UNGASS COUNTRY PROGRESS REPORT

The Gambia

Reporting period: January 2006–December 2007

Submission date: 15th January 2008

NATIONAL AIDS SECRETARIAT
OFFICE OF THE PRESIDENT
JANUARY 2008

With support from

UNAIDS
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### ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti Retroviral drug</td>
</tr>
<tr>
<td>BSS</td>
<td>Behavioural Sentinel Surveillance</td>
</tr>
<tr>
<td>CIAM</td>
<td>Centre for Innovation Against Malaria</td>
</tr>
<tr>
<td>CCSI</td>
<td>Community and Civil Society Initiative</td>
</tr>
<tr>
<td>DoC</td>
<td>Declaration of Commitment</td>
</tr>
<tr>
<td>DoSH</td>
<td>Department of State for Health</td>
</tr>
<tr>
<td>DoSE</td>
<td>Department of State for Education</td>
</tr>
<tr>
<td>GCCI</td>
<td>The Gambia Chamber of Commerce and Industry</td>
</tr>
<tr>
<td>GLF</td>
<td>Gambia Local Fund</td>
</tr>
<tr>
<td>HARRP</td>
<td>HIV/AIDS Rapid Response Project</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HOC</td>
<td>Hands on Care</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MDG</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MRC</td>
<td>Medical Research Council</td>
</tr>
<tr>
<td>NAC</td>
<td>National AIDS Council</td>
</tr>
<tr>
<td>NACP</td>
<td>National AIDS Control Programme</td>
</tr>
<tr>
<td>NCPI</td>
<td>National Composite Policy Index</td>
</tr>
<tr>
<td>NHLS</td>
<td>National Health Laboratory Services</td>
</tr>
<tr>
<td>NAS</td>
<td>National AIDS Secretariat</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>OI</td>
<td>Opportunistic Infections</td>
</tr>
<tr>
<td>PTCT</td>
<td>Parent to Child Transmission</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PLWHA</td>
<td>People Living with HIV/AIDS (this term is now replaced with PLHIV)</td>
</tr>
<tr>
<td>TANGO</td>
<td>The Association of Non-Governmental Organizations</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint UN Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDP</td>
<td>United Nations Development Programme</td>
</tr>
<tr>
<td>UNGASS</td>
<td>United Nations General Assembly Special Session</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
I  STATUS AT A GLANCE

Introduction
The preparation of The Gambia’s 2008 UNGASS country report followed a participatory and inclusive process. The 2008 reporting guidelines provided by UNAIDS were presented to the Task Force established to oversee the process. Two local consultants supported the process to collect data as per the revised core indicators and prepare a draft report. Key partners were interviewed, programme reports reviewed. Two validation meetings were conducted, firstly to review and validate the collected data and secondly to review the draft report.

Status of the Epidemic
Two decades after the first confirmed case, The Gambia continues to have a relatively low prevalence of HIV and AIDS. Preliminary reports from the National Sentinel Surveillance (NSS) indicate a prevalence of 2.8% for HIV-1 and 0.9% for HIV-2 among antenatal women between the ages of 15 and 49 years attending clinic.

Data on HIV prevalence is routinely collected from pregnant women through the NSS. The first round of the HIV NSS among antenatal women was conducted between May 2000 and August 2001 in four health facilities in different parts of the country, namely Serre Kunda, Sibanor, Farafenni and Basse. In 2002, two additional sentinel sites were added (Brikama and Kuntaur) and in 2005 two more sites again added (Essau and Soma). In 2006 one more site (Poly Clinic in Banjul) was included. The total number of sentinel sites is now nine. These nine sites are distributed among the country’s eight local government areas (LGA), with the Brikama and Kerewan LGAs having 2 sites each. Only one LGA, Janjangbureh, is without a sentinel site.

In The Gambia, as in the rest of Africa, two transmission mechanisms account for most new HIV infections in the country: heterosexual contact, accounting for nearly 80% of all new infections; and parent-to-child (PTCT) transmission, accounting of between 10-15% of new infections).

Policy and Programmatic Response
The response to the epidemic has evolved over the years. Initially it was health focused, with the setting up of a National AIDS Control Programme under the Ministry of Health, and policies and guidelines on HIV/AIDS developed in 1995 with two stated 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 2000 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). In November of the same year 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. The HARRP project triggered 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:

- 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.

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, states:

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 programme covers six broad objectives, namely:

1. To provide access to voluntary counselling and testing for 20% of the population by 2006
2. To provide access to the prevention of parent to child transmission for 30% of pregnant mothers in The Gambia by 2006
3. To provide access to clinical care including the treatment and prevention of opportunistic infection for 30% of eligible PLWHAs by 2006
4. To provide access to safe and well monitored ART for 20% of all PLWHAs eligible for HAART by 2006.
5. To provide community care services to 20% of PLWHAs by 2006.
6. To build capacity in the health sector (government, NGO and private sector) and civil society organisations to provide high quality care for PLWHAs by 2006

In 2006 the HIV/AIDS policy guidelines were revised to cover the period 2006-2010. The goal of the policy is:

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

The period between January 2006 and December 2007 witnessed major events in the HIV and AIDS national response. The World Bank (WB) funded HIV/AIDS Rapid Response Project (HARRP) ended in December 2006. The US$15 million WB credit has been providing major support to HIV and AIDS prevention efforts especially to community and civil society initiatives (CCSI), including non-governmental organizations (NGOs), which received approximately 53% of project funds.
Overview of UNGASS Indicator Data

NATIONAL COMMITMENT AND ACTION

Expenditures:
1. Domestic and international AIDS spending by categories and financing sources
   D465,615,883.80
   (Source: National AIDS Secretariat)

Policy Development and Implementation Status
2. National Composite Policy Index

National Programmes
3. Percentage of donated blood units screened for HIV in a quality assured manner:
   No Data Available
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy:
   Jan-Dec 2006: 5.3% (339/6208)
   Jan-Sep 2007: 8.8% (423/4787)
   (Source: NAS/CIAM)
5. Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of
   mother-to-child transmission
   Jan-Dec 2006: 11.1% (102/920)
   Jan-Sep 2007: 14.1% (100/709)
   (Source: NAS/CIAM, 2007)
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV
   No Data Available
7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and
   who know their results
   9.6% (220/2294)
   (Source: BSS 2005)
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and
   who know their results:
   No Data Available
9. Percentage of most-at-risk populations reached with HIV prevention programmes:
   No Data Available
10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic
    external support in caring for the child:
    No Data Available
11. Percentage of schools that provided life skills-based HIV education in the last academic year:
    32.6% (198/607)
    (Source: DoSE, 2007)

KNOWLEDGE AND BEHAVIOUR

12. Current school attendance among orphans and among non-orphans aged 10–14:
    Part A: Current school attendance rate of orphans aged 10-14
    Both sexes: 65.1%
    Males: 76.8%
    Females: 55.3%
    (Source: MICS3, 2006)
    Part B: Current school attendance rate of children aged 10–14 both of whose parents are
    alive and who live with at least one parent
    Both sexes: 75.3%
    Males: 77.8%
    Females: 72.9%
    (Source: MICS3, 2006)
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission:
   29.5% (336/1139)
   (Source: BSS 2005)

14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission:
   No Data Available

15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15:
   Both sexes: 7.4% (84/1139)
   Males: 7.4% (42/570)
   Females: 7.4% (42/569)

16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months:
   6.8% (156/2294)
   Males: 11.3% (129/1143)
   Females: 2.3% (27/1151)

17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse:
   No Data Available

18. Percentage of female and male sex workers reporting the use of a condom with their most recent client:
   Using male and female respondents who have had sex with commercial partners as a proxy, 70.0% and 60.0%, respectively, reported using condoms
   (Source: BSS 2005)

19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner:
   No Data Available

20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse:
   No Data Available

21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected:
   No Data Available

IMPACT

22. Percentage of young women and men aged 15–24 who are HIV infected:
   2.4% (44/1847)
   (Source: 2006 National Sentinel Surveillance, Preliminary Results)

23. Percentage of most-at-risk populations who are HIV infected:
   No Data Available

24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy:
   92% (112/122)

25. Percentage of infants born to HIV-infected mothers who are infected:
   No Data Available
Global Commitment & Action

1. Amount of bilateral and multilateral financial flows (commitments and disbursements) for the benefit of low and middle income countries:
   US$4,915,370.15 for the period January 2006 – December 2007
   (Source: Interviews with bilateral and multilateral partners)

2. Amount of public funds for Research and Development of preventive HIV vaccines and microbicides:
   US$0
   (Source: NAS)

3. Percentage of trans-national companies which are present in developing countries and which have HIV/AIDS workplace policies and programmes:
   15.4% (4 out of 26 companies)
   (Source: GCCI and interviews with companies)

4. Percentage of international organizations which have workplace policies and programmes:
   75.0% (9 out of 12 international organizations)
   (Source: TANGO, and interviews with organizations)

II OVERVIEW OF THE HIV AND AIDS EPIDEMIC

Table 1: Prevalence of HIV-1 and HIV-2 among antenatal women by sentinel site, 2002 to 2006

<table>
<thead>
<tr>
<th>Sentinel Site</th>
<th>Indicator</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serekunda</td>
<td>Sample</td>
<td>500</td>
<td>503</td>
<td>501</td>
<td>498</td>
<td>498</td>
</tr>
<tr>
<td>HIV-1</td>
<td>1 (0.2%)</td>
<td>12 (2.4%)</td>
<td>11 (2.2%)</td>
<td>5 (1.0%)</td>
<td>14 (2.8%)</td>
<td></td>
</tr>
<tr>
<td>HIV-2</td>
<td>2 (0.4%)</td>
<td>6 (1.2%)</td>
<td>7 (1.4%)</td>
<td>3 (0.6%)</td>
<td>0 (0.0%)</td>
<td></td>
</tr>
<tr>
<td>Brikama</td>
<td>Sample</td>
<td>500</td>
<td>505</td>
<td>500</td>
<td>499</td>
<td>499</td>
</tr>
<tr>
<td>HIV-1</td>
<td>12 (2.4%)</td>
<td>4 (0.8%)</td>
<td>10 (2.0%)</td>
<td>13 (2.6%)</td>
<td>24 (4.8%)</td>
<td></td>
</tr>
<tr>
<td>HIV-2</td>
<td>5 (1.0%)</td>
<td>3 (0.6%)</td>
<td>2 (0.4%)</td>
<td>3 (0.6%)</td>
<td>10 (2.0%)</td>
<td></td>
</tr>
<tr>
<td>Sibanor</td>
<td>Sample</td>
<td>500</td>
<td>502</td>
<td>502</td>
<td>500</td>
<td>496</td>
</tr>
<tr>
<td>HIV-1</td>
<td>17 (3.4%)</td>
<td>14 (2.8%)</td>
<td>14 (2.8%)</td>
<td>11 (2.2%)</td>
<td>21 (4.2%)</td>
<td></td>
</tr>
<tr>
<td>HIV-2</td>
<td>10 (2.0%)</td>
<td>15 (3.0%)</td>
<td>7 (1.4%)</td>
<td>4 (0.8%)</td>
<td>12 (2.4%)</td>
<td></td>
</tr>
<tr>
<td>Farafenni</td>
<td>Sample</td>
<td>346</td>
<td>446</td>
<td>488</td>
<td>486</td>
<td>489</td>
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<tr>
<td>HIV-1</td>
<td>0 (0%)</td>
<td>3 (0.7%)</td>
<td>9 (1.8%)</td>
<td>2 (0.4%)</td>
<td>12 (2.5%)</td>
<td></td>
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<tr>
<td>HIV-2</td>
<td>5 (1.4%)</td>
<td>1 (0.2%)</td>
<td>4 (0.8%)</td>
<td>1 (0.2%)</td>
<td>1 (0.2%)</td>
<td></td>
</tr>
<tr>
<td>Kuntaur</td>
<td>Sample</td>
<td>159</td>
<td>498</td>
<td>402</td>
<td>446</td>
<td>424</td>
</tr>
<tr>
<td>HIV-1</td>
<td>1 (0.6%)</td>
<td>6 (1.2%)</td>
<td>4 (1.0%)</td>
<td>4 (0.9%)</td>
<td>1 (0.2%)</td>
<td></td>
</tr>
<tr>
<td>HIV-2</td>
<td>1 (0.6%)</td>
<td>4 (0.8%)</td>
<td>0 (0%)</td>
<td>5 (1.1%)</td>
<td>1 (0.2%)</td>
<td></td>
</tr>
<tr>
<td>Basse</td>
<td>Sample</td>
<td>312</td>
<td>504</td>
<td>505</td>
<td>528</td>
<td>444</td>
</tr>
<tr>
<td>HIV-1</td>
<td>1 (0.3%)</td>
<td>4 (0.8%)</td>
<td>14 (2.8%)</td>
<td>7 (1.3%)</td>
<td>18 (4.1%)</td>
<td></td>
</tr>
<tr>
<td>HIV-2</td>
<td>0 (0%)</td>
<td>2 (0.4%)</td>
<td>4 (0.8%)</td>
<td>3 (0.6%)</td>
<td>6 (1.4%)</td>
<td></td>
</tr>
</tbody>
</table>

Trans-national companies are defined as companies operating in more than one country, including The Gambia, and registered with the Gambia Chamber of Commerce and Industry.
The National Sentinel Surveillance (NSS) conducted among antenatal women, aged 15-49 years, has been the main methodology used by The Gambia to estimate the prevalence of HIV in the country. Preliminary results from the 2006 sentinel surveillance show 2.8% prevalence for HIV-1 and 0.9% for HIV-2. The NSS started in 2000/2001 in four sites: Serrekunda, Sibnor, Farafenni and Basse health centres. The ninth site was opened at the Polyclinic in the capital, Banjul, in 2006. At the start of the epidemic in 1986, HIV-2 was more prevalent. The pattern has changed over the years with HIV-1 now the main virus driving the epidemic.

<table>
<thead>
<tr>
<th></th>
<th>Sample</th>
<th>HIV-1</th>
<th>HIV-2</th>
<th>543</th>
<th>407</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>0 (0%)</td>
<td>13 (3.2%)</td>
</tr>
<tr>
<td></td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>0 (0%)</td>
<td>4 (1.0%)</td>
</tr>
<tr>
<td>Soma</td>
<td>Sample</td>
<td>HIV-1</td>
<td>HIV-2</td>
<td>529</td>
<td>424</td>
</tr>
<tr>
<td></td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>1 (0.2%)</td>
<td>6 (1.4%)</td>
</tr>
<tr>
<td></td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>6 (1.1%)</td>
<td>1 (0.2%)</td>
</tr>
<tr>
<td>Banjul</td>
<td>Sample</td>
<td>HIV-1</td>
<td>HIV-2</td>
<td>458</td>
<td>4139</td>
</tr>
<tr>
<td></td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>7 (1.5%)</td>
<td>2 (0.4%)</td>
</tr>
<tr>
<td></td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>Not yet introduced</td>
<td>2 (0.4%)</td>
<td>1 (0.0%)</td>
</tr>
<tr>
<td>Total</td>
<td>Sample</td>
<td>HIV-1</td>
<td>HIV-2</td>
<td>4029</td>
<td>4139</td>
</tr>
<tr>
<td></td>
<td>32 (1.4%)</td>
<td>43 (1.5%)</td>
<td>62 (2.1%)</td>
<td>43 (1.1%)</td>
<td>116 (2.8%)</td>
</tr>
<tr>
<td></td>
<td>23 (1.0%)</td>
<td>31 (1.0%)</td>
<td>24 (0.8%)</td>
<td>25 (0.6%)</td>
<td>37 (0.9%)</td>
</tr>
<tr>
<td>15-24</td>
<td>Sample</td>
<td>HIV-1</td>
<td>HIV-2</td>
<td>1180</td>
<td>1847</td>
</tr>
<tr>
<td></td>
<td>10 (0.8%)</td>
<td>19 (1.3%)</td>
<td>27 (2.0%)</td>
<td>10 (0.5%)</td>
<td>44 (2.4%)</td>
</tr>
<tr>
<td></td>
<td>7 (0.6%)</td>
<td>11 (0.8%)</td>
<td>5 (0.4%)</td>
<td>6 (0.3%)</td>
<td>13 (0.7%)</td>
</tr>
</tbody>
</table>

Source: National AIDS Secretariat, 2007
Prevalence among younger antenatal women (15-24 years) has always been slightly lower than the estimates for older antenatal women (25-49 years), see Figure 2. In 2006 prevalence among 15-24-year old antenatal women was 2.4%, whilst for antenatal women 25-49 years it was 3.1%.

According to the 2006 annual statistics report, the HIV prevalence rate amongst those visiting voluntary counselling and testing (VCT) centres in 2006 was 9.8%. This higher prevalence may be due to a higher uptake of VCT services by those at greatest risk of contracting HIV. These groups include sex workers, commercial transport workers and partners of PLHIV. There was no difference between males and females. Among antenatal women receiving VCT for the prevention of parent-to-child-transmission (PTCT) of HIV, a prevalence of 2.7% was reported. This is almost equal to the 2.8% documented under the NSS for antenatal women.

Figure 3 shows the cumulative number of reported AIDS cases by age and sex, between 2004 and 2006. Reported cases represent only a small proportion of all AIDS cases; nonetheless, they can provide useful information about the nature of the HIV/AIDS epidemic in The Gambia.

As observed in Figure 3, more than 90% of AIDS cases are found among adults between the ages of 20 and 54. The peak ages amongst the reported AIDS cases are 30 to 44 for females and 40 to 49 for males.
III NATIONAL RESPONSE TO THE AIDS EPIDEMIC

1 National Commitment and Action

The government of The Gambia is strongly committed to achieving the Millennium Development Goal for HIV and AIDS. The political resolve has been expressed by the President, who is the Chairman of the National AIDS Council, and senior government officials. HIV and AIDS continue to be a national concern and priority with multi-sectoral approach. The National HIV/AIDS Policy was updated in 2006 and this document reflects the agenda for the response.

From the first PLHIV support group in the mid 90s there are now ten such groups nationwide and a network of AIDS support societies (GAMNASS). The period also witnessed the emergence of the private sector in the national response to HIV. A business coalition has been established in 2007 to provide the leadership role for private sector involvement in the HIV response.

In 2007, however, there was a decrease in national spending on HIV and AIDS, attributed to the ending of the WB funded HARRP project. The HARRP was a major source of funds for civil society organizations, including national and international NGOs. Since the end of the project there has been a huge funding gap in the HIV response. This has significantly limited action in the fight against the epidemic.

2 National Programmes and Behaviour

2.1 Blood Safety

The Gambia has a National Policy on Blood Transfusion, 2000. The aim according to the policy is:

The provision of adequate and safe blood for appropriate treatment of patients.

The policy provides guidelines for blood donor recruitment system through education and motivation of appropriately selected population groups and promotes appropriate use of blood and blood products. There is universal screening of donated blood with standard safety procedures. All donated blood is screened for HIV and VDRL. The National Health Laboratory Services (NHLS) is, however, not participating in an external quality assessment scheme for HIV screening. This is an important quality check in which external assessment of the NHLS’s performance is conducted using samples of known, but undisclosed, content to assess its quality system and assist in improving standards of performance.
2.2 HIV Treatment: Antiretroviral Therapy (ART)

As the epidemic increases the number of people reaching advanced stages of HIV infection also increases. At the beginning of January 2006, 166 PLHIV were on ART. By the end of 2006 the cumulative total on ART has increased to 339 (5.3%) out of an estimated 6208 PLHIV who should be reaching the advanced stages of HIV and therefore needing ART. As at end of September 2007 a cumulative total of 423 PLHIV were on ART. This number excludes those who have died, travelled out, defaulted or withdrawn from the treatment.

2.3 Prevention of Mother-to-Child Transmission

In the absence of any preventative interventions, infants born to and breastfed by HIV-infected women have roughly a one-in-three chance of acquiring infection themselves. This can happen during pregnancy, during labour and delivery or after delivery through breastfeeding. The risk of mother-to-child transmission can be significantly reduced through the complementary approaches of antiretroviral prophylactic regimes for the mother with or without prophylaxis to the infant, implementation of safe delivery practices and use of safe alternatives to breastfeeding. Antiretroviral prophylaxis followed by exclusive breastfeeding may also reduce the risk of vertical transmission when breastfeeding is limited to the first six months.

In 2006 a total of 102 HIV-infected pregnant women received antiretrovirals during the last 12 months to reduce mother-to-child transmission out of an estimated 920 HIV-infected pregnant women for the same 12 months. The percentage of HIV-infected pregnant women who received antiretrovirals in 2006 to reduce the risk of mother-to-child transmission is therefore 11.1%. (Source: NAS/CIAM)

Between January and September 2007, 100 HIV-infected pregnant women received antiretrovirals during the last 12 months (Source: NAS/CIAM). Figures for October to December 2007 will not be available in time to be included in the UNGASS report.

2.4 Co-management of Tuberculosis and HIV Treatment

Tuberculosis (TB) is one of the commonest causes of morbidity and mortality in people living with HIV, even those on antiretroviral therapy. Intensified TB case-finding and access to quality diagnosis and treatment of TB in accordance with international/national guidelines is essential for improving the quality and quantity of life for people living with HIV. A measure of the percentage of HIV-positive TB cases that access appropriate treatment for their TB and HIV is important.

Whilst this indicator is relevant for The Gambia, no data is currently available. Both the NAS and the Tuberculosis Control Programme recognize the importance of collecting data on the indicator. The two institutions are collaborating to collect the required data.
2.5 HIV Testing in the General Population

In order to protect themselves and to prevent infecting others, it is important for individuals to know their HIV status. Knowledge of one’s status is also a critical factor in the decision to seek treatment.

This indicator was derived from the 2005 National BSS study. Out of a total of 2294 respondents between 15-49 years, 220 (9.6%) received an HIV test in the previous 12 months and who knew their results. (Source: 2005 BSS Study)

2.6 Indicators for Most-at-risk Populations

No data are currently available on indicators for CSWs, IDUs and MSM.

2.7 Support for Children Affected by HIV and AIDS

As the number of orphaned and vulnerable children continues to grow, adequate support to families and communities needs to be assured. In practice, care and support for orphaned children comes from families and communities. As a foundation for this support, it is important that households are connected to additional support from external sources.

In 2006, 1,303 orphans and vulnerable children (OVC) received free basic external support. By September 2007 the number of OVC receiving free basic external support has increased to 1,587 (Source: NAS/CIAM).

2.8 Life Skills-based HIV Education in Schools

Life skills-based education is an effective methodology that uses participatory exercises to teach behaviours to young people that help them deal with the challenges and demands of everyday life. It can include decision-making and problem-solving skills, creative and critical thinking, self-awareness, communication and interpersonal relations. It can also teach young people how to cope with their emotions and causes of stress. When adapted specifically for HIV education in schools, a life skills-based approach helps young people understand and assess the individual, social and environmental factors that raise and lower the risk of HIV transmission. When properly implemented, it can have a positive effect on behaviours, including delay in sexual debut and reduction in number of sexual partners.

According to the Department of State for Basic and Secondary Education a total of 198 (32.6%) out of 607 lower basic, upper basic and senior secondary schools are conducting life skills-based HIV Education. A curriculum was developed by the department for use by schools under the Population and Family Life Education subject.
2.9 Orphans: School Attendance

AIDS is claiming ever-growing numbers of adults just at the time in their lives when they are forming families and bringing up children. As a result, orphan prevalence is rising steadily in many countries, while fewer relatives within the prime adult ages mean that orphaned children face an increasingly uncertain future. Orphanhood is frequently accompanied by prejudice and increased poverty, factors that can further jeopardize children’s chances of completing school education and may lead to the adoption of survival strategies that increase vulnerability to HIV. It is important therefore to monitor the extent to which AIDS support programmes succeed in securing the educational opportunities of orphaned children.

The Gambia/UNICEF MICS3 study conducted in 2005/2006 report 65.1% of children aged 10-14 yrs., who have lost both parents are attending school; and 75.3% of children aged 10-14 yrs., both of whose parents are alive, who are living with at least one parent are attending school.

2.10 Young People: Knowledge about HIV Prevention

HIV epidemics are perpetuated primarily through sexual transmission of infection to successive generations of young people. Sound knowledge about HIV is an essential pre-requisite—albeit, often an insufficient condition—for adoption of behaviours that reduce the risk of HIV transmission.

This indicator is constructed from responses to the following set of prompted questions:

1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing food with someone who is infected?

<table>
<thead>
<tr>
<th>Question</th>
<th>Both Sexes</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?</td>
<td>80.6%</td>
<td>80.7%</td>
<td>80.5%</td>
</tr>
<tr>
<td>Can using condoms reduce the risk of HIV transmission?</td>
<td>69.3%</td>
<td>70.7%</td>
<td>67.8%</td>
</tr>
<tr>
<td>Can a healthy-looking person have HIV?</td>
<td>72.2%</td>
<td>75.1%</td>
<td>69.1%</td>
</tr>
<tr>
<td>Can a person get HIV from mosquito bites?</td>
<td>66.6%</td>
<td>71.4%</td>
<td>61.9%</td>
</tr>
<tr>
<td>Can a person get HIV by sharing a meal with someone who is infected?</td>
<td>68.2%</td>
<td>69.5%</td>
<td>67.0%</td>
</tr>
</tbody>
</table>
A total of 336 out of 1139 respondents aged 15-24 years gave correct answers to all 5 questions. The percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission is therefore 29.5%. (Source: 2005 BSS Study)

2.11 Sex Before the Age of 15

A major goal in many countries is to delay the age at which young people first have sex and discourage premarital sexual activity because it reduces their potential exposure to HIV. There is also evidence to suggest that first having sex at a later age reduces susceptibility to infection per act of sex, at least for women.

In the 2005 BSS Study 84 (7.4%) out of 1134 respondents aged 15-24 yrs. reported having had sexual intercourse before the age of 15. According to MIC3, 3.9% of females aged 15-19 years reported having had sexual intercourse before the age of 15.

2.12 Higher-risk Sex

The spread of HIV largely depends upon unprotected sex among people with a high number of partnerships. Individuals who have multiple partners (concurrently or sequentially) have a higher risk of HIV transmission than individuals that do not link into a wider sexual network.

In the 2005 BSS Study a total of 156 (6.8%) out of 2294 respondents aged 15–49 years have had sexual intercourse with more than one partner in the last 12 months.

2.13 Condom Use During Higher-risk Sex

Condom use is an important measure of protection against HIV, especially among people with multiple sexual partners.

Whilst this indicator is relevant for The Gambia, no data are currently available.

2.14 Reduction in HIV Prevalence

The goal in the response to HIV is to reduce HIV infection. As the highest rates of new HIV infections typically occur in young adults, more than 180 countries have committed themselves to achieving major reductions in HIV prevalence among young people—a 25% reduction in the most affected countries by 2005 and a 25% reduction globally by 2010.

Preliminary findings from the 2006 National Sentinel Surveillance report out of 1847 antenatal women aged 15-24 years who were tested for their HIV infection status, 44 (2.4%) are HIV-1 infected.
2.15 HIV Treatment: Survival After 12 Months on Antiretroviral Therapy

One of the goals of any ART programme is to increase survival among infected individuals. As ART is scaled up in countries around the world, it is also important to understand why and how many people drop out of treatment programmes. These data can be used to demonstrate the effectiveness of those programmes and highlight obstacles to expanding and improving them.

Between October 2005 and September 2006 a total of 112 out of 122 persons were still alive and on antiretroviral therapy (ART) at 12 months after initiating treatment. The percentage of persons with HIV known to be on treatment 12 months after initiation of antiretroviral therapy, is therefore 91.8%. (Source: NAS/CIAM)

2.16 Reduction in Mother-to-Child Transmission

In high-income countries, strategies such as antiretroviral therapy during pregnancy and following birth, and the use of breastfeeding substitutes have greatly reduced the rate of mother-to-child HIV transmission. In low-income countries, significant difficulties exist in implementing these strategies due to constraints in accessing, affording and using voluntary counselling and testing services, reproductive health, and maternal and child health services, which have integrated prevention of mother-to-child transmission (PMTCT) interventions, including breast milk substitute (where this is part of the country’s policy on PMTCT). Nevertheless, substantial reductions in mother-to-child transmission can be achieved through approaches such as short-course antiretroviral prophylaxis.

Whilst this indicator is relevant for The Gambia, no data are currently available. The NAS recognizes this and is committed to remedying the gaps.

IV BEST PRACTICES

Best practices from countries will most certainly vary. For The Gambia there are two best practices to share:

- Community and Civil Society Initiatives (CCSI), under HARRP.
- Outsourcing of the M&E component to CIAM

1. CCSI, one of the components of the WB funded HARRP project, was a pilot strategy that was implemented nationwide. It is a financing mechanism that provided grant resources to support community, civil society, worker associations, and “establishment or primary unit” initiatives (“establishments or primary units” are businesses, military camps, prisons, refugee camps, religious groups, trade associations, sports clubs and the like). This component has been
therefore supporting both “community-based” and “community-involved” activities. The CCSI had, in 5 years, disbursed over D241 million for 3881 projects. This vast quantum of funds enabled organizations participate in the HIV/AIDS response and fulfilled the key objective of the strategy of providing a financing mechanism for civil society organizations.

The CCSI funded projects have enhanced community knowledge about HIV/AIDS, its transmission and prevention, especially among females. It has brought the epidemic to the forefront and people are now willing to discuss about the disease more than ever before. The contribution of the project towards the capacity building of the participating groups by encouraging them to gain legal status that allowed them to source funding and support from other organizations is recognized. The empowering nature as well as other benefits and impacts of the strategy listed above have all contributed immensely to the fight against the epidemic. The strategy ensured increased availability of resources to civil society organizations which helped to strengthen capacity of the community based organizations.

As part of the CCSI strategy the Stepping Stones was implemented by a consortium of NGOs. The Peer Health Education programme also implemented under the CCSI was estimated to have reached approximately 80,000 school children between 2003 and 2006.

2. The outsourcing the M&E component to a public health research institution was very innovative. NAS recognized that there would delay in developing a Monitoring Plan, for the GFATM funded HIV/AIDS component, to inform and guide monitoring activities due to limited in house capacity within the Secretariat as the Principal Recipient for the project.

The Centre for Innovation Against Malaria (CIAM), a public health institution based in The Gambia, was then assigned to set up and implement a Monitoring System for the GFATM funded HIV/AIDS Project. The responsibilities of NAS, CIAM and the sub-recipients were outlined in the Monitoring Plan. The overall purpose of the Monitoring System is to assist the project management and sub-recipients to comply with the project’s goal, objectives and strategies. The development of the Monitoring Plan was the first step in the process.

The purpose of the assignment was to provide valuable assistance to the NAS in a bid to carry out the monitoring functions as required by the Global Fund and the HIV/AIDS Rapid Response Project (HARRP), by meeting reporting and other M&E requirements to the Country Coordination Mechanism (CCM), the Local Fund Agent (LFA) and the Global Fund and the World Bank.
CIAM as the monitoring coordinator was expected to facilitate the successful development and effective implementation of a Monitoring Plan for the Global Fund HIV/AIDS programme. This entailed close interaction with all involved partners.

The Monitoring Plan emphasised the collection of valid and reliable quantitative and qualitative data obtained from a combination of integrated monitoring system and external spot-checking field visits. Furthermore, the plan addressed the assessment of strengths and weaknesses of the existing Monitoring System and proposed measures of sustainable adjustment as appropriate.

V MAJOR CHALLENGES AND REMEDIAL ACTIONS

1. Progress made on key challenges reported in the 2005 UNGASS Country Progress

Progress has been made in many of the key challenges reported in 2005. These include:

- **Access to HIV/AIDS services**: The GFATM funded project has enabled a significant increase in access to HIV/AIDS services in both urban and rural areas. As at end of September 2007, 26 health facilities were offering VCT services and a cumulative total of 27,022 people have undergone VCT. In the same period 19 health facilities were offering PTCT services, a cumulative total of 562 health workers have been trained in PTCT, and a cumulative total of 17,369 pregnant women have completed the counselling and testing process. Three hundred and fifty HIV-1 infected pregnant women received a complete course of ARV prophylaxis (Nevirapine) to reduce the risk of PTCT. Eight treatment centres are offering ART with appropriate laboratory facilities providing all essential tests for ART, 321 health workers have been trained in the management of HIV related opportunistic infections (OIs), and 327 health workers have been trained in the provision of ART. A total of 13 NGOs/private clinics were providing HIV/AIDS services.

- **Stigma, discrimination and denial** have also reduced considerably. PLHIV are now more willing to appear on television and disclose their status than ever before.

- **Mainstreaming HIV/AIDS** into all poverty reduction and other national developmental programmes and strategies. In December 2007 an HIV/AIDS mainstreaming training of trainers workshop was held in Dakar Senegal. A team of four Gambians participated in the training and it is expected they will conduct follow up activities at national and sub-national levels to mainstream HIV/AIDS in national developmental programmes. An issue paper was developed and
currently there is draft action plan to facilitate the mainstreaming of HIV in the Poverty Reduction Strategy Papers (PRSP). Resources would be available from the UN System to implement the action plan.

2. Challenges faced throughout the reporting period (2006-2007) that hindered the national response, in general, and the progress towards achieving the UNGASS targets, in particular.

Many of the challenges reported in 2005 still continue to be relevant during the 2006-2007 period. These include:

- **Co-ordination**: The National AIDS Secretariat continues to function without any legal mandate. This poses a great challenge, especially in enforcing the Three Ones principle. The re-structuring of NAS in 2007 and the termination of the post of Divisional/Municipal AIDS Co-ordinators at the close of the HARRP virtually ended the active presence of a regional structure for NAS at that level.

- **Capacity**: The inadequate human resources capacity due to the high attrition rate of mainly nurses and other professional health personnel continue to pose a great challenge.

- **Weak M&E framework**: Whilst the GFATM M&E indicators are being reported on periodically, other HIV/AIDS indicators, such as UNGASS, have not been given due attention.

- **Limited data on specific groups**: Unavailability of data on behavioural and biological characteristics of high-risk groups such as commercial sex workers, men who have sex with men, intravenous drug users, uniformed personnel, long distance truck drivers and fisher folks.

- **Sustainability**: The ending of the WB funded HARRP project created a significant gap in funding HIV/AIDS programmes and activities. In 2007 IEC activities have considerably scaled down. This is likely to have long term impact not only on knowledge but also on behaviour, especially among young persons.

- **Behaviour change**: Closing the gap between knowledge and behaviour.

- **Cross-border issues**: There should joint planning and collaboration with neighbouring countries.

3. Remedial actions

Many of the remedial actions recommended in 2005 to help achieve the agreed UNGASS targets continue to be relevant. These include:

- Promulgation of legislation establishing the National AIDS Council and National AIDS Secretariat.
Pursue the implementation of the Three Ones principle, which advocates for compliance to one strategic framework, one coordinating body and one M&E framework.

Invest both in pre-service and in-service training of professional health workers.

Review and operationalise the M&E framework to track core UNGASS and other national HIV/AIDS indicators.

Conduct a DHS+, which will help bridge the data gap

Creation of a budget line for the line departments by the government to ensure adequate funding to sustain the national response.

Diversifying the sources of funding through resource mobilization by NAC.

Increase IEC/BCC interventions to reduce the gap between knowledge and behaviour.

Enhancing dialogue and joint planning between countries in the sub-region on cross-border HIV/AIDS programmes.

Continue to expand the number of sites for VCT/PTCT (including youth friendly sites).

Establishment of additional treatment sites (including mobile treatment services) to increase access to ARVs.

VI SUPPORT FROM THE COUNTRY’S DEVELOPMENT PARTNERS

Major development partners continue to support the country’s HIV/AIDS response with inputs ranging from financial resources to equipment, materials and capacity building. Partners include the GFATM, WB, UNAIDS, WHO, UNICEF, UNDP, UNFPA, WFP, MRC, CIAM, and international and local NGOs. Under such an environment the challenge is to ensure proper co-ordination of programmes and maximization of resources.

At the end of 2006 the WB HARRP ended and with it considerable financial and material resources stopped flowing into the HIV/AIDS response. This gap has led to limited IEC/BCC activities in 2007. The country’s development partners should examine the impact that the HARRP has created with a view to providing support to continue to build on the achievements. Other support required includes:

- Technical assistance to the M&E Unit, including the introduction of CRIS;
• Collecting data on behavioural and biological indicators among most-at-risk groups;

• Human resource development especially for the health sector, where qualified personnel are in short supply;

• Assistance in the development of workplace HIV/AIDS policies and training of personnel to implement HIV/AIDS workplace programmes.

The *Three Ones* principle continues to be of relevance.

• *One* agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.

• *One* National AIDS Coordinating Authority, with a broad based multi-sector mandate.

• *One* agreed country level Monitoring and Evaluation System.

As stated earlier resources required to consolidate and expand the national response will be utilized most efficiently and effectively if there is maximum coordination between all stakeholders.

**VII MONITORING AND EVALUATION ENVIRONMENT**

The goal of M&E according to The Gambia HIV/AIDS Strategic Plan is to institutionalise an integrated and sustainable M&E system that is effective, efficient and responsive to guide programme implementation and performance. The NAS M&E component has been plagued with lack of personnel and attrition over the years. This has affected implementation of a unified M&E system as envisaged in the 2003-2008 strategic plan. An M&E task force was created but this body has not been meeting. The original task force membership and that of Departmental and sector HIV/AIDS focal points have changed without being replaced, or their replacements not quite knowing what their roles are. All these have combined to weaken the M&E component of NAS.

In spite of this weakness NAS, in partnership the National AIDS Control Programme (NACP) of the Department of State for Health (DoSH) and the Medical Research Council (MRC) Laboratories have been able to conduct the National Sentinel Surveillance (NSS) among antenatal women attending clinic. Another fruitful collaborative initiative is the outsourcing of the M&E component of the GFATM funded HIV/AIDS project to the Centre for Innovation Against Malaria (CIAM) in 2005 due to the absence of in-house capacity at NAS. CIAM is a non-profit organisation hosted by MRC. The Gates Malaria Partnership (GMP) set up the Centre in 2001 as one of four capacity building centres in sub-Saharan Africa. CIAM has set up a detailed and elaborate M&E system with customized and tested data collection tools. At the end of each quarter CIAM conducts supervisory visits to reporting centres to validate returns submitted by the centres.
before submitting its quarterly report to NAS. This innovative approach employed by CIAM ensures data of high quality are used for reporting.

The collaboration between NAS, DoSH, MRC and CIAM can be strengthened and expanded to cover a unified national HIV/AIDS M&E system. External technical assistance would be required to set up a unified national HIV/AIDS M&E system and build capacity at NAS, DoSH, MRC and CIAM. A new M&E Specialist has recently been recruited. An M&E Officer and two data entry clerks have also been hired. With these personnel the M&E Unit will be strengthened. The current M&E framework, expiring in 2008 will be reviewed with the aim of producing a revised comprehensive framework. The Gambia has not started using CRIS. It is hoped that with support from the country's UNAIDS office Country Reporting Information System (CRIS) will be introduced in 2008.

REFERENCE


ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?
   a) NAC or equivalent: Yes\(\sqrt{\text{ }}\), No
   b) NAP: Yes\(\sqrt{\text{ }}\), No
   c) Others (please specify): Yes\(\sqrt{\text{ }}\), No

2) With inputs from Ministries:
   - Education: Yes\(\sqrt{\text{ }}\), No
   - Health: Yes\(\sqrt{\text{ }}\), No
   - Labour: Yes, No\(\sqrt{\text{ }}\)
   - Foreign Affairs: Yes, No\(\sqrt{\text{ }}\)
   - Others (please specify): Yes\(\sqrt{\text{ }}\), No
   - Youth and Sports
   - Local Government and Lands
   - Tourism and Culture
   - Defence (the Armed Forces)
   - Interior (Police, Prisons, Fire and Ambulance Service)
   - National Nutrition Agency

   - Civil society organizations: Yes\(\sqrt{\text{ }}\), No
   - People living with HIV: Yes\(\sqrt{\text{ }}\), No
   - Private sector: Yes, No\(\sqrt{\text{ }}\)
   - United Nations organizations: Yes\(\sqrt{\text{ }}\), No
   - Bilaterals: Yes, No\(\sqrt{\text{ }}\)
   - International NGOs: Yes\(\sqrt{\text{ }}\), No
   - Others (please specify): Yes\(\sqrt{\text{ }}\), No
   - Medical Research Council
   - Centre for Innovation Against Malaria

3) Was the report discussed in a large forum? Yes\(\sqrt{\text{ }}\), No

4) Are the survey results stored centrally? Yes\(\sqrt{\text{ }}\), No

5) Are data available for public consultation? Yes\(\sqrt{\text{ }}\), No
6) Who is the person responsible for submission of the report and for follow-up if there are questions on the Country Progress Report?

Name / title: Mr. Alieu Jammeh, Director National AIDS Secretariat

Date: 15 January 2007

Signature:  

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