The Gambia’s perspective on preparing for new TB vaccines introduction

TIMBER – The Gambia team

MINISTRY OF HEALTH • THE GAMBIA

Two National Health Programmes, One Mission

PART ONE — EPI → PART TWO — TUBERCULOSIS

September 2026

PART ONE

Overview of EPI

The Expanded Programme on Immunisation — The Gambia

A Little Bit of History

1967

Smallpox & measles control begins

Launched by Dr. P. J. N'Dow. Smallpox coverage reached 93% (scar-verified, 3+ months); measles coverage reached 92% among children 6 months–6 years.

1979

The Gambia EPI is established

Founded with the traditional antigens BCG, DPT, OPV and Measles, plus Yellow Fever (97% coverage among the population above 6 months).

1980–81

Routine coverage climbs fast

Routine immunisation (RI) coverage reached 86% in 1980 and 96% in 1981, cementing EPI as a national public-health pillar.

Programme Background

Established May 1979

14 antigens currently in use

Delivery Strategy

- Base: 427 clinic sessions
- Outreach: 366 clinic sessions

Vaccine Financing

- Gavi co-financing for new vaccines
- Government funds all traditional vaccines

Cold Chain

- Solar power for all health facilities
- WICR central & regional level stores
- UCC (Ultra Cold Chain) capacity

Coordination

- ICC-led advocacy & approvals
- Regional & facility-level oversight
- Community sensitisation network

BCG Vaccination in the Gambia

Year introduced	**May 1979**
Age at vaccination	**Soon after birth**
Dosage	**0.05 ml**
Site of administration	**Left upper arm**
Mode of administration	**Intradermal**

Type of syringe	**AD syringe**
Target population	**Live births (~73,000)**
Vial size	**20 doses**
Manufacturer	**Japan BCG Laboratory**

BCG

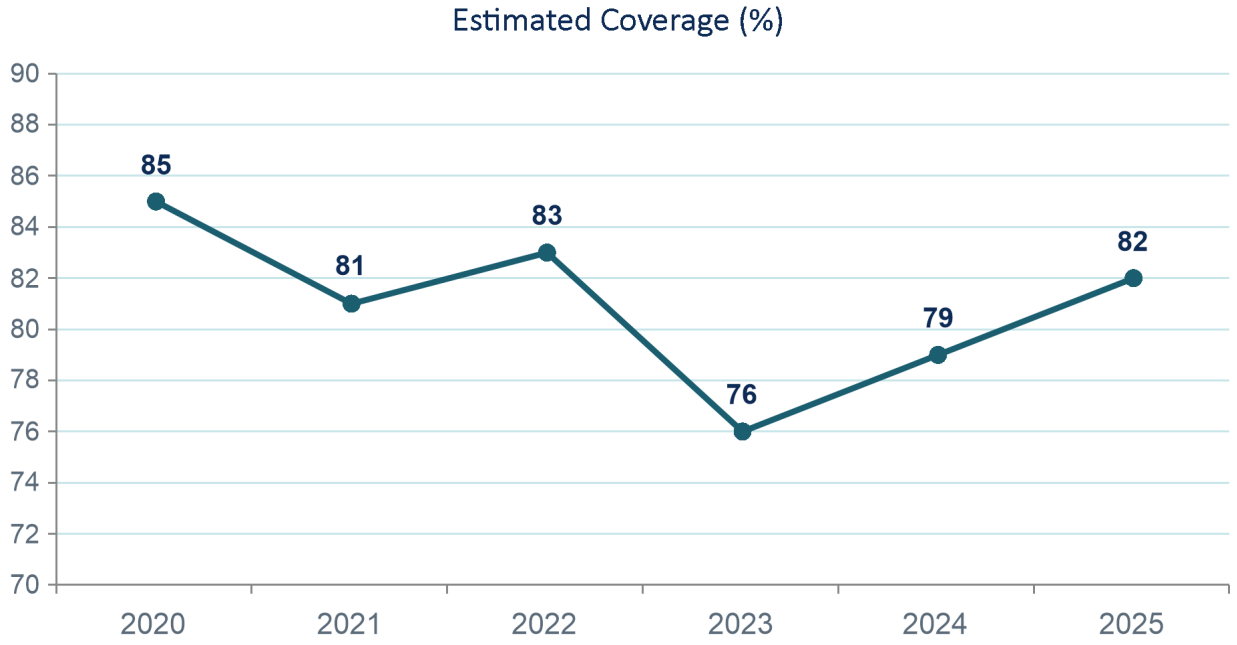
Bacillus Calmette–Guérin

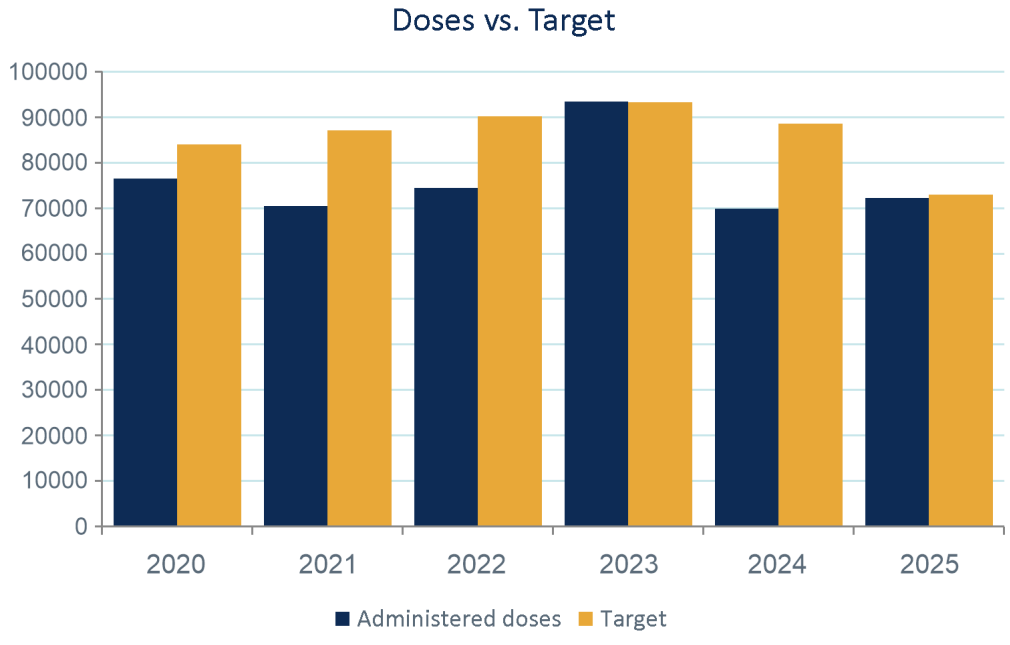
~73,000

live births targeted annually

BCG Coverage, 2020–2025

KEY MESSAGE • Estimated BCG coverage fell to 76% in 2023 and recovered to 82% by 2025.



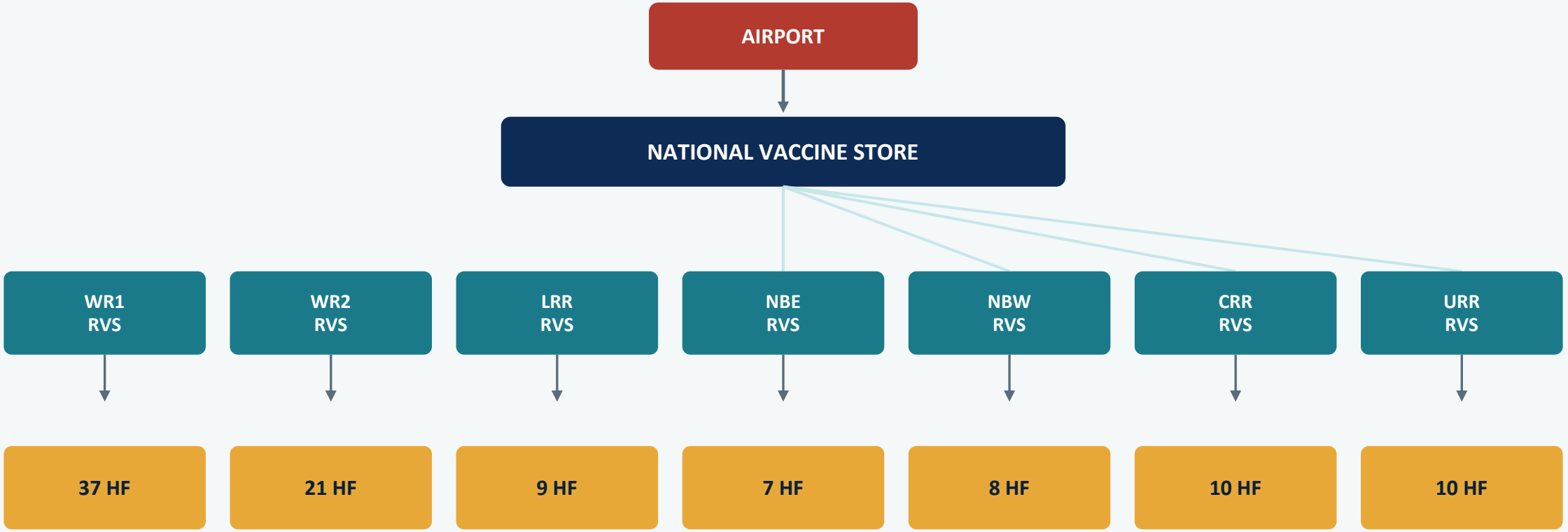


Note: In 2020 and 2025, WUENIC-estimated coverage differs from reported administrative coverage; the chart above shows WUENIC estimates. Administered-dose and target figures are drawn from routine reporting.

New Vaccines Introduced

Antigen	Year	Notes
Yellow Fever	1979	Introduced with the establishment of EPI
Hepatitis B	1990	Added to the routine schedule
Hib	1997	Haemophilus influenzae type b
Rotavirus	2013	Protection against severe diarrhoeal disease
PCV	2013	Pneumococcal conjugate vaccine
MenA	2019	Meningococcal A vaccine
HPV	2019	Human papillomavirus vaccine
Malaria vaccine	**Apr 2026**	Planned, pending NITAG approval
MCV5	**Forecast**	Included in current forecasting
Hexavalent	**Forecast**	Planned within the next 5 years

Immunisation Supply Chain



7 Regional Vaccine Stores **102** Health Facilities Served

Requirements for New Vaccine Introduction

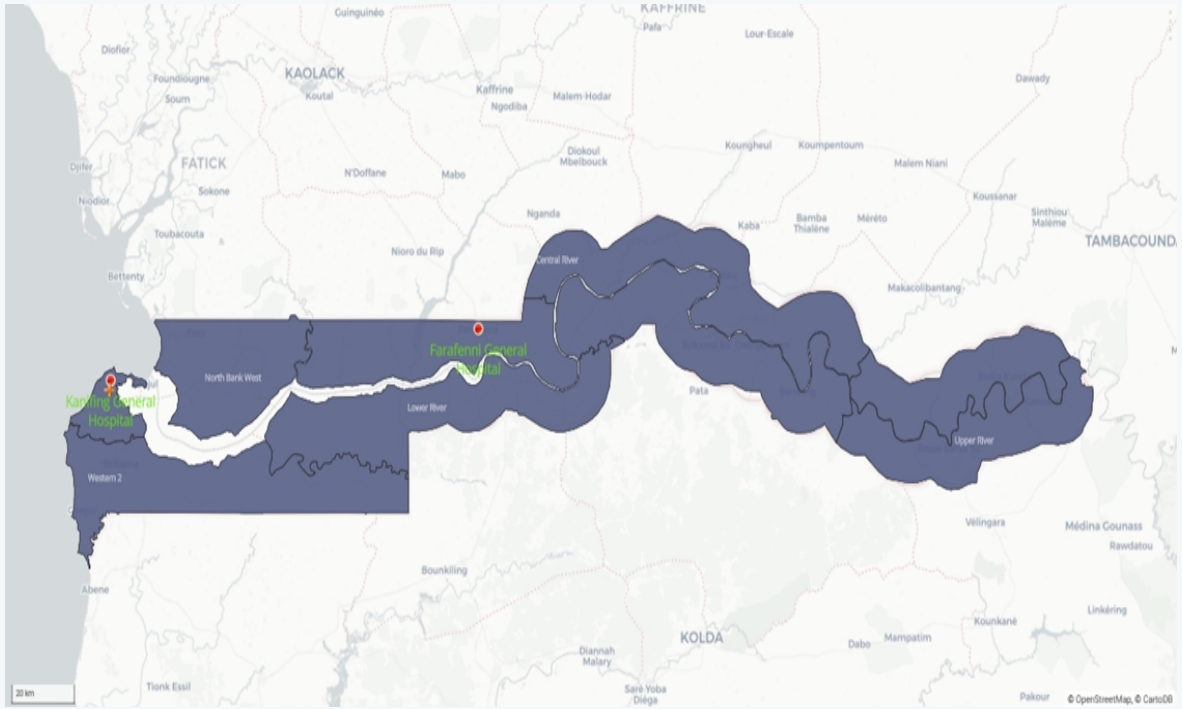
1. ICC approval and advocacy
2. Assessment of cold chain capacity
3. Possible expansion of cold chain storage space
4. Training of Trainers (ToT)
5. Cascade orientation / training of field staff
6. Printing of new data-collection & reporting tools (registers, ledgers, tally sheets)
7. Sensitisation of beneficiaries via print & electronic media
8. Motorcycle / vehicle support to strengthen services
9. Co-financing commitment (20%)

PART TWO

Advancing Evidence to End TB

The Gambia's National Tuberculosis Programme — From Research to Impact

Background



National TB programme coverage area

1,857,181

National population

138

TB incidence /100,000 population

8.1

Est. MDR-TB incidence /100,000

2%

National HIV prevalence

88%

DS-TB treatment success rate

64%

MDR-TB treatment success rate

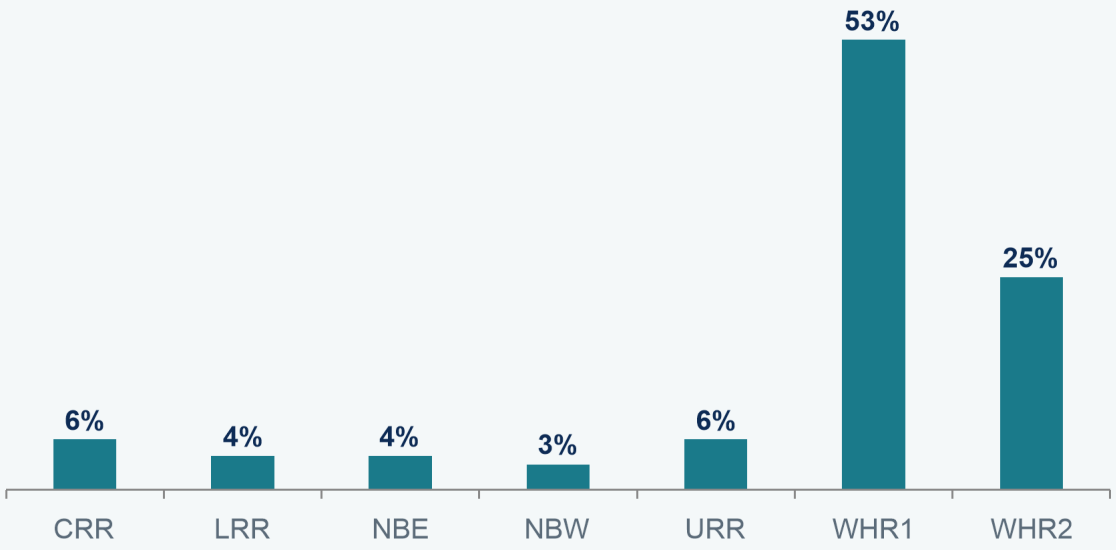
TB Notifications

KEY MESSAGE • TB notifications fell 8% in 2025; WHR 1 and WHR 2 accounted for 78% of notifications.

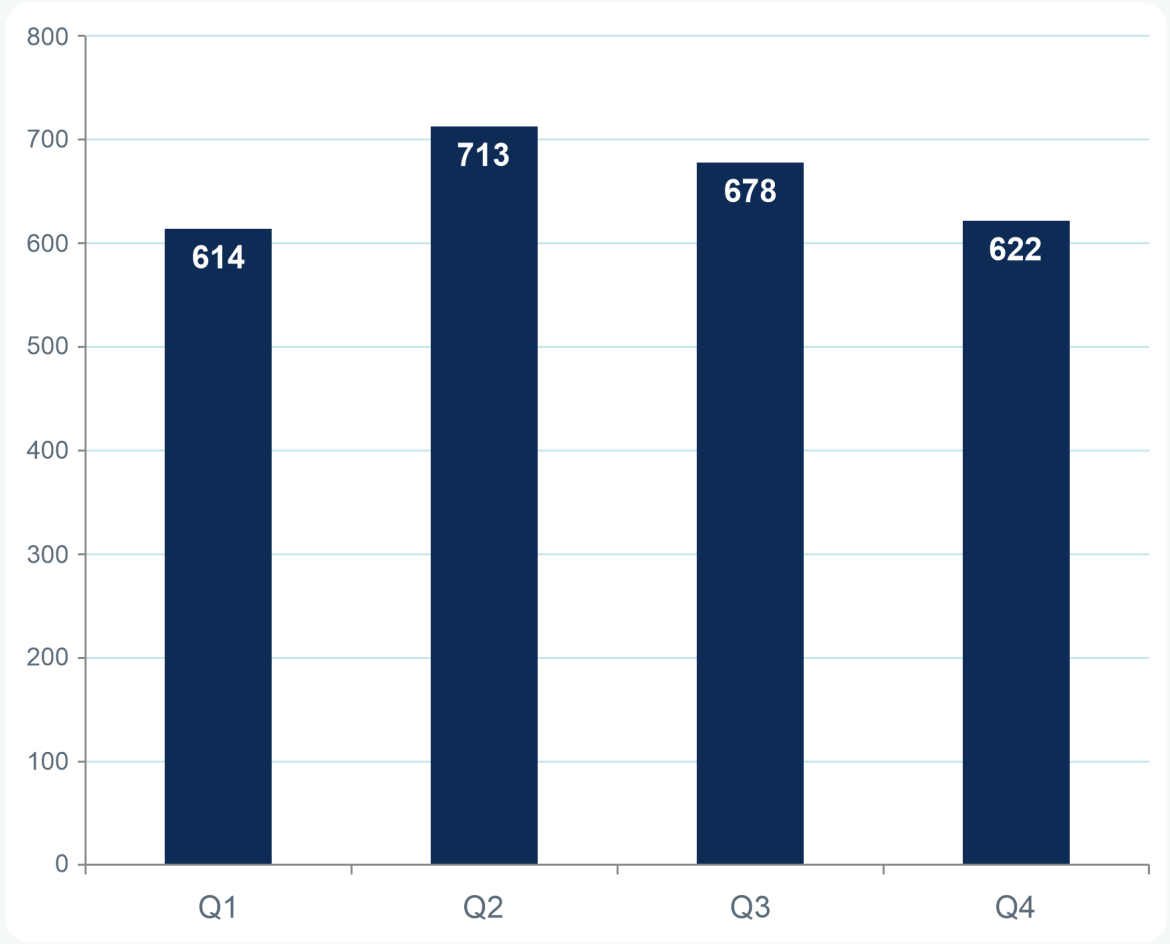
TB notifications declined by 233 cases — 8% in 2025 (2,860 in 2024 → 2,627 in 2025)

78% of all cases were notified from WHR 1 & WHR 2

Notification Share by Region, 2025



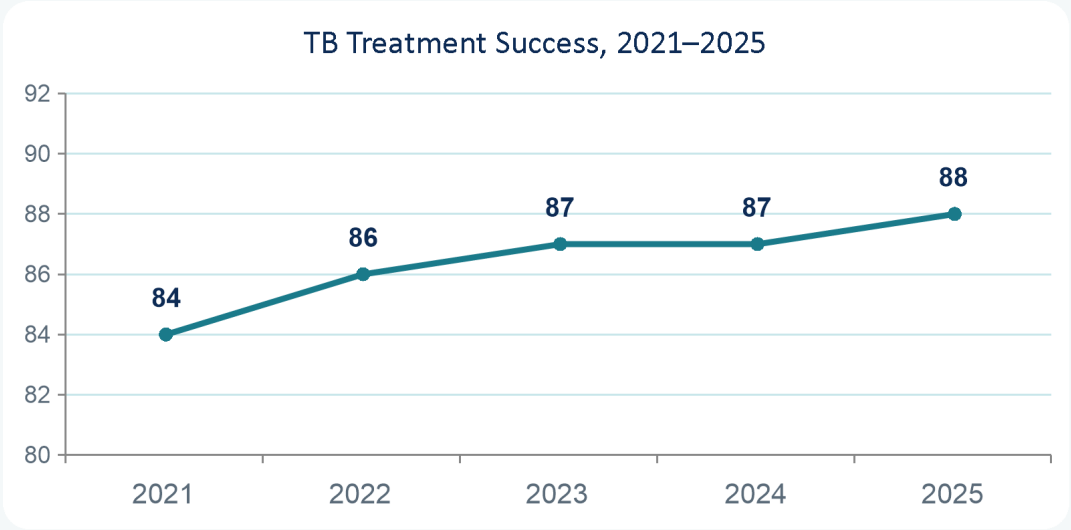
Quarterly Notifications, 2025



TB Treatment Outcome

KEY MESSAGE • Overall treatment success was 88% in the 2024 cohort, with variation across regions.

Region	Cases	Success	Deaths	LTFU
CRR	177	78.0%	7.3%	5.1%
LRR	121	77.7%	7.4%	12.4%
NBW	112	86.6%	7.1%	5.4%
NBE	68	89.7%	7.4%	2.9%
URR	149	95.3%	2.0%	0.0%
WHR 1	1,528	88.2%	4.1%	6.2%
WHR 2	673	90.6%	5.5%	3.0%
Total	**2,828**	**88.0%**	**4.9%**	**5.2%**



95%
Success among child TB

78%
Success among inmates

84%
Success among TB/HIV

PART TWO · TB

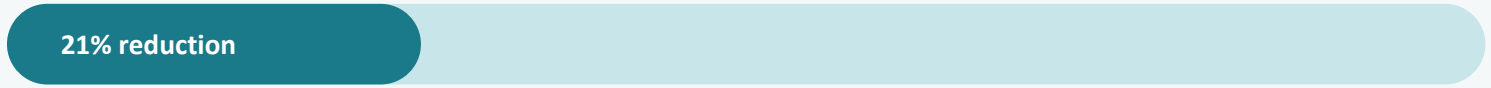
Progress Towards END TB Strategy 2025

KEY MESSAGE • Progress is evident, but substantial gaps remain against the stated 2025 END TB milestones.

TB Incidence Rate

Milestone: 50% reduction by 2025

Number of TB Deaths



Milestone: 75% reduction by 2025

Households Facing Catastrophic Costs

Milestone: 0% by 2025

Alignment with WHO Recommendations

National TB guidelines are aligned with WHO recommendations through the introduction of:

Increased access to mWRD

Molecular WHO-recommended rapid diagnostics

Scale-up of stool testing

Improves access to child-friendly diagnostics

BPaL/M as preferred regimen

First-line treatment for RR/MDR-TB

3HP for TB preventive therapy

Shorter, safer regimen for TPT

Representative TB medicines used under the updated regimens

Key Challenges

KEY MESSAGE • Priority constraints span case detection, diagnostics, workforce capacity and financial burden.

Case Detection Gap

- Passive case-finding approach
- Notification below estimated incidence, particularly among children
- Limited progress on childhood TB indicators

Diagnostic Gaps

- Single diagnostic focal point at NLTP
- Limited drug-susceptibility testing (DST)
- Staffing gaps at peripheral laboratories

Human Resources

- Frequent rotation of trained staff
- Variable staff qualification
- Ongoing data-quality challenges

High Financial Burden

- 45.6% of households face catastrophic costs
- Heavy dependency on donor financing

Summary of the New NSP (2027–2031)

KEY MESSAGE • The 2027–2031 NSP links expanded case finding and prevention with treatment, management and innovation.

GOAL

Reduce the burden and suffering from TB and Leprosy by 2030

VISION

A Gambia free from TB and Leprosy — zero deaths, zero disease, zero suffering

MISSION

Deliver high-quality, equitable TB and Leprosy services through strong, sustainable partnerships

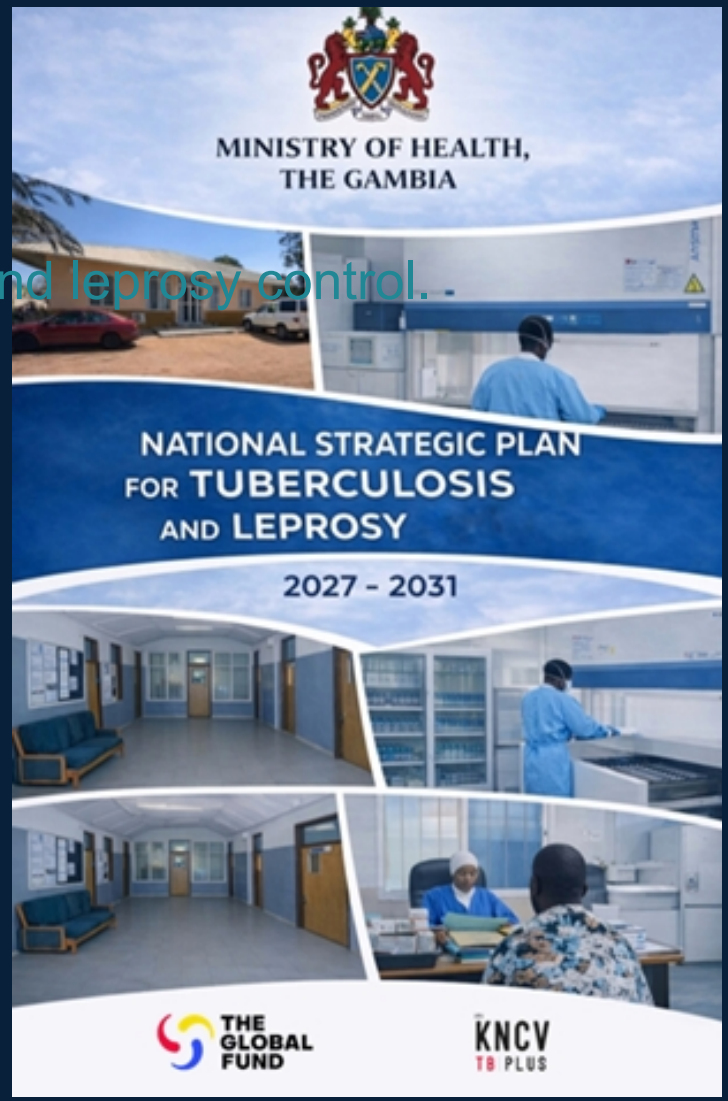
- SO 1 — Increase case finding and diagnostic capacity for DS-TB and DR-TB
- SO 2 — Increase TB preventive treatment for all eligible contacts
- SO 3 — Increase DS-TB and DR-TB treatment success and cure rates
- SO 4 — Strengthen programme management, coordination and accountability
- SO 5 — Strategic information, research and innovation

PART TWO · TB

From strategy to implementation: a five-year roadmap for TB and leprosy control.

Launch of the New NSP

The National Strategic Plan for Tuberculosis and Leprosy, 2027–2031, developed with support from The Global Fund and KNCV TB Plus, sets the roadmap for the next five years.



New TB Vaccine: Considerations NITAG Review

The **new TB vaccine** is one of **four new vaccines** currently under consideration by NITAG.

PUBLIC HEALTH IMPACT

- Reduction in disease incidence in at-risk populations
- Reduction in disease severity in at-risk populations
- Reduction in mortality
- Reduction in transmission

VACCINE & PROGRAMME

- Number of injections required
- Minimum duration of protection
- Annual vaccine and vaccination-material costs
- Feasibility of delivery to the target population

CONTEXT & ACCEPTABILITY

- Stigma associated with TB and implications for vaccine uptake
- TB treatment is available at health facilities
- Added value of vaccination alongside existing TB services
- Local evidence gaps and relevance of evidence from other settings

NITAG is reviewing the available evidence to inform prioritisation and future recommendations; some country-specific evidence is still being developed.

EVIDENCE TO INFORM DECISION-MAKING

NITAG: Building the Evidence Base

Local evidence remains limited, so NITAG is actively seeking and appraising evidence from The Gambia and comparable settings.

1 ACCEPTABILITY & STIGMA

How communities, families and providers perceive the intervention, including concerns about stigma, trust and uptake.

2 COST & COST-EFFECTIVENESS

Affordability, programme costs, value for money and implications for sustainable national implementation.

3 TRANSFERABLE EVIDENCE

Evidence from neighbouring and comparable settings is being considered while stronger local data are generated.

Priority now: identify the most decision-relevant evidence, understand where local evidence gaps remain, and determine what can reasonably be drawn from other settings.

Thank You