

**THE GAMBIA
HUMAN DEVELOPMENT REPORT
2003**

**Fighting HIV/AIDS, Tuberculosis
and Malaria in The Gambia:
A Call for Partnership and Action**



Published by the United Nations Development Programme
Banjul, The Gambia

April 2004

Cover photograph: bed net protection against mosquito bites and transmission of Malaria, UNICEF.

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Foreword

HIV/AIDS and Tuberculosis (TB) have overshadowed Malaria as the major killer in developing tropical countries. As a result, the fight against HIV/AIDS and TB has now taken centre stage, occupying the attention of the international community and the leadership of developing countries, particularly in Sub-Saharan Africa. At the end of 2002, the region was home to 29.4 million of the 42 million people living with HIV/AIDS (PLWHA) worldwide. In addition, 3.5 of the 5 million persons newly infected with HIV/AIDS were in the region.

In light of these grim statistics, governments have begun to recognise HIV/AIDS as the most pressing challenge facing the continent's development - how to win the confrontation with the deadliest disease known to date, a disease which does not discriminate between the affluent or poor, between educated or uneducated, or between man, woman or child. Realising that resources are a *sine qua non* for meeting the challenge, some African governments have made strong commitments to increase their social spending for education and health to at least 15% of total government expenditures. In the absence of a known cure or vaccine, the objective of the commitment is to minimise the spread and impact of the disease through prevention, control, treatment, and improvement and extension of the lives of those infected and affected.

Although HIV/AIDS and TB have overtaken Malaria as the leading causes of adult mortality in Africa, Malaria nevertheless continues to kill at least a million persons each year, and is the cause of death for a fifth of Africa's children. In The Gambia, Malaria kills about a 1,000 children annually and contributes to the high annual maternal mortality rate in the country. Thus, the threat posed by Malaria has not diminished despite major advances in the search for a vaccine to prevent the disease. Increasing on-going efforts to implement the "Roll Back Malaria" programme could raise awareness and increase knowledge among Gambians about the disease and the measures needed to reduce its incidence.

In light of the experience obtained from other countries in the region, the three diseases have the potential to impact severely on all aspects of development in The Gambia – with dire consequences for families, communities and the economy as a whole. Therefore, assessing the situation now to determine the potential impacts of these diseases is both imperative and timely. Failure to contain these diseases will seriously hamper the country's on-going and future efforts to achieve sustainable human development.

It is for this reason that the United Nations Development Programme (UNDP), in collaboration with key stakeholders in Gambian society, has chosen the fight against HIV/AIDS, TB and Malaria as the theme for the 2003 Human Development Report for The Gambia.

Like previous reports, the 2003 report aims to inject the human development concept into national policy dialogues – not only through human development indicators and policy recommendations, but also through a country-led process of consultation, data collection and report writing. Previously, the 1997 and 2000 Human Development Reports for The Gambia reached a wide range of readership, including government partners, NGOs and the wider public. The 1997 report assisted both government and the donor community in preparing documentation for the Round Table Conference for the Social Sectors held in July 1998. The conference underscored Government's overriding concern for poverty alleviation, which the 1997 report had articulated. The theme of the 2000 report was *Promoting Good Governance for Human Development and Poverty Reduction*. It contributed to the formulation and subsequent launching of the National Governance Policy and Programme.

The 2003 report reviews and assesses the potential risks posed by HIV/AIDS, TB and Malaria in realising the country's development objectives as identified in various national and sectoral policies, including Vision 2020 and the Poverty Reduction Strategy Paper. The purpose of this report is to identify priority areas for action for prevention, control and treatment of the diseases, by serving as a reference point for policy-makers, researchers, development practitioners and students of development economics.

CHAPTER 1 reviews the concept of human development, recalls internationally agreed goals and strategies for the achievement of sustainable human development, and examines the progress that Africa, in general, and The Gambia, in particular, are making towards reaching these development goals.

CHAPTER 2 begins with an overview of the global challenge posed by HIV/AIDS, TB and Malaria, highlighting how Sub-Saharan Africa bears the brunt of these diseases and the emerging gender ramifications that need to be addressed. This is followed by an assessment of the current status of the diseases in The Gambia, with the latest data and information on prevalence rates at the national and local levels, modes of transmission and risk factors. In particular, the chapter takes a “Janus look” at some of the socio-cultural beliefs and practices, which expose and dispose Gambians to the risks of HIV/AIDS, TB and Malaria. Since the three diseases do not respect international boundaries or nationality, the chapter also examines the movement of people in and out of The Gambia and the potential for the spread of the diseases throughout the country.

CHAPTER 3 reviews and assesses the linkages between HIV/AIDS, TB and Malaria, as well as their potential impacts on the key social sectors of the economy such as health, education and agriculture. In the absence of nationally reliable studies and data on impact, the analysis relies heavily on experience from countries in the region hardest hit by the diseases.

CHAPTER 4 discusses prevention, control and treatment of the diseases and explores the levels of leadership commitment, multi-sectoral policy development and resource mobilisation and partnerships that have emerged.

CHAPTER 5 highlights the major challenges posed by the three diseases and recommends priority areas for action. These areas include the need to end the “conspiracy of silence and denial” about the existence of HIV/AIDS, accelerated implementation of the ‘Directly Observable Therapy’ Strategy recommended by the World Health Organisation for the management of TB, improving the implementation rate of the Roll Back Malaria programme and investing in the health care system.

This report is the latest in a series of national development reports prepared by UNDP on issues of national concern. Previous reports have focused on the issues of human development in 1997 and governance in 2000. The current report aims to reflect the debates and discussions occurring throughout The Gambia, and does not profess to have all the “answers” for addressing these diseases. Rather, the objective of the report is, hopefully, to enhance and advance the debate about how these diseases can be addressed in the Gambian context over the coming months and years.

The report’s central message is that the most strategically important requirement in stemming the potential devastation of the diseases is the need for a much higher level of pro-active involvement on the part of all stakeholders. A wide range of stakeholders - not just Government - need to make a tangible commitment to implementing recommended priority areas for action. For this to happen, Government must play a pivotal role in forging innovative partnerships at both national and international levels, including civil society, private sector and the donor community, as the foundation for mobilising the resources necessary to avoid an erosion of the socio-economic gains already made by The Gambia and expand the frontiers of the nation’s sustainable human development efforts.

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The analysis and policy recommendations highlighted in this report are derived from extensive collaboration between independent consultants and numerous other contributors indicated in the acknowledgments, and do not necessarily reflect the official views of the United Nations Development Programme, its Executive Board or its Member States.

Acknowledgements

The preparation of this Report would not have been possible without the support and valuable contributions of a large number of individuals and organisations.

CONSULTANTS

A team of four national consultants prepared background papers on HIV/AIDS, TB and Malaria in The Gambia based on desk and field research: Joseph Koroma, Burang Goree-Ndiaye, Fatou Kinteh, and Nyakassi Sagnia. Lead consultant, Joseph Koroma, synthesised, edited and laid out the report for publication.

CONTRIBUTORS

Many organisations generously shared their data series and other research materials. These include the National AIDS Secretariat, Medical Research Council, United Nations Children's Fund, Food and Agriculture Organisation, World Health Organisation, National Agricultural Research Institute, Department of State for Health and Social Welfare, Department of State for Agriculture and Natural Resources, Department of State for Education, Central Statistics Department, National Women's Bureau, and Department of State for Local Government. The team of consultants also gratefully acknowledges policy papers received from the Country Offices of the United Nations Development Programme, United Nations Children's Fund and the United Nations Fund for Population.

THEMATIC GROUP ON ECONOMIC MANAGEMENT AND GOVERNANCE

The report has benefited greatly from the intellectual advice and guidance of members of the Thematic Group on Economic Management and Governance, including: Lamin Beyai, Charles Camara, Njie, Saihou Ceesay, Graham Chipande, Suwareh Darbo, Elizabeth Forbes, Momodou Jallow, Mamo Jawla, Lamin Kassama, Mariatu Kassim-Loum, Alhagie Kolley, Abdoulie Mam Alieu Ndow, Jainaba Nyang, Katie Paine, Muhammed Singhateh, Fanta Sisay, Sheriffo Sonko, Bintou Suso, Momodou Touray and Sonia Turay.

KEY PERSONS INTERVIEWED

The consultants interviewed a number of key stakeholders to refine and update information obtained during review. For the invaluable advice, information and materials they were good enough to make available, we are very grateful. We thank all of them for their help and support. Lack of space precludes naming everyone here, but we would like to recognise, in particular, the contributions of A. Akum, Baboucarr Bouy, Amadou Ceesay, Mamadi Cessay, Kemo Conteh Tumani Corrah, Emily Foon-Sarr, Kawusu Jatta, Malick Jeng, Awa Jow-Auber, Kejaw Saidy Khan, Alhagie Kolley, Eusebio Muloshi, Katie Paine, Ayo Palmer, Margaret Pinder, Saihou Sabally and Modou Touray.

UN COUNTRY TEAM

The report has received many helpful inputs from the entire UN system in The Gambia. We therefore wish to extend our most sincere thanks and appreciation to Representatives James Mwanzia (World Health Organisation), Maria Teresa Hevia (United Nations Children's Fund), Heimo Mikkola (Food and Agricultural Organisation), Alice Martin-Dahirou (World Food Programme) and Reuben Mboge (United Nations Fund for Population Activities).

UNDP TEAM

A dynamic team at the United Nations Development Programme's office in The Gambia has also made many useful contributions to the report. We are most grateful to both John O. Kakonge, the Resident Representative, and Israel Desalegne, his Deputy, for their leadership and active support of the national human development reporting process in The Gambia. The effective co-ordination of inputs from numerous individuals, departments and organisations would not have been possible without the management skills of Graham Chipande and other members in the Resident Representative's team: Baboucarr Sarr and Elizabeth Loum of UNDP's Operations Department, and Mariama Bojang provided administrative support. Suwareh Darbo also provided invaluable assistance. Finally, special thanks are due to Neil Boyer, UNDP's Economic Adviser, for co-ordinating final revisions to the text and David Bourn of the Environmental Research Group Oxford Limited for design and desk-top-publishing.

Acronyms and Abbreviations

ADF	African Development Forum
ART	Anti-Retroviral Therapy
BAFROW	Foundation for Research on Women's Health, Productivity and the Environment
BSS	Behavioural Sentinel Surveillance
CBO	Community-Based Organisation
CDR	Case Detection Rate
CFTC	Commonwealth Fund for Technical Corporation
CM	Cerebral Malaria
CNR	Case Notification Rate
CRD	Central River Division
CSP	Country Strategic Plan
CSW	Commercial Sex Worker
DFID	Department for International Development (U.K.)
DHT	Divisional Health Teams
DoSH&SW	Department of State for Health and Social Welfare
DOT	Directly Observable Therapy
ERP	Economic Recovery Programme
ESU	Epidemiology and Statistical Unit
FAO	Food and Agricultural Organisation
FAWE-GAM	Forum for African Women Educators/Gambia
GAMWORKS	Public Works and Capacity Building Programme
GBA	Greater Banjul Area
GCCI	Gambia Chamber of Commerce and Industry
GDF	Global Drug Facility
GDP	Gross Domestic Product
GEAP	Gambia Environmental Action Plan
GER	Gross Enrolment Ratio
GFATM	Global Fund for AIDS, TB and Malaria
GFPA	Gambia Family Planning Association
GMS	Gender Management System
GNP	Gross National Product
GOTG	Government of The Gambia
GRTS	Gambia Radio and Television Services
GTTI	Gambia Technical Training Institute
HARRP	HIV/AIDS Rapid Response Project
HBC	Home-based Care
HDI	Human Development Index
HDR	Human Development Report
HIPC	Highly Indebted Poor Countries
HPI	Human Poverty Index
IFAD	International Fund for Agricultural Development
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
ITN	Insecticide Treated Nets
LDCs	Least Development Countries
LGA	Local Government Area
LRD	Lower River Division

MCH	Maternal Child Health
MCP	Malaria Control Programme
MCT	Mother-to-Child Transmission
MDI	Management Development Institute
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MRC	Medical Research Council
NACP	National AIDS Control Programme
NAS	National AIDS Secretariat
NBD	North Bank Division
NEPAD	New Partnership for Africa's Development
NIBTP	National Insecticide Bed net Treatment Programme
NLTP	National Leprosy and Tuberculosis Control Programme
NMCP	National Malaria Control Programme
NSS	National Serological Survey
NYSS	National Youth Service Scheme
PBT	Pauci-Bacillare Tuberculosis
PDI	Participatory Development Initiative
PHC	Primary Health Care
PHPNP	Participatory Health Population and Nutrition Project
PLWHA	People Living With HIV/AIDS
POP/FLE	Population/Family Life Education
PRSP	Poverty Reduction Strategy Paper
PTA	Parent Teachers' Association
RBM	Roll Back Malaria
S/RH	Sexual and Reproductive Health
SCB	Standard Chartered Bank
SDF	Social Development Fund
SHD	Sustainable Human Development
SIF	Social Investment Fund
SIP	Sex workers Intervention Project
SMA	Severe Malarial Anaemia
SPA	Strategy for Poverty Alleviation
STD	Sexually Transmissible Disease
STI	Sexually Transmissible Infections
SWAAGAM	Society for Women and AIDS in Africa/Gambia
TAYAM	The Association of Youth Against Malaria
TB	Tuberculosis
TSMA	Total Severe Malaria Anaemia
UNDAF	United Nations Development Assistance Framework
URD	Upper River Division
VCT	Voluntary Counselling and Testing
VISACA	Village Savings and Credit Association
WFP	World Food Programme
WHO/AFRO	World Health Organisation/Africa Regional Office
WID	Women in Development
WTO	World Trade Organisation

CHAPTER 1: State of Human Development

Global Perspective

As noted in previous Human Development Reports (HDRs), the concept of human development has been deliberated upon throughout the development community since UNDP's first HDR was published in 1990. Behind the heated discussions among development practitioners about definitions and the quantitative indicators used, the fundamental concept of human development remains steadfast. Human development is ultimately about "expanding people's choices." All countries – developed or developing – face the task of helping to ensure that their citizens – of all ages and both sexes – have a range of options and choices available to enable individuals to improve their lives and achieve economic, social and cultural fulfilment for themselves and their families. This challenge applies no less to Japan, the United Kingdom, Norway, or Canada, as it does to The Gambia.

Since 1990, the United Nations has sponsored a series of world summits and global conferences with a view to laying out a comprehensive development agenda – including quantitative goals, time-bound targets and numerical indicators. The consensus is that goals and targets mobilise national and international partners into action and help forge new alliances for development.

The World Summit for Social Development (WSSD), held in Copenhagen in 1995, was perhaps the most historic because nearly 180 countries endorsed specific policies and programmes to "eradicate poverty as an ethical, social, political and imperative of humankind". The Social Summit pledged to formulate or strengthen national policies and strategies geared towards accelerating the economic, social and human resource development of Africa and the Least Developed Countries (LDCs). This task was to be accomplished through promoting the development of democratic institutions and addressing issues, such as external debt, economic reform, food security and diversification of exports.

Millennium Development Goals

In a second historic international summit in September 2000, 147 Heads of State and Government – and 191 nations in total – adopted the Millennium Declaration, which outlined peace, security and development concerns, especially in the areas of environment, human rights and governance. The Declaration also stressed the special needs of Africa and mainstreamed a set of inter-connected and mutually reinforcing Millennium Development Goals (MDGs):

- **Eradicate Extreme Poverty and Hunger**
Target for 2015: Halve the proportion of people living on less than a dollar a day and those who suffer from hunger.
- **Achieve Universal Primary Education**
Target for 2015: Ensure that all boys and girls complete primary school.
- **Promote Gender Equality and Empower Women**
Targets for 2005 and 2015: Eliminate gender disparities in primary and secondary education preferably by 2005 and at all levels by 2015.
- **Reduce Child Mortality**
Target for 2015: Reduce by two thirds the mortality rate among children under five.
- **Improve Maternal Health**
Target for 2015: Reduce by three quarters the ratio of women dying in childbirth.
- **Combat HIV/AIDS, Malaria and Other Diseases**
Target for 2015: Halt and begin to reverse the spread of HIV/AIDS and the incidence of Malaria and other major diseases.
- **Ensure Environmental Sustainability**
Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources.
By 2015, reduce by half the proportion of people without access to safe drinking water.
By 2020, achieve significant improvement in the lives of at least 100 million slum dwellers.
- **Develop a Global Partnership for Development.**

The challenge of the MDGs for Africa, however, is that rather than making steady progress towards meeting these goals and targets, most indicators seem to be heading downwards. Under current trends, Africa, as a developing region, is not expected to achieve the targets set for poverty reduction and human development.

According to the 2002 Human Development Index (HDI), Africa has the lowest level of human development and the greatest need for rapid progress. Ironically, Africa is the only region where all indicators show signs of deterioration using the aggregate HDI based on education, health and income. The only region that comes close to facing such a predicament is south Asia. Aside from Gross Domestic Product (GDP) per capita and adult literacy, where Africa is slightly better than south Asia, Africa is at the bottom of all other indices. Aggregate school enrolment is falling in Africa (less than 50%), dropout rates are increasing

and the overall quality of education is falling. Life expectancy is lowest in the region, and the other health indicators – infant mortality rate, maternal morbidity and mortality rates – are among the worst in the world.

It is against this background that Africa's increasing disease burden, brought about by the spread of HIV/AIDS, TB and Malaria, holds the grim potential for further decline in the continent's human development indicators. A concerted effort is, therefore, imperative to reduce the tragic consequences of these diseases, not simply because of their terrible toll on individuals, but also their immediate and long-term impact on African societies as a whole.

Human Development in The Gambia

At the time of the last census in 1993, the total population of The Gambia was 1,038,145. Estimated to have increased to some 1.4 million in 2000, the population has grown at 4.2% per annum, with natural growth and

immigration rates of 2.7% and 1.5%, respectively. The 2000 Demographic Profile projects the population to reach 1.7 million by 2005. If this exceptionally high rate of increase continues, the economic and social implications will be dire, and the impact on the demand for health and other social services will be a critical factor in the country's development process.

Demographically, the high growth rate is attributable principally to the high fertility rate estimated at 6.0 live births per woman, rather than a significant decline in mortality. As a result, Gambian society has a very youthful population structure, with nearly 45% of the population below 15 years and another 19% between the ages of 15 and 24. The 1993 National Population and Housing Census revealed that there were 519,950 (50.1%) males compared to 518,195 (49.9%) females. Average life expectancy at birth is 59.3 years overall, 60 and 58.3 years for females and males, respectively. Some 60% of the population live in rural areas.

Table 1: Gambian Human Development Indicators at a Glance: 2002

Indicator	The Gambia	Sub-Saharan Africa
Human Development Index (HDI)	0.405 (2000)	0.471 (2000)
HDI Rank	160 (of 173 countries)	n/a
Human Poverty Index (rank)	84 (of 88 countries)	n/a
Human Poverty Index (value %)	48.5	n/a
Gender Development Index (GDI)	136 (of 146 countries)	n/a
GNP Per Capita (US\$ PPP)	1,649	1,690
Life Expectancy at Birth	46.2	48.7
Infant Mortality Rate	92	107
Under-Five Mortality Rate	128	174
Adult Literacy Rate	36.6	61.5
Female Literacy Rate	29.4	53.6
Primary School Net Enrolment Ratio	61 (1998)	n/a
Secondary School Net Enrolment Ratio	23 (1998)	n/a
Combined Gross Primary, Secondary and Tertiary Enrolment Rate (%)	45	42

The changing demographic character of the country implies that the overall demand for essential services could increase among all age groups. More specifically, the expected increase in demand for health services by the young will mean that the country's health care delivery system must be prepared to treat an increasing number of patients infected and affected by the spread of HIV/ADS, TB and Malaria. Unless the Government is able to make significant investments in and provide preventive and primary health care services for the populations at-risk of these conditions, the may be an increase in diseases, disabilities and early deaths. This in turn will have significant financial implications for Government and individuals in terms of inpatient and outpatient care, productivity and income loss. As a result, Government's past and on-going efforts at achieving sustainable human development in The Gambia through improvements in macro-economic performance, infrastructure development, and institutional and social development will be adversely affected.

Macro-economic Performance

From independence in 1965 to the late 1970s, the Gambian economy registered an average growth rate of 4.1% per annum, although this was heavily dependent on a single crop, groundnuts, as its main export. By 1983, the economy had deteriorated considerably due to the fall-out from a number of factors, including: the 1973 oil crisis; declining terms of trade brought about by the global recession; and the debt crisis. The main contributory factors from the domestic front were: an over-extended public sector; expansionary fiscal and monetary policies; and drought for the first time. GDP registered negative growth of 0.1%, while the debt service, as a percentage of GDP, was well over 200% and inflation rose to 20%. The country, thus, faced its worst economic crisis and was unable to import adequate quantities of various basic essentials, including rice, fuel and fertiliser.

The adoption of the Economic Recovery Programme (ERP) in 1985 reversed the decline. The programme stabilised the economy by correcting the balance of payments difficulties, and laying the foundations for sustainable economic growth. By the end of the adjustment period in 1990, the economy had achieved a growth rate of 5%: inflation had been brought down to 5%; and the budget deficit, as a percentage of GDP, was reduced from 17% to 4%.

Success on the macroeconomic front still left The Gambia ranking low in terms of social indicators. The overall standard of living remained low at US\$302 per capita income; life expectancy stood at 47 years; infant and maternal mortality rates were high at 137/1000 and 1,050/100,000 live births, respectively; while 40% of the population were below the Food Poverty Line (FPL) and illiteracy remained high at 75%.

The year 1994 marked a period of political and economic transition with the coming to power of the Armed Forces Provisional Ruling Council. The military takeover was accompanied by a series of adverse shocks, including: an expansionary fiscal regime; increasing structural weaknesses; and a marked decline in private sector confidence. These shocks were exacerbated by the suspension of new project aid and cancellation of budgetary assistance by the country's traditional donors. Real GDP fell by 3.5% in 1994/95 and, regardless of the modest economic recovery in 1995/96, growth remained slow (amidst a tight monetary regime designed to contain inflation and preserve exchange rate stability). From 1994 to 1997, external assistance declined sharply, affecting all sectors except social development. The trade in domestic and internal goods and services was also severely affected. By 1996, a reversal of the trend was discernible following the restoration of constitutional rule.

The agriculture and natural resources sector has been one of the prime areas of investment aimed at raising incomes, improving food security and reducing poverty over the past decade. The Strategy for National Agricultural Development Horizon 2010 (developed with FAO assistance following the World Food Summit and still being implemented) was a major contributor to the improvement in overall economic performance. During the latter part of the decade, the growth rate of nominal GDP averaged 5% per annum. During the same period, crop production in value terms grew by 5.4% per annum. Coarse grains production increased at an annual rate of 4.5%, the livestock sub-sector grew at 3.3% per annum, while artisanal fisheries production increased from 9.9 to 20.8 thousand tons.

Improving the abilities of the financial sector to enhance domestic resource mobilisation has also been a priority for the Government. Presently, there are six commercial banks and seven insurance companies operating in the country. Although a few banks have begun to establish branches in rural areas, the general situation is characterised by a concentration of banks in the capital city and its peri-urban areas (to the disadvantage of the rural

areas). However, with support from the donor community, Government plans to create an enabling environment for a range of viable micro-finance intermediaries to complement existing Village Savings and Credit Schemes (VISACAs).

Value-added from the service sector to the overall national income rose from 67.9% in 1990/91 to 70.6% in 1998, and accounted for the bulk of GDP. Real GDP, at constant prices, increased by 4.64% in 1999, compared to 3.5% in 1998 and more than the Poverty Reduction and Growth Facility (PRGF) target of 4.2%.

Infrastructure Development

The country's physical assets include a road network, modern capital equipment in energy generation, transport, communication and agricultural production, as well as key institutions in the financial sector.

In the transport sector, the total road network in 1998 was 2,859km long, comprising 495km tarmac, 1,064km gravel and 1,300km earth roads. Farm access roads, which are mainly path and causeways linking farms to homesteads, are also part of the network. Based on general international standards, only 21% of the road network is classified as good, with 33% regarded as fair and 46% as critical. A National Transport Policy and implementation plan for the period 1998-2006 serves as the basis for development of the transport system. This strategy seeks to involve the private sector in road construction and rehabilitation. New construction through donor financing is in progress for the establishment of a coastal road network and a main road along the North Bank of the River Gambia, while a number of feeder roads, access roads and bridges to farms have been constructed over the past decade, with support from the European Union (EU) and NGOs.

In air transport, Banjul International Airport has steadily evolved from a fuelling stop for trans-Atlantic and Europe-bound flights to one catering for a significant volume of traffic. Recent data indicates the level of traffic at 275,000 passengers per annum. The National Air Transport Policy 1998-2006 has the long-term objective of developing the airport as the main gateway to the West African Region and as the transport hub of the region.

The seaport of Banjul has developed into a key gateway for the movement of bulk freight to and from Europe and other international locations. This linkage between the global and domestic economy enhances the potential for reducing the overall cost of living of The Gambian population by minimizing the landed costs of imports and securing the competitiveness of exports. Government developed a Port Master Plan in 1991 aimed at modernising and expanding port capacity and realising the long-term vision of developing the country into a regional entrepôt.

In the area of electrical power supply, generating capacity has increased in the Greater Banjul Area (GBA) from 16 to 22 megawatts. During the same period, elec-

trical production increased from 66.26kWh to 126.64kWh, although poor transmission and distribution systems and the high cost of fuel result in frequent load-shedding and power cuts. Nevertheless, the strategic objective of the sector remains that of establishing partnership arrangements with multinational energy companies.

The supply of pipe-borne water to the GBA and most provincial towns for domestic, industrial and agricultural purposes increased from 5.353 million cubic metres in 1991/92 to 13.564 million cubic metres in 1998. The water supply system has, thus, improved to a fairly reliable 24-hour service for domestic and industrial purposes, particularly in the GBA.

Institutional and Social Development

Social development indicators reveal significant progress in access to education and health care, potential for improved gender relations, and a framework for facilitating access to low cost housing in the urban areas. However, a number of challenges need to be addressed to ensure further progress towards sustainable development.

Health

The 1994 National Health Policy (NHP) outlined multi-disciplinary and inter-sectoral approaches to the solution of health problems in the country, which have the potential to improve the reliability of basic health services for the vast majority of the Gambian population.

The Health Sector Plan of Action 1999 – 2003 sought to implement the objectives of the health policy. This was to be done through the extension of the health services coverage to the entire Gambian population through the equitable distribution of the country's limited health resources. The Plan also envisaged the decentralisation of health services management, improvement of the existing cost recovery system and reducing the incidence of the main diseases (including HIV/AIDS, TB and Malaria).

The National Health Policy 1994 did not set target ratios for the supply of health workers. Out of the 260 doctors nationwide, only 23 (9%) are Gambians.

Key health indicators, such as Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR), reveal a declining trend in morbidity and mortality. Rapid population growth, however, has hindered Government's efforts to increase per capita health expenditure. The main reasons for this include inadequate financial and logistic support, insufficient trained staff and a dependence on foreign doctors. Contributing factors include high attrition rates and an inadequate referral system.

Although there has been significant progress in reducing vaccine preventable diseases, communicable diseases like Malaria, diarrhoea, acute respiratory infections and TB continue to account for high morbidity and mortality rates.

According to a recent Public Expenditure Review (PER) of the Department of Health and Social Welfare, the ratio of doctors to population is 1/5,679 persons. The ratio for nurses to the general population is 1/1,964, while for public health officers it is 1/24,206 and technicians 1/25,026 persons. The ratios for doctors, nurses and public health officers per population vary significantly between health divisions. Demand for health personnel is greatest in the Upper River Division (URD), followed by Western and North Bank Divisions (NBD). Demand for technicians is highest in the NBD, followed by the URD and Central River Divisions (CRD).

The National Health Policy 1994 did not set target ratios for the supply of health workers. One area of growing concern, therefore, is the number of medical personnel in terms of nationality. Out of the 260 doctors nationwide, only 23 (9%) are Gambians (DoSH&SW, 2001). The Government aims to enhance local capacity by establishing a medical school at the University of The Gambia and in support of this initiative, the Royal Victoria Hospital has been upgraded into a teaching hospital.

The distance travelled (or time taken) to reach the nearest health facility is a measure of physical access to health services. The National Health Policy recommends that all persons should be within a maximum of 5km (estimated as one-hour walking distance) from the nearest health facility. Only three divisions – Lower River Division (LRD), URD and Banjul – satisfy this criterion. The majority of Gambians do not have easy access to health services. Health services are least accessible in Western Division (WD), where the average travelling time to a health facility by foot is 97 minutes.

Education

The development of the country's human resource through meaningful education is a key element found in Vision 2020, the country's development blueprint. Public expenditure in the sector has increased by an average yearly rate of 9% since 1994, with over 50% of resources invested in basic education. The result is that Government has built more schools to provide increased access to all children. It has also revised the education structure and cycle to make it possible for every Gambian child of school age to have nine years of basic education.

Government recognises the importance of education as a tool for national development and gives the sector top priority.

A Revised Education Policy covering the period 1998-2005 guides the present educational programme. The new policy focuses primarily on promoting a broad-based education that will enable the development of the full potential of the learner and enhance national development. It espouses the acquisition of literacy, numeracy and life skills for self-reliance. Under the new policy, the education system has been restructured from a 6 – 3 – 3 – 4 system to a 9 – 3 – 4 model. The capacity

of education personnel is being enhanced through additional training and professional development, whilst improvements in the management of the sector are being made through streamlining and decentralisation.

In 1998, Government reorganised the Department of State for Education to enhance efficiency, and created and resourced directorates for specific areas. In addition, the system was decentralised with management and authority delegated to regional offices. Thus, Government has not only recognised the importance of education as a tool for national development, but since 1994 has also placed the sector at the top of the country's development agenda.

These developments have resulted in significant progress in the education sector. The Gross Enrolment Rate (GER) in the basic cycle (grades 1-9) increased and exceeded the Jomtien target of 65%, set to be achieved by 1996/7. This success led Government to set a new target of 90% enrolment by 2005. For the period 1994/5 to 1999/2000, school enrolment in grades 1-9 steadily increased from 134,469 to 209,969. During this period 45% girls attended school, compared with 64% of boys. In 2001/2, there was an improvement in the gender balance, with a large rise in the number of girls (63%) and a smaller rise in the number of boys (70%). Regions 1 and 2, which cover the Greater Banjul Area and Western Division, respectively, have the highest enrolments, with Region 1 in the lead. The population is concentrated and demand for education is greatest in these two regions. However, the high enrolment figures mask significant regional disparities in access to education based on gender.

Using Arabic as a medium of instruction, Koranic schools are becoming increasingly important in the educational landscape of the country. Because The Gambia is a predominantly Muslim country, Government has recognised these schools as parallel educational facilities and is considering the possibility of integrating them into the mainstream educational system, so that English becomes the medium for teaching. Adoption of such a policy would enable these students to acquire skills and competencies comparable to those who go through the Western style education system. This would improve employment opportunities for Koranic school students. In 2001/2 there were 164 Madrassas at the lower basic school level, with 31,377 students. At the upper basic level, the enrolment stood at 22,367.

For far too long, girls have received short shrift in the educational system. This can be attributed to negative parental attitudes towards the education of girls, forced early marriage, teenage pregnancy, poverty, harmful traditional beliefs, and the low level of awareness of many parents of the benefits of education (both to the individual and the nation). The growth in the number of female students in the education system is due to the introduction of free education for girls at the basic cycle level. It is also due to the various awareness-creation campaigns that Government has undertaken to promote girls' education; e.g. the "Big Bang Education Cam-

paign" mounted in August 2002 in the LRD, CRD, and URD to encourage parents to send their daughters to school. The high point of the drive to boost girls' education came on October 2002 when the Head of State launched the President's Empowerment of Girls Education Project (PEGEP), which provides sponsorship for girls in schools, both public and private, from grades 1 to 12.

The major challenge facing Government in the education sector is to continue to improve the quality and relevance of education for all Gambians. The magnitude of the task ahead is reflected in insufficient teachers and schools to enrol all children of school age; inadequate supply of learning materials to schools; high cost of education; and increasing poverty. The poor learning environment at home for most students also has an adverse effect on student learning and scholastic achievement. Incentives for teachers, especially those working in rural areas, are inadequate or unattractive resulting in low motivation and low productivity. The lack of teaching and learning materials and the low standard/quality of teachers, especially at the primary level, compound the problem. In some institutions, where the double-shift system is practised, teachers are overloaded and classes are too large.

To achieve the goals outlined in the new education policy, Government needs to make basic education free and compulsory for children aged 7 to 15, and provide more incentives to attract and retain qualified and experienced Gambians into the teaching profession. Those who are academically inclined and motivated to pursue education at higher levels need secondary schools that are more advanced. The school system, thus, needs further expansion without sacrificing the quality, relevance and functionality of the curriculum and with minimal inequalities in access (in terms of gender and regions). Implementation of the Education Master Plan is expected to address these concerns.

Food Security

There has been substantial progress towards global food security, especially as indicated by declining levels of malnutrition (protein-energy malnutrition and micronutrient deficiency). This progress, however, has been uneven within and among countries and regions, leaving an unacceptably large number of developing countries with food insecure and undernourished populations. Food insecurity and undernourishment reduce the body's ability to withstand infection and, thus, increase the risk of contracting diseases, such as HIV/AIDS, TB and Malaria.

Food security requires that basic food commodities are available and affordable. Improving food security, therefore, implies improving the access, means of production or the opportunity to earn adequate regular income to purchase the food needed from accessible markets and at affordable prices (FAO, 1996). Increased availability of food is expected to reduce protein-energy malnutrition, especially among the more vulnerable components of the population (such as children under

five years of age (U5) and pregnant/lactating women). In the Gambia, although there has been a substantial reduction in the percentage of U5 children identified as stunted (with the proportion falling from 16.8% in 1998 to 9% in 2000), the percentage of U5 children classified as wasted increased by 47% (from 6.8% to 10.%) during the same period. With regards to micro-nutrient deficiency, a recent study conducted among pregnant and lactating women found that 73% of those surveyed were moderately anaemic, while 5% were severely anaemic (DoSH&SW, 2001).

Government policy before 1985 emphasised improving nutritional standards in rural areas, limiting bulk cereal imports, increasing cash crop production, and diversifying the agricultural base. The intent of this policy was to reduce the vulnerability of the economy to both internal and external forces. Under the 1985 ERP, Government's strategy for the agricultural sector encouraged increased efficiency in groundnut production, diversification into other cash crops, and expansion of the area planted with food crops. Implementation of the strategy relied on price incentives for the agricultural sector and the elimination of pricing distortions and subsidies (in input and output markets). The strategy also envisioned an expansion of the role of the private sector in output marketing and input supply, and provision of credit for input on market terms. In short, the Government sought to establish a framework within which farmers' choice of crops and purchases of inputs would reflect economic returns and costs.

Water, Sanitation and the Environment

Eighty-four percent of the population have access to safe drinking water (95% in urban and 77% in rural areas). Forty percent of the population obtain drinking water from public taps; 24% from wells (15% from unprotected dug wells and 9% protected dug wells); 19% from tube well/boreholes fitted with pumps; and 17% from piped water sources (10% piped into yard, and 7% piped into dwelling) (GOTG/UNICEF, 2000).

Various factors have contributed to improved access to safe drinking water in The Gambia, including: updating of the Water Act; development of an appropriate operational policy, focusing on the reduction of urban/rural disparities and the privatisation of water services; and donor support for these initiatives.

Persistent drought, low national budgetary allocations and weak co-ordination impede progress in the water and sanitation sub-sector.

Drinking water quality is variable and subject to contamination of rural wells, salt-water intrusion and high iron content. The use of fertilisers and pit latrines in close proximity to wells also affects water quality. Inadequate disposal of human excreta and poor personal hygiene is associated with a range of diseases, including diarrhoea and polio in children below 5 years of age. An estimated 96% of the urban and 83% of the rural population live in households with sanitary means of excreta disposal.

The establishment at both national and divisional levels of water and sanitation sub-committees (with particular emphasis on the participation of women), has enhanced development of the sub-sector. Constraints remain, however, including persistent drought and low budgetary allocations to the sub-sector. With regard to sanitation, there are many conflicting priorities and weak co-ordination among the public, NGO and private sector health delivery actors (UNICEF, 2000).

The alarming rate of environmental degradation caused by the growing imbalance between population and the country's natural resource-base is a threat to the quality of life for a large majority of the Gambian population.

Creating awareness and understanding about the causes, modes of transmission and means of preventing such diseases as Malaria and TB, which are linked to environmental conditions, is of paramount importance. Environmental sanitation, hitherto a largely neglected subject, has become a priority concern for Government with the introduction of a Pilot Rural Environmental Sanitation Project in 18 Primary Health Care villages. The project has succeeded in generating interest and demand among rural communities, and latrines are increasingly seen to be essential for good health and hygiene. A Primary Environmental Care Strategy has also been launched in communities in North Bank Division, using eight schools as entry points, to strengthen existing projects in those schools and to increase environmental awareness and knowledge among children.

The Second Gambia Environmental Action Plan (GEAP-2), formulated in February 2000, is intended to consolidate the achievements of GEAP-1, with further integration of environmental impact assessment procedures in the management of the natural resources and industrial sectors. Programme areas include improvement of institutional capacity; public awareness creation/ advocacy; and strengthening public and private sector capacity in environmental and natural resource management. The estimated US\$6.5 million required to implement the plan, however, have yet to be mobilised (GOTG/UNDP 2001).

Many Gambians are now more aware of the need for sustainable management of the environment, thanks in large part to the efforts of Government, but poor farming practices and unsustainable use of natural resources continue. The alarming rate of environmental degradation caused by the growing imbalance between population and the country's natural resource-base is a threat to the quality of life for a large majority of the Gambian population, especially children and women.

Governance

Governance is the institutional capability of public organisations to provide the public goods and services demanded by a country's citizens, or their representatives, in an effective, transparent, impartial and accountable manner, subject to resource constraints (World Bank, 2000). In recent years, governance has become an

important issue in Africa. Sound governance is perceived as indispensable to development, effective economic management, peace, stability and security. Much of the concern and drive for sound governance today was born out of widespread frustration with the poor economic performance and misplaced priorities of African countries in the '90s, and many Africans viewed their governments as unrepresentative of their interests.

Good governance requires a clear definition of the mission of the state, as well as its relations with the individual, the private sector and civil society.

Good governance requires a clear definition of the mission of the state, as well as its relations with the individual, the private sector and civil society (African Futures, 2000). The New Partnership for Africa's Development (NEPAD) and its integral peer review process clearly demonstrate the collective will of African states to institutionalise democracy and good governance.

National Governance Policy & Programme: 1999–2004

In 1993, Government, with the support of the World Bank, took action to integrate governance strategies into national development planning. The challenges encountered in implementing development policies underscored the need to address the issues of public resource management constraints and administrative reforms. An assessment of the governance environment, which focused on key governance elements, such as accountability, the rule of law and transparency, revealed that most public institutions, either directly or indirectly concerned with governance, lacked adequate capacity to perform efficiently in this area. In addition, certain laws and policies carried over from the colonial era and the First Republic needed to be completely changed or up-dated. In 1994, therefore, Government with support from the UNDP articulated a long-term development vision and governance framework to guide policy-makers.

The objectives of the 1994–2004 National Governance Policy and Programme included: consolidation and reinforcement of constitutional democracy; strengthening capacity for elections; improving the efficiency, transparency and accountability in the discharge of government functions; and the administration and dispensation of justice.

Progress in establishing the enabling legislation and infrastructure for good governance has been significant. The High Court and the Department of State for Justice are currently undergoing a decentralisation process, and plans are under-way to establish Judicial Divisions of the country (the objective being to make justice more accessible to people living in the provinces). The Cadi Courts and District Tribunals have been expanded and there are plans to establish a Faculty of Law at the University of The Gambia. In addition, an autonomous and business-oriented Companies Registry and the Office of the Curator of Intestate Estates have been restructured, while several legal notices amending the legal code of The Gambia have been collated into a compact compendium.

Decentralisation and Local Government Act

Reforms and decentralisation in local government in The Gambia began many years ago, and significant progress has been made in putting in place the necessary policies and processes. In 2002, the National Assembly passed the Local Government Act calling for the establishment and regulation of a decentralised system of local government for The Gambia. The Act makes provision for the functions, powers and duties of local authorities and for the effective running of all matters relating to those roles.

There is need for decentralisation to increase citizens' willingness to pay taxes in return for more accountability and transparency in the management and delivery of local government services and infrastructures.

The Local Government Act provides for the demarcation of local authority areas, establishment of councils and development committees and lays down guidelines for the devolution of functions from Central Government to Local Councils. With this framework, the planning system at the divisional level will be based on bottom-up data and information collection, while a programme on the multi-disciplinary facilitation process will be established (with standards premised on the effective co-ordination of micro-projects).

With strong donor support, efforts are being made all over the country to include these standards in the design of all projects. The central goal of the local government reforms and decentralisation is to ensure that local communities have the opportunity to take part in the development process in their areas. Power and authority will devolve from the centre to competent and responsive local governance structures. These structures are empowered to use participatory approaches in the political, social and economic decision-making processes of their communities. Based on progress made so far, there is need for decentralisation to increase citizens' willingness to pay taxes in return for more accountability and transparency in the management and delivery of local government services and infrastructures.

The successful implementation of the decentralisation programme will depend largely on the ability of Government and other stakeholders to create the necessary institutional opportunities for those outside Central Government, not only to make inputs but also to take critical decisions and provide services. In this regard, a strong, independent, highly professional, well staffed and adequately equipped Government Comptroller/General Accounting/Auditor General Office can contribute to a more transparent and accountable government.

The Gambian reality reflects both hopes and challenges, all of which relate to common features of governance. Good governance is based on universal values and basic freedoms, including legitimacy, accountability, competence, and respect for human rights and the rule of law. This is only possible through a system of governance capable of translating ideas into practical actions to fulfil the desire for economic development and sustainable growth.

Poverty Reduction

One of the paradoxes confronting development practitioners and experts is the persistence of widespread poverty despite tremendous expansion of global and national economies. With more than a fifth of the world's population (1.3 billion) classified as poor or very poor, eking out an existence on less than US\$1 per day during the 1990s, national leaders have endorsed the world community's focus on poverty reduction and its ultimate elimination as the central issue of their development efforts.

UNDP's HDRs have shed new light on the extent of absolute and relative poverty around the world, and contributed to a consensus for improved measures for human progress based on the HDI, which combines income, education and health indicators. Participatory assessments and surveys have also increased understanding of poverty, both as seen by the poor and in terms of statistical coverage. In addition to low incomes and assets, participatory assessments have drawn attention to exclusion and isolation, as well as lack of trust in public agencies (World Bank, 2000).

Such participatory poverty assessments and surveys in The Gambia have shown that the average income of the poor has declined significantly, despite the provision of financial services to support the poor under the Strategy for Poverty Alleviation (SPA) launched in 1992/93 and improvements in income and food security in some rural areas. At that time, the poverty profile indicated that 29% of the population had an annual income below US\$150, and 48% below US\$200. In the rural areas, 66% of residents had an annual per capita income of less than US\$200, while 17% fell below the US\$100 threshold (GOTG/UNDP, 2001).

The first National Human Development Report for The Gambia, published in 1997, demonstrated the uneven pattern human development across the country. Measured on a scale from zero to one, highest HDI levels were in Banjul and Kanifing (0.519 and 0.433, respectively), declining with distance from the capital city and its surroundings to Brikama (0.328), Kerewan (0.287), Mansakonko (0.274), Janjanbureh (0.260), Kuntaur (0.249) and Basse (0.210). The average HDI for the country as a whole was 0.350. (See Appendix 1 for details of how the HDI is calculated.)

The Poverty Reduction and Strategy Paper calls for the reduction of poverty by 50% within the next fifteen years, based on an annual GDP growth rate of 6%.

Overall, the incidence of poverty in The Gambia, according to the 1998 Household Poverty Survey, has increased progressively over the past two decades, with the extremely poor category increasing from 18% to 51% and the poor from 16% to 18%. Medium and large-scale groundnut producing households were particularly vulnerable at 80% and 85%, respectively. This level of poverty is amongst the highest in the West Africa sub-region, and is attributed to a combination of low eco-

nomie growth, social decline, a weak governance environment and inadequate commitment to back policy prescriptions on poverty reduction with sustained effort to implement the identified measures.

In addition to income poverty, the participatory poverty assessments highlighted food security, powerlessness in decision-making and limited access to assets and basic social services, as important areas of individual and community concern. The Poverty Reduction Strategy Paper (PRSP) addressed many of the challenges identified in these assessments, including: a comprehensive information system on the poor to facilitate tracking poverty reduction programmes; a wider scope of interventions to maximise impact and enhance sustainability; better donor co-ordination; broadening of participatory processes to enhance empowerment; and improved targeting of and stronger linkage of poverty reduction programmes with macro-economic policies.

While these programme-specific design elements may enhance poverty reduction, the persistence of acute poverty in the country is also explicable in terms of fundamental capacity constraints. Many of these constraints are in basic factors of production, such as technology, capital equipment, scientific information and finance. The PRSP set a target of reducing poverty by 50% within the next fifteen years, based on an annual GDP growth rate of 6% and five inter-related "pillars" or avenues of intervention:

- Pillar I consists of programmes in macro-economic strategy, income-generating activities, food security and the creation of a poverty reduction fund;
- Pillar II focuses on improving access to and performance of social services through social service delivery and improving public resources management;
- Pillar III aims to build capacities at local levels for people-oriented development management;
- Pillar IV seeks to promote participatory processes and good governance through effective co-ordination and monitoring of poverty reduction;
- Pillar V emphasises redistributive activities and improving participation in local decision-making.

Gender and Development

From the perspective of economic opportunities, there is a bias in Gambian society in favour of men, especially in the formal sector, reflecting the low levels of education among the majority of Gambian females (GOTG, 2003). The cultural perception, especially among the rural population, is that a good woman marries and bears children and, therefore, has no need for formal education. This attempt by society to separate the sexes on social grounds has resulted in unequal opportunities to education, leading to the feminisation of poverty and social seclusion.

The low socio-economic status of Gambian women that is due to gender-based inequalities and inequities constitutes a serious challenge for Gambian society. In response to this challenge, the Government in 1999 adopted the National Policy for the Advancement of Gambian Women (NPAGW), which focuses on improving gender relations, while taking cognisance of the constraints Gambian women face because of limited access to education, adequate healthcare, finance, jobs, decision-making powers and related matters. The policy aims at mainstreaming gender issues and concerns into national development processes.

Previously in 1980, an Act of Parliament established both the National Women's Council and its executive arm, the Women's Bureau to provide the institutional framework for greater participation in national development processes.

The role of the Gender Focal Points is to mainstream gender into the programme activities of their respective sectoral departments of state and in the programmes of NGOs.

The Bureau was set up as a legal entity and placed under the Office of the Vice President to give it greater visibility, but has achieved limited results during its 22 years of operation. This is due to several factors, including: high rates of staff turnover; inadequately trained staff; and poor co-ordination and information flows among relevant stakeholders. In recent years, the Bureau, with donor support from DFID, AfDB and UNFPA, has attempted to improve its effectiveness and outreach by changing the focus of its activities, in recognition of the large pool of human, financial and advocacy capacity residing within the domestic NGO and CBO sector. The task of the Bureau now consists of harnessing these resources to form a critical mass, so that critical issues of gender equality and equity can be tackled and resolved through mass mobilisation and popular participation. Facilitating effective partnerships and co-ordination among these bodies, through the establishment of the Gender Experts' Network and Gender Focal Points (GFPs), will provide the synergies that the Bureau needs for effective implementation of its work plan.

The Bureau's shift in focus reflects the transition to gender mainstreaming, the current international approach to promoting equality between women and men. It is based on the recognition that gender inequality operates at all levels and in all sectors of society, and thus needs to be addressed in the mainstream rather than only through women's bureaux. It seeks not only to close the gap between women's and men's access to resources, but also to ensure that they are equally empowered to take part in society's governance and decision-making processes.

Currently, a network of Gender Focal Points exists in almost all sectoral departments of state, and some non-governmental and international organisations in the country.

In 2002, Government institutionalised the network by Cabinet Decision, which stipulates, among other things, that each GFP co-ordinator in the network should not be below the rank of Principal Assistant Secretary. The co-ordinators' main role is to take action on mainstreaming poverty and gender into their respective sectoral department of state's programme of activities. Thus, while the main role of the Bureau is to co-ordinate, the role of the GFPs is to implement poverty and gender programmes. The GFPs are also charged with promoting linkages between poverty and gender in key sectors, through regular dissemination of information within and between institutions concerned.

Political support, combined with skilled administrative and programme management staff, are vital to the effectiveness of the Women's Bureau. These must be linked with a more efficient use of available resources, if the Bureau is to remain effective over time.

The Bureau undertakes fieldwork, conducts research and analysis, communicates and disseminates information and data to strengthen gender policy-making and implementation processes. As such, the Bureau's programme approach is based on the establishment of co-ordination mechanisms on both governmental and non-governmental levels to facilitate more effective communication and negotiation among sectoral interests and among national, divisional and local authorities.

CHAPTER 2: Challenges of HIV/AIDS, TB and Malaria

Overview

The World Bank's "Co-ordinates 2002" report gives the first consolidated view of the extent of HIV/AIDS, TB and Malaria in the world. It also describes how these diseases interact to affect the impact and effectiveness of current response efforts. According to the report, half of all new infections occur among young people, with Sub-Saharan Africa having the highest HIV prevalence, followed by the Caribbean. The most rapid spread of the disease is occurring in Eastern Europe and Central Asia. Moreover, HIV and TB comprise a lethal mixture, with TB causing 15% of all deaths of HIV-infected people, while HIV itself has been responsible for a steep rise in TB cases in Africa over the past decade. The report also indicates that 40% of the world's population is at risk from Malaria, with more than 80% of children infected with the disease in some parts of Africa.

In addition to the "Co-ordinates 2002" report, the United Nations "Report on Global HIV/AIDS - 2002" estimates that at the end of 2001, the total number of PLWHA was 42 million. Of these, 38.6 million were adults, 19.2 million were women and the rest, 3.2 million, were children under 15 years. It also estimated that 5 million people were newly infected with HIV in 2002 and, of these, 4.2 million were adults, 2 million women and the remaining 800,000 were children below 15 years. AIDS-related deaths in the same period were estimated at 3.1 million of which 2.5 million were adults, 1.2 million women and the rest, 610,000, children under 15 years. The number of children (0-14 years) orphaned (children who have lost one or both parents) by AIDS was 14 million. Table 2 summarises global HIV/AIDS figures to December 2002.

Table 2: Global Summary of HIV/AIDS, December 2002

Number of People Living with HIV/AIDS	Total	42 million
	Adults	38.6 million
	<i>Women</i>	<i>19.2 million</i>
	Children under 15 years	3.2 million
People Newly Infected with HIV/AIDS in 2002	Total	5 million
	Adults	4.2 million
	<i>Women</i>	<i>2 million</i>
	Children under 15 years	800 000
AIDS Deaths in 2002	Total	3.1 million
	Adults	2.5 million
	<i>Women</i>	<i>1.2 million</i>
	Children under 15 years	610 000

Source: UNAIDS/WHO, December 2002.

HIV is one of the most important co-factors leading to the increasing incidence of TB in many parts of the world, particularly Sub-Saharan Africa. Diagnosed results have proven that people infected with HIV are more likely to develop TB. Tuberculosis is primarily a disease of the respiratory system (airborne contagious disease) and spreads by coughing and sneezing. Though curable, the disease causes some 2 million deaths annually and threatens one-third of the world's population. In 1993, the WHO declared TB a global health emergency.

Without an effective co-ordinated control effort, TB could infect an estimated 1 billion more people and kill 70 million by 2020. The WHO also estimates that each year, 1% of the global population is infected with TB and 5-10% of those infected become sick or infectious. About 35% of the African population is infected with the disease, compared with a similar percentage in the Western Pacific and 44% in Southeast Asia. The lowest level of

TB infection is found in Europe with 15%. Research studies on the disease have shown that prisoners are at higher risk than the rest of the population and that more men than women are diagnosed with TB and die from it.

Malaria is one of the most serious challenges facing the public health sector, causing high morbidity and mortality. It exists in some 90 countries inhabited by more than 2 billion people, roughly a third of the world's population. The worldwide prevalence of Malaria cases is between 300-500 million clinical cases each year. More than 90% of all these cases are in Sub-Saharan Africa. In addition, mortality due to Malaria ranges from 1.5 to 2.7 million deaths each year, with the vast majority of deaths occurring among young children in Africa, especially in remote areas with poor access to health services. Other high-risk groups are women during pregnancy, non-immune travellers, refugees, displaced persons and labourers entering endemic areas.

The United Nations Commission on Macro-economics and Health estimates that at least US\$8.1 billion of additional resources will be needed annually to reduce the incidence of the HIV/AIDS, TB and Malaria in developing countries. Although the majority of most heavily infected countries have prepared plans and programmes for funding, the current Global Fund to fight these three diseases constitutes only 11% of total needs.

Sub-Saharan Africa Bears the Brunt

Malaria and HIV/AIDS occur around the world, but are concentrated in Africa. Eighty percent of the world's Malaria cases occur in Africa, accounting for 11% of the continent's disease burden and costing more than 1% of GDP in many African countries (African Futures, 2000). Two-thirds of the world's HIV/AIDS cases are found in Africa. Ominously, although life expectancy in Africa increased between 1950 and 1990, albeit at a lower rate than elsewhere, life expectancy has stagnated in the region since 1990, largely due to HIV/AIDS.

Whereas in 1982 only one African country had an adult HIV prevalence rate above 2%, today there are 21 countries where more than 7% of adults live with HIV/AIDS.

The diseases have become a source of serious concern for African governments and institutions. The African Development Forum (ADF) has highlighted the fact that not only is Africa the worst HIV/AIDS-infected continent, it is also the world's poorest region with the lowest access to quality health care. The Organisation of African Unity (OAU), in its concern over the potential impact of HIV/AIDS on Africa's younger generation, has called on member states to provide youth with frank and youth-friendly information about the disease, as well as access to condoms and appropriate management of sexually transmitted diseases (STDs). Likewise, the Special Summit of African Heads of State and Government meeting in Abuja in April 2001 adopted a Declaration and a Framework for Action calling on governments to earmark at least 15% of their annual budgets for the health sector to help address HIV/AIDS in their respective countries.

The devastation of HIV/AIDS and Malaria has been compounded by the increasing incidence of TB, recognised as a co-factor of HIV/AIDS, with 200 million of the estimated 600 million people in Africa already infected with the bacillus. TB alone is one of the most common preventable causes of death.

The economic burden of Malaria on Africa is heavy, and the illness has become a major development issue. According to a Harvard University study, Sub-Saharan Africa's GDP in the year 2000 would have been 325% higher had Malaria been eliminated 25 years ago. It is worth noting, however, that the cost of rolling back Malaria in Sub-Saharan Africa remains relatively small compared with the potential benefits. According to other studies, the short-term benefits of control could amount to US\$12 billion a year.

Left unchecked, the increase prevalence of HIV/AIDS and associated TB in Sub-Saharan Africa will rob the continent of citizens in their prime and leave a generation of orphaned children. The devastation caused by HIV/AIDS will also deprive entire African households and nations of their young and most productive population; deepen poverty, and reverse hard won gains in human development.

In recent years, HIV/AIDS has been recognised as an emerging gender issue because the risks and consequences are different for women and men. Women are more susceptible to HIV infection on each sexual encounter because of the biological nature of the process and the vulnerability of reproductive tract tissues to the virus, especially in young women. Circumcision in males (not females) appears to confer some protection against sexually transmitted diseases, including HIV. For both men and women, the risks of becoming infected with HIV escalate in the presence of other Sexually Transmissible Infections (STIs), which are more difficult to detect in women, who are therefore less likely to be diagnosed and treated.

In addition to the stigma of STIs in women acting as a further obstacle in their seeking treatment, they are also often less able to negotiate safe sex due to their lower status. Furthermore, older men seeking "safe" partners are increasingly targeting young women and girls for sex. Recent information suggests that 12 to 13 African women are infected for every 10 African men.

HIV/AIDS, TB and Malaria affect both women and men, and have become an emerging gender issue. Due to the gender dimension of the diseases, the majority of infections and deaths have been among men, but infection rates amongst women have risen steeply in recent years.

With regard to Malaria, a number of national studies have shown that although the infection rate among males and females are almost the same, the impact of the disease on women is greater, particularly among the under-fives and pregnant women (UNICEF, 2000). Malaria causes iron deficiency in girls and gets worse when they become mothers, and when both mother and baby need iron reserves. This contributes to abortions, premature delivery and low birth weights (as well as anaemia during pregnancy) and increases the risk of maternal mortality (AWA, 1990). Anaemia is directly responsible for 12% of maternal deaths and is a co-factor in 34% of other deaths. Prevention and control of the disease would reduce these risks.

Gender analysis has emerged as crucial to understanding HIV/AIDS transmission. It highlights the socially constructed aspects of male/female relations that underpin individual sexual behaviour, as well as the gender rules, norms and laws governing the broader social and institutional context. Gender analysis forms the basis of the changes required to create an environment in which women and men can protect themselves and each other. Only then can they effectively meet the challenges resulting from the impact of the disease.

Situation in The Gambia

While the incidence of both HIV/AIDS and TB is increasing in The Gambia, Malaria has also risen to rank as the number one public health problem and most serious communicable disease in the country. Statistics indicate that the disease has always accounted for the great majority of outpatient visits, hospital admissions and many deaths in health institutions, accounting for 40 – 60% of all consultations at health facilities, with a 10% – 15% fatality rate. Between 1989 and 1999, there are estimated to have been some 2.6 million cases of Malaria in The Gambia and 1,000 Gambian children die each year from the direct and indirect effects of the disease (Association of Health Journalists, 2002).

Disease Prevalence

HIV/AIDS

Since the first HIV/AIDS case was recognised in The Gambia in 1986, a reported 1,400 Gambians have died of the disease. HIV-1 and HIV-2 infections rates are estimated at 1.2% and 0.9%, respectively. The HIV-1 prevalence rate has almost doubled in seven years from 0.7% in 1995, and an estimated 8,000 adults in The Gambia are now infected with HIV-1.

The 2000-2001 National Sentinel Surveillance Survey revealed significant differences between four testing sites with Sibanor in the Western Division registering the highest increase from 0.6% in 1993/95 to 3.0% in 2000/01. In the other surveillance sites of Serekunda, Farafenni and Basse, the increase of 1.4% was similar across the three sites. Given that HIV-1 infections are typically more common in urban areas, the unexpected

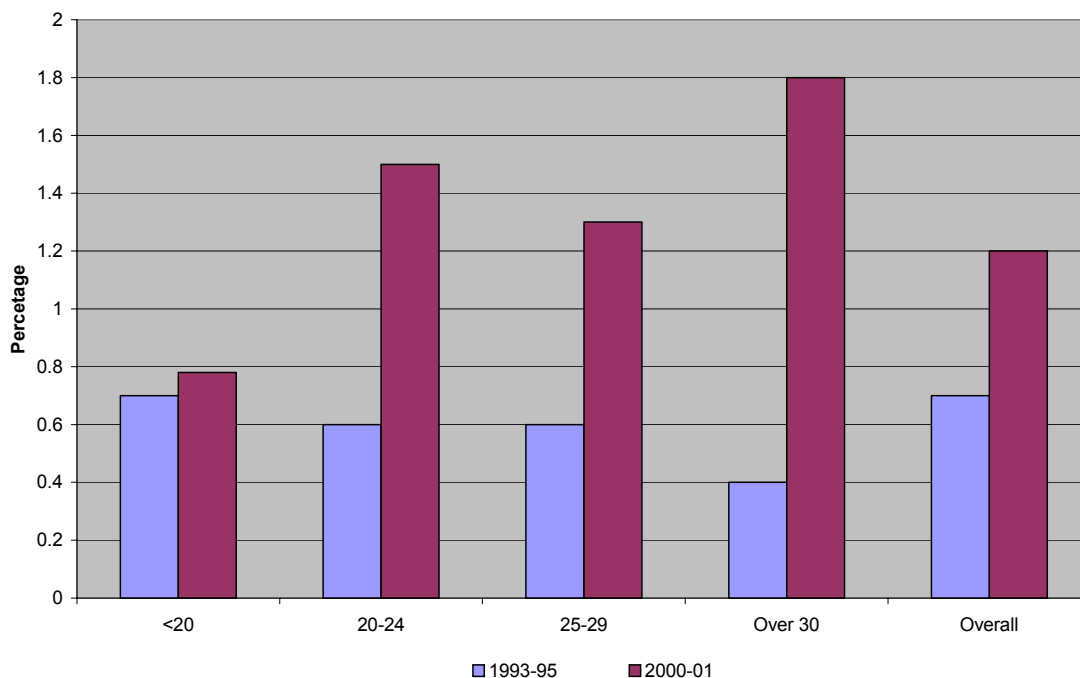
finding in Sibanor is the subject of on-going study. The Sentinel Survey will be conducted annually, with an increased number of surveillance sites.

Clinical data for 2000 suggests that young females between 15 – 24 years of age (Figure 1) are the most vulnerable segment of the female population. In 2000, approximately 86% of the 384 reported cases of HIV/AIDS were females within that age range. In addition, 77% (59) of 77 new female AIDS cases diagnosed by the MRC in 2001 were adult females between 25 and 54 years of age. During the first half of 2002, 84% (52) of 62 newly diagnosed female AIDS cases were in the same age range.

By contrast, adult males in the 24-54 age range are the most vulnerable segment of the male population, constituting 90.5% of the 2,810 HIV/AIDS cases reported in June 1999. Similarly, out of 140 new AIDS cases observed by the MRC in 2001, an estimated 63 were males and 92% (58) of these were in the 25-54 years age range. During the first half of 2002, 38% (39) of the 101 new cases reported were males of which 92% (36) were between 25-54 years of age.

Females between 15-24 years of age are the segment of the female population most vulnerable to HIV infection. By contrast, males between 24-54 years of age are the most vulnerable segment of the male population.

Figure 1: Prevalence of HIV-1 by Age Groups



Tuberculosis

There is no nationwide data on TB incidence in The Gambia, but Case Notification (CN) records (Table 3 and Figure 2) indicate that the number of diagnosed cases has increased substantially since 1995.

With an overall Case Notification rate of 118/100,000 for all cases of TB and 66/100,000 for new sputum smear-positive cases in 2000, The Gambia ranked 17 and 16, respectively, out of 46 African countries, compared with 99/100,000 for South Asia and 43/100,000 for Latin America and the Caribbean (WHO, 2000).

High prevalence of TB is correlated with high rates of HIV/AIDS, so the increasing prevalence of TB in The Gambia may, at least in part, be due to the immune deficiency caused by HIV/AIDS.

Figure 2: TB Case Notifications

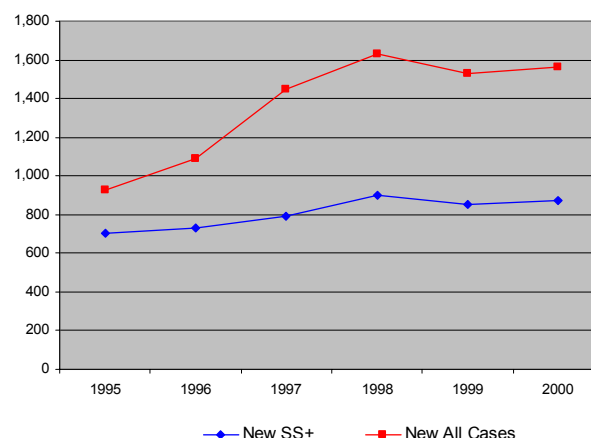


Table 3: Case Notification: 1994 – 2001

Year	New SS+	Rate /100,000 New SS+	New All Cases	Rate /100,000 (All Cases)	% of New SS+/All Cases
1994	653	61	882	82	74
1995	706	64	930	84	76
1996	729	63	1091	95	67
1997	795	67	1451	122	55
1998	900	73	1631	132	55
1999	850	66	1527	119	56
2000	872	66	1561	118	56
2001	851	59	1489	103	57

Source: NLTP, September 2001.

In response to the increasing number of TB cases, the Department of State for Health and Social Welfare (DoSHSW) has initiated a programme of Directly Observable Therapy (DOTS), the initial results of which are most encouraging, and should reduce prevalence and lead to effective control of the disease.

Case detection in western, urbanised areas is two to three times higher than in more rural, central and eastern areas, due to the greater availability health services and movement of patients from rural to urban areas. The distribution of TB cases by Local government Area (LGA) and by sex is shown Table 3.

Kanifing has the highest number of TB cases, followed by Banjul and Brikama. Kuntaur Local Government Area has the fewest notification of TB cases. One of the reasons for the high incidence of TB in the Kanifing area may be associated with overcrowding.

In one year alone, a smear-positive TB person is capable of transmitting the infection to between 10 and 15 persons they live with. Out of these, 1 to 2 persons may develop the disease.

Approximately a third (31%) of the caseload is between 35 and 54 years of age. Seventy percent of all new smear-positive cases are 15 to 44.

In about a quarter of smear-negative cases, diagnoses are made in the absence of sputum smear examination and based on radiological evidence only. Some of these cases die in the first week after registration, with no further evidence supporting the diagnosis and are of unknown HIV status.

Seventy-one per cent of notified TB cases in 2001 were male, consistent with global trends, ascribed to greater mobility and more smoking by males.

Table 4: All Cases of TB, by LGA and Sex

LGA	2000		2001		Total
	M	F	M	F	
Banjul	297	89	13		102
Kanifing	616	500	184		684
Brikama	193	181	94		275
Mansakonko	42	32	21		53
Kerewan	167	106	48		154
Kuntaur	42	26	7		33
Janjanbureh	115	50	31		81
Basse	89	68	39		107
Total	1,561	1,052	437		1,489

Source: NLTP, September 2001; and unpublished DoSH data.

Malaria

The Medical Research Centre (MRC) Ward in Fajara is a major treatment and referral centre for Malaria cases in The Gambia. The number of confirmed cases amongst outpatients risen substantially in recent years, from 3,015 in 1996 to peak at 7,270 in 1999 and decline to 5,317 in 2001, as shown in Figure 3.

Relatively dry years following the exceptionally heavy rainfall of 1999 are believed to have contributed to the reduction of Malaria cases in 2000.

The disease occurs throughout the years, but is most common during the rainy season from September to November (Figure 4), when mosquitoes are most abundant. Malaria is the main cause of illness in pregnant women in The Gambia, resulting in anaemia and babies with low birth weight.

Using fever as a proxy indicator of Malaria, the overall prevalence rate amongst children under five years in 2000 was 15%. Prevalence was lowest in babies less than 5 months old and highest in those between 6-11 months. Girls had a slightly higher prevalence (15.3%) than in boys (14.4%) (GOTG/UNICEF, 2000).

Prevalence across the country in 2000 was highest in Brikama (21%), followed by Mansakonko (19%) and Banjul (7.3%). Little difference in prevalence was found between rural (15%) and urban areas (14%).

Figure 3: Positive Blood Films MRC Outpatients: 1996-2001

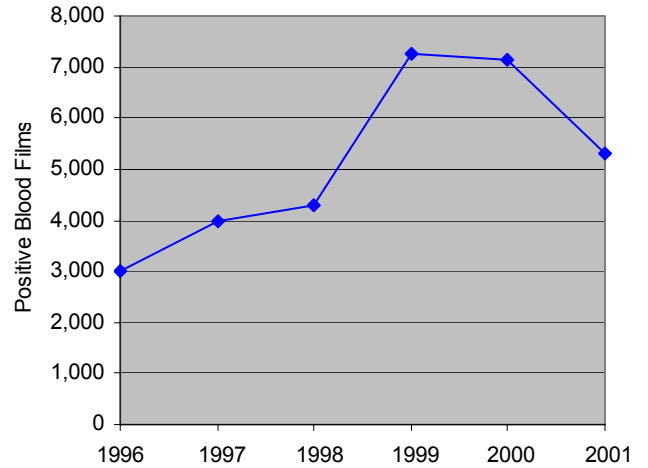
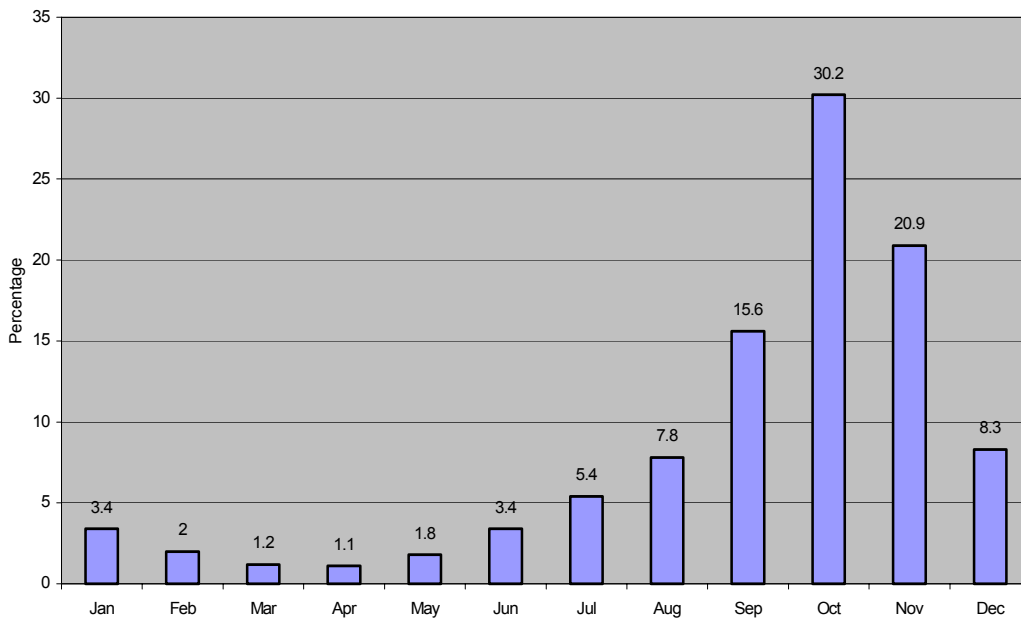


Figure 4: Mean Monthly Distribution of Confirmed Malaria Cases MRC Outpatients, Fajara: 1996 - 2001



Modes of Transmission & Risk Factors

HIV/AIDS

When HIV/AIDS was first diagnosed in the early 1980s, the major routes of infection were through the sharing of needles amongst intravenous drug users and homosexual contacts. Today, the main ways in which infection spreads are through heterosexual intercourse, unsafe blood transfusions, mother-to-child transmission in the peri-natal period, and breastfeeding.

Sexually transmitted infections (STIs) increase the probability of HIV transmission (Gross-Kurth *et al.* 1995; Laga *et al.* 1991, 1993).

The prevalence of sexually transmitted infections (STIs), including: Gonorrhoea, Chlamydia, Trichomoniasis and Syphilis, is high in The Gambia. Such disease are risk factors for the spread of HIV/AIDS.

Figure 5: World AIDS Day March



Members of the Santa Yalla Support Society march in support of people living with HIV/AIDS, December 2000.

Various socio-cultural practices in The Gambia, including initiation and naming ceremonies, weddings, wrestling, home coming events and *lumos* (market days), some of which last for days, attract large numbers of people and provide opportunities for casual sexual contacts and HIV infection.

Female genital mutilation (FGM) is widely practised in The Gambia. Women who have undergone FGM may be at increased risk of HIV infection (MRC, 2001).

Between a quarter and a third of babies born to HIV-infected women become infected themselves, through placental transfer or breast-feeding (UNAIDS, 1998). Children who escape infection from HIV positive mothers are likely to be orphaned eventually by their parents dying of HIV/AIDS. Risk factors include positive syphilis serology, death of last baby, multiple sexual partners and commercial sex.

Commercial sex workers play a significant role in the spread of HIV and in the efforts being made to prevent the transmission of HIV/AIDS. A socio-cultural study of HIV/AIDS in The Gambia found that although 95% of CSWs claimed to use condoms with clients, interviews at *lumo* sites suggested that condom use might be less common than indicated (GOTG/UNDP, 2002).

Tourism brings many tens of thousands of visitors a year to The Gambia and constitutes some 12% of GDP. Close to 10,000 Gambians are actively engaged in tourism and related activities. The lifestyle and behaviour of some young men and women associated with tourism may pre-dispose them to STI's and HIV/AIDS.

In recent years, The Gambia has provided refuge to many thousands of people fleeing from Sierra Leone, Guinea Bissau, Liberia and the southern Senegal region of Casamance. At times of insecurity and civil war, females are at higher risk of sexual violence and exposure to HIV infection, and basic health services in such areas are inevitably disrupted. An increasing number of HIV/AIDS and TB cases in can be anticipated with this influx of refugees.

Tuberculosis

Tuberculosis is caused by a myco-bacterium: *Mycobacterium tuberculosis*. The disease is spread by airborne particles, known as droplet nuclei, which can be generated when people with pulmonary or laryngeal TB sneeze, cough, speak or sing.

People who share the same airspace with individuals with infectious TB disease are at greatest risk for infection. Infection occurs when a susceptible person inhales droplet nuclei containing tubercle bacilli and these bacilli become established in the alveoli of the lungs and spread throughout the body.

Malaria

Malaria is transmitted by mosquitoes of the *Anopheles gambiae* complex, which includes: *A. gambiae s.s.*, *A. arabiensis* and *A. melas*. *A. gambiae s.s.*, and *A. arabiensis*, the major vectors, are distributed throughout the country. *A. melas* is, however, is restricted to the western half of the country and probably contributes less to the overall disease burden. The rate of entomological inoculation is in the range of 1 – 80 infected bites per person per year (DoSH, 2002). Mosquitoes breed in stagnant water, which is most plentiful during the wet and early dry seasons.

Malaria transmission in The Gambia occurs mainly during the rainy season from June to November. Clinical attacks are, therefore, far more common during and immediately after the rains, as indicted in Figure 4.

In such areas of highly seasonal Malaria, parasite success depends on its survival and transmission during the dry season. However, the dry-season biology of the malarial parasite and its vectors is poorly understood and has been the subject of study by the MRC.

Preliminary results indicated that mosquitoes of the *A. gambiae* complex survive the dry season by aestivation (i.e. seasonally arrested or retarded development) and maintenance of low level breeding populations. The main resting site for adult mosquitoes appears to be inside occupied huts. (MRC, Annual Report, 2001).

Mosquitoes and malaria can be maintained through poor sanitation. In many households, particularly in peri-urban and rural areas with no waste collection services, open ditches are dug in backyards for dumping refuse and provide breeding sites for mosquitoes. Cattle are also tethered close to houses at night and since mosquitoes feed on wild and domestic animals as well as people, they may support the survival mosquitoes and persistence of Malaria through the dry season.

As with HIV/AIDS and TB, socio-cultural practices play a major role in the transmission of Malaria.

The peak period for the disease is during the rainy season when temperatures range from 29°C to 34°C and people spend much of the night outdoors unprotected against mosquito bites. It is also traditional for families

to sit together in the open air as a way of socializing after a day's work on the farm, while old women use this time to tell stories to grandchildren, thereby providing an ideal environment for a single mosquito to bite one person after another.

Gender Implications

The Gambia is a pluralistic society with five major ethnic groups and a variety of minority groups. Despite this pluralism, there is a high degree of homogeneity in cultural practices and beliefs among ethnic groups.

Studies in other parts of Africa and recently in The Gambia (GOTG/UNDP, 2002) have shown that gender inequalities in HIV/AIDS cases appear to be directly linked to gender inequalities at a cultural, educational, social and sexual level. There are indications that the fight against HIV/AIDS in The Gambia could be made more difficult by the numerous socio-cultural characteristics of the society.

The recent Behavioural Sentinel Surveillance (BSS) study on HIV/AIDS in The Gambia has revealed that: women have less access to formal education; are less educated about STDs (including HIV/AIDS); and in some areas of the country, may be at greater risk of coerced sex, (GOTG, 2003).

A major factor contributing to the rapid increase in the incidence of HIV/AIDS, TB and Malaria in The Gambia is the existence of social behaviour that intertwine with religious beliefs and cultural practices to reinforce existing patterns of gender inequality.

In addition, the practice of early marriage for girls is often associated with high drop out rates for female students, resulting in increased economic dependence. Moreover, cultural norms particularly in rural areas, dictate that a woman's marital and childbearing status is a key element of their identity in society.

A major contributory factor to the rapid increase in the incidence of HIV/AIDS, TB and Malaria in The Gambia is the existence of social behaviours that intertwine with religious beliefs and cultural practices to reinforce existing patterns of gender inequality. In most cases, these beliefs and practices are used interchangeably, with both giving prominence to patriarchy and, by implication the subordination of women. The patriarchal nature of Gambian society is also a major factor in the high rates, among women, of illiteracy (81%) and poverty. Being illiterate and poor, Gambian women lack adequate decision-making powers to negotiate safe sex and access to appropriate reproductive health services, such as contraceptives, although they are well aware of the need and advantages of family planning.

Commercial sex work is an outward manifestation of poverty and deprivation, especially among the young. According to Stock (1998) and Loum (2000), commercial sex work in The Gambia is a lucrative and highly mobile trade, especially during *lumos* and the tourist season. Over 60% of commercial sex workers are less than 25 years of age, with the majority coming from neighbouring Senegal and Guinea.

CHAPTER 3: Linkages and Impacts of HIV/AIDS, TB and Malaria

Linkages

The disastrous consequences of the linkages between these diseases are caught in the tragic irony of coffin makers doing brisk business outside city hospitals, capitalising on the surge in deaths, as the spread of HIV/AIDS and TB surpass the devastation of either disease on their own. The linkage between and devastation of HIV/AIDS and TB has been scientifically demonstrated. As their full medical names indicate, the Human Immuno-deficiency Virus that causes Acquired Immune Deficiency Syndrome weakens an individual's immune system. For a person who is also infected with TB, this can speed the progression to the active form of the disease. It has been estimated that a person who is HIV-positive and infected with TB is 30 times more likely to become sick with TB than a person infected with TB, but who is HIV-negative. It has also been estimated that more than 30% of HIV patients have active TB, while HIV infected patients are at an increased risk of developing TB, possibly because of the reactivation of past infection.

A person who is HIV-positive and infected with TB is 30 times more likely to become sick with TB than a person infected with TB, but who is HIV-negative.

Malarial infections cause immune depression, which predisposes the host to infection with other microorganisms. Malaria infection affects the victim's T-cells, both qualitatively, and quantitatively. In addition, since the containment of TB infection depends on an intact cellular immunity, the influence of TB on a Malaria-induced impairment of the immune response is explained by the fact that a decrease in the number of the cells (CD4 and T-cells) also decreases the effective TH1 response necessary for TB control (Whittle et al., 1984). The impairment of cell functions in Malaria may thus create a window of relative immune ineffectiveness, during which the host may be particularly vulnerable to TB and other opportunistic diseases.

In children, one of the complications of Malaria-anaemia is a known risk factor for progressive TB disease because it causes immuno-incompetence (Udani, 1977). Other studies (Adebajo et al., 1994) have found a statistically significant association between the presence of anti-Malarial antibodies and diagnosis of TB. This finding supports the notion that Malaria may be one of the important factors that affect the progression of myco-bacterial disease. Furthermore, repeated or prolonged Malaria attacks cause a decrease in the host's immune mechanisms, and increases susceptibility to, and re-activation and faster progression of, TB.

Impacts

The impact of HIV/AIDS, TB and Malaria focuses attention on a wide range of issues that move well beyond simply the tragic health implications of the diseases. Adding to an already heavy disease burden in poor countries, HIV/AIDS is deepening and spreading poverty, reversing human development, worsening gender inequalities, eroding the capacity of governments to provide essential services, reducing labour productivity, and hampering pro-poor growth.

Repeated, or prolonged Malaria attacks can cause a decrease in the host's immune mechanisms, and increases susceptibility to TB.

HIV/AIDS is reversing years of hard-won gains in economic and social development. The scale and severity of the social and economic impacts of the pandemic, already large, will continue to increase for many years. For instance, by 2000, an estimated one in every four children in five countries in Sub-Saharan Africa were orphans. Soon the proportion will be one in five in an additional four countries, with others not far behind. Life expectancy will drop to 40 years, or less, in nine Sub-Saharan Africa countries by 2010 and AIDS-related mortality will substantially reduce gains made in child survival in many countries.

The disease is not only an increasing cause of death among adults, infants and young children, it is also slowly impoverishing and tearing apart family institutions, and leaving a growing numbers of orphans in its wake. At all stages of the disease, families bear most of the social and economic consequences of the disease. These human consequences, in turn, are wiping out health, social and economic gains and threatening the future of development in many African countries.

The HIV/AIDS, TB and Malaria crisis, thus, has far-reaching implications for the attainment of the Millennium Development Goals (MDGs) and related nationally determined poverty targets. One of the MDG targets is to reduce HIV prevalence in persons aged 15-24 by 25% by 2005 in the worst affected countries and by 2010 globally. Given the unique devastation of the disease, reversing HIV/AIDS becomes the most important MDG. Without progress in tackling HIV/AIDS, the prospect of achieving any other goal is in great jeopardy (UNDP, 2002).

Potential Impacts in The Gambia

There are no nationwide studies on the impact of HIV/AIDS, TB and Malaria on progress towards the attainment of sustainable human development in The

Gambia. However, the demographic impact begins to emerge from a breakdown of statistics on PLWHA, which shows that 54% were females and 46% male. Moreover, females account for the majority of infections within the age group of 15-34 years. Males on the other hand account for the majority of infections within the 35-55 years and over age group. Furthermore, female youth are seven times more likely to be infected than their male counterparts. On the other hand, males within the 35-55 year and above age group are twice as likely to be infected than their female counterparts. Cases of infection in the 0-14 year's age category are few, but they do nevertheless exist. Vertical transmission is a key mode of transmission within the 0-5 year age group (NAS, 2002).

The fact that HIV infection rates in The Gambia are predominantly high in the youth population highlights the vulnerability of this segment of the population. Generally, female youth tend to be at higher risk of infection due to the generational sex practices that exist, for economic or social reasons as well as cultural factors, such as early or forced marriage.

Emerging from the current evidence is the gender factor. Relative to their male counterparts, females within the 15-24 year age group are at greater risk of HIV infection, while there is higher prevalence in the male group aged between 25-54 years and above, which equally puts this male category at risk. Generally, females tend to be at higher risk of infection due to the generational sex practices that exist, for economic or social reasons as well as cultural factors, such as early or forced marriage.

The vulnerability associated with poverty as a risk factor is demonstrated by the differences in prevalence between urban and rural areas. Furthermore, the high prevalence rates recorded among CSWs emanate principally from the lack of economic and educational opportunities. A similar trend exists among the female youth who are also engaged in sexual practices as a poverty alleviation or income generation strategy.

Economics

Presently, the overall potential impact of HIV/AIDS in The Gambia can be partly assessed on the basis of experience from countries already devastated by the disease – Botswana, South Africa, Swaziland, Uganda and Zambia – to name only the most severely affected. Evidence from these countries already shows that virtually all sectors of the economy are feeling the impact – in terms of productivity losses, or increased demand for services, especially health care.

In The Gambia where the prevalence is low, the impact of HIV/AIDS on the country's macro-economic and demographic trends will depend largely on how rapidly the disease spreads across the population and how quickly behavioural changes can slow the spread.

At the macro-economic level, the World Bank has predicted a slowing down of per capita income growth by 0.3% a year in the 10 sub-Saharan countries worst affected by HIV/AIDS. For persons already living on less than a dollar a day, even this small drop in income per capita is projected to decline by between 0.1% and 0.8% per year due to the disease, a figure that has already fallen by 0.2% in recent years. Losses in income will affect savings at all levels of the economy and impact on investments in social welfare and infrastructure sectors over the long-term. In turn, this will force governments into an increased dependence on foreign aid for development, especially at a time when the decline in direct foreign investment (due to falling productivity and increased costs of skilled labour), continues to reduce the profitability of investment.

The economic burden facing The Gambia will be made worse by the threat posed to youth and other productive age groups in general. With over 8,000 PLWHA and growing trends in the transmission of HIV/AIDS, the combined effect on persons that are ill (disease burden in the country that is attributable to HIV/AIDS) is growing. Related statistics on TB, for instance, attest to this fact. Furthermore, opportunistic infections could also be on the rise and add to the problem. The health effect has related consequences that affect economic conditions. Firstly, the costs to health system increase due to the increased Anti-Retroviral Therapy (ART) and clinical palliative care associated with opportunistic infections. Secondly, the economic effects that arise from the loss of productivity, human resources, skills and time, contribute to diminished economic growth and development in the country.

From the perspective of sustainable human development, HIV/AIDS is, therefore, more than a disease; rather it is a massive development catastrophe. Most infectious diseases kill off the weak – the very young and the very old. HIV targets people indiscriminately, currently affecting most people in the prime of their working and parenting lives. Around half of all people who acquire HIV become infected before they turn 25. Typically, they develop and finally die of the illness before their 35th birthday. This age factor makes AIDS uniquely threatening to families, communities and economies.

In The Gambia, where the prevalence is currently low, the impact of HIV/AIDS on the country's macro-economic and demographic trend will depend largely on how rapidly the disease spreads across the population and how quickly behaviour change slows the spread.

Malaria is a major health problem in the Gambia and is the number one killer disease. During the last ten years, approximately three million cases have been reported by the Epidemiology and Statistics Unit of the Department of State for Health. Between 40-60% of outpatient consultations in health facilities are due to Malaria and about 20% of ante-natal consultations are also due to Malaria. Annually, between one and two thousand children die in the country as a result of Malaria.

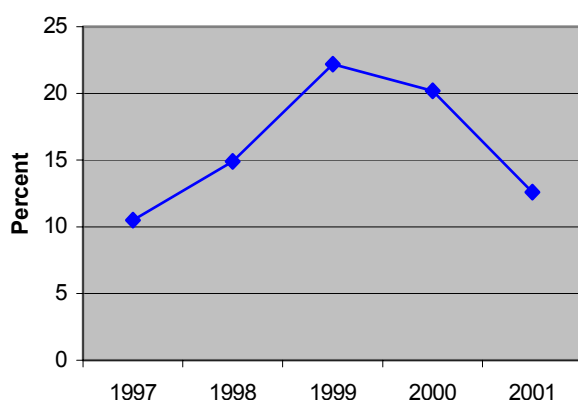
In contrast to HIV/AIDS, The Gambia bear a substantial Malaria burden. Malaria infections caused by *Plasmodium falciparum*, are the most severe and life-threatening form of the disease.

Malaria is the cause of more than 4% of infant deaths and approximately 25% of deaths in children aged between 1-4 years. Each year, between 1-2,000 children die from the direct effects of the disease, which accounts for nearly 40% of all visits to the Maternal Child Health clinics and also contributes to the high maternal mortality rate of 730/100,000 live births (DoSH&SW PER, 2001).

Malaria affects the health and wealth of the nation and individuals alike, and is both a disease of poverty and a cause of poverty.

At the Royal Victoria Hospital in Banjul Malaria ranks as the second most common cause of death, accounting for nearly a third of all deaths amongst children (Fig. 3.5). The overall case fatality rate varies between 8% and 13%. However, in the case of cerebral Malaria where deaths are more frequent, the case fatality rate is between 20% and 30%.

Figure 6: Malaria Case Fatality Rate for Children, RVH: 1997-2001



Reliable data and information on the impact of Malaria on economic development in The Gambia are unavailable. However, based on experience from other countries, the WHO has estimated that annual economic growth in countries with high Malaria transmission has historically been lower than in countries without Malaria. Economists believe that Malaria is responsible for a growth penalty of 1.3% per year in some African countries. When compounded over the years, this penalty leads to substantial differences in GDP between countries with and without Malaria and severely restrains the economic growth of the entire region. The WHO also highlights the direct cost of Malaria, which includes a combination of personal and public expenditures on both prevention and treatment of the disease. In some countries with a heavy Malaria burden, the disease may account for as much as 40% of public health expenditures, 30%-50% of inpatient admissions and up to 50% of outpatient visits.

Malaria also has a greater impact on human resources than simple lost earnings. Although difficult to express in currency, another indirect cost is the human pain and suffering caused by the disease. It hampers children's schooling and social development, through both absenteeism and permanent neurological and other damages associated with severe episodes of the disease. The existence of the disease in a community or country, thus, impedes individual and national prosperity due to its influence on social and economic decisions. The risk of contracting Malaria in endemic areas can deter both international and external investment and affect individual and household decision-making in many ways that have a negative impact on economic productivity and growth. On average, those either affected personally or through the need to care for an affected child, could lose 12 days per year of productive output. In short, it is obvious that Malaria is a major obstacle to progress and, therefore, a critical development issue.

According to the WHO, Malaria has significant measurable, direct and indirect costs, and has recently been shown to be a major drag on economic development. For developing economies, this has meant that the gap in prosperity between countries with and without Malaria has become wider every single year. In the Gambia, the effect of Malaria on the population is absenteeism in work place and schools. Malaria affects the health and wealth the nation and individuals alike, and is both a disease of poverty and a cause of poverty

Education

Studies have yet to be carried out on the impact of HIV/AIDS on the education sector in general and teachers and pupils in particular. While the need for such studies clearly exists, there is growing recognition that the impact on education could be very serious, especially with respect to the demand for, supply and quality of education provided at all levels of the system.

Experience from other countries has shown that the pattern of demand for education may change as fewer children are born, or are able to attend school because of the early death of one, or both parents.

Fewer families may be able to afford to send their children to school because of loss of income due to AIDS, illness and death of productive members and increased expenditure on treatment, care and funerals.

HIV/AIDS could also reduce the educational opportunities available. Again, there is as yet little or no hard data about the impact of HIV/AIDS on the supply of education in The Gambia. Schools with low enrolments might have to be closed and remaining pupils moved to other schools.

Fewer students and reduced demand might lead to reduced Government allocations and contraction and/or restructuring of the education sector.

If the disease were to gain hold and spread in The Gambia, the quality of learning outcomes and education

would also be affected by several confounding factors. The education system would experience progressively more serious problems of staff absenteeism and loss at all levels: teachers, inspectors, education officers, planning and management personnel, with profound negative impacts on system functionality.

Schools are also likely to be affected by the psychological impacts of infection, illness and death in their midst. Active measures will be required to guard against discrimination, ostracism and isolation in the classroom and the provision of training and skills necessary for the integration of affected children within society.

Health Care

Further expansion of HIV/AIDS would also afflict The Gambia's already limited trained medical personnel and affect the supply and quality of service. At the Mama Yemo Hospital in Kinshasa, Democratic Republic of the Congo, 6.4% of a random sample of over 2,000 health workers were diagnosed with HIV. Mortality of nurses in two hospitals in southern Zambia rose more than five-fold from 0.5% in 1980 to 2.7% in 1991, exceeding the rate at which new nurses were trained. Another study found HIV prevalence rates ranging from 5% to 44% among health care personnel in Uganda and Zambia. These are chilling examples of HIV's erosion of capacity in the very sector that is critical to responding to the challenges posed by the disease. In most of these countries, treatment for people with HIV-related illnesses is usually limited to those who are seriously ill, and may be only palliative care. Anti-viral drugs are rarely available. TB, an opportunistic infection to which people with HIV are prone, has increased the cost of treatment and lengthened hospital stays.

With a currently estimated 8,000 PLWHA in The Gambia ultimately needing medical care, public expenditure on their treatment is expected to be considerable. The cost to the family could be overwhelming with the ever-increasing costs in both formal and traditional health care systems. Despite existing difficulties in health care delivery, effective responses must be developed, including family home care and local community support.

Agriculture

Labour-intensive agriculture, heavily dependent on women's work, forms the backbone of The Gambia's economy, providing food and income to the majority, rural-based population. Many farmers already operate on the economic margin, especially women-headed households, where labour and other inputs at critical periods are key to crop success, or failure.

Loss of farm labour due to HIV/AIDS, TB and Malaria can quickly force subsistence farmers into a cycle of declining food production and increasing poverty. In the end, household and community food security could be threatened.

Not only would the person living with any of these diseases be unable to cultivate his or her crops, family

members would also neglect farming to take care of the sick. The impact on crop production could be manifest in three ways: an outright reduction in food produced; a reduction in land use with fewer family members available to work; and a decline in the range of crops grown. Similarly, limited availability of farm labour for tasks such as weeding, mulching and clearing and an increase in pests and diseases could reduce crop yield per area. Loss of farm labour due to HIV/AIDS, TB and Malaria could quickly force subsistence farmers into a cycle of declining food production and increasing poverty. In the end, household and community food security could be seriously threatened.

Households

The impact of HIV/AIDS on families and communities could become immediately apparent – households permanently altered and on the edge of survival, and communities with large numbers of children without parents. At the level of the country's most basic societal units, therefore, the disease could cut an irreparable swath of damage and create new groups of impoverished people.

The impact of HIV/AIDS, TB and Malaria on children and youth could be catastrophic, as those most important to the young – parents, teachers, doctors, peers and siblings – fall ill and die, causing close-knit families and communities to disintegrate. For many children, the loss of parents would plunge them into absolute poverty, terminate any formal, fee-based education and greatly diminish their future prospects.

Information is limited on the prevalence of HIV/AIDS, TB and Malaria amongst the aged and the disabled. However, the impact of any of these diseases on disadvantaged and vulnerable groups would be disastrous, making them even more vulnerable and dependent on meagre household resources. The death of a family "bread winner," caring for aged or disabled relatives, would have dire consequences for their survival.

Overall, the impact of any significant increase in HIV/AIDS, TB and Malaria on The Gambian household could mean radical changes for family structure, as parents die, households crumble and extended family networks are unable to cope with the excessive burdens of care. Enormous child welfare needs would arise; school enrolments would decline, especially for girls, as children substitute for the loss of labour; and diminishing household resources are diverted to care for the sick. The impact of a generation of lost educational opportunities would reverberate far into The Gambia's future.

As families lose their breadwinners and caretakers, income is lost, agricultural output declines and nutrition deteriorates; spending on health care increases, funeral costs soar, savings turn into debt, children drop out of school and future prospects diminish. All of these factors would severely constrain Government's efforts to consolidate past gains and expand the frontiers of The Gambia's sustainable development horizon.

CHAPTER 4: Prevention, Control and Treatment

The most effective interventions against HIV/AIDS, TB and Malaria rely on a combination of prevention, control and treatment services. Fewer than 5% of the people who need treatment for HIV/AIDS in the developing world have access to the medicines they need and only one-fifth of all TB cases globally receive quality treatment. In 28 countries, half of the current anti-Malarial medicines on the market are ineffective due to bad quality or drug resistance. Yet, pioneering countries, such as Vietnam and Peru, have shown that it is possible to achieve targets for detection and cure.

Governments need to create the supportive environment in which there can be open discussion of the sensitive issues related to HIV/AIDS and reproductive health.

As the number of people with HIV-related illnesses increase, various options and models of care are now being tried, as countries begin to implement policies for the care of PLWHA. In The Gambia, Government's priority should be to prevent the further spread of sexually transmitted diseases and HIV. Such a program would promote public education to create a supportive environment in which there can be open discussion of the sensitive issues related to HIV/AIDS and reproductive health. Central to this is an improvement in the status of women in Gambian society, which can be achieved only by effective partnership between policy-makers, educators, health officials, scientists, donors and the public.

National Commitment and Action

National leadership commitment to the effective delivery of reproductive health services in general and combating the HIV/AIDS epidemic in particular, has been significant. Building upon the high level of commitment achieved in previous years, the national HIV/AIDS response programme has intensified advocacy activities for greater political leadership to combat the disease.

Leadership Commitment

Political leadership, from the community to the national level, has made substantial contributions in the fight against HIV/AIDS, TB and Malaria. This contribution has been particularly strong with respect to HIV/AIDS. For instance, in addition to chairing the National AIDS Council, the President has launched a number of high-profile national initiatives on HIV/AIDS and also made important public statements. He has publicly declared that no civil servant shall be removed from office due to his or her HIV status and warned religious leaders against discouraging people from using the condom¹.

1 Statement at the National Youth Conference in Basse, 2001.

He is also on record as having called "on all Gambians to join him in declaring war against HIV/AIDS²".

A national leadership increasingly committed to openly addressing and taking action on the prevention, control and treatment of HIV/AIDS can significantly increase the success of the national response to the disease.

However, the commitment to fighting HIV/AIDS expressed by national leadership has not yet resonated throughout Gambian society. In fact, a number of prominent opinion leaders have made public statements, which are counter-productive to efforts to sensitise the population and modify risk behaviours. A "conspiracy of silence and denial" continues for various reasons.

The relatively low prevalence rate and limited present impact of HIV/AIDS in the country may in part be responsible, but there are other, more deep-rooted and misguided attitudes. Where, for example, the existence of HIV/AIDS is openly acknowledged, it is generally believed to be limited to commercial sex workers and foreigners.

Recent research suggests that many women, who are expected to be primary carers of those with HIV/AIDS in The Gambia, harbour high levels of intolerance towards HIV positive individuals. Sixty per cent of female respondents in a recent survey indicated that they would not eat with an HIV positive person; over half would not respect the confidentiality of an HIV positive family member, while more than forty percent said they would not care for someone with HIV/AIDS (GOTG, 2003).

Both the Santa Yalla Support Society and the Nganiyaa Kiling Society, confirm that, because of this intolerance, only a small proportion of PLWHA reveal their status to their immediate families.

A broad, society-wide leadership, committed to openly addressing and taking action on the prevention, control and treatment of HIV/AIDS is required for a national response to be effective.

Policies and Programmes

The National HIV/AIDS Response Programme

The National AIDS Control Programme (NACP) was established in 1987 under the then Minister of Health. It set the stage for the formulation of the National AIDS Committee (NAC) and the National HIV/AIDS Secretariat (NAS).

2 National AIDS Forum, November 2000.

Figure 7: Montage of Anti-Malaria Bed Nets and Birth Registration Campaign.



Source: UNICEF.

In 1995, the NAC was reconstituted into a multi-sectoral organisation. The first national forum on HIV/AIDS was organised in November 2000. The earlier perception of HIV/AIDS as a problem to be addressed by the health sector alone has begun to fade as people realise that all sectors of society and the economy are affected. Hence, there is growing recognition of the importance of a multi-sectoral approach in combating the disease.

Under the HIV/AIDS Rapid Response Project (HARRP), the Department of State for Health and Social Welfare is responsible for providing medical supplies, clinical services and ensuring blood safety. Other government departments, including Education; Defence; Interior and Religious Affairs; Youths and Sport; Tourism; and Agriculture, are involved in awareness, prevention and mitigation activities.

The HARRP takes a multi-sectoral and pro-active approach to combating the spread of HIV/AIDS in the country. As such, the Project's *Capacity Building and Policy Development* component focuses on strengthening the country's capacity to cope with the spread of the disease through support to the NAC, NAS and the Divisional and Municipal HIV/AIDS Committees (DACs/MACs).

From a policy perspective, the NAC has overall responsibility for policy formulation in the fight against HIV/AIDS. It was established under the Office of the President, with the Head of State serving as Chair. This

has given the Council and its activities greater visibility. Membership of the NAC includes: Secretaries of State, NGOs, CBOs, private sector operators, representatives of religious organisations, women and youth groups as well as PLWHA. Moreover, the *Multi-sectoral Responses for HIV/AIDS Prevention and Care* component of the HARRP assists the non-health sector departments to develop departmental policies for responding to HIV/AIDS, with emphasis on prevention and care.

Effective Treatment of TB

People with TB can be cured and the disease can be controlled effectively with regular treatment. Present difficulties encountered in tracking TB patients within the high prevalence area of the Kanifing Municipality requires the establishment of mechanisms needed to easily locate patients who disappear while still undergoing treatment. In addition, the public's attitude towards patients must change to encourage them to report to health centres for treatment.

People with TB can be cured and the disease can be controlled effectively with regular treatment

The difficulty of the task is increased by the fact that the TB/Leprosy Unit is severely under-resourced. Research studies in The Gambia have shown that it takes an average of 60 days to diagnose TB patients in urban areas and 90 days in rural areas. The allocation of adequate resources, especially trained staff, would increase the availability and accessibility of services to control and eradicate the disease.

Rolling Back Malaria

Government has developed a Malaria Control Policy intended to Roll Back Malaria (RBM). The implementation of the 2002 – 2003 Plan of Action aims to ensure that every family has access to insecticide treated bed-nets. The plan also provides for adequate and prompt treatment of all persons affected by Malaria. It also ensures access to preventive, intermittent treatment and facilitates efforts to predict and control the disease. The RBM programme involves collaboration with Divisional Health Teams (DHTs) and partnership with youth and the donor community.

Sleeping under an insecticide-treated bed net has been shown in trials to have a marked impact on morbidity in children under 5 years in The Gambia and other countries. (See Figure 7 and front cover illustration). As a result, insecticide-treated bed-nets are seen as an important tool for preventing Malaria, and are being widely promoted by international agencies and national governments. The challenge is to convince those at risk to use these devices and ensure that bed-nets and insecticide(s) are widely available at an affordable price. In this regard, the WHO has requested Government to reduce or waive taxes and tariffs on mosquito nets and insecticides, in keeping with commitments made under the Abuja Declaration.

Sleeping under an insecticide-treated bed net has been shown in trials to have a marked impact on morbidity in under 5s in The Gambia and other countries.

Social mobilisation in communities on environmental control, proper drainage and use of impregnated bed-nets has increased community participation in control activities in several health divisions. Currently, national impregnated bed-net coverage has reached 35.3% (GOTG/UNICEF, 2000), while 200 doctors and nurses have been trained in the management of severe and complicated Malaria.

The Integrated Management of Childhood Illnesses (IMCI) is a Government programme supported by UNICEF and WHO. The programme combines strategies for control and treatment of five major killers of children including Malaria. The IMCI focuses on the improvement of family and community practices in the prevention and early management of childhood illnesses.

The officially recommended first line drug for treatment of uncomplicated Malaria is chloroquine, and the second line drug is sulphadoxine/pyrimethamine. Quinine is reserved for treatment of severe and complicated Malaria. However, there is concern that Malaria parasites are becoming increasingly resistant to chloroquine. Resistance of *Plasmodium falciparum* to chloroquine was first detected in The Gambia in 1986, and in recent years chloroquine resistance has become increasingly widespread.

One of the major problems in the prevention, control and management of the three epidemics is the dearth of

information at the national, divisional or local levels. The absence of detailed data on the differential or collective impacts of these diseases on key development sectors is a major impediment to the design of an effective response. Although there is some information on the incidence of the disease, it is very scanty and disorganised. Moreover, some public health centres do not submit returns of their Malaria cases to the Divisional Health Teams as required. This has made it more difficult for the DHTs to send their statistical returns to the Epidemiology and Statistical Unit in Banjul.

To fill the gap, the Department needs to train health centre staff, as well as DHTs, in completing the health statistical return forms. It is also necessary to facilitate the flow of information between private clinics and the Medical and Health Department, as this may help build capacities through sharing of information, knowledge and techniques in the control, prevention and management of the epidemics. Policy guidelines are also needed that would require private clinics to collect and send statistical returns to the Medical and Health Department for monitoring and evaluation purposes.

Resource Mobilisation

Many of The Gambia's bilateral and multilateral partners in the health sector operate primarily with the Department of State for Health, which is also their conduit for channelling funding to the sector. Some partners also channel funds through NGOs and CBOs.

In 2002, eight donor agencies supported implementation of the national HIV/AIDS response programme and will contribute a total of US\$16.7 million to 2006. The HARRP accounts for nearly 90% (US\$15 million) of the total and is being implemented under a credit agreement with the World Bank, signed by Government in February 2001. Government's counterpart contribution is estimated at US\$1.6 million.

UNICEF supports youth sensitisation and the Prevention of Parent-to-Child Transmission (PPTCT) activities with an annual commitment of US\$225,000.

Donors providing US\$16.7 million to support implementation of the national HIV/AIDS response programme.

Research carried out by the MRC in the 1990s demonstrated that the use of impregnated treated nets reduced deaths from Malaria by 30% in children under-five years. As part of the plan to apply this important finding, UNICEF has advocated strongly for children less than five years of age and pregnant mothers to sleep under impregnated mosquito nets. Towards this end, the agency, in 2001, imported 3,420 litres of the insecticide permethrin for the dipping of mosquito nets. Despite these efforts, it is estimated that currently only one in three children in the target age group sleeps under an impregnated mosquito net.

UNICEF has also provided support to The Gambian Chapter of the Forum for African Women Educators (FAWE-

GAM). Some 1,300 mosquito nets have been distributed to ten girl-friendly schools, as a means of addressing absenteeism and low enrolment of girls in schools due to Malaria.

UNDP has supported the NACP and sensitisation of national security forces with an average annual allocation of US\$195,000. The WHO provides approximately US\$130,000 for support to basic health services related to HIV/AIDS, as well as the implementation of the Sex Workers Intervention Project (SIP). The latter project was co-funded by the UNAIDS at a cost of US\$200,000. The SIP was designed to improve the health-seeking behaviour of CSWs. UNAIDS funding for SIP ended in 2002, and was replaced by funding from the World Bank under the Participatory Health Population and Nutrition Project. Under its 2002 – 2006 Country Programme for The Gambia, the UNFPA supplies male condoms to DoSH&SW and female condoms to the Maternal Child Health and Family Planning (MCH/FP) Unit at an estimated cost of US\$30,000.

The US Embassy in The Gambia undertook its first HIV/AIDS intervention in 2002 under the US Ambassador's HIV/AIDS Fund (US\$75,000). Assistance has been allocated to support: voluntary counselling and sensitisation activities in the Farafenni/Soma catchment areas; the National Population Commission Secretariat (NPCS); and a local NGO targeting truckers and CSWs. Additional support to PLWHA and HIV/AIDS sensitisation has also been provided by the United States Peace Corps, at an estimated cost of US\$80,000.

The UNAIDS Global Fund to Fight AIDS, TB and Malaria was set up in January 2002 as a financial instrument to complement existing programmes in combating the diseases.

Inter-country Initiatives

In 1999, the President of The Gambia initiated an inter-country Health for Peace Initiative (HPI). The initiative is based on a partnership between countries of the Gambia River Basin. Member states are charged with taking lead roles in addressing major diseases affecting their respective countries: Senegal (HIV/AIDS); The Gambia (Malaria and Eye Care); Guinea-Bissau (National Immunisation Days); and Guinea-Conakry (Emergency Preparedness). Development of this initiative was supported by UNAIDS, WHO and UNICEF.

In 2002, HIV/AIDS and Malaria activities under the HPI consisted of planning, policy dialogue and exchange visits between countries. In addition to the HPI, a number of organisations in The Gambia were involved in sub-regional and cross-border initiatives, including: development of a sub-regional strategy for HIV/AIDS (Catholic Relief Services/The Gambia); introduction of Peer Health Counselling Programme in Sierra Leone (Nova Scotia/Gambia Association); and promoting the "Stepping Stones" approach to HIV/AIDS prevention in Guinea-Bissau (Action Aid/The Gambia). The Medical Research Council has also shared the results of its HIV/AIDS survey with research institutions in Guinea-Bissau.

Collaboration with NGOs

One of the outcomes of the Good Governance and Decentralisation Policy of Government over the last few years has been the growing involvement of civil society in the development process. The emergence of NGOs and grassroot CBOs complement over-stretched national budgets by providing much needed human, technical and financial resources. Where Government has been constrained to act, these organisations have provided education, prevention, care, counselling and advocacy for PLWHA. They have also taken the lead in providing home-based care by building on The Gambia's reservoir of caring and community spirit.

The Community and Civil Society Initiatives component of the HARRP provides grants to community, civil society, worker associations and establishment or primary unit initiatives³. More than 50% of HARRP funds are to be allocated as grants to NGOs and CBOs. An amount of US\$683,000 for research, treatment and care has been provided to a consortium of NGOs (TARUD, World View, and the Gambia Red Cross Society) headed by the MRC. Their interventions are cross-cutting and touch on all aspects of the fight against HIV/AIDS.

The MRC is a central actor in the campaign against HIV/AIDS, providing facilities for testing, diagnosis and care, in addition to giving technical support for the HIV/AIDS Sentinel Survey. The Council has sites around the country that provide medical care and basic services to PLWHA, as well as supporting the programme for home-based care for PLWHA in Brikama (provided by the Worldwide Evangelical Crusade).

The referrals for membership of the Santa Yalla Support Society (SYSS) and the Nganiya Kiling Society in Brikama come largely from MRC and its health facilities. SYSS is most active in the Greater Banjul Area. With higher HIV/AIDS prevalence in Sibanor and Basse, additional service providers are needed in those areas.

The MRC, Action Aid/The Gambia, Worldview International, Trust Agency for Rural Development and The Gambia Red Cross Society constitute the core institutions implementing the "Stepping Stones" programme. This programme comprises a series of participatory workshops designed to stimulate discussion within all segments of the community and share information on reproductive health, STIs and HIV/AIDS.

To date, many proposals submitted by NGOs to the National AIDS Secretariat for funding have been unsuccessful. This has been because the proposals failed to meet the stringent financial accounting requirements, or were unable to demonstrate a strategic vision of how their requests would fit into the country's overall response to HIV/AIDS.

3 "Establishment or primary unit initiatives" include businesses, military camps, prisons, refugee groups, trade associations, sports clubs, etc..

It was anticipated that by 2002 at least six proposals would have been approved for funding, considering that submissions from line departments have been slow in coming. For the purpose of providing technical advisory and support services in this area to the DACs and MACs, NAS has recruited a Municipal Co-ordinator and five Divisional AIDS Co-ordinators. In future, it is expected that existing NGOs will be able to “scale up” their operations significantly to utilise programme funds disbursed as part of the national response to HIV/AIDS.

Private Sector Involvement

As HIV/AIDS spreads, the amounts of money and other resources needed to prevent, control and manage the epidemic are enormous. There is, therefore, a need for strong partnerships with the private sector, which is awakening to the problem of AIDS-related costs. These costs include absenteeism from work, insurance and the cost of recruiting and training replacement workers. In some countries, it has been estimated that the costs of HIV/AIDS to an individual firm is equivalent to one-fifth of its potential profits.

In The Gambia, the private sector has begun to complement government efforts in the area of prevention and care. Standard Chartered Bank-Gambia Limited, Trust Bank Limited and Shell Company Gambia Limited are at the leading edge of the private sector involvement.

Standard Chartered Bank-Gambia Limited has an internal programme aimed at sensitising and educating its staff about HIV/AIDS through its “*Staying Alive*” campaign handbook. Following its campaign in 2000, the bank organised training sessions for representatives from each of its national chapters on how to support PLWHA. These sessions included training on information sharing and how to initiate sound workplace programmes. As part of its interventions in the work place, the bank launched its “*Living with AIDS*” campaign in 2002. On World AIDS Day, the bank carried slogans on its bank statements and pay slips. It is currently supporting the construction of a National Child Centre, which will house a library, internet café and sports and games facilities. The centre will also provide food and drinks to encourage effective use of the facility by children in The Gambia. The bank has also donated funds and distributed male and female condoms, posters and copies of its “*Staying Alive Handbooks*” to the Society for Women and AIDS in Africa/Gambia Chapter to enhance its information, education and communication campaigns and training activities.

Trust Bank Limited, through its “*Health Donation and Sponsorship Policy*” organised a series of workshops on HIV/AIDS in 2002. The bank also provided financial support to the Royal Victoria Hospital Sanatorium and the Maternity Ward of the AFPRC Hospital in Farafenni.

Under its Pan-African Retail Aid Awareness Initiatives, Shell Marketing companies in West and Central Africa launched an AIDS awareness programme in 2002. This programme was implemented throughout their service station networks across countries in the region. The programme is based on dissemination of thought-provoking posters at Shell Service Stations. The posters are designed to increase general awareness of HIV/AIDS and to encourage people, especially youths, to take protective measures against contracting the HIV/AIDS. In addition, “Select” and “Jet Wash” attendants have been trained to create greater awareness among the public with the message: “*You have the right to live. Do not let AIDS take it away. Choose life.*”

Local private businesses have also been involved in the anti-HIV/AIDS campaign. A number of local restaurants have offered free dinners as prizes to winners of competitions organised by the “*Children against AIDS*”. This club of 11 – 17 year olds has 200 members and is sponsored by UNICEF. In addition to having its own website, the club has also extended its activities to neighbouring Senegal, where they have set up a similar club. HIV/AIDS prevention messages are also broadcast from several local private radio stations, including West Coast, Sud FM, Brikama FM and City Limits.

The Association of Youths against Malaria is actively involved in promoting awareness about the disease and how it can be prevented and controlled. The Association was established in 1997 with the objective of complementing government efforts in rolling back Malaria. The activities of the association have focused on environmental sanitation (reducing potential breeding grounds for mosquitoes) and public sensitisation campaigns.

So far, progress in combating HIV/AIDS, TB and Malaria has been due largely to the increasing support provided by the international community (through bilateral and multilateral donors). The need for sustainable disease prevention and control measures is highlighted by uncertainties in the global economy.

The Gambian private sector is gradually becoming aware and understanding the implications of these diseases for national economic growth. Much more needs to be done and many more organisations need to become involved, however, if the country’s on-going and future policy and programme initiatives are to be made sustainable and targeted goals are to be achieved. An essential element of this involvement is the contribution of human, financial and technical resources. The pooling and leveraging of resources would also accelerate the mainstreaming of policies aimed at the prevention and treatment of HIV/AIDS, TB and Malaria into Government poverty reduction strategies. Co-ordinated implementation of these proposals would generate the most effective response to the epidemics, whilst supporting overall sustainable development.

CHAPTER 5: Challenges and Priorities for Action

At the regional level, many African countries, including The Gambia, have taken up the challenges posed by HIV/AIDS, TB and Malaria. This commitment has been demonstrated by their effective participation in numerous summits – notably, the Africa Development Forum (2000), Abuja (2001), Lusaka (2001), and UN General Assembly Special Session 2001. At all these occasions, Heads of State have endorsed actions to combat epidemics in their respective countries through greater political commitment and further strengthening of measures to: prevent transmission of HIV; tackle the scourge of TB; and roll back Malaria.

Given the characteristics of the Gambian economy, a high population growth rate of 4.2% per annum and a demographic profile with 60% of the population under 25 years old, the challenge to confront these diseases is closely interrelated with the attack on poverty.

National surveys conducted in 1998 to assess the impact of the SPA indicated that poverty had increased by 32% overall between 1992 and 1998. The proportion of extremely poor people increased from 18% to 51%, and poor from 16% to 18%, with 80% of medium and 85% of large-scale groundnut producing households hardest hit. It is against this background of rising levels of poverty that Government must face the challenges posed by the spread of HIV/AIDS, TB and Malaria in formulating its development initiatives.

Ending “Silence and Denial” about HIV/AIDS

More than ever before, the national HIV/AIDS response programme has benefited from the political will and commitment expressed at the highest levels of Government. The programme nevertheless faces a number of major challenges.

The first is the need to urgently and fully translate the overwhelming national leadership commitment to fighting HIV/AIDS into scaled-up responses to the disease.

More than ever before, the national HIV/AIDS response programme has benefited from the political will and commitment expressed at the highest levels of Government.

Second, with more people, groups and entities involved in the fight against the disease, nationwide co-ordination and harmonisation of programme activities have become more demanding. The need for increasing effective co-ordination of programme activities is particularly demanding on the National AIDS Secretariat, Divisional and Municipal AIDS Committees, the UNAIDS

Thematic Group and similar institutions formed to enhance co-ordination, partnership and networking.

Lastly, there is the challenge of creating an environment conducive to and supportive of behavioural changes geared towards preventing the spread of the HIV infection. Creating such a friendly environment discourages discrimination and stigmatisation and enhances the uptake of counselling and other social support services. The challenge of translating increased awareness to concrete behavioural changes towards PLWHA remains far from realised.

Figure 8: HIV/AIDS Awareness Raising



Spreading the word about HIV/AIDS amongst rural women in Lower River Division by members of the Santa Yalla Support Society.

A pervasive perception of “shame and silence” contributes to the critical status of the HIV/AIDS epidemic across Sub-Saharan Africa, including The Gambia. Despite the fact the epidemic has been spreading for more than two decades, a stigma still clings to HIV/AIDS in many places. Arising from irrational fears of contamination and from the association of AIDS with sex and death, the AIDS stigma not only leads to cruel rejection of people known to have HIV, but also discourages discussion and dialogue about the epidemic. Without discussion, there is no way for communities to become aware of, or take seriously the threat of an invisible virus that can be spread, unknowingly, by people who feel and look perfectly well.

The challenge of translating increased awareness to concrete behavioural changes towards PLWHA remains far from realised

Many policy-makers and opinion leaders remain unwilling to talk about AIDS even when it is killing members of their own families. Until recently, some were still denying the evidence that an epidemic was under way. Now, as the epidemic rages over the continent, there is a

new momentum of public acknowledgement, with African leaders speaking out about HIV, encouraging solidarity with those already infected or affected, and openly advocating safer forms of sexual behaviour. As this report notes, national leadership in The Gambia is at the leading edge of this movement, although still more needs to be done. Breaking the silence is the key to sustained nationwide action against the epidemic.

Early public acknowledgement of the HIV threat, starting with the key political and civil leadership, needs to be combined with frank information campaigns, sexual health education, condom promotion and decisive steps to dispel the AIDS stigma and help HIV-infected individuals to live positively. At the same time, it has become clear that AIDS is not just a disease, but is also a development challenge; hence the joint responsibility of many different actors, including religious institutions and other parts of civil society. It is not just a problem for the Department of State for Health. A comprehensive approach to tackling the HIV/AIDS epidemic is the only way to reduce and ensure low infection rates in The Gambia.

Implementing the DOT Strategy for TB

Public health officials estimate that US\$1 billion a year will be needed to treat patients and control TB in the 22 low-income countries that now account for 80% of the world's TB cases (WHO/The Gambia, 2002). The Directly Observable Therapy (DOT) strategy developed by the WHO is considered to be one of the most cost-effective programmes ever devised against a major killer disease.

A major challenge and key component of the DOT strategy is Government commitment to TB control. The protocol includes: detection by microscopic examination of sputum smears; supervised treatment for six to eight months; a regular supply of TB drugs, and a standardised reporting system.

The increase in the number of TB cases in The Gambia underscores the need to ensure that TB does not become a major public health problem. Government needs to reduce the incidence of the infection and ensure that individuals who develop the infection are placed rapidly on effective chemotherapy and made to complete their treatment.

Rolling Back Malaria

The limited capacity of the National Malaria Control Programme (NMCP) is a major challenge to the effective implementation of disease control measures. Consequently, there is an urgent need to finalise a National Malaria Control Policy, as a tool for the prevention, treatment and management of the disease. It is envisaged that this policy will focus on: case management; Malaria in pregnancy; vector control; information, education, communication and advocacy; and surveillance and research.

There is an urgent need to finalise a National Malaria Control Policy, as a tool for the prevention, treatment and management of the disease.

The key to success of the NMCP should be the proper management and building of partnerships in support of the programme. Institutional structures for co-ordination need to be strengthened and linkages with other programmes and stakeholders improved. Government's contribution to Malaria control activities also needs to be increased and a mechanism established to co-ordinate donor inputs. This will foster intra-country collaboration and partnership, in line with the sub-regional Health for Peace Initiative. Likewise, further concerted efforts by all stakeholders, including the private sector, local government and village communities, are needed to focus on disease prevention and controlling mosquitoes and Malaria in the home.

Investing in Health Care

Research conducted by the Commission on Macroeconomics and Health, established by the WHO, has revealed that the economic impact of ill health on individuals and societies is far greater than previous estimates. Providing basic health care to the world's poor is both technically feasible and cost effective.

The results could be dramatic – saving eight million lives annually and fuelling development by generating hundreds of billions of dollars in new economic activity every year. The price tag, however, is high.

The health care sector in The Gambia derives its financial resources from Government, households (in the form of user charges) and donors. Whilst total health expenditure increased rapidly in the early 1990s, it declined significantly on withdrawal of donor support after the military takeover in 1994 (GOTG/UNICEF 20/20 Initiative Study, 2000). Moreover, per capita expenditure on health has not increased due to rapid population growth of 4.2% per annum.

In this respect, the declaration of the WHO that “poverty itself is the principal cause of illness in poor countries”, and that “disease in some low-income regions, especially Sub-Saharan Africa, stands as a stark barrier to economic growth”, underscores the need for international assistance to The Gambia.

The financing required for the prevention, control and treatment of HIV/AIDS, TB, and Malaria will assist government efforts to improve health outcomes, in line with the Millennium Development Goals, adopted by world leaders at the 2000 Millennium Summit in New York).

The Commission on Macro-economics and Health argues convincingly that these objectives can be reached most effectively by targeting the handful of communicable diseases responsible for the great majority of deaths and illness in developing countries. These diseases include HIV/AIDS, TB, Malaria, childhood diseases and dietary deficiencies.

Many of the necessary treatments and services are highly effective and can be applied in low-income settings, but to a quite shocking extent, they do not reach the poor because neither the poor themselves, nor their national governments have the resources to obtain these life-saving interventions. The problem is not that the interventions fail to work, but rather that the solutions to the problems do not reach enough people.

The solution, the Commission's report asserts, is to forge a new global partnership between developed and developing countries for the delivery of health care. Poor countries could increase health spending, but the Commission acknowledges that only a fraction of the costs can be met from domestic resources. A more effective strategy would be agreement by governments to re-order national health priorities away from an excessive emphasis on urban elites and more towards the rural areas and the poor, where the need is greatest.

While donor support is necessary for investment in health care, Government's system of allocating public resources, which favours the hospital sub-sector, should be restructured. This restructuring should ensure that resources are channelled to primary and secondary health care services, where significant efficiency and equity can be realised.

Fostering New Partnerships

The UN Commission on Macro-economics and Health estimates that if there is to be a significant improvement in health outcomes, annual spending on health care in the Least Developed Countries and other low-income states will have to substantially increase from US\$53.5 billion in 2002 to US\$93 billion by 2007, and to US\$119 billion by 2015. These figures do not include an additional US\$8-12 billion needed yearly for the Global AIDS and Health Fund. The proposed increases are far beyond the means of developing countries such as The Gambia and require a huge and extremely unlikely rise in ODA from donor states.

Africa's development partners, including the World Bank, have pledged to increase their commitments to the fight against HIV/AIDS, TB and Malaria and to assist in raising an estimated US\$3 billion. This amount will be needed annually to treat at least half of those infected and to launch an effective preventative campaigns. However, except for a US\$500 million loan facility launched early in 2001 by the World Bank, no firm financial commitments were announced during the Addis Ababa Forum. So far, despite the devastating impact of HIV/AIDS in Africa, resources to address the epidemic have been limited.

These devastating epidemics must remain centre stage in global discussions on reducing poverty, achieving the Millennium Development Goals, financing development, providing debt relief and negotiating trade and investment agreements to ensure universal access to essential drugs. The inadequate attention given to HIV/AIDS at the 2002 Monterrey Conference on Finance for Development and in the New Economic Partnership for African Development (NEPAD) seems symptomatic of the international community's inability to come to grips with the wider development implications of this unparalleled pandemic that affects so many countries and so many people.

A broad coalition of partners is needed to provide increased support to the Government and People of The Gambia to strengthen national capacity to arrest the further spread of HIV/AIDS, TB and Malaria and reduce their socio-economic impacts. This support should be provided within a new framework of a partnership and co-operation between all stakeholders, focussing on local implementation of national solutions to banish the scourge of these tragic but preventable diseases.

BIBLIOGRAPHY

- African Development Forum The African consensus and plan of action: leadership to overcome AIDS, 2000.
- African Futures (2000) Alioune Sall (Ed.) The future competitiveness of African economies, African Futures, Karthala, Sankore.
- Association of Health Journalists Health and Nutrition Magazine, Issue 1, June 2002 Edition.
- Commonwealth Secretariat Towards gender equality, 2000.
- Link in to gender and development.
- DoSE Policy documents, Vol. 1, Education 1998.
- Education policy: 1988 – 2003.
- EFA 2002 assessment report – The Gambia.
- Press release on HIV/AIDS and education, education sector programme, 2002.
- The impact of HIV/AIDS on the demand for education in The Gambia, briefing paper by SoS for education.
- DoSH&SW Adolescent health survey: preliminary report, 2000.
- Public expenditure review 2001.
- DoSTC Visit The Gambia.
- Enel, C. Societal and behavioural risk factors for STD and HIV transmission in the Si-banor area, The Gambia: A report for the Medical Research Council Laboratories, Banjul, 1995.
- FAO Food security assessment, 1996.
- Food security and nutrition, 1996.
- Flebenkamper, S. Knowledge of HIV/AIDS and attitude towards HIV testing and caring for people with HIV/AIDS in Brikama and Kombo District, The Gambia (unpublished), 2000.
- GOTG Country report, World Summit for Social Development, 1995.
- The Gambia 2002 behavioural sentinel surveillance on HIV/AIDS, final report 2003.
- National household poverty survey, 1998.
- Second strategy for poverty alleviation/poverty reduction and strategy paper (SPA-II/PRSP), 2002.
- National AIDS control programme, policies and guidelines on HIV and AIDS, 1995.
- Malaria control policy, second draft, March 2002.
- Health sector requirements studies, Phase III Report, 1996.
- The Gambia Government investment policy, 1999.
- GOTG/UNDP The Gambia Human Development Report 2000, January, 2001.
- A socio-cultural study on HIV/AIDS, 2002.
- Maraalii Saharingo, The National Governance Newspaper/The Gambia, Vol. 1, Issue 1, Dec. 2001 – March 2002.
- Maraalii Saharingo, The National Governance Newspaper/The Gambia, Vol. 1, Issue 2, April – August 2002.
- GOTG/UNICEF The multiple indicator cluster survey report, 2000.
- Final report on the 20/20 initiative country study for The Gambia, 2000.
- End-decade assessment report on the World Summit for Children Goals, 2000.
- Gross-Kurth, H. et al. (1995) Impact of improved treatment of sexually transmitted diseases on HIV infection

	in rural Tanzania: randomised controlled trial. <i>The Lancet</i> 346 (8974):530-536.
ILO	Gender, poverty and employment: turning capabilities into entitlements, 1995.
Jallow-Jatta, A.	Report on household food security.
Laga, M., N. Nzila and J. Geeman J. (1991)	The interrelationship of sexual transmitted diseases and HIV infection: implications for the control of both epidemics in Africa. <i>AIDS</i> 5 (suppl.1) S55-S63.
Laga, M. et al. (1993)	Non-ulcerative sexually transmitted diseases as risk factors for HIV-1 transmission in women: results from a consultant study. <i>AIDS</i> 7 (1): 95-102.
Loum A.J.	Report on familiarisation and orientation of new field workers to intervention sites, 3-30 April 2002. Sex Workers Intervention Project NACP/WHO.
—	Report on mapping and re-mapping of sex work sites for HIV/AIDS/STI prevention and control. Sex Workers Intervention Project, NACP/WHO.
MDI	Women in top management in The Gambia, 2000.
MRC	Medical Research Council, The Gambia, Annual Report, 1992.
—	Medical Research Council, The Gambia, Annual Report, 1997.
—	Medical Research Council, The Gambia, Annual Report, 1998.
—	Medical Research Council, The Gambia, Annual Report, 1999.
—	Medical Research Council, The Gambia, Annual Report, 2000.
—	Medical Research Council, The Gambia, Annual Report, 2001.
—	The long-term reproductive health consequences of female genital cutting in rural Gambia: A Community-Based Survey. <i>Tropical Medicine and International Health</i> , Volume 6, August 2001.
NLTP	Report on the mid-term evaluation of the National Leprosy and Tuberculosis Control Program, by Kefas Samson, Toure and Jan Voskens, September, 2001.
Patton, C.	Last served? Gendering the HIV Pandemic, 1994.
Sall, A. (Ed.)	The competitiveness of African economies, 2000.
UN	Third United Nations Conference on the Least Developed Countries, Country Presentations: The Gambia 2001 – 2010.
—	<i>Africa Recovery</i> , Vol. 14, No. 4, January 2001.
—	<i>Jokkoo</i> Vol. 7, 1997: Focus on gender and development.
—	<i>Jokkoo</i> Vol. 9, 1999: Education and development.
—	<i>Jokkoo</i> Vol. 10, 2002: Malaria & HIV/AIDS.
UNAIDS	Report on the global HIV/AIDS epidemic. Joint United Nations Programme on HIV/AIDS, Geneva.
—	AIDS disease update, December, 2001.
—	Declaration of commitment on HIV/AIDS – UNGASS on AIDS, 2001.
UNAIDS/WHO	Report on global HIV/AIDS – 2002, December 2002.
UNCTAD	LDCs: Building capacities for mainstreaming gender in development strategies, 2002.
UNDP	AIDS and Africa: A challenge to human development, 1995.
—	Human development report 2000.
—	Human development report 2001.
—	The Gambia human Development Report 2001a.
—	Challenges and prospects for sustainable human development in Africa.
—	HIV/AIDS and poverty reduction strategies, policy note, 2002.
—	Poverty eradication: Where Africa stands, 2000.
—	Reporting on the Millennium Development Goals at country level: guidance note, October 2001.

UNICEF	The impact of HIV/AIDS on education systems in the eastern and southern Africa region and response of the education systems to HIV/AIDS: life skills programme, 1999.
—	Report on the donor profile study for water, environment and sanitation sub-sector, December 2000.
—	Situational analysis of children and women in The Gambia, 2001.
WHO	Global TB control report, 2000.
WHO/The Gambia	Newsletter, Vol.1 Issue 2, 2002.
WHO/UNAIDS/UNICEF	Young people and HIV/AIDS: Opportunities in crisis. 2002.
Women's Bureau	Female genital mutilation in The Gambia, a desk review, 2002.
World Bank	Can Africa claim the 21 st Century? 2000.
—	Development outreach: putting knowledge to work for development, Vol. 1, No. 2, 1999.

APPENDIX 1: Technical Notes

Human Development Indices

The Human Development Index (HDI) is a summary measure of human development. It measures the average achievements in a country in three basic dimensions of human development⁴:

- A long and healthy life, as measured by life expectations at birth;
- Knowledge, as measured by the adult literacy rate (with two-thirds weight) and the combined primary, secondary and tertiary gross enrolment ratio (with one-third weight);
- A decent standard of living, as measured by GDP per capita (PPP US\$).

Before the HDI itself is calculated, an index needs to be created for each of these dimension indices – the life expectancy, education and GDP indices – minimum and maximum values (goalposts) are chosen for each underlying indicator.

Performance in each dimension is expressed as a value between 0 and 1 by applying the following general formula:

$$\text{Dimension index} = \frac{\text{actual value} - \text{minimum value}}{\text{maximum value} - \text{minimum value}}$$

The HDI is then calculated as a simple average of the dimension indices.

Goalposts for Calculating the HDI

Indicator	Maximum value	Minimum value
Life expectancy at birth (years)	85	25
Adult literacy rate (%)	100	0
Combined gross enrolment ratio (%)	100	0
GDP per capita (PPP US\$)	40,000	100

Calculating the HDI for The Gambia

1. Life Expectancy Index

The life expectancy index measures the relative achievement of a country's life expectancy at birth. For The Gambia, with a life expectancy of 53.7 years in 2001, the life expectancy index is **0.478**.

$$\text{Life expectancy index: } (53.7 - 25) / (85 - 25) = \mathbf{0.478}$$

2. Education Index

The education index measures a country's relative achievement in both adult literacy and combined primary, secondary and tertiary gross enrolment. First, an index for adult literacy and one for combined gross enrolment are calculated. Then these two indices are combined to create the education index, with two-thirds weight given to adult literacy and one-third weight to combined gross enrolment. For The Gambia, with an adult literacy rate of 37.8% in 2001 and a combined gross enrolment ratio of 47% in the school year 2000/01, the education index is **0.408**

$$\text{Adult literacy index: } (37.8 - 0) / (100 - 0) = 0.378$$

$$\text{Gross enrolment index: } (47 - 0) / (100 - 0) = 0.470$$

$$\text{Education index: } \frac{2}{3} (\text{adult literacy index}) + \frac{1}{3} (\text{gross enrolment index})$$

$$\frac{2}{3} (0.378) + \frac{1}{3} (0.470) = \mathbf{0.408}$$

4 Human Development Report, 2003.

3. Gross Domestic Product Index

The GDP index is calculated using adjusted GDP per capita (PPP US\$). In the HDI, income serves as a surrogate for all the dimensions of human development not reflected in a long and healthy life and in knowledge. Income is adjusted because achieving a respectable level of human development does not require unlimited income. For The Gambia, with a GDP per capita of 2,050 (PPP US\$) in 2001, the GDP index is **0.503**.

$$\begin{aligned}
 \text{GDP index} &= \frac{\log(2050) - \log(100)}{\log(40,000) - \log(100)} \\
 &= \frac{3.311 - 2}{4.602 - 2} \\
 &= \frac{1.311}{2.602} = \mathbf{0.503}
 \end{aligned}$$

4. Human Development Index

Once the dimension indices have been calculated, determining the HDI of The Gambia in 2001 is to take a simple average of the three dimension indices:

$$\begin{aligned}
 \text{HDI} &= \frac{1}{3} (\text{life expectancy index}) + \frac{1}{3} (\text{education index}) + \frac{1}{3} (\text{GDP index}) \\
 &= \frac{1}{3} (0.478) + \frac{1}{3} (0.408) + \frac{1}{3} (0.503) \\
 &= 0.159 + 0.137 + 0.167 = \mathbf{0.463}
 \end{aligned}$$

Human Poverty Index

While the HDI measures average achievement, the Human Poverty Index for developing countries (HPI-1) measures *deprivation* in the three basic dimensions of human development captured in the HDI:

- A long and healthy life – vulnerability to death at a relatively early age, as measured by the probability at birth of not surviving to age 40;
- Knowledge – exclusion from the world of reading and communication, as measured by the adult illiteracy rate;
- A decent standard of living – lack of access to overall economic provisioning, as measured by the un-weighted average of two indicators, the percentage of the population without sustainable access to an improved water source and the percentage of children under weight for age.

Calculating the HPI-1 of The Gambia is more straightforward than calculating the HDI. The indicators used to measure the deprivations are already normalised between 0 and 100 (because they are expressed as percentages), so there is no need to create dimension indices as for the HDI.

Originally, the measure of deprivation in a decent standard of living also included an indicator of access to health services. However, because reliable data on access to health services are lacking for recent years, deprivation in a decent standard of living is now measured by two rather than three indicators: the percentage of the population without sustainable access to an improved water source; and the percentage of children under weight for age.

Calculating the HPI-1 for The Gambia

1. Measuring deprivation in a decent standard of living in The Gambia

An un-weighted average of two indicators is used to measure deprivation in a decent standard of living for 2000:

Population without sustainable access to an improved water source	38%
Children under weight for age:	17%
Un-weighted average:	$\frac{1}{2}$ (population without sustainable access to an improved water source) + $\frac{1}{2}$ (children under weight for age)
	$= \frac{1}{2} (38) + \frac{1}{2} (17) = 27.5\%$

2. Calculating the HPI -1

The formula for calculating the HPI-1 is as follows:

$$\text{HPI-1} = [\frac{1}{3} (\rho_1\alpha + \rho_2\alpha + \rho_3\alpha)]^{1/\alpha}$$

Where:

ρ_1	=	Probability at birth of surviving to age 40 (times 100)
ρ_2	=	Adult literacy rate
ρ_3	=	Un-weighted average of population without sustainable access to an improved water source and children under weight for age
α	=	3

For The Gambia:

ρ_1	=	29.6% (2000 -05)
ρ_2	=	62.2% (2001)
ρ	=	38% (2000)
HPI-1	=	$[\frac{1}{3} (29.6^3 + 62.2^3 + 38^3)]^{1/3} = 45.8$

Prevalence Rates of HIV/AIDS and TB

HIV

Prevalence Rate = (Number of persons infected)/Total number of persons tested * 100

TB

New Smear Case Notification Rate = Number of new smear-positive cases/population * 100,000

All Cases Notification Rate = Number of all cases /population * 100,000.

APPENDIX 2: Definitions of Technical Terms

Debt relief committed under HIPC initiative involves the forgiveness of loans as a component of official development assistance under the debt initiative for Heavily Indebted Poor Countries (HIPCs). The initiative is the first comprehensive approach to reducing the external debt of 42 of the world's poorest, most heavily indebted countries⁵.

Gross Enrolment Ratio: The number of students enrolled in a level of education, regardless of age, as a percentage of the population of official school age for that level. The gross enrolment ratio can be greater than 100% because of grade repetition and entry at ages younger or older than the typical age for that grade level.

Net Enrolment Ratio: The number of students enrolled in a level of education who are of official school age for that level, as a percentage of the population of official school age for that level.

Gross Domestic Product (GDP) The sum of value added by all resident producers in the economy, plus any product taxes (less subsidies) not included in the valuation of output. It is calculated without making deductions for depreciation of fabricated capital assets, or for depletion and degradation of natural resources. Value added is the net output of an industry after adding up all outputs and subtracting intermediate outputs.

GDP index: One of the three component indices of the HDI, based on GDP per capita (PPP US\$).

GDP per capita: GDP (US\$) divided by midyear population.

Gender-related Development Index (GDI): A composite index measuring average achievement in the three basic dimensions captured in the HDI: life expectancy; knowledge; and standard of living; adjusted to account for inequalities between men and women.

HIV prevalence among pregnant women: Percentage of pregnant women in a specific age group infected with HIV.

Human Development Index (HDI): A composite index measuring average achievement in three basic dimensions of human development: life expectancy; knowledge; and standard of living.

Human Poverty Index for developing countries (HPI-1): A composite index measuring deprivation in the three basic dimensions captured in the HDI: life expectancy; knowledge; and standard of living.

Malaria cases: The number of Malaria cases reported to the World Health Organisation (WHO) by countries in which Malaria is endemic. Many countries report only laboratory-confirmed cases, but many in Sub-Saharan Africa report clinically diagnosed cases as well.

Official Development Assistance (ODA), net: Disbursements of loans made on concessional terms (net of repayments of principal) and grants by official agencies of the members of the Development Assistance Committee (DAC), by multilateral institutions and by non-DAC list of aid recipients. It includes loans with a grant element of at least 25% (calculated at a discount rate of 10%).

People Living with HIV/AIDS (PLWA): Number of people living with HIV/AIDS at the end of a specific year.

Population growth rate, annual: Average annual exponential growth rate for the period indicated.

PPP (purchasing power parity): Rate of exchange that accounts for price differences across countries, allowing international comparisons of real output and incomes. At the PPP US\$ rate (as used in this report), PPP US\$1 has the same purchasing power in the domestic economy as US\$1 has in the United States.

Tuberculosis cases: Patient in whom TB has been bacteriologically confirmed or diagnosed by a clinician.

Tuberculosis cases detected under DOTS: Percentage of estimated new infectious TB cases detected (diagnosed in a given period) under the directly observable treatment, short course (DOTS) case detection and treatment strategy.

Tuberculosis-related mortality rate: Total number of deaths caused by TB per 100,000 people, compiled from reports provided at registration of death.

Water source, improved, population with sustainable access to: Share of population with reasonable access to any of the following drinking water supplies: household connections; public standpipes; boreholes; protected dug wells; protected springs; and rainwater collection. Reasonable access is defined as the availability of at least 20 litres per person per day from a source within one kilometre of the user's dwelling.

5 Human Development Report, 2003.