**UN EBOLA RESPONSE MPTF**
**ANNUAL PROJECT NARRATIVE REPORT**

**Year: 2017**

# POSITIVE HEALTH, DIGNITY AND PREVENTION PROJECT

**UNAIDS IN COLLABORATION WITH CHRISTIAN AID, NATIONAL AIDS SECRETARIAT, NATIONAL AIDS CONTROL PROGRAMME, NETWORT WORK OF HIV POSITIVES IN SIERRA LEONE, SIERRA LEONE EBOLA SURVIVORS, WOMEN IN CRISIS, ROFUTHA DEVELOPMENT ASSOCIATION (RODA) AND WORLD FOOD PROGRAMME**

1. **Project Summary:**

<table>
<tr><td>Project Number and Title:<br>#63- Title: Positive Health, Dignity and Prevention Project</td><td rowspan="2">PROJECT START DATE[1]:<br>January 2017</td><td rowspan="2">AMOUNT ALLOCATED by MPTF<br>$165,850</td><td rowspan="3">RECIPIENT ORGANIZATION<br><br>UNAIDS</td></tr>
<tr><td>Project ID:<br>00102292</td></tr>
<tr><td>Project Focal Point:<br>Dr Michael Gboun<br>Executing Agency:<br>UNAIDS</td><td>EXTENSION DATE:<br>31st December 2017</td><td>FINANCIAL COMMITMENTS:<br>$165,850.</td></tr>
<tr><td>Strategic Objective (STEPP)<br>RS01 – Health, Nutrition and WASH</td><td rowspan="2">PROJECTED END DATE:<br><br>31st December 2017</td><td rowspan="2">EXPENDITURES as of [December 2017]<br><br>$165,850.</td><td rowspan="2">IMPLEMENTING PARTNER(S):<br><br>National AIDS Control Programme<br>Women in Crisis (WICM).<br>Network of People Living with HIV(NETHIPS)<br>SL Association of Ebola Survivors (SLAES)<br>Rofutha Development Association (RODA)<br>World Food Programme</td></tr>
<tr><td>Mission Critical Action<br>MCA – Description<br>It was indeed part of the recovery strategy and investment value</td></tr>
<tr><td colspan="2">Location: Sierra Leone</td><td colspan="2">Sub-National Coverage Areas:<br>WESTERN RURAL, WESTERN URBAN (WESTERN AREA)<br>PORT LOKO, BOMBALI, KOINADUGU (NORTHERN PROVINCE)<br>BO, PUJEHUN, MOYAMBA (SOUTHERN PROVINCE)<br>KAILAHUN, KENEMA (EASTERN PROVINCE).</td></tr>
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[1] The date project funds were first transferred.

## 2. PROGRESS REPORT RESULTS MATRIX

| OUTPUT INDICATORS | | | | | |
|---|---|---|---|---|---|
| **Indicator** | **Geographic Area** | **Projected Target (as per results matrix)** | **Quantitative results for the quarterly reporting period** | **Cumulative results since project commencement (quantitative)** | **Delivery Rate (cumulative % of projected total) as of date** |
| ***Description of the quantifiable indicator as set out in the approved project proposal*** | | | | | |
| Number of community watch networks in place among sex workers as early system warnings | Western Area | 30 | Community watch networks comprised 30 mentors x 3 locations | 90 | 100% |
| Number of prevention and harm reduction outreach sessions conducted and 'one stop shop' locations established for sex workers and other KPs | Western Urban<br><br>Western Rural I Western Rural II | 50 | 30 outreach sessions per location, completed and sex workers engaged. One stop shop established and in use | 50 | 100% |
| Number of EVDs and PLHIV attending EVDHIV collaborative… to integrate network efforts and reduce stigma and discrimination | National | 500 | 500 PLHIV & EVDs anti-stigma ambassadors attended EVD/HIV district and national collaborative meetings to integrate network efforts and reduce stigma and discrimination and other barriers to social integration | 500 | 100% |

| | | | | | |
|---|---|---|---|---|---|
| Number of Participants in HIV TOT training sessions for CPES supervisory staff | Pujehun Moyamba Bo Koinadugu Kailahun Kenema. | 15 | 15 | 15 | 100% |
| Number of media outlets used for sensitization on EVDS and section of stigma and discrimination | Bo Kailahun Kenema Koinadugu Moyamba, Pujehun | 15 | Activities not started (NACP) 6 Media Outlets engaged (NETHIP/SLAS) | Partially Met Not started for NACP (6 outlets) Ongoing for NETHIPS/SLAES (8 outlets) | 80% |
| Number of people reached through community meetings, peers and couples counseling sessions | All selected districts | 1,000 | 82 community meetings held. 3500 individuals engaged | 840 | 80 |
| Number of condoms distributed to mitigate sexual transmission of and other STI, HIV | All selected districts | 3,000,000 | 50 condom dispensers erected. 72752 condoms distributed | Partially Met | Partially achieved |
| Number of staff provided with stipend and trained for community and counseling sessions | Moyamba Bo Bombali Koinadugu Kailahun Kenema. Pujehun | 12 | 24 | 24 | 200% |
| **EFFECT INDICATORS (if available for the reporting period)** | | | | | |
| Number of sex workers reached with Ebola/HIV prevention and harm reduction message | Western, Kenema | Baseline= 0 | Target: 20,000 | 20,000 | Met |
| Number of support groups members reached with integration of EVD and HIV efforts | National | 0 | 2 per districts | 2 per districts | met |

| | | | | | |
|---|---|---|---|---|---|
| and training on stigma and discrimination | | | | | |
| Number of adults provided with counselling and information to address concerns related to Ebola, HIV and SRH | 3 of the prioritized districts- Bo, Kenema, Kailuhum. Moyamba and Kainadugu | 0 | 1000 | 1000 | met |

**2.1 Additional investment**

| **OUTPUT INDICATORS** | | | | | |
|---|---|---|---|---|---|
| **Indicator** | **Geographic Area** | **Projected Target (as per results matrix)** | **Quantitative results for the quarterly reporting period** | **Cumulative results since project commencement (quantitative)** | **Delivery Rate (cumulative % of projected total) as of date** |
| ***Description of the quantifiable indicator as set out in the approved project proposal*** | | | | | |
| Number of Girl Headed Households with OVC provided with cash transfer livelihood support to reduce HIV vulnerability through sex work | Makeni, western Urban and Rural | 105 | 105 | Scope Verification and ID distribution for Conditional Cash Transfer | 100% |
| Number of OVC provided with material and education support | Makeni, Western urban & Rural | 105 | 105 | Registered in School, educational material provided | 100% |
| Number of Girl Headed Households with OVC provided with cash transfer for training on vocation skills | Makeni, Western Urban and Rural | 105 | 105 | Scope Verification and ID distribution for Conditional Cash Transfer | 100% |
| **EFFECT INDICATORS** | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 105 Girl Headed Households had improved access to education and increased literacy levels. | Makeni, Western Urban & Rural | 105 | 105 | | 100% | |
| 105 GHH with enhanced livelihood for vulnerable girls & households | Makeni, Western Urban & Rural | 105 | 105 | | 100% | |

## EXECUTIVE SUMMARY

The Positive Health, Dignity and Prevention Project was one of post-ebola equity project to increase resilience of those who survived the Ebola outbreak and were made vulnerable. The project was coordinated and implemented through National Aids Control Programme (NACP), National AIDS Secretariat, Women in Crisis (WIC), Sierra Leone Association of Ebola Survivors (SLAES) and Network of HIV Positives (NETHIPS), World Food Programme and other sex work organizations.

The project has achieved significant milestones– enhanced capacity of local mentors who reached over 20,070 sex workers with Ebola/HIV prevention and harm reduction messaging with strengthened watch networks; two support groups per district were reached with integrated EVD/HIV messaging and trained on stigma and discrimination reduction; 3500 adults were provided with counseling and information to address concerns related to Ebola, HIV and sexual Reproductive Health and most vulnerable households were further supported to have dignity and safe space.

The overall impact is that a strong foundation has been laid for the sustained engagement among key actors in the fight against the re-emergence of Ebola and the spread of HIV as well as strengthened local level mechanisms for addressing stigma and discrimination against sex workers, people living with HIV and Ebola survivors.

This model of partnership where partner agencies were given direct implementation support without the burden of managing administrative financial requirements of the project has been a best practice. This has been an impactful project for the project beneficiaries and the implementing agencies, greatly enhancing coordination and support for sex workers, Ebola survivors and people living with HIV and building of livelihood skills. It is evident that the gains made through this project will strengthen earlier investments to promote the wellbeing of people living with HIV and Ebola survivors and reducing stigma and discrimination and promoting rights.

1. **Current Situation and Trend** (*please provide a brief introduction to the project and the related outcomes in relation to implementation of the project (1-2 paragraphs)*)

Sierra Leone has a mixed and generalized HIV epidemic with an HIV prevalence of 1.5% since 2005. The 2013 Demographic and Health Survey (SLDHS, 2013) indicates that some districts have significantly higher HIV prevalence than others. Six districts in particular have been noted to have a high burden of HIV; Bo, Bombali, Kono, Kenema, Port Loko and Western Area.

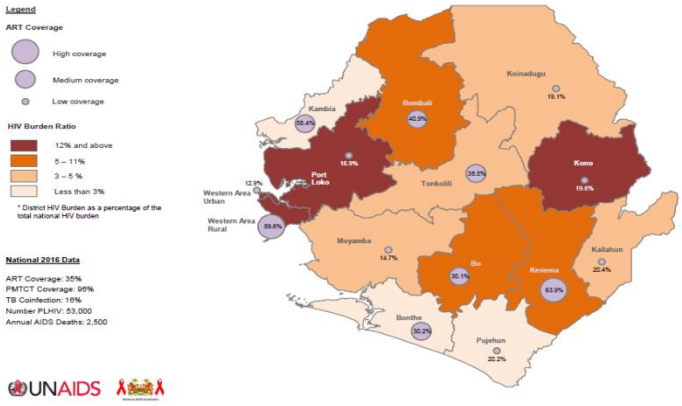



**Figure 1: HIV Burden in Sierra Leone by district in 2016**

According to spectrum estimates, there were 67,000 PLHIV in Sierra Leone in 2016. The total number of new infections (0.86 incidence in 2016) is also on the decrease among all categories. The

evidence indicates that females between the ages of 15 – 19 are the most vulnerable with the highest new infections recorded between this age group.

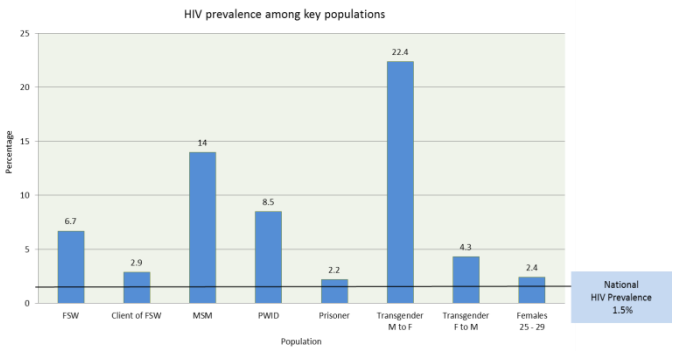



**Figure 2: HIV prevalence of key populations, 2015**

Key Populations (KP), including Sex Workers (SW), Men having Sex with Men (MSM), People Who Injects Drugs (PWID) are estimated to be about 4% of the national population, but according to the HIV sero-prevalence study (2015), KPs accounts for approximately 40% of persons living with HIV (PLHIV). HIV prevalence among KP members are significantly higher than the national average; MSM has 14% HIV prevalence, SW have 6.7% HIV prevalence, and PWID have 8.5% HIV prevalence.

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 (of which clients of sex workers account for 25.6% and sex workers 13.7%). Also, people in discordant monogamous relationships contribute 15.6% of new infections; fisher folks contribute 10.8%, traders 7.6%, transporters 3.5% and mine workers 3.2%. Men who have sex with men (MSM) and people who inject drugs (PWID) have also been identified to be at higher risk of HIV infection, representing 2.4% and 1.4% of the new infections respectively.

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 mobilizing 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 Strategic Plan on HIV/AIDS (2016 – 2020) is a multi-sectoral plan that provides the overall framework and guidance for all prevention interventions to achieve a goal of zero new infection, zero discrimination and zero AIDS related deaths. The NSP is also aligned to the global targets of 90-90-90 and Fast-tracking approach.

Sierra Leone's fragile health system was weakened by the Ebola Virus Disease (EVD) outbreak in 2014-2015. EVD severely eroded the trust in the health system as people perceived health facilities as potential points of infections. During this period, the Government recorded a decrease in health care uptake from 80% to 50%, a 23% drop in institutional deliveries, a 23% decline in the number of pregnant women accessing prevention of mother-to-child transmission (PMTCT) services, and a 21% increase in HIV patients lost to follow-up from their antiretroviral (ARV) treatment. According to a review of the long-term impacts and cost of EVD, the biggest impact on the health sector is related to the non-treatment of other health conditions, specifically HIV.

Late in 2016, it was identified that implementation of work plans and absorption of existing funds was low, therefore to address these bottleneck and gaps, a Catch Up Plan (CUP) was developed. The CUP aims to accelerate the implementation of the Operational Plan 2016 – 2018 with the focus of Tripling Treatment Access, from 17,843 in 2016 to 45,000 in 2019. This will be done by prioritizing high impact interventions within high burden areas and facilities in the next year in order to place the country back on track to achieving its National Strategic Plan (NSP) targets which are in line with global 90-90- 90 targets. It focuses on three areas: (1) increasing case detection, (2) Increase treatment coverage, and (3) Increase Viral detection. The country has just launched the fast track cities initiative to mobilize communities towards the 90.90.90 targets.

Sierra Leone has significantly scaled up its treatment efforts by increasing eligibility to treatment, increasing outreach testing points, and strengthening defaulter tracing programmes. The number of people tested and received results in 2016 was 564,403, including general population and pregnant women attending ANC and PMTCT services. There are 17,058 on ART, these clients report once a month at the 136 ART sites located within their communities for follow up care and a refill of their medications. A pilot programme of viral load testing indicates that 67% of PLHIV have suppressed viral load.

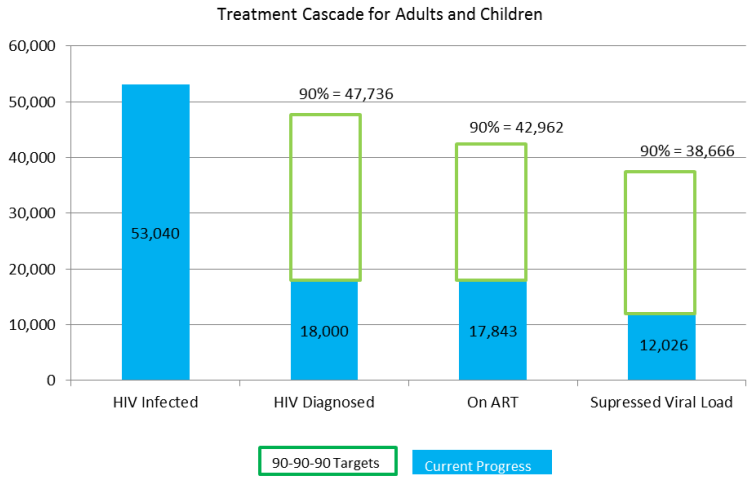



**Figure 3: Treatment cascade for adults and children, 2016**

The Ebola Virus Disease (EVD) is an infectious disease, which has seen its widest and deadliest outbreak since its discovery in 1976 during the period of 2014/15. While most countries managed to control the outbreak in terms of infections and deaths, West African countries have been heavily affected by the epidemic. In Guinea, Liberia and Sierra Leone, the outbreak has been massive and long lasting, claiming the lives of children and adults. In these three countries the epidemic has led to a major health crisis; which has inevitably disrupted social and economic life for the long term.

Sierra Leone has been one of the most affected countries during the Ebola crisis, with the latter exerting detrimental impact on the health care system and the population of the country. In addition to the confirmed 14,124 cases and 3,956 deaths,[2] a significant portion of those surviving the disease soon suffered from post-Ebola syndromes like musculoskeletal pain, headaches, ocular- and auditory problems. Moreover, the Ebola disease put tremendous pressure on an already fragile health care sector, which prior to the outbreak experienced critical shortages in both staff and crucial resources, such as basic equipment for service delivery and laboratory work. Importantly, as the Sierra Leonean authorities rushed to contain the epidemic and treat the people suffering from the malady, critical resources were shifted away from the monitoring and treatment

[2] WHO Ebola Situation Report, as of 27 March, 2016.

of diseases like malaria, HIV, and measles that, in effect, led to increased proliferation across the country. As such, the Ebola epidemic has resulted in significant health consequences on a nationwide scale and, with it, mounting costs that threaten the country's economic outlook for years to come.

The United Nations Secretary-General launched the United Nations System Response to the Ebola Outbreak to unite efforts of all concerned UN Entities and act as a platform for the global control of the Ebola Outbreak. The Strategic Objectives of the UN System Response to the Ebola Outbreak are: 1) Stop the outbreak 2) Treat the infected 3) Ensure essential services
4) Preserve stability 5) Prevent outbreaks in countries currently unaffected

A Comprehensive programme of services for Ebola survivors (CPES) was developed and implemented as part of the recovery process from the Ebola outbreak. It was aimed at providing access to basic and complex services for survivors, prevent resurgence and fight community stigma through counselling and direct support. The Positive Health, Dignity and Prevention project was an innovation to implement the part of the CPES programme.

It was aimed to seek reinforced engagements towards enhancing the health and dignity of survivors as well as prevent resurgence of the Ebola virus and the spread of HIV/STIs among survivors and their partners or communities. It provided an opportunity for various partners who work with Ebola survivors and PLHIV to engage in a collaborative way that broadens and sustains the support systems for their target participants. The project presents a good example of how to build on gains made during an emergency response (the Ebola response) and to maintain zero new infections in the country. The implementation strategy includes provision of prevention and harm reduction intervention to increase awareness of risk of transmission and create early warning system among the highly sexually active group, increase condom use among sex workers, their clients and other high vulnerable people such as men-who-have-sex-with-men and establish community based one stop drop in centers for comprehensive and integrated services to support the mitigation of sexual transmission of HIV and EVD and the community watch networks and conditional cash transfer to the very poor and most vulnerable households.

During project implementation, partner agencies showed excitement and commitment through coordinated manner amidst existing challenges of terrain and reach. The process ensured that a collaborative front was built and strengthened for addressing the overlapping needs of both Ebola survivors and people living with HIV.

*2.* **Narrative section** *(About 1,000 words)*

A comprehensive programme of services for Ebola survivors (CPES) has been developed by the Government of Sierra Leone with support from partners. There is especially a need to provide for specialized care to EVD survivors with increased vulnerabilities, such as those living with immunodeficiency (such as PLHIV) and children, who are often marginalized in broad programme approaches.

Another critical component to CPES is the provision of counseling and support for the reduction of stigma & discrimination and the mitigation of potential sexual transmission. Initiated as Project Shield Phase 3 & 4 and later incorporated into CPES, counseling and social outreach have proven to provide strong dividends towards the sensitization and behavior change within communities, thus providing improved quality of life among EVDS to live with respect and dignity. Hence, the initiatives of the project- Positive Health, Dignity and Prevention in 4 districts.

## 2.1 Objectives

The objectives of the project were:

1. Provide continuous supportive counseling and peer support for EVD survivors Living with HIV, EVDS, their partners and affected population
2. Mitigate the risk of resurgence of Ebola and spread of HIV/STI from sexual transmission to sexual partners of EVD survivors

## 2.2 Partnerships

Partner engagement and due diligence – including compliance with administrative and financial management systems and procedures was ensured all through the implementation of activities. Christian Aid Sierra Leone (CASL) engaged with partners to access their capacities in view of the elements of the project they were being asked to implement and the plans completed reflecting activities and timelines. CASL accompanied the partners, providing support all through, to ensure that a collaborative approach to project implementation. Monitoring, mentoring and supportive capacity building of partners in planning, reporting and general accountability in project implementation has been ensured by CASL to date. Also, CASL facilitated focused joint revision of activity plans and budget for the partners – NETHIPS/SLAES, Women in Crisis and National Aids Control Programme (NACP). When plans were submitted, CASL met with each agency to talk through the plan and recommended adjustments to the plan and the budget to ensure alignment and fit within the available resources.

**National Aids Control Programme (NACP**) completed the eighty-two (82) community entry sensitization meetings in 82 communities, reaching a total of 3500 people with counselling services and information on HIV and AIDS prevention and control. A total of 43 Counsellors were trained in three sessions to address issues of stigma and support Ebola survivors. Those trained reached out and further provided counselling services to people living with HIV as well as Ebola survivors. Fifty (50) dispensers were procured and distributed throughout the operational districts. Fifteen CPES supervisors were trained that closely monitored and supported Ebola survivors in the targeted district.

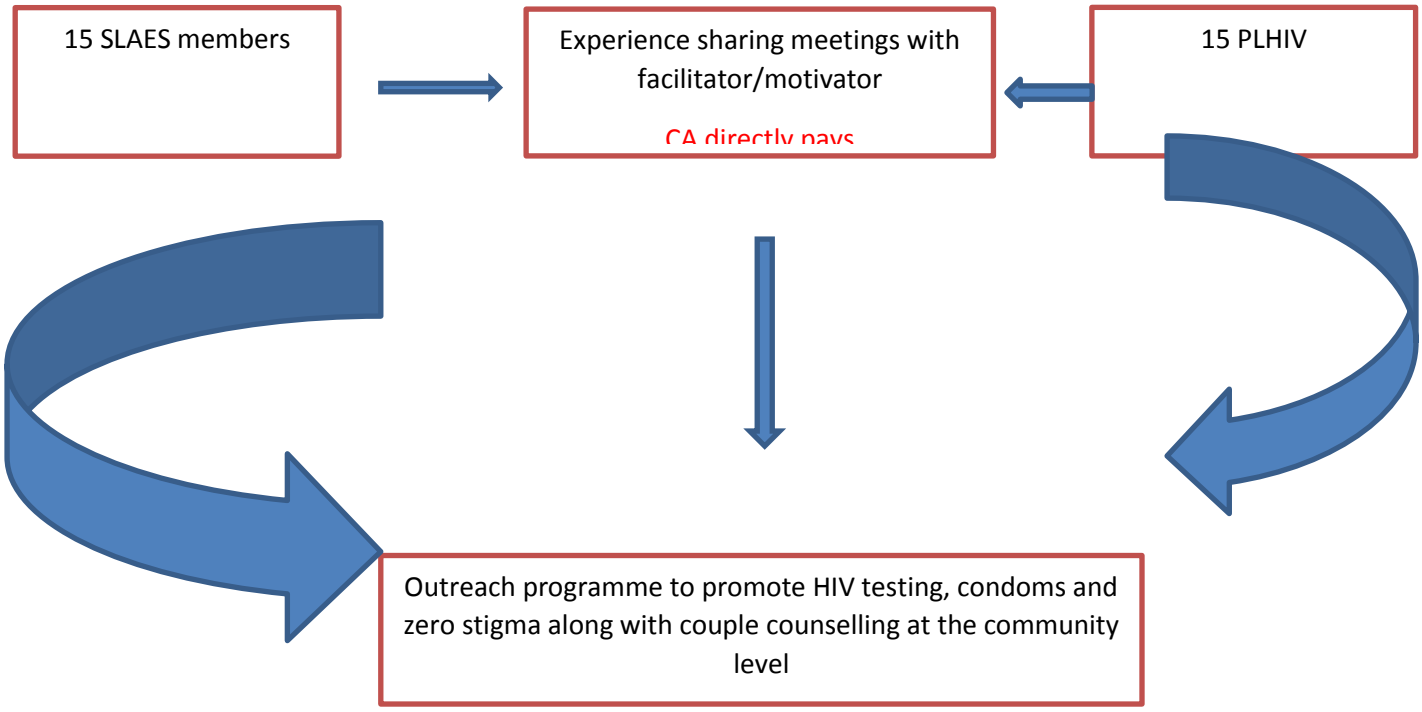
**NETHIPS/SLAES** completed all trainings for fifteen (15) peer motivators who worked with their peers in the targeted communities. Collaborative meetings between stakeholders (NETHIPS and SLAES) in seven districts took place and improved cross fertilization and learning from each other. One hundred and ten (110) stakeholders have participated in the collaborative meetings, where discussion on how to work in a concerted way to address issues of stigma and discrimination against their constituencies were resolved. It has emerged from the meetings that it would be important for both organizations to continue these meetings at the district level and extend to districts that are not part of this project. Twenty-eight (28) Support Groups have been represented in the collaborative meetings so far aimed at building a broader front to fight stigma and discrimination in target districts.

**Women in Crisis (WIC): Women in Crisis (WIC**) have created the Watch Networks (three training sessions for the mentors completed which led to the formation of the Watch Networks); the One-Stop Shop set up and equipped and functional (serving CSWs for counselling and other support); reached 20,070 CSWs through 90 mentors who carried out 30 outreach sessions.

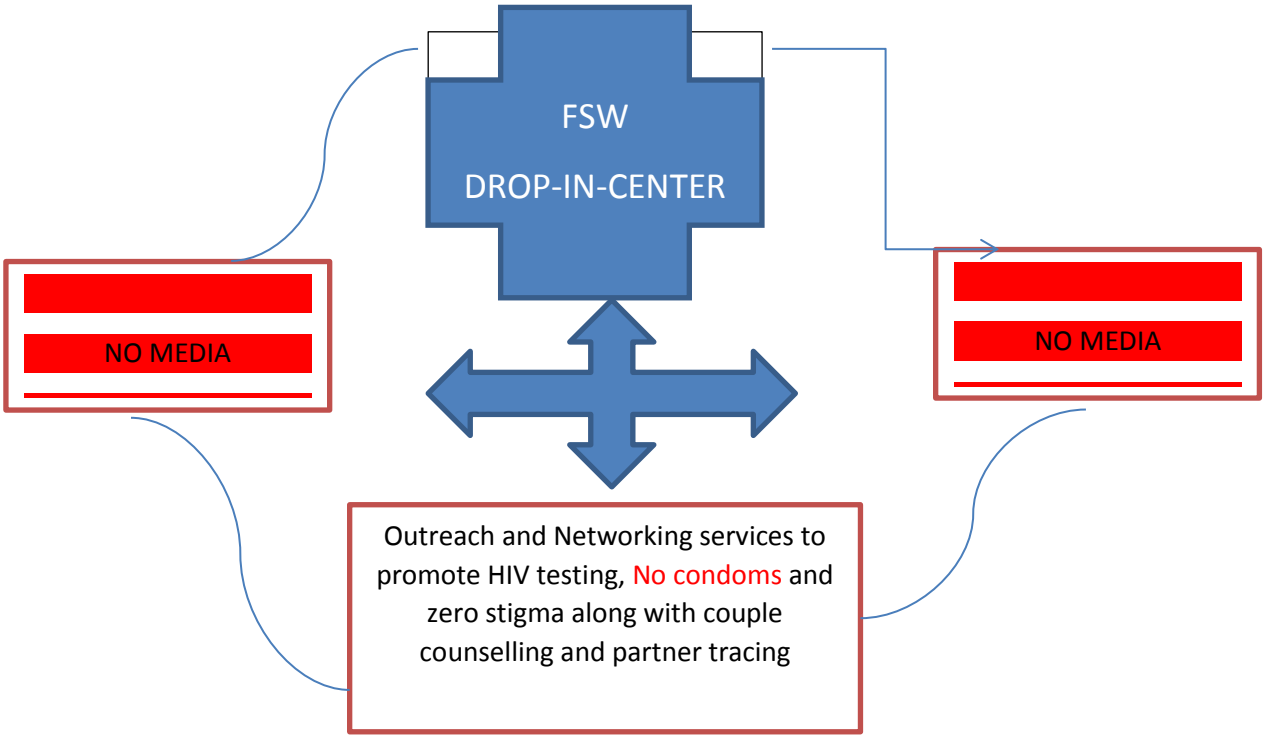
### 2.3 Implementation Models

See below a constructed diagram of delivery models by the review team based on the interaction with implementing partners.

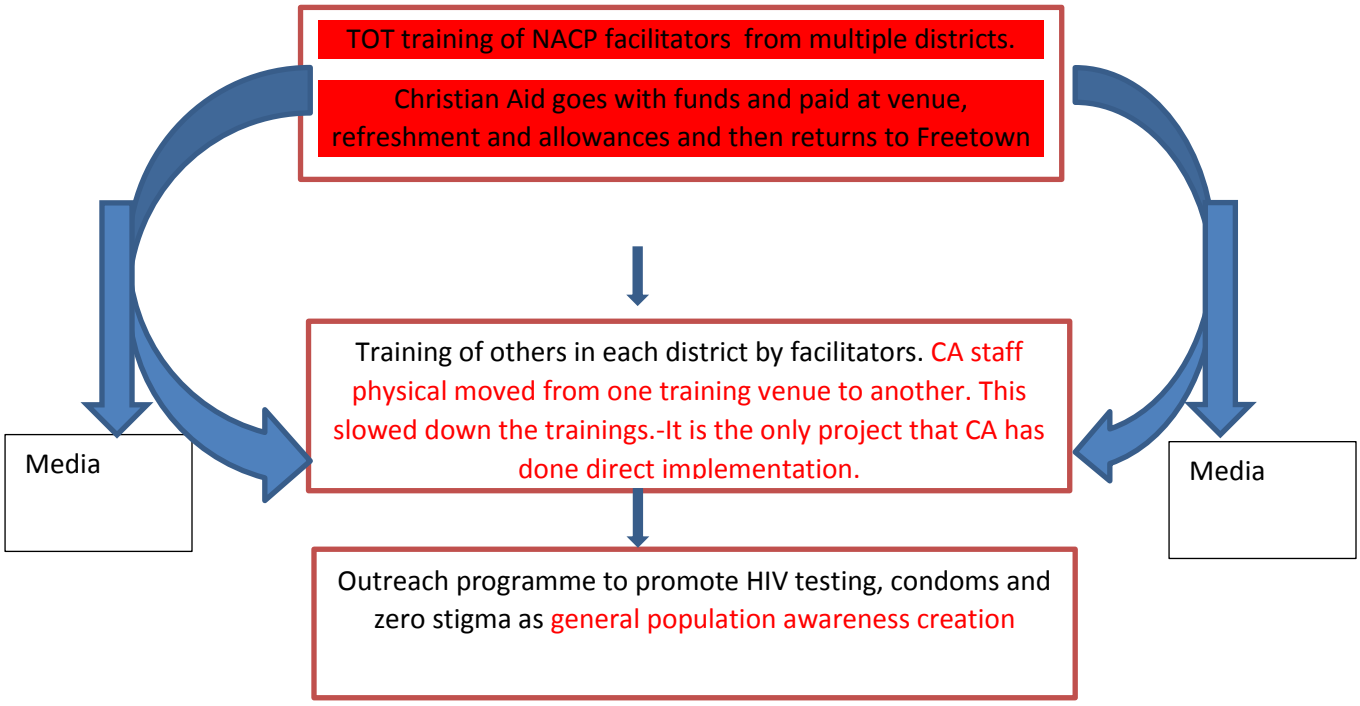
Box 1: NETHIPS-SLEAS Model 1



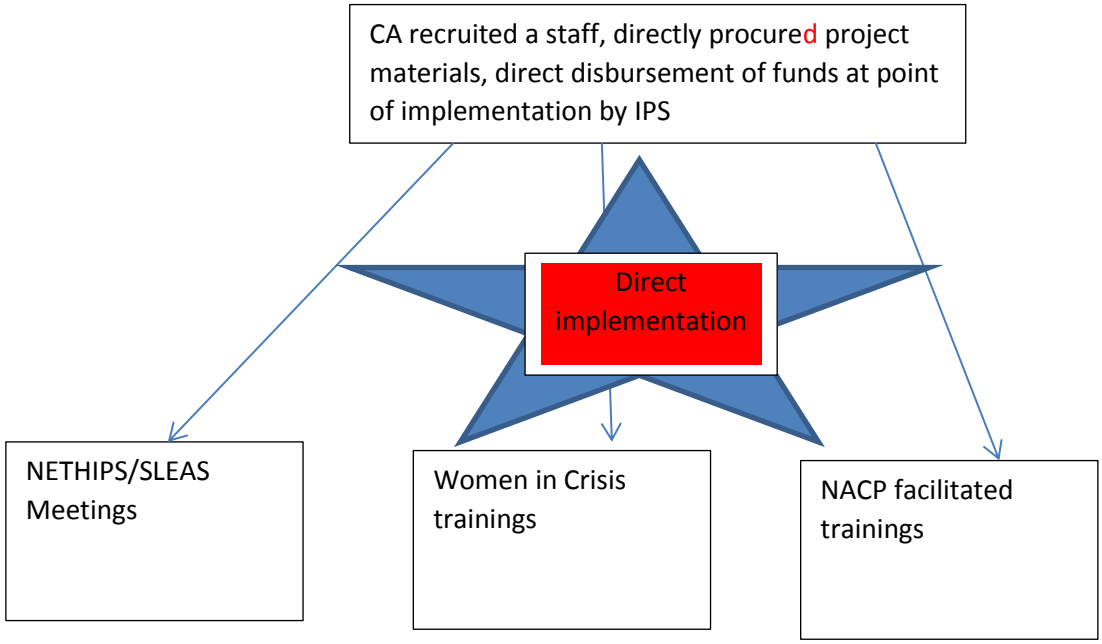
Box 2: WC Model 2



Box 3: NACP Delivery Model 3




Box 3: CA Execution model 4



**2.3 Achievements**
Please describe the achievements and their contribution moving toward the output indicators initially set.

- Getting partners' buy-in and trust takes some time to achieve but has proved critical for ensuring quality and timely execution of activities – every clear about its roles and responsibilities and how much resources are available to them.
- Capacity building, mentorship and accompaniment takes a time but is critical for sustainability of gains and for ensuring that local partners strengthen their internal management and accountability systems which are important for their survival.
- CASL as an executing organization is learning along with its new partners (Women in Crisis, SLAES) on the Positive Health, Dignity and Prevention Project and CASL will use this as an opportunity for future partnerships on similar or related work in the future.

So far, the project have received testimonies of reduced community, family and self stigma by EVD survivors and affected families, based on the psychosocial couselling services provided through this project. There is also indication of improved access to HIV prevention services at the community and strengthened community networks and access to peer supported integrated services for Sex workers to reduce HIV, STI transmission and potential ebola resurgence.

- **Community based partnership building and networking**

The project built partnerships and trust, and capacitated community actors to deliver on services to reduce stigma and discrimination, improved programming skillls and community outreach and counselling services.

- **Reduction in self-stigma and discrimination**

Supportive counseling is a critical component to increasing knowledge and understanding about the persistence of Ebola in bodily fluids and the ramifications of such persistence to the individual's sexual reproductive health and interactions in the community as well as HIV transmission, treatment literacy and peer support for adherence. Lessons from the HIV response also show gains in strengthening support groups, community session and couples sessions to reduce stigma and discrimination and support individuals through challenging times.

Following the investment releases so far, there is a strong positive value of the projects by most beneficiaries-Ebola survivors and PLHIV. There was better integration into their families, relief from self and community stigma, improved knowledge on prevention skills and protection of spouses. The support groups and community networks received further strengthening.

- **Scale up of services for sex workers**

EVDS are faced with social challenges especially with sexual relationships in their respective communities. Most of these vulnerable populations resolve to sexual practices with sex workers within their communities. It is estimated that there are upwards to 300,000 sex workers in Sierra Leone. With growing societal concerns of potential sexual transmission of Ebola to these high-risk population groups, there is a need for targeted interventions to protect these populations and their partners.

The project has equipped and operational an additional integrated drop-in centers for vulnerable groups to access prevention, treatment and psychosocial counseling services in a hard to reach location. It also provided other harm reduction interventions to increase awareness of risk of transmission, created early warning system among highly sexually active group and promoted access condom use among sex workers, their clients and other high vulnerable people such as men-who-have-sex-with-men (MSM)

2.4 Best Practice and Summary Evaluation – *(Please indicate what are the best practice guidelines adopted and the impact on the implementation process*

Below are some life stories from beneficiaries among many received:

**Box 1: EVD Couples session –NACP**

A 27-year old male survivor in Pujehun district, revealed how he benefited from the couples sessions that had been held in his community so far, during the implementation. He has been challenged since he survived Ebola on the use of condom; he said 'when I was given the option at the Ebola treatment unit (ETU) to use condoms for 6 months after recovery or I abstain from sex, I choose abstinence….. This was because I had never use condom in my life and I always thought condoms had some substance in it that causes some strange conditions on someone…..like STIs and even infertility…. and thought it could even slip into a woman's vagina and cause severe bleeding'. As a result of the couples 'sessions, he now appreciates condoms and can negotiate their use comfortably with his sex partner. Initially when we had the 1st meeting, I thought it was impossible, but when my colleagues shared their experiences, I then became curious to know, tried it and found it was good…..I also thought as survivor, I should not be bothered about HIV….. I have learnt a lot about HIV and I now know that everyone is at risk….. I have taken the bold step to go for an HIV test and have also taken my partner for the test.

**EBOLA SURVIVOR**

**Box 2: TESTIMONY OF PRINCESS KOROMA - ANTI-STIGMA AMBASSADOR IN MAKENI - NETHIPS/SLAES**

I have lived as a commercial sex worker before the onset of the Ebola Virus Disease. I used it as my main source of livelihood. I was stigmatized as a result of my way of life. Stigma and discrimination was not new to me. My first experience with stigma and discrimination was as a commercial sex worker.

When the Ebola Virus Disease broke out in Makeni in July 2014, I was among those affected. I was first quarantined, later admitted for treatment and after I recovered I was discharged.

I am part of the NETHIPS/SLAES collaboration as an anti-stigma ambassador in Bombali District. I attended four anti-stigma meetings. During these collaborative meetings, I came to learn that we can work amicably with persons living with HIV & AIDS to fight stigma. I have suffered from stigma at different point in my life – as a commercial sex worker and then as an EVD survivor. Now, through this collaboration, I have now joined the fight against stigma. These collaborative meetings have also helped me to live above stigma. Initially, I was discouraged and had low self-esteem because of the way other people looked at me. Through the collaboration, I received counseling and now live above stigma. In terms of livelihood, I received a heavy package from the president's Post Ebola Recovery Plan Initiative. Because I never had any training on sustaining livelihood, I wasted close to 2 million Leones foolishly. Through the NETHIPS/SLAES collaboration, I came to learn techniques on how to improve my livelihood strategy. I came to discover that complete dependency on handouts was not helping me and would not help me in future. I need to acquire skills that will enable me become self-reliant. Now, I can boldly say that I can sustain myself and will sensitize family and friends to be part of the collaboration, and be encouraged to learn skills in order to obtain self-dependency.

- **Asmau- Sex Worker**

'you have no idea what this means to me and my child, it's the difference between life and death"

***2.4 Delays or Deviations –*** *(Please indicate, if applicable, any reason that may have contributed to any delays or deviation, and describe the measures adopted to move forward to achieve the expected results )*

There were initial delays in the start-up of the project as Christian Aid and partners worked together towards building a strong understanding of the project and trust for programme implementation through the clarification of expectations and the approach to the execution of the project. This included compliance with programme and financial management systems and procedures and reporting. Also, fostering a collaborative front between NETHIPS and SLAES and getting them to the same table took some time to achieve but was critical for achieving greater cross-learning for impact. Budgetary negotiations including revisions to earlier versions and the related administrative processes also took some time to finalize – but was critically important for ensuring that once the project gets started, there was adequate support to ensure timely implementation.

***2.5*** **Lessons learned – (Please, share a couple of lessons learned that can be beneficial for future projects)**

- Community psychosocial counselling improved use of services by target participants in targeted communities.
- Career transition and vocational skill development programmes are necessary for sex workers beyond prevention services – a critical consideration to be made for future interventions.
- Integrated services through the one stop shops give opportunities for sex workers to benefit from multiple services during one visit

- Collaboration of different vulnerable communities have improved access to prevention services and increased coping mechanisms
- Direct disbursement of funds by the executing agency as guided by UNAIDS predisposed to lack of ownership of project activities by IPs
- When the required resources to support effective engagement with beneficiaries are available, implementation can be fast-tracked. The incentives provided by WIC helped significantly in achieving the target – reaching 20,000 CSWs.
- The demand for condoms has grown as beneficiaries received counseling. The participants demanded condom supplies but WIC was not able to provide as they did not have in stock. It would be good that partners dealing with CSW have access to stocks to respond to demands after counseling sessions.
- That it is important to consider alternative engagement support for some of the beneficiaries who demonstrated willingness to go back to school or to skills training. WIC was not able to respond girls who wanted to go back to institutions to learn skills due to lack of resources.
- Integrating interventions was helpful to reach the girls. WIC leveraged its earlier work with CSWs through Global Fund to quickly reach the target number of girls.
- To scale up stigma reduction, there is need to build capacity of HIV support groups on circulating information on HIV and status checking. Also, collaboration has enhanced interaction and scaled up requests for HIV tests.
- Close collaboration with SLAES improved access to the EVD Survivors – some of whom are living with HIV.
- Involvement of peers in counselling facilitated openness in the discussion of issues related to survivorship and HIV prevention/management

### *2.6* Photos of the project

*Figure 1: distribution of condoms to prevent resurgence among Ebola victims*

Figure 2: Condom dispensers in the communities

**Figure 3: Improved collaborative learning sessions between Ebola survivors and People living with HIV**

**Figure 4: Training session on Counselling for Ebola survivors**

**Figure 5: cash transfer beneficiaries**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