



APMG
HEALTH

FOCUSED EVALUATION

HIV TYPE 1: GAMBIA

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Abbreviations and Acronyms

ADR	Adverse Drug Reactions
AIDS	Acquired Immuno-Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
BCC	Behavior Change Communication
BEMONC	Basic Emergency Obstetric and Newborn Care
BFCI	Baby-Friendly Community Initiative
BHS	Basic Health Service
BI	Bamako Initiative
BSS	Behavioral Surveillance Surveys
CAC	Catchment Area Committees
CBC	Community Birth Companion
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CDC	Center for Disease Control
CHBC	Community Home-Based Care
CHN	Community Health Nurse
CHW	Community Health Worker
CMS	Central Medical Store
CRR	Central River Region
CSO	Civil Society Organization
DHS	Demographic Health Survey
DHIS 2	Demographic Health Information System-2
DPI	Department of Planning and Information
DRF	Drug Revolving Fund
EID	Early Infant Diagnosis
EMTCT	Elimination of Mother to Child Transmission
EPI	Expanded Program of Immunization
FGD	Focus Group Discussion
FGM	Female Genital Mutilation
FSW	Female sex worker
GAMNASS	Gambian Network of AIDS Support Societies
GARPR	Global AIDS Response Progress Reporting
GAVI	Global Alliance for Vaccine Initiatives (Gavi, The Vaccine Alliance)
GBoS	Gambian Bureau of Statistics
GBV	Gender-based violence
GCCM	Gambia Country Coordinating Mechanism
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GMD	Gambian Dalasi
GoG	Government of The Gambia
HBC	Home-based care
HC	Health Center
HCT	HIV Counseling and Testing
HCW	Health care worker
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HOC	Hands-On Care
IBBS	Integrated Bio-Behavioral Surveillance

ICU	Intensive Care Unit
IEC	Information, Education, and Communication
IHP	International Health Partnership
IMNCI	Integrated Management of Newborn and Childhood Illness
IYCF	Infant and Young Child Feeding
KP	Key Populations
LMIS	Logistics Management Information System
LRR	Lower River Region
M&E	Monitoring and Evaluation
MaHC	Major Health Centre
MCH	Maternal and Child Health
MCNHRP	Maternal and Child Health Nutrition and Health Result Project
MDFT	Multi-Disciplinary Facilitation Team
MDG	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MiHC	Minor Health Centre
MMR	Maternal Mortality Rate
MoHSW	Ministry of Health and Social Welfare
MSM	Gay and other men who have sex with men
NACP	National AIDS Control Program
NANA	National Nutrition Agency
NAS	National AIDS Secretariat
NBE	North Bank East
NBW	North Bank West
NCD	Non-Communicable Disease
NFM	Previous HIV grant (2014-2016)
NPCS	National Population Commission Secretary
NPHL	National Public Health Laboratory
NSP	National Strategic Plan
NTD	Neglected Tropical Disease
OI	Opportunistic Infections
PC	Current HIV/TB grant (2017-2020)
PHC	Primary Health Care
PIC	Project Implementation Committee
PITC	Provider-initiated Testing and Counseling
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to child Transmission of HIV
PNC	Postnatal Care
PR	Principal Recipient
PReP	Pre-exposure prophylaxis
PSM	Procurement and Supply Management
PWID	People who inject drugs
RBF	Result Based Financing
RCH	Reproductive and Child Health
RFH	Riders for Health
RHD	Regional Health Directorate
RHT	Regional Health Team
RMNCH	Reproductive, Maternal, Newborn, and Child Health
RMS	Regional Medical Stores
RSSH	Resilient and Sustainable Systems for Health
SBA	Skilled Birth Attendant

SOGI	Sexual and Gender Orientation
SR	Sub Recipient
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
SSR	Sub-SR
SW	Sex worker
TAC	Technical Advisory Committee
TB	Tuberculosis
TBA	Traditional Birth Attendant
TG	Transgender persons
TRP	Technical Review Panel
TTBA	Trained Traditional Birth Attendant
UNFPA	United Nations Population Fund
UNICEF	United Nations Children’s Fund
UoI	University of Ibadan
URR	Upper River Region
USD	United States Dollar
VCT	Voluntary Counseling and Testing
VDC	Village Development Committee
VHW	Village Health Workers
VSG	Village Support Group
WB	World Bank
WHO	World Health Organization
WHR 1	Western Health Region 1
WHR 2	Western Health Region 2

Executive Summary

Evaluation Abstract

A Type 1 Evaluation was carried out of the HIV and TB responses in The Gambia, concentrating on those programs funded under the Global Fund's grants since 2014. This is the report of the HIV evaluation. Methods used included desk review, key informant interviews, focus group discussions, site visit observations, data investigations and a debriefing meeting.

The Gambia HIV National Strategic Plan 2015-2020 (GoG, 2014) was revised in August 2017 to include strategies to address weaknesses identified in the mid-term review. Goals and strategies are generally appropriate except for the lack of focus on prisoners, and lack of investigation of people who inject drugs (PWID) and transgender persons' (TG) needs. There are very substantial health system issues that need to be addressed. Key populations programming is nascent by comparison to other West African countries.

The Gambia, with the support of the Global Fund, has managed to considerably improve its response to HIV within a political environment that all stakeholders referred to as deeply problematic. However, the country is not on track to reach global or national targets on HIV prevention, testing, treatment, and viral suppression. The general direction of the revised National HIV Strategic Plan appears to be correctly formulated but there are many ways in which the HIV response can be improved and expanded. To do so will require significant changes to the ways that the Government of The Gambia (GoG) leads the HIV response, as well as some re-orientation of GF-funded activities. Specific recommendations are laid out below and in the annexes.

Given the difficult political environment, it is highly unlikely that HIV prevalence and new infections in the country would have fallen in recent years in the absence of the GF investments. Given its income level and its disease burden, the country should remain eligible for GF HIV grants for a considerable period, but GF grants at their current (and predicted future) levels will not be sufficient to scale up the country's response to meet global and national targets. This will require substantial leadership and funding from the GoG.

Recommendations are provided, relating to political and Ministry leadership; loss to follow-up of ART patients; expansion of reach and services to key populations (KP), men, adolescent girls; expansion of combined HIV/TB services; enhanced quality of medical services for people living with HIV (PLHIV); expansion of partnerships between government services and NGOs; and expansion of cross-border collaboration.

Background

APMG Health, Inc. is carrying out independent evaluations of HIV, tuberculosis (TB), and malaria programs in 64 Focused Countries in 2018-2020. The overall objective of this project is to evaluate effectiveness and impact of Global fund investments in Focused Countries, and the extent to which these investments have helped countries prepare for a sustained response to the three diseases over time.

Evaluation Objectives

1. To evaluate the extent to which – and how – the Global Fund grants have helped enable the country to achieve a) the goals and objectives described in its national disease strategic plan and overall health sector strategy, and b) the goals and objectives agreed in the grant agreement.
2. To evaluate the extent to which service delivery systems (health facility and community) deliver quality services.
3. To evaluate the extent to which country data systems generate, report, and use quality data.
4. To evaluate the extent to which Global Fund investments have helped the country prepare financially and programmatically for a sustained response to HIV.
5. To support countries to use the findings from the evaluation to help inform investment decisions and efforts to improve the quality, efficiency and sustainability of the response to HIV in The Gambia.

Due to the current HIV/TB grant, the Country Team asked that the HIV and TB evaluations be conducted simultaneously and work together to assess HIV/TB strategies and activities.

Methodology

The evaluation used a mix of methods to meet evaluation needs within the resources available, including:

- *Desk review* of materials available from the Country Team and from internet searches
- *Key informant interviews* with 95 individuals from stakeholder organizations
- *Focus group discussions*: 36 PLHIV as well as 9 people each from the gay and other men who have sex with men (MSM), sex worker (SW) and PWID communities of the Greater Banjul Area
- *Site visit observations* at 4 ART Centers (Brikama, Kanifing, Sibanor and Basse), a Wellness Center (Basse), Mobile Clinic (Banjul) and an MSM Drop-In Center
- *Data investigations* on Demographic Health Information System-2 (DHIS 2) through portals at National AIDS Secretariat (NAS) and ActionAid, as well as at Basse District Hospital
- *Debriefing meeting* for 37 stakeholders

Key Findings

Objective 1 Findings

The Gambia HIV National Strategic Plan 2015-2020 (GoG, 2014) is in place and guides the national response to HIV. It was revised in August 2017 to include strategies to address weaknesses identified in the mid-term review and to incorporate key recommendations from the gender assessment conducted in 2016. Goals and strategies are generally appropriate except for the lack of focus on prisoners, and lack of investigation of PWID and TG needs. There are very substantial health system issues including human resources for health (especially the disparity between health care worker (HCW):patient ratios in urban and rural areas; and training of staff, from doctors to village health workers); procurement and supply management (PSM) (consistent reports of stockouts in many separate reports); laboratory systems (including both machines not working or not available and

stockouts of reagents and other consumables); disparity between health facilities in Western regions and rest of country.

Substantial regional differences exist especially in women's access to (sexual and reproductive health) SRH and adolescent girls and young women's ability to negotiate safe sex in Eastern regions. Intimate partner violence and gender-based violence (GBV) are major issues requiring interventions. Key populations programming is nascent by comparison to other West African countries. Very high levels of stigma and violence are experienced by MSM in particular, compounded by the cultural and social values of healthcare workers. MSM reported that they do not disclose that they are MSM or avoid seeking healthcare altogether.

Objective 2 Findings

HIV services in The Gambia have improved considerably since 2014 as a result of the GF's NFM and PC investments in the country. The GF grants have:

- Increased provision of ART, opportunistic infections (OI) medications, STI medications, test kits, reagents, condoms, lubricant, and GeneXpert machines for viral load testing
- Expanded ART sites and training of ART staff, especially nurses; transport refunds and nutrition packages for PLHIV provided to encourage attendance at ART sites (under NFM); funded ART site staff including top-ups for nurses and others and salaries for social workers; expanded home-based care; introduction of viral load testing
- Expanded prevention of mother to child transmission of HIV (PMTCT) and PMTCT staff (together with United Nations Children's Fund [UNICEF], World Bank [WB]) and introduction of early infant diagnosis (EID)
- Funded 11 HIV Support Societies, together with funding for nutrition packages, community sensitization and counseling at ART sites (under NFM), with ongoing, limited funding under PC
- Expanded HIV prevention and testing among SW and initiation among MSM; prevention packages designed and implemented for MSM and SW; BCC to KPs through outreach; purchased 2 mobile clinics and 3 wellness centers to work with SW and MSM
- Expanded and refurbished regional medical stores

While most of the elements of the HIV response are unlikely to meet the country's NSP targets or its Catch-Up Plan targets, there is no question that the HIV situation in the country would have been far worse without the GF's investment. Overall, many aspects of the response are well developed but are not yet provided at a scale that will control and reduce the epidemic.

Objective 3 Findings

Data quality, through improvements in the Health Management Information System (HMIS) and DHIS 2, has improved considerably during the past five years. But significant problems persist. Bawo (2018) provides a comprehensive set of recommendations for changes to HMIS and DHIS 2 (included in Annex 7). These mostly reflect the author's interest in and examination of the architecture of the HMIS and the ways in which data are collected and used. For Gambia's HIV response, an important additional element relates to what data are collected; how they are collated, disaggregated, analyzed and reported; and who shares and discusses these reports and uses them to drive changes to policy and practice. An important recommendation of this evaluation is that the GF not be seen as responsible for the overhaul of the HMIS to address the many recommendations in the HMIS report. GF's strategic investment should concentrate on ensuring that the appropriate DHIS 2 data are collected regularly and verified for accuracy to ensure that key data are used for decision-making.

Objective 4 Findings

Global Fund investment has assisted The Gambia survive a period of intense political difficulty and expand the HIV program in this difficult political environment. As Ministry of Health and Social Welfare (MoHSW) officials pointed out, the current climate is one of transition from that environment; however, observations of and interviews by the evaluation team found little evidence that the MoHSW is emerging as a force for leadership in the HIV response in The Gambia. The NAS, under the President, has a mandate to set policies and to direct the response overall – and is carrying out this mandate – but many of the specific tasks, especially in surveillance, planning, data systems and provision of health services must be carried out by the MoHSW. The National AIDS Control Program (NACP) is able to carry out the tasks for which it is funded by GF through NAS, but there was little evidence that the MoHSW is devoting (or planning to devote) significant resources to ensuring that its operations can be scaled up.

Conclusions & Limitations

Effective Strategic Investment

The Gambia, with the support of the Global Fund, has managed to considerably improve its response to HIV within a political environment that all stakeholders referred to as deeply problematic. However, the country is not on track to reach global or national targets on HIV prevention, testing, treatment and viral suppression. The general direction of the revised National HIV Strategic Plan appears to be correctly formulated but there are many ways in which the HIV response can be improved and expanded. To do so will require significant changes to the ways that the GoG leads the HIV response, as well as some re-orientation of GF-funded activities. Specific recommendations are laid out below and in the annexes.

Impact

Given the difficult political environment, it is highly unlikely that HIV prevalence and new infections in the country would have fallen in recent years in the absence of the GF investments. However, it cannot be said that GF-funded activities – in the absence of additional investments from the GoG – have made a substantial impact on the epidemic to date. However, GF investments have prepared most institutions and, to a lesser extent, community systems, to scale up to reach global and national targets.

Sustainability

Sustainability questions are difficult to answer for The Gambia. The difficult political environment only ended last year, and it will take time to build all systems to the point where domestic stakeholders can take over all the functions of the national HIV response. Given its income level and its disease burden, the country should remain eligible for GF HIV grants for a considerable period, but GF grants at their current (and predicted future) levels will not be sufficient to scale up the country's response to meet global and national targets. This will require substantial leadership and funding from the GoG.

Recommendations

1. Promote the message that The Gambia could become the first West African country to end AIDS before 2030: build political commitment to ensure that the MoHSW removes roadblocks to full scale-up of the country's response to HIV
2. Addressing ART loss to follow-up, including
 - clinical, laboratory, data systems and social dimensions, and

- an enhanced role for PLHIV Support Society members in support of advocacy & home-based care
3. Expand HIV education, prevention, testing, treatment, care and support for MSM, and initiate prevention and testing services for PWID, in Greater Banjul Area; maintain services for SW nationally; expand services to prisoners; investigate TG situation
 4. Expand combined HIV/TB services and ensure TB screening for all at risk of or living with HIV
 5. Develop and implement a strategy to attract men to HIV testing, ART, adherence & support
 6. Remove any current regulatory or programmatic barriers to access by adolescent girls and young women to HIV testing, ART, adherence and support
 7. Enhance quality monitoring, mentoring and peer support among HIV clinicians, nurses and social workers
 8. Work with traditional healers to ensure they refer PLHIV to ART
 9. Develop partnership between government services and NGOs to deliver full range of needed HIV services, including social contracting mechanism
 10. Expand cross-border collaboration, particularly with the HIV programs in Senegal, including ART, PMTCT, and key populations programming

Limitations

The evaluation is based on limited indicators, due to the limited resources and time available both for desk review and in-country evaluation. The desk review was limited by the information available to the reviewer. In particular, there were few documents referring to results of the previous grant, both in terms of outputs and outcomes. The in-country evaluation was limited by the amount of time the evaluation team was able to spend in the country. A two-week visit was sufficient for the evaluation team to meet with all key stakeholders and carry out the observations, focus groups and site visits needed for the evaluation. However, some issues relating to missing or confusing data – particularly related to the number of people on ART who have been lost to follow-up, the number of those who have died, the number of people with HIV who know their status – will require further investigation. Similarly, while this evaluation concurs with the recent HMIS reviewer’s recommendations to changes to HMIS and DHIS 2 architecture, the specific changes required for data collection, collation, disaggregation, analysis, reporting and use are beyond the scope of this evaluation.

Figure ES1 Dashboard of Core Evaluation Indicators

Dashboard Key	
	Very poor
	Poor
	Moderate
	Good
<i>Further details on scoring metrics are available in Annex 1.</i>	

Indicator	Score	Justification
Strategic planning: Availability of National Strategic Plan		National Strategic Plan 2015-2019 (now extended to 2020 through a revision in 2017) in place. General costings by type of intervention included.
Strategic investment: Appropriateness of goals and objectives for epidemic context		Goals and strategies appear to be generally appropriate, but no analysis available to determine appropriate goals and objectives.

Performance: Achievement of targets set in grant agreement ¹		Reporting for NFM grant showed 1 target met; 1 greatly exceeded; 3 not met; and 1 for which no data is available; for PC grant, no targets yet met. Where targets are provided in other documents such as the National HIV Strategic Plan 2015-20 and Catch-Up Plan, results are generally far below targets.
Resilient and sustainable systems for health (1): Stockouts of key commodities ²		No stockouts of ART were reported by clinics or PLHIV societies anywhere visited. No stockouts of condoms or lubricant reported by SW or MSM.
Resilient and sustainable systems for health (2): Recognition and realization of role of community response and systems in the national response		The revised National Strategic Plan recognizes that community systems are too weak to support implementation. Overall, community systems are under-developed and under-utilized.
Supportive and sustainable legal, policy and financial environments³: Identification and address of rights, legal, and gender barriers to health outcomes for individuals and populations		A Gender Assessment of the National HIV, TB and Malaria response in The Gambia was conducted in 2016. Criminalization of HIV transmission, illicit drug use and same-sex sex and partial criminalization of SW; together with high levels of stigma and violence experienced by KP, create significant barriers to accessing HIV services.
Indicator – HIV ONLY	Score	Justification
Key populations reached: % of 2 key populations with highest prevalence reached by defined packages of services		Difficult to judge from available sources and from KP data collection methods. Likely that SW coverage is under 50% and all other KP much lower.
PLHIV who know their status: % of estimated people living with HIV who know their positive status		NAS (2018) estimates this number as 7,100 (about 34% of estimated 21,000 PLHIV), but no details are available on how this number is calculated.
Linkage to treatment and care: Availability and types of linkage programs between diagnosis/screening and treatment		Evidence of some linkage between ANC and HIV programs; increasing linkage between HIV and TB programs. No evidence of KP being unable to access services.
ART coverage: % of estimated people living with HIV currently on ART (adults and children)		7,350 on ART of estimated 21,000 (35%) as of 30 September 2018 (DHIS 2 records).
12-month ART retention: % of people who ever initiated ART and are still on ART at 12 months after ART initiation (adults and children)		2015 ART survival report found survival rates of 2012 and 2013 cohorts on treatment at 12 months at 83% and 74% respectively. Loss to follow-up is difficult to calculate but all stakeholders agree it is a significant problem.

¹ Refers to most recent grant agreement except when the grant was signed less than 12 months before evaluation: in these cases, this refers to previous grant agreement

² A list of key commodities will be developed for each disease program.

³ Supportive environments may vary considerably by population. Details on rationale for scoring this indicator will be provided with scoring. In some cases, this indicator may be sub-divided and scored for different populations. In this case, an average score will be calculated for the indicator overall.

Viral suppression: % of people who are retained in ART for at least 6 months with viral load <1,000 copies/ml		Viral load testing not yet widespread. Consistent reports of viral load test results either not being provided to ART centers or being provided up to 6 months after samples sent. Impossible to tell how many ART patients have reached VLS.
Indicator	Score	Justification
Data availability (1): HMIS deployment		Bawo (2018) found that all health facilities/reporting units are expected to submit regular reports to HMIS. HMIS Strategy 2017-2025 developed but no targets included for % of health services reporting regularly.
Data availability (2): availability of disease reporting in the national HMIS		Bawo (2018) found data are collected on a complete range of health system, health status and risk factor indicators (70 in all).
Data quality (1): completeness		Bawo (2018) found that, overall, the result for the quality of Health Information System (HIS) data in Gambia was 70%.
Data quality (2): timeliness		Bawo (2018) found timeliness of reporting on 10 indicators varied between 33-78%. For HIV, it was 76%.
Indicator	Score	Justification
Domestic funding for drugs for treatment		No domestic funds provided for ART to date. National budget for 2018 has budgeted for HIV first-line drugs for 1,000 patients: not yet expended.
Domestic funding for diagnostic commodities		GF funds almost all costs of diagnostic commodities for HIV.
Domestic funding for adherence/social support		GF funds all costs of adherence/social support for PLHIV.
Domestic funding for CSO-led service provision		No evidence was found of domestic funding for civil society organization (CSO) service provision.
Domestic funding for commodities for prevention		GF and United Nations Population Fund (UNFPA) fund almost all costs of prevention commodities for HIV.
Domestic funding for surveillance/strategic information		Difficult to ascertain exact data but it appears that little funding is provided by government for surveillance/ strategic information
Domestic funding for human resources for National Program management (excluding general health service staff delivering services)		MoHSW funds healthcare workers and infrastructure through which ART delivery occurs, but GF continues to fund both additional staff (such as social workers) and additional salaries for doctors and nurses at ART centers.
Domestic funding for overall financing of program		Gambia Country Coordinating Mechanism (GCCM, 2017) shows that the government spent US\$7.8m during the NFM period and predicted a higher expenditure during the PC grant.

Background

Project Background

During the Differentiation for Impact (D4I) process in 2016, the Global Fund divided countries eligible for Global Fund support into three groups: High Impact, Core and Focused. For greater efficiency and enhanced impact, investments in the three groups of countries are now managed in a differentiated manner, with major resources allocated to the High Impact portfolios and streamlined processes put in place for management of investments in Focused portfolios. As of August 2018, there are 25 High Impact countries, 29 Core countries and 53 Focused Countries plus regional grants covering Focused portfolios. Focused Countries represent 7.4% of the global disease burden and have a total 2017-2019 allocation of US\$1.7B. Each portfolio has an allocation of less than US\$30M.

APMG Health, Inc. will carry out independent evaluations of HIV, tuberculosis (TB), and malaria programs in 64 Focused Countries in 2018-2020.

The overall objective of this project is to evaluate effectiveness and impact of Global fund investments in Focused Countries, and the extent to which these investments have helped countries prepare for a sustained response to the three diseases over time. More specifically, objectives include:

1. To evaluate the extent to which – and how – the Global Fund grants have helped enable countries to achieve a) the goals and objectives described in their national disease strategic plans and overall health sector strategy, and b) the goals and objectives agreed in the grant agreements.
2. To evaluate the extent to which service delivery systems (health facility and community) deliver quality services.
3. To evaluate the extent to which country data systems generate, report and use quality data.
4. To evaluate the extent to which Global Fund investments have helped countries prepare financially and programmatically for a sustained response to the three diseases.
5. To support countries to use the findings from the evaluations to help inform investment decisions and efforts to improve the quality, efficiency and sustainability of the response to the three diseases.

In addition to the objectives listed above, three high-level evaluation questions will be answered during each evaluation. These questions include:

- **Effective strategic investment:** To what extent have Global Fund grants been strategically invested in national disease strategies? To what extent have they helped achieve the national strategic objectives?
- **Impact:** To what extent – and how – have the Global Fund investments contributed to helping countries achieve impact in the response to HIV, tuberculosis and malaria?
- **Sustainability:** To what extent – and how – have the Global Fund investments contributed to helping countries build up in-country systems and mechanisms for a response to HIV, tuberculosis and malaria that can be effectively sustained over time?

Disease Background

The number of HIV infections has declined globally, from a peak of 3.4 million new infections in 1996 to 1.8 million new infections in 2017. The number of deaths due to AIDS-related illness among people living with HIV (PLHIV) has also decreased 51%, from 1.9 million in 2004 to 940,000 in 2017, and since 2010, AIDS-related mortality has decreased by 34%. Much of this progress is due to the estimated 21.7

million PLHIV who were receiving antiretroviral therapy (ART) at the end of 2017 - an increase of 2.3 million from 2016, and 8 million from 2010 (UNAIDS, 2018).

Despite this progress, globally only 75% of PLHIV know their HIV status, and only 59% are on ART. Significant increases will be needed to meet the Joint United Nations Program on HIV/AIDS (UNAIDS, 2018) targets of 90% of PLHIV knowing their status, 90% of those diagnosed enrolled on treatment, and 90% of those on treatment achieving viral suppression.

However, progress - and the gaps that remain to meet targets - varies by region. For instance, the largest decrease of AIDS-related mortality has been in eastern and southern Africa, where mortality declines of 42% in this hardest-hit region have had significant impact on global gains. Since 2010, Eastern Europe and Central Asia saw no reduction in mortality, and AIDS-related mortality in the Middle East and North Africa increased by 11% (UNAIDS, 2018). Tuberculosis (TB) remains a leading cause of death for PLHIV worldwide, and PLHIV remain particularly vulnerable to stigma, discrimination and violence.

Notably, in all regions outside of sub-Saharan Africa, the HIV epidemic is heavily concentrated among key populations, including people who inject drugs (PWID), gay men and other men who have sex with men (MSM), sex workers (SW), and transgender person (TG). These populations have a risk of HIV acquisition up to 27x higher than the general population; they bear the burden of 47% of new infections, globally, and 95% of new infections in the Eastern Europe and Central Asian and the Middle East and North African regions (UNAIDS, 2018). They also account for 16% of new infections in the sizeable epidemics of Eastern and Southern Africa.

While US\$21.3 billion was available for the global HIV response at the end of 2017 (UNAIDS, 2018), approximately 56% of those resources are from domestic sources. According to the Global Fund's eligibility policy, many of the Focused Countries will transition from eligibility for grant funds in coming years, due to a combination of disease burden and country income status (Global Fund, 2016). Therefore, many Focused Countries, while working to address gaps in reaching PLHIV to meet UNAIDS 90-90-90 targets, also face the imperative to address sustainability of services in the near future. While some countries have begun to take positive steps towards domestic financing of ART and some other core services elements, prevention programming - particularly for key populations - remains heavily reliant on external sources, including the Global Fund. It is within this dynamic, of urgent need for scale up among key populations and questionable future financial stability, in which most Focused Countries implement their HIV grants.

Country Profile

The Gambia is a Low-Income Country, as defined by the World Bank, with a population of 2.04 million. Its disease burden is categorized as "High" by the Global Fund for HIV. The Gambia received its first Global Fund grant in 2004; continues to be eligible for HIV funding and is not approaching transition. Main programmatic elements of focus of the current Global Fund grant (called here PC): Substantial HSS component aimed at improving the overall operation of the health sector, with reduced focus on HIV and TB (when compared to previous grants, called here NFM). For HIV, main expenditures are on ART; treatment, care and support for PLHIV; prevention among SW and MSM; human resources, procurement and supply management (PSM), Health Management and Information System (HMIS) and monitoring and evaluation (M&E).

Methodology

The country program's needs, the level of burden of the disease in the country, and the level of Global Fund investment determined the focus and intensity of this evaluation. Three types of evaluations are available, and the decision about the type of evaluation to be carried out for each particular disease and country was made by the Global Fund Country Team (CT) and the country stakeholders, in consultation with APMG.

Gambia was selected for a Type 1 evaluation of the HIV program. This is an evaluation of all relevant components in the national disease program, with an emphasis on Global Fund investments. Type 1 evaluations consist of the following methodological steps:

Prioritization: Each evaluation was initiated by the Global Fund Country Team receiving the Prioritization Form for Desk Review, which mirrors the sections of the Basic Protocol, and provided an opportunity for Country Teams (as well as in-country stakeholders, including the Country Coordinating Mechanism [CCM] and Principal Recipient [PR], at the discretion of the Country Team) to give input on which areas should be prioritized for the evaluation, as well as any other critical background information related to specific domains of the protocol. The content of this form drove the focus of the desk review.

Desk Review: This evaluation included a desk review prior to the extended in-country engagement. The desk review process aimed to gather as much information and data as possible from pre-existing sources, so that in-country work could be sharply focused on generating new findings or augmenting existing ones with new information. This desk review has been carried out by one experienced consultant, Dave Burrows. The Global Fund Country Team and in-country stakeholders, including the CCM, were requested to share key documents to be included in the desk review. The Desk Reviewer has further conducted a thorough search of all literature and documents related to the country and disease component, including peer-reviewed literature as well as grey literature.

Evaluation Planning: After the desk review was completed, preliminary findings were used to determine priorities for in-country investigation. These were submitted in the Prioritization Form for In-Country Evaluation, along with a proposal for the additional team members. These elements were finalized with the consensus of the Country Team. Based on the priorities identified for in-country investigation, the Evaluation Lead worked with the Regional Lead to develop a detailed evaluation plan (In-Country Evaluation Planning Form) including a mix of methods to suit the situation. The In-Country Evaluation Planning Form provided a description of which of the above methods were used, in what scope/number and for what purpose, aligned with the priorities identified.

In-Country Evaluation: The in-country portion of this evaluation took place 22 October to 2 November 2018. The evaluation was conducted by a team of five consultants, which were selected by APMG and approved by the Global Fund Country Team.

Table 1. Evaluation Team for Gambia HIV Type 1 Evaluation

Consultant Name	Position
Dave Burrows	Evaluation Lead
Keith Adrian Mienies	International Team Member
Abass Bah	Local Team Member
Cherno Jallow	Local Team Member
Pa Jaye	Local Team Member

As a result of this tailored approach, evaluators employed a uniquely adapted methodology for this evaluation using a mix of methods to meet evaluation needs within the resources available, including:

- *Key informant interviews* with 95 individuals from NAS, National AIDS Control Program (NACP), NTLP, Ministry of Health and Social Welfare (MoHSW), UN agencies, District Hospitals, ART Centers, UN agencies and NGOs
- *Focus group discussions*: 36 PLHIV across 4 sites - Brikama (2), Sibanor and Basse – as well as 9 people each from the MSM, SW and PWID communities of the Greater Banjul Area
- *Site visit observations* at 4 ART Centers (Brikama, Kanifing, Sibanor and Basse), a Wellness Center (Basse), Mobile Clinic (Banjul) and an MSM Drop-In Center
- *Data investigations* on DHIS 2 through portals at NAS and ActionAid, as well as at Basse District Hospital
- *Debriefing meeting* for 37 stakeholders

For each of these methods, consultants utilized data capture tools, which included detailed note-taking, in order to ensure accuracy of documented findings. Interviews and focus group discussions were not recorded as participants were nervous of disclosure of either or both their status as HIV-positive and/or as a member of a key population. All key informants and focus group participants were read an informed consent statement, and their identities kept anonymous in connection with specific data or quotes, unless permission for attribution was expressly obtained.

Limitations

The desk review process is limited by nature due to the unavailability of some information and data. Type 1 and Type 2 evaluations are followed up with in-country evaluations, specifically to verify information found during the desk review process and obtain further data and information with regard to the selected indicators and the priorities of the evaluation plan.

The evaluation itself is based on limited indicators, due to the limited resources and time available both for desk review and in-country evaluation.

Desk Review Limitations

The Desk Review was limited by the information available to the reviewer. In particular, there were few documents referring to results of the previous grant, both in terms of outputs and outcomes. In addition, it was impossible from the data provided to assess the quality of data being provided to the HMIS.

In-Country Evaluation Limitations

This evaluation was limited by the time the evaluation team was able to spend in the country. A two-week visit was sufficient for the evaluation team to meet with all key stakeholders and carry out the observations, focus groups and site visits needed for the evaluation. But some issues relating to missing or confusing data – particularly related to the number of people on ART who have been lost to follow-up, the number of those who have died, the number of people with HIV who know their status – will require further investigation. Similarly, while this evaluation concurs with the recent HMIS reviewer's recommendations to changes to HMIS and DHIS 2 architecture, the specific changes required for data collection, collation, disaggregation, analysis, reporting and use are beyond the scope of this evaluation.

Findings

Objective 1. To evaluate the extent to which – and how – the Global Fund grants have helped enable countries to achieve a) the goals and objectives described in their national disease strategic plans and overall health sector strategy, and b) the goals and objectives agreed in the grant agreements.

Throughout this document, it should be noted that there are references to three grants from the Global Fund:

- Current grant: TB/HIV 2018-2020 (GCCM, 2017), here called PC
- Previous grant: HIV 2015-2017 (GCCM, 2014), here called NFM
- TB/HSS grant 2015-2017 (GCCM, 2014a)

In most sections, where data on inputs could be found, they are split into those related to the previous grant and the current grant.

Figure 1. Dashboard of Objective 1 Core Indicators

Indicator	Score	Justification
Strategic planning: Availability of National Strategic Plan		National Strategic Plan 2015-2019 (now extended to 2020 through a revision in 2017) in place. No costed HIV action plan found. General costings by type of intervention included.
Strategic investment: Appropriateness of goals and objectives for epidemic context		Goals and strategies appear to be generally appropriate, but no analysis available to determine appropriate goals and objectives. No interventions or strategic priorities are included for prisoners, and no investigations for PWID and TG needs are planned. No reports planned on human rights and gender-related barriers to accessing services.
Performance: Achievement of targets set in grant agreement ⁴		Reporting for NFM grant showed 1 target met; 1 greatly exceeded; 3 not met; and 1 for which no data is available; for PC grant, no targets yet met. Where targets are provided in other documents such as the National HIV Strategic Plan 2015-20 and Catch-Up Plan, results are generally far below targets.
Resilient and sustainable systems for health (1): Stockouts of key commodities ⁵		While regular stockouts of many items across health system were reported in many assessments over past 5 years, no stockouts of ART were reported by clinics or PLHIV societies anywhere visited. PSM for pharmaceuticals appears to have improved considerably. No stockouts of condoms or lubricant reported by SW or MSM.
Resilient and sustainable systems for health (2): Recognition and realization of role of		The revised National Strategic Plan recognizes that community systems are too weak to support implementation. Citing inadequate

⁴ Refers to most recent grant agreement except when the grant was signed less than 12 months before evaluation: in these cases, this refers to previous grant agreement

⁵ A list of key commodities will be developed for each disease program.

community response and systems in the national response		funding, poor linkages with health facilities, poor targeting of key populations (KPs) through community interventions and low capacity to monitor and assess service quality and quantity. Overall, community systems are under-developed and under-utilized.
Supportive and sustainable legal, policy and financial environments⁶: Identification and address of rights, legal, and gender barriers to health outcomes for individuals and populations		A Gender Assessment of the National HIV, TB and Malaria response in The Gambia was conducted in 2016. Some findings and recommendations have been incorporated into the revised National Strategic Plan 2015-2020 and no costed action plan is available. Criminalization of HIV transmission, illicit drug use and same-sex sex and partial criminalization of SW; together with high levels of stigma and violence experienced by KP, create significant barriers to accessing HIV services, affecting overall health seeking behavior. The HIV and AIDS Prevention and Control Act (2015) includes provisions to protect vulnerable groups from discrimination and violence, but there are currently no programs in place or policies found supporting this provision. The Stigma Reduction Strategy 2012-2014 has not been renewed. Stigma reduction interventions are implemented ad-hoc and occasionally.
Composite across all six components		

Dashboard Key	
	Very poor
	Poor
	Moderate
	Good
<i>Further details on scoring metrics are available in Annex 1.</i>	

The Gambian HIV epidemic is unusual in its mix of PLHIV with HIV 1-only; HIV 2-only and both HIV 1 and 2; as well as its substantial reduction in overall HIV prevalence from 2.2% (2,200 cases) in 2006 to 1.4% (1,400 cases) in 2017 (UNAIDS, 2018).

Domain 1.1. Strategic information, planning, and investment

Inputs: From the Desk Review, it is unclear what inputs in strategic planning are supported by GF. In the previous HIV grant (GCCM 2014, called here NFM), mention is made of “the capacities of actors (state and non-state) in the national response (being) strengthened to ensure that investments in the HIV response in the country achieve impact and are sustainable.” Support was provided to the NAS which is responsible for the NAS, as well as to the NACP of the MoHSW, which implemented the health

⁶ Supportive environments may vary considerably by population. Details on rationale for scoring this indicator will be provided with scoring. In some cases, this indicator may be sub-divided and scored for different populations. In this case, an average score will be calculated for the indicator overall.

sector HIV activities, and to ActionAid (NGO PR), which, through its Sub-Recipients, implemented the community sector HIV activities.

Inputs to be supported in the current HIV/TB Funding Request (GCCM, 2017, called here PC) are not clearly identified for strategic planning. But support continues for NAS, NACP and ActionAid, and a substantial budget (see HSS below) is earmarked for the Department of Planning and Information (DPI) in MoHSW.

Outputs: Support was provided to institutions as noted above, and continues to be provided to NAS, NACP, DPI and ActionAid.

Outcomes: A Mid-Term Review of the National Strategic Plan (NSP) (NAS, 2014) was carried out in 2017 (Anyanwu, 2017). Its findings are displayed in the following table (using a six-point scale from highly unsatisfactory to highly satisfactory).

Table 2. Findings from Mid-Term Review of the National Strategic Plan (Anyanwu, 2017)

Category	Score
Outcomes/outputs	Unsatisfactory: at this rating they are not expected to meet end of project objectives
HIV prevention	Satisfactory
HIV counselling and testing	Moderately satisfactory as results showed progress with significant shortcomings
Prevention of mother to child transmission of HIV (PMTCT)	Moderately satisfactory as results showed progress with significant shortcomings
Blood safety and PEP	Satisfactory
ART coverage	Moderately unsatisfactory with major shortcomings towards end of project targets
PLHIV care and support	Moderately unsatisfactory with major shortcomings towards end of project targets
HIV/TB co-infection	Satisfactory
Home-based care	Moderately unsatisfactory with major shortcomings towards end of project targets
Gender mainstreaming	Unsatisfactory
Monitoring and evaluation	Highly satisfactory, except for the lack of a national training/learning curriculum and full set of training/learning modules for M&E and operational research
Coordination and implementation arrangements	National AIDS Council performed satisfactorily, but performance of the National HIV and AIDS Policy Advisory Committee was Highly Unsatisfactory
Accountability mechanisms	Moderately satisfactory to satisfactory, but the efficiency and effectiveness towards end of project objectives had logistics and turn-around time issues.
Financing	Moderately unsatisfactory: there will likely be a major shortfall to meet end of project objectives

After the Mid-Term Review, the NSP was extended to 2020 (NAS 2017), with many of the targets increased. But there were no additional resources and few new strategies included to show how these new targets would be met in light of the problems identified in the Mid-Term Review.

Impact: It is hard to know whether the NSP is based on epidemiology with the highest priorities in the Plan reflecting those most at risk of or already living with HIV. Only two key populations (KP) appear

to have been investigated: SW and MSM. A single study on each of MSM and female SW (both were IBBS) were carried out in 2012; and questions on MSM and SW behavior were asked in a BBS for the general population in 2012. A further study in 2017-18 looked at behavior and HIV prevalence among MSM and SW in the Greater Banjul region. No other studies were found on these KP, and no studies or assessments were found relating to drug use, TG or prisoners. It is therefore understandable that no activities are identified for any KP except MSM and SW.

The revised NSP (NAS 2017) includes strategies to reach SW, but does not define a package of services for them as described in World Health Organization (WHO) (2016). No strategies are provided for other KP. The country's National Development Strategy 2018-2021 (Republic of Gambia, 2018) also sets the following HIV-related targets:

- Percentage of adult and children with HIV known to be on treatment 12 months after initiation of ART increased from 78.8% in 2017 to 95% in 2021
- Reduce mother to child transmission of HIV at six weeks from 10% to less than 5% by 2021
- Increase the coverage of anti-retroviral therapy from 21% to 90% by 2021

Domain 1.2. Resilient and sustainable systems for health

Inputs: The previous grant (referred to in this report as NFM) refers to the following issues that were addressed by the previous TB/HSS grant (GCCM, 2017):

- Enhancement of storage conditions for health commodities through the provision of solar equipment, refurbishment of medical stores and procurement equipment to facilitate warehousing and distribution
- Strengthening of the inventory management system by maintaining and using an effective software capable of tracking batches and expiry dates of all medicines and other health products to Regional Medical Stores (RMS) and National Public Health Laboratory (NPHL) stores, while Channel inventory software is used for the rest of the RMS, hospitals and major health facility stores
- Improvement of internet connectivity and electricity supply alongside provision of related IT equipment to enable scale up of e-Logistics Management and Information System (eLMIS) from central, hospital, and regional levels
- Strengthening and maintaining the data management system (LMIC and HMIS) by recruiting and supporting the staff
- Strengthening reporting system by using DHIS 2 platform with plans to link it with other software
- Strengthening service delivery and supply chain management through capacity building
- Ensuring timely distribution of health products and pharmaceuticals, including redistribution of any overstocks between low and high incidence areas within the country
- Strengthening linkages between the health and community systems and ensuring that referrals are completed, including PLHIV groups and community home-based care (CHBC) programs to strengthen follow-up and adherence support for PLHIV
- Investments in community systems will focus on better and improved coordination, planning and organizational capacity building, including strengthening of referral systems and M&E to facilitate increased access to quality health services.

The current HIV/TB grant (PC) (GCCM, 2017) states that the Resilient and Sustainable Systems for Health (RSSH) program will continue to focus investments in the intervention areas highlighted above with a view to addressing the related challenges; and that the country anticipates more collaboration and support from government and other donors under the new political dispensation. The request states that the country strategy (unspecified) aims to ensure availability and accessibility of quality

medicines throughout the supply chain and ensure patient safety through rational use of medicines. In this regard, strategies such as solarization of regional medical stores, contracting an internet service provider to maintain the infrastructure needed for both LMIS and HMIS, capacity building on PSM with emphasis on quantification and forecasting, procurement of the storage equipment, assessment and upgrading of the storage capacity and suitability of the central and regional medical stores will be strengthened. Other strategies include insurance of medical stores and commodities, strengthening Quality Assurance Systems, pharmacovigilance and data quality audit.

A budget of US\$2.02M is earmarked for the DPI in the MoHSW, largely for a National Health Accounts study, upgrading data systems and improving data use.

Outputs: From the in-country assessment, it was clear that substantial funding from GF had been invested in data systems and PSM in the NFM grant. Some of these investments are continuing in the PC grant. Community systems strengthening interventions in the NFM grant, coordinated by GAMNASS (Gambian Network of AIDS Support Societies), included training for members of 11 PLHIV Support Societies and 1 female network of PLHIV. Capacity building activities included training on stigma and discrimination, positive living, governance of civil society organizations (CSOs), financial management and administration, income generation, palliative care and lay counseling skills. A total of 360 PLHIV Support Society members were trained between 2015 and 2017.

Outcomes: GCCM (2017) states that there have been (unspecified) improvements in the RSSH intervention areas mentioned above. But it states that there are still challenges such as unreliable electricity and internet connectivity, inadequate storage and distribution capacity, skilled health workforce, data management and supervision, weak pharmacovigilance system related to adverse drug reactions (ADR) reporting and unavailability of guidelines and high staff attrition rate.

The PLHIV support societies have been instrumental in promoting treatment adherence and providing peer-to-peer psychosocial support to ART patients and their families. As an extension of their role, and with Global Fund support, members of PLHIV support societies were stationed at ART clinics to provide support to ART initiates and those newly diagnosed with HIV, inviting them to support society meetings, and working alongside the ART clinics to track loss to follow-up and reach out to defaulters.

Impact: Numerous recent reports suggest that many problems persist. The excellent Roadmap for Revitalization and Scale-up of Primary Health Care (MoHSW, 2017) points to an urban-rural divide, clearly visible with the distribution of human resources. The proportion of health workforce for 1,000 population in urban areas is twice as high as rural areas (1.76 vs 0.82). Such variation of proportion is profoundly visible in physicians whereby the proportion is 10 times higher in urban areas and 6 times higher for registered nurses. Furthermore, 31.9% (638) of the total health workforce is found in 6 health centers. In interviews with the MoHSW, the evaluation team was informed that the Ministry has not rolled out this Roadmap, as it is awaiting support from external donors.

Several studies have looked specifically at issues for pregnant women and newborns, both generally and in the context of HIV. The Impact Study Report on the Reduction of HIV Transmission from Mother to Child (MoHSW, 2015) found that a large proportion of mother-child pairs were lost to follow-up and many infants born to HIV positive mothers were not tested. The health system weaknesses identified include:

- Shortage of trained doctors and nurses and allied health professionals in providing HIV care and support services including monitoring and supervision
- Weak organizational procedures and guidelines to maintain contact with clients to prevent loss to follow-up

- Poor documentation and management of data recorded in PMTCT and infant registers at health facilities resulting in missing data
- Lack of basic laboratory tests such as HB, Urinalysis, VDRL and sickle test for pregnant mothers, late antenatal bookings, lack of communication between providers and recipients of services, lack of monitoring and recording of vital signs and blood availability for transfusion.

The National Health Strategy (Government of The Gambia [GoG], 2013) contains many strategies, activities and targets to address many of the above issues but no assessment of its outcomes or impact are available as yet. A health system assessment is scheduled to be finalized later in 2018. To date, drafts have been developed of the HMIS report (Bawo, 2018: dealt with under Objective 3) and Human Resources for Health (WHO/MoHSW 2018). The latter echoes the earlier reports and states that a strategy lasting 15-20 years may be needed to ensure that sufficient numbers of appropriately trained and remunerated healthcare workers are in place to meet the country's needs.

Quality Care Assessments were carried out in Western Regions 1 and 2 (MoHSW, 2018a and 2018b) earlier this year. As noted above, the Western regions are better served with health services than the largely rural central and eastern regions. The assessment on Western Health Region 1 (WHR 1) found that almost all health facilities assessed under-performed in almost all areas of assessment. The assessment in Western Health Region 2 (WHR 2) found most health facilities under-performed in most areas of assessment, but some performed to the maximum possible in some assessment areas.

Linkages between CHBC services and health facility-based services have been established with support from the NFM grant. However, referral mechanisms and capacity to follow-up patients remain a challenge in the PC grant due to limited funding for transport. There is no formal community HIV strategy, except for its mention in the National Strategy. There is some political willingness by the government to work with CSOs to deliver services and reduce the strain on the healthcare system, but no funding commitments have been made to date.

Domain 1.3. Supportive and sustainable legal, policy, and financial environments

Inputs: NFM: The 2014 HIV Concept Note (GCCM, 2014) refers to the integration of stigma and discrimination into all trainings for healthcare workers on HIV and AIDS to ensure that stigma emanating from healthcare settings is minimized. The 2012-2014 Stigma Reduction Strategy would be reviewed, revised and its recommendations implemented to support the scale up of HIV prevention, treatment, care and support services. Health workers and community health services providers would be trained to make the health environment safe, acceptable and welcoming for PLHIV and key populations.

The PC grant plans training of health care workers (HCW) on TB/HIV stigma related issues and sensitization of communities (GCCM, 2017). In addition, training materials have been developed by *Enda Santé* that target policy-makers and government officials on MSM service delivery, human rights and leadership.

Outputs: GCCM (2017) refers to the following outputs from the NFM grant. A manual for the clinical management of gender-based violence (GBV) was developed. Over 100 health workers were trained and modules on GBV case management were incorporated into health training curricula of all higher learning institutions. A training of trainers was done for lecturers and other related service providers on forensic evidence with expert support from the Finnish government. ActionAid provided (and is continuing to provide) financial support to the Female Lawyers Association to provide legal Aid to GBV survivors who cannot access legal services due to cost. No reference is made to the stigma strategy, which does not seem to have been updated or renewed beyond 2014. A total of 65 key population

members – and 463 police, religious and community leaders, policy makers and regional authorities – were trained between 2015 and 2017 on “Sensitization on HIV and AIDS and GBV.” Through the community sensitization program of the NFM, members of the PLHIV Support Societies publicly disclosed their HIV status on television, radio and at community symposiums.

The adoption of the HIV and AIDS Prevention and Control Act (2015) was a landmark measure, given that it contains provisions to protect the rights of PLHIV and states that KPs should have access to services. A Gender Assessment was carried out in 2016 (NAS, 2016). Its key recommendations were to reduce human rights and gender-related barriers to accessing health services, increase knowledge on HIV/AIDS among women and girls including female sex workers (FSWs), increase access to and knowledge of sexual and reproductive health and rights (SRHR), provide education to in-school boys and girls (15-18 years-old) on GBV, and reducing harmful traditional practices.

Outcomes: There remains much to do to address human rights barriers to accessing HIV services. Interviews with MSM in particular, and with women living with HIV, pointed to a wide range of barriers related to gender and stigma: most participants in focus groups stated that their situation related to these barriers has not improved during the past five years. Training of healthcare workers to provide KP-friendly services remain inadequate and redeployment of trained HIV healthcare workers to other health facilities or departments is a key challenge to retaining a KP-sensitized healthcare workforce. An MSM representative has been elected on the CCM to participate in national decision-making processes, however, the MSM community reported lack of training on how to meaningfully participate and engage in these structures as a barrier and that they require network strengthening and capacity building on leadership, sexual orientation and gender identity and human rights literacy.

Gambia Country Coordinating Mechanism (GCCM, 2017) states “the ban on Female Genital Mutilation (FGM) and the enactment of the HIV and AIDS Prevention and Control Act and the new political dispensation provide an opportunity for improved human rights and addressing gender base violence” during the PC grant period. The National AIDS Secretariat will work with a partner NGO (Network of Gender Base Violence) that coordinates GBV and FGM-related issues across the country during the PC grant. Two of the main ART sites also serve as One Stop Centers for GBV.

Impact: Some of the recommendations from the Gender Assessment have been incorporated into the revised National Strategic Plan 2015-2020 where a particular focus was placed on the reduction of GBV and stigma and discrimination. However, its recommendation to mainstream HIV, AIDS and gender in the national response is not clearly demonstrated in the revised NSP. Female genital mutilation (FGM) and harmful traditional practices remain a major challenge in the HIV response for women, adolescents and girls, including SWs. The 2018 IBBS found that 66% of FSW participants had been cut or mutilated.

No other rights-related analyses have been undertaken or are currently planned. The Gambia criminalizes HIV transmission, illicit drug use and same-sex sex; and there is partial criminalization of sex work. In addition, a new charge was created in 2014 of “aggravated homosexuality” in which a person convicted may be imprisoned for life. The charge can be brought when the person against whom the offense is committed is below the age of 18 years; the offender is a person living with HIV; the offender is a parent or guardian of the person against whom the offence is committed; the offender is a person in authority over the person against whom the offence is committed; the victim is a person with a disability; the offender is a serial offender; or when the offender applies, administers or causes the use by any man or woman any drug or material with intent to stupefy or overpower him or her, so as to enable any person to have unlawful carnal connection with any person of the same sex.

There are specific gender issues related to the Eastern, more rural provinces. From 13% to more than 18% of girls in these provinces married before the age of 15; fewer than 15% of girls aged 10-19 in these provinces have comprehensive knowledge of HIV; and 75% of girls aged 10-19 in these provinces believe wife-beating can be justified. Nationally, only 2.2% of girls aged 10-19 in marriages/unions are using any effective form of contraception (United Nations Population Fund [UNFPA], 2018). MoHSW (2016) found that 5.6% of sexually active females in the general population reported that they had suffered either sexual or physical violence from a partner in the past 12 months. Females aged 15-19 years reported more than twice as much intimate partner violence than those aged 25-49 years.

There appear to have been no investigations of stigma and other issues among PWID, TG or prisoners. Very high levels of stigma and violence are experienced by MSM and SW, and significant numbers of PLHIV experience stigma and discrimination. Of the 147 MSM interviewed for the 2018 IBBS, 42% had forced sex/rape; 24% had been blackmailed for having sex with men; 17% are afraid to seek healthcare; and 12% avoided accessing healthcare completely. Sex workers' (SW) experiences of stigma decreased since the 2012 IBBS. Of the 354 FSW participants in the 2018 IBBS, 33.9% have been arrested because of sex work and 14.3% had forced sex/rape. Stigma from uniformed officers, including confiscation of condoms (3.6%) and refusal from police to protect them because they were SWs (2.3%) remain some of the biggest challenges faced by this community (IBBS, 2018).

Financial issues are dealt with under Objective 4.

Objective 1. Analysis

The Gambia HIV National Strategic Plan 2015-2020 (GoG, 2014) is in place and guides the national response to HIV. It was revised in August 2017 to include strategies to address weaknesses identified in the mid-term review. The 2015-2019 National Strategic Plan was developed under the previous political regime and was constrained in some of the language used, particularly in describing activities for MSM, referred to as "other key affected populations." The revised strategic plan has incorporated key recommendations from the gender assessment conducted in 2016. Goals and strategies are generally appropriate except for the lack of focus on prisoners, and lack of investigation of PWID and TG needs. General costings by type of intervention are included in the NSP as well as an M&E budget and work plan and performance framework for the period 2015-2020. No analysis was found on the appropriateness of goals and strategies: such analyses include investment cases, Optima exercises or efficiency studies.

There are very substantial health system issues including in human resources for health (especially the disparity between HCW:patient ratios in urban versus rural areas; and training of staff from doctors to village health workers); PSM (consistent reports of stockouts); laboratory systems (including both machines not working or not available and stockouts of reagents and other consumables); and disparity between health facilities in Western regions and rest of country.

Substantial regional differences exist especially in women's access to sexual and reproductive health (SRH) and adolescent girls and young women's ability to negotiate safe sex in Eastern regions. Intimate partner violence and GBV are major issues requiring interventions. The Network Against GBV in The Gambia has been instrumental in revisions to the Sexual Offences Act of 2013 to raise the legal age for marriage and sex to 18 years-old, advocating for amendments to the Women's Act (2015) and Children's Act (2016) to include protections on FGM and cutting, promoting sexual and reproductive health and education rights. However, in practice, these laws are poorly enforced, particularly in rural communities where traditional practices are more common than in urban areas. In addition, no redress mechanisms are in place for people who have experienced sexual abuse, trauma or human rights violations, which means that these violations remain unreported to police and investigation and prosecution rarely happens.

Key populations programming is nascent by comparison to other West African countries. Very high levels of stigma and violence are experienced by MSM in particular. The 2014 Amendment of the Criminal Code fuels hostility and violence towards MSM from communities, police enforcement and healthcare facilities. Compounded by the cultural and social values of healthcare workers, MSM reported that they do not disclose that they are MSM or avoid seeking healthcare altogether (IBBS 2018; MSM focus group discussion (FGD)).

“More discrimination and stigma are experienced by women than men, if women disclose their status, they risk complete abandonment with their children, which is not the case for men.” – HIV Support Society member

“A woman is always controlled by a man, first by her father when she is a daughter, then by her husband when she is a wife and finally by her son when she is old.” – HIV Support Society member

Objective 2. Evaluate the extent to which service delivery systems (health facility and community) delivery quality services.

Figure 2. Dashboard of Objective 2 Core Indicators

Indicator – HIV ONLY	Score	Justification
Key populations reached: % of 2 key populations with highest prevalence reached by defined packages of services		Difficult to judge from available sources and from KP data collection methods. Likely that SW coverage is under 50% and all other KP much lower.
PLHIV who know their status: % of estimated people living with HIV who know their positive status		NAS (2018) estimates this number as 7,100 (about 34% of estimated 21,000 PLHIV), but no details are available on how this number is calculated. This must be an under-estimate as there are 7,350 people currently on ART. No figure is provided in Global AIDS Response Progress Reporting (GARPR), UNAIDS (2018) or any other source consulted.
Linkage to treatment and care: Availability and types of linkage programs between diagnosis/screening and treatment		Evidence of some linkage between antenatal care (ANC) and HIV programs (65% pregnant PLHIV accessing ART and 12% early infant diagnosis [EID] [UNAIDS, 2018]); increasing linkage between HIV and TB programs. No evidence of KP being unable to access services but MSM and SW hide their KP status, and programs linking KP to care are only now starting with mobile clinics and wellness centers.
ART coverage: % of estimated people living with HIV currently on ART (adults and children)		7,350 on ART of estimated 21,000 (35%) as of 30 September 2018 (DHIS 2 records)
12-month ART retention: % of people who ever initiated ART and are still on ART at 12 months after ART initiation (adults and children)		2015 ART survival report found survival rates of 2012 and 2013 cohorts on treatment at 12 months at 83% and 74% respectively. New survival report is needed, based on Test and Treat protocol. Loss to follow-up is difficult to

		calculate but all stakeholders agree it is a significant problem.
Viral suppression: % of people who are retained in ART for at least 6 months with viral load <1,000 copies/ml		Viral load testing not yet widespread. Technical Review Panel (TRP) comments on 2017 grant request notes limited access to viral load and other lab tests. Consistent reports of viral load test results either not being provided to ART Centers or being provided up to 6 months after samples sent. Unlikely that more than 20% of ART patients have reached VLS.
Composite across all six components		

Dashboard Key	
	Very poor
	Poor
	Moderate
	Good
<i>Further details on scoring metrics are available in Annex 1.</i>	

Domain 2.1. Prevention

Due to its history of higher HIV prevalence (reaching 2.2% in 2006 and still at 1.4% among pregnant women), there has been an emphasis on prevention in the general population, with key populations (KP) programming starting more recently and restricted to MSM and SW. This section will therefore be split into prevention related to general population, condoms (which are distributed to both general population and key populations), and KP.

General population

Inputs: NFM: The HIV Concept Note (GCCM, 2014) states that behavior change communication (BCC) targeting at-risk groups in the general population would be used to prevent HIV. Male and female condoms as well as lubricants would be promoted and distributed. The BCC messages would also deepen people’s knowledge on HIV prevention methods to help drive down new HIV infections. There would also be a focus on screening and syndromic management of sexually transmitted infections (STIs). A small provision for general population prevention (US\$51,000) is included in the ActionAid PC budget.

Outputs: A wide range of BCC was undertaken during the NFM period, generally without any mass media attention, due to the difficult political environment. Methods included a range of community education initiatives down to the district and village levels, including working with members of HIV support societies who disclosed their status, discussed their ART use and encouraged HIV counseling and testing (HCT) and enrollment to ART if positive.

ActionAid (2016) developed a document to guide further development of messages for general prevention (as well as to encourage HCT, enrollment and adherence to ART and PMTCT, and reduction of myths and stigma towards PLHIV). It appears that the reduced funding for these efforts in the PC grant has meant that these messages have not been promoted widely.

Outcomes: MoHSW (2016) found some disturbing trends when data is compared to earlier behavioral surveillance surveys (BSS) studies. The researchers surveyed 4,807 respondents, 50% male and 50%

female. In 2010, 53.7% had knowledge of HIV prevention methods; dropping to 49.9% in 2012; and to 25.4% in 2014. By 2016, comprehensive knowledge about HIV prevention – which combines the correct responses for 5 questions – had fallen to 23.5% (males 28.0% and females 19.1%). Yet, approximately 62% reported that they have heard or seen HIV and AIDS messages in the past 12 months.

A performance letter sent by the Global Fund this year (GF, 2018) referred to a previous management action that the PR should identify the bottlenecks with regards to its information, education and communication (IEC)/BCC interventions to enhance program delivery; and that a plan of action for the improvement of IEC/BCC should be developed and shared with the GF.

Impact: While many stakeholders felt that the reduction in general population prevention programs was inappropriate in an epidemic where more than 1% of the population have HIV, the cost and dubious effectiveness of previous prevention campaigns suggests that a different approach may be needed. It should also be noted that, despite the poor outcomes noted above, annual new infections fell from 2,200 in 2005 to 1,400 in 2017 (UNAIDS, 2018a). The UNAIDS approach to prevention now suggests that investments be curtailed into general prevention campaigns unless they are directed toward specific HIV services (such as acquiring and using condoms, HCT, ART enrollment and adherence) (UNAIDS, 2017).

Condoms

Inputs: Annual need for condoms is estimated per the 2017 Programmatic Gap Table (GPG, 2017) as 5.5 million male condoms each year and 11,000-13,000 female condoms (from 2018-2020). United Nations Population Fund (UNFPA) has undertaken to supply 2 million male condoms each year. The PC grant seeks to supply the following male and female condoms, displayed in the table below.

Table 3. PC Grant Distribution of Male and Female Condoms, 2018-2020

	2018	2019	2020
Male condoms	2,269,585	2,405,760	2,550,105
Female condoms	2,014	2,135	2,263

Outputs: A total of 3,934,494 condoms have been distributed between 2015-2017 through the Gambia Family Planning Association (GFPA) with GF support. Of these, Worldview reported distributing 1,163,010 to SWs and MSM between 2016 and 2017. No condom distribution data were available for 2015 for Worldview (the sole KP program implementer). Condom distribution needs are determined using an average monthly consumption methodology, which is reported to the GFPA through its community-based distribution centers and community-based distribution agents.

Outcomes: MoHSW (2016) found substantial condom use. Among those who had sex with commercial partners 77.5% had used condoms with their last partner (males 92.9% and 41.7% females); and 40.0% reported consistent use of condoms with commercial partners in the past year (males 50.0% and females 16.7%). Among those who had sexual intercourse with non-regular partners, 73.4% used condoms with their last partner (males 77.4% and females 54.2%); with 52.8% reporting consistent condom use with a non-regular partner (males 58.5% and females 25.0%). It should be noted that female condom use is consistently lower than for men.

Challenges noted by the GFPA include limited fuel supply to distribute condoms (\$10/month), which affects transportation and delivery of condoms to the 5 branches in the network. Condom distribution data have been recorded in DHIS 2 since 2017.

Impact: It is possible that the relatively high condom use rates are contributing to the reduction in new HIV infections.

Key Populations

There is confusion about the size of the SW and MSM populations. Official UNAIDS (2018) reports provide a figure of 3,100 SW nationally. The Performance Framework for the PC grant (GPG, 2017) reports a figure of 6,078 derived from Johns Hopkins University research, but the same document's denominator for SW needing HIV tests is 242. The 2018 IBBS estimates the SW population size in the Greater Banjul area at 1,117. For MSM, official UNAIDS (2018) reports provide a figure of 150. The Performance Framework for the PC grant (GPG, 2017) uses a figure of 5,780 also derived from Johns Hopkins University research, but the same document's denominator for MSM needing HIV tests is 20. The 2018 IBBS estimates the population size for MSM in the greater Banjul area to be 1,202.

Inputs: NFM: The HIV Concept Note (GCCM, 2014) states that targeted BCC strategies would be directed at all target populations especially KPs like FSWs and other KPs (meaning MSM) using community outreach strategies to engage them one-on-one or in small groups to provide the minimum package of HIV prevention interventions. GCCM (2017) refers to the purchase of mobile vans and wellness centers in the previous grant and states that these vans, together with outreach workers, would carry out prevention activities among KP during the PC grant.

Gambia Country Coordinating Mechanism (GCCM, 2014) states that interventions for SWs include providing the minimum package of prevention services for FSWs and their clients – which includes male and female condoms, lubricants, IEC materials, STI screening and spot-counseling – using a community-based approach via CSOs to strategically position the wellness centers which will serve as safe places to get information, interact with supportive peers, learn about health services, obtain appropriate referrals and organize social activities to reach more SWs. The PR would provide technical assistance, build the capacity of peer educators and ensure quality assurance systems for this intervention. In addition, linkages between CSOs and 'friendly' health facilities would be created and the IBBS completed.

For MSM, the minimum package of services includes one-on-one IEC materials, HCT, STI screening, condoms and lubricants, and referral to other services (HIV/TB). Training for KP peer educators will be conducted to deliver the minimum package of services for this group. Furthermore, advocacy trainings will be conducted targeting the police, human rights institutions and the judiciary to ensure that the rights of MSM are protected to increase access to services.

For the current grant, the target is to reach 2,509 SW in 2018, rising to 3,853 in 2020 (61% of SW by 2020) with the defined minimum package of services; and to reach 2,390 MSM in 2018, rising to 3,643 in 2020 (61% of MSM by 2020) with the minimum package of services.

The budget for KP activities in the ActionAid PC grant is difficult to understand, when viewed in conjunction with the findings from site visits and key informant interviews. The budget states that US\$234,321 will be spent on comprehensive programs for SW over the current 3-year cycle; while US\$509,669 will be spent on prevention with "other vulnerable populations." As the evaluation team was only able to find a small MSM outreach program, together with a drug user outreach program funded by another donor, it is difficult to see what this budget for other vulnerable populations is designed to address.

Outputs: Distinct KP friendly services are not provided through the government health system and no KP data is recorded at health facility level. Health facilities overall are not KP friendly, operating only

during business hours with no mobile outreach or after-hours services. One respondent noted that even at facilities where nurses and doctors have been trained on working with KPs, service provider stigma still exists and some healthcare workers refuse to accept that some people have anal sex.

Worldview is the only NGO that provides tailored services for MSM and SWs. MSM and SW attend 3-monthly meetings discussing topics on relationships, psychosocial support, HCT, correct condom use, distribution of prevention commodities and to receive IEC materials. A total of 27 MSM and 97 SW peer educators have been trained to carry out prevention activities with KP. (Worldview is also hosting a project with funding from Luxembourg to provide outreach education to PWID in the Greater Banjul Area.)

According to program records, between 2015 and 2017, 10,107 SWs and 2,531 MSM were reached with the minimum prevention package through the program. The evaluation team believes these figures are untrustworthy due to the data collection methods used for KP program data (see Objective 3) and due to the population size estimations for the KP (3,100-6,078 SW and 150-5,780 MSM). Two mobile clinics have been purchased and outfitted. The evaluation team visited one unit, and it was clear that a wide range of prevention activities, HCT and medical examinations could be carried out using these units. Three wellness centers have been purchased and placed in positions believed to be hotspots for KP. These centers – built inside shipping containers – also have the facilities needed to carry out prevention activities, HCT and medical examinations. An MSM drop-in center has been operating in Banjul for the past few months.

Between 2015 and 2017, approximately 26,400 condoms and 2,400 lubricant sachets per year have been distributed to MSM via the drop-in center and through peer educators. Between January and September 2018, 890 MSM were recorded as reached with the minimum prevention package. In addition, 138 MSM have accessed the drop-in center between June and October this year.

Outcomes: Several issues were observed by the evaluation team when visiting a mobile clinic (outside Worldview's Banjul office) and a wellness center in Basse, and in conversations with KP. These issues include:

- Evaluation team had difficulty understanding the rationale for the placement of wellness centers or the routes taken by mobile clinics in relation to MSM. The three wellness centers are placed in strategic sites near border crossings, where many SWs move to and from The Gambia. The mobile clinics work with a wide range of brothels and bars in the Greater Banjul Area. In both cases, their usefulness to and attraction of SW are well documented. Yet most of the costs for these facilities and services are listed in the PC grant under "prevention for other vulnerable populations." To avoid stigma, the general population are welcome to use the services of the mobile clinics and wellness centers, though peer educators try to steer mostly KP towards these services. The mobile clinics, wellness centers and 97 SW peer educators form a comprehensive approach to HIV

prevention with SW, but more work is likely to be needed to set up similar arrangements for MSM (and potentially PWID).

- This issue is illustrated by the clinic's first 13 months' operations report. Between July 2017 and October 2018, the mobile clinics had delivered HCT to 32 male and 230 female KP members and 18 male and 42 female general population members. Other consultations were provided to 44 male and 274 female KP; and 94 male and 168 female general population. Between January and September of 2018, 2,781 SWs are said to have accessed services through the mobile units, exceeding the target of 2,509 for 2018. Again, it is difficult to verify this, given the data collection methods used.
- Wellness centers are not yet operational due to staffing issues. To enhance integration between government and NGO health services, ActionAid and Worldview have asked the MoHSW to provide nurses to work at the centers. They will receive additional salary for their work, which will be carried out from 18h00-22h00 on Mondays, Wednesdays and Fridays. The Ministry has to provide these nurses, so the NGOs may soon be forced to hire nurses to start services at the centers.
- During a site visit to the wellness center in Basse, it was discovered that there is no temperature control except during operating days/hours, posing significant risk to drugs, commodities and equipment. It is recommended that these supplies are stored in a nearby facility and transported by the nurse on-duty to the wellness centers when needed.
- Knowledge about HIV and STIs among SW increased from the 2012 IBBS to the 2018 IBBS. Difficulty accessing condoms significantly decreased from 49% in 2012 to 6% in 2018. Physical and verbal harassment remain unchanged between 2012 and 2018 at 38%. SWs who had been forced into having sex/raped increased from 10.3% in 2012 to 14.3% in 2018. SWs reported that access to information, prevention commodities and education is easier than it was 5 years ago. When asked about stigmatizing attitudes of healthcare workers, SWs responded that as long as they don't disclose that they are an SW, they are treated fairly. Access to ART was not cited as a challenge for the SW community.
- Sex workers (SWs) insisted during in-country consultations that a health card or form of identification similar to the Senegalese *Carte de Santé* be introduced by Gambian local authorities. Currently, Senegalese SWs in possession of this card are less likely to be harassed by the police. Overall, SWs interviewed in the focus group said they are satisfied with the quality and quantity of condoms available, and with the services currently being provided through GF-supported programs.
- For MSM, difficulty in accessing lubricants decreased from 87.6% in 2012 to 30% in 2018; but 32% of respondents stated they have never used a condom. Knowledge on HIV is low with only 7% answering all three questions correctly.
- These findings signal the need to strengthen and enhance prevention, treatment and care programming for MSM using innovative methods, including virtual outreach and other tech solutions. This would be particularly useful considering that MSM in the greater Banjul area meet other MSM for dates, hook-ups and to chat through closed Facebook groups, WhatsApp, some house parties and in clubs. Given their increased risk of exposure, violence and arrests, careful thought needs to be given to strengthening the MSM network to improve prevention strategies on the basis of trust between members to eradicate fear of stigma within the community itself. Evidence suggests that organizations staffed by MSM are more credible and accessible to the community (Avert, 2018).
- Challenges noted by the MSM community includes little interaction and socialization with other MSM in the city, lack of training, especially leadership development, legal literacy and

management skills on how to operate the drop-in center and the need for a social worker or trained psychologist to provide psychosocial support in events of trauma and mental distress.

- The MSM sector is represented on the CCM. However, limited knowledge of how to engage in these platforms poses challenges to the representative, inadvertently leaving them behind in prioritization, programming and especially advocacy around policy reform.
- Pre-exposure prophylaxis (PrEP) is not used as a prevention tool for key populations in The Gambia. The 2018 IBBS recommended its introduction and suggests that it would be highly beneficial for KPs.
- There are no planned investigations for PWID and TG. This influences prioritization of programming and resources for these communities. PWID noted that they have a good understanding of HIV and AIDS. However, they do not have access to rehabilitation or maintenance therapy programs and indicated that methadone and needle and syringe programs would be well received in their community. In addition, to better serve this community, a mapping exercise of PWID in The Gambia is needed.

Impact: While there are some methodological issues that raise questions about the IBBS data, there appears to have been a reduction in HIV prevalence among SW between 2012 and 2018, and a significant rise in HIV prevalence among MSM, at least in the Greater Banjul area. The 2018 IBBS found that the HIV prevalence in FSW decreased from 15.9% in 2011 to 11% in 2018 and increased more than three-fold for MSM from 9.8% in 2011 to 35.3% in 2018. SW services are increasingly easier to access through the two mobile units and the wellness centers.

The difference in change of HIV prevalence between the two populations can likely be explained by several factors:

- A willingness, even in the previous political environment, to provide large-scale HIV prevention and testing services for SW; with a much-reduced willingness to do similar work with MSM. (There may have been very good reasons for this – to even speak about MSM under the previous regime meant risking potential dismissal or worse.)
- A community acceptance of sex work due to its public nature – most people in most communities are at least aware that some women are SWs in their local area, and many may know one or more SWs (as clients, friends, family, neighbors). This community acceptance appears to be completely absent for MSM, according to both MSM representatives and other stakeholders.
- A clear understanding built up by Worldview, about how to work with SW, how to reach them and what services to provide. As shown by the remarks above about mobile clinics and Wellness Centers, it was not evident to the evaluation team that the organization yet has a clear understanding of how to work with the very closed and hidden MSM population in The Gambia.
- The law treats SW and MSM very differently. While there is partial criminalization of sex work, there are clear and very strong penalties for same-sex sex.

The MSM drop-in-center may prove to be an effective method to engage MSM in a safe space, provide support and to provide socialization with other MSM. However, fears of safety and leaks of identities were cited by MSM FGD participants as key concerns for MSM accessing the drop-in-center. Also, a single drop-in center in Banjul can hardly serve the needs of MSM throughout The Gambia.

Domain 2.2. Screening/testing and diagnosis/knowledge of status

NAS (2018) states that 7,100 PLHIV have been tested and know their status. This cannot be accurate as there are currently 7,350 patients on ART in The Gambia. MoHSW (2016) found that in the past 12

months before the survey, 16.2% of respondents had an HIV test and returned for their results (11.0% for males and 21.4% for females).

Inputs: NFM: Gambia Country Coordinating Mechanism (GCCM, 2014) states HCT services would be provided via health facilities and community outreach using CSOs targeting high risk and vulnerable groups as well as regions with relatively higher HIV prevalence. The HCT strategy would involve identifying, cultivating and mobilizing HCT champions at local, regional and national levels to build a network of supporters. Community mobilization and demand creation for HCT would be done to increase the visibility of, and support for, HIV testing at all levels. There would be targeting of vulnerable and key affected populations as well as other at-risk groups (e.g. men involved in multiple concurrent sexual partnerships), adults 25 years and above and targeting in regions with high burden of HIV disease. There would be identification and engagement of key community gatekeepers like Imams and other members of the religious community. National advocacy strategies would include a series of key messages for HIV testing for early HIV treatment.

PC: Gambia Country Coordinating Mechanism (GCCM, 2017) refers to a pilot for self-testing and test and treat for KPs to be carried out through the mobile clinics and wellness centers purchased under the previous grant. It also refers to strengthening of linkages to care for KPs through peer navigators and trainings for health care providers. The program would continue to strengthen HCT outreach services to enhance access.

Outputs: NFM: Gambia Country Coordinating Mechanism (GCCM, 2017) noted that HCT sites increased from 45 in 2014 to 57 in 2016. All stakeholders agreed that the reach of HIV testing into the female Gambian population had been massively increased through interaction between ANC and reproductive, maternal, newborn, and child health (RMNCH) services and ART Centers. The World Bank (WB) has funded a large project in five districts to improve maternal and child health. This program, linked with an extensive PMTCT program (supported by GF and United Nations Children’s Fund [UNICEF]), has been successful in discovering substantial numbers of women with HIV.

For key populations, the two mobile clinics purchased under the previous grant are operational and the three wellness centers are currently being operationalized. The HIV self-screening pilot with MSM and SW has been pushed back to 2020. The terms “peer navigators” and “peer educators” are used interchangeably, indicating that the purpose of having peer navigators – HIV positive peers – is not fully utilized to support HIV-positive people with treatment adherence or access. The evaluation found no engagement with community gatekeepers and religious leaders on KP issues.

Outcomes: The number of people tested increased from 43,713 in 2014 to 45,148 in 2015, declining to 43,909 in 2016 partly due to the political impasse (Project Update ActionAid [PUDRAA], 2018). Gambia Country Coordinating Mechanism (GCCM, 2017) notes that the proportion of pregnant women tested for HIV has increased from 59% in 2015 to 64% in 2016. Testing behavior among MSM is low with over half of the respondents in the 2018 IBBS reporting that they had never received an HIV test, and 72% saying they had never received a test for another STI. In contrast, 75% of SW interviewed said they had been previously tested for HIV (IBBS, 2018).

The TB/HIV Testing Strategy 2018-2020 (MoHSW, 2017a) has been developed. It includes the same testing strategies of earlier publications (notably the HIV Treatment Manual [MoHSW, 2015]), in which a physician or nurse are the only personnel qualified to carry out HIV tests. The Final Draft Regulations of the HIV Prevention and Control Act appears to widen the category of those who can carry out HCT by defining “health practitioners” as “any person trained to care for clients.”

The regulations also state, “the offering of HIV counseling and testing by a health practitioner shall be required in clinical settings so as to promote earlier detection of HIV with unrecognized risk factors including:

- a) Services or treatment for sexually transmitted infections and tuberculosis;
- b) Clinical services for injecting drug users unless such test is deemed inappropriate by a medical practitioner caring for the client;
- c) A medical practitioner or health practitioner attending any person for family planning services shall include HIV testing in these settings so as to promote earlier detection of HIV with unrecognized or non-identified risk factors; and
- d) All other outpatients and inpatients.”

These regulations are not yet in force; therefore, HIV tests are not offered to all outpatients and inpatients. Additionally, given that men are under-represented in testing statistics, ensuring that all men visiting health care centers to address wounds or for other reasons are encouraged to undergo HCT is also important.

Impact: It is unlikely that the HCT program as implemented under the previous grant had a substantial impact on the epidemic. The changes to testing strategies included in the new grant offer a chance to better target HCT for greater impact. The two mobile units are increasing access to HCT and other services for MSM and SW. A remaining challenge is to reduce stigmatizing attitudes and discrimination from within the sex work and MSM communities towards their members living with HIV. HIV positive MSM and SW do not disclose their status to each other and thus the use of peer navigators is limited and requires enhanced efforts to address internalized stigma and intra-group discrimination.

However, none of the strategies mentioned above, together with the funding currently available, will enable The Gambia to meet its HIV testing targets described in the table below, from NAS (2018).

Table 4. Gambia HIV Testing Targets 2018-2020 (NAS, 2018)

	2018	2019	2020
Est. no. of PLHIV	20,938	21,188	21,410
Target to be tested positive and know their status	18,845	18,965	19,280

As noted in the Gambia Catch-Up Plan (NAS, 2018), substantial government leadership and resources will be required to achieve these targets.

Domain 2.3 Linkage to treatment and care

Inputs: NFM: Gambia Country Coordinating Mechanism (GCCM, 2014) notes that syndromic management of STIs would be strengthened in the RMNCH services. Health workers would continue to be trained and retrained and there will be community sensitization by CSOs and community health workers (CHWs) on the need for safer sex practices and better access to sexual health services. A task-shifting policy would be developed and adopted to strengthen integration and the delivery of decentralized services. It also notes that priority for linkage to care would be given to couples’ counseling, testing and notification to address the challenge of sero-discordance. Survivors of GBV would also benefit from post-exposure prophylaxis (PEP) to reduce the risk of HIV infection.

PC: Includes strengthening of linkages to care for key populations through peer navigators and through trainings for health care providers; and inclusion of TB screening and prevention in all KP related activities (training to peer educators, health services provided through mobile clinics and wellness centers, etc.). The joint cross border program targeting key and vulnerable populations will also continue to mitigate challenges related to access to HIV services as well loss to follow-up among KPs.

The Programmatic Gap Table for the new grant (GPG, 2017) shows that 12,491 PLHIV will be screened for TB in 2018, rising to 15,466 in 2020; and that 100% of HIV positive new and relapse TB patients will be on ART while on TB treatment by 2019 (517 patients).

Outputs: NFM: The activities described in inputs have been carried out.

PC: Ten sites now have co-located TB and HIV services. NACP believes most HIV/TB co-infected patients are on ART. The mobile units offer HCT to all SW and MSM who access the units. If tested positive, the nurse navigates the HIV-positive client to the ART clinic for a confirmatory test and to initiate ART. However, there are no active follow-ups after this. Since the start of the new grant, 16 males and seven females have been referred to ART sites from the mobile unit.

Outcomes: As with testing, the major gap in linkage to care for people testing HIV-positive appears to be among men. Also, some stakeholders suggested that the previous ART enrollment process – excluding those with 500 CD4 cells and above, except in specific circumstances – had contributed to loss to follow-up. They believe – though this was not possible to verify during the evaluation mission – that many people lost to follow-up received a positive test result and were told they could not enroll yet on ART and then disappeared from the system. This issue should be overcome with the new Test and Treat strategy (see below).

All ART Centers visited showed the evaluation team the pre-ART checklists they use to ensure TB screening is carried out for all people who test HIV-positive, and staff showed a clear understanding of which symptoms should lead to a TB test. In general, collaboration between ART Centers and TB departments in hospitals has improved in recent years, according to a wide range of stakeholders. Similarly, HIV stakeholders expressed the belief that the process of developing a HIV/TB grant for the PC has helped to bring the sectors closer together, and this was also aided by regular TB/HIV monitoring visits.

The sub-recipient (SR) implementing KP programs indicated that the follow-up data and tracking systems between themselves and the health facilities are nonexistent. Data of patients accessing ART and adhering to treatment at 12 and 24 months are not shared between service providers.

Impact: Successfully addressing linkage to care will require expanding the HIV testing program among pregnant women to 100% and, in particular, a strategy to encourage men into HCT. For those testing HIV-positive, care will need to be taken that both women – especially after delivering babies – and men are enrolled in ART and encouraged to adhere to treatment (see below). Significant challenges persist relating to linkage to treatment and care for KPs. No specific strategies were found that would assist SW and MSM who tested positive to access ART and remain adherent.

Domain 2.4 Treatment, clinical care, and monitoring

Inputs: NFM: Gambia Country Coordinating Mechanism (GCCM, 2014) stated that there would be continuous enrollment and subsequent assessment of patients for treatment eligibility with ART. The ART coverage of all PLHIV in 2013 was 21% and NAS (2018) intends to increase ART coverage to 90% in 2018. Major health centers and public and private hospitals would be assessed, strengthened and accredited as ART sites to increase access to quality HIV treatment in all regions, adding 5 new ART

sites to the existing 10. All existing ART sites will be actively linked with neighboring PMTCT to provide referral services as well as oversight and treatment monitoring support for mothers to HIV-positive pregnant women and positive nursing mothers put on ART. Task-shifting would be introduced and strengthened by training healthcare workers (nurses and midwives especially) to screen for treatment eligibility and initiate patients on ART, as well as monitoring patients in care and treatment at the decentralized level. Mentoring teams would be established at the regional levels to ensure that new ART/PMTCT sites delivering ART services through task-shifting at the lower levels provide the best of care to their patients. With technical support from WHO, the national treatment guidelines would be reviewed in line with the WHO (2013) consolidated guidelines on ART for treatment and prevention of HIV infection to guide the scale up.

The NFM grant supported the salary of a home-based care coordinator, transport reimbursements, nutritional support, volunteer support and some materials (lotion, disinfectant, gloves); as well as significant support to 11 HIV Support Societies (comprising PLHIV) and a network of HIV-positive women.

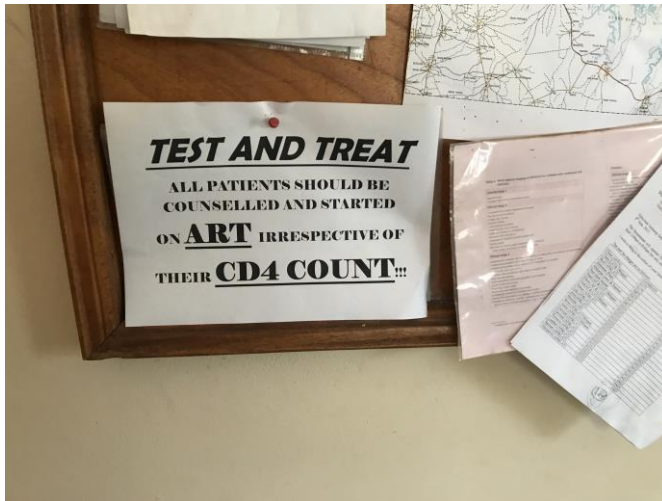
PC: The Programmatic Gap Table (GPG, 2017) states that the assumption for enrollment on ART for adults is based on a modest increase to reach 41% (1,210 total new patients) of PLHIV in 2018, including 130 from the general population, 50 from KPs, 270 TB/HIV co-infected patients and 760 PMTCT mothers on lifelong treatment. These enrollments would increase to reach 53% of PLHIV adults by 2020. It also states that children aged 0-14 on ART will increase from the 2016 baseline of 544 to 644 in 2018 (35% of a predicted 1,563 HIV-positive children) and to 769 in 2020 (52% of a predicted 1,472 HIV-positive children).

The following strategies are expected to contribute to achievement of the following targets: moderate increase in the enrollment rate, introduction of mobile clinics for KP, strengthening of TB/HIV collaboration, providing mentoring and supervision services to the regional ART sites and the involvement of PLHIV network groups to improve retention and adherence to ART and enrollment.

Outputs: A total of 14 ART sites now operate in The Gambia. All ART patients are expected to attend these centers at least every three months for ART supply (with occasional shortfalls in ART stocks meaning that visits may need to be every two months), as well as clinical monitoring visits every six months. Little evidence was found of the use of ART clubs or other methods to distribute ART medications to patients that would reduce transport costs and time spent on travel and in ART centers. Task-shifting has occurred with most ART centers headed by trained nurses, with a clinician available for consultations. ART centers have social workers (funded by the GF) to assist PLHIV and to help prevent loss to follow-up.

A comprehensive manual on HIV treatment was developed (MoHSW, 2015), including information on all KPs, with comprehensive guidance on all aspects of testing for and treating HIV and associated conditions. The guidance recommends ART for those with CD4 counts below 500, with faster access to those with counts below 350 and with a range of co-existing conditions. This strategy was amended in 2017 to “Test and Treat.”

Image 2. Test and Treat



The manual suggests that all ART delivery needs to be through clinics and no community treatment access is possible, and the TB/HIV Testing Strategy (MoHSW, 2017a) repeats these recommendations. The PC grant has seen a massive reduction in support to HIV support societies and, consequently, to their activities related to adherence support. Now the facility social worker acts as the home-based care coordinator, no materials are provided for those providing home-based and transport reimbursements have decreased.

Outcomes: ART was provided to 7,350 patients in September 2018 (DHIS 2 records), or 35% of the estimated 21,000 PLHIV. In the 2018 Performance Letter (GF, 2019), it was stated that a spot check was conducted on HIV/AIDS and TB service provision. Findings of the spot check clearly showed the inadequacies of biological and biochemistry monitoring of PLHIV on ART. Most ART sites have no or very limited CD4 and viral load monitoring of patients. Liver and kidney function tests were not routinely done, nor was testing for cryptococcal meningitis. The main challenges were the functionality of the CD4 machines and the availability of laboratory supplies, reagents and test kits. However, there were also artificial shortages caused by poor communication between the laboratory personnel and the care teams.

In visits to ART centers, the problems with laboratory results were repeated many times. Issues included:

- Sending samples for viral load testing and never receiving the results
- Sending samples for viral load testing and receiving the results up to six months later
- Not having funds to transport samples for testing (some AIDS centers waited until a nurse or other staff member was traveling toward the laboratory site and asked them to transport samples)
- AIDS Center staff being told that machines are unavailable or that consumables have run out, only to find that other hospital departments have received results from those machines.

The National Public Health Laboratory (discussed at length in the TB Evaluation Report) continues to experience the problems outlined in several previous reports. These problems with laboratory operations are particularly serious for viral load monitoring and associated clinical decision-making. NAS (2018) estimates that all ART patients are at viral load suppression, but this is both unlikely to be true and unable to be verified, due to the very small number of patients for whom viral load results are available.

In ART centers, the evaluation team found very few instances of patients being transferred from first line to second-line ART medications and it appeared that the lack of access to regular monitoring

results is hampering clinicians from making the decision as to when to transfer patients to different regimens. The DHIS 2 results (which are incomplete as they only track ART patient records since 2012), show there were 5,091 patients defaulting from ART from 2012 to 2017, and 2,289 restarting ART (note: due to the way data is gathered, it is uncertain how many individuals have defaulted from and restarted ART as the same person may have defaulted and restarted several times). Those individuals who have restarted ART after a significant period without medication should at least be considered for second-line regimens.

The 2015 ART survival report found survival rates of 83% and 74% for 2012 and 2013 cohorts on treatment at 12 months, respectively. A new survival report is needed, based on the Test and Treat protocol. Interviews with ART center staff offered the following major reasons for loss to follow-up:

- Transport: many people travel long distances, requiring at least one day for each visit to the AIDS center. Transport problems and costs were the most commonly cited reasons by AIDS centers for loss to follow-up.
- Lack of disclosure: because many ART patients, especially women, have not disclosed their status to their families, they cannot find excuses to attend ART centers on a regular basis. Stigma and fear of disclosure were commonly cited reasons by HIV support societies for loss to follow-up.
- Traditional healers: most stakeholders agreed that for a range of reasons, many people choose to visit traditional healers when they are ill and only come to the AIDS center as a last resort.
- Travel: Senegalese and Gambians cross national borders regularly and several AIDS centers said they had sent people to investigate patients who had missed appointments, only to find that the addresses provided were fake. They assume that these patients have moved to Senegal from Gambia.
- Death: Most AIDS center staff believe that most of those lost to follow-up are likely dead. This is partly due to the former ART strategy and to PLHIV presenting for ART treatment when they are already very ill.

Tracking and reducing loss to follow-up and improving treatment adherence is a challenge. As noted above, the data system is confusing and incomplete. It is difficult to understand the rationale for the distinction between defaulters (usually missing two or three appointments) and those lost to follow-up (not being seen by the AIDS center for more than six months). A better system would use patient numbers to track ART patients, categorizing them as adherent, mostly adherent (and therefore to be followed up with adherence support), missing an appointment (to be followed up more rigorously to determine what has happened to the patient) and finally, loss to follow-up (which should be a very small number). The new boxes being trialed in three ART centers (see Objective 3) will help to address some of these issues, once they are in general use, but much more needs to be done to assist ART patients in remaining adherent. The challenge is particularly strong for SWs, who are highly mobile and move between places (and across national borders) regularly for work.

The 11 PLHIV support societies, each with a membership exceeding 250, have been instrumental in promoting treatment adherence and providing peer-to-peer psychosocial support to ART patients and their families under the NFM. With nutritional packages and transport reimbursements, more than 30 PLHIV attended monthly meetings, and many others dropped in to society premises for a meal and discussions when they came to town to attend the ART center. As an extension of their role, and with GF support, members of the societies were stationed at ART clinics to provide support to ART initiates and those newly diagnosed with HIV, inviting them to meetings, and working alongside the ART clinics to track loss to follow-up and reach out to defaulters. In doing so, the relationships between the ART clinics and the PLHIV support societies were strengthened and the ART clinics interviewed during this assessment noted improved treatment adherence with the active involvement of the PLHIV support

societies. Funding for these activities was mostly removed in the PC grant, but HIV support society members at the clinics visited continue to volunteer to assist people newly diagnosed with HIV.

One method to improve adherence and address loss to follow-up would be to enlist some members of each HIV support society for paid roles as counselors to those newly diagnosed with HIV, social workers to assist PLHIV with adherence, ART delivery staff to take ART medications to patients that find it difficult to regularly access the ART Center, and to track down ART patients defaulting on treatment before they become lost to follow-up.

There are no differentiated ART delivery modalities in place, except through the Home-Based Care (HBC) program that occasionally delivers ART to patients who are unwell. ART clubs are uncommon, particularly due to high levels of stigma and discrimination at community level, which deter PLHIV from disclosing their status. The majority of PLHIV interviewed indicated that they prefer to collect their own treatment. No mention of planned efforts to increase access to ART for KPs was found.

No disaggregated data for KPs currently on ART exists. The nurse at the mobile clinic does not follow-up or track new ART initiates after treatment started. Program data shows that through the mobile clinics, 16 male and 7 female KPs, and 2 male and 1 female general population have been referred for ART. With the introduction of the wellness centers and further collaboration between these KP service modalities and the formal health system, increased efforts are needed to improve monitoring of all KP PLHIV across the continuum of care.

Impact: At the current rate of ART provision, and with high dropout rates, it is unlikely that the ART program is having a major impact in controlling HIV in The Gambia. As NAS (2018) correctly points out, the number of people enrolled in and adherent to ART needs to more than double and do so very quickly. This will most likely require a large investment and leadership from the Gambian government.

Mothers and infants

Inputs: NFM: The 2014 Concept Note (GCCM, 2014) stated that PMTCT sites would be increased from the 32 sites to 57 sites by 2017. Within the context of an increasing availability of more PMTCT sites, capacity would be built for midwives and other nurses for longer tracking and health supervision for pregnant women, mothers and infants and the delivery of PMTCT and pediatric HIV services within ANC and RMNCH services. There would be promotion of provider-initiated family planning for all PLHIV especially HIV positive women in care to contribute to addressing the unmet needs for family planning. Early Infant Diagnosis (EID) was being piloted in 5 sites in three regions and would be scaled up to all regions. Lessons learned from this would be used for the national scale up of EID services. The coverage for EID would be about 50% in 2015 and over 90% by the end of 2017.

PC: Increase pregnant women on ART from 760 at baseline (in 2016) to 780 (from 2018-2020) (GPG, 2017).

Outputs: An additional 15 PMTCT sites have been set up. The RMNCH centers supported by WB and UNICEF are providing PMTCT to all women and children who test HIV-positive, but there are many women attending ANC at which PMTCT is not available. The percentage of pregnant women receiving a HIV test and the provision of PMTCT to those that test positive remains below national targets.

Outcomes: The proportion of pregnant women tested for HIV has increased from 59% in 2015 to 64% in 2016. The Gambia has stated its intention to eliminate mother-to-child transmission, but this remains problematic, given the numbers being tested. There were differences of opinion among stakeholders about the true reach of PMTCT in the country, with some believing that virtually all

pregnant women are offered HIV testing, while others believe the percentage is closer to 50-60%. The PMTCT system that exists appears to be working well and, to reach higher targets, the MoHSW will need to expand services to those areas where they currently do not exist.

Impact: Even with the targets in the revised NSP, it is unlikely that elimination of mother to child transmission (EMTCT) will be achieved in the short term. Yet, with such a small population, limited distances and a strong PMTCT system covering a large part of the country, such a goal should be achievable within five years.

Domain 2.5 Approach and methods for quality assurance

Inputs: Monitoring visits for both clinical care and data quality have been designed and included in both the NFM and PC grants.

Outputs: Monitoring visits have generally taken place as planned. The country has developed norms and protocols for most aspects of the work carried out on HIV.

Outcome: There are two main processes used for quality assurance for clinical services related to HIV. NAS carries out quarterly service monitoring visits and DPI carries out quarterly data quality monitoring visits. Hands-On Care (HOC), which operates the largest AIDS Center at Brikama, provides mentoring assistance to the other 12 AIDS centers.

In both cases, the feedback is usually provided verbally, rather than in a written form that can be used in the following monitoring visit to ensure that issues have been addressed. The Quality Care Assessments carried out in WHR 1 and 2 earlier this year – modeled on the processes used in the WB project in the other five regions – are also helping to identify quality issues within a range of health facilities. Site visits confirmed that protocols at AIDS centers are being followed.

Training materials and guidance documents have been developed and are in use for peer education with KP, as well as for the operation of the mobile clinics and wellness centers. There was some uncertainty about whether MSM peer educators had received the same level of training as SW peer educators. Drop-in center staff had not received training on operating such a center.

Impact: Overall, quality assurance mechanisms are mostly in place to ensure that Gambians receive good HIV services. Problem areas include assessing and improving the quality of services for MSM and PWID.

Objective 4. Analysis

HIV services in The Gambia have improved considerably since 2014 as a result of the GF's NFM and PC investments in the country. The GF grants have:

- Increased provision of ART, OI medications, STI medications, test kits, reagents, condoms, lubricant, GeneXpert machines for viral load testing;
- Expanded ART sites and training of ART staff, especially nurses; provided transport refunds and nutrition packages for PLHIV to encourage attendance at ART sites (under NFM); funded ART site staff including top-ups for nurses and others and salaries for social workers; expanded home-based care; introduced viral load testing;
- Expanded PMTCT and of PMTCT staff (together with UNICEF and WB) and introduction of EID
- Funded 11 HIV support societies, together with funding for nutrition packages, community sensitization and counseling at ART sites (under NFM), with ongoing, limited funding under PC

- Expanded HIV prevention and testing among SW and initiation among MSM; prevention packages designed and implemented for MSM and SW; BCC to KPs through outreach; purchased 2 mobile clinics and 3 wellness centers to work with SW and MSM; and
- Expanded and refurbished regional medical stores.

While most of the elements of the HIV response are unlikely to meet the country's NSP targets or its Catch-Up Plan targets, there is no question that the HIV situation in the country would have been far worse without the GF's investment. Overall, many aspects of the response are well developed, yet are not provided at a scale that will control and reduce the epidemic.

"Taking ART on an empty stomach is like taking poison." – HIV support society member

"We are unable to find the drug users." – NGO staff member

"It's difficult to bring men to facility, women are easier because of SRH visits. More women default than men because they go to the traditional healers instead of coming to facility." – ART center staff

"ART Clubs are difficult to envision because forming clusters in communities is hard given that people don't want to disclose their status." – HIV support society member

"I am not comfortable at home, don't tell anyone at home my status, rather come here for support and to feel welcome, less alone." – HIV support society member

"We know other people with HIV, it is secret, but we know, and we are ourselves also." – PWID FGD participant

"If you are HIV positive, everyone will abandon you, including your family." – HIV support society member

"Two weeks back, five MSM were attacked, beaten and taken by the police." – MSM peer educator

"[MSM are]...underground and not known here! Untraceable and cannot find them." – Basse

Objective 3. The extent to which country data systems generate, report, and use quality data

Figure 3. Dashboard of Objective 3 Core Indicators

Indicator	Score	Justification
Data availability (1): HMIS deployment		Bawo (2018) found that all health facilities/reporting units are expected to submit regular reports to HMIS. HMIS Strategy 2017-2025 developed but no targets included for % of health services reporting regularly.
Data availability (2): availability of disease reporting in the national HMIS		Bawo (2018) found data are collected on a complete range of health system, health status and risk factor indicators (70 in all).
Data quality (1): completeness		Bawo (2018) found that, overall, the result for the quality of Health Information System (HIS) data in Gambia were 70%.
Data quality (2): timeliness		Bawo (2018) found timeliness of reporting on 10 indicators varied between 33-78%. For HIV, it was 76%.
Composite across all four components		

Dashboard Key	
	Very poor
	Poor
	Moderate
	Good
<i>Further details on scoring metrics are available in Annex 1.</i>	

Domain 3.1 Epidemiology, surveillance, and context data

Inputs: Related to epidemiology, surveillance and context, the NFM grant included about US\$112,000 for ANC sentinel surveys through NAC and US\$192,000 for an IBBS with SW and MSM through ActionAid. The PC grant contains substantially greater funding for data systems and M&E (see below). Under NAS, US\$72,000 is budgeted for ANC sentinel surveys, with a further US\$8,200 for training NAS staff in Spectrum.

Outputs: The IBBS for SW and MSM scheduled to be conducted under the NFM grant was ultimately completed under the PC grant: a draft report was provided to the evaluation team. ANC Sentinel surveys were carried out as scheduled.

Outcomes: A review of the HMIS in The Gambia (Bawo, 2018) was carried out as part of the RSSH reviews under way in The Gambia. The review found, overall, that in relation to epidemiology, surveillance and context the system has considerably improved since the previous assessment in 2006. In particular, capacity has improved in core health information sciences, including epidemiology, demography and statistics. However, the review looked at issues across the HMIS, not specifically at those related to HIV. In interviews and observations of AIDS centers, numerous issues were discovered with the ways that data are fed into surveillance and planning documents. For example:

- It was impossible to enumerate how many people had ever started on ART, how many had defaulted from ART (a distinction is made between defaulting and loss to follow-up), those lost to

follow-up, those who had restarted ART and those who had died. Various aggregating methods used mean there is no clarity about how effectively loss to follow-up is managed;

- Forms within DHIS 2 ask many questions about HIV testing but there appears to be no method by which to calculate the first 90 figure: percentage of PLHIV who have received an HIV test and know their status. (In the UNAIDS 2018a dataset, The Gambia is one of the few countries for which this figure is not provided and attempts to discover the figure in-country were unsuccessful);
- With the current forms used to record interactions with KPs, it is impossible to state with certainty how many are being reached.

While these issues relate to program data (see below), they are also vital for strategic planning and surveillance of the epidemic. The recently conducted IBBS is restricted to SW and MSM in the Greater Banjul area so that there is no recent information about HIV prevalence and behaviors of these populations in other parts of the country, or of the HIV prevalence and behaviors among PWID, TG or prisoners.

Impact: While there is no immediate cause for concern that the National Strategic Plan is misdirected in terms of its goals and strategies, it is likely that better reporting, understanding and use of key data would lead to better strategic outcomes.

Domain 3.2 Service use and program data and reporting

Inputs: NFM grant invested about US\$90,000 in upgrading the HMIS, developing HIV-specific sections of DHIS 2, providing portals for the MoHSW (through DPI) and the PRs to access, upload and analyze data within DHIS 2, and training staff in use of the systems. In addition, US\$13,500 was set aside to develop “electronic registers for HIV patients.” For the PC grant, GCCM (2017) states the LMIS (for both HIV/AIDS and TB) products will be re-designed to create visibility within the supply chain through adoption of eLMIS; and there will be recruitment and training of additional data entry clerks to improve forecasting and quantification of health products. A total of US\$2.02M in the PC grant is earmarked for the DPI in the MoHSW, and almost US\$700,000 is provided for HMIS and for upgrading M&E. In the PC grant, one-line item for expansion of internet services amounts to US\$244,973.51 over the life of the grant, while another funds salaries of 52 data entry clerks and a data manager (US\$230,502 over 3 years).

Outputs: Gambia Country Coordinating Mechanism (GCCM, 2017) states that a template has been developed and built in to the DHIS 2 to report logistics data (consumption data, stock on hand, adjustment) and patient per regimen. It states that this program should strengthen on-site supervision, mentoring/training and quarterly review/validation to improve data quality. It is evident from the HMIS review that substantial training and investment in infrastructure has occurred during the lifetime of the NFM and PC grants.

Outcomes: Gambia Country Coordinating Mechanism (GCCM, 2017) mentions that reports on data relating to laboratory commodities are not forthcoming and inadequate data on patient per regimen remain a challenge. An HMIS Strategic Plan and Policy 2017-2023 (MoHSW, 2016 and 2016a) have been developed. These include many strategies and steps for their implementation, but no timelines and no allocation of responsibility. Bawo (2018) found many reports of frequent stockouts of basic materials such as recording returns (forms), paper, pencils and other supplies for recording health services and disease information at the facility level and community level.

Bawo also found:

- Failure receiving full information from all private care providers;

- Only 1-9% of districts have a cadre of trained health information staff who have at least 2 years of specialized training in HMIS and are in place;
- Less than 5% of health workers in health facilities (clinics and hospitals) receive regular training in health information that is either integrated into continuing education or through in-service training in the public sector;
- The mechanisms for supervision are adequate, however, supervision does not cover all the sub-systems of the HMIS at all levels;
- The sub-national levels struggle to compile disaggregated monthly/quarterly and annual summary reports;
- There is infrequent use of findings from surveys, civil registration or other vital statistics systems by managers and analysts at national and region levels to assess the validity of clinic-based data.

In addition, the evaluation team noted:

- Patient numbering and patient records (on paper in cardboard files) in ART centers appeared to be adequate, but the piles of folders (stacked on top of filing cabinets and elsewhere) of defaulters, and the boxes of patient folders lost to follow-up, suggested that the patient record process is only working for those who remain consistently on ART. The evaluation team found no evidence of the use of electronic patient registers.
- A simple follow-up process (using a timber box in which patient appointment cards are placed) is being trialed in 3 ART centers and should be immediately extended to all ART centers. With this system, staff are alerted immediately if a patient misses an appointment and immediate follow-up occurs.

Image 3. Follow-Up Box



- While, as noted above, it is difficult to know how many people started on ART and were eventually lost to follow-up, various key informants felt secure that the current number of patients on ART is accurate, due to regular checking (including the counting of active patient files at all ART centers) by regional and national staff.
- For KP members, a simple data collection form has been developed, using pictures and images that illiterate peer educators can complete. While this is an innovative solution to the problem of illiteracy, the way that data are captured does not enable the SR or those compiling data to say with reasonable accuracy whether the same person has come a dozen times for services or 12 separate individuals have accessed services. ActionAid is currently devising a new system, which will incorporate a unique identifier code and other changes to address these issues. Discussions are underway to include KP indicators in DHIS 2 in order for data from the two KP SRs (Worldview

and Hands-On Care) to be reported nationally and used for routine reporting, monitoring and decision-making.

Image 4. Data Form

The image shows a data collection form titled "MARPS PRIMARY DATA COLLECTION TOOL". At the top, there are fields for "Month:" and "Year:". Below this, the form is organized into three main data entry sections, each with a grid of small circles for recording data. The first section is labeled "MINIMUM PACKAGE" and includes a sub-section for "Condoms" with an image of condoms. The second section is for "Counseling" with an image of people talking. The third section is for "Preventive messages (IEC Materials)" with an image of a poster titled "Best ways to prevent HIV". Each section has a grid of circles, with some circles already filled in. A red folder is visible in the background.

Impact: Current data collection methods for ART patients and for key populations – assuming wide uptake of the patient appointments system and the new KP data forms – are adequate for most tasks. Due to the paper-based system, substantial time is occupied in sending specific data to Regional Health Directorates, where the data are entered into DHIS 2, with the potential for significant data entry error. An electronic system – linked by internet – would obviously reduce much of the time and staff costs associated with this exercise, but it makes sense for HIV services to be part of a general move by the health system towards computerizing records (rather than using GF funds for a stand-alone system).

Domain 3.3 Using data to drive service design and practice

Inputs: The ActionAid NFM grant included a budget of almost US\$85,000 to support capacity strengthening of PR and SR staff on statistical data analysis, epidemiology, survey techniques for KP programming. In the organization’s PC budget, there are line items for studies to determine the ART retention and adherence among KP, and to measure the death rate among the HIV positive KP on ART in the Gambia. Both of these studies were excluded from final funding. The NAS PC budget contains US\$25,000 for a DHIS 2 academy to be held in the country.

Outputs: From interviews, it appears that training occurred as scheduled, but no register was found on numbers of personnel trained and on which topics. Individual training reports were provided, showing several trainings on M&E, use of data collection forms, etc. for PR and SR staff.

Outcomes: Bawo (2018) found significant weaknesses in the use of data: “The assessment findings for dissemination and use of information are that it is present but not adequate with a score of 47%. This finding has not change since the HMIS assessment in 2006... The analysis and use of information,

information use for planning and priority setting and information use for implementation and action all recorded being available but not adequate.” The evaluation team found that few interviewees outside NAS or ActionAid had seen data reports or had used data generated by HMIS2 in their decision-making.

Impact: This appears to be the weakest part of the HIV data system. The way that DHIS 2 is organized, the ways that data are stored and analyzed, the ways that reports are generated and provided to PRs, SRs, ART Centers, etc. – all of these processes need to be carefully examined and improved. While electronic data transfer is needed, a higher priority at present should be given to ensuring accuracy of data inputs, and training in use of data for programmatic decision-making and strategic planning. By examining issues related to use of the data, changes may be made to the DHIS 2 forms to make the data more useful to decision-makers.

Objective 3. Analysis

Data quality, through improvements in the HMIS and DHIS 2, has improved considerably during the past five years. However, significant problems persist. Bawo (2018) provides a comprehensive set of recommendations for changes to HMIS and DHIS 2 (included in Annex 7). These mostly reflect the author’s interest in and examination of the architecture of the HMIS and the ways in which data are collected and used. For Gambia’s HIV response, an important additional element relates to what data are collected; how they are collated, disaggregated, analyzed and reported; and who shares and discusses these reports and uses them to drive changes to policy and practice. An important recommendation of this evaluation is that the GF not be seen as responsible for the overhaul of the HMIS to address the many recommendations in the HMIS report. GF’s strategic investment should concentrate on ensuring that the appropriate DHIS 2 data are collected regularly and verified for accuracy to ensure that key data are used for decision-making.

Objective 4. Evaluate the extent to which global fund investments have helped countries prepare financially and programmatically for a sustained response to the three diseases.

Figure 4. Dashboard of Objective 4 Core Indicators

Indicator	Score	Justification
Domestic funding for drugs for treatment		No domestic funds provided for ART to date. National budget for 2018 has budgeted for HIV first-line drugs for 1,000 patients, but not yet expended.
Domestic funding for diagnostic commodities		GF funds almost all costs of diagnostic commodities for HIV.
Domestic funding for adherence/social support		GF funds all costs of adherence/social support for PLHIV.
Domestic funding for CSO-led service provision		No evidence was found of domestic funding for CSO service provision.
Domestic funding for commodities for prevention		GF and UNFPA fund almost all costs of prevention commodities for HIV.
Domestic funding for surveillance/strategic information		Difficult to ascertain exact data but it appears minimal funding is provided by the government for surveillance/strategic information.
Domestic funding for human resources for National Program management (excluding general health service staff delivering services)		MoHSW funds healthcare workers and infrastructure through which ART delivery occurs, but GF continues to fund both additional staff (such as social workers) and additional salaries for doctors and nurses at ART centers.
Domestic funding for overall financing of program		GCCM (2017) shows that the government spent US\$7.8M during the NFM period and predicted a higher expenditure during the PC grant.
Composite across all relevant (8) components		

Dashboard Key	
	Very poor
	Poor
	Moderate
	Good
<i>Further details on scoring metrics are available in Annex 1.</i>	

Domain 4.1 Sustainable service models

Inputs: The main inputs budgeted for the NFM related to sustainable service models were the linked services described below in outputs.

Outputs: Under the NFM grant, PLHIV support societies were funded to assist at ART centers, particularly in counseling those newly diagnosed with HIV. Funding for most of these activities was removed from the PC grant. Another important output was the wellness centers being developed for

KP in three sites – funded partly from the NFM grant and with ongoing funding from the PC grant. The work of HOC is another example of government-NGO collaboration. Hands-On Care, an independent NGO with its own board (and an SR under both NAS and ActionAid), occupies a building in the Brikama District Hospital from which it provides sexual and reproductive health services, runs the largest ART center in the country, provides home-based care and funds sub-SRs (SSR) to provide home-based care in 11 other sites, and provides mentoring for care and support of PLHIV nationally. Hands-On Care works with the MoHSW and the Brikama Hospital under a memorandum of understanding that defines its roles and relationships with the rest of the health system.

Outcomes: No plan to integrate GF-funded services with government health services was found during the evaluation process. The GCCM (2017) states that under the NFM HIV grant one of the SRs (NGO) uses structures and staff of the MoHSW to deliver services and an approach whereby support for people living with HIV and AIDS is mainstreamed into the health system and offers the best chance for success in medium to long term. This refers to the system whereby PLHIV support societies were funded to assist at ART centers, particularly in counseling those newly diagnosed with HIV. Funding for most of these activities was removed from the PC grant. Another important outcome was the wellness centers being developed for KP in three sites – funded partly from the NFM grant and with ongoing funding from the PC grant.

Impact: The investment by GF in HIV/TB co-located service delivery is likely to lead to increased efficiency and reduced deaths in the long-term, particularly if the MoHSW institutes similar practices at the other ART centers around the country. The wellness centers and HOC are an excellent example of government and GF collaboration and of government/NGO collaboration, and may lead to increased understanding of the mutual roles of each sector in scaling up differentiated service delivery. Similarly, if the recommended approach to recruiting PLHIV into key ART service delivery roles moves forward, this may lead to closer collaboration between ART centers and PLHIV support societies, as well as substantially increased effectiveness in preventing loss to follow-up and providing differentiated ART delivery.

Domain 4.2 Transition to increased levels of domestic funding

Inputs: The main input budgeted for the NFM related to sustainability was advocacy to National Assembly members; this advocacy was not included in the PC budget.

Outputs: Gambia Country Coordinating Mechanism (GCCM, 2017) states that the national budget commitment during the NFM period financed health system requirements related to HIV, which mainly include human resources, infrastructure, drugs, transportation, logistics, operational costs and M&E. The CCM stated that the government contribution is slightly increasing over the PC period as resources have been leveraged from other partners in meeting additional programmatic needs and further reducing identified gaps.

Outcomes: In its examination of the budgets and reports of the PRs, and in meetings with representatives of the MoHSW at national and regional level, it was difficult to ascertain the role of the MoHSW in funding the HIV response. Costs such as maintenance of vehicles and provision of fuel for everyday tasks are included in both the NFM and PC budgets, even for staff that are not funded through these grants. Most health centers – ART clinics, hospitals, Regional Health Directorate – stated that they had no budgets from the government even for transport of samples to laboratories for testing. In the PC grant, one-line item for expansion of internet services amounts to US\$244,973.51 over the life of the grant. It is questionable whether this funding should be from GF or from MoHSW.

Impact: At its current level of domestic investment, it is highly unlikely that the GoG will achieve its NSP targets, or its 90-90-90 or EMTCT targets. A substantial increase in both funding and leadership of the HIV response is required from the government, and particularly from the MoHSW.

Objective 4. Analysis

GF investment has assisted The Gambia to survive a period of intense political difficulty, and to expand the HIV program in this environment. As MoHSW officials pointed out, the current climate is one of transition from that environment, but observations of and interviews by the evaluation team found little evidence that the MoHSW is emerging as a force for leadership in the HIV response in The Gambia. The NAS, under the President, has a mandate to set policies and to direct the response overall – and is carrying out this mandate – but many of the specific tasks, especially in surveillance, planning, data systems and provision of health services must be carried out by the MoHSW. The NACP is able to carry out the tasks for which it is funded by GF through NAS, but there was little evidence that the MoHSW is devoting (or planning to devote) significant resources to ensuring that its operations can be scaled up.

The decision by the government to budget for the funding of first-line ART for 1,000 patients in 2018 is commendable. But this needs to be a first step in a wide-ranging investment by the government in leading the HIV response in the country. Advocacy for this purpose should be included in the PC budget. It should be noted that, due to its size and to the achievements of the past decade, it would be possible for The Gambia, with sufficiently strong leadership by the government and a modest investment in basic costs of the health system, to become the first country in West Africa to eliminate AIDS and to achieve the 90-90-90 and EMTCT targets.

One set of costs that the government could take over from GF is the provision and maintenance of vehicles and fuel for HIV-related tasks by Department of Health staff. There is currently an arrangement for other areas of health whereby an NGO (Riders for Health [RFH]) purchases and maintains vehicles and the MoHSW pays for their use on a monthly basis. It would be sensible for the government to expand this system so that all vehicles required for HIV activities by government staff are provided through RFH. In the PC budget, the amounts set aside for these line items are more than US\$250,000 across 3 years (plus more than US\$150,000 for generator fuel). Models such as wellness centers and HOC should be examined to determine if there are efficiencies in expanding use of these models, rather than relying on the limited numbers of healthcare staff in the government health system.

Conclusion

Effective Strategic Investment

The first important conclusion is that The Gambia, with the support of GF, has managed to considerably improve its response to HIV within a political environment that stakeholders referred to as deeply problematic. Under the former President – who promoted his own “cure” for AIDS – the ability of various actors in the country to carry out effective HIV prevention, treatment and care was severely constrained. Yet the country has made great strides towards implementing a comprehensive response to HIV during this review period.

Despite this, the country is not on track to reach global or national targets on HIV prevention, testing, treatment and viral suppression. The Gambia Catch-Up Plan (NAS, 2018), while useful in its description of strategies to achieve greater coverage, sets unreasonable targets for the country within its current circumstances. For example, the target for PLHIV who have been tested and know their status needs to rise from its current level – a number that is unclear but almost certainly below 10,000 people – to 18,845 by the end of 2018. This is obviously not achievable.

The general direction of the revised National HIV Strategic Plan appears to be correctly formulated but there are many ways in which the HIV response can be improved and expanded. To do so will require significant changes to the ways that GoG leads the HIV response, as well as some re-orientation of GF-funded activities. Specific recommendations are laid out below and in the annexes.

Impact

Impact can be thought of in two ways: 1) whether GF investments have made a substantial impact on the country’s HIV epidemic, and 2) whether a hypothetical lack of GF investments would have resulted in a greater magnitude and impact of the epidemic. In the Gambia, the latter effect is particularly evident. Given the difficult political environment, it is highly unlikely that HIV prevalence and new infections in the country would have fallen in recent years in the absence of GF investments. However, it cannot be said that GF-funded activities – in the absence of additional investments from the **GoG** – **have made a substantial impact on the epidemic to date. Regardless, GF investments have prepared most institutions and, to a lesser extent, community systems, to scale up to reach global and national targets.**

Sustainability

Sustainability questions are difficult to answer for The Gambia. The difficult political environment only ended last year, and it will take time to build all systems to the point where domestic stakeholders can take over all the functions of the national HIV response. Given its income level and its disease burden, the country should remain eligible for GF HIV grants for a considerable period, but GF grants at their current (and predicted future) levels will not be sufficient to scale up the country’s response to meet global and national targets. This will require substantial leadership and funding from the GoG.

Detailed Conclusions

Note: This section provides the conclusions on which the recommendations are based.

First, the level of HIV testing is too low to enable a scale-up of ART programs. Without PLHIV knowing they have HIV, they cannot come forward for treatment. HIV prevention programs are still required, but they need to be linked very closely to HIV testing. The widely acknowledged disparity between

men and women being tested for HIV needs to be addressed, as does the practice of PLHIV only presenting for ART when they are very ill. The activities described in **NAS 2018 – including Parliamentary leadership on HIV testing – should assist in this process.**

Importantly, it should be widely understood that the highest priority for HIV testing needs to be with KPs where HIV prevalence may already be at levels of 10-30%. Prevention and testing efforts with SW appear to be on track and should improve with the operationalization of the three wellness centers, and with more strategic use of the two mobile clinics. Some modifications are needed to critical enabler activities. To prevent stigma, both the wellness centers and mobile clinics deal with members of the general public – though they are located near hotspots for sex work – and may therefore be used to attract men to testing.

The situation with MSM is very different. The barriers to accessing and building trust with MSM are significant and will require substantial effort and resources to overcome. In focus group discussions, it was clear that MSM were afraid even to meet for an hour, in case neighbors at the drop-in center should become suspicious and violent. Similar problems were described by researchers trying to recruit MSM for the IBBS 2018 study. These are important dynamics because HIV is spreading among MSM at a higher rate than among any other KP, to the best of current knowledge. Careful work by peer educators (where it is safe to do so) and using social media methods will need to link closely with mobile clinics and other HCT providers to attract MSM to both prevention and testing. Studies in other countries in the region and globally have noted a strong reluctance among many MSM to test for HIV, due to the perceived effects a positive diagnosis will have on their intimate relationships and friendships. This, too, will require a careful approach including HIV-positive MSM reaching out to other MSM with messages about ART and the ability to live well with HIV. While in most countries, separate methods may need to be used to reach MSM and TG women, the legal and stigma situation in The Gambia mean it is unlikely that a separate program to reach TG will be effective in the short term, so this population should be included with MSM for prevention and testing efforts.

People who inject drugs (PWID) are currently not well understood in the country, but it was evident in the PWID focus group that some people regularly inject illicit drugs such as cocaine and heroin, while others inject when drugs are available and switch to other preparations when cocaine or heroin become less available. Most injectors share injecting equipment. Focus group participants said that smokable versions of these drugs – such as crack – were used with pipes. Evidence from North America and the Caribbean suggests that shared use of crack pipes can also be a HIV transmission risk. Participants said they knew some drug users who were HIV-positive and that up to 40% of drug injectors are women. Further exploration is needed of this population and HIV prevention and encouragement to HCT should be extended to this population. Little is known about HIV among prisoners in the Gambia; however, this population should also have access to HIV prevention, testing, and treatment.

With a very young population, The Gambia is one of the countries in which HIV prevention among adolescent girls and young women will become increasingly important in coming years. Currently, there appears to be uneven access to services for adolescent girls. At one site, the evaluation team was told that adolescent girls can get an HIV test and family planning services without parental consent; at other sites, this is not done.

Having increased the number of PLHIV knowing their status, the ART system needs to be ready to provide PLHIV with treatment, care and support. The current group of 14 ART centers spread out geographically across the country may be sufficient to provide clinical monitoring of ART patients but are evidently not sufficient to provide regular medication supplies to all people with ART, especially as the number on ART approaches 18,000 as is planned. Differentiated approaches to ART provision

are required. Human immunodeficiency virus/TB care is crucial for this population. TB screening is carried out for all people who test HIV-positive, but ART/ TB treatment co-located centers remain at pilot levels and need to be expanded.

Perhaps **the greatest problem in The Gambia’s HIV response is the loss to follow-up of ART patients.** In the past, this could partly be explained by an enrollment process that turned away many people with HIV who were subsequently difficult to track down. With the introduction of Test and Treat, all PLHIV should start on ART and should be monitored for adherence, drug resistance, interactions with other infections and medications, so that at least 90% of those on ART reach viral load suppression. This will take a multi-pronged approach involving ART centers, PLHIV support societies, laboratory systems, work with traditional healers and potentially other regional and district health centers (apart from AIDS centers).

A final, important programmatic issue is the nature of cross-border work, particularly with Senegal. With common languages across borders and freedom of movement between the countries, some Senegalese are accessing HIV testing and treatment in Gambia (often giving false addresses to AIDS centers) and limited studies suggest that some Gambians are accessing services in Senegal. Cross-border issues are difficult to overcome but greater collaboration between the health systems of the two countries and at least some degree of data sharing can help each country to ascertain the true state of their epidemic. The memorandum of understanding between ActionAid and Enda Sante of Senegal, seeking to work together on cross-border KP issues, is an excellent example of this type of collaboration.

Ultimately, The Gambia can indeed meet ambitious targets within the next few years if the government takes up the challenges identified in this evaluation and in other reports on the health system, and with some adjustments to current and future GF grants.

“The Gambia could become the first country in West Africa to End AIDS.” – UNAIDS

“Healthcare workers may wear several hats. They may have a religious or cultural hat. But at work, they need to be wearing their public health hat. And that means treating everyone ethically, regardless of what religion or culture may say.” – NACP staff

Objective 5: To support countries to use the findings from the evaluations to help inform investment decisions and efforts to improve the quality, efficiency, and sustainability of the response to the three diseases.

Recommendation	Priority	Who to implement?	By when?	Implications for GF funding
Promote the message that The Gambia could become the first West African country to end AIDS before 2030; build political commitment to ensure that the Gambian MoHSW removes roadblocks to full scale-up of the country's response to HIV	High	UNAIDS, other UN family members, GF, other donors, NAS, ActionAid and other NGOs	Early 2019 onwards	<p>Ensure funding available for advocacy by NAS and ActionAid to MoHSW, Ministry of Finance, and National Assembly Select Committee on Health, Women, Children, Disaster, Humanitarian Relief and Refugees; advocacy targets to include adopting the interventions described in NAS 2018 for political leadership; addressing legal barriers to access to services for SW, MSM, TG, PWID, prisoners and adolescent girls; and encouraging MoHSW to:</p> <ul style="list-style-type: none"> • resolve longstanding issues related to laboratories, supply management of reagents/ test kits and transport of samples for testing; • resolve disputes between TB and HIV physicians about urgency of testing samples; • address low salaries of healthcare workers; • reconsider redeployment of trained HIV staff to non-HIV roles; • expand national coverage of EMTCT services; • ensure all ART centers are co-located with TB treatment; • and, determine the role of HIV services in health sector reforms and UHC
Addressing ART loss to follow-up, including clinical, laboratory, data systems and social dimensions,	High	NAS, ActionAid and MoHSW	2019	<p>Ensure funding available for amending DHIS 2 database, data entry and use to ensure more accurate tracking of ART patients; ensure clinicians trained in use of diagnostics and protocols to determine timing of change from first-line to second-line ART; re-allocate budget towards PLHIV</p>

and an enhanced role for PLHIV Support Society members in support, advocacy & home-based care				support society members to provide support, advocacy and home-based care (see Annex 8); GoG address nutrition issues for PLHIV
Expand HIV education, prevention, testing, treatment, care and support for MSM, and initiate prevention and testing services for PWID in Greater Banjul Area; maintain services for SW nationally; expand services to prisoners; investigate TG situation	High	ActionAid, Worldview, MSM group, NAS and MoHSW	2019-2020	Re-allocation will be needed to add to existing funding for KPs to develop programming and amend data systems as shown in Annex 9
Expand combined HIV/TB services and ensure TB screening for all at risk of or living with HIV	High	NAS, ActionAid and MoHSW	2019-2020	Small re-allocation may be required for ensuring TB screening is carried out with KPs and PLHIV (see Annexes 8 and 9); improve monitoring of HIV/TB services with the use of written reports and national benchmarking; further integration of TB care into PLHIV home-based care.
Develop and implement a strategy to attract men to HIV testing, ART, adherence and support	High	NAS	2019	Small re-allocation may be required for strategy development; service changes, such as extended opening hours of clinics to attract working men; opt-out HIV testing and counseling for men accessing health services for any reason (PITC); promotion of HIV testing to men, should be funded by MoHSW
Remove any current regulatory or programmatic barriers to access by adolescent girls and young women to HIV testing, ART, adherence and support	Med	NAS	2019	Ensure funding available for advocacy by NAS and ActionAid for policy and regulatory changes to MoHSW, Ministry of Finance, and National Assembly Select Committee on Health, Women, Children, Disaster, Humanitarian Relief and Refugees

Enhance quality monitoring, mentoring and peer support among HIV clinicians, nurses and social workers	Med	NAS	2019	Small re-allocation may be required to trial electronic and other methods to improve peer mentoring and support
Work with traditional healers to ensure they refer PLHIV to ART	Med	NAS	2019	Costs of working with traditional healers should be sought from MoHSW
Develop partnership between government services and NGOs to deliver full range of needed HIV services, including social contracting mechanism	Med	NAS, MoHSW, ActionAid, NGOs	2019 or 2020	Small re-allocation may be required for partnership development; some re-allocation may be needed for TA for development of social contracting mechanism and piloting of social contracting
Expand cross-border collaboration, particularly with the HIV programs in Senegal, including ART, PMTCT, and KP programming	Med	NAS, ActionAid, MoHSW	2019-2020	Small re-allocation may be required for cross-border discussions to harmonize systems where possible

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Dave Burrows and Keith Mienies. (December 2018) HIV Type 1: Gambia Evaluation Report. APMG Health, Washington, DC.

Annexes

Annex 1. Core Indicator Score Metrics

Component	Level Definitions			
	Very Poor	Poor	Moderate	Good
Strategic planning: Availability of National Strategic Plan	No disease-specific National Strategic Plan in place. Component score = 1	Recently outdated ⁷ disease-specific National Strategic Plan in place. Component score = 2	Current National Strategic Plan in place but does not include costed Action Plan. Component Score = 3	National Strategic Plan is current and includes costed Action Plan. Component Score = 4
Strategic investment: Appropriateness of goals and objectives for epidemic context	No analysis available ⁸ to determine appropriate goals and objectives for National Strategic Plan. Component score = 1	Analysis available to determine appropriate goals and objectives for National Strategic Plan, but investments only partially mirror recommendations. Component score = 2	Goals, objectives and investments in National Strategic Plan mirror recommendations from available analyses, but there are significant funding gaps in some areas. Component score = 3	Goals, objectives and investments of National Strategic Plan mirror recommendations from available analyses, and all elements are fully funded in line with epidemic burden. Component score = 4
Performance: Achievement of targets set in grant agreement ⁹	Most recent grant rating score of C. No evidence ¹⁰ of significant improvement.	Most recent grant rating score of B2, no evidence of significant improvement.	Most recent grant rating score of B1, no evidence of significant improvement.	Most recent grant rating score of A2 or A1, with no

⁷ End-date of National Strategic Plan is within the last calendar year.

⁸ Such as efficiency analysis, Optima, efficiency inputs to Investment Case, etc.

⁹ Refers to most recent grant agreement except when the grant was signed less than 12 months before evaluation: in these cases, this refers to previous grant agreement.

¹⁰ Evaluation teams will look for documentation of changes specifically related to previous grant rating shortcomings. This methodology applies to each level of this indicator.

	<p><i>OR</i> Most recent grant rating of B2, but evidence of significant regress.</p> <p>Component score = 1</p>	<p><i>OR</i> Most recent grant rating score a C, but evidence of significant improvement.</p> <p><i>OR</i> Most recent grant rating of B1, but evidence of significant regress.</p> <p>Component score = 2</p>	<p><i>OR</i> Most recent grant rating score a B2, but evidence of significant improvement.</p> <p><i>OR</i> Most recent grant rating score of A2 or A1, but evidence of significant regress.</p> <p>Component score = 3</p>	<p>evidence of significant regress.</p> <p>Component score = 4</p>
Resilient and sustainable systems for health (1): Stockouts of key commodities ¹¹	<p>Evidence¹² of stockouts in multiple provinces of at least one key commodity, more than once in a year.</p> <p>Component score = 1</p>	<p>Evidence of occasional (once per year) stockouts in more than 2 provinces of at least one key commodity.</p> <p>Component score = 2</p>	<p>Evidence of occasional (once per year) stockouts in 1-2 provinces of at least one key commodity.</p> <p>Component score = 3</p>	<p>No evidence of stockouts of key commodities.</p> <p>Component score = 4</p>
Resilient and sustainable systems for health (2): Recognition and realization of role of community response and systems in the national response	<p>The importance of community is not explicitly recognized in the National Strategic Plan.</p> <p>Component score = 1</p>	<p>The importance of community is recognized in the National Strategic Plan, but specific roles in service delivery are not specified.</p> <p>Component score = 2</p>	<p>Specific roles in service delivery by community sector are in the National Strategic Plan, but are mostly supported by donors</p> <p>Component score = 3</p>	<p>Specific roles in service delivery by community sector are in the National Strategic Plan, and are supported by domestic and external funding.</p> <p>Component score = 4</p>
Supportive and sustainable legal, policy and financial environments¹³: Identification	<p>No rights-related barriers assessment carried out and</p>	<p>Rights-related barriers assessment has been carried</p>	<p>Assessment carried out, activities identified to address</p>	<p>Assessment carried out, activities identified to address barriers, and</p>

¹¹ A list of key commodities will be developed for each disease program.

¹² Evidence may include procurement and supply management records, but may also include verbal reports by program beneficiaries. Where verbal reports are received, evaluation teams will work to triangulate reports through other data and/or sources in order to assign a score which best reflects reality.

¹³ Supportive environments may vary considerably by population. Once an indicator receives a score, rationale will be provided. In some cases, this indicator may be sub-divided and scored for different populations, and then an average score will be calculated for the indicator overall.

and address of rights, legal, and gender barriers to health outcomes for individuals and populations	no/minimal activities planned to address barriers. Component score = 1	out but no/minimal activities planned to address barriers. Component score = 2	barriers, but minimal funding available for these activities. Component Score = 3	substantial funding available for these activities. Component Score = 4
Composite across all six components	Composite score (average of component scores) less than 2.	Composite score (average of component scores) equal to or greater than 2 and less than 3.	Composite score (average of component scores) equal to or greater than 3 and less than 4	Composite score (average of component scores) equal to 4.

Component – HIV	Level Definitions			
	Very Poor	Poor	Moderate	Good
Key populations reached: % of 2 key populations with highest prevalence reached by defined packages of services	is less than 20%. Component score = 1	is equal to or greater than 20% and less than 50%. Component score = 2	is equal to or greater than 50% and less than 70%. Component Score = 3	is equal to or greater than 70%. Component Score = 4
PLHIV who know their status: % of estimated people living with HIV who know their positive status	is less than 40%. Component score = 1	is equal to or greater than 40% and less than 55%. Component score = 2	is equal to or greater than 55% and less than 70%. Component Score = 3	is equal to or greater than 70%. Component Score = 4
Linkage to treatment and care: Availability and types of linkage programs between diagnosis/ screening and treatment	Little evidence ¹⁴ of linkage to care or linkage from TB and antenatal programs. Component score = 1	Some evidence of linkage to care or linkage from TB and antenatal programs but with consistently-reported gaps related to multiple key populations or geographic areas. Component score = 2	Evidence of linkage to care or linkage from TB and antenatal programs, but with consistently-reported gaps related a single key population or geographic area. Component Score = 3	Evidence of linkage to care or linkage from TB and antenatal programs but with no consistently-reported gaps related to any key population or geographic area. Component Score = 4

¹⁴ There are no universal, agreed-upon measurements for tracking linkage to care. In the absence of reliable, HMIS-driven data on this indicator, evidence in this area is likely to arise from reports by health care workers or program beneficiaries, collected during key informant interviews or focus groups. Once evaluators feel that credible evidence has been obtained from these sources, they will work to triangulate this evidence with other sources, in order to select a score for this indicator which best reflects reality.

ART coverage: % of estimated people living with HIV currently on ART (adults and children)	is less than 30%. Component score = 1	is equal to or greater than 30% and less than 50%. Component score = 2	is equal to or greater than 50% and less than 70%. Component Score = 3	is equal to or greater than 70%. Component Score = 4
12-month ART retention: % of people who ever initiated ART and are still on ART at 12 months after ART initiation (adults and children)	is less than 60%. Component score = 1	is equal to or greater than 60% and less than 75%. Component score = 2	is equal to or greater than 75% and less than 85%. Component Score = 3	is equal to or greater than 85%. Component Score = 4
Viral suppression: % of people who are retained in ART for at least 6 months with viral load <1,000 copies/ml	is less than 20%. Component score = 1	is equal to or greater than 20% and less than 35%. Component score = 2	is equal to or greater than 35% and less than 50%. Component Score = 3	is equal to or greater than 50%. Component Score = 4
Composite across all six components	Composite score (average of component scores) less than 2	Composite score (average of component scores) equal to or greater than 2 and less than 3	Composite score (average of component scores) equal to or greater than 3 and less than 4	Composite score (average of component scores) equal to 4

Component	Component Scoring			Level Definitions			
				Very poor	Poor	Moderate	Good
HMIS deployment¹ (data availability)	Percentage of health facilities/reporting units that are expected to submit monthly/quarterly reports to the electronic HMIS is greater than or equal to 80%. Component score = 1	Percentage of health facilities/reporting units that are expected to submit monthly/quarterly reports to the electronic HMIS is less than 80%. Component score = 0	Composite Score = Sum of component scores	Composite score equal to 0 or 1	Composite score equal to 2	Composite score equal to 3	Composite score equal to 4

<p>Availability of disease reporting in the national HMIS² (data availability)</p>	<p>Aggregate data for all standard WHO disease (HTM) specific indicators or for all relevant GF PF disease indicators are available in the electronic national HMIS.</p> <p>Component score = 1</p>	<p>No aggregate data for disease (HTM) specific indicators are available in the national HMIS or aggregate data for a few disease specific indicators are available in the electronic national HMIS.</p> <p>Component Score = 0</p>					
<p>Completeness³ (data quality)</p>	<p>Percentage of expected reports from health facilities/reporting units that were actually received is equal to or greater than 80%.</p> <p>Component score = 1</p>	<p>Percentage of expected reports from health facilities/reporting units that were actually received is less than 80%.</p> <p>Component score = 0</p>					
<p>Timeliness⁴ (data quality)</p>	<p>Percentage of reports from health facilities/reporting units submitted to the electronic HMIS that are received on time is equal to or greater than 80%.</p>	<p>Percentage of reports from health facilities/reporting units submitted to the electronic HMIS that are received on time is less than 80%.</p> <p>Component score = 0</p>					

	Component score = 1						
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Component	Very Poor	Poor	Moderate	Good
		Minimal funding for key program priorities from domestic sources LMI: <20% UMI: <40%	Some funding for key program priorities from domestic sources LMI: 20-39% UMI: 40-59%	Fairly significant funding for key program priorities from domestic sources LMI: 40-60% UMI: 60-80%
Drugs for treatment	Component score = 1	Component score = 2	Component score = 3	Component score = 4
Diagnostic commodities	Component score = 1	Component score = 2	Component score = 3	Component score = 4
Adherence/social support	Component score = 1	Component score = 2	Component score = 3	Component score = 4
CSO-led service provision	Component score = 1	Component score = 2	Component score = 3	Component score = 4
Commodities for prevention	Component score = 1	Component score = 2	Component score = 3	Component score = 4
Surveillance/strategic information	Component score = 1	Component score = 2	Component score = 3	Component score = 4
Human resources for National Program management (excluding general health service staff delivering services)	Component score = 1	Component score = 2	Component score = 3	Component score = 4
Overall financing of program	Component score = 1	Component score = 2	Component score = 3	Component score = 4

Composite across all relevant (8) components	Composite score (average of component scores) less than 2.	Composite score (average of component scores) equal to or greater than 2 and less than 3.	Composite score (average of component scores) equal to or greater than 3 and less than 4	Composite score (average of component scores) equal to 4.
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Annex 2. Evaluation Schedule

Date	Activity	Place
22 Oct 2018	Introductory meeting with CCM HIV & TB discussions with MoHSW HIV & TB discussions with NAS	Banjul
23 Oct 2018	HIV & TB discussions with DPI HIV discussions with NACP HIV & TB discussions with EFSTH HIV & TB discussions with MRC	Banjul
24 Oct 2018	HIV discussions with ActionAID HIV & TB discussions with Unicef, UNFPA, WHO HIV discussions with Worldview HIV discussions with GFPA	Banjul
25 Oct 2018	HIV & TB discussions with WEC Health Center Focus group with PLHIV Society Focus group with PLHIV Societies (2)	Sibanor Sibanor Brikama
26 Oct 2018	HIV & TB discussions with Hands-On Care and observe ART Clinic Focus group with MSM Focus group with SW Focus group with PWID	Brikama Banjul Banjul Banjul
28 Oct 2018	Travel to Basse	
29 Oct 2018	HIV & TB discussions with Regional Health Directorate HIV discussions with Basse Regional Hospital, observe ART Clinic Focus group with PLHIV Society	Basse
30 Oct 2018	Travel from Basse	

	HIV discussions with Kanifing Hospital, observe ART Clinic	Kanifing
31 Oct 2018	HIV discussions with ActionAid HIV discussions with NAS HIV discussions with UNAIDS	Banjul
1 Nov 2018	Attend validation workshop of 2017 IBSS at ActionAid Debriefing presentation to CCM and stakeholders	Banjul
2 Nov 2018	Meetings related to report development	Banjul

Annex 3. List of Key Informant Interviews

Name	Institution
Ousman Badjie	NAS
Saikuna Sagnia	NAS
Lamin Badjie	NAS
Baba AF Jamneh	NAS
Ousman Camara	NAS
Sait M Kebbeh	NAS
Landing Jabang	NAS
Alpha Khan	NAS
Dr Saikou Sabally	HOC
Momodou A Bah	HOC
Lamin Ceesay	CADO (Catholic Development Office)
Yady Nget	CADO
Saikou S Ceesay	NLTP (National Leprosy and TB Control Program)
Adama Jallow	NLTP
Kebba .D. Sanneh	NLTP
Musa .B. Jallow	NLTP
Anne Able-Thomas	NLTP
Abdoulie M Njie	CCM Secretariat
Francois S Mendy	CCM/NSGA (Nova Scotia Gambia Association)
Mbara Saine	CCM/MOBSE (Ministry of Basic and Secondary Education)/BSEPD
Adama Jallow	WCOV
Ousman B Njie	CCM/CRS
Edna Sampson	CCM/BUCAHA (Business Coalition Against HIV/AIDS)
Adama Dubois	CCM Secretariat
Sirra Ndow	UNAIDS

Yahya Muhammed Bah	CCM/GARD (Gambia Association of Resident Doctors)
Yusufa Gomez	CCM/GAFNA (Gambia Food and Nutrition Association)
Sally Jatta	CCM/PHE
Ebrima Camara	Worldview
Ahmad Jaegan Loum	Worldview
Alhajie M Joof	Worldview
Fadel Hydera	Worldview
Jainaba Barry	Worldview
Marie Barry	Worldview
Fatoumatta Kujabi	Worldview
Isatou Trawally	Worldview
Dawda J Cham	Worldview
Dr Mamady Cham	MoHSW
Muhammadou .L. Jaiteh	MoHSW
Ebrima Danso	NYAAMA
Sukai Nyassi	CCM/BUCAHA
Almamo Barrow	ActionAid
Ndey Jarju	ActionAid
Burama Mendy	ActionAid
Sulayman Kinteh	ActionAid
Bai Cham	ActionAid
Fanta Jatta Sowe	ActionAid
Omar Badjie	ActionAid
Ngansa Touray	ActionAid
Mam Kumboa Touray	ActionAid
Isatou Cham	ActionAid
Mariama Janneh	UNICEF
Dr Shahid Awan	UNICEF
Alieu Jammeh	UNFPA

Alpha Jallow	WHO
Momodou Njie	GFP (Gambia Family Planning Association)
Ebrima Sarr	GAMNASS
Bakary Sanneh	NPHL (National Public Health Laboratories)
Ignatius Baldeh	NPHL
Pa Ousman Bah	NACP (National AIDS Control Program)
Sherrif Badjie	NACP
Mbinki Sanneh	NACP
Elizabeth Ninson	NACP
Haddy Jagne	NACP
Halimatou J Jesuorobo	NACP
Fatoumatta Jallow	DPI
Haddy Badjie	DPI
Hassan Njie	DPI
Yaya Banjo	DPI
Dr Jayne Sutherland	MRC (Medical Research Council)
Dr Sophie Gomez	ART Center Banjul
Momodou Trawalleh	ART Center Banjul
Jalimory Njie	ART Center Banjul
Dr Mariatou Jallow	ART Center Sibanor
Kulaymatu Badjie	ART Center Sibanor
Yero Bah	ART Center Sibanor
Philip Mendy	ART Center Sibanor
Nimama Suso	ART Center Sibanor
Landing Nyassi	ART Center Sibanor
Sainabou Drammeh	ART Center Sibanor
Famara Badjie	ART Center Sibanor
Abdoulie Jammeh	ART Center Basse
Ousman T Baldeh	ART Center Basse

Mariama Joof	ART Center Basse
Isatou Bah	ART Center Basse
Sulayman Keith	ART Center Basse
Amidou Nyassi	ART Center Basse
Sambang Ceesay	ART Center Basse
Kaddy Marong	ART Center Basse
Abou Kebbeh	ART Center Basse
Yafaye Badjan	ART Center Kanifing
Lamin Ceesay	Basse RHD (Regional Health Department)
Majula Kuyateh	Basse RHD
Babacan Ngum	Basse RHD
Sulayman Sanneh	Basse RHD
Sang Pierre	Basse RHD

Annex 4. Interview Guide for Key Informants

The below was used as an introduction to each interview. Beyond the introduction are the questions developed for each interview.

Key Informant Interview

Interview Guide and Capture Sheet

Country: _____ The Gambia _____ Component: H Evaluation Type: 1

This form completed by: _____

Other evaluation team members present: _____

Informant Interviewed: _____

Position/Affiliation: _____

Was this informant read an informed consent statement? Yes No

Date of Interview: _____ Start time: _____ End time: _____

Location: _____

Informed consent statement: Thank you for agreeing to meet with me. I am here collecting information for an evaluation currently being conducted with support from The Global Fund. The evaluation focuses on the country's response to HIV/TB/malaria.

The information gathered will be used by The Global Fund to inform further funding decisions and programming in this country. Do you consent to this interview?

Do you have any questions for me at this stage? Shall we begin?

Key Questions:

CCM	
1	In your opinion, what are the strengths and weaknesses of the current response?
2	Are there any indications of effects of activities to date on epidemic; are there any plans to assess impact?
3	What has been the difference between having an LFA and not having an LFA?
MOH	
1	What is the status of health systems review, and plan to implement recommendations; also, rollout of quality care assessments; primary health care (PHC) roadmap; pharmacovigilance and data quality audit: how do these involve HIV services? What effects are expected on HIV services?
2	How is the MoH ensuring that HIV and TB services are working together to maximize efficiency and effectiveness?

3	Linkage between HIV and MCH systems: Plans and progress to date to increase pregnant women with HIV on ART and early infant diagnosis?
4	If ART is provided to 90% of PLHIV in The Gambia, are there sufficient human resources in the health system to provide ART and regular clinical work and tests? If not, has any thought been given to task-shifting to CSOs?
5	Are there any plans to integrate Global Fund-funded service elements into sustainable public, community and private health systems? If so, what steps have been taken and what have been the effects of those steps? What efficiencies could be achieved by further integration?
6	What was/is the role of previous/ current grant in improving PSM issues related to HIV. What is the current situation with ART stockouts? Do you have data on ART stockouts for the past 5 years? Same for STI treatment medications and OI medications? Same question for HIV test consumables, male and female condoms, lubricants.
7	What plans are in place to improve PSM for these commodities?
NAS	
1	Are there any indications of effects of activities to date on epidemic; are there any plans to assess impact?
2	Is there a condom promotion/ marketing strategy? Please provide details including number of condoms provided free of charge by population.
3	HIV testing and treatment protocols: what is currently in use and what is planned? Are there any plans for differentiated models of testing and treatment, self-testing, expansion of testing by NGOs, provision of ART through NGOs, etc.?
4	How many people have ever tested HIV-positive? How many have died from AIDS? (Provides figure for 1st 90)
5	Please provide most recent testing results and coverage by sex, age and KP; what are barriers to testing?
6	Plans and progress to date to increase pregnant women with HIV on ART and early infant diagnosis
7	Enrolment to ART is fairly low: any idea why this is so and what can be done to improve the situation?
8	Loss to follow-up rates are fairly high: why do you think this is so and what can be done to improve the situation?
9	What is the current approach to quality assurance in HIV prevention, testing, treatment and care? What have been the activities carried out to date? What is planned for the next 2-3 years?
10	Full list of planned HIV/TB activities in previous and current grant; and activities implemented in past grant and to date in current grant
11	Have there been any changes to HIV testing/ ART among TB patients or TB testing/ treatment among PLHIV in past 5 years? What are the changes? What are their causes?

12	Are there any plans to integrate Global Fund-funded service elements into sustainable public, community and private health systems? If so, what steps have been taken and what have been the effects of those steps? What efficiencies could be achieved by further integration?
13	At beginning and end of previous grant, levels of domestic funding for ART and OI drugs; diagnostic commodities; adherence/ social support; CSO-led service provision; commodities for prevention; surveillance/strategic information; overall financing of HIV program. Current funding levels as percentage of total spending in each of these areas.
NACP	
1	Are there any indications of effects of activities to date on epidemic; are there any plans to assess impact?
2	Is there a condom promotion/ marketing strategy? Please provide details including number of condoms provided free of charge by population.
3	HIV testing and treatment protocols: what is currently in use and what is planned? Are there any plans for differentiated models of testing and treatment, self-testing, expansion of testing by NGOs, provision of ART through NGOs, etc.?
4	How many people have ever tested HIV-positive? How many have died from AIDS? (Provides figure for 1st 90)
5	Please provide most recent testing results and coverage by sex, age and KP; what are barriers to testing?
6	Plans and progress to date to increase pregnant women with HIV on ART and early infant diagnosis?
7	Enrolment to ART is fairly low: any idea why this is so and what can be done to improve the situation?
8	Loss to follow-up rates are fairly high: why do you think this is so and what can be done to improve the situation?
9	What is the current approach to quality assurance in HIV prevention, testing, treatment and care? What have been the activities carried out to date? What is planned for the next 2-3 years?
10	Full list of planned HIV/TB activities in previous and current grant; and activities implemented in past grant and to date in current grant
11	Have there been any changes to HIV testing/ ART among TB patients or TB testing/ treatment among PLHIV in past 5 years? What are the changes? What are their causes?
12	Are there any plans to integrate Global Fund-funded service elements into sustainable public, community and private health systems? If so, what steps have been taken and what have been the effects of those steps? What efficiencies could be achieved by further integration?
13	At beginning and end of previous grant, levels of domestic funding for ART and OI drugs; diagnostic commodities; adherence/ social support; CSO-led service provision; commodities for prevention; surveillance/strategic information; overall financing of HIV program. Current funding levels as percentage of total spending in each of these areas.
14	Please describe M&E system for current grant.
15	Please show us examples of forms, data captured, how data is aggregated and disaggregated, how data is used to drive service design and practice?

16	For KPs: Is a unique identification code used? What is it? Is it the same across implementers, regions, KP? Pls show examples of data from UIC (if used), including data reports, disaggregation.
17	Do you capture critical enablers in routine reporting?
18	What steps have been undertaken to ensure appropriate HIV reporting in the national HMIS?
UNAIDS	
1	Gambia has its own Catch-Up Plan as part of the WCA regional plan? Can we get a copy and what are the major steps and how will they be funded?
2	Are there any indications of effects of activities to date on epidemic; are there any plans to assess impact?
3	Has there been or is there planned to be any analysis to determine appropriate goals and objectives for current or future NSP? (Modes of Transmission study, Investment Case, etc.)
4	Plans and progress to date to increase pregnant women with HIV on ART and early infant diagnosis
5	What are barriers and options for overcoming barriers to KP access to services and increasing efficiencies: specific focus on role of peer educators, community networks, community-based organizations (CBOs)
6	Enrolment to ART is fairly low: any idea why this is so and what can be done to improve the situation? Loss to follow-up rates are fairly high: why do you think this is so and what can be done to improve the situation?

Annex 5. List of Focus Group Discussions

HIV focus group discussions were held as follows:

- PLHIV: 9 PLHIV at each of 4 HIV Support Societies: Brikama (2), Sibanor and Basse
- MSM: 9 community members, at the MSM Drop-In Centre in Banjul
- SW: 9 community members, at the Worldview office in Banjul
- PWID: 9 community members, at the Worldview office in Banjul

Annex 6. Interview Guide for Focus Groups

Key Questions for Focus Groups – PLHIV, SW, MSM, ex-TB Patient Association

- Could you tell me a bit about the support society/association, particularly how many members it has, what activities it implements, how it does its work?
- How are the activities mentioned being funded, implemented, and paid for?
- Without providing details from your personal life, can you describe the most significant challenges for your community of PLHIV?
- Are condoms and lubricant easily accessible for you? (probe for quality, quantities, timeliness)
- What other services help you to stay HIV-negative or help you if you are positive? Can you comment on the quality of these services?
- Are there any support services available to you? Can you comment on the quality of these services?
- Are members of your community discriminated against? In what ways? Has this situation improved or grown worse in the past 5 years?
- (For PLHIV, SW) Has the situation for women and girls improved during the past 5 years? In what ways has it become better/ worse?
- In your own lives, have you found that violence is increasing or decreasing in recent years? (Probe for: gender-based violence, violence from police and other authorities, community violence)
- (For PLHIV) Have you experienced any problems enrolling onto or continuing with ART? Have there been ART stockouts in this area? Are there more now or less than in previous years? What activities could improve linkage for MSM and SW to treatment and care (including role of PLHIV)?
- (For MSM and SW) what activities could improve linkage for your community to treatment and care?
- (For ex-TB Association) What is being done at a community level for TB patients?
- (For ex-TB Association) What does this association do for TB and ex-TB patients in the community?
- (For ex-TB Association) Do you have easy access to treatment where you live? Prompt rural/urban access issues, working with health facilities, VHN, community health nurse (CHN), etc.
- (For ex-TB Association) What about women? Do they have more issues than men?
- (For ex-TB Association) What are some of the most pressing challenges faced by people with TB? In the community, at the facility, in their families?

- (For ex-TB Association) How does the ex-TB patient association do community sensitization for TB? What is the effects of this and what are the challenges?
- (For ex-TB Association) What should be done to increase access to TB treatment?

Annex 7. Recommendations from Bawo (2018) on HMIS

- Revisit MoHSW and DPI organogram to make units positional suited for enhanced coordination and proper implementation of units' mandates
 - Locate Research, HIS and M&E within the same directorate with improved coordination
 - Make ICT an independent unit to enable it to carry out its full mandate
- Revise the terms of references of HIS, M&E, ICT and Research to ensure less overlap and more synergy
- Advocate for the inclusion and allocation of an MoHSW budget line for HSS activities specific to HIS, M&E, ICT and Research strengthening
- Organize stakeholders to conceptualize an HIS architecture that everyone would buy into and plan for development
- Promote, through action, the "One M&E" concept to ensure sustainable system strengthening
- Leverage resources available through external funding (GF, GAVI [Gavi, the Vaccine Alliance], UN, etc.) for integrated systems development and management
- Develop a comprehensive HSS plan for strengthening HIS, M&E, ICT and Research
- Develop an M&E and HIS capacity building plan for central, region and facility levels
- Establish an M&E/HIS team in each region comprising a full time M&E officer (head), data clerks and region registrars to coordinate all data collection and entry, quality checks and M&E functions. This team will report to and be supervised by the central M&E/HIS
- Update strategic documents (Policies, Plans, Guidelines, etc.) and develop sector documents that do not currently exist
- Empower the central MoHSW units to play leadership role and begin to lead coordination mechanisms
- Strengthen health sector coordination mechanisms
- With the involvement of stakeholders, revise data collection and reporting instruments at all levels and align a common data flow
- Update and streamline the DHIS 2 entry screen removing duplicate or unneeded data elements
- Integrate all sub-information systems under the management of the HMIS Unit
- Compile the comprehensive list of health sector indicators
- Train additional persons to serve as DHIS 2 system administrators
- Improve ICT infrastructure
- Consider other means of data back-up other than the use of external hard drives

Annex 8. Expanded recommendations related to ART adherence and PLHIV Support Societies

Primary drivers of loss to follow-up of ART patients appear to be:

- Time and costs of transport to access ART centers
- Stigma, leading to lack of disclosure to family members, leading to problems finding excuses to attend AIDS centers on a regular basis
- Lack of disclosure and/or personal beliefs leading to preferring traditional healers' treatments
- Difficulty in understanding the need for lifelong treatment when the patient is feeling well

Decisions were made in the development of the PC grant to reduce funds for refunding transport costs and providing nutrition packages for ART patients, as well as to remove most funds provided to PLHIV support societies for nutrition support, advocacy and community education, regular meetings of 30 members and counseling at ART centers. ART centers are minimally staffed by underpaid nurses (mostly) who receive small salary top-ups from GF. A single social worker in most ART centers is responsible for a wide range of tasks including tracking down those lost to follow-up.

Despite the cut in funding, PLHIV support societies have continued their work. Society members feel a strong bond with each other and with other PLHIV. In particular, in each society visited, the primary message that members share with other PLHIV is the importance of staying adherent to ART. These societies' members contain a large group of people who could potentially be a workforce to address issues related to adherence and loss to follow-up.

PLHIV societies should be sufficiently resourced to carry out the following tasks:

- Ensure that a PLHIV who is trained in counseling is available quickly to meet with anyone receiving a positive HIV confirmatory diagnosis
- Participate in treatment education for newly diagnosed PLHIV
- Lead the pre-ART counseling process and assist in streamlining this process to ensure that PLHIV living far from the AIDS center do not have to return twice to complete three pre-admission sessions
- Provide treatment education, life skills and peer psychosocial support – based on shared meals – on a daily basis at society premises
- Participate in home-based care visits to PLHIV who are too ill to attend AIDS centers
- Use mass media such as radio to encourage people to test for HIV by sharing their stories of HIV diagnosis and benefits of ART
- Deliver ART from AIDS centers to PLHIV who struggle to attend AIDS centers, and to District Health Centers that agree to provide ART
- Help PLHIV to disclose to their families when and where they believe it is safe to do so
- Encourage adherence support among all ART patients
- Screen patients met at the society premises or on outreach for TB. While screening is currently carried out as part of the pre-ART checklist, it is important that this screening is done regularly for PLHIV
- Seek to identify (confidentially) SW and MSM society members and ensure that these individuals are trained (potentially by Worldview) in working with HIV-positive MSM and SW
- Work (together with AIDS center staff) to persuade traditional healers to refer PLHIV to ART centers and to accept that herbal treatments may cause problems for people on ART

For such a system to work well, there needs to be an integration of the medical/nursing/social work tasks at the AIDS centers with the tasks noted above carried out by the PLHIV societies. This may require regular (at least weekly) meetings between AIDS center and PLHIV society/ies to provide updates on ART patients with transport or other problems, those who have missed appointments, those who require home-based care or delivery of ART, etc. In addition, ART supplies should be made available at least to those District Health Centers at the greatest distance from ART centers, together with a discrete sign that shows that ART is available there. Society members could help to keep these centers stocked with ART and could explain both the sign and the location of these centers to PLHIV in the local area.

In addition, AIDS centers should use the Follow-Up Boxes on trial at three centers. These allow staff to know immediately if a patient has missed an appointment. If the center's social worker does not have time and resources to follow up with the patient, the society should be asked to help. The MoHSW needs to ensure that laboratories are functioning at a high level of effectiveness and efficiency so that any tests carried out for PLHIV can be used in a timely way for clinical management of the patient. The Ministry, NAS, ActionAid and Worldview also need to ensure that all staff at AIDS centers is trained in working with KP. As increasing numbers of KP are tested and identified as HIV-positive, they will need to be enrolled to and assisted with adherence on ART. NAS and DPI should work to ensure that DHIS 2 captures the real situation of the number of people on ART (disaggregated by age and sex), numbers defaulting from and/or restarting the program (similarly disaggregated); and record any attempt to determine what has happened to those lost to follow-up. This may require an electronic patient registration system in which patients can be followed up as individuals to see how many stayed on ART from the beginning with no or few breaks; how many stopped and restarted; and how many were completely lost to follow-up.

Annex 9. Expanded recommendations related to Key Populations

For all KP

Conduct an assessment of human rights and gender-related barriers in The Gambia. In order to develop robust and comprehensive programs for KP, it is imperative to understand which legal, social and political barriers to HIV-related and TB-related services for KPs exist. A mapping of available human rights programs will aid prioritization for future investments and identify opportunities to strengthen for further collaboration. Specific issues to be explored include ways to amend the laws relating to sodomy and effeminate behavior by men, and the potential for introducing a health card similar to that used in Senegal for SW.

MoHSW should ensure that all trained staff in mobile clinics and wellness centers, as well as a group of KP peer educators are approved to carry out HIV tests. The trial of self-testing among MSM and SW should be brought forward to 2019. Also, regulations should be amended as needed to allow ART delivery to KP through mobile clinics and wellness centers.

Specifically for MSM

Enhance prevention and support services for MSM through virtual outreach, MSM network strengthening and increased knowledge on sexual orientation and gender identity (SOGI). This includes:

- Introduce virtual prevention for reducing HIV/STI risks among MSM, increasing knowledge and access of MSM to sexual and mental health services. This is particularly relevant as MSM in The Gambia face punitive legal and social environments and are less likely to seek and access appropriate healthcare services. MSM already use social networking, dating applications and closed WhatsApp groups (applications used by MSM in Greater Banjul area include Grindr, Blued, Hornet). Virtual prevention would contribute to creating awareness on sexual health, HIV, prevention and general information; where to access services that are more ‘friendly;’ thematic sessions on drugs, voluntary counselling and testing (VCT), SOGI should be developed by MSM for MSM and should be informative, service-related, interrogative and supportive. These prevention strategies should be linked to encouragement to HCT.
- Ensure MSM peer educators and drop-in center staff is adequately trained, including in techniques of virtual outreach, in HCT and in TB screening.
- Increase frequency of HIV prevention workshops at the drop-in-center from 3-monthly to monthly. The drop-in center is under-utilized with room and scope for expansion. Topics discussed in workshops should extend beyond the traditional HIV prevention messages, and include sessions on HIV testing, living positively with HIV, human rights and legal literacy, sexual orientation and gender identity and leadership development.
- Improve legal and psychosocial support to MSM. The lawyer and psychologist supported in the current grant is sub-optimal in providing psychosocial and legal support to survivors of human rights abuses, KPs in mental distress and emergency situations. The 2018 IBBS found that 100% of MSM showed signs of clinical depression, with 54% being severely depressed. Among SW, 84% showed signs of clinical depression and 28% were moderately to severely depressed.
- Build the capacity of the MSM community representative on the CCM is needed, including training on leadership, GF-related processes, how to engage on the CCM, and general management skills.
- While the mobile clinics and wellness centers will continue to be oriented mostly towards SW, ensure that the staff are well-trained in working with MSM and that MSM peer educators are supported to work with these facilities to attract MSM. Also ensure that mobile clinics attend sites where gatherings of MSM take place.
- Investigate the situation for TG women, using MSM peer educators, to determine whether future programming is needed for this population.

Specifically, for SW

Enhance prevention and support services for SW through the already-established mobile clinics, wellness centers and peer educator network. Ensure that prevention messages and commodities are accompanied by encouragement to HCT, and that peer educators and other staff are trained in TB screening. PMTCT and family planning services should be incorporated into HIV prevention activities for SW.

Specifically for PWID

A sufficient number of PWID has been discovered to warrant the establishment of a pilot needle syringe program in the Greater Banjul area. This can be quite small at the beginning, catering for perhaps 200 PWID. The pilot program should last for 12-18 months and should be used to provide HIV prevention and encouragement to HCT (including TB screening) for PWID, as well as to map the extent of regular and irregular drug injecting in The Gambia.