

# **NATIONAL HIV/AIDS SECRETARAT**

## **SUMMARY ON HIV/AIDS ISSUES**

**June 2004**

## **1.0 Overview Of HIV/AIDS**

The world is now entering its third decade with what may be called the most devastating epidemic in human history - HIV/AIDS. The epidemic has created devastating human tragedy throughout the world, especially in resource poor countries. It continues to ravage families, communities and countries throughout the world. In addition to the 20 million people who have already died of AIDS, most of the 40 million people now living with the virus are likely to die prematurely within a decade or more. Each day about 14,000 people, comprising 12,000 adults and 2,000 children become infected with HIV. At least 95% of these new infections occur in less developed countries. HIV is now the fourth leading cause of death worldwide. The estimated death toll of the disease since the epidemic began is 20 million, and it is estimated that an additional 68 million will die unless immediate and full-scale prevention and treatment efforts are taken.

Sub-Saharan Africa is the hardest hit region in the world; more people die of AIDS related illnesses than of any other cause. In 2003, an estimated 26.6 million people in this region were living with HIV, including the 3.2 million who became infected during the past year. AIDS has killed approximately 2.3 million people.

In Sierra Leone, since the first HIV/AIDS case was detected in 1987, about 2399 individuals have tested positive for HIV/AIDS, of which 794 of these have developed the AIDS disease, and 438 are reported to have died. In April 2002, a national zero-prevalence survey conducted jointly by the Sierra Leone Statistics Office (SSL) and the U.S. Centre for Disease Control (CDC) showed a national HIV prevalence of 0.9%; 2.1% in Freetown and 0.7% outside Freetown. Also, the preliminary results of the first antenatal prevalence study based upon a total of eight testing sites reported an overall national prevalence of 3.4%, and 4.7% for the capital Freetown. These more reliable figures regarding HIV prevalence in the country, further demonstrate why the country needs urgent assistance to stem a potential post conflict epidemic. According to these estimates at least 100,000 Sierra Leoneans may be living with HIV.

## **1.1 Poverty and HIV/AIDS**

The relationship between HIV and poverty is complex. HIV is a very personal, but also very global. Its impact is felt by individuals, families, businesses, communities and countries. HIV makes families and communities disinvest in productive activities as resources are shifted to the care and treatment of people living with HIV/AIDS. When a member of a household (especially the bread winner) becomes ill with HIV/AIDS, one or more family members who are not sick may leave their jobs to provide care for others in the family. Caring for a sick family member disrupts the work schedules of others, further limiting income. Families' savings may dwindle and assets sold off to meet living and medical expenses and, eventually, funeral expenses. Another outcome is an increase in medical expenses to treat conditions associated with the infection and income is spent on medical care instead of food, clothing, household goods and other commodities. Children are withdrawn from school and put to work to compensate for the lost labour and income. Although HIV/AIDS is by no means the only reason for such changes, it is often a precipitating factor.

The linkage could also be better understood in the context of epidemic curve of diseases. In contrast to other epidemic curves, which are predictable (that is illness leads to death and ultimately the epidemic curve goes down). The epidemic curve of HIV/AIDS can be divided into four:

- i) the wave of HIV infection
- ii) the wave of diarrhoea, tuberculosis (most common opportunistic infections in Africa)
- iii) the wave of AIDS illness and death
- iv) the wave of impact (includes household poverty and orphaning)

With AIDS it is difficult to predict. HIV ultimately leads to AIDS and death, with no recovery. What we do not know is what will happen to the epidemic curve in the aftermath of massive AIDS related deaths.

In Africa HIV is transmitted mainly through heterosexual intercourse. Pressing concerns for short-term survival may lead poor women to engage in survival sex, which paradoxically can expose them to the long-term risk of illness and death through HIV infection. Poverty also limits people's access to sexual health information, prevention technologies and treatment. Whilst this is true for women and men, gender inequality shapes different experiences of poverty and impacts on women and men's ability to move out of poverty. Social spending cuts often lead to increased pressure on women and girls to take on the role of social safety

net, caring for sick relatives and securing a livelihood as earning family members become sick and die. This is one of the invisible impacts of HIV/AIDS. However, sexual behaviour cannot be seen in isolation; migration, the status of women and their (lack of) access to economic resources, general health care etc. are all important factors. Thus, *poverty in itself does not cause an AIDS epidemic but certainly contributes to it.*

However, more than poverty, inequality is a crucial factor (e.g. rich men buying sex from poor women). Attacking poverty is important, but there are *multiple factors* that need to be addressed.

The youth/adult additional deaths caused by AIDS have huge implications for both health care and the division of labour and production. AIDS alters or changes population distribution. The main changes result in less good ratios between dependents and producers, which has implications in terms of food availability, medical spending, care of orphans etc. A decline in life expectancy will affect employers and organisations and ultimately have a macro-level impact. On a household/community level, the effect will be seen most clearly in terms of farming systems and food production.

The key areas in terms of the effect of AIDS are therefore:

- skills structure
- orphans and elderly (altered dependency ratio)
- organisations (carry cost of medications and other employee related liabilities)
- employment
- subsistence agriculture

All of these are potentially impoverishing issues, and will have to be taken into account for any development intervention to be effective more especially, when HIV/AIDS shifts the parameters on which development is based. In as much as prevention work is crucial in order to curb the spread of infection, there is also need to look beyond infection to address, and deal with, the impact of the epidemic.

## **2.0 Challenges**

The national response to HIV/AIDS is faced with serious challenges. Firstly, national HIV/AIDS response is chronically under-funded. The current World Bank funded SHARP Project was designed for four districts on the assumption that other resources would be available to target the remaining districts. The funding situation is so acute that the funds from the Multi-country AIDS Project (MAP) have been spread over the whole country instead of the four districts planned for the program. Responding to the acute funding situation, the National HIV/AIDS Secretariat is soliciting additional funding from donors. Government on the 30<sup>th</sup> June 2004 was informed of an US\$18 million grant from the Global fund, to support the national response in the fight against HIV/AIDS. NAS is also soliciting additional support from other international organizations including the UN system to support the national effort.

The second challenge is the low level of literacy in the country. With a literacy rate of 33%, most messages on HIV/AIDS are not understood by a great majority of the population. It is therefore not surprising that in the HIV survey conducted in 2002, it was reported that knowledge among women 15-49 years is relatively low with only 54% (78% urban and 44% rural) having heard of AIDS and 21% able to state three ways of avoiding HIV infection. Also, only 34% was aware of mother-to-child-transmission of HIV; 67% did not know any specific method HIV can be transmitted from mother to child. Overall, Sierra Leoneans, even in the Western Area incorporating Freetown, continue to lack knowledge and understanding regarding HIV/AIDS. For example, a recent survey indicated that many people still do not know that HIV is the virus that causes AIDS.

The third challenge is the low level of capacity of Community Based Organizations and Non-Governmental Organization in implementing HIV/AIDS programs. There is a willingness among national organizations to help in the fight against HIV, but most do have a good understanding of the issues that needs to be addressed. Hence most of these programs are shallow and lack impact.

The fourth challenge is the availability of reliable data. There have been no large-scale studies and almost no biological data (HIV, Syphilis, or other STI) among various highly vulnerable subgroups in Sierra Leone. Baseline and ongoing data is essential for effective program planning and later program evaluation

Also, affordable, acceptable male condoms are an essential part of Sierra Leone's HIV prevention strategy. However, there is currently low acceptance, poor utilization and access to condoms. Similarly, people testing positive for HIV require follow-up for psychosocial, medical, and in some cases, economic support. These care and support services will increase survival rates of People Living with HIV/AIDS (PLWHAs) and enable them to enjoy life with dignity and respect. Presently, very few organizations provide care for PLWHAs, and most have no support do not benefit from any support at all. Most PLWHAs who need antiretroviral drugs (ARVs) cannot afford them. The World Bank MAP-funded SHARP Project did not budget any amount for the purchase of ARVs..HIV/AIDS is bound to lead to an increase in the number of orphans and street children in the country. Without support, these children are vulnerable to various forms of abuses and HIV/AIDS. NAS does not have sufficient resources to provide sufficient support for these orphans.

### **3.0 National HIV/AIDS Strategic Framework**

The national response to the HIV/AIDS epidemic is built on five pillars:

- Prevention of new infections;
- Care and Support;
- Human and Legal Rights;
- Decentralized implementation of HIV/AIDS Programme; and
- Research, Monitoring and Evaluation.

In addition, the following are considered as priority population groups especially in the areas of Prevention, Research and Monitoring, youth and adolescents, commercial sex workers, uniformed personnel, migrant populations, truck and taxi drivers etc.

Prevention is the main strategy to addressing HIV/AIDS in Sierra Leone. The implementation of the strategy is governed by the context of low awareness of basic issues such as what H/V/AIDS is; and subsequently, knowledge and education on how it is spread and be prevented. In addition there are cultural and traditional practices that require recognition of cultural values and beliefs of the people. It has been recognized that ideal implementation of such practices that may have risks should be undertaken through the structures and leadership of the community. This approach summarizes the basic principle approach - of a people centered strategic framework.

Providing care to People Living with HIV/AIDS (PLWHAs) as well as psychosocial support both to PLHWAs and affected persons shall be considered as part of the overall continuum of care. Development of the health care system and strengthening of the referral system and overall quality improvements is an opportunity that presents itself via the provision and access to anti-retroviral therapy, prevention of mother to child transmission as well as through counseling and testing. This approach entails restructuring and strengthening of the public health system.

Gender focus in the Strategic Framework more than any other group assumes a critical role. The relationships — social and economic — that revolve around gender require special focus. The role of women in which they are emerging from being victims of the consequences of armed conflict such as sexual violence or the less likelihood to acquire income and employment, especially in the urban areas are issues that form part of this focus. The recognition of female-headed households and the need to have mechanisms for increasing their role in terms of economic and social activities are also crucial.

Similarly, HIV/AIDS prevention poses a challenge, more especially to the youths. The immediate historical context of Sierra Leone is well articulated in most development programmes. The roles of re-settlement and rehabilitation of sub-populations are well demonstrated. The challenge therefore is that the prevention, control and reduction efforts should address issues that make youths vulnerable to HIV/AIDS.

Human rights and legislative reform are also necessary with respect to HIV/AIDS. Since the disease is characterized by stigma and discriminatory practices that may be induced by various sources such as religion, fear, shame and essentially ignorance, it is imperative to further identify related practices such as may concern gender, children or other traditional practices which provide for either increased risk of infection or lead to discrimination and bias.

The implementation of the strategic framework recognize the need to apply intervention with the full participation of the communities, regardless of the geographical setting i.e. whether rural or urban areas. Recognition is made of the diversity between urban and rural areas. The institutional framework or structures require the coordination capacities of the Government at the district levels, chiefdom and or village levels. Similarly in the urban areas the coordinating role of the local Government structures and the Councils are key to the implementation

process. Coordination of all stakeholder programmes in implementation, monitoring, evaluation and reporting is again similarly much more efficiently and effectively undertaken through community-based responses. To ensure that there is ownership and acceptance of HIV/AIDS and its consequences, it is imperative that the implementation focuses on the process of local community coordinating structures and mechanisms.

Accurate and timely information on H/V/AIDS and related issues, both biomedical and other multi-dimensional data is an area that is vital for awareness, resource mobilization and appropriate policy response and intervention formulation and implementation. Designing and implementing surveillance, monitoring and evaluation procedures that provide for the evidence base of the social, biomedical and economic effects and progress provide the framework for the strategy of monitoring, evaluation, surveillance and reporting.

#### **4.0 Costing of the National HIV/AIDS Strategic Framework in US\$.**

<b>PROGRAMME AREA</b>	<b>YEAR 1 (2004)</b>	<b>YEAR 2 (2005)</b>	<b>YEAR 3 (2006)</b>	<b>YEAR 4 (2007)</b>	<b>YEAR 5 (2008)</b>	<b>TOTAL</b>
Prevention	3,601,370	3,069,990	4,416,390	4,004,330	3,948,930	<b>19,041,010</b>
Anti-Retroviral	1,500,000	3,600,000	7,200,000	10,800,000	14,400,000	<b>37,500,000</b>
Care And Support	1,095,890	1,359,770	1,277,050	692,025	816,270	<b>5,241,005</b>
Impact Mitigation	500,150	419,675	641,000	114,750	153,600	<b>1,829,175</b>
Supporting Decentralization	187,320	60,480	170,100	80,640	185,220	<b>683,760</b>
Research, Monitoring and Evaluation	104,700	50,250	113,775	70,725	110,626	<b>450,075</b>
<b>Total Programme Cost</b>	<b>6,989,430</b>	<b>8,560,165</b>	<b>13,818,315</b>	<b>15,762,470</b>	<b>19,614,646</b>	<b>64,745,026</b>

*The table presents the budget for the Strategic Framework by year and by priority area.*