behaviour related to HIV prevention, treatment, care & support.	• Develop a national operational research agenda to support implementation of the NSP. • Design and conduct operational research studies.
	No robust independent evaluation of the national response to HIV since 2004.	Commission an independent evaluation in 2017 based on internationally recognised standards.
C: Using data for decision making		
12. Data dissemination and use	Inadequate interpretation of data and incomplete consideration of implications of available data during programme planning.	Emphasise module on interpretation of data and systems thinking in programme planning and implementation during M&E and operational research training.

c) Opinion on need for M&E technical assistance and capacity-building

- NAS in collaboration with partners should conduct a comprehensive training and capacity needs assessment to articulate the capacity needs with regards data analysis, reporting, presentation and use. Such an assessment should culminate in the development of a realistic M&E training and capacity development plan.
- Capacity building for training in M&E and financial management
- Updating of M&E system from manual registers to computerized system
- Provide alternative energy system for modernised and upgraded M&E system
- Training of M&E staff at all levels of implementation
- PLHIVs will need technical assistance in the areas of monitoring and evaluation,
- Build capacity of NAS and partners to conduct evidence based studies
- Document the minimum M&E and operational research knowledge and skill requirements for M&E personnel at each level of the The Gambia HIV M&E system which could be done by TA
- Develop and deploy new electronic register to capture & follow up individual PLHIV in care (for those on care and ART)
- Capacity building of the M&E Team on Monitoring and Evaluation will greatly enhance knowledge and skills of the team
- Technical assistance in the areas of capacity building as well as strategic plan development e.g. the national response has never conducted a gender

vulnerability assessment and this strategic information is needed to inform programmes about their areas of intervention.

Annex 1: GARPR Validation Workshop Participants' List

Name	Institution
1. Ousman Camara	National AIDS Secretariat
2. Lamin Badjie	National AIDS Secretariat
3. Buramy Mendy	ActionAid International
4. Sulayman Keita	ActionAid International
5. Bai Cham	ActionAid International
6. Saikuna Sagnia	National AIDS Secretariat
7. Ousman Sowe	National AIDS Secretariat
8. Baba Jammeh	National AIDS Secretariat
9. Nfamara Keita	HMIS, MoHSW
10. Ivan Coker	RHT W1, MoHSW
11. Kebba D. Sanneh	National Leprosy & Tuberculosis Control Programme, MoHSW
12. Haddy Jagne	National AIDS Control Programme, MoHSW
13. Olymatou Cox	UNAIDS
14. Alpha Khan	National AIDS Secretariat
15. Samba Sey	Santa Yallah Support Society
16. Cherno Jallow	Riders for Health
17. Lamin D. Njie	National AIDS Secretariat
18. Momodou L. Bah	Santa Yallah Support Society
19. Alhagie Kolley	UNFPA
20. Omar Gaye	National AIDS Secretariat
21. Ousman Badjie	National AIDS Secretariat
22. Momodou K. Cham	CIAM Public Health Research and Development Centre
23. Haddy M. Barrow	National AIDS Secretariat
24. Sira Ndow	UNAIDS
25. Annet Burungi	World Food Programme