Sierra Leone

National Strategic Plan on HIV/AIDS

2016-2020

RAPID RESPONSE INITIATIVE TO ENDING HIV AS A PUBLIC HEALTH AND DEVELOPMENT PROBLEM

November 2015

National Strategic Plan on HIV/AIDS 2016-2020

NATIONAL AIDS SECRETARIAT IN COLLABORATION WITH PUBLIC SECTOR, PRIVATE SECTOR, CIVIL SOCIETY, COMMUNITY, UNITED NATIONS, BILATERAL AND MULTILATERAL PARTNERS

Foreword

The Government of Sierra Leone is pleased to present the 2016 - 2020 National Strategic Plan on HIV and AIDS – ***Towards Making HIV and AIDS no longer a Public Health Threat*** in Sierra Leone by 2020 to all our partners**.** This is our third multi-sectoral response strategic plan on HIV and AIDS and our second comprehensive results-based and beneficiary centered strategic plan on HIV and AIDS. This strategic plan will chart the roadmap for Sierra Leone to "Ending AIDS" by 2030.

The implementation of our response between 2010 and 2015 was informed and guided by the Sierra Leone National HIV and AIDS Strategic Plan 2010 - 2015. A review of this Plan shows that we have continued to maintain a prevalence rate of 1.5% among the adult population 15 – 49 years. However, new emerging issues have been identified such as key affected populations that must be addressed now. We however remain committed to fulfilling our international and regional obligations towards the Maputo plan of action, the Global Plan towards elimination of new infections in children and keeping mothers alive and most recently the Sustainable Development Goals.

As we endeavour to achieve Universal Access to HIV prevention, treatment, care and support, we must ensure availability, accessibility and affordability of HIV and AIDS services to all. In this regard we must strengthen our health and community structures and systems to ensure sustained and equitable services delivery.

The goal of our 2016 – 2020 HIV and AIDS Strategic Plan is to achieve zero new infection, zero discrimination and zero AIDS related deaths. The main strategy will be to **Test All, Treat All, and Retain All**. Our approach to achieve this challenging task will be based on combination prevention that delivers multiple HIV prevention services focusing on people and places where it makes the most difference and elimination of mother to child transmission and HIV treatment as prevention. This National Strategic Plan also emphasizes the importance of targeted counselling and Information Education and Communication.

This Plan has been developed through the collective effort and active participation of numerous partners engaged in HIV and AIDS work in the country - Government Ministries, Department and Agencies; faith-based organizations, community-based organizations, civil societies and Network of people living with HIV, the private sector, multilateral and bilateral donors and individuals. This is in fulfillment of our commitment towards a multi-sectoral approach in the fight against HIV and AIDS. We will continue with this approach to ensure that all sectors play their role based on their mandate and comparative advantage.

This Strategic Plan is fully costed and has a consolidated road map and an operational plan facilitating its implementation. The implementation process and achievements will be closely monitored and evaluated based on a costed Monitoring and Evaluation Plan. Our multi-sectoral actors will have shared

responsibilities and accountability enshrined in the “three ones” principles. It is my profound hope and desire to see all HIV and AIDS resources in the country aligned to this plan in a coordinated manner.

As we embark on another five-year journey guided by the 2016-2020 strategic plan, it is necessary to focus on targeted, measurable and achievable results. This demands concerted efforts and strong commitment at policy and operational levels to ensure that everyone plays a complementary role in the fight against HIV and AIDS.

It is my profound hope and trust that we will all stay on course and remain committed as we make HIV and AIDS no longer a public health threat in Sierra Leone by 2020.

His Excellency Dr. Ernest Bai Koroma (GCRSL)
PRESIDENT OF THE REPUBLIC OF SIERRA LEONE

Acknowledgements

The successful development of the Sierra Leone HIV and AIDS Multi-sectoral Strategic Plan 2016 – 2020 involved a long consultative process with stakeholders. The successful completion of this document was made possible by their joint efforts and their participation needs to be acknowledged. Thanks are due to the Drafting Team.

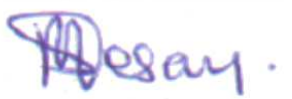
We wish to acknowledge with deep gratitude the contributions of the United Nations family in Sierra Leone, the Global Fund, the KfW (German Development Bank), PEPFAR through CDC for their financial and technical assistance towards the process.

We are also grateful to Government Ministries, Departments and Agencies, Network of people living with HIV, representatives from Civil Society Organizations, private, formal and informal sectors, Faith-Based Organizations and religious leaders who contributed their time, effort and ideas to finalize this plan.

Finally, we would like to thank the UNAIDS Country Office for providing the technical support and the international Consultant Dr. Nathan Nshakira whose tireless effort made the development this plan possible.

Overall coordination by the staff of the National HIV/AIDS Secretariat involving long working days was crucial to the success of this process. It is our expectation that the same support will be provided for the coordination of partners who will eventually take up the task of its implementation

> ***"Let us now come together, mobilize the needed resources to implement the strategies outlined in this Plan, so that together we can make HIV and AIDS no longer a Public Health Threat in Sierra Leone by 2020"***



Alhaji Dr. Momodu Sesay
DIRECTOR-GENERAL
NATIONAL HIV/AIDS SECRETARIAT

Abbreviations and Acronyms

AIDS	Acquired Immuno-Deficiency Syndrome
AHF	AIDS Healthcare Foundation
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCAASL	Business Coalition Against AIDS in Sierra Leone
BCC	Behavioural Change Communication
CAC	Chiefdom AIDS Committee
CARE	Cooperative American Relief Everywhere
CASL	Christian Aid in Sierra Leone
CBO	Community Based Care
CCM	Country Coordination Mechanism
CDC	U.S Centre for Disease Control
CHO	Community health Officer
CSO	Civil Society Organization
DAC	District AIDS Committee
DBS	Dried Blood Spot
DfID	U.K Department for International Development
DHMT	District Health Management Team
DHO	District Health Officer
DMO	District Medical Officer
ETWG	Extended Technical Working Group
EU	European Union
GF	The Global Fund for HIV/AIDS, TB and Malaria
GIZ	Deutsche Gesellschaft fur Internationale Zusammenarbeit
HARA	HIV and AIDS Reporters Association
HBC	Home Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
ILO	International Labour Organization
INGO	International Non-Governmental Organization
IOM	International Office of Migration
JPR	Joint Programme Review
KFW	Krebital ftaltfürWieberaufbau (German Development Bank)
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MELSS	Ministry of Employment, Labour and Social Security
MEYS	Ministry of Education, Youth and Sport
MLGCD	Ministry of Local Government and Community Development
MoD	Ministry of Defence
MoFED	Ministry of Finance and Economic Planning
MoHS	Ministry of Health and Sanitation

MoIC	Ministry of Information and Communication
MoJ	Ministry of Justice
MoTCA	Ministry of Tourism and Cultural Affairs
MoU	Memorandum of Understanding
MoWHI	Ministry of Works, Housing and Infrastructure
MoYS	Ministry of Youth and Sports
MSM	Men who have Sex with Men
MSWGCA	Ministry of Social Welfare, Gender and Children's Affairs
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NACSA	National Commission for Social Action
NAS	National HIV/AIDS Secretariat
NECHRAS	Network of Christians Response to AIDS Sierra Leone
NETHIPS	Network of HIV Positives in Sierra Leone
NGO	Non-governmental Organization
NSP	National Strategic Plan
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PEP	Post Exposure Prophylaxis
PEPFAR	U.S President Emergency Plan for AIDS Relief
PHC	Primary Health Care
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSM	Procurement and Supply Management
PSO	Private Sector Organization
PWID	People Who inject Drugs
RH	Reproductive Health
SLDHS	Sierra Leone Demographic and Health Survey
SLIRAN	Sierra Leone Inter-religious AIDS Network
SLLC	Sierra Leone Labour Congress
STI	Sexually Transmitted Infections
TBA	Traditional Birth attendants
TWG	Technical Working Group
UCC	UNAIDS Country Coordinator
UCO	UNAIDS Country Office
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USG	United States Government
VOW	Voice of Women
WFP	World Food Programme
WHO	World Health Organization

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Executive Summary

Sierra Leone is located on the west coast of Africa and is divided into four regions, namely: Eastern, Northern, Southern Provinces and the Western Area. The Local Government Act of 2004 decentralized government operations to 19 Local Councils (13 District Councils and 6 Urban/ City Councils); further subdivided into 149 Chiefdoms in the provinces, and 12 Wards in Western Area. Local councils are responsible for basic social services that are the primary mechanism for delivery of HIV services and mainstreaming of HIV into local development.

The country health care system is based on the primary health care concept. The public health delivery system comprises three levels: (a) Peripheral health units (community health centres, community health posts, and maternal and child health posts) for first line primary health care, (b) District hospitals for secondary care; (c) regional/national hospitals for tertiary care. In July 2015, there were a total of 1280 functional health facilities across the country; 51 Hospitals, 45 Clinics, 233 Community Health Centres (CHC), 319 Community Health Posts (CHP) and 632 Maternal and Child Health Posts (MCHP). In addition, the country had up to 13,000 Community Health Workers (CHW) deployed at community level to provide a range of health promotion and health care services.

The education sector strategic plan 2007-2015 recognizes HIV as one of the concerns which cut across all levels and sub-sectors of education; alongside health and sanitation, gender, disability/special needs, and disadvantaged children and communities. The sectors has demonstrated commitment to mainstreaming HIV, e.g., by the 2006 HIV/AIDS policy for education, establishment of an HIV/AIDS Focal Point at the Ministry, infusion of HIV/AIDS education into the school and the teacher training curricula, and training of peer educators and counsellors for HIV/AIDS.

Sierra Leone experienced its first Ebola Virus Disease (EVD) outbreak in 2014, which grew into an extensive epidemic that resulted in 8,704 laboratory confirmed cases, and 3,955 deaths. Although the two viruses are very different from each other, parallels are often drawn between the development of the EVD and HIV responses. It is estimated that there are 400 PLHIV among the registered EVD survivors (EVDS).

As Sierra Leone works towards “Getting to Zero Ebola cases” and prepares to implement its post Ebola Recovery Plans, it is crucial that implementing partners and community leaders have a strong understanding of how best to utilize the resources, not only for the pressing concerns outlined by the EVD outbreak, but to holistically support the systems in health. A Health Sector Recovery Plan 2015-2020 has been adopted and is currently under implementation.

The new National AIDS Strategic Plan is designed as a rapid response initiative to bring hope, ensure no one is left behind, aim to be at the right place for the right people and right location most affected by the epidemic, and Working together to ensure that AIDS ceases to be a public health problem by 2020 in the country.

The HIV epidemic in Sierra Leone has been considered as mixed, generalized and heterogeneous. HIV affects different population sub-groups and all sectors of the population through multiple and diverse transmission dynamics. The HIV prevalence in Sierra Leone increased from 0.9% in 2002 to 1.5% in 2005

and has remained at the same level since 2008 (2013, SLDHS). The 2013 DHS in Sierra Leone reported adult HIV prevalence (15-49 years old) at 1.7% in women and 1.3% in women. An estimated 54,000 Sierra Leoneans are living with HIV in 2015; out of which 29,000 are women and 5,000 are children.

- Number of people living with HIV -54,000 [47,000 - 61,000]
- Adults aged 15 to 49 prevalence rate- 1.4% [1.2% - 1.6%]
- Adults aged 15 and up living with HIV- 50,000 [44,000 - 56,000]
- Women aged 15 and up living with HIV- 29,000 [26,000 - 33,000]
- Children aged 0 to 14 living with HIV- 4,300 [3,800 - 5,000]
- Deaths due to AIDS- 2,700 [2,100 - 3,600]
- Orphans due to AIDS aged 0 to 17 -19,000 [13,000 - 41,000]

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

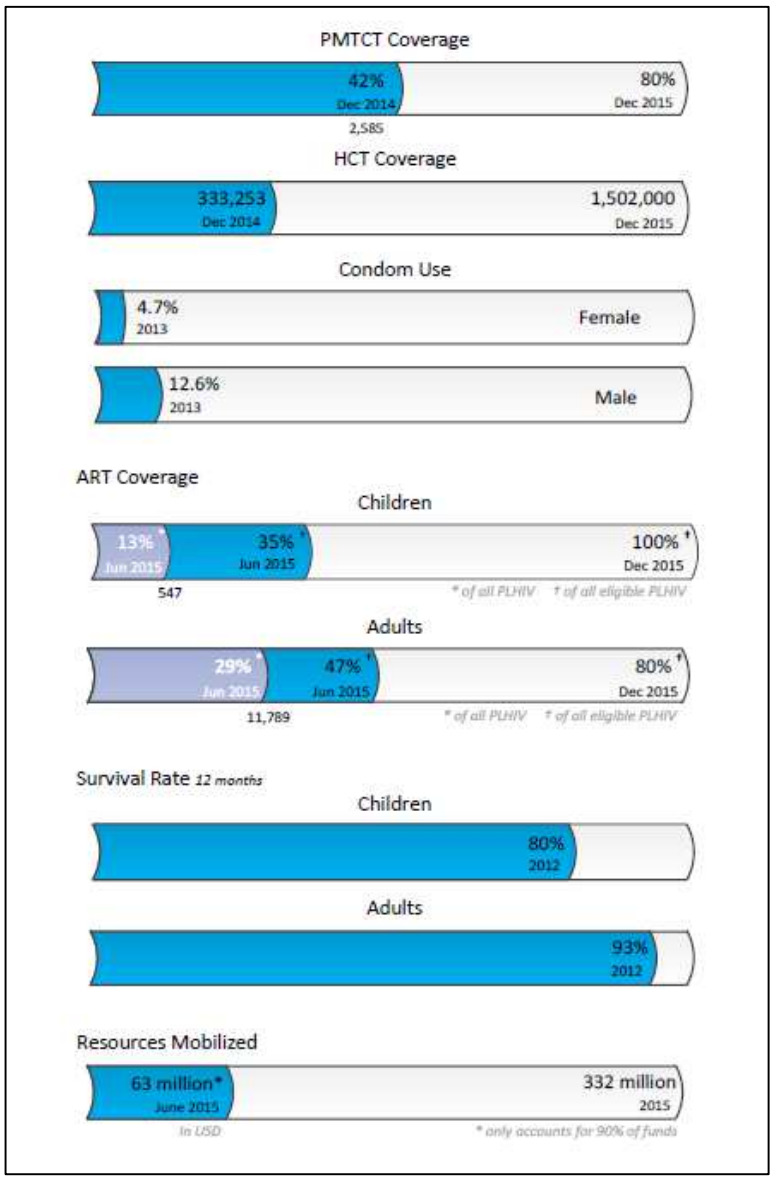
HIV prevalence – by District (DHS 2013)

District	Women	Men	Total
Kailahun	0.9	1.0	0.9
Kenema	1.1	0.9	1.0
Kono	3.6	1.2	2.5
Bombali	1.6	0.6	1.2
Kambia	0.9	0.9	0.9
Koinadugu	1.2	0.7	1.0
Port Loko	1.7	1.2	1.5
Tonkolili	1.0	0.3	0.7
Bo	1.8	1.0	1.4
Bonthe	1.3	0.5	0.9
Moyamba	1.3	0.6	1.0
Pujehun	1.5	0.1	0.8
Western Rural	3.3	3.6	3.4
Western Urban	2.1	3.0	2.5
National	**1.7**	**1.3**	**1.5**

An HIV sero-prevalence study conducted in 2015 among Key Affected Populations (KAP) revealed an HIV prevalence rate of 14% among MSM; 22.4% among TGs; 85% among PWID; and 6.7% among FSWs (Details in Figure 3 below). These key populations together constitute only 4% of the total population; but account for 44% of the total incidence of HIV in the country. A projected total of 1,000 new cases of HIV have occurred in Sierra Leone in 2015; directly linked to these key population groups.

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

reverse the spread of the HIV/AIDS by 2015. It is multi-sectoral with the overall vision towards zero New Infection, Zero Discrimination and zero AIDS related deaths. The thematic areas of the NSP are (i) coordination, institutional arrangements, resource mobilisation and management; (ii) policy, advocacy, human rights and legal environment; (iii) prevention of new infections (iv) treatment of HIV and other related conditions (v) care and support for infected and affected by HIV and AIDS and (vi) research, monitoring and evaluation. Key achievements from implementation of the NSP 2011-2015 are presented below.



The main challenges and gaps affecting the National AIDS response are:

- **Insufficient behavioural impact of prevention interventions** for adolescents and young people. High rate of early marriage, low condom use and multiple sexual partners with early sexual debut
- **Large coverage gap for testing, services to prevent mother-to-child transmission and antiretroviral therapy** for adults and children. Health and community systems, including procurement and supply management remain weak.
- **Over-reliance on international funding** (GFATM) **at 95%** because actionable political commitment, multiple competing priorities, weak governance, low allocative efficiency and limited absorption of funds undermine the sustainability of the response.
- **Persistent stigma and discrimination, gender inequalities and violence against women.**
- **Weak sex- and age-disaggregated epidemiological and programmatic national and subnational data** especially on key populations, young people and adolescents.
- **Emergencies and disasters:** including the 2012 cholera epidemic; the 2014/2015 ebola epidemic, and the 2015 floods

The key game changers of the national AIDS response are:

- Collaborative frameworks at national and local levels to ensure practical solutions for key populations to access services despite challenging legal environments.
- Geographical targeting in line with the burden of HIV across the country; with particular focus on high burden districts and urban centres.
- Cities initiative with mayors and community leaders engagement and strengthening community delivery systems.
- Community-based HIV counseling and testing and delivery of antiretroviral therapy through task shifting and the use of new technologies.
- Services to prevent mother-to-child transmission of HIV integrated into all maternal, newborn and child health services and sexual and reproductive health services as an entry point for achieving integration of the HIV response in the health sector at all levels.
- Innovative financing mechanisms to increase domestic funding while optimizing resource allocation and reducing costs in the context of implementing the African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria.
- The full potential of adolescents and young women and men unleashed to help realize the demographic dividend and reduce risk of and vulnerability to HIV infection.
- Fully leveraging TRIPS flexibilities to secure sustainable access to affordable medicines, and strengthening local capacity to develop and manufacture quality affordable health products.

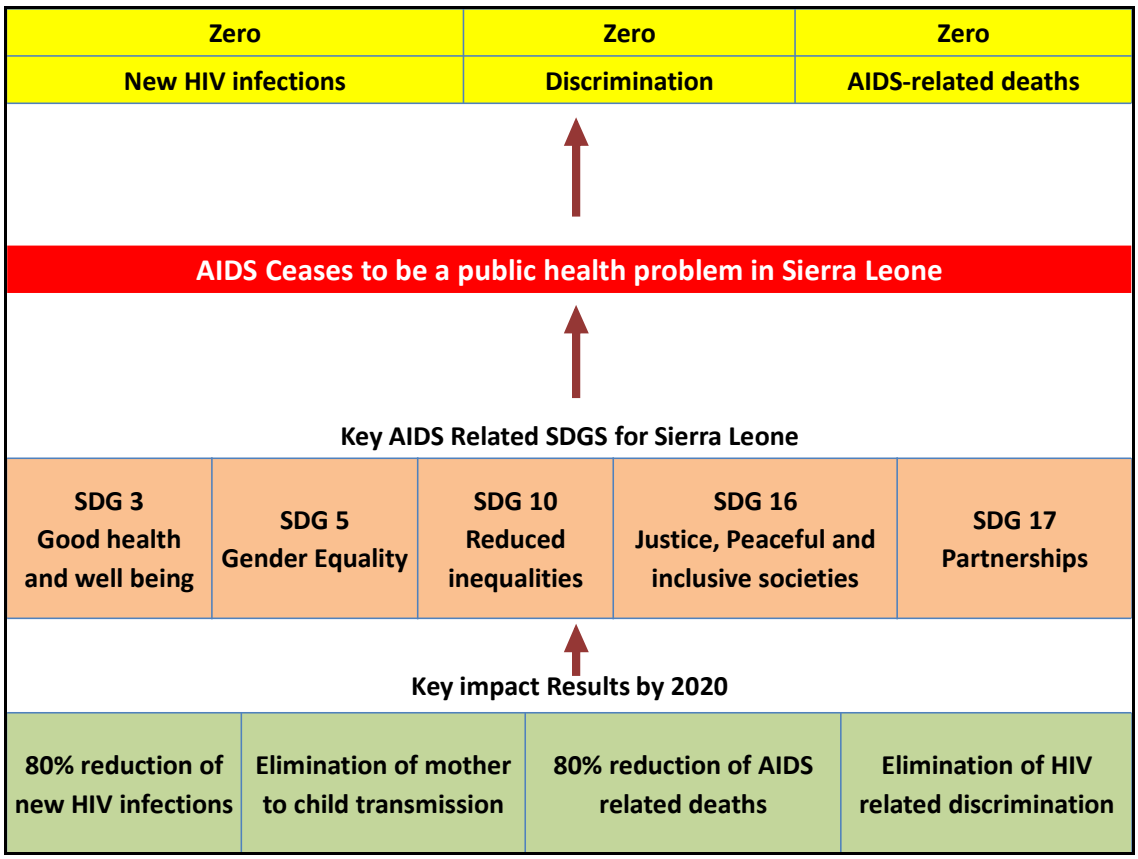
The National AIDS Secretariat will explore the current existing opportunities to strengthen national accountability and improve efficiency of the national response.

- Implementation of the **African Union Roadmap on AIDS, TB and Malaria** and the **African Union Framework on Social Protection** provides an opportunity to Fast-Track the response.
- **The Economic Community of West African States/West African Health Organization** represent a collaborative forum to maximize access to commodities, including through the antiretroviral medicines security stock and **ECOWAS Regional Pharmaceutical Plan**.
- The **Cities Initiative** based on the Paris Declaration on Fast-Track Cities: Ending the AIDS Epidemic will help to mobilize engagement and catalytic funding and serve as an accountability framework for monitoring progress.
- The **Global Maternal Newborn & Child Health initiative** will be instrumental to Fast-Track the provision of integrated quality services, and leverage the support of O**rganization of African First Ladies Against HIV/AIDS**.
- The **Health Sector Recovery Plan 2015-2020**; and the updated **Basic Package for Essential Health Services 2015-2020** provide an opportunity to leverage AIDS funding and support for health system strengthening.

The vision for the NSP 2016-2020 is: A Sierra Leone where HIV is no longer a public health threat. Its goal is to attain the three zeros: Zero new infections; Zero AIDS-related Deaths; and Zero AIDS-related discrimination. The NSP impact results are:

i. To reduce HIV incidence among adults and adolescents by 50% from 0.04% in 2015 to 0.02 % by 2020.
ii. To reduce HIV incidence among infants born to HIV positive mothers from 13% in 2015 to less than 5% by 2020
iii. To reduce HIV-related mortality by 80% for both adults and children by 2020.
iv. To increase domestic financing of the HIV response to 30% by 2020

The NSP is aligned to the global Sustainable Development Goals for 2030; and the national development strategy; the Agenda for Prosperity 2013-2018.



The table below provides a summary of the results and strategies that will guide the operationalization of the NSP in the next five years.

SGD	Outcome results	Strategic Outputs
Good health and well-being (SDG 3	**90% of all adults and adolescents who know their positive HIV status receive comprehensive treatment, care and support, including sustained antiretroviral therapy; and have durable viral load suppression**	• Adults, adolescents and child PLHIV who receive complete clinical, psychosocial and socio-economic assessment (annually) and are placed on the appropriate care and support package increased from 2015 level to 95% by 2020 • PLHIV who access ART and complementary care and support services increased from 2015 level to 90% by 2020 • PLHIV on ART who attain sustained viral suppression increased from 2015 level to 90% by 2020 • PLHIV under care and are co-infected with TB who attain TB cure increased from 2015 level to 90% by 2020 • PLHIV who need social protection to overcome specific vulnerability and do receive such protection increased from the 2015 level to 90% by 2020
	New HIV infections among children eliminated and their mothers health and well-being is sustained	• HIV positive mothers that attain viral load suppression during pregnancy, labour and over the entire period of breastfeeding increased from the 2015 level to 95% by 2020 • HIV-exposed infants (born to HIV positive mothers) that receive the full dose of prophylactic ARVs increased from 29% in 2014 to 95% by 2020 • HIV positive mothers that get unplanned pregnancies reduced by 67% between 2015 and 2020
Reduced inequalities (SDG 10)	**Young people especially young women and adolescent girls, who access combination prevention services and are empowered to protect themselves from HIV increased from 2015 level to 90% by 2020**	• Young people (10-24 years) reached with comprehensive life skills, Sexuality, HIV and AIDS education increased from 2015 level to 80% by 2020 • Chiefdoms that are reached with consistent demand generation interventions for SRHR (incl. HIV, EBV, STI) services increased from 2015 level to 95% by 2020 • Young people and their sexual partners who access youth-friendly HIV, SRH, EVD and harm reduction information and services increased from 2015 level to 90% by 2020 • Adolescents and young people who make and accomplish appropriate personal SRH commitments (e.g., sexual abstinence, FP use, etc.) increased from 2015 level to twice that level by 2020

SGD	Outcome results	Strategic Outputs
	Key populations, including sex workers, men who have sex with men, transgender, PWID, EVDS, prisoners , TB patients, migrant workers (fisher-folk, miners, transporters) and traders , and uniformed personnel that access tailored HIV combination prevention services and are empowered to protect themselves from HIV, EVD and TB increased from 2015 level to 90% by 2020	• Health facilities that provide combination prevention services tailored to targeted Key Populations increased from 2015 level to 80% by 2020 • Targeted Key Populations that access relevant combination prevention services increased from 2015 level to 90% by 2020 • Targeted Key Populations that have un-interrupted access and consistent and correct utilization of male and female condoms for dual benefit (contraception and disease prevention) increased from 2015 level to 90% by 2020
Gender equality (SDG 5)	**Women and men who practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to three times that level by 2020**	• Women and men that are empowered to practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to 60% by 2020 • Laws and policies that enable women, girls men and boys to promote gender-based, sexual and intimate partner violence, and protect themselves from HIV and EVD, and access HIV and EVD-related services increased from 2015 level to twice that level by 2020
Just, peaceful and inclusive societies (SDG 16)	**People living with, at risk of and affected by HIV and EBV who report no discrimination especially in health, education and workplace settings increased from 2015 level to 90% by 2020**	• PLHIV, EVDS and Key Populations at most risk of HIV that are empowered and participating effectively in advocacy and programme interventions to eliminate stigma and discrimination increased from 2015 level to twice that level by 2020 • Community members that are adequately informed about HIV, EVD and TB; and access HCT increased from 2015 level to 60 percent (of the total population) by 2020

SGD	Outcome results	Strategic Outputs
Global Partnerships (SDG 17)	**Departments, Agencies and Institutions (including CSOs) participating in the national response with adequate capacity to effectively and efficiently manage a multi-sectoral response increased from 2015 level to twice that level by 2020**	• Investment of a minimum of $50 million annually for the national AIDS response • Domestic funding mobilized to support at least 12% of annual resource needs • Financial sustainability transition plans and national HIV budget line, AIDS trust funds implemented • HIV, EVD and TB resource mobilization from international sources diversified from 2015 level to 10 sources by 2020 • Stakeholders in the national HIV response that make evidence-based strategic and operational decisions increased from 2015 level to 70% by 2020 • Local Councils (districts/cities) where integrated health and community systems include HIV among the priority health issues of focus in service delivery, staff training and CIS/HMIS reporting increased from 2015 level to 10 by 2020

Implementation of this NSP is projected to require a total of USD 357 million over the five years. The annual cost summary across four investment areas is presented in the table below.

Indicative cost areas	2016	2017	2018	2019	2020	TOTAL
Targeted Prevention	12,193,113	14,922,047	18,029,258	21,599,818	24,232,695	90,976,932
Treatment, care and support	14,572,886	19,941,844	26,077,796	32,980,742	39,883,688	133,456,956
Development synergies	4,392,600	5,566,580	7,480,891	8,346,479	9,328,913	35,115,463
Critical Enablers:	16,450,171	17,660,042	19,330,113	21,016,209	23,348,114	97,804,649
	47,608,769	**58,090,513**	**70,918,057**	**83,943,248**	**96,793,411**	**357,353,999**

1. INTRODUCTION

Sierra Leone is located on the west coast of Africa and covers an area of about 71,740 square kilometers (approximately 28,000 square miles). The country is bordered in the north and north-east by the Republic of Guinea, on the east and southeast by the Republic of Liberia and the west and southwest by the Atlantic Ocean. Administratively, the country is divided into four regions, namely: Eastern, Northern, Southern Provinces and the Western Area. The Local Government Act of 2004 decentralized government operations to 19 Local Councils (13 District Councils and 6 Urban/ City Councils); further subdivided into 149 Chiefdoms in the provinces, and 12 Wards in Western Area. The 2010 Decentralization Policy further clarifies the operational mechanism to realize the decentralization intentions as articulated in the Local Government Act. However, the commitment to decentralization in Sierra Leone is not yet backed by specific constitutional provision. Local councils are responsible for basic social services that are the primary mechanism for delivery of HIV services and mainstreaming of HIV into local development.

The Sierra Leone Third Poverty Reduction Strategy Paper (PRSP III) 2013-2018 (The Agenda for Prosperity) recognizes that HIV/AIDS can cause loss of human capital, reduce labour productivity, and increase poverty. The strategy has controlling HIV as a specific sector priority; with focus on further reducing HIV prevalence to 1.15% by 2017. This is premised on recognition that HIV is a development concern, because it can cause loss of human capital, reduce labour productivity, and increase poverty. It prioritizes a twin focus on identifying HIV positive people and reaching them with treatment to reduce transmission; and reaching the population groups at highest risk with the appropriate HIV prevention interventions.

Sierra Leone is a 'youthful' country, with 75 percent of its population below the age of 35. However, 60 percent of young people are structurally unemployed (they are unable to provide sufficiently for themselves and their families); and only 37% of the school-age youth population is in education.[1] Youth mobilization, empowerment and participation in governance and national development are key priorities in the country over recent years. The country health care system is based on the primary health care concept. The public health delivery system comprises three levels: (a) Peripheral health units (community health centres, community health posts, and maternal and child health posts) for first line primary health care, (b) District hospitals for secondary care; (c) regional/national hospitals for tertiary care. In July 2015, there were a total of 1280 functional health facilities across the country; 51 Hospitals, 45 Clinics, 233 Community Health Centres (CHC), 319 Community Health Posts (CHP) and 632 Maternal and Child Health Posts (MCHP). In addition, the country had up to 13,000 Community Health Workers (CHW) deployed at community level to provide a range of health promotion and health care services.

The education sector strategic plan 2007-2015 recognizes HIV as one of the concerns which cut across all levels and sub-sectors of education; alongside health and sanitation, gender, disability/special needs, and disadvantaged children and communities. The sectors has demonstrated commitment to mainstreaming HIV, e.g., by the 2006 HIV/AIDS policy for education, establishment of an HIV/AIDS Focal Point at the Ministry, infusion of HIV/AIDS education into the school and the teacher training curricula, and training of peer educators and counsellors for HIV/AIDS.

[1] Ministry of Youth Affairs (2014) A blueprint for youth development: Sierra Leone's National Youth Programme 2014-2018.

Sierra Leone experienced its first Ebola Virus Disease (EVD) outbreak in 2014 and it continues to battle this outbreak into 2015. A robust national structure was created to manage the outbreak with the support from international partners and donors. All throughout the country, Ebola treatment units and survivors clinics are functioning to ensure that those infected with EVD are cared for. In order to ensure another outbreak of EVD is prevented or mitigated in the future, investments in strengthening the health systems are also taking place. During Serra Leone's EVD outbreak, the responses to diseases such as HIV were negatively affected, thus endangering the lives of many people living with HIV (PLHIV) and affecting service coverage. Although the two viruses are very different from each other, parallels are often drawn between the development of the EVD and HIV responses. It is estimated that there are 400 PLHIV among the registered EVD survivors (EVDS).

The Ebola Virus Disease (EVD) epidemic in the country since May 2014 has taken a heavy toll on the health system. On the supply side; the EBV infections and deaths among health workers and the related fear resulted in declined service delivery. On the demand side, the fear of EVD transmission in health facilities, and the movement restrictions as part of the EVD response combined to erode community confidence in the health system and reduce service utilization.

As Sierra Leone works towards "Getting to Zero Ebola cases" and prepares to implement its post Ebola Recovery Plans, it is crucial that implementing partners and community leaders have a strong understanding of how best to utilize the resources, not only for the pressing concerns outlined by the EVD outbreak, but to holistically support the systems in health. A Health Sector Recovery Plan 2015-2020 has been adopted and is currently under implementation.

The new National AIDS Strategic Plan is designed as a rapid response initiative to bring hope, ensure no one is left behind, be at be at the right place for the right people and right location most affected by the epidemic, and Working together to ensure that AIDS ceases to be a public health problem by 2020 in the country.

2. HIV SITUATION AND AIDS RESPONSE ANALYSIS

2.1.HIV Situation

The HIV epidemic in Sierra Leone has been considered as mixed, generalized and heterogeneous. HIV affects different population sub-groups and all sectors of the population through multiple and diverse transmission dynamics. The HIV prevalence in Sierra Leone increased from 0.9% in 2002 to 1.5% in 2005 and has remained at the same level since 2008 (2013, SLDHS). The 2013 DHS in Sierra Leone reported adult HIV prevalence (15-49 years old) at 1.7% in women and 1.3% in women (details in Table 1).

- Number of people living with HIV -54,000 [47,000 - 61,000]
- Adults aged 15 to 49 prevalence rate- 1.4% [1.2% - 1.6%]
- Adults aged 15 and up living with HIV- 50,000 [44,000 - 56,000]
- Women aged 15 and up living with HIV- 29,000 [26,000 - 33,000]
- Children aged 0 to 14 living with HIV- 4,300 [3,800 - 5,000]
- Deaths due to AIDS- 2,700 [2,100 - 3,600]
- Orphans due to AIDS aged 0 to 17 -19,000 [13,000 - 41,000]

Women are disproportionately infected by the epidemic. An estimated 54,000 Sierra Leoneans are living with HIV out of which 29,000 are women and 5,000 are children. According to the 2013, SLDHS, prevalence rate for men was 1.3% while that for women was 1.7%. HIV prevalence among pregnant women attending antenatal clinics (ANC) also declined progressively from 4.4% in 2007 to 3.5% in 2008 to 3.2% in 2010 respectively but 3.2% is still twice higher than the national prevalence of 1.5%. There was a three-fold increase in syphilis prevalence among pregnant women from 0.4% in 2006 to 1.4% in 2010; concerns being that STIs are co-factors to HIV infection. Syphilis prevalence is higher amongst rural pregnant women (1.8%) compared to their urban counterparts (1.3%).

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

This stabilization means the country is rated as one of the least affected compared to others in the sub-region and globally. Prevalence was 2.3% in urban areas compared to 1.0% in rural areas.

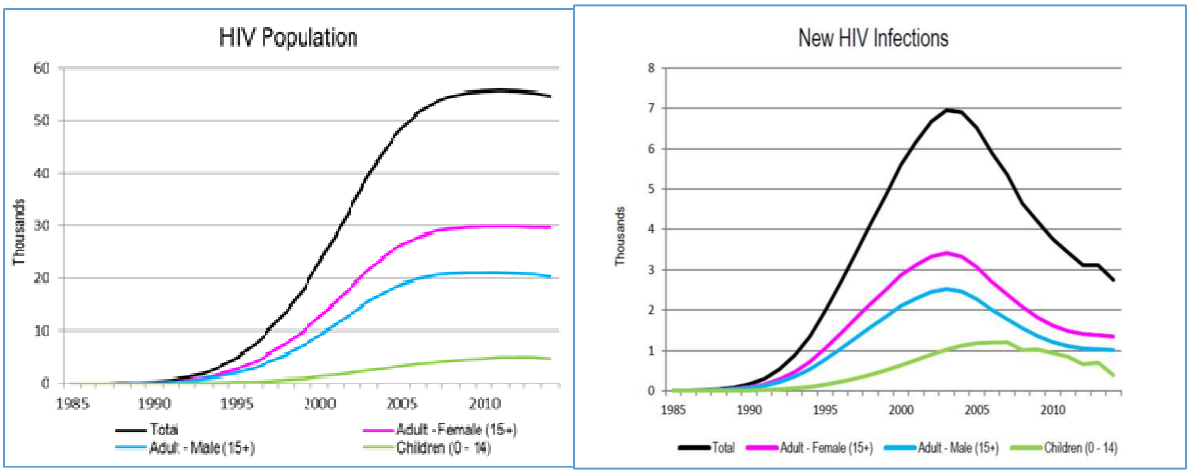
Table 1: HIV Prevalence by district – DHS 2013

District	Women	Men	Total
Kailahun	0.9	1.0	0.9
Kenema	1.1	0.9	1.0
Kono	3.6	1.2	2.5
Bombali	1.6	0.6	1.2
Kambia	0.9	0.9	0.9
Koinadugu	1.2	0.7	1.0
Port Loko	1.7	1.2	1.5
Tonkolili	1.0	0.3	0.7
Bo	1.8	1.0	1.4
Bonthe	1.3	0.5	0.9
Moyamba	1.3	0.6	1.0
Pujehun	1.5	0.1	0.8
Western Rural	3.3	3.6	3.4
Western Urban	2.1	3.0	2.5
National	**1.7**	**1.3**	**1.5**

There are major variations in HIV prevalence among women and men across the districts. An HIV sero-prevalence study conducted in 2015 among Key Affected Populations (KAP) revealed an HIV prevalence rate of 14% among MSM; 22.4% among TGs; and 6.7% among FSWs. These figures underscore the granular nature of the epidemic in Sierra Leone; and the need for a similarly aligned HIV response.

HIV incidence has been on a downward trend with incidence estimated to be 40 in every 100,000 population in 2015. An estimated 54,427 Sierra Leoneans are living with HIV[2] in 2015; out of which 26,566 are women and 4,390 are children.

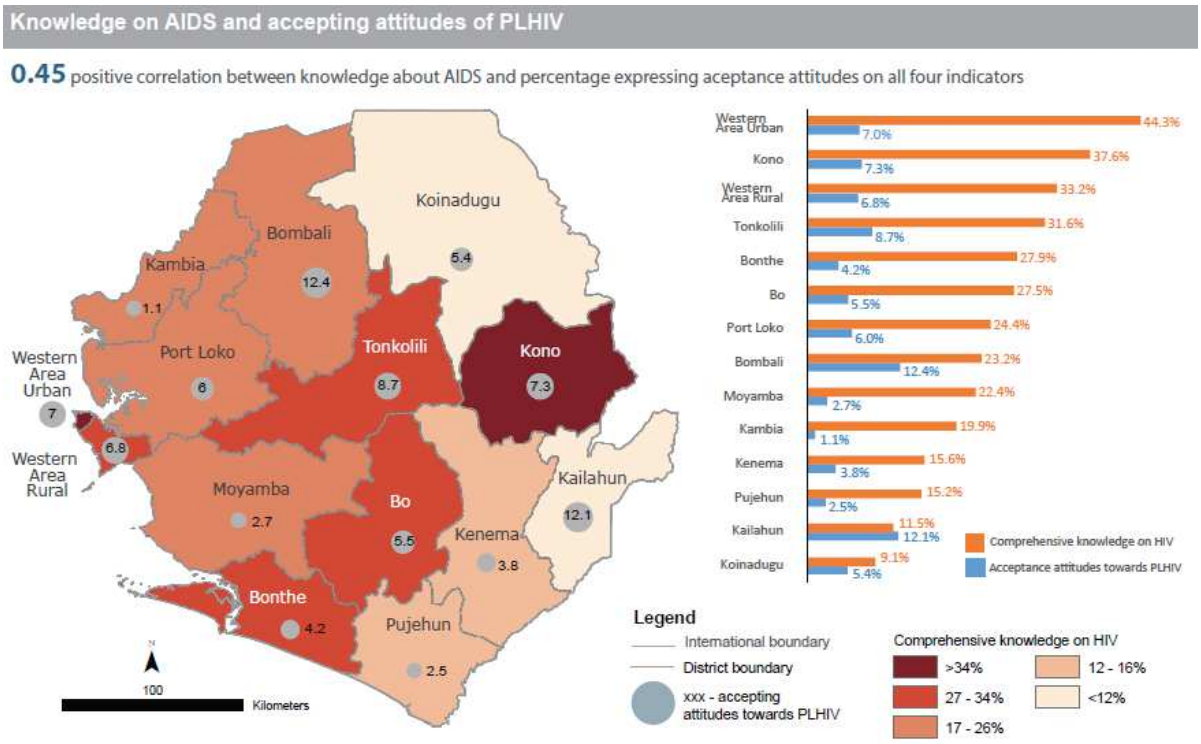
Figure 1: HIV Prevalence and Incidence Trends – Spectrum 2015



[2] 2015 Spectrum Estimates

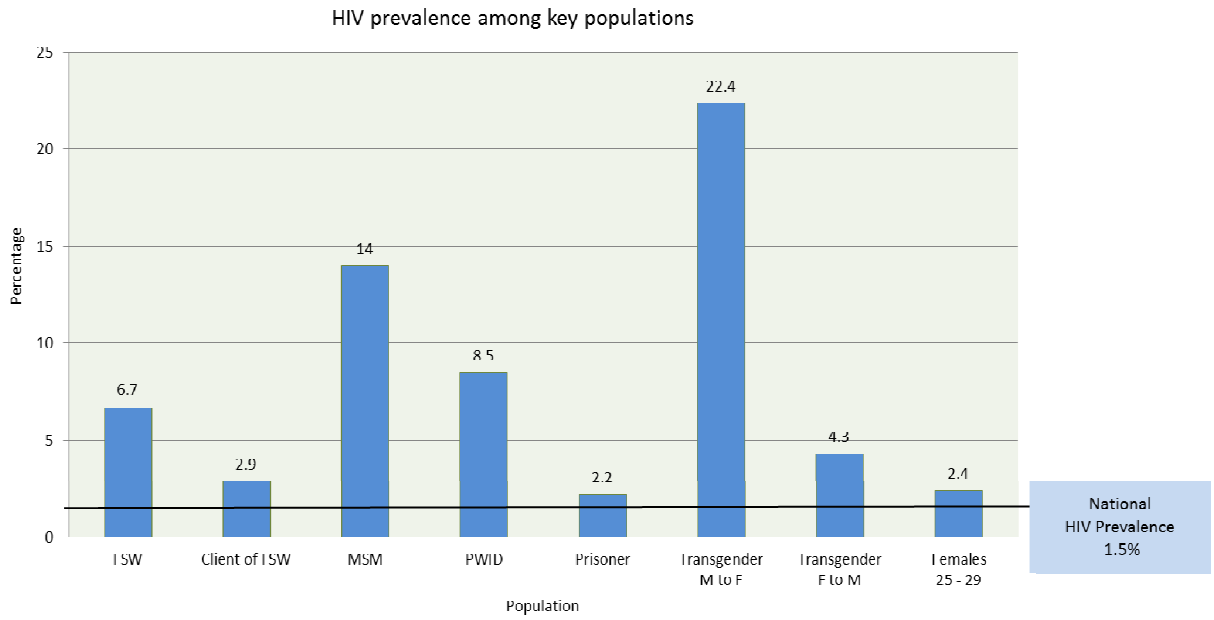
According to the Modes of Transmission Study 2010, four population groups accounted for 81 percent of new HIV infections among adults; 39.7% in female sex workers, their clients and their non-paying sexual partners; 15.6% among people in discordant monogamous relationships; 15.1% in persons with multiple sexual partners; and 10.8% in fisher-folk. Other population groups contributing to new infections include: traders (7.6%), transporters (3.5%), mine workers (3.2%), men-having sex with men (2.4%) and persons who inject drugs (1.4%). Key populations have been identified to contribute greatly to HIV transmission. Key populations are estimated to be 240,000 female sex workers (FSW), 20,000 men who have sex with men (MSM), and 1,500 people who inject drugs (PWID).

Figure 2: Knowledge on AIDS and accepting attitudes of PLHIV – DHS 2013



An HIV sero-prevalence study conducted in 2015 among Key Affected Populations (KAP) revealed an HIV prevalence rate of 14% among MSM; 22.4% among TGs; 85% among PWID; and 6.7% among FSWs (Details in Figure 3 below). These key populations together constitute only 4% of the total population; but account for 44% of the total incidence of HIV in the country. A projected total of 1,000 new cases of HIV have occurred in Sierra Leone in 2015; directly linked to these key population groups.

Figure 3: HIV Prevalence among Key Populations – 2015 Sero Survey



2.2. Overview of the Policy and Programmatic Response

Table 2: Summary Milestones – 2013 And 2014

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

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

The National AIDS Commission (NAC) and the National HIV/AIDS Secretariat (NAS) have been established in the Office of the President with the responsibility of providing leadership in coordinating, monitoring and mobilising resources for the national response. With the support of the key stakeholders, NAS is

providing strategic direction for the national multi-sectoral and decentralized response in the programmatic areas of HIV prevention, treatment of HIV and other related conditions, care and support, policy and advocacy. The National AIDS Control Programme (NACP), which is placed within the Ministry of Health and Sanitation, is focused on providing support to the health programming and service provision of the national response.

The current national response is guided by the National Strategic Plan of 2011-2015 which charts the roadmap for Sierra Leone to achieve the Millennium Development Goal to have halted and begun to reverse the spread of the HIV/AIDS by 2015. It is multi-sectoral with the overall vision towards zero New Infection, Zero Discrimination and zero AIDS related deaths. The thematic areas of the NSP are (i) coordination, institutional arrangements, resource mobilisation and management; (ii) policy, advocacy, human rights and legal environment; (iii) prevention of new infections (iv) treatment of HIV and other related conditions (v) care and support for infected and affected by HIV and AIDS and (vi) research, monitoring and evaluation.

Analysis of implementation of the 2011-2015 NSP found progress in all thematic areas. Treatment, care and support services have gradually been scaled up across the country since the inception of multi-sectoral response. Key population groups including FSW, MSM, PWID were identified as priority populations, alongside the fisher folks; transporters; uniformed service personnel; prisoners; miners; cross-border and informal traders; women, girls and children; youths and general population. Over the years, guidelines have been developed and reviewed for effective service delivery. These guidelines include HCT guidelines, ART guidelines, OVC guidelines, Nutritional guidelines, Home-based Care guidelines and workplace policy. The 2014 EVD outbreak significantly affected the national AIDS response by halting specific interventions, redirecting resources to support efforts in EVD sensitization and impact mitigation, and endangering progress that has made in supporting PLHIVs.

The Prevention and control of HIV and AIDS Act was enacted in 2011. The agenda for elimination of Mother to Child Transmission was launched by the First Lady in 2012. The country implements comprehensive public health approaches for targeted HIV programming for key affected populations. There is also livelihood support for PLHIV and a successful ART defaulter tracing to mi□gate EVD impact on treatment services in 2014. PLHIV support groups provided care and support to HIV and EVD affected people during EVD outbreak and NGOs in country are available to address key population needs programmatically and increase in quantity and quality of strategic information and its use for evidence-informed program improvement.

Key achievements include: increase in ART coverage rate from 15% (2011) to 21% (2014) for all PLHIV adults and children; PMTCT Coverage is 41% (2014); and Decrease in rate of HIV transmission from mother to child from 22% (2011) to 13% (2014). There is 100% safe blood screening and nearly 100% male circumcision experience. 689 HIV Testing and Counseling (HTC) sites, 691 Prevention of Mother to child transmission (PMTCT) sites, 136 Antiretroviral Treatment (ART) sites, 170 Tuberculosis (TB) sites in line with WHO 2013 Treatment Guidelines in effect. Strong and effective networks of People Living with HIV (PLHIV) and key affected populations are participating in community engagement.

Figure 4: Prevention interventions for HIV – DHS 2013

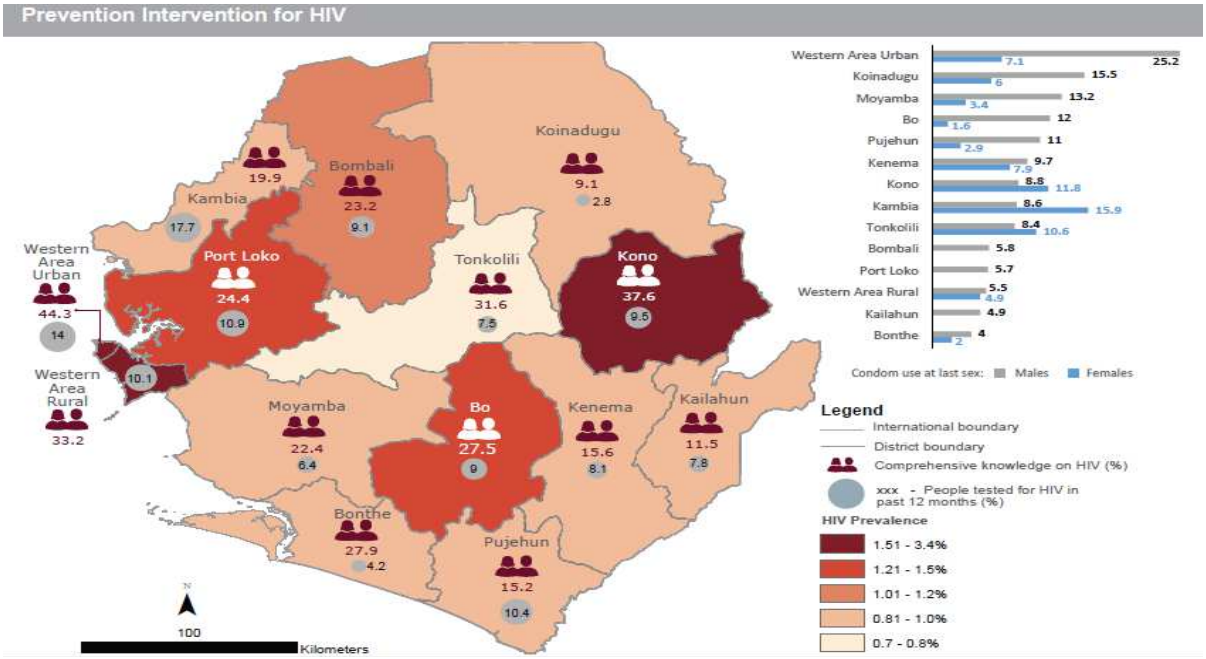


Figure 5: HIV Burden and ART Uptake – DHS 2013

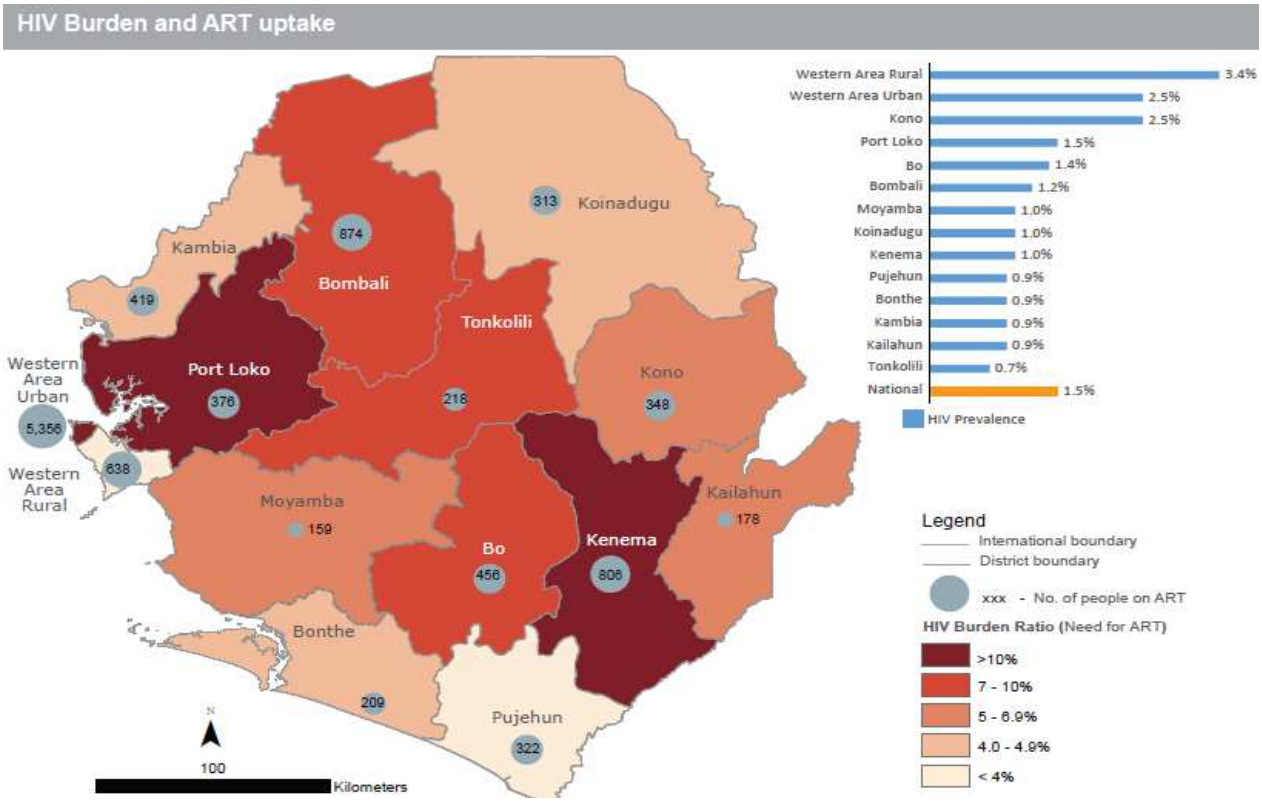
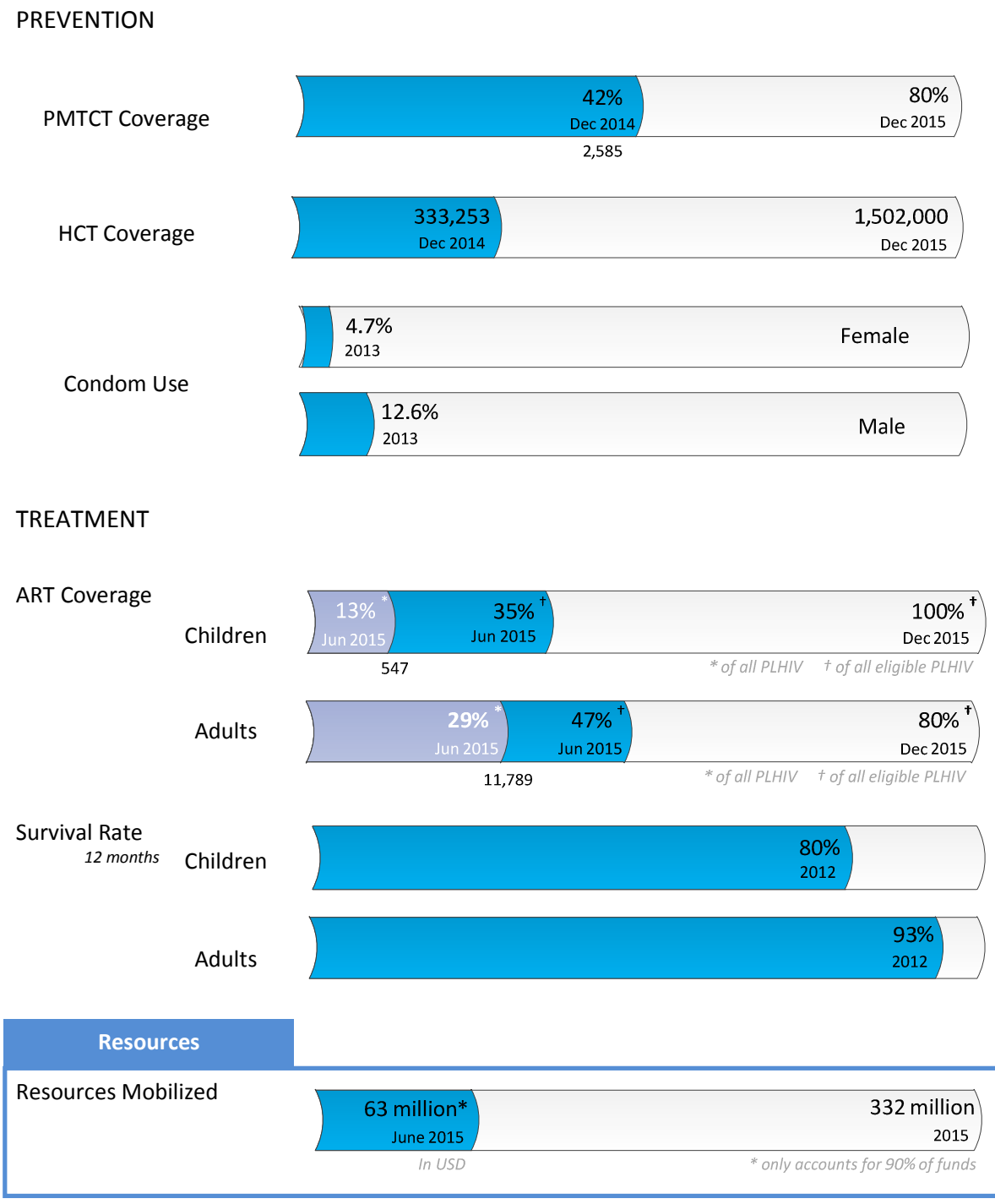


Figure 6: Summary Milestones in the last five years



2.3. Gaps and challenges

The main challenges and gaps affecting the National AIDS response are:

- **Insufficient behavioural impact of prevention interventions** for adolescents and young people. High rate of early marriage, low condom use and multiple sexual partners with early sexual debut
- **Large coverage gap for testing, services to prevent mother-to-child transmission and antiretroviral therapy** for adults and children. Health and community systems, including procurement and supply management remain weak.
- **Over-reliance on international funding** (GFATM) **at 95%** because actionable political commitment, multiple competing priorities, weak governance, low allocative efficiency and limited absorption of funds undermine the sustainability of the response.
- **Persistent stigma and discrimination, gender inequalities and violence against women.**
- **Weak sex- and age-disaggregated epidemiological and programmatic national and subnational data** especially on key populations, young people and adolescents.
- **Emergencies and disasters:** including the 2012 cholera epidemic; the 2014/2015 ebola epidemic, and the 2015 floods

Further illustrative details are captured according to thematic areas in Table 3 below.

Table 3: Key Achievements and Gaps in 2011-2012 OP Implementation

Theme/Progress achieved	Gaps/Challenges
Prevention of New Infections	
HCT services: sites increased from 497 in 2010 to 708 in 2015 • 1,138,256 tests were done (not including HTC in PMTCT services) between 2011 and 2014 • A total 33,799 HIV positive tests were reported; 59% of the projected cumulative total of PLHIV in the country in 2014 ***PMTCT services:*** sites increased from 495 in 2010 to 691 in 2015. • 846,459 pregnant women reached with PMTCT services between 2011 and June 2015 • A total of 14,489 HIV mothers were identified and linked into further PMTCT and on-going HIV care and treatment services; virtually representing all 14,223 HIV positive mothers projected to be pregnant over the period	Very low retention of persons who test positive in on-going care and due enrolment on ART Follow up of HIV-exposed infants to confirm HIV status is still weak • Only 13% of HIV-exposed infants in PMTCT services for 2014 received timely EID Limited male involvement in PMTCT • Only 2% of mothers in PMTCT in 2014 had their male partners tested
Treatment, care and support for PLHIV and the affected	
ART services: sites increased from 113 in 2010 to 136 in 2015 • Adults and children on ART increased from 5,978 in 2010 to 12,336 by end of June 2015 • 40 PLHIV support groups nationwide; functional national network (NETHIPS)	There was a net decline in number of children on ART; from 533 in 2011 to 383 in 2014
Coordination and management	
National AIDS Commission: Legal backing for national and subnational coordination framework • Platform for domestic resource mobilization for the HIV response	Underfunded response (30% of projection; virtually all from external sources) Delayed response to EVD crisis impact on HIV response

2.4. Situation Analysis Recommendations

The HIV response situation analysis conducted as part of drafting this NSP noted and commended the strengths and achievements over the 2011-2015 strategy period. It made specific recommendations to address noted gaps and challenges as highlighted below; which provided the initial basis for development of the NSP.

1. Overall focus: The NSP 2016-2020 should include an explicit vision that takes into consideration the level and nature of the HIV epidemic; the national health and development context; and the strategic focus in the global HIV response framework.

- The principles that underpin the NSP and its implementation should be refined; with a view to delineating the overarching strategic principles, and the specific programming principles that may fit better with the respective programme pillars.

2. Coordination: The NSP 2016-2020 should adopt a fully decentralized approach that links response coordination to technical programming and budgeting; resource deployment and program implementation; and to monitoring and responsive adaptation of decision-making.

- This should include district-based operational planning; and deployment of required Technical Assistance to support program management
- It should be based on a systems strengthening approach for relevant institutions (health, education, child protection, etc.), and for the full range of relevant community actors.
- The current NSP should develop a robust disaster management program to address as best as possible HIV response issues.
- There should be very strong and sustainable collaboration between TB and HIV Programs at all levels
- The DACS should be made fully functional and capacitated to discharge their functions while at the same time considering the establishment of Chiefdom AIDS Committees (CACs).
- Domestic Resource Mobilization should look beyond in country partners to other external players

3. Policy and Advocacy: The NSP 2016-2020 should articulate issues related to policy and advocacy as a functional area within the coordination and governance theme. This should focus on the critical advocacy and policy change elements at a higher strategic level; such as the National HIV and AIDS Commission Act; National HIV/AIDS Policy and National Workplace Policy on HIV/AIDS.

- Policy issues of more operational relevance should be addressed within the respective programmatic and service focused themes. This should include the stigma analysis and response as described in this section

4. Prevention: The NSP 2016-2020 should re-package prevention of new HIV infections to primarily focus on three programing areas, which should constitute the key building blocks for HIV prevention:

1. Programming for Key Affected Populations (KAP)
2. EMTCT linked to integration of HIV and SRH
3. Positive Health, Dignity and Prevention (PHDP).

Key intersection areas across the three blocks include: behavior change communication; necessary social and economic support to enable sustained change or complete avoidance of high risk behaviours; STI prevention and treatment; condom promotion; services for HIV positive persons among the other KAPs, Paediatric HIV care, etc.

HTC should be retained as a cross cutting strategic theme for HIV prevention within the above linked programming, and in reaching the general population. This is in recognition of its critical role as the entry point into the continuum of HIV services. It is also an opportunity for strategic advocacy to strengthen counseling capacity as a core skill and potential professional cadre within Human Resources for Health systems at different levels.

- HCT targeting for the general population should prioritize specific population groups and geographical locations where an increased risk of HIV transmission is accompanied by limited access and utilization of HCT.

5. Treatment: The NSP 2016-2020 programming for HIV treatment should be developed around an ART program built around:

a) Structured and comprehensive (psychosocial, clinical and socio-economic) preparation to start on ART;
b) Quality and comprehensive clinical care services based on the 'whole person' approach (not just another PLHIV); and
c) Structured systems to enable and track retention, closely linked to provision and linkage to ensure all necessary support in line with assessed need in the preparation process.

The NSP should prioritize structured integration of HIV care and treatment services into routine chronic care services in hospitals and PHC facilities.

- The model for integrated chronic care services (that includes HIV and TB care) alongside other chronic conditions in each context, should include explicit provision for efficient and sustainable community and home-based follow up and care

6. Care and support: The NSP 2016-2020 should promote integration of all elements of psycho-social support into the continuum of HIV care and treatment; within the framework of PHDP.

- Social and economic care and support for children, adolescents and adults affected by HIV should be integrated into the broader social protection and economic strengthening strategies in the country. HIV-specific elements of support in this respect could include: representation in the broader policy and programming processes; development of social protection and support models based on HIV impact, and demonstration implementation; and resource pooling for such combined support initiatives.

7. Monitoring, evaluation and Learning: The 2016-2020 should adopt close alignment between the NSP themes, the results frameworks for each theme, and the accompanying M&E framework for each theme.

- This alignment should be periodically analyzed and used as a basis for necessary adaptations in the HIV response

In line with the recommended district-based approach to programming and coordination of the HIV response (in recommendation 1); the M&E framework for NSP 2016-2020 should adopt a district-based format and utilization approach.

2.5. Game changers

The key game changers of the national AIDS response are:

- Collaborative frameworks at national and local levels to ensure practical solutions for key populations to access services despite challenging legal environments.
- Geographical targeting in line with the burden of HIV across the country; with particular focus on high burden districts and urban centres.
- Cities initiative with mayors and community leaders engagement and strengthening community delivery systems.
- Community-based HIV counseling and testing and delivery of antiretroviral therapy through task shifting and the use of new technologies.
- Services to prevent mother-to-child transmission of HIV integrated into all maternal, newborn and child health services and sexual and reproductive health services as an entry point for achieving integration of the HIV response in the health sector at all levels.
- Innovative financing mechanisms to increase domestic funding while optimizing resource allocation and reducing costs in the context of implementing the African Union Roadmap on Shared Responsibility and Global Solidarity for AIDS, TB and Malaria.
- The full potential of adolescents and young women and men unleashed to help realize the demographic dividend and reduce risk of and vulnerability to HIV infection.
- Fully leveraging TRIPS flexibilities to secure sustainable access to affordable medicines, and strengthening local capacity to develop and manufacture quality affordable health products.

2.6. Opportunities and accountability frameworks to be explored

The National AIDS Secretariat will explore the current existing opportunities to strengthen national accountability and improve efficiency of the national response.

- Implementation of the **African Union Roadmap on AIDS, TB and Malaria** and the **African Union Framework on Social Protection** provides an opportunity to Fast-Track the response.
- **The Economic Community of West African States/West African Health Organization** represent a collaborative forum to maximize access to commodities, including through the antiretroviral medicines security stock and **ECOWAS Regional Pharmaceutical Plan**.
- The **Cities Initiative** based on the Paris Declaration on Fast-Track Cities: Ending the AIDS Epidemic will help to mobilize engagement and catalytic funding and serve as an accountability framework for monitoring progress.
- The **Global Maternal Newborn & Child Health initiative** will be instrumental to Fast-Track the provision of integrated quality services, and leverage the support of O**rganization of African First Ladies Against HIV/AIDS**.
- The **Health Sector Recovery Plan 2015-2020**; and the updated **Basic Package for Essential Health Services 2015-2020** provide an opportunity to leverage AIDS funding and support for health system strengthening.

3. RATIONALE, JUSTIFICATION AND APPROACH

The National AIDS Strategic Plan is linked to development agenda of the country, the transition plan and the global sustainable development goals. There is every indication that the country can begin ending AIDS epidemic in every district, region, in every location, in every population and every community and the country. There are multiple reasons from the evidence before us supporting this hope and conviction.

The country despite the Ebola outbreak, we are moving one step closer to eliminating new HIV infections among our children from HIV positive pregnant mothers. In addition more people living with HIV know their status and are receiving most efficacious HIV treatment as lifesaving drugs, relatively fewer people are dying of AIDS-related illnesses in the country. More efforts is need to be made to increase the functionality, quality, laboratory capacity of the existing service delivery centres. The epidemic still remains feminized with women and girls bearing most the burden and risk. Female prevalence was generally higher than that of males.

This is the bedrock of the NSP is promoting smart investment on children, adolescent, young people, girls, key populations and women and prioritized geographical locations while building on the successes of the last five years and committed to filling the gaps. The plan has also domesticated global instruments and commitments such as 90.90.90 and fast tracking, SDG, prioritizing the cities, Africa Union roadmap on domestic sustainable financing, ending AIDS etc.

The rationale of this plan therefore is informed by:

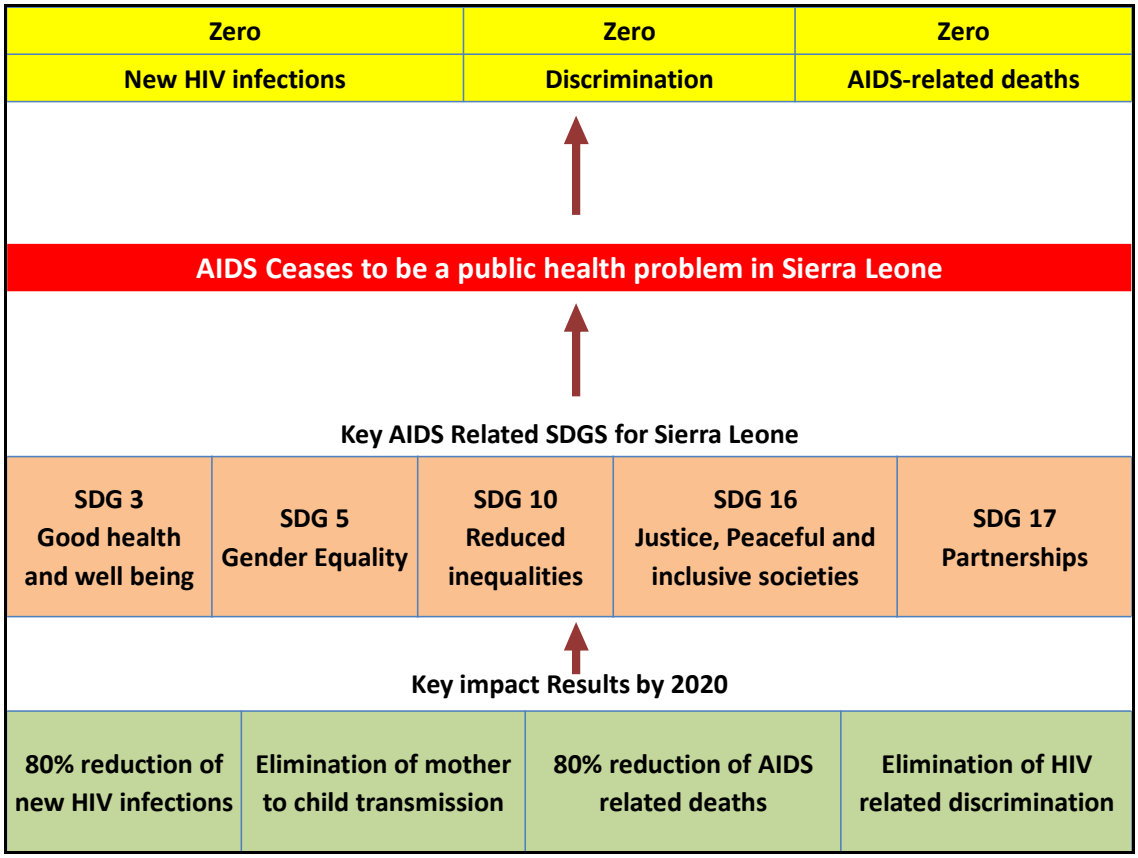
- The multi-sectoral response will need to match with where most new infections are coming
- AIDS is not yet a finished public health problem but still remain a development issue
- Predictable and sustainable domestic and international financing will need to be achieved using the invest case approach
- Fast-tracking strategies to ending of the AIDS epidemic is possible by working together— fostering innovation, securing sustainable financing, strengthening health systems and communities, ensuring commodity security, promoting human rights, gender equality and ensuring access to HIV prevention and treatment services.

The development of NSP was participatory with contributions from various multi-sectoral stakeholders involved in the national response to HIV. The government constituted a national Steering committee comprising of NAS, MOHS, UN, donors, INGO, CSO and community representatives to oversee and guide the process. The plan was developed based on empirical evidence generated through document review, analysis and synthesis of data

The strategic priority areas reflected in the plan were identified and agreed upon through a participatory process that involved thematic working groups, technical working groups, and the HIV Partnership Forum; with a total of over 250 stakeholders contributing. In addition, the M&E working group assisted to prepare the Results Framework that detailed the impact and outcome results and targets expected to be achieved by 2020. A financial gap and programmatic gap analysis was carried out to identify bottlenecks and essential needs for effective acceleration of the multi-sectoral efforts on HIV and AIDS up to 2020.

4. VISION AND GOAL

4.1. Vision, Goal and Targets at Glance



4.2. Goal

Zero	Zero	Zero
New HIV infections	discrimination	AIDS-related deaths

4.3. Vision

The vision for the NSP 2016-2020 is: A Sierra Leone where HIV is no longer a public health threat.

4.4. Impact Results

iii. To reduce HIV incidence among adults and adolescents by 50% from 0.04% in 2015 to 0.02 % by 2020.
iv. To reduce HIV incidence among infants born to HIV positive mothers from 13% in 2015 to less than 5% by 2020
iii. To reduce HIV-related mortality by 86% for both adults and children by 2020.
iv. To increase domestic financing of the HIV response to 30% by 2020

4.5. Guiding Principles

The key principles for this strategy are based on:

- **Equity for fairness and justice**: The HIV response will uphold equity oriented interventions that promote allocation of resources preferentially to the needy so as to address challenges related to unfair differences.
- **Evidence Informed**: The interventions for the HIV response will be based on evidence provided and responding to community needs. Resources allocation will be determined by the value, impact and potential for scaling up evidence based initiatives.
- **Strong political and institutional leadership:** demonstrated at all levels of governance for the national response; and commitment to transparency and prudent management of all resources
- **A multi-sectoral and human rights and gender-based approach:** based on acknowledging, understanding, and addressing the HIV and AIDS implications in all sectors; and focusing on all people at risk and living with HIV through a human rights and gender-based approach. Specific focus in this regard will be on emergencies and disasters; and on mitigating their negative impacts on the HIV response.
- **Participation, partnership and collaboration:** with evident and exemplary government leadership; and including all other actors working closely together – development partners; the private sector; faith-based organizations; civil society.
- **Equity and empowerment:** recognizing and acknowledging vulnerability to HIV and all its determinants; prioritizing empowerment of all at risk and affected; and considering individuals, families and communities within their environment and from their perspective.
- **TATARA:** commitment to HIV testing, treatment and retention as core and inter-related elements in the continuum of care.
- **Beneficiary-oriented:** in service provision focus; mobilization and empowerment for effective participation; and in public accountability.
- **Accountability:** Multisectoral involvement, mutual involvement, financial and program reporting will be the basis for accountability.
- **Shared Responsibility and Global solidarity:** For successful implementation of the AIDS response, the Sierra Leonean government will ensure commitment of political leadership; allocation of resources in a way that ensures high impact; and have a fair share of the HIV investment gap with assistance from developmental partners in line with.
- **Gender sensitivity and responsiveness:** A gender responsive national multisectoral AIDs response will be promoted and implemented in the next five years of the national AIDs response.

- **Sustainable financing:** Due to the poor economic situation in the country- companies closing down, donor fatigue, the resource funding is dwindling negatively affecting the HIV funding situation. The NSP III will pursue the investment approach to resource mobilization and optimize on available resources using all available avenues.
- **Good Practices for learning:** The HIV response will take into account lessons learnt and best practices documentation at critical stages of programmes implemention for an improved and effective response.
- **Community involvement ownership and partnership:** The communities will be empowered to take control of their resources, programmes for sustainable well-being. The concerted efforts in responding the HIV and AIDS epidemic of the multisectoral stakeholders including government sectors, development partners, FBOs, CSOs Private sector-including the informal sector (SMEs), PLHIV will be aligned towards achieving the country's goals and results.
- **Positive Health, Dignity, and Prevention (PHDP):** The NSP III recognizes the important role played by PLHIV in the national HIV response and strives to ensure their involvement in all interventions. The strategy provides for meaningful involvement of PLHIVs in all the implementation and monitoring of the response. The multisectoral actors at all levels are expected to adhere to this guiding principle.
- **Country ownership and partnership:** All HIV stakeholders including the government**,** development partners, private sector, faith-based organisations and communities of people living with HIV shall align their efforts towards the results envisioned.
- **Rights-based and gender transformative approaches:** The success of the HIV response is dependent on protecting and promoting the rights of those who are socially excluded, marginalised and vulnerable. This NSP rooted in gender equality and rights-based approach.
- **Efficiency, effectiveness and innovation:** Sierra Leone is experiencing economic crisis and flattening of donor resources with potential decline, further exacerbating the HIV funding situation. The NSP III has taken active steps to sustainable domestic funding options through improved efficiency in service delivery and innovative approaches aimed at achieving more at reduced cost without compromising on quality.
- **The importance of location and population:** The plan is designed to ensure that NAS and its partners stand shoulder to shoulder with community and city leaders". Cities and urban areas are engines of transformation. They are home to most dynamic economies and they are energized by young, mobile and diverse populations with talent, creativity and innovation. Urban areas are also home to thousands of people who have fallen through the cracks of social, political and economic life. People who lack access to education, health services and prevention measures face significantly higher health risks. Under these social conditions, many diseases, including HIV, EVD, TB spread more quickly. Additionally, poor sanitation and crowding foster the spread of tuberculosis, which is the leading cause of death among people living with HIV. This plan will give space for cities to address their significant disparities in access to basic services, social justice and economic opportunities.

4.6. Priority Areas of Focus

The global financial crisis has sent a stark reminder that Sierra Leone - in order to avert an AIDS crisis – need to prevent the maximum of new infections at minimum expense. The cost of treating someone with HIV for life means it makes financial as well as ethical sense to minimise new infections. Sierra Leone needs to commit to adequately resourced high-impact HIV prevention. The following are key areas of focus:

- Reduce acute stage transmission and acquisition by changing the structure of sexual networks and concurrency, condom use during concurrent relationships and high risk sex, with risk reduction counseling;
- Reduce vertical transmission through the 4-pronged PMTCT approach: only planned pregnancies amongst HIV positive women, screening of all pregnant women, scale-up early antiretroviral treatment for all HIV-positive pregnant women, and ARV prophylaxis for the infant;
- Reduce acquisition from or transmission to a long-term sexual partner through couple HTC, targeted HTC, consistent male & female condom use among key populations, and PrEP
- Reduce transmission from PLHIV through ART with risk reduction counselling and condom promotion;
- Reduce transmission from and acquisition during casual heterosexual sex, condom use, and a comprehensive HIV prevention programme for sex workers and other KP.
- Reduce HIV transmission among adolescent and young people through early treatment, HTC and comprehensive HIV prevention programme
- Maintenance of PLWA on treatment, with nurse care, infrequent care visits (patient initiated) and automatic ART stock control.
- Tailored intervention in the economics of sex for young women.
- All pregnant women, infants and children diagnosed and referred to care through multiple maternal, infant and early childhood health entry points.
- Active social dialogue on inclusion, morality, selling sex and MSM.
- Health accountability led by PLWA
- HIV and Cities
- HIV and Emergencies including EVB survivors

5. RESULTS LINKED TO STRATEGY AT A GLANCE

Table 4 provides a summary of the results and strategies that will guide the operationalization of the NSP in the next five years.

Table 4: NSP Results and Strategies

SGD	Outcome results	Strategic Outputs
Good health and well-being (SDG 3	**90% of all adults and adolescents who know their positive HIV status receive comprehensive treatment, care and support, including sustained antiretroviral therapy; and have durable viral load suppression**	• Adults, adolescents and child PLHIV who receive complete clinical, psychosocial and socio-economic assessment (annually) and are placed on the appropriate care and support package increased from 2015 level to 95% by 2020 • PLHIV who access ART and complementary care and support services increased from 2015 level to 90% by 2020 • PLHIV on ART who attain sustained viral suppression increased from 2015 level to 90% by 2020 • PLHIV under care and are co-infected with TB who attain TB cure increased from 2015 level to 90% by 2020 • PLHIV who need social protection to overcome specific vulnerability and do receive such protection increased from the 2015 level to 90% by 2020
	New HIV infections among children eliminated and their mothers health and well-being is sustained	• HIV positive mothers that attain viral load suppression during pregnancy, labour and over the entire period of breastfeeding increased from the 2015 level to 95% by 2020 • HIV-exposed infants (born to HIV positive mothers) that receive the full dose of prophylactic ARVs increased from 29% in 2014 to 95% by 2020 • HIV positive mothers that get unplanned pregnancies reduced by 67% between 2015 and 2020

SGD	Outcome results	Strategic Outputs
Reduced inequalities (SDG 10)	**Young people especially young women and adolescent girls, who access combination prevention services and are empowered to protect themselves from HIV increased from 2015 level to 90% by 2020**	• Young people (10-24 years) reached with comprehensive life skills, Sexuality, HIV and AIDS education increased from 2015 level to 80% by 2020 • Chiefdoms that are reached with consistent demand generation interventions for SRHR (incl. HIV, EBV, STI) services increased from 2015 level to 95% by 2020 • Young people and their sexual partners who access youth-friendly HIV, SRH, EVD and harm reduction information and services increased from 2015 level to 90% by 2020 • Adolescents and young people who make and accomplish appropriate personal SRH commitments (e.g., sexual abstinence, FP use, etc.) increased from 2015 level to twice that level by 2020
	Key populations, including sex workers, men who have sex with men, transgender, PWID, EVDS, prisoners , TB patients, migrant workers (fisher-folk, miners, transporters) and traders , and uniformed personnel that access tailored HIV combination prevention services and are empowered to protect themselves from HIV, EVD and TB increased from 2015 level to 90% by 2020	• Health facilities that provide combination prevention services tailored to targeted Key Populations increased from 2015 level to 80% by 2020 • Targeted Key Populations that access relevant combination prevention services increased from 2015 level to 90% by 2020 • Targeted Key Populations that have un-interrupted access and consistent and correct utilization of male and female condoms for dual benefit (contraception and disease prevention) increased from 2015 level to 90% by 2020

SGD	Outcome results	Strategic Outputs
Gender equality (SDG 5)	**Women and men who practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to three times that level by 2020**	• Women and men that are empowered to practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to 60% by 2020 • Laws and policies that enable women, girls men and boys to promote gender-based, sexual and intimate partner violence, and protect themselves from HIV and EVD, and access HIV and EVD-related services increased from 2015 level to twice that level by 2020
Just, peaceful and inclusive societies (SDG 16)	**People living with, at risk of and affected by HIV and EBV who report no discrimination especially in health, education and workplace settings increased from 2015 level to 90% by 2020**	• PLHIV, EVDS and Key Populations at most risk of HIV that are empowered and participating effectively in advocacy and programme interventions to eliminate stigma and discrimination increased from 2015 level to twice that level by 2020 • Community members that are adequately informed about HIV, EVD and TB; and access HCT increased from 2015 level to 60 percent (of the total population) by 2020

SGD	Outcome results	Strategic Outputs
Global Partnerships (SDG 17)	**Departments, Agencies and Institutions (including CSOs) participating in the national response with adequate capacity to effectively and efficiently manage a multi-sectoral response increased from 2015 level to twice that level by 2020**	• Investment of a minimum of $50 million annually for the national AIDS response • Domestic funding mobilized to support at least 12% of annual resource needs • Financial sustainability transition plans and national HIV budget line, AIDS trust funds implemented • HIV, EVD and TB resource mobilization from international sources diversified from 2015 level to 10 sources by 2020 • Stakeholders in the national HIV response that make evidence-based strategic and operational decisions increased from 2015 level to 70% by 2020 • Local Councils (districts/cities) where integrated health and community systems include HIV among the priority health issues of focus in service delivery, staff training and CIS/HMIS reporting increased from 2015 level to 10 by 2020

5.1. Synergies

Gender responses, the linkages between HIV and sexual and reproductive health, EVB, TB and malaria responses, linkages between HIV and maternal health and child survival, strengthening education and social protection, food security, livelihoods and youth empowerment are all key synergistic areas to be enhanced in the national response. Partnerships with private sector and academia to support resource mobilization, quality of equitable service delivery and operational research cannot be over-emphasized. A strong government led National AIDS response at all administrative levels will support cross sectoral linkages and collaboration for scaling up of prevention, treatment and care and support efforts. High-impact advocacy campaigns on key populations, as well as national advocacy networks that are linked to global networks will be strengthened.

5.2. Key Strategies

5.2.1. Targeted Combination Prevention

Reducing HIV incidence in Sierra Leone depends in large part on the outcome result of preventing HIV transmission through sex, which accounts for 85% of HIV incidence. The complementary outcomes of eliminating biomedical and mother-to-child HIV transmission are necessary to reduce the other 15% of HIV incidence.

The key results that underpin these outcomes and core strategies to achieve them are presented in Table 5 below.

Table 5: Key results and core strategies for targeted combination prevention

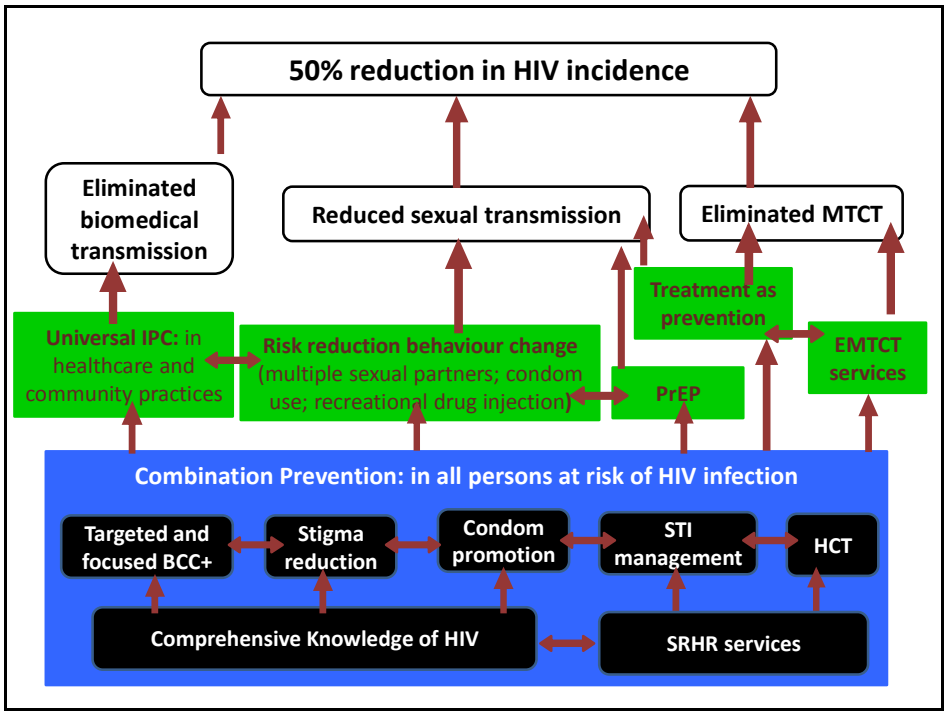
Results	Key strategies to achieve the results
Outcome 1: Young people, especially young women and adolescent girls, who access combination prevention services and are empowered to protect themselves from HIV increased from 2015 level to 90% by 2020	
Output 1.1: Young people (10-24 years) reached with comprehensive life skills, Sexuality, HIV and AIDS education increased from 2015 level to 80% by 2020	Strengthening the capacity of stakeholders to manage SRH, HIV&AIDS programmes for young people.
	Increasing access and utilization of integrated quality SRH and HIV youth friendly services by young people.
	Strengthening young people involvement in the national HIV, EVD, TB responses; and in promotion of SRHR services.
	Strengthening in, out of school and tertiary institutions Life Skills, Sexuality, HIV and AIDS education.
	Improving the use of multi-media (e.g., social media, radio, youth-focused print media, etc.) to increase reaching out to young people.
	Increasing access and utilization of integrated quality SRH, HIV&AIDS youth friendly reproductive health services by adolescents young people.
	Strengthening the capacity of sectors and partners in implementing the "All In" initiative young people involvement in the national response to SRH, HIV&AIDS.
	Expanding coverage of integrated Adolescent-friendly SRHR services in all public and private health facilities.
Output 1.2: Chiefdoms that are reached with consistent demand generation interventions for SRHR (incl. HIV, EBV, STI) services increased from 2015 level to 95% by 2020	Intensifying advocacy and access to prevention information
	Strengthening integration of condom promotion, demand creation, IPC, workplace programmes, SBCC operational research,
	Promoting evidence based and targeted behaviour change communication interventions, effective parent-child communication, youth and key population friendly HIV and AIDS services.
	Promoting community engagement in SBCC initiatives
	Advocating for an enabling environment to facilitate access to services and promote health seeking behaviour of KPs;
Output 1.3: Young people and their sexual partners who access youth-friendly HIV, SRH, EVD and harm reduction information and services increased from 2015 level to 90% by 2020	Youth friendly HIV, SRH, EVD and harm reduction information and services accessed independently and equally by young people, women and men
	Adult models of young people and young people themselves access HIV combination prevention and SRHR services; and reduce HIV related risk behavior

Results	Key strategies to achieve the results
	Targeted and sustained condom promotion services (including procurement, distribution and delivery) to reach young people and sustain motivation and skills for consistent and correct condom use
Output 1.4: Adolescents and young people who make and accomplish appropriate personal SRH commitments (e.g., sexual abstinence, FP use, etc.) increased from 2015 level to twice that level by 2020	Quality comprehensive sexuality and reproductive health education, and life skills training, accessed by all adolescent and young people
	Information accessed, awareness raised and demand created among young people through traditional and new forms of communication and outreach for HIV, EVD and TB services
	Young people are meaningfully engaged in the HIV, EVD and TB responses to ensure effectiveness and sustainability
Outcome 2: Key populations, including sex workers, men who have sex with men, transgender, PWID, EVDS, prisoners , TB patients, migrant workers (fisher-folk, miners, transporters) and traders , and uniformed personnel that access tailored HIV combination prevention services and are empowered to protect themselves from HIV, EVD and TB increased from 2015 level to 90% by 2020	
Output 2.1: Health facilities that provide combination prevention services tailored to targeted Key Populations increased from 2015 level to 80% by 2020	Combination prevention services adequately resourced and available, tailored to populations, locations and interventions with maximum impact
	Outreach and new media inform and create demand for use of traditional and new HIV and EVD prevention technologies, including condoms and PrEP
Output 2.2: Targeted Key Populations that access relevant combination prevention services increased from 2015 level to 90% by 2020	10,000 people on PrEP annually, focused particularly on key populations and people at high risk in high prevalence settings
	Key Populations, Migrant workers, Refugees and other crisis affected populations have access to HIV, EVD and TB services
	PLHIV, EVDS and other Key Populations meaningfully engaged in decision-making and implementation of HIV, EVD and TB prevention programmes
Output 2.3: Targeted Key Populations that have un-interrupted access and consistent and correct utilization of male and female condoms for dual benefit (contraception and disease prevention) increased from 2015 level to 90% by 2020	Strengthening leadership by coordination of partnerships in the condom programme in demand creation, access and utilization of condoms; condom procurement and quality assurance.
	Facilitating the expansion of the distribution networks for condoms, appropriate lubricants, etc.
	Promoting integrated (double dividend) condom programming.
Outcome 3: New HIV infections among children eliminated and their mothers health and well-being is sustained	
Output 3.1: HIV positive mothers that attain viral load suppression during pregnancy, labour and over the entire period of breastfeeding increased from the 2015 level to 95% by 2020	HIV, SRH, TB, EVD, maternal and child health services integrated and accessible for all women 15-49 (especially during pregnancy), to identify and ensure continued services for women living with HIV
	Immediate treatment accessible to all pregnant women living with HIV (Option B+)
	HIV prevention services for male partners promoted including HCT, PrEP and HIV treatment as required

Results	Key strategies to achieve the results
	Scaling up innovative approaches and best practices to enhance male involvement and community leadership and structures involvement in comprehensive PMTCT.-Option B+ and pediatric HIV care, treatment and support;
Output 3.2: HIV-exposed infants (born to HIV positive mothers) that receive the full dose of prophylactic ARVs increased from 29% in 2014 to 95% by 2020	Accelerating the roll out and supporting scale-up of Option B+ and initiate operation research on EMTCT integrated services for mother-baby pairs and their families.
	Strengthening the capacity of sectors and partners in initiating the integrated (double dividend) approach in response to the pediatric HIV.
	Strengthening procurement, packaging and delivery of pediatric ARVs (for prophylaxis and treatment); integrated into adult ARV and essential drugs procurement, delivery and dispensing systems
	Improving the generation, dissemination and use of strategic information for decision making in planning, implementation, monitoring and evaluation of comprehensive PMTCT and pediatric care, treatment and support programmes; including integration into routine MNCH data and information systems.
Output 3.3: HIV positive mothers that get unplanned pregnancies reduced by 67% between 2015 and 2020	Strengthening health systems for provision of comprehensive and integrated MNCH, SRH, FP and HIV prevention services.
	Strengthening community systems for supporting and sustaining integrated MNCH, SRH, FP and HIV prevention services.

Figure 7 below presents the logic model for achieving the goal and key outcomes of HIV prevention.

Figure 7: Logic model for HIV prevention results



The intervention approach to achieve these outcomes will be based on combination prevention; which delivers multiple HIV prevention services that have good evidence of effectiveness (e.g., condom promotion, targeted behavior change communication, STI treatment, HIV treatment as prevention, Pre-exposure prophylaxis, etc.), combined in packages that maximize mutual reinforcement and collective impact. A beneficiary-focused and participatory approach will be prioritized in the design and delivery of combination prevention interventions focused on the following socio-demographic categories:

1. **Key Affected Populations (KAP):** with priority attention on populations among whom HIV prevalence and transmission is highest (FSW, MSM/Transgender, PWID); and due focus on Other Vulnerable Populations (OVP) such as Prisoners, Migrant workers (e.g., fisher-folk, transporters, miners, traders, etc.), Uniformed Personnel, adolescents and young people, etc.). Interventions for and by these population groups will include a combination of:
    a. Risk reduction behavior change, primarily in relation to sexual behaviours that are associated with higher HIV transmission and their underlying determinants (e.g., poverty and sex trade, abuse of alcohol and other intoxicating substances, etc.). It also includes behaviours with a direct relationship to non-sexual transmission of HIV, especially recreational injection of drugs.
    b. Timely, targeted and confidential delivery of the full continuum of biomedical or health services for HIV detection, prevention, care and treatment to enable un-interrupted access for these hard-to-reach and often mobile/migrant population groups.

c. Addressing the structural and socio-economic factors that influence the adoption (especially among adolescents and young people) of specific behavioural practices that increase HIV risk; and the factors that inhibit access to and sustained utilization of health and other social services

2. **Women of child-bearing age:** reached through comprehensive EMTCT programming across the four prongs:
    a. Young women 15-24 years old are empowered to adopt life choices that enhance protection from HIV and unplanned pregnancy
    b. HIV positive women are empowered to prevent unplanned pregnancy; and to ensure protection in their sexual relations (for themselves and their sexual partners)
    c. HIV positive pregnant and lactating women (and their HIV-exposed babies) have sustained access to lifelong ART, and to other quality and efficient health and psycho-social support services to prevent HIV transmission (e.g., prophylactic ARVs for exposed infants, EID, infant and young child feeding support, etc.)
    d. HIV positive mothers, their sexual partners and their HIV infected children receive family-focused care to prevent further HIV transmission.

3. **Adolescents and young people:** ensuring safe and successful sexual and reproductive transition; with focus on three key elements:
    a. ***Access and utilization of integrated SRH services:*** female and male adolescents and young people have sustained access and increasing utilization of comprehensive sexual and reproductive health and other HIV prevention services
    b. ***Sexual behaviour formation and change:*** female and male adolescents and young people adopt planned and evidence-based sexual and reproductive life choices
    c. ***Life planning and livelihood:*** female and male adolescents and young people have life planning skills; life goals and livelihood means that enhance resistance to pressures for transactional, short-term and high risk sexual relations

4. **Integration of HIV and EVD prevention:** Follow up care among the more than 4,000 EVDS is the country has shown persistent virus in semen, and in some cases in breast milk. The HIV and EVD responses are already working closely to empower EVDS support groups and promote condom use to prevent sexual transmission of EVD. This NSP will consolidate and scale up these initial initiatives to a national scale; and support greater collaboration and integration in the control of both HIV and EVD epidemics.

5. **Service providers and clients:** in health care and community settings. This will include universal infection prevention and control practices in the health care setting; especially with respect to blood safety (screened for HIV and other common blood-borne infections), minimizing accidental pricks (e.g., through improved 'sharps' waste management). It will also cover community settings and practices where sharp equipment is used (e.g., piercing body parts to enable insertion of decorative wear, decorative scarification, circumcision, etc.).

Use of ARVs will be an important element in the HIV prevention interventions within this NSP, including:
a) Pre-exposure prophylaxis for individuals at high risk of repeated exposure to HIV (e.g., in discordant couples, sex work, etc.); and
b) Post-exposure prophylaxis (e.g., in health care setting, sexual violence victims, etc.)

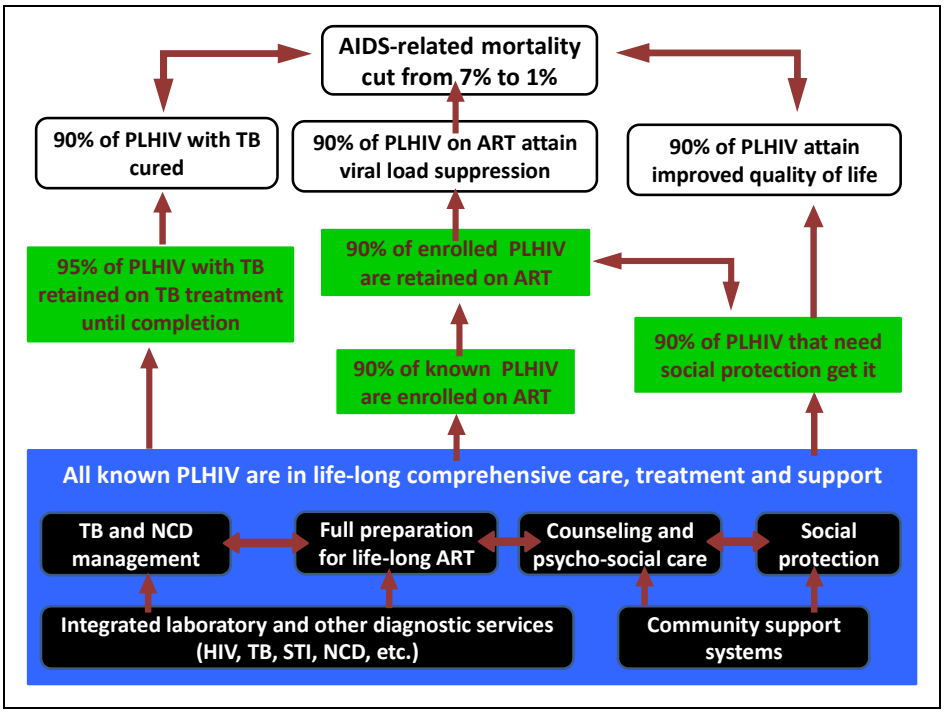
c) Life-long treatment of PLHIVs to reduce viral load and ultimately eliminate HIV transmission through sex or from HIV positive mothers to their babies;

The NSP will promote Positive Health, Dignity and Prevention (PHDP) as the core mechanism to improve the dignity, quality, and length of life of people living with HIV. This will be the key approach to reducing the likelihood of new infections, especially in the context of discordant couples.[3] It will be the main programming model for targeted and sustained support to all persons in HIV-discordant long term sexual relationships; and for empowering and involving PLHIV in delivery of HIV and other health services.

5.2.2. All treatment for all PLHIV

The key outcomes that will achieve the NSP goal of reducing AIDS-related mortality are in three main areas: viral load suppression; TB care among the HIV-TB co-infected clients; and improvement in quality of life among PLHIVs in situations of unique vulnerability. Figure 8 below illustrate the logical linkage across these outcomes and the key output results that precede their realization. The core strategies for achieving the results are presented in Table 6.

Figure 8: All Treatment for All PLHIV – Logic model



[3] PHDP is the UNAIDS-recommended framework for achieving the benefits of positive prevention; as in: UNAIDS, GNP+. (2013). Positive Health, Dignity and Prevention: Operational Guidelines. Geneva and Amsterdam.

Table 6: Key results and core strategies for HIV treatment, care and support

Results	Key strategies to achieve the results
Outcome 5: 90% of all adults and adolescents who know their positive HIV status receive comprehensive treatment, care and support, including sustained antiretroviral therapy; and have durable viral load suppression	
Output 5.1: Adults, adolescents and child PLHIV who receive complete clinical, psychosocial and socio-economic assessment (annually) and are placed on the appropriate care and support package increased from 2015 level to 95% by 2020	Strengthening community response, integration and linkages to health facilities to support HTC uptake, client follow-up and reporting, taking into account special needs of children, adolescents and youth living with HIV/AIDS.
	Early infant diagnosis services accessible to all HIV-exposed children
	All adults, adolescents and children offered ART and linked to treatment services upon HIV diagnosis
	People treatment supported and monitored regularly, including scaled-up viral load monitoring and treatment literacy and nutritional support
	Accessibility, affordability and quality of HIV treatment improved including through community delivery systems
	HIV services scaled-up and adapted to the five districts local context including cities, fragile communities and humanitarian emergencies
Output 5.2: PLHIV who access ART and complementary care and support services increased from 2015 level to 90% by 2020	Increasing ART service delivery points; number of children, adolescents, and adults; and HIV/TB co-infected patients accessing ART services.
	Strengthening health systems for provision of comprehensive and integrated HIV&AIDS treatment and care services.
	Strengthening community systems for supporting and sustaining integrated care and support services for PLHIV.
	Improving timely identification, linkage and retention in care for persons diagnosed with HIV.
	Increasing the number and capacity of health facilities providing quality HIV and AIDS care and treatment services and distribute them equitably so as to increase access.
	Promoting creative and innovative approaches to increase retention of ART clients, improve yield of tracing lost to follow up clients and reduce double counting of already registered clients during enrolment while preserving human rights and dignity (e.g. use of electronic systems/technology, mobile technology, treatment support groups).
	Strengthening clinical management of HIV-related non-communicable diseases.
Output 5.3: PLHIV on ART who attain sustained viral suppression increased from 2015 level to 90% by 2020	Increasing adherence to treatment and mechanisms for early identification of PLHIVs experiencing ART treatment failure and switching them to appropriate second line regime.

Results	Key strategies to achieve the results
Output 5.4: PLHIV under care and are co-infected with TB who attain TB cure increased from 2015 level to 90% by 2020	Percentage of PLHIV under care and are co-infected with TB who are retained on TB treatment for the full duration of the treatment course increased from 2015 level to 95% by 2020.
	Percentage of PLHIV under care who are screened for TB increased from 2015 level to 95% by 2020
Output 5.5: PLHIV who need social protection to overcome specific vulnerability and do receive such protection increased from the 2015 level to 90% by 2020	Promote provision of integrated HIV treatment, care and support services.
	Strengthening coordination mechanisms and a comprehensive community and family-centred plan of action for the protection, care and support of OVC and their caregivers; based in the social protection framework.
	Strengthening the linkages and synergies with developmental partners for strengthened care and support for OVC through social protection.
	Facilitating increased access to services by all OVC and their caregivers.
	Strengthening community systems; civil society capacity; and services for adolescents and young people for necessary social protection.

ART enrolment and retention: The central element in the treatment pillar is enrolment and retention of ALL known PLHIV on ART; to achieve and maintain viral load suppression. In the first 2 years of the NSP (2016 and 2017), the target will be to get all PLHIV with CD4 count below 500 onto ART. Starting in the third year (2018), all known PLHIV will be enrolled on ART irrespective of their CD4 count. Over the NSP period, the 14,000 PLHIV on ART by December 2015 will be retained; and an additional 38,000 PLHIV will be progressively enrolled and retained on ART.

HIV treatment, care and support will be underpinned by comprehensive clinical, psychosocial and socio-economic assessment at the time of enrolment. This will provide critical information to guide development and delivery of the appropriate care and support packages tailored to the unique needs of each PLHIV. It will also provide baseline parameters to guide tracking of client progression in treatment and care. The assessment shall be repeated periodically as needed (at least once a year), for the purpose of progress tracking.

HIV-TB co-management: The other key result area in the treatment pillar is HIV-TB co-management; to ensure that all PLHIV who are infected with TB are identified early, started and maintained on the appropriate TB treatment course until completion, and verified as cured of TB. The HIV-TB co-management will also include Isoniazid Preventive Therapy for all PLHIV with no clinical features of TB. It will be further integrated with screening and management of other illnesses among PLHIV, including STIs, cancers and other Non-Communicable Diseases (NCDs).

The National AIDS Control Programme (NACP) and the TB and leprosy Control Programme will work closely to enhance operational collaboration and linkage in delivery of HIV and TB services. Over this NSP period, specific attention will be paid to structured integration of HIV and TB care, into chronic diseases clinics and services at the different levels of the health care system.

Social protection: This NSP recognizes that social protection is relevant to HIV because it addresses social and economic inequalities, HIV risk behaviour and HIV-related stigma and discrimination, which exacerbate marginalization and vulnerability to HIV infection.[4] The NSP promotes HIV-sensitive social protection; which serves PLHIV, EVDS and key populations that are uniquely vulnerable to HIV; alongside other equally underserved groups. This will minimize stigmatization that may be associated with interventions that exclusively focus on PLHIV. The key elements of HIV and social protection interventions promoted by this NSP shall:

1. Protect the financial streams of individuals and households affected by and most vulnerable to HIV to secure the minimum income necessary for care, child care, children's education, food and nutrition, water, housing and other essential items.
2. Secure and increase access to essential medical and social services for people in need, including adolescents, women and key populations, including people living with HIV, to prevent risk of exposure to HIV infection and enhance access to HIV prevention, treatment, care and support.
3. Advocate for enacting appropriate laws, policies and programmes to reduce stigma and discrimination of those living with and affected by HIV, including women and key populations, and reducing barriers to employment, housing and access to social services, including protecting the rights of workers living with HIV to retain their employment and for those living with HIV to ensure access to general health services as well as HIV-related medical services.

The critical service elements that will enable realization of the outcomes in the treatment pillar are highlighted below:

1. ***Full preparation for life-long ART:*** including clinical and psycho-social assessment and support services as needed; and socio-economic profiling as a baseline for tracking and enabling resilience and recovery.
2. ***Counselling and psycho-social care capacity:*** largely based on professional services by health and/or counseling professionals; and the critical social support from family, other PLHIV, and other social support networks (e.g., in faith- context, workplace, etc.).
3. ***Management of TB, other infections and a range of non-communicable diseases:*** as may be experienced by PLHIV under care; including periodic clinical screening and diagnostic testing as may be indicated; co-management of all concurrent morbidities; and preventive treatment as may be indicated (e.g., Isoniazid Preventive Treatment for TB, PrEP for HIV negative in sero-discordant stable sexual relations, etc.).
4. ***Integrated laboratory and other diagnostic services:*** based on the 'hub and spokes' model that ensures that:
    a. All HIV treatment and care sites have (on-site) basic laboratory services for TB and STI diagnosis, HIV antibody testing, and sample collection for specialized HIV and TB testing (e.g., CD4 viral load, TB culture, genexpert, etc.);
    b. Appropriate laboratory hubs are established and functional to provide the referral laboratory services;
    c. Efficient transportation system for timely delivery of samples from the primary HIV treatment and care sites to the referral laboratory hubs; and
    d. Functional communication system between the laboratory hubs, HIV treatment and care sites; and the individual clients to enable timely transmission of laboratory test results, and necessary adjustment in client management

[4] UNAIDS (2014) Guidance Note: HIV and Social Protection.

5.2.3. Response Coordination And Management

The final element in the NSP strategic model is constituted by five elements that define essential responsibilities in the management and coordination of the national HIV response; which are:

1. ***Financing for the HIV response:*** in line with the costing projections in the NSP, and the programming budget details that will be developed within the multi-year operational plans; and based on a combination of government and other domestic financing mechanisms, and a broad range of international support.
2. ***Coordination and decentralization:*** across the multi-sectoral stakeholders in the HIV response; and along the different levels of government structure and operation as guided by the 2010 decentralization policy. This NSP is the framework and mechanism for bringing together all stakeholders and enabling the necessary linkage in their programming, implementation and reporting at all levels of operation in the national response.
3. ***Monitoring, evaluation and research:*** to provide an evidence base for effective programming and appropriate policy decisions; and as the mechanism for tracking implementation results and utilizing the information to make necessary adjustments.
4. ***Integration and systems strengthening:*** ensuring an integrated approach in programming and service delivery across the NSP pillars of prevention and treatment, and into the health system at national and sub-national levels. It also includes integration and mainstreaming of the HIV response in other sector and institutional systems in government social services (e.g., education, social welfare, youth development, etc.); in the faith/religious sector and civil society; and in industry, business and other private sector operations. The NSP further prioritizes strengthening community systems for livelihood, social support and joint working, as the ultimate framework for mobilizing and empowering all Sierra Leoneans to play their due role in ending AIDS.
5. ***Policy support:*** as may be necessary to ensure a supportive environment for realization of the NSP goals and outcomes. This includes evidence-based policy advocacy to address HIV-related stigma and discrimination; gender-based factors that enhance HIV vulnerability; and access to HIV-related services for most affected populations.

Table 7: Key results and core strategies for HIV response coordination

Results	Key strategies to achieve the results
Outcome 6: People living with, at risk of and affected by HIV and EBV who report no discrimination especially in health, education and workplace settings increased from 2015 level to 90% by 2020	
Output 6.1: PLHIV, EVDS and Key Populations at most risk of HIV that are empowered and participating effectively in advocacy and programme interventions to eliminate stigma and discrimination increased from 2015 level to twice that level by 2020	PLHIV and others affected by HIV, Key populations at most risk of HIV, and EVDS know their rights and are able to access services and challenge violation of human rights
	HIV and EVD related stigma and discrimination eliminated among service providers in health care, workplace and education settings
	Policies and programmes to prevent and address violence against key populations issued and implemented
	Positive Health, Dignity and Prevention (PHDP) interventions promoted for PLHIV, EVDS, and other population groups that face stigma and discrimination based on health status and specific behaviours

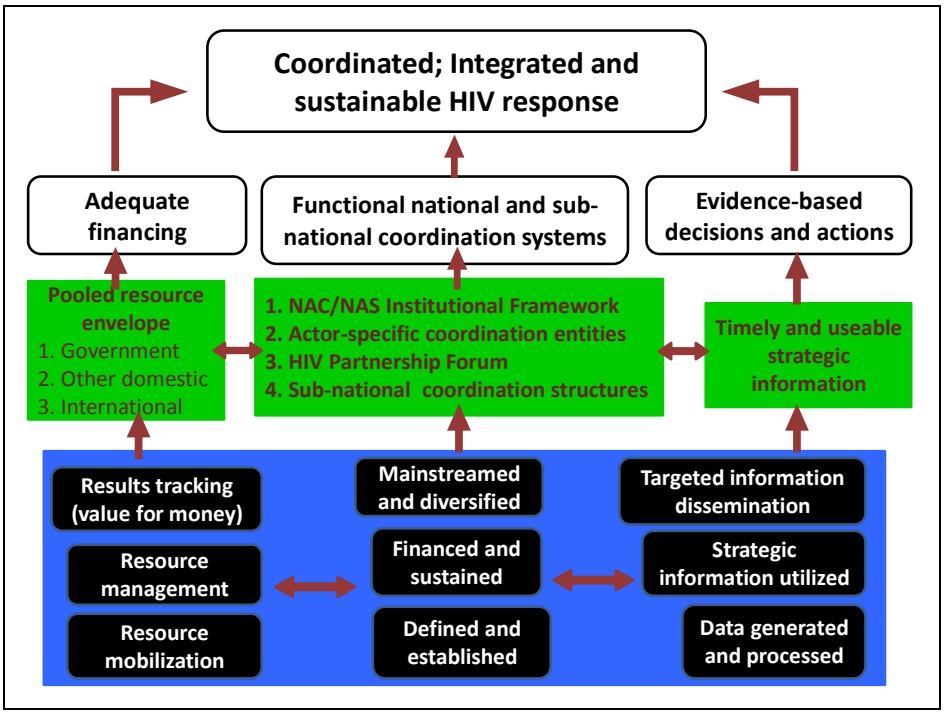
Results	Key strategies to achieve the results
Output 6.2: Community members that are adequately informed about HIV, EVD and TB; and access HCT increased from 2015 level to 60 percent (of the total population) by 2020	Scaling up diverse innovative approaches and epidemiologically targeted community-based HIV testing and EVDS monitoring.
	Advocating and promote political leadership and commitment to support HCT the programme.
	Supporting pilot innovative interventions to scale up HCT (e.g. door-to-door testing, community and institution-based, workplace, etc.) and at all health facility categories; and scaling them up.
	Promoting integrated testing and treatment for sex workers and other KPs; positive attitudes among health care providers towards KPs; and public- private partnerships with appropriate stakeholders working with KPs.
Outcome 7: Women and men who practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to three times that level by 2020	
Output 7.1: Women and men that are empowered to practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to 60% by 2020	Women and girls and men and boys engaged and empowered to prevent gender-based, sexual and intimate partner violence, and promote healthy gender norms and behavior
	Sexual and reproductive health and rights needs fully met to prevent HIV and EVD transmission
	Young women and men in high prevalence settings access economic empowerment initiatives
	Women and men meaningfully engaged in decision-making and implementation of the HIV and EVD responses
Output 7.2: Laws and policies that enable women, girls men and boys to promote gender-based, sexual and intimate partner violence, and protect themselves from HIV and EVD, and access HIV and EVD-related services increased from 2015 level to twice that level by 2020	Women and men meaningfully engaged in legal and policy advocacy to promote gender-based, sexual and intimate partner violence, and protect themselves from HIV and EVD, and access HIV and EVD-related services
	Laws, policies and practices enable women and girls to protect gender-based, sexual and intimate partner violence, and promote themselves from HIV and EVD, and access HIV and EVD-related services
Outcome 8: NAS and its partners including CSO have capacity to effectively and efficiently manage a multi-sectoral response	
Output 8.1: National AIDS response is fully funded and efficiently implemented based on reliable strategic information.	Investment of a minimum of $50 million annually for the national HIV, EVD and TB response
	Effective roll-out of the Domestic Resource Mobilization Strategy; to accelerate mobilization of in-country resources to support at least 12% of annual resource needs for the response
	Financial sustainability transition plans and national HIV budget line, AIDS trust funds implemented

Results	Key strategies to achieve the results
	Use timely, appropriate, reliable, real time strategic information to prioritize resource allocation, monitor and evaluate the response and inform accountability processes
	Allocative and productive efficiency gains fully exploited and commodity costs reduced including overcoming restrictive intellectual property and trade barriers
	Investment and support to civil society, including networks of PLHIV and EVDS, scaled up to enhance their essential role in the response
Output 8.2: HIV, EVD and TB resource mobilization from international sources diversified from 2015 level to 10 sources by 202	Promote integrated resource mobilization for the three related epidemics; within the framework of SDGs and their realization
	Promote donor confidence through efficient use of resources
	Strengthen accountability reporting
	Eliminate HIV, EVD and TB responses fragmentation and building horizontal integrated systems
	Integrate national capacity strengthening for sustainable domestic resource mobilization into international resource mobilization dialogue
	Improve capacity of donor coordination and realignment to the national priorities
Output 8.3: Stakeholders in the national HIV response that make evidence-based strategic and operational decisions increased from 2015 level to 70% by 2020	Strengthen system for real time monitoring of incidence and program impact data with partners
	Support generation of relevant strategic information to support improved programming
	Build capacity to improve evaluation practices and use of data at all levels
	Improving strategic information management at Indicators level; Data Source level; Data Collection Tools level; Data Collection Method level; Data Analysis and Data Use level; Information Products level; and Stakeholders level.
	Harmonizing and enhancing M&E capacity among the multi-sectoral stakeholders in: using data for decision-making; building capacity in people for partnerships and planning; and collecting, verifying, and analyzing data.
	Strengthening coordination, collaboration, joint planning and joint action/learning, and linkages.
	Facilitating alignment of Stakeholder M&E IT/IS to the National HIV M&E Strategy.
	Developing Systems and Data for sharing and integrating information and business processes by use of common standards and work practices for program me.
	Improving the generation, dissemination and use of strategic information for decision making in planning,

Results	Key strategies to achieve the results
	implementation, monitoring and evaluation of comprehensive PMTCT and pediatric care, treatment and support programmes.
Output 8.4: Local Councils (districts/cities) where integrated health and community systems include HIV among the priority health issues of focus in service delivery, staff training and CIS/HMIS reporting increased from 2015 level to 10 by 2020	PLHIV, EVDS and Key Populations at risk of and affected by HIV access integrated services including HIV, TB, EVD, SRH, MNCH, hepatitis, drug dependence, food and nutrition support and NCDs, especially at the community level
	Comprehensive systems for health strengthened through integration of community service delivery with formal health systems
	Human resources for health trained, capacitated and retained to deliver and manage integrated health and HIV services; including critical capacity for integrated health and HIV planning and management at local councils and health facilities
	Stock-outs prevented through strengthened health procurement and supply chain systems
	Strengthening civil society participation in health and HIV services delivery, monitoring and management; including capacity strengthening for CSO networks, and their structured and sustained participation in local councils development and social service planning and management
Output 8.5: Policies, strategies reviewed and implemented regularly to provide an enabling environment for implementation of the multi-sectoral response	Strengthen leadership forums that involve political, religious and traditional leaders to promote effective response
	Mobilize and support media and journalist for meaningful engagement
	Policy review and analysis for improved enabling environment
	Reviewing and strengthening coordination structures at all levels and their roles to effectively respond to the needs of the HIV, EVD and TB response
	Strengthening capacities for enhanced use of resources and HIV, EVD and TB programming at the community level
	Expanded access to integrated, comprehensive quality HIV, EVD and TB services through effective and sustainable public – private partnerships that include increased SMEs involvement.

The first three elements together represent the main result areas for the National HIV and AIDS Commission and its operations as the coordinating mechanism for the national response (details in Figure 9).

Figure 9: Response Coordination – Core Functions



Over the NSP period 2016-2020, the HIV response coordination system will continue to operate at four main points: the NAC/NAS institutional framework; the actor-specific coordinating entities (e.g., for religious organizations, private sector, Key Affected Populations, PLHIV, etc.); the HIV Partnership Forum, and the sub-national coordination structures in line with government decentralization. At each of these points, the required systems and structures will be reviewed and redefined, appropriately established or strengthened, adequately financed to achieve the immediate results; and sustained through integrated financing from government and other sources. The ultimate goal is to have these structures and functions fully mainstreamed into the operations of government at all levels by 2020; and thereby diversified to address other development and social service priorities.

Financing of the response will depend upon a combination of government and other domestic resources; and an expanded pool of international sources. This will be achieved through intensified and targeted resource mobilization; efficient and transparent management of available resources; and tracking the disbursement and utilization of the resources to ensure and demonstrate good value for money. The principle of pooling resources for the combined HIV response as described in this NSP will underpin all budgeting, disbursement and accountability mechanisms for the NSP resources.

Strategic information from monitoring, evaluation and research will be coordinated and managed with focus on three main aspects:

1. Generating and processing data at different levels for use at each level and timely reporting to other levels;

2. Analyzing the data to produce information that is useable in informing immediate decisions and routine management at the point of generation and the respective reporting levels; and
3. Targeted sharing and dissemination of data and information to influence critical decisions and actions that will support and enhance realization of the NSP goals

The key result from the M&E component in the response coordination and management pillar will be timely and useable strategic information, available to all major stakeholders in the response. The NSP prioritizes four main stakeholder levels and categories of focus for strategic information availability and utilization, as presented in Table 8 below.

Table 8: Strategic information availability and utilization - priority levels and stakeholders

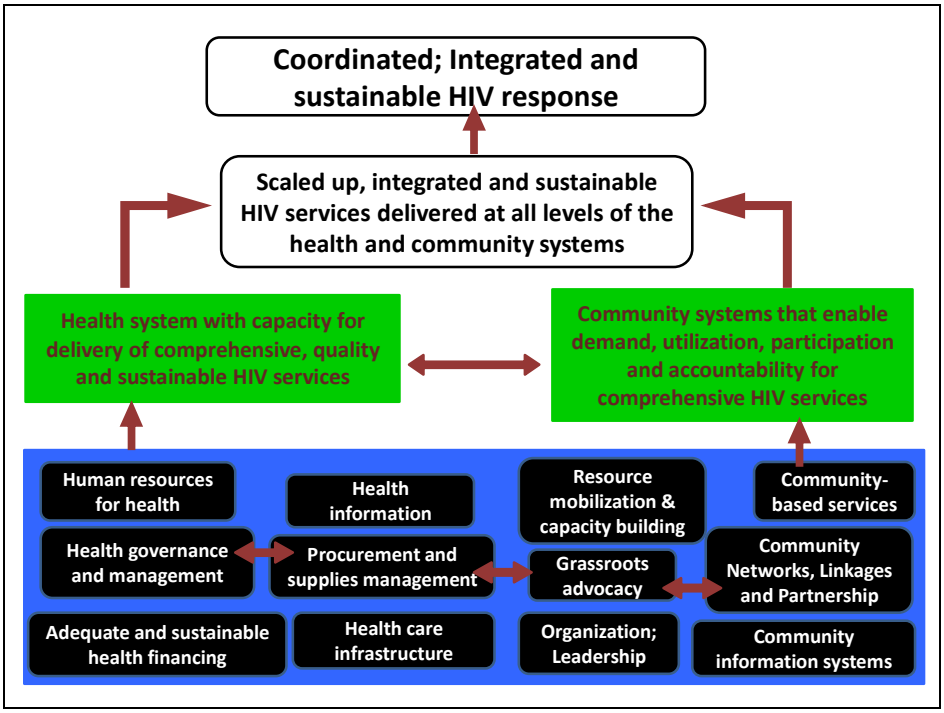
Level	Key stakeholders
Intervention implementation and service delivery	Service providers and other programme staff and volunteers Service users and other associated beneficiaries
Sub-national Programme Management and Local Level Coordination	District and City Authority – technical teams, administration and management staff, and elected leaders Implementing agency managers Regional support and coordination teams
National level	Sector and institutional management and strategic oversight units – MDAs, agency headquarters, etc. National HIV response coordination mechanisms (NAC/NAS, Constituency Coordination entities, etc. Policy makers (e.g., Parliament) policy advocacy networks , media Multi-lateral and Bilateral development partners; international support agencies
International/Global level	International support centres – governments, foundations, etc. International advocacy and accountability mechanisms

Systems strengthening for service delivery: realization of the NSP goals is entirely dependent on the systems that will be used to deliver the critical HIV services; and how effectively they are mobilized and coordinated to participate in the multi-sectoral response. The bulk of HIV services will be delivered through the different levels of the national health system. Other systems critical for the HIV response include: the education sector; social welfare, gender and children sector; youth development; and local government systems. The NSP provides for necessary strengthening of these systems; to effectively absorb the scaled up service delivery and management as required.

Implementation of the NSP will include sustained support and strengthening of Civil Society Organizations (CSO) as HIV response implementers; including: a) strengthening the organizational and institutional capacity of Associations of Key Affected Populations and CBOs; and b) enhancing the role of CSOs in rights advocacy and stigma reduction. It will also build on community systems such as the chiefdom leadership structures, Village Development Committees that lead the government-supported initiatives for community-driven development; community-based organizations, and community groups.

The NSP results for system strengthening are illustrated in Figure 10 below.

Figure 10: Strengthening service delivery systems – Logic model



Policy advocacy: The NSP supports appropriate policy development and implementation partnerships in place to address these HIV-related issues; and necessary change in existing laws and policies for HIV response coordination, and for social protection of PLHIV and other vulnerable groups. It further promotes policy and social research and its utilization to inform policy decisions; and regular interaction between researchers, policy-makers and the leaders of public health programmes to ensure that policies and other elements in the HIV and TB responses take account of up to date evidence.

The NSP is cognizant of the fact that public interest is best served when the rights of those living with HIV or are at risk of infection are respected, protected and promoted. It therefore puts premium on the right to know enough about HIV and to know ones HIV status; closely linked to the responsibility to act – protecting oneself and others; and seeking and staying in HIV care and treatment in line with ones known HIV status. The NSP further emphasizes the right of access to:

- Adequate, consistent and up to date information on HIV
- Timely and confidential HCT services – whenever and wherever needed
- Timely, comprehensive and integrated HIV treatment, care and support
- Protection and restitution with respect to stigma and discrimination

The rights and responsibilities related to the sexual and reproductive transition of adolescents are another area of priority for this NSP. These include the right to access information and services; and the right to protection, guidance and social support to enable effective transition to safe, wholesome and productive adulthood.

Participation; ownership and accountability: is promoted in and by this NSP at all levels; through empowerment, communication and coordination. At the community level, beneficiaries and service providers will work together in a broad partnership for ending AIDS, health transformation and general socio-economic development. Health management and governance systems at health facilities and district level will be the main mechanism for mobilizing and coordination of the participation and partnership processes. The district and chiefdom structures for coordination of the HIV response will be the main mechanism for linking the health sector response with other key sectors in mainstreaming HIV as a development and human rights concern.

The NSP promotes accountability and responsibility for HIV program plans; response implementation and co-ordination at all levels; and in program results monitoring, reporting and utilization in decision making. Mechanisms for public participation in accountability dialogue, and for provision and dissemination of accountability information as a public good will be strengthened at all levels. This will enhance appropriate ownership for reporting and implementation outcomes. The entire NSP implementation and co-ordination process will have clear and open communication, to enable a common understanding of the relevant facts, expectations and requirements for evidence-based decision making.

6. IMPLEMENTATION ARRANGEMENTS

The strategy will be implemented as a multisectoral response. The implementation of services would be designed in integrated manner. It will be an accelerated implementation more than ever taking into broader cross-sectoral partners, decentralized taking into consideration promotion of domestic resources and efficiency gains, clear sectoral and partner roles and responsibility and sustainability.

7. MONITORING AND EVALUATION FRAMEWORK

This section of the NSP presents highlights on the comprehensive monitoring and evaluation (M&E) system for the NSP. The system will be based on existing monitoring and evaluation systems being implemented by different stakeholders in implementation and management of the national HIV response; and aligned to government planning and monitoring frameworks and policies at different levels. Where necessary, the NSP M&E framework will propose and enable adjustments in current M&E and planning mechanisms; to enable timely and accurate generation and utilization of key strategic information in the HIV response across its entirety.

The NSP monitoring and evaluation framework is the main basis for monitoring the transitions in the HIV epidemic and its determinants; and for monitoring and periodic reporting on implementation of the NSP. It is also the basis for development and implementation of an HIV evaluation and research agenda for Sierra Leone; to be addressed over the NSP implementation period. The impact and outcome indicators for the NSP are presented in Table 9 below.

Table 9: NSP Monitoring and Evaluation Indicators

Results	Indicator
PREVENTION	
Outcome 1: Young people, especially young women and adolescent girls, who access combination prevention services and are empowered to protect themselves from HIV increased from 2015 level to 90% by 2020	**Percentage of young people, (disaggregated by age-group and sex) who access combination prevention services and are empowered to protect themselves from HIV**
Output 1.1: Young people (10-24 years) reached with comprehensive life skills, Sexuality, HIV and AIDS education increased from 2015 level to 80% by 2020	Percentage of young people (disaggregated by age-group, sex and district) reached with comprehensive life skills, Sexuality, HIV and AIDS education
Output 1.2: Chiefdoms that are reached with consistent demand generation interventions for SRHR (incl. HIV, EBV, STI) services increased from 2015 level to 95% by 2020	Percentage of chiefdoms (disaggregated by district) that are reached with consistent demand generation interventions for SRHR (incl. HIV, EBV, STI) services
Output 1.3: Young people and their sexual partners who access youth-friendly HIV, SRH, EVD and harm reduction information and services increased from 2015 level to 90% by 2020	Percentage of young people and their sexual partners (disaggregated by age-group, sex and district) who access youth-friendly HIV, SRH, EVD and harm reduction information and services

Results	Indicator
Output 1.4: Adolescents and young people who make and accomplish appropriate personal SRH commitments (e.g., sexual abstinence, FP use, etc.) increased from 2015 level to twice that level by 2020	Percentage of adolescents and young people (disaggregated by age-group, sex and district) who make and accomplish appropriate personal SRH commitments (e.g., sexual abstinence, FP use, etc.)
Outcome 2: Key populations, including sex workers, men who have sex with men, transgender, PWID, EVDS, prisoners , TB patients, migrant workers (fisher-folk, miners, transporters) and traders , and uniformed personnel that access tailored HIV combination prevention services and are empowered to protect themselves from HIV, EVD and TB increased from 2015 level to 90% by 2020	**Percentage of targeted Key populations (disaggregated by category, age-group, sex, district) that access tailored HIV combination prevention services and are empowered to protect themselves from HIV, EVD and TB**
Output 2.1: Health facilities that provide combination prevention services tailored to targeted Key Populations increased from 2015 level to 80% by 2020	Percentage of Health facilities (disaggregated by facility level, ownership, district) that provide combination prevention services tailored to targeted Key Populations
Output 2.2: Targeted Key Populations that access relevant combination prevention services increased from 2015 level to 90% by 2020	Percentage of targeted Key Populations (disaggregated by category, age-group, sex, district) that access relevant combination prevention services
Output 2.3: Targeted Key Populations that have un-interrupted access and consistent and correct utilization of male and female condoms for dual benefit (contraception and disease prevention) increased from 2015 level to 90% by 2020	Percentage of targeted Key Populations (disaggregated by category, age-group, sex, district) that have un-interrupted access and consistent and correct utilization of male and female condoms for dual benefit (contraception and disease prevention)
Outcome 3: New HIV infections among children eliminated and their mothers health and well-being is sustained	**Percentage of HIV-exposed infants (disaggregated by sex and district) that are infected with HIV**
Output 3.1: HIV positive mothers that attain viral load suppression during pregnancy, labour and over the entire period of breastfeeding increased from the 2015 level to 95% by 2020	Percentage of HIV positive mothers (disaggregated by age group and district) that attain viral load suppression during pregnancy, labour and over the entire period of breastfeeding
Output 3.2: HIV-exposed infants (born to HIV positive mothers) that receive the full dose of prophylactic ARVs increased from 29% in 2014 to 95% by 2020	Percentage of HIV-exposed infants (disaggregated by sex and district) that receive the full dose of prophylactic ARVs
Output 3.3: HIV positive mothers that get unplanned pregnancies reduced by 67% between 2015 and 2020	Percentage of HIV positive mothers (disaggregated by age-group and district) that get unplanned pregnancies
TREATMENT CARE AND SUPPORT	
Outcome 4: 90% of all adults and adolescents who know their positive HIV status receive comprehensive treatment, care and support, including sustained antiretroviral therapy; and have durable viral load suppression	**Percentage of all adults and adolescents (disaggregated by age-group, sex and district) who know their positive HIV status receive comprehensive treatment, care and support, including sustained antiretroviral therapy; and have durable viral load suppression**
Output 4.1: Adults, adolescents and child PLHIV who receive complete clinical, psychosocial and socio-economic assessment (annually) and are placed on the appropriate care and support package increased from 2015 level to 95% by 2020	Percentage of Adults, adolescents and child PLHIV (disaggregated by age-group, sex and district) who receive complete clinical, psychosocial and socio-economic assessment (annually) and are placed on the appropriate care and support package

Results	Indicator
Output 4.2: PLHIV who access ART and complementary care and support services increased from 2015 level to 90% by 2020	Percentage of PLHIV (disaggregated by age-group, sex and district) who access ART and complementary care and support services
Output 4.3: PLHIV on ART who attain sustained viral suppression increased from 2015 level to 90% by 2020	Percentage of PLHIV on ART (disaggregated by age-group, sex and district) who attain sustained viral suppression
Output 4.4: PLHIV under care and are co-infected with TB who attain TB cure increased from 2015 level to 90% by 2020	Percentage of PLHIV under care and are co-infected with TB (disaggregated by age-group, sex and district) who attain TB cure
Output 4.5: PLHIV who need social protection to overcome specific vulnerability and do receive such protection increased from the 2015 level to 90% by 2020	Percentage of PLHIV who need social protection to overcome specific vulnerability and do receive such protection (disaggregated by age-group, sex and district)
ENABLING ENVIRONMENT	
Outcome 5: People living with, at risk of and affected by HIV and EBV who report no discrimination especially in health, education and workplace settings increased from 2015 level to 90% by 2020	**Percentage of People living with, at risk of and affected by HIV and EBV (disaggregated by sex, age-group, district) who report no discrimination especially in health, education and workplace settings**
Output 5.1: PLHIV, EVDS and Key Populations at most risk of HIV that are empowered and participating effectively in advocacy and programme interventions to eliminate stigma and discrimination increased from 2015 level to twice that level by 2020	Percentage of PLHIV, EVDS and Key Populations at most risk of HIV (disaggregated by sex, age-group and district) that are empowered and participating effectively in advocacy and programme interventions to eliminate stigma and discrimination
Output 5.2: Community members that are adequately informed about HIV, EVD and TB; and access HCT increased from 2015 level to 60 percent (of the total population) by 2020	Percent of community members (disaggregated by sex, age-group and district) that are adequately informed about HIV, EVD and TB; and access HCT
Outcome 6: Women and men who practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to three times that level by 2020	**Percentage of women and men (disaggregated by sex, age-group, district) who practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD**
Output 6.1: Women and men that are empowered to practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD increased from 2015 level to 60% by 2020	Percentage of women and men (disaggregated by sex, age-group and district) that are empowered to practice and promote healthy gender norms and work together to end gender-based, sexual and intimate partner violence to mitigate risk and impact of HIV and EVD
Output 6.2: Laws and policies that enable women, girls men and boys to promote gender-based, sexual and intimate partner violence, and protect themselves from HIV and EVD, and access HIV and EVD-related services increased from 2015 level to twice that level by 2020	Number of Laws and policies that enable women, girls men and boys to promote gender-based, sexual and intimate partner violence, and protect themselves from HIV and EVD, and access HIV and EVD-related services
Outcome 7: Departments, Agencies and Institutions (including CSOs) participating in the national response with adequate capacity to effectively and efficiently manage a multi-sectoral response increased from 2015 level to twice that level by 2020	**Percentage of Departments, Agencies and Institutions (including CSOs) participating in the national response with adequate capacity to effectively and efficiently manage a multi-sectoral response (dis-aggregated by category and level of operation (specific districts,**

Results	Indicator
	national level, etc.)
Output 7.1: Investment of a minimum of $50 million annually for the national HIV, EVD and TB response	Total amount invested in the national HIV response in the year of measurement (disaggregated by source, amount, thematic and geographical focus of investment)
Output 7.2: HIV, EVD and TB resource mobilization from international sources diversified from 2015 level to 10 sources by 2020	Number of international sources for HIV, EVD and TB financing (disaggregated by amount and thematic, geographical focus of the investment)
Output 7.3: Stakeholders in the national HIV response that make evidence-based strategic and operational decisions increased from 2015 level to 70% by 2020	Percentage of stakeholders in the national HIV response that make evidence-based strategic and operational decisions (disaggregated by category and level of operation)
Output 7.4: Local Councils (districts/cities) where integrated health and community systems include HIV among the priority health issues of focus in service delivery, staff training and CIS/HMIS reporting increased from 2015 level to 10 by 2020	Number of Local Councils (districts/cities) where integrated health and community systems include HIV among the priority health issues of focus in service delivery, staff training and CIS/HMIS reporting
Output 7.5: Policies, strategies reviewed and implemented regularly to provide an enabling environment for implementation of the multi-sectoral response	Number of policies, strategies reviewed and implemented regularly to provide an enabling environment for implementation of the multi-sectoral response

A decentralized, district-based approach: in view of the granular nature of the HIV epidemic, and the adopted district-based approach in HIV response programming and service delivery; the HIV response M&E framework will also adopt a district-based format and utilization approach.

Periodic NSP implementation reviews: to enhance timely processing and utilization of data in HIV response management, annual joint program reviews will be conducted at district and national levels. A mid-term review of the NSP will be conducted in 2018; with focus on achievements, challenges, emerging issues and recommendations for the remaining NSP period. An end-of term evaluation will be conducted in the final year of the NSP.

An HIV research agenda: to enhance relevant and targeted HIV research, a comprehensive HIV research agenda will be developed through a consultative and participatory process; and will be extensively disseminated and used as a reference framework for research prioritization and resource allocation.

8. COSTING AND FINANCING THE NSP 2016-2020

Costing of this NSP is based on the projected volume of work needed to achieve the NSP goals; articulated as service delivery targets. The unit costs used to compute the total cost projections for each service area were derived from past implementations experiences in the country, and on experiences in other countries as consolidated in the Avenir Health Unit Cost Repository <avenirhealth.org>. Costing clusters adopted below are based on the UNAIDS 2014 modelling of needed HIV response investments. The projected cost summary for the 5 years of the NSP is presented in Table 10 below.

Table 10: Five-year NSP Cost Projection – by Investment Categories

Indicative cost areas	Cost (US $)	Percent
Targeted Prevention	**90,976,932**	**25.46**
PMTCT (all four prongs)	33,817,267	9.46
MSM	2,374,500	0.66
FSW	14,004,000	3.92
PWID	217,350	0.06
Prisoners	813,263	0.23
PHDP (bundled services and social support; discordant couples)	7,037,552	1.97
Workplace (migrant work, uniformed personnel, etc.)	11,904,000	3.33
Condom promotion and provision	6,480,000	1.81
Adolescents and young people (community-located)	14,329,000	4.01
Treatment, care and support	**133,456,956**	**37.35**
Treatment (including ART, TB-HIV, Laboratory support, NCD monitoring)	89,610,000	25.08
Psycho-social support (facility, peer and tracer-based)	9,891,900	2.77
Nutritional support	5,428,800	1.52
Social protection	28,526,256	7.98
Development synergies	**35,115,463**	**9.83**
School-based programmes (Primary level)	7,981,440	2.23
School-based programmes (Secondary and tertiary level)	3,904,512	1.09
STI management	7,490,700	2.10
Blood safety	5,900,000	1.65
PEP	2,450,000	0.69
Safe injection	50,000	0.01
Universal precaution	900,000	0.25
Policy advocacy	6,438,811	1.80
Critical Enablers	**97,804,649**	**27.37**
HCT	34,000,000	9.51
Mass media and phone-based education, advocacy and social mobilization	24,000,000	6.72
Community mobilization and systems support	10,830,000	3.03
Program coordination and management (including M&E)	28,974,649	8.11
	357,353,999	**100.00**

The annual cost summary across the four investment areas is presented in Table 11 below.

Table 11: Annual NSP cost distribution summary – 2016 to 2020

Indicative cost areas	2016	2017	2018	2019	2020	TOTAL
Targeted Prevention	12,193,113	14,922,047	18,029,258	21,599,818	24,232,695	90,976,932
Treatment, care and support	14,572,886	19,941,844	26,077,796	32,980,742	39,883,688	133,456,956
Development synergies	4,392,600	5,566,580	7,480,891	8,346,479	9,328,913	35,115,463
Critical Enablers:	16,450,171	17,660,042	19,330,113	21,016,209	23,348,114	97,804,649
	47,608,769	**58,090,513**	**70,918,057**	**83,943,248**	**96,793,411**	**357,353,999**