Sierra Leone: Country Updates

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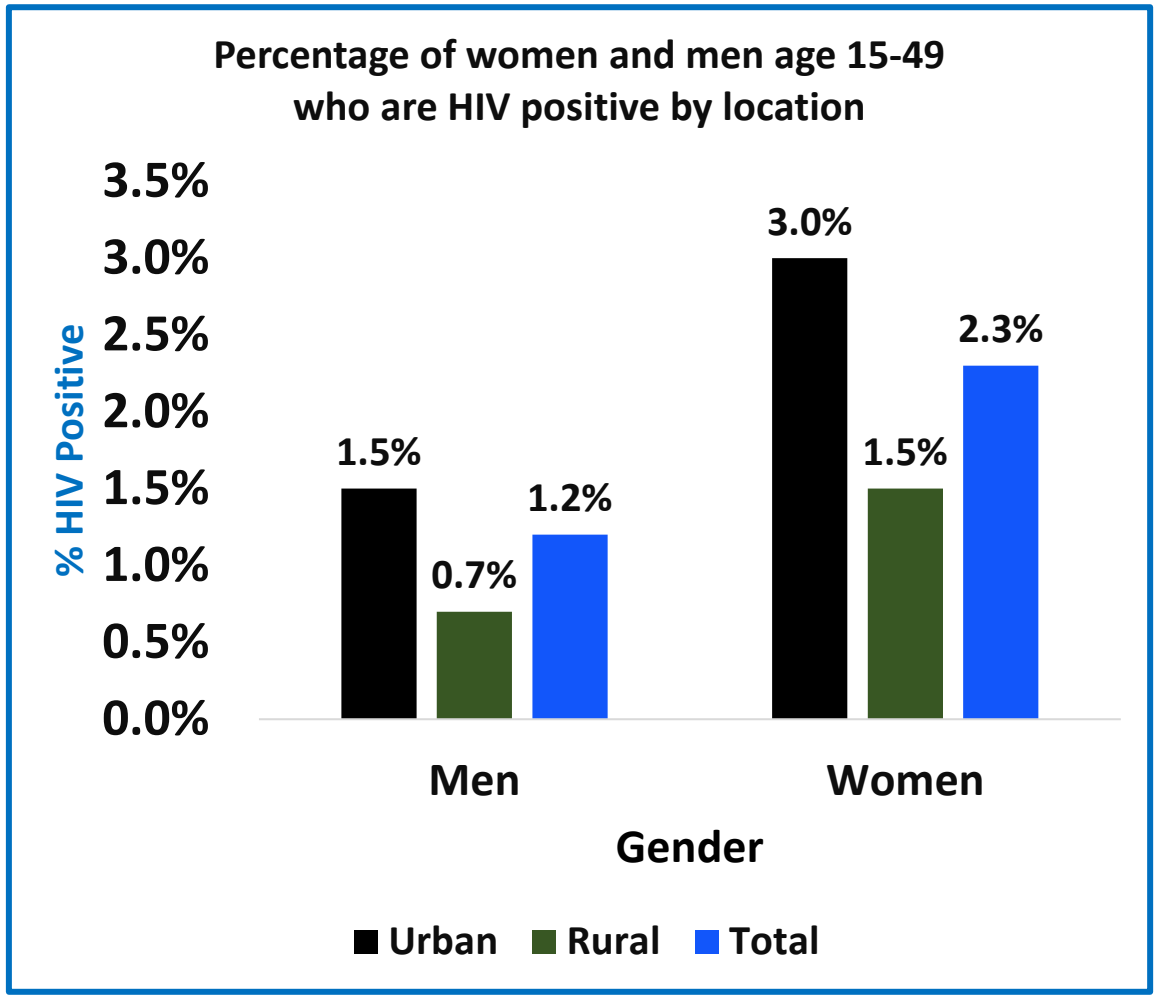
Presentation Outline

- Country Epidemic Overview
- Funding Shifts and Programmatic Realignment
- Summary of Prioritized HIV Services and System Adaptations
- M&E System Adaptations, Key Indicator Trends and Implications
- Community Engagement
- Lessons Learnt
- Next Steps

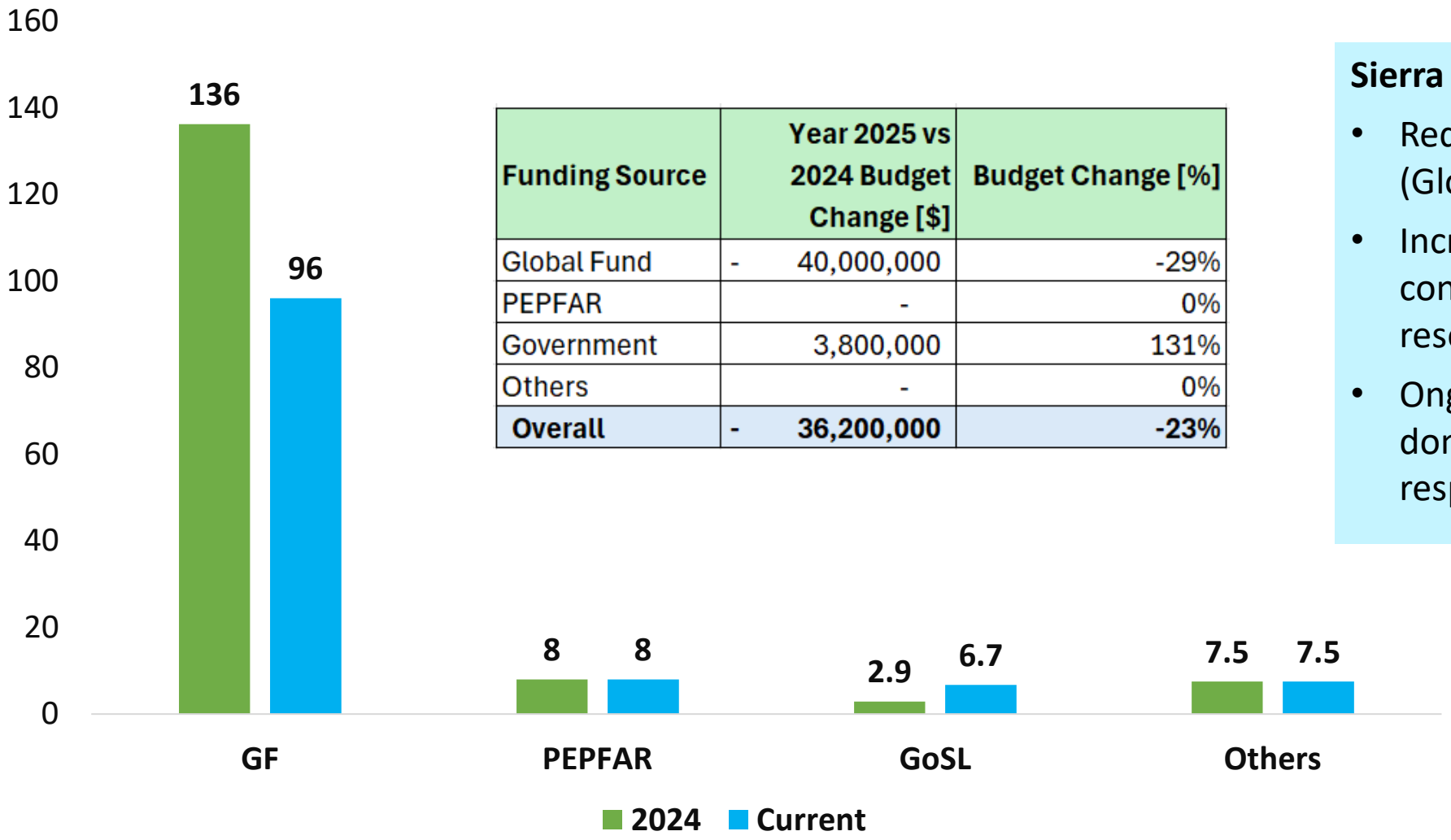
Country's Epidemic Overview

- Generalized Epidemic with **~81,000** PLHIV
  - Adult Cascade: **87:86:63**
  - Peadiatric Cascade: **39:35:23**
- National HIV prevalence is **1.7% [1.4, 2.0]**
- Geographic location
  - Urban is over two times higher than rural (***2.3% urban versus 1.2% rural***)
- Young People
  - AGYW (15-24) are three times infected than their male counterparts (***1.5% AGYW versus 0.5% AGYM***)

Spectrum, 2024



Funding Shifts



Funding Source	Year 2025 vs 2024 Budget Change [$]	Budget Change [%]
Global Fund	- 40,000,000	-29%
PEPFAR	-	0%
Government	3,800,000	131%
Others	-	0%
Overall	**- 36,200,000**	**-23%**

Sierra Leone HIV Funding Landscape

- Reduction in major external funding (Global Fund)
- Increase in domestic resource contributions, including human resources
- Ongoing efforts to further strengthen domestic funding to sustain the HIV response

Programmatic Realignment

- Strategic program alignment through resource allocation for prioritized interventions
- Integration of services by streamlining and reducing duplication of services
- Data-driven decision making through use of data to identify cost effectiveness, and the use of a dashboard to track progress
- Stakeholder engagement through the involvement of Civil Society Organizations and communities
- Strengthened partnership with international partners and the private sector
- Strengthened resource mobilization

National Prioritized HIV Services

- Scale up HIV combination prevention targeting high-risk, key affected, and vulnerable populations
- Expand community and facility differentiated testing services, especially in underserved communities:
  - HIV self-testing (HIVST) and community-led HIV testing () models
  - Index testing
  - Social network testing
- Elimination of Mother-to-Child Transmission (eMTCT)
  - Strengthen integration of eMTCT into all maternal and child health platforms in existing eMTCT sites, with the establishment of mother-baby care and treatment services
- Strategic Information through digitalization
  - Scale up EMR and EMIS or HIV Case-Based Surveillance platforms to all ART-providing facilities

National Prioritized Prevention Services

HIV PREVENTION SERVICES		SL
Component	**Intervention**	
Infant prophylaxis	Infant prophylaxis (AZT and NVP); High risk first 6 weeks	
	Infant prophylaxis (AZT or NVP); High risk weeks 6-12	
	Infant prophylaxis (AZT or NVP); Low risk	
PEP	Facility-based post exposure prophylaxis (PEP) as per national guidance	
	Community-based PEP availability - GBV services, maintained community-based KP services	
Condoms	Facility-based condom (and lubricant) availability	
	Community collection points for condom (and lubricant) for key populations	
	Community collection points for condom (and lubricant) for all populations	
DSD	Facility based oral PrEP maintenance for key populations, known sero discordant where VL of partner with regular use - minimum 3MMD with testing every 6 months (including with HIVTST)	
	Facility based oral PrEP maintenance for pregnant and breastfeeding women- minimum 3MMD with testing every 6 months (including with HIVTST)	
	Facility based oral PrEP maintenance for other populations with regular use - minimum 3MMD with testing every 6 months (including with HIVTST)	
	Annual clinical PrEP review for PrEP maintenance for those with regular use, including STI screening and treatment and HIV test	

DSD	6-monthly clinical PrEP review for PrEP maintenance for those with regular use	
	Individual DSD models based at facilities for PrEP maintenance	
	Individual out-of-facility PrEP maintenance (through existing and maintained out-of-facility DSD treatment locations), including refill collection and HIVST	
PrEP continuation	Provide PrEP refills throught virtual delivery models	
	Adherence and behaviour risk reduction counselling at every clinical visit	
	Provide continuation of dapivirine vaginal ring for PrEP	
	Provide continuation of long-acting injectable HIV prevention modalities	
PrEP initiation (& re-initiation)	Oral PrEP initiation for pregnant and breastfeeding women self-identifying vulnerability (no risk assessments)	
	Oral PrEP initiation for all at risk pregnant and breastfeeding women	
	Oral PrEP initiation for key populations	
	Oral PrEP initiation for AGYW self-identifying vulnerability (no risk assessments)	
	Oral PrEP initiation for other populations self-identifying vulnerability (no risk assessments)	
	HIV testing (rapid or HIVST) 1-3 months after initiation for missed acute infection	
	PrEP demand creation for those who are eligible	
	Provide continuation of dapivirine vaginal ring for PrEP	
	Provide continuation of long-acting injectable HIV prevention modalities	
	PrEP education and risk reduction counselling at PrEP initiation	
Harm reduction for people who inject drugs	Sterile needles, syringes and naloxone for collection in the following order: facility-based services, existing maintained out-of-facility DSD collection points or KP services	
	Sterile needles and syringes and naloxone in the following order: Community locations where community members can collect and distribute, community outreach locations	
	Continuation of OAMT refills to people who inject drugs already initiated on ART	
	Initiation and continuation of OAMT refills to people who inject drugs	
VMMC	Integrated VMMC services in settings/districts with high HIV prevlance and low circumcision prevalence	

The selected prevention services are tailored towards cost-effective, life-saving, and high-impact services focusing on high-burden districts targeting high-risk populations.

Critical focus will be on infant prophylaxis, PEP, DSD, condom distribution, PrEP, and harm reduction.

	Keep (No Change)
	Keep (Modify)
	Drop
	Not applicable
	Missing Data

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National Prioritized Testing Services

HIV TESTING SERVICES		SL
Component	**Interventions**	
Blood products	Mandatory screening all blood products	
Facility-based	All people with signs/symptoms of HIV at all facility entry points	
	Ante-natal first visit/ first test	
	Ante-natal additional test in third trimester/delivery	
	Post-natal testing for HIV negative breastfeeding women all: 6-monthly until 6-weeks post cessation	
	HIV exposed infants at 6 weeks and, if breastfeeding, at 6/9- & 18-month EPI visit	
	HIV exposed infants additional birth testing	
	TB clients (newly diagnosed)	
	TB clients (presumptive TB)	
	STI clients (new STI)	
	Hepatitis B or C (newly diagnosed)	
	Inpatient (new admission)	
	Children in malnutrition clinics	
	Children in immunization services after positive screening for possible exposure + missed 18 month testing	
	All family planning clients at FP initiation	
	All family planning clients under 25 years at initiation and annually thereafter	
	All family planning clients at initiation + every second year + self-reported change in partnership	
	All family planning clients at FP initiation and annually thereafter	
	Self-initiated VCT/HIVST collection available (limit to annual/specific risk exposure)	
	VCT/HIVST collection available (any frequency)	
	PrEP users: 1 month after oral PrEP (re)initiation, then 6-monthly	
	PrEP users: 1 month after oral PrEP (re)initiation, then 3-monthly	
	VMMC clients	
Network-based (including facility/virtual and community-based)	Newly diagnosed client: Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision and available facility-based testing	
	Newly diagnosed client: Sexual partner testing utilizing provider-assisted notification for facility based testing (consider centralized/virtual notification and HIVST collection at ART DSD points)	
	Newly diagnosed client: Sexual partner testing utilizing provider-assisted notification with provision of testing in community	
	Newly diagnosed female client: Biological children facility-based testing or HIVST by caregiver	
	Newly diagnosed female client: Biological children in community	
	ART client with VL>1000 or re-engaging after 3 months+ interruption: Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision	
	New family planning/ANC client <25 years: Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision	
	New family planning/ANC client all: Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision	
	Newly diagnosed/on ART key population individuals: Streamlined social network testing with HIVST kits for distribution	
	Newly diagnosed/on ART AGYW: Streamlined social network testing with HIVST kits for distribution	
	STI clients from 95s gap populations with HIV negative result: Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision	
	STI clients with HIV negative result: Sexual partner testing utilizing enhanced passive notification with HIVST kit/s provision	
	STI clients with HIV negative result: Sexual partner testing utilizing provider-assisted notification for facility-based testing (consider centralized/virtual)	
Community-based (virtual and in-person)	All populations >15 years: Community-based HIVST collection points after self-managed virtual registration (limited to annual)	
	All 95 gap populations: Community-based HIVST collection points after self-managed virtual registration (limited to annual)	
	Key populations: Community-based HIVST collection points after self-managed virtual registration (limited to annual)	
	Aligned targeting/segmentation social media + previous outreach sites advertising of the virtual HIVST access platform	
	Key populations: High volume outreach points and drop in centres run by community-based organizations	
	Key populations: All previous outreach points and drop in centres run by community-based organizations	
	AGYW: Targeted outreach (educational facilities, youth centres)	
	Men: Targeted outreach (congregant settings - transport hubs, bars)	
	Men: Workplace testing funded and provided by workplaces	
	Children: Targeted outreach (e.g. orphanages/places of safety)	
	Prisoners: On entry/discharge	
	Prisoners: On entry/discharge and annually	
	ABYM: Targeted outreach (educational facilities, youth centres)	
Recency testing	Recency testing	

The focus of testing will be shifted to high-risk populations.

Risk stratification using a special tool will be conducted to assertain risk before testing.

Community testing will be optimized with special focus on index and self testing.

Network testing will also be optimized.

	Keep (No Change)
	Keep (Modify)
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	Not applicable
	Missing Data

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National Prioritized Treatment Services

Component	Intervention
ART continuity	Provide uninterrupted ART treatment to ALL people who are already on ART, all populations and all regimens
	Provide a minimum of 3MMD for all, unless clinically unwell (including re-engaging clients) with 6MMD preferred for those established on ART (for all over 5-years of age)
	Conduct an annual quality clinical review if established on ART and virally suppressed with longest scripting period allowed 6-12 months
	Enroll eligible clients in less-intensive DSD models
	Sustain individual DSD models based at facilities
	Sustain individual DSD models for key populations not based at facilities
	Sustain group DSD models managed by clients
	Sustain group DSD models for adolescents managed by healthcare workers
	Susatin individual DSD models not based at facilities
	Sustain group DSD models managed by healthcare workers
	Actively support transfer all clients from facilities that are closing to preferred public sector facility with same day continuation of ART, minimum 3MMD, offer less-intensive DSD model without required transfer documentation
Continuity OI prophylaxis	Provide cotrimoxazole prophylaxis to adults Stage 3 and 4 or CD4 <350. Note recommendation when to stop
	Provide cotrimoxazole to adults in settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or WHO stage; Note recommendation when to stop
	Provide cotrimoxazole to patients living with HIV and TB
	Provide cotrimoxazole to children living with HIV; Note recommendation on when to stop
	Provide cotrimoxazole to HIV exposed infants; Note recommendation when to stop
	Provide secondary fluconazole prophylaxis (maintenance); Note recommendation on when to stop
ART initiation (and re-initiation)	Initiate children under 5 years
	Initiate pregnant and breastfeeding women
	Initiate those with clinical signs and symptoms of HIV/AIDS or CD4<200 if known (AHD)
	Initiate all people testing positive for HIV (new and re-engaging) and transferring
	Initiate all people testing positive for HIV - stage 3 or 4 or if CD4 known or baseline CD4 (CD4 nadir) below 200/350/500
	Initiate all people testing positive for HIV - stage 1 or 2 or if CD4 known or baseline CD4 (CD4 nadir) above 200/350/500
Viral load monitoring	Provide VL testing for those presenting with signs and symptoms of treatment failure
	Provide VL testing clients with a previously elevated viral load (VL>1000 copies/ml), perform viral load after 3 months
	Provide first viral load to ensure result is available by 6 months on ART enabling earlier DSD enrolment (consider at 3 months post initiation)
	Provide first viral load for anyone with no previous VL
	For all pregnant women: If already on ART, provide VL testing at first ANC (if no suppressed VL in the last 3 months) or after 3 months on ART
	For all pregnant women: Provide VL testing at 34-36 weeks of pregnancy (or latest delivery)
	For all breastfeeding women, provide viral load testing 3 months after delivery and every 6 months thereafter
	For clients with low level viraemia (VL<1000 copies/ml), perform repeat VL after 3 months
	Provide VL annually for those with previous suppressed viral load
	VL monitoring every 2-3 years once a person has two consecutive suppressed viral loads (when further rationing is required)
	Provide resistance testing according to national guidelines for regimen change
OI management	Provide TB testing with Xpert MTB/Rif all symptomatic
	Provide TB testing with WHO approved rapid diagnostics test eg: Truenat
	Provide TB treatment
	Provide TPT (consider TPT regimen of choice)
	Conduct CRAG testing for symptomatic
	Provide cryptococcal treatment (consider treatment protocol of choice)
AHD package	Provide LAM for those with Stage 3,4, seriously unwell IPD
	Provide CRAG for those with Stage 3, 4, IPD
	Conduct CD4 testing for those with Stage 3 and 4 (newly diagnosed and more than 90 days late)
	Conduct CD4 testing for those with Stage 1 and 2 (newly diagnosed and more than 90 days late)
	Conduct LAM for those with Stage 1 and 2 CD4 <200
	Conduct CRAG for those with Stage 1 and 2 CD4 <200
	Provide fluconazole for pre-emptive treatment
Integration	Conduct PAP smear for those who have never been screened
	Provide HPV screening for those who have never been screened
	Integrate hypertension management (as per national guidelines)
	Integrate diabetes management (as per national guidelines)
	Integrate family planning services (as per national guidelines)
	Provide cervical cancer screening (VIAC) for women living with HIV annually
Tracking and tracing	Confirm contact details at every clinical visit or ART refill collection
	Conduct phone tracing for clients with abnormal lab results
	Conduct phone tracing for the following groups who have missed their scheduled appointment by more than 7/14/28 days: those with active OIs, (re)started ART stage 4, CD4 <200, children and adolescents, pregnant and breastfeeding women
	Conduct phone tracing for all who have missed their scheduled appointment by more than 28 days
	Condcut home tracing if no response to calls for clients with abnormal lab results
	Conduct home tracing if not response to phone calls: those with active OIs, (re)started ART stage 4, CD4 <200, children and adolescents, pregnant and breastfeeding women
	Conduct home tracing if no response to phone calls for all who have missed their scheduled appointment by more than 28 days
Psychosocial support/ Counselling	Provide ART treatment literacy at ART start (including VL education)
	Conduct an adherence assessment at clinical review visits
	Provide viral load education & preparation for DSD model choice by clinician at visit before VL taken
	Provide enhanced adherence counselling for people with a high VL
	Support child disclosure counselling processes
	Conduct mental health screening at ART initiation (if services available)
	Conduct mental health screening for those with high VL (if services available)
	Mental health screening for all at clinical visits

The shift will focus on:

- Optimizing linkage to care and treatment and retention, service integration, and task sharing.
- Optimization of DSD and multi-month dispensing.
- Adherence counselling, viral load testing, and management of co-morbidities and AHD.

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	Keep (Modify)
	Drop
	Not applicable
	Missing Data

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National Prioritized HIV Services

Supply Chain Management

- Strengthen health product management: forecasting, quantification, procurement, distribution
- Quarterly HIV commodity forecasting using updated consumption & morbidity data

Community Systems Strengthening

- Enhance community service delivery and engagement
- National community systems strategy aligned with the Person-Centered Life Stages Approach

Laboratory Services & Diagnostics for HIV

- Improve lab supplies management; national lab plan with targets for HIV diagnostics & External Quality Assessment (EQA)
- Integrated sample referral system for TB, HIV, and surge samples

Leadership, Governance, & Program Management

- Integrated leadership development for HIV coordinators; boost local ownership & district engagement
- Governance dashboard: track performance, equity, and accountability indicators

From Planning to Practice

- Conducted an end-of-term review of the National Strategic Plan ending in December 2025 to identify gaps
- Reviewed program data and conduct cascade analysis to identify high-risk populations and geographical locations highly affected
- Defined a minimum package of service that will provide high efficiency and impact
- Mapped existing funding sources and identify gaps, and align the existing funding with the prioritized activities
- Strengthened coordination
- Promoted domestic resource mobilization
- Strengthened integration of prioritized activities with the national health system at the service delivery level
- Strengthened differentiated service delivery

Service Delivery Models

- Integration of services and task sharing
- Differentiated service delivery models
  - Expansion of community-based services by working with the private sector (pharmacies), and the PLHIV support groups
  - Decentralization of services
  - Increase involvement of CSOs through the use of expert clients
- Provision of targeted services focusing on high-impact interventions
- Maximization of public-private and community partnership
- Cost optimization
- Use of data to identify inefficiencies

Quality Assessments Adaptation

- Adapted and simplified the quality assessment tool
- Integrated service quality assessment into routine supportive supervision and mentorship
- Use of digital platforms to collect information on service quality assessment
- Prioritization of geographical location (high burden facilities)
- Adjusted time frame for review, i.e., from quarterly to semi-annually
- Focus on key quality domains

System Adaptations to Support Priorities

- Institutionalize a fully integrated, **real-time digital data ecosystem that links** facility, district, and national **dashboards to enable rapid performance monitoring** and evidence-based allocation of limited resources
- Establishing a **structured domestic HIV financing framework** that expands government budget commitments and leverages private-sector contributions
- Implement a streamlined, **end-to-end commodity pipeline management system** - including electronic LMIS, accurate forecasting, last-mile visibility, and decentralized buffer stock mechanisms
- **Strengthen the governance architecture** by clarifying institutional roles, enforcing accountability mechanisms, and updating enabling policies to ensure coordination, efficiency, and **resilience in a reduced-funding environment**

M&E Indicator Prioritization

#	Program Area	Indicator	Sierra Leone >=50%
1	VTP	1st ANC attendance	
2		1st ANC testing	
3		1st ANC HIV+	
4		1st ANC Known HIV+	
5		HEI 1st EID	
6		HEI final outcome	
7		HEI ARV prophylaxis	
8		_TST	
9		_POS	
10		_TST by modality	
11		_POS by modality	
12	ART	TX_NEW	
13		TX_NEW by CD4 count	
14		TX_CURR by MMD	
15		Interruption in Treatment [IIT]	
16		AIDS-related mortality	
17	VL	VL results received	
18		VL results <1,000 C/ml	
19	TB	TB diagnosis	
20		Initiated on TPT	
21		Completed TPT	
22	HIV Prevention	PrEP_NEW	
23		Received PrEP	
24		Received PEP	
25		Received condoms	

Key	
Keep [No Change]	
Keep [But Modify]	
Drop	
N/A	

The M&E indicator prioritization was adapted based on global priorities and aligned with the national indicator priorities

i. Critical indicators on HIV combination prevention, eMTCT, and care and treatment, including viral load and TB co-infection, were prioritized

ii. There is a reporting rate of 98% with 98% completeness and 75% timeliness of reporting

M&E Systems Assessment Over Time

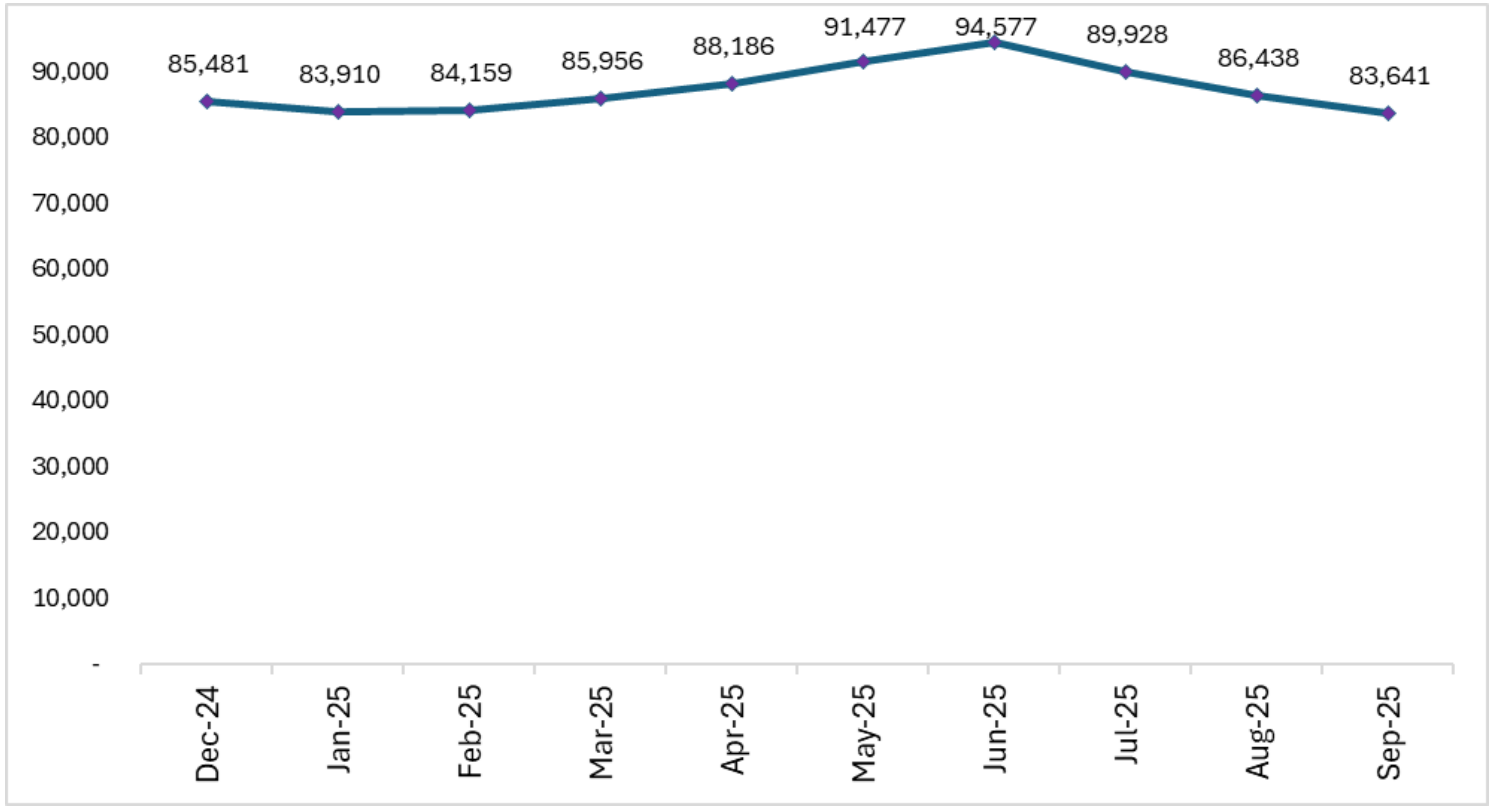
Stop Work (Feb 2025) - Post Stop Work (May and Sep 2025)				
Domain	**Functionality**	**Sierra Leone**		
		25-Feb	**25-May**	**25-Sep**
Data collection	M&E Tools Availability			
	Data Quality and Completeness			
	Community Based Monitoring			
	Retention Monitoring and Follow Up			
	Commodity Tracking Systems			
Databases, reporting, and use	HMIS reporting			
	EMR Functionality			
	Data Dissemination and Data Use			
HRH capacity	M&E HRH Capacity			
	Supervision and Mentorship for HRH			
	Capacity Building for M&E Staff			

Key: Impact of the SWO			
None	Partial	High	No data

- The M&E assessment was a component of the DQA conducted this year to assess the functionality to identify gaps
- Findings show gaps in tool availability, data quality and completeness and EMR functionality
- However, there was an improvement in the community monitoring and tracking system due to CLM implementation
- Also, even though data is disseminated, it remains a challenge, especially at sub sub-sub-national level

Trend in Monthly TX_CURR and Implications – 1

[Data Source: National Aggregate HMIS]



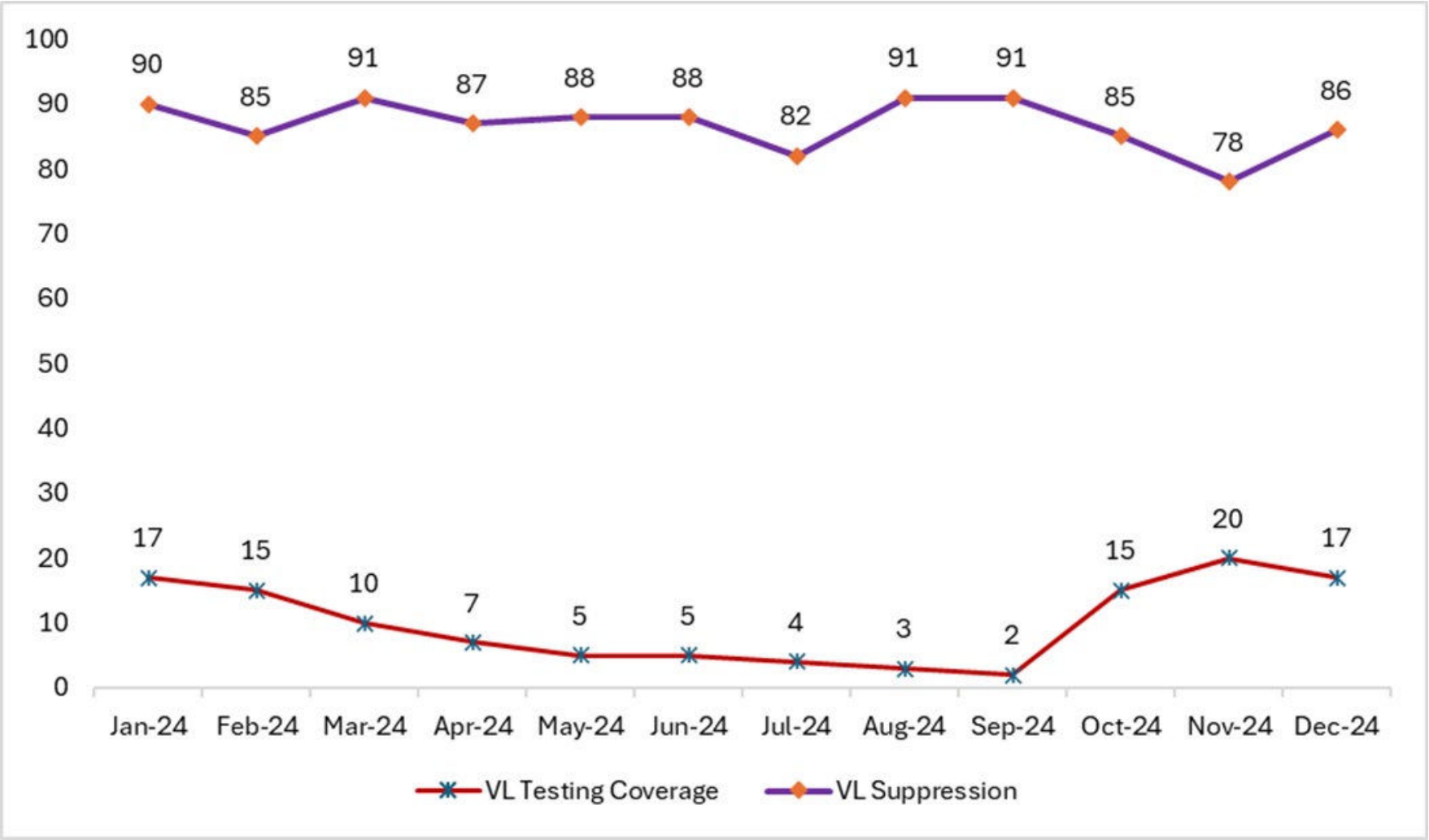
- Fluctuations in national TX_CURR likely reflect data quality challenges, especially during the transition to the revised tools
- New registers were printed in April 2024, but the program required data entry to start retrospectively from Jan 2024, resulting in rushed transcription from old tools
- Limited staff understanding of the new registers and difficulty interpreting updated indicators contributed to inconsistencies in reported TX_CURR

Ongoing corrective actions:

- Training HF staff on the new tools
- Developing an indicator definition guide
- Conducting regular data reviews with district teams to improve accuracy and consistency

VL Testing Coverage and Suppression Trends and Implications – 2

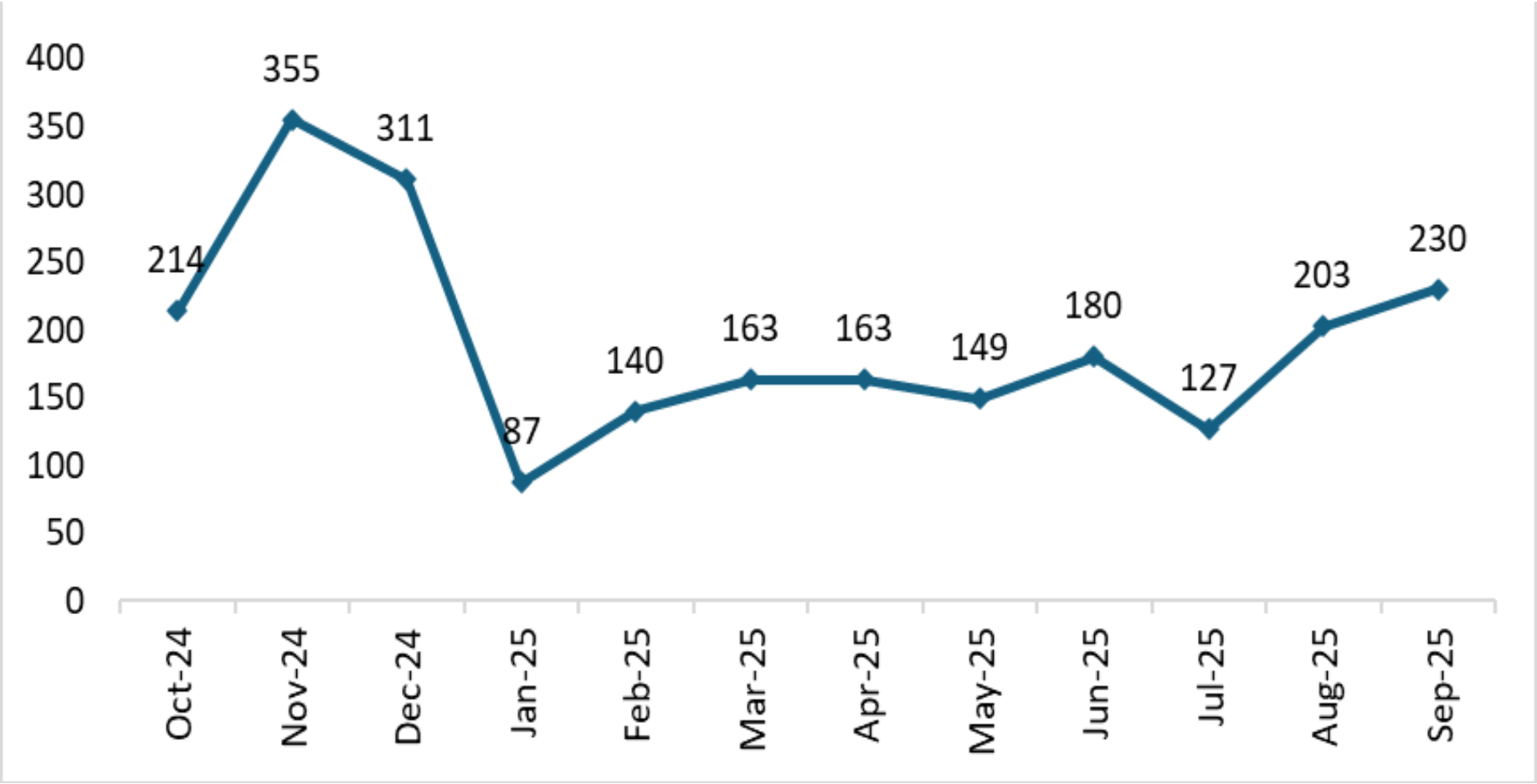
[Data Source: National Aggregate HMIS]



- Sierra Leone has faced chronic challenges with VL/EID testing due to frequent breakdowns of CPHRL platforms and GeneXpert POC machines
- Viral load testing resumed in Oct 2024 after installation of two new machines
- VL coverage remains low, but viral suppression is high, driven by widespread use of the DTG-based regimen

Trend in EID at 2 Months and Implications – 3

[Data Source: National Aggregate HMIS Data from Oct. 2024 to September. 2025]



- New testing platforms and partner contributions boosted overall performance.
- Pediatric services strengthened through rollout of the pediatric toolkit and clinician training.
- GeneXpert installed at the National Referral Pediatric Hospital, improving EID testing capacity

Community Engagement - 1

Impact of funding reductions on Community Engagement

- Reduction in the number of mentor mothers and expert clients providing follow-up and adherence counselling, resulting in a reduction of health facilities with mentor mother and expert client services.
- Interruption in the support group meetings
- Interruption in community-led monitoring interventions

Engagement of RoCs in the re-prioritization of HIV services and M&E indicators

- RoCs are active members in the Expanded Technical Working Group (ETGW) and have representation in all program component TWGs. They were represented in all the TWG meetings relating to reprioritization and M&E indicator review.
- RoCs actively participate in all stakeholders' consultative meetings relating to reprioritization and M&E indicator review.
- The critical recommendations from the report from the community lead monitoring conducted by the RoC were used as one of the references for the reprioritization and M&E indicator review.

Community Engagement - 2

ROCs contribution in sustaining the HIV response, including sustaining community engagement activities

SN	Service area	What has been done
1	Clinical Services (Testing, ART, Lab, eMTCT	Community mobilization on linkage, adherence support, and viral load demand creation
2	Supply Chain (ARVs, Test Kits, Reagents)	Advocacy for uninterrupted supply & monitoring stockout through community lead monitoring
3	Policy & Program Designs	Community representation at the policy level
4	Facility-based Counseling	Peer-led psychosocial support, stigma reduction through support group meetings
5	National Health Workforce	Support with Peer Educators, expert clients & Mentor Mothers extending reach into households

Challenges and Lessons Learnt

System Challenges

- Inadequate commodity supply leading to intermittent stockouts
- Capacity gaps among healthcare workers due to frequent staff attrition
- High dependency on donor funding
- Limited contingency planning for epidemics, stockouts, or funding interruptions
- Weak performance review mechanisms

Service Challenges

- Inadequate adherence counselling
- Weak implementation of DSD models in rural areas
- Persistent stigma affecting service uptake
- Limited male involvement and engagement
- Reliance on paper-based data entry

Lessons Learned

- Integrating services into the mainstream MoH enhances sustainability
- Decentralized, task-shifted, facility-led models are more resilient under fiscal pressure
- Accelerating domestic resource mobilization is essential to sustain program gains
- Strengthening data governance, real-time dashboards, and analytics is critical for prioritizing limited resources

Next Steps

- Finalize the 2026–2030 National Strategic Plan (NSP) with emphasis on HIV, TB, and malaria program integration
- Strengthen integration of program activities and intensify mentorship, leveraging partner support
- Conduct active supply pipeline monitoring and regular risk mapping for ARVs and critical commodities
- Improve data quality through capacity building, mentorship, and supportive supervision

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Thank You!