



# 2010 Sierra Leone UNGASS Progress Report



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National HIV/AIDS Secretariat

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## II. Status at a glance

### (a) Background of Sierra Leone

Sierra Leone has an estimated population of about 5.6 million people and its average annual growth rate is 2%. The female population accounts for 52% of the total population with an average total fertility rate of 5.1 children per woman (3.5 urban vs. 5.8 rural). The country's total surface area is about 72,000 Km<sup>2</sup>. Administratively, the country is divided into 4 regions, namely, the Western Area, Northern Region, Southern Region and Eastern Region. These four regions are further sub divided into 19 Local Council areas: 14 district councils areas and 6 towns (including the city of Freetown). The Districts are subdivided into Chiefdoms and chiefdoms are further sub divided into wards into sections. In all, there are 149 chiefdoms. The Western Area is divided into Western Rural and Western Urban which is the capital city, Freetown and the seat of Government.

Sierra Leone is potentially a rich country but the economic and health indices of the population have remained unsatisfactory since the end of 1990s. The country suffered from a 10-year long brutal civil-war that led to the displacement of about 60% of the population from their homes and destroyed most of the social service delivery infrastructure. The majority of population in Sierra Leone, especially in rural areas, lacks access to basic social services. The 2008 SLDHS indicate that 51% of households have access to clean and safe drinking water (83% urban vs. 34% rural); 12% of households have access to electricity (33% urban vs. 1.4% rural). The adult literacy rate is estimated at 26% for women and 45% for men. About 71% of the population is poor. Sierra Leone's Infant (IMR), Under five (UMR) and Maternal Mortality ratio (MMR) have been among the highest in the world, standing at 89, 140 and 857, respectively.

### (b) Process and Methodology

In preparing this report the following activities were undertaken which ensured inclusion of stakeholders and quality assurance.

- I. Review of secondary data from data sources and reports which include:
  - 2003, 2006, 2007 & 2008 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 Survival Analysis for PLHIV on Antiretroviral Therapy
  - 2009 Pulmonary Tuberculosis Among PLWHAs Attending Care and Treatment Centers in Freetown, Sierra Leone
  - 2009 Prevalence of HIV Infection Amongst Children Born to HIV-Infected Mothers
  - 2008 and 2009 NAS/NACP HIV Programme Data
  - 2008 and 2009 Ministry of Education, Youth and Sport Life Skills Programme Data
  - 2006 and 2009 Partnership Forum Reports
  - 2006 and 2007 National AIDS Spending Assessment
  - 2008 Sierra Leone UNGASS Progress Report
  - 2004 Census Report on Population Size, Age and Sex Structure
  - 2004 Census Report on Projection for Sierra Leone
  - 2004 Census Report on Poverty
  - 2009 UNAIDS/WHO Epidemic Update
  - 2005 Multi Cluster Indicator Survey
  - National Strategic Framework -2006-2010
  - 2010 EPP and SPECTRUM Output
  - Monitoring and Evaluation Framework 2006-2010 and
  - 2009 Institutional Review of National HIV/AIDS Secretariat
2. Interviews with relevant stakeholders from the following institutions: National AIDS Secretariat, Ministry of Health and Sanitation-National AIDS Control Programme, UN Joint Team on AIDS , a number of civil society organizations including PLWHA, faith based organization, and international organizations. The data presented in this report was reviewed and validated by the various stakeholders including the National AIDS Secretariat to gain consensus and absolute country ownership.

A multidisciplinary and multi-sectoral taskforce of the National AIDS Secretariat constituted the technical team, which provided technical oversight and validation throughout the report generation process.

The detailed roadmap of the process involved:

- Review of the 2008 UNGASS report;
- Establishment of a UNGASS taskforce with clear roles and responsibilities;
- Monthly taskforce meeting;
- Identification of data gaps and quality related issues;
- Development of data collection roadmap;
- Consultation of key stakeholders;
- Recruitment of a national consultant and two NCPI coordinators;
- Report writing;
- Report validation and consensus building meeting;
- Final consensus meeting and report validation;
- Report approval process by government; and
- Final submission

### **(c) Status of the Epidemic**

Sierra Leone, a post-conflict country, has not been spared with the spread and burden of the HIV and AIDS epidemic. Between 2002 and 2005, the HIV prevalence has steadily increased from 0.9% to 1.5%, respectively. According to the most recent 2008 SLDHS, the prevalence remained stable at 1.5%. The annual ANC Sentinel Surveillance surveys, however, show a steady decrease from 4.4% in 2007 to 3.5% in 2008, among pregnant women. HIV prevalence levels tend to be significantly higher in urban than rural areas in both the population based surveys and ANC sentinel surveillance surveys. The HIV prevalence is two-and- half times higher in urban (2.5%) compared to rural (1.0%) areas, and it is also significantly higher than the national average of 1.5%. The 2008 ANC sentinel surveillance also reveals a similar pattern. The mean HIV prevalence for urban areas is 4.6% and 3.3% for rural areas.

With regards to sex, the SLDHS reveals that the burden of HIV is higher among women (1.7%) compared to men (1.2%). HIV prevalence is also higher among the adult population 25 years and older (1.7%) compared to young people less than 25 years (1.0%). A similar pattern is observed among both men and women of the same age groups. The HIV prevalence among women and men 15-24 years is 1.4% and 0.5%, respectively. Among women and men 25 years and older, the HIV prevalence is 1.9% and 1.5% respectively.

HIV prevalence among most- at- risk populations and other vulnerable groups such as miners, uniformed personnel (police and military), mobile and border population, and sex workers is relatively higher than the national average. HIV prevalence among the diamond and gold

miners is 1.13%; the military 3.29%; the police 5.8%; the mobile and border population estimated at 2.2%; and the female sex workers' prevalence stands at 8.5%.

HIV prevalence among discordant couples is 1.9%, 0.7% among men and 1.2% among women. Discordance among couples is about twice higher in urban (2.9%) compared to rural couples (1.5%).

#### **(d) The Policy and Programmatic Response**

##### **I. The National Response to HIV/AIDS**

The government of Sierra Leone recognized AIDS as a multisectoral development challenge, and has therefore adopted a multisectoral, multi-partner response to address the epidemic. There are over 300 agencies including Government, UN, NGOs, Civil Society, FBO, PLHIV, Media and Private Sector engaged in AIDS activities. In addition, a number of umbrella organizations have been established including the Business Coalition Against AIDS in Sierra Leone (BCAASL), the Network of HIV Positives in Sierra Leone (NETHIPS), the Coalition of the Public Sector Against AIDS Sierra Leone (COPAASL), The Parliamentary Committee on AIDS & the HIV & AIDS Reporters Association (HARA).

##### **II. National AIDS Council (NAC)**

The increasing interest in addressing HIV/AIDS and the exigencies of coordination resulted in the establishment of the National AIDS Council in 2002 for the overall policy and coordination of HIV/AIDS related national response. The National AIDS Council chaired by His Excellency the President is the highest strategic body in the national response. The council comprises of public and non-public sector representatives in roughly equal parts, as well as People living with HIV (PLHIV). In 2008 two NAC meetings were chaired by H.E. the President and a third consecutive meeting was chaired by H.E. the President in 2009.

##### **III. Parliamentary Committee on HIV and AIDS**

The Government has maintained its political commitment to the national HIV response by establishing a Parliamentary Committee on HIV and AIDS, whose role has been to provide policy direction and guidance to the National AIDS Secretariat. The committee also monitors the involvement of government ministries, departments and agencies (MDA) in the national HIV/AIDS response on behalf of parliament. The committee continues to perform its critical role of informing the NAC and parliament through NAS

on important matters concerning HIV and AIDS in the country, especially with regards to existing laws, policies and regulations.

#### **IV. National AIDS Secretariat (NAS)**

The NAC is responsible for the overall policy and management of the HIV/AIDS response but it is the National AIDS Secretariat under the Office of H.E. the President who coordinates the implementation of the policies agreed upon by the NAC. Established in 2005 the National AIDS Secretariat works by involving key Ministries, UN, NGOs, local councils, the private sector, civil society, PLHIVs and the media in the design, planning, implementation, monitoring and evaluation of programmes. For two consecutive years 2008 & 2009 the Director of NAS has signed, on behalf of all implementing partners, a performance contract with H.E. the President assuring that targets set for 2008 and 2009 would be achieved. At the NAC meeting held June 2009 NAC members supported the recommendation from the Institutional Review of NAC/NAS that both should be established by an Act of Parliament.

#### **V. National AIDS Control Program (NACP)**

Working alongside NAS, the Ministry of Health and Sanitation (MOHS) established the AIDS Response Group in October 2002. Now referred to as the National AIDS Control Program (as per decision of the NAC) is the health sector's technical arm for HIV/AIDS response with four major areas of focus: surveillance, prevention, care and capacity building.

#### **VI. District AIDS Committees (DACs)**

As part of the wider context of health sector reform in Sierra Leone, in particular Decentralization, a total of 19 District AIDS Committees (DACs) have been established nationwide serving all districts to enhance the coordination of HIV/AIDS activities. This move is designed to transfer authority and power from national to sub-national levels, facilitating decision-making that is faster and more appropriate for local circumstances, particularly in the area of public planning, management and accountability of HIV/AIDS activities.

#### **VII. Technical and Other Support Groups**

As part of NASs' mandate to coordinate the multisectoral national response to HIV and AIDS epidemic in a synchronized and cooperative manner. In order for the various partners in the multisectoral response to interpret and implement national policies, NAS has to draw the technical expertise of stakeholders through well constituted technical



working and advisory groups. The other available forums and technical working groups are:

- The Partnership Forum
- Donor Partners Consultative Group on AIDS
- Expanded Technical working Group
- IEC/BCC Steering Committee
- Monitoring and Evaluation Technical Working Group
- Treatment Technical Working Group and
- Laboratory Technical Working Group

#### **VIII. Greater Involvement of People Living with HIV (PLHIV)**

The Network of HIV positives in Sierra Leone (NETHIPS) is an umbrella organization for all people living with HIV and AIDS. NETHIPS Secretariat was inaugurated by the First Lady of the Republic of Sierra Leone H.E. Sia Koroma on August 2008. NETHIPS a legally registered umbrella organization represents over 33 PLHIV support groups nationwide. It has given a human face to the epidemic playing a significant role in all sectors of the HIV/AIDS response, including awareness raising, VCCT, treatment, care and support services. NETHIPS are represented in the National AIDS Council, in the CCM, BCAASL and at many key coordinating entities.

#### **IX. Private Sector**

Established in 2008, and the Business Coalition against AIDS in Sierra Leone (BCAASL) is the leading independent national alliance of 49 small, medium-sized and large businesses committed to preventing the spread of HIV/AIDS and mitigating its impact on those infected and affected by the disease in Sierra Leone. It facilitates the development and implementation of corporate sector HIV/AIDS workplace policies as an embodiment of corporate social responsibility and business solidarity in Sierra Leone.

#### **X. Government Workplace Public Sector**

Established in 2008, the Coalition of Public Sector against HIV and AIDS in Sierra Leone (COPSAASL) is an innovative and robust national alliance of HIV and AIDS Focal Points of 19 Government ministries and departmental agencies in Sierra Leone committed to implementing the HIV and AIDS workplace programmes relating to HIV prevention, treatment, care and support, and information sharing.

#### **XI. Media**

The HIV and AIDS Reporters Association (HARA) was launched on 27<sup>th</sup> October 2008. This is an initiative by the media in collaboration with the Ministry of Information and Communication,

and the National AIDS Secretariat to raise awareness and attention about HIV and AIDS issues. This is in a bid to disseminate accurate HIV and AIDS information, mobilize people to access HIV services, reduce stigma and discrimination, and advocate for enforcement and protection of human rights of people infected with and affected by HIV.

## **XII. The Uniformed Personnel**

The uniformed personnel comprise the Armed Forces, Police, Fire Force and Prisons. They are involved in the HIV and AIDS multisectoral response through raising awareness of troops, their dependants, and the host communities on HIV, AIDS, gender-based violence, reproductive health, VCCT, STI treatment, and provision on nutritional support to PLHIVs.

### **(e) Strategic Documents in support of the National HIV and AIDS Response**

#### **I. An Agenda for Change**

An Agenda for Change has been developed as part of the development of the Sierra Leone Poverty Reduction Strategy Paper II 2008-2012 (PRSP II). In June 2009 at the UN General Assembly, Dr. Ernest Bai Koroma H.E the President of the Republic of Sierra Leone presented his governments 'Agenda for Change'. It focuses on four key priority areas - Energy, Agriculture, Transportation and Human Development) 'An agenda for Change' is to serve as the overall guiding policy document for sustainable development in Sierra Leone. Recognizing HIV/AIDS as a development issue the key priority area 'Human development' states that "*The prevention of HIV/AIDS and mitigating its effects will remain a priority of the Government*".

#### **II. Poverty Reduction Strategy Paper II 2008-2012 (PRSP II)**

The PRSP II recognizes that whilst the prevalence of HIV remains low (at 1.5%), existing conditions could contribute to the population becoming more vulnerable and at risk of increasing transmission of infection. The focus therefore will be on:

*Prevention of new infections including treatment of sexually transmitted infections, condom promotion and distribution, VCCT and PMTCT. Treatment, Care and support will also be provided to people living with HIV/AIDS, including orphans and vulnerable children.*

#### **III. National Strategic Plan on HIV/AIDS**

In 2006 Sierra Leone developed a **National Strategic Plan on HIV/AIDS 2006 -2010 (NSP)** which placed strong emphasis on the prevention of new infections; treatment, care and support for PLHIV and communities, human and legal rights, decentralization programmes, research, monitoring and evaluation.

#### IV. National HIV/AIDS Monitoring and Evaluation Framework

Tied to the development of the NSP, in 2006 a [National HIV/AIDS Monitoring and Evaluation Framework 2006 – 2010](#) was developed which contributes towards the provision of strategic information for tracking of the HIV/AIDS epidemic and to enhance informed decision-making at all levels of implementation. It has a list of sixty-eight (68) core and harmonized indicators to track progress on the HIV and AIDS multisectoral response.

#### V. UN Joint Vision for Sierra Leone

The UN Joint Vision for Sierra Leone-2009 to 2012 defines the UNs contribution to implementing 'An Agenda for Change'. The Joint Vision sets out a number of joint planning, implementation and coordination mechanisms with the aim of enhancing the impact of the joint United Nations' assistance as part of the international communities' efforts of consolidating peace and promoting sustainable development in Sierra Leone.

The UN Joint Vision is aligned with the benchmarks identified in the 'Agenda for Change', NSP, and the PRSP II. Under Priority Area 4 'Equitable and affordable access to health', the Joint Vision sets a benchmark that:

*By the end of 2012 to have contributed to improved national health services through a national response to AIDS that can provide universal access to HIV prevention, treatment, care and support*

#### VI. Joint Review of the National Response to HIV/AIDS

In May 2008 a [Joint Review of the National Response to HIV/AIDS](#) was carried out to monitor how successfully the National Strategic Plan on HIV/AIDS 2006-2010 was guiding HIV activities in the country. The Joint Review was also to develop a road map that clearly defines the role and responsibilities of stakeholders in implementing the provisions of the NSP. Based on the recommendations of the Joint Programme Review a two year [National HIV/AIDS Operational Plan 2009-2010](#) has subsequently been developed.

#### VII. Institutional Review of the National AIDS Secretariat

In January 2009 following recommendations made in the Joint Review of the National Response, an [Institutional Review of the National AIDS Secretariat](#) was undertaken. Following recommendations from the Institutional Review of NAS (which were endorsed by the National AIDS Council), both the National AIDS Council and the National AIDS

Secretariat are soon to be established by an Act of Parliament giving NAS legal status as a state institution with financial allocation in the governments annual budget.

### VIII. National HIV and AIDS Policy

The first strategic document to be developed nationally in support of the national response was the [National HIV and AIDS Policy](#) which was adopted by cabinet and endorsed by Parliament in 2002. A strategic planning process and plan of action for implementation of the National AIDS Policy, was developed with support from the UN Theme Group on HIV/AIDS in 2005.

### IX. Prevention and Control of HIV and AIDS Act

In 2007, the draft [Prevention & Control of HIV & AIDS Act](#) was present to Parliament to revise and enact it into law. The revisions are to address stigma and discrimination, prevention, treatment, care and support for People Living with HIV. The Act is in its final review and amendment stage before being passed into law.

#### (e) Overview of UNGASS Indicator Data

Indicators	2008	2009	Comments
<b>Expenditures</b>			
<b>1. Domestic and international AIDS spending by categories and financing sources</b>	Domestic source - 2% International Source - 98% Private source - 0%		National ADS Spending Assessment 2006 & 2007
	2006 - USD 7,616,723 2007 -USD 9,172,666		
<b>Policy Development and Implementation Status</b>			
<b>2. National Composite Policy Index (Areas covered: prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)</b>		6	NCPI Survey, 2010
<b>National Programmes (blood safety, antiretroviral therapy coverage, prevention of mother-to-child transmission, co-management of TB and HIV treatment, HIV testing, prevention programmes, services for orphans and vulnerable children, and education)</b>			
<b>3. Percentage of donated blood units screened for HIV in a quality assured manner</b>	100%	100%	NAS Program Data
<b>4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy*</b>	28%	50%	1950 out of 6891 in 2008; 3660 out of 7,277 in 2009; NAS Programme Data & SPECTRUM

Indicators	2008	2009	Comments
5. Percentage of HIV-positive pregnant women who receive antiretroviral medicines to reduce the risk of mother-to-child transmission	17%	18%	579 out of 3389 in 2008; 637 out of 3472 in 2009; NAS Programme Data
6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	Data Not available		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
7. Percentage of women and men aged 15–49 who received an HIV test in the last 12 months and who know the results	<b>15-49 years</b> Men 3.4% Women 4.1% <b>15-24 yrs</b> Men 1.2% Women 4.4%		2008 SLDHS
8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	47.5%		BBS, 2005
9. Percentage of most-at-risk populations reached with HIV prevention Programmes	Data Not available		
10. Percentage of orphans and vulnerable children whose households received free basic external support in caring for the child	1.30%		MICS 2005
11. Percentage of schools that provided life skills-based HIV education within the last academic year	Primary Schools 14.7%		MEYS Programme Data
<b>Knowledge and Behaviour</b>			
12. *	<b>Total Orphans 61.2%</b> ; male orphans 66.4%; Female orphans 56.2% <b>Total Non Orphans 73.8%</b> ; male non-orphans 75.8%; Female non-orphans 71.9% <b>Total Ratio =0.83</b> ; Male Ratio=0.88; Female Ratio=0.78		SLDHS, 2008

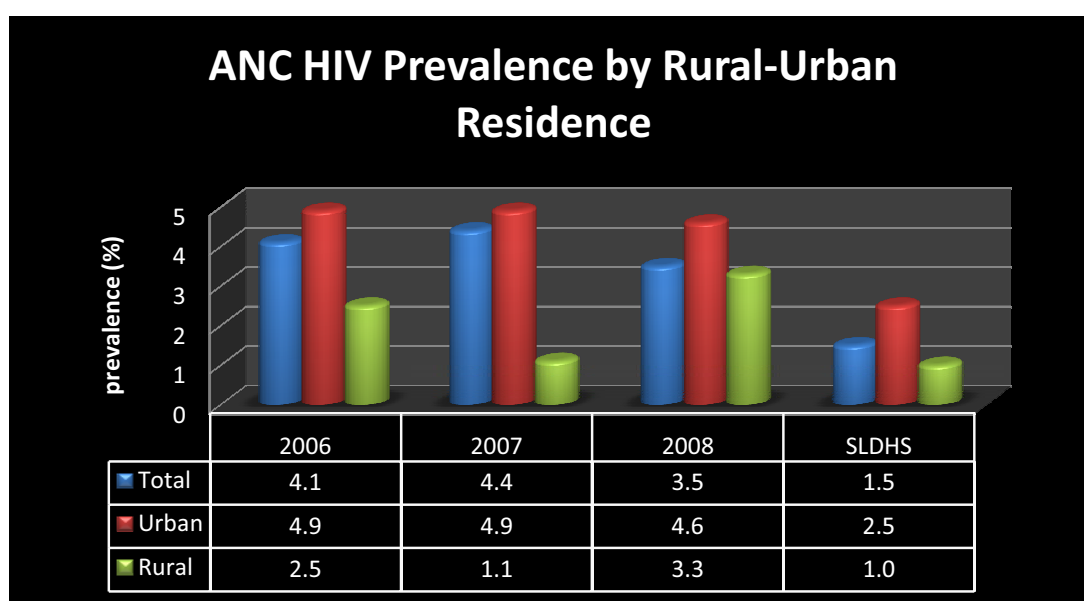
Indicators	2008	2009	Comments
13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	<b>15-24yrs</b> women 23.7% Men 32.9% <b>15-19yrs</b> women 23.2% Men 30.1% <b>20-24yrs</b> women 24.2% Men 36.6%		SLDHS, 2008
14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	Data Not available		
15. Percentage of young women and men who have had sexual intercourse before the age of 15	<b>15-24yrs</b> women 24.6% Men 11.0% <b>15-19yrs</b> women 22.3% Men 11.4% <b>20-24yrs</b> women 26.8% Men 10.5%		SLDHS, 2008
16. Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months	<b>15-49yrs</b> women 4.9% Men 20.8% <b>15-24yrs</b> women 6.4% Men 18.9%		SLDHS, 2008
17. 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*	<b>15-49yrs</b> women 6.8% Men 15.2% <b>15-24yrs</b> women 12.2% Men 29.2%		SLDHS, 2008
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	Female – 68%		BBS 2005
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	Data Not available		

Indicators	2008	2009	Comments
20. Percentage of injecting drug users who reported the use of a condom at last sexual intercourse	Data Not available		
21. Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Data Not available		1.6% of CSW reported injecting themselves & 87% shared needles and syringes, BBS 2005
<b>IMPACT</b>			
22. Percentage of young women and men aged 15–24 who are HIV infected*	<b>15-24yrs</b> Total 1.0% women 1.4% Men 0.5% <b>15-19yrs</b> Total 0.7% women 1.3% Men 0.0% <b>20-24yrs</b> Total 1.4% women 1.5% Men 1.3%		SLDHS, 2008
23. Percentage of most-at-risk populations who are HIV infected	<b>Female Sex Workers</b> Total 8.5% <b>Miners</b> Total 1.1% <25yrs 0.5% 25+yrs 1.3% <b>Military</b> Total 3.3% <40yrs 3.0% 40+yrs 3.3% <b>Police</b> Total 5.8% <25yrs 5.3% 25+yrs 5.8% <b>Mobile and Border</b> 2.2%		Behavioural and Biologic Survey of CSWs, 2005  HIV Surveillance Report on Mine Workers in Sierra Leone, 2008  Prevalence of HIV and other Sexually Transmitted Infections in the Republic of Sierra Leone Armed Forces, 2007  HIV Surveillance Report on the Police in Sierra Leone, 2007  2009 Border Communities, Mobile Populations and Exposure to HIV in Countries of the Mano River Union
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	84%		MoHS and NAS, 2008, Survival Analysis for PLHIV on Antiretroviral Therapy

Indicators	2008	2009	Comments
25. Percentage of infants born to HIV-infected mothers who are infected	55.5%		MoHS and NAS, 2009, Prevalence of HIV Infection amongst Children Born To HIV-Infected Mothers

### III. Overview of the AIDS epidemic

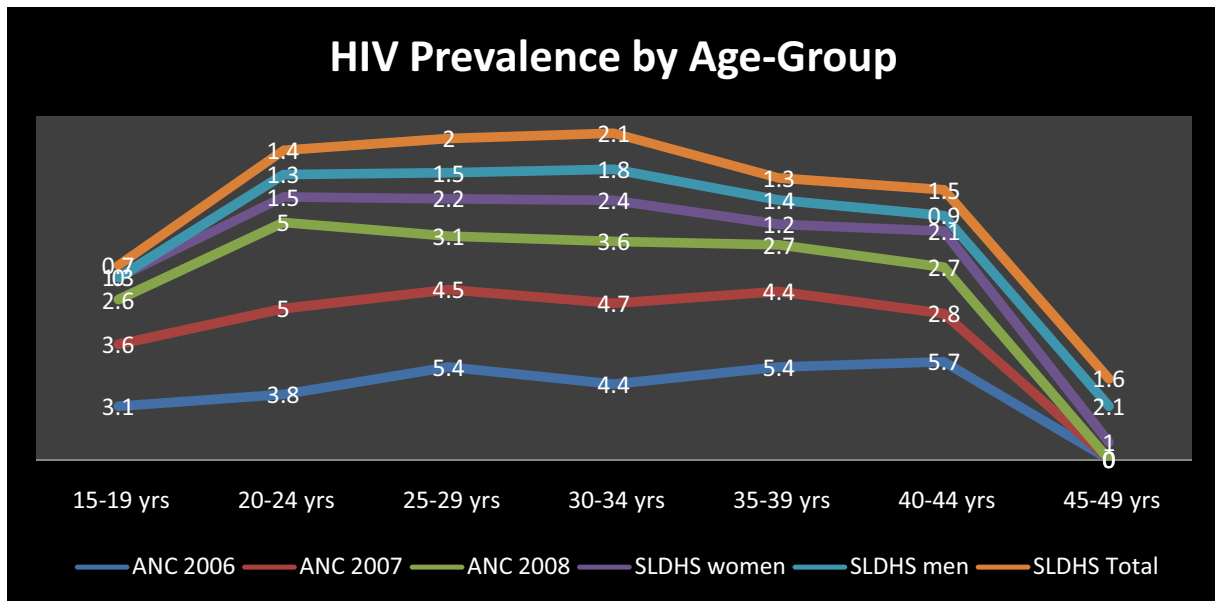
According to data from the ANC Sentinel Surveillance Reports (2006, 2007 & 2008) and 2008 SL DHS shows that HIV prevalence in urban areas is significantly higher than rural areas and the national average. HIV prevalence among pregnant women is declining steadily between 2007 and 2008, from 4.4% to 3.5%. A similar pattern is observed among urban women, where the HIV prevalence has declined from 4.9% to 4.6 in the same reference period. However, HIV prevalence has shown a three-fold increase among rural pregnant women, rising from 1.1% in 2007 to 3.3% in 2008.



Source: 2006, 2007 & 2008 ANC Sentinel Surveillance Reports and 2008 SL DHS

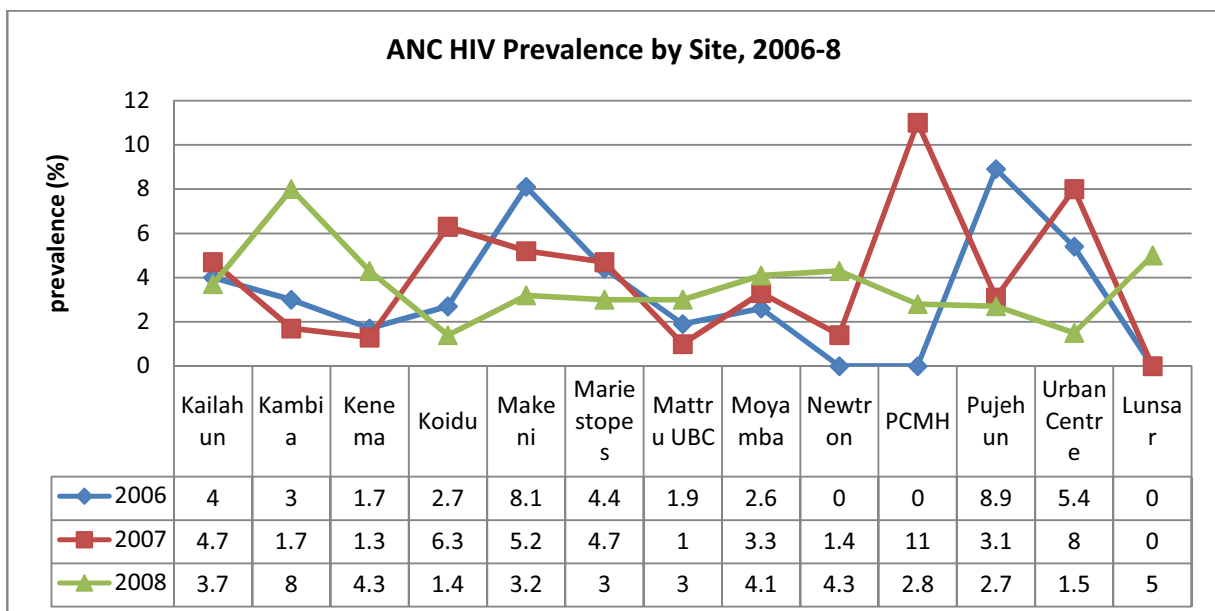
Analysis of HIV prevalence by various age groups shows that the levels are lower among terminal age groups – 15-19 years and 45-49 years. HIV prevalence increases sharply between 15-19 years and 20-24 years. There is a broad peak of HIV prevalence between 25 and 39 years, before stabilizing in the 40-44 years age group, and sharply declining in the 45-49 years age-group. The burden and impact of HIV is much more in the prime and productive age groups of 20-39 years.





Source: 2006, 2007 & 2008 ANC Sentinel Surveillance Reports and 2008 SLDHS

HIV prevalence by site shows a mixed picture between 2007 and 2008, with some sites showing an increase while others the rates are reducing. Notable among sites that show an increase in HIV prevalence is Kambia (1.7 % to 8%), Kenema (1.3% to 4.3%), Mattru (1% to 3%), Moyamba (3.3% to 4.1%) and Newton (1.4% to 4.4%). The remaining sites showed a reverse trend of declining prevalence.



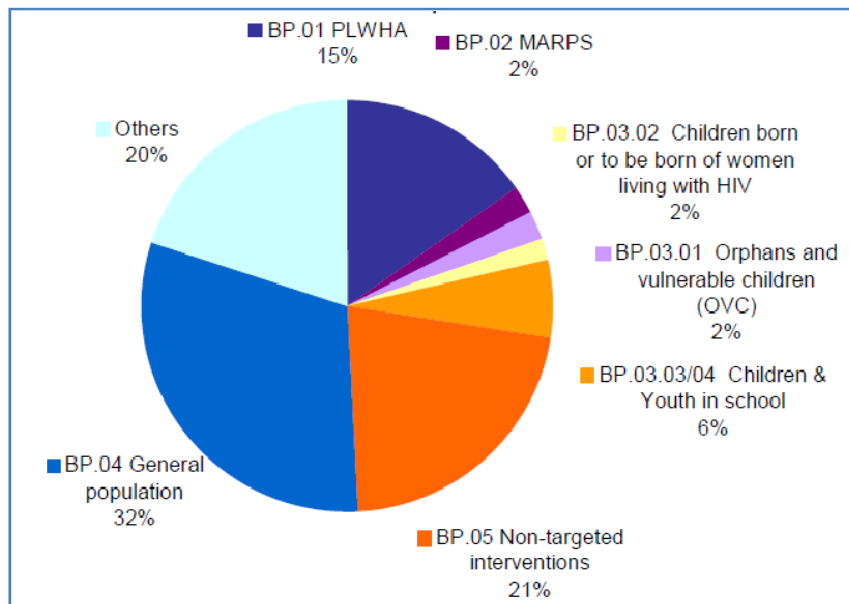
Source: 2006, 2007 & 2008 ANC Sentinel Surveillance Reports

## IV. National response to the AIDS epidemic

### a) Financing Sources and Expenditures

According to the 2006 and 2007 NASA report, the HIV response in Sierra Leone is highly dependent on international funds. Ninety eight percent (98%) of the funds in 2006/2007 came from international sources. Multilateral sources are the main source of funding in Sierra Leone, however 51% of the funds are managed by public institutions, mainly the National AIDS Secretariat. Prevention is the programmatic area which captures most of the spending, capturing 49% and 61% of total HIV spending in 2006 and 2007, respectively. Programme management captures a significant share of HIV spending in Sierra Leone (23% and 19% in 2006 and 2007 respectively).

Central Government Revenue is the only public source of funding in 2007 (\$ 200,598). Financing from the multilateral agencies is the main international source of funding in 2007. The Global Fund to Fight AIDS, Tuberculosis and Malaria is the main financing source, contributing with 25% of the resources spent in Sierra Leone in 2007. The World Bank was another major source of funds contributing with 22% of total spending. The governments of Germany and of United Kingdom were the main bilateral contributors, financing 6% of the response each, while International not-for profit organizations and foundations finance 3% of the HIV spending in 2007 (\$306,456)



Source: NASA 2006 and 2007, pg 29

When AIDS spending categories are analyzed, 61% was spent on prevention programmes, 19% on programme management and administrative strengthening and 11% was spent on care and treatment services. Within prevention interventions, 28% was spent on social and behavioural change communication, 17% among migrant population and uniformed populations, and 9% for in-school youth prevention interventions. Furthermore, analysis of beneficiary populations in the HIV national response show that all major sub-populations were being targeted. The figure below shows that the general population accounted for 32%, management and M&E 21%, PLHIVs 15%, in-school youth 6%, MARPS 2%, PMTCT 2%, and OVC 2%.

### b) Prevention

Programmatic Area	Indicator	2008	2009
ART	No. of ART sites	103	116
	No. patients currently on treatment	1,950	3,660
	No. in need of ART	6,891	7277
VCCT	No. of VCCT sites	369	416
	No. tested and received results	54,193	181,962
	No. tested positive	3,492	4,779
PMTCT	No. of PMTCT sites	326	364
	No. of pregnant women tested and received results	91,212	99,256
	No. of pregnant women tested positive	1,362	1,584
	No. of pregnant women on ART prophylaxis	579	637
TOTAL	No. of HIV+ pregnant women in need of ART prophylaxis	3,389	3,472
	Total No. tested and received results	145,405	281,218
	Total No. tested positive	4,854	6,363
STI	No. treated for STIs	19,461	27,310
Blood Safety	No. of blood units screened for HIV, Syphilis and Hepatitis B and C	24,555	25,072
Condoms	No. of male condoms distributed	2,676,141	2,185,920
	No. of female condoms distributed	4,452	16,200
OVC	No. of OVC provided support	803	836
Nutritional Support	No. of PLHIVs provided with nutritional support	341	678
Total Facilities	No. of Health Facilities	1050	
	Public Facilities	903	
	Private Facilities	147	

Source: NAS/NACP, 2008 and 2009 Programme Data

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 326 health facilities in 2008 to 364 in 2009. Consequently, this helped to increase uptake of PMTCT services. The number of pregnant women receiving ART prophylaxis increased from 579 to 637 between 2008 and 2009. This represents 17% and 18% coverage of the intended HIV+ pregnant women. In 2008, a total of 145,405 people were counseled, tested and received their results, while 281,218 were served in 2009. Voluntary Confidential Counseling and testing was undertaken in both PMTCT sites and VCCT stand alone sites, coupled with outreach activities. VCCT sites increased from 369 in 2008 to 416 in 2009. On average, about 25,000 blood units were collected in both 2008 and 2009, and all (100%) were screened for HIV, syphilis, and hepatitis B and C, in conformity to national guidelines. On STIs, a total of 19,461 and 27,310 people were treated in 2008 and 2009, respectively. Over 500,000 people were reached with HIV and AIDS behavior change messages. About 2,676,141 male condoms and 4,452 female condoms were distributed in 2008. In 2009, 2,185,920 male condoms and 16,200 female condoms were distributed.

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 counseling 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 only 2% 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, thereby 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.

### **c) Care and Support**

Tuberculosis (TB) is one of the common opportunistic infections 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 to the recent (2009) report on Pulmonary Tuberculosis among PLHIVs, 14% are co-infected with TB, 7% among women and 21% among men.

Recent estimated number of PLHIV in need of treatment and care and support is pegged at 7101. 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, 341 PLHIV were provided with nutritional support in 2008 and increased nearly two-fold to 678 in 2009. In the same reference period, OVC support increased from 803 to 836, respectively. The

Network of HIV Positives in Sierra Leone (NETHIPS) had a total of 33 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 2007, an impact mitigation study was undertaken to better understand the perspectives of persons living with HIV and AIDS with regards to available care and support services. The study revealed that over two-thirds of PLWHA described their health as good, and that they were able to perform their daily activities without much assistance. However, only about half (53.2%) of PLHIV surveyed had disclosed their status to their spouses for fear of losing the relationship. The survey found that PLHIVs would rather disclose their HIV status to their relatives than spouses because latter would not abandon them.

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.

Recent SLDHS results indicate that orphans are less likely to attend school than non-orphaned children. About 61% of the orphans compared to 74% of non-orphans were attending school. The pattern is similar when disaggregated by sex. Female-orphans are more disadvantaged in attending school than their male counterparts, (56% vs. 66%), respectively.

#### **d) 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 2008 and 2009, uptake of ART increased from 1,950 to 3,660 clients. This represents 28% and 52% of those in need of ART. Treatment centers also increased from 103 to 116 in the same reference period. According to the 2008 NAS report of Survival Analysis for PLHIV on ART, 84% of them are known to be on treatment 12 months after initiation of ART.

Mother-to-child-transmission of HIV is known to be transmitted during pregnancy (transplacental spread), during delivery through infected birth canal (intra-partum) or after birth from breastfeeding. In trying to determine the effectiveness of PMTCT interventions in

Sierra Leone since it was introduced in 2004, the Ministry of Health and Sanitation in collaboration with NAS instituted a study in 2009 to evaluate the prevalence of HIV infection among children born to HIV positive mothers. The study found overall HIV prevalence of 55.5% infection in children born to HIV infected mothers without prior introduction of prevention interventions. On the contrary, the risk of HIV transmission to the child of pregnant women who were on ART prophylaxis was found to be at 9%.

## **e) Policy/Strategy Development and Implementation**

### **i. Political Commitment**

The commitment of His Excellency the President Ernest Bai Koroma immediately after assuming office in taking the lead in mobilizing the nation on World AIDS Day 2007 and spearheading the National AIDS Council has contributed to raise the profile of the national response to HIV/AIDS in Sierra Leone. The National AIDS Council (NAC), the highest policy-making body in the national response, convened two meetings in 2008 and one in 2009 all of which were chaired by His Excellency the President. At these meetings, the President obligated all Ministries to be involved in the response to AIDS, informing Ministers that their commitment to the AIDS response would be assessed as part of their management agreement previously signed with the President. Of critical importance is that the President has also identified AIDS as a priority within his governments 'Agenda for Change'. In 2008 The First Lady of Sierra Leone Mrs. Sia Koroma became a member of OAFLA (Organization of African First Ladies Against AIDS) attending the General Assembly in Egypt and the subsequent Annual meeting in Addis Ababa Ethiopia. The First Lady has been selected to be a member of the Steering Committee for West & Central Africa. In 2009, the First Lady also graced the World AIDS campaign.

### **ii. Participation of Civil Society Organizations**

Considerable advances have been made regarding involvement and representation of PLHIV in the national response, most notably with the inauguration of NETHIPS (Network of HIV Positives in Sierra Leone) Secretariat by the First Lady of the Republic of Sierra Leone H.E. Sia Koroma on August 2008. NETHIPS represents over 33 PLHIV support groups nationwide. It has given a human face to the epidemic playing a significant role in all sectors of the HIV/AIDS response, including awareness raising, VCCT, treatment, care and support services. NETHIPS are represented in the National AIDS Council, in the CCM, BCAASL and at many key coordinating entities.

To date, NETHIPS and other CSOs have advocated for laws focusing on the Human Rights of PLHIV's and women. Frequent consultations with parliamentarians and other major

stakeholders have led to the first draft of a Bill on the Prevention and Human Rights of PLHIV. The Bill was initially enacted by Parliament in 2007, but has subsequently been reviewed and amendments made to improve the legislation. CSOs have been fully involved in the review process. With the enactment of the Bill it is envisaged that there will be improved implementation of policies, laws and practices as well as an increase in the government's response to support people both infected with and affected by HIV.

In February 2009 a 'Mapping and Capacity Needs Assessment of PLHIV Support Groups in Sierra Leone' was conducted, a number of opportunities and potentials for meaningful involvement of PLHIV in the national response as well as key capacity challenges were identified. In May 2009 the Joint UN Team on AIDS drafted a proposal to secure PAF funding which complimented the Irish Aid fund to support activities designed to address these challenges and to strengthen the capacity of NETHIPS.

### **iii. Line Ministries**

The National AIDS Secretariat serves as the lead organization supporting Line Ministries in the national response. A sensitization seminar was conducted in November 2008, out of which responsible Line Ministries were selected to spearhead workplace programs with HIV focal points identified by each Ministry. In December 2008 a capacity building and planning workshop was convened for all HIV Focal Persons in which action plans for 2009 were developed for their respective Line Ministries. NAS in consultation with UNAIDS has mapped out a strategy to secure the commitment of the Permanent Secretaries that are critical for the success of workplace AIDS programmes in Line Ministries. HIV Focal Points have shown marked commitment to HIV work place issues in their ministries and a Declaration of commitment was signed in December 2008.

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#### **iv. Global Fund**

As a step to further scale up the national response, the Country Coordination Mechanism (CCM) in Sierra Leone received an USD 18 million dollar grant from the Global Fund (Round 4) to develop a comprehensive national response to HIV/AIDS encompassing adequate prevention, treatment, care and support for those affected in Sierra Leone. The five years (2005-2009) 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.

Sierra Leone was also successful in the Global Fund Round 6 securing USD 26 million that caters for a scale up of the existing comprehensive national response to HIV/AIDS that includes prevention, treatment, care and support for those affected. In 2009, Sierra Leone submitted a proposal for Global Fund Round 9 and was successfully accepted. The proposals seek funding to fill implementation gaps in the national response towards achieving accelerated universal access and health systems strengthening in Sierra Leone. The total funds requested from the Global Fund Round 9 amounts to \$ 29 million.

## V. Best practices

### The National Partnership Forum on AIDS

Established in December 2006, The National Partnership Forum on AIDS is Chaired by H.E. the President and has two co-chairs, one from the United Nations, one from Civil Society. It provides an annual forum through which partners can share information, discuss emerging issues and also promote networking and collaboration among those involved in the response to HIV/AIDS in Sierra Leone.

The forum strives for representation and participation from all sectors involved in the response including Government, UN, Donors/Partners, NGOs, CBOs, FBOs, Civil Society, PLHIVs, the Private Sector, Uniformed Services and the Media. The distinct feature about the Forum is that it attracts political/policy and technical representation of high level actors in the response, its members are both knowledgeable and through their respective positions, highly influential, therefore, well-placed to bring about substantive change.

One of the key objectives of the Forum is to ensure that all partners are informed and aware of HIV/AIDS activities and programs happening on the ground, the understanding being that this will in turn improve coordination of activities.

The first Partnership Forum (December 2006) brought together approximately 200 participants for two consecutive days from all regions representing all sectors in the response to discuss and develop a road map for scaling up the national response to HIV/AIDS in Sierra Leone. The Forum also concentrated on key areas integral to the scale up of the national response including implementation of the 'three ones' (One national coordinating authority, One National Strategic Plan and One National M&E Framework), the greater and meaningful involvement of PLHIV (GIPA) and universal access towards HIV prevention treatment, care and support. The outcomes and recommendations of the 2006 Partnership Forum were presented in April 2008 at the first ever National AIDS Council meeting chaired by H.E. the President.

The National Partnership Forum was designed to be an annual event. However, parliamentary and presidential elections of 2007 greatly challenged the planning and organisation of the 2007 event. In 2008, HE the President was engaged in chairing the National AIDS Council (NAC) for the first time and chairing a second NAC meeting later in the same year. Consequently it was found strategic to shift the Partnership Forum meeting to November 2009 in order to secure H.E. the President as Chair. The second Partnership Forums' main purpose was to give partners an opportunity to share information about their activities, accomplishments, challenges and proposals for the way forward towards reaching Universal Access targets while enhancing coordination of HIV/AIDS activities. Discussions were held in eight groups dealing with: District Aids Committee, Treatment, Co-infection TB and hepatitis, The Workplace, Children and HIV, Prevention, Care and Support, Resource Mobilization and Coordination.

### Public Private Partnership in the Mining Sector

Public-Private Partnerships are voluntary and collaborative relationships among various actors in both public (state) and private (non-state) sectors, in which all participants agree to work together to achieve a common goal or undertake specific tasks. The HIV intervention in the mining sector started in 2006 with support from ILO/AIDS. It began with the signing of a Memorandum of Understanding between the National HIV/AIDS Secretariat (Coordinating Body for HIV/AIDS in the country) the United Mine Workers' Union (Representing the Workers) and the Sierra Rutile Limited (Representing the Employer). The main objective of the intervention was to usher in co-operation in the field of HIV/AIDS Prevention and Impact Mitigation. Other activities were centered on (a) Capacity Building of United Mine Workers' Union membership, Company Staff on HIV prevention by the National HIV/AIDS Secretariat Officials (b) linking mine workers, families and surrounding communities to VCT, ARV and other ancillary Services provided by NAS and (d) developing workplace policies by UMU in collaboration with Mining Companies and NAS.

As a result of this partnership, a joint Labour Committee on HIV/AIDS with a tripartite outlook was established; a national workplace policy for the mining sector and that of Sierra Rutile Company were formulated; HIV/AIDS issues in the community-based activities the Mining Companies were included. Also, awareness raising among workers have been ongoing on a daily basis. A unique strategy (**Toolkit Talk**) adopted by the Company is used every morning before workers embark on their daily routine of work. Miners are addressed on Universal Safety Precaution of which HIV/AIDS is part of that precaution. There has also been improved access to condoms through the establishment of a number of outlets within the company, and most importantly the integration of HIV/AIDS Services (VCT, ART and PMTCT) within the Company Healthcare Delivery.

The lessons learnt from this partnership and collaboration is that:

- i) Working in partnerships reduces cost of doing business, enhances effectiveness, and ensures wider coverage. The cost that would have been incurred in delivering services by NAS such as personnel cost and office space is met by the company, and the Union Workers (Shop Stewards) volunteer to mobilize workers to take advantage of the HIV and AIDS services.
- ii) Working in partnership of a tripartite outlook (NAS, Union and the Company) ensures collaboration and common agenda for addressing health concerns, including HIV and AIDS.
- iii) Community Involvement (Re: Joint Labour Committee) ensures local ownership and commitment and
- iv) Integrating services into the healthcare delivery ensures sustainability in terms of service delivery

### **Business Coalition Against AIDS in Sierra Leone (BCAASL)**

Established in 2008, The Business Coalition against AIDS in Sierra Leone (BCAASL) is the leading independent national alliance of 42 small, medium-sized and large businesses committed to preventing the spread of HIV/AIDS and mitigating its impact on those infected and affected by the disease in Sierra Leone. It facilitates the development and implementation of corporate sector HIV/AIDS workplace policies as an embodiment of corporate social responsibility and business solidarity in Sierra Leone.

Fundamentally, the work of the Coalition involves the following:

- Harmonizing community and national Private sector HIV prevention, care, treatment psycho-social support and HIV/AIDS work place policies
- Strengthening the response interventions of the private sector
- Mobilizing and raise business and public awareness on and advocate for access to treatment, corporate principles and fundamental values of sound public health and corporate social responsibility
- Raising awareness on the challenges facing businesses in the fight against HIV/AIDS and means to address them and
- Advocating for strong political, business and community leadership and commitment to HIV prevention, treatment, care and promotion of human rights.

The target population is the employers and employees of the private sector and it is expected to be extended to include their families. The strategy that is used by the coalition is advocacy and campaigns. A total of 42 companies of the coalition are collectively providing HIV services to their employees. To a large extent, the coalition has contributed to changing the lives of the target population through the reduction of HIV/AIDS related stigma and discrimination in the workplace. Similarly, adherence to HIV preventive methods has helped improve the quality of life and productivity of the employers and employees alike.

### **Coalition of Public Sector Against HIV and AIDS in Sierra Leone (COPSAASL)**

The Coalition of Public Sector against HIV and AIDS in Sierra Leone (COPSAASL) is an innovative and robust national alliance of HIV and AIDS Focal Points of Government ministries in Sierra Leone committed to implementing the HIV and AIDS workplace programmes relating to HIV prevention in the various government ministries.

In fulfillment of its mandates, the Coalition implements the following activities:

- Sensitization and awareness raising to increase knowledge about HIV/AIDS
- Provision of treatment, care and support
- Information sharing and experiences
- Building capacity of ministries to accelerate the implementation of workplace programmes

The primary target group is the staff of all Government ministries including permanent secretaries and professional head of departments. As of date, there are nineteen (19) registered ministries who are members of the coalition providing services to the entire workforce of the government ministries.

The following main strategies are adopted by the Coalition in carrying out its activities:

- Advocacy
- Networking and Partnership
- Capacity building

The work of the Coalition has impacted positively on the lives of the people in the various ministries. It has contributed greatly to the improvement of their health and productivity.

## VI. Major challenges and remedial actions

### a) Overall Challenges to the National HIV and AIDS Response

During the second Partnership forum on HIV and AIDS meeting with over 200 participants drawn from Government, the UN, Donors/Partners, NOG's, CBO's, FBO's, Civil society, PLHIV'S, the private sector, uniformed services and the media, a thorough review of the national HIV and AIDS response was done. The forum came up with concrete achievements, challenges and recommendations segmented by broad categories of prevention, treatment, care and support, children and HIV, workplace. The NCPI also notes the challenges and remedial actions

The following were the main **overall challenges**

- i. Translating knowledge into behavioural change
- ii. Eliminating stigma and discrimination against PLHIVs
- iii. Promoting gender and human rights, especially the vulnerability of women and girls
- iv. Cultural practices that promote HIV/AIDS transmission
- v. Reduce over dependency on donor funds which tends to undermine sustainability
- vi. Synchronize uncoordinated funding sources with different channeling sources
- vii. Decentralizing NAS activities at district and chiefdom levels

The following were the main **overall recommendations as part of the remedial actions**

- i. A full scale education and sensitization programme on the nature of the epidemic is required together with the appropriate response.
- ii. The NSP and the M&E plans to be reviewed after their expiry to include new and emerging issues and strategies
- iii. A UNAIDS sponsored National Aids Spending Assessment (NASA) exercise to determine type of activities, source of funding and scope of operations
- iv. An UNGASS 2010 Country progress Report to be conducted as part of tracking performance and information sharing
- v. A requirement for the decentralization of NAS activities to include District AIDS Committees and Chiefdom AIDS Committees. Particularly, NAS should strengthen the capacity of DACs; provide incentives for focal points, decentralize funds for HIV/AIDS to councils and provide incentives for the maintenance of all DAC equipment. There should also be full involvement of development partners working with the councils.

- vi. A follow up should be undertaken on the recommendations of the institutional review so as to establish the process and finalize a new structure
- vii. All partners to share information and no activities would be conducted without the knowledge of NAS.

## b) Prevention

### i. Challenges

The following challenges were noted for the prevention programmatic area:

- a) Stigma and discrimination for PLHIVs
- b) Low male involvement in PMTCT activities because of negative cultural perceptions
- c) Only a quarter of all pregnancies are delivered at health facilities
- d) Low risk perception about HIV among the general population with many not knowing
- e) Multiple concurrent sexual partners
- f) Low condom use during risky sexual encounters with non-regular partner
- g) Misconceptions about HIV transmission
- h) HIV/AIDS messages for the deaf and dumb
- i) Lack of services for vulnerable groups such as MSMs and IDUs
- j) Early sexual debut among young people
- k) The weak capacity of the Ministry of Education, Youth and Sports in taking leadership in reaching out to the in-school and out-school population

### ii. Recommendations and/or Remedial Actions

The following were the main **recommendations as part of the remedial actions**

- a) Develop HIV and AIDS prevention strategy that will address issues of stigma and discrimination, multiple concurrent sexual partners, misconceptions, etc
- b) Scale-up HIV awareness through a combination approach of the media, religious leaders, politicians, and the youth
- c) Develop appropriate strategies and tools of reaching the deaf, dumb, MSMs and IDUs with HIV prevention services
- d) Encourage couple services at ANC clinics
- e) Target men to facilitate meaningful behavior change
- f) There is need to scale-up primary prevention initiatives under the leadership of the Ministry of Education, Youth and Sports

## b) Treatment

### i. Challenges

The following challenges were noted for the treatment programmatic area:

- a) Treatment adherence
- a) Increased number of clients needing nutritional support
- b) Paediatric treatment for children
- c) Distance for clients to available ART sites
- d) Co-infection with OIs such as TB and Hepatitis
- e) Lack of family support for clients on treatment

### ii. Recommendations and/or Remedial Actions

The following were the main **recommendations as part of the remedial actions**

- a) Intensify the provision of reassurance and adherence counseling
- b) Scale-up the provision of nutritional support for PLHIVs on treatment
- c) Increase the number of ART sites throughout the country
- d) In order to expand paediatric care and treatment, more specialized training for health care providers should be trained
- e) The existing integration of TB and AIDS programmes should be maintained and improved in all health facilities.

## c) Care and Support

### i. Challenges

The following challenges were noted for the care and support programmatic area:

- a) PLHIVs on treatment and with co-infections of OIs experience adverse drug reaction and adverse side effects
- b) There is no standardize package of care or policy for PLHIVs and OVC
- c) There are few trained caregivers caring for children with HIV
- d) There is high level of duplication of beneficiaries support by partners
- e) Inconsistent supply of nutritional support to beneficiaries

### ii. Recommendations and/or Remedial Actions

The following were the main recommendations as part of the remedial actions

- a) Scale up ART sites and train more health care staff to monitor ART patients
- b) Develop a standardized care and support package (nutritional, education, training) for PLHIVS and OVCs and caregivers
- c) Mainstream care and support activities at all levels of implementation



- d) Implement effective entry and exit strategies of care and support services

#### **d) Cross-cutting Issues**

##### **i. Challenges**

The following were the main recommendations as part of the remedial actions

- a) Current labour laws do not address HIV and AIDS in the workplace
- b) Stigma and discrimination in the workplace is affecting access of HIV services by workers
- c) Low budget allocation towards HIV and AIDS activities in the workplace by both private and public sector
- d) Some partners are reducing their HIV /AIDS budget while others are duplicating activities
- e) Lack of decentralized implementation of NAS HIV/AIDS activities

##### **ii. Recommendations and/or Remedial Actions**

- a) Engage government to fast track the revision of the labour laws to include HIV and AIDS issues
- b) Intensify HIV prevention and awareness programmes in the workplace
- c) Lobby for adequate budgetary allocation for HIV and AIDS activities in both private and public sectors
- d) NAS should engage partners through annual donors consultative meetings, donor mapping and continue to monitor the inflow of HIV/AIDS resources.
- e) NAS should decentralize their HIV/AIDS activities at district and chiefdom levels

## **VII. Support from the country's Development Partners**

The national response is supported both financially and technically by the following partners: The World Bank, African Development Bank (ADB), Global Fund to fight HIV and AIDS, TB and Malaria (GFATM), Irish Aid, Department for International Development (DfID), Department of Defence, American Embassy- Sierra Leone, German Embassy, the UN Family namely: UNAIDS, UNICEF, WHO, UNFPA, WFP, UNDP, UNHCR, ILO, FAO, IOM, IMF, World Bank and ADB

In general, the mechanism of their respective support to the national response is either directly to the NAS or through partner international and national nongovernmental organizations; notable organizations in this group are: NETHIPS, CARE International, Christian AID, GOAL, Concern Worldwide, International Rescue Committee, CRS, Oxfam-GB, CARITAS etc. Their overall support during the reporting period has resulted into the scaling up of HIV prevention, treatment, care and support services in the country.

In the HIV and AIDS workplace programmes, ILO has been supporting the national response in spearheading the 'World of Work' response. Specifically, ILO is one of the co-sponsors supporting the Unions (Miners, Dock Workers, Artisanal Fishermen Union); the Employers Federation, and the Ministry of Employment and Social Security in developing a Decent Work Country Programme for Sierra Leone that will address HIV and AIDS from the employment perspective. ILO is also spearheading the review of the Labour Laws that will address discrimination against PLHIVs in the work place and create equal opportunities.

Partners need to keep their interaction and joint planning and monitoring through the Donor Partners Consultative Group on AIDS and the Expanded Technical working Group, with representation in at the National AIDS Council and various technical working groups.

## VIII. Monitoring and Evaluation Environment

### a) An overview of current Monitoring and Evaluation System

Sierra Leone has a National Strategic Framework 2006-2010, developed and validated through a stake holder consultative process that is based on the principles of the 'Three Ones' – One agreed National HIV and AIDS Framework, one agreed Monitoring and Evaluation System and One National Coordinating Authority. There have been a number of key developments towards enhancing an effective Monitoring and Evaluation environment for the National response. These include the following:

- i. A 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 in 2009. The group 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 the national HIV and AIDS Strategic Plan 2006-2010. It meets quarterly and three meetings were held in 2009. An M&E capacity building training was conducted and is on-going.
- ii. The National AIDS Secretariat (NAS) has a functional Monitoring and Evaluation Unit headed by a Senior Monitoring and Evaluation Specialist with technical backstopping provided by the newly assigned UNAIDS Monitoring and Evaluation Adviser, and the GF supported International M&E Consultants. There are two M&E Officers and two M&E Assistants

- iii. NAS in conjunction with the support from various partners disseminated key strategic information documents on HIV and AIDS in the period under review. Notable among them was the first Sierra Leone Demographic and Health Survey, HIV Prevalence studies among miners, police and the military, TB/HIV Co-infection study, ART Survival Analysis, ANC Sentinel Surveillance and the PMTCT study.
- iv. NAS also conducted a Joint Review of the national response to HIV and AIDS in may 2008, developed a two-year Operational Plan 2009-2010, NAS Institutional Review of 2009; NASA 2006 and 2007, and developed technical assistance plan.
- v. With support from the Global Fund, NAS developed a GAP analysis document that highlights national targets, targets being reached by Rounds 4, 6 and 9, and the gaps being filled by these grants.
- vi. The M&E unit and other NAS programme staff undertook quarterly supervisory field visits to partners and provided appropriate feedback and technical assistance on the quality of data.

#### **b) Challenges faced in the implementation of a comprehensive M&E system**

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

- i. There is lack of a national dissemination strategy of sharing key strategic information that informs programmatic review and management decisions.
- ii. Inadequate documentation (comprehensive inventory) and sharing of HIV/AIDS studies undertaken by various implementing partners. In addition, there is lack of a clear research agenda to fill the gap of already existing wealth of HIV and AIDS information.
- iii. There is lack of a clearly developed entry and exit strategy of OVC and nutritional support beneficiaries, which poses a big challenge in monitoring eligible clients.
- iv. Limited capacity within the M&E unit at NAS continues to be a challenge, coupled with the non-existence of a national HIV database, and district M&E officers to oversee data collection and collation.

- v. Although CRIS was successfully deployed at national and sub-national levels, the system is not being used partly because of the departure of the CRIS manager, and that the Ministry of Health and Sanitation is rolling-out the District Information Management System.

### **c) Remedial Actions Planned to overcome the challenges**

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

- i. The M&E technical working group should keep the momentum to monitor the implementation of key activities in 2010. These are the NASA 2008 and 2009, Epidemiological Synthesis of HIV/AIDS information, Joint Review of the NSP, development of the 2011-2015 NSP and M&E Plan, and a 2011-2012 costed Operational Plan.
- ii. M&E International staff to continue backstopping, mentoring and training of staff of the M&E Unit
- iii. Decentralize M&E data collection, collation, storage and transmission at district level.
- iv. Conduct assessment of the viability of CRIS system in view of the Ministry of Health's District Information Management System, and NASs' impending development of a national repository database.
- v. NAS with the support of the M&E technical working group need to develop a dissemination strategy and plan, research agenda and technical assistance plan.

### **d) Technical Assistance and Capacity Building Needs**

The technical assistance and capacity building needs of NAS are in the following:

- i. Training of NAS M&E staff in monitoring and evaluation concepts and application, advanced use of spreadsheets, manipulation of data and analysis.
- ii. Financial support and consultants in
  - a. Dissemination strategy development
  - b. Know Your Epidemic, Know Your Response
  - c. National AIDS Spending Assessment
  - d. Joint Review of the NSP
  - e. NSP 2011-2015 development
  - f. M&E Plan 2011-2015 development
  - g. 2011-2012 Operational Plan

## **IX. Conclusion**

Despite being a post-conflict country, Sierra Leone has made significant progress towards the goal of universal access to comprehensive HIV prevention, treatment, care and support by 2010 and halting and reversing the epidemic by 2015. The HIV prevalence has stabilized; prevention, treatment, care and support services have been scaled up with more people in need accessing the required quality services. Furthermore, the HIV and AIDS multisectoral response continues to enjoy strong political commitment and greater participation and meaningful involvement of civil society organizations, and the private sector.

However, some challenges still remain in provision of HIV and AIDS services to other vulnerable groups such as MSMs, IDUs, and sex workers. The delay in enacting the Prevention & Control of HIV & AIDS Act still poses a challenge in reducing stigma and discrimination and protecting the human rights of the affected and infected people. Also, although strategic information about HIV and AIDS is widely available, the challenge of information sharing without a dissemination strategy and lack of a research agenda, may affective programmatic design and decision making processes. Capacity building of the M&E staff remains the top priority in improving the overall monitoring and evaluation of the HIV and AIDS multisectoral response in Sierra Leone.

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