Sierra Leone

National HIV Prevention Strategy

2011-2015

March 2012

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
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 Organisation
CCM	Country Coordination Mechanism
COPSAASL	Coalition of Public Sector Against HIV and AIDS in Serra Leone
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DAC	District AIDS Committee
DPC	Disease Prevention and Control
EID	Early Infant Diagnosis
ETWG	Extended Technical Working Group
FP	Family Planning
FSU	Family Support Unit
GF	The Global Fund on HIV/AIDS, TB and Malaria
GoSL	Government of the Republic of Sierra Leone
GWT	Gender Working Team
HARA	HIV and AIDS Reporters Association
HBC	Home Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HR	Human Rights
IDU	Injecting Drug Users
IEC	Information, Education and Communication
IMC	Independent Media Commission
INGO	International Non Governmental Organization
JPR	Joint Programme Review
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
MoD	Ministry of Defence
MoHS	Ministry of Health and Sanitation
MoT	Modes of Transmission
MoU	Memorandum of Understanding
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
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
PHC	Primary Health Care
PHDP	Positive Health, Dignity and Prevention
PHE	Public Health Educators
PHU	Peripheral Health Units
PIHCT	Provider Initiated HIV Counseling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSM	Procurement and Supply Management
PSO	Private Sector Organization
RH	Reproductive Health
RST	Regional Support Team
SL	Sierra Leone
SLDHS	Sierra Leone Demographic and Health Survey
SLIRAN	Sierra Leone Inter-religious AIDS Network
SLYCHA	Sierra Leone Youth Coalition on HIV and AIDS
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SWAASL	Society of Women and AIDS in Africa, Sierra Leone Chapter
TBA	Traditional Birth attendants
TTI	Transfusion Transmitted 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
USP	Universal Safety Precautions
VOW	Voice of Women
WFP	World Food Programme
WHO	World Health Organization

FOREWORD

The National HIV/AIDS Secretariat is pleased to make this ***National HIV Prevention Strategy*** available to all partners engaged in the national response to HIV/AIDS. This is our first comprehensive strategy on the prevention of new HIV infections in the country, and the need for such a strategy has never been greater. The strategy takes into account and reflects the priorities set in the National HIV/AIDS Strategic Plan 2011 – 2015. Furthermore, it builds on the 10 years' experience of our country in implementing the multi-sectoral strategy to HIV/AIDS prevention, treatment, care and support.

Although Sierra Leone has already made great efforts to stabilize the epidemic among the general population and pregnant women in particular, the national estimate of people living with HIV/AIDS is slowly approaching 60,000. But these statistics tell only part of the story. The annual number of new HIV infections currently estimated at 5,844 outstrips by far, the annual enrolment into antiretroviral therapy (ART). In addition to this clinical issue, the existing behavioural and structural HIV prevention interventions in the country still fall short of the universal target in terms of both coverage and access to services.

This Prevention Strategy aims at intensifying measures and actions to prevent HIV and to mitigate its impact in a comprehensive and complementary way. It is intended to serve as guideline for all sectors and partners engaged in HIV/AIDS activities. Programme Managers can further develop their activities set forth here according to their respective tasks, functions and capabilities.

Please note that this Strategy for preventing new HIV infections in Sierra Leone has been developed almost entirely by our strategic partners who have been a source of ideas and support. This is testimony to their commitment and contribution to the national response to HIV/AIDS in every sphere and in every community across the country.

However, no prevention strategy can stand alone in assuring that it will prevent new HIV infections, we must commit ourselves to addressing the issues we have documented in the strategy that hamper effective HIV prevention in Sierra Leone. We hope to continually engage with you in the implementation of our National HIV Prevention Strategy and I trust you will all remain committed to supporting our course of Zero New HIV infections by 2015.

Dr. Brima Kargbo
Director

ACKNOWLEDGEMENTS

This National HIV Prevention Strategy represents Government's continued effort and commitment to achieving Zero New HIV Infections in Sierra Leone by 2015. Many individuals from various institutions who provided information and relevant data informed the writing of this strategy. Such wealth of information will no doubt be tremendously useful in charting our roadmap to achieving Zero new HIV infections and meeting the Universal Access Targets for Sierra Leone. We would like to acknowledge their contributions and shared experiences to the entire process.

We are grateful to the National Consultants, Messes Dominic Lamin and Kalilu Totangi who facilitated the compilation of information and discussions by displaying enormous tact, determination and attention to detail. We would like to thank all the stakeholders they interviewed and those who contributed information during the drafting and finalization of this strategy.

We offer our personal thanks to the team established to guide and to serve as source of ideas and support to the entire process. Specifically, we would like to thank the National HIV/AIDS Secretariat Staff, Messes Abdul Rahman Sessay and Abu Bakarr Koroma, the UNAIDS staff Mr. Chibwe Lwamba, Ms. Helen Lane and Ms. Aki Yoshino and the UNICEF Staff, Mr. Edmond Makiu.

We are also grateful to the UN Family in Sierra Leone and the sub-Region who contributed their time, effort in providing ideas to finalize this Prevention Strategy.

This Prevention Strategy would not have been possible without generous financial and other support from the UNICEF. We appreciate the Agency's continued support to strengthening our national response to HIV/AIDS.

Introduction

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 on the north and northeast by the Republic of Guinea, on the south and southeast by the Republic of Liberia and the west and southwest by the Atlantic Ocean. Administratively, the country is divided into four regions, namely the Western Area, Northern, Southern and Eastern provinces. The regions 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.

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% per annum during the 1985-2004 periods. 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%of the population is under age 15 years and adolescents accounted for 19.4% of the estimated population in 2004.

The first case of HIV/AIDS in Sierra Leone was diagnosed in 1987 and currently the number of people living with HIV/AIDS is estimated at 50,000. The country adopted a multi-sectoral strategy in 2002 by establishing the National HIV/AIDS Secretariat (NAS) as the Secretariat for the National AIDS Council, to provide policy and strategic direction including monitoring, mobilizing, managing resources and coordinating partners engaged in the response.

From the outset of the multi-sectoral strategy in 2002, prevention of HIV transmission remains the most important priority of the national response. The key aspect of this has been the mobilization of society. In this regard, the Government of Sierra Leone has just commenced the implementation of the second National Strategic Plan on HIV/AIDS 2011 – 2015 that aims at ***Zero New HIV Infections by 2015.*** This is the second multi-sectoral strategic plan and the first comprehensive results-based strategic plan on HIV/AIDS that aligns HIV prevention intervention resources to sources of new infections. The key prevention interventions in this strategic plan are to ensure a significant increase in the number of young people adopting key HIV prevention behaviours, virtual elimination of vertical transmission of HIV and ensuring safe blood transfusion practices throughout the country.

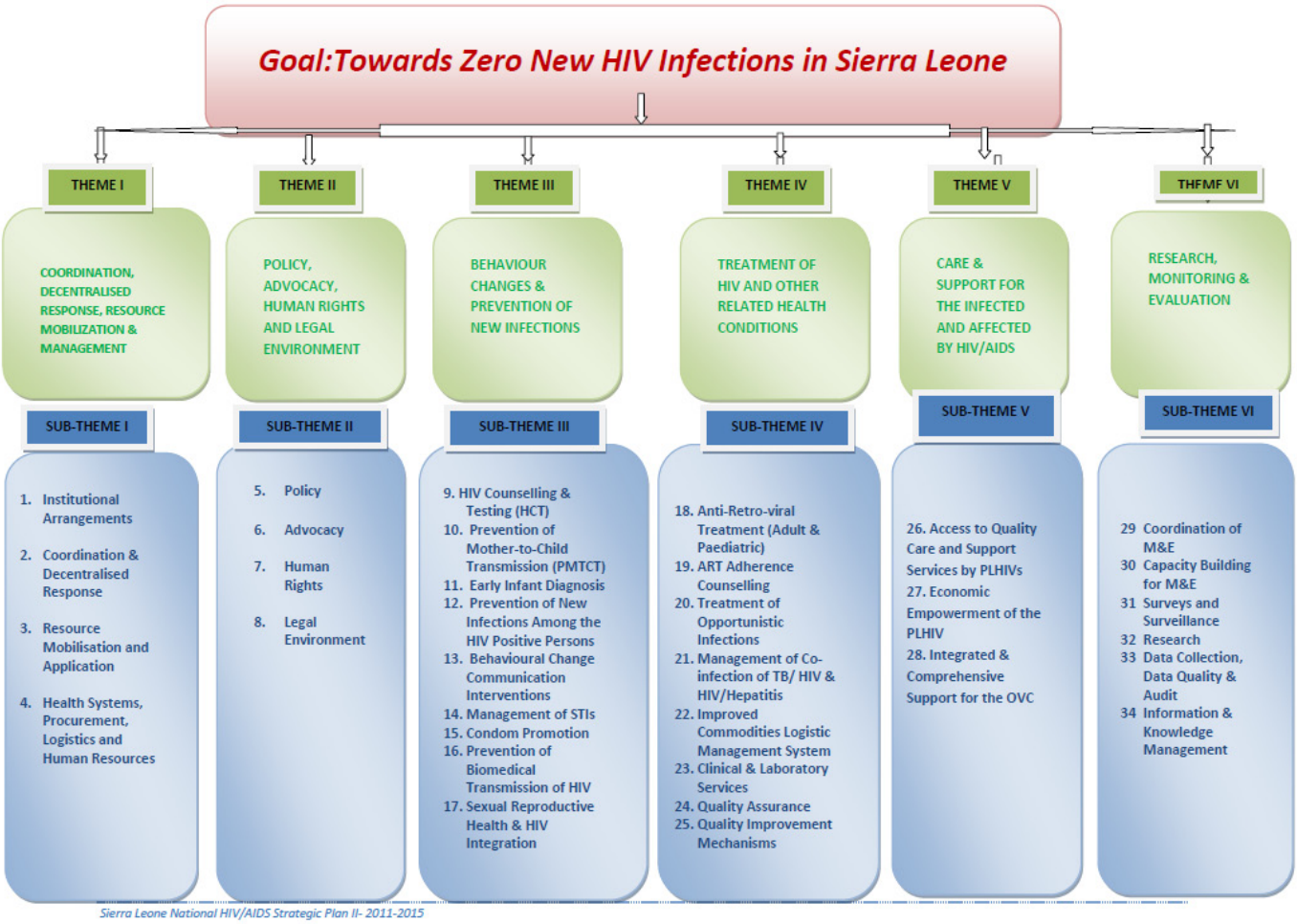
The implementation of the country's first multi-sectoral Strategic Plan on HIV/AIDS 2006 – 2010 through the support from partners has resulted in the country witnessing stability in HIV prevalence among the general population. Since 2005 the national prevalence rate of HIV among the general population has remained at 1.5%. There are signs of declining HIV prevalence among antenatal clinic attendees from 3.5% in 2008 to 3.2% in 2010.

Despite this progress, the number of new HIV infections on an annual basis currently estimated at 5,844 outstrips by far the AIDS-related mortality and annual enrolment into antiretroviral therapy (ART)[1]. The existing behavioural and structural HIV prevention interventions in the country still fall short of the universal target in terms of both coverage and access to services. With the emergence of most-at-risk populations like men having sex with men (MSM), Intravenous Drug Users (IDUs) that are new phenomena to the Sierra Leone society, without a targeted and re-invigorated prevention interventions, the gains already made in scaling up HIV/AIDS treatment and care and blood transfusion interventions are likely to be eroded. Comprehensive knowledge of HIV prevention and in particular condom use in the population is still very low. The achievement of the MDG on HIV/AIDS and long-term sustainability of the national response require an intensification and increased effectiveness of HIV prevention.

The 2011 – 2015 National Strategic Plan on HIV/AIDS – ***Towards Zero New Infections in Sierra Leone by 2015*** charts the roadmap towards an accelerated HIV Prevention effort by Government supported by development partners and various stakeholders Involved in the national response. The National HIV prevention Strategy is aligned with the HIV prevention goals and targets set in the 2011 – 2015 National Strategic Plan on HIV/AIDS; the Government's Agenda for Change (PRSP II); international development frameworks such as Millennium Development Goals 4, 5 and 6; the UNGASS Declaration of Commitment and Universal Access commitments and targets. This Prevention Strategy aims at revolutionising the country's HIV prevention efforts by increasing coverage and effectiveness of HIV prevention interventions. It is anchored on the 2010 HIV Modes of Transmission Study "Know Your Epidemic, Know Your Response". HIV prevention interventions are directed to sources of new HIV infections and population groups most at risk.

[1]Sierra Leone HIV Modes of Transmission Study "Know Your Epidemic, Know Your Response", August 2010, pp.52

Figure 1: Sierra Leone's National Strategic Plan 2011-2015



Sierra Leone National HIV/AIDS Strategic Plan II- 2011-2015

1.1 Development of the National HIV Prevention Strategy

The National HIV Prevention Strategy is Sierra Leone's first national prevention strategy on HIV. The plan outlines the unique challenges faced in the national prevention efforts. With a low national HIV prevalence, denial among the general population remains very high. The development of the plan was based on the principles of consultation, participation, involvement of key stakeholders, ownership and evidenced-based planning. A steering committee comprising of NAS, UNAIDS and UNICEF was established to provide technical guidance to two national consultants to develop the document.

The development process was preceded by a review of the 2010 HIV Modes of Transmission Study and the Final Joint Programme Review of the National HIV/AIDS Strategic Plan 2006 – 2010 Reports. The Modes of Transmission Study in particular describes the HIV epidemiology and drivers of the epidemic and the scope, while the Final Joint Programme Review of the National HIV/AIDS Strategic Plan 2006 – 2010 describes attempts at describing the national coverage and effectiveness of existing biomedical, behavioural and structural HIV prevention interventions in the country.

The HIV prevention review was followed by a five-day retreat of a participatory process involving key partners from the public sector, the UN Family, PLHIV Network, Media institutions; implementing partners including HIV/AIDS service providers to develop a draft framework.

The consultants had iterative discussions with various technical working groups of key HIV prevention interventions including HCT, PMTCT, primary prevention, condom programming, Information, Education and Committee, MARPs, the UN Joint Team on HIV/AIDS, Institutional Heads/Programme Managers etc.

The Steering Committee and the Consultants had a two-day interactive discussions and sessions with the District Councils HIV/AIDS Focal Persons including their respective Health Committee Chairpersons on the draft framework.

Also discussions and sessions targeting partners dealing with young people and representatives of the target group were held. The consultative process was concluded by a national validation workshop.

1.2 Prevention Strategy Goals and Objectives

In line with the National Strategic Plan on HIV 2011-2015, the **goal** of the Prevention Strategy is to:

Provide strategic guidance for implementing the HIV prevention and behaviour change programmes and to increase the effectiveness, coordination and comprehensiveness of HIV prevention and behaviour change interventions in Sierra Leone by 2015.

The key **objectives** of the Strategy are to:

i. Reduce the sexual transmission of HIV
ii. Increase the number of people accessing HCT services
iii. Reduce the vertical transmission of HIV during pregnancy, childbirth and breastfeeding (work towards virtual elimination by 2015)
iv. Increase the implementation and effectiveness of behaviour change communication on HIV prevention
v. Increase the number of couples who disclose their status to their partners
vi. Increase the number of MARPS adopting safe behaviour (& accessing specific risk reduction services for MARPS)
vii. Increase the number of people adopting safer sexual behaviour
viii. Increase number of people accessing quality treatment of STIs
ix. Reduce the biomedical transmission of HIV
x. Increase the integration of sexual reproductive health and HIV services.

1.3 Institutional Arrangement for Coordination

The National HIV Prevention Strategy is an offshoot of the National HIV/AIDS Strategic Plan 2011 – 2015. The institutional framework for the coordination of the Prevention Strategy shall be in line with the National HIV/AIDS Strategic Plan 2011 – 2015. The institutional framework for coordinating the strategy is presented in figure 1.

1.3.1 National Level Coordination

In line with the principles of three ones, NAS will be responsible for coordinating and providing the overall leadership for the prevention response in the country. It will do this by ensuring that all stakeholders and partners align their prevention priorities and interventions with the National Prevention Strategy. It will popularize and mobilize technical support including resources for the implementation of this strategy including other national plans (strategic, sectoral and operational) and other strategic documents. The existing coordination platforms and those that will emerge during the course of implementation of this plan will continue to play an increasing role in coordination while NAS and other

partners continue to provide necessary support (technical, financial etc.) and policy guidance.

1.3.2 District Level Coordination

The District AIDS Committees (DACs) within the District Councils (19 in all) will be responsible for coordinating the HIV prevention response at the district levels. NAS Regional Offices will provide technical support for the DACs to assume the overall leadership and to integrate HIV/AIDS activities into the District Development Plans.

1.3.3 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. 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

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

(iii) ***Business Coalition against AIDS in Sierra Leone (BCAASL),*** an umbrella organization of private sector organizations involved in HIV response.

(iv) ***Sierra Leone Inter-religious AIDS Network(SLIRAN)*** responsible for the coordination of faith-based organizations (Muslim and Christian organizations) working on HIV/AIDS in Sierra Leone.

(v) ***HIV/AIDS Reporters Association (HARA)*** responsible for coordinating the activities of its members who are basically journalists reporting on HIV and AIDS issue

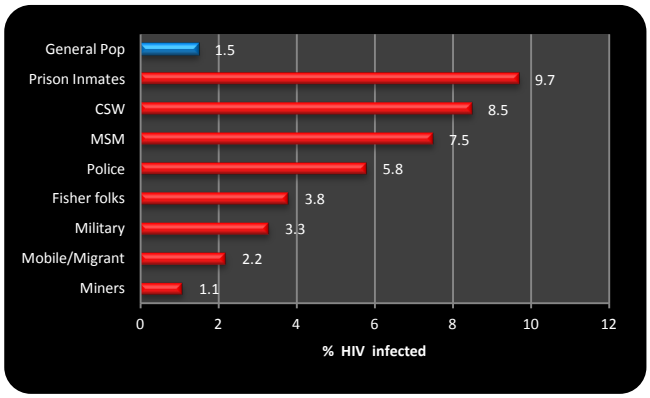
(vi) ***Sierra Leone Youth Coalition on HIV and AIDS (SLYCHA)*** responsible for the coordination of youth organisations involved in the AIDS response

(vii) ***National HIV & AIDS Coalition*** which coordinates activities of NGOs working on HIV in Sierra Leone

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.

2.0 Situational Analysis of the HIV Epidemic in Sierra Leone

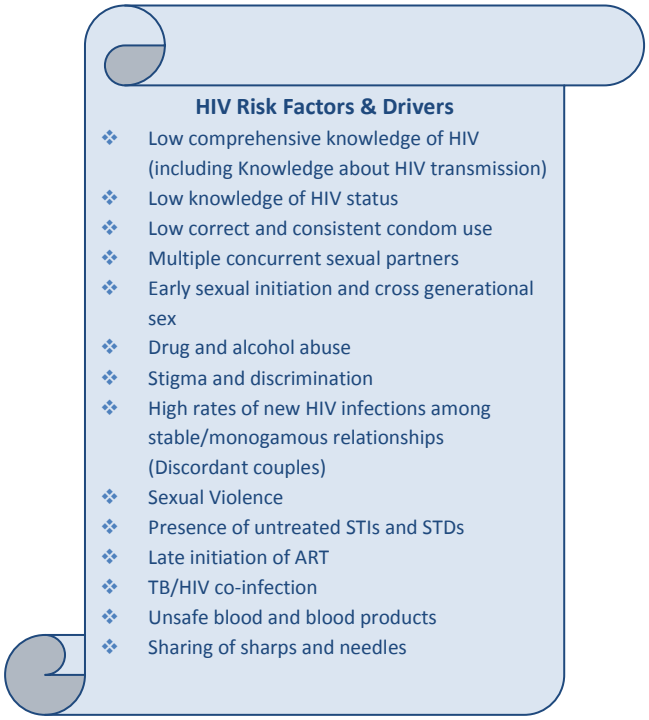
Figure 2: HIV Prevalence by Various Population Sub-Groups



The first case of AIDS in Sierra Leone was reported in 1987. Between 2002 and 2005 the incidence of HIV increased from 0.9% to 1.5% among the 15 -49 age group and has since stabilized at this level (DHS 2009).The prevalence for men was estimated at 1.2% while that for women was 1.7%. There were no consistent patterns of HIV prevalence by age among either men or women; rather the levels fluctuated by age group. HIV prevalence peaked at 45-49 years among men, while it peaked among women at 30-35 years.

HIV prevalence is also higher among the adult population age 25 years and older (1.7%) compared to young people less than 25 years (1.0%). Prevalence among young women and men 15-24 years is 1.4% and 0.5% respectively.

Figure 3: HIV Risk Factors & Drivers



HIV prevalence among pregnant women attending antenatal clinics (ANC) is 3.2% (NACP 2010) and is significantly higher than the national prevalence. The HIV prevalence among pregnant women over the years shows a declining trend from 4.4% to 3.5% between 2007 and 2008, and to 3.2% in 2010, respectively.

While the HIV epidemic is a nationwide concern, there are some notable geographical differences, particularly across the urban-rural divide. HIV prevalence was found to be higher in urban areas (2.7%) than in the rural areas (1.2%), as were levels of knowledge about HIV. The northern district of Koinadugu showed the highest prevalence (3.0%), 6 times higher than the district with lowest prevalence, Tonkolili (0.5%).Pujehun and the Western Urban Area both stand at 2.2%.

Studies conducted between 2007 and 2010 provided information on HIV prevalence among some key populations at risk – sex workers, fisher folks, uniformed personnel, MSM, miners, prison inmates, and cross-border traders.. Incidence modeling 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%. Fisher folks 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

2.1 Socio-cultural factors affecting the spread of HIV/AIDS among adolescents in Sierra Leone

The complex mix of distinctive spiritual, material and emotional features that make up the culture of a community play a key role in shaping perceptions in that society, including perceptions and behaviours relating to HIV. According to a study published in Medwell Journal, 2011, alcohol and drug abuse, access to pornographic materials, cultism, cosmetic factors, vulnerable sexual practices and blood swearing covenants, are among the factors that fuel the spread of HIV in the society.

The study notes that peer pressure to consume alcohol, especially at social gatherings, has a negative consequence for HIV prevention. Alcohol impairs judgement and often leads to unintended and unprotected sex. Access to pornographic media materials through the some community media centres exposes young people to experimental sex on video, thereby increasing their desire to practice unprotected sex at early ages.

The study also reveals that the use of sharps to shed blood as part of initiation rites in some schools' and colleges' social clubs has the potential to contribute to HIV transmission. Unsterilized sharps are also used and shared during rites of passage and to make tribal marks, including black gum, male and female circumcision and the borrowed practice of tattooing. The practice of 'blood swearing covenants' that has become in vogue among gangs of young people and which encourages the shedding and sharing of blood by tying the hands together also exposes the participants to HIV infection.

The practice of 'dry sex', which supposedly tightens the vagina thus increasing the pleasure of the opposite sex, is bound to increase the friction during intercourse, thereby increasing the risk of bruising of skin and the potential of contracting HIV.

In light of the above and the available national surveys particularly the Modes of Transmission Study 2010, the following section identifies and describes the key factors which are contributing to the spread of HIV in Sierra Leone.

3.0 Key Risk Factors & Drivers of the HIV Epidemic

Figure 4: Sources of new infections/Key Drivers (MoT 2010)

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

a. Low Comprehensive Knowledge of HIV (including modes of HIV transmission):

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 but higher among young people aged 15-24 years (23.7% and men 32.9%)(DHS 2008). This could be due to their low risk perception. As such there is much effort placed in the areas of behavior change communication including awareness rising. A BCC strategy was developed in 2004 but has never been revised. Many BCC interventions including materials such as posters, billboard, T-shirts, media programmes such as radio jingles and television adverts as well as discussion and face- to- face interactions on various issues such as HCT, condoms, PMTCT and general knowledge about HIV prevention are implemented nationwide. A greater percentage of the BCC materials focused on prevention education while there were very few relating to issues of stigma and discrimination.

While the majority of Sierra Leoneans (women 69.4% and men 82.9%) are aware of HIV and AIDS, just 14% of women and 25% of men have comprehensive knowledge of the issues surrounding it (DHS 2008). A person is said to have comprehensive knowledge on HIV and AIDS if they reject common misperceptions on HIV and AIDS, accurately identify three modes of transmission (i.e. breastfeeding, sexual intercourse, sharing needles, etc) and if they know a healthy person can have HIV.

There are higher levels of knowledge amongst urban populations compared to rural populations; one in four urban women have comprehensive knowledge compared to one-in-six amongrural men. Comprehensive knowledge ishigher among urban men (38.8%) and lowest among rural women (7.5%).Young people (15 – 24 years) are somewhat more likely to have a comprehensive knowledge of HIV and AIDS than the population at large (17% of young women and 28% of young men).

There is a pervading public misconception about the modes of HIV transmission in the country. According to the DHS (2008), roughly one in two men and one in three women believe that AIDS can be transmitted by mosquito bites, can be transmitted by supernatural means, and that sharing food with an infected person can cause infection.

The discrepancy between rural and urban areas is noticeable, with almost four out of five rural women and roughly two out of five rural men holding on to these inaccurate beliefs. A greater proportion of young people are able to reject misconceptions about how HIV is transmitted (about four out of five young men and three out of four young women).

Low comprehensive knowledge of HIV and AIDS, including misconceptions about HIV transmission, has led to high levels of stigma and discrimination towards PLHIV, which in turn makes people reluctant to be tested. It inhibits PLHIV from revealing their HIV positive status, which similarly impedes access to prevention, treatment, care and support. Low knowledge also makes people more likely to engage in high-risk behaviours, such as unprotected sex, multiple concurrent partners or intravenous drug use.

b. Low knowledge about HIV status

Linked to the low level of knowledge about HIV is the low number of people who know their HIV status. In spite of efforts to scale-up HIV counselling and testing in the country and the increase in the number of HCT sites from 19 in 2005 to 543 in 2010, a majority of the Sierra Leoneans do not know their HIV status. Estimates from the Demographic and Health Survey (2008) reveal that only 13% of women and 8% of men aged 15-49 years have ever had an HIV test. Only 9.4% of women and 7% of men have actually received a test result.

In addition, there is a marked difference between rural and urban men and women who know their HIV status (18.8% for urban women, 4.6% rural women, 13.2% for urban men and 3.2% for rural men). The percentage of young people who have tested and know their status is even lower (1.2% of young women and 4.4% of young men).This low percentage of young people(15-24 years) in Sierra Leone who know their HIV status is particularly worrying.

c. Low condom use

Condom promotion is one of the key strategies in response to HIV. However its use continues to be very low (less than 30%) among the population. A national condom programming committee is in place while the national strategic plan for comprehensive condom programming (2010-2014) is in place. There is also no national condom policy in place. Capacities of some service providers have been built on Condom negotiation

skills. The 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 and the Ministry of Health and Sanitation with condoms for free distribution. Female condoms are less popular and not widely used.

The use of condoms consistently during risky sexual encounters is low in Sierra Leone. According to the 2008 DHS, only 19.3% of women and 41.3% of men reported ever used male condoms. Female condom use is extremely low and is estimated at 1.4%. Condom use at last risky sex was lower among the rural population for women (urban –8.5%, rural-5.3%) and for men (urban-34.4%, rural-10.3%). Condom use is also lower among young people (15-24 years), at 13.8% for females and 22% for males. Very few people report using a condom during their first sexual encounter; just 2.9% of females and 7.3% of males.

The availability and accessibility of condoms is also low. It is estimated that 19% of people source condoms from public health facilities, 4.2% from private health facilities, 26% from pharmacies 0.5% from outreach initiatives and 38% from friends or relatives.

d. Early initiation of sexual relations and cross-generational sex

Women are more likely to have sexual intercourse earlier than men (27.4% of women had their first sexual encounter at 15 years, compared to 7.6% of men) and rural women tend to engage in sexual intercourse the earliest, with the median age at first sex standing at 15.8 years. The median age for first sex for urban and rural men is 18 years. This is despite the fact that the legal age for sexual intercourse is 18 years.

It is not uncommon for young people to engage in cross-generational sex in Sierra Leone. Young women exchange sex for basic needs such as food, accommodation, clothing and other favours. Findings from the DHS (2008) show that over one in ten young women aged 15 -19 years are engaged in sexual relations with male partners aged ten years above their age. In addition, condom use among cross-generational sexual partners is relatively low. HIV prevalence among young women and among older men reflects this trend, with HIV prevalence among women peaking between the ages of 15 – 35 years and among men aged 45 years and above.

Teenage pregnancy and the risk of early contraction of STIs, including HIV stand out as significant implications. Being sexually active at an early age facilitates early marriage, possibly intergenerational. There are also possible complications associated with childbirth including maternal mortality and morbidity. There is also a possibility of increased chances of high school dropout, with resulting socio-economic inequality and low status of women and girls.

The existing school curriculum has been revised to include topics on HIV/AIDS and Life skills although HIV is not examinable in schools. A number of life skills and HIV/AIDS manuals have been developed and introduced in schools and communities. 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.

e. Transactional Sex

Transactional sex involves the exchange of sex for money, favours and gifts. Statistics from the Sierra Leone DHS 2008 study suggests that transactional sex among men is prevalent and stands at 1.9%, with highest among 25-29 years (3.8%). Transactional sex is more prevalent in rural areas (2.2%) compared to urban areas (1.9%), respectively. Results further show that payment for sex is more prevalent among the divorced/widowed/separated (4.4%) compared to the never married (2.3%), and the married or living together (1.8%). Further analysis by education level reveals that men with secondary or higher education (2.3%) are more likely to pay for sex compared to those with primary (2.0%) and no formal education (1.9%), respectively.

Payment for sex by men is exacerbated by low condom use. According to the DHS, 93.6 % of women and 77.9% of men engaged in transactional sex do not use condoms. A society where transactional sex is common increases the vulnerability of young women and clients to HIV and also propels the spread of new HIV infections among the general population.

f. Drug and alcohol abuse

Injecting drug users are an emerging concern for the national HIV response, as their behavioural patterns put them at high risk of HIV transmission. In 2007, 4.8% of drug users surveyed reported an HIV positive status (2007 IDU and non-IDU Report, UNODC) and the Sierra Leone Modes of Transmission Study estimated that IDUs accounted for 1.4% of all new HIV infections in 2008. Almost half (46.7%) reported sharing needles.

g. Commercial Sex Work and Men who have sex with men

Although everyone is at risk of infection with HIV, yet targeting the most at risk populations has been a challenge. While sex workers are periodically targeted others like MSM and IDUs are just are often considered non-existent. It is only now that few of such groups are becoming visible but with much stigma and

discrimination. There is also the need to train more service providers to service this group of people.

According to the 2010 Modes of Transmission study, sex workers and their clients accounts for over a third (35%) of all new HIV infections in Sierra Leone. Prevalence among CSWs is high at 8%and according to the ARC Report of 2007, over one third of CSWs have never used a condom with their clients. One quarter reported having no knowledge of HIV. A study done in 2009 (KAP, CARE) reported that 55% of CSWs indicated that they had never used condoms but would like to in the future.

MSM account for 2% of all new HIV infections. The HIV prevalence rates stands at 7.5%. Condom use is low and STI prevalence is 10.2%.

h. High levels of stigma and discrimination

Stigma and discrimination against PLHIVs is one of the biggest challenges in the HIV response. About 9 in 10 women (94.9%) and about 8 in 10 men (86.6%) have negative attitude towards PLHIVs. This pattern is similar among rural and urban dwellers as well as young people. Accordingly, 51.7% women and 27.2% men state that they would be unwilling to care for PLHIVs when sick. In addition, 79.9% of women and 59.7% of men indicate that they would not buy vegetables from an HIV positive person.

High stigma and discrimination frustrates the implementation of HIV and AIDS prevention, treatment, care and support services, particularly with regards people being discouraged to access these services. This in turn increases the risk of HIV transmission.

i. HIV among discordant couples

Discordant couples are those in which one partner is positive and one is negative. About 1.9% of couples can said to be Discordant, with higher levels in urban areas (urban - 2.9% and rural - 1.5%). Fidelity or mutual faithfulness among partners in stable and monogamous relationships tends to be protective with regards to transmission of HIV. Despite this, the 2010 Modes of Transmission study shows that over a third of new HIV infections in Sierra Leone emanate from stable and monogamous sexual relationships.

Low condom use by men and women in this category contributes to a high number of new HIV cases. In addition, to the numerous negative cultural norms surrounding HIV infection, gender inequalities continue to pose serious barriers to women initiating safer sex practices such as condom use

j. Low uptake of PMTCT

Although HIV prevalence among pregnant women continues to decline, there appears to be insufficient knowledge regarding the benefits of PMTCT. Only 14.2% of women and 24.0% of men believe that the use of ARV drugs can reduce the risk of MTCT, and the percentages are much lower in rural areas for women (urban – 23.4%, rural – 8.9%) and for men (urban – 33.6%, rural – 18.0%). Just over one-in-ten women and one-in-five men have knowledge about PMTCT (Breastfeeding and ARV).ART uptake still remains low among pregnant women and just over half, or 511 of health facilities in the country offer PMTCT services.

Effective PMTCT services can reduce HIV infection among newborn babies and positive pregnant women on ARVs can live longer and healthy lives. Therefore, if coverage and access to PMTCT services are not expanded, babies born to positive pregnant women will be at a risk of contracting HIV. In addition, pregnant positive mothers not accessing a complete course of ARVs or not on ART for their own health have a higher chance of not surviving to an older age.

k. Multiple Sexual Partners

Among both men and women, multiple concurrent sexual partnerships are reportedly high. According the 2008 DHS, 5% of women and 20.8% of men reported having more than two concurrent sexual partners. A similar pattern is observed among urban (women 6.1% vs men 21.3%) and rural dwellers (women 4.3%vsmen 20.4%). The pattern is similar among young people15-24 years.

Furthermore, fewer women (7.4%) than men (22.1%) used a condom at their last risky sexual encounter. Similarly, among young people 15-24years, 14% of women and 22% of men used condoms at their last risky sexual encounter. On the overall, more men than women tend to engage in multiple and risky sexual partnerships.

By implication, these findings suggest that without reducing the number of partners and an increase in condom use during risky sexual behaviour, HIV will continue to spread.

l. Sexually Transmitted Infections

Sexually transmitted infections (STI) are highly prevalent among the population. Hence management of STIs is a core component of the prevention of HIV. A Protocol for Syndromic Management of STIs was developed and disseminated. PHU staff were 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.

The occurrence of Sexually Transmitted Infections (STI) including HIV is below one in ten among the sexually active population (15-49 yrs), with a marginal difference between women and men (8.5 and 8.3% respectively). However, the presence of genital sores and ulcers are more common in women than in men (19.3 and 11.4% respectively) and those are higher

in urban than rural both in women (urban - 12.7% and 10.6%) and men (urban - 24% and rural- 16.3%).

The percentage of people reporting symptoms suggestive of STIs and seeking treatment from clinical services is higher among men than women (51% and 41% respectively). In terms of knowledge about STI prevention, men have more knowledge than women at all age groups, and among women 15-24 age group has more knowledge than 15-49 group (23.7% in women and 32.9 in men between age 15-25 and 19.7% in women and 31.2% in men between 15-49 (2008 DHS).

In terms of Men having Sex with Men (MSM), one of the most-at-risk populations, the 2010 study showed an STI prevalence of 10.2%, which is higher than general public. Condom use among MSM was reported at 8.2%, thereby leaving over 90% of them exposed to the risk of contracting STIs including HIV.

According to the 2008 DHS, there is no difference in the prevalence of HIV among women with STIs and those without; however, HIV prevalence is higher among those who did not know whether they had an STI (2.4 %) than those who knew their STI status. STI and HIV co-infection in general is 1.5% (1.6% in women and 1.1% in men, respectively). Men who reported having an STI or STI symptoms were slightly less likely to be HIV positive than those who did not report having an STI, although the difference is small (1.1 and 1.5 %, respectively). Currently close to 1,800 health care workers and other service providers are trained in STI treatment and the number is increasing as part of priority intervention of *National Strategic Plan on HIV*.

m. Integration of Sexual and Reproductive Health Services:

The duplication of some services and gaps in other services exists due to lack of integration of sexual and reproductive health (SRH) services. Programmes are sometimes set up which could be more efficiently managed by existing institutions. The number of health facilities with integrated SRH and HIV services is still limited. The procurement of drugs by different institutions targeting the same beneficiaries leads to wastage of scarce resources. Monitoring and supervision of on-going implementation is hindered due to the lack of integration of services.

n. Late initiation of Anti-Retroviral Therapy:

The timely initiation of antiretroviral therapy (ART) is critical in HIV prevention because a dramatically lowered viral load suppresses the onward transmission of HIV to other people when adherence levels are high. Sierra Leone's ART guidelines, which were aligned to international guidelines in 2007, adjusted eligibility from a CD4 count of 200 to 350. As such, people could begin treatment before they became ill and more infectious. However, as per the 2010 *Joint Programme Review of the National HIV and AIDS Strategic Plan 2006-2010*, although ART treatment services has been dramatically scaled up, only 52 % of eligible adults and 5 % of eligible children were receiving ART by 2010, and adherence and delivery continue to pose grave challenges in Sierra Leone.

In fact, the number of ART sites of 132 is far below those of the HCT sites of 556. Most people tested and received positive status in HCT sites are often referred to ART facilities for treatment. Therefore many are presented late to the ART facilities and delay in initiating ART. Currently about 6,000 patients are on ART and 88% of those survive after 12months. Only 64% of the identified women infected with HIV receive ART for PMTCT, which is far below the national target of 90%.

o. HIV/TB Co-infection:

Tuberculosis (TB) is the most common opportunistic infection among PLHIVs and the number one cause of death in HIV patients. HIV infection predisposes to TB re-activation or new infection, and TB/HIV co-infection increase morbidity and mortality, multi-drug resistant of TB cases, drug interactions, and increased drug adverse reactions.

In Sierra Leone, the HIV/TB co-infection rate is estimated to be high, but the level of screening for co-infection is low; only 23% of all HIV positive patients have been screened for TB.

According to the health facility based study in 2009, 14.4% of the HIV patients were found to have pulmonary TB with the highest occurrence found in patients over age 50yrs, between 11-20yrs and 31- 40yrs (54.17%, 18.75% and 15.22% respectively). TB/HIV co-infection was also found to be three times higher among men (20.7%) than women (7.3%). Currently there is no data on the rate of TB/HIV co-infection in children.

p. Blood Safety and Universal Safety Precaution:

The medical need for blood is increasing especially with the advent of the Free Healthcare Initiative launched in 2010. Blood and blood products however can be a source of HIV transmission if not safely screened for HIV, syphilis and hepatitis. Although only a small number of infections occur as a result of medical injections and blood transfusions (0.2%), there are reasons for concern of medical transmission of HIV.

In Sierra Leone there are only five operational blood banks in the whole country (3 in the Western area and 1 each in Bo and Kenema). The lack of sufficient blood banks means that people have to go a long way to get safe blood and this might lead to a compromise of normal procedure. The number of voluntary blood

donors is also still low and concentrated in the urban areas.

The biomedical transmission of HIV can be reduced through enhancing of the universal safety precautions, increase in availability of PEP services in health facilities, prompt administration of PEP to HIV 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.

Sierra Leone is in the process of rolling out facility based blood safety programme, which are critical for reducing the risk of medical transmission of HIV. National Safe Blood Programme at Ministry of Health and Sanitation indicates that all blood meant for transfusion should be screened for Hepatitis, Syphilis and HIV. As a result all bloods for transfusion are currently screened at 24 blood-screening sites.

There is lack of comprehensive information on injecting drug use in Sierra Leone. However, according to a UNODC study, there are about 14% of drug user are IDUs in Freetown, and nearly half (47%) of them share needles and syringes. In addition, 1.6% of sex workers are injecting drug users and 87% of them share needles and syringes.

q. Resource Mobilization for HIV:

Soon after the end of the debilitating war, Sierra Leone took a bold step of combating the new war against HIV. The Government of Sierra Leone (GoSL) took up a loan of US$ 15 million (2004-2008 period) with the World Bank for the Sierra Leone HIV and AIDS Response Project, (SHARP). The government also successfully applied for funding from the Global Fund rounds 4, 6 and 9 for US$ 18 million, US$ 26 and US$ 29 million respectively.

Over the years the national response to the HIV/AIDS has received substantial funding, however the major challenge now is how to sustain the financial support for the fight against HIV epidemic.

In fact according to the National AIDS Spending Assessment (NASA 2008/2009) there is a low financial contribution from GoSL and Private sector (2.7% and 0.7% respectively) and 95% of HIV budget is dependent on external donors.

The scarcity of national funds has limited the expansion and sustainability of HIV programmes thus increasing vulnerability of Sierra Leoneans to the epidemic. Moreover such a heavy reliance on the Global Fund and indeed on international donors generally leaves HIV programmes vulnerable to collapse as a result of donor fatigue or change in donor priorities.

r. Sexual and Gender-Based Violence:

Gender dynamics can exacerbate HIV risk, for example, certain manifestations of male and female norms, behaviours and practices create vulnerability to HIV infection. Equitable access to HIV prevention services and activities needs to be ensured, and female-controlled access to income generation and livelihood strategies should be implemented where possible. There are cultural and legal underpinnings to gender discrimination and HIV risk, with legal rulings not aligned to legislation or widespread beliefs and practices around husbands' roles in decision-making, including health care. Specifically sexual and gender-based violence directly increases the risk of HIV infection. Sierra Leone suffers from high levels of sexual violence and it also poses threats to HIV prevention. Sexual violence can take many forms, including rape, child molestation and wife battering.

More women than men (over a third compared to a quarter) believe that a women is not justified in refusing sex to her husband, implying that many women themselves are complicit in such acts. Child molestation by elderly family members and rape are often extremely disempowering situations, with the survivor having little chance of negotiating safe sex.

Apart from the obvious psychological and physiological damage, sexual violence increases the risk of HIV transmission, particularly because one of the partners is not in a position to initiate condom use. Lack of economic empowerment and higher levels of poverty among women leads women to exchange sex for money or favours, thus exposing them to HIV.

The number of SGBV cases concluded logically and reported at the magistrate and high court level has been increased gradually. According to Family Support Unit status report on SGBV cases, while in 2007, 761 cases totally reported, 326 of those cases charged, 52 resolved, and 11 convicted, in 2010 1220 cases reported, 541 charged, 70 resolved and 57 convicted.

The Family Support Unit (FSU) was established in 2000 as a branch of Criminal Investigations Department (CID) to deal with all forms of abuses against women and children including SGBV.

The number of facilities that provide assistance to survivors of gender based violence and sexual abuse free of cost has increased, with four government hospitals providing SGBV assistance in 2010. SGBV services were mainly provided by NGOs (Women in Crisis Management, International Rescue Committee etc.) previously.

Rights based and gender responsive policies, programmes and legislations have been developed and

implemented and contributed to support SGBV cases. As of 2011, three Gender Acts, The Devolution of Estates Act, The Domestic Violence Act, and The Registration of Customary Marriage and Divorce Act are enacted.

s. Divine Healing of HIV:

Within some strands of both of Sierra Leone's two main religions (Islam and Christianity), belief in divine healing is promoted as opposed to western medical interventions, i.e. ART. Quite a few of them have publicly pronounced to have prayed for HIV infected persons who have become HIV free but this is not consistently followed up with medical examination.

Failure to initiate or continue ART often due to the belief they have been healed can ultimately result in increased AIDS-related deaths. People who believe that they have been healed are less likely to practice safe sex which leads to increased risk of contracting STIs including HIV.

In regard to mitigation of religious and cultural norms, Sierra Leone is in the process of expanding dialogue with religious leaders. The Inter-religious AIDS Network and other religious bodies are addressing stigma and discrimination issues around HIV through education sessions during the religious services.

3.1 Challenges and Opportunities

Prevention is the priority of the national HIV response therefore it is crucial to identify a way forward in dealing with the existing challenges and availing of the opportunities.

Challenges for national HIV prevention include:

a) Insufficient coordination of multi-sectoral partners
b) Weak health sector
c) Inadequate monitoring and evaluation
d) Inadequate human and financial resources
e) Stigma and discrimination of PLHIVs

Opportunities for national HIV prevention include:

a) High-level leadership and commitment
b) Established coordinating bodies in all key sectors
c) Established and increasingly strengthened network of people living with HIV (NETHIPS)

4.0 Intensifying HIV Prevention

4.1 The Principles of Effective HIV Prevention

According to UNAIDS, below are the principles of implementing an effective HIV Prevention strategy

a) All HIV prevention efforts/programmes must have as their fundamental basis the promotion, protection and respect of **human rights including gender equality**.
b) HIV prevention programmes must be **differentiated and locally adapted** to the relevant epidemiological, economic, social and cultural contexts in which they are implemented.
c) HIV prevention actions must be **evidence-informed**, based on what is known and proven to be effective and investment to expand the evidence base should be strengthened.
d) HIV prevention programmes must be **comprehensive** in scope, using the full range of policy and programme interventions known to be effective.
e) HIV prevention is for life; **therefore, both delivery of existing interventions as well as research and development of new technologies require a long-term and sustained effort**, recognizing that the results will only be seen over the longer-term and need to be maintained.
f) HIV prevention programming must be at a **coverage, scale and intensity** that are enough to make a critical difference.
g) Community participation of those for whom HIV prevention programmes are planned is critical for their impact.
h) Studies reveal that **belief in self worth** helps to ward off pressure to engage in risky behaviour; thus an effective prevention programme should help young people, including adolescents to identify their personal value (worth).
i) Ability to **distinguish between what is right and what is wrong** should be key to HIV prevention. For a prevention programme to be successful, individuals should be knowledgeable about the virus, how it is transmitted and prevention methods.
j) **Weighing alternatives and effects** is essential for decision making and recognizing the necessity of considering multiple alternatives and keeping a future perspective.
k) Weighing alternatives leads to **effecting change. T**he activities that put adolescents at risk for HIV are by nature pleasurable and can occur on impulse, the scale has to be weighed on the side of commitment.
l) The fact that risky behaviours can occur unexpectedly, it is important that one be prepared always. In HIV prevention terms, this involves "always carrying a condom".
m) **Exercising self-control** should is a pillar of this prevention strategy. Adolescents and youth should

have a strategy of self-control that can be put to use at the earliest stage of the sexual sequence.

n) **Seeking pleasurable alternatives to risky sexual behaviour** can enhance self-control. Sexually active young people should have skills to make condom use enjoyable instead of aversive.

o) **Verbally negotiating sex** is a best practice in prevention efforts. With verbal negotiation, there are many more opportunities of stopping a sequence of sexual signals between young people.

p) **Making a choice to limit one's own freedom** is necessary for all self-enhancing behaviours that involve forgoing pleasure and compromising concepts of free choice and acceptance.

q) Behaving in ways that help others protect themselves directly or indirectly endorse the importance of valuing and protecting the health of others.

4.2 Essential Policy Actions for HIV Prevention

According to UNAIDS, below are the essential policy actions of implementing an effective HIV Prevention strategy

1. Ensure that **human rights** are promoted, protected and respected and that measures are taken to eliminate discrimination and combat stigma.
2. Build and maintain **leadership** from all sections of society, including governments, affected communities, non-governmental organizations, faith-based organizations, the education sector, media, the private sector and trade unions.
3. Involve **people living with HIV, in the design, implementation and evaluation of prevention strategies**, addressing their distinct prevention needs.
4. Address **cultural norms and beliefs**, recognizing both the key role they may play in supporting prevention efforts and the potential they have to fuel HIV transmission.
5. Promote gender equality and address **gender norms and relations** to reduce the vulnerability of women and girls, involving men and boys in this effort.
6. Promote widespread **knowledge and awareness** of how HIV is transmitted and how HIV can be averted.
7. Promote the links between HIV prevention and **sexual and reproductive health**.
8. Support the mobilization of **community-based responses** throughout the continuum of prevention, care and treatment.
9. Promote programmes targeted at HIV prevention needs of **key affected groups and populations**.
10. Mobilizing and strengthening **financial, and human and institutional capacity** across all sectors, particularly in health and education.
11. Review and reform **legal frameworks** to remove barriers to effective, evidence based HIV prevention, combat stigma and discrimination and protect the rights of people living with HIV or vulnerable or at risk to HIV.
12. Ensure that sufficient investments are made in the research and development of, and advocacy, for, **new prevention technologies**

4.3 Essential Programmatic Actions for HIV Prevention

a) Prevent the sexual transmission of HIV including MARPs (sex workers and their clients, men who have sex with men)
b) Focus on HIV prevention among young people
c) Prevent the transmission of HIV through injecting drug use, including harm reduction measures
d) Vertical elimination of mother-to-child transmission of HIV
e) Ensure safety of blood supply
f) Prevention of HIV transmission in healthcare settings
g) Promote greater access to voluntary HIV counseling and testing while promoting principles of confidentiality and consent
h) Promote greater access and correct and consistent use of both male and female condoms
i) Integrate HIV prevention into AIDS treatment services
j) Integrate HIV prevention into sexual and reproductive health services
k) Provide HIV-related information to enable individuals to protect themselves from infection.
l) Confront and mitigate HIV-related stigma and discrimination
m) Prepare for access and use of vaccines and microbicides
n) Focus on management of co-infection of tuberculosis and HIV
o) Remove or review punitive laws and practices around HIV transmission, sex work, drug use or homosexuality
p) Integrate human rights, gender equality and HIV prevention in national HIV responses
q) Focus on elimination all forms of gender-based violence, especially against women and girl

4.4 Prevention Approaches

Sierra Leone has a low rate of HIV infection compared to other African countries. The 2010 Mode of Transmission (MoT) study identifies the sources of new HIV infections, 85% being through sexual transmission. Therefore, in order to reach Sierra Leone's vision of ''Towards Zero new HIV infections by 2015'', intensified HIV prevention strategies and priority target groups have been put in place through the national strategic plan for HIV 2011-2015. The strategies contained in the plan do not only address the risks but also the causes of vulnerability. Strategic policies including the HIV Law, the HIV policy for the Education sector and the Workplace policy, prioritize prevention of new infections.

Figure 5: Strategies for HIV Prevention

4.5 Key HIV Prevention Areas

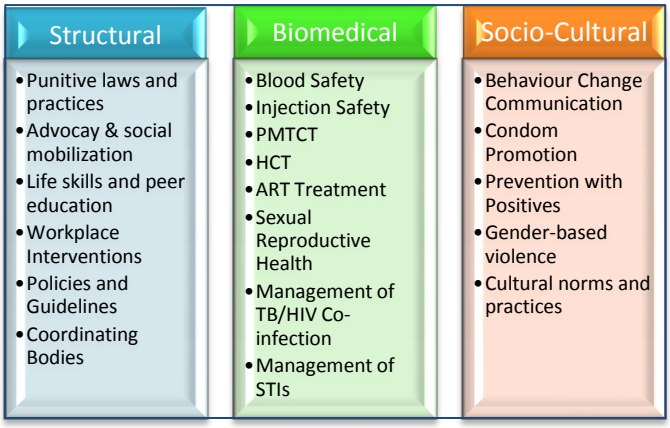
As indicated in the National Strategic Plan 2011-2015, the overall theme is Behaviour Change and Prevention of new HIV infections. The sub-prevention themes are:

1. HIV Counselling & Testing (HCT)
2. Prevention of Mother-to-Child Transmission (PMTCT)
3. Early Infant Diagnosis
4. Prevention of New Infections Among the HIV Positive Persons
5. Behavioural Change Communication Interventions
6. Management of STIs
7. Condom Promotion
8. Prevention of Biomedical Transmission of HIV
9. Sexual Reproductive Health & HIV Integration

The HIV prevention strategies can been classified into three main categories as shown below:

a. Structural Prevention Strategies
b. Biomedical Prevention Strategies and
c. Socio-Cultural Prevention Strategies

Figure 6: HIV Prevention Strategies by category



5.0 HIV PREVENTION STRATEGY

THEMES, OBJECTIVES, PRIORITY POPULATION, KEY ACTIVITIES, INTERVENTIONS AND RESULTS

Theme	**Prevention of New HIV Infections**
Sub-Theme	**HIV Counseling and Testing**
Strategic Objective	To reduce the incidence of HIV and AIDS in Sierra Leone by 50% in 2015
Strategic Intervention	*At least 80% of the adult population access gender friendly HCT services in an equitable and sustainable way by 2015*
Target Population	General population, Women and girls, Community members
Target Service Providers	National coordinators, HIV Counselors, Lab Technicians, TBAs, Nurses, Doctors

Key Activities	Indicative Interventions	Output Results
i. Implement HCT protocol ii. Capacity building for gender-sensitive HCT services at all levels iii. Scale up of HCT services delivery points at all levels of health care delivery iv. Develop and implement user friendly strategies for demand creation for HCT services at all levels (, Youth, Faith Base) v. Develop and Implement Quality Assurance/Quality Improvement (QA/QI) for HCT management	i. Develop a user friendly HCT protocol that reflects the Voluntary Confidential Counselling and Testing (VCCT) and the Provider Initiated HIV Counselling and Testing (PIHCT) ii. Disseminate and operationalize the HCT protocol iii. Develop and disseminate HCT data collection tool and train staff in use of tool iv. Establish a Prevention Technical Working Group to periodically review (quarterly) and monitor the interventions v. Train and re-train counsellors in gender sensitive HCT service delivery vi. Provide logistics support (test kits etc.) to HCT service facilities vii. Integrate HCT services into health and Community-based facilities viii. Procure mobile HCT service equipment (vehicle, PA system, etc.) to strengthen service delivery ix. Develop and produce gender-sensitive BCC/IEC materials to disseminate HCT service information x. Recruit and train peer educators to support HCT information and service delivery at all levels xi. Recruit and train religious leaders, traditional headers and Natural leaders as lay councillors to support HCT information and service delivery at all level	i. HCT protocol developed and operationalized ii. Prevention TWG established and functioning iii. HCT services system and capacity of service providers strengthened iv. Gender-sensitive service delivery addressed

Theme	**Prevention of New HIV Infections**
Sub-Theme	**HIV Counseling and Testing**
Strategic Objective	To reduce the Incidence of HIV and AIDS in Sierra Leone by 50% in 2015
Strategic Intervention	*At least 80% of adolescents/young people (aged 10-14/15-24) access HCT services in an equitable and sustainable way by 2015*
Target Population	Youth population (In and out of school youth, married and single youths, rural and urban youths, street youth)
Target Service Providers	National coordinators, Lab Technicians HIV Counselors, Youth representatives

Key Activities	Indicative Interventions	Output Results
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 at all levels	i. Adapt the HCT protocol to ensure inclusion of age and culturally sensitive issues ii. Train and retrain service providers in youth/adolescent sensitive and friendly HCT services delivery iii. Recruit and train peer educators to support HCT information and service delivery to in and out of school youth/adolescents iv. Establish and/or integrate HCT services into youth/adolescent health services v. Establish and provide logistic support (test kits, overhead costs, etc.) to youth/adolescent friendly HCT centres vi. Promote community transformation to address stigma, harmful cultural and gender norms, and strengthen community response for referral and service delivery through Participatory Approaches, e.g. community conversations vii. Adopt youth/adolescent friendly IEC activities using all channels viii. Increasing access to quality products and services by strengthening provider –client interactions for education and adherence ix. Advocate (lobby, campaign, etc.) review of the age of consent for HCT services	i. Youth/adolescent friendly HCT services established ii. Ccommunity referral and service delivery systems strengthened at all levels iii. BCC strategy targeting youth/adolescents developed iv. Number of youths/adolescents that access HCT services increased

Theme	**Prevention of New HIV Infections**
Sub-Theme	**HIV Counseling and Testing**
Strategic Objective	To reduce the Incidence of HIV and AIDS in Sierra Leone by 50% in 2015
Strategic Intervention	*At least 50% of the MARPs accessing HIV counseling and testing services by 2015*
Target Population	Sex workers and their clients, Men who have sex with men, Injecting drug users, Most-at-risk adolescents (MARA)
Target Service Providers	Counselors, , operators of entertainment centers/hotels Nurses and Doctors

Key Activities	Indicative Interventions	Output Results
i. Capacity-Building for service providers on MARPS responsive services. **ii.** Scale up of HCT services targeting MARPS	i. Map organisations providing services for MARPs ii. Develop guidelines and manuals for training service providers (NGOs, CSOs, CBOs, etc.) targeting MARPs iii. Develop peer educator manuals for MARPs iv. Train and support peer educators among MARPs v. Strengthen mobile HCT services targeting MARPS vi. Develop and operationalize a BCC strategy for MARPs vii. Strengthen and provide HCT services within prisons for MARPs into health services using Participatory Approaches viii. Provide access to prevention tools for MARPs (needles, lubricants etc.)	i. Capacity of service providers strengthened ii. Number of HCT centres providing services to MARPs increased iii. Number of MARPs counselled and tested for HIV increased

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Prevention of Mother to Child Transmission of HIV (PMTCT)**
Strategic Objective	To reduce mother to child transmission of HIV during pregnancy, child birth and breastfeeding to less than 5% by 2015 (virtual elimination of MTCT by 2015)
Strategic Intervention	*At least 80% of all pregnant women have access to quality PMTCT by 2015*
Target Population	Pregnant women with HIV, Children born from women with HIV, Spouses of pregnant women
Target Service Providers	Counselors, Midwives, Nurses, TBAs, Doctors, National coordinators ,

Key Activities	Indicative Interventions	Output Results
i. Review PMTCT guidelines and protocol ii. Ensure provision of ARV prophylaxis to all HIV positive women iii. Scale up of quality PMTCT services iv. Community mobilization and participation. v. Capacity building for PMTCT service providers (e.g. health personnel) vi. Upgrade infrastructure at PMTCT sites vii. Procure PMTCT commodities viii. Strengthen referral and linkage mechanisms ix. Increase male participation	i. Review and disseminate the current PMTCT guidelines and protocols and paediatric HIV programme to align with the nutrition and RCH guidelines ii. Convey regular PMTCT and paediatric HIV Care Technical Working Group (TWG) iii. Review, print and distribute PMTCT training manuals to train and re-train PMTCT service providers iv. Provide technical and logistics support (equipment, supplies, etc.) to PMTCT centers for monitoring and supervision v. Refurbish and upgrade infrastructure at PMTCT centres vi. Promote community sensitisation and social mobilisation activities targeting communities and leaders for utilisation of ANC/PMTCT services in all chiefdoms vii. Initiate community dialogue and other participatory approaches and to encourage participation of males in PMTCT services viii. Conduct periodic assessment of compliance and quality control ix. Procure more PCR machines and increase availability of test kits in all districts x. Provide nutritional support to HIV positive women who complete the PMTCT programme xi. Periodically update and distribute referral directory xii. Develop and disseminate IEC/ BCC material on PMTCT	i. Number of HIV infected pregnant women accessing PMCTC increased ii. Increase in male participation in PMTCT iii. Increase in the number of pregnant women accessing antenatal services iv. Number of community members with knowledge on PMTCT increased.

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Elimination of Mother to Child Transmission of HIV (EMTCT)**
Strategic Objective	To reduce mother to child transmission of HIV during pregnancy, child birth and breastfeeding less than 5% by 2015
Strategic Intervention	*At least 80% of all HIV positive pregnant women access ARV prophylaxis by 2015*
Target Population	HIV positive pregnant women, children born from HIV positive mothers
Target Service Providers	Midwives, National coordinators, Procurement specialists, ART pharmacists, traditional birth attendants

Key Activities	Indicative Interventions	Output Results
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	i. Review the PMTCT scale-up plan to meet the EMTCT target ii. Coordinate the implementation and monitoring of the revised scale-up plan iii. Upgrade infrastructure at PMTCT centres iv. Train service providers on EMTCT service delivery v. Procure and distribute test kits, reagents, ARVs and supplies to PMTCT centres in all districts vi. Provide CD4 machines and reagents at district levels and portable CD4s at PHU levels vii. Increase the number of PMTCT centres providing ARV prophylaxis viii. Provide nutritional support to HIV positive women and incentives to women who complete the PMTCT programme ix. Conduct periodic assessment of compliance and quality control	i. PMTCT service integrated into existing health services ii. Number of HIV positive pregnant women completed full PMTCT programme increased iii. Quality Assurance/Quality Improvement (QA/QI) system for PMTCT management established iv. Provision of ARV prophylaxis ensured

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Elimination of Mother to Child Transmission of HIV (EMTCT)**
Strategic Objective	To reduce mother to child transmission of HIV during pregnancy, child birth and breastfeeding less than 5% by 2015
Strategic Intervention	*All HIV exposed and infected infants receive ARV*
Target Population	Pregnant women with HIV, children born from women with HIV, and service providers
Target Service Providers	Councilors, national coordinators (pediatric and IEC/BCC), EID core group, traditional birth attendants

Key Activities	Indicative Interventions	Output Results
i. Establish and Scale-Up Early Infant Diagnosis (EID) Services ii. Capacity building for service providers iii. Provide adequate and appropriate ARV drugs for children	i. Expand and equip the pilot specimen collection, transportation, testing and feedback mechanism for early infant diagnosis ii. Train and equip service providers to provide EID services iii. Promote utilisation of ANC/PMTCT services and awareness in all chiefdoms through participatory approaches targeting parents, caregivers, traditional birth attendants and community leaders iv. Procure and distribute appropriate infant ARV drugs	i. Early Infant Diagnosis (EID) service system established and functional ii. Capacity of service providers strengthened in EID iii. Number of exposed and infected infants receiving paediatric treatment increased

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Elimination of Mother to Child Transmission of HIV (EMTCT)**
Strategic Objective	To reduce mother to child transmission of HIV during pregnancy, child birth and breastfeeding less than 5% by 2015
Strategic Intervention	*At least 80% of HIV positive pregnant women have access to quality infant feeding counselling*
Target Population	Pregnant women with HIV, children born from women with HIV, and service providers
Target Service Providers	Counselors, National coordinator (pediatric), Midwives, Nutritionists, traditional birth attendants, Parents and Partners

Key Activities	Indicative Interventions	Output Results
i. Popularise the national guidelines on infant feeding **ii.** Strengthen the capacity for service providers on infant feeding counselling **iii.** BCC for infant feeding **iv.** Coordinate and integrate EMTCT management at centers	i. Develop and implement a comprehensive dissemination plan of the national guidelines on infant feeding ii. Train caregivers to provide counselling in quality infant feeding iii. Promote awareness of quality infant feeding, including exclusive breastfeeding among parents through a coordinated IEC campaign iv. Train and support women's groups to cultivate appropriate weaning foods (benny, beans etc.) v. Advocate for the setting up of men's groups to support mothers to access quality infant feeding counselling vi. Combine options A and B at all centers	i. National guidelines on infant feeding popularized ii. Capacity of service providers on infant feeding counselling strengthened iii. BCC for quality infant feeding promoted iv. Number of Men's group set up to support mothers v. EMTCT management coordinated and integrated

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Behaviour Change Communication (BCC) Interventions**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 50% of all persons in Sierra Leone have comprehensive knowledge on HIV and AIDS by the year 2015*
Target Population	Partners and General public
Target Service Providers	NAS and Partners (private and Public), Media practitioners, PLHIV, Religious and Traditional Leaders/Healers

Key Activities	Indicative Interventions	Output Results
i. Develop and disseminate Behaviour Change Communication Strategy ii. Capacity building CSOs/CBOs working with the general population	i. Finalise, print and disseminate BCC strategy to partners and the general public to increase comprehensive knowledge of HIV and AIDS ii. Train, support and follow-up partners in innovative BCC approaches iii. Review and Decentralise IEC/BCC coordination at regional district and chiefdom level iv. Review TOR of the national IEC/BCC steering committee v. Conduct Training of Trainers, support and follow up on BCC vi. Train and (mentors) at national, regional, district and chiefdoms officers/ partners on IEC/BCC vii. Train national trainers on Community Capacity Enhancement (CCE) viii. Train and provide on-going support for community facilitators on CCE ix. Assessment and improvement of capacity of partners in BCC skills x. Develop an IEC/BCC training manual on HIV and AIDS xi. Establish a functional national prevention technical working group on HIV	i. BCC Strategy developed and popularized ii. Capacity of CSOs/CBOs working with the general population strengthened iii. Partners trained and made functional in innovative BCC approaches

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Behaviour Change Communication (BCC) Interventions**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 50% of young people 15-24 years adopting appropriate HIV and AIDS related behaviour*
Target Population	Young people age 15-24
Target Service Providers	Young people 15-24 , MEST, Community Teachers Associations, Health service provider, Tertiary institutions (Universities and other training colleges), Student unions

Key Activities	Indicative Interventions	Output Results
xi. Develop and implement relevant culturally age-appropriate and group specific SBCC oriented programs. xii. Capacity building for CSO/CBO working with young people xiii. Integrate the FLHE curriculum into the Sexual Reproductive Health and Life Skills curriculum iv. Advocacy to stakeholders	i. Develop and disseminate age/culturally appropriate BCC materials to CSOs/CBO working with young people ii. Update, strengthen and improve curriculum and life skills, HIV/AIDS education for in-school young people within the school environment iii. Promote BCC programmes targeting Community Teachers Associations (CTAs) on appropriate HIV/AIDS related behavior among young people iv. Train and equip young people as peer educators to outreach to in and out of school young people and to promote adult-youth dialogue on sexual Reproductive Health v. Establish youth-friendly service centers in every district to promote appropriate HIV and AIDS related behavior vi. Establish and strengthen Anti-AIDS clubs in and out of schools. vii. Review and develop existing materials and messages for young people on SRHE and i HIV/AIDS. viii. Develop a costed national strategy on prevention of HIV and AIDS among adolescents and young people xii. Organise inter-school and inter-district HIV/AIDS competitions	i. Culturally age-appropriate and group specific Sexual Behaviour Change Communication (SBCC) oriented programs developed and implemented ii. Capacity of CSO/CBO working with young people strengthened in BCC iii. FLHE/FLE curriculum integrated into the Sexual Reproductive Health and Life Skills curriculum iv. Increase advocacy to Relevant stakeholders v. Anti AIDS Clubs for in and out of school children established and strengthened vi. Advocacy and BCC costed Strategy produced

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Behaviour Change Communication (BCC) Interventions**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 50% of Most-At-Risk Populations (MARPs) reached with group-specific interventions and adopting appropriate HIV and AIDS related behaviour*
Target Population	MARPs
Target Service Providers	MARPs, Social workers, Health Workers, partner institutions

Key Activities	Indicative Interventions	Output Results
i. MARPS reached with appropriate strategic BCC interventions ii. Capacity-building for CSOs/CBOs working with MARPS iii. Provide prevention Services for the most at-risk persons provision	i. Develop and disseminate targeted BCC materials promoting group-specific interventions ii. Train partners (CSOs/CBOs) working with MARPs in the dissemination of group-specific interventions and adopting appropriate HIV and AIDS related behaviour iii. Harmonise BCC messages with partners and other players on appropriate HIV/AIDS related behaviour iv. Train MARPS service providers on BCC skills v. Identify and engage organisations working with MARPs. vi. Train MARPs as peer educators in BCC skills vii. Conduct sensitisation meetings among MARPs, quarterly. viii. Produce and disseminate customised/standardised IEC/BCC materials targeting MARPs ix. Develop peer educator training manual for MARPS x. Conduct and disseminate survey on MARPs xi. Integrate service provision for MARPs into SRH services	i. Number of MARPS accessing appropriate SBCC interventions increased ii. Capacity of CSOs/CBOs working with MARPS strengthened iii. Service provision for MARPs integrated into SRH services and strengthened

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Behaviour Change Communication (BCC) Interventions**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 80% of registered organizations engaging in HIV communication interventions address gender inequalities and comply with national standard/guidelines by 2015*
Target Population	General Population
Target Service Providers	IEC/BCC Officers, Media Practitioners, Media houses

Key Activities	Indicative Interventions	Output Results
i. Build capacity on gender mainstreaming ii. Document and disseminate best practices on strategic BCC iii. Monitoring of the implementation of BCC strategy	i. Develop BCC messages addressing gender inequalities in compliance with national guidelines ii. Conduct periodic review of BCC messages and dissemination of module iii. Conduct training for IEC/BCC officers on gender mainstreaming iv. Train media practitioners on HIV and gender mainstreaming v. Collect, document and disseminate best practices on BCC strategy vi. Conduct periodic supervision of the implementation of the strategy	i. Capacity of IEC/BCC officers and media practitioners on gender mainstreaming strengthened ii. Best practices on strategic BCC documented and shared iii. Implementation of BCC strategy monitored and supervised

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Behaviour Change Communication (BCC) Interventions**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*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*
Target Population	People at work place and their families
Target Service Providers	BCAASL, COPAASL, HARA, Trade Union, HIV service providers (NAS, Civil Society)

Key Activities	Indicative Interventions	Output Results
i. Review and Popularize the HIV workplace policy ii. Build the Capacity of private and public sector organizations at all levels iii. Provide Technical Assistance iv. Develop Public-private sector partnerships v. Develop monitoring mechanisms for workplace programmes vi. Improve coordination with and involvement of national media in HIV/AIDS advocacy vii. Standardise training of peer educators and health promoters viii. Standardise and harmonise messaging on HIV/AIDS	i. Establish and maintain partnerships with private and public sector organisations implementing the HIV work place policy ii. Review and produce, then popularise the national work place policy to include recommendation No. 200 among public and private sector organisations implementing the HIV work place policy iii. Hold orientation session with bar association on the National AIDS Commission Act iv. Train focal persons of all MDAs and private business institutions on HIV prevention v. Train employers and workers in organisations to integrate HIV issues and relevant provisions on non- discrimination into their collective bargaining agreement vi. Advocate for the review of labour laws to include HIV services, protection and respect for the right of PLHIV, labour migrants and their families and host communities. vii. Conduct regular Partnership forum meetings (Biannual, Regional and Annual national meetings) viii. Review and strengthen relationship with HARA and national media in HIV/AIDS advocacy ix. Develop training modules for peer educators and health promoters x. Coordinate message development on HIV/AIDS	i. HIV workplace policy reviewed and popularized ii. Capacity of private and public sector organizations for implementation of the HIV work place policy strengthened iii. Public-private sector partnerships developed iv. Monitoring mechanisms for workplace programmes developed v. Labour laws reviewed vi. Media involved in HIV/AIDS advocacy vii. Training of peer educators and health promoters standardised viii. HIV messaging standardised and harmonised

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Integration of sexual reproductive health & other relevant Health issues into HIV prevention programme**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*SRH services integrated into HIV prevention programs at all levels by 2015*
Target Population	Men and women of reproductive age (MWRA)
Target Service Providers	Health workers, traditional and religious leaders, National youth commission, societal heads and traditional healers

Key Activities	Indicative Interventions	Output Results
i. Advocate for the integration of SRH and other health issues ii. Build Capacity for health care providers iii. Procure SRH and other health commodities iv. Sensitize service providers on family planning services	i. Advocate for the review of National Youth Policy to address SRH issues ii. Develop and disseminate guidelines and protocol on SRH and HIV integration iii. Train the health service providers on youth friendly service provision for sexual reproductive health iv. Sensitize traditional and religious leaders on the availability of contraceptives/ family planning for informed decision- making v. Advocate with the MOHS for the integration of SRH services into HIV programmes vi. Train HIV service providers on SRH services xi. Conduct radio/TV programmes on availability of FP services	i. Review of National Youth Policy advocated to address SRH issues ii. HIV/AIDS programmes integrated into MOHS SRH Services iii. Capacity of health care providers strengthened iv. Commodities procured v. Service providers sensitized on the availability of family planning services

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Integration of sexual reproductive health & other relevant Health issues into HIV prevention programme**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*Integrate reduction of substance abuse in 50% of HIV prevention programs by 2015*
Target Population	Substance abusers
Target Service Providers	Anti-drug agencies, Health care workers, NAS, Traditional and Religious leaders

Key Activities	Indicative Interventions	Output Results
i. Develop and operationalize the policy and guidelines at all health levels ii. Advocate for the reduction of substance abuse iii. Build Capacity of health care providers iv. Develop appropriate and strategic BCC activities v. Develop referral and linkage mechanisms	i. Develop and operationalize policy and guidelines on substance abuse and HIV prevention programmes ii. Train healthcare workers on the relationship between substance abuse and HIV prevention iii. Develop appropriate BCC messages promoting knowledge of the relationship between substance abuse and HIV iv. Strengthen stakeholder involvement in the development and operationalization of substance abuse policy and guidelines v. Conduct quantitative research on the prevalence of substance abuse as well as qualitative research on the reasons and environmental factors influencing the behaviours vi. Train traditional and religious leaders to take the lead in preventing substance abuse in their communities vii. Advocate for resources and technical backstopping on substance abuse viii. Train service providers for the provision of HIV prevention services for substance abuse. xii. Produce customised/standardised IEC/BCC materials targeting substance abuse	i. Policy and guidelines developed and operationalized at all health levels ii. Resources and technical backstopping provided for substance abuse iii. Capacity of health care providers strengthened iv. Appropriate and strategic BCC activities developed v. Referral and linkage mechanisms established

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Management of Sexual Transmitted Infections (STIs)**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 50% of sexually active persons in Sierra Leone have access to quality and gender responsive STI services by 2015*
Target Population	Sexually active men and women
Target Service Providers	Counselors, healthcare workers, prison authorities, partners, national coordinator (IEC/BCC coordinator), Community/religious/traditional leaders, peer educators

Key Activities	Indicative Interventions	Output Results
i. Build capacity of service providers ii. Demand creation for service utilization iii. Resource Mobilization iv. Prioritize service provision for target populations and drivers of the epidemic v. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for STI management vi. Increase comprehensive knowledge of STIs vii. Improve STI surveillance and partner notification in STIs management	i. Review and implement the guidelines and protocols for syndromic and differential management of STIs ii. Train service providers on the diagnosis and management of STIs iii. Provide equipment and supplies for management of STIs at clinics iv. Advocate the integration of STIs management into the National Healthcare delivery system at all levels, including prisons v. Recruit and train STI surveillance personnel vi. Establish mobile STI service centres vii. Promote awareness of STIs prevention and management through targeted IEC campaign viii. Advocate increased resource allocation to quality and gender responsive STIs service provision ix. Provide orientation and support health service providers to provide services friendly to all target populations (adolescents, MARPs, etc.) x. Strengthen partnership and coordinate STIs service provision with other partners xi. Strengthen sexual and reproductive health education curriculum in schools at an early age xii. Produce and disseminate IEC/BCC materials on STIs xiii. Promote partner notification in STI management	i. Capacity of service providers strengthened ii. Number of people access to service increased iii. Resource for STI management mobilized and increased iv. Service provision for target populations assured v. Quality Assurance/Quality Improvement (QA/QI) for STI management developed and implemented vi. Sexual and reproductive health education curriculum introduced in schools vii. IEC/BCC materials on STIs produced disseminated viii. Partner notification promoted in STI surveillance

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Management of Sexual Transmitted Infection (STIs)**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*STI treatment & prevention services integrated into HIV prevention services by 2015*
Target Population	Men and women of reproductive age (MWRA)
Target Service Providers	Healthcare workers, partners, national coordinator, procurement specialists, ART Pharmacists/care givers

Key Activities	Indicative Interventions	Output Results
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 health service centers vi. Procure drugs viii. Improve Laboratory testing facilities	i. Advocate the integration of STIs service provision into HIV prevention and reproductive health programmes at all levels (public/private) ii. Train and retrain HIV prevention and care service providers on diagnosis and management of STIs iii. Procure and distribute STIs drugs and supplies at appropriate HIV service provision sites iv. Establish and maintain partnerships with Government, private, Non-governmental organisations, communities and target populations to improve HIV/STI prevention and treatment services v. Strengthen existing Logistics Management Information Systems at all levels for improve STIs management	i. Capacity of service providers built ii. Integration of STIs service advocated iii. STI services into HIV prevention programs integrated iv. Partnerships developed and strengthened v. Logistics support at the Health service centers for STI Management provided and drugs procured vi. Laboratory testing facilities improved

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Condom Promotion**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 80% of men and women of reproductive age (MWRA) have knowledge about dual protection benefit of condoms*
Target Population	Men and women (young people and adults aged 15-49)
Target Service Providers	Public and private sector health care workers, outreach workers, peer educators

Key Activities	Indicative Interventions	Output Results
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	i. Disseminate the comprehensive condom programming strategic plan, which includes both free distribution and social marketing of both male and female condoms and lubricants ii. Raise public awareness of the dual benefits of condom use through advocacy and a coordinated IEC campaign iii. Develop and implement IEC campaign promoting female condom use iv. Establish and increase condom distribution outlets (private/public) v. Promote participatory approaches targeting community and religious leaders for addressing cultural and religious perceptions on condoms vi. Strengthen partnerships with media houses, HARA, SLAJ, MEDIAC, etc. to promote the benefits of condom use vii. Establish partnerships with entertainment centres, hotels, guesthouses and beauty salons and other meeting points of MARPs to improve knowledge of the benefits of condom use through participatory approaches viii. Train peer educators among MARPs on the dual benefits of condom use ix. Collaborate with MDAs and Local Councils to set up condom outlets	i. Number of sexually active men and women using male and female condoms increased ii. Number of private and public outlets providing male and female condoms increased iii. Awareness about consistent and correct use of male and female condoms increased

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Condom Promotion**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 50% of sexually active males and females use condoms consistently and correctly by 2015*
Target Population	Sexually active men and women (young people and adults)
Target Service Providers	Public and private sector health care workers, outreach workers, peer educators

Key Activities	Indicative Interventions	Output Results
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	i. Procure and distribute (social marketing and free of cost) high quality male and female condoms ii. Produce and disseminate age and culturally sensitive IEC/BCC materials on correct and consistent condom use iii. Advocate for the review of education policy to allow condom education in schools iv. Update empirical research on availability, pricing, branding of condoms v. Organize specific condom promotion activities on negotiation skills vi. Integrate condom promotion and distribution into all SRH/FP service delivery	i. Consistent and correct condom use promoted ii. Appropriate operational research promoted iii. Referral and linkages with other SRH services promoted iv. Forecasting, procurement and distribution of male and female condoms and water-based lubricants undertook

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Condom Promotion**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 80% of MARPS use condoms consistently and correctly with non-marital partners by 2015*
Target Population	Sex workers and their clients, MSM, Injecting and non-injecting drug users
Target Service Providers	Public and private sector health care workers, outreach workers, peer educators

Key Activities	Indicative Interventions	Output Results
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	i. Train and support representatives of MARPs as peer condom promoters and distributors ii. Make condoms (male and female) available, accessible and affordable around areas frequented by MARPS iii. Orient and support condom service providers on provision of services friendly to MARPs, etc. iv. Utilize multi-media channels to increase demand for correct and consistent use of condoms (male and female) v. Conduct operational research on condom use among MARPS	i. Consistent and correct condom use promoted ii. Capacity of service providers strengthened iii. Appropriate operational research promoted iv. SRH services integrated and mainstreamed in HIV programmes, policies and guidelines targeting MARPs

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Prevention of Biomedical Transmission of HIV**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 80% of all private and public health institutions practicing universal safety precautions and procedures by 2015*
Target Population	Health care providers (both public and private), Auxiliary staff, Survivors of rape case
Target Service Providers	Health care providers, auxiliary staff, counsellors

Key Activities	Indicative Interventions	Output Results
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 vi. Provide safe means of biomedical waste disposal	i. Develop a universal precaution hand book (including infection control and injection safety) ii. Develop and disseminate a national protocol on PEP iii. Procure and distribute sufficient infection control commodities (gloves, disinfectants, safety boxes etc) iv. Print and distribute copies of the universal safety precaution manual and national waste management policy guidelines v. Develop the national PEP protocol to meet universally accepted standards vi. Procure and distribute PEP kits to all healthcare facilities vii. Train health care personnel and auxiliary staff on universal safety precaution and infection control viii. Provide incinerators to all health care facilities and train operators ix. Develop and disseminate BCC materials on injection safety and healthcare waste management	i. Capacity of service providers strengthened ii. National protocol on PEP reviewed iii. Injection Safety Policy and Guidelines and National Health Care Waste Management Policy reviewed and disseminated iv. Use of safe injection commodities promoted v. BCC strategies for target groups developed vi. Safe means of biomedical waste disposal established

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Prevention of Biomedical Transmission of HIV**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*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.*
Target Population	Health care providers, HIV counsellors, blood donors
Target Service Providers	Health care providers (both public and private), Blood donor organisations,

Key Activities	Indicative Interventions	Output Results
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 for blood donation and screening v. Operational research with special focus on incidence studies vii. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for PEP management	i. Review, print and disseminate the blood transfusion policy and guidelines to reflect the screening of all blood for HIV, syphilis, hepatitis etc. ii. Advocate to professional associations of doctors, Nurses, laboratory scientists, etc. to comply with the policies iii. Train laboratory staff and clinicians on safe blood services iv. Provide test kits and other blood safety materials for public and private health facilities v. Provide appropriate equipment and reagent for blood storage and cross matching vi. Institute awareness raising campaigns through all media channels to promote voluntary blood donation vii. Celebrate national and international blood donor day nationwide viii. Establish and strengthen Blood Donor clubs to promote voluntary blood donations (provide orientation and office space and equipments at national, regional and district level) ix. Advocate for national recognition of voluntary blood donor as motivation x. Establishment of blood bank at all Government Hospitals xi. Conduct mass media campaigns on blood donation xii. Organize institutional base voluntary blood donation campaigns in private sector institutions	i. Blood transfusion policy and guidelines reviewed and operationalized at all levels ii. Capacity for health facility staff strengthen in blood transfusion and management iii. Voluntary blood donation promoted iv. Compliant of the policies advocated v. Research focusing on incidence studies conducted vi. Quality Assurance/Quality Improvement (QA/QI) for PEP management developed and implemented vii. Blood testing and screening improved

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Prevention of Biomedical Transmission of HIV**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*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*
Target Population	Injecting drug users, non-injecting drug users
Target Service Providers	Health service providers and Anti-drug agencies, Drug users, Law marker and law enforcement agencies

Key Activities	Indicative Interventions	Output Results
i. Develop national policies and guidelines and disseminate ii. Advocacy iii. Develop strategic BCC messages viii. Develop and Implement of Quality Assurance/Quality Improvement (QA/QI) for IDU management	i. Develop and disseminate guidelines on service provision targeting IDUs and non IDUs ii. Conduct study on drug users (IDUs and non IDUs) iii. Advocate for review of laws and policies that act as barriers to quality prevention services/programmes in accordance with the revised national guidelines iv. Train health service providers and strengthen the capacity of existing ones to broaden access to quality prevention services for IDUs and non-IDUs v. Train and support peer educators among IDUs and non IDUs to disseminate prevention and access information vi. Develop and disseminate BCC and IEC messages targeting IDUs and non IDUs vii. Establish advocacy groups to work with national anti-drug groups to bring out the side effect of harmful drugs	i. National policies and guidelines developed and disseminated ii. Review of laws and policies that act as barriers to quality prevention services advocated iii. Strategic BCC messages developed and disseminated iv. Quality Assurance/Quality Improvement (QA/QI) for IDU management developed and implemented

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Prevention of Biomedical Transmission of HIV**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 50% of traditional medical practitioners adopt universal safety precaution (USP) by 2015*
Target Population	General public accessing services from traditional healers
Target Service Providers	Traditional medical practitioners, Councils of "Sowei" and TBA's

Key Activities	Indicative Interventions	Output Results
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 Quality Assurance/Quality Improvement (QA/QI) for USPI management	i. Develop and disseminate universal safety guidelines for traditional medical practitioners ii. Train traditional healers, TBAs and traditional society initiators in use of sterile skin piercing materials iii. Procure and distribute sterile skin piercing materials to traditional healers, TBAs and secret society initiators iv. Train traditional medical practitioners on sterilisation and safe disposal of skin piercing materials (gloves and disinfectants) v. Establish partnerships with traditional medical practitioners and engage them on mainstreaming USP in their work vi. Train peer educators among traditional medical practitioners on USP and support them with BCC and IEC materials viii. Provision of incentives for TBA's and other traditional medical practitioners for prompt referrals	i. National policies and guidelines developed and disseminated ii. Capacity of traditional medical practitioners strengthened iii. USP mainstreamed into all engagements with TBAs and traditional medical practitioners iv. Commodities procured v. Quality Assurance/Quality Improvement (QA/QI) for USPI management developed and implemented

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Prevention of Biomedical Transmission of HIV**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*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*
Target Population	Rape victims, People accidentally exposed to HIV
Target Service Providers	Health care providers, Social workers, Law enforcement agencies, Family Service Unit (FSU), Military

Key Activities	Indicative Interventions	Output Results
i. Develop/Strengthen Strategic BCC for target groups ii. Strengthen awareness and multi-sectoral linkages for PEP (Health, Police, Military,) iii. Capacity building for PEP service providers	i. Develop and disseminate BCC and IEC materials on PEP to all (public and private) health facilities, police, military and ii. Conduct multi-sectoral trainings on PEP administration for health workers and iii. Provide PEP at all centres that manage rape victims and those accidentally exposed to HIV vii. Establish a technical working group on PEP comprising of nurses association, Sierra Leone Medical and Dental Association, FSU, NACP and other relevant organizations	i. Strategic BCC for target groups developed and strengthened ii. Awareness and multi-sectoral linkages for PEP strengthened iii. Capacity of PEP service providers built

Theme	**Prevention of New HIV Infections**
Sub-Theme	**Prevention of Re-infections and Transmission amongst People**
Strategic Objective	To reduce incidence of HIV in Sierra Leone by 50% by 2015
Strategic Intervention	*At least 50% of people living with HIV have access to Positive Health, Dignity and Prevention (PHDP) interventions by 2015*
Target Population	PLHIV and their families
Target Service Providers	PLHIV and their families, Health care providers, Traditional and Religious leaders, Media practitioners, National coordinators and other partners (Private and Public), MARPs

Key Activities	Indicative Interventions	Output Results
i. Capacity building (Health care providers and PLHWA networks) ii. Scale up PHDP interventions iii. BCC for PHDP iv. Promote adherence, disclosure and monitoring of viral loads	i. Develop a training package on positive health, dignity and prevention (PHDP) ii. Train healthcare workers, PLHIVs, CSOs, on PHDPs and universal precautions iii. Provide BCC and IEC materials to PLHIV and support groups on positive living and advantages of disclosure iv. Train Health workers and Counsellors on stigma and discrimination reduction. v. Train health workers and Counsellors on adherence counselling vi. Train PLHIVs as peer counsellors and attach them to treatment sites. vii. Establish/strengthen support groups viii. Train PLHIVs in livelihood/income generation skills and provide start-up kits. ix. Train PLHIVs on advocacy skills and human rights issues. x. Strengthen HBC services by training of volunteers as HBC providers and training family care givers on HBC xi. Review and popularise HBC manual. xii. Train Traditional and Religious Leaders and elders as community counsellors and HBC service providers. xiii. Produce and disseminate IEC/BCC materials on HBC and Treatment adherence xiv.	v. Capacity of health care providers and PLHWA networks strengthened vi. PHDP interventions scaled up vii. BCC for PHDP promoted viii. BCC materials for PHDP developed and disseminated

6.0 Monitoring and Evaluation of the National HIV Prevention Strategy

The indicators for monitoring impact and outcome level results are already stated in the National M&E Plan and Strategic Plan on HIV2011-2015.The output indicators are also worked out in greater details in the M&E plan. However, critical strategic interventions for M&E of the Prevention Strategy are:

i. 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.
ii. Popularization of the national targets for service delivery in prevention areas that have been set in M&E Plan.
iii. Strengthening the monitoring and evaluation mechanisms to capture the 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 prevention strategy are as described below:

(a) Joint Mid-term Review and Final Review of the Prevention Strategy: As already included in the NSP, there will be Joint Mid-term Review of the Prevention Strategy and the Operational Plan to be undertaken in 2013 while the final review 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, NAS and NACP to programme sites to assess how the programmes are doing and provide the technical support that may be required.

(c) Surveys and surveillance: such as the Behavioural Surveillance Survey (BSS), Demographic Health Survey (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 strategy 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 using programme data. The programmes to be reviewed will include BCC, Condom Promotion, HCT, STI Treatment, PMTCT, Sexual and Reproductive Health, PEP, Injection Safety, and Blood Safety.

(e) Performance Contract Monitoring: NAS 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.

6.1 Strategic Results Framework for Prevention of New Infections

Table 1 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.

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.

Table 1: 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
	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
	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
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

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.

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.

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

It will be achieved through increased awareness about STIs symptoms and demand for STI treatment, increased availability and accessibility to high quality STI treatment and access to quality family planning services.

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.

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.

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.

Table 2: Indicators for Outcomes and intermediary Outcomes for thematic area 3 with Respective baseline and targets

Nr.	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%
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

6.2 Strategic Results Framework for Treatment of HIV

Table 3: 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	Identification of eligible PLHIV and initiation of treatment increased
	Output 1.2	Follow up of HIV exposed Infants according to national guidelines improved
	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

Table 3 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.

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.

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.

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

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%

7.0 Cost Summary of the National HIV Prevention Strategy

The total budget five year budget for the implementation of the Prevention Strategy is USD 106.5million accounting for 33% of the total (USD322 million) AIDS response resource needs. Within the broad Prevention category, 50% (USD53.6 million)of the resource requirements are for service delivery (condom promotion, PMTCT, VCCT, STI and mass media) 41% (USD 43.7 million) for priority populations -MARPs, community mobilization and workplace activities. The remaining 9% (USD 9.3 million) is earmarked for health care delivery such as PEP, blood safety, universal precaution and injection safety

Table 5: Cost Summary of Resource for the AIDS Response in Sierra Leone 2011-2015

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 / OVC	2.4	4.5	6.4	8.0	8.9	30.3	**9%**
Policy, admin., research, M&E	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	**81,743.1**	**150,613.3**	**232,850.6**	**327,066.6**	**447,515.2**	**1,239,788.7**	

Note: Adapted from the National Strategic Plan for HIV 2011-2015, Page 52-54

Table 6: Prevention Cost Breakdown for the AIDS Response in Sierra Leone 2011-2015

SERVICE DELIVERY AREA/YEAR	2011	2012	2013	2014	2015	Totals
Prevention	**8.3**	**14.1**	**20.1**	**26.9**	**37.2**	**106.5**
Priority populations						***43.7***
Youth focused interventions	0.3	0.6	1.0	1.5	2.0	5.5
Female sex workers and clients	0.2	0.6	1.1	1.8	2.7	6.5
Other MARPs (MSMs, IDUs, clients)	1.1	2.7	3.7	4.2	7.0	18.7
Workplace	0.5	1.0	1.8	2.7	3.8	9.7
Community mobilization	0.3	0.5	0.6	0.8	1.1	3.3
Service delivery						***53.6***
Condom provision	3.3	5.0	7.1	9.6	12.7	37.6
STI management	0.44	0.5	0.7	0.8	0.9	3.4
VCT	0.7	1.0	1.4	1.8	2.4	7.3
PMTCT	0.2	0.4	0.5	0.7	1.0	2.8
Mass media	0.4	0.4	0.5	0.5	0.6	2.5
Health care						***9.3***
Blood safety	0.6	0.8	1.1	1.5	1.9	5.9
Post-exposure prophylaxis	0.21	0.33	0.46	0.63	0.82	2.4
Safe injection	0.01	0.01	0.01	0.01	0.01	0.1
Universal precautions	0.1	0.1	0.2	0.2	0.3	0.9

Note: Adapted from the National Strategic Plan for HIV 2011-2015, Page 52-54

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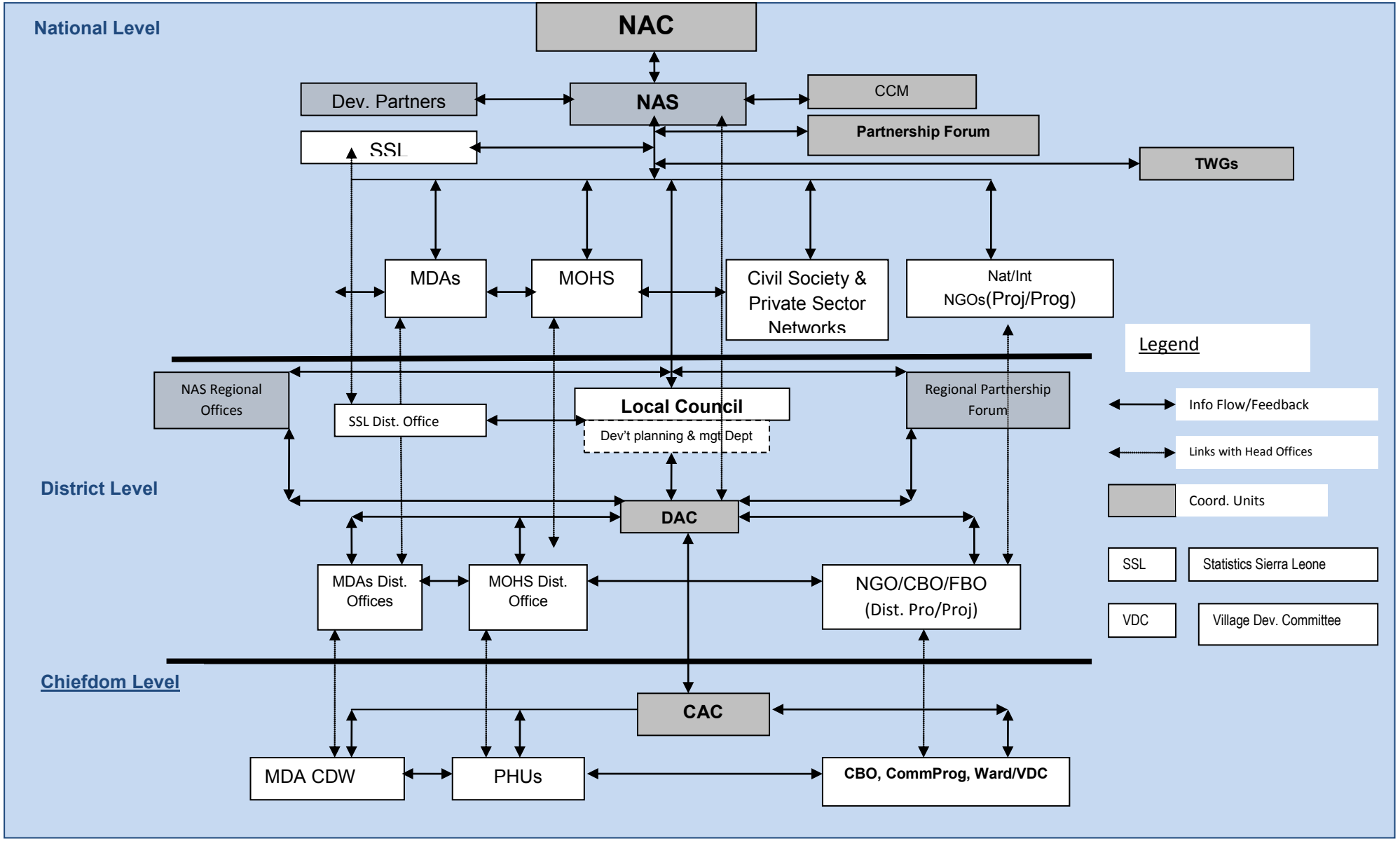
ANNEX1: INSTITUTIONAL FRAMEWORK FOR COORDINATION AND IMPLEMENTATION



ANNEX 2: Attendance List – Initial Drafting Workshop, September 4-10, Taiama, Moyamba District

NO.	NAME	INSTITUTION
1.	James M. Fofanah	Restless Development
2.	Abdul H. Sankoh	MOHS
3.	Lansana Conteh	MOHS
4.	Mohamed K. Sandi	NAS
5.	Hudson Tucker	Global Rights
6.	Moi Tenga Sartie	NAS
7.	Susan Tucker	NACP
8.	Idrissa Songo	NETHIPS
9.	Mariama M. Conteh	NACP
10.	Sullay Lakoh	MOHS
11.	Sulaiman K. Fogbawa	CARE
12.	Abu B. B. Koroma	NAS
13.	Abdul Rahman Sessay	NAS
14	Nyaibor Ngombu	UNFPA
15	Jusu Squire	UNFPA
16	Adama Thorlie	UNDP
17	Chibwe Lwamba	UNAIDS
18	Helen Lane	UNAIDS
19	Edmond Makiu	UNICEF
20	Kalilu Totangi	Consultant
21	Dominic Lamin	Consultant

ANNEX 2: Consultation with the District and City Councils, October 17 – 18, 2011, Bo District

NO.	NAME	INSTITUTION
1.	Henry K. Martin	Bonthe Municipal Council
2.	Dalton K. Charles	Bonthe Municipal Council
3.	Julia T. Amara	Bo District Council
4.	Remie Musa	Bo District Council
5.	Tahim Fullah	Pujehun District Council
6.	Mohamed S. Salifu	Pujehun District Council
7.	Namisa Kramer	NAS Regional Office, Bo
8.	Gabriel T. Ndanema	Moyamba District Council
9.	Thomas Brima	Bo City Council
10.	Mary J. Coker	Bo City Council
11.	Ansu Feika	Bonthe District Council
12.	Sheku A. Sheriff	Bonthe District Council
13.	Thaim S. Kargbo	NAS Regional Office, Bo
14.	Eric M. Sam	Kailahun District Council
15.	Edward Alpha	Koidu New Sembehun City Council
16.	Ahmed Samba Turay	Freetown City Council
17.	Ramata Mansaray	Tonkolili District Council
18.	Arthur Allieu	Tonkolili District Council
19.	Alimany B. L. Mansaray	Kono District Council
20.	David Sesay	NAS Regional Office, Makeni
21.	Thaimu s. Kanu	Western Area Rural District Council
22.	Abioseh Mansaray	Western Area Rural District Council
23.	Abdul Karim Marah	Freetown City Council
24.	Mohamed M. B. Sisay	NAS Regional Office, Kenema
25.	Augustine K. Luseni	NAS Regional Office, Kenema
26.	Fatmata Dassama	Kenema District Council
27.	Fatmata Sannoh	Kailahun District Council
28.	Junisa Jamiru	Kono District Council
29.	Alie B. Mansaray	Kono District Council
30.	Komba L. Wonneh	Koidu New Sembehun City Council
31.	M. S. Conteh	Kenema City Council
32.	Afiju Pokawa	Kenema District Council
33.	Anthony Fonnie	Kenema City Council
34.	Mohamed B. Jalloh	Kambia District Council
35.	Abu Salia Kamara	Kambia District Council
36.	Isatu Mansaray	Makeni City Council
37.	Nyuma Manigo	Makeni City Council
38.	Frank Kanu	Bo District Council
39.	Alhassan Kamara	NAS Regional Office, Makeni
40.	Abdul Rahman Sesay	NAS Headquarters
41.	Abu B. B. Kamara	NAS Headquarters
42.	Joseph Samura	Makeni City Council
43.	Arnold Mason	Bonthe Municipal Council
44.	Joseph Tholley	Tonkolili District Council
45.	Chibwe Lwamba	UNAIDS
46	Aki Yoshino	UNAIDS
47	Edmond Makiu	UNICEF
48	Salieu Jalloh	UNICEF
49	Dominic Lamin	Consultant
50	Kalilu Totangi	Consultant

ANNEX 3: Consultation with Young People, -October 27, 2011, Freetown

No.	Name	Organization
1.	Ibrahim Mansaray	Artist United for Children and Youth Development in Sierra Leone
2.	George R. Freeman	Why can't we get married.com
3.	George D. Morris	Youth Action for Development
4.	Hajie Bah	Network Movement for Youths – Sierra Leone
5.	Yamarie Jah	Youth & Children Advocacy – Advocacy Network
6.	Ernest H. Aruna	Restless Development
7.	Fatmata Sall	AIESEC – Sierra Leone
8.	Princess Owiredu	Young Potential Forum Network
9.	Sheku Kamara	Young Potential Forum Network
10.	Kenneth M. Libby	Restless Development
11.	Helen Lane	UNAIDS
12.	Alimamy S. Kargbo	Sierra Leone Youth Coalition on HIV/AIDS (SLYCHA)
13.	Idrissa A. Conteh	Sierra Leone Youth Coalition against AIDS
14.	Leslie A. A. Sesay	Young Potential Forum Network
15.	Samuel Makiu	UNICEF
16.	Alusine J. L. Rogers	Action for Social Rights (AfSOR)
17.	Mohamed B. Koroma	Sierra Leone Youth AIDS Network (SILYAN)
18.	Mariama Bangura	United Nations of Youths
19.	Regina Lumeh	Restless Development
20.	Daniel F. H. Keita	Restless Development
21.	Abrahman Bah	Free Your Mind
22.	Abdul Rahman Sessay	NAS
23.	Aminata Shaw Korjie	NACP
24	Abu Bakarr Koroma	NAS
25.	Kalilu Totangi	Consultant
26	Dominic Lamin	Consultant

ANNEX 3: National Validation Workshop, 9th November 2011, Freetown

NO.	NAME	INSTITUTION
1.	Lillian B. Khanu	Business Coalition Against AIDS in Sierra Leone
2.	Alpha Y. Kargbo	HIV/AIDS Reporters Association
3.	Doris Bah	Sierra Leone Inter Religious Network on AIDS
4.	Rev. Christiana Sutton-Koroma	Sierra Leone Inter Religious Network on AIDS
5.	Sylvester W. E. Bell	Business Coalition Against AIDS in Sierra Leone
6.	Samuel R. Hyde	Business Coalition Against AIDS in Sierra Leone
7.	Dr. Sulaiman Conteh	NACP
8.	Brima Sorie Kanu	Network of HIV Positives in Sierra Leone (NETHIPS)
9.	Hon. Marie Jalloh	Parliamentary Committee on HIV HIV/AIDS
10.	Veronica Smith	AFRICARE
11.	Saffa Smart	AFRICARE
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19.	Idrissa Songo	Network of HIV Positives in Sierra Leone (NETHIPS)
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23.	Mohamed K. Sandi	NAS
24.	Martha S. Kamara	NACP
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35.	Marian Kargbo	Aureol Insurance Company
36.	Lansana Conteh	MOHS
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38	Mohamed Kutubu	COOPASL
39	Chibwe Lwamba	UNAIDS
40	Dr. Dorothy Ochola-Odongo	UNICEF
41	Mulunesh Tennangashaw	UNAIDS
42	Salieu Jalloh	UNICEF
43	Edmond Makiu	UNICEF
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45	Helen Lane	UNAIDS
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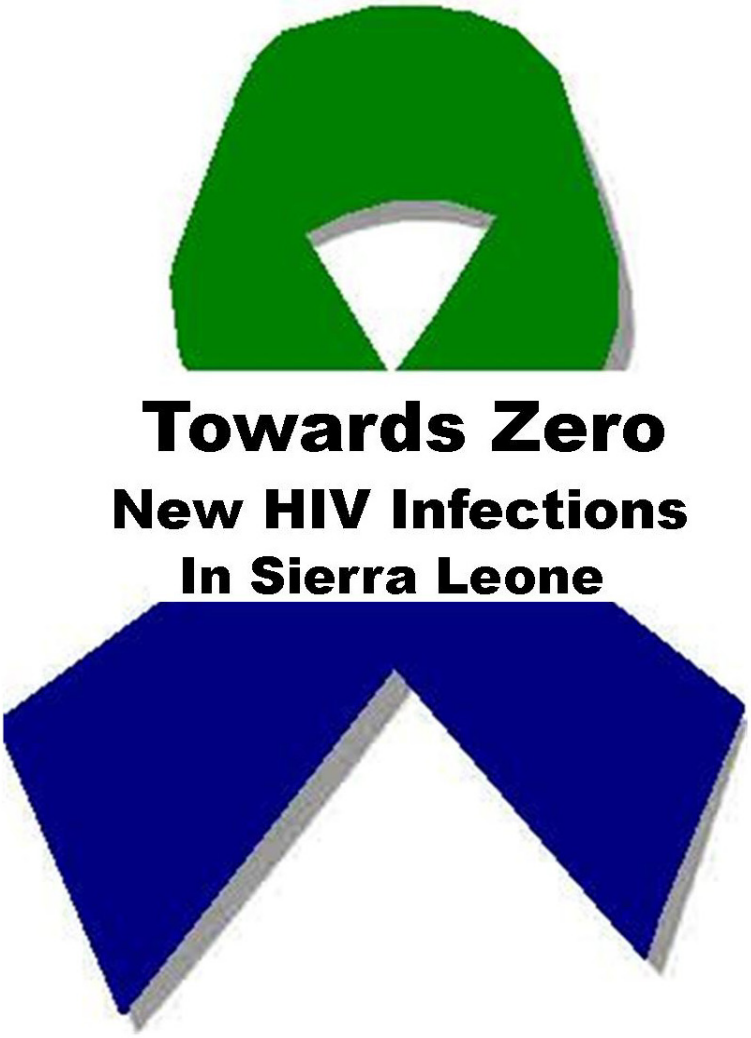
47.	Abdul Rahman Sessay	NAS
48.	Tunie M. Kargbo	NAS
49.	Donald M. Charles	NAS
50.	Mohamed S. Sannoh	NAS

National HIV Prevention Strategy

2011-2015



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