SIERRA LEONE NATIONAL AIDS RESPONSE PROGRESS REPORT 2015

June 2015

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AHF	AIDS Healthcare Foundation
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BCAASL	Business Coalition Against AIDS in Sierra Leone
BCC	Behavioural Change Communication
CAC	Chiefdom AIDS Committee
CARE	Cooperative American Relief Everywhere
CASL	Christian Aid in Sierra Leone
CBO	Community Based Care
CCM	Country Coordination Mechanism
CCYA	Centre for Coordination of Youth Activities
CDC	U.S Centre for Disease Control
CHO	Community health Officer
COPSAASL	Coalition of Public Sector Against HIV and AIDS in Serra Leone
CSO	Civil Society Organization
DAC	District AIDS Committee
DANIDA	Danish International Development Agency
DBS	Dried Blood Spot
DfID	U.K Department for International Development
DHMT	District Health Management Team
DHO	District Health Officer
DMO	District Medical Officer
ETWG	Extended Technical Working Group
EU	European Union
GF	The Global Fund for HIV/AIDS, TB and Malaria
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit
HARA	HIV and AIDS Reporters Association
HBC	Home Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HSS	Health sector System Strengthening
IEC	Information, Education and Communication
INGO	International Non-Governmental Organization
IOM	International Office of Migration
JPR	Joint Programme Review
KFW	Krebital ftaltfürWieberaufbau (German Development Bank)
MDA	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

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
MoTCA	Ministry of Tourism and Cultural Affairs
MoU	Memorandum of Understanding
MoWHI	Ministry of Works, Housing and Infrastructure
MoYS	Ministry of Youth and Sports
MSM	Men who have Sex with Men
MSWGCA	Ministry of Social Welfare, Gender and Children Affairs
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NACSA	National Commission for Social Action
NAS	National HIV/AIDS Secretariat
NECHRAS	Network of Christian Response to HIV and AIDS in Sierra Leone
NETHIPS	Network of HIV Positives
NGO	Non-governmental Organization
NSP	National Strategic Plan
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PEP	Post Exposure Prophylaxis
PEPFAR	U.S President Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipient
PSM	Procurement and Supply Management
PSO	Private Sector Organization
PWID	People Who inject Drugs
RH	Reproductive Health
RODA	Rofutha Development Organization
SLANGO	Sierra Leone Association of Non-Governmental Organization
SLDHS	Sierra Leone Demographic and Health Survey
SLIRAN	Sierra Leone Inter-religious AIDS Network
SLLC	Sierra Leone Labour Congress
SLYDCL	Sierra Leone Youth Development and Child Link
SOLTHIS	Therapeutic SOLIDARITY and Initiatives Against HIV/AIDS
SR	Sub Recipient
SSL	Statistic Sierra Leone
STI	Sexually Transmitted Infections
SWAASL	Society of Women and AIDS in Africa, Sierra Leone Chapter
TBA	Traditional Birth attendants
TOR	Terms of Reference
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
UNICEF	United Nations Children Fund
USG	United States Government
VOW	Voice of Women
WFP	World Food Programme
WHO	World Health Organization
WICM	Women in Crisis Movement

1 Status at a Glance

1.1 Reporting Process

This document details Sierra Leone's National AIDS Response Progress Report for 2015 as part of the submission for the annual Global AIDS Response Progress Reporting (GARPR) process. It was created with input from numerous civil society organizations, bilateral agencies, international organizations and other key partners in order to enhance the ownership and quality of the overall report. The process undertaken to complete the report is outlined below.

1. Preparatory activities (February 10 – 17, 2015)

The coordinating body (National HIV/AIDS Secretariat) identified a team of pertinent stakeholders to steer the reporting process. Membership was composed of members from the national M&E technical working group (M&ETWG), United Nation (UN) organizations, other bilateral organizations, international and national nongovernmental organizations, civil society organizations, Faith based institutions, Human Right Institutions, and advocacy groups including the Network of People Living with HIV (NETHIPS). The Terms of Reference (ToR) of the team included facilitation of the data collection process, analysis of data, validation and report writing. Weekly steering committee meetings were held in order to collect data, ensure quality assurance and enhance ownership throughout the process.

2. Compilation of data (February 18 – 27, 2015)

Programmatic data was gathered from the National AIDS Control Programme (NACP) which is within the Ministry of Health (MoH) and recognized as the lead Sub Recipient (SR) for the Global Fund, and closely monitored and supervised by the Principal Recipient (PR), the National HIV/AIDS Secretariat (NAS). Additionally, a desk review was undertaken to verify currently reported information and studies. This desk review included the following documents.

- 2013 - SLDHS Report
- 2012 - Country Progress Report, Sierra Leone
- 2014/2015 - Spectrum output
- 2013 - Mid Term review of the National strategic Plan (NSP) 2011-2015
- 2013 M&E System Strengthening Tool (MESST)
- 2013-2015 Strategic Plan towards elimination of Mother to child transmission of HIV and for paediatric HIV care in Sierra Leone
- 2013 Population Size Estimation of key populations
- 2013 BSS Report, General Population, Preliminary Report
- 2009-2013/2017 National Strategic Plan for Comprehensive Condom programming in Sierra Leone
- 2011-2012 National HIV/AIDS Operational Plan
- 2010 ANC Sentinel Surveillance Reports
- 2006 – 2011 National AIDS Spending Assessment
- 2013 and 2014 National TB Control Program Data
- 2011 AIDS at 30, Nations at the crossroads

- 2010 Multi Cluster Indicator Survey MICS IV
- 2011-2015 National Strategic Plan on HIV and AIDS
- 2011-2015 Monitoring and Evaluation framework
- 2013 and 2014 National AIDS Control Program (NACP) Data
- 2005 National Population Based HIV Sero-Prevalence Survey of Sierra Leone
- 2009 Border Communities, Mobile Populations and Exposure to HIV in Countries of the Mano River Union
- 2008 HIV Surveillance on Mine Workers in Sierra Leone
- 2007 Prevalence of HIV and other STIs in Sierra Leone among Armed Forces
- 2007 Report on HIV Surveillance among Sierra Leone Police Force
- 2008 and 2011 Survival Analysis for PLHIV on Antiretroviral
- 2009 Pulmonary Tuberculosis among PLHIV attending care treatment, at treatment centers in Freetown
- 2009 and 2011 Prevalence of HIV infection amongst children born to HIV-infected Mothers
- 2011-2015 Sierra Leone National HIV Behaviour Change Communication & Advocacy Strategy
- 2011 HIV&AIDS Commission Act
- 2010 Sierra Leone HIV Modes of Transmission Study
- Voluntary Confidential Counseling and Testing Quality Assurance Tool
- 2011 Sustainability analysis of HIV/AIDS services HAPSAT Sierra Leone

3. Data processing, analysis and report writing (March 2 – 15, 2015)

Database managers from NAS and NACP worked in collaboration with the M&E team of both institutions to facilitate the data compilation process. The Strategic Information Advisor from UNAIDS provided extensive technical input to the team and ensured that data entering commenced in time by the assigned country rapporteur. The country rapporteur approved viewer rights to key stakeholders; this ensured transparency and continuous monitoring of the on-line data entry tool.

4. Validation, finalization and submission of the report (March 25 – 31, 2014)

A full day validation workshop was held for stakeholders from diverse background across the Country aimed inclusion of the collective and genuine contributions. There were 63 participants in attendance, including members from United Nations Country Team, public and private sector, faith based organizations, bi and multi-lateral donors, print and electronic media, key populations, Network of people living with HIV, international and national nongovernmental organizations, Country Coordinating Mechanism body of the Global Fund, Academic Institutions-University of Sierra Leone, Human Right Institutions and Youth Serving Agencies. For a complete list of participants, please consult Annex A. Following a succinct presentation on the overall 2015 GARPR indicators, discussions were held and recommendations compiled for inclusion in the overall report before final submission. The zero draft of the narrative report was forwarded to UNAIDS for review and necessary input on June 12, 2015.

5. Limitations in Report

Although enough time was allocated to the entire process, it was difficult to receive input from partners in time to compile the entire document. Secondly, the final approved SPECTRUM data arrived a bit late, leading to last-minute review of data for specific indicators before final inclusion into the overall report. Thirdly, comments are still being received from the submitted GARPR 2015 on-line tool; as a result, answers to future comments will not be captured in this report due for submission now.

1.2 Status of the HIV Epidemic

The HIV epidemic in Sierra Leone has been considered as mixed, generalized and heterogeneous. HIV affects different population sub-groups and all sectors of the population through multiple and diverse transmission dynamics. The HIV prevalence in Sierra Leone increased from 0.9% in 2002 to 1.5% in 2005 and has remained at the same level since 2008 (2013, SLDHS). This stabilization means the country is rated as one of the least affected compared to others in the sub-region and globally. Prevalence was 2.3% in urban areas compared to 1.0% in rural areas.

Women are disproportionately infected by the epidemic. An estimated 54,000 Sierra Leoneans are living with HIV out of which 29,000 are women and 5,000 are children. According to the 2013, SLDHS, prevalence rate for men was 1.3% while that for women was 1.7%.

HIV prevalence among pregnant women attending antenatal clinics (ANC) also declined progressively from 4.4% in 2007 to 3.5% in 2008 to 3.2% in 2010 respectively but 3.2% is still twice higher than the national prevalence of 1.5%. There was a three-fold increase in syphilis prevalence among pregnant women from 0.4% in 2006 to 1.4% in 2010; concerns being that STIs are co-factors to HIV infection. Syphilis prevalence is higher amongst rural pregnant women (1.8%) compared to their urban counterparts (1.3%).

The 2010 HIV modes of transmission study revealed that commercial sex workers, their clients and partners of clients contribute 39.7% of the new infections. Also people in discordant monogamous relationships contribute 15.6% of new infections of which clients of sex workers account the most (25.6%), sex workers 13.7% and partners of new infections accounting the remaining of 0.37%. Fisher folks contribute 10.8%, traders 7.6%, transporters 3.5% and mine workers 3.2%. MSM and People Who Inject Drugs (PWID) have also been identified to be at higher risk of HIV infection; 2.4% and 1.4% of the new infections respectively.

1.3 Overview of the Policy and Programmatic Response

The National HIV and AIDS Commission Act 2011 was enacted to establish the National HIV and AIDS Commission to be responsible for making policies for all HIV and AIDS related services in the country. The Act makes provision for the monitoring of the HIV Prevalence and contains penalties for discriminatory acts against those infected and affected by HIV and AIDS.

The National AIDS Commission (NAC) and the National HIV/AIDS Secretariat (NAS) have been established in the Office of the President with the responsibility of providing leadership in coordinating, monitoring and mobilising resources for the national response. With the support of the key stakeholders, NAS is providing strategic direction for the national multi-sectoral and decentralized response in the programmatic areas of HIV prevention, treatment of HIV and other related conditions, care and support, policy and advocacy. The National AIDS Control Programme (NACP), which is placed within the Ministry of Health and Sanitation, is focused on providing support to the health programming and service provision of the national response.

The national response is guided by the National Strategic Plan of 2011-2015 which charts the roadmap for Sierra Leone to achieve the Millennium Development Goal to have halted and begun to reverse the

spread of the HIV/AIDS by 2015. It is multi-sectoral with the overall vision towards zero New Infection, Zero Discrimination and zero AIDS related deaths. The thematic areas of the NSP are (i) coordination, institutional arrangements, resource mobilisation and management; (ii) policy, advocacy, human rights and legal environment; (iii) prevention of new infections (iv) treatment of HIV and other related conditions (v) care and support for infected and affected by HIV and AIDS and (vi) research, monitoring and evaluation. The Mid-Term Review of the NSP was conducted in December 2013 and the country has prepared an Operational Plan for 2014-215. Treatment, care and support services have gradually been scaled up across the country since the inception of multi-sectoral response. Key population groups including FSW, MSM, PWID were identified as priority populations, alongside the fisher folks; transporters; uniformed service personnel; prisoners; miners; cross-border and informal traders; women, girls and children; youths and general population. Over the years, guidelines have been developed and reviewed for effective service delivery. These guidelines include HCT guidelines, ART guidelines, OVC guidelines, Nutritional guidelines, Home-based Care guidelines and workplace policy.

The 2014 EVD outbreak significantly affected the national AIDS response by halting specific interventions, redirecting resources to support efforts in EVD sensitization and impact mitigation, and endangering progress that has made in supporting PLHIVs.

1.4 Overview of the Indicator Data

Indicator	2013	2014	Source
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015			
Indicators for the General Population			
1.1 -- Percentage of young women and men aged 15-24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	15-24yrs: Women 28.8% Men 30.0% 15-19yrs: Women 28.0% Men 28.5% 20-24yrs: Women 29.9% Men 32.5%		2013 SLDHS, Page 200 & 201
1.2 -- Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	15---24yrs women 19.5% Men 10.5% 15---19yrs women 19.3% Men 10.4% 20---24yrs women 19.8% Men 10.7%		2013 SLDHS, Page 226
1.3 -- Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	15-49yrs Women 6.0% Men 25.3% 15-24yrs Women 6.2% Men 15.7% 15-19yrs Women 5.2% Men 8.2% 20-24yrs Women 7.6% Men 26.6%		2013 SLDHS, Page 211 & 212
1.4 -- Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	15-49yrs Women 4.7% Men 12.6% 15-24yrs Women 5.9% Men 20.9% 15-19yrs Women 9.7% Men 23.5% 20-24yrs Women 2.1% Men 19.8%		2013 SLDHS, Page 211 & 218
1.5 -- Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	15-49yrs Men 6.2% Women 13.6% 15-24yrs Men 4.7% Women 13.7% 15-19yrs Men 3.0% Women 11.0% 20-24yrs Men 7.1% Women 17.7%		2013 SLDHS, Page 217 & 218
1.6 -- Percentage of young people aged 15-24 who are living with HIV	15-24yrs Women 1.4% Men 0.7% 15-19yrs Women 1.5% Men 0.7% 20-24yrs Women 1.2% Men 0.9%		2013 SLDHS, Page 242
Indicators for Sex workers			
1.7 -- Percentage of sex workers reached with HIV prevention programs	10.4%	14.9%	BSS 2013 Key Population, Preliminary Report
1.8 -- Percentage of sex workers reporting the use of a condom with their most recent client	68.7%	88.2%	BSS 2013 Key Population, Preliminary Report

Indicator	2013	2014	Source
1.9 -- Percentage of sex workers who have received an HIV test in the past 12 months and know their results	47.0%	61.1%	BSS 2013 Key Population, Preliminary Report
1.10 -- Percentage of sex workers who are living with HIV	8.5%	8.5%	Female Sex Workers study, 2005
Indicators for Men who sex with men			
1.11 -- Percentage of men who have sex with men reached with HIV prevention programs	25.0%	21.3%	BSS 2013 Key Population, Preliminary Report
1.12 -- Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	32.2%	47.8%	BSS 2013 Key Population, Preliminary Report
1.13 -- Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	46.7%	41.2%%	BSS 2013 Key Population, Preliminary Report
1.14 -- Percentage of men who have sex with men who are living with HIV	7.5%	7.5%	MSM Study, 2010
Target 2. Reduce transmission of HIV among people who inject drugs by 50 percent by 2015			
2.1 -- Number of syringes distributed per person who injects drugs per year by needle and syringe programs	Data not available	Data not available	--
2.2 -- Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	Data not available	32.1%	BSS 2013 Key Population, Preliminary Report
2.3 -- Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	25.2%	40.7%	BSS 2013 Key Population, Preliminary Report
2.4 -- Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	4.5%	13.0%	BSS 2013 Key Population, Preliminary Report
Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related deaths			
3.1 Percentage of HIV-positive pregnant women who receive anti-retro-virals to reduce the risk of mother-to-child transmission	79.8%	67.9%	Program Data
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	35.1%	13.1%	Program Data
3.3 Mother-to-child transmission of HIV (modelled)	14.4%	12.7%	Spectrum
Target 4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015			
4.1 -- Percentage of eligible adults and children currently receiving antiretroviral therapy	33.6%	46.8%	Program Data
4.2 -- Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	69.7%	70.5%	2011 ART Survival Analysis study
Target 5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015			

Indicator	2013	2014	Source
5.1 -- Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	5.6%	611	Program Data
Target 6. Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries			
6.1 -- Domestic and international AIDS spending by categories and financing sources	Domestic Source: 3.1% International Source: 96.7% Private source: 0.2% 2009: USD 14,309,550	Domestic Source: 0.8% International Source: 99% Private source: 0.2% 2011 : USD 20,905,243	2010 – 2011 NASA Study
Target 7. Eliminating gender inequalities			
7.1 -- Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	9%	28.6%	2009 KAP Survey
Target 8. Eliminating stigma and discrimination			
8.1 -- Percentage of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	Male: 59.7%, Female:79.9%	Male: 57.2%, Female:55.9%	2013 SLDHS
Target 10. Critical enablers and synergies with development sectors			
10.1 -- Current school attendance among orphans and non-orphans aged 10–14	Orphans attending school: (79.9%male & 68.2%female) Non-orphans attending school: (84.1% male & 83.8% female)*	Orphans attending school: (70.6% male & 61.7% female) Non-orphans attending school: (80.0% male & 81.1% female)**	*2011 MICS 4 **2013 SLDHS
10.2 -- Proportion of eligible households who received external economic support in the last 3 months	Data not available	Data not available	--

2 Overview of the AIDS Epidemic

Sero-prevalence studies were not conducted during the period of 2012 to 2014 due to funding and logistical issues. However, existing data has been used to create new estimates.

Number of people living with HIV	Total*	54,708
	Females*	29,676
	Males*	20,326
	Children <15*	4,706
People newly infected with HIV in 2013	Total*	2,746
	Total Females*	1,347
	Total Males*	1,010
	Children <15*	388
AIDS related deaths in 2012	Total*	2,659
	Total Females*	1,325
	Total Males*	1,334
	Children <15*	295
ART	Adults in need*	26,495
	Adults receiving+	10,289
	Children in need*	1,810
	Children receiving+	383
	ART Coverage	37.7%
PMTCT	Pregnant women in need*	3,055
	Pregnant women receiving+	2,585
	PMTCT Coverage	84.6%
Rate	Incidence (Adult) *	0.06 %
	Prevalence	1.5%

Table 1: Summary Table of 2014 Epidemiological Data for Sierra Leone

*Value gathered from Spectrum
+Value gathered from programmatic data

During 2014, it is estimated that there are 54,708 people living with HIV in Sierra Leone, over half of which are female over the age of 15. Figure 1 illustrates the growing HIV population.

Although the number of people with HIV is stagnating, estimates affirm that the number of new infections is decreasing (Figure 2). Although the most dramatic decrease appears to be within the females above the age of 15, they are clearly still vulnerable than males to HIV infection, with females from 15 to 19 years of age being the most vulnerable.

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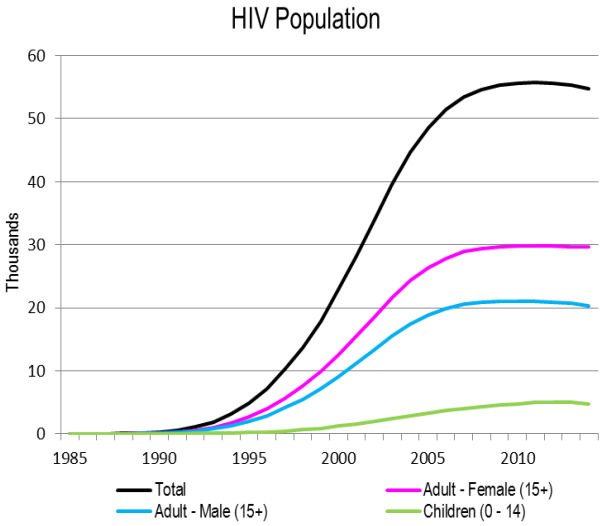
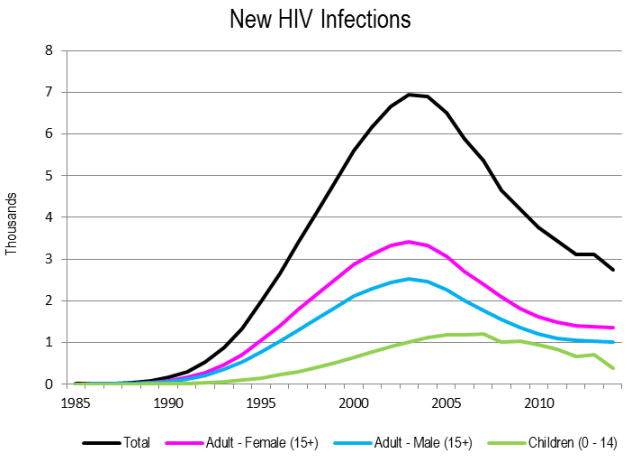


Figure 1: Estimated number of people living with HIV in Sierra Leone



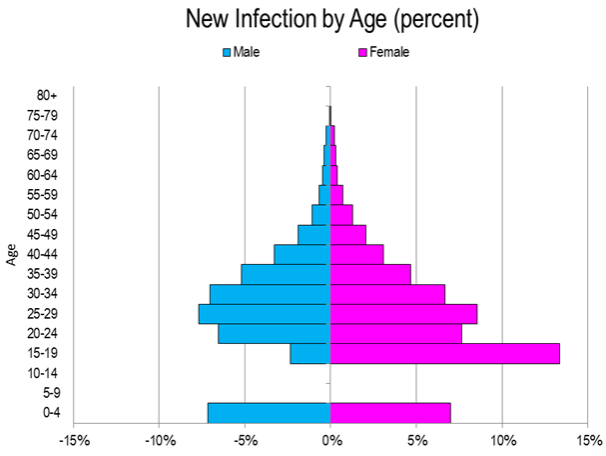


Figure 2: Estimated new infections

Although it is estimated that roughly 1,198 deaths were averted due to ART, ART coverage rate remains very low amongst adults eligible for treatment (38.8%) (Figure3).

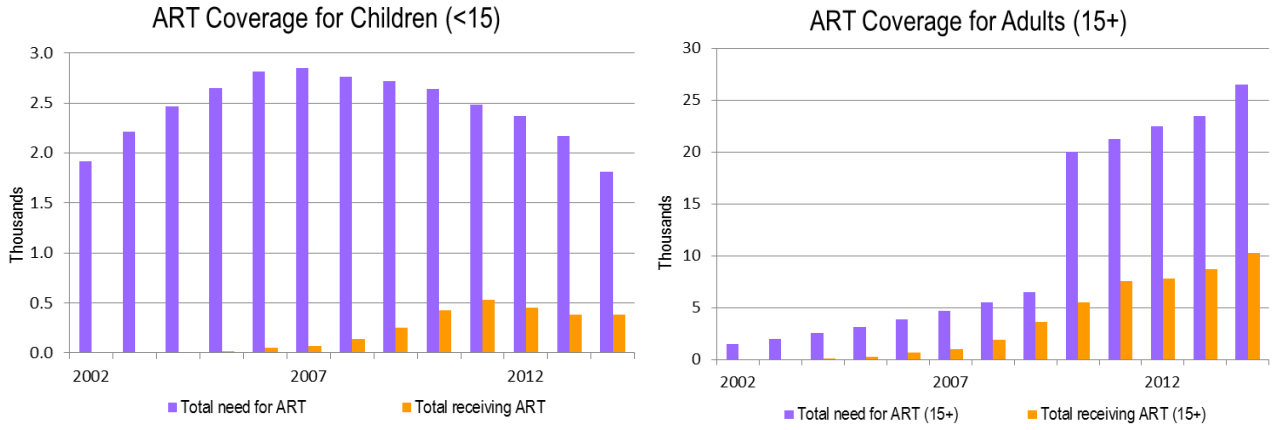


Figure 3: ART Coverage in Sierra Leone

Unlike ART coverage, PMTCT coverage rates are very high (84.6%) (Figure 4) This accomplishment is also reflected in the low mother-to-child transmission rate (3.9% for MTCT rate at 6 weeks, and 12.7% for final transmission including breastfeeding period). Note that PMTCT coverage rates in this instance relate to the access that pregnant women have to PMTCT services; i.e. % of HIV-positive pregnant women who receive ARVs to reduce the risk of mother-to-child transmission (Treatment coverage). However, amongst pregnant women who received complete course of ARVs and those who have been on ARVs for own health before current pregnancy, the coverage was 40.1 %. (Comprehensive PMTCT coverage)

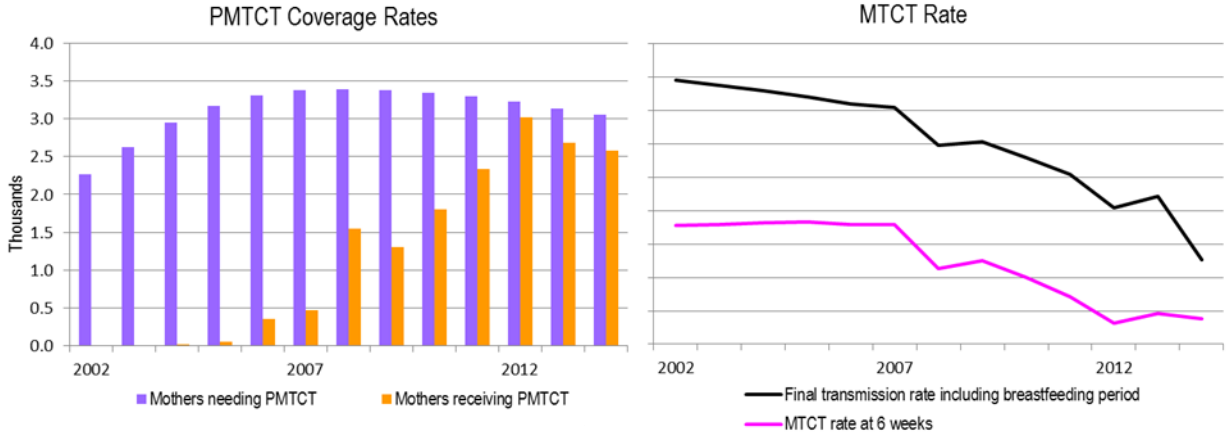


Figure 4: PMTCT Coverage in Sierra Leone

It is encouraging to note that despite the increase in the number of people living with HIV and the poor ART coverage rates, there is a general decline in AIDS deaths amongst adult females and children (Figure 5). This is further supported by the Survival Rate Study performed in 2013 that found 93% survival rate amongst its cohort despite a 71% retention rate to treatment (for past 12 month span). Worth noting is that the models show that AIDS related deaths among adult males is increasing. Due to PMTCT and ART programming, roughly 698 infections and 1,198 deaths were averted in 2014 (see Figure 6).

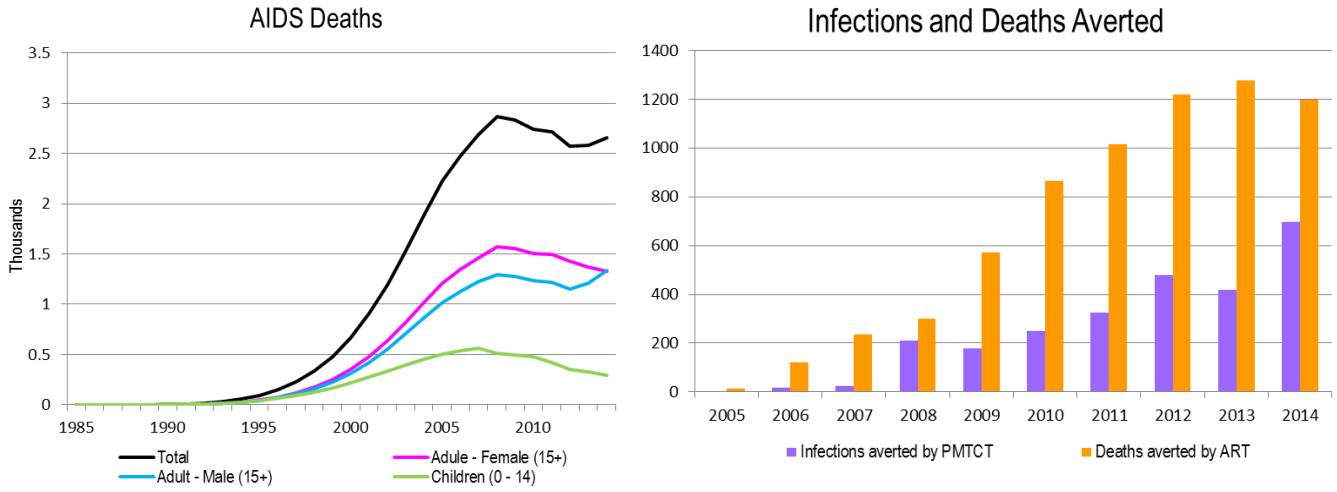


Figure 5: Impact of National AIDS Response

3 National Response to the AIDS epidemic

Programmatic Area	Indicator	2013	2014
VCCT	No. of VCCT sites	689	689
	No. tested and received results	285,275	169,818
	No. tested positive	8,796	5,439
PMTCT	No. of PMTCT sites	691	691
	No. of pregnant women tested and received results	219,912	165,707
	No. of pregnant women tested positive	3,198	2,126
	No. of HIV+ pregnant women on ART for own health	305	206
	No. of HIV+ pregnant women receiving ARVs at ANC	2,381	2,585
	No. of HIV+ pregnant women receiving complete course of ARV prophylaxis	1,179	530
	No. of HIV+ pregnant women in need of ART prophylaxis	3,368	3,055
Blood Safety	No. of blood units screened for HIV, Syphilis and Hepatitis B and C	37,940	30,289
Condoms	No. of male condoms distributed	4,755,293	2,466,936
	No. of female condoms distributed	7,000	2,100
Total Facilities	No. of Health Facilities	1,295	1,434
	Public Facilities	1,142	1,265
	Private Facilities	153	153

Table 2: Programmatic Data for Prevention

Source: NAS/NACP, 2013 and 2014

3.1 Prevention

Key prevention strategic documents guide HIV prevention programming in the country; these documents include the Strategic Plan towards Elimination of Mother to Child Transmission of HIV and for Paediatric HIV Care 2013-2015, Population Size Estimation of Key Populations, National HTC Guidelines 2013, National Strategic Plan for Comprehensive Condom Programing in Sierra Leone PMTCT technical guidelines. Also of significance importance was the National AIDS Spending Assessment (NASA) Report 2013. Furthermore the Poverty Reduction Strategy Paper III (Agenda for Prosperity 2013 to 2017) recognizes HIV and AIDS as an important human development issue and

prescribes clearly the policy direction of Government in its fights against the epidemic. Finally, an Operational Plan for 2014 and 2015 was created which prioritized programmes and interventions to focus on the most effective interventions that have the potential for halting and reversing the epidemic by 2015 and increasing value for money from the response implementation.

Results from the DHS 2013 Preliminary Report show encouraging results from the prevention efforts that have been implemented throughout the years. Knowledge about HIV and AIDS is high; 96% of men responded that they have heard of AIDS compared to 94% of women. Awareness is higher in urban areas and among those with secondary or higher education. Additionally, 68% of women and 79% of men aged 15-49 know that consistent use of condoms is a means of preventing the spread of HIV; 75% of women and 83% of men know that limiting sexual intercourse to one faithful and uninfected partner can reduce the chances of contracting HIV. While 74% of men know that both using condoms and limiting sexual intercourse to one faithful and uninfected partner can reduce the chance of being infected with HIV, only 63% of women are aware of this.

Having multiple concurrent sexual partners and inconsistent use of condoms with non-regular partners increases the risk of contracting HIV and other sexually transmitted infections such as syphilis. The DHS 2013 Preliminary Report indicates that 6% of women reported that they had two or more partners in the last 12 months. Among women who had two or more partners in the last 12 months, only 5% reported using a condom at the last sexual intercourse. Among all female respondents who have ever had sexual intercourse, the mean number of partners in their lifetime is 2.5. Reporting multiple sexual partners is more common among men, as 25% of men age 15-49 reported that they had two or more partners in the last 12 months. Among men who had two or more partners in the last 12 months, only 13% reported using a condom at the last sexual intercourse. Among all male respondents who have ever had sexual intercourse, the mean number of partners in their lifetime is 6.6.

Despite the progress noted in the 2013 DHS, the Ebola outbreak of 2014 significantly affected efforts towards preventing HIV. Public movement was limited and homes were quarantined, thus men and women were not able to access condoms as readily. Programs aimed to raise awareness on condom use, HIV knowledge, and safe sex was halted due to inability to gather groups according to State of Emergency decree. The exact effects of lack of prevention programming have not been measured, however anecdotes from PLHIV groups regarding lack of condom access or NGOs unable to implement prevention interventions illustrates the gap in provision of services to beneficiaries.

3.1.1 PMTCT

Prevention of Mother-to Child Transmission (PMTCT) is critical in ensuring that we achieve the vision of zero new infections encapsulated by UNAIDS Strategy. Some of the proposed strategies for achieving this include: Scaling-up of quality PMTCT services as well as upgrading of the PMTCT infra-structure, intensifying community mobilization and participation, increased male involvement, strengthening referral and linkage mechanisms as well as capacity of PMTCT service providers.

In the period under review, prevention efforts were scheduled to be scaled up, however the Ebola outbreak prevented many women from accessing ANC and PMTCT services due to fear of health services or restricted movement due to changes in transport curfews. According to NAS/NACP programme data, nearly every indicator showed significant decrease in results. The number of pregnant women tested for HIV and received their test results decreased by 25% from 219,912 to 165,707

between 2013 and 2014. Regarding positive pregnant women receiving complete course of ARV prophylaxis for HIV, figures in absolute terms decreased from 1179 to 530.

3.1.2 EID

Although paediatric care services are now provided in 19 sites including 12 District Hospitals and 7 peripheral health units in the western area, EID activities were halted due to the Ebola outbreak in Sierra Leone. As health workers were accused of propagating the spread of Ebola, bloodletting activities were difficult to implement. Since May 2014 most pregnant women do not go to clinics for PMTCT services simply because of fear of the Ebola Virus which can easily be caught by simple body contact and body fluids. During this period, most women delivered at home. This had very negative consequences on the health sector resulting in poor performance of key indicators and negatively impacting the gains made in previous years. The threat to the HIV program prompted the Global fund to support the HIV Response with an Ebola Impact Mitigation Intervention aimed at tracing PLHIV defaulters and sensitising them through their peers for adherence. The result of this intervention boosted health service utilization and treatment adherence considerably.

3.1.3 HCT

HCT is an important entry point for most forms of HIV prevention and control interventions including PMTCT, treatment and care. In 2013, a total of 285,275 people were counselled, tested and received their results, while only 169,818 were served in 2013. This result indicates that people who were tested for HIV have decreased by 41%. Voluntary Confidential Counselling and testing was undertaken in both PMTCT sites and VCCT stand-alone sites, coupled with outreach activities. There are 689 VCCT sites since 2012. As mentioned earlier, the effect of the Ebola Virus disease has adversely affected Health service utilization, especially for bloodletting related activities and it will take some time for the communities to rebuild the confidence in the system and subject themselves voluntarily for testing.

3.1.4 Blood Screening, Condom Promotion

On a whole, a total of 30,289 blood units were collected and all (100%) were screened for HIV, syphilis, and hepatitis B and C, in conformity to national guidelines. About 2,466,936 male condoms were distributed in 2013; a significant decrease of 48% from the previous year.

3.1.5 Health Facilities

A total of 1,434 health facilities were reported to be available in Sierra Leone. Majority of the Health facilities (88%) were government while (11%} were run by private entities or FBO/NGOs.

3.2 Care and Support

Programmatic Area	Indicator	2013	2014
TB/HIV	No. of HIV+ persons screened for TB	9,048	10,476
	TB sites	170	170
OVC	No. of OVC provided support	1,805	2,418
Nutritional Support	No. of PLHIVs provided with nutritional support	2,922	3,053

Table 3: Programme Data for Care and Support

Source: NAS/NACP, 2013 and 2014 Programme Data

Tuberculosis (TB) is one of the common opportunistic infection among PLHIV. Therefore, in order to improve the quality of life of PLHIV co-infected with TB, it is necessary for them to have access to treatment of TB. According to the recent (2009) report on Pulmonary Tuberculosis among PLHIVs, 14% are co-infected with TB, 7% among women and 21% among men. Programme data for 2014 from the ministry of health show that a total of 10,476 HIV positive persons were screened for TB in HIV settings.

Adequate and a well-balanced nutrition decrease the risk of rapid progression of HIV to AIDS and increases PLHIV capacity to fight opportunistic infections. According to the NAS programme data, 3,053 PLHIV were provided with nutritional support in 2014; an increase from 2013 (2,922). In the same reference period, OVC support increased from 1805 to 2418 in 2014; though these are still significant decreases from 2012 (8114). This decrease is attributed to a shift in focus to treatment rather than nutritional support by the main donor.

During the Ebola outbreak, interventions related to OVC were halted while nutritional support was supported by other NGOs in order to aid PLHIV quarantined homes.

The Network of HIV Positives in Sierra Leone (NETHIPS) had a total of 33 support groups nationwide. NETHIPS has played a significant role of mobilizing PLHIV and the general population to access various HIV and AIDS services that include PMTCT, VCCT, treatment, nutritional support, and raising awareness to reduce stigma and discrimination.

3.3 Treatment

Programmatic Area	Indicator	2013	2014
ART	No. of ART sites	136	136
	No. patients currently on treatment	9,065	10,672
	Adults	8,680	10,289
	Children	385	383
	No. in need of ART	27,490	22,782

Table 4: Program Data for Treatment

Source: NAS/NACP, 2012 and 2013 Programme Data

Early initiation of treatment for PLHIV improves their quality of life and prolongs their survival. Since the provision of free ART policy came into effect in 2005, there has been a significant increase in the uptake of ART services and subsequent scale-up of ART sites. Between 2013 and 2014, uptake of ART increased from 9,065 to 10,672 clients. According to the 2014 NAS report of Survival Analysis for PLHIV on ART The study suggested a survival rate of 93% with a retention rate of 71% for adults and children.

3.4 Financing

Although a NASA was not conducted for 2012 and 2013, the most from previous NASAs are able to illustrate the priorities of expenditures within the national AIDS response. Table 5 outlines the expenditure priorities in the most recent NASA and Figure 6 illustrates the spending trends since 2006.

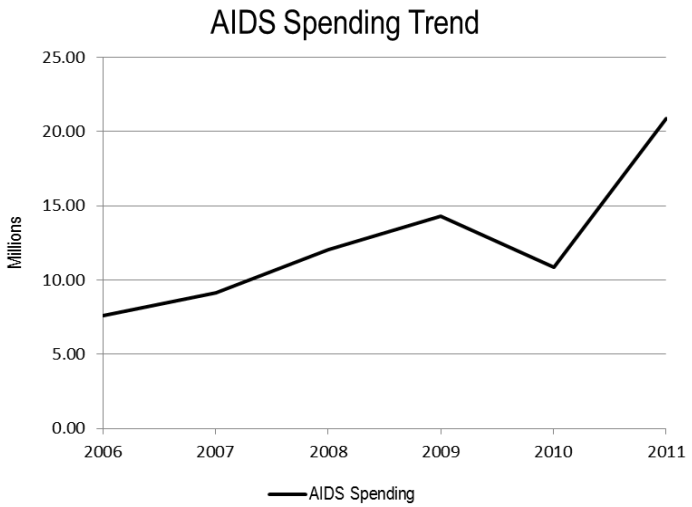


Figure 6: AIDS Spending Trend 2006 - 2011

	2010		2011	
	Amount (USD)	**%**	**Amount (USD)**	**%**
HIV and AIDS Expenditure by Funding Sources				
Total Spending	**10,875,295**	**100**	**20,905,243**	**100**
Public	253,499	2.3	168,584	0.8
Private funds	0	0.0	40,385	0.2
International	10,621,796	97.7	20,696,274	99.0
HIV and AIDS Expenditure by Programmatic Area				
Prevention	3,957,230	36.4	3,544,829	17.0
Care and treatment	1,514,910	13.9	1,960,743	9.4
OVC activities	67,170	0.6	822,896	3.9
Program management activities	4,168,193	38.3	12,680,742	60.7
Human resources	482,531	4.4	855,954	4.1
Social protection and social services	161,114	1.5	326,363	1.6
Enabling environment	524,147	4.8	486,545	2.3
Research activities	0	0.0	227,171	1.1

Table 5: AIDS Expenditures for 2010 and 2011

Source: NASA 2010/2011 Report, NAS, Sierra Leone

The total spending on HIV and AIDS in Sierra Leone was $10,875,295 (SLL 44,588,709,500) and $20,905,243(SLL 85,711,496,300) in 2010 and 2011 respectively using an exchange rate of $1:SLL4100. Funding in 2010 decreased from the $14,309,550 level in 2009 due to a global capping on HIV financial resources. International funds constituted an overwhelming majority (97% in 2010 and 99% in 2011) of financial resources for the HIV response in Sierra Leone. Public funds accounted for 2.3% of the total spending in 2010 but decreased to 0.8% in 2011. Private funds remained unimpressive, however, the trend depicts that there is an increased interest amongst private financing sources in contributing towards the HIV response in Sierra Leone with a contribution of 0.2% in 2011. Programmatic decisions on the HIV response were mainly by the international donors in 2010 but the National AIDS Secretariat took the centre stage in 2011 and If this trend continues, it will engender

country ownership and stewardship of the national response. The providers of the HIV goods and services in both years were by the public sector which demonstrates the donor's confidence in Government to deliver quality service to the populace. However, it is worth of note that the services rendered the bi- and multilateral entities were mainly in the areas of programme management, coordination, monitoring, and evaluation. The proportion of funds spent on prevention (36% in 2010 and 17% in 2011) and treatment (14% in 2010 and 9% in 2011) generally decreased. However, the proportion of financial resources expended on programme management and administration rose to 61% in 2011 compared to 38% in 2010 which were mainly by the Global fund through the Directorate of Planning and Information for salaries, staff tax and other fringes. This resulted in high expenditure on non-targeted interventions in both years with the general population benefitting from only a marginal proportion of the total expenditure on HIV (18% in 2010 and 9% in 2011).

3.5 Policy/Strategy Development and Implementation

3.5.1 Political Commitment

Since the first case of HIV/AIDS was diagnosed in Sierra Leone in 1987, the Government of Sierra Leone (GoSL) has maintained a strong political commitment to stopping the HIV/AIDS epidemic. In recent years, His Excellency the President Ernest Bai Koroma who is the Chairman of the National AIDS Council(NAC) has taken the lead in mobilizing the nation on Key HIV events such as World AIDS Day, Partnership Forum and chaired the National AIDS Council meetings, which is the highest policy-making body in the national response. This act has raised the profile of the national response to HIV/AIDS in Sierra Leone as most dignitaries, Ministries, Institutions, MDAs, national and International partners attend and express their concerns and commitment to the national response. At these meetings, members are urged to be involved and to ensure that HIV AIDS is mainstreamed into their main businesses. As a policy, HIV AIDS is a cross cutting issue for all Government institutions and ministries and contained in both the Agenda for Change (2008-2012) and the agenda for Prosperity (2013-2017). As a cross cutting theme, HIV AIDS commitment and performance of Ministries and MDA is assessed annually by the Government through the Performance Tracking Tables (PTT) as part of their management agreement previously signed with the President

3.5.2 Participation of Civil Society Organizations

The bulk of the people championing HIV AIDS issues and leading the national response in Sierra Leone are from Civil Society Organizations. Most notably amongst them is NETHIPS, an umbrella Organization for the Network of People living with AIDS that currently have over 40 registered Care and Support organizations they oversee. This organization in partnership with the Ministry of Health and Sanitation (MOHS), national and other International Non-Governmental Organizations, WHO, UNAIDS, Statistics Sierra Leone (SSL) have conducted several studies including the Stigma Index Study in 2014. NETHIPS has given a human face to the epidemic playing a significant role in all sectors of the HIV/AIDS response, including awareness raising, VCCT, treatment, care and support services. It is represented in the National AIDS Council, in the CCM, BCAASL and at many key coordinating entities. The organization and other CSOs have advocated for laws focusing on the Human Rights of PLHIV's and women. Apart from this the National AIDS secretariat which is a coordinating body, works with about 30 other organizations directly engaged in the implement HIV AIDS activities throughout the country. In particular, CSOs have been instrumental during the EVD outbreak in mobilizing their networks for EVD sensitization and awareness, and provision of nutritional and social support.

3.5.3 Line Ministries

Since its inception in 2002, the National AIDS Secretariat had serve as the lead organization supporting Line Ministries in the national response. It has conducted sensitization seminar, and identified technocrats within these ministries to serve in various Technical working groups including the M&E technical working Group. The Line Ministries have also streamed lined HIV AIDS into their core businesses and identified HIV AIDS Focal persons in each ministry to spearhead workplace programs. HIV Focal Points have shown marked commitment to HIV work place issues in their ministries and their commitment to HIV is also being assessed annually through the Government Performance Tracking Tables (PTT).

4 Best Practices

Sierra Leone has made much progress in its national AIDS response in the past few years. Most notably, three experiences that it has undergone which it can share as a good case practice are (1) Improving medical records systems, (2) EVD Response support: Paediatric tracing project, and (3) Implementation of an EID Programme.

4.1 Improving medical records systems - SOLTHIS

Rationale:

A paper-based records system is used for daily hospital patients' records; these records are then used to create a monthly report. It is cumbersome for the HIV counsellors to compile monthly reports in addition to their routine tasks as it requires manual aggregation of data from patient files and registers. The large volume of paper work also makes it hard to have proper patient follow up, in addition to not being environment friendly.

Activity:

Open MRS, a computerized medical records system, was installed and operationalized within the two largest hospitals in Freetown which handled the largest volume of adults and children with HIV/AIDS; Connaught hospital and Ola During Children's hospital (ODCH). At Connaught hospital, an Open MRS database was set up and the staff given initial training. The database was set up based on the existing patient files. A data entry clerk was hired to do the data entry during visits. Some additional data clerks were hired to do a backlog data entry of all files that had not been entered in the system.

Results:

All patient charts at Connaught hospital HIV clinic were computerized in Open MRS which resulted in easier management of patient records and identification of duplicate records. As a result of this initial database, Open MRS EMR was also installed at ODCH, thus staff at Connaught and ODCH received training on EMR.

Lesson:

Setting up an EMR like Open MRS can help organize the patient information in HIV facilities in Sierra Leone. But for EMR projects to be successful in Sierra Leone there has to be a strong sense of ownership by the national actors. The facilities in which the EMR is to be set up should have the capacity to endure long dry spells without electricity, have enough manpower to uninterruptedly do the data entry, and have the financial capacity to cover maintenance costs of the equipment.

Next steps:

Add pharmacy data into the database so that we can pilot a point-of-care system in the HIV clinic. Upon anticipated success of this pilot, we hope that the national program shall take up this project and install this EMR at least in all the district hospitals.

4.2 EVD Response Support: Paediatric Tracing Project – SOLTHIS, HAPPY, UNICEF

Rationale:

The Ebola outbreak increased the defaulter rates countrywide. HAPPY – an NGO working with children affected by HIV/AIDS, proposed and carried out a paediatric patient tracing project. This project was funded by UNICEF and supported both technically and operationally by Solthis. Among pregnant women and children from the sites that were selected for the intervention, 603 women and children of the total 1,574 on ARVs had defaulted their treatment.

Activity:

Eight districts were selected, from which HIV positive children and pregnant & lactating women that had defaulted their treatment as of August 2014 were included to be traced over a period of three (3) months. The aim of this study was to have the defaulting PLHIV back on treatment. The objectives were to have patients return back to the facility, to have medication delivered to those patients that couldn't return to the facility, and to estimate the incidence of Ebola amongst the defaulting PLHIVs. Trained volunteers from HIV support groups were recruited to trace the defaulters under the supervision of the NACP HIV counsellors. In order to convince them to return to care, defaulters were called up to a maximum of 3 times, upon failure of which a maximum of two home visits was made. The phone call and home visit outcomes were systematically recorded on phone log and home visit forms respectively. Through the HAPPY coordinator, the call and home visit logs were then submitted to the Solthis HIS for data cleaning, entry and analysis.

Results:

From the first month, the tracers were able to reach out to 569 (94.4%) of the defaulters, of whom at least 50% received their treatment. 47% returned to the facilities while 8% had their medication delivered at home. A total of 14 homes had been quarantined because of Ebola.

Lesson

Tracing can be useful to have patients back in care. Tracing using peers (PLHIV) seems to be effective and relatively cheap. Tracers can reach patients from all parts of the country, even very remote places. Patients are afraid to come to the facility, but with re-assurance they can come back. Many of them had to be followed up (called or visited at home) before they could receive their treatment. The tracers have to be extra careful so as to avoid being infected with Ebola.

Next steps:

The pediatric tracing project should be extended:

1. In length. Initially for a period of three (3) months, it can be extended over a longer period of time, even after the EVD outbreak.
2. To the entire country.

4.3 NETHIPS support to Ebola outbreak response

Rationale:

Ebola outbreak had a worrying impact on PLHIVs in Sierra Leone. At the start of the outbreak, PLHIVs in quarantined households stood the risk of under nutrition and subsequently poor treatment

adherence. Although Government, through the World Food Programme, provided food to quarantined households, there was a general opinion that food was not enough to sustain people until the end of quarantine period. Inadequate food for the quarantine period has serious impact on treatment access for PLHIVs particularly in quarantined households. Without treatment issues of default and drug resistance are likely to become serious challenges for the national HIV response programme.

Activity:

NETHIPS (The Network of HIV Positives in Sierra) worked with partners to protect its members from contracting Ebola and also facilitate access to ART. NETHIPS adopted a strategy to strengthen the capacity of PLHIVs as volunteers to reach out to HIV positive clients either by phone, or through visits to their homes, so that they can access their life saving antiretroviral drugs. This involved engaging community volunteers on Ebola awareness campaigns, tracing PLHIV defaulters and LTFU to refer them to health facilities and provision of nutritional support to TB and HIV clients.

Results:

The immediate results of the activities are as follows:

- Identified and trained 300 PLHIVs (25 per district x 14) as defaulter tracers
- Provided transport incentive and monthly stipend to 300 PLHIV in defaulter tracing
- Engaged community volunteers on Ebola awareness campaign in all districts in Sierra Leone
- 773 defaulters and LTFU were traced and referred to health facilities out of 4321 cases

Lesson

- PLHIVs can play critical role in peer counseling for treatment uptake and adherence
- The intervention carried out is an alternative option of reaching PLHIVs at home with treatment encourages treatment uptake
- Nethips as umbrella organization should be involved as key partner in ART management

Next steps

- Follow up to ensure that defaulters stay on treatment
- Work with treatment facilities to ensure willing PLHIVs are referred to support groups
- Advocate for PLHIV active involvement in defaulter tracing

4.4 AHF support to Ebola outbreak response

Rationale:

AHF started operations in Kenema in June 2014. An audit of clinic registers revealed that there were 476 active clients; of which 309 clients received ARVs and/or Cotrimoxazole in June and July consecutively. However, the number of clients who received treatment in April and May were 334 and 351 respectively; that was before Kenema became an EVD epicentre. We realized that the number of defaulters was increasing and number of patients utilizing healthcare services were dwindling compared to the months preceding the Ebola outbreak in Kenema because of fear of being infected with EVD by staff, or being tested Ebola positive and sent to the isolation unit. Clients who felt they were not sick would request a relation or friend to pick up their drugs from the clinic or call a staff of the clinic to drop off their drugs at an agreed location other than the clinic.

Activity:

Considering that AHF is patient centered and wants to provide quality care for clients and patients, the clinic was relocated to the NAS office to provide a safe working environment for staff, partners and clients. Twelve (12) HIV support group members were identified in collaboration with the NACP staff and NETHIPS Kenema branch, to trace defaulters and encourage them to come to the clinic for care and treatment. The aim of the intervention was to ensure that at least 95% of registered clients and patients receive ARVs during the period of the EVD outbreak. The support group members received a day's orientation on how to trace HIV clients to ensure non-disclosure of clients' status and prevent stigma, to be able to identify sick patients and notify clinic/hospital staff or encourage them to seek medical support, to refill ARVs at community level for stable clients who do not want to come to the clinic and most importantly to avoid body contact as they visit clients at home. They visited the homes of all registered defaulters and lost to follow up clients. Patients who were stable are given 3-months' supply of ARVs. Clinic staff make follow up calls on difficult clients as monthly top up is provided for all AHF staff. A weekly allowance of Le50,000 is given to the support group members for tracing defaulters and refilling of ARVs for stable patients at community level. PPEs and a weekly risk allowance of Le 250,000 are given to all AHF and NACP staff as they provide care and treatment at clinic level. Monthly meetings are held with the support group members to discuss challenges, support needs and the way forward.

Results:

Increase in number of clients receiving ARVs and/or Cotrimoxazole monthly thereby decreasing the number of defaulters especially amongst the adult clients - in August 527 clients received ARVS and/or Cotrimoxazole with 18 paediatric defaulters; in September 544 clients with 12 paediatric defaulters and in October 563 clients with 12 paediatric defaulters and in November 624 with 6 paediatric defaulters. By the end of October, enrolment in the two support groups in Kenema increased from 68 and 54 members to 175 and 152 members respectively as a result of the house to house visit in search of defaulters. Staff and support group members continue to show increased commitment in ensuring patients receive care and treatment

Lesson:

Success of any programme depends largely on the involvement of community members. The community refill initiative had been a success not only because it provides direct access to people in their comfort zone or setting; but also because of involvement of the support group members which gives a feeling of ownership and increases individual/community commitment. Follow-up by committed healthcare providers and community based structures had increased ARV uptake and numbers enrolling in support groups during the period under review. Involvement of all key stakeholders (AHF, NAS, NACP, NETHIPS, MOHS PHU staff) increases participation, build capacities and makes it possible for the healthcare workers to provide to care for larger numbers of patients even in the most difficult period. Staff continued to be courageous and committed despite the risks involved in testing and caring for patients because they are motivated by the concern shown and incentives being provided by AHF management

Next steps:

- To work with NETHIPS and/or their support groups in Freetown to start tracing defaulters and where possible refill ARVs at community level.

- Increase weekly allowance to support group members during the EVD outbreak to motivate them to continue tracing and where possible refill at community level
- The strategies used in Kenema has been integrated in our 2015 budgets and will be implemented as part of our normal HIV programming and will be replicated in all our operational areas

Quote from an implementing actor

"I am happy to be part of the team reaching out to our compatriots to provide care during this difficult period, when most of our clients are scared to visit medical facilities. I hope the successes registered will be replicated in the whole of the district" Gladys Gassama, Nurse and Counselor - Kenema Clinic

Quote from Beneficiary

"I was really confused when Kenema became an Ebola hotspot because our members were too scared to go for treatment and a good number of them were getting sick. Your intervention came at the right time. We were not only able to get them to receive their drugs, but we were able to locate most of those already considered lost to follow up and those not in support groups were enrolled in a support group. It feels good to note that you care for our welfare to the point that you reach out to us when others are scared or not willing for fear of the unknown. We appreciate the good work you are doing" Patrick Kpakra, Regional Coordinator, NETHIPS

5 Major Challenges and Remedial Action

5.1 Major Challenges

Notwithstanding the above achievements, the National AIDS Response still faces several challenges:

- Ineffective coordination structures/entities and mechanisms resulting in little or no coordination at the sub-national level
- Little or no enforcement of the policies and laws and limited options for redress of those whose rights are violated.
- High staff attrition rates and need for increased skill capacity building
- High dependence on external funding and weak mobilization efforts for domestic resources
- Low uptake of HCT services as well as low retention of ART
- Strong support for scale up of interventions, but maintenance of the quality of these services is unclear
- Inadequate lab equipment
- Frequent stock-outs of OI drugs and laboratory reagents.
- Weak PSM processes and linkage to M&E
- Stigmatization and discrimination of the PLHIV and the key populations which often constrains them for accessing services
- M&E activities are still largely GF focused with non-GF supported activities not being captured
- Data management, knowledge management and sharing systems are still weak

5.2 Remedial Actions

To overcome the above challenges, NAS is planning on implementing the following activities:

- Develop a Resource Mobilization Strategy (DRM) in order to more efficiently and sustainably finance the National AIDS Response
- Integrate activities from the M&E Assessment into the M&E TWG ToR
- Provision of targeted programming for key populations as per findings of the PSE
- Implementation of Standard Operating Procedures for data monitoring
- Scale up of HCT, ART, PMTCT (EID) interventions

6 Support from the country's development partners

In 2010, the Global Fund (GFATM) signed a $90,000,000 million project with NAS for 5 years. It has disbursed $42,500,000 from 2011-2013 with an additional $16,361,320 in 2014 and $6,024,320 in 2015. Due to the negative consequences of the Ebola virus disease in the country, the GFATM is considering the possibility of flexible reprograming to enhance the HIV program intervention. The National AIDS Secretariat is also partnering with KFW program and had received substantial support from the Government of Sierra Leone for its interventions.

Solthis has been actively involved in strengthening electronic data collection within the facilities and providing technical support and guidance within the facilities. AHF has been supporting treatment and EVD impact mitigation activities throughout 2014.

The UNCT has provided financial and technical support in 2014. Most notably, they have assisted in crucial studies such as the Stigma Index Report, Survival Study 2013, Investment Case Scenario Assessment, and the Data Verification Exercise of PLHIV. Additionally, they have provided funds and technical support for the scale up of PMTCT, PLHIV livelihood activities and EVD impact mitigation activities.

7 M&E Environment

The M&E system for the national AIDS response is coordinated by the M&E team of the National AIDS Secretariat. A team leader and 3 M&E officers oversee the M&E processes and activities. They are also supported by 4 M&E officers within the National AIDS Control Programme who oversee programmatic monitoring and research for the health / clinical data. The work of the M&E teams is guided by the national M&E Plan which is complimentary to the National Strategic Plan of 2011 – 2015. The teams also conduct quarterly routine supervisory field visits to collect data and provide technical assistance and M&E guidance to monitoring in the sub-national offices. A national M&E technical working group comprised of national and subnational stakeholders convenes once a quarter to provide guidance and oversight on on-going research and M&E activities. The METWG Terms of Reference (ToR) were updated according to the needs outlined from the 2013 M&E Systems Assessment.

According to the 2013 M&E Systems Assessment, the main weaknesses in the M&E system are (1) organizational structures, (2) human capacity, (3) Partnerships, and (4) Subnational and national databases. [Note that Component 7: Routine Monitoring was assessed in a different manner] The main strengths of the M&E system were found to be (1) Advocacy, Communication and Culture, (2) Surveys and Surveillance, (3) Supervision and Auditing, and (4) Evaluation and Research. Refer to Figure XXX for the overall M&E Assessment.

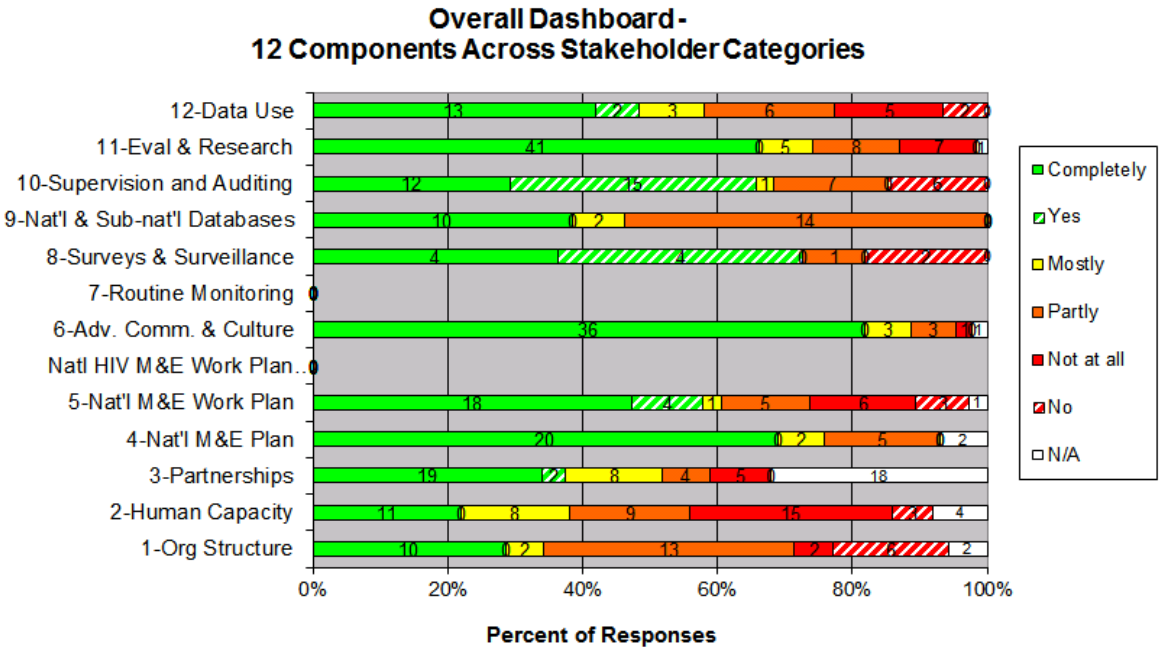


Figure 7: M&E Systems Assessment 2013

Key studies / reports that were completed during 2014 are:

- Stigma Index 2014
- BSS for General Population and Key Populations

- Investment Case Scenario Assessment
- Survival Study 2013

According to the NSP MTR, the main challenges and limitations of the M&E system are the following.

- M&E activities within the NAS places a great emphasis on Global Fund based M&E activities
- Lac of information regarding non-GFATM activities
- Lack of staff career planning and capacity building leads to low staff retention rates
- Lack of human capacity (number of staff and level of skills) for M&E at all levels of the national response
- Lack of nationally standardized data collection tools and processes apart from those delivered to the GFATM
- Decreasing funds for M&E activities is hampering implementation of critical M&E activities
- Limited documentation of HIV/AIDS activities often hampers the data collection and reporting
- Uncoordinated research and evaluation efforts between partners

To address these challenges, NAS is in the process of implementing the following:

- Training on a newly created Standard of Operations for all monitoring tools used within sub-national and national level
- M&E training for staff within NAS, NACP and partnering agencies
- Working closely with documentation and publications unit of NAS to ensure an updated repository of documentation
- Initiating the research agenda and the METWG mandate of overseeing it
- In order to strengthen the M&E work, the following are immediate needs for technical assistance
- Funds for NASA 2012/2013 and piloting an institutionalized NASA
- Funds to support additional research and evaluation outlined in the research agenda
- Technical support in training organizations on M&E foundations, developing evaluations / analysis and strengthening / creating an electronic monitoring system for HIV related data at the sub-national and national levels

Annex A: List of GARPR Validation Workshop Institutions

- National AIDS Secretariat
- National AIDS Control Programme
- HIV M&E Technical Working Group
- Dignity Association
- UNAIDS
- SWAASL
- UNICEF
- COPAASL
- SOLTHIS
- NECHRAS
- NETHIPS
- SLYDCL
- HRCSL
- HACSA
- RODA
- WICM
- SSL
- Ministry of Youth
- Ministry of Finance
- Ad Media
- Child Fund - SL
- PPASL
- SLADA / Care SL
- Radio Democracy
- HSS - MOHS
- CCYA
- Star Radio