Sierra Leone

National Strategic Plan on HIV/AIDS

2011-2015

April 2011

Volume 3

Sierra Leone

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National AIDS Secretariat
Freetown, Sierra Leone

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National AIDS Secretariat

Five for One

Five for One: Represents the **Five** 'Pillars' strategically designed to compliment and feed into one another delivering **One** robust and comprehensive road map for the multi-sector response to HIV/AIDS in Sierra Leone.

The **Five Pillars** will contribute towards the goal of Zero New HIV Infections, Zero Discrimination, Zero AIDS Related Deaths in Sierra Leone guided by and in line with the governments Agenda for Change, the UN Joint Vision for Sierra Leone, the UNAIDS Strategic Outcome Framework and the scaled up the national response towards Universal Access and the MDGs.

Five Pillar Activities:

Know your Epidemic, Know your Response (Modes of HIV Transmission):
The purpose of the Know your Epidemic is to better characterize Sierra Leone's epidemic, to assess the extent to which existing responses address the real drivers, sources of new HIV infections and to recommend strategies to improve the effectiveness of Sierra Leone's response to HIV/AIDS.

Final Joint Programme Review of the NSP 2006-2010:
The final Joint Programme Review is to undertake a comprehensive consultative Review in respect of the NSP 2006-2010. The Joint Programme Review and Know your Epidemic will provide recommendations that will guide the development of a new National Strategic Plan 2011-2015, the new National M&E Plan 2011-2015 and an Operational Plan.

National Strategic Plan on HIV/AIDS 2011-2015
The current (NSP 2006-2010) concludes its time frame tin 2010, therefore a new National Strategic Plan on HIV/AIDS will be developed for 2011-2015 The new NSP will have clear and measurable goals, objectives and priorities that are going to guide the country's future programmes and operational plan that will benefit the response as follows.

National M&E Plan on HIV/AIDS 2011-2015
The current National M&E Plan concludes its time frame in 2010. The new M&E Plan will include a robust Monitoring and Evaluation Framework that will guide the collection, collation analysis and dissemination of strategic information on the HIV/AIDS epidemic and the responses to the epidemic in the country.

National Operational Plan 2011-2012
Based on the findings of the Know your Epidemic study, the outcome of the Joint Programme Review and NSP, a national Costed Operational Plan will be developed for the period 2011-2012. The OP will serve as a road map that clearly defines the role and responsibilities of stakeholders in implementing the provisions of the NSP.

FOREWORD

The Government of Sierra Leone is pleased to present the 2011 - 2015 National Strategic Plan on HIV/AIDS – ***Towards Zero New Infection on HIV Zero Discrimination, Zero AIDS Related Deaths by 2015*** to all our partners***.*** This is our second multi-sectoral response strategic plan to HIV/AIDS for the country and our first comprehensive results-based strategic plan on HIV/AIDS. This strategic plan will chart the roadmap for Sierra Leone to achieve the Millennium Development Goal **to have halted and begun to reverse the spread of HIV/AIDS by 2015**.

Five Years into the implementation of our first National Strategic Plan on HIV/AIDS 2006 – 2010, our epidemic is on the verge of stabilizing at a national prevalence of 1.5%. We also won the Millennium Development Goal Award on HIV/AIDS in 2010. However, we continue to grapple with the critical challenge of people adopting behaviours that could prevent them from contracting HIV. We need to take cognisance of the emergence of most-at-risk populations that we never thought of. As we move closer to the Millennium Development Year of 2015, we need to engage ourselves in diverse combination methods and approaches that are result-based in achieving the Millennium Development Goals on HIV/AIDS.

This Strategic Plan has been put together almost entirely by our numerous partners engaged in HIV/AIDS work in the country - the UN System including the World Bank, other Development Partners (Bi-and Multilateral); Government Ministries, Department and Agencies; Non Governmental Organizations; the Private Sector and Civil Society Groups including People living with HIV. This is testimony to the enormous contribution partners continue to make in our fight against HIV/AIDS in Sierra Leone. However, no Strategic Plan can stand alone in assuring that it will strengthen our HIV/AIDS response.

The main aim of our 2011 – 2015 HIV/AIDS Strategic Plan is to drive the response towards zero new HIV infections in Sierra Leone. To achieve this challenging target, efforts to prevent sexual and mother-to-child transmission of HIV will have to be strengthened and scaled-up. We will continue to ensure that programmes, services and support for HIV prevention reach the general population, while at the same time ensuring that the most at risk populations are targeted with programmes that respond to their specific situations.

The NSP also emphasizes the importance of behaviour change not as a one-off process, but a continuous one that requires the active involvement of communities and capacity building at all levels. This requires strengthening our current partnership while developing new ones. We must all commit ourselves – Government, Development Partners and Civil Society groups to addressing the myriad of social and economic issues that hamper effective coordination of our partnerships and our national response.

Please regard this Strategic Plan as belonging to all Sierra Leoneans and the global community of Development Partners who struggle daily with us in strengthening our national HIV/AIDS, prevention, treatment, care and support services. A Plan like this one is a living document. As we begin to implement it, we would have to constantly re-shape our strategies that would be of maximum use to all of us.

The implementation of this plan requires technical, financial and human resources and the collective will and total commitment of all partners to have a buy-in. It is my profound hope and desire to see all HIV/AIDS resources in the country aligned to this plan in a coordinated way to ensure we realize aid effectiveness. We will continually engage our partners on the implementation of the plan. As we move towards halting new HIV infections and begin to reverse the spread of HIV in Sierra Leone by 2015, it is my profound hope and trust that we will all stay on course and remain committed.

His Excellency, Dr. Ernest Bai Koroma

President of the Republic of Sierra Leone

ACKNOWLEDGEMENTS

The process of developing this Strategic Plan started way back in 2009 and was a mammoth task requiring leadership, commitment, courage, energy and vision. There were many rigorous and frank consultations with our invaluable stakeholders including our development partners around our strategic pillar activities. Over roughly a year, many contacts were made on various issues pertaining to our national response to HIV/AIDS. As a result, our NSP evolved as a concept and will continue to evolve during its implementation. The National HIV/AIDS Secretariat would like to take this special opportunity to express its deep appreciation and sincere thanks to all who contributed to the development of our 2011 – 2015 NSP.

We wish to offer our personal thanks and gratitude for the invaluable contributions of the United Nations family, spearheaded by the UNAIDS Office in Sierra Leone particularly in mobilizing resources and providing technical support. Specifically, we would like to express special thanks to the World Bank AIDS Strategy and Action Plan (ASAP) in providing technical and financial assistance through UNAIDS Technical Support Facility (TSF) for Western and Central Africa. We further acknowledge the support provided by our numerous partners such as the U.S Center for Disease Control and Prevention (CDC), WHO-IST West Africa and Health Systems 20/20 Group. We also acknowledge the tireless contributions of all other partners at all stages of developing the NSP. Given the unwavering commitment and support that we have continued to receive from them, the National HIV/AIDS Secretariat wishes to pledge its commitment to maintaining effective programming as it coordinates the national response towards achieving zero new HIV infections in Sierra Leone by 2015.

We offer our personal thanks to the Consultants and technical advisers who facilitated the compilation of the discussions and by their display of enormous tact, determination and attention to detail. Without them, this NSP would never have been finalized.

We also express our gratitude to the staff of the National HIV/AIDS Secretariat for their dedication, commitment and facilitation of the entire process. Without their support the development of the NSP would have been delayed.

Finally, we want to acknowledge Sierra Leoneans living with HIV/AIDS who have been the inspiration for this NSP. Their strength is celebrated and their struggle is not forgotten.

BRIMA KARGBO (DR.)

DIRECTOR

NATIONAL HIV/AIDS SECRETARIAT

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ABBREVIATIONS

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARG	AIDS Response Group
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASAP	World Bank AIDS Strategy and Action Plan
AWP	Annual Work Plan
BCAASL	Business Coalition Against Aids in Sierra Leone
BCC	Behavioural Change Communication
BSS	Blood Safety Services
CAC	Chiefdom AIDS Committee
CBO	Community Based Care
CCM	Country Coordination Mechanism
CDC	U.S Centre for Disease Control
COMAHS	College of Medicine and Allied Health Sciences
COPSAASL	Coalition of Public Sector Against HIV and AIDS in Serra Leone
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DAC	District AIDS Committee
DAAG	Disability Awareness Action Group
DBS	Dried Blood Spot
DHMT	District Health Management Team
DHO	District Health Officer
DMO	District Medical Officer
DOO	District Operational Officers
DPC	Disease Prevention and Control
DPI	Directorate of Planning and Information
ETWG	Extended Technical Working Group
FAO	Food and Agricultural Organization
FAWE	Forum for African Women Educationists
FSU	Family Support Unit
GF	The Global Fund on HIV/AIDS, TB and Malaria
GIS	Government Information Service
GoSL	Government of the Republic of Sierra Leone
GWT	Gender Working Team
HACSA	HIV and AIDS Care and Support Association
HARA	HIV and AIDS Reporters Association
HBC	Home Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HR	Human Rights

IDU	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
IMC	Independent Media Commission
INGO	International Non Governmental Organization
IOM	International Office of Migration
JPR	Joint Programme Review
KFW	Krebital ftaltfürWieberaufbau (German Development Bank)
KYE,KYR	Know Your Epidemic, Know Your Response
Le	Leone (Sierra Leone currency)
MARPs	Most-at-Risk Populations
MDAs	Ministries, Departments and Agencies
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MELSS	Ministry of Employment, Labour and Social Security
MEYS	Ministry of Education, Youth and Sport
MIALGRD	Ministry of Local Internal Affairs, Local Government and Rural Development
MLGCD	Ministry of Local Government and Community Development
MoD	Ministry of Defence
MoFED	Ministry of Finance and Economic Planning
MoHS	Ministry of Health and Sanitation
MoIC	Ministry of Information and Communication
MoJ	Ministry of Justice
MoT	Modes of Transmission
MoTCA	Ministry of Tourism and Cultural Affairs
MoU	Memorandum of Understanding
MoWHI	Ministry of Works, Housing and Infrastructure
MoYS	Ministry of Youth and Sports
MRU	Manor River Union
MSM	Men who have Sex with Men
MSWGCA	Ministry of Social Welfare, Gender and Children Affairs
NAC	National AIDS Council
NACP	National AIDS Control Programme
NACSA	National Commission for Social Action
NAS	National HIV/AIDS Secretariat
NASSIT	National Social Security and Insurance Trust
NECHRAS	Network of Christian Response to HIV and AIDS in Sierra Leone
NETHIPS	Network of HIV Positives
NGO	Non-governmental Organization
NOW	National Organization for Welbodi
NSP	National Strategic Plan
OHCHR	United Nations Office of the High Commissioner for Human Rights
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children

PABA	People Affected By AIDS
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PHE	Public Health Educators
PHU	Peripheral Health Units
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSM	Procurement and Supply Management
PWD	People Living With Disabilities
PSO	Private Sector Organization
RH	Reproductive Health
RST	Regional Support Team
SEAC	Sexual Exploitation and Abuse Committee
SHARP	Sierra Leone HIV and AIDS Response Project
SL	Sierra Leone
SLANGO	Sierra Leone Association of Non-Governmental Organization
SLDHS	Sierra Leone Demographic and Health Survey
SLLC	Sierra Leone Labour Congress
SPU	State House Patrol Unit, State House
STI	Sexually Transmitted Infections
SWAASL	Society of Women and AIDS in Africa, Sierra Leone Chapter
TBA	Traditional Birth attendants
TFCs	Therapeutic Feeding Centres
TTIs	Transfusion Transmittable Infections
TWG	Technical Working Group
UCC	UNAIDS Country Coordinator
UCO	UNAIDS Country Office
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
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
UNIDO	United Nations Industrial Development Organization
UNIPSIL	United Nations Integrated Peace Building in Sierra Leone
USG	United States Government
VOW	Voice of Women
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

The Sierra Leone HIV/AIDS National Strategic Plan describes how the epidemic poses serious challenges to the social and economic development of the country. Several initiatives in 2010 helped in providing a better understanding of the nature of the epidemic Sierra Leone was confronted with, the strengths, weaknesses, challenges and opportunities of the national response to HIV/AIDS. The entire process of developing the NSP was spearheaded under the leadership of the National HIV/AIDS Secretariat. All these activities took place with the active involvement of partners and various stakeholders including people living with HIV, minority groups and civil society.

This NSP is Sierra Leone's second multi-sectoral strategic plan on AIDS response. The plan describes the unique challenges that HIV and AIDS pose to Sierra Leone's economic and social development and how it will be addressed. With an estimated national prevalence of 1.5% among the general population, Sierra Leone is one of the less affected countries in the sub-Saharan Africa. However, the HIV transmission is far from being under control. Even though about 52% of the people in need are receiving anti-retroviral therapy (ARV), the epidemic continues to pose a heavy social and economic burden on those infected and affected by the disease.

The NSP was developed based on the principles of participation and involvement of key stakeholders, ownership and buy-in, and evidenced-based planning. Its development was also in the context of the 1991 Constitution, The President's Agenda for Change- which stresses the prevention of new infections, treatment, care and support to people living with HIV, including orphans and vulnerable children, the Second Poverty Reduction Strategy (PRSP II), 2008-2012, Modes of Transmission Study, 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, UNAIDS Strategy 2011-2015 and* the UNAIDS *Outcome Framework 2009–2011.*

The NSP interventions are premised on the following principles and commitments amongst others: i) Strong political leadership of the national HIV/AIDS response as currently demonstrated by The President and judicious utilisation and management of financial resources, ii) Multi-sectoral approach which engenders collaboration with different actors, iii) Protection and promotion of the rights and access of PLHIV to comprehensive prevention, treatment, care and support services, iv) Commitment to protecting rights of PLHIV, reduction of stigma and discrimination and ensuring greater involvement of PLHIV in the AIDS response at all levels, v) Commitment to promoting and protect the rights of women, children, young people and marginalized groups and reduce their vulnerability to HIV infection, and vi) Scaling up of HIV prevention among the most-at-risk populations (MARPs) since they have been identified as one of the sources of new HIV infections in Sierra Leone.

The NSP has set very ambitious targets as a means of making the Universal Access to HIV Prevention, Treatment, and Care and Support a reality as well the country's goal of achieving zero new infections. In addition, the set targets are also in line with Millennium Development Goals of halting and beginning to reverse new HIV infections. In spite of this, many challenges lie ahead in the area of prevention, treatment, care and support if Sierra Leone is to reverse the epidemic.

Recent statistics, classify Sierra Leone as being one of the 56 countries that has stabilised and beginning to reduce the incidence of HIV by 25% in the period 2001 to 2009.

The revised six thematic areas for the 2011-2015 NSP are:

a) Coordination, Institutional arrangements, Resource Mobilisation and management
b) Policy, Advocacy, Human Rights and Legal Environment
c) Prevention of New Infections
d) Treatment of HIV and Other Related Health Conditions
e) Care and Support for the Infected and affected by HIV and AIDS and
f) Research, Monitoring and Evaluation

The impact/outcome level results for this NSP are as follows:

i) Coordinating structures at national and decentralized level effectively manage implementation.
ii) Laws and policies protecting the rights of PLHIV and orphans are widely applied.
iii) Incidence of HIV is reduced by 50%.
iv) Morbidity and mortality amongst the PLHIV are reduced.
v) People infected and affected have the same opportunities as the general population
vi) Research, monitoring, and evaluation systems strengthened at all levels

Each of these impact level results has their outcomes and outputs as well as their indicators. In terms of strategic key interventions it is expected that priority will be given to strengthening coordination at the lower levels of the national response; targeting the key drivers of the epidemic such as MARPs (FSW, MSM, IDUs) with appropriate interventions; increasing the number of the general population that have comprehensive knowledge of HIV/AIDS as well as those who get tested and know their HIV status; increasing level of support for the PLHIV and OVC particularly in the area of skills training and economic empowerment, enactment and/or review of appropriate laws and policies that would reduce stigmatization and discrimination as well as standardize the provision of services; capacity-building of the actors in technical and managerial aspects as well as integration of HIV services into existing health programs. Gender considerations and systems strengthening of logistics management, human resources for health, research, monitoring and evaluation have also been emphasised.

The costing of the NSP was done using the resource need model due to the limited time available. The costing exercise estimated that to fully implement the five-year planned interventions, the country will require resources valued US$ 322 million. From the records, the country is assured financial resources totalling US$ 106 million. This means that the country has to mobilise resources totalling US$ 216 million to ensure that the NSP is fully implemented for the next five years.

1.0 COUNTRY CONTEXT AND SITUATION ANALYSIS

1.1 Social, Demographic and Economic Characteristics

Sierra Leone is located on the west coast of Africa and covers an area of about 71,740 square kilometres (approximately 28,000 square miles). The country is bordered in the north and north-east by the Republic of Guinea, on the north and northeast by the Republic of Liberia and the west and southwest by the Atlantic Ocean.

Administratively, the country is divided into four provinces namely the Western Area, three provinces namely; Northern, Southern and Eastern. The provinces are further divided into fourteen (14) Districts and 149 chiefdoms. The 14 Districts are sub-divided into 19 Local councils following the enactment of the Decentralization Act. Out of the 19 Councils, 6 are City Councils and the remaining 13 are District Councils. Government is at present implementing a devolution plan, which will see the devolution of the central government's functions to the councils. At the moment 19 out of the 34 core functions have been devolved to the councils. To further strengthen the decentralization process, a Chiefdom Governance Act has been enacted and approved by Parliament.

The 2004 Population and Housing Census estimated the country's population at 4,976,871 with 37.1% residing in urban areas. The results of the previous censuses indicated an annual population growth rate of 1.8 percent per annum during the 1985-2004 period. Women account for about 51.5% of the total population with 47.8% of the estimated total population within the age brackets of 15 – 49 years. The Total Fertility Rate (TFR) has remained at slightly above 6 children per woman and this rate has remained constant for over a decade. This high TFR level has largely contributed to the youthful nature of the population. 47% percent of the population is under age 15 years and adolescents accounts for 19.4% of the estimated population in 2004.

Over the years, the urban population has been increasing at a faster rate than the rural, largely as a result of rural neglect and the civil conflict, which ended in 2002. The result of the rural- urban migration has led to an upsurge in movement to the urban centres resulting in some sort of disintegration in the communal traditions and family bonds that once held the communities together. These communal traditions and family bonds are crucial in providing social protection not only for PLHIVs but the population at large.

Sierra Leone's gross national income (GNI) per capita is US$ 809 (UN HD Report 2010). Based on consumption levels, 66.4% of the population could be defined as 'poor' (47% in urban areas versus 79% in rural areas). The 2010 UNDP Human Development Report ranked Sierra Leone 158th out of 169 on the Human Development Index.

Sierra Leone has commenced the implementation of Universal Access to Primary Education. However, school enrolment and retention still pose some challenges. Some 30% of children of primary school-going age are still out of school[1]. Many of those who eventually access schooling do not complete. Causes of non-attendance and completion include hidden and indirect costs, socio-cultural barriers to girl-child education, child labour and high rate of teenage pregnancy.

[1] Poverty Reduction Strategy 2008-2012, An Agenda for Change, January 2009, pp 18, 102

About 25% of the young men in Sierra Leone are unemployed and 30% of them are between the ages of 20 – 24 years (PRSP II). The Sierra Leone Integrated Household Survey estimated 53.4% of the youths aged 15 – 35 years are illiterate and most live in urban areas[2]. To address these issues the country has formulated a National Youth Policy and recently established a Youth Commission to promote opportunities for youth advancement. This is yet to have any profound effect on youth unemployment. Largely due to the war, many of the youths do not have formal education and skills with only 20% of 15-35 year olds having finished primary school. Unemployment among urban youth is very high and also higher than among the rural youth. There are fewer opportunities in formal employment for youths. Young women are further disadvantaged and have less access to paid employment and formal employment[3].

1.2 Sierra Leone's Health System

Sierra Leone remains committed to a primary health care approach and prevention as cost-effective strategies. Peripheral Health Units (PHUs) are the first level of health care delivery and are variously categorized as community health centres, community health posts, and maternal and child health posts. District hospitals are the second level of healthcare delivery supporting the PHUs and serving as referral points for the management of more complicated cases outside the competency of the PHUs. The third level of service delivery is at the tertiary level, to support district hospitals and address conditions requiring specialized care. It should also be noted that the public healthcare delivery is also been complemented by the private sector, NGOs and FBOs that operate at the different levels.

The delivery of health care is based on the development of an integrated health system that has clear and inter-linked roles for the primary, secondary and tertiary levels of care, the involvement of communities and collaboration between sectors[4]. On the basis of set criteria[5], the current national priority health problems are:

i) Malaria
ii) Sexually Transmitted Infections including HIV/AIDS
iii) TB
iv) Unsatisfactory reproductive health including maternal and neo-natal mortality
v) Acute Respiratory Infections
vi) Childhood immunizable diseases
vii) Nutrition-related disease
viii) Water, food and sanitation-borne diseases
ix) Disability
x) Mental illness

[2] Poverty Reduction Strategy 2008-2012, An Agenda for Change, January 2009, pp 18, 102
[3] Youth Employment in Sierra Leone, World Bank, 2009.
[4] National Health Policy, 2002
[5] National health priorities have been set on the basis of a number of criteria. These are:

- severity of the disease in terms of its contribution to the overall burden of disease in the country
- distribution of the health problem within the country as a national problem
- feasibility and cost-effectiveness of interventions concerning the health problem
- public expectations concerning the problem
- compliance with international regulations

Sierra Leone's health systems comprise of promotion, prevention, curative and rehabilitation services delivered by health workers and related support structures. They include both public services, private services that operate on either profit or non-profit basis (e.g. NGOs, including those that are faith-based) and traditional health care. The Ministry of Health and Sanitation has the overall responsibility for the performance of the health sector and the lead in the provision of health care. It also has the responsibility for regulating, coordinating, monitoring and evaluating health care delivery in the country. However, health care delivery are ineffective because of limited geographical access due to inadequate numbers and inequitable distribution of facilities; high cost of services for the majority of Sierra Leoneans; inadequate participation of communities in health care delivery; weak coordination and communication among programmes and partners; shortage of critical health professionals etc.[6]

1.2.1 Some Key Health-Related Indicators

Health is a major component of the human development priority of the Second Poverty Reduction Strategy 2008 – 2012 "**An Agenda for Change"**. Much emphasis is placed on maternal health, child health, and nutrition to promote productivity and future growth of the economy. However, maternal and child health indicators are appalling. Infant and child mortality is estimated at 89 and 140 deaths per 1,000 live births, while maternal mortality is estimated at 857 deaths per 100,000 live births[7]. Malnutrition and malaria are the major causes of infant and under-five mortality and morbidity in Sierra Leone.

Women in Sierra Leone do not receive antenatal care services early during pregnancy. According to the 2008 Demographic and Health Survey, only 30% of women obtained antenatal care in the first 3 months of pregnancy, while 41% made their first visit in the 4th or 5th month, and 17% made the first ANC visit in the 6 or 7 month; 1% of women had their first antenatal care visit in the 8th month of pregnancy or later. Such a trend present challenge for PMTCT services. The challenge is further compounded by the fact that only 42% of the births are attended by skilled health personnel.[8]

In response to the appalling maternal and child health indicators, Government in April 2010 introduced free health care for pregnant women, lactating mothers and under-five children. User fee which has been one of the limiting factors for accessing health services has been removed.

1.2.2 Health Care Financing

Health care financing in Sierra Leone remains a big challenge in Sierra Leone largely due to high Health care costs. Though data relating to the burden of health expenditure on households is not available, it is clear that the bulk of the population cannot afford the orthodox medical care costs leading to poor utilization. Considering the fact that over 65% of the population live below the poverty line, the user fees almost excludes the bulk of the population from seeking healthcare. Despite the removal of user fees for pregnant, lactating mothers and under-five children through the free health care initiatives, there remain infrastructural and human resource challenges for this group to access health care. The health system is still heavily dependent on external financing.

[6] Poverty Reduction Strategy 2008-2012, An Agenda for Change, January 2009,
[7] 2008 Demographic and Health Survey
[8] UNDP Human Development Report 2010

The annual budgetary allocation to the sector falls far below the Abuja Declaration of 15%. Most of the funding (over 80%) for this sector still comes from development partners making the country vulnerable to external shocks. It also shows the grave implications of financial sustainability for the health system and the national response to HIV/AIDS in the medium to long term.

The 2004 Decentralization Act empowers the District Councils to play a key role in the financing and management of district hospitals and PHUs as part of the devolution plan. Also, Government is therefore seriously thinking of setting up a National Social Health Insurance Scheme that will ensure access and affordability of quality health care service to all Sierra Leoneans. The financing of such a scheme still remains to be seen.

1.2.3 Health Systems Challenges within the Context of HIV/AIDS

The health systems in Sierra Leone face several constraints that can negatively impact on the national response to HIV/AIDS prevention, treatment and care interventions. Capacity is inadequate and substantial improvements will be required in infrastructure, human resources, and procurement and supply management systems so as to maintain an uninterrupted supply of drugs. The health information system (HIS) is also weak resulting into information and communication systems not providing adequate support at the district levels in terms of collection, analysis and feedback. In addition to the weak HIS, there is inadequate harmonization and coordination in disease management. HIV/AIDS interventions within the health systems are yet to be fully integrated.

2.0 HIV/AIDS RESPONSE IN SIERRA LEONE

2.1 Overview of HIV/AIDS in Sierra Leone

The first response of Sierra Leone was the establishment of a National AIDS Committee in 1987 with support from World Health Organization (WHO). Later in that same year, the National AIDS Committee was transformed into National AIDS Control Programme (NACP) within the Ministry of Health and Sanitation. Incidentally the first case of HIV was also diagnosed in 1987. Until about the year 2000, the national HIV response was largely health-sector focused with the training and re-training of medical and health staff as well as execution of health related activities. This led to other sector intervention being largely un-coordinated.

However following the country's participation at the Durban meeting in 2000 in which the need to adopt multi-sectoral approach to the HIV/AIDS was discussed; Sierra Leone also began to take steps towards adopting the multi-sectoral approach to HIV/AIDS.

Through collaboration and partnership with development partners including the UN Theme Group on HIV/AIDS and the World Bank, the country's first Policy on HIV/AIDS was formulated in 2001. Also in partnership with the US Centres for Disease Control and Prevention (CDC) the country undertook its first comprehensive HIV sero-prevalence study. With funding support from the World Bank, National HIV/AIDS Council (NAC) and the National HIV/AIDS Secretariat (NAS) were established in 2002 under the Office of the Presidency, with the responsibility of providing leadership in coordinating, monitoring and mobilizing resources for the national response.

Since 2002, the Government of Sierra Leone has adopted the multi-sector approach for combating the HIV/AIDS epidemic. This has resulted into a flurry of stakeholders including the development partners, public sector; private sector entities, unions, religious bodies and people living with HIV becoming actively involved in the national response. For instance, NAS in 2006 with support from donor partners developed the country's first multi-sectoral National HIV Strategic Plan as well as Monitoring and Evaluation Framework. These two documents have formed the basis for receiving assistance (cash and in-kind) from both bi and multilateral partners including the UN Family. This support has contributed to strengthening the country's response to the epidemic.

2.2 HIV/AIDS Coordinating Structures

(a) National AIDS Council: This is the highest decision-making body for HIV/AIDS in the country and is chaired by His Excellency, The President. Established in 2002, it is responsible for the overall policy and coordination of HIV/AIDS related national response. The NAC is a Public-Private-Civil Society Partnership with development partners and People Living with HIV and AIDS as its members.

(b) National HIV/AIDS Secretariat: Established in 2005, and is located in the Office of H.E. the President. The National AIDS Secretariat is responsible for coordinating the national HIV/AIDS response. It works with NGOs, local councils, 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.

(c) District AIDS Committees (DACs): are to coordinate HIV/AIDS activities at the district levels. The membership is multi-sectoral with Chairperson of the Council as the Chair of DAC. Other members include the Chief Administrator of the Council, Chair of the health Committee of the Council, education/social welfare, Labour Unions, representative of Inter-religious council, PLHIV and implementing partners. Their responsibilities include: developing the district HIV and AIDS strategic plan and mobilizing resources for the district response; tracking the implementation of HIV and AIDS programme, managing of all actors; monitoring HIV programme in the district as per NAS M&E framework; directing the financial and human resources for HIV/AIDS activities in the District etc.

(d) Coalition of Public Sector against HIV and AIDS in Sierra Leone (COPSAASL): Established in 2008, 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. They meet periodically and serve as a coordination platform.

(e) The Network of HIV positives in Sierra Leone (NETHIPS): is an umbrella organization for all people living with HIV and AIDS. NETHIPS a legally registered umbrella organization comprising over 40 PLHIV support groups nationwide. It coordinates the activities of the support groups and plays great advocacy roles. It also plays significant roles 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 many key coordinating entities.

(f) Business Coalition against AIDS in Sierra Leone (BCAASL): Established in 2008, it is a network of the leading 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 coordinates and facilitates the development and implementation of corporate sector HIV/AIDS workplace policies as well as mobilizes resources from the sector.

(g) Sierra Leone Association of Non-Governmental Organizations (SLANGO): is the network of all NGOs in Sierra Leone and is therefore charged with responsibility for coordinating HIV/AIDS response within the Civil Society sector. Currently it has a membership of 238 members.

(h) Inter-Religious Council of Sierra Leone (ICSL): is the network of faith-based organizations (Muslim and Christian organizations) working on HIV/AIDS in Sierra Leone. The council coordinates and facilitates the development and implementation of HIV/AIDS activities as well as encourage resource mobilization for and from the sector.

(i) HIV/ AIDS Reporters Association (HARA): is an association of Journalists working with different media organizations (print and electronic) and reporting on HIV/AIDS issues. The objective of this association among others is to raise awareness about HIV/AIDS issues; 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. The association is also responsible for coordinating the activities of its members.

(j) Technical and Other Support Groups: As part of NAS's mandate to coordinate the multi-sectoral national response to HIV/AIDS epidemic in a synchronized and cooperative manner, NAS draws on the technical expertise of stakeholders through well constituted technical working and advisory groups. They are:

- 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

2.3 Epidemiological Situation, Trends and Challenges

The 2010 modes of transmission study conducted in Sierra Leone characterized the HIV epidemic as mixed, generalized and heterogeneous affecting different population sub-groups and resulting in multiple and diverse transmission dynamics. The HIV epidemic affects all sectors of the economy and is both a developmental as well as epidemiological challenge that requires appropriate sectoral responses.

The HIV prevalence in Sierra Leone increased from 0.9% in 2002 to 1.5% in 2005. It appears the epidemic peaked in 2005 with a national prevalence of 1.5% and remained same in 2008 (DHS 2008). The survey estimated a national HIV prevalence of 1.5% among the general population aged 15 – 49 years. The prevalence rate for men was 1.2% while that for women was 1.7%.

Female prevalence peaked at 30 to 34 years (2.4%) while their male counterparts peaked at 45 to 49 years (2.1%). There were no consistent patterns of HIV prevalence by age among either women or men; rather the levels fluctuated by age group. Prevalence was found to be higher in urban areas (2.7%) than in the rural areas (1.2%). Compared with the previous population-based sero-prevalence survey of 2005, there was no change in the national prevalence rate and the same prevalence pattern was exhibited for the sexes and the settlement patterns.

However, HIV prevalence among pregnant women attending antenatal clinics (ANC) is 3.2% (NACP 2009) and is significantly higher than the national prevalence. The HIV prevalence among pregnant women over the years show declining trend from 4.4% to 3.5% and 3.2% for 2007, 2008 and 2009, respectively. The 2008 DHS and the 2009 ANC survey show urban-rural regional variation in HIV prevalence. Other cohort studies conducted between 2007 and 2010 provided information on HIV prevalence among some key drivers of the epidemic. Among miners, men having sex with men and fishermen, the prevalence rates were estimated at 1.13%, 7.5% and 3.9% respectively.

Incidence modelling in the 2010 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% of new infections. The study also revealed that people in discordant monogamous relationships contributed 15.6% of new infections whereas people reporting multiple partnerships and their partners contributed 40%. Of these, multiple sex partnership groups with the casual heterosexual sex group and their partners contributed about 15%. Fisherfolks contributed the second highest incidence (10.8%) followed by traders, transporters and mine workers with 7.6%, 3.5% and 3.2% respectively. MSMs and IDUs are slowly emerging in the Sierra Leone society. They contributed 2.4% and 1.4% of the new infections respectively.

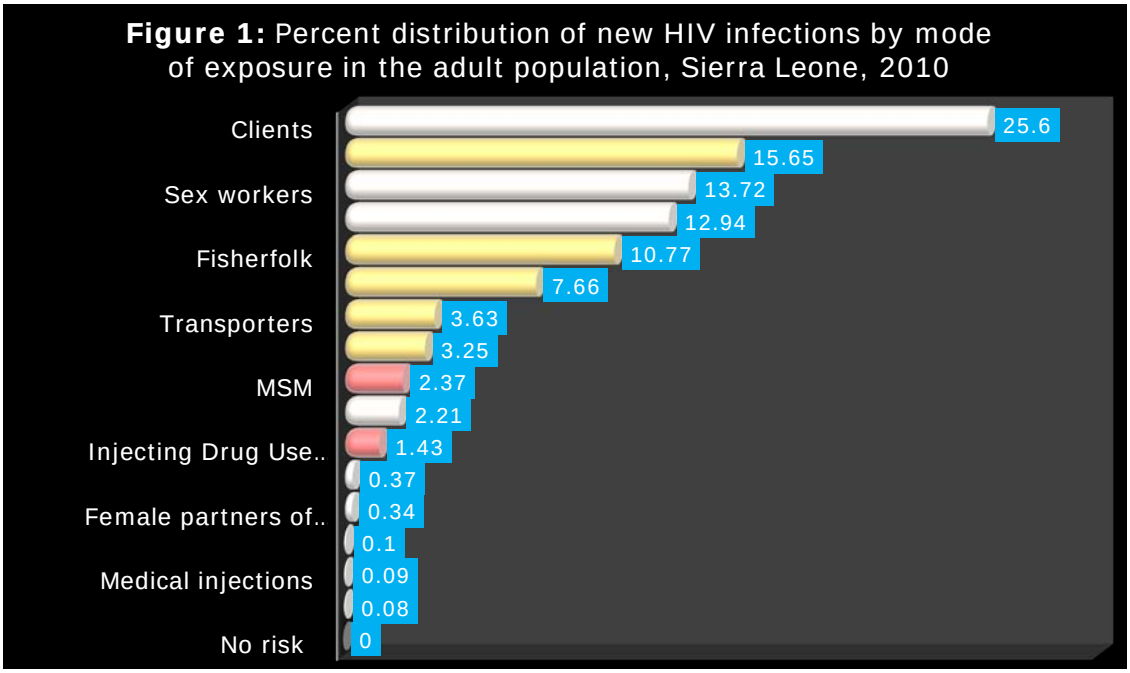


Figure 1: Percent distribution of new HIV infections by mode of exposure in the adult population, Sierra Leone, 2010

Based on the review of the epidemiology of HIV (especially drawing on the analysis of the DHS and various studies carried out among vulnerable populations between 2005 and 2008), the risk factors and contextual factors driving the HIV epidemic in Sierra Leone are summarized in the Box 1 below.

Box 1: Summary of Risk Factors and Contextual Factors Driving the HIV Epidemic in Sierra Leone

Risk Factors for HIV Transmission	Contextual Factors of the HIV/AIDS Epidemic
• Commercial sex networks • Multiple partners • Discordance and non-disclosure • Low condom use • Alcohol and drug use • Presence of STIs, especially HSV-2 • Transactional sex • Cross-generational sex	• Human rights, stigma & discrimination • Wealth and poverty • Low status of girls & women • Socio-cultural factors • Inequity and access to prevention • Care and treatment

Based on the pattern emerging from the incidence modelling, several challenges could be outlined with respect to HIV response among the general population. These include:

a) ***High Incidence among Sex Workers and the Network***

This could either be as a result of difficulty in targeting the group, the disperse nature of the profession or lack an identifiable community. It is often assumed that it is more efficient to reach sex workers with structured interventions, prevention and other services without focusing on the clients of sex workers. The central focus of HIV prevention must be to reach clients of sex workers. The challenge therefore is identifying and targeting workplaces associated with demand for sex work.

b) High incidence within marriage or regular partnerships

High sero-status discordance rate indicates that marriage and regular partnerships may well be at risk of HIV. Given that the social norms regarding marital relationship often put the women at a disadvantage in the country, their vulnerability is often increased. Besides, they are often unaware of their partner's infection status or their level of risk. Sexual coercion, domestic violence and economic vulnerability are factors which impinge on their ability to negotiate safer sex practices. These are difficult challenges for prevention. Besides testing, discordant couples are virtually impossible to identify and target with services.

c) Low Condom Use

Condom use among the population engaged in multiple sexual relationships (that is having more than one sexual partner) was found to be low among the sexes (women 7% and men 22%). In addition, condom use among the proportion of women engaging in higher-risk sexual intercourse declined from 20% in the 2005 Multiple Indicator Cluster Survey to 10% in the 2008 DHS.[9] The higher-risk sexual intercourse and condom use by women compared with men may be a consequence of the lack of condom negotiation skills among women.

[9] 2008 Demographic and Health Survey pp.198

d) Low Levels of knowledge about HIV status and Where to obtain services

About 13% of women and 8% of men aged 15-49 years have ever had an HIV test. Also few of them knew where to get an HIV test (27% for women and 33% for men).[10] The testing rates show similar pattern across the regions (3.5% for the East, 3.8% North, 5.3% South and 17.5% West). Similar pattern is also exhibited in terms of knowledge where to get an HIV test (26.2% for the East, 21.7% North, 28.2% South and 62.2% West). The increase in testing among women might be due partly to PMTCT services and testing at antenatal clinics. This is a critical challenge for prevention interventions most especially when HCT is a gateway to prevention.

e) Lack of Comprehensive data on MARPs

Comprehensive data on the MARPs such as IDUs, MSMs and sex workers are difficult to come by. Where information exists, they are very scanty for any meaningful programmatic interventions such as quantifying accurately their size in terms of population as well as the difficulty in targeting them with services. MSMs and IDUs are gradually emerging as a group in the society.

In addition, sex work, MSM and IDU are not formally recognized in Sierra Leone. Besides, there is religious and cultural resistance among the population often leading to stigmatization and discrimination of these groups. The 2011 – 2015 NSP will have the challenge of de-criminalizing them and work with all most at risk groups. Programmes will have to adopt innovative ways to reduce HIV transmission among these groups.

f) TB/HIV Collaboration

Despite the fact that TB patients are tested for HIV, the integration link between TB/HIV remains weak. The challenge therefore will be to strengthen the TB/HIV collaboration by integrating HIV component into the TB facilities.

2.4 Synopsis of the National Strategic Plan for HIV/AIDS (2006-2010) Response Analysis

The summary of the response for this period was based on information gathered from various documents such as the mid-term and final joint review of the NSP I, UNGASS reports, donor reports, Programmatic reports, as well as discussions and key-in depth interviews with the various stakeholders.

The response analysis was carried out based on the thematic areas agreed upon for the development of the NSP II (2011-2015) and they are as follows:

(i) Coordination, Decentralized Response, Resource Mobilization And Management
(ii) Policy, Advocacy, Human Rights and Legal Environment.
(iii) Prevention of New HIV Infections
(iv) Treatment Of HIV And Other Related Health Conditions
(v) Care And Support for the Infected and Affected By HIV/AIDS
(vi) Research, Monitoring And Evaluation

For each of the areas listed above, the key findings (achievements and constraints) and the strategic recommendations are discussed.

[10] 2008 Demographic and Health Survey pp.198

2.4.1 Coordination, Decentralized Response, Resource Mobilization and Management

2.4.1.1 Key Findings

a) Coordinating structures have been established at two levels of the National response (National and District levels) and in line with devolution of responsibilities to the lower levels of governance. Coordinating structures are yet to be set up at the Chiefdom levels. Coordination structure at the National level is relatively strong while it is not effective at the District level as there are no linkages with other partners at that level and neither are they funded.

b) Technical and managerial capacities at NAS have been re-engineered for enhanced performance but there are still gaps in certain areas (such as financial and programmatic) both in terms of quality and quantity. Institutional review of NAS was done but the recommendations are yet to be implemented. Managerial and technical capacities at the district level are considerably weak. All Ministries have HIV/AIDS Committee.

c) Various coordination platforms have been set up within and amongst the sectors. They include: COPSAASL (for public sector actors), BCAASL (for private sector actors), NETHIPS (for PLHIV), SLANGO (for other CSO actors), Inter-religious Council (for FBOs) and HARA (for media). Capacity needs assessment has been done for only NETHIPS. There is also the NAS interface with other actors through fora such as the NAS-development partners' forum, NAS-Implementing Partner forum. Coordination meetings are found to be largely irregular.

d) The CCM which is the body responsible for coordinating the Global Fund grants is also in existence and functional. The capacity assessment of CCM was done and assistance has been provided. It is still the view of most people that it needs further capacity building.

e) The Partnership forum which is made up of about 300 members was also established as a coordinating forum for the response. It however appears largely unstructured with most members not understanding the purpose while most decisions taken are often not followed up.

f) Most of the networks could be said to be emerging with relatively weak capacities and little or no resource base. The network for the other CSOs-SLANGO appears too big and diffused for any meaningful engagement as it consists of different NGOs working in different fields such as education, human rights, etc.

g) NACP is responsible for coordinating the health sector response and is located in NAS but is getting limited support from the parent Ministry- Ministry of Health and Sanitation.

h) NAS is still a committee and has no budget line of its own though it functions largely as a commission and signs performance contract with the President like any other MDA. As such it is still largely dependent on donor partners for funding of its activities. Most of the MDAs also do not have budget line for HIV/AIDS activities

i) Two National AIDS Spending Assessment (NASA) exercise were conducted during the period and it showed that the National HIV response is still largely donor dependent with over 95% of what is used in resourcing the national response coming from donors while government accounts for only 3%. Furthermore, the response has two major donors currently (Global Fund and KfW) making the response highly susceptible. The UN system (and in conjunction with NAS) has been actively involved in resource mobilization and providing most of the technical assistance needed.

j) Capacities of CSOs and FBOs to mobilize resources from external sources are still very limited. Private sector contributions to funding the response are also very limited though commitment in terms of participation is on the increase.
k) Little in-house capacity exists in NAS for procurement while logistics management systems are still weak. Procurement management is still contracted out.
l) Human resources available for the National HIV response are grossly inadequate with few ones being overworked. Capacities of the few ones available will need to be built for high quality service delivery.

2.4.1.2 Strategic Recommendations

a) Strengthening of the coordination structures at the national and district levels while coordinating structures should be established at the chiefdom levels. Capacities should also be built at all levels for effective coordination. Periodic meetings between NAS and DACs, and between DACs and CACs should be instituted.
b) The recommendations of the Institutional review of NAS should be looked into with a view to implementing the recommendations. The Ministry of Health and Sanitation should increase its support to NACP financially and otherwise.
c) There is need to streamline the various coordination platforms such as the expanded technical working group and partnership forum to make them more focused and functional. Partnership forum should also be decentralized for increased participation.
d) NAS-development partner forum should be revitalized. Definite times should be set aside for the meetings and such communicated well in advance to partners. Bilateral meetings between NAS and networks only should be instituted.
e) Technical assistance plan for the entire national HIV response should be developed.
f) Strengthen the capacities of the various networks such as COOPASL, BCAASL, NETHIPS and Youth network for effective service delivery and coordination of their members. Network for CSOs involved in HIV/AIDS activities should be established for proper focus and effective engagement.
g) NAS should develop a resource mobilization plan and pursue it aggressively to diversify its donor base. Joint Financing Arrangement or pooled funding could be explored with the donor partners.
h) NAS should also work assiduously to transforming into a Commission within the shortest possible time. NAS should also advocate for mainstreaming of HIV/AIDS into planning and budgetary processes at the National and district level.
i) Procurement and Logistics management systems should be strengthened. NAS should be empowered to take over the procurement functions developing indigenous capacities.
j) Given the limited availability of human resources, strategies for maximizing the use of the available ones should be developed. This could include task-shifting, pluralization of skills within the health facilities, mainstreaming HIV/AIDS training into the curriculum of training institutions of health service personnel amongst others.

2.4.2 Policy, Advocacy, Human Rights and Legal Environment

2.4.2.1 Key Findings

a) Sierra Leone National HIV response has been captured in relevant strategic documents such as the 'Agenda for Change' and Poverty Reduction Strategy Paper II. There is also considerable level of political support for the response at the highest level of government.

b) Sierra Leone is a signatory to International Human Rights Protocols and conventions such as the UN charter on Human Rights, Ndjamena Accord, Convention on the Elimination of forms of Discrimination Against Women (CEDAW), UNGASS resolution, Universal Access etc.

c) The Prevention and Control of HIV/AIDS Act (2007) was enacted. The Child Rights Acts as well as three "Gender Acts"; the Domestic Violence Act 2007, the Devolution of Estate Act 2007 and the Registration of Customary Marriage and Divorce Act 2007 which protects the women from domestic violence and other forms of abuse which make them more vulnerable to HIV/AIDS were enacted. Family Support Units (FSU) were also established to take up issues related to gender and sexual violence. Enforcement of these laws is still a key issue as some of the law enforcement agents are not often aware of them. Some aspects of the HIV/AIDS Prevention Act are also considered discriminatory and are being reviewed.

d) Cases of discrimination against PLHIV particularly the women are still very rampant and even within the health care settings.

e) The National HIV policy and the national HIV workplace policy were developed but the dissemination of these policies major gap as most people were not aware of them. Most of the Public sector organizations were able to disseminate the policies in their workplaces. HIV/AIDS communication has been mainstreamed into the Education Sector policy.

f) Some private sector organizations like Zain (now Airtel), Sierra Leone Brewery, National Petroleum and Standard Chartered Bank have workplace policies. However, most of these organizations are multinationals that are just implementing policies of their home offices. A development partner-GTZ (with technical assistance from NAS) has also developed workplace policy for the Sierra Leone country office.

g) National policies/protocols and guidelines were also developed for the following: ART, HCT, Blood transfusion, PMTCT, Youths, Management of Paediatric HIV/AIDS and Health-care Waste management, etc. However, there is also no national policy on OVC, home-based care and condom. As it is with laws, popularization of the policies is still a major challenge.

h) Advocacy activities during the reporting period were carried out by NAS, development and implementing partners as well as by NGOs and CBOs. The advocacy targeted developments partners, policy makers as well as the communities. Engagement with the religious organizations appears limited.

2.4.2.2 Strategic Recommendations

a) Advocacy efforts should be intensified to ensure that reviewed HIV/AIDS Prevention Act as well as the enactment of a law against stigma and discrimination of PLHIV. Available laws should also be simplified and disseminated to the populace. The populace should also be sensitized on these laws particularly the one that relates to sexual and gender-based violence. FSUs should also be established where they do not exist currently.

b) There is need to support the review to study all laws that are HIV related to be able to advocate for those that need to be reviewed.
c) Human Rights organizations, networks, CSOs and Law enforcement agencies should also be sensitized on the appropriate laws so as to enlist their support in the enforcement. Capacities of CSOs should also be built on human rights-based approach to programming. The judiciary and lawyers also need to be sensitized.
d) Most of the policies (e.g. National HIV/AIDS policy and the national HIV workplace policy) have become obsolete given the current realities and emerging issues and should be reviewed. Review processes should be participatory and the policies when developed should be widely popularized. National policies on home-based care, OVC and condom should also be developed
e) Technical assistance should be provided for workplaces to develop their workplace policy and also implement them. Strategies should also be developed to reach the micro and small enterprises with these policies.
f) There is need to develop sustainable strategies for providing assistance to those whose rights are violated or being discriminated against. Development of linkages with appropriate institutions (at national and district level) as well as exploration of alternative dispute mechanisms could be considered as part of the strategies. This obviously buttresses the need for sensitization of the stakeholders.
g) Advocacy and sensitization of the communities, religious and traditional leaders should be pursued with renewed vigour as they are critical in achieving the targets sets for this NSP given that they remain custodians of the culture and traditions and are also highly respected.

2.4.3 Preventions of New HIV Infections

2.4.3.1 Key Findings

a) Prevention was given priority attention during the last NSP (2006-2010). This is obviously not surprising given that Sierra Leone is a low HIV prevalence country and there is need to larger population who are uninfected to remain so. It also affirms UNAIDS (2005) position paper which states that "A comprehensive approach to HIV prevention must address not only risk but also deep-seated causes of vulnerability which reduce the ability of individuals and communities to protect themselves and others against infections[11]". As such, the bulk of the activities implemented was largely prevention focused.
b) National guidelines/protocols for HCT was developed during the period and disseminated to some extent. HCT services were scaled up during the period through establishment of more HCT sites. Number of HCT sites increased from 56 in 2006 to 416 in 2009 and to 546 as at November, 2010. Number of people tested increased from 18,860 in 2006 to 181,962 in 2009. However all the HCT services is facility based and this limits the accessibility by populace. Even at that, slightly above 50% (546 of the 1050 health facilities offer HCT).[12] Most of the facilities do not offer gender-friendly youth services probably ruling out a large proportion of the young people.

[11] UNAIDS (2005): 'Intensifying HIV Prevention' UNAIDS Policy Position Paper, p.17
[12] Government of Sierra Leone (2010): Report of the Final Joint Review of the NSP, 2006-2010.

The percentage of people who know their results is still relatively low (4.1% -women and 3.4% men aged 15-49 years- SLDHS- 2008). Very few youth-friendly centres have also been established

c) National Guidelines/Protocols on PMTCT were developed and disseminated. Emphasis is placed on PMTCT in the Prevention and Control of HIV/AIDS Act as one of the key prevention strategies. As mentioned earlier some aspects of this Act are discriminatory and is being reviewed. Health care personnel were also trained on PMTCT.

d) Establishment of PMTCT working groups consisting of nurses and TBAs in all ante-natal clinics (ANC) while HCT is linked to PMTCT in some ANC and there is availability of prophylactic drugs in every ANC providing PMTCT services

e) PMTCT sites were scaled up for improved service delivery. Number of PMTCT sites grew from 90 in 2006 to 364 in 2009 and 514 in November 2010. Number of pregnant women tested for HIV and who got their results also increased from 21,127 in 2006 to 99,256 in 2009 but still account for 10.4% of those who need it (SLDHS, 2008). However, there are limited facilities for EID and limited involvement of TBAs in PMTCT programmes in some areas and districts. Though the TBAs are not recognised by government but the fact that about 70% of deliveries take place outside the formal health care facilities means that they need to be targeted for linkages.

f) During the period a lot of BCC materials such as posters, billboard, T-shirts, face were produced. Radio jingles and television adverts as well as discussions were also held on various issues such as HCT, condoms, PMTCT and general knowledge about HIV prevention. A greater percentage of the BCC materials focussed on prevention education while there were very few relating to issues of stigma and discriminate.

g) The BCC strategy was developed but never reviewed or properly disseminated since 2004. There is an IEC/BCC Steering Committee but meeting is largely irregular. The quality of messages on some BBC materials is still very scary. No clear guidance on the minimum package of BCC interventions to be used for effectiveness. The BCC/IEC guide was developed but needs to be updated.

h) Knowledge about HIV/AIDS preventive education is still very low among the populace (19.7% for women and 31.2% for men aged 15-49 years-SLDHS 2008) but higher among young people aged 15-24 years (23.7% and men 32.9%). This could be due to their low risk perception.

i) The national condom programming committee was set up while the national strategic plan for comprehensive condom programming (2010-2014) is in place. Use of condoms is still also very low with less than 10% (SLDHS 2008) of the population reporting the use and there is also no national condom policy in place. Capacities of some service providers have been built on condom negotiation skills.

j) Number of condoms distributed however increased from 1,968, 646 in 2006 to 3,750,000 in 2009 indicating considerable opportunities exists for condom distribution. Two organizations-CARE and GOAL are engaged in social marketing of condoms while UNFPA also supplies NAS with condoms for free distribution.

k) The HIV/AIDS curriculum has been mainstreamed into the SRH/Life skills education curriculum but there is need to make it examinable. Some of the teachers have been trained but many still need to be trained. Some of the youths have been trained as peer educators but reaching the out-of-school youths with preventive education remains a challenge.

l) Targeting the MARPs (sex workers) was done largely during the period but other ones like MSM and IDUs are just becoming visible. There is also the need to train more service providers to service this group of people.

m) Protocol for Syndromic management of STIs was developed and disseminated. PHU staff was also trained on STI management. There was also implementation of routine STI surveillance. Little or no evidence of effective SRH/HIV as well as HIV/AIDS and STI integration exists.

n) National blood transfusion and healthcare waste management is in place but there is the need to evolve more comprehensive policies on injection safety. Information on availability of PEP within health care settings particularly the private health facilities is limited. Equally very limited information is available for the public on the use and availability of PEP for victims of sexual and gender abuse.

2.4.3.2 Strategic Recommendations

a) Scale up the provision of HCT services to meet the universal access targets of which Sierra Leone is a signatory. This calls for the development of strategies that would not only limit the provision of HCT services to the confines of the health facilities but also encourage setting up of stand-alone HCT centres. The centres could be located within CSOs and FBOs offices manned by trained counsellors.

b) HCT protocols and guidelines should be reviewed and disseminated while more people should be trained as counsellors. Integration of HCT into existing services at the health facilities should be intensified. HCT and PMTCT scale up plans should be reviewed to make room for support from other non-traditional donor partners.

c) Youth friendly centres should be established while also designating some health care facilities for the provision of youth-friendly centre. Staff of such facilities should be equipped youth-friendly skills.

d) The SRH and Life Skills education curriculum should be widely disseminated while the capacities of teachers and principals should be developed for its implementation. Parent-child communication should also be promoted. More peer educators should also be trained particularly in the rural areas. Appropriate strategies for reaching out of school youths should be designed and implemented.

e) Develop a comprehensive National HIV Prevention Plan as well as the BCC strategy. One of the key objectives of the plan should be how to increase the knowledge of people on HIV/AIDS.

f) Scale up the social marketing of condoms as well as the distribution outlets to make it readily available. Capacities on condom use should also be built. Furthermore, plan condom programmes with MARPs instead of planning condom programmes for them[13]

g) Increase access of PLHIV to Positive Health, Dignity and Prevention (PHDP) interventions[14] through capacity building of PLHIV and service providers as well as make the services available.

[13] Republic of Sierra Leone: National Strategic Plan for Comprehensive condom Programming in Sierra Leone 2010-2014 p.22-23

[14] This is one of the key strategies for reducing sexual transmission of HIV as itemised in one of the recent UNAIDS documents-Joint for Action Results: UNAIDS Outcome Framework, 2009-2011.

Size estimation and needs of MARPs should be carried out as a basis of developing appropriate interventions

h) Strengthen the linkages between SRH and HIV as well as between STIs and HIV services.
i) Communities should be sensitized on the availability and use of PEP particularly for victims of sexual abuse. BCC materials on the use of PEP should also be developed and distributed.
j) Develop comprehensive national guidelines on injection safety and disseminate.

2.4.4 Treatment of HIV and other related Health Conditions

2.4.4.1 Key Findings

a) ART national guidelines were reviewed to accommodate the new WHO guidelines while health care personnel were trained on the guidelines.
b) Progressive increase in the number of clients receiving ARVs from 295 in 2005 to 3660 in 2009 while number of sites increased from 16 in 2005 to 116 in 2009. However only about 52% of adults and 5% of children who require it are accessing the services. Inadequate human resource exist at service delivery level especially in rural areas
c) Seven CD4 counters positioned in all the three regions and the western area to monitor ARV treatment and also to ascertain eligibility criteria for ARVs. Diagnosis and treatment are provided for children aged at 12-18 months in all the 116 treatment sites at district level and Freetown while Cotrimoxazole prophylaxis provided to exposed children in all the 116 treatment sites and PMTCT sites. Survival rate of those on ART in the last 12 months is 84%.
d) Scale up plan for paediatric HIV care as well as the training curriculum was developed but currently no guidelines on paediatric HIV care. 440 health care providers (doctors, nurses, MCH Aides and HIV counsellors) were trained. Two (2) PCR equipment has been procured for Early Infant Diagnosis but installation is yet to be done.
e) Limited paediatric formulations and little or no linkage between Paediatric HIV care and under-fives clinic/Therapeutic Feeding centres (TFCs-stabilization centres) and Supplementary Feeding Centres (SFCs).
f) Linkage between prevention and treatment not evident while adherence monitoring mechanism of patients on ARVs is non-existent. Stigma and discrimination deters people from accessing ARVs
g) Drugs for OI are provided free to clients but stock out is sometimes reported.
h) TB/HIV collaboration exists but no guidelines. TB/HIV technical working group exist but meeting is irregular. ART treatment guidelines provides regimen for co-infection while screening of HIV patients for TB is on-going. Staff trained on the management of TB/HIV co-infections. Percentage of HIV patients screened for TB in HIV care or treatment setting is 23%.
i) Quality assurance and quality improvement mechanism appears very weak.
j) Weak laboratory systems to support monitoring of patients before and after commencement of ARVs (CD4 counters in the regions not optimally utilized due to lack of electricity especially during the dry season). Monitoring of viral load among patients not in place, biochemistry analysis not reliable. Little or no resistance drug monitoring.

k) Efforts are on to strengthen the laboratory systems through the establishment of a Laboratory Technical working group while the laboratory strategic plan has also been developed. US Centre of Diseases Control has been the lead agency in this regard.

2.4.4.2 Strategic Recommendations

a) Scale-up ART coverage to other sites and develop strategies to meet the human resource development capacity needs in terms of quality and quantity.
b) Develop policies and guidelines for paediatric HIV care and early infant diagnosis and disseminate. Train staff on the use of the protocols. Establish coordination mechanism for scaling up diagnosis and ART for paediatric HIV. Nutritional support should be provided for infants and PLHIV particularly women.
c) Establish a clear mechanism to ensure patient retention in care through good tracking system to prevent and manage loss to follow-up.
d) Strengthen quality assurance and quality improvement in HIV care, treatment and support services as well as adverse drug reaction monitoring, evaluation and reporting. Engage appropriate authorities for effective pharmacovigilance-adverse reactions of medicines for HIV, TB and OIs.
e) Strengthen the logistics management systems to avoid stock outs. Advocate for the inclusion of OI drugs in list of essential drugs under the government's free health care programmes.
f) Develop MOU between TB and HIV programme as well as guidelines for TB/HIV collaborative activities. DOTS service providers should be trained on HIV. INH prophylaxis should be implemented for HIV/TB patients.
g) Build capacities on adherence counselling and treatment literacy within health settings.
h) Data collation within the health care systems should be improved while linkages between NAS M&E, NACP M&E and the MOHS monitoring and information systems should be strengthened for effective harmonization. Data needs of the different stakeholders should also be integrated and health facilities trained on the use of the tools developed.
i) Promote community involvement in HIV and TB prevention, treatment, care and support because community volunteers such as PLHIV and care providers have supported case detection and provided appropriate linkages. Treatment literacy and drug adherence can also be enhanced by community involvement.
j) Strengthen the laboratory systems to support delivery of high quality HIV prevention, treatment and care services.

2.4.5 Care and Support for the Infected and Affected By HIV/AIDS

2.4.5.1 Key Findings

a) NETHIPS-network of people living with HIV was established while support groups are established in all districts. Mapping of support groups was done in 2008. More PLHIV are now disclosing their HIV status and thus qualify for support in one form or another. Capacities are still limited in terms of service provision.

b) There is no policy for HBC and OVC though guideline manuals on HBC and OVC are available. HBC services are not standardized and are limited in scope. Services primarily concentrated on addressing the immediate material needs of PLHIV- nutritional and HBC kit.
c) PLHIV are receiving livelihood support from UNAIDS while nutritional support is provided by WFP and EU through some NGOs. NETHIPS, with assistance of partners, have trained members on income-generating activities. However, there are still very limited economic empowerment opportunities for the indigent PLHIV.
d) Very few facilities are available for the chronically ill patients as there are only two hospices in the whole country for the chronically ill patients. There is also limited involvement of health workers in home-based care. Most of the care givers are immediate relatives of PLHIVs who do not have the capacity to provide adequate services
e) Situational analysis of OVC was conducted while available statutory documents on children are not adequately implemented (children's Act of 1998, National programme of Action for children 1992). There is no concrete plan of action for OVC. Currently only 120 OVC out of the identified 8,000 OVC are being supported by some NGOs. For OVCs, only two (nutritional and educational) out of the six pillar of support (which include medical, psycho-social, shelter and protection) are provided.
f) Limited opportunities are also available for older OVC in terms of livelihood skills training. Very few CBOs and NGO are involved in HBC.

2.4.5.2 Strategic Recommendations

a) Develop and disseminate national policy on home-based care and review the HBC manual already developed to align with the policy. Treatment, care and support services should be integrated. Provide free comprehensive medical support for PLHIV as only the CD 4 test is free for now.
b) Train more PLHIV as well as CBOs, NGOs and communities to provide HBC services. Engage more with the community to provide support for the PLHIV.
c) More PLHIV should be given skills training and other forms of economic empowerment through increased funding. Business start-up pack should be provided for those trained for ease of take-off. For sustainability, PLHIV should also be linked to existing poverty alleviation programmes of government and micro-credit institutions for micro-credit.
d) Develop national policy on OVC and disseminate. This policy should incorporate the seven pillars for OVC activities instead of two that is being provided currently. Develop the national OVC plan of action.
e) Sensitize communities to garner their support for ease of integration of OVC into the communities rather than putting them in institutionalized settings like orphanages. There is also need to enforce child protection laws which incorporates OVC as well as policies on orphanages and fostering to ensure that OVC are not abused.
f) Provide income-generating activities for the OVC care-givers so that they can continue to provide the necessary care and support for the OVC. Older OVC who want to opt out of formal education should also be provided skills training and business start-up kit at the end of the training.
g) Capacities of CBOs and communities should be built on OVC programming while there should also be a coordinating mechanism for NGOs/CBOs implementing OVC programmes.

2.4.6 Research, Monitoring and Evaluation

2.4.6.1 Key Findings

a) Coordination structures for M&E have been established at the national and district levels but none at the Chiefdom levels. The district M&E unit is largely non-functional. A variety of organizations such as the implementing partners – NGOs, FBOs, CBOs, Private Sector, MDAs, coordinating bodies & networks, and bilateral & multilateral development partners are also involved in monitoring and evaluating the response. This is done through the Expanded Technical Working Group. There is also the M&E TWG at the national level and none at the district level. The meetings of these groups have been irregular.

b) The National M&E plan for NSP I (2006-2010) was developed but not adequately disseminated. It was also not largely reviewed. The M&E unit have also been producing the relevant information to meet the reporting requirements of the funders such as global fund and to also meet international obligations e.g. UNGASS, Universal Access.

c) M&E unit at the National level (NAS) have staff with relevant skills but adequacy is a challenge. Inadequate skills are pervasive at the sub-national levels. Capacities of staff have been built over the years but needs upgrading. Institutional capacity to train and retain qualified M&E staff of all cadres is also a challenge. However, NAS has two international advisors placed at Headquarters to build capacity of staff and its partners through mentoring in addition to other on-going training efforts.

d) Key surveys and studies have been by NAS in conjunction with other key stakeholders and it includes: 2006, 2007, 2008 & 10 ANC Sentinel Surveillance (2006, 2007, 2008 and 2010), SLDHS (2008), NASA (2006-2009), HIV Prevalence Among MSM in Sierra Leone Study, Sierra Leone Modes of Transmission Study (2010) HIV Prevalence Among Fisher folks in Sierra Leone Study (2010), EPP and SPECTRUM Output (2010), Border Communities, Mobile Populations and Exposure to HIV in Countries of the Mano River Union (2009), HIV Surveillance on Mine Workers in Sierra Leone (2008), Prevalence of HIV and other STIs in Sierra Leone Among Armed Forces (2007), Impact Mitigation Survey Among PLHIVs in Sierra Leone (2007), Survival Analysis for PLHIV on Antiretroviral Therapy (2008), 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 (2009) and Sexual Networking Among Young People in Rural Sierra Leone (2009). Currently no national agenda on research exists and there are data gaps for most-at-risk populations (IDUs, CSWs, MSM, transporters).

e) Most of behavioural and biological studies conducted were not comprehensive and are out-date. NAS has conducted regular quarterly supervisory visits and on-the-spot checks to partners but no scheduled joint quarterly supervisory visits with development partners. Routine program data is collected for PMTCT, HCT, ART, STI, condom distribution, OVC, HBC, Nutritional support while harmonised national data collection tools have been developed.

f) National core indicators have not been revised since 2006 in line with additional core indicators suggested by UNAIDS and other development partners. The District Health Information System (DHIS) is fully functional and collecting facility based HIV/AIDS data. Field Operations Manual pertaining to data quality assurance has been developed.

There is lack of national HIV/AIDS database at NAS HQ. Some partners (especially the private sector) working in the HIV/AIDS multi-sectoral response do not report to NAS while NAS does not also make efforts to collect information from partners not benefiting from Global Fund grants. Late submission of reports by partners is also a challenge.

g) NAS has three fully functional resource centres with an inventory of most of the HIV/AIDS studies undertaken in the within the country and little from outside. It also has a fully functional website but not regularly updated.

h) Forums for information sharing exist and they include quarterly & annual partnership forum, meeting and conferences such as the Children and AIDs conference held annually. However, most of the platforms are limited and there needs to be one that would be more encompassing and encourage cross-country exchanges.

i) National dissemination strategy for sharing key strategic information that informs programmatic review and management decisions does not exist. Inadequate documentation (comprehensive inventory) and sharing of HIV/AIDS studies undertaken by various implementing partners is also a challenge.

2.4.6.2 Strategic Recommendations

a) Strengthen the M&E coordination systems at the districts and chiefdom levels. Set up M&E TWG at the district levels while M&E officers should be appointed at the district level to oversee data collection and collation. Capacity building and training should be institutionalized and formalized.

b) National research agenda should be developed while capacities for research should be built. Integrated Biological and Behavioural Surveillance Survey among MARPS and operations studies for specific thematic areas should be conducted. Develop plan of action for studies & surveys to be conducted.

c) Develop a national HIV/AIDS database at NAS HQ that will be able to meet the data needs of current and anticipated donors. Review national core indicators periodically and in line with global core indicators. Develop a strategy of reaching out to all partners working in the HIV/AIDS multi-sectoral response with the aim of getting the required information. Institute a schedule of joint quarterly supervisory visits with development partners.

d) Strengthen program planning through timely production and dissemination of information. Develop a national information dissemination strategy. Regularly update the NAS website and document and disseminate lessons learned from implementing programmes.

e) Establish more documentation centres at the district level to make HIV/AIDS information more accessible by people at the grassroots.

f) Conduct biennial AIDS Conference to serve as a platform for cross country and inter-country exchanges as well as promote scholarships.

3.0 NATIONAL HIV/AIDS STRATEGIC PLAN II (2011-2015): PROCESS, CONTEXT AND PRINCIPLES

3.1 Preparatory activities for Development of National HIV/AIDS Strategic Plan

Several important activities took place in 2010, which together provided the platform for the development of National Strategic Plan on HIV/AIDS II covers the period 2011 – 2015. These activities were meant to provide a better understanding on the nature of the HIV epidemic in Sierra Leone and the strengths, weaknesses, challenges and opportunities of the national AIDS response. The leadership for entire process of developing the NSP was provided by the National HIV/AIDS Secretariat with the active involvement of partners/stakeholders including people living with HIV and the civil society. The NSP was developed between October and December 2010, though the preparatory processes started in January 2010. The key activities that informed the development of the 2011 – 2015 National Strategic Plan is outlined below:

3.1.1. Know Your Epidemic; Know Your Response Study (Modes of Transmission Study)

The study lasted for four months (May – August 2010). The aim was to describe and understand the HIV epidemiological situation, prevention response and recommend improvements in prevention policies, programmatic actions and resource allocation to the national HIV response. The process involved a desk review, field data collection and incidence modelling. The draft report was discussed at a one-day national consultative forum attended by key agencies involved in the HIV/AIDS response such as: MDAs, private sector, civil society organizations, District AIDS Committees, People living with HIV, technical and donor partners. After the meeting the report was finalized. The key issues emanating from the study provided the much needed evidence for developing the HIV/AIDS strategic plan (2011-2015), especially with regards to sources of new HIV infections in Sierra Leone.

3.1.2 Final Joint Programme Review of the National HIV/AIDS Strategic Plan I (2006 – 2010)

The review gave an indication of the level of implementation of the National HIV/AIDS Strategic Plan 2006-2010. The process lasted for a month (August, 2010) and involved document review, group meetings with sectoral/institutional representatives, individual interviews of key people such as His Excellency, The President, provincial, district and chiefdom key informants on the six priority areas of the 2006 – 2010 National Strategic Plan. The Draft report from the consultations was then presented for a broad spectrum of about 80 stakeholders for validation in August 2010.

3.2 The NSP Development Process

The National HIV/AIDS Strategic Plan (2011-2015) is Sierra Leone's second multi-sectoral strategic plan on HIV/AIDS. The plan describes the unique challenges that HIV and AIDS pose to Sierra Leone's economic and social development and how it will be addressed. With an estimated national prevalence of 1.5% among the general population, Sierra Leone is one of the less affected countries in the sub-Saharan Africa and provides HIV/AIDS services at no cost to the population. In spite of this, many challenges lie ahead in the area of prevention, treatment, care and support if Sierra Leone is to reverse the epidemic. This Strategic Plan sets realistic and ambitious targets towards achieving Universal Access and the Millennium Development Goal of halting and beginning to reverse the new HIV infection in Sierra Leone.

The development of the plan was based on the following principles: **participation** and **involvement of key stakeholders**, **ownership** and **buy-in** and **evidenced-based planning**.

The key stakeholders consulted at the various stages of the NSP development processes are as follows:

- **Civil Society Organizations** which included NGOs, CBOs, Labour Unions, Community representatives, Faith-based Organizations (FBOs), PLHIV, MARPs (MSM and IDUs), People Living with Disabilities (PLWD), Youths,
- **Public Sector Organizations** such as Ministries, Department and Agencies (MDAs-Ministries of Health, Education, Agriculture, Social Welfare, NAS, etc), Decentralization Secretariat, City/District Councils and DAC.
- **Private sector** such as the employers unions, business houses and informal sector operators
- **Development/Donor Partners** such as DFID, GTZ, EU, World Bank, Irish AID, United States Government (USG) and the UN system.
- **International NGOs** such as ActionAID, Concern Worldwide, PLAN, Christian AID, AIDS Healthcare Foundation. (See Annexes 3-5 for the detailed list of the persons and organizations consulted.)
- **Country Coordinating Mechanism of the Global Fund in Sierra Leone**

The entire NSP development process consisted of the following:

(i) **Desk review of relevant Documents:** relevant documents such as the reports of some of the major activities mentioned above (Know your response, know your epidemic; mid-term and final JPR), programme reports and various HIV/AIDS documents were reviewed (See Annex 4 for the list of documents reviewed). The outcome was the response analysis contained in section 2.3 of this report.

(ii) **Consultations with Stakeholders (October 18-22, 2010):** Consultations were held with different stakeholders on how to avoid the shortfalls of the past NSP development as well as solicit for inputs into the new strategic plan. Consultations were made with MDAs, private sector, civil society organizations, District AIDS Committees, People living with HIV, technical and donor partners.

(iii) **Training in Results Based Management (October 27-28, 2010):** The training was organized by the National HIV/AIDS Secretariat in collaboration with UNAIDS setting out the principles for results based planning and management of the new NSP; priority setting and evidence based monitoring and evaluation. The training attracted 40 participants from the public sector, implementing partners, civil society including people living with HIV.

(iv) **NSP Development (November 7-9, 2010):** A retreat was organized for key technical people to participate in the drafting of the NSP. This is in line with principle stated earlier**.** About 40 stakeholders from the public and private sectors, implementing partners (NGOs and CBOs), Network of HIV Positives in Sierra Leone, MARPs Representation, Chairperson Parliamentary Committee on HIV and AIDS, UN Agencies, WHO-IST West Africa and CDC took part.

The retreat defined the key strategies and activities for inclusion in the new National Strategic Plan. After the retreat, the team of consultants fine-tuned the strategic intervention framework

(v) **One-Day Consultation on Women and HIV in Sierra Leone (November 15, 2010):** A one-day consultative meeting was held with 80 participants drawn from network of positive women, UNAIDS, UNIFEM, NAS, Action Aid etc. The purpose of the meeting was to identify issues relating to women, girls, gender equality and HIV to be considered during the finalization of the 2011-2015 National HIV/AIDS Strategic Plan and to propose a road map for addressing gender issues in the new NSP.

(vi) **Validation and Finalization of the National Strategic Plan:** A one-day validation meeting was held with a larger group of stakeholders (120 participants) to review the first draft of the NSP after the retreat. Stakeholders included people from the UN system, the public and private sectors, Sierra Leone Parliament, CDC, Health Systems 2020 as well as implementing partners, PLHIVs groups, MARPs, the media, labour unions etc. Their comments were used in finalizing the Strategic intervention framework. The finalized version was also shared with WB ASAP and TSF-WCA and on that basis refined further.

3.2 Policy Context and Considerations for the Development of the NSP II

This NSP II is developed in the context of:

i) 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.

ii) 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, 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, the *UN Joint Vision for Sierra Leone, UNAIDS Strategy 2011-2015 and* the UNAIDS *Outcome Framework 2009–2011*.** The UN Joint vision for Sierra Leone aims at supporting the Government to improve national health services that can deliver universal access to HIV prevention, treatment, care and support. The UNAIDS Outcome Framework advocated for comprehensive national response, including scaled-up prevention efforts that will break the trajectory of the epidemic and refocus on achieving results in the ten priority areas

iii) **Sierra Leone's commitment to various international conventions:** Convention on Elimination of All Forms of Discrimination Against Women (CEDAW); Millennium Development Goals Declaration (2000), which targets 2015 for halting and reversal of the HIV epidemic; 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 (2006) as well as the United nations charter on Human Rights.

The key considerations that informed the development of this NSP are:

a) The heavy burden of HIV and AIDS on those infected with HIV and those affected such as the families, communities, and the country as a whole.

b) HIV/AIDS is still a great public health challenge in the country in spite of the low HIV prevalence. It is capable of reversing the progressive development gains and affect the government free health care initiative for pregnant women and under-fives and place unprecedented stress on an already overstretched health care delivery system

c) Comprehensive HIV prevention, treatment, care and support services are mutually reinforcing elements on the continuum of an effective HIV/AIDS response.

d) Females constitute about 60% of the infected persons in Sierra Leone out of the total estimated number of 50,000 people infected (UNAIDS, 2009). The prevalence of HIV in the country peaks at female age group of 30-34years with a sero-prevalence level of 2.4%. In general, the most-at-risk groups include female sex workers and their clients, fisher-folks, traders, transporters, intravenous drug users, and men having sex with men, long-distance drivers and members of the uniformed services. The leading route of HIV transmission in Sierra Leone is heterosexual intercourse, accounting for over 80 percent of the infections. Mother-to-child transmission and transfusion of infected blood and blood products are generally estimated as ranking next.

e) Other modes of transmission such as intravenous drug use and same-sex intercourse are slowly growing in importance. The drivers of the HIV epidemic in Sierra Leone include: low risk perception, multiple concurrent partners, informal transactional and inter-generational sex, lack of effective services for sexually transmitted infections (STIs), and poor quality of health services. Gender inequalities, sexual based gender violence, poverty and HIV/AIDS-related stigma and discrimination also significantly contribute to the continuing spread of the infection.

f) HIV/AIDS related stigma and discrimination remains pervasive in the society (including health care settings) and PLHIV are discriminated against and denied access to care (within and outside health care settings), support, psycho-social and other related services.

g) Culture, traditions and religion have a strong influence of behaviours, attitudes, and practices of majority of Sierra Leoneans most especially with 'self-acclaimed spiritual and traditional healers of HIV/AIDS'. As such traditional and faith-based institutions, as gate keepers of attitudes and behaviours, are key in the HIV/AIDS response.

h) Effective response to HIV/AIDS requires respect for and protection and fulfilment of all human rights (civil, political, economic, social, and cultural) and upholding the fundamental freedoms of all people in accordance with the country's constitution and existing international human rights principles, norms and standards. Ample evidence exists that demonstrate MARPs and gender related issues are key drivers of the epidemic and as such appropriate programmatic interventions to meet their HIV/AIDS prevention, treatment, care and support service needs should be designed.

i) Multi-sectoral partnership involving government, the private sector, the civil society, the UN system, and development partners remains the pillar of the national HIV response.

3.3 Guiding Principles and Commitments

The NSP interventions are premised on the following principles and commitments:

i. Strong political leadership of the national HIV/AIDS response as currently demonstrated by His Excellency, The President as well as commitment to prudent management and utilization of financial resources at all levels.

ii. Multi-sectoral approach which engender collaboration with different actors particularly the grassroots as well as promote community-based approaches to issues through dialogue, consultations, integration to ensure sustainability.
iii. Protection and promotion of the rights and access of PLHIV to comprehensive prevention, treatment, care and support services
iv. Commitment to protecting rights of PLHIV, reduction of stigma and discrimination and ensuring greater involvement of PLHIV in the HIV/AIDS response at all levels.
v. Commitment to promote and protect the rights of women, children, young people and marginalized groups and reduce their vulnerability to HIV infection.
vi. Scaling up of HIV prevention among the most-at-risk populations (MARPs) since they have been identified as key drivers of the epidemic
vii. Commitment to strengthen linkages between HIV/AIDS programs and poverty eradication initiatives/institutions in order to empower the affected and infected in a more sustainable manner.
viii. Commitment to address social, economic, and cultural factors responsible for increased vulnerability of women and girls to HIV infection particularly sexual-based gender violence
ix. Commitment to evidence-based planning, designing and implementation of interventions
x. Dedication to forge consistent, effective partnerships and collaboration with development partners, the private sector, and civil society through harmonized and aligned ways of working to support the national HIV/AIDS response

3.4 Priority Intervention Groups

Based on the MOT study, the following groups will be given highest priorities in implementing interventions

a) Female Sex workers and their clients
b) MSM,
c) IDUs
d) Fisher folks
e) Transporters
f) Uniformed personnel
g) Prisoners
h) Miners
i) Cross-border and informal Traders
j) Women and children
k) Youths
l) General Population

4.0 SIERRA LEONE NSP II (2011-2015) RESULTS FRAMEWORK

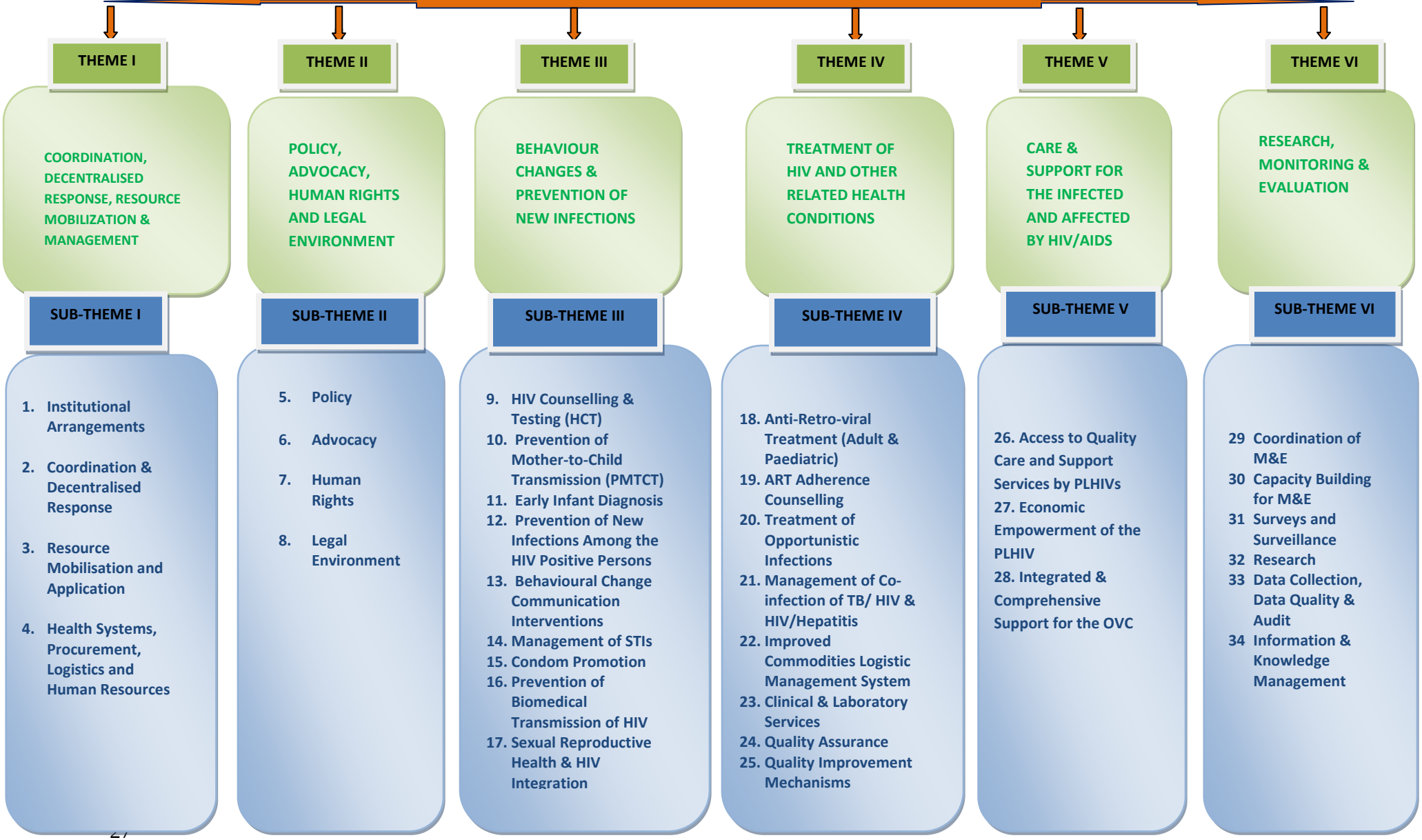
4.1 Introduction

As stated earlier in section 2.0, the development of the NSP is along the thematic areas as agreed upon by the stakeholders and they are as follows:

(i) Coordination, Decentralized Response, Resource Mobilization And Management
(ii) Policy, Advocacy, Human Rights and Legal Environment.
(iii) Prevention of New HIV Infections
(iv) Treatment Of HIV And Other Related Health Conditions
(v) Care And Support for the Infected and Affected By HIV/AIDS
(vi) Research, Monitoring And Evaluation

The thematic areas and the sub-themes are as schematically represented in the diagram below. Based on the above, impact and outcome level results were generated. The details are contained in the subsequent sections.

Goal: Towards Zero New HIV Infections, Zero Discrimination, Zero Related Deaths in Sierra Leone



4.2 Overarching and Impact Level Results

The overarching result of SLNSP II (2011-2015) is to have **Zero-new HIV infections, Zero Discrimination, Zero AIDS Related Deaths in Sierra Leone by 2015.**

To achieve this, **six impact and outcome level results** are to be achieved by 2015, and they are as follows:

i) Coordinating structures at national and decentralized level effectively manage implementation.
ii) Laws and policies protecting the rights of PLHIV and orphans are widely applied.
iii) Incidence of HIV is reduced by 50%.
iv) Morbidity and mortality amongst the PLHIV are reduced.
v) People infected and affected have the same opportunities as the general population
vi) Research, monitoring, and evaluation systems strengthened at all levels

A combination of the results at the output and outcome levels (including intermediary outcomes), strategies and actions will ensure that these results are achieved.

The impact and outcome level indicators for measuring progress with respective baselines and targets are shown below:

Table 1: Indicators for Measuring Impact of the NSP with Respective baseline and targets

Result No.	INDICATOR	BASELINE	2013	2015
1	Percentage of the implementation level of the NSP	To be determined	50%	75%
2.	Percentage decrease in the number rights violation reported and disposed of according to existing policies and laws.	To be determined	30% reduction	50% reduction
3.	Percentage of young women and men aged 15–24 who are HIV infected	SLDH, 2008 –Total 1.0% Women 1.4% Men 0.5%	Total 0.7% Women 1.0% Men 0.35%	Total 0.5% Women 0.7% Men 0.25%
4.	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	84%	87%	90%
5.	Percentage of PLHIV living below poverty line is not more than of the general population	To be determined	Not more than 30%	Not more than 50%

4.2.1 Strategic Results Framework for Coordination, Decentralized response, Resource Mobilization and Management

The table below shows the impact level result as well as outcomes and output for this thematic area. The impact level results is that '**Coordinating structures at national and decentralized level effectively manage implementation'.**

Table 2: Outcomes and Outputs for Coordination, Decentralised Response, Resource Mobilization and Management

THEME 1: COORDINATION, DECENTRALIZED RESPONSE, RESOURCE MOBILIZATION AND MANAGEMENT		
Outcome	**Coordinating structures at national and decentralized level effectively manage implementation**	
Outcome 1	**Coordination mechanisms at national and sub-national levels strengthened**	
	Output 1.1	DACs strengthened
	Output 1.2	CACs established and functional
	Output 1.3	Coordinating bodies strengthened
Outcome 2	**National HIV/AIDS Strategic Plan is funded**	
	Output 2.1	Funding from Government is increased
	Output 2.2	Funding from Partners and Private sector is increased
Outcome 3	**Effective human and logistical Systems in place**	
	Output 3.1	Procurement and distribution system improved
	Output 3.2	Community based system developed and strengthened
	Output 3.3	Human Resource capacity strengthened

Three outcomes are expected to contribute to achieving the impact result and they are: coordination at national and sub-national levels strengthened, national HIV/AIDS strategic plan is funded and effective human and logistical systems in place.

4.2.1.1 *Outcome 1: Coordination mechanisms at national and sub-national levels strengthened*

Response analysis showed that coordination mechanisms are weak particularly the district and chiefdom levels. It is therefore expected that this outcomes will be achieved through the establishment and/or functioning of the DACs, CACs as well as the private sector, CSO and FBOs networks

Key **interventions** in this respect include capacity need assessment, development and implementation of the capacity-building and technical assistance plan, setting up and equipping of the offices or upgrading of office infrastructure, recruitment of appropriate staff where necessary and capacity of staff. The indicators for the outcomes and outputs is as shown in Annex

4.2.1.2 *Outcome 2: National HIV/AIDS Strategic Plan is funded*

It is expected that the outcome will be achieved through increased funding from both the government, private sector and the development partners. Currently, government funding of the response is still about 3% of the total funding available for the response.

Key interventions include increased advocacy for the transformation of NAS into a Commission, mainstreaming of HIV/AIDS into the budget of key line ministries and agencies, capacity building of NAS, MDAs, CSOs, FBOs and private sector in resource mobilization and resource tracking for increased resource use efficiency and effectiveness.

4.2.1.3 *Outcome 3: Effective human and logistical Systems in place*

This outcome will be achieved through the improvement in procurement and distribution system as well as strengthening of the community-based systems and human resource capacities.

Key **intervention activities** include: strengthening of the logistics management information systems developed and training of staff, mainstreaming of HIV/AIDS into the curricular of Health Institutions and also into the pre-service training, implementation of task shifting strategies, engagement of un-orthodox medical practitioners and the community.

Table 3: Outcome indicators for thematic area 1 with Respective baseline and targets

Outcome No.	INDICATOR	BASELINE	2013	2015
1	% of DACs and CACs strengthened and fully functional	0% (2010)	75%	100%
2.	(a) % of the annual funds required by the costed National Strategic Plan that is realized.	(TBD)	60%	80%
	(b) % of government's contribution to total HIV/AIDS spending annually.	3% (2009)	10%	15%
3.	% of facilities that experienced no stock-out of commodities annually (by ARVs, OI drugs, Male & Female Condoms	TBD	70%	80%

4.2.2 Strategic Results Framework for Policy, Advocacy, Human Rights and Legal Environment

Table 4 shows the strategic results framework for this thematic area. The impact result for this thematic area is to see that '***Laws and policies protecting the rights of PLHIVs widely applied'.***

One outcome will contribute significantly in achieving the impact result and it is that existing laws and policies are strengthened for social protection of the PLHIV, OVC and other vulnerable groups.

Table 4: Outcomes and Outputs for Policy, Advocacy, Human Rights and Legal Environment

THEME 2: POLICY, ADVOCACY, HUMAN RIGHTS AND LEGAL ENVIRONMENT		
Outcome	**Laws and policies protecting the rights of PLHIVs widely applied**	
Outcome 1	**Existing laws and policies are strengthened for social protection of the PLHIV and other vulnerable groups**	
	Output 1.1	Bills passed/laws amended in parliament
	Output 1.2	HIV and AIDS International guidelines and policies adopted
	Output 1.3	National policies developed/reviewed

4.2.2.1 *Outcome 1: Existing laws and policies are strengthened for social protection of the PLHIV, OVC and other vulnerable groups*

The above outcome will be achieved through the passage of appropriate bills or review of existing laws, adoption of policies and international conventions/charter as well as the development or review of national guidelines and policies for service delivery to ensure standardization.

Key interventions for achieving the outcomes include: dissemination of the policies developed; advocacy for the enactment of appropriate policies and laws (e.g. anti-stigmatization and discrimination) as well as policy and law enforcement; capacity building on the relevant laws and statues for the judiciary, law enforcement agents and the communities; capacity-building for CSOs on right-based approach to programming and policy engagement; sensitization of duty bearers such as the traditional and religious leaders on human rights issues.

Table 5: Outcome indicators for thematic area 2 with Respective baseline and targets

Outcome No.	INDICATOR	BASELINE	2013	2015
1	% PLHIV networks/support groups who report their rights are protected and they are empowered	TBD (2010)	60%	80%
2.	Prevention & Control of HIV & AIDS Act and other relevant Acts are enacted into law and enforced.	No (2010)	Yes	Yes

4.2.3 Strategic Results Framework for Prevention of New Infections

Table 6 below shows the strategic results framework for this thematic area. The impact result for this thematic area is to see that **'Incidence of HIV is reduced by 50% by 2015'**

Three outcomes are expected to contribute to achieving the impact result and they are i) Reduced Sexual Transmission of HIV; ii) Reduction in biomedical transmission of HIV; and iii) Reduction in Mother-to-Child Transmission of HIV.

Table 6: Impact, Outcomes, Intermediary Outcomes and Outputs for Prevention of New Infections

THEME 3: PREVENTION OF NEW INFECTIONS		
IMPACT	**Incidence of HIV is Reduced by 50% by 2015**	
Outcome 1	**Reduced Sexual Transmission of HIV**	
Intermediary Outcome 1.1	**MARPs and clients adopt safe behaviour**	
	Output 1.1.1	MARPs (Female Sex Workers and their clients,, MSM and IDUs) are reached by Comprehensive Prevention Programmes
	Output 1.1.2	MARPS who know their HIV status
	Output 1.1.3	Condom and other prevention commodities are available and accessible by MARPs
Intermediary Outcome 1.2	**Reduction of Risky sexual behaviour**	
	Output 1.2.1	General Population Reached by Comprehensive Prevention Programmes
	Output 1.2.2	Young People aged 15-24 are at reduced risk of HIV Infection
	Output 1.2.3	People Living with HIV including sero discordant couples provided with positive prevention services
	Output 1.2.4	HIV infections resulting from sexual or gender-based violence are prevented
	Output 1.2.5	Increased number of people use condoms correctly and consistently
	Output 1.2.6	Male and Female Condoms are available and accessible by the general populations
	Output 1.2.7	Increased number of people know their HIV status
Intermediary Outcome 1.3	***Increase in Quality Treatment of STIs***	
	Output 1.3.1	Increased awareness of STIs symptoms and demand for STI treatment
	Output 1.3.2	Increased availability and accessibility to high quality STI treatment
	Output 1.3.3	All patients have access to quality family planning services

Table 6: Impact, Outcomes, Intermediary Outcomes and Outputs for Prevention of New Infections

THEME 3: PREVENTION OF NEW INFECTIONS		
IMPACT	**Incidence of HIV is Reduced by 50% by 2015**	
Outcome 2	**Biomedical transmission of HIV is reduced.**	
	Output 2.1	Universal medical safety precautions is enhanced
	Output 2.2	Increased availability of PEP services in all health facilities
	Output 2.3	All HIV exposed health workers and other cases in need are provided with PEP services
	Output 2.4	All blood donated for transfusion is screened for HIV, Hepatitis and other TTIs
Outcome 3	**Reduction in Vertical Mother-to-Child Transmission of HIV.**	
Intermediary Outcome 3.1	***Reduction in transmission of HIV during pregnancy, child birth and breastfeeding***	
	Output 3.1.1	Increased availability and accessibility of high quality PMTCT services
	Output 3.1.2	All HIV positive pregnant women complete the full PMTCT program
	Output 3.1.3	All HIV exposed infants have access to Early Infant Diagnosis (EID) Services and treatment
Intermediary Outcome 3.2	***HIV positive women are empowered to take informed reproductive health decisions.***	
	Output 3.2.1	HIV Positive women have access to quality family planning services

4.2.3.1 *Outcome 1: Reduced Sexual transmission of HIV*

The mode of transmission study suggests that sexual transmission of HIV still account for greatest number of new infections. Furthermore the MARPS account for the greater percentage of new infections through their sexual networks. It follows therefore that reducing the sexual transmission of HIV particularly amongst the MARPs still remains the key pillar for reducing the incidence of HIV.

Three intermediate outcomes will contribute to reduced sexual transmission and they are i) MARPS and clients adopt safe behaviours; ii) reduction of risky sexual behaviour amongst the general population and; iii) increase in quality treatment of STIs.

i) Intermediary Outcome 1.1: MARPS and clients adopt safe behaviours

It is expected that this will be achieved through reaching the MARPS with comprehensive prevention programmes, encouraging them to know their status and ensuring that condom and other prevention commodities are readily available and accessible.

Key interventions include: the size estimation of MARPs for commodity quantification, design and implementation of appropriate activities targeted at the MARPs, training of service providers to provide services to MARPs, training of peer educators amongst the MARPs as well as scaling up of HCT services targeting MARPs.

ii) Intermediary outcome 1.2: Reduction of Risky sexual behaviour

This will be achieved through reaching the general population with Comprehensive Prevention Programmes, targeting the young people aged 15-24 with innovative programmes to reduce the risk of new infections, providing positive prevention services to PLHIV and sero-discordant couples, reducing infections from sexual and gender-based violence, increase in the number of people who use condom consistently and correctly as well as availability and accessibility to female and male condoms by the general population.

Key interventions include; increasing the proportion of the population with knowledge on HIV prevention, sensitization and awareness creation in the communities on HIV/AIDS issues and sexual and gender-based violence (SGBV), availability of PEP services for victims of SBGV, training of peer educators amongst the young people, capacity building of service providers, scaling up of the HCT sites as well as demand creation for HCT services, procurement and distribution of female and male condoms, scaling up of condom distribution outlets and increasing knowledge on condom use through capacity building and peer education training.

iii) Intermediary outcome 1.3: Increase in Quality Treatment of STIs

Achieved through increased awareness of STIs symptoms and demand for STI treatment, increased availability and accessibility to high quality STI treatment and access to quality family planning services.

Key interventions include prioritization of service provision by target population and drivers of epidemic, development and implementation of quality assurance and quality improvement for STI management, integration of STI services into HIV prevention programmes, demand creation for service utilization and building capacity of service providers.

4.2.3.2 Outcome 2: Biomedical transmission of HIV is reduced.

Anecdotal evidence revealed that most health facilities do not practice the universal safety precautions neither do most of them have post exposure prophylaxis in case of medical accidents. Though transmission of HIV through blood transfusion is still very low, most stakeholders said there are rampant cases of unscreened blood transfusion taking place in the rural areas. There is therefore the need to continue to screen all the blood in order to maintain this low level of HIV while encouraging people to also donate blood.

The biomedical transmission of HIV will be reduced through enhancing of the universal safety precautions, increase in availability of PEP services in all health facilities, prompt administration of PEP to exposed health workers and those who need it and screening of all donated blood for HIV and other Transfusion Transmittable Infections (TTIs) such as hepatitis.

Key interventions include: capacity building of health workers in area of universal safety precautions, increased availability of PEP, dissemination of the national guidelines on PEP and blood transfusion, engagement of the unorthodox medical practitioners to adopt universal safety precautions, development and distribution of appropriate BCC materials, promotion of HCT and voluntary blood donation.

4.2.3.3 Outcome 3: Reduction in Mother-to-Child Transmission of HIV

Studies revealed that the HIV prevalence among women attending ante-natal clinic is 3.2% while that of the general women is population is about 1.5%. The MoT study further shows that mother-to-child transmission of HIV accounts for about 13% of all new HIV infections in Sierra Leone. This clearly shows that mother-to-child transmission is one of most important routes for HIV transmission. Therefore efforts should be made to eliminate the transmission of HIV from infected mothers to their unborn infants.

This outcome will be achieved through two intermediary outcomes: i) Reduction in transmission of HIV during pregnancy, child birth and breastfeeding; and ii) HIV positive women are empowered to take informed reproductive health decisions.

i) Intermediary Outcome 3.1: Reduction in transmission of HIV during pregnancy, child birth and breastfeeding

This will be achieved through: increased availability and accessibility of high quality PMTCT services, completion of full PMTCT program by all HIV positive pregnant women, and ensuring all HIV exposed infants have access to Early Infant Diagnosis (EID) Services and treatment.

Key interventions include: scaling up of PMTCT sites and services, community mobilization and participation, development and distribution of BCC materials, development of referral and linkage mechanism, enrolling the support of TBAs and other unorthodox medical practitioners, capacity-building for service providers, increased male participation and procurement and distribution of PMTCT commodities, strengthening of service integration and intensification of early infant diagnosis, treatment and provision of infant feeding.

ii) Intermediary Outcome 3.2: HIV positive women are empowered to take informed reproductive health decisions.

This will be achieved largely by ensuring that HIV positive women have access to quality family planning services.

Key interventions include: ensuring availability and accessibility to family planning commodities, capacity building of service providers, scaling up of family planning counselling, development and distribution of BCC materials and sensitization of positive women on family planning.

Table 7: Indicators for Outcomes and intermediary Outcomes for thematic area 3 with Respective baseline and targets

Outcome/ Intermediary Outcome No.	INDICATOR	BASELINE	2013	2015
1.1a	Percentage of MARPs (female sex workers, MSMs, Fisherfolks, Uniformed Personnel) who are HIV infected	Sex Workers- 8.5% MSM-7.5% Uniformed Personnel- 4.4% Fisherfolks- 3.8% (MOT Study- 2010)	Sex Workers- 7% MSM-4% Uniformed Personnel- 4% Fisherfolks- 3%	Sex Workers 5% MSM-4% Uniformed Personnel- 3% Fisherfolks- 3%
1.1.b	Percentage of MARPs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	TBD	60%	80%
1.1c	Percentage of female sex workers reporting the use of a condom with their most recent client	68%, 2005 CSW Study	70%	80%
1.1d	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	2010 70%	75%	80%
1.2a	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (disaggregated by age and sex)	15-24yrs women 24.6% Men 11.0% 15-19yrs women 22.3% Men 11.4% 20-24yrs women 26.8% Men 10.5% (SLDHS, 2008)	15-24yrs women 18% Men 8% 15-19yrs women 16% Men 9% 20-24yrs women 18% Men 8%	15-24yrs women 13% Men 5% 15-19yrs women 11% Men 6% 20-24yrs women 13% Men 5%
1.2b	Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by age and sex)	15-24yrs women 23.7% Men 32.9% 15-49yrs women 19.7% Men 31.2% SLDHS, 2008	15-24yrs women 30% Men 40% 15-49yrs women 30% Men 40%	15-24yrs women 50% Men 60% 15-49yrs women 40% Men 60%
1.2c	Percentage of population aged 15-49 who had more than one sexual partner in the past 12 months (disaggregated by age and sex)	15-49yrs women 4.9% Men 20.8% 15-24yrs Women 6.4% Men 18.9% (SLDHS, 2008)	15-49yrs women 3% Men 15% 15-24yrs women 4% Men 12%	15-49yrs women 2% Men 10% 15-24yrs women 3% Men 9%
1.2d	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 women 6.8% Men15.2% 15-24yrs women 12.2% Men 29.2% (SLDHS, 2008)	15-49yrs women 30% Men 40% 15-24yrs women 30% Men 40%	15-49yrs women 50% Men 60% 15-24yrs women 50% Men 60%

Outcome/ Intermediary Outcome No.	INDICATOR	BASELINE	2013	2015
1.3a	Percentage of people reporting symptoms suggestive of STIs and seeking treatment from clinical services (disaggregated by sex)	women 41%, men 54% (SLDHS, 2008)	women 60%, men 60%	women 80%, men 80%
2a	Percentage of people in the general population reporting that last injection was given with a syringe and needle taken from a new, unopened package	women 95.8%, men 93.1% (SLDHS, 2008)	women 96%, men 96%	women 96%, men 96%
2b	Percentage of donated blood units screened for HIV in a quality assured manner	100%, NAS Report 2009	100%	100%
3.1	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	56% NAS Report 2010	60%	80%
3.2	Percentage of women of reproductive age attending HIV care and treatment services whose needs for family planning were met.	TBD	40% increased from baseline	60% increase from baseline

4.2.4 Strategic Results Framework for Treatment of HIV and Other Related Conditions

Table 8 overleaf shows the strategic results framework for this thematic area. The impact result for this thematic area is to see that **'Morbidity and mortality among PLHIVs are reduced by 2015'.**

The impact result will be achieved through the following outcomes: i) Adult PLHIVs and Children PLHIVs eligible for ART receive it; ii) PLHIVs receive OI prophylaxis, treatment and other co-infection treatment.

Table 8: Impact, Outcomes, and Outputs for Treatment of HIV and other Related Conditions

THEME 4: TREATMENT OF HIV AND OTHER RELATED CONDITIONS		
IMPACT	**Morbidity and mortality among People Living with HIV (PLHIVs) are reduced**	
Outcome 1	**Adult PLHIVs and Children PLHIVs eligible for ART receive it.**	
	Output 1.1	Increase in eligible PLHIV identified in order to initiate treatment
	Output 1.2	Improved HIV exposed Infant follow-up according to national guidelines
	Output 1.3	Coverage of facilities offering ART is increased
	Output 1.4	Quality Standards for ART are maintained
Outcome 2	**PLHIVs receive OI prophylaxis, treatment and other co-infection treatment by 2015**	
	Output 2.1	PLHIVs receive OI and other co-infections prophylaxis and treatment according to need
	Output 2.2	PLHIVs with STIs receive treatment for STIs
	Output 2.3	PLHIVs with HIV and TB receive appropriate treatment for TB

4.2.4.1 Outcome 1: Adult and Children PLHIVs eligible for ART receive it.

This outcome is critical to achieving the impact results as evidences abound indicate that only 52% of adults who are eligible for ARV receive it. It is even worse for the children as only 5% of those eligible are receiving it.

The outcome will be achieved through: i) Increase in eligible PLHIV identified in order to initiate treatment; ii) Improved HIV exposed Infant follow-up according to national guidelines; iii) Coverage of facilities offering ART is increased; and iv) Quality Standards for ART are maintained.

Key interventions include: Capacity building and training of health care workers, PLHIVs and caregivers, decentralization and integration with other HIV services (PMTCT, HCT), procurement of medical commodities and equipment, upgrade of physical infrastructure of ART sites, clinical pharmacovigilance for ARVs, strengthening of follow-up system, development and implementation of Quality Assurance/Quality Improvement (QA/QI) for ART management and provision of nutritional support.

4.2.4.2 Outcome 2: PLHIVs receive OI prophylaxis, treatment and other co-infection treatment

This will be achieved through; PLHIVs receiving OI and other co-infections prophylaxis and treatment according to need, PLHIVs with STIs receive treatment for STIs and PLHIVs with HIV and TB receive appropriate treatment for TB.

Key interventions include: Upgrade laboratory infrastructure for OI and HIV/TB management, Quality Improvement for OI and HIV/TB management, strengthening of the TB/HIV Technical Working Group, Training and Capacity Building for Health Care Workers on TB and HIV, Community Mobilization and participation, Strengthen monitoring and follow-Up, Cotrimoxazole Preventive therapy for PLHIV with TB Intensified medical examination of PLHIV for TB, Upgrade Laboratory infrastructure for TB and MDR-TB diagnosis in HIV infection and pharmacovigilance for anti-TB drugs and review of the laboratory policy and protocols.

Table 9 shows the indicators for each outcome.

Table 9: Indicators for Outcomes for thematic area 4 with Respective baseline and targets

Outcome No.	INDICATOR	BASELINE	2013	2015
1	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	2010 - Adults 52% 2010 - Children 5%	Adults 60% Children 60%	Adults 80% Children 100%
2a	Percentage of people enrolled in HIV care and treatment who receive cotrimoxazole prophylaxis in the last 12 months	TBD	60%	80%
2b	Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings	23%, (NAS Report 2010)	60%	80%
2c	Percentage of hospitals and health centers offering full package of HIV services (HCT, PMTCT, ART, TB)	2010 53%	70%	80%

4.2.5 Strategic Results Framework for Care And Support for those Infected and Affected by HIV/AIDS and OVC

Table 10 below shows the strategic results framework for this thematic area. The impact result for this thematic area is to see that **'People living with HIV and/or affected by HIV/AIDS have same opportunities as the general population'.**

The impact result will be achieved through the following outcomes: i) People living with HIV and/or affected by HIV/AIDS have improved economic opportunities and social protection by 2015; ii) Social and economic protection is ensured for orphans and vulnerable children; iii) Stigma and discrimination towards PLHIVs is reduced; and iv) PLHIV receive care and support according to needs.

Table 10: Impact, Outcomes, and Outputs for Care and Support for those Infected and Affected By HIV/AIDS and OVC.

THEME 5: CARE AND SUPPORT FOR THOSE INFECTED AND AFFECTED BY HIV/AIDS AND OVC		
IMPACT	**People living with HIV and/or affected by AIDS have same opportunities as the general population**	
Outcome 1	**People living with HIV and/or affected by HIV/AIDS have improved economic opportunities and social protection.**	
	Output 1.1	Increased skills and education for infected and/or affected persons
	Output 1.2	Creation of employment opportunities for infected and affected persons
	Output 1.3	Households of persons infected and/or affected have access to credit
Outcome 2	**Social and economic protection is ensured for orphans and vulnerable children.**	
	Output 2.1	Increased number of OVC access minimum package of services
Outcome 3	**Stigma and discrimination towards PLHIVs is reduced.**	
	Output 3.1	PLHIV and OVC have access to legal aid services
	Output 3.2	The rights of people infected and/or affected by HIV are assured in legal framework
	Output 3.3	Increased acceptance of persons infected/affected in the community
	Output 3.4	Increased self-acceptance of persons infected/affected by HIV
Outcome 4	**PLHIVs receive care and support according to needs.**	
	Output 4.1	PLHIV receive psychosocial support, including palliative care
	Output 4.2	PLHIV receive nutritional support according to needs

4.2.5.1 Outcome 1: People living with HIV and/or affected by HIV/AIDS have improved economic opportunities and social protection

Economic empowerment remains one of the key factors for breaking the yoke of poverty by the PLHIV and those affected by HIV/AIDS. This new plan would therefore concentrate on that. This outcome will be achieved by: Increased livelihood skills and education for infected and/or affected persons, creation of employment opportunities for infected and affected persons, and Households of persons infected and/or affected have access to credit.

Key interventions include: development and dissemination of relevant policies and guidelines, capacity building for care providers, PLHIV and PABAs, provision of alternative means of livelihood and sensitization of the communities and linkage to other poverty alleviation agencies.

4.2.5.2 Outcome 2: Social and economic protection for Orphans and Vulnerable Children is ensured

This outcome will be achieved largely through making a minimum package of at least six services available to the OVC – ***medical, education, health, nutrition, shelter, protection and psychosocial***. Currently there are only two packages available for OVC.

Key interventions include; development of appropriate policies and guidelines and dissemination, training of care-givers, skills training for older OVCs who do not want to continue with formal education, mobilization of resources and mapping of OVC and organizations engaged with OVC.

4.2.5.3 Outcome 3: Stigma and discrimination towards PLHIVs is reduced

The major contributory factors towards achieving this outcome are that: the PLHIV and OVC have access to legal aid services, the rights of people infected and/or affected by HIV are assured in legal framework, increased acceptance of persons infected/affected in the community and increased self-acceptance of persons infected/affected by HIV.

4.2.5.4 PLHIVs receive care and support according to needs

The major contributory factors to the achievement of the outcome are that: PLHIV receive psychosocial support, including palliative care as well as PLHIV receive nutritional support according to needs.

Key interventions include: capacity-building for health care workers, PLHIV, support groups, CBOs and other service providers; needs assessment, development of BCC materials and distribution as well as sensitization of the communities.

The outcome indicators and targets as shown below:

Table 11: Indicators for Outcomes for thematic area 5 with Respective baseline and targets

Outcome No.	INDICATOR	BASELINE	2013	2015
1	Percentage of PLHIV network members applying for credit who accessed credit mechanism per year	TBD	60%	80%
2a	Percentage of OVC aged 0-17 whose households received free basic external support in caring for the child	1.30% (DHS, 2008)	15%	30%
2b	Current school attendance among orphans and non-orphans aged 10-14	Total Ratio =0.83; Male Ratio=0.88; Female Ratio=0.78	Total Ratio =0.90; Male Ratio=0.90; Female Ratio=0.90	Total Ratio =0.90; Male Ratio=0.90; Female Ratio=0.90
3a	System for officially documenting cases of stigma and discrimination exist	**NO (**2010)	YES	YES

Table 11: Indicators for Outcomes for thematic area 5 with Respective baseline and targets

Outcome No.	INDICATOR	BASELINE	2013	2015
3b	Percentage of population expressing accepting attitudes in relation to people living with HIV	15-49yrs women 5.1% Men 14.7% 15-24yrs women 5.2% Men 13.6% SLDHS, 2008	15-49yrs women 30% Men 35% 15-24yrs women 25% Men 30%	15-49yrs women 45% Men 50% 15-24yrs women 50% Men 60%
4	Percentage of PLHIVs receiving nutritional support in the last 12 months	5%, (NAS Report 2009)	30%	60%

4.2.6 Outcomes for the Research, Monitoring and Evaluation Thematic Area

This thematic area is considered at outcome and intermediary outcome levels which are shown in Table 12 below.

Research, monitoring and evaluation systems particularly are still relatively weak at national level while it is virtually non-existent at the sub-national levels.

Table 12: Outcome, Intermediary Outcomes and Outputs for Research, Monitoring and Evaluation

THEME 6: RESEARCH, MONITORING AND EVALUATION		
Outcome 1	**M&E, research and knowledge management systems at the national and sub-national systems are strengthened**	
Intermediary Outcome 1.1	**Capacities for M&E increased**	
	Output 1.1.1	Number and capacities of M&E officers increased
	Output 1.1.2	M&E TWG established and functional at Regional level
Intermediary Outcome 1.2	**Research and Surveillance activities are enhanced.**	
	Output 1.2.1	Increased capacities to conduct more researches and surveys
	Output 1.2.2	HIV/AIDS related research and evaluation studies conducted

Table 12: Outcome, Intermediary Outcomes and Outputs for Research, Monitoring and Evaluation

THEME 6: RESEARCH, MONITORING AND EVALUATION		
Outcome 1	**M&E, research and knowledge management systems at the national and sub-national systems are strengthened**	
Intermediary Outcome 1.3	**Data quality, information generation and dissemination is improved.**	
	Output 1.3.1	M&E systems are integrated with the existing Health Management Information Systems (HMIS)
	Output 1.3.2	Information sharing amongst stakeholders increase
	Output 1.3.3	Harmonised data collection forms are readily available
	Output 1.3.4	Implementing partners reporting HIV/AIDS activities increase
	Output 1.3.5	HIV/AIDS databases integrated and linked

4.2.6.1 Outcome 1: M&E, Research and knowledge management systems at the national and sub-national systems are strengthened

Effective M&E systems and research are critical to evidence-based planning, designing programming, and implementation. There is therefore a need to ensure that M&E systems and research are strengthened for increased performance. This will be achieved through three intermediary outcomes: i) Capacities for M&E increased; ii) Research and surveillance activities are enhanced; and iii) Data quality, information generation and dissemination are improved.

i) Intermediary Outcome 1.1: Capacities for M&E increased

This will be achieved through the following: Increase in number and capacities of M&E officers as well establishing M&E TWG at district level and making them functional.

Key interventions include: capacity needs assessment and development of a technical capacity-building plan, recruitment/redeployment of additional staff at the national and sub-national level and capacity building for staff.

ii) Intermediary Outcome 1.2: Research and surveillance activities are enhanced

This will be achieved mainly through increased capacities to conduct researches and surveys as basis for planning programming interventions to a large extent.

Key interventions include: advocacy and resource mobilization for research, capacity building of the stakeholders, strengthening the research and ethics review committee/technical working group.

iii) Intermediary Outcome 1.3: Data quality, information generation and dissemination is improved

This will be achieved mainly through: integrating the M&E system with the existing Health Management Information Systems (HMIS), increased sharing of information amongst stakeholders, availability of harmonised data collection forms, implementing partners reporting HIV/AIDS activities increase, and integration and linkage of HIV/AIDS databases.

Table 13: Indicators for Outcomes for thematic area 6 with Respective baseline and targets

Outcome/ Intermediary Outcome No.	INDICATOR	BASELINE	2013	2015
Outcome 1a	% of DACs submitting report to NAS at least once a year	2010 - 0%	80%	100%
Outcome 1a	Number of HIV/AIDS related researches and studies conducted	2010 - 6	8	10
Intermediary Outcome 1.1a	% of DACs and CACs with designated M&E Officers	0% (2010)	60%	80%
1.1b	No of regions with functional M&E systems	0 **(**2010)	6	9
Intermediary Outcome 1.2	No. of organizations carrying out researches and surveys	TBD	30% increase over the baseline	50% increase over the baseline
Intermediary Outcome 1.3a	HIV/AIDS databases integrated into existing HMIS	No (2010)	YES	Yes
1.3b	No of specific research and lesson learnt dissemination fora held annually	1 (2010)	2	3

5.0 COORDINATION AND IMPLEMENTATION OF THE NSP

5.1 Institutional Framework for Coordination

5.1.1 National Level Coordination

The institutional framework for coordinating the NSP is as shown in figure 1. NAS, in line with principles of three ones[15] is responsible for coordinating and providing leadership for the AIDS response in the country. It does this by ensuring that all stakeholders align their priorities and strategies with National ones. However, for greater alignment, NAS needs to do a lot to popularise national plans (strategic, sectoral and operational) and other strategic documents. Equally, there would be the need to support the various key public sectors such as Education; Agriculture; Social Welfare, Gender and Children Affairs; Youths and Sports as well the CSOs networks such as NETHIPS, SLANGO and private sector network-BCAASL to develop strategic and operational plans. They should also be encouraged to align their own plans with the national plans for better coordination.

Currently, various coordination platforms for HIV interventions exist including information sharing. These are: Partnership forum and Technical Working Groups such as: 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 (See section 2.2 for details). While some of these are emerging, others are already well established. Additional ones are also being established. It is expected that these platforms will continue to play an increasing role in coordination while NAS and other partners would continue to provide necessary support (technical, financial etc.) and policy guidance for effective functioning.

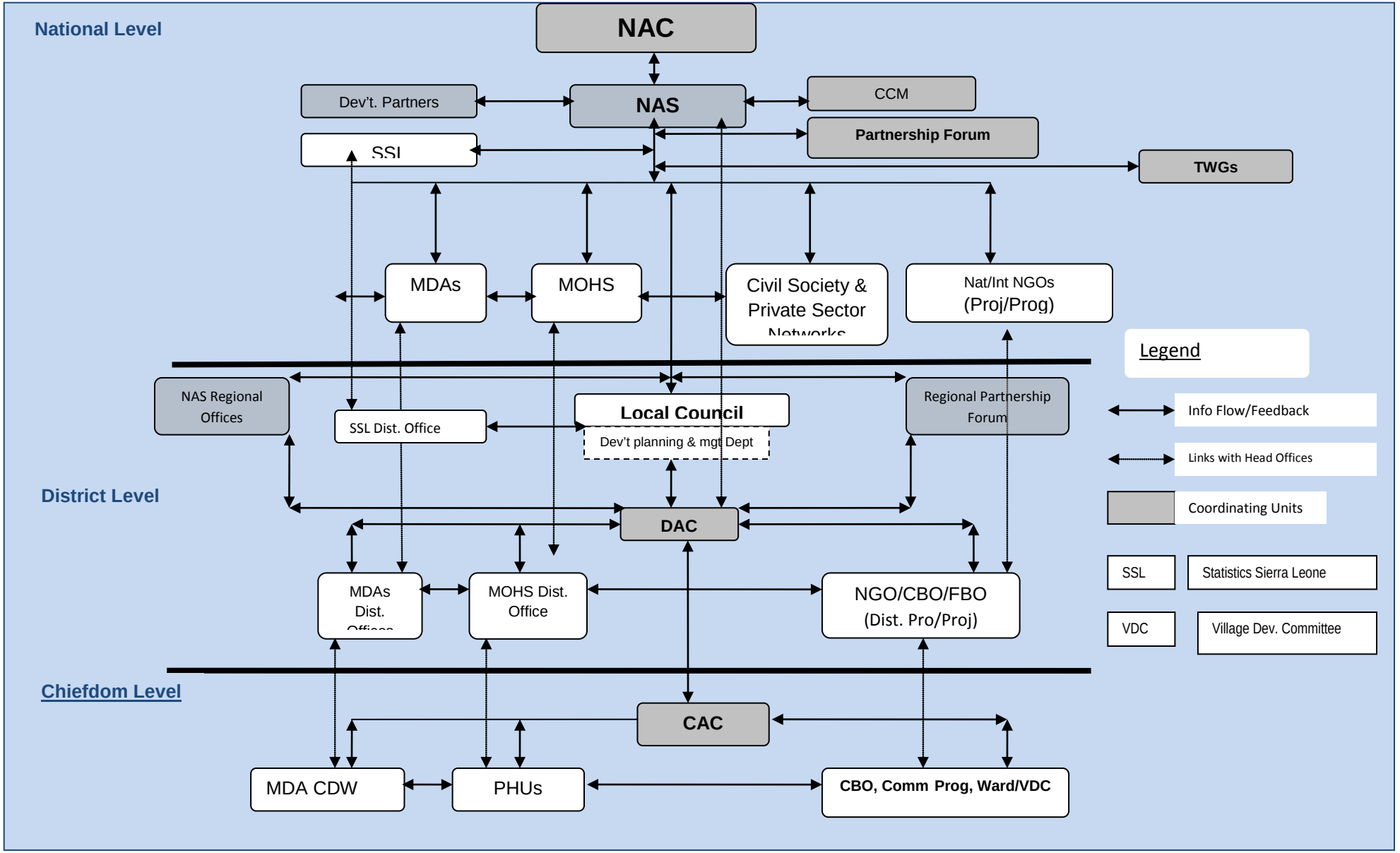
5.1.2 District Level Coordination

The District AIDS Committees (19 in all) are responsible for coordinating HIV response at the district levels and their composition is multi-sectoral in nature comprising amongst others the following: District Medical Officer, representatives of MDAs at the district levels, PLHIV, Civil Society Representatives, implementing partners and the community representatives. Their responsibilities (See section 2.2 for details) include: developing the district HIV and AIDS strategic plan and mobilizing resources for the district response and monitoring HIV programmes in consultation with the stakeholders.

Currently, all the DACs have been inaugurated but evidence from the field indicate that the DACs are largely non-functional and are not properly positioned to carry out these responsibilities. In line with the decentralization policy that is being pursued by the present government, DACs' capacities will also be strengthened to perform their roles effectively and efficiently. Critical actions include supporting DACs to develop their own plans taking into consideration the local peculiarities of each district. Technical support will also be provided by the NAS regional offices to be established.

[15] One national coordinating body, one national strategy and one national M&E framework.

Figure 2: INSTITUTIONAL FRAMEWORK FOR COORDINATION AND IMPLEMENTATION



5.1.3 Chiefdom Level Coordination

Plans are on-going to establish Chiefdom AIDS Committees (CACs) in all the 149 Chiefdoms which is the third-tier of government in line with decentralization policy. They would also be responsible for coordinating the HIV/AIDS activities at the chiefdom levels. The terms of reference (ToR) for the CACs are being developed.

5.1.4 Constituents Coordinating Entities

In addition to the structures mentioned above there are other Coordinating entities within the response that play critical roles in coordinating activities of the different constituencies within the national response (See section 2.2 for details). They include the following:

(i) Coalition of Public Sector against HIV and AIDS in Sierra Leone (COPAASL): which serve as a coordination platform for public sector HIV interventions in 19 Government ministries and departmental agencies in Sierra Leone.

(ii) The Network of HIV positives in Sierra Leone (NETHIPS): is an umbrella organization for all people living with HIV and comprises over 40 PLHIV support groups nationwide.

(iii) ***Business Coalition against AIDS in Sierra Leone (BCAASL):*** is an umbrella organization of private sector organizations involved in HIV response. Currently it has a membership of 30 private sector organizations.

(iv) Sierra Leone Association of Non-Governmental Organizations (SLANGO): is the network of all NGOs in Sierra Leone and currently has 238 members.

(v) Inter-Religious Council of Sierra Leone (ICSL): is the network of faith-based organizations (Muslim and Christian organizations) working on HIV/AIDS in Sierra Leone.

(vi) HIV/ AIDS Reporters Association (HARA): is responsible for coordinating the activities of its members who are basically journalists reporting on HIV and AIDS issues.

The various coordinating entities will continued to be strengthened to perform these roles while additional ones will be formed for more effective coordination. For instance, the Network of Youths Organization involved in HIV/AIDS has just been formed. Representatives of some of these networks are also on the National AIDS Council and other TWGs. Plans have reached an advanced stage to establish a coalition of NGOs against AIDS in Sierra Leone.

5.1.5 Key sectors and Line Ministries

As already indicated above, COPAASL coordinates the public sector HIV response, but their activities are limited largely to workplace response. There is the obvious need to strengthen key Ministries that are already charged with coordinating activities in the key economic and social sectors to include HIV/AIDS activities. While this may come with its challenges, it is better than creating new structures that may not be sustainable in the long run. For instance, the Ministry of Fisheries and Marine Resources already work with fisher folks (identified as one of the key drivers of the epidemic in the MOT study) through extension workers.

It is more cost-effective to build the capacities of these extension workers in HIV prevention so that they can also pass HIV prevention messages to the fisher folks while delivering their normal extension messages. The Ministries that coordinate activities for key social and economic sectors whose capacities will be strengthened during the NSP period are:

a. Health and Sanitation: coordinates the health sector response which is a very important aspect of response

b. Agriculture: coordinates activities and relates directly with the farmers and farming communities.

c. **Education:** coordinates education sector activities that target the in-school children, adolescent and youths as well as the teachers.

d. **Fisheries and Marine:** which deal with fisher folks (men and women) that are one of the key drivers of the epidemic.

e. **Youths and Sports:** coordinates the activities of youths (out-of-school) who are engaged in high risky sexual behaviours.

f. Trade and Industry: which works cross-border and informal traders who are also one of the identified key drivers of the epidemic**.**

g. **Mineral Resources:** who coordinates the activities in the mineral resources sector. The workers (miners) in this sector were also identified as key drivers of the epidemic.

h. **Social Welfare, Gender and Children Affairs:** coordinates the activities of women and children (particularly the OVC).

i. **Labour and Social Security:** that is responsible for workers' welfare and safety.

j. **Defence:** responsible for coordinating activities of the armed forces who also belong to the most-at-risk population.

k. **Internal Affairs:** responsible for coordinating the activities of the para-military forces such as the police, immigration, fire service, prison services and by extension prisoners who are also classified as most-at-risk persons.

l. **Local Government:** they are in charge of the decentralization process of government and would invariably be important in the establishment of CACs at the Chiefdom levels.

5.2 Implementation of the NSP

5.2.1 Implementation Environment

There is a good implementation environment for the NSP in Sierra Leone given the track record of implementation as well as political will and commitment at the level of his Excellency, The President. He personally presides over the National AIDS Council meetings (which superintends over NAS) instead of delegating this function.

He has also been quite supportive of HIV/AIDS activities through personally attending HIV/AIDS events such as the World AIDS Day. The Vice President, First Lady and the Parliamentary Committee on HIV/AIDS have also contributed immensely to AIDS response. HIV/AIDS also featured prominently in various policies of government such as the 'Agenda for Change' and Second Poverty Reduction Strategy Paper (PRSP II), 2008-2012. Given that Sierra Leone is a low HIV prevalence and post-conflict country with very competing demands, such high level political commitment is a great opportunity.

Government recognises the roles of the different stakeholders such as development partners, national and international NGOs, civil society and the private sector as well as the faith-based organizations and communities, and will continue to support them to enhance implementation, coordination and harmonization of donor assistance.

Though there is limited number of donors supporting Sierra Leone HIV/AIDS response, they are very committed and have been providing funds and technical assistance to NAS, implementing partners, PLHIV, CSOs, Private sector and other stakeholders. The steadfastness of all stakeholders despite competing developmental needs contributed in no small way in making the country (actually one of the two countries in the whole world) that got the **MDG award** in 2010 for stabilizing the HIV epidemic and strong political commitment. While the receipt of this award is a further call to duty, the key partners also remain committed to ensuring that Sierra Leone HIV prevalence does not only stabilize but reversed. The UN system in Sierra Leone, Global Fund, KfW, USG and EU remain committed to this through their guaranteed funding for some part or through entire period of the NSP. NAS and other stakeholders have also planned to embark on an extensive resource mobilization drive with a view to attracting other funders to Sierra Leone.

5.2.2 Implementation Arrangements and Roles of Stakeholders

NSP will be implemented by a range of stakeholders that include: NAS, DAC, Key MDAs, Donor partners, Implementing partners, private sector organizations, as well as individual CSOs, FBOs and CBOs as indicated in the Institutional framework contained in **Figure 2 .**

The role of NAS, DAC and CACs will be limited largely to coordination and providing enabling environment for the entire AIDS response. NAS will also facilitate the implementation of activities particularly Global Fund supported activities as the principal recipient. CACs and DACs will also support the facilitation of implementation as much as practicable.

Development partners particularly the UN system will also continue to support NAS through the provision of technical assistance. There are also assurances that individual NGOs, CBOs and FBOs and their networks will continue to be supported by the UN system and other development through provision of technical assistance and direct grant support.

Ministries, Departments and Agencies will also continue to coordinate and facilitate the implementation of HIV interventions. They may also engage in direct implementation of activities as much as possible while also engaging in implementation where possible.

The Ministry of Health and Sanitation will continue to coordinate the health sector response through the National AIDS Control Programme (NACP).The Public health approach has been adopted for the treatment programme to include both public and private health facilities. Currently, the NACP is being supported by the Global Fund, DFID and CDC in strengthening the country's health systems. For instance the health management information systems, laboratory systems, logistics management information systems are currently being strengthened while dilapidated rural health infrastructures are being renovated and new ones are being built.

NGOs, FBOs and CBOs will be concerned largely with implementation of interventions at the community level. This is because they have structures that are closer to the people or located within the communities. Their roles will include awareness creation, sensitization, advocacy, community engagement and demand creation for HIV services. Therefore, efforts should be geared towards capacity-building of the CSOs in all the identified areas as contained in the NSP. The private sector will also support the implementation of the AIDS response in the small, medium and large business enterprises and companies.

5.2.3 Operationalising the Strategic Plan

The first step in implementing the NSP will be to popularise the document to stakeholders and encourage the stakeholders and sectors to align their own plans to the NSP. Critical sectors (education, defence, youth and sports) would also be encouraged to develop their own Strategic Plans based on the NSP.

The fifth key pillar for driving the response in Sierra Leone is the **2011-2012 Operational Plan**. The operational plan will be developed early in 2011 in consultation with the stakeholders as it happened in the development of the NSP. The Operational Plan will provide detailed quarterly implementation of activities of the six thematic areas. It will also go further to identify lead entities/stakeholders that are better placed to implement the agreed activities based on comparative advantage.

Once the National HIV/AIDS operational plan is developed, it will be disseminated up to the chiefdom levels. Capacities of different entities to develop their own operational plan or align it (where they already have) with national operational plan will be built. It has to be emphasised that stakeholders' plans should be evidence-based.

6.0 COSTING AND FINANCING OF THE NATIONAL HIV/AIDS STRATEGIC PLAN 2011-2015

6.1 Costing of the NSP

6.1.1 Introduction

NAS commissioned a study to estimate the resource needs for Sierra Leone's HIV/AIDS multi-sectoral response in line with the new National HIV/AIDS Strategic Plan and M&E Plan for the next five years (2011 - 2015). The objective of this exercise was to assist the national-level strategic planning efforts by providing an estimate of financial resources needed to implement a variety of HIV/AIDS interventions and programme-level costs.

6.1.2 Costing Approach and Methodology

To achieve the objectives of the national response to the HIV/AIDS epidemic, the NSP was costed in line with the Results-Based Framework relating to the three impact areas: a) Prevention, b) Care and Treatment, and c) Impact Mitigation as well as three cross-cutting areas, namely (1) Coordination, Decentralised Response, Resource Mobilisation and Management, (2) Policy, Advocacy, Human Rights and Legal Environment, and (3) the results framework for Research, Monitoring and Evaluation.

The Results Needs Model (RNM) tool used in estimating the resources needed to implement the Sierra Leone HIV/AIDS national response. The RNM calculates the total resources needed for prevention, care, and support for orphan and vulnerable children on a national level. It also estimates the programme level expenses needed to create the capacity required for scaling-up interventions envisaged under the new NSP. To estimate the resource needs, data were collected on:

a) the demographic and epidemiological profile of Sierra Leone;
b) Coverage or access levels that are envisaged under the NSP; and
c) Unit costs of the inputs to be used implementing the interventions.

The Resource Needs Model (RNM) uses a combination of these three elements to determine the financial resources required for the HIV/ programmes. In the case of the different program-level costs, the RNM calculated them as a percentage of the total budget.

6.1.3 Costing Process

A national team was constituted to work with the international consultant;

a) Data were collected on socio-demographic variables such as health systems; HIV prevalence and condom use, treatment, testing regimes and the accompanying services; the costs of prevention and care programmes; as well as details on the youths and MARPs affected and infected by the disease;
b) The data gathered were analysed and entered into the RNM and costed;
c) The draft costing report was reviewed with the stakeholders and then revised to incorporate their comments/contributions.

6.1.4 Key Assumptions

The resource needs estimation was based on the following key underlying assumptions:

i. The demographic data are based on the 2009 Spectrum projections and the 2008 SLDHS.
ii. The NSP defines the target groups needing intervention and coverage levels that the nation plans to reach by 2015.

iii. The unit costs of inputs are determined by reference to the CIF (cost, insurance, freight) values of inputs procured plus all expenses necessarily incurred to bring them to their present location and condition (including clearing, transportation, warehousing etc);
iv. Human resource costs (obtained from payroll, budgets and discussions with management etc) are assumed to remain stable over the Plan period, taking annual salary raises into account.
v. On the macro-economic scene, it is assumed that the inflation levels will remain around the current levels of 11% over the period to 2015.
vi. In view of the fact that all the strategies, targets and coverage levels in the NSP are linked to a single costing model, consistency, transparency, and replicability of the costing process are assured.

6.2 National HIV/AIDS Strategic Plan Cost Estimates

From the resource needs estimation exercise, Sierra Leone will require **US$ 322 million** for the national HIV/AIDS response as envisaged under the National Strategic Plan for the five year period, 2011 to 2015. Please refer to the table below that presents the resource needs classified by impact result.

Table 14: Overall Cost by intervention (U.S. $ million)

Cost summary	2011	2012	2013	2014	2015	Totals	%
Prevention	8.3	14.1	20.1	26.9	37.2	106.5	**33%**
Treatment	7.2	14.4	24.3	36.5	51.4	133.8	**42%**
Care and support	1.1	1.9	3.1	4.5	6.2	16.9	**5%**
Mitigation for PLHIVs /	2.4	4.5	6.4	8.0	8.9	30.3	**9%**
Policy, admin., research,	2.3	4.2	6.5	9.1	12.5	34.5	**11%**
Total Millions of USD	**21.2**	**39.1**	**60.5**	**85.0**	**116.2**	**322.0**	**100%**
Total Millions of Leones	**81,743.**	**150,613.**	**232,850.**	**327,066.**	**447,515.**	**1,239,788.**	

The above table indicates that to achieve the goal of zero new infections by 2015, 33% of the resources will be required for Prevention activities (of which about 24% earmarked for MARPs), 42% for Treatment interventions (ARV Therapy, prophylaxes, diagnostic Testing), 5% to care and support of those infected and affected by HIV/AIDS, and 9% for Mitigation for PLHIV and OVC. In addition, 11% of the resources will be required to support the cross-cutting activities needed to underpin the scaling up of the interventions needed to zero new infections by 2015. These cross-cutting activities include:

i. Institutional arrangements;
ii. Coordination & decentralized response;
iii. Response mobilization and application;
iv. Health systems strengthening, procurement & supply chain management, human resources;
v. Capacity building for M&E;
vi. Coordination of M&E;
vii. Surveys and surveillance;
viii. Research, data collection, data quality and audit;
ix. Information & knowledge management.

Table 15 presents the detailed resource needs by HIV/AIDS activities envisaged under the Sierra Leone HIV/AIDS National Strategic Plan 2011-2015.

Table 15: Details of Resource Needs

SERVICE DELIVERY AREA/YEAR	2011	2012	2013	2014	2015	Totals	%
Prevention	**8.3**	**14.1**	**20.1**	**26.9**	**37.2**	**106.5**	**33%**
Priority populations							
Youth focused interventions	0.3	0.6	1.0	1.5	2.0	5.5	2%
Female sex workers and clients	0.2	0.6	1.1	1.8	2.7	6.5	2%
Other MARPs (MSMs, IDUs, clients)	1.1	2.7	3.7	4.2	7.0	18.7	6%
Workplace	0.5	1.0	1.8	2.7	3.8	9.7	3%
Community mobilization	0.3	0.5	0.6	0.8	1.1	3.3	1%
Service delivery							
Condom provision	3.3	5.0	7.1	9.6	12.7	37.6	12%
STI management	0.44	0.5	0.7	0.8	0.9	3.4	1%
VCT	0.7	1.0	1.4	1.8	2.4	7.3	2%
PMTCT	0.2	0.4	0.5	0.7	1.0	2.8	1%
Mass media	0.4	0.4	0.5	0.5	0.6	2.5	1%
Health care							
Blood safety	0.6	0.8	1.1	1.5	1.9	5.9	2%
Post-exposure prophylaxis	0.21	0.33	0.46	0.63	0.82	2.4	1%
Safe injection	0.01	0.01	0.01	0.01	0.01	0.1	0%
Universal precautions	0.1	0.1	0.2	0.2	0.3	0.9	0%
Treatment	**7.2**	**14.4**	**24.3**	**36.5**	**51.4**	**133.8**	**42%**
ARV therapy	6.2	13.4	23.2	35.2	50.0	128.0	40%
Care and prophylaxis in the	0.9	0.9	1.0	1.1	1.1	5.0	2%
Diagnostic testing	0.1	0.1	0.1	0.2	0.3	0.8	0%
Care and support	**1.1**	**1.9**	**3.1**	**4.5**	**6.2**	**16.9**	**5%**
Palliative Care	0.1	0.1	0.2	0.2	0.3	1.0	0%
Home-based care	0.1	0.2	0.4	0.5	0.8	2.1	1%
Training for ART care	0.7	1.4	2.3	3.5	5.0	12.9	4%
Nutritional support	0.2	0.2	0.2	0.2	0.2	1.0	0%
Mitigation for PLHIVs/ OVC	**2.4**	**4.5**	**6.4**	**8.0**	**8.9**	**30.3**	**9%**
Education	0.17	0.22	0.26	0.30	0.32	1.3	0%
Health care support	0.19	0.25	0.29	0.33	0.34	1.4	0%
Family/home support	1.85	3.64	5.29	6.62	7.44	24.8	8%
Community support	0.01	0.02	0.02	0.02	0.02	0.1	0%
Organization costs	0.22	0.41	0.59	0.73	0.81	2.8	1%
Subtotal	**19.0**	**34.9**	**54.0**	**75.9**	**103.8**	**287.5**	**89%**
Policy, admin., research, M&E	**2.3**	**4.2**	**6.5**	**9.1**	**12.5**	**34.5**	**11%**
Total Millions of Le	**81,743.1**	**150,613.3**	**232,850.6**	**327,066.6**	**447,515.2**	**1,239,788.7**	
Total Millions of USD	**21.2**	**39.1**	**60.5**	**85.0**	**116.2**	**322.0**	**100%**

6.3 Gap Analysis

6.3.1 Introduction

As an important component of the costing exercise, a gap analysis was carried out at the outcome level to determine the current and potential financial resources that will be available to fund the planned interventions. To determine the gap, data on the total available and potential resources over the Plan period were obtained from the records of NAS (including the recently signed Global Fund Round 9 Proposal) and some of the key stakeholders such as the UN agencies, the relevant Government Ministries and Departments as well as NGOs and CBOs. Interviews with some key stakeholders constituted a secondary source of data for the exercise.

6.3.2 Available Funding by Source

The table below presents details of the resources that are currently assured to finance the implementation of the NSP from 2011 to 2015:

Table 16: Funding Available for the NSP

Source	2011	2012	2013	2014	2015	Total
GOSL funding	0.3	0.6	0.80	0.90	1.00	3.6
Global Fund	13.9	17.8	17.70	19.00	18.20	86.6
Domestic: Private sector	0.1	0.2	0.30	0.40	0.50	1.5
KFW	0.8	0.6	-	-	-	1.4
UN Family	2.6	2.6	2.63	2.63	2.63	13.2
Total funding Available(Millions in USD)	**17.7**	**21.8**	**21.4**	**22.9**	**22.33**	**106.2**
Equivalent in Leones (Millions)	**68,304**	**83,975**	**82,511**	**88,287**	**85,977**	**409,053**

6.3.3 Resource Gaps by Intervention Area

The projected financial resources were pro-rated to the various interventions. The amounts apportioned to each thematic area were further allocated on a yearly basis over the period 2011 - 2015. Subtracting the available resources from the resource needs revealed the resource gaps for each intervention. A high level view of the resource gaps is presented as follows:

Table 17a: Summary Resource Gap Analysis of the NSP

Source	2011	2012	2013	2014	2015	Total
Resource needs (Millions in USD)	22.6	39.1	60.5	85	116.2	**322.0**
Total funding Available (Millions in USD)	17.8	21.8	21.4	22.9	22.3	106.2
Resource gaps (Millions in USD)	**4.8**	**17.3**	**39.1**	**62.1**	**93.9**	**215.8**

Details of the financing gaps by HIV/AIDS activity is presented in the table below:

Table 17b: Financing Gap Analysis Millions of US$

Details	2011	2012	2013	2014	2015	Total	%
Prevention: Resource need	8.3	14.1	20.1	26.9	37.2	106.5	
Available funding	5.5	6.9	6.9	7.3	7.1	33.6	
Resource gap	***2.7***	***7.2***	***13.2***	***19.5***	***30.2***	***72.9***	***33.8%***
Treatment: Resource need	7.2	14.4	24.3	36.5	51.4	133.8	
Available funding	6.0	7.7	7.7	8.3	8.0	37.8	
Resource gap	***1.2***	***6.7***	***16.6***	***28.2***	***43.4***	***96.0***	***44.5%***
Care and Support: Resource need	1.1	2.0	3.1	4.5	6.3	16.9	
Available funding	0.7	0.9	0.9	1.0	0.9	4.8	
Resource gap	***0.8***	***1.4***	***2.2***	***3.2***	***4.5***	***12.1***	***5.6%***
Mitigation for PLHIVs & OVC	**3.4**	**4.5**	**6.5**	**8.0**	**8.9**	30.4	
Available funding	3.2	3.3	2.9	3.0	3.0	15.4	
Resource gap	***0.2***	***1.2***	***3.6***	***5.0***	***6.0***	***15.0***	***6.9%***
Policy, admin., research, M&E	2.7	4.2	6.5	9.1	12.5	34.5	
Available funding	2.3	3.0	3.1	3.3	3.3	15.0	
Resource gap	***0.4***	***3.0***	***4.7***	***6.5***	***8.9***	***24.7***	***11.5%***
Total Resource Need	**22.6**	**39.1**	**60.5**	**85.0**	**116.2**	**322.0**	
Total Available Funding	**17.8**	**21.8**	**21.4**	**22.9**	**22.3**	**106.2**	
Total resource gap	***4.8***	***17.3***	***39.1***	***62.1***	***93.9***	***215.8***	***100%***

From the above table, overall, there is a **US$ 215.8 million** resource gap over the five-year NSP period. On a year-by-year basis, with only **US$17.8 million** of resources that are currently assured for 2011, the country will require an additional **US$4.8 million** to be able to implement the interventions in the **first year** of the NSP. Similarly, US$17.3 million additional resources will be needed in 2012, US$39.1 million in 2013, US$ 62.1 million in 2014, and US$93.9 million in 2015.

The significant increases in resource needs from year to year is premised mainly on the fact that the country envisages a significant scaling up of operations to reach about 80% in some cases of the target populations in need of HIV and AIDS interventions, up from the current levels. This will entail greatly increasing activity levels and this calls for a corresponding increase in resources needed to reach such levels.

6.4 Financing the NSP

6.4.1 Resource Mobilization

Over the years the national response to the HIV/AIDS has received substantial funding. According to the 2010 National AIDS Spending assessment (NASA), about 2.7% of the funding came from the Government of Sierra Leone while the Global fund contributed 95% of the funds.

Other contributors were KFW 1.5% and the domestic private sector 0.7%. It is expected that each of these financiers will increase the levels of funding substantially and that new partners will buy into the new NSP.

Although currently short of the target of 15% of national budget set in the NHSSP, there is a strong political will to reach this target. The Government is planning to introduce dedicated taxes for health financing (e.g. on alcohol, tobacco, cell phones) to ensure that at least 15% of national budget is allocated to health. This move will certainly translate into more funds for HIV financing.

6.4.2 Key Partners/Funders

Sierra Leone's development partners have played a key role in the fight against HIV/AIDS. The main donors for the new NSP (2011 – 2015) will be the Government of Sierra Leone, the Global Fund, the World Bank, the UN Agencies, International NGOs, and the domestic private sector. In the case of the Global Fund (Rounds 9), on-going projects will run until the end of the NSP. However, even though the UN agencies may not feature prominently individually in the list of financiers, nevertheless they provide technical support for coordination and implementation of activities which are often neglected by the main donors.

6.4.3 Sustainability

Sustainability of the NSP will depend on two key factors. Firstly, it is crucial that the strategies accurately address the disease profile of the country and the interventions must closely meet the needs of the affected and infected. Furthermore, there must be an effective mechanism to monitor and evaluate the operations. Secondly, there must be reliable and assured sources of resources necessary for the implementation of the interventions. These include not only financial resources but also human and material resources such as essential drugs and commodities, infrastructure, vehicles and equipment.

Most of the financial resources for HIV/AIDS activities are obtained from external funding, with the Global Fund being by far the largest contributor. At the community level, except the faith-based organisations which can secure most of their funds from their religious bodies, most of the civil society organisations (CBOs) depend on external donors for funds to implement their programmes. Another key source of resources is the services of volunteers. However, volunteers need to be trained to ensure their effectiveness.

In view of the fact that huge financial resources are required for the national HIV/AIDS response, the country will continue to require the input of her development partners. But to secure the continued support of the external donors there must be concerted efforts at assuring the partners that their resources will be accounted for and put to good use. NAS is therefore strengthening the management system to reassure the partners that their resources will continue to be used judiciously and properly accounted for.

In addition to the issues pertaining to financial sustainability, NAS is also taking the necessary measures to ensure the sustainability of the programmes. The capacities of communities will be built up through cross-cutting activities to ensure they take ownership of the programmes.

6.5 Financial Management and Auditing

As emphasized above, the best way to secure continued finding is to assure the financiers that their resources are well managed and accounted for. Given the expected scaling up of operations under the NSP, management is introducing a robust financial management system that is capable of capturing all the transactions of the programmes, analyzing and promptly recording them to facilitate the production of timely, accurate and relevant financial and programmatic reports for planning, managing and controlling the operations. This system will be underpinned by an enhanced system of accounting and internal controls based on a fully integrated computerized financial management system maintained by well qualified and properly trained personnel.

To further strengthen the systems of accounting and internal controls, NAS has introduced an internal audit department, staffed with personnel seconded from the Ministry of Finance. The department's responsibility is to constantly review the systems and processes of the programmes and provide feedback as to the adequacy of the systems and whether they continue to function as planned. In addition to this statutory audits are carried out on the accounts of NAS every year by an international firm of auditors. This improves the credibility of the financial reports and provides assurance that the spending mechanisms follow the national legal and regulatory framework as well as international best practices.

Also, the implementing agencies have their own accounting systems and auditing arrangements. NAS ensures accountability by including provisions in the Grant Agreement that oblige the implementing agencies to establish credible financial management and reporting systems. They are also required to provide prescribed reports and returns to NAS at specified times.

Sierra Leone will also continue to conduct the National AIDS spending Assessment (NASA) which serves as a useful tool for tracking HIV-related expenditure in the calendar year. The NASA approach is structured to inform a multi-sectoral perspective. NASA reflects actual expenditures associated with the delivery of a service or a product that differentiates commitment and disbursements.

In addition to these, the LFA plays a crucial role in the judicious management of the Global Fund grants that constitute about 95% of the funding for HIV/AIDS in Sierra Leone. The LFA plays an oversight role on behalf of the Global Fund that enhances the Performance Based Funding model. They conduct Progress Reviews quarterly and also vet and recommend disbursements. The other key roles the LFA plays include reviewing the acceptability of auditor, their terms of reference and sub-recipient audit plans. They also review the audit reports and advise the Global Fund accordingly.

NAS and some of the implementing agencies have well established M&E units that engage in periodic monitoring of the activities to ascertain the levels of implementation. The results of these monitoring visits are then shared and used to improve the quality and quantity of implementation.

7.0 MONITORING AND EVALUATION OF THE NSP

The indicators for monitoring impact and outcome level results are already stated in the NSP and are in line with the aspiration of the stakeholders. The output indicators will be worked out in greater details in the Comprehensive M&E plan that is being developed. However, critical strategic interventions for M&E of the NSP are

- Harmonization and/or alignment of the HIV/AIDS M&E data management systems with the health sector and other implementers for greater efficiency and effectiveness of the overall response.
- Popularization of the new national targets for service delivery areas that have been set during the NSP development.
- Strengthening the monitoring and evaluation mechanisms to capture other interventions other than GF supported activities to ensure that achievements of the National response are not understated. This also calls for re-alignment and/or development of new partnerships with stakeholders.

The processes for monitoring and reviewing the NSP (2011-2015) and the operational plan are as described below:

(a) **Joint Mid-term Review and Final Review of the NSP (2011-2015)**: As already included in the NSP, there will be Joint Mid-term Review of the NSP to be undertaken in 2013 while the final review of the NSP will be undertaken in 2015. It will be done with active participation of the stakeholders. A follow-up operational plan covering the last three years of implementation (2013-2015) will be developed.

(b) **Joint Supervisory Visits:** At periodic intervals there would be joint supervisory visits by the implementing partners, funders and NAS to programme sites to assess how the programmes are doing and provide the technical support that may be required.

(c) **Surveys:** such as the ANC, IBBSS, DHS, Sexual behavioural Surveys (SBS) will be carried out at specified periods to generate data and provide information on the progress being made in implementing the NSP and whether desired outcomes are being achieved.

(d) **Programmatic Reviews:** will be carried out periodically to assess progress and address challenges and also plan ahead. The programmes to be reviewed will include ART, PMTCT, HCT, Care and Support, BCC, M&E systems etc.

(e) **Performance Contract Monitoring:** NAS as an Agency of Government signs performance contract with government on annual and quarterly basis. This contract contains the deliverables agreed upon with NAS on annual and quarterly basis, which are monitored on quarterly by the Strategic and Planning Unit of the Office of the President. This is used to track progress that NAS is making in implementing planned activities and also planning for the immediate future as well as putting in place timely corrective measures.

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Annex 1: STRATEGIC INTERVENTIONS

THEME 1: COORDINATION, DECENTRALIZATION RESPONSE, RESOURCE MOBILIZATION & MANAGEMENT		
STRATEGIC OBJECTIVE: To ensure decentralization and strengthen coordination structures and systems at all levels for a sustainable and gender-sensitive multi-sectoral HIV/AIDS response in Sierra Leone by 2015		
1.1 Sub-Theme: Coordination and Institutional Response, Institutional Arrangements		
	Strategic Interventions	***Key Activities***
1.1.1	NAS, DACs' and CACs' capacity to effectively coordinate sustainable gender-sensitive and multi-sectoral response at the National, District and Chiefdom levels, respectively strengthened.	i. Strengthen capacity of NAS ii. Strengthen DACs iii. Strengthen CACs.
1.1.2	Strengthened coordination mechanisms of implementing and development partners at National, Districts and Chiefdoms to harmonize support to the HIV response.	i. Make NAS-Development Partners forum more functional ii. Strengthen NAS-Implementing Partners (Expanded Technical Working Group) and DAC-Implementing
1.1.3	Strengthened coordination mechanisms of CSO, PSOs and implementing partners at National and District levels by 2015	i. Strengthen NAS-PSOs Operational Mechanism at National and District level ii. Strengthen NAS- Public Sector Operational Mechanism iii. Strengthen capacities of private and public sector networks iv. Institutional Capacity Building of CCM
1.2 Sub-Theme: Financial Resources		
	Strategic Interventions	***Key Activities***
1.2.1	Increase in the financial contribution of governments at all levels to HIV/AIDS interventions to at least 2% of GDP by 2015.	i. Advocacy to key stakeholders for the transformation of NAS into a commission ii. Integrate HIV issues into the national budgetary process iii. Mainstreaming of HIV & AIDS into all MDA's budget and Local councils by at least 5%. iv. Mainstreaming of HIV & AIDS into all MDA's budget and Local councils by at least 5%.
1.2.2	Mobilize adequate financial resources in support of the implementation of the National HIV/AIDs response by 2015	i. Build capacities of NAS, MDAs and DACs on resource mobilization ii. Develop Partnerships iii. Develop and/or Operationalize Joint Financing/Pooled funding
1.2.3	Increase the effectiveness of HIV/AIDS resource tracking and efficiency of fund management for HIV/AIDS programs by 2015	i. Strengthen/Develop donor funding co-ordination and budget tracking mechanisms on HIV/AIDS ii. Advocate for improved coordination and information sharing between NAS and partners

THEME 2: POLICY, ADVOCACY, HUMAN RIGHTS AND LEGAL ENVIRONMENT		
STRATEGIC OBJECTIVE: To protect the rights and empower PLWHIV and PABA and other vulnerable groups through enactment and enforcement of gender-sensitive policies, guidelines and legislations thereby reducing their cultural, legal, and socioeconomic vulnerabilities by 2015**.**		
	Strategic Interventions	***Key Activities***
2.1	Advocate for the protection of the rights of and empower PLHIV (including children, women, and men)	i. Education on human rights and channels to access justice. ii. Advocacy iii. Capacity building for Human Rights Commission and Human Right CSOs on human rights and HIV and AIDS. iv. Education on human rights for community, traditional, opinion and religious leaders. v. Advocacy for the enactment and/or review passage of Anti-discrimination laws by the parliament. vi. Establish and strengthen linkages between NETHIPS, support groups and poverty reduction agencies and private sector organizations for gender responsive economic empowerment for PLHIV. vii. Provision of social protection services
2.2	Facilitate the meaningful involvement of PLHIV on HIV/AIDS decision making bodies at all levels of the National HIV response.	i. Promote affirmative action for economic empowerment and other opportunities for PLWHIV. ii. Advocacy for greater and meaningful gender-responsive inclusion of PLWHIV in HIV response in Sierra Leone iii. Strengthen capacity of NETHIPS and support groups to enhance their participation in decision making processes.
2.3	Protect women, children and other socially vulnerable (e.g. physically challenged) and marginalised groups from HIV Infections.	i. Promote the removal of cultural and traditional barriers/practices that impede access to reproductive health information and services. ii. Advocacy for the review/enforcement of laws that protect the rights of women and children at all levels (National, District and Chiefdoms) iii. Advocacy for the review/enforcement of laws that protect the rights of women and children at all levels (National, District and Chiefdoms) iv. Removal of legal barriers to access prevention and care
2.4	Progressive increase in funding HIV/AIDS response at all levels.	i. Advocate for the transformation of NAS into a Commission for improved budgetary allocation and release. ii. Advocacy for sustained political leadership and support at all levels. iii. Strengthen capacity of stakeholders (NAS, DAC, CACs private sector, media, PLWHIV and CSOs) in advocacy and policy analysis and development.

2.5	Compliance with existing policy, guidelines, international standards, ethics and laws on HIV/AIDS	i. Establish the National HIV Ethics Committee ii. Strengthening compliance with human rights guidelines with regard to mandatory testing and discrimination against PLHIV at all institutions (workplace, religious etc) iii. Advocacy to Ministry of Labour, health professionals, labour unions, employers, legislators, educational institutions, media and Faith-based bodies on ethics, human rights and HIV and AIDS. iv. Review of Policies on Nutrition, Occupational Safety, and other related matters

THEME 3: PREVENTION OF NEW HIV INFECTIONS		
STRATEGIC OBJECTIVE: To reduce the incidence of HIV/AIDS in Sierra Leone by 50% in 2015.		
3.1 Sub-Theme: HIV COUNSELING AND TESTING (HCT)		
	Strategic Interventions	***Key Activities***
3.1.1	At least 80% of adults access gender friendly HCT services in an equitable and sustainable way by 2015	i. Implement HCT protocol ii. Capacity building for gender-sensitive HCT services at all levels iii. Scale up of HCT services delivery iv. Develop and implement strategies for demand creation for HCT services v. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for HCT management
3.1.2	At least 80% of young people (aged 15-24) access HCT services in an equitable and sustainable way by 2015	i. Implement HCT protocol ii. Capacity building for youth sensitive HCT services at all levels iii. Service provision of HCT iv. Develop BCC strategy for demand creation for HCT services
3.1.3	At least 50% of most at-risk-populations (MARPs) accessing HIV counseling and testing by 2015	i. Capacity-Building for service providers on MARPS responsive services. ii. Scale up of HCT services targeting MARPS
3.2 Sub-Theme: PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV (PMTCT)		
	Strategic Interventions	***Key Activities***

3.2.1	At least 80% of all pregnant women have access to quality HCT by 2015	i. Review PMTCT guidelines and protocol ii. Scale up of quality PMTCT services iii. Community mobilization and participation. iv. Capacity building for PMTCT service providers (e.g. health personnel) v. Upgrade infrastructure at PMTCT sites vi. Procure PMTCT commodities vii. Strengthen referral and linkage mechanisms viii. Increase male participation
3.2.2	At least 80% of all HIV positive pregnant women access ARV prophylaxis by 2015	i. Strengthen PMTCT service integration ii. Ensure provision of ARV prophylaxis for all positive pregnant women iii. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for PMTCT management
3.2.3	All HIV exposed infants receive ARV	i. Establish and Scale-Up Early Infant Diagnosis (EID) Services ii. Capacity building for service providers
3.2.4	At least 80% of HIV positive pregnant women have access to quality infant feeding counseling	i. Popularise the national guidelines on infant feeding ii. Strengthen the capacity for service providers on infant feeding counseling iii. BCC for infant feeding
3.3 SUB-THEME: MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS (STIs)		
	Strategic Interventions	***Key Activities***
3.3.1	At least 50% of sexually active persons in Sierra Leone have access to quality and gender responsive STI services by 2015.	i. Build capacity of service providers ii. Demand creation for service utilization iii. Resource Mobilization iv. Prioritize service provision by target populations and drivers of the epidemic v. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for STI management
3.3.2	STI treatment & prevention services integrated into HIV prevention services by 2015	i. Build capacity of service providers ii. Advocacy iii. Integration of STI services into HIV prevention programs iv. Develop and/or strengthen partnerships v. Provide logistics support at the PHUs for STI Management vi. Procure drugs vii. Improve Laboratory testing facilities
3.4 SUB-THEME: CONDOM PROMOTION)		
	Strategic Interventions	***Key Activities***
3.4.1	At least 80% of men and women of reproductive age (MWRA) have knowledge about dual protection benefit of condoms	i. Accelerate the scale up of social marketing of condoms (especially female condoms) and lubricants ii. Intensify BCC and Social mobilization outreach iii. Scale up distribution of free and socially marketed male and female condoms and water-based lubricants iv. Engage religious and traditional leaders to discuss HIV prevention v. Involve Media Networks in condom promotion

3.4.2	At least 50% of sexually active males and females use condoms consistently and correctly by 2015	i. Promote consistent and correct condom use ii. Promote appropriate operational research iii. Promote referral and linkages with other SRH services iv. Undertake forecasting, procurement and distribution of male and female condoms and water-based lubricants
3.4.3	At least 80% of MARPS use condoms consistently and correctly with non-marital partners by 2015	i. Promote consistent and correct condom use ii. Capacity building of service providers iii. Promote appropriate operational research iv. Promote referral and linkages with other SRH services
3.5 SUB-THEME: Prevention of Biomedical Transmission of HIV		
	Strategic Interventions	***Key Activities***
3.5.1	At least 80% of all private and public health institutions practicing universal safety precautions and procedures by 2015	i. Capacity building of service providers ii. Review national protocol on PEP. iii. Review and Disseminate Injection safety policy and guidelines and National Health Care waste Management Policy iv. Promote Use of safe injection commodities v. Develop BCC strategies for target groups
3.5.2	All (100%) donors of blood, blood products and organs for transplant including sperm for assisted reproductive technology shall be screened for HIV and other transfusion transmissible infections (TTIs) according to relevant national protocol, standards and guidelines by the 2015.	i. Review and operationalize the blood transfusion policy and guidelines at all health levels ii. Capacity building for personnel of public and private health facilities iii. Promote Voluntary Blood donation iv. Advocacy v. Operational research with special focus on incidence studies vi. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for PEP management
3.5.3	At least 50% of drug dependant persons (IDUs and non-IDUs) have access to quality prevention programs/services in accordance with national guidelines by 2015	i. Develop national policies and guidelines and disseminate ii. Advocacy iii. Develop strategic BCC messages iv. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for IDU management
3.5.4	At least 50% of traditional medical practitioners adopt universal safety precaution (USP) by 2015	i. Develop national policies and guidelines and disseminate ii. Capacity building for traditional medical practitioners iii. Mainstream USP into all engagements with TBAs, traditional medical practitioners etc. iv. Procure commodities v. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for USPI management
3.5.5	At least 80% of health facilities provide post-exposure prophylaxis (PEP) to relevant health workers and survivors of rape in line with national protocols by 2015	i. Develop/Strengthen Strategic BCC for target groups ii. Strengthen awareness and multi-sectoral linkages for PEP (Health, Police, Military,)
3.6 SUB-THEME: Prevention of Re-infections and Transmission amongst People living with HIV (PLHWA)		
	Strategic Interventions	***Key Activities***

3.6.1	At least 50% of people living with HIV have access to Positive Health, Dignity and Prevention (PHDP) interventions by 2015.	i. Capacity building (Health care providers and PLHWA networks) ii. Scale up PHDP interventions iii. BCC for PHDP
3.7 SUB-THEME: BEHAVIOUR CHANGE COMMUNICATION INTERVENTIONS		
	Strategic Interventions	***Key Activities***
3.7.1	At least 50% of all persons in Sierra Leone have comprehensive knowledge on HIV and AIDS by the year 2015	i. Develop and disseminate Behaviour Change Communication Strategy ii. Capacity building CSOs working with the general population
3.7.2	At least 50% of young people 15-24 years adopting appropriate HIV and AIDS related behavior	i. Develop and implement relevant culturally age-appropriate and group specific SBCC oriented programs. ii. Capacity building for CSO working with young people iii. Integrate the FLHE curriculum into the Sexual Reproductive Health and Life Skills curriculum iv. Advocacy to stakeholders
3.7.3	At least 50% of Most-At-Risk Populations (MARPs) reached with group-specific interventions and adopting appropriate HIV and AIDS related behaviour.	i. MARPS reached with appropriate strategic BCC interventions ii. Capacity-building for CSOs working with MARPS iii. Service provision
3.7.4	At least 80% of registered organizations engaging in HIV communication interventions address gender inequalities and comply with national standard/guidelines by 2015	i. Build capacity on gender mainstreaming ii. Documentation and dissemination of best practices on strategic BCC iii. Monitoring of the implementation of BCC strategy
3.7.5	At least 50% of members of organized private sector (BCAASL)60% of the affiliated unions under the Sierra Leone Labour Congress and 60% of public sector organizations are implementing HIV workplace policy	i. Popularize the HIV workplace policy ii. Capacity building of private and public sector organizations iii. Provide Technical Assistance iv. Develop Public-private sector partnerships v. Develop monitoring mechanisms for workplace programmes
3.8 SUB-THEME: INTEGRATION OF SEXUAL REPRODUCTIVE HEALTH & OTHER RELEVANT HEALTH ISSUES INTO HIV PREVENTION PROGRAM		
	Strategic Interventions	***Key Activities***
3.8.1	SRH services integrated into HIV prevention programs at all levels by 2015	i. Advocacy ii. Capacity building for health care providers iii. Procure the commodities iv. Sensitization of availability of family planning services

3.8.2	Integrate reduction of substance abuse in 50% of HIV prevention programs by 2015	i. Develop and operationalize the policy and guidelines at all health levels ii. Advocacy iii. Capacity building for health care providers iv. Develop appropriate and strategic BCC activities v. Develop referral and linkage mechanisms

THEME 4: TREATMENT OF HIV AND OTHER RELATED HEALTH CONDITIONS		
STRATEGIC OBJECTIVE: To reduce morbidity and mortality among people living with HIV by 2015**.**		
4.1 SUB-THEME: ANTI-RETROVIRAL TREATMENT		
	Strategic Interventions	***Key Activities***
4.1.1	At least 80% of eligible adults (women and men) and 100% of children (boys and girls) are receiving ART by 2015	i. Capacity building and training of health care workers, PLHIVs and caregivers ii. Decentralization and integration with other HIV services (PMTCT, HCT) iii. Procurement of medical commodities and equipments iv. Provide additional and/or upgrade of physical infrastructure of ART sites v. Clinical Pharmacovigilance for ARVs vi. Capacity building for adherence counseling for. health care workers, PLHIVs and caregivers vii. Strengthen follow-up system viii. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for ART management ix. Provide nutritional support
4.2 SUB-THEME: TREATMENT OF OPPORTUNISTIC INFECTIONS		
	Strategic Interventions	***Key Activities***
4.2.1	At least 80% of adults (men and women) and all children (boys and girls) on ART are receiving quality management of OIs(diagnosis, prophylaxis, and treatment) by 2015	i. Capacity Building for health care workers, PLHIV and care givers ii. Upgrade laboratory infrastructure for OI management iii. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for OI management
4.3 SUB-THEME: MANAGEMENT OF TB AND HIV AND OTHER CON-INFECTIONS		
	Strategic Interventions	***Key Activities***

4.3.1	Effective TB/HIV collaborative interventions are being implemented at the national and District levels by 2015	i. Establish and/or strengthen TB/HIV Technical Working Group ii. Training and Capacity Building for Health Care Workers on TB and HIV iii. Community Mobilization and participation iv. Strengthen monitoring and follow-Up
4.3.2	To ensure all TB patients have access to quality comprehensive HIV and AIDS services by 2015	i. HIV Counselling and Testing for TB patients ii. Cotrimoxazole Preventive therapy for PLHIV with TB iii. ARVs for PLHIV with active TB iv. Procure medical commodities and equipments
4.3.3	To ensure all PLHIV have access to quality and comprehensive TB services by 2015	i. Intensified medical examination of PLHIV for TB ii. Upgrade Laboratory infrastructure for TB and MDR-TB diagnosis in HIV infection iii. Procure medical commodities and equipment iv. Pharmacovigilance for anti-TB drugs v. TB infection control in HIV health care delivery sites vi. Isoniazid Preventive therapy for PLHIV
4.4 SUB-THEME: CLINICAL AND LABORATORY SERVICES		
	Strategic Interventions	***Key Activities***
4.4.1	To strengthen clinical and laboratory services to effectively manage HIV and other associated diseases such OIs and TB BY 2015	i. Develop/review the laboratory policy and protocols ii. Coordination and Integration iii. Capacity-Building of laboratory staff iv. Establish Quality assurance mechanism and linkages

THEME 5: CARE AND SUPPORT FOR THE INFECTED AND AFFECTED BY HIV/AIDS		
STRATEGIC OBJECTIVE: To improve the quality of life of PLHIV and people affected by HIV/AIDS (PABA) especially OVC by 2015.		
5.1 SUB-THEME: CARE AND SUPPORT FOR PLHIV		
	Strategic Interventions	***Key Activities***
5.1.1	At least 60% PLHIV receive quality care and support services (as contained in national guidelines) by 2015	i. Advocacy to relevant stakeholders ii. Review/develop and disseminate national policies, standards and protocols for care and support services iii. Strengthen Community and home-based services iv. Develop/review existing BCC existing strategies v. Capacity building for health care personnel (public and private), CSOs, PSOs, FBOs, support groups and other community-based groups providing care and support services

5.1.2	To reduce stigma and discrimination targeted at PLHIV and PABA by at least 50% on baseline value by 2015	i. Advocacy to relevant stakeholders ii. Review/develop and disseminate national policies, standards and protocols for care and support services iii. Advocate for free legal services for proven cases of stigma and discrimination
5.1.3	To improve by 50% effective referral and linkages within and between relevant health care facilities and communities based care service points.	i. Advocacy to relevant stakeholders ii. Strengthen referral, follow-up and feed-back systems iii. Capacity building of support groups, CBOs, CSOs, health care workers and other service providers
5.2 SUB-THEME: ECONOMIC EMPOWERMENT		
	Strategic Interventions	***Key Activities***
5.2.1	At least 50% of PLHIV and PABA especially women, marginalized and people with special need are provided with alternative livelihoods.	i. Capacity building for PLHIV and PABA (especially women, young girls and people Living with disabilities) on income generating activities ii. Mobilization of Resources iii. Provision of appropriate and adequate business/livelihoods start-up packs for PLHIV and PABA iv. Provide nutritional support
THEME 6: RESEARCH, MONITORING AND EVALUATION		
STRATEGIC OBJECTIVE: To have a cost-effective, multidimensional and gender sensitive monitoring and evaluation system which informs the continuous improvement of the national HIV response by 2015.		
6.1 SUB-THEME: COORDINATION OF M&E		
	Strategic Interventions	***Key Activities***
6.1.1	To enhance the leadership and managerial skills and gender sensitivity of National and district authorities for the delivery of an effective One national M&E system by 2015	i. Review and strengthen the M&E competencies (professional and managerial) at National, District and facility levels. ii. Capacity development for M&E staff at national, sub national and sectoral levels iii. Resource mobilization for M&E
6.1.2	To establish a gender sensitive M&E coordination system/mechanism for HIV/AIDS at all levels (National, District, Organizations etc) by response by 2015	i. Develop/strengthen appropriate M&E coordination mechanisms at all levels (National, districts, Chiefdoms, CSO networks and health facilities etc.) ii. Convene periodic meetings of the M&E Technical Working group iii. Establish M&E technical working Group at the Regional level iv. Train the TWG members on relevant areas including developing gender sensitive M&E
6.1.3	To improve the efficiency and effectiveness of the delivery of the costed multi-sectoral HIV M&E plan by 2015	i. Develop/harmonise financial reporting tools and formats ii. Train Implementing partners, CSOs, PSOs on the financial reporting tools and format iii. Procure necessary hardware and software iv. Conduct periodic Monitoring and supervision of HIV/AIDS activities of implementing institutions

6.2 SUB-THEME: SURVEY AND SURVEILLANCE		
	Strategic Interventions	***Key Activities***
6.2.1	To periodically determine the drivers, incidence and prevalence rates of the epidemic at national and district level as evidence for planning HIV interventions by 2015	i. Conduct Specific Studies on the behaviours of MARPS (Sex Workers, MSMs, Uniform Personnel, Fisherfolks, Mobile Migrant, Miners , Dock Workers, IDUs;.) ii. Conduct national sero-prevalence of HIV surveys iii. Conduct Ante-natal surveillance surveys iv. Conduct behavioural surveillance surveys among the general population

Annex 2: LIST OF CONSULTANTS & TECHNICAL ADVISER

S/No	Name	Position
1.	Timi Owolabi	International Consultant/Team Leader
2	Abdul Rahman Sessay	National Consultant
3.	Momodu Sesay (Dr.)	National Consultant
4.	Joseph C. Kobba	National Consultant
5.	Chibwe Lwamba	UNAIDS Adviser
6.	Alex Abugri	International Costing Consultant
7.	Louise Thomas Maploh	WHO-IST West Africa Adviser

Annex 3: Attendance List at Result – Based Management (RBM) Workshop

NAME	ORGANISATION
Mohamed B. Koroma	SALYAN
Idrissa A. Conteh	SLYN on HIV/AIDS
Hassan Ruad Kanu	UNAIDS
Salamatu Barley	UNAIDS
Andrew M. Kamara	SLPMMA
Abdul Rahman Sessay	NAS
Jonathan Winnebah	HACSA
Momodu Sesay	NACP
Fatmata B. Kabba	CCSL
Francis K. Tamba	NACP
Brima A. Kanu	MAEES
Ibrahim Kanu	YWDO
Abu Bakarr Kargbo	HARA
Zena Cummings-wray	COMAHS U.S.L.
Alice Kandeh	MILGRD
David Austin Lemoh	BBN 93.0
John B. Baimba	UNICEF
Prof. N.G. Gage	
Daniel Kettor	RESTLESS DEVELOPMENT
Dr. Sulaiman Conteh	NAS/MOHS
Victor T. Tanty	UMC
David Ray-Macauley	BCASL
Musa A. Jimmy	VOW
Jerry Sevalie	GLCS
Maybelle A. Gamanga	MEYS
Amiru K. Daboh	BCAASL
Abdul Sheriff	G/S
Aruna R. Koroma	RODA
Idrissa Songo	NETHIPS
Lamin Bangura	NACP
Ella Syl Maty	YWCA
Marie Benjamin	SWAASL
Alimatu Fofanah	NUMY
Christian F. Yajah	MIALGRD
Ahmed Saybom Kanu	Statistics Sierra Leone
Val Tucker	PORSHE
Ochola Odongo Dorothy	UNICEF

Agnes Fornah	SLBC
Timi Owolabi	CONSULTANT
Joseph C. Kobba	National Consultant
Chibwe Lwamba	UNAIDS
Victor S. Kamara	NAS
Moi-Tenga Sartie	NAS
Fatmata B. Kallay	NAS
Umu N. Nabieu	NAS
Kemoh S. Mansaray	NAS
Dr. Saidou Hangadoumbo	NAS International Consultant

Annex 4: List of Technical Working Group for Development of Sierra Leone NSP II (2010-2015)

NAME	Agency/Organisation
Kemoh S. Mansaray	NAS
Victor S. Kamara	NAS
Delips S. Allieu	Plan International, S.L.
Salamatu Barley	UNAIDS
Marie M. Jalloh (Hon.)	Parliament
Edward Alpha	Kowa - Focal Person
Michael A. Yamba	Decentralization Secretariat
Adama Thorlie	UNDP
Konah M. Moore	UNDP
Joyce Wuyah Abu	BCAASL
George Gage (Prof.)	
Bockarie Samba	UNAIDS
Abdul Rahman Sessay	NAS
Joseph C. Kobba	National consultant
Sualiman Conteh (Dr.)	NACP
Brima V. Kamara	PPASL
Hudson Tucker	SLANGO
Farai Muronzi	Restless Development
Hossinatu Kanu	NACP
Lamin Bangura	NACP
Martha S. Kamara	NAS
Francis K. Tamba	NACP
Idrissa Songo	NETHIPS
Neil Tobin	UNAIDS
Val Tucker	PORSHE
Josephine Kainessie	CARE-Sierra Leone
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Dorothy Ochola-Odongo	UNICEF

Annex 5: Attendance List at Validation Workshop of the National HIV/AIDS Strategic Plan (2011-2015)

NAMES	ORGANIZATION
George N. Gage	Private Consultant
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Kiskama Swarray	NACP
Umu Nabieu	NAS
Kemoh Mansaray	NAS
Dr. Saidou Hagadoumbo	NAS
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Juliana S. Fornah	UNIDO
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Julia T. Amara	Bo District Council
Alhassan Jalloh	Koinadugu District
Edward Alpha	Koidu City Council
Joyce Wuyah Abu	BCAASL
Augustine B. Amara	Kenema District Council
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Alieu Fofanah	S.L.L.C. (Dock Workers
Daphne During	LEOCEM
Maybelle A. Gamanga	MEYS

NAMES	ORGANIZATION
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Saidu Conteh	NETHIPS (South)
Abdul Sheriff	GIS
Jerry Sevalie	GLCS
Hudson tucker	SLANGO
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Kristy Baughman	UNICEF
Edmund Makiu	UNICEF
Monica Cole	Standard Chartered
Alpha Wurie	Diyanaty
Mariama M. Conteh	NACP
Hossinatu M. Kanu	NACP
Abu B.B. Koroma	NAS
Khadyatu Bakar	CARE
Yayah Mansaray	Dignity
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George L. Massaquoi	NETHIPS (East)
Moi-Tenga Sartie	NAS
Joseph Pessima	NETHIPS (North)
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Zainab Mansaray	WFP

National Strategic Plan on HIV/AIDS
2011 – 2015

Sierra Leone Towards
Zero New HIV Infections
Zero Discrimination
Zero AIDS Related Deaths

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