THE REPBULIC

OF THE GAMBIA

National HIV and AIDS Policy 2014

Zero new HIV infections,

Zero HIV related deaths,

Zero Discrimination of People Living with HIV in the Gambia by 2020

NATIONAL AIDS COUNCIL

2014

FOREWARD

HIV and AIDS is still one of the major public health and development challenges of The Gambia. The estimated number of PLHIV in the country according to the 2012 sentinel surveillance is projected at 32,380; the age groups 15-49 accounting for 11,030 PLHIVs[i]. The socio-economic burden of HIV/AIDS on individuals, families and the state is very high.

Heterosexual transmission, however, continues to be the main mode of spread of HIV in the country. Preliminary DHS 2013 Report indicates a national prevalence of 1.9%. This figure is higher than the 2011 and 2012 Sentinel Surveillance estimates of 1.65% and 1.57% for HIV prevalence respectively. The DHS findings indicate that despite the several policy, strategy and financial investments in the fight against this major social menace, HIV is still a major challenge to the socio-economic development of The Gambia.

A trend review of findings of behavioural sentinel surveillance reports over the years shows that whilst knowledge of the infection and prevention methods is growing in the population, this is not accompanied by any significant behavioral change pattern. The 2012 Behavioural Change Surveillance indicates an increase in risk of infection with age of the woman. The percentage of positive women age 25-34 years almost doubles (54.9%) those within the 15-24 years (32.1%). The 2012 report also shows that women with college level education were least infected with HIV (0.9%) as opposed to women who attained primary, secondary (15.2%), madarasa/Arabic and no education (39.3%). The Reports also indicates an increase in the risk of infection with parity. Infection rate was higher among pregnant women who reported more than four pregnancies. The findings tend to show a strong correlation between the socio-economic status of the woman and risk of HIV infection. These findings, therefore, call for revolutionary approaches for prevention of new HIV infection in the population to achieve the national goal of ***have reduced the burden of HIV and AIDS on the population of The Gambia to a level where it cease to be a major public health problem***

We have made tremendous progress in reducing morbidity and mortality related to HIV and AIDS, however, additional efforts are required for the country to achieve universal access to a comprehensive prevention, treatment and care package. This policy will provide the framework for the delivery of a comprehensive national response to HIV and AIDS burden reduction.

We are very much aware of the tremendous support being provided by the health development partners, notably the Global Fund to fight HIV and AIDS, Tuberculosis and Malaria to the national efforts in communicable disease burden reduction, I urge us all to embrace this policy to achieve the “Three Zeros” – Zero New Infection, Zero Deaths due to HIV and AIDS, Zero Discrimination- for improved quality of life of the population and the accelerated socio-economic development of The Gambia.

H.E Sheikh Prof. Alhagie Dr. Yahya A.J.J. Jammeh
President of the Republic of The Gambia
Chairman National AIDS Council

ACKNOWLEDGEMENT

H.E The President and Head Of State of the Republic of The Gambia, who is Chair of the National AIDS Council, and the National AIDS Secretariat wish to extend their gratitude to the various Departments and Agencies for their invaluable assistance in the development of this document, a revised version of the 2007-2011 National HIV and AIDS Policy Guidelines. The Ministry of Health and Social Welfare and all other Ministries, the Public Health Research center –Center for Innovation against Malaria (CIAM), the Catholic Relief Service (CRS), Action Aid International the Gambia, Gambia Radio and Television Services and other stakeholders who have contributed tremendously to the revisions of the necessary policies and guidelines to facilitate HIV and AIDS prevention and control.

Special mention must be made of the Join United Nation against AIDS (UNAIDS) for the provision of technical assistance through the TSF/WCA and the UNDP and AAITG for the financial assistance, and the United Nations Country Team for their contribution.

Finally, to our able partner and Brother Mr. Momodou MK Cham whom we owe a depth of gratitude for supporting the revision of the entire document to its final stage (validation)

TABLE OF CONTENTS

LIST OF ACRONYMS

AIDS Acquired Immuno Deficiency Syndrome

ART Antiretroviral Therapy

ARV Antiretroviral

AZT Azidothymidine (Retroviral)

BCC Behaviour Change Communication

BSS Behavioural Surveillance Survey

BTS Blood Transfusion Service

CBO Community Based Organisations

CHN Community Health Nurse

CSO Civil Society Organisation

CT Counselling and Testing

ELISA Enzyme Linked Immuno-absorbent Assay

GFATM Global Fund to fight AIDS, Tuberculosis and Malaria

GFPA Gambia Family Planning Association

HAART Highly Active Antiretroviral Treatment

HARRP HIV/AIDS Rapid Response Project

HBC Home Based Care

HCT HIV Counseling and Testing

HIV Human Immuno-Deficiency Virus

HSS HIV Sentinel Survey

IEC Information, Education and Communication

ILO International Labour Organisation

M&E Monitoring and Evaluation

MDG Millennium Development Goals

MRC Medical Research Council

NAC National AIDS Council

NAS National AIDS Secretariat

NACP National AIDS Controll Programme

NGOS Non-Governmental Organisation

OI Opportunistic Infections

OVC Orphans and Vulnerable Children

PCR Polymerase Chain Reaction

PHC Primary Health Care

PICT Provider Initiated Counseling and Testing

PLWA Persons Living with AIDS

PLWHA Persons Living with HIV and AIDS

PMTCT Prevention of Mother to Child Transmission

PPTCT Prevention of Parent to Child Transmission

PTCT Parent to Child Transmission of HIV

PRSP Poverty Reduction Strategy Paper

RAC Regional AIDS Committee

EFSTH Edward Francis Small Teaching Hospital

STIs Sexually Transmitted infections

TANGO The Association of Non-Governmental Organization

TB Tuberculosis

TBA Traditional Birth Attendants

UN United Nations

UNAIDS Joint United Nations Programme on HIV/AIDS

UNGASS United Nations General Assembly Special Session

UNICEF United Nations Children's Fund

UNDP United Nations Development Programme

VCT Voluntary Counselling and Testing

WB World Bank

WHO World Health Organisation

1.0 Introduction

HIV and AIDS is one of the major public health problems of The Gambia. The estimated number of PLHIV in the country according to the 2012 sentinel surveillance is projected at 32,380; with age group 15-49 accounting for 11,030 PLHIV.[ii]Heterosexual transmission, however, continues to be the main mode of spread of HIV in the country.

The National policy on HIV and AIDS, provide the broad framework for action for the prevention and control of HIV in The Gambia

1.1: *Country Profile*

Geography

The Gambia is located on the West African coast and extends about 500 kms inland, with a population density of 128 persons per square km. The width of the country varies from 24 to 28 kms and has a land area of 10,689 square kilometres. It is bordered on the North, South and East by the Republic of Senegal and on the West by the Atlantic Ocean.

Administrative Structure

The country is divided into seven Administrative Regions including two Municipalities. The Regions are West Coast Region (WCR), Lower River Region (LRR), Central River Region (CRR), Upper River Region (URR) and North Bank Region (NBR). The Municipalities are Banjul and Kanifing. The two Municipalities have elected Mayors whilst the other Regions have Governors appointed by the President of the Republic. A varying number of districts constitute a region.

Economy

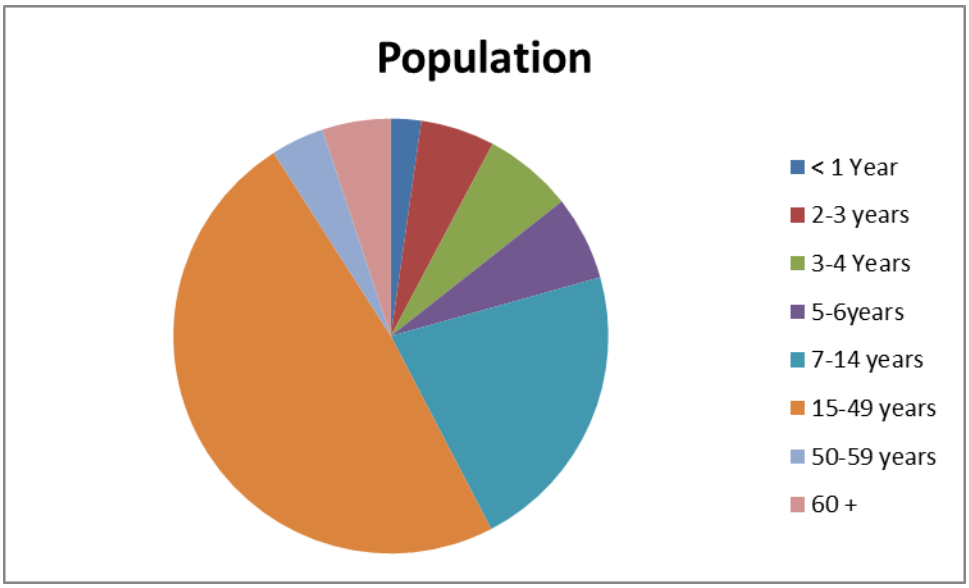
The Gambia is classified as a low-income economy country, with Gross National Income (GNI) per capita of US$510 in 2012.[iii] Low-income economies by World Bank Classification are countries with GNI US$ 1,025 or less. The Gambia is ranked 168 out of 187 in the United Nations Development Programme's Human Development Report (HDR) for the year 2011.The main drivers of economic growth for The Gambia remain the agriculture sector and tourism industry.[iv]

Demography

Preliminary results of the 2013 population and housing census show that 1,882,450 persons were enumerated in the Gambia. Overall, provisional results of the 2013 population census revealed that there more females than males in the country. According to the results, 50.5 per cent of the population is females compared to 49.5 per cent males.

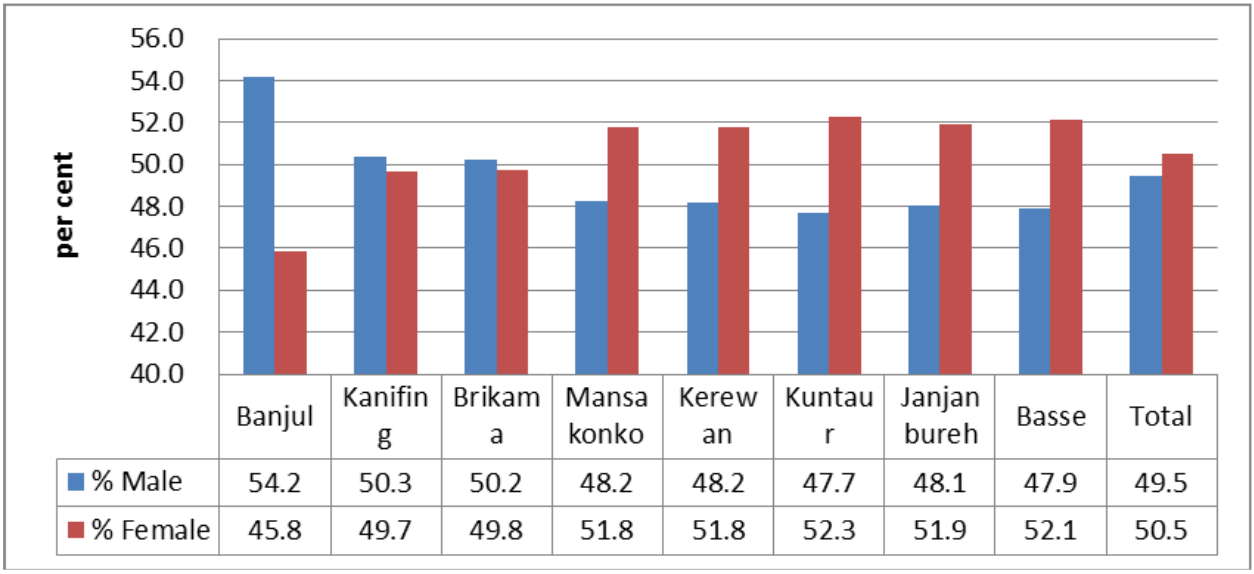
The under-five mortality rate is 109/1000 (MICS 2010). DHS 2013 preliminary report shows maternal mortality ratio at 433/100,000 live births

Population Distribution by Age groups



Source: Census 2003

Population Distribution by Sex by Region



	Banjul	Kanifing	Brikama	Mansakonko	Kerewan	Kuntaur	Janjanbureh	Basse	Total
% Male	54.2	50.3	50.2	48.2	48.2	47.7	48.1	47.9	49.5
% Female	45.8	49.7	49.8	51.8	51.8	52.3	51.9	52.1	50.5

Source: Census 2013

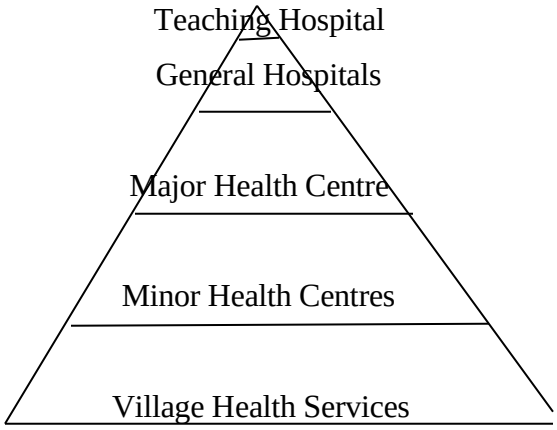
1.2 Health System

Governance

The Ministry of Health and Social Welfare (MOHSW) is responsible for the protection and improvement of the health of the population. The Ministry is headed by a Minister, supported by a Permanent Secretary as head of finance and administration and the Director of Health Services as head of health programmes. A number of health legislations exist and the various registered health professional councils support regulation of services delivery and the practice of service providers.

Heath Care Provision

Figure 2: **Health Service Pyramid**



The public sector has a three-tier health service delivery system comprising the primary, secondary and the tertiary levels. The primary level comprises the Village Health Services and Community Health Posts; the secondary includes Minor and Major Health Centres while the tertiary level consists of hospitals.

For most of the rural communities, government is the major service provider.

The public sector comprises of 1 Teaching/Specialist Hospital, 4 General Hospitals, 6 Major Health Centres, 42 Minor Health Centres; 38 Community Health Posts and 492 Village Health Posts.

The public health system is complemented by 60 Private, NGO and Community Managed Health Facilities. In addition, there exist Private-for-profit Pharmaceutical and other medical Commodities import and wholesale facilities, a number of community Pharmacies and drugs stores are mostly in the Greater Banjul Area. The traditional healing system still continues to be used by a proportion of the population

Health Management Information System

Reliable and readily available health information is crucial for evidence based planning, monitoring and decision making for health service management.

Currently HMIS is in the process of being reviewed to address the limited capacity and resource requirement for research and effective management of national health information system. Recent development in the HMIS is the introduction of DHIS2 system which has since contribute to more reliable information generation

Medical Commodities including Pharmaceuticals Supply Management System

Reliable availability of essential medical commodities (medicines, basic equipment, vaccines, contraceptives and other medical supplies) are critical to provide quality health care delivery and towards the attainment of positive health outcomes. However, uninterrupted availability of supplies requires that the requisite financial resources are allocated effectively and efficiently. Government budgetary allocation for health products has not increased significantly lately despite major increase in demand due to population increase, rapid increase in public hospitals and a significant decrease in the purchasing power of the national currency, (Gambian Dalasi). These factors contribute to the periodic shortages of medicines and other medical supplies. The bureaucratic process involves in the procurement of pharmaceuticals and other medical supply also requires improvement. The Global Fund Project for Malaria, HIV/AIDS and TB are major contributors to the provision of pharmaceutical and medical products.

Human Resources for Health

In recognition of the growing demand for health care services which led to an increase in the number of health facilities, the need for more skilled staff becomes apparent. This is exacerbated by inadequate outpust from the health training institutions and the high attrition rate from the public health sector. Inequitable distribution of available health care professionals is also a major concern. The pay and incentive packages for health care professionals currently under review to attract and retain health staff in the public health sector especially.

Health Financing

The Government through its annual budgetary allocations to the health sector funds health services and care provision for the population. The Global Fund is the main donor to the health sector and partners such as UNICEF, WHO, UNDP, UNFPA, IDB, Global Alliance for Vaccine Initiative (GAVI) and various bilateral partners, also provide financial and/or technical support to the health sector. As at 2013, the health financing strategy in place is the Cost Recovery Programme – payment of user fees. This strategy was introduced in 1988 as part of the Economic Recovery Programme of the country.

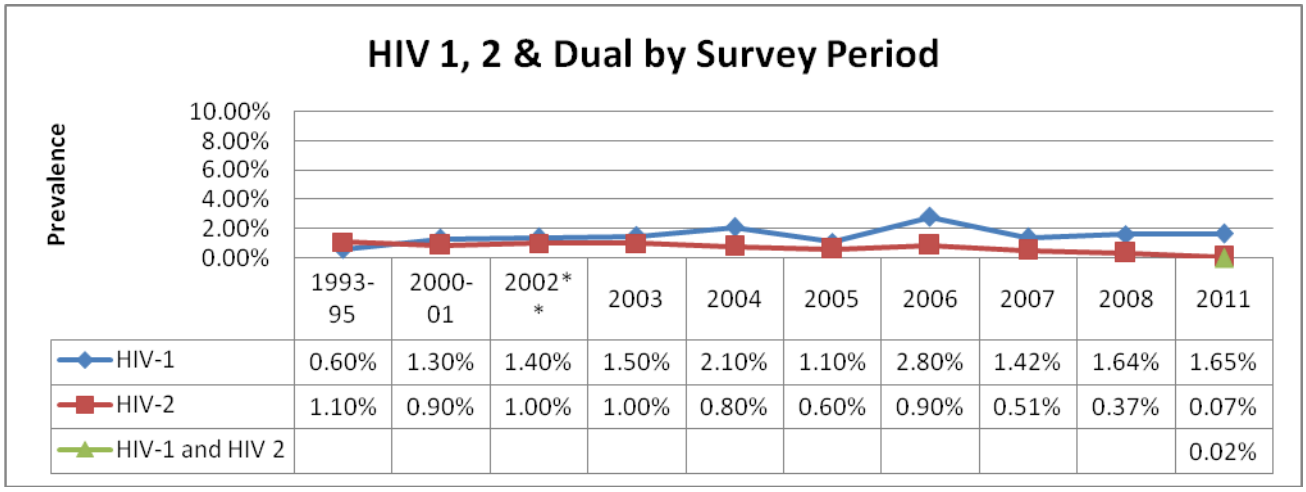
Government allocations to the health sector as a percentage of the total national budget have ranged from 7% to 10% over the past five years[1]. This is still below the 2000 Abuja Declaration of 15% of total government budget to be allocated to the health sector. In 2007, the first National Health Accounts (NHA) for The Gambia was produced covering the fiscal years 2002 – 2004. The results revealed marginal increase in total health expenditure. As a percentage of GDP, the total health expenditure was 16.1% in 2002, 13.9% in 2003 and 14.9% in 2004. Per capita health expenditure was D895 in 2002, D1026 in 2003 and D1203 in 2004

2.0: *The Status of the Epidemic*

The first case of HIV in The Gambia was diagnosed in May 1986.

Epidemiology Trend

HIV Prevalence and trends among ANC attendees 2000 – 2011



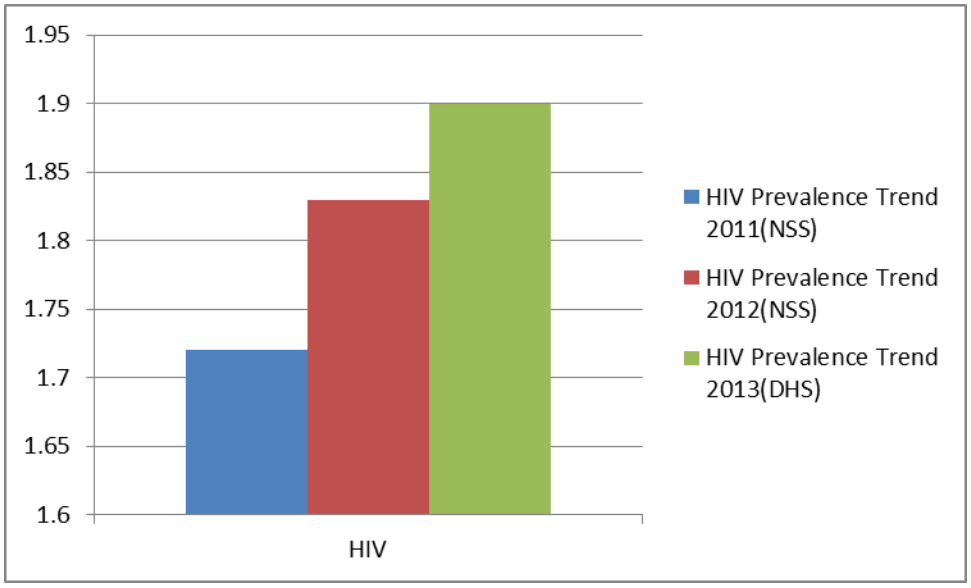
	1993-95	2000-01	2002**	2003	2004	2005	2006	2007	2008	2011
HIV-1	0.60%	1.30%	1.40%	1.50%	2.10%	1.10%	2.80%	1.42%	1.64%	1.65%
HIV-2	1.10%	0.90%	1.00%	1.00%	0.80%	0.60%	0.90%	0.51%	0.37%	0.07%
HIV-1 and HIV 2										0.02%

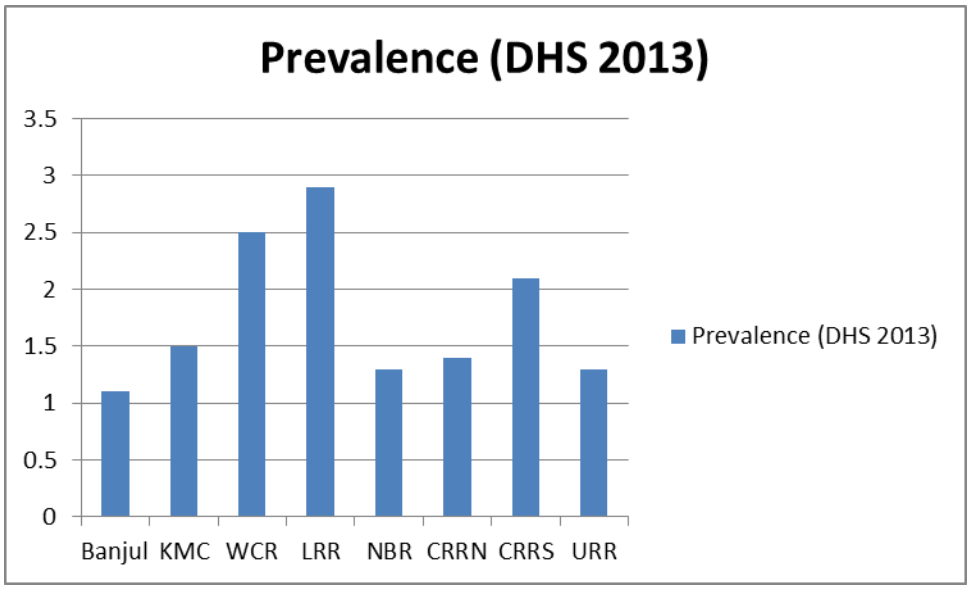
Source: NAS Report 2012[v]

[1] Budget estimates for the period 2002 - 2007

HIV Prevalence Trend

	2011(NSS)	2012(NSS)	2013(DHS)
HIV 1	1.65	1.57	1.9
HIV 2	0.07	0.26	
HIV	1.72	1.83	1.9





Heterosexual transmission, however, continues to be the main mode of spread of HIV in the country.

3.0 : Policy and Strategy Review

3.1: HIV and AIDS Policies, Strategies and Investments 1995 to 2008

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

- To prevent and control the spread of HIV and 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

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

- Maintaining the current low level of the HIV and 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 and AIDS.

The HARRP witnessed the decentralization of HIV and AIDS programmes and activities to regional, district and community levels, with funds being provided to community based organizations (CBOs) and non-governmental organizations (NGOs). Divisional and municipal structures were created headed by co-ordinators and supported by AIDS committees.

The main source of funding for many local NGOs and CSOs was from the Community and Civil Society Initiative component of the World Bank HARRP. With the closure of the project and without any guaranteed funding from other sources, most of the civil society organizations significantly reduced their activities in the national HIV/AIDS programme.

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.

In 2004 The Gambia successfully secured a grant for its HIV and AIDS response under the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). The goal of the programme, captured in the HIV/AIDS National Strategic Plan of The Gambia is to stabilise and reduce the prevalence of HIV and AIDS in the Gambia and provide treatment, care and support for people living with or affected by HIV and AIDS. The Global Fund support bridged the gap on treatment, care and support not covered by the HARRP.

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

2007-2011 Policy Review

The objectives of the policy were:

I. Prevent new infections through focused preventive actions to reduce risk and control the spread of HIV and AIDS in the Gambia.
II. Reduce morbidity and mortality of HIV and AIDS in the general population.
III. Reduce and mitigate the socio-economic and other consequences of HIV and AIDS on the individual and the society.
IV. Increase efficiency and effectiveness of the response to HIV and AIDS.

Strategic Directions of the Policy were:

1. Reducing the susceptibility and vulnerability of special groups and the general population to HIV and AIDS in the Gambia
2. Strengthening the capacity of the health system to manage and support HIV and AIDS.
3. Reducing morbidity and mortality and mitigate the socio-economic, psychosocial, individual, community and national consequences of HIV and AIDS
4. Ensuring effective and efficient coordination of HIV and AIDS intervention programmes

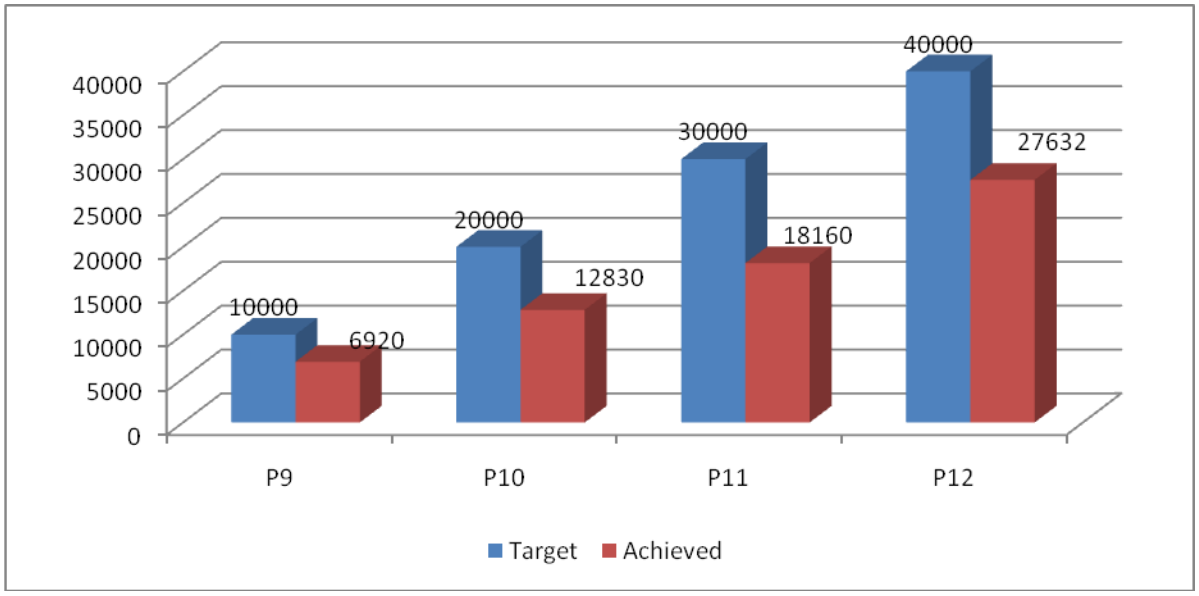
In 2008 a new GFATM round 8 funding was secured for HIV and AIDS. The aim is to accelerate access to prevention, treatment, care and support services. The GFATM Round 8 Project supported the implementation of the 2007-2011 Policy.

3.2 Key Achievements

Geographic Access

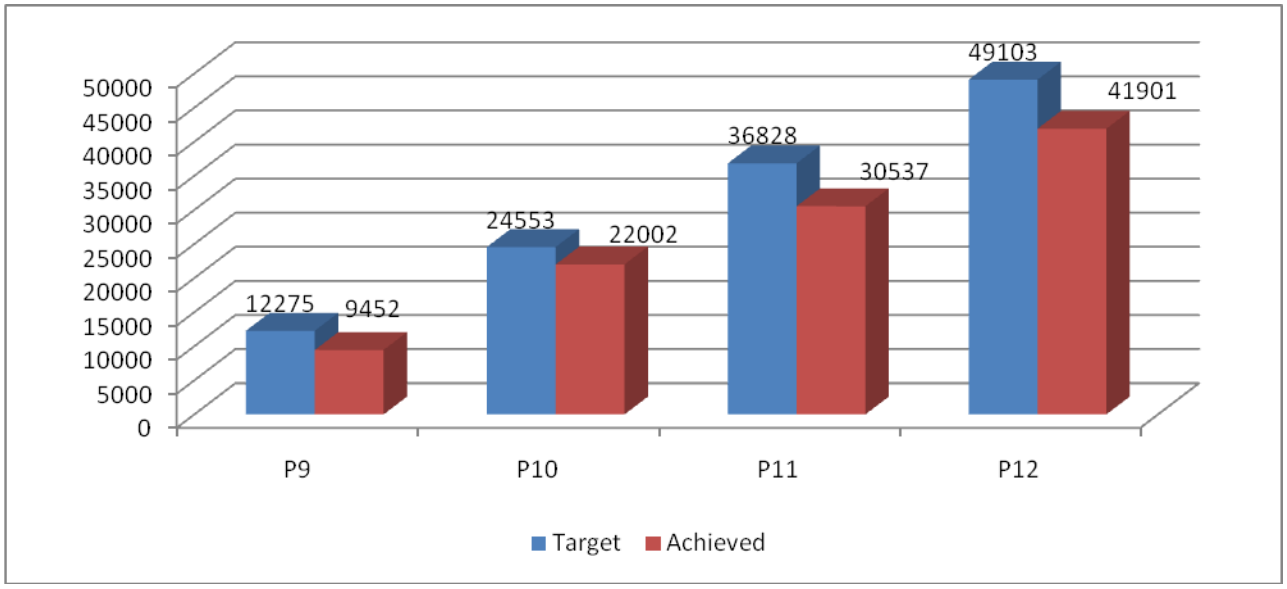
As at end 2012, a total of 45 health facilities offer HCT (23 government , 22 private), 32 facilities provide PMTCT (22 government, private) and 10 ART centres (6 government , 4 private) exist in the country. See annexes 1,2,3 for geographic distribution

HCT uptake among the general population by period



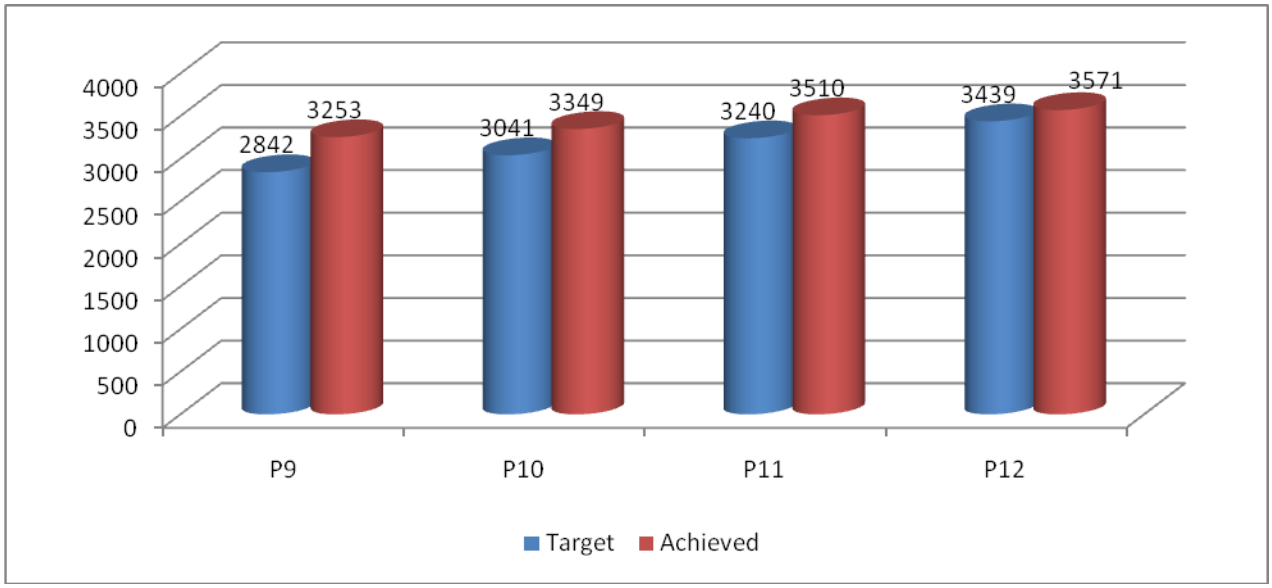
Source: NAS Report 2012[vi]

PMTCT HCT uptake



Source: NAS Report 2012

Number of Persons on ART

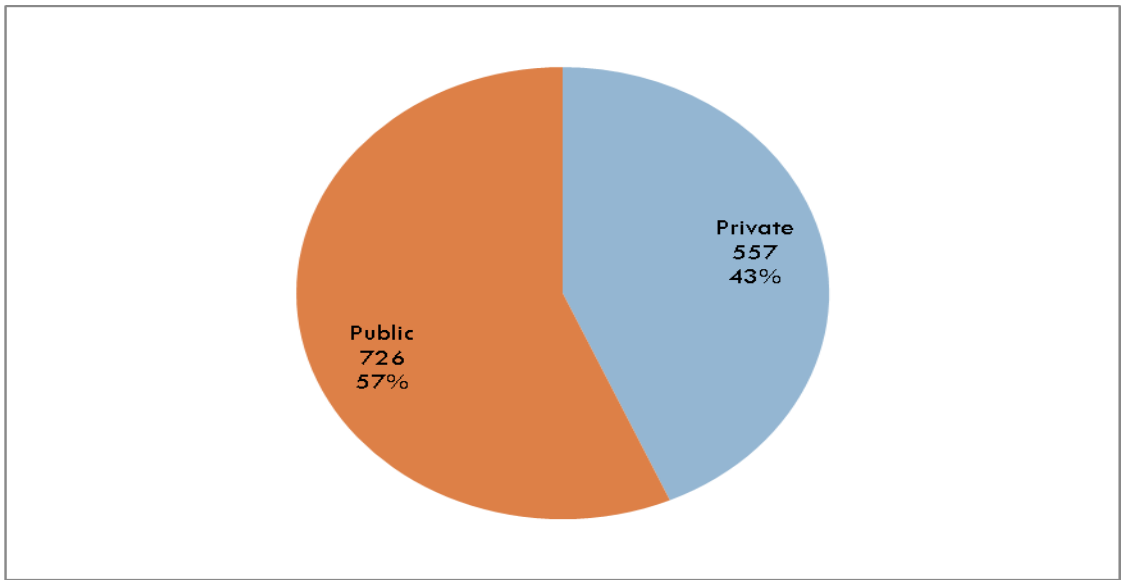


Source: NAS Report 2012

Morbidity and Mortality Reduction

The ART Survival Study (2013) documented mortality rates at 12 months among those started on ART of 12% and 8% for 2010 and 2011 cohorts respectively. The 24 months mortality rate for the 2010 cohort fell dramatically to 3%. Secondary analysis of the available data from the ART Survival Study gave an overall mortality of 8.5 per 100 person-years of observation. Additionally, data from the RVTH (now EFSTH), national tertiary centre, indicates a mortality rate of 6.2% for all enrolled PLHIV in 2012.

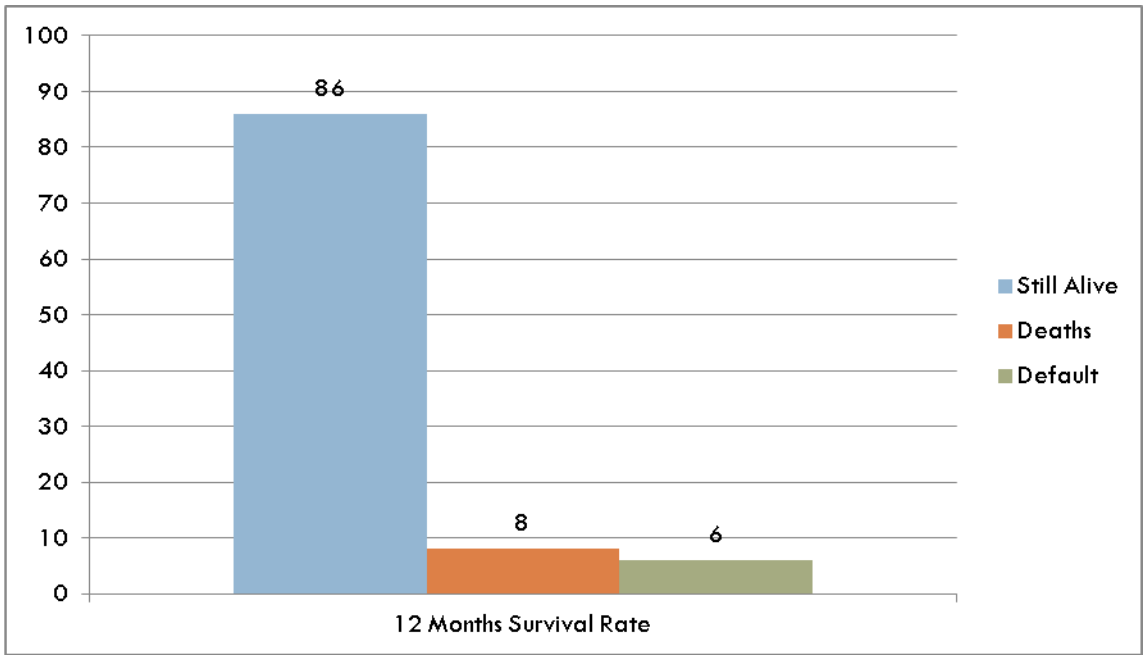
Figure 1: Distribution of patients by service provider in the 2011 cohort



Source: ART Survival Study (2013)

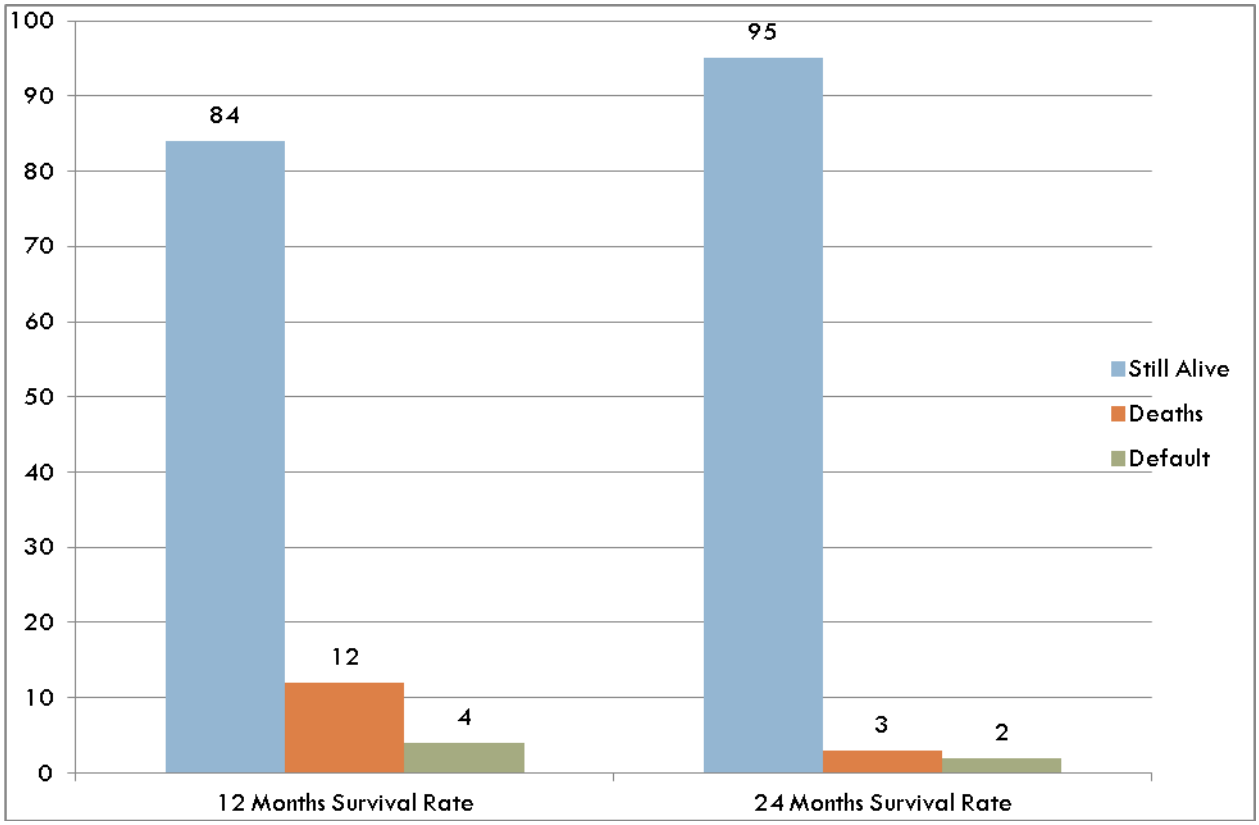
The proportion of patients seen by the private ART service providers increased from 36% in 2010 to 43% in the 2011 cohort

Survival, Mortality and Defaulter rates in the 2011 cohort



Source: ART Survival Study (2013)

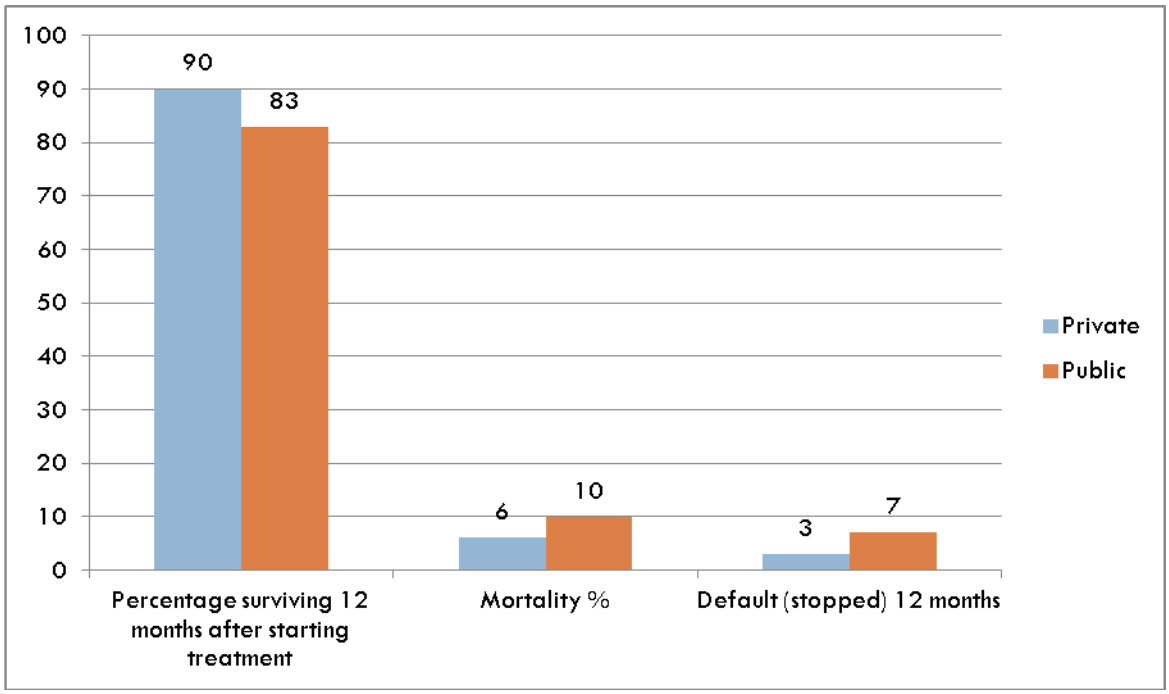
Comparison between survival and death rates of PLHIV at 12 and 24 months in the 2010 cohort



Source: ART Survival Study (2013)

After 24 months of treatment, survival rates increased from 84% to 95% whilst deaths dropped from 12% to 3%. The defaulter rate also went down from 4% at 12 months to 2% at 24 months of treatment.

Comparison of survival, mortality and defaulters by type of service provider



Source: ART Survival Study (2013)

3.3 Major Bottlenecks

Despite the huge investments the following major bottlenecks still exist and affect achievements of set goals, these include:

Low use of Family Planning: According to the 2012 survey, the risk of infection increases with parity. Infection rate was higher among pregnant women who reported more than four pregnancies. Almost 28.6% of those infected have more than four pregnancies, followed with third and fourth pregnancies 23.2% and 18.8% respectively

Low knowledge of prevention methods: From the trend analysis, no significant improvement on knowledge of all the 3 ABC methods has been observed within the general population over the years

Low use of condoms: In the general population, less than half of those who had sex with commercial and non-regular partners used condoms

Low uptake of HCT: In the general population about a fifth (20%) had had a voluntary HIV test in the past year.

Low access to basic services: Low reliability on timely availability of core diagnostic laboratory services for routine haematology and blood transfusion, diagnostic microbiology and clinical chemistry in hospitals and major health centres

No Early Infant Diagnosis by DNA PCR (molecular methods)

Weak ARV Adverse Drug Reactions Monitoring

Stigma and discrimination is still a critical challenge and the human right of PLHIV and OVC needs further safeguards

Low physical access to ART, PMTCT and even HCT services for all the administrative regions

Weak protection of the human rights of PLHIV: The draft Model Law has still not been enacted

Weak Governance: NAC and NAS Bill and the HIV Prevention and Control Draft Bill 2010 are yet to be enacted.

High dependency on external financing of the National Program: External financial support currently covers about 96% of our national HIV response

4.0 Problem Statement

HIV and AIDS is still a major public health problem of The Gambia. Preliminary DHS Reports shows national prevalence of 1.9. But prevalence in West Coast Region, Central River Region South and Lower River Region are much higher than the national average. Prevalence of the disease seems to be higher in the Regions than in The Greater Banjul Area. A high HIV burden in the rural community is a major worry as it will further exacerbate poverty in those communities. Despite the high investments in prevention and control interventions, the prevalence of HIV in the population seems to be on the rise. HIV related death rate is still high and stigma and discrimination of PLHIV is still high.

Access to some of the essential services is very limited; as a result, uptake of some of the basic prevention services is low. Health system weaknesses are numerous these include limited access to essential HIV prevention, treatment and care services, weak financial risk protection system, due to the high dependence on external funding and weak governance as the National AIDS Secretariat is yet to attain the " three One" status advocated by UNAIDS.

5.0 Rationale for Policy Revision

The above problem statement is a major reason for the revision of the national policy. Also, the dynamics and nature of the epidemic require appropriate policy, legal and administrative frameworks for the accelerated control of the infection and the protection of the human rights of those uninfected and at risk of infection as well as those infected and affected.

And emerging issues around HIV Testing and Counseling (HCT), Prevention of Mother to child transmission (PMTCT) leading to elimination of Mother- to-Child Transmission (eMTCT), the 2013 new WHO treatment guidelines (15 X15), option B+ and increasing availability of antiretroviral therapy call for changes in the policy direction.

6.0 Policy Priorities

Based on the above problem statement, the following are the policy and strategy priorities for the intervention areas:

Prevention of New Infections

- Scaling-up Prevention of Mother to Child Transmission (PMTCT) leading to elimination of Mother- to-Child Transmission (eMTCT),
- Improving on composite knowledge of prevention methods
- Improve management of STIs
- Increasing correct and consistent use of condoms
- Accelerating HIV testing
- Strengthen quality comprehensive services for key affected populations
- Improve on cross border activities
- Improving the tertiary education of the youths especially the female youths.
- Improving social protection for the youth and women
- Increasing demand for and access to family planning services

Reduction of morbidity and mortality

- Increasing physical access to ART, PMTCT and HCT services for all the regional administrative areas
- Improving human resource capacity and retention for the provision of a comprehensive care package.
- Ensuring availability of equipment and supplies for care and support services delivery
- Reliable and timely availability of core diagnostic laboratory services for routine haematology and blood transfusion, diagnostic microbiology and clinical chemistry in hospitals and major health centres
- Availability of guidelines on nutritional support provision for PLHIV
- Inclusion of Early Infant Diagnosis by DNA PCR (molecular methods) in the PMTCT
- Ensuring a well-established Pharmacovigilance and Post-Market Surveillance systems for ARVs and Medicines for Opportunistic Infections
- Improving community based follow-ups of patients
- Providing a structure for supportive supervision and peer support to encourage sharing of best practice and lessons learned
- Community System Strengthening

Impact mitigation

- Ensuring the enactment of the draft HIV and AIDs Prevention and Control Bill 2010
- Strengthening monitoring of stigma reduction activities
- Strengthening social protection for families affected by HIV and AIDS

Response Management

The Three Ones Principles for concerted action at country level have been recognized by international organizations and national governments as the guiding principles to ensure effective coordination of national responses to HIV and AIDS. The principles are:

- One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners;
- One National HIV and AIDS Coordinating Authority, with a broad-based multi-sectoral mandate;
- One agreed HIV and AIDS country-level Monitoring and Evaluation (M&E) System**.**

Policy and strategy priorities for the intervention area are:

- Implementation the Three Ones Principle
- Strengthening capacity for input –output and impact monitoring , analysis and reporting
- Strengthening capacity for surveillance and Operational Research
- Creation of the HIV and AIDS Policy Advisory Committee
- Strengthening financial resources mobilization for the national HIV response

7.0 Vision; Guiding Principles; Goal and Objectives

7.1 Vision:

Zero new HIV infections, Zero HIV related deaths, Zero Discrimination of People Living with HIV in The Gambia by 2020

7.2 Guiding Principles

Universal access for the population at risk

Everyone in The Gambia has the right to access HIV/AIDS prevention treatment, care and support services.

Client satisfaction

HIV and AIDS prevention, treatment, care and support services should reflect local needs and meaningful involvement of communities and People Living with HIV (PLHIV) at all levels of planning and provision of services.

Equitable access

HIV and AIDS prevention treatment, care and support services must strive to address inequity and services prioritized to the most needed.

Ethics and Standard

Respect for human dignity, rights and confidentiality; registered health professionals practices control and quality assurance of services.

Evidence-based

Social, biomedical and health systems research should inform policy and strategic choices in order to provide effective HIV and AIDS prevention and control programme.

Partnership

Effective alliances should be facilitated with National, Sub-regional and International Partners for information sharing and resource mobilization for HIV and AIDS prevention and control interventions.

Efficiency

A focus will be given to the most cost-effective strategies and interventions, based on the strategic investment approaches**.**

7.3 Goal

Have reduced the burden of HIV and AIDS on the population of The Gambia to a level where it cease to be a major public health problem

7.4 Objectives

- **Have reduced new infections**: reduced by 50% the percentage of young people age 15-24 who are infected in the population of every district in the country by 2018 (compared with a 2012 baseline) and by 80% by 2020
- **Have reduced new infections**: reduced by 50% the percentage of women age 25-34 years who are infected in the population of every district in the country by 2018 (compared with a 2012 baseline) and by 80% by 2020
- **Have eliminated new HIV infections in children (e MTCT)**: reduced new HIV infections in children by 90% in every district of the country by 2018 (compared with a 2012 baseline) and zero new infections in children by 2020
- **Have reduced HIV-related mortality**: reduced HIV –related deaths by 50 % in every district of the country by 2018 (compared with a 2012 baseline) and by 80% by 2020
- **Have reduced stigma and discrimination of People Living with HIV:** Increased by 50% the percentage of people willing to share meals with PLHIV, care for them and buy food from them in every district of the country by 2018 (compared with 2012 baseline) to achieve Zero discrimination of People Living with HIV by 2020

8.0 Policy Intervention Areas

Strategic Intervention Area 1: Prevention of new infections

Preamble

According to Behavioural Sentinel Surveillance Survey 2010, the radio and television seems to be the main source of information on HIV and AIDS

From the trend analysis, no significant improvement on knowledge of all the three (3)ABC methods has been observed within the general population. In the general population, less than half of those who had sex with commercial and non-regular partners used condoms. In the general population about a fifth (20%) had had a voluntary HIV test in the past year with most of them knowing their results

The desire is zero new HIV infections in the population especially in children and adolescents aged 15-24 of every district in the country through the provision of a comprehensive prevention package.

The following policy directions will be pursued:

Government will ensure that comprehensive prevention package is universally available, free at the point of use and national guidance available for services delivery

- The Ministry of Health will institutionalize Provider Initiated Counseling and Testing in all health care settings-public, NGO or Private
- Government will promote and support Private –Public Partnership in Social Marketing of Condoms and broader engagement in the national response
- NAS in close collaboration with the Regional Technical Advisory Committees, will promote and support communities participation in HIV and AIDS prevention planning and implementation
- NAS in collaboration with the Department of Social Welfare of the Ministry of Health and Social Welfare and the Labour Department of the Ministry of Trade and Employment will develop social protection systems for the most at risk, including or in particular youth and women

- NAS will leverage more of the Strategic investment approaches in the planning and implementation, including the generation of HIV-related data and size estimation of key populations.
- NAS in collaboration with the Ministry of Higher Education, will develop strategic plans to improve tertiary education of female youth to enhance opportunities, targeting those in the lowest and low income quintiles households
- NAS in collaboration with the Ministry of Health and other Reproductive Health development partners will support demand creation for and access to family planning services countrywide

Strategic Intervention Area 2: Reduction of morbidity and mortality

Preamble

Challenges in this area include human resource capacity development and retention, improvements in the provision of a comprehensive care package, addressing HIV-related stigma and discrimination environment and reliable availability of equipment and supplies. Lack of reliable and timely core diagnostic laboratory services for routine haematology and blood transfusion, diagnostic microbiology, clinical chemistry and radiographic services in hospitals and major health centres Lack of clear guidelines on who should be supported nutritionally. No Early Infant Diagnosis by DNA PCR (molecular methods), No established Pharmacovigilance system. Lack of supportive supervision and as well as the sharing of best practices and lessons learned. Patients' related issues such as inadequate funds for transport refunds. Weak community systems to support HIV and AIDS Prevention and Control activities.

Challenges in this area include human resource capacity development and retention, improvements in the provision of a comprehensive care package, addressing HIV-related stigma and discrimination environment and reliable availability of equipment and supplies. Lack of reliable and timely core diagnostic laboratory services for routine haematology and blood transfusion, diagnostic microbiology and clinical chemistry in hospitals and major health centres Lack of clear guidelines on who should be supported nutritionally. No Early Infant Diagnosis by DNA PCR (molecular methods), No established Pharmacovigilance system

The desire is zero HIV –related deaths in the population of every district in the country, by ensuring universal access to a comprehensive treatment, care and support services package.

The following policy directions will be pursued:

Government will ensure that ART and Care services are universally available, free at the point of use and national guidance available for services delivery

- The Ministry of Health will institutionalize Provider Initiated Counseling and Testing in all public health care settings – and encourage the NGO or Private Sector to do the same.
- Government as part of the health regulatory reforms will revise ART, PMTCT and HCT service delivery standards to support the accreditation and licensing of health facilities, public, NGO and private.
- The accreditation process will include ART, PMTCT and PICT services delivery capacity assessment of all the health facilities (public and private) in the country. Developing a plan with costs to address the capacity gaps
- The Ministry of Health will conduct annual inspection of all health facilities- public, NGO and Private for renewal of licenses
- The Ministry of Health in collaboration with the National AIDS Secretariat will review and or develop national guidelines and job-aids for ART, PMTCT and PICT
- The Ministry of Health will develop a health human resources production and training acceleration plan, leveraging the report of the national HIV-related stigma index tool.
- The Medical and Dental Council in conjunction with the Nurses and Midwives Council will be supported to develop, provide training and supervision on Guidelines on Good Clinical Practice including ART, PMTCT and PICT
- The National Pharmaceutical Services will be supported to develop, provide training and supervision on Guidelines on Good Dispensing Practice
- The Ministry of Health will be supported to develop, provide training and supervision on Guidelines on Good Laboratory Practice
- The Ministry of Health will undertake reforms in health care provision and financing and payment mechanism
- The Ministry of Health will integrate Early Infant Diagnosis in the PMTCT Program

- NAS in collaboration with the National Nutrition Agency and other development partners will develop PLHIV Nutritional Support Guidelines
- NAS in collaboration with the Ministry of Higher Education, will develop strategic plans to improve tertiary education of female youth targeting those in the lowest and low income quintiles households
- The Ministry of Health and the Medicines Regulatory Authority will strengthen systems for post-market surveillance and monitoring of the safety of the ARVs and other medicines of interest

Strategic Intervention Area 3: **Impact mitigation**

Preamble

Stigma and discrimination is still a critical challenge and the human right of PLHIV and OVC needs further safeguards. Program review in 2014, shows that about 40% of targeted OVC were not supported; situational Analysis on OVC not conducted

The desire is to have in place the required safety nets (social and economic) to reduce the burden of HIV on those infected and affected.

The following policy directions will be pursued:

- The Ministry of Health and Social Welfare will update the situation of orphans and vulnerable children in the Gambia
- Promote development and integration of stigma reduction interventions at all levels of the health system
- Strengthen coordination mechanisms on stigma and discrimination reduction activities at all levels
- NAS in consultation with key partners in social protection will support the Department of Social Welfare in developing a National Orphans and Vulnerable Children Protection Strategy and Program
- The draft HIV prevention and control Bill 2010 will be enacted and regulations developed to support implementation

This law should aim at protecting the human rights of People Living with HIV (PLHIV) as well as bridging the gap between vulnerability and resilience to HIV.

Strategic Intervention Area 4: **Response Management**

Preamble

Coordination of the response is still weak; the NAC regular meeting needs to be reactivated; NAS bill is yet to be enacted; about 96% of our national HIV response is funded from external sources.

The desire is to have in place an AIDS Secretariat with these three major capabilities:

- Authority to strengthen the three ones principles
- Providing up to date information on the situation of HIV in every district in the country and
- Effective and efficient management of the national response and accounting to stakeholders and funding partners

The following policy directions will be pursued:

- Government will fast track the enactment of the NAS Bill for the implementation of the Three Ones Principle
- NAS capacity to provide update information on the situation of HIV in every community/village in the country will be developed
- NAS capacity to design and coordinate input –output and impact monitoring , analysis and reporting, will be strengthened to show value for the investments
- NAS capacity to design and coordinate Surveillance and Operational Research will be strengthened
- Government will further promote and encourage research in traditional medicines to enhance collaboration between the orthodox and the traditional healing system, and with the ECOWAS/WAHO and WHO traditional medicines departments
- Government will encourage and support sub-regional collaboration in HIV and AIDS Control
- Government funding to the National AIDS Secretariat will be significantly increased to cover at least 15 per cent of the total annual national HIV and AIDS budget
- NAS will be supported to develop a financial resources mobilization plan

9.0 Policy Implementation Framework

Role of NAS

The National AIDS Secretariat will coordinate implementation the National Multi-Sector Policy

Role of the National AIDS Control Program

The National AIDS Control Program will coordinate implementation of the health component of the policy

The draft NAS bill seeks to establish the National AIDS Council as a statutory body, with NAS as the Secretariat.

To ensure effective implementation of this Policy, the following Committees will be constituted to support the National AIDS Council

National HIV/AIDS Advisory Committee (Expert Committee)

The National HIV and AIDS Advisory Committee will advise the Office of the President, the Minister of Health and Social Welfare and the National AIDS Council specifically on:

- Appropriate HIV and AIDS policies and standards based on data from National HIV and AIDS Program implementation as well as reviews of best available evidences
- Engagement of the country in HIV and AIDS-related initiatives especially the sub-regional collaboration in HIV Control
- Major issues and challenges to achieve the national HIV and AIDS goal
- Identification of priority activities to address identified challenges

Membership of the HIV and AIDS Advisory Committee will comprise of the following specialists: Epidemiologist, Social Scientist, Bio-Statistician, Senior Clinician, Public Health Specialist, Pharmacist and Legal Practitioner versed in human rights protection, and a representative of PLHIVs.

National HIV and AIDS Steering Committee

The National HIV and AIDS Steering Committee will ensure coordination of effective implementation of the National HIV and AIDS Strategic Plan.

The functions of the National HIV and AIDS Steering Committee will include:

- Reviewing of annual national HIV and AIDS prevention and control plan of work
- Supporting the resource mobilization efforts of NAS for the financing of the annual Program
- Monitoring performance on the milestones
- Sharing quarterly performance reports with the HIV and AIDS Advisory Committee
- Coordinating annual review of implementation of the National HIV and AIDS Strategic Plan

The Committee will comprise representatives from the Ministry of Health and Social Welfare, other government ministries and partners and it will be chaired by the Office of the President, supported by the Director of Health Services. NAS will provide secretariat functions

The National HIV and AIDS Steering Committee will constitute Technical Committees to support its work.

Annex 1: Access to ART, PMTCT and HCT

Distribution of ART Plus HCT and PMTCT Service Delivery Points (SDP)

Local Government Area	Population of the Local Government Area (2013 Census)	Name of SDP	Location of Facility (SDP)
Banjul City	**3**1301	Edward Francis Small Teaching Hospital	Banjul
Kanifing Municipal Area	382096	ASB Clinic	Dippa Kunda
		SOS Maternal and Child Clinic	Bakoteh
West Coast Region	699704	Hands on Care	Brikama
		Sibanor Health Centre	Sibanor
		Sulayman Junkung General Hospital	Bwiam
Lower River Region	82361	Soma Health Centre	Soma
North Bank Region	221054	AFPRC Hospital	Farafeni
Central River Region North	99108	Nil	
Central River Region South	126910	Bansang Hospital	Bansang
Upper River Region	239916	Basse Health Centre	Basse
Gambia	1,882,450	10	

Annex 2: Distribution of HCT Plus PMTCT Sites

Local Government Area	Population of the Local Government Area (2013 Census)	Name of SDP	Location of Facility (SDP)
Banjul City	**3**1301	Edward Francis Small Teaching Hospital	Banjul
		Leman Street Clinic	
		Polyclinic	
Kanifing Municipal Area	382096	ASB Clinic	Dippa Kunda
		SOS Maternal and Child Clinic	Bakoteh
		Serekunda Hospital	Kanifing
		Fajikunda Health Centre	Faji Kunda
		BAFROW Clinic	Serekunda
		Newfoy Clinic	Serekunda
		Old Jeshwang Clinic	
West Coast Region	699704	Hands on Care	Brikama
		Sibanor Health Centre	Sibanor
		Sulayman Junkung General Hospital	Bwiam
		Brikama Health Centre	Brikama
		BAFROW Mandinaba Clinic	Mandinaba
		Banjulunding Health Centre	Banjulunding

		GFPA Clinic	Kanifing
		JFPH	Bundung
		Gunjur Health Centre	
Lower River Region	82361	Soma Health Centre	Soma
North Bank Region	221054	AFPRC Hospital	Farafeni
		Essau Health Centre	Essau
		Kerewan Health Centre	Kerewan
Central River Region North	99108	Kaur Health Centre	
		Kuntaur Health Centre	
Central River Region South	126910	Bansang Hospital	Bansang
		Brikamaba Health Centre	Brikama
		St Lazarus Clinic	Fulabanta
Upper River Region	239916	Basse Health Centre	Basse
		Diabugu Health Centre	Diabugu
		Baja Kunda Health Centre	Bajakunda
		Fatoto Health Centre	Fatoto
Gambia	1,882,450	32	

Annex 3: HCT Only Centres Distribution

Local Government Area	Population of the Local Government Area (2013 Census)	Name of SDP	Location of Facility (SDP)
Banjul City	**3**1301	GFPA Clinic	Banjul
Kanifing Municipal Area	382096	Jobot Laboratory	Serekunda
		MedLab	Serekunda
		Nayaf	Serekunda
West Coast Region	699704	GFPA Clinic	Bwiam
		Ndeban Clinic	Ndeban
Lower River Region	82361	Nil	
North Bank Region	221054	NjabaKunda Clinic	Njaba Kunda
Central River Region North	99108	Nil	
Central River Region South	126910	Medina Lamin	Medina
Upper River Region	239916	GFPA Clinic	Basse
		CaDO	Basse

References

[ii] **2012 National Sentinel Surveillance Report**

[i] **Country Classification July 2012 World Bank**

[i] **Programme for Accelerated Growth and Employment**

[i] **The Gambia GARP Report 2012**

[i] **The Gambia 2010 Behavioural Surveillance Survey on HIV and AIDS Report**

[i] **Treatment Care and Support Situation Report (Ousman Nyan), October 2013**

2012 National Sentinel Surveillance Report

[iii] **Country Classification July 2012 World Bank**

[iv] **Programme for Accelerated Growth and Employment**

v

vi