# COUNTRY PROGRESS REPORT

# SIERRA LEONE

**March 31 2012**

National AIDS Secretariat

**National AIDS Secretariat**
15A Kingharman Road
Brookfields, Freetown
Sierra Leone
Tel: +232-22-235842/235836
Fax: +232-235843
Email: secretariat@nas.gov.sl
Website: www.nas.gov.sl

# Table of Contents

## ABBREVIATIONS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ANC** | Antenatal Care |
| **ART** | Antiretroviral Therapy |
| **ARV** | Antiretroviral |
| **BCAASL** | Business Coalition Against Aids in Sierra Leone |
| **BCC** | Behavioural Change Communication |
| **BSS** | Behavioural Surveillance and Survey |
| **CBO** | Community Based Care |
| **CCM** | Country Coordination Mechanism |
| **CDC** | U.S Centre for Disease Control |
| **COPSAASL** | Coalition of Public Sector Against HIV and AIDS in Serra Leone |
| **CSO** | Civil Society Organization |
| **CSW** | Commercial Sex Worker |
| **DAC** | District AIDS Committee |
| **DHMT** | District Health Management Team |
| **EID** | Early Infant Diagnosis |
| **ETWG** | Extended Technical Working Group |
| **EPP** | Estimation and Projection Package |
| **FSU** | Family Support Unit |
| **GF** | The Global Fund on HIV/AIDS, TB and Malaria |
| **GNI** | Gross National Income |
| **GoSL** | Government of the Republic of Sierra Leone |
| **GWT** | Gender Working Team |
| **HARA** | HIV and AIDS Reporters Association |
| **HBC** | Home Based Care |
| **HCT** | HIV Counselling and Testing |
| **HDI** | Human Development Index |
| **HIV** | Human Immunodeficiency Virus |
| **HR** | Human Rights |
| **IDU** | Injecting Drug Users |
| **IEC** | Information, Education and Communication |
| **INGO** | International Non Governmental Organization |
| **KYE,KYR** | Know Your Epidemic, Know Your Response |
| **MARPs** | Most-at-Risk Populations |
| **MDG** | Millennium Development Goals |
| **M&E** | Monitoring and Evaluation |
| **MEYS** | Ministry of Education, Youth and Sport |
| **MoFED** | Ministry of Finance and Economic Planning |
| **MoHS** | Ministry of Health and Sanitation |
| **MoT** | Modes of Transmission |
| **MoYS** | Ministry of Youth and Sports |
| **MSM** | Men who have Sex with Men |
| **MSWGCA** | Ministry of Social Welfare, Gender and Children Affairs |
| **NAC** | National AIDS Council |

| | |
|---|---|
| **NACHAN** | National Civil Societies HIV and AIDS Network |
| **NACP** | National AIDS Control Programme |
| **NAS** | National HIV/AIDS Secretariat |
| **NETHIPS** | Network of HIV Positives |
| **NGO** | Non-governmental Organization |
| **NSP** | National Strategic Plan |
| **OP** | National Operational Plan |
| **OI** | Opportunistic Infection |
| **OVC** | Orphans and Vulnerable Children |
| **PABA** | People Affected By AIDS |
| **PEP** | Post Exposure Prophylaxis |
| **PHU** | Peripheral Health Unit |
| **PLHIV** | People Living with HIV |
| **PMTCT** | Prevention of Mother to Child Transmission |
| **PWD** | People Living With Disabilities |
| **RH** | Reproductive Health |
| **SLDHS** | Sierra Leone Demographic and Health Survey |
| **SLYCHA** | Sierra Leone Youth Coalition of HIV and AIDS |
| **SLIRAN** | Sierra Leone Inter-Religious AIDS Network |
| **STI** | Sexually Transmitted Infections |
| **TWG** | Technical Working Group |
| **UNAIDS** | Joint United Nations Program on HIV and AIDS |
| **UNDP** | United Nations Development Programme |
| **UNFPA** | United Nations Population Fund |
| **UNGASS** | United Nation General Assembly Special Session |
| **UNICEF** | United Nations Children Fund |
| **VOW** | Voice of Women |
| **WFP** | World Food Programme |
| **WHO** | World Health Organization |

# I Status at a Glance

## a) Development Process and Stakeholder Involvement

Following activities were undertaken which ensured inclusion of stakeholders and quality assurance in preparing this report.

i. **Preparatory Activities (January 23- February 3, 2012):** A task team was setup by the National AIDS Secretariat, mainly drawn from the national M&E technical working group, whose main task was to facilitate data collection, analysis, validation and report drafting. The task team also drew up a detailed roadmap.

ii. **Data Gathering (February 6-14, 2012)**

a) Desk review of relevant documents and secondary data:

Task team conducted review of data and relevant documents which includes;

- ✓ 2010 Sierra Leone UNGASS Progress Report
- ✓ 2011 AIDS at 30, Nations at the crossroads
- ✓ 2011 Multi Cluster Indicator Survey
- ✓ National Strategic Plan 2011-2015
- ✓ National Operational Plan 2011-2012
- ✓ Monitoring and Evaluation Framework 2011-2015
- ✓ 2012 SPECTRUM output
- ✓ 2010 and 2011 NAS/NACP HIV Programme Data
- ✓ 2010 and 2011 TB Programme Data
- ✓ 2008 and 2009 National AIDS Spending Assessment
- ✓ 2003, 2006, 2007, 2008, 2009, 2010 ANC Sentinel Surveillance Reports
- ✓ 2008 Sierra Leone Demographic and Health Survey
- ✓ 2002 HIV/AIDS Sero-Prevalence and Behavioural Risk Factor Survey
- ✓ 2005 National Population Based HIV Sero-Prevalence Survey of Sierra Leone
- ✓ 2003 Post-Intervention Survey Report: HIV/AIDS/STI Knowledge, Attitudes and Practice
- ✓ Survey among Commercial Sex Workers, Military and Youth in Port Loko, Sierra Leone
- ✓ 2009 Border Communities, Mobile Populations and Exposure to HIV in Countries of the Mano River Union
- ✓ 2008 HIV Surveillance on Mine Workers in Sierra Leone
- ✓ 2007 Prevalence of HIV and other STIs in Sierra Leone Among Armed Forces
- ✓ 2007 Report on HIV Surveillance Among Police in Sierra Leone
- ✓ 2008 & 2011 Survival Analysis for PLHIV on Antiretroviral Therapy
- ✓ 2009 Pulmonary Tuberculosis Among PLWHAs Attending Care and Treatment Centers in Freetown, Sierra Leone
- ✓ 2009 and 2011 Prevalence of HIV Infection Amongst Children Born to HIV-Infected Mothers

b) Interviews and Consultations with Stakeholders (February 7-15, 2012):

In-depth Interviews and consultations were held with key stakeholders from various institutions which include among others, National AIDS Secretariat, Ministry of Health and Sanitation-National AIDS Control Programme, UN Joint Team on AIDS**,** a number of civil society organizations including PLHIVs, faith based organization, and international organizations.

### iii. Data processing, analysis, and report drafting (February 20 - March 10, 2012)

NCPI coordinator and Data entry operator entered collected data and information in SPSS and obtained aggregated scores. The constituted task team facilitated data processing and validation, particularly in vetting 2011 HIV estimates and projections, NCPI, NASA results and HIV/STI/TB programme data. A preliminary report was then drafted that was subjected to validation.

### iv. Validation, Finalization and Submission of the report (March 13 - 31, 2012)

A half-day validation meeting was held with a group of various stakeholders (50+ participants) to review the draft report. Stakeholders included people from UN systems, public and private sectors, bi- and multi-lateral donors as well as implementing partners, coordinating bodies, PLHIV groups, key population, the media, FBOs etc. Comments from the participants were incorporated to finalize the GARP report. Consensus was reached at the validation meeting before final submission of the report.

## b) Status of the HIV Epidemic

Adult HIV prevalence is estimated at 1.5% whilst that of pregnant women attending ante-natal clinics stands at 3.2%. Sierra Leone HIV prevalence peaked during 2005 and, according to the 2007 figures; it has stabilized at 1.5%. This makes Sierra Leone one of the least affected countries in the world. This stabilization is thought to be partially due to an increase in HIV awareness and multi-sectoral involvement of implementing and development partners. An estimated 48,000 Sierra Leoneans are living with HIV out of which 4,400 are children. Women are disproportionately affected by HIV. HIV prevalence among women is 1.7% while that of their male counterparts is 1.2%. This disparity is even greater in young women aged 15-19. Girls are more likely to become infected with HIV than boys of the same age because of early initiation of sexual intercourse as evidenced from high teenage pregnancy. The mean age at which women start having sexual relations in Sierra Leone is 16 and only 3% of young women and 7% of young men used condoms during their first sexual encounter. The study further estimated 69% of the teenage girls to have had their first child before the age of 18.

In addition, the study also revealed that HIV is prevalence is three times higher among adolescent girls (1.4%) than boys (0.5%). HIV prevalence was highest for the 23-24 age group, while among young men was highest for the 20-22 age group. Adult HIV prevalence is greater in urban areas (2.5%) than rural areas (1.0%) of Sierra Leone.

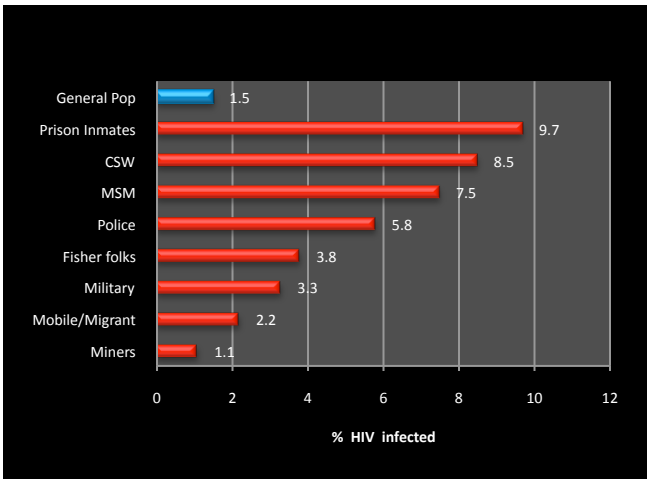
**Figure 1: Sources of new infections (MoT 2010)**

| Groups | Adult | Adult & Paediatric |
|---|---|---|
| Sex workers and clients | 39.7% | 35.1% |
| Casual heterosexual sex | 40.8% | 34.2% |
| Mother to Child Transmission (MTCT) | -------- | 13.7% |
| Heterosexual sex within union/ regular partnership | 15.6% | 13.5% |
| MSM | 2.4% | 2.1% |
| Injecting Drug Use (IDU) | 1.4% | 1.2% |
| Health Facility Related | 0.1% | 0.2% |
| Number of New Infections | 5,044 | 5,844 |

Sierra Leone's HIV epidemic has been categorized as mixed, generalized and heterogeneous – meaning that HIV affects different population sub-groups and all sectors of the population through multiple and diverse transmission dynamics. The 2010 HIV Modes of Transmission Study revealed that for all new HIV infections in adults (15-49 years), commercial sex workers, their clients and partners of clients contributed 39.7%; people in discordant monogamous relationships contributed 15.6% and people

reporting multiple partnerships and their partners contributed 40%. MSMs and IDUs are slowly emerging in the Sierra Leone society. They contributed 2.4% and 1.4% of the new infections, respectively.

**Figure 2: HIV Prevalence by Various Population Sub-Groups**




HIV prevalence is higher amongst specific groups and various studies have revealed high HIV prevalence amongst a number of key affected groups, including sex workers, mobile populations (miners, fisher folks etc.), men who have sex with men and injecting drug users. A UNODC study estimates that 14% of Intravenous Drug Users (IDUs) live in Freetown with 47% of them sharing needles. A CSW study further revealed 1.6% of sex workers were IDUs with 87% of them sharing needles.

### c) Overview of the Policy and Programmatic Response

HIV prevention has been the mainstay of the national response since the adoption of the multi-sectoral response in 2002. This has been the key aspect of mobilizing the society. The aim of the Sierra Leone National HIV and AIDS Strategic Plan (2011 – 2015) is to achieve zero new HIV infection by 2015 by using new evidence-based approaches to HIV prevention. The Priority Intervention populations and sub-groups targeted in the NSP II are Female Sex workers and their clients; MSM; IDUs; Fisherfolks; Transporters; Uniformed personnel; Prisoners ; Miners ; Cross-border and informal Traders ; Women, girls and children; Youths and General Population. Both Policy and Programmatic Response reviews were undertaken in 2010 in developing the costed NSPII, M&E Plan II and Operational Plan.

#### i. Policy Response to HIV and AIDS

This NSP II was developed in the context of:

a) The 1991 Constitution of The Republic of Sierra Leone: affirms the national philosophy of social justice and guarantees the fundamental right of every citizen to life and freedom from discrimination.

*b)* Complementary government documents that provide the basis for the NSP: The President's Agenda for Change- which stresses the prevention of new infections, treatment, care and support to people living with HIV/AIDS, including orphans and vulnerable children. Second Poverty Reduction Strategy Paper (PRSP II), 2008-2012, Joint Review of National response to HIV/AIDS, Prevention and Control of HIV and AIDS Act as well as the *UN Joint Vision for Sierra Leone and* the UNAIDS *Outcome Framework 2009–2012*.

c) Sierra Leone's commitment to various international conventions: Convention on Elimination of All Forms of Discrimination Against Women (CEDAW); Millennium Development Goals Declaration (2000); the Abuja Declaration and Framework for Action for the Fight against HIV,TB, and related diseases in Africa (April 2001); and the United Nations General Assembly Special

Session on HIV/AIDS (UNGASS) at which countries committed to ensure an urgent, coordinated, and sustained response to HIV and AIDS and the United nations charter on Human Rights.

### ii. Programmatic Response to HIV and AIDS

The programmatic response to HIV and AIDS is based on the NSPII 2011-2015. The programmatic response is organised around six main thematic areas and further sub-divided in sub-themes as follows:

(i) Coordination, Decentralized Response, Resource Mobilization And Management

a. Institutional Arrangements
b. Coordination & Decentralised Response
c. Resource Mobilisation and Application
d. Health Systems, Procurement, Logistics and Human Resources

(ii) Policy, Advocacy, Human Rights and Legal Environment.

a. Policy
b. Advocacy
c. Human Rights
d. Legal Environment

(iii) Prevention of New HIV Infections

a. HIV Counselling & Testing (HCT)
b. Prevention of Mother-to-Child Transmission (PMTCT)
c. Early Infant Diagnosis
d. Prevention of New Infections Among the HIV Positive Persons
e. Behavioural Change Communication Interventions
f. Management of STIs
g. Condom Promotion
h. Prevention of Biomedical Transmission of HIV
i. Sexual Reproductive Health & HIV Integration

(iv) Treatment Of HIV And Other Related Health Conditions

a. Anti-Retro-viral Treatment (Adult & Paediatric)
b. ART Adherence Counselling
c. Treatment of Opportunistic Infections
d. Management of Co-infection of TB/ HIV & HIV/Hepatitis
e. Improved Commodities Logistic Management System
f. Clinical & Laboratory Services
g. Quality Assurance
h. Quality Improvement Mechanisms

(v) Care And Support for the Infected and Affected By HIV/AIDS

a. Access to Quality Care and Support Services by PLHIVs
b. Economic Empowerment of the PLHIV
c. Integrated & Comprehensive Support for the OVC

(vi) Research, Monitoring And Evaluation

a. Coordination of M&E
b. Capacity Building for M&E
c. Surveys and Surveillance
d. Research
e. Data Collection, Data Quality & Audit
f. Information & Knowledge Management

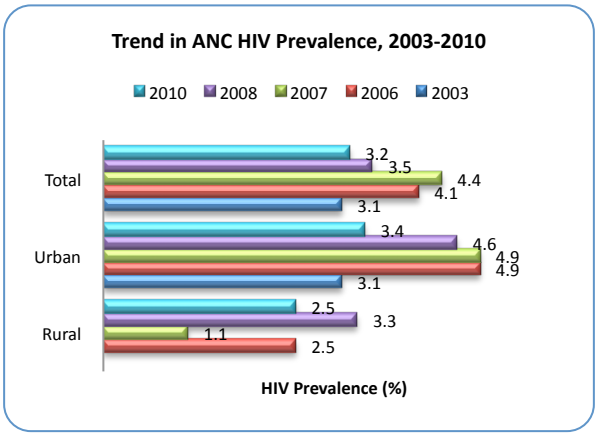
## d) Overview of the Indicator data

| Indicators | 2010 | 2011 | Comments |
|---|---|---|---|
| **Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015** | | | |
| **Indicators for the General Population** | | | |
| 1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission | 15-24yrs:<br>Women 17.2%<br>Men 27.6%<br>15-19yrs:<br>Women 16.4%<br>Men 26.1%<br>20-24yrs:<br>Women 18.0%<br>Men 29.6% | | 2008 SLDHS, Page 186-188 |
| 1.2 Percentage of young women and men who have had sexual intercourse before the age of 15 | 15-24yrs<br>women 24.6%<br>Men 11.0%<br>15-19yrs<br>women 22.3%<br>Men 11.4%<br>20-24yrs<br>women 26.8%<br>Men 10.5% | | 2008 SLDHS, Page 210 |
| 1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months | 15-49yrs<br>women 4.9%<br>Men 20.8%<br>15-24yrs<br>women 6.4%<br>Men 18.9% | | 2008 SLDHS, Page 199-200 |
| 1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse | 15-49yrs<br>women 6.8%<br>Men 15.2%<br>15-24yrs<br>women 12.2%<br>Men 29.2% | | 2008 SLDHS, Page 197-199 |
| 1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and who know their results | 15-49 years<br>Men 3.4%<br>Women 4.1%<br>15-24 yrs<br>Men 1.2%<br>Women 4.4% | | 2008 SLDHS, Page 201-202 |
| 1.6 Percentage of young women aged 15–24 who are living with HIV | 15-24yrs 2.8%<br>15-19yrs 2.1%<br>20-24yrs 3.4% | | 2010 ANC Sentinel Surveillance Survey |
| **Indicators for the Sex Workers** | | | |
| 1.7 Percentage of sex-workers reached with HIV prevention programmes | Data not available | | Size Estimation exercise not yet conducted |
| 1.8 Percentage of female and male sex workers reporting the use of a condom with their most recent client | Female sex workers 71% | | 2009 KAP Survey |
| 1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results | 82.5% | | 2009 KAP Survey |

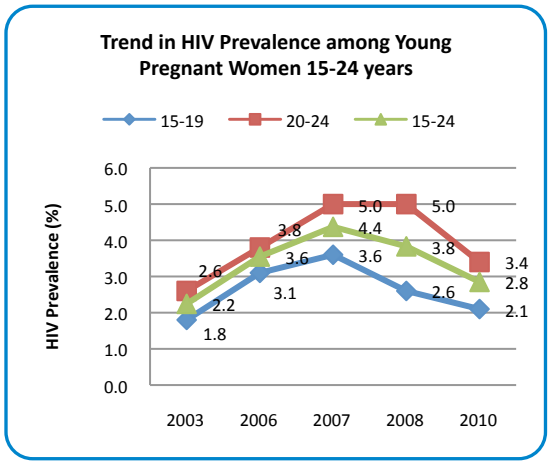
| Indicators | 2010 | 2011 | Comments |
|---|---|---|---|
| 1.10 Percentage of sex workers who are living with HIV | 8.5% | | 2010 MOT Study |
| **Indicators for Men who have sex with Men** | | | |
| 1.11 Percentage of men who have sex with men reached with HIV prevention programmes | Data not available | | Size Estimation exercise not yet conducted |
| 1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner | 59.8% | | 2010 MSM Study |
| 1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and who know the results | Data Not available | | |
| 1.4 Percentage of men who have sex with men who are living with HIV | 7.5% | | 2010 MSM Study |
| **Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015** | | | |
| 2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes | Data not available | | |
| 2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse | Data not available | | |
| 2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected | Data not available | | |
| 2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and who know the results | Data not available | | |
| 2.5 Percentage of people who inject drugs who are living with HIV | Data not available | | |
| **Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related** | | | |
| 3.1 Percentage of HIV-positive pregnant women who receive antiretroviral to reduce the risk of mother-to-child transmission | 58% | 74% | Women receiving ARVs in 2010 and 2011 was 1805 and 2338, respectively. The estimated number of positive pregnant women needing PMTCT was 3129 and 3141 in the years under review. |
| 3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth | Data not available | | Pilot Early Infant Diagnosis implemented in mid 2011 |
| 3.3 Mother-to-child transmission of HIV (modelled) | 24% | 22% | This variable can also be calculated using the variables in SPECTRUM on "New HIV infections" for children 0-14 years and dividing this by the variable "Women in need of PMTCT" = 761 in 2010 and 680 in 2011<br>Women in need of PMTCT = 3129 and 3141 in 2010 and 2011<br>2011 MoH Study indicates a 5% MTCT rate among HIV exposed children to mothers on complete course of ARV prophylaxis |

| Indicators | 2010 | 2011 | Comments |
|---|---|---|---|
| | | | |
| **Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015** | | | |
| 4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy | 33% | 42% | Adults and children in need of ART were 18,097 and 19,533, in 2010 and 2011 respectively. Those on ART treatment were 5,978 and 8,115 in 2010 and 2011 respectively. |
| 4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy | 83% | | 2011 ART Survival Analysis Study |
| **Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015** | | | |
| 5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV | 19.30% | | 2011 TB Programme Data 14.4% of PLHIV on have TB; 20.7% men and 7.27 women, 2009 Report on Pulmonary Tuberculosis among PLWHAs Attending Care and Treatment Centers in Freetown, Sierra Leone |
| **Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries** | | | |
| 6.1 Domestic and international AIDS spending by categories and financing sources | Domestic source - 3.1%<br>International Source - 96.7%<br>Private source - 0.2%<br>2009 - USD 14,309,550 | | 2008 and 2009 NASA Study See attached NASA template |
| **Target 7. Critical Enablers and Synergies with Development Sectors** | | | |
| 7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation) | See attached NCPI questionnaire | | |
| 7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months | 9% | | 2009 KAP Survey |
| 7.3 Current school attendance among orphans and non-orphans aged 10–14 | Orphans attending school (79.9% male & 68.2% female)<br>Non-Orphans attending school (84.1% male & 83.8% female) | | 2011 MICS4 |
| 7.4 Proportion of eligible households who received external economic support in the last 3 months | Data Not available | | |

## II Overview of the AIDS Epidemic




The overall HIV prevalence among pregnant women in 2010 was 3.2%. By rural-urban residence, the prevalence of HIV is higher among urban dwellers (3.4%) compared to their rural counterparts (2.5%). Between 2006 and 2010, HIV prevalence among pregnant women reduced by 22 percent, from 4.1% to 3.2%, respectively. In urban areas, HIV prevalence reduced by 31 percent, from 4.9% in 2006 to 3.4% in 2010. On the other hand, the overall HIV prevalence has remained relatively stable between 2006 and 2010, although there was a 24 percent decline between 2008 and 2010.




Results presented here show trends in HIV prevalence among young pregnant women (15-24 years) between 2003 and 2010. Overall, trends show that HIV prevalence among young pregnant women (15-24 years) increased between 2003 and 2007 from 2.2% to 4.4% respectively, and then declined to 2.8% in 2010. A similar pattern is also observed among the 15-19 years and 20-24 years. Among the 15-19 years, HIV prevalence increased from 1.8% in 2003 to 3.6% in 2007 and then declined to 2.6% in 2010. Among the 15-19 years, HIV prevalence increased from 1.8% in 2003 to 3.6% in 2007 and then declined to 2.6% in 2010. Among the 20-24 years, HIV prevalence increased from 2.6% in 2003 to 5.0% in 2007 and then declined to 3.4% in 2010. The broad peak of the HIV epidemic was between 2007 and 2008.

## III National response to the AIDS epidemic

### a) Prevention

Key prevention strategic documents and guidelines were developed or updated in the period under review. These are the PMTCT Scale-Up Plan, PMTCT technical guidelines, National Prevention Strategy for HIV 2011-2015, and National Behaviour Change, Communication and Advocacy Strategy 2011-2015. Also, of significance importance was the enactment of the HIV law in September 2011.

### i. PMTCT

In the period under review, prevention efforts were scaled up and tremendous progress was achieved. According to NAS/NACP Programme data, PMTCT sites increased from 495 health facilities in 2010 to 515 in 2011. Consequently, this helped to increase uptake of PMTCT services. The number of pregnant women tested for HIV and received their test results increased by 22% from 113,558 to 138,006 in the period under review. Regarding ART prophylaxis for HIV positive pregnant women, coverage increase from 58% to 74%, representing a 28% increase between 2010 and 2011. The number of pregnant women receiving complete course ART prophylaxis also increased from 915 to 1,131 between 2010 and 2011.

### ii. EID

In 2011, Early Infant Diagnosis (EID) was piloted in five sites. The objectives of the pilot EID were to observe challenges relating to specimen collection using DBS; packaging, storage and transportation of specimen from the sites to the National Reference laboratory; assessing the capacity of the handling and testing of samples at the national reference laboratory; and determining the average Turn Around Time for samples. A total of 266 samples were collected from HIV exposed children of which 40 were rejected and 226 were analysed. About 29 or 13% samples were found to be positive.

### iii. HCT

In 2010, a total of 232,452 people were counselled, tested and received their results, while 347,567 were served in 2011. This result indicates that about 115,015 more people were tested for HIV than in 2010. Voluntary Confidential Counselling and testing was undertaken in both PMTCT sites and VCCT stand alone sites, coupled with outreach activities. VCCT sites increased from 497 in 2010 to 556 in 2011.

### iv. Blood Screening, STI Treatment & Condom Promotion

On average, about 33,000 blood units were collected in both 2010 and 2011, and all (100%) were screened for HIV, syphilis, and hepatitis B and C, in conformity to national guidelines. On STIs, a total of 99,592 and 80,770 people were treated in 2010 and 2011, respectively. Over 560,000 people were reached with HIV and AIDS behaviour change messages. About 4,715,000 male condoms and 30,000 female condoms were distributed in 2011. This distribution of condoms increase by more than two-fold due to improved condom distribution strategies put in place at the beginning of 2011.

**Table 1: Programme Data for Prevention Indicators for 2010 and 2011**

| Programmatic Area | Indicators | 2010 | 2011 |
|---|---|---|---|
| **PREVENTION** | | | |
| **HCT** | No. of VCCT sites | 497 | 556 |
| | No. counselled, tested and received results | 232,452 | 347,567 |
| | No. tested positive | 7,187 | 10,179 |
| **PMTCT** | No. of PMTCT sites | 495 | 515 |
| | No. of pregnant women tested and received results | 113,558 | 138,006 |
| | No. of pregnant women tested positive | 1,941 | 2,620 |
| | No. of HIV+ pregnant women on ART for own health | 378 | 440 |
| | No. of HIV+ pregnant women receiving ARVs at ANC | 1,427 | 1,898 |
| | No. of HIV+ pregnant women receiving complete course of ARV prophylaxis | 915 | 1,131 |
| | No. of HIV+ pregnant women in need of ART prophylaxis | 3,129 | 3,141 |
| | PMTCT Coverage | 58% | 74% |
| **STI** | No. treated for STIs | 99,592 | 80,770 |
| **Blood Safety** | No of blood safety sites | 24 | 24 |
| | No. of blood units screened for HIV, Syphilis and Hepatitis B and C | 31,675 | 34,390 |
| **Condoms** | No. of male condoms distributed | 1,973,640 | 4,715,224 |
| | No. of female condoms distributed | | 30,000 |
| **Sensitization** | No. of adults and young people sensitized of HIV and AIDS issues | 561,372 | |

Source: NAS/NACP, 2010 and 2011 Programme Data

As a result of all these prevention efforts, according to the 2008 SLDH about 69% of women and 83% of men are aware about HIV and AIDS issues. Further, only about 38% of women and 56% of men indicated that HIV can be prevented by using condoms and limiting sexual intercourse to one HIV negative partner. In addition, a mere 14% of women and 25% of men had comprehensive knowledge about HIV and AIDS. Comprehensive knowledge means a person knowing that consistent use of condoms during sexual intercourse and having just one HIV-negative faithful partner can reduce the chances of getting the AIDS virus; knowing that a healthy-looking person can have the AIDS virus; and rejecting the two most common local misconceptions about AIDS transmission or prevention. Unfortunately, stigma and discrimination against PLHIVs still remains a challenge. According to SLDHS results only 5% of women and 15% of men expressed accepting attitudes of PLHIVs. However, 49% of women and 73% of men are willing to care for a family member with HIV.

The SLDHS also revealed that about 45% of women and 50% of men know that HIV can be transmitted by breastfeeding, and 14% of women and 24% of men know that the risk of MTCT of HIV can be reduced by mothers taking ART prophylaxis during pregnancy.

HIV testing and counselling is an entry point to receiving care and treatment. The SLDH shows that 27% of women and 33% of men know where to get an HIV. Out of the total adult population, only about one in ten (9% of women and 7% of men) had ever taken an HIV test to know their status. More surprising, however, a paltry 4% of men and 3% of men currently know their HIV status.

Having multiple concurrent sexual partners and inconsistent use of condoms with non-regular partners increases the risk of contracting HIV and other sexually transmitted infections such as syphilis. During the 2008 SLDHS, 9% of women and 8% of men reported having had an STI. About 5% of women and 21% of men reported to have had multiple sexual partners. The mean number of lifetime sexual partners for women is two and that of men seven. Among the sexually active population that engaged in risky multiple sexual relations with non-regular partners, 7% of men and 15% of women used a condom in their last sexual encounter. The survey also reveals that only2% of men paid for sex.

For the young people (15-24 years), early sexual initiation pre-exposes them to the risk of contracting HIV and other STIs, and pregnancy in the case of women. According to the SLDHS, the mean age at first marriage is 17 years for women and 25 years for men. On the contrary, 25% of women and 11% of men had sexual intercourse before the age of 15. The average age at which women start having sexual relations is 16 and 19 years for men, there by suggesting that pre-marital sex is prevalent and women initiate sexual activity three years earlier than men. Further, only 3% of young women and 7% of young men used condoms during their first sexual encounter. In addition, 12% of young women (15-24 years), 15% of young women (15-17 years) and 7% of young women (18-19 years) reported to have had higher-risk sexual intercourse with a man 10+ years older.

Male and female circumcision is almost universal, with 96% and 91% circumcised, respectively.

### v. Health Facilities

A total of 1,258 health facilities were reported to be available in Sierra Leone. A majority of the health facilities (1105 or 88%) were government, while 153 or 22% were run by private entities or FBO/NGO.

**Table 2: Programme Data for Health Facilities for 2010 and 2011**

| Programmatic Area | Indicators | 2010 & 2011 |
|---|---|---|
| **HEALTH SYSTEM STRENGTHENING** | | |
| **Health Facilities** | Total No. of Health Facilities | 1,258 |
| | No. of Public Health Facilities | 1,105 |
| | No. of Private Health Facilities | 53 |
| | No. of FBO/NGO Health Facilities | 100 |

Source: NAS/NACP, 2010 and 2011 Programme Data

### b) Care and Support

Tuberculosis (TB) is one of the common opportunistic infection among PLHIV. Therefore, in order to improve the quality of life of PLHIV co-infected with TB, it is necessary for them to have access to treatment of TB. According the recent (2009) report on Pulmonary Tuberculosis among PLHIVs, 14% are co-infected with TB, 7% among women and 21% among men. Programme data for 2011 from the Ministry of Health and NAS show that a total of 4,375 HIV positive persons were screened from TB in HIV settings, of which 358 or 8% were co-infected with TB. In TB settings from 162 DOTs sites and health

facilities, 8,934 TB patients were tested for HIV. About 774 or 9% were co-infected with HIV. Out of all co-infected patients with TB and HIV , 149 or 19% were receiving ART.

**Table 3: Programme Data for Care and Support Indicators 2010 and 2011**

| Programmatic Area | Indicators | 2010 | 2011 |
|---|---|---|---|
| **CARE AND SUPPORT** | | | |
| **TB/HIV** | No. of HIV+ persons screened for TB | 1,201 | 4,375 |
| | No. of HIV+ persons with positive TB test result | | 358 |
| | No. of TB patients tested for HIV | | 8,934 |
| | No. of TB patients co-infected with HIV | | 774 |
| | No. of co-infected patients on ARV treatment | | 149 |
| | No TB sites | | 162 |
| **OVC** | No. of OVC provided with nutritional and educational support | 1,1285 | 3,151 |
| **Nutritional** | No. of PLHIVs provided with HBC psychosocial and nutritional support | 696 | 2,910 |

Recent estimated number of PLHIV in need of care and support is pegged around 5000. Inadequate nutrition increases the risk of rapid progression of HIV to AIDS and decreases PLWHA capacity to fight opportunistic infections. According to the NAS programme data, 2,910 PLHIV were provided with nutritional support in 2011, a four-fold increase from 696 in 2010. National Home-based care guidelines for PLHIVs were also updated in 2010. The number of OVC receiving nutritional and educational support more than doubled from 1,285 in 2010 to 3,151 in 2011.

The Network of HIV Positives in Sierra Leone (NETHIPS) had a total of 40 support groups nationwide. NETHIPS has played a significant role of mobilizing PLHIV and the general population to access various HIV and AIDS services that include PMTCT, VCCT, treatment, nutritional support, and awareness raising in order to reduce stigma and discrimination.

In 2010, NETHIPS with support from the UN family started the livelihood programme focusing on empowering PLHIV through livelihood activities fitting in with and making use of local resources. As a result, 23 PLHIV support groups out of a total 40 were supported (about 1,200 PLHIV from NETHIPS 6,000 membership). Activities include small scale business (charcoal, palm oil, clothing) and agriculture (cassava, rice farming, animal husbandry) and larger business (bakery, photocopying and grocery stores). All members quantify the project impact in terms of how it increases their opportunities to support their families, particularly the women which make up to 70% of the support groups. NTEHIPS also advocated for 159 acres of land for livelihood activities.

It is a well known fact that AIDS deaths affect mostly adults in their prime and productive age groups. This has a bearing on household welfare, especially the school attendance of orphans. The 2005 Multi-Indicator Cluster Survey showed that only 1.3% of households fostering orphans received free basic external support. Nearly four-in-ten (39%) of households are fostering orphans.

The 2011 MICS results indicate that orphans are less likely to attend school than non-orphaned children. About 80% of male and 68%female of the orphans compared to 84% of male and 84% of female non-orphans were attending school. Female-orphans are more disadvantaged in attending school than their male counterparts.

### c) Treatment

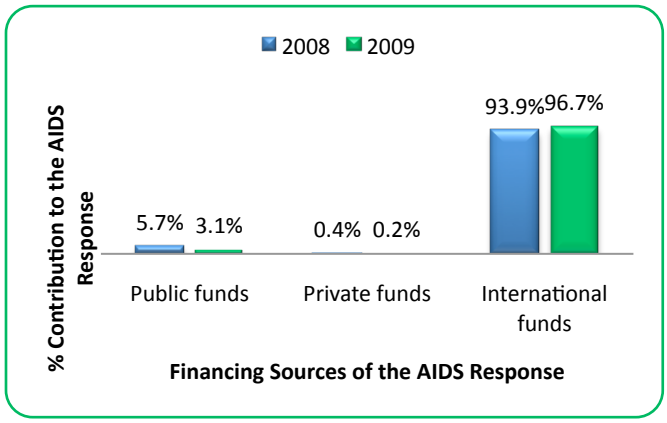
Early initiation of treatment for PLHIV improves their quality of life and prolongs their survival. Since the provision of free ART policy came into effect in 2005, there has been a significant increase in the uptake of ART services and subsequent scale-up of ART sites. Between 2010 and 2011, uptake of ART for both children and adults increased from 5,978 to 8,115 clients. This represents 33% and 42% coverage of those in need of ART. Treatment centers also increased from 113 to 131 in the same reference period. According to the 2011 MoH report of Survival Analysis for Adult PLHIV on ART, 83% of them are known to be on treatment 12 months after initiation of ART, slightly lower than 84% established in 2009. Paediatric and Adult ART guidelines were also updated in 2011.

**Table 4: Programme Data for Care and Support Indicators 2010 and 2011**

| Programmatic Area | Indicators | 2010 | 2011 |
|---|---|---|---|
| **TREATMENT** | | | |
| **ART** | No. of ART sites | 113 | 131 |
| | No. patients currently on treatment | 5,978 | 8,115 |
| | Adults | 5,552 | 7,582 |
| | Children | 426 | 533 |
| | No. in need of ART | 18,097 | 19,533 |
| | ART Coverage | 33% | 42% |

### d) Financing Sources, Financing Agents and Spending Categories

According to the 2008 and 2009 NASA report, the HIV response in Sierra Leone is highly dependent on international funds. About 94% and 97% of the funds in 2008 and 2009 came from international sources, mainly the Global Fund. Multilateral sources are the main source of funding in Sierra Leone, however most of the funds are managed by public institutions, mainly the National AIDS Secretariat. Expenditure on Prevention accounted for 33% and 43% of total HIV spending in 2008 and 2009, respectively. Programme management captures a significant share of HIV spending in Sierra Leone (40% and 18% in 2006 and 2007 respectively).




According to NASA results, about 70 percent of the funding for HIV was routed through public sector agents. The public sector controlled 68 percent of the funds in 2008 and 71 percent in 2009, and the international organizations followed at 32 percent in 2008 and decreased to 20 percent in 2009 while the private sector controlled less than 10 percent in both 2008 and 2009. Worthy noting, the main beneficiary populations were young people, children living with HIV, adult population and PLHIVs, respectively. However, of the key populations, only sex workers were beneficiaries. There were no beneficiary programmes for IDUs and MSMs.

### e) Political Commitment

The commitment of His Excellency the President Ernest Bai Koroma in taking the lead in spearheading and mobilizing the nation in the AIDS response is recognized globally. As a result, Sierra Leone was awarded an MDG award in 2010 for the high level political commitment. His Excellency the President Ernest Bai Koroma, the First Lady, Cabinet Ministers, Members of Parliament, and civic and traditional leaders graced the World AIDS Day Celebrations in 2010 and 2011, respectively.

In addition, Sierra Leone attended the June 2011 High Level Meeting led by the First Lady accompanied by Minister of Health and Sanitation, Director of National AIDS Secretariat, the National Coordinator of the PLHIV and two representatives from CSO. The outcome of the HLM were presented at the 5$^{th}$ NAC meeting chaired by H.E. the President. The currently leading Elimination of Mother to Child Transmission of HIV agenda in Sierra Leone, which was launched during the World's AIDS Campaign week of 2011.

### f) Civil Society Organizations Participation

The 2012 NCPI rating clearly shows the high participation of CSO. Particularly considerable advances have been made regarding involvement and representation of PLHIV in the national response, most notably with NETHIPS's representation in the National AIDS Council, in the CCM, BCAASL and at many key coordinating and numeral CSO's involvement in development of national strategies and in enactment of HIV law. NETHIPS represents over 40 PLHIV support groups nationwide has been playing a significant role in all sectors of the HIV/AIDS response. One notable achievement in 2011, was the election of CCM vice chairperson from the network of people of PLHIV

NETHIPS and other CSO organizations actively advocated for enactment of HIV law focusing on the Human Rights of PLHIVs. As a result, the HIV law was enacted in September 2011. CSOs have been fully involved in the process. With the enactment of the law it is envisaged that there will be improved implementation of policies and practices to protect human rights of PLHIVs and reduction of stigma and discrimination. This will also increase the government's response to support people both infected with and affected by HIV.

Establishment of new Civil Society Coordinating entities including Youth coalition and Inter-religious coalition also enforced CSO's active involvement in the national response. In order to respond more effectively, all of 7 coordinating entities from civil society and private sector have successfully developed their work plans aligning to new NSP 2011-2015 and currently mobilizing resources for implementation of HIV activities.

### g) Line Ministries

The National AIDS Secretariat serves as the lead organization supporting Line Ministries in the national response. HIV Focal Points are committed in HIV work place issues in their ministries. In November 2010, all Ministers and the Vice President attended at Children's conference on AIDS. Each of Ministers showed marked commitments for the national response particularly for children including orphan's care and support. More specifically further funding allocation from Government budget was committed by Minister of Economics and Finance. Recommendations from the Children's conference were submitted to the H.E. of President at the 2010 World AIDS Day celebrations

## IV. Best Practices

### Best Practice 1

### Key Pillar Activities

Since 2010 Sierra Leone has produced and published five strategic documents, known as the Key Pillar Activities that now guide the national response to HIV in the country. These documents are:

- The Joint Programme Review of NSP 2006 -2010 (JPR)
- Sierra Leone Mode of Transmission Study, 2010 (MOT)
- National Strategic Plan on HIV/AIDS 2011-2015 (NSP)
- National Operational Plan on HIV/AIDS 2011-2012 (OP)
- National M & E Plan on HIV/AIDS 2011-2015 (M&E)

MOT study provided a better understanding on the nature of the epidemic in Sierra Leone and JPR showed review achievements in the last five years and find out the strengths, weaknesses, challenges and opportunities of the national response to HIV/AIDS.
Key of these initiatives provide a firm basis for National HIV/AIDS response programming and implementation, hence the National Strategic Plan for the period 2011-15 was successfully developed in 2010. This is a more comprehensive result-based strategic plan on HIV/AIDS that also chart the roadmap for Sierra Leone towards achieving the Millennium Development Goal to have halted and begun to reverse the spread of HIV/AIDS by 2015.

Having launched the second National HIV/AIDS Strategic Plan, two-year costed operational plan and a new National Monitoring and Evaluation Plan were developed in 2011 to strengthen the tracking and assessment of the epidemic and the response towards the attainment of the NSP goal of "Zero New HIV Infections".

The participatory and inclusive development process has promoted ownership among all partners involved including the key coordinating bodies. The challenge therefore was to ensure all commitments with new NSP and OP are adhered to; in order to facilitate this, coordinating bodies were supported to develop costed strategic action plans aligned to the NSP and OP, to give them direction in implementing their activities and also to enable them to mobilize resources. Gender was mainstreamed in the Operational Plan through a consultative workshop of key stakeholders, led by the Gender Technical Team.

On August 2011, the official launch and handing over of the 5 Key Pillar Documents to H.E. the President Dr Ernest Bai Koroma by the Director of the National AIDS Secretariat was witnessed at the 5th National AIDS Commision meeting.

...

## Best Practice 2

## Coordination Bodies & Capacity development

A wide range of strategic and technical expertise exist within the coordinating bodies that made them an ideal partners in the programme and policy implementation of the National strategic plan 2011-2015 (NSP). To date, seven civil society umbrella bodies are functional including two newly established in 2011.


Realizing the needs of young people and their critical roles in broader HIV dialogues and decision-making, empowering youths to protect them against HIV is urgent issues in Sierra Leone. Hence, Sierra Leone Youth Coalition on HIV and AIDS (SLYCHA) was formed and launched in November 2011, which amalgamate and coordinate all youth groups working in HIV response. Sierra Leone Inter Religious on AIDS Network (SLIRAN) was also formed in order to provide leadership, strategic direction, resource mobilization, and information sharing among the Christian and Muslim members ensuring its coordinated and integrated response to expand national HIV response.

In 2010-2011, UNAIDS country office have supported the coordinating bodies in strengthening their capacity to carry out their mandate alighting to NSP. 35 key staffs from coordinating bodies and NGOs were trained in M&E and RBM. Those who received training have developed 2 or 3 year work plan of each agencies. As a result, all coordinating organizations developed the costed work plans aligning to NSP. This will give guidance and direction in implementing activities and support in mobilizing

## Best Practice 3

## Empowering PLHIV's Livelihood in Sierra Leone

In 2010 the Network of HIV Positives in Sierra Leone (NETHIPS) with support from the UN Family realized a long-term ambition implementing a livelihoods programme to benefit People living with HIV (PLHIV) and their families in Sierra Leone. NETHIPS is an umbrella/ coordinating body representing 40 PLHIV support groups throughout Sierra Leone.

**Rational:**
In Sierra Leone it is estimated there are over 50,000 People living with HIV. The burden of HIV-related illness, expenses for healthcare, food and transportation are large, while the ability to generate income without support is small. The livelihood programme focuses on empowering PLHIV through livelihood activities fitting in with and making use of local resources. To date 23 PLHIV Support Groups out of total of 40 are supported throughout each region in the country (about 1,200 PLHIV from NETHIPS 6,000 membership) Activities include small scale business (charcoal, palm oil, clothing) and agriculture (cassava, rice farming, animal husbandry) and larger business (bakery, photocopying and provision stores)

**How it works:**
The livelihoods project involve a two track approach providing direct seed funds, and providing administrative & financial trainings to strengthen the capacities of PLHIV sub recipients to manage the livelihoods projects. The livelihoods project involve a two track approach providing direct seed funds, and providing administrative & financial training to strengthen the capacities of PLHIV sub recipients to manage the livelihoods projects.

**Benefits:**
All members quantify the project impact in terms of how it increases their opportunities to support their families, particularly the women which make up to 70% of the support groups. Partnerships have been formed with chiefs, traders, bankers & the community. The Government of Sierra Leone is to lease 4 acres of land to NETHIPS. Agricultural land has been provided by Chiefs for Makeni (15 acres) & Kenema (104 acres). It's raised the profile of support groups demonstrating their skills and ability to do business, to take care of their families and to contribute to Sierra Leone's national growth and development.

**Way Forward:**
Resource constraints limit livelihoods coverage to all PLHIV groups, only 23 out of 40 are supported. No support group should miss the opportunity as livelihoods is changing lives of people living with HIV and

## V. Major Challenges and Remedial Actions

### a) Major Challenges

Notwithstanding the above achievements the following challenges have been faced in the collection, management and utilization of information that is strategic to the management of the national HIV and AIDS response in Sierra Leone:

i. Programme and survey data for key populations (sex workers, MSM and IDUs) is not available, making it difficult to monitor and evaluate programme coverage
ii. There is lack of a national dissemination strategy of sharing key strategic information that informs programmatic review and management decisions.
iii. Inadequate documentation (comprehensive inventory) and sharing of studies undertaken by partners. In addition, there isn't a clear Research Agenda yet to fill the gap of already existing wealth of HIV and AIDS information
iv. M&E capacity at sub-national and at CBO/NGO level still remains a challenge
v. Provision timely and quality data still remains a challenge for most of the implementing partners
vi. The lack of updated mapping of HIV partners posses a great challenge in capturing all the results to give a national picture of the AIDS response.

### a) Remedial Actions Planned to overcome some of the challenges

To overcome the above challenges, NAS has planned to put in place the following:

i. Conduct a size estimation exercise for key populations (sex workers, MSM and IDUs)
ii. Strengthened the M&E technical working group by revising the TORs and holding of regular scheduled meeting
iii. Develop a quarterly schedule for regular supportive and on-site data validation visits
iv. Decentralized M&E functions by employing Regional M&E Officers who will collect, collate and validate data for onward transmission to the national database manager
v. Develop a documentation, storage and dissemination strategy of programme and survey data
vi. Continue to build the M&E capacity at national and sub-national levels through in-country and international M&E trainings
vii. Develop an M&E reference manual
viii. Develop a research agenda that will guide the national AIDS response, especially in the area operations research. NAS will also support holding of regular technical discussions and
ix. Conduct a comprehensive mapping exercise of implementing partners in the national AIDS response.

## VI Support From the Global Fund, Irish AID and UN Family

As a step to further scale up the national response, the Country Coordination Mechanism (CCM) in Sierra Leone received an USD 86 million dollar grant for HIV/AIDS and Health Systems Strengthening from the Global Fund (consolidated Round 9). The five-year grant aims at scaling up existing HIV interventions in the country such as: increasing knowledge and promoting behavioral change through community drama, ensuring safe blood nationwide, promote

correct use of condom, improve and scale up PMTCT and VCCT services, improved access to ART services, provide HIV prevention, treatment care and support to special groups, to strengthen and expand the national capacity to design, implement, monitor and evaluate HIV programmes etc. About USD29 million was released for a two-year Phase I implementation and Phase II process for the remaining three years is currently underway.

The Global Fund is currently funding Round 7 Phase II TB grant amounting to USD 5.87 million and the CCM is in the final stage of applying for USD3.4 million TB Transitional Funding Mechanism. The Malaria Consolidated Round 10 grant from the Global Fund amounting to USD 24.6 million is currently being implemented.

Through the Joint Vision 2009-2012, Irish AID and UN Family Core funds, a total of USD6.2 million was spent on supporting various activities in the AIDS response. Main activities supported included livelihood activities for PLHIV, scale-up of PMTCT services, sexual and reproductive health services, technical assistance, nutritional support to PLHIVs, world AIDS campaign, M&E training and supplies, and development and dissemination of key strategic documents (HIV law, NSP, MoT, M&E, OP, Communication Brief, PMTCT guidelines, Paediatric ART guidelines, etc)

## VII Monitoring and Evaluation Environment

There have been a number of key developments towards enhancing an effective Monitoring and Evaluation environment for the National response. These include;

i. National HIV and AIDS Monitoring and Evaluation Technical Working Group (TWG) comprising of members from NAS, development partners, NGOs, Ministries and Departments and Academics, all under the stewardship of NAS was reconstituted and strengthened. Terms of reference for the TWG were revised in 2011 and four meetings were held. The TWG is charged with responsibility of providing overall technical guidance and leadership in the implementation of the National HIV and AIDS Monitoring and Evaluation framework and the M&E provisions in NSP 2011-2015. The National AIDS Secretariat (NAS) has a functional Monitoring and Evaluation Unit headed by a Senior Monitoring with technical backstopping provided by UNAIDS Monitoring and Evaluation Adviser.
ii. NAS in conjunction with support from various partners conducted key studies and evaluations on HIV and AIDS in the period under review. Notable among them was the Sierra Leone Modes of Transmission Study 2010, ANC Sentinel Surveillance 2010, MICS 4, BSS, CSW study, Survival Analysis of Adults on ART, PMTCT Review, MTCT study

iii. NAS also conducted a Joint Review of the national response to HIV and AIDS in 2010, developed a two-year Operational Plan 2011-2012, NASA 2008 and 2009, and Technical Assistance plan 2011-2012.

iv. NAS and NACP recruited Regional Coordinators of HIV and AIDS programmes and M&E officers.

v. MoHS, NAS, NACP and NTBLP provided programme data for 2010 and 2011 relating to HIV and TB.

vi. With support from the Global Fund, NAS developed a GAP analysis and Performance Framework for consolidated Round 9 grant

vii. An M&E capacity building training for M&E team of NAS and NACP at national level, UN Joint Team, Coordinating bodies, NGOs, DACs, HIV counselors, National Coordinators (ART, VCCT) were conducted. Over 80 participants were trained nationally.

viii. Capacity of national and sub-national M&E units of DACs and HIV focal points were strengthened by provision of computers, printers, scanners, photocopiers, internet modems, antivirus, mass storage data external drives, generators, and motor bikes for supervision. Tool kits for maintenance were also procured and distributed

ix. The NAS and NACP M&E units and programme staff undertook quarterly supervisory field visits to provided appropriate onsite technical assistance and feedback on the quality of data. A new national database was developed, piloted and now being rolled-out. HIV service data feeds into the national HMIS.

x. M&E Systems Strengthening Tool (MESST) assessment was conducted to identify strengths, gaps, opportunities and recommendations in developing the costed Monitoring and Evaluation Plan on HIV/AIDS 2011-2015 plan.

xi. Based on the findings and recommendations from the in the MESST Assessment, National Monitoring and Evaluation Plan on HIV/AIDS 2011-2015 was developed and disseminated in February 2011.

xii. In the period under review, national counterparts were equipped with skills in conducting size estimation of key populations and HIV and AIDS estimations and projections. To this effect, 2011 HIV and AIDS estimates and projections were updated.

xiii. As already highlighted, the main challenges relate to collecting data for key populations; M&E capacity of CBOs and at sub-national levels; under-utilization of results and data for programme design and improvement; and lack of research agenda and operations research for HIV programmes.

xiv. Therefore, technical assistance and capacity building will be required in size estimation of key populations; M&E training and mentoring; development of data dissemination strategy and training in use of data; and development of research agenda.

## REFERENCES


Ministry of Health and Sanitation and National HIV/AIDS Secretariat, 2010. ***Antenatal Surveillance on HIV Sero-Prevalence and Syphilis in Sierra Leone 2010***

Ministry of Health and Sanitation. February 2012, ***HIV/AIDS/STIs Behavioural Surveillance Survey (BSS) Among Female Commercial Sex Workers in Sierra Leone***
Ministry of Health and Sanitation. January 2012, ***Bulletin Volume 3, Number 4***

National HIV/AIDS Secretariat, 2011. ***2008 and 2009 National AIDS Spending Assessment***

National HIV/AIDS Secretariat 2009, ***Institutional Review of National HIV/AIDS Seretariat.***

National HIV/AIDS Secretariat and National AIDS Control Programme, ***2008-2011 programme data***

National HIV/AIDS Secretariat and UNAIDS, *2011.* ***2010 Sierra Leone UNGASS Progress Report***

National HIV/AIDS Secretariat and UNAIDS, ***2010 Sierra Leone Report on Universal Access to HIV Prevention, Treatment, Care & Support***

National HIV/AIDS Secretariat, 2010. ***2010 Partnership Forum Report***

National HIV/AIDS Secretariat, August 2010. ***Sierra Leone HIV Modes of Transmission Study-Know Your Epidemic, Know Your Response***

National HIV/AIDS Secretariat, 2010. ***Final Joint review of the National Response to HIV and AIDS 2006-2010***

National HIV/AIDS Secretariat. April 2011, ***Sierra Leone HIV/AIDS policy for Mining sector***

National HIV/AIDS Secretariat. February 2011, ***National Monitoring and Evaluation Plan for HIV - 2011-2015***

National HIV/AIDS Secretariat. April 2011, ***National Strategic Plan for HIV - 2011-2015***

National HIV/AIDS Secretariat. March 2012, ***National HIV Prevention Strategy - 2011-2015***

National HIV/AIDS Secretariat. March 2012, ***National HIV Behaviour Change Communication and Advocacy Strategy - 2011-2015***

Statistics Sierra Leone (SSL) and ICF Macro. 2009, ***Sierra Leone Demographic and Health Survey 2008***

Statistics of Sierra Leone & UNICEF 2011, ***Multi Cluster Indicator Survey - 4***

UNAIDS, 2010: ***UNAIDS Strategic Plan 2010-2011***

UNAIDS, 2011: ***AIDS at 30, Nations at the crossroads***

WHO, 2010 & 2011: Programme Data on TB