NATIONAL AIDS SECRETARIAT

WITH SUPPORT FROM UNAIDS

THE GAMBIA GENDER ASSESSMENT OF THE HIV RESPONSE

REVISED VERSION (#2)
POST VALIDATION MEETING

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Abbreviations and acronyms

ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CSO	Civil Society Organization
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FSW	Female sex worker
GA	Gender Assessment
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFD	Gambian Federation for the Disabled
HIV	Human Immunodeficiency Virus
KII	Key Informant Interviews
KP	Key Population
KVP	Key and vulnerable populations
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer People
M&E	Monitoring and Evaluation
MoGCSW	Ministry of Gender, Children and Social Welfare
MSM	Men Who Have Sex with Men
NCD	Non-Communicable Diseases
NYC	National Youth Council
NSP	National Strategy Plan
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWUD	People Who Use Drugs
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexual Transmitted Infection
TB	Tuberculosis
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNDP	United Nations Development Programme
WHO	World Health Organization
WLHIV	Women Living with HIV

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This report was written by Dinys Luciano, consultant. The other members of the Consultancy Team: Berry D. Nibogora (Legal Environmental Assessment Consultant) and Veronica Cenac (Human Rights Consultant) worked in conjunction with the Gender Assessment consultant in the preparation of the Inception Report and the field work carried out on 17-26 May 2023.

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TABLE OF CONTENTS

List of Figures

List of Tables

1. Introduction

Background and Rationale

The Gambia had approximately 24,000 adults living with HIV in 2022[1]. The burden of HIV infection is higher among women, girls, and key populations. In 2022, 62% of adults (15+) living with HIV were women. The prevalence of HIV among some key populations is higher than in the general population: sex workers (11%), and men who have sex with men (34.4%)[2].

During the period 2015-2022, the country made progress in reducing new infections and AIDS among adults (15+). However, in 2022, estimates showed that only 48% of men and 67% of women living with HIV knew their status, and of those, only 23% of men and 47% of women were receiving ART[3]. In the same year, the number of pregnant women who received ARV represents a decrease of 21% from 2015.

Gender and intersecting inequalities–including poverty, gender-based violence (GBV), harmful gender norms, stigma, and discrimination–are key drivers of the HIV epidemic and are preventing progress in ending the AIDS epidemic in the country. Significant challenges and gaps remain in the national HIV response, as well as in the handling of critical emerging issues such as non-communicable diseases (NCD), climate change, emergencies, migration and human mobility, and other intersecting inequalities that require innovative approaches while scaling up best practices in service provision and structural interventions.

The Gambia ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993, and has developed laws and policies toward advancing women's rights and the elimination of GBV, child marriage and female genital mutilation.

Given the commitment of the Government of The Gambia to promote gender equality, the implementation of Agenda 2030, and recognizing the relevance of strengthening gender- responsive and transformative interventions for a sound and sustainable HIV response, the NAS partnered with UNAIDS to conduct the third Gender Assessment (GA) of the HIV epidemic, context, and response. In line with the National Strategic Plan for HIV and AIDS, The Gambia 2021-2025, the National Development Plan 2023-2027 and the Global AIDS Strategy 2021-2026, the GA will inform priority areas of the Global Fund Funding Request, as well as other initiatives, to respond to the HIV epidemic for resource mobilization and to contribute toward the integration of HIV and gender equality policies and programmes.

Aim and Objectives

The GA aimed to:

- Assess the HIV epidemic, as well as other inter-related SRHR issues, including cervical cancer, GBV, and mental health and other NCD, climate change affecting women, girls, men, boys and key and vulnerable populations, as well as understand the context and response using gender/intersectional and human rights approaches.
- Provide key recommendations to guide national strategic resource mobilization and budgeting, including the development or review of national plans and to inform submissions to country investment cases and the Global Fund Funding Request 2023-2025.

[1] NAS, 2023; UNAIDS.
[2] IBBS, 2022/2023
[3] NAS, 2023; UNAIDS. Ibid

- Enable programmes and services for gender equality and diversity, women's and girls' empowerment and SRHR, NCD and climate change to be integrated into other strategic planning, budgeting, and implementing processes to address the gender/intersecting-related barriers and challenges in the HIV response.

This GA is not be the first to be conducted in The Gambia. In 2016, the UNAIDS Country Office and the National AIDS Secretariat conducted a Gender Assessment of the National HIV and AIDS & TB Response. Its objective was to determine the extent to which gender is mainstreamed into the National HIV and AIDS response and to assess gender-related aspects of the national response[4]. A further rapid gender assessment was conducted in November 2020 in support of The Gambia Funding Request to the Global Fund. The scope of the GA 2023 does not include examining the level of implementation of the recommendations of the two previous GA. However, the main findings of the GA 2023 revealed limited progress on the integration of gender and diversity considerations in the national HIV response.

2. Approaches and Methodology

Approaches: Intersectionality and Evidence-Informed Decision-Making

The GA combines intersectional and evidence-informed decision-making approaches to policy and programme development, which allow for the generation of data and the selection of evidence-informed interventions while considering the diverse needs and barriers that different population groups face.

Intersectional approaches. Historically, women and girls, men and boys, gender-diverse communities, as well as key and vulnerable populations (KVP) have been perceived as homogenous and static groups instead of comprising multiple and intersecting identities with different challenges[5]. In that sense, women and girls, boys and men, and gender-diverse communities may also belong to KVP such as sex workers, transgender people, MSM, prisoners, people who use drugs (PWUD), people experiencing homelessness, people with disabilities (PWD), people living with HIV (PLHIV), migrants and mobile populations, among others. Identifying those intersections, and consequently their different needs, barriers, and resilience, is key for the integration of services and differentiated programming, as well as tackling compounded inequalities[6].

It is critical that the data analysis process includes contextualizing the data within an individual's social location within their household, community, and institutions, and that it also involves undertaking an intersectional analysis of local, regional, and national HIV responses to functionally address

[4] Mwetwa C, M. JOOF D and Jagne SF. Final Report - Gambia Gender Assessment 2016. National AIDS Secretariat, Republic of The Gambia.
[5] Rapid Response Service. Rapid Response: Intersectionality in HIV and Other Health-Related Research. Toronto, ON: Ontario HIV Treatment Network; June 2013. http://www.ohtn.on.ca/wp-content/uploads/2018/09/RR68-Intersectionality-HIV-Other-Health-Related-Research.pdf
[6] The Global Fund. TRP Lessons Learned from Review Window 1 2020-2022 Funding Cycle.

interconnected discriminations. Multiple determinants shape differential HIV risk and vulnerability for different population groups, as well as their ability to seek treatment, care, and support[7,8,9] .

The intersectional approaches used in the GA[10,11]:

- Address the social determinants of HIV, reducing disparities in access to services, and promoting equity and social justice.
- Examine multiple inequalities and the ways in which social factors and structural barriers interact to produce major differences and outcomes in HIV, health and well-being[12,13]. This expands the limited focus on individual behaviour to include structural factors.
- Address intersecting health and development challenges such as comorbidities, needs, vulnerabilities, and risks associated with overlapping identities.
- Explore the gender dimensions of intersecting identities; multiple forms of stigma, discrimination, violence, and human rights violations against people at risk, affected by and/or living with HIV in all their diversity[14,15,16].

Evidence-informed planning and programming. The GA incorporates information from a variety of sources, including best available research, stakeholders' expertise and perspectives, and the experiences and needs of people and communities at risk, affected by, and/or living with HIV[17,18].

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[10] Nancy López and Vivian L. Gadsden. Health Inequities, Social Determinants, and Intersectionality. National Academy of Medicine. December 2016. https://nam.edu/wp-content/uploads/2016/12/Health-Inequities-Social-Determinants-and-Intersectionality.pdf

[11] Ontario Human Rights Commission. An intersectional approach to discrimination: Addressing multiple grounds in human rights claims. http://www.ohrc.on.ca/en/intersectional-approach-discrimination-addressing-multiple-grounds-human-rights-claims/introduction-intersectional-approach

[12] Wechsberg WM, Browne FA, Ndirangu J, Bonner CP, Minnis AM, Nyblade L, Speizer IS, Howard BN, Myers B, Ahmed K. The PrEPARE Pretoria Project: protocol for a cluster-randomized factorial-design trial to prevent HIV with PrEP among adolescent girls and young women in Tshwane, South Africa. BMC Public Health. 2020 Sep 15;20(1):1403. doi: 10.1186/s12889-020-09458-y. PMID: 32933510; PMCID: PMC7490774.

[13] Gibbs A. Tackling gender inequalities and intimate partner violence in the response to HIV: moving towards effective interventions in Southern and Eastern Africa. Afr J AIDS Res. 2016 Jul;15(2):141-8. doi: 10.2989/16085906.2016.1204331. PMID: 27399043.

[14] Turan, J.M., Elafros, M.A., Logie, C.H. *et al.* Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Med* **17,** 7 (2019). https://doi.org/10.1186/s12916-018-1246-9

[15] Friedland BA, Gottert A, Hows J, Baral SD, Sprague L, Nyblade L, McClair TL, Anam F, Geibel S, Kentutsi S, Tamoufe U, Diof D, Amenyeiwe U, Mallouris C, Pulerwitz J; PLHIV Stigma Index 2.0 Study Group. The People Living with HIV Stigma Index 2.0: generating critical evidence for change worldwide. AIDS. 2020 Sep 1;34 Suppl 1:S5-S18. doi: 10.1097/QAD.0000000000002602. PMID: 32881790.

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[17] Gupta, N. Research to support evidence-informed decisions on optimizing gender equity in health workforce policy and planning. *Hum Resour Health* **17,** 46 (2019). https://doi.org/10.1186/s12960-019-0380-6

[18] WHO. Evidence-informed policy-making. http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making

Methodology

Stages of the GA and Data Sources

The GA 2023 in The Gambia used the updated UNAIDS Gender Assessment Tool (GAT) for the National HIV Responses, which emphasizes the need for a holistic approach that integrates the full spectrum of people's health needs and their rights[19]. The GA was carried out through a participatory and iterative process, with each step and task feeding into the other. Stage 1 focuses on preparing for the GA including ensuring high-level commitment, developing the assessment framework, and collecting key documents and data. Activities in Stages 2 and 3 entailed data collection; analysis of the epidemic, context, and response; as well as identifying barriers, inequities, and the best and cost-effective interventions for different population groups.

The field work was done in conjunction with the three consultants (Gender Assessment, Legal Environment Assessment, and Human Rights & Gender) with KIIs, FGDs, and sites visits addressing crosscutting issues pertinent to these assessments.

Data Sources

a. *Desk review*. Available information was collected, organized, and synthesized in order to gain an understanding of the HIV context, national priorities, and key indicator trends. Desk review activities included scanning the literature and analysing secondary data such as surveys (Demographic and Health Survey 2019- 20, MICS 2018), studies and reports, laws, policies and strategies, programme documents and reports, AIDSinfo, and journal articles from PubMed, Science Direct, PLOS One and Google Scholar.
To ensure a more comprehensive HIV response, people's experiences, opinions and recommendations were collected through key informant interviews (KII) and focus groups discussions (FGD) with selected population groups at risk, affected by, and/or living with HIV; as well as multisectoral consultation meetings.

b. *Key Informant Interviews*. Interviews were conducted in person, with 21 participants:

- Government: Ministry of Gender, Children and Social Welfare, Ministry of Basic and Secondary Education, National Human Rights Commission, and the Ministry of Interior.
- CSO and networks (4 participants): The Girl's Agenda, Gambia Network of PLWHIVs (GAMNASS), The Association of Non-Governmental Organisations (TANGO) and Gambia Food and Nutrition Association (GAFNA).
- UN Partners (7 participants from 4 agencies): WHO, UNDP, High Commissioner for Human Rights, and UNAIDS.

c. *Focus Group Discussions.* Five FGDs were carried out with a total of 31 participants: women living with HIV, MSM, female sex workers (FSW), young people, and PWD. The purpose of the FGDs was to gather opinions and experiences from these population groups on the sociocultural norms and legal and political factors increasing their vulnerability to HIV, violence, comorbidities, stigma, and discrimination, as well as to identify the needs to be integrated into the HIV policies and programmes.

[19] UNAIDS (2018). UNAIDS Gender Assessment Tool. Towards a gender-transformative HIV response.

d. *Site visits.* These visits were carried out in Kanifing Hospital and the MSM Drop-In-Centre aiming to get insights on some accomplishments, challenges, and lessons learned. The interchanges were carried out with 11 staff members from Kanifing Hospital (Principal Nursing Officer, Mental Health, IDC, TB Unit, Counseling/GBV, Maternal Health) and the MSM Drop-In-Centre (1 Peer-Health Educator and 2 Health Navigators).

e. *Multi-sectoral meetings.*

- Inception meeting. This meeting aimed: i) To provide a platform for the key stakeholders to discuss and agree on the consultancy framework and process, ii) To identify gaps in the data areas; data collection methods; stakeholders to engage; the overall consultancy process; iii) To discuss deliverables and timelines of the consultancy.
- Meeting on preliminary impressions from the fieldwork. The objective of this meeting was to present initial results and observations and get first reactions from the stakeholders involved in the development of the three assessments.

Analytical Approach

The GA combined quantitative measures with qualitative data to provide deeper insight into the intersecting gender equality dimensions of the HIV epidemic, context, and response. The analysis of the country's epidemics and context included data disaggregated by sex, age, geographical location, and other social stratifiers (urban/rural, key populations, income, etc.) when available. The information from the desk review was summarized and classified according to the stages of the GA, with the aim of identifying major intersectional and gender-related gaps and inequalities. The data from the FGDs and KIIs was examined using thematic analysis of qualitative data. This is useful for organizing and summarizing data within a structure that allows comparisons across groups, by thematic area of the gender analysis domains related to the HIV context and response.

Data from multiple sources was synthesized and integrated through collection, examination, comparison, and interpretation, focusing on making findings more robust.

Guiding Principles and Ethical Considerations

The development of the GA was underscored by core values, such as respecting and protecting the rights of women and girls, the rights and engagement of KVP in meaningful participation, diversity and promoting the equality of all people without distinction of any kind, preventing human suffering, addressing social and economic inequities, and fostering social justice. The field work and the data collection process were guided by the basic mandate of "do no harm."

Ethical Considerations

The assessment used ethical guidelines established by WHO, UNAIDS, and other agencies. Measures were put in place to protect confidentiality, privacy, and to ensure that the FGDs and KIIs primary data collection

methods did not lead to suffering harms[20,21]. The ethical considerations included a framework for a people-centred approach, considering the nature of the issues addressed and the potential risks for participants including stigmatization. The development of the FGDs or KIIs was context-specific, as different cultural and religious factors could imply different challenges and risks (including of a legal nature) for the research/consultant team and participants.
The GA approach emphasized the need of ensuring the confidentiality, privacy, autonomy, including informed consent, and safety of FGD and KII participants.

Limitations of the GA

a. Limited updated behavioural information in general population and in specific groups, including among key vulnerable populations such as transgender people, prisoners, orphans, people with disabilities, refugees, and migrants.

b. Scanty emphasis on the intersecting structural determinants of the HIV epidemic, and therefore lack of empirical research and information on interventions undertaken on this issue in the country.
c. The study did not involve any regional consultations as initially planned due to time constraints associated. Likewise, people from rural or peri-urban areas did not participate in the FGDs and KIIs. The following groups/sectors were not reached despite efforts to engage: PWUD, TB patients, transgender women and other non-gender non-conforming persons.

d. The sites visits to the Kanifing Hospital and the MSM Drop-In-Centre Observe provided insights on some accomplishments, challenges, and lessons learned. However due to the limited time used for the visits, the consulting team had tight opportunities to identify diverse working practices, good examples, and how they are implemented; neither for identifying any areas that could be improved.

e. Scarce data on the gender aspects of HIV among key and vulnerable populations, in general.

f. The lack of available information on the development partners' level of investment in gender equality interventions, which limited the possibility of carrying out a gender analysis of funding and budget allocations.
g. Lack of data on people 65 years of age and older living with or affected by HIV in the Gambia.

[20] UNAIDS and WHO. Ethical considerations in biomedical HIV prevention trials. Additional guidance point added in 2012. Geneva 2012. https://www.unaids.org/sites/default/files/media_asset/jc1399_ethical_considerations_en_0.pdf
[21] MariJo Vázquez and Fiona Hale. Ethical considerations for an integral response to human rights, HIV and violence against women in Central America. Inter-American Commission of Women (CIM/OAS), 2011. Washington DC. https://www.oas.org/en/cim/docs/VIH-VAW-ConsideracionesEticas-EN.pdf

3. COUNTRY CONTEXT

As of 2022, the population of the Gambia was estimated to be 2.4 million[22]. The Gambia is divided into five administrative regions and one city, Banjul.[23] Within the regions are 8 Local Government Areas (LGA), cities that represent their regions of which two are the City of Banjul and the Municipality of Kanifing; these two collectively form Greater Banjul, although the latter now extends to parts of Brikama LGA, the former Western Division. Data from the most recent census (2013) indicates that the Brikama region is the most populated, home to 699,704 people (37.1% of the total population), and the Kanifeng region is the second-most populated with 377,134 people (20.3%)[24]. About 43% of the population is between the ages of 0-14, and 2% is 65 years or older[25]. Within the Gambian population there are various ethnic groups, the Mandinka constituting the largest share of the population at 42%, with the Fula following at 18% of the population[26].

Education. Literacy rates in The Gambia have increased in recent years, but there is still a large gap between men over 15 (61.8%) and women over 15 (41.6%)[27]. Lower secondary school completion rates are similarly low between female (48%) and male (43%) students. Completion rates for primary, lower secondary, and upper secondary schools are highest in Banjul. Brikama LGA has the highest rates of children who do not complete school across all levels of education (primary, lower secondary, and upper secondary schools)[28].

According to the DHS 2019-20, in The Gambia, among women and men age 15-49:

- 47% of women and 67% of men age 15-49 are literate.
- The median number of years of schooling completed among men is 7.4, as compared with 5.6 among women.
- 35% of women have no formal education, compared with only 22% of men.
- Less than 1 in 10 students, both AGYM and ABYM, have completed a secondary education level.

For people with disabilities, various institutional and physical barriers create a lack of accessibility and confidence in their communities and the education system.

> *"At primary level, going to school is difficult without adequate transportation. It's like only able-bodied people can go to school. No one supports people with disabilities."* (FGD, GAPD)

[22] "Population - Total." *GBoS*, www.gbosdata.org/data/40-population-and-household-characteristics/1653-population-total
[23] "Explore All Countries: The Gambia." *The World Factbook*, 6 June 2023, www.cia.gov/the-world-factbook/countries/gambia-the/#people-and-society.
[24] The Gambia Bureau of Statistics, and United Nations Population Fund. "The Gambia 2013 Population and Housing Census Preliminary Results." *Population and Housing Census Preliminary Results*, 2013, www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiu4aGlr8H_AhXijYkEHVVmA8EQFnoECA8QAQ&url=https%3A%2F%2Fcatalog.ihsn.org%2Findex.php%2Fcatalog%2F6065%2Fdownload%2F74258&usg=AOvVaw2R9WcqWz9V6Grj9Y-AGjXK.
[25] "World Population Dashboard -Gambia." *United Nations Population Fund*, 2023, www.unfpa.org/data/world-population/GM.
[26] *Gambia Population 2023 (Live)*, 2023, worldpopulationreview.com/countries/gambia-population.
[27] "Gambia." *UNESCO UIS*, 12 Apr. 2017, uis.unesco.org/en/country/gm.
[28] "The Gambia Education Fact Sheets 2020." UNICEF, 2020, www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&cad=rja&uact=8&ved=2ahUKEwitzpKVlsb_AhXmFVkFHWZ4Ck4QFnoECCwQAQ&url=https%3A%2F%2Fdata.unicef.org%2Fwp- content%2Fuploads%2F2021%2F08%2FGambia-Education-Fact-Sheet-2020.pdf&usg=AOvVaw21QpALrAGVb5_E- Tca5OBJ.

Economic context. The Gambian economy expanded by an estimated 4.3% in 2022. The country has implemented recovery measures and regained stability from the COVID-19 pandemic through agricultural production, infrastructure expenditure, and increased government spending[29]. Unemployment has also lowered to 4.8% in 2022, almost half of the rate in 2012 (9.4%)[30]. Despite increases in employment, poverty rates have increased by 8% since the start of the pandemic (from 45.8% in 2019 to 53.4% in 2022)[31]. High inflation and subsequent high food prices have worsened economic inequities. In 2020, 80.6% of the population was living below the upper-middle-income-country poverty line- those living on 125.9 in Gambian dalasi (2020) or US$6.85 (2017 PPP) per day per capita[32]. Since 1990, female labor force participation has steadily increased, from 45.4% to 57.3% in 2022. Since 1992, male labor force participation has slightly decreased, from 70.4% to 65.8% in 2022[33].

Political context. The Gambia is a multiparty republic. Under the 1996 Constitution, the President and members of the National Assembly are democratically elected, and the rights of marginalised groups- such as women, children, and people living with disabilities- are ratified. The Constitution explicitly expresses the necessity of the inclusion of women in government, yet women only held 8.6% of seats in Parliament in 2021[34] [35].

Health situation and system. The Gambia has bolstered its healthcare and treatment services in the last 10 years. Between 2015 and 2020 there was an expansion of HIV testing and counselling services, including prevention of mother-to-child transmission (PMTCT) programs. In 2018, 61.5% of women attending antenatal clinics were tested for HIV and informed of their results[36]. In 2019, life expectancy was the highest it had ever been for the country at 63.76 years[37]. The top five causes of death and disability in 2009 (neonatal disorders, HIV and AIDS, lower respiratory infections, diarrheal diseases, and malaria) had all decreased in their incidence by at least 10% each by 2019. However, the aforementioned (and other communicable diseases) remained the largest contributors to fatalities in 2019[38].

The Gambia has both universal public healthcare and private providers. In 2019, 56.8% of all health expenditures for residents was paid by external health-development assistance. Comparatively, 21.8% was paid by government health spending, and 17.7% was paid out-of-pocket[39]. Fundamental insufficiencies, such as the low availability of pharmaceutical products, are one of the main causes of

[29] The World Bank. The World Bank in The Gambia. Mar 10, 2023. https://www.worldbank.org/en/country/gambia/overview
[30] The World Bank. Unemployment, total (% of total labor force) (modeled ILO estimate) - Gambia, The. https://data.worldbank.org/indicator/SL.UEM.TOTL.ZS?end=2022&locations=GM&start=2007
[31] The World Bank. Covid-19 elevated poverty in The Gambia. Nov 09 2022. https://www.worldbank.org/en/news/press-release/2022/11/09/covid-19-elevated-poverty-in-the-gambia#:~:text=BANJUL%2C%20November%209%2C%202022%20–,to%2045.8%20percent%20in%202019.
[32] World Bank Group. Poverty and Equity Brief: The Gambia April 2023. https://databankfiles.worldbank.org/public/ddpext_download/poverty/987B9C90-CB9F-4D93-AE8C-750588BF00QA/current/Global_POVEQ_GMB.pdf
[33] The World Bank. Gender Data Portal: The Gambia. 2023. https://genderdata.worldbank.org/countries/gambia-the/#:~:text=In%20the%20Gambia%2C%20the%20labor,labor%20force%20participation%20has%20increased.
[34] The Constitute Project. Gambia (The)'s Constitution of 1996 with Amendments through 2018. April 27 2022. https://www.constituteproject.org/constitution/Gambia_2018.pdf?lang=en
[35] The World Bank. Gender Data Portal: The Gambia. 2023. Ibid
[36] UNAIDS. Country Progress Report: Republic of the Gambia. 2020. https://www.unaids.org/sites/default/files/country/documents/GMB_2020_countryreport.pdf
[37] The World Bank. Life expectancy at birth, total- The Gambia. 2021. https://data.worldbank.org/indicator/SP.DYN.LE00.IN?locations=GM
[38] Institute for Health Metrics and Evaluation. Gambia. https://www.healthdata.org/gambia)
[39] Institute for Health Metrics and Evaluation. Gambia. Ibid

private healthcare expenditures. Public sector primary healthcare is accessible on a community level, with 634 village posts recorded in 2019. Secondary and tertiary care is limited to the Banjul and West Coast localities, the more urban areas, and is primarily run by private, for-profit, non-governmental organizations. Local, traditional healers are the first connection to healthcare for many Gambians[40]. The Gambia lags behind the African regional average in antiretroviral coverage for HIV positive individuals; in 2021, only a third of Gambians living with HIV were receiving antiretroviral therapy[41].

Climate change. In 2022, the Gambian government released a climate-neutral development strategy, aiming for net-zero greenhouse gas emissions by 2050. The acceleration of climate change puts Gambia at risk to observe a large decline in quality of life, water, food, and development. Extreme weather conditions such as drought, flooding, and high temperatures threaten the ability of the country to perform in one of its largest industries, agriculture, as well as provide provisions for residents[42]. The Gambia's Poverty Reduction Strategy aims to incorporate the communicable disease prevention and conscientious environmental development into policy strategies[43]. Data from six sub-Saharan African countries (2016–2017) showed that climate change and resulting food insecurity could jeopardize progress of HIV prevention, especially among women. The communities with the highest levels of food insecurity also had the highest HIV prevalence. The significant association between food support and lower risk of HIV suggests that providing direct and targeted food support to women with severe food insecurity, especially amid extreme climatic events, could reduce HIV transmission[44].

[40]Assessment of the Health System in the Gambia. USAID, Health Policy Plus. Nov 2019. http://www.healthpolicyplus.com/ns/pubs/17372-17674_GambiaHealthSystemAssessment.pdf

[41] The World Bank. Antiretroviral therapy coverage (% of people living with HIV) - Gambia, The. 2021. https://data.worldbank.org/indicator/SH.HIV.ARTC.ZS?locations=GM

[42] Government of The Gambia Ministry of Environment, Climate Change and Natural Resources. The Gambia`s long-term climate-neutral development strategy 2050. 2022. https://unfccc.int/sites/default/files/resource/Long_Term_Climate_Change_Strategy_of_The_Gambia_Final.pdf

[43] Jaiteh, Malanding S. and Sarr, Baboucarr. Climate Change and Development in the Gambia: Challenges to Ecosystem, Goods, and Services. http://www.columbia.edu/~msj42/pdfs/ClimateChangeDevelopmentGambia_small.pdf

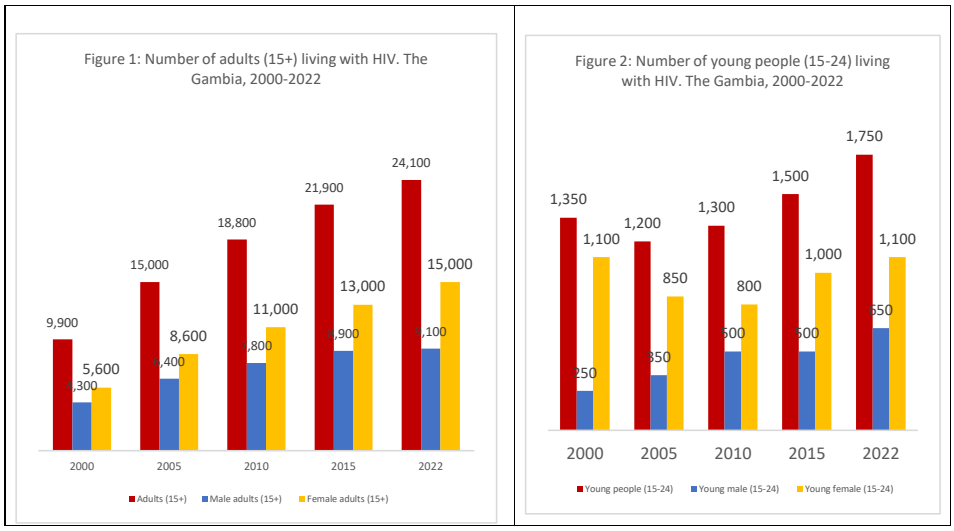
[44] PHIA. At the Nexus of Climate Change, Food Security, and Health in Sub-Saharan Africa, Women Find Themselves at High Risk for HIV. August 2022. https://phia.icap.columbia.edu/at-the-nexus-of-climate-change-food-security-and-health-in-sub-saharan-africa-women-find-themselves-at-high-risk-for-hiv/

4. NATIONAL HIV EPIDEMIC AND CONTEXT

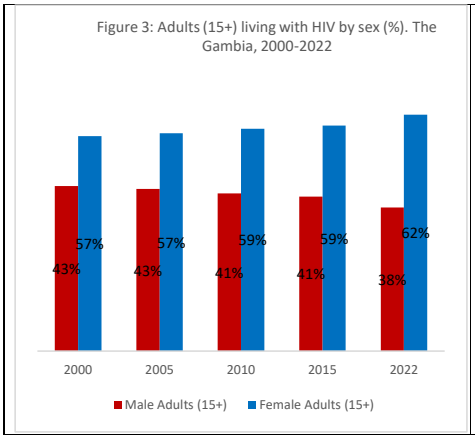
4.1 Number of people living with HIV, Prevalence and Incidence

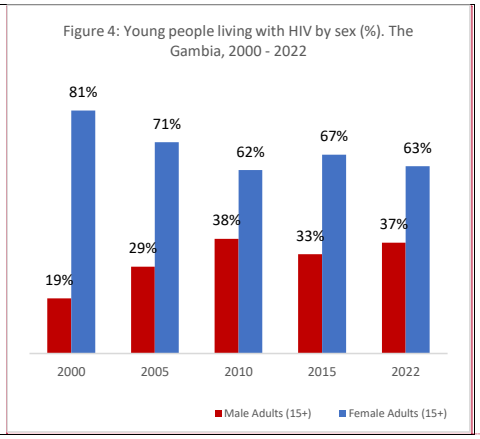
Number of people living with HIV

The first HIV case in The Gambia was recorded in 1986. Ever since, the spread has accelerated with the country having a generalized HIV epidemic with women and key subpopulations are disproportionately affected. According to UNAIDS and NAS, in 2022 there were an estimated 24,000 adults over 15 years and 2,200 children 0 to 14 years living with HIV.



Between 2015 and 2022, the increase among adults (15+) in men was 2% (8,900 to 9,100) and among women was 15% (13,000 to 15,000). Among young people (15-24) the number increased by 30% for men (500 to 650) and by 10% for women (1,000 to 1,100).





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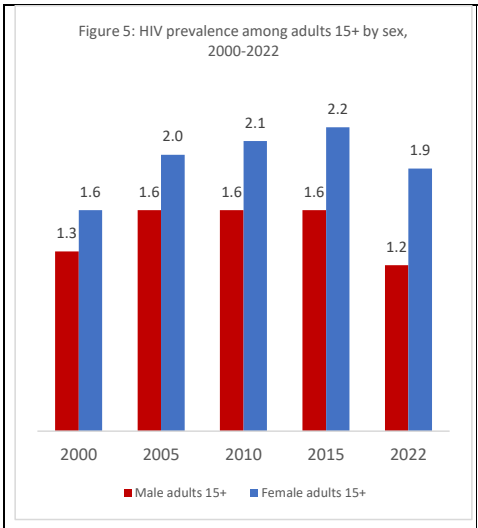
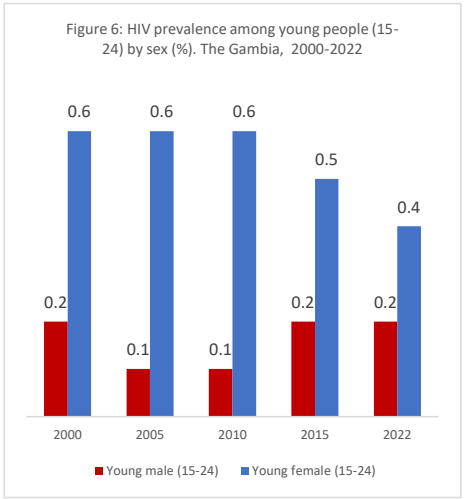
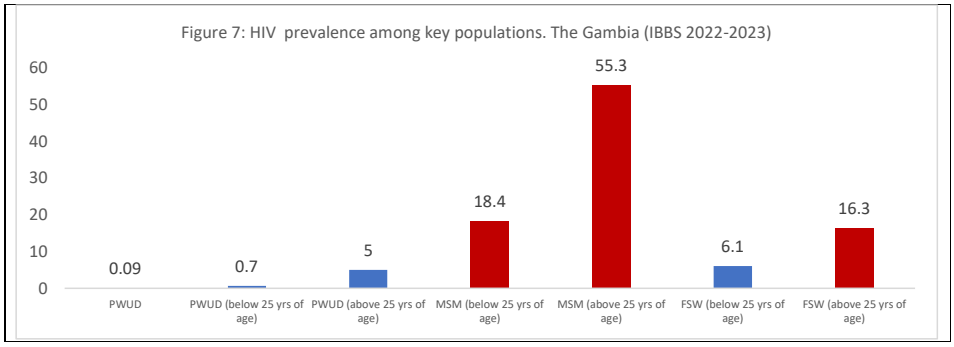
From 2000 to 2022, women represented between 57% and 62% of adults (15+) living with HIV and among young people (15-24) between 81% (2000) and 62% (2010), decreasing only 5 percent points in the last seven years, from 67% in 2015 to 63% in 2022.

Prevalence







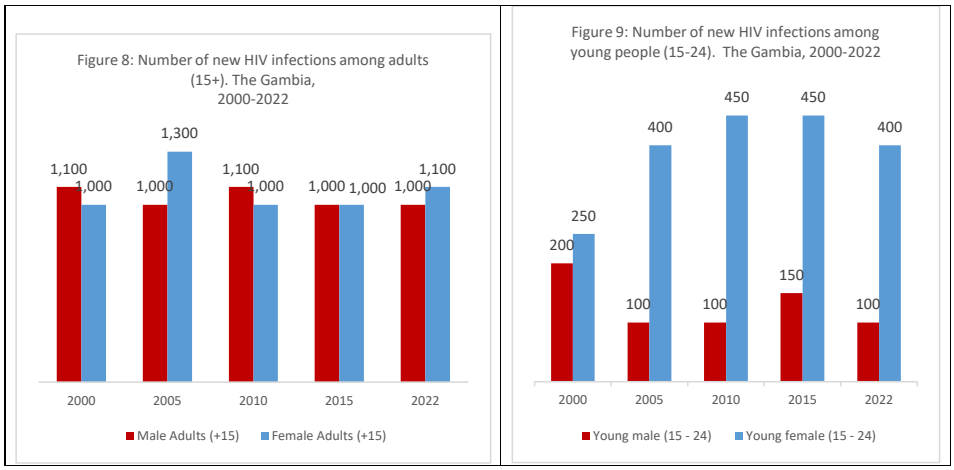
Between 2015 and 2022, among adults the HIV prevalence decreased by 26% among men and by 16% among women; among young women prevalence decreased by 20%, while among men it remained the same. Key populations in The Gambia experience disproportionate HIV burden with significant variations associated with age. According to IBBS 2022-2023, the HIV prevalence among all female sex workers was 11%, but was 16.3% among those above 25 years of age and 6.1% in those below 25 years of age. Likewise, the prevalence among MSM was 34.4% but higher among those above 25 years of age (55.3%) and lower in those below 25 years of age (18.4%). The IBBS 2022-2023 does not include data on HIV prevalence among transgender women. A study with a small sample (4 participants) found that the HIV prevalence among transgender women in Banjul was 50%[45]. The HIV prevalence among PWUD was 0.1%, while it was 0.7% among those below 25 years of age and 5% among above 25 years of age. The data available from the IBBS 2022-2023 on HIV prevalence among PWUD is not data disaggregated by sex. When analysing HIV prevalence among KPs, it is critical to consider the intersectionality between HIV status, and other marginalized group memberships, such as transgender people, orphans, migrants, refugees, returnees, PWD, prisoners [46].

[45] Cited in: Kloek, M., Bulstra, C.A., van Noord, L., Al-Hassany, L., Cowan, F.M. and Hontelez, J.A.C. (2022), HIV prevalence among men who have sex with men, transgender women and cisgender male sex workers in sub-Saharan Africa: a systematic review and meta-analysis. J Int AIDS Soc., 25: e26022. https://doi.org/10.1002/jia2.26022

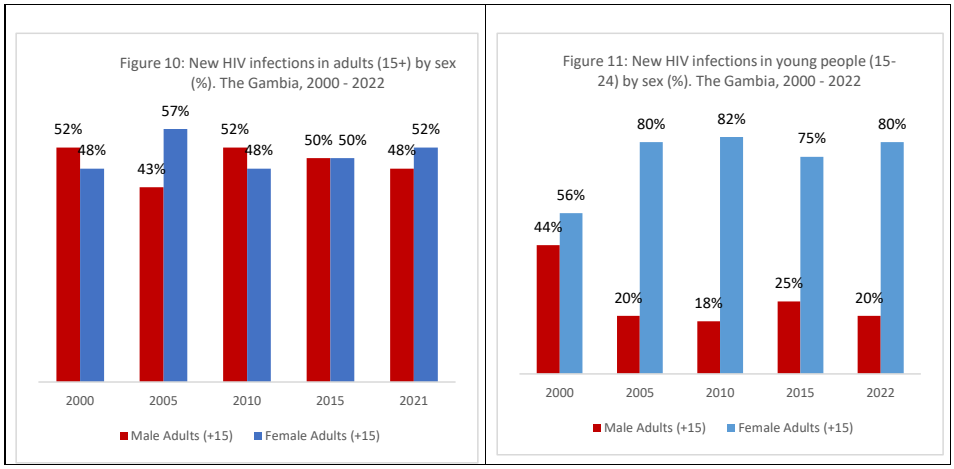
[46] Friedland BA et al. Measuring intersecting stigma among key populations living with HIV: implementing the people living with HIV Stigma Index 2.0 Journal of the International AIDS Society 2018, 21(S5):e25131. http://onlinelibrary.wiley.com/doi/10.1002/jia2.25131/full | https://doi.org/10.1002/jia2.25131

New Infections

The new infections have decreased by 28% since 2020.



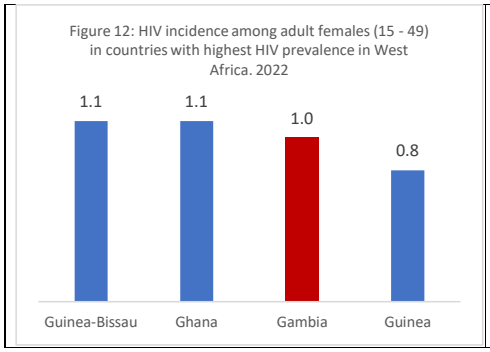
Between 2015 to 2022, among adults (15+), the new infections increased by 10% among females while among males remained unchanged. Among young people the reduction was by 33% for males and only 11% for females.

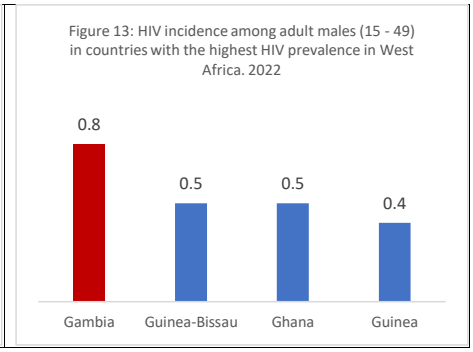


From 2000 to 2005, women represented between 48% and 57% of new HIV infections among adults (15+) and 52% in 2022. Among young people (15-24) women constitute a majority of new infections, jumping from 56% to 82% between 2000 and 2010, and representing 80% of infections in 2022. Acknowledging this, the Ministry of Gender, Children, and Social Welfare said:

"We are aware culture and the position of women in society makes them more vulnerable to HIV infection." (KII, MoGCSW)

Incidence. The HIV incidence per 1000 people among adults (15-49) was 1. (UNAIDS, AIDSinfo).





In 2022 among adults (15-49) The Gambia had the highest incidence among males and the third highest among females amidst the four countries with the highest prevalence in West Africa.

4.2 Vulnerable and Priority Populations

Vulnerable populations are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities, and migrant and mobile workers[47]. These populations are not affected by HIV uniformly across the country and the national HIV epidemic.

Although currently there is not epidemiological data on some of the following population groups, due to their vulnerability to HIV infection they should be specially considered in The Gambia HIV response:

Migrants, returnees, and refugees. Evidence shows that migration on its own is not a risk factor for HIV. Still, migration may place individuals, households, as well as transit, host, and return communities in circumstances that increase their vulnerability and worsen HIV outcomes.

Stakeholders identify some of the following barriers at community and institutional levels:

"As the funding dwindles down, we have fear. Young refugees are single parents and with no support, they could be tempted to do anything that risks infection of HIV." (KII, GAFNA)

"You go into the host community, they are overcrowded and anything can happen there. They can pick up contagious diseases and anything can happen in those type of things." (KII, GAFNA)

[47] Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations – 2016 Update. Geneva: World Health Organization; 2016. DEFINITIONS OF KEY TERMS. Available from: https://www.ncbi.nlm.nih.gov/books/NBK379697/

Different categories of mobile populations have differing needs and vulnerabilities[48]. Strategies to end the HIV epidemic, especially those that target geographical hotspots, will increasingly need to account for population mobility. Generalised mobile populations tend to be at higher risk of HIV acquisition and onward transmission[49].

There is a deficit of support systems for non-citizens:

> *"Some social services are restricted, social development fund, grants, loans are restricted to Gambians. During emergencies, Gambia Red Cross committee gives assistance."* (KII, GAFNA)

Migrants and returnees. In recent years, Gambians have emigrated at a higher rate per capita than every other nation in Africa. Between 2015 and 2020, over 33,000 Gambians arrived in Europe irregularly, while over 6,000 have voluntarily returned home since 2017[50]. The mapping and socioeconomic profiling of communities and returnees in the Gambia (2018) found that in all communities and among almost all sub-groups studied, the desire to leave is high (average of 72%). Both returnees and non-returnees report a similarly high desire to migrate (4-point difference). This suggests that the migratory cycle does not necessarily end upon re-entering society. Age and gender influence employability of returnees. Returnees (16% of the sample) are more likely to be male than female (3 :1) and older (most were aged 25-34)[51]. The country is also one of the worst affected by unsafe migration (including that of children) commonly called "back way"[52].

Refugees. According to UNHCR, as 31 May 2023 there were 3,755 refugees and 423 asylum seekers in The Gambia[53].

Prisoners. According to the World Prison Population List, the latest information available (at the beginning of October 2021) indicated that prison population in The Gambia was 543[54]. In 2019 women represented the 2.9% of the prison population while 9% were juveniles (minors/young prisoners)[55]. UNAIDS indicated that worldwide, people in prison are 7.2 times more likely to be living with HIV than adults in the general population. HIV prevalence among people in prisons increased by 13% since 2017, reaching 4.3% in 2021. Although data are limited, it is thought that around one in four of the total prison

[48] UNAIDS. Update on the implementation of the HIV response for migrant and mobile populations. UNAIDS/PCB (48)/21.15 June 2021. https://www.unaids.org/sites/default/files/media_asset/PCB_48_Migrant_Mobile_Populations_EN.pdf
[49] Susan Cassels. Time, population mobility, and HIV transmission. www.thelancet.com/hiv Vol 7 March 2020. https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(19)30413-8/fulltext
[50] IOM. Launch of Displacement Tracking Matrix (DTM) Strengthens Migration Data in The Gambia. 15 June 2021 https://www.iom.int/news/launch-displacement-tracking-matrix-dtm-strengthens-migration-data-gambia
[51] Samuel Hall (2018). Mapping and Socio-Economic Profiling of Communities of Return in the Gambia (Synthesis Report), for the Regional Office for West and Central Africa of the International Organization for Migration. https://static1.squarespace.com/static/5cfe2c8927234e0001688343/t/6056167145562a231be05e6e/1616254584091/iom-gambia-synthesis-report-201218.pdf
[52] UNICEF Gambia. https://www.unicef.org/gambia/child-protection
[53] UNHCR. Operational Data Portal. Gambia, Refugees Situations. https://data.unhcr.org/en/country/gmb
[54] World Prison Brief, World Prison Population List Thirteenth edition. https://www.prisonstudies.org/sites/default/files/resources/downloads/world_prison_population_list_13th_edition.pdf
[55] World Prison Brief data. The Gambia. https://www.prisonstudies.org/country/gambia

population has hepatitis C[56]. In The Gambia, the number of HIV-positive prisoners is unknown. Existing data suggests high prevalence rates among African prisoners compared with the general adult population[57].

A key informant identified their concerns about the misinformation about HIV in prisons.

> *"Much as the Department of Social Welfare works with the prisons there is still denial of sex in prison by the prison authorities."* (KII, MoGCSW)

Adolescent girls and young women (AGYW). Although the HIV prevalence is relatively low among young people in The Gambia, AGYW represent a higher percentage of young people living with HIV and of the new infections in that population group. They should be included in the national HIV response as priority population. They have an increased risk of acquiring HIV, often associated with the incidence of unintended pregnancies, transactional sex, GBV, as well as other factors determined by their unequal cultural, social and economic status in society[58].

One member of the National Youth Council (NYC) lent insight into how women can bear the burden of their family's economic status, leaving them with few options.:

> *"It is known that financial challenges lead to women selling their bodies for sex…Family problems also lead to young girls selling their bodies to make ends meet."* (FGD, NYC)

> "*A young girl requesting financial support was rebuked by her mother who asked "What's the use of your boyfriend?*". (FGD, NYC)

People with disabilities. According to the MICS 2018, 2.1% of women and 3.2% of men age 18-49 years have at least on functional difficulty (seeing, hearing, walking, self-care, communication, and/or remembering)[59]. In The Gambia, reports by the Gambian Federation of the Disabled (GFD), indicate that more than 10% of the population has a disability, with widespread cases of stigma and discrimination across various fronts in society which still exist, resulting in increased invisibility due to shame and other cultural beliefs[60]. UNAIDS indicates that vulnerability, combined with a poor understanding and appreciation of their sexual and reproductive health needs, places people with disabilities at higher risk of HIV infection; and whether or not they are living with HIV, people with disabilities have an unmet need

[56] UNAIDS. UNAIDS calls for access to HIV prevention, treatment and care in prisons, including access to life saving harm reduction services. 7 May 2023. https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2023/may/20230507_prevention-treatment-care-prisons-harm-reduction#:~:text=UNAIDS%20reports%20that%20HIV%20prevalence,%2C%20reaching%204.3%25%20in%202021.

[57] UNODC and UNAIDS (20027). HIV and Prisons in sub-Saharan Africa: *Opportunities for Action.* https://www.unodc.org/documents/hiv-aids/publications/UNODC_UNAIDS_WB_2007_HIV_and_prisons_in_Africa-EN.pdf

[58] International Training and Education Center for Health. Key and Priority Populations. November 2019. https://www.go2itech.org/wp-content/uploads/2019/12/Technical-Brief_Key-Pops.pdf

[59] The Gambia Multiple Indicator Cluster Survey 2018. Survey Findings Report. July, 2019.

[60] UNFPA. Enhancing the rights of persons with disabilities through ethical reporting. April 2023. https://gambia.unfpa.org/en/news/enhancing-rights-persons-disabilities-through-ethical-reporting

for health and HIV services in order to protect themselves. They represent one of the largest and most underserved populations[61].

Participants in a FGD indicated the need to strengthen disability policy development and implementation:

> *"There is lack of up-to-date data of people with disability living with HIV."* (FGD, GAPD)

> *"At national level, there is a deficiency in policies and programmes. As advocacy organisations, we have tried to advocate that led to the first draft of National Disability Bill in 2011."* (FGD, GAPD)

> *"There is no engagement of the disability people in decision making."* (FGD, GAPD)

> *"PWD are advocating for sign languages to be a national language since it's a big challenge and they are wrongly diagnosed in the hospitals and even at the police stations, someone can mislead the police because there isn't a sign language specialist."* (FGD, GAPD)

Orphans. Eighteen percent of children under age 18 are not living with a biological parent, and 9% are orphans (i.e., one or both parents are dead). The percentage of children not living with a biological parent and the percentage of children with one or both parents dead increases with age; among children age 15-17, one-third (34%) do not live with a biological parent, and for one-fifth (20%) one or both parents are deceased (DHS 2019-2020)[62].

LGBTIQ+ community. The 2021 UNAIDS Rapid Gender Assessment emphasized that sexual orientation is a gender-related issue[63]. In the Gambia, societal and legal pressures force the LGBTIQ+ community to adopt traditional lifestyles and marriages. Homophobia and masculine norms stigmatize gender-diverse communities, discouraging education and treatment-seeking.

Participants in a FGD shared the barriers that they face:

> *"Life here is a little boring and I feel like am in a cage."* (FGD, MSM)

> *"When going out you'd be mindful of the way you dress, the way you talk which is not normal. They are always watching you so it's just like you've been caged."* (FGD, MSM)

Commercial sex workers and victims of human trafficking. Commercial sex work and human and sex trafficking can contribute to the escalation of HIV. It involves risky sexual behavior, with women seeing multiple partners per day and a prevalence of intercourse without protection. The presence of the disease in this industry has risen significantly in past years[64]. Attention should also be paid to adolescent boys and bumsters (beach -boys) as they variously indulge in a complex web of sexual activity ranging from

[61] UNAIDS. The GAP Report 2014. People with Disabilities. https://www.unaids.org/sites/default/files/media_asset/11_Peoplewithdisabilities.pdf
[62] Gambia Bureau of Statistics (GBoS) and ICF. 2021. The Gambia Demographic and Health Survey 2019-20. Banjul, The Gambia and Rockville, Maryland, USA: GBoS and ICF.
[63] UNAIDS The Gambia Rapid Gender Assessment report 2021.
[64] Mweta et al, 2016. Gender Assessment of the National HIV/AIDS and TB response in the Gambia NAS

commercial to non-commercial, voluntary to socially-imposed, individual to peer-driven, heterosexual to homosexual, casual to regular, particularly with foreign tourists[65].

Domestic maids and women hotel workers

Domestic maids and women hotel workers face various challenges in their workplaces that could put them at risk of contracting HIV. Domestic maids, especially when employed by families, may be vulnerable to mistreatment by men, and this vulnerable position can lead them to give in and succumb to abuse. Similarly, women working in hotels also encounter similar situations as domestic maids, as they may be exposed to advances and exploitation by tourists and individuals seeking opportunities. Their desire to travel to Europe can sometimes cloud their judgment, leading them to accept risky situations without fully considering the potential consequences of engaging with strangers, some of whom may be HIV positive[66].

4.3 Behavioural information: HIV-related Knowledge and Sexual Behaviour

Social and behavioural information is critical to halt HIV transmission. Data on multiple levels is needed, including intrapersonal, interpersonal, community, and social factors to develop effective interventions. However, analysing gendered causal pathways linking HIV and behaviours, as well as identifying the most relevant factors, is challenging. This is partly because of the complexity of their intersections at different levels and in diverse populations, and because of the evolving nature of social and structural factors.

HIV/AIDS- related knowledge, attitudes and behaviour

Comprehensive knowledge of HIV. About one quarter of women (27%) and men (28%) age 15-49 have comprehensive knowledge about HIV. (DHS 2019-20)

Multiple sexual partners. Less than 1% of women and 10% of men reported having two or more sexual partners in the 12 months prior to the survey. (DHS 2019-20)

A focus group participant relates this stark difference to cultural expectations:

> *"The stigma toward women can be more severe because it's considered a normal for a man to have several partners."* (FGD, Mutapola)

> "*Women face stigma and discrimination which on most cases ends in divorce and husbands always blaming wives*." (FGD, Mutapola)

> "*We are culturally rooted when it comes to certain health issues. In some communities when your husband dies you are automatically transferred to his brother without knowing his HIV status.*" (KII, MoGCSW)

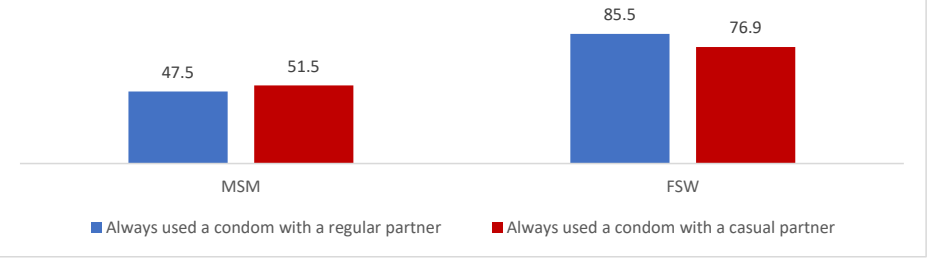
[65] Stella Nyanzi, Ousman Rosenberg-Jallow, Ousman Bah & Susan Nyanzi (2005) Bumsters, big black organs and old white gold: Embodied racial myths in sexual relationships of Gambian beach boys, Culture, Health & Sexuality, 7:6, 557-569, DOI: 10.1080/13691050500245687

[66] Touray, 2016. Consultancy to review and develop the gender thematic area of HIV/AIDS strategic framework 2015 2020

"*There are cultural barriers women are stigmatized because when a woman tests positive, they make conclusions by blaming the woman.*" (FGD, NYC)

Condom use. 28% of women and 58% of men reported using a condom during their last sexual intercourse with a nonmarital or non-cohabiting partner (DHS 2019-20). Among KP, the percentage of MSM who reported using a condom with a regular partner and a casual partner in the last 6 months is similar (47.5% and 51.5% respectively). Among FSW the use of condoms is higher in both instances, but is higher with a regular partner (85.5%) than with a casual partner (76.9%).

Figure 14: MSM and FSW that reported always used a condom in the last 6 months with regular and casual partner (%). The Gambia, IBBS 2022-2023



Knowledge about where to get a test. A majority of both female and male (70% and 69%, respectively) know where to get an HIV test. Thirty nine percent of women report having ever been tested for HIV and receiving the results, as compared with 25% of men. (DHS 2019-20).

4.4 Intersections between cultural norms, practices and other structural factors

Socio-cultural norms, gender roles, and expectations influence HIV risks, access to prevention, treatment, and care of women and girls, men and boys, and key and vulnerable populations in their diversity. While gender, intersecting inequalities, and HIV are strongly linked, improvements in gender relations may have a positive impact in stemming the spread of HIV in a population. Cultural norms and practices, within the broader context of social structural factors, constitute critical determinants of the risks of HIV infection and have varying implications in different populations. The emphasis on social structure and power imbalances reflects the implications for HIV-prevention initiatives, not only in respect to their potential to modify HIV patterns, but also to mitigate social injustice and inequality[67].

Gender Norms in Safe Sex and Acceptability of Wife Beating

Attitude towards wife beating. A greater percentage of women (55%) than men (40%) agree that a husband is justified in hitting or beating his wife under one or more specified circumstances (DHS 2019-20).

Negotiating sexual relations. More women (63%) than men (60%) believe that a woman is justified in refusing to have sexual intercourse with her husband if she knows he has sex with other women (DHS 2019-20).

[67] Steven Sovran (2013) Understanding culture and HIV/AIDS in sub-Saharan Africa, SAHARA-J: Journal of Social Aspects of HIV/AIDS, 10:1, 32-41, DOI: 10.1080/17290376.2013.807071

Cultural norms, HIV-related behaviour among young people (15–24 years) and HIV prevalence
Gender norms in many cultures combined with taboos about sexuality have a huge impact on the ability of adolescent girls and young women to protect their health and prevent HIV, seek health services, and make their own informed decisions about their sexual and reproductive health and lives. (UNAIDS, 2019)

Members of the NYC spoke on their observations of avoidant attitudes towards discussions of sex on personal, community, and educational levels:

> *"Furthermore, people do not want to talk about protected sex. While at community level, parents feel shy to talk about sex to their children. The parents can't talk about sex… No education of HIV and AIDS in schools since* Population, Family and Life Education *was taken away from the schools."* (FGD, NYC)

> *"HIV and AIDS is a concern especially about the rate at which it spreads and no proper education about HIV and AIDS and how to counter the spread of the disease. When looking at The Gambia, especially the young people, ages of sex workers are getting younger. Nothing is being done to control sex activities. The system does not consider these means."* (FGD, NYC)

A member of NAS spoke about systematic barriers posing as a challenge for men's access to services.

> "*The challenges faced are systematic: men are always not responsive to health challenges. They only seek treatment when they are sick*." (KII, NAS)

Table 1: HIV-related behaviour among young people (15–24 years) and HIV prevalence

Indicator	Male	Female
Sexual intercourse before age 15 (%)	5.8	4.7
Had sex with more than one partner in last 12 months (%)	3.3	0.3
In the last 12 months had sex with a non-marital, non-cohabiting partner (%)	92	11.9
Percentage reporting the use of a condom during the last sexual intercourse with a non-marital, non-cohabiting partner in the last 12 months (%)	61.2	34.9
Percentage with comprehensive knowledge about HIV	19.7	22.7
HIV Prevalence (15–24) 2021 (UNAIDS)	0.4%	0.2%
Sources: MICS 218[68] and UNAIDS, AIDSinfo 2022[69]		

While young men between the ages of 15 and 24 report earlier initiation of sexual activity and more than one partner in the past year, HIV prevalence rates are higher among young women than young men. Slightly more young women than young men report having comprehensive knowledge about HIV, while more men than women report using a condom during their last sexual encounter. Although HIV prevalence is higher in young women, still, they report lower levels of condom use at their last sexual intercourse than men of comparable ages.

[68] Gambia Bureau of Statistics and UNICEF. The Gambia Multiple Indicator Cluster Survey 2018. https://www.unicef.org/gambia/reports/gambia-multiple-indicator-cluster-survey-2018
[69] UNAIDS. AIDSInfo, 2020. https://aidsinfo.unaids.org/

Marriage, FGM and Sexual Activity

Child marriage. One in five young women age 15-19 (19%) are currently in union, compared with less than 1% of men in the same age group (DHS 2019-20). Girls in this situation generally do not have any control over their own bodies. They have limited access to comprehensive sexual education and family planning-particularly contraceptive commodities- and face huge resistance from their male spouse regardless[70]. Although research has increased the understanding of the factors that may make some child brides more vulnerable to HIV than women who marry later, there is a dearth of evidence regarding the relationships between child marriage and HIV[71].

Female Genital Mutilation. In The Gambia, 75.7% women age 15-49 years had any form of FGM (MICS 2018).[72] Apart from its known association with short- and long-term adverse physical, psychological, and sexual sequelae, female genital mutilation/cutting (FGM/C) could be associated with increased susceptibility to HIV. However, the available evidence in 2019 did not conclusively demonstrate the anticipated association between FGM/C and HIV.[73]
Members of the Network Against Gender-Based Violence (NGBV) expressed concerns about FGM:

> *"Through FGM, HIV can be contracted."* (KII, NGBV)

> *"Even issues of FGM, people hide behind tradition and religion to practice FGM which violates the law."* (KII, NGBV)

Polygyny. Thirty-four percent of married women report that their husband has more than one wife. Fourteen percent of men report having two or more wives (DHS 2019-20). Polygyny amplifies risky sexual behaviours such as sexual networking and concurrent sexual partnerships, all of which are significantly associated with the risk of HIV transmission[74].

Paid sex. Six percent of men age 15-49 report ever having paid for sexual intercourse, and 1% report that they paid for sexual intercourse in the 12 months preceding the survey. The percentage of men age 15-49 who report having paid for sexual intercourse in the 12 months preceding the survey remained stagnant at 1% from 2013 to 2019-20. However, the percentage reporting having ever paid for sexual intercourse rose from 2% in 2013 to 6% in 2019-20. (DHS 2019-20)

[70] Touray 2013
[71] Suzanne Petroni et al. Understanding the Relationships Between HIV and Child Marriage: Conclusions from an Expert Consultation. Journal of Adolescent Health 64 (2019) 694e696. https://www.jahonline.org/article/S1054-139X(19)30109-0/pdf
[72] Gambia Bureau of Statistics and UNICEF. MICS 2018. Ibid
[73] Noah Pinheiro YA. Associations between female genital mutilation/cutting and HIV: a review of the evidence. Afr J AIDS Res. 2019 Sep;18(3):181-191. doi: 10.2989/16085906.2019.1637913. Epub 2019 Sep 10. PMID: 31502923.
[74] Martin M Gazimbi et al. Is polygyny a risk factor in the transmission of HIV in sub- Saharan Africa? A systematic review. African Journal of Reproductive Health December 2020; 24 (4):198

Intergenerational sex. 54.3% of women ages 15-24 years who in the last 12 months had sex did so with a man 10 or more years older (MICS 2018)[75]. Age and economic disparity between partners have been shown to compromise young women's ability to negotiate safe sex[76].

Socioeconomic status and poverty

Gender inequality and poverty exacerbate the burden of HIV among women[77]. Poverty and women's lack of economic independence is an underlying factor for and poses a heightened risk for HIV transmission. In The Gambia, women-by virtue of their low level of education and structural inequalities- are relegated to low status, low paying jobs that make them dependent on their husbands for their survival. The cultural perception of man as the provider often results in unequal balance of power which is manifested at all levels of society. It disempowers women, increasing their vulnerability to sexual exploitation and risk of contracting HIV.

> *"For us women our problem is that we are not empowered" (FGD NYC)*

PLHIV suffer discrimination that affects their economic independence and further deepens the poverty and dependence of women. A member of Mutapola examined how HIV is at the simultaneously a cause and an outcome of poverty, and poverty is both a cause and an outcome of HIV.

> *"At work place, it's difficult to be engaged, enrolled or involved. Sometimes it's difficult to get work as you lose value." (FGD, Mutapola)*

4.5 Polyvictimization – GBV

Women, girls and KVP are often exposed to more than one form or type of violence. Their experiences of violence seldom fit neatly into one category or another, but rather span a number of interrelated types. Different forms of GBV overlap and have adverse cumulative effects through the life course, including for HIV[78],[79]. Integrated and intersectional responses to HIV and GBV must therefore understand these interconnections and the ways in which one form of violence can lead to others, rather than approaching GBV in a fragmented way.

[75] Gambia Bureau of Statistics (GBoS) and ICF. 2021. *The Gambia Demographic and Health Survey 2019- 20*. Banjul, The Gambia and Rockville, Maryland, USA: GBoS and ICF. https://dhsprogram.com/pubs/pdf/FR369/FR369.pdf

[76] Richard Olson. Refocusing the Lens: Recognizing and Enhancing Agency around HIV Risk Avoidance with Adolescent Girls in Eastern and Southern Africa. UNICEF. UNICEF Working Draft – April 2010. https://www.unicef.org/esaro/Adolescent_Girls_Conference_paper_R._Olson.pdf

[77] Sherafat-Kazemzadeh R, Gaumer G, Hariharan D, Sombrio A, Nandakumar A. Between JoGH © 2021 ISoGH a Rock and a Hard Place: How poverty and lack of agency affect HIV risk behaviors among married women in 25 African countries: A cross-sectional study. J Glob Health 2021;11:04059

[78] McGeough BL and Sterzing PR (2018) A Systematic Review of Family Victimization Experiences Among Sexual Minority Youth. *J Prim Prev*. 39(5):491-528. doi:10.1007/s10935-018-0523-x

[79] Schwartz B, Kaminer D, Hardy A, Nöthling J and Seedat S (2019) Gender Differences in the Violence Exposure Types that Predict PTSD and Depression in Adolescents [published online ahead of print, 2019 May 26]. *J Interpers Violence*. 886260519849691. doi:10.1177/0886260519849691

Several studies have shown that women with a history of physical and/or sexual abuse are more likely to be living with HIV, especially if that abuse first started during their childhood[80]. Women living with HIV experience intimate partner violence (IPV) and those women experience abuse by their partners after disclosing their HIV serostatus. IPV increases the risk of HIV acquisition and often interferes with victims' engagement in and adherence to HIV care[81].

Some of the prevalent forms of violence affecting women, girls, key and vulnerable populations, sometimes in combination, include:

Physical violence by anyone since age 15. 46% of women age 15-49 have experienced physical violence at least once since age 15, and 11% experienced physical violence within the 12 months prior to the survey. The percentage of women who have experienced physical violence since age 15 increased from 41% in 2013 to 46% in 2019-20. (DHS 2019-20)

Spousal violence. 41% of ever-married women age 15-49 have ever experienced any form of emotional, physical, or sexual violence committed by any husband/partner (DHS 2019-20).

A member of Mutapola, a network of women and girls living with or affected by HIV/AIDS, spoke on this:

> *"That stigma extends to you as a person with HIV. So some of the examples would be violence. Some people get beaten up. Some people get moved, pushed out of their home, where we know divorce was a key thing. They're ostracized from family and whatnot. Some people have to leave their jobs."* (FGD, Mutapola)

Prevalence of Sexual Violence. Nine percent of women age 15-49 have ever experienced sexual violence, and 2% experienced sexual violence in the 12 months before the survey. The percentage of women ever experiencing sexual violence generally increases with age; less than 1% had experienced sexual violence by age 10 and 7% by age 22. (DHS 2019-20)

Help seeking. 65% of women who ever experienced physical or sexual violence never sought help and never told anyone. (DHS 2019-20)

Violence against AGYW

- 4 in 10 adolescents age 15-19 and 5 in 10 age 20-24 have ever experienced physical or sexual violence.
- In women ages 15-49, experience of physical violence increases with number of living children, from 39% among women with no children to 51% among those with five or more children.
- Around 2 in 10 adolescents age 15-19 had experienced physical violence during pregnancy.
- More than 1 in 5 AGYW report that their current or most recent husband/partner demonstrates at least three of the following controlling behaviours: is jealous or angry if she talks to other men, frequently accuses her of being unfaithful, does not permit her to meet her female friends, tries to limit her contact with her family, and insists on knowing where she is at all times.

[80] The Well Project. Violence Against Women and HIV. February 2023. https://www.thewellproject.org/hiv-information/violence-against-women-and-hiv

[81] Sullivan TP. The intersection of intimate partner violence and HIV: detection, disclosure, discussion, and implications for treatment adherence. Top Antivir Med. 2019 May;27(2):84-87. PMID: 31136996; PMCID: PMC6550354.

Table 2: AGYW (15-24) who report have experience of violence (%). (DHS 2019-20)

Type of violence	15-19 years of age (%)	20-24 years of age (%)
Physical or sexual violence ever	40.4	51.1
Physical violence during pregnancy	18	5.9
Women whose current husband/partner displays 3 or more specific types of controlling behaviors	20.5	24.3

Violence against KP. According to IBBS 2022-23, 25.9% of FSW have ever been physically harmed due to their work (pushed, shoved, slapped, hit, choked, or otherwise physically harmed because they engage in sex work); and 16.7% of MSM have experienced these types of violence because they had sex with men. A cross-sectional survey administered among 251 FSW found that there is a high prevalence of sexual violence against FSW in The Gambia, with 29% (n = 70) of participants reporting that a client forced them to have sex in their lifetime[82].

Female sex workers reported arrest and physical harm in the hands of the Police:

> "*For female sex workers, the police will arrest you and ask you for medical paper which does not exist in The Gambia. They ask you that so they can get money from you sometimes they can keep you in for a long time. Gambians are charged 1500 and Nigerians 3000."* (FGD, FSW)

Violence against people with disabilities. They experience GBV in the families and wider community, especially physical, emotional, and sexual abuse. They are also subject to harmful traditional practices such as forced marriage and FGM. The vulnerability of women and girls with disabilities is heightened as they face multiple forms of discrimination and abuse[83].

Additionally, other vulnerable populations are subject to dangerous situations:

> *"Sexual exploitation is another issue as a challenge for the refugees."* (KII, GAFNA)

[82] Sherwood, J.A., Grosso, A., Decker, M.R. *et al.* Sexual violence against female sex workers in The Gambia: a cross-sectional examination of the associations between victimization and reproductive, sexual and mental health. *BMC Public Health* **15**, 270 (2015). https://doi.org/10.1186/s12889-015-1583-y

[83] United Nations Partnership on the Rights of Persons with Disabilities (2020). Situational analysis of the rights of persons with disabilities in The Gambia - Country report. https://www.unprpd.org/sites/default/files/library/2022-12/CR_Gambia_2021.pdf?ref=disabilitydebrief.org

4.6 Discriminatory attitudes towards PLHIV

According to the IBBS 2022-2023, approximately 1% FSW and MSM reported report experiences of HIV-related discrimination in health facilities, with a higher percentage indicating that they avoid health care because of stigma and discrimination, 5.8% and 24.1% respectively.

Table 3: Stigma and discrimination in health facilities among FSW and MSM in The Gambia (IBBS 2022-23).

Indicator	%
Have you ever been refused health care, or someone stopped you from receiving health care services because you are a sex worker?	0.75%
Have you ever avoided going to health services because you were afraid that someone would find out that you are a sex worker?	5.8%
MSM. Have you ever been denied health care because you have sex with men?	1.0%
Have you ever avoided going to health or social services because you were afraid someone would find out you had sex with men?	24.2%

In the general population, 76% of women and 73% of men ages 15-49 have discriminatory attitudes towards people living with HIV. The percentage of women and men with discriminatory attitudes decreases with age. 85% of women and 87% of men age 15-19 have discriminatory attitudes, as compared with 69% of women and 54% of men age 40-49. Also, differences in discriminatory attitudes towards people living with HIV are observed between urban and rural areas; 72% of women and 70% of men in urban areas have discriminatory attitudes, compared with 89% of women and 82% of men in rural areas. (DHS 2019-20)

Focus groups participants describe their concerns around discretion in healthcare facilities as well as the need for a related support network:

> *"Health workers should be sensitized about the privacy of those who test positive."* (FGD, NYC)

> *"There is need for privacy in terms of facilities to cater for HIV because stigma and discrimination and stereotype. When we did an outreach project in Jara Soma, many people feared to get tested because of the open space."* (FGD, NYC)

Discriminatory attitudes can lead to inadequate support for both PLHIV and those who are vulnerable to it. Stigma about assumed promiscuity, homophobia, and transphobia, among others, create a hostile environment for those who seek preventive services or care. This is visible from the treatment that World View staff encounter in the hands of police:

> *"We talk to the girls about HIV prevention and give them information and supply them with condoms but the police arrest us. They say we are the ones promoting prostitution. They will ask*

you for a staff ID and if you do not have it, they will ask you for money and you can spend long hours in the police station until World View negotiates your release. (FGD, FSW)

"Stigma and discrimination is the biggest challenge from the communities to the hospitals e.g. different colour hospital cards are given to the HIV/AIDS patients." (FGD, MoGCSW)

4.7 Sexual and Reproductive Health and Rights

As HIV has multiple effects on SRHR, SRH services are critical for women, men, and key and vulnerable populations with HIV. Access to essential SRH care should be provided in HIV prevention, care, and treatment programmes; appropriate forms of prevention and treatment of HIV should be included in all SRH services as a public health priority, particularly in sex education, family planning, pregnancy-related care, SRH-related cancers, adolescent's health, sexually transmitted infections (STI) services, cervical cancer prevention and treatment, and services addressing all types of violence[84],[85].

There is a social element to the lack of SRH services:

> *"Discussions on SRH is a taboo in our society. They will see you as someone who is disrespectful and in case something happens, the child (young person) is to be blamed."* (FGD, NYC)

Fertility rate. The Total Fertility Rate (TFR) in The Gambia is 4.4 children per woman. Urban areas have a lower TFR (3.9) than rural areas (5.9) (DHS 2019-20)**.**

Early childbearing. 14% of adolescents have begun childbearing. The percentage of teenagers who have begun childbearing is higher in rural areas (20%) than in urban areas (11%) (DHS 2019-20).

Contraception use. 19% of currently married women use a method of contraception. Injectables (8%) and implants (6%) are the most commonly used methods (DHS 2019-20).

Unmet need for family planning. 24% of currently married women and 45% of sexually active unmarried women have an unmet need for family planning (DHS 2019-20).

Exclusion from activities during menstruation. 32.5% of girls 15-19 years did not participate in social activities, school, or work due to their last menstruation in the last 12 months (MICS 2018).

Cervical and breast cancer. Cervical cancer ranks as the first leading cause of female cancer in The Gambia and is the first most common female cancer in women aged 15 to 44 years. In 2020, out of 575 new cases of cancer among females of all ages, cervical cancer was the most frequent, accounting for 286 (49.7%), followed by breast cancer (14.6%).[86] Cervical cancer is the most common cancer among women living with HIV. Compared with women who are HIV negative, women living with HIV have a risk several times higher of persistent HPV infection, and are six times as likely to develop cervical cancer and are more likely to develop it at a younger age. Reaching vulnerable women at high risk of developing cervical cancer and

[84] Hamzah, Lisa; Hamlyn, Elizabeth Sexual and reproductive health in HIV-positive adolescents, Current Opinion in HIV and AIDS: May 2018 - Volume 13 - Issue 3 - p 230-235 doi: 10.1097/COH.0000000000000456.
[85] Wojcicki JM. Silence sexual and reproductive health discussions and we fuel the rise of HIV/AIDS in sub-Saharan Africa. Reprod Health. 2017 Oct 17;14(1):131. doi: 10.1186/s12978-017-0395-1. PMID: 29041933; PMCID: PMC5646123.
[86] Globocan 2020. The Republic of The Gambia. https://gco.iarc.fr/today/data/factsheets/populations/270-the-republic-of-the-gambia-fact-sheets.pdf

acquiring HIV infection will need prioritization of integrated preventive, screening, and treatment services for both diseases to increase efficiencies and maximize impact.[87] The Gambia has one of the lowest survival rates for breast cancer in Africa. Contributing factors are late presentation, delays within the healthcare system, and decreased availability of resources[88].

A participant in a KII attributes the incidence of these illnesses to certain societal customs:

> *"It's not a surprise to see more women suffering from HIV/Cervical cancer and other diseases due to the harmful traditional practices."* (KII, NGBV)

Maternal Health

Delivery and postnatal care. More than 8 in 10 births (84%) are delivered in a health facility, primarily in public sector facilities (76%). Only 15% of births in The Gambia are delivered at home. Women with no education (78%) and those from the poorest households (71%) are least likely to deliver at a health facility. Health facility deliveries have increased since 2013 when 63% of births were delivered in a health facility. Overall, 84% of births are assisted by a skilled provider. The majority of births are delivered by a nurse or midwife (73%). Skilled assistance during delivery has increased from 57% in 2013 to 84% in 2019-20 (DHS 2019-20).

Despite general increases in health facility deliveries, there remain populations who lack access to public health services:

> *"There was once a young girl with disability who got pregnant and could not access the health facility due to the lack of ramp. She had to be attended to on the ground floor at great risk to her health. This caused a public outcry."* (FGD, GAPD)

*Mortality***.** Maternal mortality includes deaths of women during pregnancy, delivery, and within 42 days of delivery, excluding deaths that were due to accidents or violence. The maternal mortality ratio (MMR) for The Gambia is 289 maternal deaths per 100,000 live births for the 7-year period before the survey (DHS 2019-20).

STDs. According to IBBS 2022-2023, 5.7% of PWUD have Hepatitis B and 2.5% Hepatitis C. A study on STIs among 280 pregnant women attending antenatal care clinics in the West Coast Region of The Gambia found that the overall prevalence of STIs was 53.6%. The pathogenic agents isolated were Candida albicans (31.8%), Streptococcus agalactiae (15.0%), Treponema pallidum (6.8%), HIV (5.7%), Trichomonas vaginalis (3.9%), Neisseria gonorrhoea (1.8%), and Chlamydia trachomatis (0.7%). STIs were more prevalent among women in the younger age group of 15 – 24 years (54.7%), unemployed (54.0%),

[87] WHO. Global strategy towards eliminating cervical cancer as a public health problem. April 2020. https://www.who.int/publications/i/item/9789240014107

[88] Sanyang O, Lopez-Verdugo F, Mali M, Moustafa M, Nellermoe J, Sorensen J, Bittaye M, Njie R, Singhateh Y, Sambou NA, Goldsmith A, Mohammed NI, Brownson KE, Price RR, Sutherland E. Geospatial analysis and impact of targeted development of breast cancer care in The Gambia: a cross-sectional study. BMC Health Serv Res. 2021 Sep 9;21(1):943. doi: 10.1186/s12913-021-06963-7. PMID: 34503503; PMCID: PMC8428029.

Primipara (62.3%), and in the third trimester of pregnancy (72.7%)[89]. This indicates the need to promote the sexual and reproductive health of pregnant women in the country.

The youth group NYC recognized lack of education on sexual health and safety practices, as well as sensitivity of the delivery of such information:

> *"So I believe support should be provided to accelerate the educational part to make sure that people are aware of HIV and proper approach also should be taken. Not only to say that, okay, we want to go out and talk to people about HIV, but it has to be realistic. It has to be something that has to reflect what it is that is happening on the ground. That's how we'll be able to educate is not only to say, 'let's go out and talk to people,' but proper mechanisms should also be put in place involve people, especially their organization that also involved in, you know, how do we sensitize people about HIV and AIDS support those other decision support those young people are involved in."* (FGD, NYC)

4.8 Comorbidities

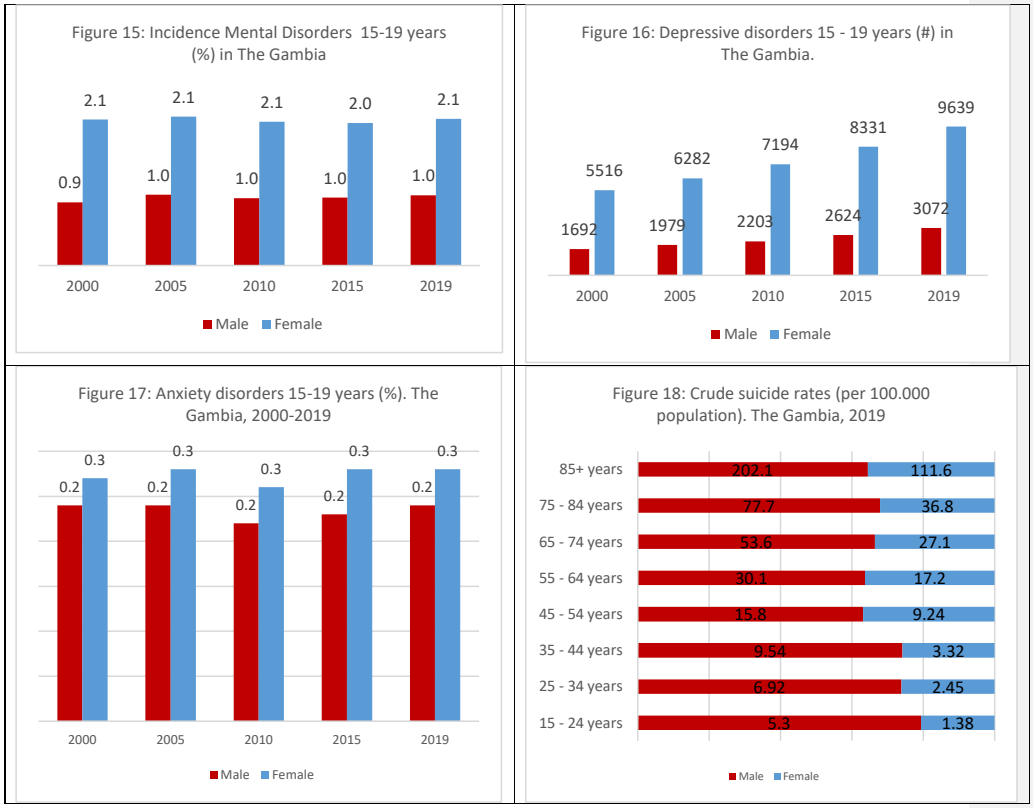
"People with HIV are increasingly likely to die of causes that are not AIDS-related." (UNAIDS, 2023)

As people living with HIV age, the burden of non-HIV related comorbidities increases and greater vigilance and integration of resources is required in the overall treatment and monitoring of HIV-positive persons for comorbidities. With access to antiretroviral therapy, people living with HIV are living longer and increasingly present with comorbid conditions, such as hypertension, diabetes, and chronic kidney disease[90].

Mental Health. Comorbidities between HIV and common mental disorders, such as depression and anxiety disorders, are also well established. Among the most frequently observed disorders in people living with HIV, depression is the most prevalent, followed by anxiety, and post-traumatic stress disorder (PTSD).

[89] Isara A, Baldeh AK. Prevalence of sexually transmitted infections among pregnant women attending antenatal clinics in West Coast Region of The Gambia. Afr Health Sci. 2021 Jun;21(2):585-592. doi: 10.4314/ahs.v21i2.13. PMID: 34795711; PMCID: PMC8568222.

[90] Bygrave H, Golob L, Wilkinson L, Roberts T, Grimsrud A. Let's talk chronic disease: can differentiated service delivery address the syndemics of HIV, hypertension and diabetes? Curr Opin HIV AIDS. 2020 Jul;15(4):256-260. doi: 10.1097/COH.0000000000000629. PMID: 32398467.



Source: World Health Observatory

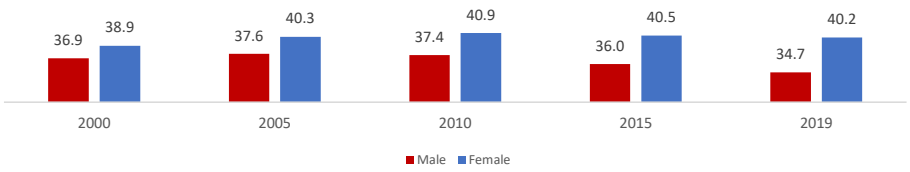
In The Gambia, in 2019, the number of depressive disorders among adolescent girls (15-19 years of age) was three times higher than in their male counterparts. The incidence of mental health disorders as well as the prevalence of anxiety disorders is also higher among adolescent girls. Inversely, the crude suicide rates are consistently higher among males than in women, in all age groups[91].

> *"Forming a community of people who are living with HIV needs a counselor or a therapist to help."* (FGD, NYC)

[91]WHO. The Global Health Observatory. https://www.who.int/data/gho

Hypertension. One-third of the adult population (25–64 years) in The Gambia are hypertensive and a high proportion of these are undiagnosed[92]. From 2009 to 2019, the hypertension prevalence has been higher among women than men and have remained virtually unchanged, while among men with slightly decrease of around 3 percent points from 2005 to 2019.

Figure 19: Prevalence of hypertension among adults aged 30 - 79 years (%). The Gambia, 2000-2019.
World Health Observatory



Most of Cardiovascular disease (CVD) risk factors are very prevalent in The Gambia, with some specific groups in the population, such as urban dwellers, being more at risk. Obesity prevalence ranged from 2.3% to 11.7%, with rates being particularly high in urban women aged ≥35 years. Hypertension prevalence ranged from 18.3% to 29%. Prevalence of hypercholesterolemia ranged from 2.2% to 29.1%. Prevalence of smoking ranged from 16% to 42.2% in men. Prevalence of insufficient fruit and vegetable consumption, inadequate physical activity, and alcohol consumption was 77.8%, 14.6%, and 2.3%, respectively[93]. People living with HIV are at risk for CVD. Cardiovascular diseases (CVD) due to atherosclerosis have become one of the major causes of death among people living with HIV (PLHIV) since effective antiretroviral therapy (ART) has been available throughout the world[94].

Diabetes. According to The Gambia's 2018 NCDs national profile, NCDs (including diabetes) account for 34% of all deaths, an increase from the 32% reported in 2014. The World Health Organization predicts that about 4% of The Gambian population could be diabetic by 2030[95]. Chronic inflammation caused by HIV and HAART medication may increase the risk of developing diabetes. This increased risk occurs in countries of all income levels. A 2021 study found that people with HIV tend to develop diabetes at a younger age than the general population[96].

[92] Bai Cham and others, Burden of hypertension in The Gambia: evidence from a national World Health Organization (WHO) STEP survey, *International Journal of Epidemiology*, Volume 47, Issue 3, June 2018, Pages 860–871, https://doi.org/10.1093/ije/dyx279

[93] Koller R, Agyemang C. Prevalence of Cardiovascular Disease Risk Factors in the Gambia: A Systematic Review. Glob Heart. 2020 Jun 17;15(1):42. doi: 10.5334/gh.827. PMID: 32923336; PMCID: PMC7427677.

[94] Ruamtawee, W., Tipayamongkholgul, M., Aimyong, N. *et al.* Prevalence and risk factors of cardiovascular disease among people living with HIV in the Asia-Pacific region: a systematic review. *BMC Public Health* **23**, 477 (2023). https://doi.org/10.1186/s12889-023-15321-7

[95] Nkoka, O., Ntenda, P.A.M., Phiri, Y.V.A. *et al.* Knowledge of diabetes among Gambian adults: evidence from a nation-wide survey. *BMC Cardiovasc Disord* **22**, 145 (2022). https://doi.org/10.1186/s12872-022-02591-z

[96] Daniel Yetman. What to Know About HIV and Diabetes. Healthline. May 2022. https://www.healthline.com/health/hiv-aids/hiv-aids-and-diabetes#takeaway

Tuberculosis

In 2020, WHO estimated that among 3,800 people who developed TB in The Gambia, 390 were children. In the same year, 620 people developed TB and were coinfected with HIV[97]. Gender affects susceptibility to tuberculosis, its diagnosis, access to treatment, adherence to treatment, the availability of supportive care, and treatment outcomes. While significantly more men than women contract tuberculosis and die from it, it can have particularly severe consequences for women, especially during their reproductive years and during pregnancy. Tuberculosis in pregnant women living with HIV increases the risk of maternal and infant mortality by almost 400%[98].

COVID-19. Between 3 January 2020 and 30 August 2023, there were 12,626 confirmed cases of COVID-19 and 372 deaths in The Gambia that were reported to WHO. By 19 March 2023, a total of 1,444,492 vaccine doses have been administered[99]. Fear of stigmatisation of patients with COVID-19 was a recurring issue among different population groups, with detrimental effects on willingness to accept COVID-19 testing and home visits to follow up patients with COVID-19 and their household contacts[100]. According to UNAIDS Country Office, repurposing HIV medical equipment and health personnel to address the fast-rising epidemic was necessary to limit COVID-19 related deaths. It also came with a cost—reducing the capacity to deliver HIV prevention and treatment services[101]. This became evident in UNAIDS staffers' interview (2021):

> *"Social unrest caused by the COVID-19 pandemic also impeded access to regular healthcare, including for people living with HIV (PLHIV) and resulted in disruptions of ART availability. Rapidly, a multi-month dispensation of ARVs was initiated to try to maintain continued availability of treatment for all stable PLHIV. During this period, a sharp decline in the number of PLHIV on ART was observed as well as a decline in HIV testing services in the general population*."[102](Sirra Ndow, UNAIDS Country Director Gambia)

[97] Stop TB Partnership & WHO. Tuberculosis situation in 2020. The Gambia.
https://www.stoptb.org/static_pages/GMB_Dashboard.html
[98] WHO (2019). Tuberculosis in Women. Geneva.
[99] WHO. The Gambia WHO (COVID-19) Homepage
https://covid19.who.int/region/afro/country/gm
[100] Diallo BA, Usuf E, Ceesay O*, et al* Clinical research on COVID-19: perceptions and barriers to participation in The Gambia *BMJ Global Health* 2022;**7:**e007533.
[101] UNAIDS. Five questions about the HIV response in The Gambia. 31 OCTOBER 2021.
HTTPS://WWW.UNAIDS.ORG/EN/RESOURCES/PRESSCENTRE/FEATURESTORIES/2021/OCTOBER/FIVE-QUESTIONS-GAMBIA
[102] UNAIDS. Five questions about the HIV response in The Gambi. Ibid

4.9 Legal Framework

The Gambia is a signatory to several international, continental, and regional commitments, including the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW),[103] the Southern Africa Development Community (SADC) Protocol on Gender and Development, [104] the Maputo Plan of Action on Sexual and Reproductive Health and Rights (2007 to 2010), [105] and the Eastern and Southern Africa (ESA) Ministerial Commitment on sexuality education and sexual and reproductive health services for adolescents and young people. These key international instruments, along with the national laws and policies, are part of the legal and political context related to government and civil society work in addressing gender equality, HIV, gender inequality, GBV, and SRHR.

The Gambia Parliament adopted the HIV and AIDS Prevention and Control Act in 2015 to provide HIV and AIDS prevention, implementation, and control measures to Gambians. It regulates care, treatment, and support for PLHIV. The Act includes provisions to protect vulnerable groups from violence and discrimination[106]. The HIV and AIDS Prevention and Control Act 2015 covers a wide range of matters, including HIV-related education and information, voluntary counseling and testing, confidentiality and informed consent, training of health providers, sensitization of the public, criminalization of willful transmission, prohibition and criminalization of false information, breach of confidentiality and discriminatory acts on the ground of suspected or real HIV positive status across sectors, gender and reproductive health rights, provisions for HIV services to prisoners and vulnerable groups[107].

The 1997 Constitution of The Gambia is the basic law of the land, the Preamble of which highlights that "the fundamental rights and freedoms enshrined in the Constitution will ensure full respect for and observance of human rights of the people at all times without discrimination based on…gender." Safeguards against the discrimination of women are also provided for in Section 33(2) of the Constitution, which states that "no law shall make any provision which is discriminatory either of itself or in effect." The legal system of The Gambia is plural in nature, with the 1997 Constitution serving as the main legal source for guarantees of human rights, including the protection of women from all forms of discrimination.

Customary and Sharia law govern all matters relating to personal law status—more specifically, laws relating to marriage, divorce, inheritance, and general family matters. Customary law also includes land tenure, and tribal and clan leadership. Sharia law, which has to some extent displaced customary law, is limited primarily to Muslim marriage, divorce, and inheritance matters, whereas the common law is based on the received English law and operates as the residual law. Over 90% of matters relating to family law

[103] UN. Convention on the Elimination of All Forms of Discrimination Against Women, 1979. https://www.un.org/womenwatch/daw/cedaw/

[104] Southern Africa Development Community protocol on Gender and Development, 2008. https://www.sadc.int/files/8713/5292/8364/Protocol_on_Gender_and_Development_2008.pdf

[105] African Union. Maputo Plan of Action 2016 – 2030. Working Group of the Specialised Technical Committee on Health, Population and Drug Control, Experts Meeting. 25 to 26 April 2016, Addis Ababa. Ministers of Health Meeting Geneva, 21 May 2016. https://www.au.int/web/sites/default/files/newsevents/workingdocuments/27513-wd-sa16952_e_original_mpoa.pdf

[106] UNAIDS. Country progress report - Republic of The Gambia 2020. https://www.unaids.org/sites/default/files/country/documents/GMB_2020_countryreport.pdf

[107] The Republic of the Gambia, The HIV and AIDS Prevention and Control Act, 2015. Cited by: Berry Didier Nibogora. Legal Environment Assessment (LEA) for HIV/AIDS Responses in The Gambia. 2023

are adjudicated in the Cadi or Islamic courts. Within the realm of customary law, district chiefs preside over local customary district tribunals[108].

In July 2016, the Children's (Amendment) Act was enacted, which prohibited child marriage and establishes the minimum age for marriage as 18 years. However, there is no minimum age of marriage under Islamic Sharia law, which is the dominant tradition governing family law in The Gambia[109].

Among the main current gaps in the legal framework provisions and implementation are[110]:

- *Marriage and family*. The Constitution does not protect women's equality with men in marriage or at its dissolution.
- *The right to education*. While the Women's Act prohibits the expulsion of girls on grounds of pregnancy, social stigma related to teenage pregnancy renders this legal provision ineffective.
- *Cultural harmful practices*. The Women's Act does not contain any provisions prohibiting the practice of other harmful practices such as levirate marriage and unequal inheritance, although these practices are rooted in patriarchy and stifle the ability of women and girls to achieve their full potential.
- *Inheritance*. In the distribution of property, under customary law, women are usually denied their share of inheritance (especially where land is involved) due to existing patrilineal land ownership systems. Consequently, the majority of land in The Gambia is owned by men, leaving women to rely on communal land for subsistence farming. While Section 15 of the Children's Act affords children the right to parental property, this right is subject to applicable personal law, leaving children (particularly girls and children born out of wedlock) vulnerable to discrimination in matters of inheritance of parental property.
- *The Sexual Offences Act, 2013* does not contain any provisions prohibiting marital rape.
- *Age of consent for HIV counseling and testing*. The National Policy Guidelines on HIV AND AIDS 2014-2020 establishes that "For those below thirteen (13) and unless for urgent medical interventions the consent of the parents or legal care giver must first be sought, whiles those above thirteen can consent on their own within define national guidelines."[111]

Patriarchal norms and beliefs, as influenced by hegemonic masculinity, pose particular barriers to women's freedom to decide on rights such as access to credit, accessing health care services, such as HIV counselling and testing (HCT), ART, or even contraceptives.

> *"We have so many laws with gaps and these laws include, Sexual Offense Act, Trafficking in Person Act, Women's Act, Women's Act (amendment), Tourism Offense Act, Domestic Violence Act, HIV Act supposed to protect PLHIV whereas some issues are not captured in the law, and secondly the laws do not protect the key population because of culture, religion and tradition."* (KII, NGBV)

[108] UN Women and Commonwealth Secretariat (2020). Mapping and Analysis of the Laws of The Gambia from a Gender Perspective: Towards Reversing Discrimination in Law. https://africa.unwomen.org/sites/default/files/Field%20Office%20Africa/Attachments/Publications/2020/Gambia%20report%20_layout_FINAL_DIGITAL_2907.pdf

[109] Girls not brides – Gambia https://www.girlsnotbrides.org/learning-resources/child-marriage-atlas/regions-and-countries/gambia/#:~:text=In%20July%202016%2C%20the%20Children's,family%20law%20in%20The%20Gambia.

[110] UN Women and Commonwealth Secretariat (2020). Ibid.

[111] https://www.childrenandaids.org/sites/default/files/2018-05/The%20Gambia_Nat%20Guidelines%20HIVAIDS_2014-2020.pdf

"Beautiful laws but difficult to implement due to lack of funds, e.g. Domestic Violence Act, needs funds allocated to support victims, medication, etc. but there are no funds." (KII, NGBV)

"Much as there are laws to protect discrimination against HIV/AIDS, people don't ask for redress because you will have more problems. However, if you are strong, you can defend yourself." (FGD, Mutapola)

"Government needs to step in to support the enforcement of the laws by providing funds." (KII, NGBV)

"HIV Act, a lot of people living with HIV have complained with the clause of willful transmission which attracts a fine of up to D 500,000 or a jail term while against stigmatization one pays only D 50,000. Therefore, the law protects the general population but not PLHIV." (FGD, Mutapola)

5. HIV NATIONAL RESPONSE

5.1 Gender Equality and HIV in policies, guidelines and programmes

National Strategic Plan for HIV and AIDS, The Gambia 2021-2025[112] *- Key components related to gender equality:*

- Gender equality is one of the Results Areas of the Strategic Priority II: Break Down Barriers to Achieving HIV Outcomes, incorporating 14 major interventions on gender-transformative innovations, addressing social and structural barriers, education, social protection, GBV, equitable and non-discriminatory legal and policy frameworks, adequate budget allocations, diversity/intersectional approaches, economic empowerment as well as women-led responses to HIV and in initiatives to support and build women's leadership—particularly networks of women and girls living with HIV, and women in KP.
- Interventions to address stigma and discrimination such as sensitisation and training of all health care providers.
- It promotes comprehensive sexuality and gender transformative approaches to prevent new HIV infections through reductions in risky behaviour, support service utilisation, and retention in care and in adherence. It aims build on positive efforts made to promote communication and stigma reduction through effective community mobilisation efforts in collaboration with religious and community leaders. Community efforts will be further aligned to support the prevention, treatment, and care continuum.

The Gambia's National Policy Guidelines on HIV and AIDS 2014 -2020. In line with the Constitution, this policy incorporates gender equality in its guiding principles.

Guidelines for Antiretroviral Therapy and Prevention for HIV in The Gambia, 2019[113]. It does not include gender equality in its principles, and most of the interventions addressing women's needs and services are for pregnant and breastfeeding women. In terms of SRHR, it includes guidelines on contraception

[112] NAS. National Strategic Plan for HIV and AIDS, The Gambia 2021-2025
[113] National AIDS Secretariat and WHO (2019). Guidelines for Antiretroviral Therapy and Prevention for HIV in The Gambia.

and cervical cancer screening and treatment as well as HPV vaccination for all eligible girls and women irrespective of HIV status.

The Strategic Plan 2021-2025 of the Ministry of Women, Children and Social Welfare indicates that the Directorate will address the basic needs of extremely poor individuals and households, prioritising those without labour capacity and other vulnerable groups such as the elderly, PLWD, and the chronically ill, including PLHIV. Likewise, *The Gambia National Gender Policy 2010-2020* included a specific objective directed at HIV and AIDS and empowering women and men to protect and care for themselves from the disease and other infectious diseases[114].

National Health Policy 2021-2030[115] includes gender equity in its guiding principles; however, in the objective related to the elimination and control the prevalence of communicable diseases such as Malaria, TB, HIV/AIDS and other STIs, the prioritized strategies do not explicitly address gender inequities.

HIV and AIDS and gender equality in sectoral policies and plans

Governance is a key and decisive factor in the outcome of efforts to respond to the HIV/AIDS epidemic, and critical for the effective implementation of programmes and policies that require coordination across different sectors and levels of government. It is increasingly recognised that no single sector can address the multiple drivers and impacts of HIV and AIDS, and that integrated, multi-level efforts by government working together with other sectors (Education, women's/Gender affairs, Labour, Migration, Social Protection, etc.) as well as civil society and the private sector, are urgently needed[116]. Strengthening the multisectoral approaches to HIV in The Gambia is critical for the sustainability and effectiveness of the national HIV response.

> *"Another challenge in The Gambia is disconnect between PLHIV and the national issues."* (KII, UN agency)

The *Gambia National Development Plan 2023-2027 (Draft)*, among its planned achievements, includes: i) improvements maternal health, neonate, infant, and child health services, ii) implementation of programmes on maternal health; and consolidation of the programmes on HIV/AIDS, TB and malaria.

Specifically, the strategies on HIV and AIDS are:

- Work with civil society organizations, community health workers, and community leaders to create awareness on e-MTCT and mobilize pregnant women to visit ANC sites.
- Conduct meetings with National Assembly Members to build the advocacy for e-MTCT at their constituency level; and to advocate for funding for PMTCT from the Government budget.
- Training of all ANC staff to enable these sites to provide PMTCT and EID services
- Provision of HIV test kits and commodities for HIV testing.
- Provide and retain trained staff at PMTCT sites.
- Provide adequate funding for the expansion of the services to all the health facilities in the country

[114] Ministry of Women's Affairs. The Gambia National Gender Policy 2010-2020.
[115] Ministry of Health. National Health Policy 2021-2030, Republic of The Gambia.
[116] Kar, M. (2014). Governance of HIV/AIDS: Implications for Health Sector Response. *International Journal of Health Policy and Management*, *2*(1), 39-44. doi: 10.15171/ijhpm.2014.07

- Make available lab commodities at the PMTCT; increase lab staff at the sites
- Implement the Stigma reduction strategy;
- Intensify community involvement and participation as well as HIV sensitization

The *Education Sector Policy 2016 – 2030* includes in its objectives to develop a healthy body and an appreciation of the value of a healthy mind in response to life threatening diseases like HIV/AIDS, malaria, cancer, and tuberculosis. Likewise, gender equity initiatives are part of its policies[117]. Moreover, the policy on Life Skills, School Health, & Nutrition of *Education Sector Strategic Plan 2013 – 2022* (Draft) includes among its components, HIV prevention and gender responsiveness and perspectives in dealing with GBV and discipline in and around schools[118].
It is crucial that schools mirror their proposed curriculum advancements with structural and institutional alterations as well. Students with disabilities require additional support to bolster accessibility within the buildings and the minds of educators as well:

> *"I had that severe disability, I used to crawl from my home to the school to and from every- at the primary level, I did it 1, 2, 3 years of the primary. You know, so this is that attitude, it what translates to the national level also…. So they go to the national level, and the replicate the same attitude at the national level."* (FGD, GAPD)

The Government of The Gambia. National Social Protection Policy and Strategy Plan 2015 – 2025. It includes people and families affected by HIV among the target groups. Likewise, in the case of people living with HIV, access to antiretroviral drugs will be expanded and complemented with counselling and psychosocial support, as well as one-off grants to cover expenses for drugs and transportation. Also planned is the strengthening of linkages between CTS and other relevant social protection transfers offered by line ministries/institutions to ensure that beneficiaries are able to access health and nutrition, education, HIV treatment, social welfare, and legal services to build human capital and reduce exclusion and marginalisation[119].

> *"Perception, especially among the communities or families we come from. The family thinks that the best we can (people with disabilities) do is street begging."* (FGD, GAPD)

Critical gaps

There is weak capacity and coordination among actors for gender mainstreaming and the use of intersectional approaches in programme design, implementation monitoring and evaluation. This limitation affects government agencies, CSOs, community-based organisations, development partners, etc.

Although several policy and programme instruments incorporate objectives and strategies related to HIV and AIDS, a multisectoral HIV response is not in place.

[117] Ministry of Basic and Secondary Education and Ministry of Higher Education Research Science and Technology (2016). Education Sector Policy 2016 – 2030. The Gambia.
[118] Ministry of Basic and Secondary Education and Ministry of Higher Education Research Science and Technology (2016). Education Sector Strategic Plan 2013 – 2022 (Draft). The Gambia.
[119] The Government of The Gambia. National Social Protection Policy and Strategy Plan 2015 – 2025.

There is an urgent need to address the potential upstream risk of poverty through economic interventions for women, girls, and gender-diverse communities, and reinforce policies (social grants and other mechanisms) that alleviate the impoverishing effects of AIDS illness for affected households.

5.2 Comprehensive HIV Response

5.2.1 HIV Prevention

HIV prevention programs focus on communities and key populations (FSW and MSM) through peer-to-peer outreach, wellness centres, and mobile clinics, as well as voluntary counselling and testing and PMTCT. The scanty prevention strategies for general population implemented in the country can hinder progress; combining programmes is key for de-stigmatizing and normalizing HIV prevention. Socio-cultural beliefs continue to prevent people, especially women and KVP, from reducing their risk to HIV infection. HIV related stigma and discrimination against women living with HIV has long-term negative impacts as disclosure of their HIV status has resulted in blame, abuse, and divorce[120]. There are no combination prevention programmes for AGYW in The Gambia.

The emphasis in behavioural risk factors, while important, cannot fully explain the disparities in HIV prevalence between KP women and general population in The Gambia. A strictly behavioral focus may also be misleading and increase stigma by implying that individuals' bad decisions are solely to blame for their poor health outcomes. Structural inequalities make them more likely to come in contact with the disease and less likely to treat it[121]. Systematic inequalities compromise the lives of women (adults 15+), who account for 52% of the new HIV infections in 2022.

Condom distribution and PrEP. The promotion of the condoms is a key prevention strategy in the national HIV response. In 2019, a total of 1,864,242 male condoms and 1,200 female condoms were distributed nationally. The male condoms are distributed in the general population but also targeting FSW, MSM, and young persons. Female condoms were mainly distributed to FSW. PrEP guidelines have been developed and are being implemented [122]. In the general population, the use of condom during most recent sexual intercourse with a nonmarital or non-cohabiting partner is lower among women than men, and among KP, is higher among FSW than MSM. A study with Gambian men who regularly interact with tourists near tourist resorts in The Gambia found that condom use at last sex was significantly higher with tourist (63%) than with Gambian partners (40%)[123].

[120] Ministry of Women, Children, Social Welfare and Women's Bureau and National Women Council (2019). National Review Report on Implementation of the Beijing Declaration and Platform for Action (BPFA) +25. The Gambia. https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/CSW/64/National-reviews/Gambia.pdf

[121] Russell Robinson. HIV/AIDS Inequality: Structural Barriers to Prevention, Treatment, and Care in Communities of Color. Why We Need A Holistic Approach to Eliminate Racial Disparities in HIV/AIDS. *University of California, Berkeley Law Working Group on HIV and Inequality and FIRE. https://www.americanprogress.org/article/hivaids-inequality-structural-barriers-to-prevention-treatment-and-care-in-communities-of-color/*

[122] Country progress report - Republic of The Gambia. Global AIDS Monitoring 2020. https://www.unaids.org/sites/default/files/country/documents/GMB_2020_countryreport.pdf

[123] Quaife M, Diallo M, Jaye A, Martinez-Alvarez M (2023) Partnership preferences, economic drivers, and health consequences of Gambian men's interactions with foreign tourists: A mixed methods study. PLOS Glob Public Health 3(2): e0001115. https://doi.org/10.1371/journal.pgph.0001115

Comprehensive health education. Implementation and promotion of Comprehensive Health Education both in and out of schools for adolescent boys and girls is limited in the country, which is a significant gap in the national HIV response considering its positive effects, including increasing young people's knowledge and improving their attitudes related to SRH and behaviors. This action can lead learners to delay the age of sexual initiation, increase their knowledge about their bodies and relationships, their risk-taking, and the frequency of unprotected sex[124]. Access to health information is a fundamental human right.

The Ministry of Basic and Secondary Education developed the Guidance and Counselling Manual for Gambian Schools in 2019 which includes issues related to adolescent sexual and reproductive health issues such as menstruation, emotional changes and sexuality, child marriage, teenage pregnancy, unprotected sexual relations, STIs (syphilis, gonorrhoea, HIV and AIDS)[125]. The Ministry of Basic and Secondary Education has also developed the Gender Action Pack 2015, the Gender Training Manual 2015. A Comprehensive Sexuality Education out of School Manual Training organized by UNFPA aiming to provide participants with the skills, information, and attitude necessary to assist young people in discovering and cultivating good values pertaining to their sexual reproductive health and rights. This education emphasizes human rights, gender equality, physical autonomy, and dangers such as discrimination, sexual abuse, and violence and includes conversations about family life, relationships, culture, and gender roles[126].

Participants in the FGDs and KIIs reiterated the importance of prevention strategies considering the cultural barriers to talk about HIV and sexuality, as well as the relevance to tailor means and methods of prevention programmes to the profile of different population groups.

> *"HIV is an epidemic although people do not want to talk about it and do not want to talk about sex that is the primary cause of the disease. Furthermore, people do not want to talk about protected sex. While at community level, parents feel shy to talk about sex to their children. The parents can't talk about sex."* (FGD, NYC)

> *"Uneducated women have memorized HIV/AIDS manuals given to them in their local languages."* (KII, MoGCSW)

> *"The sensitization is lacking and people don't believe that AIDS is a disease that exists."* (FGD, NYC)

Critical gaps

- Limited use of gender, intersectional, and structural approaches in HIV prevention strategies.
- The investment in HIV prevention programmes for KVP, the general population, and young people in and out schools is inadequate and access to prevention services is deficient.
- Lack of structural interventions that would likely decrease HIV infection rates in the country such as: microfinancing, cash transfers, childhood academic enrichment programs,

[124] UNESCO. Comprehensive sexuality education: For healthy, informed and empowered learners. 22 June 2023. https://www.unesco.org/en/health-education/cse
[125] Ministry of Basic and Secondary Education (2019). Guidance and Counselling Manual for Gambian Schools. The Gambia.
[126] UNFPA The Gambia. Comprehensive Sexuality Education; bedrock for Adolescents and Young People. October 2022. https://gambia.unfpa.org/en/news/comprehensive-sexuality-education-bedrock-adolescents-and-young-people

comprehensive sexuality/health education, harm reduction intervention, integration of HIV and other health services (SRHR, NCDs, other communicable diseases).

- Addressing notions of masculinity related to condom use and decision making in sexual relationships needs to be systematically included in health behavioural interventions and promotion of condom use.
- Inadequate prevention interventions targeting non-literate population.
- Insufficient prevention strategies in Madrassas and Koranic schools.

5.2.2 Prevention of Mother-to-Child Transmission

Over the years there has been the expansion of PMTCT to nearly all public health facilities, the training of health care workers to provide testing at community health facilities, and the use of outreach and community-based testing to increase the testing coverage[127].

Figure 20: Pregnant women who receive ARV for PMTCT (#). The Gambia, 2010 -2022

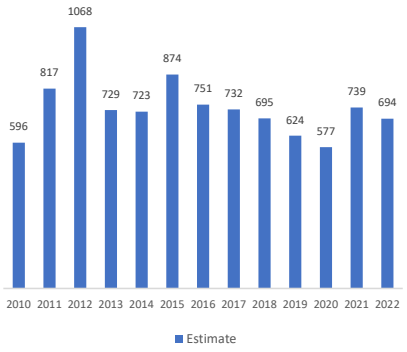
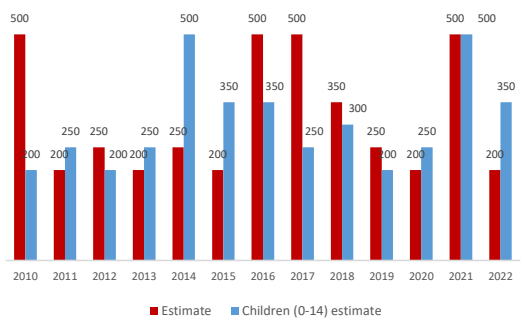


Figure 21: Number of new HIV child infections versus number of new infections averted due to PMTCT. 2010-2022



According to UNAIDS estimates the number of pregnant women who received ARV in 2022 represents a decrease of 21% from the number in 2015 (874). In the same year, 14,000 HIV-exposed children were uninfected in the Gambia, an increase of 94% from 2015 (7.200). Between 2015 and 2017 the number of new HIV child infections vs. the number of new infections averted due to PMTCT increased 150% (200 to 500) and decreased in 2018 to 2020 (from 350 to 200), while increasing in 2020 to the same number than in 2016 and 2017. Between the 2021 and 2022 the estimated number decreased by 150% (500 to 200).

A study with 5351 participants found that 38.7 and 78.8% of the women had early and adequate ANC visits, respectively, with a 65.4% HIV test coverage during ANC visits. A large proportion of women in Gambia were not using antenatal care and HIV tests during pregnancy. NC visits were higher in the rural areas compared with the urban. Women with secondary and higher education had higher odds of making early ANC visits. Women from the richest wealth quintile households had significantly higher odds of

[127] GAM 2020. The Gambia. Ibid

having early and adequate ANC visits, but not of having HIV tests. Having access to electronic media showed a positive association with adequate ANC visits[128]. A study correlates loss to follow-up (LTFU) and death prior to ART initiation among children in The Gambia, showing that HIV-infected children were enrolled into care at an advanced stage of disease with severe immunosuppression and a significant number of these treatment-eligible children die before initiating therapy. Only one-third of ART-eligible children go on to initiate ART, but face a number of out-of-program and in-program delays before treatment is eventually commenced[129]. According to DHS 2019-2020, newborns delivered in a health facility were much more likely to receive a postnatal health check during the first 2 days after birth than those delivered elsewhere (88% versus 52%).

Critical gaps

- Barriers to treatment adherence within PMTCT programmes in The Gambia, includes fears of HIV disclosure to husbands and family members, community-based stigma.
- Limited considerations included in the PMTCT related to sociodemographic differences in using maternal healthcare services such as HIV testing during pregnancy.

5.2.3 Treatment, Care and Support

95-95-95 Targets. In an effort to end HIV as a global health threat, these initial 90-90-90 goals set in 2014 were extended to achieve "95-95-95" by 2030. In Gambia, progress towards the 90-90-90 targets has been limited. The country introduced free anti-retroviral treatment (ART) services in 2004. In 2020, there were 14 ART centres (10 public, 3 private health facilities and 1 Military Clinic). Since the provision of free ART policy came into effect in 2004, there has been a gradual increase in the uptake of ART services; however, in 2022 around 50% of women and only 23% of men living with HIV were receiving ART. If these low levels of access to life-saving treatment remain, the 95-95-95 by 2025 will not be within reach. The path to ending AIDS in The Gambia is unclear.

[128] Yaya, S., Oladimeji, O., Oladimeji, K.E. *et al.* Prenatal care and uptake of HIV testing among pregnant women in Gambia: a cross-sectional study. *BMC Public Health* **20**, 485 (2020). https://doi.org/10.1186/s12889-020-08618-4

[129] Okomo, U., Togun, T., Oko, F. *et al.* Mortality and loss to programme before antiretroviral therapy among HIV-infected children eligible for treatment in The Gambia, West Africa. *AIDS Res Ther* **9**, 28 (2012). https://doi.org/10.1186/1742-6405-9-28

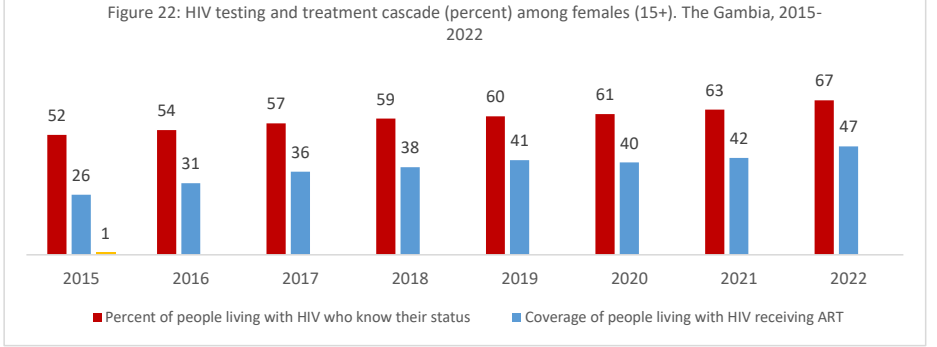


Figure 22: HIV testing and treatment cascade (percent) among females (15+). The Gambia, 2015-2022

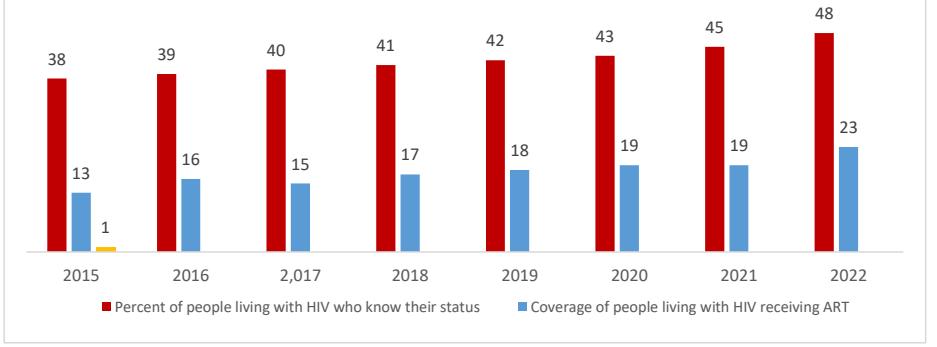


Figure 23: HIV testing and treatment cascade (%) among males (15+). The Gambia, 2015 -2022

During the period 2015–2022, women consistently displayed higher knowledge of their HIV status than men. In 2022, only 67% of women living with HIV and 48% of men knew their status, and among those, 47% and 23% respectively were on treatment. Data on PLHIV that were virally suppressed in 2022 was not available. In 2019, among PLHIV that were receiving ART, 66.7% were virally suppressed[130]. Poor viral suppression, which can be caused by treatment failure due to non-adherence, is associated with a greater risk of progression to AIDS and mortality[131, 132].

[130] Global AIDS Monitoring 2020. The Gambia. Ibid
[131] Bangsberg, D. R., Perry, S., Charlebois, E. D., Clark, R. A., Roberston, M., Zolopa, A. R., & Moss, A. (2001). Non-adherence to highly active antiretroviral therapy predicts progression to AIDS. *Aids*, *15*(9), 1181-1183.
[132] Lima, V. D., Harrigan, R., Bangsberg, D. R., Hogg, R. S., Gross, R., Yip, B., & Montaner, J. S. (2009). The combined effect of modern highly active antiretroviral therapy regimens and adherence on mortality over time. *Journal of acquired immune deficiency syndromes (1999)*, *50*(5), 529.

Men, in particular, have proved to be hard to reach, not only in HIV testing, but in ART initiations as well[133]. Early detection of HIV among men is also important for their own health as it provides opportunities for early ART initiation. A men's cross-sectional data analysis from the DHS 2019–2020 found that of 3,308 Gambian men included in the study, 11% (372) were aware of HIV Self-Testing (HIVST) and 16% (450) received HIV testing in the last 12 months. Men who were aware of HIVST had 1.76 times the odds of having an HIV test in the last 12 months, compared to those who were not aware of HIVST[134].

> *"It is really to heighten or to strengthen the advocate the service is specifically involving the male. It is both, it cannot just be targeting women and leaving the men. So, it's interesting that some of them when they go to these clinics, that they maybe diagnose this thing, and maybe because of stigma in the past, they want to keep it to hide or so with a lot of substances, and I think they can do that."* (KII, GAFNA)

HIV testing in The Gambia among reproductive women is low. A study examined the factors associated with HIV testing among reproductive women ages 15–49 years in The Gambia. Data on a weighted sample of 11,865 women from the DHS 2019–2020 found that prevalence of HIV testing among reproductive women was 42.1%. Women aged 20–24 years and 25–29 years were more likely to test for HIV than those aged 15–19 years. Married women were more likely to test for HIV compared to those who were not in any union. Respondents with higher education in urban centers were likely to test for HIV compared to those in rural areas. Age, marital status, wealth index, place of residence, educational level, recent sexual activity, previous history of risky sexual behaviors, and history of an STI were associated with HIV testing[135].

> *"So, when it comes to HIV went for testing, and you came to know about your HIV status, the first person to stigmatize you is your spouse, either your husband, your boyfriend, and then these other people who discriminate you are your family members, your immediate family members, because whenever you disclose your HIV status, you are going to be in a problem."* (FGD, Mutapola)

> *"Children need consent and even women need consent from their husbands to go to clinics."* (FGD, NYC)

A descriptive cross-sectional study among 160 PLHIV receiving ART (80% females and 20% males) found that about 88.8% (n=142) of the respondents reported adhering to their treatment and the most common reported reasons for missing ART doses include: "Travelled without medication", "Medications finished while on travel", and " Fell asleep /slept through dose time." Also, knowledge about ART score and HIV treatment regimen were found significantly associated with adherence[136].

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[133] Hlongwa, M., Mashamba-Thompson, T., Makhunga, S., & Hlongwana, K. (2019). Mapping evidence of intervention strategies to improving men's uptake to HIV testing services in sub-Saharan Africa: A systematic scoping review. *BMC infectious diseases*, *19*(1), 1-13.

[134] Soe, P., Johnston, L.G., Makuza, J.D. *et al.* The association between HIV self-test awareness and recent HIV testing uptake in the male population in Gambia: data analysis from 2019–2020 demographic and health survey. *BMC Infect Dis* **23**, 360 (2023). https://doi.org/10.1186/s12879-023-08254-4

[135] Deynu M, Agyemang K, Anokye N. Factors Associated with HIV Testing among Reproductive Women Aged 15–49 Years in the Gambia: Analysis of the 2019–2020 Gambian Demographic and Health Survey. *International Journal of Environmental Research and Public Health*. 2022; 19(8):4860. https://doi.org/10.3390/ijerph19084860

[136] Gassama O, Kao CH (2018) Factors Associated with Adherence to Antiretroviral Therapy among HIV-Infected Adults in the Gambia. J AIDS Clin Res 9: 771. doi: 10.4172/2155-6113.1000771

"The country is doing well in the first two 95s but the last two 95 is where the problem is. Due to resource constraints, we are struggling with the last two 95s." (KII, NAS)

"And the other thing, again, is we don't want to come out also, to the health centers, or hospitals to check our status, because we don't want to point out and the stigma around, again, if people see me going to the hospital, the room, because everybody in this room is like a consultant for people with HIV. Even they say it's free, you're not paying anything, but the stigma also attached to it." (FGD, NYC)

"Attitudinal change is needed. There is discrimination. For example, HIV unit is isolated and when a patient is cited or seen at such a unit, people conclude on such a person being a HIV/AIDS patient." (FGD, MoGCSW)

The care of PLHIV (which include clinical and Community Home Based Care (CHBC), Nutrition Assessment, and Counselling and Care) is a service that is provided alongside the management of TB/HIV co-infections and the provision of ART services.

The National AIDS Secretariat spoken on some of the measures in place to make services more accessible:

"We identified hotspot areas and we bring wellness centers supported by mobile support team." (KII, NAS)

"We also have drop-in centers; e.g. some are in Kanifing." (KII, NAS)

"We have a strategy known as SR/Referral strategy in order to achieve the last 95." (KII, NAS)

According to the IBSS 2022-2023, 67.7% of MSM, 64.7% of those who identifying as transgender of women who participated in the MSM survey, and 73.9% of FSW sought HIV prevention, testing, treatment and/or care services in the past 12 months.

Critical gaps

ART initiation and retention is below target for both women and men. Further research is required to explore the barriers to ART initiation and retention among all population sub-groups. The recommendations which emerge from the research need to be implemented to further close the significant gaps.

As a significant proportion of PLHIV are not receiving antiretroviral therapy, the number of virally suppressed is expected to be low. This puts them at risk of infecting others or developing clinical complications themselves. Men make up a disproportionate amount of PLHIV who are not virally suppressed.

Strengthening efforts to achieve primary prevention targets and focus attention to supporting enablers is critical to bridge inequalities in treatment coverage and outcomes and accelerate HIV

incidence reductions. This can be achieved by focusing on progress in all sub-populations, gender, age groups and geographic settings[137].

AIDS-related Deaths. In 2022, UNAIDS estimates that 1,600 adults (aged 15 years or older) died from AIDS-related illnesses, with men representing 56%. (UNAIDS). From 2009 to 2019, HIV remained one of the leading causes of death in The Gambia.

Figure 24: Number of AIDS-related deaths among adults by sex. The Gambia, 2000-2022

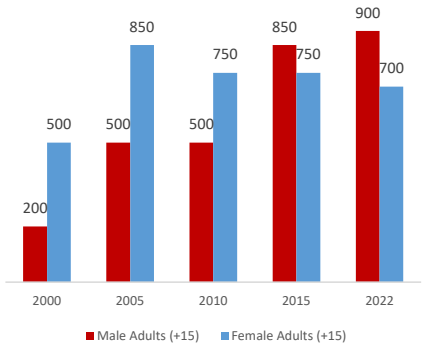
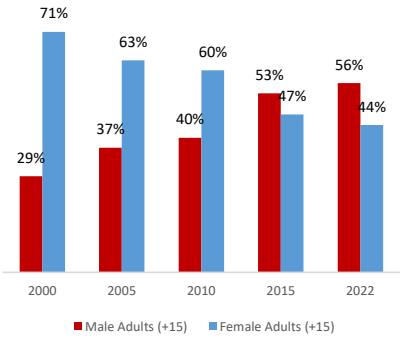
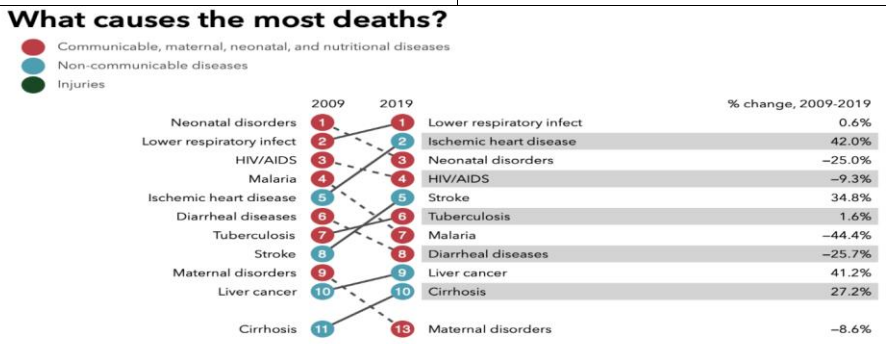


Figure 25: AIDS-related deaths among adults by sex (%). The Gambia, 2000-2022





[137] Frescura L, Godfrey-Faussett P, Feizzadeh A. A, El-Sadr W, Syarif O, Ghys PD, et al. (2022). Achieving the 95 95 95 targets for all: A pathway to ending AIDS. PLoS ONE 17(8): e0272405. https://doi.org/10.1371/journal.pone.0272405

AIDS-related deaths among adults more than doubled between 2000 to 2005 for men. From 2015 to 2022 the proportion of men among adults who died from AIDS-related illnesses increased by 6% and among women decreased by 7%. More female adults than males died from AIDS-related causes from 2000 to 2010; however, since 2015, over half of all AIDS-related deaths have been among males, a reversal of the previous situation.

Reduce HIV-related stigma and discrimination

Experiences of stigma are still exceedingly common for key and vulnerable populations; this is a barrier to accessing and adhering to HIV and other HIV related services.

> *"The first member of the association (Mutapola) to declare his status has always found it difficult to rent a house since people know him as a HIV/AIDS patient."* (FGD, Mutapola)

> *"Messaging is the most important thing to do, how we communicate the messaging? For example, if I am told that HIV kills, I may rather stay and die without coming out openly."* (FGD, NYC)

Critical gaps

High HIV related stigma and discrimination, unfavourable policies and legal environment, fear of violence, arrest, and prosecution among KP (MSM, FSW, PWUD) and women and girls are critical barriers to prevention, to health seeking behaviour, as well as engagement in care and adherence to treatment.

Context-specific interventions are needed to address stigma and discrimination of PLHIV within the community, family, health services, and other sectors such as Labour, Education, Migration, etc.

Intersecting forms of stigma are a common reality, yet they remain poorly understood. The development of instruments and methods to better characterize the mechanisms and effects of intersectional stigma in relation to various health conditions in The Gambia is critical[138].

5.2.4 HIV Integration: GBV, SRHR, NCD and other communicable diseases.

There are significant challenges in implementing integration policies and programmes due to limited infrastructural resources, which impact negatively on healthcare provider capacity.

GBV. In 2018, a Sexual and Gender Based Violence unit was established at the Ministry of Justice to monitor, investigate, prosecute, and provide support for counselling of victims of sexual and gender-based violence, most especially as it relates to women and children. Similarly, the Network against Gender-Based Violence (NGBV), made up of relevant government ministries and civil society organizations, has been established through which One-Stop Centres are created in three hospitals (EFSTH, Bansang, and Kanifing Hospitals) for provision of medical, legal, and counselling support to victims of sexual and domestic violence. The NAS works with NGBV to coordinate all GBV related issues across the country. Two of the main ART sites also serve as One-Stop Centres for GBV. Although the linkages between GBV and HIV have been established by evidence worldwide, the standard Operating Procedures for Sexual and Gender-based Violence Services at One-Stop Centers in The Gambia do not

[138] Turan, J.M., Elafros, M.A., Logie, C.H. *et al.* Challenges and opportunities in examining and addressing intersectional stigma and health. *BMC Med* **17,** 7 (2019). https://doi.org/10.1186/s12916-018-1246-9

incorporate strategies or interventions on those linkages, neither the prescription of post-exposure prophylaxis (PEP) for victims of sexual violence.

In a KII, NGBV addresses this:

> *"We have realised that HIV/AIDS have a link with SBV/GBV."* (KII, NGBV)

SRHR. In The Gambia, contraceptive prevalence among adolescents and young people is low due to limited knowledge and access to SRH information and services, provider attitudes, stigma, shame, lack of money, and cultural and religious misconceptions associated with contraception. There is also limited information on STI prevalence among adolescents and young people, with a single published study reporting a prevalence rate of 8.4%. In addition, inadequate counseling, complaints related to physical environment, as well as the process of providing SRH services and information are significant factors associated with satisfaction with SRH services among adolescents and young people[139].

> "*Testing of cervical cancer is part of the project but women do not always participate. Some days, the testing for cancer is available and free for women. The Ministry sensitizes the community to undertake free cancer testing, especially cervical cancer*." (KII, MoGCSW)

Social protection and health. Financial and structural issues remain impediments to progress in the administration of programs and the results expected by 2030.

> "*Education/nutritional support to HIV patients was stopped due to financial constraints from the Global Fund, and mitigation issues like avoiding breastfeeding cannot be applied since formula feeding is expensive."* (FGD, Mutapola)

> *"UNAIDS promised to end AIDS by 2030, but this cannot be possible since some benefits such as transport refund, educational package were cancelled. Thus, default rates have increased and new cases are increasing."* (FGD, Mutapola)

TB/HIV. PLHIV receiving care are routinely screened for TB in all the ART sites. Services for TB/HIV co-infection have improved, but challenges remain regarding to the provision of these services, including stigma and discrimination, inadequate viral load, EID, CD4 testing, inadequate funding for scaling-up, delayed referral for co-infected patients, inadequate defaulter tracing, and loss to follow-ups.

Discrimination against people with disabilities is another barrier preventing necessary administration of services by providers like the police, educators, social workers, and the like:

> *"Even when you walk to a police station and report certain cases as a disabled, people look at you and say, 'Who will do something?' But people are raping my people in the street!"* (FGD, GAPD)

[139] Lowe M, Sagnia PIG, Awolaran O, Mongbo YAM. Sexual and reproductive health of adolescents and young people in the Gambia: a systematic review. Pan Afr Med J. 2021 Dec 13;40:221. doi: 10.11604/pamj.2021.40.221.25774. PMID: 35145583; PMCID: PMC8797051.

Critical gap
Women and girls, men and boys, gender-diverse communities, key and vulnerable populations are inadequately served by the national HIV response and there are still huge gaps in their HIV care and support, in areas such as GBV, contraception, sexual health, HPV vaccines, mental health and other NCD, different types of cancer, including cervical cancer. Lack of studies on male vulnerability to HIV and their level of participation and inclusion in programmes and policies.

5.3 Meaningful Participation

In line with the principles of inclusiveness and engagement with key, priority, and vulnerable populations in the process of developing the GF funding request and implementation of programmes and grants, CSOs, national networks and international NGOs participate in the national HIV response in diverse capacities as co-implementers. Among those are: The Gambia Network of PLWHIV, Network of AIDS Service Organisation, Mutapola, Action AID, Catholic Relief Service, etc. Some provide care and support through evidence-based services, provide support on home-based care, and nutritional and educational support for PLHIV and those affected, like orphans and vulnerable children.

> *"The burden on women is too much when it comes to HIV/AIDS and this has been the major reason why the association (Mutapola) was formed. It has transited to a network for self-reliance, schemes, counselling and encouraging positive living."* (FGD, Mutapola)

Civil society stakeholders and expressed concerns about mechanisms of participation and accountability:

"In meetings that I attend, sometimes already the decisions are made. And there's also a formality and again, they underscore very early on, it's no, we are consulted. And they make decisions on our behalf. When we want to do certain things towards what we want, it's not possible, because they will tell you already this thing is designed like this where we don't change anything. I was like, why are we here that we cannot contribute?." (FGD, NYC)

"There is no engagement of the disability people in decision making." (FGD, GAPD)

"Involve the communities through sensitization on issues of HIV/prevention and response." (KII, NGBV)

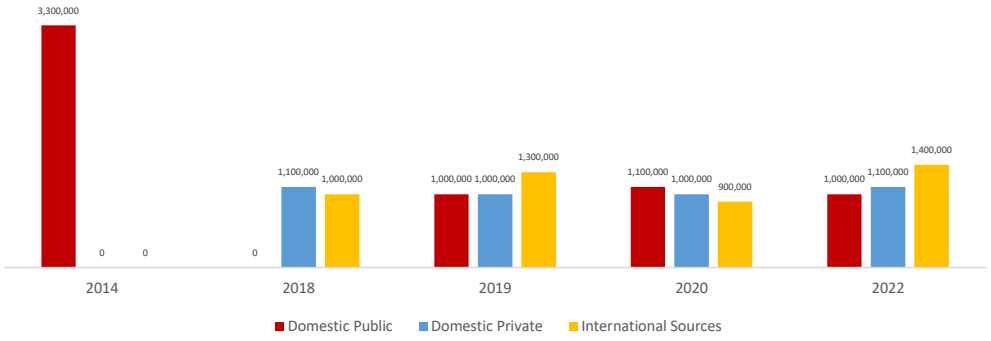
"*Participation of the women is low, persons with disability are not represented."* (KII, UN agency)

"*Young people are not consulted. It is a top down approach hence social exclusion. And we at the NYC argue that "anything for the youth without the youth is not for the youth".* (FGD, NYC)

5.4 Expenditure Allocation

Achieving the goals and objectives of the national HIV response can only be possible if sufficient resources are available to government departments, NAS, CSO, and other stakeholders. Historically, the Gambia HIV response has been largely funded by international donors, and the government and CSO remain heavily dependent upon international donors to finance critical interventions, including those for women and girls, key and vulnerable populations. Although data on National HIV and AIDS spending was not available during the development of this assignment, it is likely that the investments are concentrated in biomedical interventions, such as HIV testing and treatment and management, expenses on critical components for gender equality may be spread across programme areas, and are not reported separately.

Figure 26: Total HIV Expenditure (country-reported)



The Domestic Public expenditure has been the same in 2019 and 2022, with a slightly increase in 2020. External expenditures on HIV showed a declining trend in 2020 while increasing in 2022.

An increase in spending on HIV prevention is needed to fund a number of important initiatives, such as structural interventions addressing stigma and discrimination, and intersecting and gender-related barriers, as well as effective programmes promoting behaviour change and increasing HIV prevention knowledge and condom use. Interventions should be aligned to address the needs of women and girls, men and boys, gender-diverse communities, young people in general; and key and vulnerable populations.

Expenditure on Health by Source: The Relevance of Out-of-Pocket Expenses for the HIV Response

Out-of-pocket payments have severe consequences for health care access and utilization, and are especially catastrophic for the poor, women, girls, and key and vulnerable populations.[140] Having to pay out-of-pocket for health care can be prohibitive and even cause financial catastrophe for patients, especially those with low and irregular incomes. Although in The Gambia, public health services are provided free of charge, patients do incur costs when they access facilities and some of them forego income. The main direct cost drivers tend to be related to transport, food and groceries, as well as indirect costs associated with income lost due to time spent on getting care or hospital admission. The expenditure on health per person in 2019 in The Gambia was USD $42, of which $23.84 was from external sources

[140] Onah MN, Govender V (2014) Out-of-Pocket Payments, Health Care Access and Utilisation in South-Eastern Nigeria: A Gender Perspective. PLoS ONE 9(4): e93887. https://doi.org/10.1371/journal.pone.0093887

(Development Assistance for Health), while government health spending was $9.15, out-of-pocket spending was $7.42 and prepaid private spending $1.37[141].

The need for Government contribution to HIV /AIDS response is highlighted in one of the FGD.

> *"Government should join the fight against HIV through funding for treatment, and organisation by creating psychosocial support groups and training. When Global Fund funding stops, everything stops." (FGD, Mutapola)*

HIV is still one of the leading causes of death for both women and men. Across all age groups, people living with HIV have an increased risk of chronic complications and comorbidities, such as noncommunicable diseases and mental, neurological, and substance-use disorders. These conditions may be pre-existing, HIV-associated, or due to ageing[142].

Sex and gender-related needs and barriers among people living with HIV. Women, unlike men, are subjected to triple burden of disease, namely, noncommunicable diseases, communicable diseases, and reproductive health-related diseases. There are individual, household, and geographical differences in morbidity and mortality, which reflect disparities in access to preventive services, diagnosis and treatment among people living and/or affected by HIV and AIDS. When indirect costs are added to out-of-pocket expenditure, it often constitutes a greater amount or proportion of the monthly per capita income for women, girls, and key and vulnerable populations[143]. In particular, SRHR needs are constant throughout women's lives.

Critical gap
Lack of data on national HIV and AIDS spending and itemized budgetary allocations for gender equality impedes the analysis of investments on gender-responsive and transformative interventions. Strategic plans on HIV, SRHR, GBV, NCDs need more direct attention and investments from domestic and international sources, considering the implications of social drivers to prompt necessary changes. There is lack of gender budgeting which makes it difficult to achieve a gender-based response to HIV and AIDS.

[141] IGME. Country Profile – The Gambia. https://www.healthdata.org/gambia
[142] WHO. Chronic comorbidities and coinfections in PLHIV. n/d https://www.who.int/hiv/topics/comorbidities/about/en/
[143] Leon Bijlmakers et al. Out-of-pocket payments and catastrophic household expenditure to access essential surgery in Malawi - A cross-sectional patient survey. Annals of Medicine and Surgery Volume 43, July 2019, Pages 85-90 https://doi.org/10.1016/j.amsu.2019.06.003

6. RECOMMENDATIONS

The following recommendations are comprised of findings from the desk review, KIIs, FGDs, site visits and consultative meetings, as well as from evidence-based recommendations from WHO and UNAIDS and from the Advocacy Brief: "Adolescent Girls + Young Women and HIV: Why It Matters" that was developed as part of this Gender Assessment. Some of these recommendations were suggested in the revision of The Gambia Funding Request to the Global Fund (Allocation Period 2023-25) version #5.

Key gaps and barriers	Recommendations
	Combination prevention
Lack of prevention strategies for general population, which increase stigma and discrimination against KVP and PLHIV and stigmatize HIV prevention. Fragmented approaches to address concurrent / interlinked inequalities, social determinants of the HIV epidemic. Prevention strategies based mostly on biomedical and individual behavioral factors.	**a.** Implement innovative interventions for general population through social media (or other means) to improve knowledge, accuracy of risk perception, and address barriers to HIV-prevention behaviours related to gender norms, hegemonic masculinities (denial of men, etc.), as well as those related to partners, family members, communities, or structural factors. "*People think HIV is a myth*" (FGD, NYC). **b.** Implement advocacy strategies on women's empowerment and social determinants of HIV and health, social protection, economic empowerment, housing, education, human rights, women's rights, self-esteem, education, participation, decision making, legal protection, life skills, condom use, healthy relationships. **c.** Develop and evaluate prevention programmes for AGYW that include structural and biomedical interventions in urban, rural, and remote areas. **d.** Establish and ensure financing of networks of peer educators for diverse population groups: women and girls, mean and boys, KVP, gender-diverse communities. **e.** Implement GBV prevention programmes addressing the multiple and concurrent types of violence faced by PLHIV, women and girls, KVP throughout their lifetime. **f.** Implement prevention strategies in the Education sector, including targeted interventions with communities, families, parents, peer-led interventions (young people, women and girls, refugees, etc.), and aim to improve communication between parents and young people.
	PMTCT
Limited involvement of men on PMTCT interventions and low participation of men in SRH & maternal health. Pregnant women living with HIV fear stigma and discrimination by husbands, family members, community, schools, other parents.	**a.** Implement multilevel strategies (community, health services, schools) to promote men's participation in maternal health (for example, coming to health services with their spouses). **b.** Link partners of women seeking PMTCT treatment to treatment to facilitate access. **c.** Strengthen community-based organizations such as supportive groups, mothers to mothers, PLHIV, to support the adherence and retention for HIV+ pregnant and breast-feeding women and infants; addressing gender relations and cultural norms influencing outcomes of PMTCT. **d.** Incorporate mental health interventions in services for HIV+ pregnant and breast-feeding women.

Key gaps and barriers	Recommendations
Treatment, care and adherence support	
Interventions - lack meaningful involvement of women, men, KVP and gender-diverse communities, young people, PWD, PWUD; and insufficient consideration of the broader social and structural contexts. Late diagnosis of HIV amongst men exposes more women and other men (MSM) to new HIV infections by untested HIV-positive men.	**a.** Differentiated services delivery system using gender equality and intersectional approaches, adapting services to specific needs (KVP, PWD, young people, women, men, and gender-diverse communities); strategies targeting men/inequitable masculinities and men's involvement in SRH, testing, adherence to treatment. **b.** Strategies to reduce intersecting stigmas affecting access to treatment, and support addressing gender dimensions related to disclosure, adherence, peer and family support, mental health, co-morbidities, "fight for their rights". **c.** Mechanisms to address and prevent violations of confidentiality, harassment by health workers, family, and community members, including measures for ensuring privacy in health services and other settings. **d.** Create sustainable safe spaces for women and girls in communities and expanding availability of youth centers. **e.** Strategies for increasing availability of drop-in centers with integrated services, considering geographical and financial accessibility, expanding hours of operation, and using modalities of paid peer-community- led services.
Barriers to follow-up for GBV survivors, limited access to justice/long process, women and girls being blamed for GBV. Stigma against children affected or living with HIV.	**a.** Engage peer groups of women and girls, men and boys, other genders, and vulnerable and KP groups to educate communities about human rights, gender equality, and ethics including stigma and discrimination; confidentiality and the rights of PLHIV and KPs to services. **b.** Multisectoral strategies (education, health, communities) to address needs of children with HIV, using gender equality and diversity approaches.
Comorbidities: NCD and other communicable diseases	
Limited integration of HIV interventions and diverse health conditions affecting PLHIV in their diversity.	**a.** Develop trauma-informed interventions and increasing the number of psychologists, other mental health service providers and peer-support trained on first line support for victims of GBV, including survivors as part of KVP, young people, PWD, PWUD, people "on the move," gender-diverse communities. **b.** Develop guidelines on integrated services (HIV, GBV, SRHR, NCD (mental health, Diabetes, cardiovascular disease, different types of cancer (cervical, breast, liver, anal, etc.))); other communicable diseases to be tailored in drop-in centers and services provided by health centers, government agencies, NGOs, and community organizations. **c.** Cross-border interventions, specific HIV integrated services for refugees, migrants.
Resilient and Sustainable Systems for Health	
Lack of processes and mechanisms to ensure meaningful participation of women and girls, KVP, PWD,	**a.** Within all national and local HIV mechanisms establish/strengthen structures that women and girls, men and boys, KVPs, PWD are represented by and fully involved in. This includes representation of

Key gaps and barriers	Recommendations
migrants, refugees, gender-diverse populations. Lack of sustainable resources (domestic and international funding) backing away a comprehensive HIV response and community-centered interventions.	these populations in budget meetings to direct budget allocations and priorities. **b.** Establish regular mechanisms to monitor and regularly report on the implementation of the NSP and pertinent projects and gender/diversity interventions using an accountability framework; for pertinent stakeholders: national HIV structures, local governments, CSO, networks, development partners, and other institutions. **c.** Develop leadership priorities for funding WLHIV, KP, young people, PWD, accompanied by capacity building and mentoring.
Limited integration of intersectional gender equality in HIV policies, programs, and investments.	**d.** Strengthening multisectoral mechanisms for the implementation, M&E of interventions on gender equality and HIV established in national policies (NSP, MWCW's Strategic Plan 2021-25) and international guidelines (WHO, others).
Limited data available for examining multiple inequalities and how social factors and structural barriers interact to produce major differences and outcomes in HIV, health and well-being. The need to update the information systems to incorporate gender and diversity-related data. This will strengthen strategic information to drive progress towards achievement of the NSP goals and other sectoral policies and plans.	**a.** Develop guidelines on gender and intersectional analysis of epidemiological data, social determinants of the national HIV epidemic. Implement a training on the guidelines for key stakeholders. **b.** Revision of the information systems currently sharing information (interoperable) on HIV and AIDS related data to incorporate gender and diversity specific indicators; including the Information system for managing PLHIV in Cross-Border Areas (Gambia, Senegal and Guinea Bissau). **c.** Develop a Gender Assessment among transgender people.
Community Systems	
Urgent need to work toward the sustainability of CSOs. Limited integration of gender-responsive and transformative interventions in community systems.	**a.** Expand multisectoral and community-level investment into prevention and integration (SRH, GBV, NCD, TB) as well as mainstreaming gender equality and HIV components into key development priorities such as climate change, human mobility (migrants, refugees, returnees, displaced people), education, etc. **b.** Develop and implement a capacity building plan of community structures, including organizations of women living with HIV, youth, and KVP for the development and implementation of gender-responsive and transformative interventions. **c.** Implement community mechanisms that empower organizations of women living with HIV, youth, and KVP to take an active role in community HIV responses. **d.** Target communities where FGM is most practiced for HIV sensitization

Key gaps and barriers	Recommendations
	e. Develop systematic strategies to work with religious leaders and ensure their inclusion in programming **f.** Strengthen HIV sensitization through use of local traditional communicators.