Sierra Leone

Final Joint Review of the
National Strategic Plan on HIV/AIDS 2006-2010

August 2010

Volume 2

Sierra Leone
Final Joint Review of the National Strategic Plan on HIV/AIDS 2006-2010

National AIDS Secretariat
Freetown, Sierra Leone

August, 2010

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Five for One

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

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

Five Pillar Activities:

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

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

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

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

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

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Abbreviations

AAISL	Action Aid International Sierra Leone
ADRA	Adventist Development and Relief Agency
AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARG	AIDS Response Group
ART	Antiretroviral Therapy
ARV	Antiretroviral
AWARE	Action for West African Region
AWP	Annual Work Plan
BCAASL	Business Coalition Against Aids in Sierra Leone
BCC	Behavioural Change Communication
BSS	Blood Safety Services
CAC	Chiefdom AIDS Committee
CADO	Community Animation and Development Organization
CARE	Cooperative American Relief Everywhere
CASL	Christian Aid in Sierra Leone
CBO	Community Based Care
CCC	Community Care Coalition
CCF	Christian Children's Fund
CCM	Country Coordination Mechanism
CHASL	Christian Health Association of Sierra Leone
COMAHS	College of Medicine and Allied Health Sciences
CONCERN	Concern Worldwide, Sierra Leone
CPHHRA – SL	Campaign for Promotion of Health and Human Rights Activities in Sierra Leone
CRS	Catholic Relief Service
DAC	District AIDS Committee
DHMT	District Health Management Team
DHO	District Health Officer
DOO	District Operational Officers
DPC	Disease Prevention and Control
DPI	Directorate of Planning and Information
DSMC	District Social Mobilization Coordinator
DSO	District Surveillance Officer
FAO	Food and Agricultural Organization
GLCS	Gay and Lesbian Community Services
GWT	Gender Working Team
HACSA	HIV and AIDS Care and Support Association
HARA	HIV and AIDS Reporters Association
HBC	Home Based Care
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Users

IEC	Information, Education and Communication
IMC	Independent Media Commission
IOM	International Office of Migration
JPR	Joint Programme Review
KFW	Krebitalftalt für Wieberaufbau (German Development Bank)
Le	Leone (Sierra Leone currency)
M&E	Monitoring and Evaluation
MELSS	Ministry of Employment, Labour and Social Security
MELSS	Ministry of Employment, Labour Social Security
MEYS	Ministry of Education Youth and Sport
MIALGRD	Ministry of Local Government, Rural and Development
MLGCD	Ministry of Local Government and Community Development
MoD	Ministry of Defence
MoFED	Ministry of Finance and Economic Planning
MoHS	Ministry of Health and Sanitation
MoIC	Ministry of Information and Communication
MoJ	Ministry of Justice
MoTCA	Ministry of Tourism and Cultural Affairs
MoWHI	Ministry of Works, Housing and Infrastructure
MoYS	Ministry of Youth and Sports
MRDP	Mabanta Rural Development Project
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
NAS	National AIDS Secretariat
NECHRAS	Network of Christian Association
NETHIPS	Network of HIV Positives
NLTCP	National Leprosy TB Control Programme
NOW	National Organization for Welbodi
NSP	National Strategic Plan
OHCHR	United Nations Office of the High Commissioner for Human Rights
OI	Opportunistic Infection
PEP	Post Exposure Prophylaxis
PFSL	Pentecostal Fellowship of Sierra Leone
PHC	Primary Health Care
PHE	Public Health Educators
PHU	Peripheral Health Units
PLAN	Plan International Sierra Leone
PLHIV	People Living with HIV
PLWHAs	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PPASL	Planned Parenthood Association of Sierra Leone
RH	Reproductive Health
RODA	Rofutha Development Association
SALONE TIMES	Sierra Leone Times Newspaper

SDO	Senior Development Officer
SEAC	Sexual Exploitation and Abuse Committee
SHARP	Sierra Leone HIV and AIDS Response Project
SL	Sierra Leone
SLANGO	Sierra Leone Association of Non Governmental Organization
SLCB	Sierra Leone Commercial Bank
SLCC	Sierra Leone Chamber of Commerce
SLDHS	Sierra Leone Demographic and Health Survey
SLLC	Sierra Leone Labour Congress
SLPA	Sierra Leone Port Authority
SLPMMA	Sierra Leone Prevention of Maternal Mortality Association
SLRCS	Sierra Leone Red Cross Society
SLTU	Sierra Leone Teachers Union
SMO	Senior Medical Officer
SPU State House	State Patrol Unit State House
STI	Sexually Transmitted Infections
SWAASL	Society of Women and AIDS in Africa, Sierra Leone Chapter
TBA	Traditional Birth attendants
TSHSL	The Sheppard Hospice in Sierra Leone
UMC HOSPITAL	United Methodist Church Hospital
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Fund for Population Activities (UN 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
US$	United States (of America) Dollar
USD	United States (of America) Dollar
VCCT	Voluntary Confidential Counselling and Testing
VOW	Voice of Women
VSO	Voluntary Service Overseas (UK)
WA	West Africa
WEC	West End Clinics
WFP	World Food Programme
WHO	World Health Organization
WIC	Women in Crisis
WVSL	World Vision Sierra Leone
WVSL	World Vision Sierra Leone
YWCA	Young Women Christian Association
YWDO	Youth Welfare and Development Organization

Acknowledgements

The Lead Consultant, on his own behalf and on behalf of the rest of the Review Team, would like to thank all the stakeholders they interviewed in Freetown and in the districts or who contributed information during the Review. They also acknowledge with appreciation the unreserved support they received from Dr Brima Kargbo, Director of NAS and his staff especially Mr Abdul Rahman Sessay, Deputy Director, Mr Victor Kamara, Ms Margaret Nemahun and their colleagues who coordinated the logistics for the Review.

This Review would not have been possible if the government and various bilateral and international organizations, especially UNFPA, had not committed funds for the work. The Review was supported by: NAS, UNAIDS and UNDP.

Picture 0-1: H.E. The President, Dr Ernest Bai Koroma contributing to the review

Part I Executive summary

I.1 Background

I.1.1 The epidemic

The prevalence of HIV has stabilized at 1.5% in the general population since 2005 according to the sero-surveys. The first survey in 2002 showed a prevalence of 0.9%. The second and third sero-surveys in 2005 and 2008 indicated a prevalence of 1.5%. The prevalence among pregnant women rose from 3.0% in 2004 to 4.1% in 2006, 4.4% in 2007 and fell slightly to 3.5% in 2008, according to ANC sentinel surveillance surveys. The highest prevalence among women has shifted from the 20-24 years age group (2.0%) and males in the age group 35-39 (3.5%) in 2005 to the 30-34 age group (2.4%) and the 45-49 age group (2.1%) in 2008 respectively. HIV prevalence is higher among urban population than rural population 2.5% and 1.0% respectively, according to the 2008 Demographic and Health Survey (SLDHS).

Male circumcision, a common practice in Sierra Leone, has become a prominent global issue in HIV prevention. The 2008 SLDHS showed HIV prevalence of 1.2% among circumcised men compared to a prevalence of 2.4% men who were not circumcised.

Knowledge related to AIDS is still fairly low with nearly 30% women and 17% men having never heard of AIDS. Ignorance of AIDS is worse in rural areas.

I.1.2 National response

The government's response has involved first the formation of a National AIDS Committee in 1986 followed by the National AIDS Control Programme (NACP) in 1988 replacing the Committee to strengthen the HIV and AIDS prevention activities. Then in 2001, the government appointed a Cabinet Sub-Committee on HIV and AIDS under the leadership of the Minister of Information and Broadcasting.

The increasing interest in addressing HIV and AIDS and the exigencies of coordination resulted in the establishment of the National AIDS Council (NAC) and its Secretariat (NAS) under the Office of the President in 2002. NAC, chaired by the President, is the highest strategic body in the national response. NAS coordinates the implementation of the policies agreed upon by NAC by involving key Ministries, local councils, the private sector, and civil society in the design, planning, implementation, monitoring and evaluation of programmes. HIV and AIDS coordination activities are being decentralized to district level through the establishment of District AIDS Committees (DAC) in every district.

The end of the decade-long war provided the country with a socio-political environment for implementing a comprehensive multi-sectoral programme to combat the HIV epidemic including free treatment with ARVs. Combating HIV and AIDS is considered a major step towards poverty reduction as stated in the Presidential *Agenda for Change*.

The government continues to demonstrate its total commitment to the response against HIV and AIDS by annually increasing budgetary allocations though the allocations are inadequate.

The steps taken by the country to respond to the emerging HIV and AIDS epidemic under these circumstances are more than impressive over the past five years. The war legacy and the global economic situation are contributing to the challenges that the country has to face for a more robust response to the epidemic. The challenges include shortage of qualified people, shortage of financial resources and a very youthful population that is extremely vulnerable. The political will among the sectoral political leaders must have *an **audible call** and **visible actions** that can galvanize the residents of Sierra Leone to realize that the country is in the midst of a new war, a war that could be more devastating than the ten-year war*.

I.2 Objectives of the Joint Review

The main objective of the Joint Programme Review of the NSP 2006-2010 was provide recommendations that will guide the development of a new National HIV and AIDS Strategic Plan, new M&E Plan and an Operational Plan.

To effectively achieve this objective, the review was done under the framework of a joint review aiming at collective responsibility, enhancing ownership and increasing the likelihood of using the review findings. Development partners (stakeholders) at all levels (national, district and lower levels) were actively involved throughout the entire review process.

I.3 Summary findings, conclusions and recommendations

The Review results are presented according to the six NSP priority areas:

- Decentralized implementation
- Prevention of new infection
- Care treatment and support of PLWHAs, families and communities
- Protection of human and legal rights
- Research, M&E
- Key sectoral responses

The Joint Programme Review has brought out a number of important insights into the national response to the HIV and AIDS epidemic over the past five years. None of the six priority areas is without weaknesses or challenges.

I.3.1 Priority Area 1: Decentralized implementation

I.3.1.1 Summary findings and conclusions

There are two major strengths in the structure and management of the national response:

1. NAS is well placed in the President's Office to coordinate the multi-sectoral response including the decentralization through District AIDS Committees (DACs).
2. The current leadership of NAS is focused to its mandate and dedicated to the national response.

The national response is, however, still hampered by a lack of clarity in the minds of some stakeholders on the different roles NAS is currently playing: as a statutory coordinating body and as a conduit of funding to programmes and activities. Another weakness in the response is the poor dissemination (and communication) of key documents such as the NSP and the M&E Framework to the stakeholders.

There are opportunities the country should capitalize on during the next strategic planning period. These include:

- Recognition of HIV and AIDS as an important health and developmental issue in the President's Agenda for Change[1]
- Goodwill demonstrated by increasing resource input by the government into the national response
- Existence of the Partnership Forum which is fully supported by H.E. the President that offers a forum for sharing experiences and eventual harmonization of the national response across partners.

A number of challenges have to be addressed to achieve full decentralized national response. They include:

- The reluctance of Implementing Partners to disclose the amount of money they use, especially the organizations with no direct working relationship with NAS
- The slow speed of decentralization and inadequacy of the resources needed to ensure effective functionality of the decentralized facilities
- Inadequate numbers and capabilities of human resources in areas such as M&E
- Excessive dependency on external sources of finances for the national response (98% of resources come from donors only 2% from government)
- A disconnect between DACs and implementing partners receiving funding through NAS

I.3.1.2 Recommendations

The coordination of the national response under the decentralization of administrative responsibilities to the district level requires NAS to have sufficient staffing capacity for a timely response to district and chiefdom level needs. Establishment of district level AIDS committees should not be taken as an end but merely as part of the process of decentralization of the national response to HIV and AIDS. There are still a number of problems with the DACs such as clarification of responsibilities among DAC members and the role of the committees. Districts with city councils have to resolve whether they should have one DAC or a city council AIDS committee as well and if such a committee is established what it should be called. Chiefdom level committees should be established as soon as possible. These are the structures at the district and chiefdom levels that NAS has to work through to execute its statutory mandate. The authorities must also know who is doing what and where in the country. Monitoring the activities including financial inputs requires a cadre of well qualified and experienced people in M&E stationed at the central and district levels. The move to establish regional coordinators is noted and welcomed. In order to fully decentralise the work of NAC and NAS, it is recommended that:

1. The country should have a fully empowered multi-sectoral coordinating body. NAS must have legal status that covers decentralization of the coordinating body and gives it the authority to monitor resources coming into the country for HIV and AIDS activities.
2. The decentralization process for NAC and NAS should be continued until the DACs and CACs are fully functional as required by law [implied in Recommendation 1]
3. DACs should be part of MoUs signed between NAS and implementing partners.

[1] The Republic of Sierra Leone. *An Agenda for Change. Second Poverty Reduction Strategy (PRSP II) 2008-2012.*

4. NAS should have a clear strategy of establishing and/or strengthening district level M&E units so that they become effectively functional.
5. NAS should continue monitoring sectoral responses to the HIV and AIDS epidemic using result-oriented output and outcome indicators and using the results for vetting the continued operations of the various sectoral activities.

I.3.2 Priority Area 2: Prevention of new infections

I.3.2.1 Summary findings and conclusions

Positive strides have been made in the area of prevention over the five years period. The continuous increase of VCCT and PMTCT sites in health facilities coupled with the streamlining of condom procurement for free distribution underscores the nation's commitment to the global goal of preventing new infection. The development and distribution of policy documents and guidelines have guided implementation in the country.

Although IEC/BCC materials are distributed targeting various groups yet NAS has not designed a mechanism to ensure the vetting of information that some carry for all IEC/BCC materials. Weak synergy between the DHMT and traditional healers continues to pose a challenge to treatment.

The existence of budget lines for HIV and AIDS activities in most funding institutions and the creation of a desk in most ministries, departments and agencies is an opportunity toward an integrated response to the epidemic.

I.3.2.2 Recommendations

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The existence of budget lines for HIV and AIDS activities in most funding institutions and the creation of a desk in most ministries, departments and agencies are opportunities toward an integrated response to the epidemic. The review recommends that:

1. Prevention of new infections remains a major pillar in the new national strategic plan.
2. The new NSP should have strategies promoting establishment of channels of discussion among political, civic, religious and cultural leaders that would lead to programmes related to HIV prevention among in and out-of-school youths and adolescents, CSWs and emerging high risk groups of men who have sex with men (MSM) and injecting drug users (IDU).
3. The country should recognize the impact PLHIVs can make to the national response by *meaningfully involving* them in the planning, implementation, monitoring of activities at all levels in all sectors.

4. The importance of traditional healers should be recognized as the new NSP is prepared so that it includes strategies of drawing them in the national response to ensure that their contributions do not undermine the national response.
5. The country should have clear strategies for cross-border HIV prevention services.

I.3.3 Priority Area 3: Care, treatment and support of PLHIVs, families and communities

I.3.3.1 Summary findings and conclusions

In the area of treatment, care and support; it is positive to note that HIV and AIDS-related protocols and guidelines have been developed and disseminated within the health sector. This is followed by the training of existing health personnel in health facilities on the treatment protocols. However, the involvement and activities of traditional healers on the management of HIV and AIDS remains unknown. Inclusion of HIV and AIDS, as a strategy, in pre-service training programmes is yet to happen. Besides, putting in place systems for recurring HIV and AIDS training for health personnel is a challenge.

There has been progress on the number of facilities implementing ART, VCCT and PMTCT services including availability of free adult ARVs nationwide. However, there is no provision for the increased demand for PMTCT services created by the Free Health Care Initiative (FHCI) as there are current stock-outs of paediatric AVRs in some districts.

Though challenging, the implementation of home based care programme is important to bridge the required gaps in care and support at the community level. The involvement and subsequent training of PLHIVs as Community Health Volunteers for the implementation of the HBC programme is vital for sustainability. Despite the lack of functional OVC support programme nationwide, there are a few PLHIV support groups/associations at both national and district levels which are currently receiving some form of capacity building and material support from partners including NETHIPS. To date there two known hospice care facilities established nationwide to care for terminally ill HIV and AIDS patients requiring special care. Having at least one such facility per region will provide equal opportunity to everyone needing the service.

I.3.3.2 Recommendations

Bold steps have been taken in the area of treatment, care and support during the period of the NSP 2006-2010 with the expansion of VCCT and ART centres although the numbers are still short of the universal access targets. The treatment and care pillar, during this planning period, is still weak with regard to regular supply of paediatric ARVs, monitoring drug resistance, home based care and other community based services etc.

The country is also faced with the challenges of, for example, shortage of trained personnel needed for proper delivery of treatment, stigma and discrimination, non-comprehensive picture of OVCs and inadequate financial resources and lack of volunteerism. The NSP mid-term review observed that care treatment and support for PLHIVs is necessary for their welfare and to fight stigmatisation and discrimination. To deliver proper and effective treatment and care requires not only financial input, but the commitment of all stakeholders, the community at large and meaningful involvement of PLHIVs.

It is, therefore, recommended that:

1. The new NSP should have strategies for developing human resource capacities covering health personnel, civic, religious and traditional healers.
2. The next national strategic plan should have community based services (care for OVCs, care coalitions, volunteer services, home based care etc) as a major pillar to the national response to improve services at the community level.
3. The country should recognize the impact PLHIVs can make to the delivery of care, treatment and support by *meaningfully involving* them in the relevant services
4. A communication strategy should be revamped to guide the design, validation and dissemination of all HIV and AIDS communication materials.
5. Stigma and discrimination against people living with or affected by HIV should be a major pillar in the next national strategic plan involving religious and traditional leaders
6. NACP should create effective supply chain management system in the next NSP for HIV and AIDS pharmaceuticals and medical supplies.

I.3.4 Priority Area 4: Protection of human and legal rights

I.3.4.1 Summary findings and conclusions

Sierra Leone's position on human rights is strong because it has ratified International Human Rights Protocols and has recently enacted laws against gender-related violence and abuse. The existence of FSUs and some support groups (GWT, SEAC and VOW) in some districts is a good sign that the country is moving in the right direction towards providing support to victims of gender and sexual abuse. These embryonic support groups need to be replicated in all districts. As a result of low sensitization the laws on HIV and AIDS enacted are not known by most of the population.

I.3.4.2 Recommendations

The NSP 2006-2010 had protecting human and legal rights as one of its priority areas and a number of legal statutes were enacted during the NSP period. They include the Three Gender Acts (2007), the prevention and control of HIV and AIDS Act (2007), the national workplace policy, and the establishment of the Family Support Units in the Police. The review found that the existence of these statutes and policies have not stopped gender-based violence or stigma and discrimination. For the laws to meet the needs of the people and be acceptable they must be known and understood by the people. Laws have also to be enforced to be effective. The enforcement of these laws demands a robust legal system to try violators and an effective monitoring and reporting system. The Joint Programme Review, therefore, recommends that:

1. During the new planning period the country should improve its communication strategy in all sectors with regard to the laws on HIV and AIDS, human rights and stigma and discrimination at the workplace.
2. The judicial system should be primed to receive and adjudicate on incidents of abuse against PLHIVs.
3. Strategies for counteracting claims of curing AIDS without scientific evidence.

I.3.5 Priority Area 5: Research, Monitoring and Evaluation

I.3.5.1 Summary findings and conclusions

The existence of a data base at NAS and data banks in some districts is quite a step in the right direction. However, this must be developed into a national holistic data bank that receives input of data on HIV and AIDS activities from sub data banks in all districts to ensure effective data analysis and comprehensive nationwide coverage.

In view of the field findings, it is still evident that the issue of research on HIV and AIDS is weak. NAS in collaboration with implementing partners is required to strengthen advocacy for proper research that would enable the country to understand fully the drivers of the epidemic and the best practices in the national response.

The country has an M&E Framework to guide the monitoring of the national response with support of M&E working groups in a few districts. Establishment of functional M&E working groups in all districts is an expensive undertaking that cannot be funded solely by the Global Fund. It is a key challenge that demands an immediate action to locate and re-direct other sources of funding to implementing the entire component of the M&E Framework.

The technical capacity of the M&E structure to effectively monitor the national response remains a daunting challenge. It is imperative, therefore, to strengthen M&E nationwide, providing adequate training of personnel and building infrastructure at district level.

The channel for reporting between NAS, stakeholders and DACs as specified in the M&E Framework has not been strictly followed. This is influenced by the different provisions of funding to the implementing partners. NAS, therefore, faces the challenge of "convincing" all the partners of the need for routine reporting of their activities to NAS to work towards a comprehensive implementation of the M&E Framework.

I.3.5.2 Recommendations

An effective multi-sectoral coordination of the national response to HIV and AIDS requires a functional monitoring and evaluation system, as expounded in the "Three Ones" principles. The country has established a monitoring and evaluation mechanism to track HIV and AIDS activities at all levels from central level to chiefdoms. The weaknesses of the system with regard to human capacity and low operational resources support are making the system inefficient. Effective collection of data and smooth data flow are important components of a functional and efficient monitoring and evaluation system. There are gaps in the channels of important national HIV and AIDS data flow.

The review, therefore, recommended that:

1. Monitoring and Evaluation remains a priority pillar of the next HIV and AIDS national strategic plan
2. The new NSP identifies strategies that NAS can use to develop a national HIV and AIDS data bank, in strong collaboration with implementing partners, that captures all relevant data on the national response from all sectors and implementing partners for effective monitoring and coordination of the national response.
3. The new NSP should have clear strategies for communicating key national response policies, plans and guidelines such as the NSP, the M&E Framework and Operational Plan to all sectors and participating partners including DACs.

4. While the strategy for collaboration with traditional healers can be well addressed under prevention, care and treatment, the new NSP should have strategies to promote research as a specific objective to be applied, for example, to alternative treatment of HIV and AIDS by traditional healers, emerging issues such as CSW, MSM and IDU
5. During the next planning period, NAS in collaboration with partners should develop research agenda for information sharing and resource mobilization to support research.

I.3.6 Priority Area 6: Key sectoral responses

I.3.6.1 Summary findings and conclusions

A number of positive steps have been taken during the last five years to involve different sectors into the national response to HIV and AIDS. Most significant is the existence of an active Business Coalition bringing together major industries in the country to be actively involved in the national response to the epidemic. A number of companies belonging to the Coalition have workplace policies.

Additional strengths for sectoral response are:

- The enactment of the *Prevention and Control of HIV and AIDS Act, 2007* which has provisions against discrimination
- The establishment of the national workplace policy on HIV and AIDS protects PLHIVs against discrimination
- Existence of an affirmative action exists for the girl child primary education.

A major weakness in the sectoral responses is in connection with the programmes targeting the youth. Almost all existing HIV and AIDS preventive strategies for the youth are addressing the youth in schools. The out-of-school youth are not properly covered.

Sectoral responses have the opportunity to grow with the commitment of the private sector through the Business Coalition and Labour Congress's involvement in the national response.

Three major challenges were identified by the Joint Review in connection with sectoral responses.

1. Inadequate involvement of key sectors of Health; Education; Local Government, Employment, Labour and Social Security; Social Welfare, Gender and Children Affairs in the national response under NAS's coordination.
2. Lack of emphasis on career guidance in government schools
3. The 45% enrolment of girls in educational institutions masks the low level of girls' enrolment in secondary schools. The challenge is to bring the girls' enrolment in secondary schools to at least the same level as the boys' level.
4. The variety of BCC materials is not adequate to meet the different ages of children using them.

I.3.6.2 Recommendations

The NSP 2006-2010 identified three key public sectors: Education, Science and Technology and Labour as leaders in addressing the training and employment needs for the youth in the national response to HIV and AIDS.

Some accomplishments have been made over the past five years but a lot still remains to be done. Some of the issues that need to be addressed are sector cross-cutting such as stigma, gender-based violence, delinquency, career guidance, teenage pregnancy etc.
The Review recommendeds that:

1. Youth and adolescents should form a major pillar in the national response during the next planning period.
2. The country identifies strategies over the next planning period which will effectively bring HIV preventative services to the in and out-of-school youth and adolescents.
3. During the next planning period, the country takes serious steps to address girl-child specific issues such school enrolment and completion of school education, teenage pregnancy and gender-based violence.
4. The new NSP should include robust strategies on workplace programmes addressing discrimination and stigma.
5. The country must, during the next planning period, implement strategies that bring key sectors of Health, Education, Local Government and Rural Development, Social Welfare, Gender and Children Affairs to play their full roles in the national response under NAS's coordination.

Part II Introduction

II.1 Demography[2]

Sierra Leone is a multi-party democratic state with a republican constitution. Administratively the country is divided into the Western Area and three provinces: Northern, Southern and Eastern (Figure II.1). These are further divided into 14 districts made up of 149 chiefdoms. The Western Area is divided into Western Urban where the capital city Freetown and the seat of Government is located and Western Rural. There are 5 city councils and 14 district councils, including Freetown.

Figure II.1: Map of Sierra Leone showing provincial and district boundaries

[2] Adapted from: Government of Sierra Leone. *Sierra Leone HIV and AIDS National Strategic Plan (2006-2010).*

The Country's population, which is growing at the rate of 2.179% (2009 est.)[3] per annum, is estimated (July 2009 est.) as 5,132,000. Women account for about 51% of the total population (Statistics Sierra Leone provisional results of the December 2004 Population and Housing Census). With a persistently high Total Fertility Rate of 5 children born/woman (2009 est.) this has largely contributed to the youthful nature of the population.

Over the years, the urban population has increased at a faster rate than the rural, largely as a result of the recent civil conflict. The result of the rural-urban migration has led to a large number of people displaced from their localities (villages/chiefdoms etc) and thus separated from families and traditional ties, resulting in breakdown of communal traditions and family bonds. These communal traditions and family bonds are crucial in providing care and support for PLHIVs.

The ten-year conflict, which ended in January 2002, devastated much of the country and brought great suffering to Sierra Leoneans. It resulted in the displacement of more than half of the population, disrupted economic activity and destroyed much of the infrastructure (schools, health facilities, roads etc.). In terms of the human and social impact, it is estimated that the war claimed over 75,000 lives, and about 4,000 young men abducted by the rebels into their fold. As a war strategy, the rebels' brutal acts against the civilian population caused thousands to perish. The widespread human rights abuses such as sexual violence, rape, loss of parents/husbands, physical and psychological trauma during the war, exacerbated the vulnerability of women and children. The situation was also made worse in the face of declining government and family social service support systems.

Since the end of the conflict, there has been significant progress towards peace and recovery. These include the return of over 543,000 displaced persons, extension of civil administration throughout the country and the conduct of violent-free parliamentary and presidential elections.

II.2 Epidemiological situation

The first HIV and AIDS case was reported in Sierra Leone in 1987. The initial national prevalence was 0.9% (CDC 2002). As of 2008, there were 49,000 HIV cases and 5,000 new infections in that year. Also in 2008, a total of 18,600 cases required ART but 1,950 received treatment. The first antenatal care (ANC) sentinel surveillance based on eight sites was done in 2004 by the MOHS Health Sector Response Group (ARG). The survey showed an overall prevalence of 3% among pregnant women with a prevalence of 4% in Freetown.

In 2005 the National AIDS Secretariat (NAS) commissioned the second HIV sero-survey carried out jointly by Statistics Sierra Leone and the Ghana Nimba Research Institute. The survey showed a national prevalence of 1.5% among men and women aged 15-49 years. Annual ANC sentinel surveillances from 2006 to 2008 have given prevalence among pregnant women of 4.1%, 4.4% and 3.5% respectively. The most recent Sierra Leone Demographic and Health Survey (SLDHS; Spectrum model) in 2008 gave a prevalence of 1.5% among men and women aged 15-49 years. Table II-1 shows these survey and sentinel surveillance HIV prevalence results.

[3] Source: *http://www.theodora.com/wfbcurrent/sierra_leone/sierra_leone_people.html*

Table II-1: HIV prevalence survey and sentinel surveillance results

Year	Target	Prevalence (%)	Source
2002	General population	0.9	Sero-survey
2004	Pregnant women	3.0	ANC sentinel surveillance
2005	General population	1.5	Sero-survey
2006	Pregnant women	4.1	ANC sentinel surveillance
2007	Pregnant women	4.4	ANC sentinel surveillance
2008	Pregnant women	3.5	ANC sentinel surveillance
2008	General population	1.5	Sero-survey

The 2008 SLDHS shows that HIV prevalence does not differ significantly between males (1.2%) and females (1.7%). The highest prevalence among women has shifted from the 20-24 years age group (2.0%) and males from of the age group 35-39 (3.5%) in 2005 to 30-34 age group (2.4%) and 45-49 age group (2.1%) in 2008 respectively as shown in Table II-2.

Table II-2: Shift in the highest HIV prevalence over the years

Year	Women		Men	
	Highest Prevalence	Age group (yrs)	Highest Prevalence	Age group (yrs)
2005	2.0%	20-24	3.5%	35-39
2008	2.4%	30-34	2.1%	45-49

Prevalence has continued to be higher among urban than rural population. In 2005 the prevalence in urban areas was 2.1% as compared to 1.3% in rural areas. The results of the 2008 SLDHS show that the prevalence among urban population was 2.5% and 1.0% among the rural population.

Although the prevalence of HIV is relatively low in Sierra Leone, compared to Sub Saharan levels, it is not uniform over the whole country. The 2008 SLDHS showed that the lowest prevalence was in the Southern Region and the highest in the Western Area as shown in Table II-3.

Table II-3: HIV prevalence by geographic regions

Region	Prevalence	SLDHS sample
Eastern	1.4%	1,111
Northern	1.2%	2,488
Southern	0.8%	1,302
Western	2.9%	1,274

Source: Statistics Sierra Leone (SSL) and ICF Macro. 2009. *Sierra Leone Demographic and Health Survey, 2008*. Calverton, Maryland, USA

Table II-4 presents results of the prevalence of HIV by age at first sexual intercourse from the 2008 SLDHS. The SLDHS report gives results on a number of indicators of sexual behaviour which are not reported in this JPR report because of their questionable validity and likely bias.

Table II-4: HIV prevalence and age at first sexual intercourse

Age (yrs)	Women		Men		Total	
	HIV prevalence	SLDHS sample	HIV prevalence	SLDHS sample	HIV prevalence	SLDHS sample
< 16	1.5%	1,652	1.2%	554	1.4%	2,206
16 – 17	3.2%	639	1.9%	516	2.6%	1,155
18-19	1.5%	396	1.6%	574	1.5%	970
20+	1.7%	195	1.1%	683	1.3%	878

Source: Statistics Sierra Leone (SSL) and ICF Macro. 2009. *Sierra Leone Demographic and Health Survey, 2008*. Calverton, Maryland, USA

Women and men show the same pattern with the highest prevalence among those who had their first sexual intercourse when they were 16-17 years of age. The differences among the age groups are bigger among the women than among the men.

II.2.1 Circumcision

Male circumcision has become a prominent issue in HIV prevention towards the later years of the NSP. The 2008 SLDS collected data on male circumcision and HIV prevalence. The results were that the prevalence of HIV among the 2,616 men who were circumcised was 1.2% compared to 2.4% among the 57 men who were not circumcised. The majority of men in Sierra Leone are circumcised, a factor that should be factored into the new NSP and research on the drivers of the epidemic in the country.

II.2.2 Knowledge of AIDS and HIV prevention

In general, knowledge related to AIDS is still fairly low with nearly 30% women and 17% men having never heard of AIDS as shown in Table II-5 and Figure II.2. Ignorance of AIDS is worse in rural areas. In 2005 about 54% females and 65% men in rural areas had heard of AIDS. The 2008 SLDHS shows that the increase in knowledge of AIDS in the rural areas is marginal with only 59% women and 76% men admitting to have heard of AIDS as shown in Figure II.3.

Table II-5: Percentage of men and women 15-49 years who have heard of AIDS

Characteristic	Women		Men	
	Has heard of AIDS	Number surveyed	Has heard of AIDS	Number surveyed
All	69.4	7,374	82.9	2,944
Age				
15-24	72.7	2,384	81.2	929
25-29	68.9	1,643	85	446
30-39	67.2	2,175	81.2	899
40-49	67.5	1,172	86.3	671
Residence				
Urban	87.4	2,655	94.5	1,123
Rural	59.3	4,719	75.8	1,822
Region				
Eastern	69.6	1,325	88.1	557
Northern	58.6	3,001	78.7	1,131
Southern	65.3	1,542	70.9	414
Western	94.9	1,506	87.6	639
Education				
None	59.7	4,860	73.9	1,426
Primary	79.3	960	79	414
Secondary or higher	93.7	1,554	96	1,104

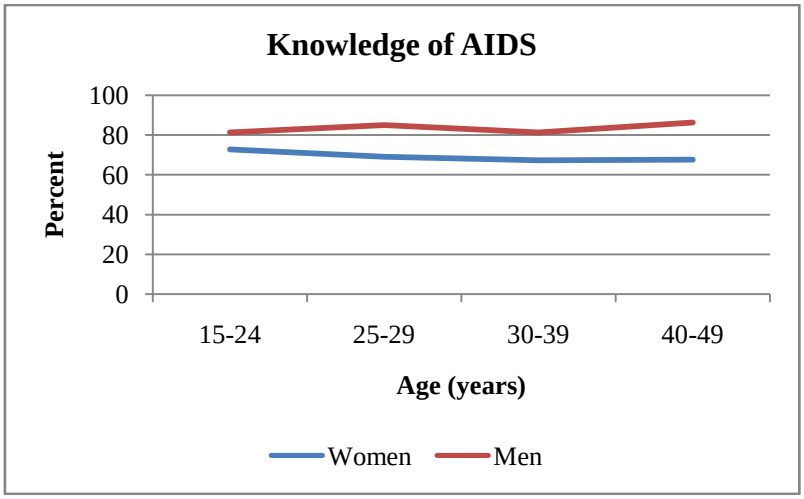


Figure II.2: Knowledge of AIDS among women and men 15-49 years

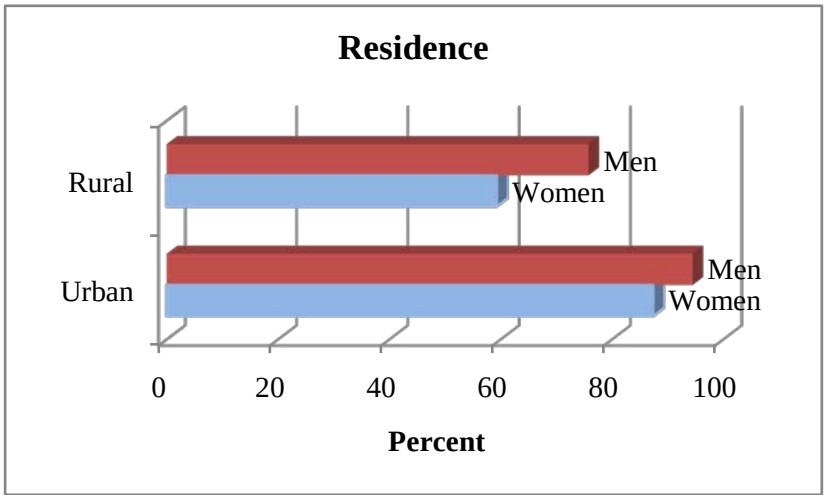


Figure II.3: Knowledge of AIDS among women and men by residence

Figure II.4 and Figure II.5 show the level of knowledge of AIDS according to region and education.

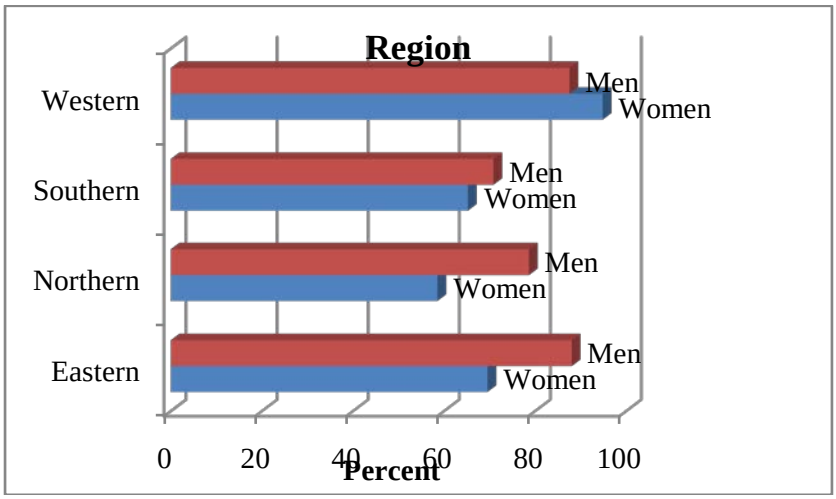


Figure II.4: Knowledge of AIDS among women and men by region

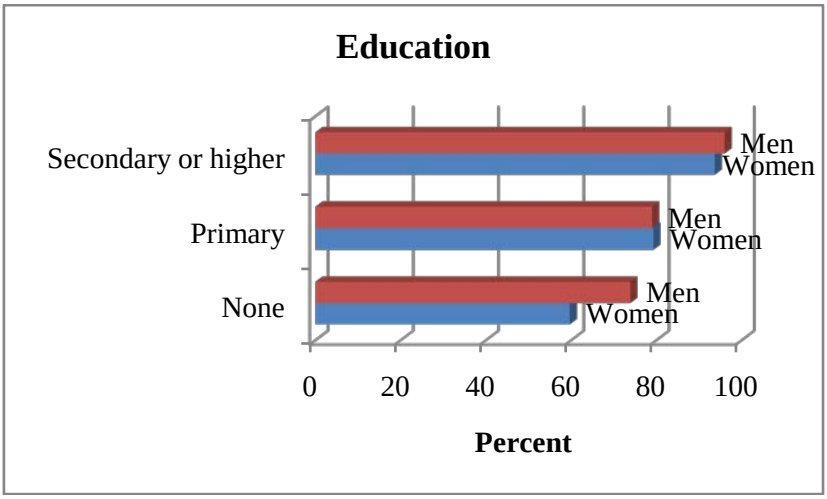


Figure II.5: Knowledge of AIDS among women and men by education

The first step taken by the government in responding to the discovery of HIV in Sierra Leone was the formation of a National AIDS Committee in 1986. This Committee was transformed into the National AIDS Control Programme (NACP) in 1988 to strengthen the HIV and AIDS prevention activities. The main focus then was raising people's awareness of HIV and AIDS but preventive and control activities were not given high priority, mainly because of the internal conflict, inadequate resources and low political commitment and advocacy. The situation however changed in 2001 when the Government recognized that HIV and AIDS was a developmental problem.

In 2001, the Government of Sierra Leone appointed a Cabinet Sub-Committee on HIV and AIDS under the leadership of the Minister of Information and Broadcasting. The Cabinet Sub-Committee collaborated with several development partners such as the UN Theme Group on HIV and AIDS, the World Bank and the US Government to establish structures that would strengthen the national response to HIV and AIDS.

Through this collaborative partnership, mostly with the expanded UN Theme Group on HIV and AIDS, a National Policy was drafted in 2001. Government also collaborated with the US Centre for Disease Control and Prevention (CDC) to conduct a national HIV Sero-Prevalence and Behavioural Survey in 2002 which provided a relatively clear status of the HIV and AIDS situation in the country. The National Policy was revised in 2007[4] to take into account advances in the National Response and the new information on HIV and AIDS that was available in the country.

There was renewed interest and awareness leading to heightened activities to respond to the HIV and AIDS epidemic. The increasing interest of development partners to work with the Government in addressing HIV and AIDS and the exigencies of coordination resulted in the establishment of the National AIDS Council (NAC) and its Secretariat (NAS) under the Office of the President in 2002 for the overall policy and coordination of HIV and AIDS related national response. Although not fully functional, District AIDS Committees (DAC) have been established as extension of NAC in all districts level to enhance the coordination of HIV and AIDS activities.

[4] Government of Sierra Leone. *National HIV and AIDS Policy. Revised August 2007*

The Ministry of Health and Sanitation (MOHS) established the AIDS Response Group (ARG) in October 2002 as the health sector's technical arm which according to the Institutional Review (2009) recommend separation of ARG and NAS and renaming of ARG to NACP. There are four major areas of focus for ARG: surveillance, prevention, care and capacity building. Combating HIV and AIDS is considered a major step towards poverty reduction.

The National AIDS Council chaired by the President is the highest strategic body in the national response. The National AIDS Secretariat (NAS) coordinates the implementation of the policies agreed upon by the NAC by involving key Ministries, local councils, the private sector, and civil society in the design, planning, implementation, monitoring and evaluation of programmes.

Over 300 agencies and organizations are engaged in HIV and AIDS activities (UNAIDS 2005) especially IEC/BCC leading to increased awareness on HIV and AIDS throughout the country. NAS is, however, yet to have legal authority to coordinate all these activities including tracking national and international funding flow in the country. In spite of the legal handicap, NAS should continue its coordination strides by building M&E capacity to strengthen DACs as well as establish CACs for effective nationwide coordination.

A mid-term review of the NSP in 2008 made a number of findings on the six thematic areas of the NSP and made recommendations to address the identified shortcomings[5]. Annex 1 gives some of the key findings of that review.

In 2009 the Government commissioned an institutional review of NAS to identify strategies and environment that would enable NAC and NAS satisfy their mandates of setting the national policy on HIV and AIDS and oversee the multi-sectoral coordination of the national response. A number of recommendations were made[6] including:

- Legally establishing NAC and NAS by Act of Parliament
- Decentralizing M&E services to district level with qualified staff
- Establishing an active public relations entity to engage the public media in "marketing" the multi-sectoral national response
- Sharing information with all stakeholders to guide them in coordinating their activities among themselves

II.2.3 Prevention

II.2.3.1 PMTCT and VCCT

Prevention of mother to child transmission is a major component in the prevention of new infections. There has been a significant progress in the establishment of services and facilities that provide PMTCT, VCCT and ART over the past five years as shown in Table II-6 and Table II-7. However, most of the VCCT services provide limited coverage because they are mostly located in fixed health facilities limiting coverage to people accessing the fixed health facilities. Coverage for VCCT could be increased by locating user-friendly VCCT services in some public facilities and establish mobile units.

[5] For details of the findings and recommendations see: Government of Sierra Leone. *Report of the Joint Review of National Response to HIV and AIDS.* May 2008.

[6] Government of Sierra Leone. *Report of the Institutional Review of the National AIDS Secretariat (NAS).* February 2009.

Table II-6: PMTCT services from 2004 to 2009

Year	Number of PMTCT sites	Number tested and received results	Number tested positive	% positive	Number of pregnant women on ART prophylaxis**
2004	15	15,998	141	0.9	7
2005	18	11,876	232	2.0	57
2006	90	21,127	493	2.3	354
2007	163	52,258	1,073	2.1	471
2008	326	91,212	1,362	1.5	579
2009	364	99,256	1,584	1.6	637
2010 Target	684				2,136

Source: NACP Programme data.

Table II-7: PMTCT, VCCT services from 2003 to 2009

Year	Number of PMTCT sites	Number of VCCT sites	Number tested and received results	Number tested positive	% positive
2003		4	2,750	389	14.1
2004	15	18	8,352	631	7.6
2005	18	19	12,498	1,327	10.6
2006	90	56	18,860	2,048	10.9
2007	163	82	26,153	2,141	8.2
2008	321	369	54,193	3,492	6.4
2009	355	416	181,962	4,779	2.6
2010 Target		564			

Source: NACP Programme database.

II.2.3.2 Condom availability and use

With regard to condom use, the SLDHS found that the prevalence of HIV among women and men who claimed to have ever used a condom was 2.5% whereas the prevalence among those who had never used a condom was 1.5%. The annual condom requirement of about 45,000,000 is by far greater than the amount distributed. Table II-8 shows the number of condoms distributed from 2006 to 2010:

Table II-8: Number of condoms distributed over the years

Year	Condoms distributed	
	Male	Female
2006	1,968,646	
2007	2, 256,918	
2008	2,676,141	4,452
2009	2,185,920	16,200
2010 (Target)	3,750,000	Unknown

Source: NACP data 2010

II.2.4 Treatment

The end of the decade-long war provided the country with a socio-political environment for implementing a comprehensive multi-sectoral programme to combat the HIV epidemic including free treatment with ARVs. Table II-9 shows that as the number of sites offering ART has increased and so have the number of people receiving treatment. The table shows, however, that the number of people on ARVs is still far short of national universal access targets irrespective of the CD4 criterion used for eligibility for treatment.

Table II-9: Percentage of AIDS patients, all ages, receiving ARVs

Year	Number of ART sites	Number on treatment	Estimates (CD4 < 200) In need of ART	Percent on treatment	Estimates (CD4 < 350) In need of ART	Percent on treatment
2005	16	295	6,500	4.5	12,000	2.5
2006	55	702	7,600	9.2	14,000	5.0
2007	81	992	8,700	11.4	15,000	6.6
2008	103	1,950	9,800	19.9	17,000	11.5
2009	116	3,660	11,000	33.3	18,000	20.3
2010 Target	116	4,370				

Source: NACP Programme data 2010

II.2.5 Financial response

Soon after the end of the debilitating war, Sierra Leone decided on the bold step of combating the new war against HIV; it had no option but to seek support from willing friends and take up loans to support the new war. The Government took up a loan of US$ 15 million with the World Bank for the Sierra Leone HIV and AIDS Response Project, (SHARP). The Response Project included the full spectrum of HIV and AIDS activities including prevention, care, and support and impact mitigation over a four year period. It had four components:

- Capacity building, policy and programme co-ordination
- Multi-sector responses for HIV and AIDS prevention and care
- Health sector responses to HIV and AIDS and STI management; and
- Community and civil society initiatives

The country 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 as shown in Table II-10.

Table II-10: Loans and grants for HIV and AIDS

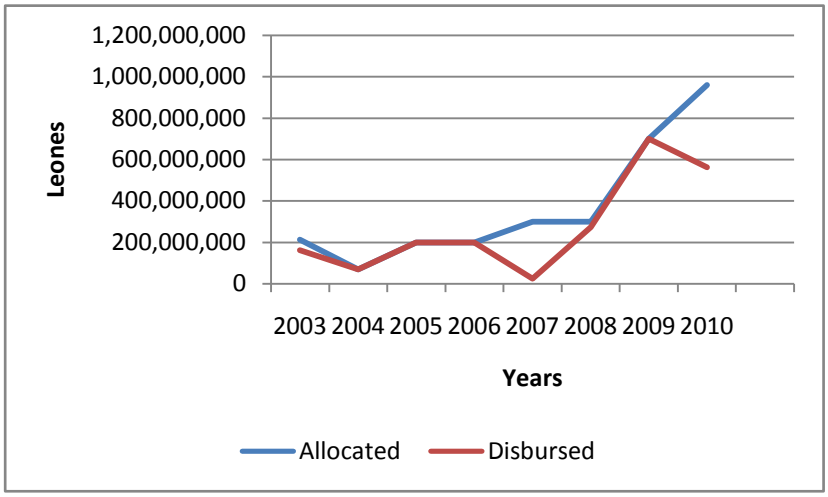
Source	Period	Amount (million)
World Bank	2004-2008	US$ 15
KFW (German)	2008-2012	US$ 3.08
Global Fund (Round 4)	2005-2009	US$ 18
Global Fund (Round 6)	2007-2011	US$ 26
Global Fund (Round 9)	2010-2014/15	US$ 29,453,291

The government continues to demonstrate its total commitment to the response against HIV and AIDS with annual budgetary allocations as shown in Table II-11. Between 2003 and 2008 the Government's commitment to the fight against the HIV and AIDS epidemic was demonstrated with the disbursement of the equivalent of US$825,303 out of a planned budgetary allocation of the equivalent of US$ 1,108,188.

Table II-11: Government of Sierra Leone (GoSL) financing the national response

Year	GoSL annual budget allocations against disbursements to the national response (Le)		Budgetary allocations to MOHS (Le)	Disbursement
	Allocated	Disbursed		
2003	214,279,000	162,000,000	582,518,852	**Unknown**
2004	70,000,000	70,000,000	911,523,000	**Unknown**
2005	200,000,000	200,000,000	1,002,675,300	**Unknown**
2006	200,000,000	200,000,000	1,102,942,830	**Unknown**
2007	300,000,000	25,000,000	1,213,237,113	**Unknown**
2008	300,000,000	274,000,000	1,054,459,146	**Unknown**
2009	700,000,000	699,700,000	987,012,000	**Unknown**
2010	960,000,000	562,000,000 (as of 3rd quarter)	1,184,400,000	**6,000,000**
Total	*2,944,279,000*	*2,192,700,000*	*8,038,768,241*	***6,000,000***
US$*	**1,108,188.30**	**825,303.74**	**3,025,687.75**	**2,258.32**

*Average rate of exchange from Oct 2002 to Sept 2007 was Le 2,656.84 to US$ 1
*The exchange rate from March to August 2010 was US$1: Le 3,750



The prevention of HIV and AIDS and mitigating its effects will remain a priority of the Government. We will utilize the various levels of leadership to play an active role in combating HIV and AIDS.
The Republic of Sierra Leone. *An Agenda for Change. Second Poverty Reduction Strategy (PRSP II) 2008-2012*

A major challenge faced with government funding of HIV and AIDS activities is the irregular and delayed disbursements of funds impacting the timely implementation of activities. On the other hand, the MoHS budget allocation made to NACP/ARG remains to be disbursed over the years as indicated in Table II-11. For the period 2003 to 2010, the government disbursed 74.5% of financial budget allocation to NAS compared to the alarming MOHS disbursement of 0.10% to NACP/ARG for national health sector response to HIV and AIDS. Sources: NAS financial allocation by GoSL and ARG planned budget allocation of the Ministry of Health and Sanitation.

II.3 Challenges to the national response

Sierra Leone has come out of a bitter and debilitating ten-year war that nearly destroyed fragile infrastructures. The steps taken by the country to respond to the emerging HIV and AIDS epidemic under these circumstances are more than impressive over the past five years.
The war legacy and the global economic situation are contributing to the challenges that the country has to face for a more robust response to the epidemic. The challenges include shortage of qualified people, shortage of financial resources and a very youthful population that is extremely vulnerable.

II.3.1.1 Shortage of qualified people

The national health care delivery system continues to face major problems in the area of human resources. Due to the decade-long civil war and search for greener pastures, health worker attrition has been alarming resulting in significant brain drain in the country. The gaps in the various health cadres by far outweigh the available numbers. MoHS has completed an aggregated national staffing requirement based on workload indicators and staffing needs (WISN) as per WHO recommendation which contributed to providing staffing gaps in Sierra Leone, showing significant shortage of required personnel. The limited human resources capacity of the MoHS has continued to negatively affect the health sector response to HIV and AIDS programming particularly in the rural areas.

There are very few qualified medical practitioners in the country. The present doctor population ratio is 1:46,296; for midwives, the ratio is 1:42,734 and for registered nurses the ratio is 1:11,363. These indicators fall far below the recommended levels for Universal Access. Table II-12 shows the gap in health personnel needed in the health sector in 2010. The attrition rate of health care personnel over the years has remained a major challenge to the overall national response.

Table II-12: Current Medical Personnel Gap in Sierra Leone in 2010

Personnel Cadre	Number of staff available			Gap
	1993	2008	2010	
Medical Officers	203	78	109	**430**
Paediatricians	16	4	1	**53**
Dentists	15	8	5	**29**
Obstetricians/Gynaecologists	23	8	4	**50**
P/H Superintendents	58	24	20	**Unknown**
Surgeons	13	7	7	**50**
Physician Specialist	5	4	3	**7**
Mid-wives	132	87	76	**224**
State Registered Nurses	625	355	224	1,162
Laboratory Technicians	**N/A**	**124**	**84**	**216**
Pharmacists			37	Unknown
Pharmaceutical Technicians	N/A	127	129	175

II.3.1.2 Shortage of financial resources

International economic indicators place Sierra Leone among the poorest countries in Africa although this is not for lack of resources but more due to how the resources are exploited for national use. The demand for post war national reconstruction means that there are fewer financial resources available for health and social issues such as malaria, HIV and AIDS, TB and other endemic diseases that have a heavy toll on the people in the country.

International and bilateral organizations have responded generously to the country's appeal for help but the major challenge now is how to sustain the financial support for the fight against these diseases.

II.3.1.3 Robust political will

HIV and AIDS is a very divisive disease because it involves social behaviours that are culturally taboo for public discussion and yet the preventive strategies call for public debates on the issues. The current relative low prevalence of HIV in Sierra Leone should not be used for complacency but be a driving force for the leadership and all partners to engage vigorously to limit the continued spread of the virus. There is evidence that countries that have come up with an open and aggressive advocacy from the very top of the political hierarchy, as in Uganda, have overcome the divisions among traditional and religious leaders, as well as social activists. The current relatively low prevalence of HIV and AIDS should not lead to complacency. The challenge is to have **audible** calls and **visible** actions that can galvanize the residents of Sierra Leone to realize that the country is threatened by a new war, a war that could be more devastating than the ten-year war

Part III Review Process

III.1 Objectives

The effectiveness of the national response to the HIV and AIDS epidemic in Sierra Leone requires periodic Joint Programme Reviews to evaluate how successfully the NSP has guided the response, thus providing a platform to redefine the responsibilities of stakeholders in implementing the provisions of the NSP. The main objective of the Joint Programme Review of the NSP 2006-2010 was provide recommendations that will guide the development of a new National HIV and AIDS Strategic Plan, new M&E Plan and an Operational Plan.

The Review was also expected to provide information that will:

a) Improve on current programme methodologies, practices and tools
b) Reinforce the strategic and functional role of NAS in guiding the response within the framework of the principles of the 'Three Ones'
c) Guide the overall process of programme development, implementation, monitoring and evaluation
d) Strengthen a platform for improved advocacy, partnership and resource mobilization
e) Give an indication of the level of implementation of the NSP

III.1.1 Review products

The Joint Review Report consists of the findings from each of the six thematic areas. It identifies strengths, weaknesses, gaps and challenges and gives recommendations for consolidating and improving the strengths and addressing the gaps, constraints and challenges. The findings and recommendations of this joint review are expected to form the basis for guiding the development of the next 5-year National Strategic Plan and Work Plan.

III.2 Methodology

III.2.1 Key thematic areas for the review

The NSP is organized along six priority areas:
(i) Decentralized implementation
(ii) Prevention of new infection
(iii) Care treatment and support of PLHIVs, families and communities
(iv) Protection of human and legal rights
(v) Research, monitoring and evaluation
(vi) Key sectoral responses

The review was organized along the same six areas.

III.2.2 Recruitment of the review consultants

Five consultants, one international and four nationals, were engaged for the review. The international consultant, who is the Team Leader, was identified and recruited by UNAIDS through the Agency's Technical Support Facility for West Africa (TSF-WA). The national consultants were identified and recruited by NAS in collaboration with UNAIDS. The names of the consultants are shown in Annex 2 and their terms of reference in Annex 3.

III.2.3 *Consultative process*

The review was done under the framework of a joint review aiming at collective responsibility, enhancing ownership and increasing the likelihood of using the review findings. The joint review framework called for active and full participation of all development partners (stakeholders) at all levels (national, district and lower levels) throughout the entire review process.

Picture III-1: Validating the review findings

The work plan developed by the Review Team involved extensive consultation with representatives of all stakeholders. The list of institutions and agencies that contributed to the review is given in Annex 4.

The findings were validated by a cross-section of stakeholders from all sectors during a one day workshop whose objective was to:

(i) Validate the findings
(ii) Identify gaps in the findings
(iii) Make recommendations on the strategies for the new NSP
(iv) Propose the next steps in the finalization of:
- the JPR exercise and the report
- the plans for the next generation of the overall national response

(v) Establish ownership of the JPR findings

The validation exercise called on the participants to answer the following questions for each strategy that was examined by the Review Team:
(i) Is the finding relevant to the NSP strategy?
(ii) Is the finding valid?
(iii) Is there any additional information that should be provided to enhance the finding?

The participants were also required to make recommendations on the strategy for the NSP 2011-2015 that will be prepared based on the report of the NSP 2006-2010 Joint Programme Review. The names of organizations and institutions represented at the validation workshop are given in Annex 5.

III.2.4 *Review team induction*

The Review Team was briefed of their work by the Director, NAS and by the Senior M&E Officer at NAS. The briefing also outlined the background to the national multi-sectoral response and the participatory process followed in developing key documents that are guiding the response. Among such documents are the HIV and AIDS National Strategic Plan (2006-2010) and the National HIV and AIDS Monitoring and Evaluation Framework (2006-2010), HIV and AIDS Policy, the Prevention and Control of HIV and AIDS Act, 2007, the report of the Joint Review of the National Response to HIV and AIDS (May 2008), and the report of the Institutional Review of the National AIDS Secretariat (NAS).

III.2.5 *Scope of the Review*

The Review was an assessment of the extent of the implementation of the NSP over the past five years, and tried to look for answers to the basic questions:

- To what extent have the strategies been implemented?
- What gaps, strengths, weaknesses, opportunities and threats can be identified in the implementation of the NSP?

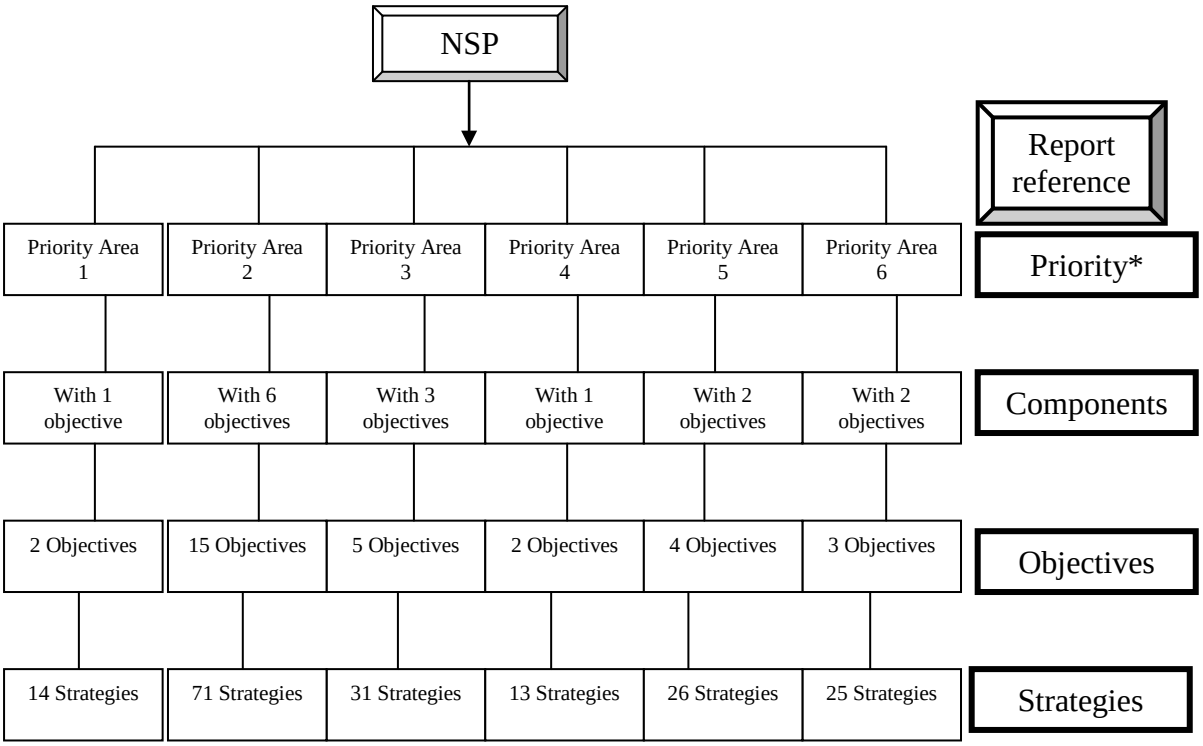
Part IV Review Results

IV.1 Presentation of the results

The presentation of the results follows very closely to the presentation of the mid-term Joint Programme Review of the NSP in April 2008 to make the comparisons easier.

It was observed in the mid-term Joint Programme Review report that the reference to "objectives" within "objectives" in the NSP was confusing. It was suggested that the first level "objectives" should be referred to as "Components" as shown in Figure IV.1

Figure IV.1: Diagrammatic presentation of the NSP structure



* The six NSP Priority Areas are:
- (i) Decentralized implementation
- (ii) Prevention of new infection
- (iii) Care treatment and support of PLHIVs, families and communities
- (iv) Protection of human and legal rights
- (v) Research, monitoring and evaluation
- (vi) Key sectoral responses

This Joint Review report follows the same approach to avoid confusion of objectives within objectives, by referring to the structure of the NSP as being: *Priority Areas*, *Components*, *Objectives* and *Strategies*.

Eighty five of the 180 strategies in the NSP were examined during the review as shown in Table IV-1. A judicious sample was made within each objective for the strategies that the Review Team believed would provide the necessary information on how that objective had been achieved over the five years of the NSP.

Table IV-1: Distribution of strategies reviewed per NSP priority area

NSP Priority Area	Number of strategies		Percent
	Total	Examined	
Decentralized implementation	14	4	28.6
Prevention of new infection	71	27	38.0
Care treatment and support	31	21	67.7
Protection of human and legal rights	13	4	30.8
Research, monitoring and evaluation	26	17	65.4
Key sectoral responses	25	12	48.0
Total	**180**	**85**	**47.2**

The results answer the question:
To what extent have the [examined] *strategies been implemented?* The lessons learnt (*strengths*, *weaknesses*, *opportunities* and *challenges*) over the NSP period are presented to inform the preparation of the next NSP.

IV.2 Priority area results

IV.2.1 Decentralized implementation

The National Strategic Plan was structured to be in line with the district level decentralization that the country is undergoing. District AIDS Committees (DACs) were expected to be established within the district councils to oversee HIV and AIDS district-level response as part of the local councils' responsibility for social and economic development of their communities. The role of the District Medical Officer (DMO) is to provide technical backstopping to the DAC on the health sector response. The DACs role is outlined in the NSP as:

- developing and coordinating district HIV and AIDS response plan
- monitoring and supervising HIV and AIDS activities in the districts, and
- maintaining oversight responsibilities over implementing partners

District HIV and AIDS Focal Points were expected to be established in each district to serve as full time District HIV and AIDS Officers and Secretaries to the DACs.

The priority area of decentralized implementation of the national response has one component of establishing strong coordination and implementation framework of HIV and AIDS at all levels. The objectives of the NSP for this priority area and component are:

- Develop a framework for multi-sectoral, multidisciplinary national response to HIV and AIDS at all levels; and
- Develop and implement the new partnership framework

The review examined the following strategies in order to assess the level of coordination at all levels:

(i) Strengthening the capacity of NAS to coordinate and oversee the national response; and build the capacity of other partners.
(ii) Establishing and strengthening district and chiefdom HIV and AIDS/STIs committees.
(iii) Facilitating mainstreaming by establishing and supporting an HIV and AIDS Unit in the Central Planning Office of MoFEP.

(iv) Developing and launching new Partnership Framework by Strengthening existing Partnerships Forums e.g. Inter Faith Coalition and supporting the establishment of new ones.

IV.2.1.1 Findings

To what extent have the strategies been implemented?

Strategy (i): NAC is mandated to coordinate all agencies, organizations and individuals involved in HIV and AIDS activities in the country through its secretariat NAS. NAC continues to be administratively well placed within the Office of the President as a national coordinating authority for the multi-sectoral response to the epidemic. For NAS to execute its functions effectively it must have the capacity to do so. The institutional review of NAS in 2009 aimed at identifying ways in which NAS could be strengthened to effectively execute its coordinating mandate. Some of the key recommendations are being implemented. For example the process of legally establishing NAC and NAS has started with the drafting of the Parliamentary Statute. It is noted, further, that:

- NAS has helped build capacities for HIV and AIDS workplace programmes, with ILO support, to GTZ, PPSL and Sierra Rutile and the fishing industry. NAS is also providing office equipment to the districts for the DACs for lack of resources.

- NAS does not have the legal authority to monitor and coordinate the resources (especially financial) coming into the country for HIV and AIDS activities

Strategy (ii): It was observed in the NSP mid-term review report that coordination of the national response involves more than working with sectors and organizations at the national level. An effective multi-sectoral coordination of HIV and AIDS activities which is in line with the national decentralization process requires that essential structures such as HIV and AIDS/STIs committees are established at district and chiefdom levels. While progress has been made in decentralization of the coordination of the national response with the establishment of DACs, more is yet to be accomplished. It has been found that:

- District AIDS Committees (DACs) have been established in 19 district and city councils. For this strategy to be counted as fully executed the DACs have to be fully functional which they are not. The DACs are, however, seen as being proactive in spite of their infancy. At the chiefdom level no CACs have been set up yet
- The establishment of AIDS Committees in districts with city councils is not well harmonized between the district and city councils. There are still conflicts in the roles of DHMTs and district councils in the formation of DACs; and between City Council AIDS Committees and DACs
- DACs are being strengthened with internet communication links with NAS and are provided with logistical support
- Three regional coordinators are being recruited to be responsible for the East Region, South Region and the a combined West and North Region

Strategy (iii): HIV and AIDS is no longer seen as a health issue alone. The epidemic is impacting all aspects of life hence the national response that requires all sectors of society, public and private, to be actively involved in the fight. The NSP strategy called on the establishment of an HIV and AIDS Unit in the Central Planning Office of MoFEP as a first step on mainstreaming HIV and AIDS in the public sectors.

The Ministry has a Focal Point for HIV and AIDS who is acting as a link among the MDAs. The MoFED plans to have sectoral votes for HIV and AIDS in the 2011/2012 budget. The findings for sectoral involvement were that:

- VCCT coordination is a health sector responsibility. NAS develops the VCCT guidelines in collaboration with the health sector
- NAS is supporting the health sector by paying the salaries of the coordinators for PMTCT, ART, VCCT with some logistical support

Strategy (iv): Multi-sectoral coordination requires structures that can be used to reach the different stakeholders in the various sectors and bring them together as they plan their activities and review the results of their work. Such a structure suggested by the NSP is the establishment of a Partnership Forum. It was found that:

- The Partnership Forum continues to be an effective way of bringing all partners together under the chairmanship of H.E. the President
- DACs are engaging partners in the some districts into an equivalent of the central level partnership forum

IV.2.1.2 Conclusions

IV.2.1.3 Strengths

- NAS is well placed in the President's Office to coordinate the multi-sectoral response
- The current leadership of NAS is focused to its mandate and dedicated to the national response

IV.2.1.4 Weaknesses

- Lack of clarity in the minds of some stakeholders on the different roles NAS is currently playing; as a statutory coordinating body and as a conduit of funding to programmes and activities
- Poor dissemination (and communication) of key documents such as the NSP and the M&E Framework to the stakeholders

IV.2.1.5 Opportunities

- Existence of the Partnership Forum which is fully supported by H.E. the President offers a forum for sharing experiences and eventual harmonization of the national response across partners
- Recognition of HIV and AIDS as an important health and developmental issue in the President's Agenda for Change[7]
- Goodwill demonstrated by increasing resource input by the government into the national response

[7] The Republic of Sierra Leone. *An Agenda for Change. Second Poverty Reduction Strategy (PRSP II) 2008-2012.*

IV.2.1.6 Challenges

- IPs are reluctant to disclose the amount of money they use especially the organizations with no direct working relationship with NAS
- Low level and slow speed of decentralization and the resources needed to ensure effective functionality of the decentralized facilities
- Inadequate numbers and capabilities of human resources in areas such as M&E
- Excessive dependency on external sources of finances for the national response (98% of resources come from donors only 2% from government)
- A disconnect between DACs and implementing partners receiving funding through NAS

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IV.2.1.7 Recommendations

The coordination of the national response under the decentralization of administrative responsibilities to the district level requires NAS to have sufficient staffing capacity for timely response to district and chiefdom level needs. Establishment of district level AIDS committees should not be taken as an end but merely as part of the process of decentralization of the national response to HIV and AIDS. There are still a number of problems with the DACs such as clarification of responsibilities among DAC members and the role of the committees. Districts with city councils have to resolve whether they should have one DAC or a city council AIDS committee as well and if such a committee is established what it should be called. Chiefdom level committees should be established as soon as possible. These are the structures at the district and chiefdom levels that NAS has to work through to execute its statutory mandate. The authorities must also know who is doing what and where in the country. Monitoring the activities including financial inputs requires a cadre of well qualified and experienced people in M&E stationed at the central and district levels. The move to establish regional coordinators is noted and welcomed. In order to fully decentralise the work of NAC and NAS, it is recommended that:

1. For the country to have a fully empowered multi-sectoral coordinating body, NAS must have legal status that covers decentralization of the coordinating body and gives it the authority to monitor resources coming into the country for HIV and AIDS activities.
2. The decentralization process for NAC and NAS should be continued until the DACs and CACs are fully functional as required by law [implied in Recommendation 1]
3. DACs should be part of MoUs signed between NAS and implementing partners.
4. NAS should have a clear strategy of establishing and/or strengthening district level M&E units so that they become effectively functional.
5. NAS should continue monitoring sectoral responses to the HIV and AIDS epidemic using result-oriented output and outcome indicators and using the results for vetting the continued operations of the various sectoral activities.

IV.2.2 Prevention of new infections

At the time of the preparation of the NSP the main thrust was on prevention of new HIV infections and mitigation of the impact of HIV and AIDS. The NSP identified the following components under prevention of the spread of HIV:

(i) Promote safer sex and healthy sexual behaviour.
(ii) Improve the Management of STIs.
(iii) Prevent Mother-to-Child Transmission (PMTCT).
(iv) Promote Voluntary Confidential Counselling and Testing (VCCT).
(v) Promote Safe Blood Supply.
(vi) Reduce HIV Transmission through Medical Waste and other accidental exposure.

The Joint Review looked at all these components to see the lessons that can be learnt over the past five years that could be used to guide the country during the next five years.

IV.2.2.1 Findings

IV.2.2.2 Promote safer sex and healthy sexual behaviour

The objective of the NSP in the domain of promotion of safer sex and healthy behaviour are:

- Promote improved health seeking behaviour and adoption of safer sex practices
- Broaden responsibility for HIV prevention to public/private sectors, civil society, faith based organization and traditional leaders
- Promote use of male and female condoms and improve accessibility, availability and affordability
- Implement HIV and AIDS/STI prevention programme for refugees, host community, internally displaced persons and migrant populations

The following strategies were examined when reviewing promotion of safe sex and healthy sexual behaviour component:

(i) Apply Unified Multi-sector Extension Strategy (UMES) for BCC consisting of geographic mapping and training of public and private sector outreach personnel (Peer Health Educators, Health and Agricultural Extension Workers, Red Cross Animators, Social Workers etc) to engage in Interpersonal Communication and education through entertainment (drama, films, videos etc) in rural areas and urban slums.
(ii) Supply inputs for UMES (IEC vans, drama props, caps, vest and bags for PHEs).
(iii) Establish UMES coordination framework consisting of delineation and management of specific geographic areas by identified institutions with strong supervision, monitoring and evaluation for feedback.
(iv) Mobilize financial resources to support inter-school completions (drama, sports, quiz etc.).
(v) Produce and disseminate IEC/BCC materials to different target groups.
(vi) Develop and implement sector-specific policies for HIV and AIDS/STI prevention
(vii) Strengthen and expand social marketing of condoms.
(viii) Improve access to condoms among vulnerable groups such as Youth and CSWs in high transmission areas, such as lorry and long distance taxi parks, night clubs, mining areas, brothels, hotels, motels and guest houses.
(ix) Promote condom negotiation skills.

To what extent have the strategies been implemented?

Strategies (i), (ii) & (iii): During the past five years the country planned to have a maintained unified multi-sector extension strategy (UMES) for BCC and mapping of HIV and AIDS activities. The NSP mid-term review found that these strategies had not been implemented as outlined in the NSP. This review found that nothing had changed since the mid-term review in 2009.

Strategies (iv) & (v) NAS and other partners are mobilizing resources to support IEC and BCC activities in schools. IEC and BCC materials are produced and disseminated to various target groups.

Strategy (vi): Sector-specific policies have been developed as was found during the mid-term review.

Strategies (vii), (viii) & (ix): The NSP required social marketing of condoms to be strengthened and increase the overall availability and accessibility of condoms to people who need them and promote negotiation skills for their use. The review found that:

- NAS procures its own condoms, but can obtain condoms from UNFPA through the reproductive health, which are passed on to IPs for free distribution
- UNFPA procures condoms for the government
- Two organizations: CARE and GOAL are engaged in the social marketing of condoms in their operational areas
- Female condoms have not taken root in the country as their promotion is weak
- NAS coordinates condom procurement and distribution by chairing the condom social marketing body
- A national body: the National Condom Programming Committee coordinates condoms in the country

IV.2.2.3 Improve the management of STIs

The NSP 2006-2010 had four objectives to improve the management of STIs:

- Contribute to the development and implementation of a National RH/STIs Policy
- Ensure the development and use of standardised STIs Syndromic Management Protocol in all public and private health institutions
- Improve accessibility, affordability and quality STIs/ reproductive health services
- Monitor STIs treatment and antibiotic resistance in Health Institutions

The end-term review examined the strategy of training staff of health institutions on STI research which was the only strategy in the NSP related to the STI that had not been implemented by the mid-term review.

To what extent have the strategies been implemented?

- The Review found no evidence that there was any health staff trained in STI research

IV.2.2.4 Prevent mother-to-child transmission (PMTCT).

The NSP objectives for prevention of mother-to-child transmission of HIV are:

- Improve quality and access to VCCT in ANC's
- Provide prophylactic treatment to HIV positive women, their new born and promote safe delivery and other maternal services delivery points

The NSP mid-term review in 2008 examined the following 11 strategies and found that they had been implemented.

(i) Establish PMTCT Working Group including various partners.
(ii) Develop and Disseminate counselling guidelines.
(iii) Train and Deploy Counsellors.
(iv) Establish VCCT sites in ANC.
(v) Orient MCHAs and TBAs on PMTCT services.
(vi) Develop and disseminate appropriate guidelines and other sensitization materials.
(vii) Train health personnel involved in the provision of prophylactic treatment.
(viii) Make the prophylactic drugs available at all PMCT sites.
(ix) Update and disseminate the national treatment guidelines.
(x) Train all health personnel on the administration and recommended drug regimen and feeding options.
(xi) Develop surveillance system to guide PMTCT programme

To what extent have the strategies been implemented?

- The findings in 2008 confirmed that PMTCT services are implemented in all districts

IV.2.2.5 Promote voluntary confidential counselling and testing (VCCT).

Voluntary confidential counselling and testing is at the centre of HIV preventive measures. One of the objectives of the NSP 2006-2010 for promoting voluntary confidential counselling and testing was to increase the number of HIV testing and counselling sites.

During the NSP mid-term review in 2009 the following strategies were examined and found to have varied levels of implementation. They were examined again during the end-term review to see whether there had been any changes over the past two years. The strategies are:

(i) Disseminate national HIV counselling guidelines to all partners.
(ii) Expand VCCT to district and chiefdom levels by integrating it into PHC.
(iii) Establish Post-test Clubs at Chiefdom level.
(iv) Make VCCT services user friendly

To what extent have the strategies been implemented?

Strategies (i) – (iv) aimed at enabling the country to provide a comprehensive coverage of the country with VCCT services. It was found that:

- There is a national guideline to HIV counselling and it is distributed to some partners
- VCCT is established in all government hospitals and in most maternity facilities. (There are 416 out of 1010 health facilities offering VCCT)
- No post-test clubs have been established at district and chiefdom levels
- Most VCCT services are user friendly i.e. without stigmatization and discrimination

IV.2.2.6 Promote safe blood supply

The NSP objective for promoting safe blood supply is to maintain the safety of blood and blood products with two strategies:

(i) Develop and disseminate policy and guidelines on safety of blood and blood products.
(ii) Train relevant medical personnel

To what extent have the strategies been implemented?

- The NSP end-term review confirmed that blood transfusion services continue to guarantee all transfused blood and blood products with the medical personnel properly trained and policy guidelines being followed

IV.2.2.7 Reduce HIV transmission through medical waste and other accidental exposure

The NSP objective for reducing HIV transmission through medical waste and other accidental exposure is:

- To minimize the risk of accidental transmission of HIV

This component of the NSP was not reviewed. The NSP mid-term review had, however, found that a national medical waste management policy has been developed but there were no training programmes for traditional healers in the use of sharps.

IV.2.2.8 Conclusions

IV.2.2.9 Strengths

- Streamlined condom purchasing procedures for free distribution
- Existence of STI syndromic management protocols in most of the health units and routine STIs surveillance
- Existence of policies guiding the national response in preventing HIV transmission e.g. the national blood transfusion policy, national medical waste management policy

IV.2.2.10 Weaknesses

- Lack of clear robust process of vetting all IEC/BCC materials distributed throughout the country
- Inadequate dissemination of key document such as the *Guideline for medical waste management* outside of medical settings

IV.2.2.11 Opportunities

The opportunities for intensified preventive responses identified during the NSP mid-term review are still valid. They included:

- Most government ministries having focal points on HIV and AIDS
- Most International funding agencies have a component for HIV and AIDS activities
- Existence of petty traders in all settlements in the country who could be used as outlets for socially marketed condoms

IV.2.2.12 Challenges

- *Meaningfully* involving PLHIVs in the national response
- Assessing the required quantities of condoms for country
- Comprehensive costing of condoms in the country including free condoms distributed by NAS
- Delivering HIV prevention messages, that include the use of condoms, into schools with the existence of the policy relating to promotion of condoms to school children
- Establishing synergy with religious leaders in designing and delivering HIV prevention messages

IV.2.2.13 Recommendations

Positive strides have been made in the area of prevention over the five years period. The continuous increase of VCCT and PMTCT sites in health facilities coupled with the streamlining of condom procurement for free distribution underscores the nation's commitment to the global goal of preventing new infection. The development and distribution of policy documents and guidelines have guided implementation in the country.

Although IEC/BCC materials are distributed targeting various groups yet NAS has not designed a mechanism to ensure the vetting of information for all IEC/BCC materials. Weak synergy between the DHMT and traditional healers continues to be a challenge to preventive initiatives.

The existence of budget lines for HIV and AIDS activities in most funding institutions and the creation of a desk in most ministries, departments and agencies are opportunities toward an integrated response to the epidemic. The Review recommends that:

1. Prevention of new infections remains a major pillar in the new national strategic plan.
2. The new NSP should have strategies promoting establishment of channels of discussion among political, civic, religious and cultural leaders that would lead to programmes related to HIV prevention among in and out-of-school youths and adolescents, CSWs and emerging high risk groups of men who have sex with men (MSM) and injecting drug users (IDU).
3. The country should recognize the impact PLHIVs can make to the national response by *meaningfully involving* them in the planning, implementation, monitoring of activities at all levels in all sectors.
4. The importance of traditional healers should be recognized as the new NSP is prepared so that it includes strategies of drawing them in the national response to ensure that their contributions do not undermine the national response.
5. The country should have clear strategies for cross-border HIV prevention services.

IV.2.3 Care, treatment and support of PLHIVs, families and ocmmunities

The following priority components were identified by the NSP for the priority area of care, treatment and support of PLHWAs, families and communities:

(i) Strengthen the Capacity of Health Institutions to Provide Care for PLHIVs.
(ii) Provide adequate treatment, Care and Support Services to all individuals, families and Communities.
(iii) Develop and Implement Programme for Care and Support for Orphans and Vulnerable Children.

IV.2.3.1 Findings

IV.2.3.2 Strengthen the capacity of health institutions to provide care for PLHIVs

The objectives for strengthening the capacity of health institutions to provide care for PLHIVs are:

- Improve treatment, care and support for People Living with HIV and AIDS
- Sensitization on ARV therapy

When reviewing this component the following strategies were examined:

i. Develop and disseminate treatment protocols for PLHIVs including the prevention and treatment of opportunistic infections
ii. Develop and implement training programmes for all categories of health staff in care and treatment of PLHIVs including treatment of opportunistic infections
iii. Ensure availability of relevant facilities for implementation of ARVs therapy
iv. Ensure adequate and regular supply of ARVs and other commodities
v. Ensure link between health facilities providing treatment to PLHIV and traditional healers and CBOs)
vi. Initiate and strengthen sensitization programmes to focus on confidentiality and reducing stigmatisation attached to HIV and AIDS in the health care settings
vii. Include the involvement of PLHIV in provision of care
viii. Monitor compliance and drug resistance
ix. Hospice care, provision of facilities for terminally ill patients to die in dignity

To what extent have the strategies been implemented?

Strategies (i) and (ii): In order to strengthen the capacity of health institutions to provide care for PLHIVs, treatment protocols should be developed and disseminated to all health institutions as well as training all categories of health personnel in their use. The review found that:

- Not all DAC members in the districts were familiar with the PLHIV treatment protocols although the DHMT confirmed the availability of the protocols
- Protocols for STI, PMTCT, VCCT and ART are widely disseminated at the health facility levels and health personnel have received training on the protocols

Strategies (iii), (iv), (vii) and (viii): There must be facilities for the delivery of ARVs to ensure access to the treatment. Successful ART must have drug compliance monitoring ideally involving trained PLHIVs. The review found that:

- While ARV therapy facilities exist in the districts and are equipped to provide ART, they are not in every chiefdom and there is differential coverage of services between rural and urban areas. In Kono for instance, there are 8 ART and 35 PMTCT sites out of 74 health facilities in the district and 17 ART centres in the Western Area
- There are regular and adequate quarterly supplies of ARVs for adults
- Supply of paediatric ARVs is sometimes unreliable
- There are problems with access to treatment due ineffective distribution of consignments
- There are systems in place to monitor compliance. In some districts, monitoring compliance of PLHIVs is done by PLHIVs who are trained as Community Health Workers
- NOW, an NGO in Kono, is piloting training of CHWs to carryout home visits to monitor clients' drug compliance
- Counsellors in some districts carry out defaulter tracing home visits and drug compliance

Strategy (v): It is essential to have an established link between the health personnel and traditional healers. The review noted that:

- There is no formal or informal relationship between traditional healer and the health personnel
- So far, the only involvement of traditional healers is with the DMHTs on surveillance for specific diseases such as poliomyelitis
- CBOs are represented within DACs but traditional healers are not

Strategy (vi): Issues relating to stigma and discrimination still exist countrywide and for more PLHIVs to have the confidence to declare their status, strategies must be put in place to address the predominate stigmatization to HIV and AIDS. The review found that:

- Stigma and discrimination are well entrenched in society
- There were anecdotal stories of messages on stigma and discrimination not being properly coordinated and existence of controversial messages

Strategy (ix): The review found out that:

- Hospices care services are limited and found only in Western Area and Bo in the south of the country

IV.2.3.3 Provide adequate treatment, care and support services to all individuals, families and communities

The objectives in the NSP for this component are:

- Improve the capacity of families and communities to provide care and support for PLHIVs
- Provide good quality home-based care for PLHIVs

The following strategies were examined when reviewing this component:

i. Intensify IEC/BCC to reduce stigmatization and improve accepting attitudes towards PLHIVs
ii. Encourage and strengthen the capacity of HIV and AIDS Support Association
iii. Improved community based, financial, material and psycho-social support for PLHIVs and care givers

iv. Develop appropriate home based care guidelines
v. Train CBO members and families in the implementation of home-based care
vi. Procure and make available home-based care kits and other logistics
vii. Provision of nutritional and vocational support to PLHIVs and their families

To what extent have the strategies been implemented?

Strategy (i): To improve capacity of families and communities to provide care and support for PLHIVs, IEC/BCC messages should be intensified to reduce stigmatization and improve accepting attitudes towards PLHIV. The review found that:

- IEC materials are available but inadequate in some districts and some may be inappropriate
- Posters on living positive, for instance, are displayed in PHUs, public places and some private health facilities
- Some DACs carry out community sensitizations programmes via the district radio stations in collaboration with some implementing partners which includes radio jingles and discussion programmes
- Some implementing partners in the districts carryout HIV and AIDS sensitization activities without the knowledge of DAC
- Lack of linkages between some implementing partners and DACs

Strategy (ii): Strengthening the capacity of PLHIV support associations/groups are vital for sustainable care and support for PLHIVs. The review found that:

- Few HIV and AIDS support associations and groups exist in some districts
- DACs are neither providing support nor capacity building to PLHIV associations and groups due to lack of funding
- PLHIVs are involved in the DACs

Strategies (iii) – (vii): Care and support for PLHIVs comprises financial, material, vocational, nutritional and psycho-social support which are community-based. The review was informed that:

- Home based care guidelines have been developed by NAS although they are not widely known and followed
- Some form of home based care programmes are ongoing in the districts though not well established
- Trainings are provided to PLHIVs in districts in transformational leadership skills
- Some OVCs are also being supported with educational material
- Nutritional guidelines for PLHIV have been developed but not disseminated
- Some of the registered PLHIVs are receiving nutritional support from NGOs, NETHIPS and WFP in the form of dry ration of cereal, beans and oil for PLHIV and their families on a quarterly basis (WFP provides nutritional support to PLHIV on monthly basis)
- NOW, an NGO, is piloting HBC by providing one month training to CHWs to carryout house-to-house visits to support PLHIVs for a monthly financial incentive of two hundred thousand Leones (Le 200,000) per person monthly

IV.2.3.4 Develop and implement programme for care and support for orphans and vulnerable children

The objective in the NSP for this component is to:

- Develop and implement programmes to support quality care for orphans and vulnerable children

The following strategies were examined when reviewing this component:

i. Assessment of the situation
ii. Linkage with health sector to facilitate health care for OVCs under decentralization
iii. Develop capacity of communities and care coalitions for orphans and vulnerable children
iv. Support to existing orphanages
v. Facilitate the establishment of laws to protect the human and social rights of the children including education etc

To what extent have the strategies been implemented?

Strategy (i): To develop and effective implement programmes for OVCs, the magnitude of the OVC problem should be assessed. The review found that:

- A comprehensive assessment of the OVC situation is yet unknown

Strategy (ii): The need for linkage with health sector to facilitate health care for OVCs under decentralization could not be overemphasized. The review found that:

- OVCs under five years of age receive free health care but PLHIVs including OVCs above the age of five do not access free health care in the health facilities except in the amputee camp where PLHIVs are entitled to free medication
- UNICEF and NGOs are providing nutritional support to severely malnourished OVCs with medical complication at Stabilization Centres in some districts

Strategies (iii) & (iv): To provide sustained care and support for OVCs, community care coalitions (CCCs) should be formed and their capacity built. The review found that:

- No community care coalition exist
- Orphanages are not widely available and where they exist they are not supported by DACs

Strategy (v): The establishment of laws to protect the human and social rights of the children including education is required to cover OVCs. The review found that:

- Child rights bill has been enacted into law in August 2007 covering OVC issues

IV.2.3.5 Conclusions

IV.2.3.6 Strengths

- Protocols have been developed, disseminated in health facilities and health personnel trained in their use
- ART and VCCT sites have been scaled up in the health facilities across the country
- PLHIVs are becoming involved in Home Based Care, (a project in Kono district is an example)
- HBC kits are provided to promote care and support to PLHIVs
- Support associations/groups are operational in some districts

IV.2.3.7 Weaknesses

- ARVs for children are not widely available
- Communities and families are not trained in HBC
- Development of IEC materials not properly coordinated
- No established systems for monitoring drug resistance for PLHIVs
- Lack of financial incentive to PLHIVs to implement HBC programme which may not be sustainable
- Lack of information on OVC status in the country
- Limited programmes supporting OVCs

IV.2.3.8 Opportunities

- The willingness of PLHIVs to be 'meaningfully involved in HIV and AIDS programming' is encouraging
- Piloting the training of PLHIVs in four chiefdoms in Kono district to carryout regular drug compliance is proving to be successful

IV.2.3.9 Challenges

- Shortage of trained health personnel particularly in the area of monitoring and evaluation
- Lack of dedicated physical space for delivery of services in some DACs
- There is no decline in the high level of stigma and discrimination at all levels even among health personnel
- HIV and AIDS stigma and discrimination is still very high at all levels throughout the country as contradictory messages continue to promote stigma
- The issue of inadequate financial resources to carry out intended HIV and AIDS programmes remains a problem. Moreover, some health professionals are demanding special allowances for managing PLHIVs
- Inadequate capacity to implement HBC programme countrywide

IV.2.3.10 Recommendations

Bold steps have been taken in the area of treatment, care and support during the period of the NSP 2006-2010 with the expansion of VCCT and ART centres although the numbers are still short of the universal access targets. The treatment and care pillar, during this planning period, is still weak with regard to regular supply of paediatric ARVs, monitoring drug resistance, home based care and other community based services etc. The country is also faced with the challenges of, for example, shortage of trained personnel needed for proper delivery of treatment, stigma and discrimination, non-comprehensive picture of OVCs and inadequate financial resources and lack of volunteerism.

The NSP mid-term review observed that care, treatment and support for PLHIVs is necessary for their welfare and to fight stigmatisation and discrimination. To deliver proper and effective treatment and care requires not only financial input, but the commitment of all stakeholders, the community at large and meaningful involvement of PLHIVs. It is, therefore, recommended that:

1. The new NSP should have strategies for developing human resource capacities covering health personnel, civic, religious and traditional healers.

2. The next national strategic plan should have community based services (care for OVCs, care coalitions, volunteer services, home based care etc) as a major pillar to the national response to improve services at the community level.
3. The country should recognize the impact PLHIVs can make to the delivery of care, treatment and support by *meaningfully involving* them in the relevant services
4. A communication strategy should be revamped to guide the design, validation and dissemination of all HIV and AIDS communication materials.
5. Stigma and discrimination against people living with or affected by HIV should be a major pillar in the next national strategic plan involving religious and traditional leaders
6. NACP should create effective supply chain management system in the next NSP for HIV and AIDS pharmaceuticals and medical supplies.

IV.2.4 Protection of human and legal rights

The NSP identifies creating an enabling legal and social environment as a priority component of the national response in connection with protection of human and legal rights with the following objectives:

- Create a legal and social environment which protects the rights of all persons infected with HIV as well as other vulnerable groups.
- Monitor human rights abuses and develop enforcement mechanisms to prevent and redress violations against PLHIVs and other vulnerable groups

The following strategies were examined:

(i) Advocate and enact laws to promote, protect and reinforce the rights, duties and responsibilities of PLHIVs.
(ii) Improve the knowledge of the general public on HIV and AIDS and the rights of PLHIVs
(iii) Support programmes to address sexual and gender based violence.
(iv) Strengthen statutory bodies to monitor, investigate, collect data and report on human right violations and abuses against PLHIVs, CSWs and other vulnerable groups.

IV.2.4.1 Findings

To what extent have the strategies been implemented?

Strategies (i) – (iii): The findings of the mid-term review of the NSP in 2008 have not changed for this strategic area. The findings then showed that the law on prevention and control of HIV and AIDS had been enacted in 2007. The law has clauses for the protection of human and legal rights but there is yet to be a case of abuse against PLHIV before a court of law. The review noted, however, that the population is being sensitized on their rights through radio programmes.

Strategy (iv): While there is no information on statutory bodies being strengthened to monitor, investigate, collect data and report on human right violations and abuses against PLHIVs, CSWs and other vulnerable groups, the review found evidence of reports on rights violation being made to the authorities such as the police. The reports are, however, not being investigated. Information gathered from districts shows the existence of Family Support Units (FSUs) ready to take up issues related to gender and sexual violence but these structures do not usually exist at chiefdom level.

IV.2.4.2 Conclusions

IV.2.4.3 Strengths

- Existence of Family Support Units (FSU) ready to take up issues related to gender and sexual violence
- Sierra Leone's position on human rights is strong because of it has ratified International Human Rights Protocols
- Existence of the "Gender Acts"; the Domestic Violence Act 2007, the Devolution of Estate Act 2007 and the Registration of Customary Marriage and Divorce Act 2007
- The commitment of the government to review the laws on HIV and AIDS

IV.2.4.4 Weaknesses

- Not much support to programmes on gender and sexual violence

IV.2.4.5 Opportunities

The following are opportunities towards Sierra Leone as a member of the international community caring for, respecting and protecting human rights of its citizens:

- The existence of HIV and AIDS 2007 Act with clauses for the protection of human rights
- The existence of a national workplace policy and similar polices in some sectors and some organizations
- International human rights networks proving technical support to the process of reviewing the laws

IV.2.4.6 Challenges

The challenges the country faces with regard to care and protection of human rights include:

- Some PLHIV's ignorance of their human rights
- Non prosecution of incidents of abuse by PLHIVs as claimed by NETHIPS

IV.2.4.7 Recommendations

The NSP 2006-2010 had protecting human and legal rights as one of its priority areas and a number of legal statutes were enacted during the NSP period. They include the Three Gender Acts (2007), the prevention and control of HIV and AIDS Act (2007), the national workplace policy, and the establishment of the Family Support Units in the Police. The review found that the existence of these statutes and policies have not stopped gender-based violence or stigma and discrimination. For the laws to meet the needs of the people and be acceptable they must be known and understood by the people. Laws have also to be enforced to be effective. The enforcement of these laws demands a robust legal system to try violators and an effective monitoring and reporting system. The Joint Programme Review, therefore, recommends that:

1. During the new planning period the country should improve its communication strategy in all sectors with regard to the laws on HIV and AIDS, human rights and stigma and discrimination at the workplace.
2. The judicial system should be primed to receive and adjudicate on incidents of abuse against PLHIVs.
3. Strategies for counteracting claims of curing AIDS without scientific evidence.

IV.2.5 Research, Monitoring and Evaluation

The NSP-2006 identifies two key components for research, monitoring and evaluation: (i) Establish, strengthen and expand the national HIV and AIDS M&E system and (ii) Conduct Policy Research.

IV.2.5.1 Findings

IV.2.5.2 Establish, strengthen and expand the national HIV and AIDS M&E system

The objectives for establishing, strengthening and expanding the national HIV and AIDS M&E system component of the NSP are:

- Develop a national M&E plan and data collection system
- Collect and analyse data and disseminate strategic information
- Monitor the trends of HIV infection among the general population and population sub-groups
- Ensure high quality programmes

The following strategies were examined in reviewing this component:

(i) Develop a national M&E framework.
(ii) Revive and strengthen M&E working group at all levels.
(iii) Develop and disseminate guidelines and tools for data collection.
(iv) Capacity building of M&E staff in M&E and data collection techniques.
(v) Set up data bank at various levels.
(vi) Strengthen reporting system.
(vii) Develop programmes for long and short training to improve capacities of district Staff to conduct HIV and AIDS/STIs related activities, surveillance and research.
(viii) Develop protocols for surveillance and research.
(ix) Develop Epidemiological bulletins.
(x) Establish quality assessment and quality assurance criteria for all programmes.
(xi) Annual reviews of yearly plans and mid-term reviews of the NSP.

To what extent have the strategies been implemented?

Strategies (i) – (vi): A monitoring evaluation system forms an integral component of the national response to the epidemic. The system therefore, must have operational guidelines, trained staff and an effective streamlined reporting system. The Joint Review found that:

- A national M&E framework exists at the central level in Freetown but not implemented at lower levels
- M&E working groups have not been fully established nationwide
- There are a few M&E trained staff but they are not found in all districts. They received training in thematic areas and localized responses through MOHS and UNAIDS
- Guidelines and tools on M&E have been developed but poorly disseminated to the districts. Therefore data collection is seemingly dormant on HIV and AIDS activities

- There are a few data banks in some districts. Provision of internet modems by NAS is also not widespread and some of the data banks deal with IPs and not MoHS
- The reporting system is inefficient and not effective in all of the districts. There is a distinct gap in reporting between NAS and DACs as the activities of implementing partners are poorly regulated

Strategy (vii) – The capacity of M&E can be enhanced with well trained technical staff in all districts for proper conduct of HIV and AIDS/STI related activities, surveillance and research. It was found that:

- Short term training has been conducted but it is limited to only few districts
- The number of AIDS counsellors is inadequate and their activities not properly coordinated by DAC in some districts

Strategies (viii) – (x) deal with the development of protocols for surveillance and research, production of periodic epidemiological bulletin and the establishment of quality assessment and assurance criteria for all programmes. The review found that;

- Protocols for surveillance and research exist only at headquarters and are not disseminated to the districts
- No periodic epidemiological bulletins are been produced
- Quality assessment and assurance criteria is done in some districts but not strictly and regularly followed. There are guidelines and tools formulated by NAS in collaboration with MOHS but it has not been effectively disseminated to the districts

Strategy (xi) – This is important in identifying how appropriately activities are been implemented and points out the areas of strength and weaknesses in programme implementation ignored to have a good monitoring and evaluation system for the HIV and AIDS response in the country. Thus, the need for annual reviews of yearly plans and mid- term reviews of the NSP. The review found that;

- A multi-year and annual work plan was developed by NAS in close collaboration with the MOHS. The work plan is reviewed annually but it is still not replicated in all of fourteen districts

IV.2.5.3 Conduct policy research

The overall objective for this component is:

- To conduct research on effective alternative forms of treatment and prevention of HIV and AIDS

The following NSP strategies were examined for this component:

(i) Capacity building for research
(ii) Mobilize funds for research (solicit and evaluate research proposals)
(iii) Strengthen the research and ethical review committee.
(iv) Ensure proper dissemination of findings.
(v) Annual forum to discuss about ongoing research.
(vi) Collaborating with traditional healers.

To what extent have the strategies been implemented?

Strategies (i), (ii) & (iii) – A monitoring and evaluation system required for the HIV and AIDS response must be able to effectively conduct research on alternative forms of treatment and prevention of the epidemic. This requires adequate mobilization of funds to develop the capacity for research.

The review found that:

- There are research proposals, almost all originating from Freetown, but attracting very little funds
- There was no initiative to mobilize funds for research at the district level. Any research work done at the district level depends on funding from NAS, the Global Fund and a German Fund (KFW)
- The capacity building for research is very weak

Strategies (iv) & (v): This ensures adequate dissemination of research findings and increases investment. Hence, there is the need for effective research and ethical review committees to be established. The review found that;

- An ethical review committee exists at MOHS in Freetown
- There has been evidence of research activity but no annual forum for discussions
- A research on policy orientation was conducted by NAS and it revealed the existence of MSN in Sierra Leone. Such findings have not been widely disseminated

Strategy (vi) – One of the strategies in the NSP 2006-2010 was to harness the cooperation of traditional healers in the national response. Traditional healers are accessed by the majority of the population for social and medical remedies. If an effective collaboration is established between western medical services and traditional healers they could be powerful partners in the response to HIV epidemic communicating non contradictory messages to their clients and encouraged to provide relief services that may be effective. This would therefore require a strong collaboration so as to have a harmonized approach for treatment and care for PLHIVs. The review found that;

- There is still a weak link between western health staff and traditional healers for treatment and care of PLHIVs

IV.2.5.4 Conclusions

IV.2.5.5 Strengths

- The development of protocols for surveillance and research to track the trend of the epidemic
- First phase training of monitoring and evaluation staff from global fund to increase its capacity level
- Establishment of a national database that collects and analyses data from all Global Fund sub-recipients including stakeholders

IV.2.5.6 Weaknesses

- Poor sensitization and circulation of the M&E Framework at all levels of the country
- NAS has no database covering all HIV and AIDS activities in the country beyond programmes funded by the Global Fund Lack of data collection structures at the community level in sprite of functional structures existing at the facility levels

- M&E systems of implementing partners not synchronized with that of NAS
- There is inadequate number of technically trained staff on data collection, analysis and M&E skills at both central and district levels
- Nonexistence of a reporting mechanism for NAS and the districts on how data sent is used for planning and decision making
- Research information dissemination is only restricted to national level
- No research agenda developed in new interventions in treatment and care

IV.2.5.7 Opportunities

- The collapse of CRIS at all levels provides another opportunity for the development of a data bank with a well computerized information centre
- Referral of reports by stakeholders to their respective sources of funding continues to be a major opportunity for mainstreaming reporting system to the national requirement
- The area of research is yet to be fully utilized. Emerging issues such as MSM and the intervention of treatment of HIV and AIDS using traditional medicine offer research opportunities on the best way of incorporating them into the national response
- The existence of a National Strategic Plan 2006-2010 as a guide to implementation
- The existence of a national M&E Framework of 2006-2010 as bases for research, monitoring and evaluation

IV.2.5.8 Challenges

- Insufficient financial resources prevent thorough implementation of the M&E framework
- Lack of knowledge as to how the number of trained staff members would translate into capacity building in the long term remains a challenge
- Harmonizing the smooth and general inflow and outflow of data from a common pool. This must consider coordinating data flow from NAS to NGOs and other implementing partners and vice versa
- To ensure M&E work plans are synchronized with those of the implementing partners based on the national M&E Framework
- Required logistics for the setting up of well computerized database system
- Coordination of more partners to HIV and AIDS activities with a directed budgetary provision
- Establish ownership by all the different partners to the national plan
- The capacity for effective programme evaluation is still short of that required
- The trend of HIV and AIDS in the country need to be closely followed due to changing behavioural patterns
- The expansion of partnership forum to enhance initiation and review of research proposals

IV.2.5.9 Recommendations

An effective multi-sectoral coordination of the national response to HIV and AIDS requires a functional monitoring and evaluation system, as expounded in the “Three Ones” principles. The country has established a monitoring and evaluation mechanism to track HIV and AIDS activities at all levels from central level to chiefdoms. The weaknesses of the system with regard to human capacity and low operational resources support are making the system inefficient.

Effective collection of data and smooth data flow are important component of a functional and efficient monitoring and evaluation system. There are gaps in the channels of important national HIV and AIDS data flow. The review, therefore, recommended that:

1. Monitoring and Evaluation remains a priority pillar of the next HIV and AIDS national strategic plan
2. The new NSP identifies strategies that NAS can use to develop a national HIV and AIDS data bank, in strong collaboration with implementing partners, that captures all relevant data on the national response from all sectors and implementing partners for effective monitoring and coordination of the national response.
3. The new NSP should have clear strategies for communicating key national response policies, plans and guidelines such as the NSP, the M&E Framework and Operational Plan to the all sectors and participating partners including DACs.
4. While the strategy for collaboration with traditional healers can be well addressed under prevention, care and treatment, yet the new NSP should have strategies to promote research as a specific objective to be applied, for example, to alternative treatment of HIV and AIDS by traditional healers, emerging issues such as CSW, MSM and IDU
5. During the next planning period, NAS in collaboration with partners should develop a research agenda for information sharing and resource mobilization to support research.

IV.2.6 Key sectoral responses

The mid-term NSP review report correctly observed that the youth are an obvious and appropriate group for targeting preventive measures as they are the backbone of the future of the country and are highly vulnerable. Workplace programmes were also identified as important because HIV and AIDS is causing development downturns in many countries. It is, therefore, evident that as the country moves the multisectoral response forward it has to ensure that the fight is taken to the workplace. Sectoral and organization specific policies which are in line with the national policy and laws form the foundation of control programmes.

IV.2.6.1 Findings

IV.2.6.2 Youth

The objectives are:

- Promote improved health seeking behaviour & adoption of safer sex practices amongst youths
- Ensure employment opportunities for youths

When reviewing the national response in connection with the youth component of the priority area, the following strategies were examined:

(i) Curriculum revision and development on HIV and AIDS for Primary Schools, Vocational Schools and out of school youth.
(ii) Strengthen and expand Family Life Education & Life Skills in secondary schools, including training of Peer Health Educators to cover all schools, public and private.
(iii) Provision of appropriate user friendly BCC packages for all secondary, vocational and tertiary students.
(iv) Develop and implement programmes that mainstream HIV and AIDS education, prevention and sexual violence into all youth programmes.

(v) Establish Youth BCC taskforce
(vi) Establishment of multi-purpose youth centres in all communities nationwide with recreational facilities, VCCT services, skills training, health education and STI preventive services etc.
(vii) Promote girl child education.
(viii) Educate and sensitize on career options.

To what extent have the strategies been implemented?

Strategies (i) - (vi): Aggressive youth-targeted HIV preventive measures are a centre piece in the fight against HIV and AIDS globally. The NSP gives due priority to the youth in the national fight against the epidemic. HIV and AIDS and life skills training are included in the primary, secondary and tertiary schools' curriculum with BCC covered under life skills training in primary, secondary and tertiary schools. Sexual violence is included under emerging issues in life skills training and family life education in primary and secondary schools.

The NSP called for the establishment of multi-purpose youth centres in all communities nationwide with recreational facilities, VCCT services, skills training, health education and STI preventive services. The Review found that:

- Few peer educators are trained in life skills
- There are youth centres in some districts but they are not multipurpose
- The MEYS has and Education Sector Workplace Policy on HIV and AIDS and the Youth Network on HIV and AIDS is drafting an HIV and AIDS Youth Policy supported by AWARE (Action for West African Region) with NAS involvement

Strategies (vii) & (viii): There have been deep rooted gender inequalities in the society that have to be removed by promoting the education of girls to equip them with knowledge and skills to adopt healthy lifestyles, protect themselves from HIV and AIDS and other sexually transmitted diseases, and encourage them to take an active role in social, economic and political decision-making as they changeover to adolescence and adulthood. The Review found that

- Girl's enrolment in government and government supported schools is 45% for the 2009/2010 school year
- Some government and government assisted schools provide career guidance

IV.2.6.3 Workplace programmes

The objective is:

- Develop and implement workplace HIV and AIDS policy in all sectors

The following strategies were examined in connection with workplace programmes:

(i) Establishment of an HIV and AIDS Business Coalition and mobilise additional private sector expertise and resources for HIV and AIDS.
(ii) Enactment of workplace policy law that eliminates discrimination and stigma in workplace.

(iii) Support Trade Unions and staff Association to implement HIV and AIDS Workplace policy by Identifying and Training of Peer Educators and Focal Points in all workplaces.
(iv) Expand NASSIT to become comprehensive social security scheme that can provide unemployment benefits and health insurance on a contributory basis for all workers.

To what extent has the strategy been implemented?

Strategy (i): The country has to tap resources from within the country for the sustainability of the national response. There is too much dependency on external resources. The suggestion to call on all sectors to provide matching resources to support the fight against the epidemic cannot be over emphasised. The NSP requires the establishment of an HIV and AIDS Business Coalition and the mobilization of additional private sector expertise and resources for HIV and AIDS in Sierra Leone. The review found that:

- The Business Coalition has been established and is active with a secretariat housed in NAS

Strategies (ii) & (iii) of the NSP called for the enactment of workplace policy law that eliminates discrimination and stigma in workplace and support trade unions and staff association to implement HIV and AIDS workplace policy by identifying and training of Peer Educators and Focal Points in all workplaces. The review found that these strategies had been implemented as noted in the mid-term NSP review report.

Strategy (iv): NASSIT is a statutory public Trust that is charged with the responsibility of administering Sierra Leone's National Pension Scheme. The Trust was established to provide retirement and other workers' benefits. The primary responsibility of the Trust is the partial replacement of income lost due to old age, invalidity and death. The NSP requires the expansion of NASSIT to become comprehensive social security scheme that can provide unemployment benefits and health insurance on a contributory basis for all workers. The Review found that:

- NASSIT is not providing unemployment benefits but providing retirement, survivor and invalidity benefits and is working on modalities of including health insurance in the social security package recommended in Part IV, Section 20 Article 1 of the *Prevention and control of HIV and AIDS Act, 2007*

IV.2.6.4 Conclusions

IV.2.6.5 Strengths

- Existence of an active Business Coalition bringing together major industries in the country to be actively involved in the national response to the epidemic. A number of companies have workplace policies
- The *Prevention and control of HIV and AIDS Act, 2007* has provisions against discrimination
- Affirmative action exists for the girl child primary education
- The national workplace policy on HIV and AIDS protects PLHIVs against discrimination

IV.2.6.6 Weaknesses

- Almost all existing HIV and AIDS preventive strategies for the youth are addressing the youth in schools. The out-of-school youth are not properly covered

IV.2.6.7 Opportunities

- Commitment of the private sector through the Business Coalition
- Labour Congress's involvement in the national response

Picture IV-1: Children to be protected (Photo curtsey of S.K. Lwanga)

IV.2.6.8 Challenges

- Lack of emphasis on career guidance in government schools
- The 49% enrolment of girls in educational institutions masks the low level of girls' enrolment in secondary schools. The challenge is to bring the girls' enrolment in secondary schools to at least the same level as the boys' level
- The variety of BCC materials is not adequate to meet the different ages of children using them

IV.2.6.9 Recommendations

The NSP 2006-2010 identified three key public sectors: Education, Science and Technology and Labour as leaders in addressing the training and employment needs for the youth in the national response to HIV and AIDS. Some accomplishments have been made over the past five years but a lot still remains to be done. Some of the issues that need to be addressed are sector cross-cutting such as stigma, gender-based violence, delinquency, career guidance, teenage pregnancy etc.

It is recommended that:

1. Youth and adolescents should form a major pillar in the national response during the next planning period.
2. The country identifies strategies over the next planning period which will effectively bring HIV preventive services to the in and out-of-school youth and adolescents.
3. During the next planning period, the country takes serious steps to address girl-child specific issues such school enrolment and completion of school education, teenage pregnancy and gender-based violence.

Picture IV-2: The girl-child (Photo curtsey of S.K. Lwanga)

4. The new NSP should include robust strategies on workplace programmes addressing discrimination and stigma.
5. The country must, during the next planning period, implement strategies that bring key sectors of Health, Education, Local Government and Rural Development, Social Welfare, Gender and Children Affairs to play their full roles in the national response under NAS's coordination.

Part V Conclusions

Sierra Leone has come a long way in past five years of the national response to HIV and AIDS. A number of "pillars" of the NSP 2006-2010 have demonstrated very positive results. Successful pillars have been: the prevention of new infections, care, treatment and support. Pillars with reasonable positive results are: decentralization and protection of human and legal rights.

The NSP end review has identified areas that should be considered as major pillars during the next planning period. These include:

- The youth and adolescents who, it is recommended, should be regarded as a new pillar
- Prevention of new infections should remain a major pillar in the new national strategic plan
- Monitoring and Evaluation should remain a priority pillar of the next HIV and AIDS national strategic plan
- The country must, during the next planning period, implement strategies that bring key sectors of Health, Education, Social Welfare, Gender and Children Affairs to play their full roles in the national response under NAS's coordination
- The country should recognize the impact PLHIVs can make to the delivery of preventive services, care, treatment and support by *meaningfully involving* them in the relevant services

Only strategic recommendations are given in this report directed at the next stage of preparing the NSP for the next five years.

Concept of *meaningful involvement*

PLHIVs involvement in a national response to HIV goes beyond inviting them to attend meetings and functions or token representation in committees and working groups. PLHIVs' effective contribution to any national response is when they are *meaningfully involved* in the response. *Meaningful involvement* means:

> *Competently trained PLHIVs engaged in the planning and development of activities that affect their welfare. PLHIVs involved in preparing national guideline, policies, strategic and operational plans and funding proposals. PLHIVs trained and employed in VCCT centres and as mentors for colleagues on receiving ART monitoring adherence to treatment.*

V.1 Priority Area 1: Decentralized implementation

There are two major strengths in the structure and management of the national response:

1. NAS is well placed in the President's Office to coordinate the multi-sectoral response including the decentralization through District AIDS Committees (DACs).
2. The current leadership of NAS is focused to its mandate and dedicated to the national response.

The national response is, however, still hampered by a lack of clarity in the minds of some stakeholders on the different roles NAS is currently playing: as a statutory coordinating body and as a conduit of funding to programmes and activities. Another weakness in the response is the poor dissemination (and communication) of key documents such as the NSP and the M&E Framework to the stakeholders.

There are opportunities the country can the country should capitalize on during the next strategic planning period. These include:

- Recognition of HIV and AIDS as an important health and developmental issue in the President's Agenda for Change[8]
- Goodwill demonstrated by increasing resource input by the government into the national response.
- Existence of the Partnership Forum which is fully supported by H.E. the President offers a forum for sharing experiences and eventual harmonization of the national response across partners.

A number of challenges have to be addressed to achieve full decentralized national response. They include:

- The reluctance of IPs to disclose the amount of money they use especially the organizations with no direct working relationship with NAS
- The slow speed of decentralization and inadequacy of the resources needed to ensure effective functionality of the decentralized facilities
- Inadequate numbers and capabilities of human resources in areas such as M&E
- Excessive dependency on external sources of finances for the national response (98% of resources come from donors only 2% from government)
- A disconnect between DACs and implementing partners receiving funding through NAS

V.2 Priority Area 2: Prevention of new infections

Positive strides have been made in the area of prevention over the five years period. The continuous increase of VCCT and PMTCT sites in health facilities coupled with the streamlining of condom procurement for free distribution underscores the nation's commitment to the global goal of preventing new infection. The development and distribution of policy documents and guidelines have guided implementation in the country.

Although IEC/BCC materials are distributed targeting various groups yet NAS has not designed a mechanism to ensure the vetting of information that some carry for all IEC/BCC materials. Weak synergy between the DHMT and traditional healers continues to pose a challenge to treatment.

The existence of budget lines for HIV and AIDS activities in most funding institutions and the creation of a desk in most ministries, departments and agencies is an opportunity toward and integrated response to the epidemic.

[8] The Republic of Sierra Leone. *An Agenda for Change. Second Poverty Reduction Strategy (PRSP II) 2008-2012.*

V.3 Priority Area 3: Care, treatment and support of PLHIVs, families and communities

In the area of treatment, care and support; it is positive to note that HIV and AIDS related protocols and guidelines have been developed and disseminated within the health sector. This is followed by the training of existing health personnel in health facilities on the treatment protocols. However, the involvement and activities of traditional healers on the management of HIV and AIDS remains unknown. Inclusion of HIV and AIDS in pre-service training programmes is yet to happen. Besides, putting in place systems for recurring HIV and AIDS training for health personnel is a challenge.

There has been progress on the number of facilities implementing ART, VCCT and PMTCT services including availability of free adult ARVs nationwide. However, there is no provision for the increased demand for PMTCT services created by the Free Health Care Initiative (FHCI) as there are current stock-outs of paediatric AVRs in some districts.

Though challenging, the implementation of home based care programmes is important to provide bridge the required gaps in care and support at the community level. The involvement and subsequent training of PLHIVs as Community Health Volunteers for the implementation of the HBC programme is vital for sustainability. Despite the lack of functional OVC support programme nationwide, there are a few PLHIV support groups/associations at both national and district levels which are currently receiving some form of capacity building and material support from partners including NETHIPS. To date there two known hospice care facilities established nationwide to care for terminally ill HIV and AIDS patients requiring special care. Having at least one such facility per region will provide equal opportunity to everyone needing the service.

V.4 Priority Area 4: Protection of human and legal rights

Sierra Leone's position on human rights is strong because it has ratified International Human Rights Protocols and has recently enacted laws against gender-related violence and abuse. The existence of FSUs and some support groups (GWT, SEAC, KWT, and VOW) in some districts is a good sign that the country is moving in the right direction towards providing support to victims of gender and sexual abuse. These embryonic support groups need to be replicated in all districts. As a result of low sensitization the laws on HIV and AIDS enacted are not known by most of the population.

V.5 Priority Area 5: Research, Monitoring and Evaluation

The existence of a data base at NAS and data banks in some districts is quite a step in the right direction. However, this must be developed into a national holistic data bank that receives input of information data on HIV and AIDS activities from sub data banks in all districts to ensure effective data analysis a comprehensive nationwide coverage.

In view of the field findings, it is still evident that the issue of research on HIV and AIDS is weak. NAS in collaboration with implementing partners is required to strengthen advocacy for proper research that would enable the country to understand fully the drivers of the epidemic and the best practices in the national response.

The country has an M&E Framework to guide the monitoring of the national response with support of M&E working groups in a few districts. Establishment of functional M&E working groups in all districts is an expensive undertaking that cannot be addressed only by funds solely funded by the Global Fund. It is a key challenge that demands an immediate action to locate and re-direct other sources of funding to implementing the entire component of the M&E Framework.

The technical capacity of the M&E structure to effectively monitor the national response remains a daunting challenge. It is imperative, therefore, to strengthen M&E nationwide, providing adequate training of personnel and building infrastructure at district level.

The channel for reporting between NAS, stakeholders and DACs as specified in the M&E Framework has not been strictly followed. This is influenced by the different provisions of funding to the implementing partners. NAS, therefore, faces the challenge of "convincing" all the partners of the need for routine reporting of their activities to NAS to work towards a comprehensive implementation of the M&E Framework.

V.6 Priority Area 6: Key sectoral responses

A number of positive steps have been taken during the last five years in to involve different sectors into the national response to HIV and AIDS. Most significant is the existence of an active Business Coalition bringing together major industries in the country to be actively involved in the national response to the epidemic. A number of companies belonging to the Coalition have workplace policies.

Additional strengths for the sectoral response are:

- The enactment of the *Prevention and Control of HIV and AIDS Act, 2007* which has provisions against discrimination.
- The establishment of the national workplace policy on HIV and AIDS protects PLHIVs against discrimination.
- Existence of an affirmative action exists for the girl child primary education.

A major weakness in the sectoral responses is in connection with the programmes targeting the youth. Almost all existing HIV and AIDS preventive strategies for the youth are addressing the youth in schools. The out-of-school youth are not properly covered.

Sectoral responses have the opportunity to grow with the commitment of the private sector through the Business Coalition and Labour Congress's involvement in the national response.

Three major challenges were identified by the Joint Review in connection with sectoral responses.

1. Inadequate involvement of key sectors of Health; Education; Local Government, Employment, Labour and Social Security; Social Welfare, Gender and Children Affairs in the national response under NAS's coordination.
2. Lack of emphasis on career guidance in government schools
3. The 45% enrolment of girls in educational institutions masks the low level of girls' enrolment in secondary schools. The challenge is to bring the girls' enrolment in secondary schools to at least the same level as the boys' level.
4. The variety of BCC materials is not adequate to meet the different ages of children using them.

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29. National HIV and AIDS Secretariat: Teacher' Manual on HIV and AIDS For Basic Education Schools, (July 2006)
30. National HIV and AIDS Secretariat: The Partnership Forum 2009 &Partners Annual Report 2008 (2010)
31. National HIV and AIDS Secretariat: The Sierra Leone HIV and AIDS National Strategic Plan 2006 – 2010.
32. Statistic Sierra Leone: Sierra Leone Demographic and Health Survey 2008, (July 2009).
33. UNAIDS: Joint Action for results UNAIDS outcome framework 2009-2011, (May 2008).
34. United Nations Country Team Sierra Leone: Joint Vision for Sierra Leone of the United Nations Family (May 2009).

Part VII Annexes

VII.1 Annex 1: Findings of the NSP Mid-Term Joint Review

VII.1.1 Decentralized implementation

- The physical capacity of NAS was being reduced and there were gaps in Secretariat's coordination of funds coming into the country for HIV and AIDS with some agencies being involved in HIV and AIDS activities without reference to NAS or the NSP
- NAS coordination of DHMTs with other sectors in the districts was haphazard at the time

VII.1.2 Prevention of new infections

- Not all IEC/BCC materials were being vetted by NAS
- There were sector and organization specific policies for HIV and AIDS/STI prevention in addition to the National HIV and AIDS policy
- Free male condoms were widely available to the vulnerable groups especially youths and CARE was marketing condoms through their social marketing approach
- Most of the hospitals and VCCT services are user friendly i.e. without stigmatization and discrimination
- STI syndromic management protocols were available in the country and distributed to most of the health units and nurses at PHU levels were being trained in their use
- STI surveillance training was integrated in health workers' training and there was routine STIs surveillance
- VCCT was established in all district headquarter towns and in most maternity health care facilities and linked with PMTCT in some ANCs with all MCHAs and some TBAs in ANCs being orientated on PMTCT
- Medical personnel in hospitals dealing with blood had been trained in blood safety and blood products but not much training had been given to traditional health care providers involved in skin piecing

VII.1.3 Care treatment and support of PLWHAs, families and communities

- ARVs were provided free to all who need treatment and were readily available in the existing ART sites although more treatment sites and laboratory support were needed to cover the whole country
- Sensitization programmes focussing on confidentiality and reducing stigmatization were found to be sub-optimal with non-harmonized messages with stories of a break in confidentiality through "shared-confidentiality"
- Some training had been conducted in the implementation of home-based care (i.e. nursing care, palliative care and basic concepts on HIV and AIDS) but without country-wide hospice care

- NAS was providing home-based care kits for PLHWAs through sub recipients in some districts
- The situation of orphans and OVCs was not fully known but there was an ongoing situation analysis. There was no coordinated support for existing orphanages.

VII.1.4 Protection of human and legal rights

- The law covering stigma at the workplace had been enacted but not all people were aware of its existence
- International Protocols were being "domesticated" with the ratification of the UN Laws, Ndjamena Accord etc.

VII.1.5 Research, Monitoring and Evaluation

- The existence of a spectrum of research done by students mainly on behavioural and social issues of HIV and AIDS but without strategies in place for disseminating research findings
- The existence of a technical M&E working group at the national level but without equivalent M&E groups at district and chiefdom levels
- Lack of data banks (stipulated by the NSP) established at national, district and chiefdom levels although CRIS databases existed at district and national levels
- Lack of strict adherence to the reporting strategy depicted by the management and information flow chart in the NSP and M&E Framework by all stakeholders implementing HIV and AIDS activities
- Protocols, guidelines and tools at national level for quality assurance, based on the WHO quality assessment tool, developed by MoHS in collaboration with NAS
- Lack of collaboration between established health services and traditional healers in HIV and AIDS

VII.1.6 Key sectoral responses

- HIV and AIDS and life skills training had been included in the primary, secondary and tertiary education institutions' curricula
- A number of institutions in the public and private sectors had work place policies
- Steps were being taken to establish a Business Coalition to draw the private sector into the national response to the epidemic
- HIV and AIDS was integrated into signed legally binding agreements covering Collective Bargaining Public Utilization Trade Group, Construction and Mines Enterprise. The Services Trade Groups and Manufacturing Group Agreements were being negotiated

VII.2 Annex 2: List of names of the Joint Review Consultants

Name	Telephone	e-mail
Stephen K Lwanga. (Team Leader)	+256 772-770099	slwanga@utlonline.co.ug
Mohamed S. Bah	+232 76-303835	msalieub@yahoo.com
John K. Brima	+232 33-320249	brimajohn@yahoo.com
Mohamed Hashim Rogers	+232 33- 312852	shimo_5592@yahoo.co.uk
Joseph V. Senesie	+232 76 - 608106	jvsenesie@yahoo.com

VII.3 Annex 3: Terms of reference for the Review Team

Terms of Reference for the Final Joint Programme Review of the Sierra Leone National HIV and AIDS Strategic Plan - 2006-2010

1.0 Background

The National HIV and AIDS Secretariat (NAS) coordinates the response to the growing Human Immunodeficiency Virus (HIV) epidemic, which causes the Acquired Immune Deficiency Syndrome (AIDS). Its activities are therefore geared towards reducing HIV and AIDS prevalence and also mitigate the impact of the disease on persons infected/affected through a multi-sector approach. To effectively carry out this mandate, the secretariat wishes to carry out a final Joint Programme Review (JPR) of the NSP 2006-2010 as it expires at the end of the year. In line with the above, NAS in collaboration with UNAIDS is seeking to recruit an external consultant to lead a team of national consultants to carry out the task.

2.0 Objectives, Scope & Process

2.1 Rationale

The effectiveness of the national response to the HIV and AIDS epidemic in Sierra Leone requires periodic Joint Programme Reviews to evaluate how successfully the NSP had guided the response, thus providing a platform to redefine the responsibilities of stakeholders in implementing the provisions of the NSP. The main objective of the consultancy therefore is to undertake a Joint Programme Review in respect of the NSP 2006-2010, and provide recommendations that will guide the development of a new National HIV and AIDS Strategic Plan, new M&E Plan and an Operational Plan. Other outcomes that will benefit the response are as follows:

a) Improve on current programme methodologies, practices and tools
b) Reinforce the strategic and functional role of NAS in guiding the response within the framework of the principles of the 'Three Ones'
c) Guide the overall process of programme development, implementation, monitoring and evaluation
d) Strengthen a platform for improved advocacy, partnership and resource mobilisation
e) Give an indication of the level of implementation of the NSP

Against this background, the consultant should ensure that the output from the final joint programme review is explicit, user friendly, accessible and capable of addressing the changing needs of the response as a new strategy is developed.

2.2 Scope of Work

The focus of the consultancy will include:

- Conducting interviews and data collection from key stakeholders
- Facilitation of a participatory process for the final Joint Programme Review
- Drafting of the final JPR Report
- Validation of the final JPR Report
- Submitting the final Reports to NAS, UCO and RST

2.3 Principles

The process will be guided by the following principles and key considerations:

- Consistency with the NSP 2006-2010
- Extensive stakeholder participation
- Coherency with the National Policy framework provisions and National institutional setup and systems
- Adoption of realistic strategies in target development, managing the complexity of stakeholder activities, in-country human capacity and the availability of funds
- Consistency with the National M&E Framework

2.4 Consultancy Team and Key Players

The Joint Programme Review will include the following categories of stakeholders who will be central to the participatory process:

- National AIDS Council and Secretariat
- International Consultant
- National Consultants
- Expanded Technical Working Group on HIV and AIDS (& other thematic sub groups)
- Joint UN Team on AIDS
- Cross section of stakeholders representation (including: Government agencies, National Bureau of Statistics, International CSOs, National CSOs, Donors-bilateral and multilateral, FBO, PLHIV, Research and training institutions, decentralized units, urban authorities, private sectors, Health Facilities)

For the entire duration of this task, the consultant will work closely with a team of four national consultants and the M&E Adviser of the UNAIDS Country Office

3.0 Outputs of the Consultancy

3.1 Consultancy Deliverables

The consultancy will have the following outputs, namely:

a) The final JPR Report and
b) A process report for the entire consultancy. The following reports or documentation will be required from the consultant, Inception report, interim report and final process report.

3.2 Reporting and Supervision

Throughout the consultancy, the reporting and supervisory requirement will be as follows:

a) Interim reports on the status of activities will be addressed to the Director of NAS, UCC, Chair of the UN Theme Group on HIV and AIDS, and members of the Technical working group copied.
b) Final report of the consultancy should be addressed to the Director of NAS, UCC, Chair of the UN Theme Group on HIV and AIDS, and Members of the M&E Working Group. HIV and AIDS focal points of line ministries and UN Agencies, Statistics Sierra Leone, DECSEC, research and training Institutions and other partner organisations copied.
c) Supervision of the entire consultancy will be carried out by the National HIV and AIDS Secretariat and the UNAIDS Country Coordinator.

3.3 Duty Station and Duration:

The duty station for the consultant will be the office of the National AIDS Secretariat, Freetown, Sierra Leone. The duration for the entire consultancy is expected to last for a period of thirty (30) working days[9].

4.0 Key Processes and Activities

4.1 Processes

The consultancy will involve the following key processes and approaches:

- Briefing and planning meetings/consultations
- Literature review
- Key Informant Interviews
- Site visits
- Training Sessions
- Drafting the documents
- Technical Working Group meetings
- Stakeholder consultative validation workshops

5.0 Consultancy Requirement (Qualification and Skills)

5.1 International Consultant

The lead consultant requires interdisciplinary experience, understanding, insight and instincts relating to development, humanitarian, relief, health and HIV and AIDS issues. Hence, the consultant should:

- Have wide experience in leadership, M&E and finance;
- Must have worked in the field of HIV and AIDS consulting for at least five years;
- Be experienced in managing projects wherein systematic input, output and process are used to guide programming;
- Must have previously undertaken such or similar assignments;
- Have a Bachelor or Masters Degree in a relevant field (Public Health/Health, Social Sciences, Management, Monitoring and Evaluation) with at least five years experience in the field);
- Good communication and interpersonal skills;
- Be able to work as a team with national counterpart staff, with the mutual understanding of the current situation

5.2 National Consultants

In addition to having a mutual understanding of the current situation, the national counterparts should possess the following:

- A first degree in field (Public Health/Health, Social Sciences, Management, Statistics Monitoring and Evaluation) with at least three years experience
- Must have previously undertaken such or similar assignments;
- A good understanding of the national response
- Knowledge of the status of the response
- Familiarity with the regions and administrative structures
- Knowledge of the status of the epidemic

[9] It was actually 22 working days based on 5 working days per week. The work was done from 2 to 31 August 2010.

VII.4 Annex 4: List of organizations, agencies and institutions contributing to the review

Annex 4a: Sectoral and individual meetings in Freetown

H.E. Dr. Ernest Bai Koroma, President of the Republic of Sierra Leone

Government Ministries

Marion Karimu	MEWR	HIV Focal Point
Augusta J. Abibo-Jones	MFA & IC	HIV Focal Point
Sia A. Tejan	MFA & IC	HIV Focal Point
M. Kemoh Mansaray	MFMR	HIV Focal Point
Alice Kandeh	MIALGRD	HIV Focal Point
Alice Kandeh	MIALGRD	HIV Focal Point
John Kpaua Manu	MIC	HIV Focal Point
Abdul Karim Conteh	Ministry of Labour	HIV Focal Point
Usman Bangura	MoD	HIV Focal Point
Mohamed I. Kutubu	MoFED	HIV Focal Point
Patrick M. Sama	MoTCA	HIV Focal Point
David N. Kamara	MoW, H & I	HIV Focal Point
Rhoderick K. Bernard	Office of the Chief of Staff	HIV Focal Point

International Nongovernmental Organisations

Frank Kobba	WVSL	HIV Officer
Konima Bobor-Kamara	Concern	Mainstreaming Advisor
Ibrahim Kamara	Plan SL	Health Advisor
Uzo Gilpin	CARE	HIV/Health coordinator
Bockarie Sesay	CARE	DME Coordinator
Mohamed Conteh	AFRICARE	Program Manager
John. S. Kamara	Nova Scotia SL	Programme Manager
Ernest Gaie	AFRICARE	Country Representative
Gilbert N'habay	Child Fund –Sierra Leone	Grant and Partnership Coordinator
Aminata Jalloh	CRS	Program Officer-Life skills
Kadiatu S. Koroma	GOAL	HIV and AIDS Trainer
Sebester Baraud	Marie Stopes Sierra Leone	Country Director
Thaim Kargbo	PPASL	M&E Manager
Olive Stober	SLRCS	H.S Field Manager
Lawrence Teh	Christian Aid	Senior Program Officer
Sallay R. Kamara	AAISL	HIV and AIDS Officer

M & E Technical working group

Joyce Abu	BCAASL	National Coordinator
Lillian B. Khanu	BCAASL	Project Officer
Zaniab Kamara	CAMONDY	
Sulaiman Fogbawa	CARE	
Henry H. Conteh	CAYMUD – SL	
Rev. Christiana Sutton-Kamara	CCSL	
Jotham F. Conteh	Children's Forum Network, Lungi	
Albert Macauley	FAHOCHA	
Alex H. Gandi	LWFOMI, PFSL	
Maybelle A Gamanga	MYES	
Abu B.B. Koroma	NAS	IEC/BCC Coordinator
Mohamed Kai Sandi	NAS	IEC/BCC Officer
Martha S. Kamara	NAS	Documentation Officer
Francis T. Farma	NECHRAS	
Arnold Macauley	NETHIPS	Advocacy Officer
John. S. Kamara	Nova Scotia SL	Programme Manager
Rev. Aron Simbo	PFSL	Pharmacist
Ibrahim Kamara	Plan Sierra Leone	
Sfano Njawa Sesay	SMPEA	
Salamatu Barley	UNAIDS	Information Asst
Aki Yosnino	UNAIDS	UNV
Mohamed K. Kanu	Youth Network (YACAN)	

National HIV and AIDS Secretariat

Lamin Bangura	NACP	M&E
Francis K. Tamba	NACP	M&E
Kiskama F. Swaray	NACP	M&E
Dr. Momodu Sesay	NACP, MOHS	Programme Manager
Dr Brima Kagbo	NAS	Director
Abdul Rahman Sesay	NAS	Deputy Director
Dr Saidou Hangadoumbo	NAS	M&E
Abu Ba karr Koroma	NAS	IEC/BCC Coordinator
Max Kanu	NAS	Finance Officer
Victor S. Kamara	NAS	M&E
Moi Tenga Sartie	NAS	M&E
Ms Umu Nabieu	NAS	M&E
Mr Kemoh Mansaray	NAS	M&E
P.M. Bangura	NAS	Logistics Coordinator

Nongovernmental Organizations

Diana Koroma	CADO	Operations Officer
Jestina Coker	CHASL	Acc. Assist.
Victor Koroma	CPHHRA-SL	National Coordinator
Jerry Sevalie	Graceland Counselling Service	Program officer
Mirian Meama	HACSA	HIV and AIDS Counsellor
F.S. Samura	MRDP	Project Director
Francis T. Farma	NECHRAS	HIV and AIDS Officer
Arnold Macauley	NETHIPS	Advocacy Officer
Abdul K. Dumbuya	Pampana Community	Project Officer
Aruna R Koroma	RODA	Programme Coordinator

Hudson Tucker	SLANGO	Health Coordinator
Andrew M. Kamara	SLPMMA	Project coordinator
Sylvia Jabbie	SWAASL	Care & Support Specialist
Theresa Cooper	TSHSL	Advocacy Officer
Tommy Mansaray	UMC Hospital Kissy	Administrator
Yvonne Sannoh	WEC	HIV Coordinator
Kalilu Kamara	Women In Crisis	HIV Focal Point
Radd Norma	YWCA	Programme. Assistant
Ibrahim Kamara	YWDO	National Programme Coordinator

Focal Points in the Private Sector

Davil Zibo Konteh	African Minerals	Human Resource Administrator
Marian Kargbo	Aureole Insurance	
Poindester Sana	AWOKO	Reporter
Samuel S. Lewis	Clas Legal	
A.K Lusani	COMAHS	Administrative .Assistant.
Hanna E. Koroma	COMIUM Sierra Leone Ltd	Marketing Manager
Victoria Saffa	Concord Times	Reporter
Eugene Sawyer	DACO/MOFED	AIDS Information Analyst
Fatu Yumkella	Dalan Consultancy	Managing Director
Absatu Daramy	Guaranty Trust bank	
Daphne During	LEOCEM	Human Resource Manager
Joseph Koroma	Mercury International	
Abdul R. Fornah	Portee Traders Association	Administrative Head
Abdul S. Koroma	Portee Traders Association	Secretary
Bolaji S. Ojumu	Rokel Commercial Bank	
Michael P. Yambasu	Sierra Leone Bottling Company	
Jamiru Kposowa	Sierra Leone Commercial Bank	
Elizabeth Marrah	Sierra Rutile	Nursing Sister
David Ro-Macauley	SLAA	
Alpha Lebbie	SLAA	
Agnes Fornah	SLBL	HIV Focal Point
Shuab Kamara	SLCB	Supervisor
Daniel N'dama	SLLC	Org. Sec.
Doreen Smith	SLNPC	
Kumba Ngongou	Standard Charted Bank	Head of Corporate

		Affairs
Alie S. Kamara	Standard Times	Reporter
Ivan M. Koroma	Zain SL Ltd	
Patrica Amara	Zain SL Ltd	Shared Services Administrator
Agnes K. Libbie	Zenith Bank	

UN Country Team

Michael von der Schulenburg	UNIPSIL
Mr Sam Onwona	AfDB
Mr Kevin Gallagher	FAO
Mr Joseph Kanu	IOM
Mr Brian Ruane	OHCHR
Mr Roberto Ricci	OHCHR
Ms Beatriz Balbin	OHCHR
Ms Mulunesh Tennagashaw	UNAIDS
Ms Mia Seppo	UNDP
Ms Ratidzai Ndlovu	UNFPA
Mr Valentin Tapsoba	UNHCR
Mr Mahimbo Mdoe	UNICEF
Ms Christa Rader	WFP
Dr Wondimagegnehu Alemu	WHO
Mr Vijay Pillai	World Bank

UN Theme group

Sandy Jambawai	ADB	Programme Analyst
Rugiatu Sesay	FAO	Women Empowerment and Gender Officer
Paul Kargbo	IOM	Program Coordinator
Mulunesh Tennagashaw	UNAIDS	UCC
Chibwe Lwamba	UNAIDS	M & E Adviser
Neil Tobin	UNAIDS	Programme Officer
Aki Yoshino	UNAIDS	Programme Officer
Salamatu Barley	UNAIDS	Information Associate
Adama Thorlie	UNDP	HIV/Gender Program

		Specialist
Nyaibor Ngombu	UNFPA	HIV Officer
Ben Musa	UNHCR	Project. Assistant
Edmond Makui	UNICEF	HIV and AIDS Specialist
Dorothy Ochola	UNICEF	HIV and AIDS Manger
John Baimba	UNICEF	Health Officer
Kabba P. Sesay	UNIDO	National Expert
Melrose Kargbo	UNIFEM	National Programme Officer
Patrick Buse	UNIPSIL	Civil Affairs Office
Zainab Mansaray	WFP	Senior Programme Assistant
Hannah Yankson	WFP	Nutritionist
Dr. Louisa Ganda	WHO	National Programme Officer

Annex 4b: District level contacts

Bo

Koyama Saffa	ARG/MOHS	HIV Counsellor
Thomas Brima	Bo District City Council	HIV Focal point
Joe P. L. Pyne	Bo District City Council	Deputy Mayor
P.L.Sheriff	Bo District Council	
Abu Bakar Daboh	Bo District Council	
Mathew M. Margao	Bo District Council	
Remie Musa	Bo District Council	
Chief F. J. N. Foray	Bo District Council	
Milton D. Vandy	Bo District Council	M&E Officer
Mary J. Coker	Bo District Council	
Beatrice J. Vandi	Bo East End Community Women	Chair Lady
Alex Nallo	Civil Society Organisation	Chairman
Julia T. Amara	DAC – Bo District	HIV Focal point
Dr. S. M. Stevens	DHMT	DMO
Alice Jeneba Koroma	MSWGCA	
Sahr A. Tejan	MSWGCA	Social Development officer
John B Kamara	NETHIPS	Regional Sec.
Pastor Albert Freeman	NETHIPS, Inerelar SL	
Alpha B. Bah	One World Link (OWL)	Chairman
Fanta Daboh	Restless Development	Field Officer
Francess M. Jebati	S.L.A.J SLBC, Bo	
Hawa Kamanda	S.L.T.U.	
Alhaji H. Koker	UCI	District chief Imam

Bombali

Victor Sahr Dugba	ARD – Micro-Finance	Branch manager
Ibrahim Dumbuya	ARG/MOHS	HIV and AIDS Counsellor
Bai Tombo	B.D.C	Counsellor
Frank Kanu	B.D.C	HIV and AIDS Focal Point
Joseph Dawson Kamara	B.D.C	Counsellor
Amadu Daramy	B.D.C	-
A.T. S. Kargbo	B.D.C	Finance Officer
Alpha Kamara	Bike Riders Union	Secretary General
Alusine Suma	CARE	BCC Officer
Patson Songo	Health	Health Ed. Officer
Daniella Misalie	HIV and AIDS Information and Documentation Centre	Information Officer
Nyuma Maningo	M.C.C	HIV and AIDS Focal Point
Abdulai Sesay	M.C.C	M&E Officer
Adama F. Conteh	M.C.C	Chair Person
Fatmata Saffa	Makeni Police Station	CID Officer
Muctarr Bangura	NETHIPS	Administrative Assistant
Larisa I. Sesay	NETHIPS	Coordinator
Bockarie Pompey Sesay	PHC	DHMT Rep
Mohamed Conteh	PHC	DHMT Rep
Eleanor Lans-Bagoley	Restless Development	Field Officer
Mohamed A Kamara	Restless Development SL	Field Officer
Captain B. Marrah	RSLAF – Makeni	Adjutant

Abraham Tucker	Scripture Union	Field officer
Amadu Falilu Sesay	SLBC	Production Manager
George Momoh	SLP	Information Officer
Salieu Jalloh	UNICEF	Project Officer
Abu Bakarr Turay	WOCEGAR	Field Officer

Kambia

Adama Bangura	ABC - Development	Secretary
Abdul Deen Sesay	Action Aid	Acting District Manager
Ansumana J. Bangura	DADA-SL	Finance Officer
Alusine Kamara	DHMT/MOHS	HIV Counsellor
Mohamed A. M. Mansaray	KDC	HIV Focal Point
Alfred N. Samura	KDC	Chief Administrator
Alie B. Fofana	KDC	Deputy C.A
Mohamed M. B. Sesay	KDC	Technical Facilitator
Abdul B. Sankoh	KDC	Assistant. HIV Focal Point
Nabieu Yaya Yillah	KDC	Deputy Chair, Health Committee
Alusine Sesay	KDC	Accountant
Dr. Chernor Jalloh	MOHS	DMO
Mariatu Turay	NETHIPS	Chair Person Voice of women
Ansumana Kamara	NETHIPS	PLHIV Representative

Kenema

Abdul James	ARG/MOHS	Dist. HIV Counsellor
Yatta Samah	DAC	HIV Counsellor
Alhaji Kamara Sheku	DAC	
Esther Kaisamba	DAC	
Abu Bakarr Sesay	DAC	
M. S. Conteh	KCC	HIV Focal Point
Bintu A. Vangahun	KCC	Deputy Chief Administrator
Emmanuel M. Sartie	KCC	M&E
Margaret A. Shiaka	KCC	Deputy Mayor
Roland Barrnett	KCC	
Chief Brima Kargbo	KCC	Mayor
Bockari Buanie	KCC	Chief Administrator
Charlie P. Jay Kallon	KD	Chief Administrator
Augustine B. Amara	KDC	HIV Focal Point
Baimba A. Tejan	KDC	Finance Officer
Patrick M. Sama	KDC	Chairman
John A. Swaray	Mininisty of Education	Education Officer
Mohamed Nyallay	MOHS	Environmental Health Officer
Mathew Sesay	MSWGCA	
George L. Massaquoi	NETHIPS	Regional Coordinator

Kono

Sia Tongu	50/50	Coordinator
Eddie Sam	Children Forum Network, Eastern Radio	President
Sahr Amara Moriba	DHMT	HIV Focal Point
Saah Alex Joe	HACSA	PLHIV Rep.
Manneth S. Senesie	HARA	Reporter
Samuel B. Conteh	HARA	President HARA
Edward Alpha	KNSCC	HIV Focal Point
Sahr M. Senesie Gbenda	KNSCC	Mayor
Aiah A.Y Arouna	KNSCC	Counsellor
Komba L. Worneh	KNSCC	Counsellor
Margaret K. Albert	Koidu Govt	HIV Counsellor
Fodei Daboh	MACSA	Coordinator
Patrick L. Tongu	NMJD	District Manager

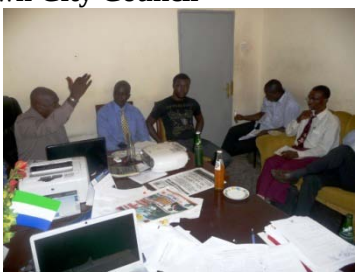
Moyamba

Dr J. N. Kandeh	DHMT	DMO
David S. Woobay	MDC	Chairman -Council
Madam Vivian Senesie	MDC	Act. Chief Administrator
Haja Mamie A. Vanja	MDC	Rep. Women's Group
Syl Fannah	MDC	Youth Leader
Lahai Macavoray	MDC	HIV Focal Point
Ibrahim G. M Coker	MEYS	Rep-MEYS
Sylvester Samba	MoHS	HIV Counsellor

Western Rural- Waterloo City Council

Peter S. Kargbo	WARDC	Human Resource officer
Abioseh Mansaray	WARDC	HIV- Focal point
Christiana Cole	WARDC	Rep. women's Group
Sulaiman Kamara	WARDC	Health committee chairman
Paul Kamara	WARDC	Youth chairman
Essa Kamara	WARDC	-
Temu S. Kanu	WARDC	-
Mustapha Coker	WARDC	Rep. DMO
Joshua B. M. Sesay	WARDC	Dist. HIV Focal Point
Lesiby Wenzie	Waterloo Community	Waterloo Head Man

Western Urban – Freetown City Council



Duke E. Pratt	DECSEC	Coach
Ben Coker	DHMT	Western Area
Joshua B.M Sesay	DHMT	HIV Focal Point-Western/Area
Abdul K. Marah	FCC	HIV Focal Point
Claudius J. Campbell	FCC	
Ahmed Samba Turay	FCC	
Mariama M. Conteh	NACP	Ag. VCCT Coordinator
Arnold Macauley	NETHIPS	Advocacy Officer

VII.5 Annex 5: List of institutions, agencies and individuals at the validation workshop

Participants in the validation workshop were organized into six groups according to the six NSP priority areas according to their perceived areas of strength in the national response.

NSP Priority Area 1: Decentralized Implementation

	Name	Institution
1.	Julia T. Amara	Bo District Council
2.	Thomas Brima	Bo District Council
3.	Ansu Ferka	Bonthe District Council
4.	Dalton K. Chailes	Bonthe District Council
5.	Abdul Karim Marah	Freetown City Council
6.	Sahr Bundor	Kailahun District Council
7.	Mohamed Mansaray	Kambia District Council
8.	Al-Hassan Jallon	Koinadugu District Council
9.	Sia J. Kembay	Kono District Council
10.	Edward Alpha	Kono District Council
11.	Frank Kanu	Makeni District Council
12.	Nyama Maningo	Makeni District Council
13.	Alice Kandeh	MIALGRD
14.	Mohamed A.S. Koroma	Pujehun District Council
15.	Arthur Allieu	Tonkolili District Council
16.	Adama Thorlie	UNDP
17.	Abioseh P. Mansaray	Waterloo City Council

NSP Priority Area 2: Prevention of New Infections

	Name	Institution
1.	Mohamed Conteh	AFRICARE
2.	Dinna Koroma	CADO
3.	Uzo Gilpin	CARE
4.	Glbert N'habay	CHILD FUND – S/LEONE
5.	Konima Bobor- Kamara	CONCERN
6.	Aminata Jalloh	CRS
7.	Kadiatu S. Koroma	GOAL
8.	F.K. Samura	MRDP
9.	Mohamed H. Rogers	NAS/Consultant
10.	Abdul K. Dumbuya	Pampana Community
11.	Ibrahim Kamara	PLAN S/LEONE
12.	Aruna R. Koroma	RODA
13.	Andrew M. Kanu	SLPMMA
14.	Nyabor Ngombo	UNFPA
15.	Ochola Dorothy	UNICEF
16.	Kaliku Kamara	WIC
17.	Frank Kobba	WVSL
18.	Ibrahim Kamara	YWDO

NSP Priority Area 3: Care, Treatment and Support of PLHIVs, Families and Communities

	Name	Institution
1.	Enest Cole	AFRICARE
2.	Jeshina Cola	CHASL
3.	Jerry Sevalie	GLCS
4.	Miriam Meama	HACSA
5.	Lamin Bangura	NACP
6.	Francis K. Tamba	NACP
7.	Dr. Momadu Sesay	NACP/MOHS
8.	Kemoh S. Mansaray	NAS
9.	P.M. Bangura	NAS
10.	Moi-Tenga Sartie	NAS
11.	Umu N. Nabieu	NAS
12.	Joseph Senesie	NAS/Consultant
13.	Arnold Macauley	NETHPS
14.	Thaim Kargbo	PPASL
15.	Olive Stober	SLRCS
16.	Sylvia Jabbie	SWAASL
17.	Theresa Cooper	TSHSL
18.	Tommy Mansaray	UMC HOSPITAL
19.	Yvonne Sandi	W.E.C
20.	Hanna Yankson	WFP
21.	Dr. Louis Ganda	WHO
22.	Rachael Norman	YWCA

NSP Priority Area 4: Protection of Legal and Human Rights

	Name	Institution
1.	Sally R. Kamara	AAISL
2.	Poindester Sama	Awoko News Paper
3.	Lawrence The	CHRISTIAN AID
4.	Victoria Saffa	Concord Times
5.	Samuel B. Conteh	HARA
6.	Abdul K. Conteh	MELSS
7.	Abu R.B. Koroma	NAS
8.	Mohamed S. Bah	NAS Consultant
9.	Francis T. Forma	NECHRAS
10.	Abu Kalokoh	New Citizen
11.	Josephine Lagawo	SALONE TIMES

NSP Priority Area 5: Research, M&E

	Name	Institution
1.	Bockarie Sesay	CARE
2.	A.K. Lusani	COMAHS
3.	Fatu Yumkalla	DALAN
4.	Eugene Sawyer	DHO/MOFED
5.	Rugiatu Sesay	FAO
6.	Mohamed Sandi	NAS
7.	John Brima	NAS Consultant
8.	Kiskama F. Swarray	NAS/MOHS
9.	Hudoon Tucher	SLANGO
10.	Momoh bockorie	SPU State House
11.	Chibwe Lwamba	UNAIDS
12.	Aki Yoshino	UNAIDS
13.	John Baimba	UNICEF
14.	Kabba Sesay	UNIDO

NSP Priority Area 6: Key Sectoral Responses

	Name	Institution
1.	Lillian Khanu	BCAASL
2.	Joyce W. Abu	BCAASL
3.	Victor Koroma	CPHHRA – SL
4.	Agnes Fornah	Employers
5.	Alex Gandi	Faith Based
6.	Maybelle Gamanga	MEYS
7.	Elizabeth Alarrah	Sierra Rutile
8.	Shuab Kamara	SLCB
9.	David N'dena	SLLC
10.	Kumba Ngongn	Standard Chartered
11.	Alie S. Kamara	Standard Times
12.	Salamatu Bartey	UNAIDS

Final Joint Review of National Strategic Plan on HIV/AIDS 2006 – 2010

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

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