Sierra Leone

National HIV/AIDS Monitoring and Evaluation Plan 2016 - 2020

SIERRA LEONE

NATIONAL HIV AND AIDS MONITORING AND EVALUATION PLAN 2016-2020

November 2015

FOREWORD

The 2016-2020 Sierra Leone Monitoring and Evaluation (M&E) Plan for HIV and AIDS response is the third in the series since the establishment of the National HIV/AID Secretariat in 2002. The plan is designed to track and assess the three thematic areas of the 2016-2020 National Strategic Plan for HIV and AIDS response (Targeted Combination prevention, Treatment for all PLHIVs, Response Coordination and Management).

It is also designed to respond to reporting needs of the Government of Sierra Leone. Development Partners including the Global Fund, UN Agencies, German Development Fund, International and national implementing partners, private sector, academia and researchers.

As one of the principles of "Three Ones", the 2016-2020 M&E Plan for HFV and AIDS is developed with the main objective of strengthening systems and capacities for data collection and collation, and tools to improve the monitoring and evaluation of the AIDS response. It also includes flow of information at all levels - Community, facility, district and national. In addition, the M&E plan outlines how information will be generated, packaged, disseminated and used by different partners at national, regional and international levels for programme design and implementation.

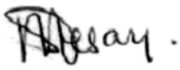
The development of the M&E Plan went through key processes: preparation and planning; assessment of M&E structures and leadership, human resource availability and capacity needs, data sources, collection, flow and reporting; information use; M&E planning and integration; formulation of the Plan and a stakeholder validation and consensus building workshop.

Furthermore, a rigorous, transparent, participatory and evidence-based process was used in determining the baseline values, targets, implementation period, and activities and their associated costs.

Finally, the implementation and tracking of annual results requires technical, financial and human resources and the collective will and total commitment of all partners. I wish to implore all national and international partners in the AIDS response to align their M&E plans to this national strategic document. As we move towards ending HIV as a public health and development threat in Sierra Leone by 2020, it is my profound hope and trust that we will all stay on course and remain committed in the next five years of implementation.

The development of the M&E plan was led, managed and coordinated by NAS with technical support from UNAIDS and other national and international agencies.

The Secretariat will roll-out this M&E plan to all partners and stake holders involved in the HIV and AIDS work Countrywide. It is worth mentioning that the draft M&E plan was subjected to external and internal reviews and validation. Also, assessment of the M&E systems and practices gathered from all categories of partners and stakeholders involved in the AIDS response informed the development of this plan.



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ACKNOWLEDGEMENT

Writing this document would not have been a possible reality, had it not been the relentless support of all partners.

We are thankful to the Leadership and entire staff of UNAIDS-Sierra Leone for providing the financial and technical support to compile this document.

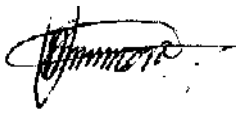
We also offer our profound regards and gratitude to the leadership of the NAS and NACP M&E Teams for their technical skills provided.

The development of the M&E plan was led, managed and coordinated by NAS with technical support from UNAIDS and other national and international agencies. Our sincere thanks and appreciation therefore goes to the M&E team as well as staff of UNAIDS for their commitment throughout the process.

Special thanks to the international consultant Dr. Nathan NShakira for his hard work and commitment demonstrated in developing this M&E plan

Finally, the NAS expresses its appreciation to all other individuals and institutions for their commitment in the ongoing HIV and AIDS campaign, aimed at improving the health of Sierra Leoneans.

We hope that together we can achieve the Sustainable Development Goals (SDGs).



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Acronyms	Explanation
AIDS	Acquired Immunodeficiency Syndrome
CAC	Chiefdom AIDS Council
CBOs	Community Based Organizations
CCM	Country Coordinating Mechanism
DAC	District AIDS Council
FSW	Female Sex Worker
GFATM	Global Fund Against HIV/AIDS, Tuberculosis, Malaria
HIV	Human immunodeficiency Virus
IPT	Isoniazid Preventive Therapy
M&E	Monitoring and Evaluation
MAP	Multi-Sectoral AIDS Program
MESST	Monitoring and Evaluation System Strengthening Tool
MSM	Men who have sex with men
NAC	National AIDS Council
NAS	National AIDS Secretariat
NGO	Non-Governmental Organization
OVC	Orphans and Vulnerable Children
PLHIV	People Living with the HIV Virus
EMTCT	Elimination of Mother to Child Transmission
PWID	People who inject drugs
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Joint Program for AIDS
VCCT	Voluntary Confidential Counseling and Testing
SARA	Service Availability and Readiness Assessment

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1.0 Background

1.1 Country Context

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 government sectors that provide a basis for the national HIV response include: health, education, youth, social welfare, agriculture and labour. Other important sectors are defense, prisons and police.

Health sector: 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. Monitoring and evaluation of services in the health sector is primarily based in health facilities, and currently operates on the District Health Information System (DHIS) platform. Complementary information systems in the sector include: a) the Logistics Management Information System (LMIS); b) the Integrated Human Resources Information System (IHRIS); and c) the Integrated Financial Management Information System (IFMIS).

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 sector 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. The Education Management Information System (EMIS) is the main basis for M&E in the education sector; operating at school, district and national levels.

Youth sector: Sierra Leone is a 'youthful' country, with75 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 National Youth Policy of 2003, the 2009 National Youth Commission Act, and the Ministry of Youth Affairs established in 2013 provide the necessary policy framework and institutional backing to these efforts. One example of such commitments that is relevant for the HIV response is the planned establishment of a National Youth Service for Sierra Leone. The 2012 initial framework for the service includes specific orientation towards HIV skills building among youth, for personal protection and to enable them act as a service and mobilization resource in the national response to HIV. The National Youth Program

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

2014-2918 includes life skills and HIV awareness as expected results from youth-friendly public services.

Agriculture sector: accounts for about half of the national GDP, and employs about 75% of the economically active population (most of them women). The National Sustainable Agriculture Development Plan (NSADP) 2010-2030 mentions a focus on mainstreaming HIV and AIDS among the cross-cutting issues in agriculture; alongside gender, youth employment, and self-sufficiency.[2] The plan acknowledges that a number of projects and programmes in the agricultural sector have health components, principally for raising the awareness of farmers and their families on preventing oneself from contacting certain diseases such asHIV/AIDS, malaria, tuberculosis and other common diseases prevalent within the farming communities.

The social welfare sector: is coordinated in Sierra Leone by the Ministry for Social Welfare, Gender and Children's Affairs. It is responsible for a range of social protection programmes and policies address gender-based and child-specific vulnerabilities; and a broad range of other social welfare issues such as disability and its impacts; human trafficking; religious freedoms, the elderly, and disaster preparedness and response. Sierra Leone has many laws and policies that provide for the social and economic rights and needs of the different focus categories in the social welfare sector. Examples include: the Anti Human Trafficking Act of 2005; the Child Rights Act of 2007;and the three 'GenderJustice Laws' also enacted in 2007: the Registration of Customary Marriage and DivorceAct; the Domestic Violence Act; and the Devolution of Estates Act. Others include the National Disability Act of 2011, and the Child Welfare Policy of 2013. The National Gender Strategic Plan 2010-2013 and the MSWGCA strategy for 2014-2018 both include specific commitments to address sexual and reproductive health and rights issues that include gender-based sexual violence and post-exposure HIV prophylaxis; teenage pregnancy; and access to PMTCT services. This reflects strong commitment and opportunity for further strengthening HIV mainstreaming. However, planning for disaster preparedness and mitigation, and mainstreaming of HIV-related concerns therein are largely limited.

Employment, labour and social security: Sierra Leone has experienced substantial economic growth in recent years; much of this growth is concentrated in the informal agricultural, fishing, mining, andservices sectors that make up the bulk of the economy. Formal economic activity is confined primarily tolarge scale mining, infrastructure, retail services, tourism, and government employment.However, unemployment remains a key challenge; especially because of the low levels of formal education and skills. The proportion of women and men that have some form of education is 49% and 59% respectively. Only 29% of women 15 years and above (and 43% of the men in the same age group) have completed primary school or higher. There is general inadequacy in up-to-datelabour market data especially in the agriculture and agro-processing, sectors - fisheries, mining sector,informal economy and infrastructure development.

Local councils and central government have weak system for labour management. The core structures of the Ministry of Employment, Labour and Social Security; includingemployment services, occupational health and safety, industrial relations and labour market information are weak in terms ofhuman resources, possession of relevant skills, equipment and other logistics. The Sierra Leone Employers' Federation and the Sierra Leone Labour Congress havea good social dialogue relationship; but are also weak in terms of institutional capacities, membership mobilization, and participation of women. Occupational Safety and Health (OSH) is a major concern, and child labour (especially in domestic work, mining and informal trade) is high. Although the impact of HIV in the workplace is recognized, there is limited progress in workplace HIV prevention and mitigation action.

[2] Ministry of Agriculture, Forestry and Food Security (2009) National Sustainable Agriculture Development Plan 2010-2030.

1.2 HIV and AIDS Epidemiological Profile

The HIV epidemic in Sierra Leone was initially considered as mixed, generalized and heterogeneous; however recent studies indicate that it is a concentrated epidemic. 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 (2013, SLDHS). 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.

- Number of people living with HIV - 54,000 [47,000 - 61,000]
- Adults aged 15 to 49 prevalence rate - 1.5% [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]

Figure 1: Sierra Leone HIV Epidemic at a glance

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.

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**

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[3] in 2015; out of which 26,566 are women and 4,390 are children.

[3] 2015 Spectrum Estimates

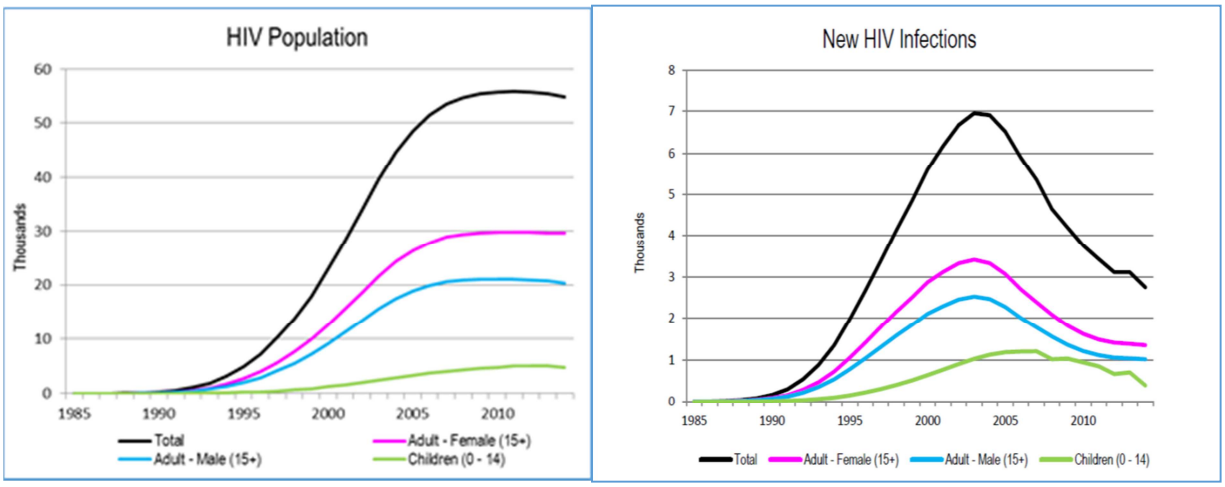


Figure 2: HIV prevalence and incidence in Sierra Leone

DHS 2013 data also reveals that there are varying degrees of knowledge on AIDS and levels of acceptance towards PLHIVs throughout the country, as shown in Figure 4. Districts with the highest levels of comprehensive knowledge on HIV are found in Western Area Urban and Kono. Districts with the highest accepting attitudes of PLHIVs are Bombali and Kailahun.

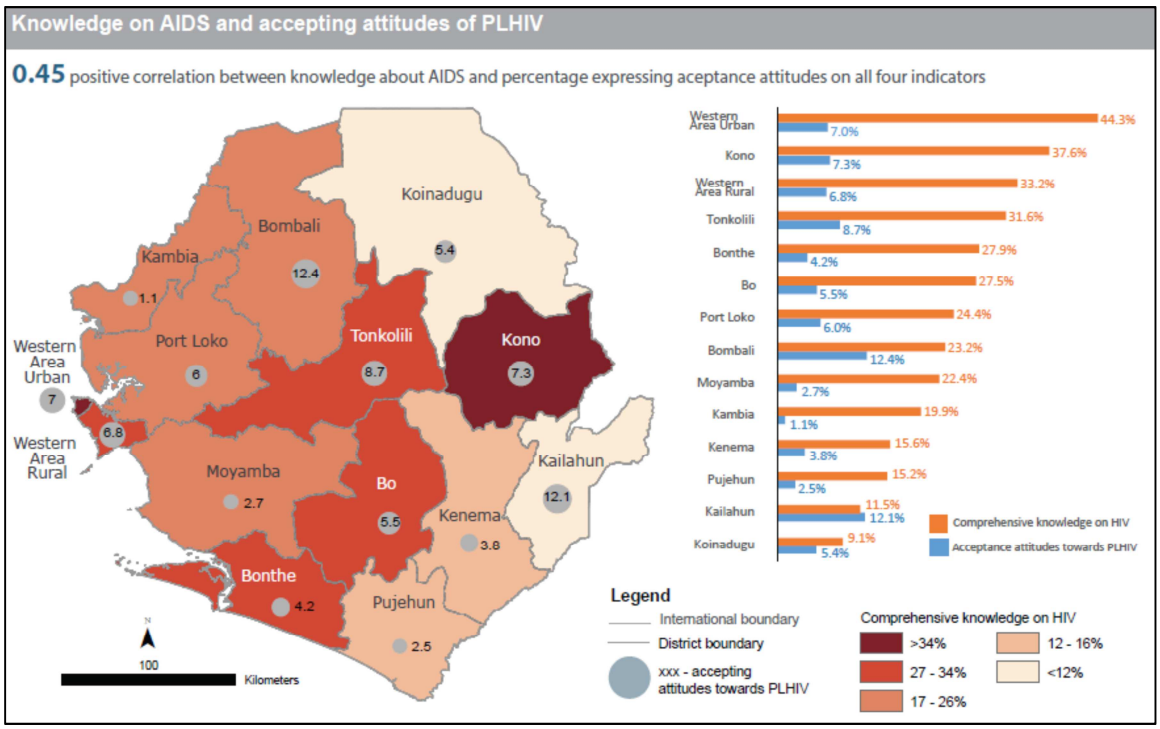


Figure 3: Knowledge on AIDS and accepting attitudes of PLHIV in Sierra Leone

1.3 National HIV Response

Sierra Leone has had a structured multi-sectoral response to HIV and AIDSsince 2002, when the National AIDS Committee (NAC) and its operating base, the National AIDS Secretariat (NAS), were established. In 2011, the coordination framework for the national HIV response was consolidated into a statutory National HIV and AIDS Commission based in the President's Office and still serviced by NAS. The multi-sectoral HIV response has been guided by five-year National Strategic Plans (NSP) since 2006. The NSP 2011-2015 has an overall vision of: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 results from implementation of the NSP are presented in Figure 4 below.

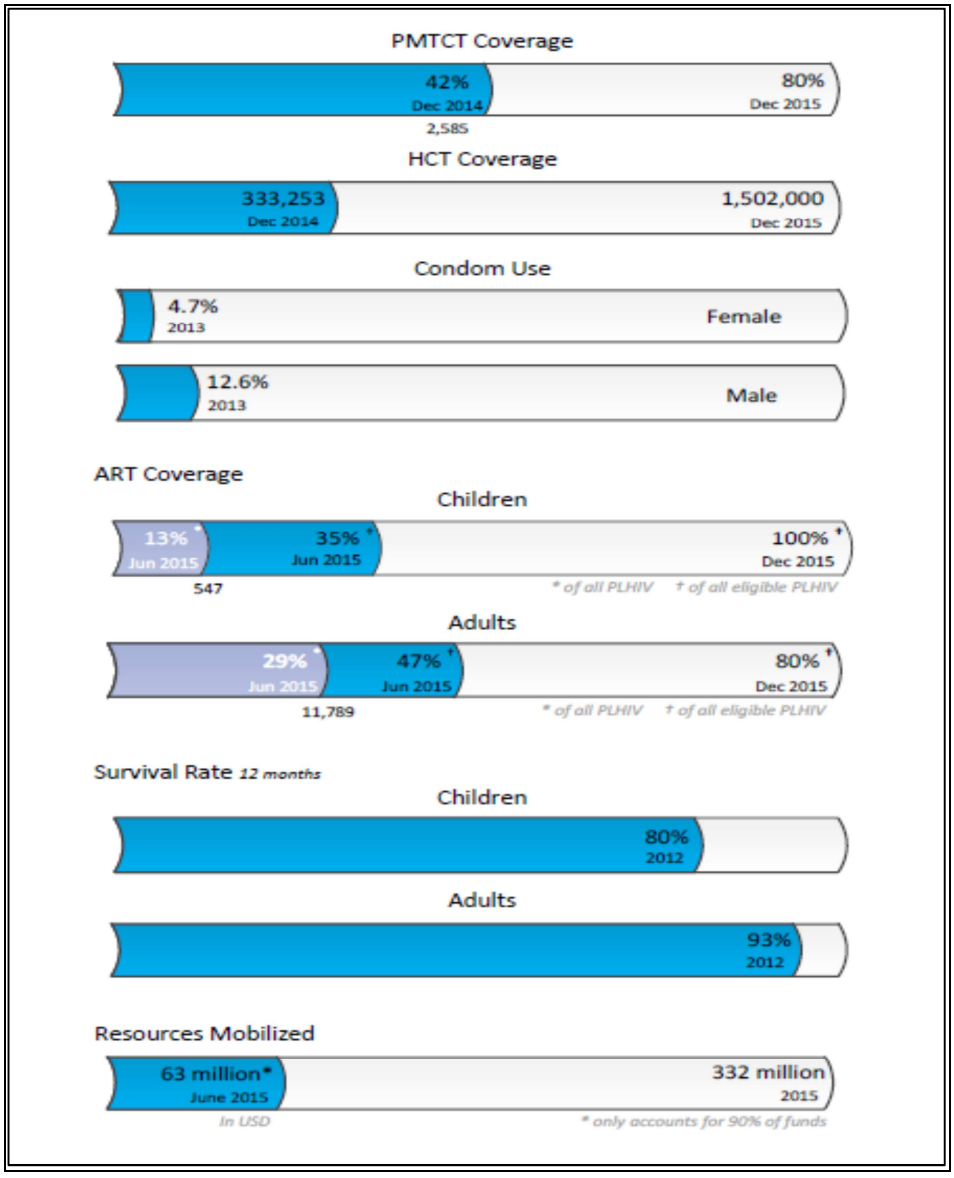


Figure 4: summary of key results from NSP 2011-2015 implementation

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 Ebola Virus Disease (EVD) outbreak in 2014 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).A Health Sector Recovery Plan 2015-2020 has been adopted and is currently under implementation.

1.4 Overview of the NSP 2016-2020

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 is aligned to the global Sustainable Development Goals for 2030; and the national development strategy; the Agenda for Prosperity 2013-2018, as presented in Figure 3 below.

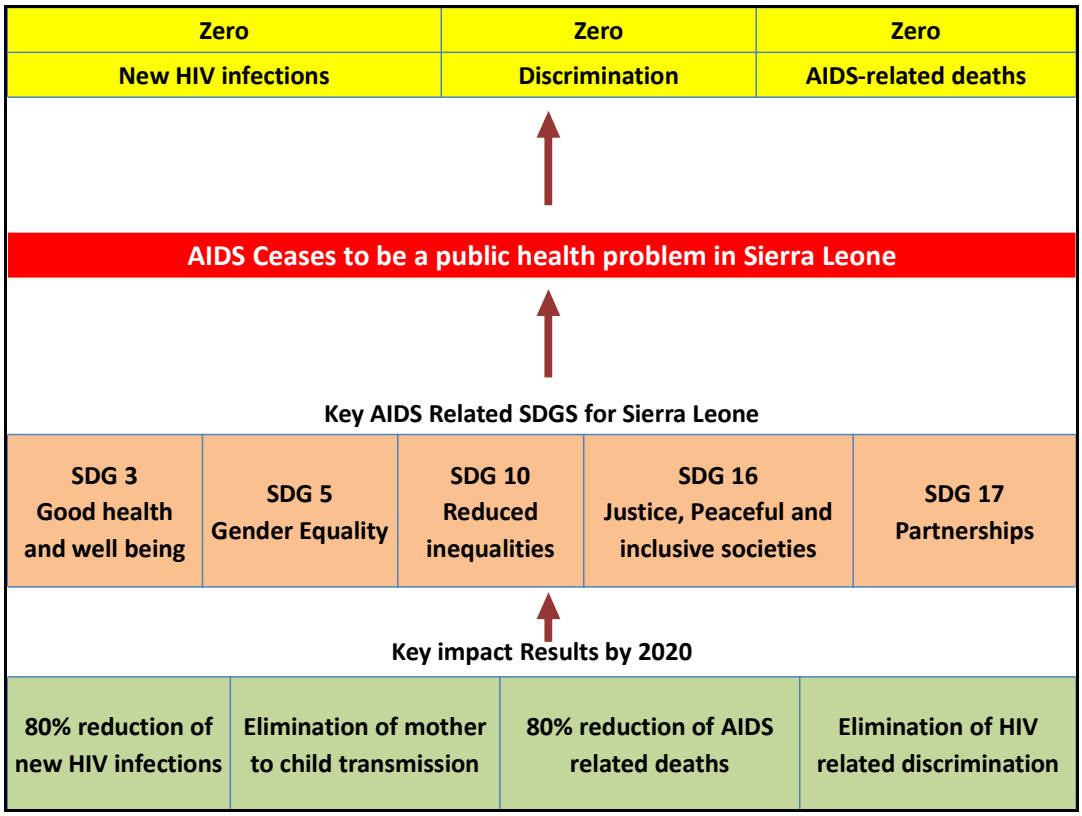


Figure 5: NSP 2016-2020 results summary

1.5M&E Situation Assessment

The monitoring and evaluation of the national HIV response is a core responsibility of NAS. This M&E function is accomplished through three main mechanisms:

1. An M&E Unit with core staff at the NAS head Office, also represented by an M&E Officers in the three Regional offices
2. An M&E Technical Working Group – constituted by individuals with specific M&E expertise and representing the range of stakeholder organizations in the HIV response; to provide Technical guidance and oversight to the M&E operations; established at national and regional levels
3. The M&E and routine reporting systems and mechanisms of the different implementers of the national HIV response – most of them in the health sector, in other government sectors, and across a range of non-government and private sector settings.

The M&E function is based on the UNAIDS organizing and assessment framework for national M&E systems for HIV. The framework has 12 intersecting and inter-dependent elements, subdivided and arranged into three linked resource and activity rings (details in Figure 6):

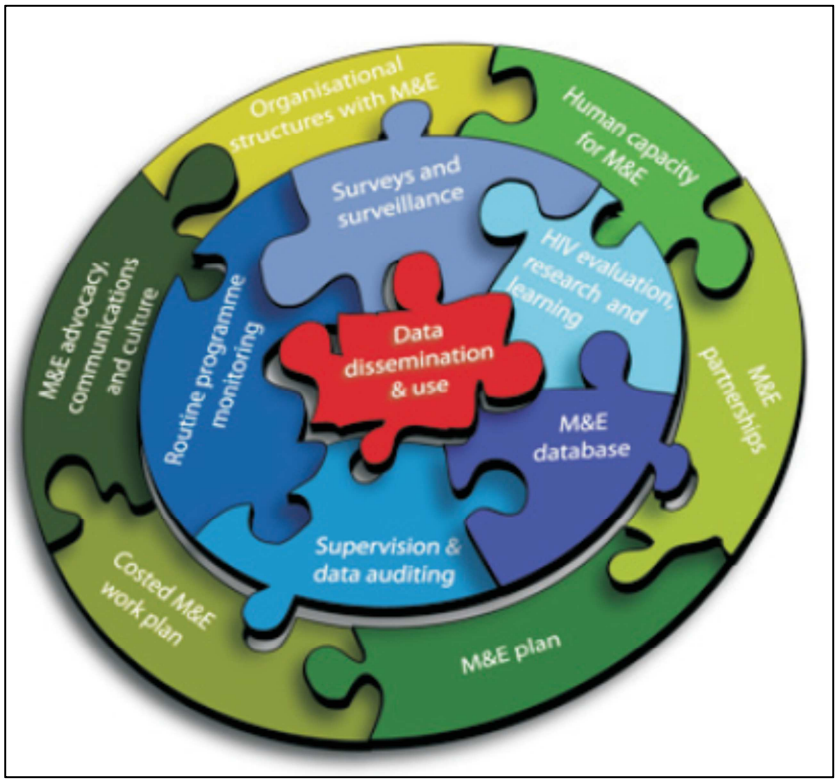


Figure 6: Key components in the M&E system for the national HIV response

The outer ring (green) links six components related to people, partnership, and planning that support data production and use. These constitute the enabling environment for HIV M&E to function. The middle ring (blue) links five components related to data management processes. They constitute the functional elements in the M&E operations of the different stakeholder agencies in the HIV response.

The inner ring (red) involves analyzing data to create information, which is then disseminated to inform and empower decision-making at all levels. It is an integral element in the M&E function at all levels of the HIV response – implementation/service delivery points; institutional and sub-national management level; and national coordination level.

The UNAIDS Monitoring and Evaluation Systems Strengthening Tool (MESST) that is based on this framework has been applied to review and strengthen the Sierra Leone M&E system for HIV in 2009, 2011 and 2013. Modest progress has been achieved over the NSP period 2011-2015; more with respect to the outer and middle rings, and very limited with regard to the inner ring. The priority action points from the 2013 MESST exercise, which underpin this M& plan, are presented in Table 2 below.

Table 2: Priority Action Points from the 2013 MESST Exercise

Organizational Structure: • Recruit 1 Epidemiologist and 2 I.T. Specialists for NAS and NACP • Provide technical M&E Support to improve the capacity of other Partners • Give mandate for MOHS/ NACP staff to conduct research and evaluation • Create permanent employment status for all M&E staff with attractive remuneration and other benefits	**Human Capacity for M&E:** • Conduct capacity building needs assessment • Develop a Human Capacity Building Plan for NAS and NACP • Develop an M&E training Curriculum for all Partners • Integrate HIV/AIDS M&E training modules in the curriculum for tertiary institutions • Develop staff capacity on M&E, Data Management and Information Technology through short courses at national and sub-regional level • Develop database on trainers and people who have received training
M&E Partnership: • Incorporate members of NAS M&E TWG in MOHS M&E TWG • Establish a committee for production and dissemination of quarterly M&E Bulletin; • Strengthen feedback mechanism between NAS and other stakeholders	**M&E Plan:** • Develop specific HIV/AIDS M&E Plan for Local Councils • Synchronize other entities' M&E Work Plans in line with National M&E Plan
Costed M&E Workplan • Review the current national M&E Work Plan by all entities • Allocate adequate budget for M&E activities at all levels	**M&E Advocacy and Culture** • Develop M&E Policy and Advocacy Strategy for NAS • Provide strong advocacy and support for NACP M&E • Recruit Advocacy personnel for M&E
Surveys and Surveillance • Develop National Guidelines for Routine Monitoring and Supportive Supervision • Develop National Guideline for Reporting HIV Data at all levels • Develop Guidelines for Key Populations (FSW, MSM and PWID) • Develop guidelines for Data Quality by CSOs • Develop strategy for routine monitoring of non-Global Fund resources	**HIV Evaluation Research and Learning** • Conduct Workplace and Second Generation Surveys
M&E Database • Expedite the integration of NACP data collection	**Supervision and Data Auditing** • Develop Protocol for HIV Data Auditing

tools into the DHIS • Strengthen the human resource capacity for maintaining and updating the database • Harmonize data sources and reports for all UN agencies	• Conduct joint annual Data Quality Audit
Routine Programme Monitoring • Develop mechanism for data use and dissemination of HIV research and evaluation results/reports at all levels • Develop an inventory of HIV Research Institutions • Develop and update HIV Research Inventory • Mobilize resources for planned research and evaluation • Develop and implement a proper and coordinated research and evaluation dissemination plan	**Data Dissemination and Use** • Develop a costed Information Dissemination Plan • Disseminate relevant information products to providers • Establish Repositories for all HIV/AIDS research and publications at the NAS Information Centres • Conduct regular update of NAS website. • Conduct stakeholders' information needs assessment • Provide internet service for data providers • Develop guidelines for data use at facility level • Develop User Group Communication for all entities • Advocate for data use in research and academic institutions

2.0 Introduction

2.1 Goal of M&E Plan

The goal of this M&E Plan is to contribute to realization of the NSP 2016-2020 objectives and targets, through providing an efficient mechanism to track and demonstrate the achievement. The NSP goals and targets that underpin this commitment are:

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

2.2 Objectives of M&E Plan

The M&E plan is designed and will be implemented to attain the following objectives:

1. Strengthened leadership and Coordination of HIV/AIDS Monitoring and Evaluation (M&E)
2. Enhanced Strategic, Human resource and Logistical capacity for Monitoring and Evaluation (M&E) of the National Response
3. Improved routine HIV/AIDS data collection, management and quality
4. Strengthened systems to undertake HIV/AIDS and related biological and behavioural Surveillance, Surveys and Research
5. Enhanced HIV/AIDS Information & Knowledge Management
6. Strengthened HIV/AIDS Financial monitoring, budget and expenditure analysis

The main outputs to be realized under each of the objectives are presented in Table 3 below.

Table 3: Key Outputs for the M&E Plan

Objective	Outputs
Strengthened leadership and Coordination of HIV/AIDS Monitoring and Evaluation (M&E)	1. Strengthened HIV/AIDS M&E Coordination units/function at National, sectoral and local council levels 2. Strengthened technical leadership and coordination function of HIV/AIDS M&E Technical Working Groups or other relevant M&E TWGs at National, Sectoral and local councillevels 3. M&E Planning protocols and strategic reference resources 4. National, Sectoral and local councillevel HIV/AIDS Coordination structures with office and field logistical M&E resources
Enhanced Strategic, Human resource and Logistical capacity for Monitoring and Evaluation (M&E) of the National Response	1. Management performance contracts in public service, civil society and private sector revised to reflect M&E management and data utilization and dissemination with respect to HIV response management 2. Guidelines and practices for staff deployment and appraisal reflect adequate attention to M&E and appropriate evidence-base for programme activities and service delivery processes 3. Adequate M&E Human resources deployed by public, civil society and private sector stakeholders in the HIV response at national, district and other relevant levels to ensure effective and sustainable M&E support across all levels of the HIV response 4. Adequate and sustained M&E skills capacity development (based on assessed need in line with function) for management and program staff; and for leaders at different levels to ensure appropriate collection, reporting and utilization of M&E data
Improved routine HIV/AIDS data collection, management and quality	1. Standard user-friendly routine HIV/AIDS data collection and reporting tools reviewed and in use; integrated in existing management systems and processes 2. Strengthened M&E support supervision, data quality assurance and quality audit processes 3. Strengthened the data capture, analysis, storage and reporting systems of the HIV/AIDS implementing agencies
Strengthened systems to undertake HIV/AIDS and related biological and behavioural Surveillance, Surveys and Research	1. HIV/AIDS surveillance and survey protocols reviewed/ developed, adopted and in use 2. The national HIV/AIDS research agenda updated, disseminated and in use 3. Strengthened Surveillance, surveys and research on HIV/AIDS 4. HIV/AIDS special studies, epidemiological analyses and projections undertaken to enhance knowledge of the epidemic
Enhanced HIV/AIDS Information & Knowledge Management	1. An HIV/AIDS Knowledge management policy developed, adopted and in use 2. Enhanced integration and co-operability of HIV/AIDS related data bases and sharing of information
Strengthened HIV/AIDS Financial monitoring, budget and expenditure analysis	1. National HIV/AIDS Spending Assessment conducted biennually 2. Regular budget and expenditure analysis to promote resource allocation, utilization efficiency and equity in the national response 3. Unit cost studies, analyses and schedules completed

2.3 M&E Plan Development Process

This M&E plan has been developed as a companion document to the Sierra Leone HIV response NSP for 2016-2020. The process to develop the M&E plan was closely aligned to development of the NSP, to ensure alignment and harmony across both documents. The process was led by the Technical Working Group (TWG) for M&E in the national HIV response, and was coordinated by the M&E Unit at NAS. It included four main stages: initial review of key documents; stakeholder consultations on their M&E experiences; a 3-day plan drafting retreat; review and validation of the draft plan by the TWG for M&E and a wider forum of stakeholders in the HIV response. Technical support was provided to the process by the UNAIDS Strategic Information Advisor for Sierra Leone, and the Consultant who supported the NSP development process.

The plan is based on the following key M&E considerations:

M&E is learning: M&E is meant to initiate a learning process in the course of HIV service delivery and implementation of other HIV support activities. Throughcollecting and analyzing the experiences that have been made during HIV service delivery and implementation of other programme activities, M&E contributes to a learning andgrowing process at individual;organizational/institutional; and at community levels. The logic in this is that: if programmepeople improve their work (personallevel), the organizations will progress (institutional level), which then will spread tothe community at large (community level); with ultimatebenefit to the targetedbeneficiaries.

M&E is for accountability:proving to others that our work is effective. This accountability must be both towards those who provide resources for HIV programmes; and the people and communities served. It should include successes (what has worked well); and also the failures and lessons learnt from them. This plan is based on the principle of social accountability; which is about holding all stakeholders accountable for service delivery from two dimensions (as illustrated in Figure 7):

- The right and opportunity for citizens to hold the state accountable for information and enforcement; through influencing policymakers, and policymakers influencing providers (long-route accountability); and
- The exercise of client power by citizens through direct interaction with service providers; the 'short route' accountability based on client-provider relationship.

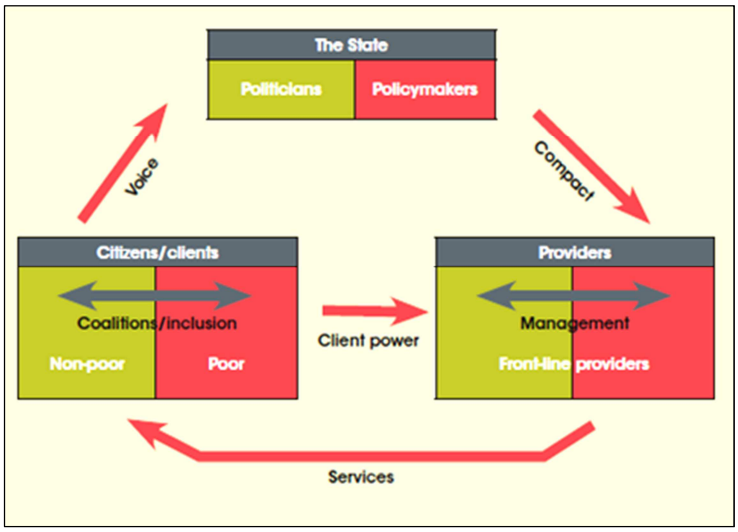


Figure 7: Framework of Accountability Relationships

M&E generates know-how and knowledge: Data collected in implementing HIV programmes can result in new knowledge and better understanding about service delivery. For example, on ways to increase efficiency in health care, strengthening partnership between communities and health

facilities to improve access and quality of services; recognizing and meeting the needs of health care workers related to HV risk, burnout, etc. This knowledge can be used for lobbying and to share good practices with otheractors in the field; and to influence spread and application of these lessons elsewhere. It is crucial to remember that information is power: the more one knows about a programme approach, the easier it will be to make a strong case for it.

M&E is dialogue: M&E should be understood as a dialogue between all stakeholders in the process of service delivery and programme activities. Therefore, all stakeholders need to agree on an appropriate M&E framework that meets the different information needs, and is suited to the capacity and context realities in each setting. This should always take into consideration the mechanisms and tools already in use to collect, process, use and share information. It is easier, more efficient and more likely to be sustainable to build any new information needs into what already exists, than to start up new systems altogether.

Participation is central: people at risk of HIV infection, and PLHIV are the primary beneficiaries of HIV programmes and services. Equally, they should also be at the centre of the M&E activities of the programmes. For many HIV response interventions there is a strong emphasis on engaging local stakeholders and particulargovernment institutions and civil society actors, in order to help build local ownership of and assist the long termsustainability of services. Using a strong participatory approach to M&E, with the activeengagement of government officials and civil society stakeholders, helps to build, strengthen and embed local M&Ecapability and oversight processes.

2.4 Components of M&E Plan

This M&E plan is structured in 5 main components that follow after this section. They are:

1. The M&E Plan – including the structure of the M&E system, data management and storage, data flow and transmission; and data quality assurance
2. Research studies and evaluation learning
3. Information products, dissemination and utilization
4. Implementation of M&E Plan – including roles and responsibilities, key partnerships, M&E communication and advocacy, and technical assistance needs
5. Performance framework for the M&E process

An indicative implementation plan and budget is included as Annex 1. This will be refined each year based on implementation progress and any needs for adjustment.

3.0 The M&E Plan

3.1 M&E System structure

The M&E unit at NAS is responsible for providing support in the areas of monitoring, evaluation and coordination of HIV and AIDS M&E activities of the secretariat and its programs. It is comprised of a Senior M&E Officer, 2 M&E Officers and 2 Program Officers. It provides monitoring and evaluation support to all the components and Units within TGF projects. The unit has three main objectives:

1. To improve the collection, management and utilization of strategic HIV/AIDS information for response planning, performance assessment and epidemic trends and patterns analysis
2. To enhance informed HIV/AIDS policy development, best practices identification and transfer, making of strategic choices; coordination and capacity building and
3. To improve HIV/AIDS resource mobilization, allocation, efficient and effective utilization.

An M&E Technical Working Group (M&E TWG) that provides continuous technical support and guidance to NAS has been established. This working group consists of individuals who have M&E experiences and skills. The membership is based on professional expertise from partners and stakeholders. The TWG meets quarterly and provides technical support to the Unit.

The Coordination arrangements for the implementation of the National HIV/AIDS response require each of the 14 District Councils and 5 City Councils in Sierra Leone to have a District HIV/AIDS Committee. These committees support the District Planning and Management Department to monitor HIV/AIDS activities in the district. They will be supported to ensure vibrant decentralized response and monitoring. These structures also support evaluation activities normally executed by the national agencies but implemented at the population level in respective decentralized localities.

Similarly, Chiefdoms are mandated to constitute an HIV/AIDS Committee or task force; or to designate an already existing committee to take up HIV/AIDS as one of its core functions. This plan provides for support to the Chiefdom AIDS Committees(CAC) in coordination and monitoring of the HIV/AIDS Interventions in the chiefdom. This CAC role will be closely linked to the community level service and data generation and management mechanisms, such as Primary Health Care facilities, social welfare staff, etc.

3.1.1 Human capacity for HIV M&E

Capacity building for stakeholders including NAS is vital for the successful implementation of M&E activities and systems. The priority capacity building needs for both the M&E Coordination units and stakeholders based on the M&E systems and practices assessment are reflected in the MESST report extracts in Annex 2. Thecapacity building plan based on these findings will be retained and implemented to address the capacity needs at the different levels of the HIV response coordination. The capacity building approach will integrate M&E skills with other thematic content on HIV prevention and treatment, and on programme management and advocacy. It will be a continuous and on-going undertaking; to minimize the impact of the high turnover of M&E staff.

3.1.2 Partnerships for HIV M&E

Under this plan, the first level of M&E partnership will be between NAS and the HIV and TB control programmes of MOHS. These programmes have overall responsibility for data generation, processing and reporting on the respective indicators for disease prevention and management. The key partner for decentralized management and utilization of health information will be the District Health Management Team (DHMT). Statistics Sierra Leone (SSL) is the mandated government agency for collection, compilation, analysis, validation and dissemination of all official and other statistical information in the country. It will continue to be a key partner in HIV-related surveys, and in providing technical support to other operational studies. The other key stakeholders in the HIV M&E partnerships are presented in Table 4 below.

Table 4: Key Stakeholders in the HIV M&E Partnerships

National HIV/AIDS Commission Statistics Sierra Leone Government Ministries Departments and Agencies (MDAs) District Councils, Districts HIV/AIDS Committees City Councils, City AIDS Committees, Chiefdom AIDS Committees,	Development Partners: Bi-lateral and Multilateral partners CSO/ NGO Networks and individual International Civil Society Organizations Community Based Organizations (CBOs) Faith Based Organizations (FBOs),	Associations and networks of PLHIVs and other KAP Research and Training institutions Private sectors practitioners and their associations Service Delivery Points, Service users/ Beneficiaries

3.2 Data Management

3.2.1 Indicators Framework

The M&E indicators framework for this plan as presented in Table 5 is based on the NSP high level impact and outcome results; and the detailed output indicators that will be monitored at program level. The output indicators will be further refined alongside the Operational Plan for the NSP for 2016-2018; and the respective annual programme implementation plans.

The alignment of the NSP results and indicators to the SGDs will be further refined in 2016, when the global SDG monitoring framework is released.

Table 5: M&E Framework – illustrative indicators

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Prevention															
Reduction in HIV incidence by 50%															
Impact 1.1	Reduction in HIV incidence by 50% from 0.04% in 2015 to 0.02% in 2020	Percent reduction in HIV incidence	It measures progress towards reducing HIV infection	N/A	N/A	0.04%	0.035%	0.03%	0.025%	0.02%	0.02 %	EPP spec-trum model-ing	Annual-ly	Sex, age, geographical location	NAS
Impact 1.2	Young people aged 15–24 who are living with HIV reduced from 1.1 in 2015 to 0.45 in 2020	Percentage of young people aged 15–24 who are living with HIV	This indicator is calculated using data from pregnant women attending antenatal clinics in HIV sentinel surveillance sites in the capital city, other urban areas and rural areas	Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results	Number of antenatal clinic attendees (aged 15–24) tested for their HIV infection	1.1%	1.0%	0.9%	0.8%	0.6%	0.45 %	ANC Survey DHS	Annual-ly Every five years	Sex, age, geographical location	NAS
Impact 1.3	Female sex workers who are living with HIV reduced from 6.7% in 2015 to 4 in 2020	Percentage of Female sex workers who are living with HIV	This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites	Number of sex workers who test positive for HIV	Number of sex workers tested for HIV	6.7%		6%		5%	4%	IBBSS Special survey	Two to three years	Age, geographical location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Impact 1.4	Men who have sex with men who are living with HIV reduced from 14% in 2015 to 9% in 2020	Percentage of men who have sex with men risk who are living with HIV	This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites	Number of MSM who test positive for HIV	Number of MSM tested for HIV	14%		13%		11%	9%	IBBSS Special survey	Two to three years	Sex, age, geographical location	NAS
Impact 1.5	People who inject drugs who are living with HIV reduced from 8.5% in 2015 to 6% in 2020	Percentage of people who inject drugs who are living with HIV	This indicator is calculated using data from HIV tests conducted among respondents in the primary sentinel site or sites	Number of people who inject drugs who test positive for HIV	Number of people who inject drugs tested for HIV	9%		8%		7%	6%	IBBSS Special survey	Two to three years	Sex, age, geographical location	NAS
Outcome 2.1	people aged 15–49 who had more than one sexual partner from 6% among women and 25.3% among men in 2015 to 3% among women and 15% among men in 2020	Percentage of people aged 15–49 who had more than one sexual partner	It measures progress towards preventing exposure to HIV through unprotected among people with multiple sexual partners	Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last	Number of respondents (15–49) who reported having had more than one sexual partner in the last 12	Women 6.0% Men 25.3%			Women 4.0% Men 19.3%		Women 3.0% Men 15%	DHS	Every five years	Age, sex, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 2.1.1	IEC/BCC materials distributed	Number of IEC/BCC materials distributed	It measures progress in improving coverage of an essential HIV prevention service	Number of IEC/BCC materials distributed	N/A	N/A	TBD	TBD	TBD	TBD	TBD	Program Data	Annually	Age, sex, geographic location	NAS
Output 2.1.2	General population reached with BCC messages from 80.000 in 2015 to 230,000 in 2020	Number of general population reached with BCC messages	It measures progress in improving coverage of an essential HIV prevention service	Number of general population reached with BCC messages	N/A	80,000	80,000	85,000	90,000	95,000	100,000	Program Data	Annually	Age, sex, geographic location	NAS
Output 2.1.3	Peer educators, outreach workers and animators trained from 360 in 2015 to 7200 in 2020	Number of peer educators, outreach workers and animators trained in BCC implementation	It measures progress in improving coverage of an essential HIV prevention service	Number of peer educators, outreach workers and animators trained in BCC implementation	N/A	360	1440	1440	1440	1440	1440	Program Data	Annually	Age, sex, geographic location	NAS
Outcome 3.1	Young women and men aged 15-24 who have had sexual intercourse before the age 15 reduced from 19.5% among women and 10% among men in 2015 to 14.5% among women and 7.5% among men in 2020	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (disaggregated by age and sex)	It measures progress in increasing the age at which young women and men aged 15–24 first have sex	Number of respondents (aged 15–24 years) who report the age at which they first	Number of all respondents aged 15–24 years	Women-19.5% Men 10.%			Women-16.5% Men 8.5%		Women-14.5% Men 7.5%	DHS	Every five years	Age, sex, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 3.1.2	in school youth reached with BCC messages increased from 62,813 in 2015 to 288,813 in 2020	Number of in school youth reached with BCC messages	Knowledge of HIV prevention	Number of in school youth reached with IEC/BCC messages	N/A	62,813	108,013	153,213	198,413	243,613	288,813	Program Data	Annually	Age, sex, geographic location	NAS
Outcome 4.1	women and men aged 15- 49 who receive an HIV test and know the result increased from 14%in women and 6% among men in 2015 to 90% in 2020	% of women and men aged 15 to 49 who receive an HIV test and know the result	Measure individuals who received HIV T&C from any service delivery point	Number of people aged 15-49 who have been tested for HIV during the last12 months and know their results	Number of all respondents aged 15-49	Women-14% Men-6%			Women-60% Men-56%		Women-90% Men-90%	DHS	Every five years	Age, sex, geographic location	NAS
Outcome 4.2	Sex workers who have received an HIV test in the past 12 months and know their results increased from 61% in 2015 to 90 in 2020	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Measure sex workers, who received HIV test and know their result	Percentage of sex workers who have received an HIV test in the past 12 months and know their results	Number of all respondents	61%	67%	73%	78%	84%	90%	BSS IBBSS	Two to three years	Age, sex, geographic location	NAS
Outcome 4.3	Men who have sex with men that have received an HIV test in the past 12 months and know their results increased from 41% in 2015 to 90% in 2020	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	Measure men who have sex with men, who received HIV test and know their result	Percentage men who have sex with men who have received an HIV test in the past 12 months and know their results	Number of all respondents	41%	51%	61%	70%	80%	90%	BSS IBBSS	Two to three years	Age, sex, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Outcome 4.4	People who inject drugs that have received an HIV test in the past 12 months and know their results increased from 13% in 2015 to 90% in 2020	Percentage of people who inject drugs, who have received an HIV test in the past 12 months and know their results	Measure men who inject drugs, who received HIV test and know their result	Number of people, who inject drugs , who have received an HIV test in the past 12 months and know their results	Number of all respondents	13%	28%	44%	60%	75%	90%	BSS IBBSS	Two to three years	Age, sex, geographic location	NAS
Output 4..1.1	women and men aged 15 to 49 who receive counseling and testing for HIV and receive their test result increased from 839,745 in 2015 to 2,576,716 in 2020	Number of women and men aged 15 to 49 who receive counseling and testing for HIV and receive their test result	Measure individuals who received HIV T&C from any service delivery point	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	N/A	Women-261474 Men - 71779	839,745	1,030,762	1,546,080	2,061,398	2,576,716	Program Data	Annually	Age, sex, geographic location	NAS
Output 4.1.3	Eligible people provided with pre-exposure prophylaxis (PrEP) increased from 0 in 2015 to 10,000 in 2020	Number of eligible people provided with pre-exposure prophylaxis (PrEP)	Measure individuals at risk who are provided with Prep	Number of individual provided with PrEP	Number of eligible people in need of (PrEP)	0%	10,000	10,000	10,000	10,000	10,000	Program Data	Annually	Age, sex, geographic location	NACP
Output 4.1.4	Eligible people provided with post-exposure prophylaxis (PEP) increased	Number of eligible people provided with post-exposure prophylaxis (PEP)	Measure individuals at risk who are provided with PEP	Number of individual provided with PEP	Number of eligible people in need of (PEP)	N/A	TBD	TBD	TBD	TBD	TBD	Program Data	Annually	Age, sex, geographic location	NACP

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Outcome 5.1	Adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse increased from 4.7% among women and 12.6% among men in 2015 to 80% among men and women in 2020	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	It measures progress in preventing exposure to HIV among adults aged 15–49	Number of respondents (aged 15–49) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	Number of respondents (15–49) who reported having had more than one sexual partner in the last 12 months	Women 4.7% Men 12.6%			Women 56% Men 59%		Women and men 80%	DHS	Every five years	Age, sex, geographic location	NAS
Output 5.1.1	Male condoms distributed increased from 2466936 in 2015 to 6000,000 in 2020	Number of male condoms distributed	It measures progress in preventing exposure to HIV among adults aged 15–49	Number of male condoms distributed	N/A	2,466,936	4,000,000	4,500,000	5,000,000	5,500,000	6,000,000	Program Data	Annually	Age, sex, geographic location	NAS/NACP
Output 5.1.2	Female condoms distributed increased from 7,000 in 2015to 10,000in 2020	Number of female condoms distributed	It measures progress in preventing exposure to HIV among adults aged 15–49	Number of female condoms distributed	N/A	7,000	8,000	8,500	9,000	9,500	10,000	Program Data	Annually	Age, sex, geographic location	NAS/NACP

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Outcome 6.1	female sex workers reporting the use of a condom with their most recent client increased from 88.2% in 2015 to 100% in 2020	Percentage of female sex workers reporting the use of a condom with their most recent client	It measures progress in preventing exposure to HIV among sex workers through unprotected sex with clients	Number of Sex workers who reported that a condom was used with their last client	Number of Sex workers who reported having commercial sex in the last 12 months	88.2%		93%			100%	IBBSS	Two to three years	Age, geographic location	NAS
Outcome 6.2	Female sex workers reached with HIV prevention programmes increased from 1,672 in 2015 to 45,000 in 2020	Number of Female sex workers reached with HIV prevention programmes	It measures progress in implementing basic elements of HIV prevention programmes for SW	Number sex who benefited from the defined package	Total number of sex workers surveyed	1,672	17,000	24,000	31,000	38,000	45,000	Program Data	Two to three years		NAS
Outcome 6.3	men reporting the use of a condom the last time they had anal sex with a male partner increase from 48% in 2015 to 90% in 2020	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	It measures progress in preventing exposure to HIV among men who have unprotected anal sex with a male partner	Number of MSM who reported that a condom was used the last time they had anal sex	Number of MSM who reported having had anal sex with a male partner10 in the last six months	48%		65%			90%	IBBSS	Two to three years	Age, geographic location	NAS
Outcome 6.4	MSM reached with HIV prevention programmes increased from 1,200 in 2015 to 10,000 in 2020	Number of MSM reached with HIV prevention programmes	It measures progress in implementing basic elements of HIV prevention programmes for MSM	Number MSM who benefited from the defined package	Total number of MSM surveyed	1,200	5,000	6,000	8,000	9,000	10,000	Program Data	Two to three years	Age, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Outcome 6.5	people who inject drugs who report the use of a condom at last sexual intercourse increased from 32% in 2015 to 90% in 2020	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	It measures progress in preventing exposure to HIV among PWID through unprotected sex with clients	Number of PWID who reported that a condom was used with their last client	Number of PWID who reported having sex in the last 12 months	32%		55%			90%	IBBSS	Two to three years	Age, sex, geographic location	NAS
Outcome 6.6	PWID reached with HIV prevention programmes increased from 0 in 2015 to 1,500 in 2020	Number of PWID reached with HIV prevention programmes	It measures progress in implementing basic elements of HIV prevention programmes for PWID	Number PWID who benefited from the defined package	Total number of PWID surveyed	N/A	1,500	1,500	1,500	1,500	1,500	Program re data	Two to three years	Age, geographic location	NAS
Outcome 6.7	People who inject drugs who reported using sterile injecting equipment the last time they injected increase from 51% in 2015 to 90% in 2020	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	Measuring increase in percentage of People who inject drugs	Number of respondents who report using sterile injecting equipment the last time they injected drugs.	Number of respondents who report injecting drugs in the last month.	40.7% (79/194)		61%			90%	IBBSS	Two to three years	Age, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Outcome 6.8	people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission increased from 28%among women and 30% among men in 2015 to 50% among women and men 2020	Percentage of people aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	It measures progress towards universal knowledge of the essential facts about HIV transmission	Number of respondents aged 15–24 years who gave the correct answer to all five questions	Number of all respondents aged 15–24	15-24yrs Women 28.8% Men 30.0%	35%		50%		70%	DHS	Every five years Two to three years	Age, sex, geographic location	NAS
Outcome 6.9	women and men aged 15 to 49 who reported having an STI in the past 12 months reduced from 9% in 2015 to 2% in 2020	Percentage of women and men aged 15 to 49 who reported having an STI in the past 12 months	STI prevalence among the general population aged 15-49	Number of respondents reporting having an STI and/or symptoms of an STI in the	Number of respondents age 15-49 who ever had sexual intercourse	Women-10.5% Men-10.6%	9%		5%		2%	DHS	Two to three years	Age, sex, geographic location	NAS
Outcome 6.10	women and men aged 15-49 years expressing accepting attitudes toward people living with HIV increased from 6% in 2015 to 90% in 2020	Percentage of women and men aged 15-49 years expressing accepting attitudes toward people living with HIV	This indicator measures accepting attitudes toward people living with HIV among women and men aged 15-49	Number of women and men aged 15-49 who report accepting attitudes towards people living with HIV.	All respondents aged 15-49 who have heard of HIV.	Women -6.6 Men - 6.2	23%		56%		90%	DHS	Every five years Two to three years	Age, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Outcome 6.11	Women and men age 15-49 reporting that syringe and needle were taken from new un open package increased from 97% in 2015 to 100% in 2020	Percentage of women and men age 15-49 reporting that syringe and needle were taken from new un open package	Use of sterile needle and syringe among the general population	Number women and men age 15-49 reporting that syringe and needle were taken from new un open package	Number respondents 15-49 reporting that syringe and needle were taken from new un open package	Women-97% Men-97.6			100%		100%	DHS	Every five years	Age, geographic location	NAS
Outcome 6.12	Donated blood units screened for HIV in a quality assured manner maintained	% of donated blood units screened for HIV in a quality assured manner	Donated blood screened in quality assured manner	Number of donated blood units screened for HIV in blood centers or blood screening laboratories that	Total number of blood units donated	100%	100%	100%	100%	100%	100%	Program data/ DHIS	Annual-ly	Age, geographic location	NAS
Outcome 6.13	HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother-to child transmission increased from 85% in 2015 to 100% in 2020	Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother-to child transmission	It measures progress in preventing mother-to-child transmission of HIV during pregnancy and delivery through the provision of antiretroviral drugs	Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery	Estimated number of HIV-positive pregnant women within the past 12 months	85%	100%	100%	100%	100%	100%	Program data	Annual-ly	Age, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 6.13.1	pregnant women who received HIV counseling and testing for PMTCT and received their test results increased from % in 2015 to 100% in 2020	% of pregnant women who received HIV counseling and testing for PMTCT and received their test results	This indicator assesses efforts to identify the HIV serological status of pregnant women in the previous 12 months.	Number of pregnant women of known HIV status.	Estimated number of pregnant women in the past 12 months	67.3%	70%	75%	85%	90%	100%	Program Data	Annual-ly	Age, geographic location	NAS
Output 6.13.2	All HIV-positive pregnant women received antiretrovirals to reduce risk of mother-to-child-transmission	Number of HIV-positive pregnant women who, received antiretrovirals to reduce risk of mother-to-child-transmission	It measures progress in preventing mother-to-child transmission of HIV during pregnancy and delivery through the provision of antiretroviral drugs	Number of HIV-positive pregnant women who received antiretroviral drugs during the past 12 months to reduce the risk of mother-to-child transmission during pregnancy and delivery	Not Applicable	2,585	3,160	3,239	3,192	3,129	3,058	Program Data	Annual-ly	Age, geographic location	NAS
Output 6.13.3	antenatal care attendees positive for syphilis who received treatment increased	Percentage of antenatal care attendees positive for syphilis who received treatment	Percentage of antenatal care attendees during a specified period with a positive	Number of antenatal care attendees with a positive syphilis serology who received at least one dose of benzathine penicillin 2.4	Number of antenatal care attendees with a positive syphilis serology	TBD	TBD	TBD	TBD	TBD	TBD	DHIS	Annual-ly	Age, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
				mU IM											
Output 6.13.4	virological test for HIV within 2 months of birth increased from 13.2% to 90%	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Measures 2 months of life to determine their HIV status and eligibility for ART, disaggregated by test results	Number of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	Estimated number of infants born to HIV-positive women in the last 12 months	13%	30%	45%	60%	75%	90%	Program Data	Annual-ly	Age, geographic location	NAS
Output 6.13.5	Pregnant women attending ANC care whose male partners were tested for HIV in the last 12 months increased from 3% to 20%	Percentage of pregnant women attending ANC care whose male partner was tested for HIV in the last 12 months	Measures partner involvement	Number of pregnant women attending ANC care whose male partner was tested for HIV in the last 12 months	Number of pregnant women attending ANC care in the last 12 months	2.7%	5%	8%	10%	15%	20%	Program Data	Annual-ly	Age, geographic location	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 6.13.5	Orphaned and vulnerable children (OVC) aged 0–17 years whose households received free basic external support increased	Percentage of orphaned and vulnerable children aged 0–17 years whose households received free basic external support	Measure nutritional support provided to OVC	Number of orphaned and vulnerable children aged 0–17 years provided with nutritional support	Estimated number of OVCs	37%	40%	42%	46%	50%	60%	Program Data	Annual-ly	Age, geographic location	NAS
TREATMENT															
REDUCTION OF AIDS RELATED MORTALITY FROM 7% TO 1%															
IMPACT 2.1	Reduction of aids related mortality from 7% to 1%	Percentage of AIDS related deaths amongst PLHIVs	Measures AIDS related deaths amongst PLHIVs enrolled on ART care	Number of estimated deaths amongst PLHIVs	Number of estimated PLHIVs	2,374 (7%)	1975	1576	1178	780	382(1%)	Spectrum	Annual-ly	Sex, Age, district	NAS, NACP
Outcome 7.1	PLHIV on ART attain viral load suppression from current level to 90% in 2020	Percentage of PLHIV on ART that attain viral load suppression	Measures viral load suppression amongst PLHIVs enrolled on ART as per national guidelines	Number of PLHIVs (adults & children) with an undetectable viral load at 12 months (<1000 copies/ml)	All PLHIVS(adults & Children) currently enrolled in the program	TBD	90%	90%	90%	90%	90%	Program data	Annual-ly	Sex, Age, district	NAS, NACP
Output 7.1.1	All health facilities(ART & PMTCT sites)managed by trained staff increased 136 to 701	Number of health facilities(ART & PMTCT) managed by trained staff	Measures the number of facilities managed by trained and qualified staff	Facilities managed by trained staff	All facilities providing HIV care services	136	475	701	701	701	701	Program data	Annual-ly	Sex, Age, district	NAS, NACP

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 7.1.2	PLHIV on ART who are virologically tested increased from current level to51,664 (90%) in 2020	Number of PLHIV on ART who are virologically tested	Measures viral load testing amongst PLHIVs enrolled on ART as per national guidelines	Number of PLHIV on ART who are virologically tested	N/A	0.00	19,675	24,406	33,492	42,578	51,664	Program data	Annual-ly	Sex, Age, district	NAS, NACP
Outcome 8.2	PLHIV started on ART retained for life increased from 70.5% in 2015 to 90% by 2020	Percentage of PLHIV retained on treatment 12, 24 and 60 months after initiation	Measures PLHIV retention on ART 12, 24 and 60 months after initiation	Number of PLHIVs on ART at 12, 24 and 60 months	All PLHIVS currently enrolled in the program 12, 24 and 60 months	70.5%	81%	85%	87%	88%	90%	NACP Program data, Survival Analysis study	Annual-ly	Sex, Age, district	NAS, NACP
Output 8.2.1	Eligible adults and children currently receiving ART increased from 35% in 2015 to 90% in 2020	Percentage of eligible adults and children currently receiving ART	Measures PLHIV currently on treatment	Number of eligible adults and children currently receiving ART	All eligible estimated number of adults and children with advanced HIV infection	35%	36%	45%	60%	75%	90%	NACP Program data, spectrum	Annually	Sex, Age, district	NAS, NACP
Output 8.2.2	Health facilities dispensing ARVs that experienced a stock out of at least one required ARV in the last 12 months reduced	Percentage of health facilities dispensing ARVs that experienced a stock out of at least one required ARV in the last 12 months	Measures whether health facilities dispensing ARV drugs have run out of Stock	Number of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV drug in the last 12 months.	Total number of health facilities dispensing ARVs.	N/A	TBD	TBD	TBD	TBD	TBD	Special Survey	Annually	By facility type and district	NAS, NACP
All PLHIVs and affected persons have improved quality of life by 2020															
Outcome 9.1	PLHIVs and caregivers engaged in sustainable resilient livelihood	Percentage of PLHIVs/caregivers engaged in sustainable livelihood	Measures socio-economic status of PLHIVs to access	Number of PLHIVs engaged in sustainable livelihood	Number of PLHIVs/caregivers	N/A	10%	15%	20%	25%	30%	Program data,	Once every 3 - 5 years	Sex, district	NAS, NETHIPs, UNAIDS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
	increased to 30% by 2020		treatment												
Outcome 9.2	PLHIVs have accessing quality and reproductive health services increased to 100% by 2020	Percentage of PLHIVs accessible to quality health services	Measures PLHIVs access to quality health services	Number of PLHIVs enrolled in HIV care	Number of PLHIVs	35%	36%	44%	65%	85%	100%	Program data,	Once every 3 - 5 years	Sex, Age, district	NAS, NETHIPs, UNAIDS
Outcome 9.3	All PLHIVs and affected persons rights Protected by 2020	Percentage of PLHIVs and affected persons whose rights are protected	Measures the proportion of PLHIVs and affected persons whose rights are Protected	Number of PLHIVs who reported human rights violation	Number of PLHIVs	N/A	100%	100%	100%	100%	100%		Once every 3 - 5 years	Sex, Age, district	Partners
Outcome 9.5	PLHIV with TB retained in TB care until cured increased from 46% in 2015 to 90% by 2020	Percentage of PLHIV with TB **retained** in TB care until cured	Measures the effectiveness of TB/HIV co-infection management within the program	Number of HIV/TB co-infected clients cured of TB	Number of HIV/TB co-infected clients enrolled in TB care	46%	55%	65%	75%	85%	90%		Annual-ly	Sex, Age, district	NACP/TB
Outcome 9.4	PLHIV with TB cured increased to 100% by 2020	Percentage of PLHIVs with TB cured	Measures the effectiveness of TB/HIV co-infection management	Number of PLHIVs cured of TB	Number of PLHIVs with TB enrolled in TB program	46%	100%	100%	100%	100%	100%	Program Data	Annually	Sex, Age, district	NACP/TB

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 9.5.1	Estimated HIV-positive incident TB cases that received treatment for both TB and HIV increased	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	It measures progress in detecting and treating TB in people living with HIV	Number of adults with advanced HIV infection who received antiretroviral combination therapy and who were started on TB treatment within the reporting year	Estimated number of incident TB cases in people living with HIV	N/A	TBD	TBD	TBD	TBD	TBD	Program Data	Annual-ly	District Sex, Age, district	NAS
Output 9.5.2	Health care facilities providing ART services for people living with HIV with demonstrable infection control practices that include TB control increased from 136 in2015 to 701 in 2020	Number of health care facilities providing ART services for people living with HIV with demonstrable infection control practices that include TB control	This indicator measures if health facilities receiving a large number of people living with HIV have implemented measures to prevent the risk of person to person transmission of TB	Number of health care facilities providing ART services for people living with HIV with demonstrable TB infection control practices consistent with international guidelines	N/A	136	701	701	701	701	701	Program Data	Annually	By facility type, district	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 9.5.3	Adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT) increased from 12% in 2015 to 100% in 2020	Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	Measures newly enrolled PLHIVs in HIV care started on treatment for latent TB infection	Number of adults and children newly-enrolled (i.e. started) in HIV care (pre- ART and ART) who also start (i.e. given at least one dose) IPT-treatment	Number of adults and children newly-enrolled (i.e. started) in HIV care during the reporting period.	12%	31%	38%	60%	80%	100%	Program Data	Annual-ly	District Sex, Age, district	NAS
Output 9.5.4	Adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit increased	Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	Number of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit.	Number of adults and children in HIV care, who had their TB status assessed and recorded during their last visit. HIV care includes pre-ART and ART.	Total number of adults and children in HIV care in the reporting period.	63%	100%	100%	100%	100%	100%	Program Data	Annual-ly	District Sex, Age,	NAS
Goal/Impact: A robust and functional Coordinating HIV Systems fully implemented and Integrated at all levels by 2020															
Outcome 10.1	Existing laws and policies are strengthened for social protection of the PLHIV and other vulnerable groups	Percentage of PLHIV network who report their rights are protected and empowered	Enabling environment for PLHIVs and other vulnerable groups	Number of PLHIVs and vulnerable groups protected and empowered	Number of PLHIVs and vulnerable groups	N/A	TBD	TBD	TBD	TBD	TBD	Program Data	Annual-ly	Districts, urban/rural, age and sex	Partners

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Outcome 10.2	Gender mainstreamed into HIV/AIDS program	Gender coordinating mechanisms related to HIV/AIDS established and functional	Measures the effectiveness of Gender coordinating mechanisms	Gender coordinating mechanisms related to HIV/AIDS established and functional	N/A	N/A	TBD	TBD	TBD	TBD	TBD	Program Data	Annual-ly	Districts	Partners
Output 10.2.1	Gender violence reduced	Number of people reached explicitly on issues that address gender based violence and coercion related to HIV/AID	Measures human rights abuse and violation among women and girls	Number of people reached explicitly on issues that address gender based violence and coercion related to HIV/AID	N/A	N/A	TBD	TBD	TBD	TBD	TBD	Program Data	Annual-ly	Districts, and sex	Partners
Output 10.2	PLHIV have their views expressed, rights protected and economically empowered	Number of policy makers and program planners trained on gender mainstreaming	Measure capacity of policy makers in gender mainstreaming	Number of policy makers and program planners trained on gender mainstreaming	N/A	N/A	TBD	TBD	TBD	TBD	TBD	Program Data	Annual-ly	Districts, and sex	Partners
INTEGRATED AND SUSTAINABLE HIV RESPONSE (Strategic Information)															
Outcome 11.1	Improved utilization of strategic information for the effectiveness of the National HIV Response	Percentage of institutions implementing HIV/AIDS activities in accordance to the NSP	Measures utilization of strategic information	Number of institutions implementing HIV/AIDS activities in accordance to the NSP	Number of institutions implementing HIV/AIDS activities	N/A	100%	100%	100%	100%	100%	Program Data	Annual-ly	District, Rural/Urban	NAS
Output 11.1.1	Partner institutions effectively capacitated to	Number of institutions capacitated to effectively	Measures NSP utilization	Institutions effectively utilizing NSP for HIV	NA	TBD	TBD	TBD	TBD	TBD	TBD	Program Data	Annual-ly	District, Rural/Urban	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
	utilize the NSP	utilize the NSP		service delivery											
Output 11.1.2	Strategic HIV/AIDS information is produced and disseminated	Existence of HIV strategic information dissemination plan developed	Measures the existence of a disseminati on plan	NA	NA	0	1	1	1	1	1	Program Data	Annual-ly	NA	NAS
Outcome 11.2	M&E, research and knowledge management systems at the national and sub-national levels are strengthened	HIV/AIDS related researches and studies conducted	Measures the availability of key research and other studies for effective National HIV Response	NA	NA	4	6	5	5	5	5	Program Data	Annual-ly	NA	NAS
Output 11.2.1	Timely and complete routine reports submitted to National and sub-national levels	Percentage of implementing partners submitting complete and timely routine report to NAS	Measures timeliness and completeness of reports.	Number of institutions submitting timely and complete reports	Number of reporting institutions	78%	85%	90%	93%	97%	100%	Program Data	Annual-ly	District	NAS
Relevant Coordinating bodies are actively operational at all levels															
Output 12.1.1	NAC and NAS are functional	Existence of functional National coordinating bodies(NAC & NAS)	Functionality of NAC and NAS	Number of functional National coordinating bodies(NAC & NAS)	Not Applicable	1	1	1	1	1	1	NAS Report	Annual-ly	NA	NAS
Output 12.1.2	M&E TWGs are functional	Existence of functional M&E Technical Working Group at National and three Regional Levels	Functionality of National and regional M&E TWGs	Number of Functional National and regional M&E TWGs	Not Applicable	4	4	4	4	4	4	Program Data	Annual-ly	Region	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 12.1.3	Sectoral technical working groups are functional	Existence of functional sectoral Technical Working Groups at National Level	Functionality of National sectoral Technical Working Group	Number of Functional National sectoral Technical Working Group	Not Applicable	1	1	1	1	1	1	Program Data	Annual-ly	NA	NAS
Output 12.1.4	DACs conduct quarterly meetings	Number of District AIDS Committees that meets at least three times to address HIV issues.	Functionality of Districts AIDS Committees	Number of District AIDS Committees that meets at least three times to address HIV issues.	N/A	14	14	14	14	14	14	Program Data	Annual-ly	Districts,	NAS
Output 12.1.6	HIV/AIDS emergency response plan developed and ready for implementation	Existence of HIV/AIDS emergency response plan	Preparedness of HIV response to emergency situation	Implementation rate of HIV/AIDS emergency response plan	N/A	1	1	1	1	1	1	NAS Report	Annual-ly	Cost category	NAS
The national response funding is increased from 30% to 70% by 2020.															
Output 13.1.1	Local councils HIV/AIDS activities funded	% of the district with at least 5% budget allocation for HIIV	District level budget allocation to HIV response	Budget allocation to HIV	Total budget allocation to the district	N/A	50%	65%	75%	90%	100%	NAS Report	Annual-ly	Districts,	NAS
Output 13.1.2	Local Councils HIV/AIDS work plans in place	Number of local councils with HIV/AIDS work plan	Availability of District HIV/AIDS work[plan	Number of local councils with HIV/AIDS work plan	N/A	N/A	100%	100%	100%	100%	100%	NAS Report	Annual-ly	Districts,	NAS
Output 13.1.3	Government financing for HIV response increased	% of funding for the national response provided by government increase from current level to 30% by 2020	Government budgetary allocation to HIV	Amount of funding for the national response provided by government	Total amount funding available for HIV response	5%	6%	7%	13%	16%	20%	Program Data	Annual-ly	Cost category	NAS

	RBM statement	Indicator	What the indicator measures	Numerator	Denominator	Baseline	Target Year					Data source	Frequency	Disaggregation	Responsible Institution
						2015	*2016*	*2017*	*2018*	*2019*	*2020*				
Output 13.1.4	External donor financing for HIV response increased	% of funding for National response provided by external donor	External budgetary allocation to HIV	Amount of funding for the national response provided by external donor	Total amount funding available for HIV response	95%	92%	88%	80%	75%	70%	NAS Report	Annual-ly	Cost category	NAS
Output 13.1.5	Domestic resources for HIV response generated from private sector increased	% of funding for the national generated through domestic resource mobilization strategy	Private sector budgetary allocation to HIV	Amount of funding for the national response provided by Private sector	Total amount funding available for HIV response	N/A	2%	5%	7%	9%	10%	NAS Report	Annual-ly	Cost category	NAS
Community and Health Systems providing effective and accessible HIV services by 2020.															
Output 14.1.1	Community participation in HIV response increased	Existence of functional support groups/network (PLHIV, religious, Youth, women, media, etc.	Functionality of support groups and networks	Number of functional support groups/networks	N/A	40	TBD	TBD	TBD	TBD	TBD	NAS Report	Annual-ly	District, network	Partners
Output 14.1.2	Community leaders participated in HIV /gender equality interventions	Number of religious and traditional leaders that participate in HIV and gender equality interventions	Community participa-tion	Number of religious and traditional leaders that participate in HIV and gender equality issues	N/A	14,900	14,900	14,900	14,900	14,900	14,900	Program Data	Annual-ly	Districts, urban/rural, age and sex	Partners
Output 14.1.3	Community Health Workers trained to integrate HIV into existing community health system	% of CHWs trained to integrate HIV into existing community health system	Integration of HIV into community health system	Number of CHWs trained to integrate HIV into existing community health system	Total number of CHWs	1,382	1,382	1,382	1,382	1,382	1,382	Program Data	Annual-ly	Districts, urban/rural, age and sex	Partners

3.2.2 Data sources and data processing

Various types of data are required to support the measurement of the M&E indicators discussed in Section 5 above. These include routine and non-routine data, periodically generated from primary and secondary data collection and collation processes. The key sources of such data over the NSP period 2016-2020 are presented in Table 6 below.

Table 6: Indicative data sources for the 2016-2020 M&E Plan

Data Source	Lead Institutions	Frequency
Routine Programme Monitoring Data		
1. Health sector programme activity monitoring data	NACP, MOHS	Quarterly
2. Non health public sector programme activity monitoring data	NAS, other MDAs, projects, DACs	Quarterly
3. Routine programme Monitoring Data from other non-health and non-public sector agencies & (Self Coordinating Entities (SCE)	NAS & SCE secretariats, projects, DACs	Quarterly
4. Field Monitoring and Support Supervision	NAS & SCE secretariats, projects, DACs	Quarterly
Surveys and Surveillance		
5. Biological surveillance	MOHS (NACP)	Annual
6. Behavioural surveillance	MOHS (NACP)	Biennial
7. Quality of Health services delivery and related HIV Services Assessments	MOHS (NACP)	Biennial
8. Programme specific evaluations, assessment and surveys and sustainability analysis assessments	Refer to Information products table	Annual & Biennial
9. HIV/AIDS in Workplace Survey	Ministry of Labour Establishment Secretary's Office	Biennial
10. Integrated Household Surveys	Statistics Sierra Leone	Biennial
Other Essential Studies		
11. Assets Inventory, procurement and supply management and Administrative records analysis	All stakeholders	Annual
12. Stakeholders and Service Mapping	NAS	Annually
13. Resource Tracking and HIV/AIDS Accounts, Budget and Expenditure analysis	NAS, MOFPED	Biennial
14. HIV /AIDS operational research and special studies	NAS & Statistics Sierra Leone, MOHS, Development Partners, Research & training institutions	Periodically
15. Social Economic Impact Studies (SEIS)	NAS,	Every 3 yrs
16. National HIV/AIDS Estimates and Projections	NAS, MOHS, SSL	Annually

The health sector is the main platform for delivery of most HIV prevention and treatment services as prioritized in the NSP. Therefore, the Health Management Information System (HMIS) will continue to be the primary data source on the health-related HIV services. This plan will prioritize support to production of data collection and data processing tools, and in building capacity and mentoring support at the different levels for full integration of HIV data into DHIS2. Specific attention will be paid to strengthening HIV data collection and reporting in the private sector health care points. Most of these sites are not yet integrated into the national HMIS; and they often have very weak M&E systems.

The other element of key focus in routine health monitoring will be support to timely data processing at all health and HIV service points, for on-site use and reporting purposes in line with DHIS2 provisions.

This will include basic analysis and collation of data at health facilities and from community-based services for HIV prevention, care and support, treatment follow up, etc. The integrated analysis will generate information for site-level service review and improvement; local level accountability to beneficiaries and the general community; and for grassroots advocacy and mobilization of sustained community participation.

Data processing at district level will focus on collation, quality assurance, analysis and utilization of programme data in decentralized health and HIV management, and in mentoring and support supervision of health facilities and other service mechanisms. It will also include data reporting in line with the DHIS2 standards and requirements.

Routine programme reporting at all levels of the health system will address three inter-related elements:

1. Vertical reporting and feedback
2. Horizontal sharing and utilization of data and information for integrated and multi-sectoral development planning
3. Public accountability and reporting to beneficiaries – through dialogue and other appropriate mechanisms.

Data collection and reporting in other sectors: The existing NAS reporting tools for all non-health sector HIV services will be updated in line with the NSP 2016-2020 priorities, and used across the different service and programme delivery settings to report routine data on the non-health output level indicators. The Government Ministries, Departments and Agencies (MDAs) at the national level offering non health HIV services will complete the Service Coverage Reporting (SCR) forms on a quarterly basis. For the district level non health sector departments, the form will be completed in triplicate to be able to share the reports with the other national level offices, the District HIV/ AIDS Focal Person/s (DHAP) and retain a file copy. The DHAP will collate data from the individual forms onto one District level summary form, and send it to NAS. NAS will collate the District level summary forms and produce a Quarterly Service Coverage Report. NAS will also be expected to disseminate the Quarterly Service Coverage Report to stakeholders at all levels at national and district levels on quarterly and annual basis.

3.3 Data Storage and data bases

The relevant national and district data bases will be strengthened and adapted to have inter-operability to enhance the sharing of information on HIV. The NAS database will be adapted to cover the full scope of the NSP 2016-2020. It will serve as the main national repository for HIV information for both programme coverage data; population based survey, surveillance and assembles; as well as financial monitoring data. A database management protocol will be developed for the database to ensure that data are updated regularly, consistently and on time. This protocol will define the different aspects of database operation, including:

- Data update process – when it should be updated, what it will be updated with, who will update it;
- Access control – who will have access, levels of access rights
- Data processing and protection – who will be able to make changes to the data, how data will be protected, levels of expertise and leadership for data analysis, generation of reports

The database will provide for geographical and demographic disaggregation, and relevant thematic categorization of data. This will enable the spatial analysis of data relating to the supply of HIV/AIDS services, the demand for services, and the provision of financial and resources to fund services and thus

better planning. NAS will encourage and work towards the creation of geo referenced HIV/AIDS data. Once such data exists, relevant geo referenced data will be used to create maps and data atlases for inclusion in M&E information products for enhanced strategic information management. The NAS database will be web-based, to enable real-time access by all stakeholders within and outside the country. It will have necessary linkage to DHIS, EMIS and other relevant databases.

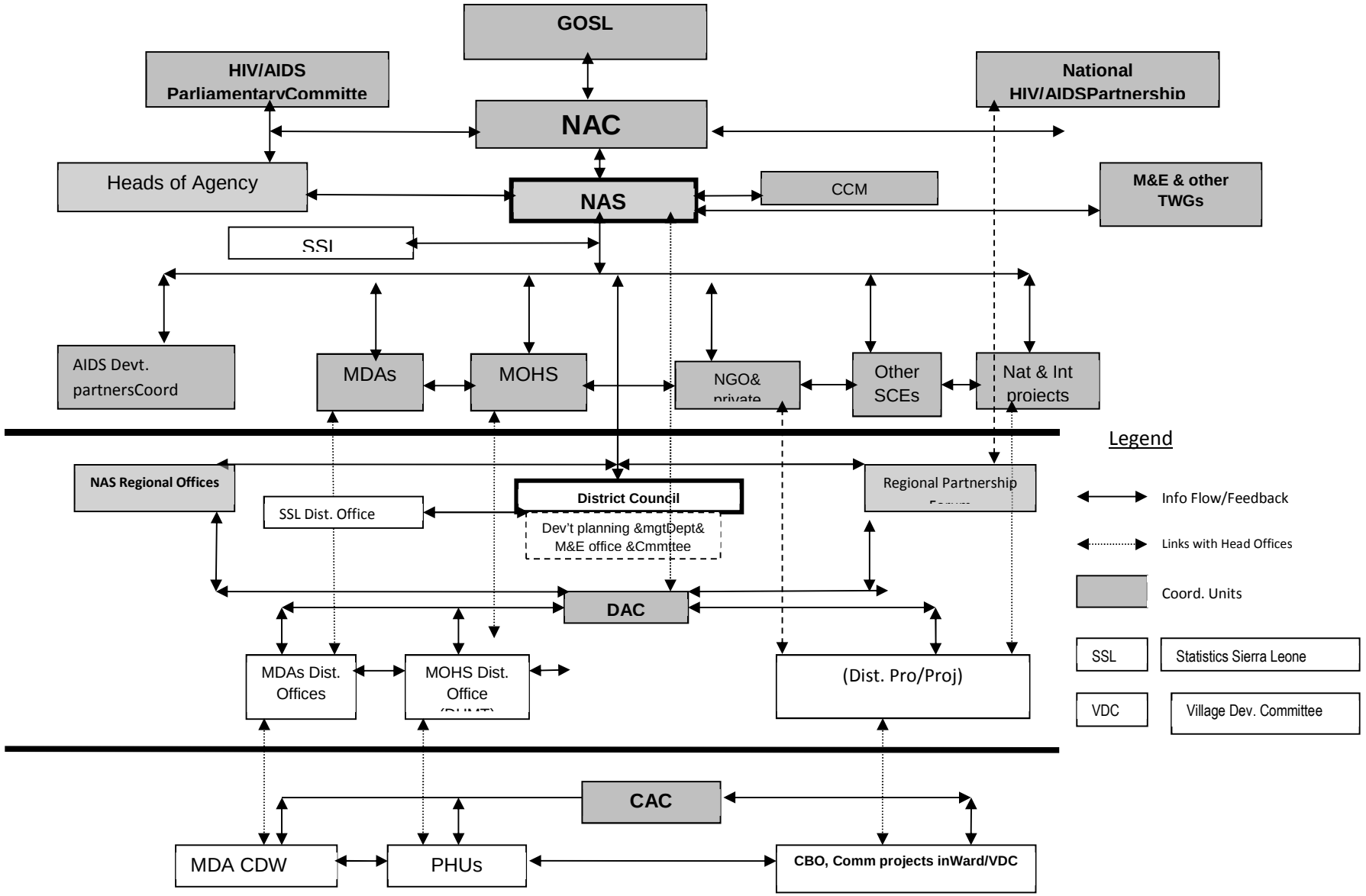
3.4 Data flow and transmission

The flow of datawill be between three main levels: service delivery/community; district and national. Coordination of information flow at each level will be managed by the respective HIV response coordination body – CAC, DAC and NAC. This coordination will be complementary to the routine management responsibility for data reporting and transmission within local government systems at different levels; and at national level. Actual transmission of data, and the quality thereof, will remain the direct responsibility of the respective staff as deployed by government or by other actors in the HIV services at different levels.

This plan will support bi-directional data flow. Each point of data generation and/or consolidation will transmit data to the next level of responsibility on all programme and service delivery activities at that point or within its geographical area of responsibility. The receiving point will be responsible to transmit feedback data on: a) the received data (e.g., quality, completeness, timeliness, etc.); b) how the point compares to others of similar category; and c) consolidated data that reflects how the different reporting centres are contributing to progress and performance.

Figure 7 below illustrates the data/information flow and reporting arrangements between different programme levels and sectors for the M&E plan.

Figure 8: HIV Data flow chart



The National HIV/AIDS Secretariat will monitor the national response and the epidemic in a bottom top approach through the decentralized structures. Coordination, data collection, analysis, reporting and dissemination will be carried out via the activities of the CAC, DAC, the councils, the TWG, MOHS, HIV/AIDS Focal Persons in the MDAs, Development Partners and the Partnership Forum. HIV/AIDS information will be shared horizontally and vertically by the institutions and coordinating entities as depicted in the flow chart above. Feedbacks are also made to the information sources and coordinating bodies

At the central level, NAS collates the information provided by the Districts. It provides feedback to the respective districts through the CACs on their reports as well as their standing from a national perspective with other districts. At this level, Statistic Sierra Leone (SSL), M&E Technical Working Group (M&E TWG) and the Partnership Forum are provided opportunities to review the reports and help the National HIV/AIDS Secretariat to make informed decisions and to advise the National AIDS Council (NAC) periodically.

3.5 Data quality assurance

This plan includes commitment to support review and update of the HIV guidelines for support supervision to include enhanced focus on M&E strengthening and data quality audit. Greater attention will be paid to data quality verification as an integral element in validation of reports and provision of feedback in the HIV response. This process will be extended to DHMTs, civil society agencies and networks, coordinating entities for different stakeholders in the HIV response partnerships, and other HIV response coordination and management entities.

The current quality controls for when data from paper-based forms are entered into a computer (e.g., double entry, post-data entry verification) will be strengthened.Every year there will be an internal and external data audit according the protocol and guidelines. The results of such audit will be shared accordingly.

4.0 Evaluation Research and Learning

The existing HIV research agenda will be updated in line with the NSP priorities; and will be used to inform operational research and evaluation studies on specific elements of the HIV response. Key areas of focus will include: treatment monitoring and adherence improvement in different contexts; programming models for comprehensive and sustained services to KAP; and workplace HIV programming in settings of high vulnerability (e.g., fisheries, transport services, mobile trade, etc.). The other categories of prioritized special studies include:

- Procurement and Logistics Supply Management Information systems audit and improvement
- Stakeholders and Service Mapping
- Resource Tracking, HIV/AIDS Accounts, budget & Expenditure analysis
- Social Economic Impact Studies (SEIS)

4.1 Surveys and Surveillance

Biological and behaviouralHIV surveillance surveys that are prioritized in this plan include:

- HIV and STI sentinel surveillance at ANC clinics
- Behavioural Surveillance Survey at population level
- Demographic and Health Survey
- Behavioural and Sero-prevalence survey among Key Affected Populations
- Health service provision and quality assessment survey

Implementation of most of the surveys will be a multi-stakeholder undertaking. The main role and contribution to these surveys that is supported through this plan will focus on ensuring appropriate and adequate data collection on HIV-specific indicators; and appropriate analysis, utilization and wide dissemination of the results relevant to HIV. It will include secondary analysis of the survey data; and targeted reporting with focus on HIV implication.

5.0 M&E Data Utilization and Information Dissemination

NAS will lead stakeholders in disseminating and promoting the use of information generated by this Plan. The sustainability of the application and the buy-in into this plan will to a large extent depend on the ease for stakeholders to utilize the information products produced by this Plan. The ultimate use of data will serve to direct the HIV response at all levels: national, Sectoral, district and the chiefdom levels.

The following mechanisms will be prioritized for data and information dissemination; and promoting the utilization.

1. The National Partnership Forum: will bring together stakeholders' at national and District levels to share the information products. This forum will provide opportunity for all categories of stakeholders to share the HIV/AIDS Status reports and other information resources. It will also be the channel for sharing information on the national response in the preceding implementation period with key focus on the scope of service coverage, the best practices and management of challenging and emerging issues.

2. Quarterly and annual coordination, review and planning meetings: at national and district levels will be used to discuss progress of HIV response implementation, and to share other available HIV/AIDS information; to identify the lessons learnt, and to plan response improvements.

3. Periodic status reports: including the Global AIDS Response Reporting Process (GARPR), Annual Joint HIV Response Review Reports, etc.

4. Electronic and print media: including online and e-mail based sharing; discussion issues and news items on radio, TV and in the print media, etc.

5. Resource centres and libraries; at national and district level, and in various institutions such as schools, etc.

6.0 Implementation of the M&E Plan

6.1 Roles and Responsibilities

The role of the NAS M&E unit includes the following:

- Coordination, supervision and provision of technical assistance andguidance to monitoring and evaluationof the entire national HIV response and trackingprogress made in the programme activities at all levels;
- Coordination and provision of a national coherent plan for monitoringprogress and evaluating outcomes of the comprehensive HIV response. NAS is responsible for defining strategic objectives andtargets; guiding and supervising systematic data collection, processingand analysis of data at various levels. It provides the platform forpartnership, networking and collaboration between the national level andsub-national stakeholders in M&E.
- Creation of a multi-sectoral functional HIV M&E system, with a database,that links with other information systems, research organizations and othermicro/M&E units in other government ministries, civil societyorganizations and the private sector. NAS has developed asimplified, but complete reporting format for use by all thestakeholders/partners;
- Supervision and data auditing: The responsibility of supervision as acomponent of coordination remains the key role of the NAS M&E unit. The NAS M&E Unit will coordinate the standardization of M&Emethodologies and tools across multiple actors at various programmelevels, to enable data collation and meaningful comparison.
- Generation of national information products, as agreed and demanded byboth the national and international stakeholders, and disseminating theseproducts in a user friendly and in a timely manner. NAS will ensure and facilitate the annual nationaldissemination and review activities;
- Coordinate and support all capacity building in M&E at bothnational and district levels. This is to ensure that the M&E systems, at thedistrict level in particular, are functioning and have necessary resources. NAS will organize periodic supervision visits and reviews of districtbased M&E systems and organize for capacity building activitiesaccordingly.

The Regional NAS offices will play a critical supportive role to the district and urban local government councils, to enable effective and sustainable routine HIV program monitoring and reporting. Such support will include:

- Capacity building and mentoring;
- Linking districts in the same region and across regions to facilitate exchange learning;
- Advocacy for integrated management of the HIV response M&E by local councils, chiefdoms and the respective HIV response coordination mechanisms; and
- Enhancing data and information flow between districts and the national level.

The Roles and Responsibilities of District M&E Focal Persons

Given the decentralisation of the HIVresponse in Sierra Leone, data collectionand collation on HIV activities and services is the responsibility of districts. The DACcoordinate the monitoring of outputindicators from the different programmme activities; including utilization of the data within the district, and timely transmission to the national level. The M&E-specific roles of DACsinclude:

- Maintaining an updated register of all actors in HIV in the district, and the specific contribution each of them makes to the HIV response;

- Coordination of M&E at the district level and ensuring M&E support supervision at all levels in the district;
- Follow up and facilitating as necessary accurate completion and timely submission of all relevant reporting data at the different levels;
- Demonstrate and promote utilization of data and information products forprogramming activities; and
- Disseminate information and sensitize partners at the District and community levels on the epidemic.

The roles of other key stakeholders in M&E of the HIV response are presented in Table 7 below.

Table 7: Other Key stakeholders and their roles in HIV response M&E

Stakeholder Category	Key roles
Government ministries and other public institutions/ organizations at national level	• Mainstream the HIV/AIDS interventions in their core business • Mobilize resources and coordinate HIV/AIDS activities within their institutions • Advocacy and sensitization on HIV/AIDS at workplace • Facilitate training on the HIV response M&E for relevant staff • Participate in the M&E Technical Working Group (TWG) as assigned • Report on specific indicators for the institution to NAS using standardized reporting format and in a timely manner • Participate in periodic HIV response reviews.
Civil Society, Umbrella Organizations and The private sector	• Participate in the M&E Technical Working Group (TWG) as assigned • Ensure that their members are familiar with the national HIV response NSP and M&E Plan • Ensure strengthening for their M&E units using the national HIV response M&EFramework/plan as provided by NAS • Submit Annual plans and budgets for HIV services and activities to NAS and to the respective DAGs in their districts of operation • Submit required data to DACs using a standardized format and based on an agreed timelines • Sensitization and advocacy for M&E strengthening and use of M&E data in programming and advocacy • Participate in the national and sub-national HIV response dialogue and reviews.
Research Organizations and Universities	• Participate in the update and implementation of the HIV Research Agenda • Conduct high quality and ethical research, in a timely manner; • Disseminate research findings to all key stakeholders (e.g., NAS, relevant government sectors, districts, non-government programme implementers). • Use research findings to inform policy and programmes • Plan, facilitate and contribute to information sharing and dissemination forums and publications • Participate in the M&E Technical Working Group (TWG) as assigned • Participate in the national and sub-national HIV response dialogue and reviews.
Development Partners	• Be part of the HIV/AIDS M&E Technical Working Group • Support the strengthening of the national HV and AIDS M&E system • Build the culture of M&E strengthening and accountability among their implementing partners, and make it a mandatory requirement in their MoUs • Build consensus on harmonizing information requirements and reporting framework to avoid duplication • Participate in national HIV response dialogue and reviews

6.2 Advocacy and Communication for HIV M&E

NAS will coordinate the process to generate and communicate information relevant to the HIV response to all stakeholders; and will follow through utilization of the information in programming, policy development and other key decision making processes. It will work closely with the respective inter-agency and intra-agency communication units to enhance sharing of reports, review and generation of progress updates, and timely communication of information to decision makers.

Effectiveness of HIV communication will be monitored to ensure that stakeholders reflect greater understanding of HIV issues; and that information available is guiding intervention strategies and their adjustment as needed. NAS will facilitate periodic reviews to identify, document and disseminate good practice experiences and innovations in the national HIV response.

6.3 Technical Assistance needs

All the key coordinating units for the implementation of this plan will require sustained support to execute specific core M&E planning, coordination and technical support activities whose capacity may not be available in-house. This may include: the NAS M&E unit; the relevant MOHS programme, planning and information management units; DHMTs and DACs; the Secretariats of Stakeholders' Self Coordinating Entities (SCE) and Networks and Sector HIV/AIDS Focal Offices. The structural appropriateness of these responsible M&E Coordination units will also be reviewed and accordingly developed/ strengthened.

Based on the assessment of needs, the TWG working through NAS or outsourcing to an appropriate service providers will mobilize and provide technical support using common M&E plan budget/ funding its or the identified development partners may provide technical support services.For major and specialized M&E activities in the plan such as surveillance and surveys, NAS may, as has been the case in the past, solicit technical support from the specialized agencies such as UNAIDS and WHO to help in availing resource persons to assist the validation process. While such technical support is being provided, the following considerations are important for effective procurement of the technical assistance:

- Development of a clear scope of work contained in a terms of reference;
- Adopting a participatory approach, to ensure necessary capacity development for sustainable and scaled up implementation of similar undertakings
- Detailed documentation of the processes; to generate resource materials for future learning and reference

7.0 Performance Framework

This M&E plan covers the NSP period 2016 – 2020. This plan will support an effective and robust monitoring and evaluation system; and will facilitate tracking of progress in the implementation of the national HIV/AIDS response and guide programs, policies, and service delivery.It will be reviewed and updated as necessary in 2018, based on the NSP implementation and M&E experiences from the first two years (2016-2017). The performance framework for implementation of the plan is presented in Table 8 below, and is based on the core results framework for the plan.

Table 9: M&E Performance Framework summary

Results	Performance indicator	Frequency of measurement
Outcome 1: Strengthened leadership and Coordination of HIV/AIDS Monitoring and Evaluation (M&E)	Number of HIV Coordination meetings held at Nationl and sub National levels	Quarterly
Output 1.1: Strengthened HIV response M&E Coordination units/function at National, sectoral and local council levels	Existence of functional National coordinating bodies (NAC & NAS) at National and sub-national levels.	Annually
Output 1.2: Strengthened technical leadership and coordination function of HIV/AIDS M&E Technical Working Groups or other relevant M&E TWGs at National, Sectoral and local council levels	Number of M&E technical Working Group meetings held at ntional nd subnational levels	Quarterly
Output 1.3:M&E Planning protocols and strategic reference resources	Existence of a costed M&E Operational Plan	Biannually
Output 1.4: National, Sectoral and local council level HIV AIDS Coordination structures with office and field logistical M&E resources	Existence of a regional AIDs coordinating Structure with M&E staff at National and sub National Level	Annually
Outcome 2: Enhanced Strategic, Human resource and Logistical capacity for Monitoring and Evaluation (M&E) of the National Response	Existence of trained and competent M&E staff and coordinated M&E structure at all levels of the response	Annually
Output 2.1: Management performance contracts in public service, civil society and private sector revised to reflect M&E management and data utilization and dissemination with respect to HIV response management	Existence of an explicit data collection dissemination and utilization structure to support the response	Annually
Output 2.2: Guidelines and practices for staff deployment and appraisal reflect adequate attention to M&E and appropriate evidence-base for programme activities and service delivery processes	Existence of a M&E guidelines on Staff appointment deployment and appraisal system in place.	Annually
Output 2.3: Adequate M&E Human resources deployed by public, civil society and private sector stakeholders in the HIV response at national, district and other relevant levels to ensure effective and sustainable M&E support across all levels of the HIV response	The existence of an M&E unit and staff in all partner organization and institutions in the HIV response at all levels	Quarterly
Output 2.4: Adequate and sustained M&E skills capacity development (based on assessed need in line with function) for management and program staff; and for leaders at different levels to ensure appropriate collection, reporting and utilization of M&E data	Existence of an M&E Capacity development Plan in all partner institutions at National and sub national level engage in the HIV Response.	Quarterly
Outcome 3: Strengthened systems to undertake HIV/AIDS and related biological and behavioural Surveillance, Surveys and Research	Existence of an HIV AIDS Research Agenda with related biological and behavioural surveys and reserhes.	Annually
Output 3.1:HIV/AIDS surveillance and survey protocols reviewed/ developed, adopted and in use	Existence and use of an HIV AIDS Surveillance Protocol	Annually
Output 3.2: The national HIV/AIDS research agenda updated, disseminated and in use	1 National Research Agenda updated and disseminated	Every six months

Results	Performance indicator	Frequency of measurement
Output 3.3: Strengthened Surveillance, surveys and research on HIV/AIDS	HIV AIDS Surveillance and Research structures strengthened and supported to undertake studies.	Annually
Output 3.4:HIV/AIDS special studies, epidemiological analyses and projections undertaken to enhance knowledge of the epidemic	Review of epidemiological analyses and projections for Sierra Leone undertaken	Annually
Outcome 4.: Enhanced HIV/AIDS Information & Knowledge Management	An HIV/AIDS Knowledge management Assessment conducted	Annually
Output 4.1: An HIV/AIDS Knowledge management policy developed, adopted and in use	Existence of an HIV/AIDS Knowledge management policy	Annually
Output 4.2: Enhanced integration and co-operability of HIV/AIDS related data bases and sharing of information	Existence of an HIV Data dissemination strategy in place	Quarterly
Outcome 5: Strengthened HIV/AIDS Financial monitoring, budget and expenditure analysis	1 HIV AIDS Financial Monitoring and Budgetting guidelines developed and disseminated to partners	Annually
Output 5.1: National HIV/AIDS Spending Assessment conducted biennually	1 National AIDS spending Assessment study conducted	Biannually
Output 5.2: Regular budget and expenditure analysis to promote resource allocation, utilization efficiency and equity in the national response	Existence of National AIDS Spending report	Annually
Output 5.3: Unit cost studies, analyses and schedules completed	1 Unit cost study initiated, conducted and report disseminated	Every 5 years

Annex 1: Indicative costing of the M&E Plan

Activity	LEVEL OF IMPLEMENTATION N=National R= Regional D=District	Responsible Person / Department	Target per year	ANNUAL COSTS (USD)					Funding source	OUTPUT
				2016	2017	2018	2019	2020		
Outcome1. Improved utilization of strategic information for the effectiveness of the National HIV Response **Outcome 2**.M&E, research and knowledge management systems at the national and sub-national levels are strengthened										
1. M&E coordination										
Output 1: M&E TWG established and functional at Regional level										
Quarterly Support M&E Technical working group at Regional Level. (15 persons in 3 regions)	R	NAS	**4**	**2,400**	**2,412**	**2,424**	**2,436**	**2,448**	GF, GOSL,	4 quarterly M&E TWG meetings held annually
Quarterly Support to the National M& E Technical working group meetings. (25 people)	N	NAS	**4**	**600**	**603**	**606**	**609**	**612**	GF, GOSL,	5 quarterly M&E TWG meetings held annually
Conduct MESST	N	NAS	**1**	**14,000**		**14,140**			GF, UN Family,	1 mest conducted everu 2 years
Develop national guidelines IEC/BCC for Youths and General Population and Key Populations	N	NAS	**1**	**4,000**		**2,500**			GF,	1 National Guideline for KPs and Youths developed and rviewed in 2018
Develop an inventory of HIV research institutions and their planned activities	N	NAS	**1**	**2,500**		**2,500**			GF, GOSL,	1 HIV &AIDS Research Inventory developed
Develop Program specific M&E plans(GF, KFW,)	N	NAS	**2**	**4,000**		**4,040**			GF, KFW, GOSL.	All Programs coordinated By Nas have program specific M&E plan
Print and distribute data reporting forms to all stakeholders CSOs and partners for quarterly reporting	N	NAS	**1**	**5,000**	**5,025**	**5,050**	**5,075**	**5,101**	GF, GOSL,	Essential data collection and reporting forms printed and distributed to all

Activity	LEVEL OF IMPLEMENTATION N N=National R= Regional D=District	Responsible Person / Department	Target per year	ANNUAL COSTS (USD)					Funding source	OUTPUT
				2016	2017	2018	2019	2020		
										stakeholders/partners
Develop a nationally accepted M&E curriculum (consultant,Logistics& Process)	N	NAS	**1**	**6,000**					GF, GOSL,	1 HIV &AIDS M&E cirriculum developed
Sub Total				**38,500**	**8,040**	**31,261**	**8,121**	**8,161**		
2. Routine programmatic data collection and Reporting										
Output 2: Information sharing amongst stakeholders increase										
Technical Assistance for the Implementation Of Open MRS in 5 HIV Facilities In Sierra Leone & Roll out to 14 Districts	R	SOLTHIS/NAS	5	**193,000**	**193,965**	**580,000**	**582,900**	**585,815**	GF, GOSL, SOLTHIS	Open MRS operational in 5 facilities in 2016 and 14 by 2020
Monitor the integration of NAS data into the DHIS.	D	MOHS/NAS	12	**2,000**	**2,010**	**2,020**	**2,030**	**2,040**	GF, GOSL	NAS data integrated into DHIS II
Revise the national guidelines & procedures (SOP) on recording, collecting, collating, and reporting on data; data quality;	N	NAS,NACP	1	**4,000**		**4,040**			GF,	1national guidelines & procedures (SOP) on recording, collecting, collating, and reporting on data produced and disseminated
Validate national guidelines & procedures (SOP) on recording, collecting, collating, and reporting on data; data quality;	N	NAS,NACP,CSO	1	**1,700**		**1,717**			GF,	SOP /guidelines validated
Print and distribute 800 Copies of SOP to Health Facilities and regional staff	N	NAS	2	**4,500**		**4,545**			GF, GOSL,	800 Copies of SOP distributed to Health Facilities and regional staff
Develop guidelines for analysis, presentation and data use at facility level;	N	NAS	1	**2,500**		**2,525**			GF, GOSL,	Guide lines f or data use at all levels and facilities developed.
Establish a structured	N	NAS,NACP	1	**500**	**503**	**505**	**508**	**510**	GOSL	Feedback mechanism

Activity	LEVEL OF IMPLEMENTATION N=National R= Regional D=District	Responsible Person / Department	Target per year	ANNUAL COSTS (USD)					Funding source	OUTPUT
				2016	2017	2018	2019	2020		
feedback mechanism for information providers										for staff and partners developed and operationalised
Sub Total				**208,200**	**196,478**	**595,352**	**585,438**	**588,365**		
3. Evaluation, Surveys,Surveillance & Special studies										
Output 3: Increased capacities to conduct M&E researches and surveys										
Conduct ANC Surveillance study (to be conducted by CDC)	N	NAS, CDC, CSOs, NACP	1	**40,000**	**40,000**	**40,000**	**40,000**	**40,000**	CDC, GOSL,	NASA institutionalised and conducted annually
Conduct National AIDS Spending Assessment (NASA) study	N	NAS, CSOs, NACP,Academia	1	**35,000**		**35,351**		**35,705**	GF, UN Family	ANC surveillance conducted annually
Conduct for cohort analysis for PLHIV survival rate after 12 months on ART	N	NAS, NACP	1	**40,000**	**40,200**	**40,401**	**40,603**	**40,806**	GF, GOSL	1 survival analysis study annually
Conduct IBBSS for Key population (FSWs, MSMs, PWIDs) -2017	N	NAS, CSOs, NACP,Academia	1	**120,000**			**121,809**		GF,	IBBSS for Key populations conducted
Conduct BSS for General population	N	NAS, CSOs, NACP,Academia	1	**250,000**			**253,769**		GF	BSS for general population conducted
Conduct situational analysis of OVCs in Sierra Leone (2017)	N	NAS, CSOs, NACP,Academia	1	**30,000**					GF	1 OVC Study conducted
Early Warning Indicator (EWI) survey	N	NAS, CSOs, NACP,Academia	1	**5,000**	**5,025**	**5,050**	**5,075**	**5,101**	GF, GOSL,	Early Warning indicator Monitoring instituted in all districts
Size Estimation study for Key Populations	N	NAS/UNAIDS	1			**202,005**			UN Family	Key Population size estimated
HIV drug resistance monitoring	N	NAS, CSOs, NACP,Academia	1	**40,000**	**40,000**	**40,000**	**40,000**	**40,000**	GF	1 drug resistance study conducted annually
Midterm and Terminal Evaluation of NSP 2016-2020	N	NAS, NACP	1			**17,675**			GF, GOSL	MID Term and Terminal review of the SL NSP conducted
Terminal Evaluation of NSP 2016-2020	N	NAS	1					**30,000**	GF,	
Know Your Epidemic Know Your response (MOT)Study	N	NAS, CSOs, NACP,Academia	1	**125,000**					UN Family	1 MOT study conducted

Activity	LEVEL OF IMPLEMENTATION N=National R= Regional D=District	Responsible Person / Department	Target per year	ANNUAL COSTS (USD)					Funding source	OUTPUT
				2016	2017	2018	2019	2020		
Prepare and conduct HIV Estimates and projection data for regional levels covering high burden districts	N	NAS,NACP	1	**12,000**	**12,060**	**12,120**	**12,181**	**12,242**	UN Family	HIV projections and estimates for Regions in Sierra Leone developed
Conduct PMTCT DQA and impact study	N	NAS, NACP	1	**30,000**	**30,000**	**30,000**	**30,000**	**30,000**	GF, GOSL	PMTCT DQA conducted
Sub Total				**242,000**	**87,085**	**306,851**	**87,256**	**117,343**		
4. Data quality assurance and M&E related supportive supervision										
Output 4: M&E systems are integrated with the existing Health Management Information Systems (HMIS)										
Provide logistics to Regional M&E Teams for quarterly monitoring and supervision (DSA, fuel and vehicle lubricant) for 5 days	R	M&E TWG	4	**22,000**	**22,110**	**22,221**	**22,332**	**22,443**	GF, GOSL	Management support for Regional TWG provided
Provide logistics to National M&E Teams for quarterly monitoring and supervision (DSA, fuel and vehicle lubricant) for 7 days	N	NAS	4	**18,160**	**18,251**	**18,342**	**18,434**	**18,526**	GF, GOSL	Management support for National TWG provided
conduct Joint quarterly supervision and mentoring of service delivery points (HCT, PMTCT and ART sites) by NACP	N	NAS	4	**10,000**	**10,050**	**10,100**	**10,151**	**10,202**	GF, GOSL	Joint quarterly supervision of service delivery points conducted
Develop strategies for information dissemination. Develop a costed dissemination plan for information dissemination and disseminate relevant information products to providers	N	NAS	**1**	**16,000**	**10,000**	**10,000**	**10,000**	**10,000**	GOSL,	1 strategy for data dissemination developed and implemented

Activity	LEVEL OF IMPLEMENTATION N=National R= Regional D=District	Responsible Person / Department	Target per year	ANNUAL COSTS (USD)					Funding source	OUTPUT
				2016	2017	2018	2019	2020		
Provide Annual refresher Training on Databases for District Counsellors,Supervisors and Health facility staff	R	NAS	3	**9,000**	**9,045**	**9,090**	**9,136**	**9,181**	GF	1 training on M&E, data collection and reporting conducted
Develop and update database on Staff/Partners receiving training (to avoid duplication)	N	NACP/NAS	1	**500**	**503**	**505**	**508**	**510**	GF, GOSL	Data base on capacity of staff at all levels developed
Conduct DQA on TB/HIV management	D	NACP/NAS/TB	4		**18,090**		**18,271**		GF, GOSL	TB/HIV Management jointly supervised
Conduct annual Rapid service Quality Audits	N	NACP/NAS	1	**6,000**	**6,030**	**6,060**	**6,090**	**6,121**	GF	1 audit on service quality conducted
Production and distribution of routine M&E bulletins,reports through the TWG	N	NAS	2	**3,000**	**3,015**	**3,030**	**3,045**	**3,060**	GF,	M&E bulletins produced and disseminated biannually
Develop,print and distribute National guideline for reporting HIV Data from all partners & stakeholders	N	NAS/NACP	1	**5,000**	**5,025**	**5,050**	**5,075**	**5,101**	GOSL,	1 M&E Guideline for collecting and reporting HIV Data produced and disseminated
Routine M&E TWG oversight support to District and regional facilities .(4 TWG members/semester x3days)	R,D	NAS	2	**2000**	**2,010**	**2,020**	**2,030**	**2,040**	GF	biannual oversight visits to regional facilities by 4 TWG members /semester conducted
DHIS integration and staff support	N,D	NACP/NAS/MOHS	13	**2500**	**2,513**	**2,525**	**2,538**	**2,550**	GF, GOSL,	HIV Data integrated into DHIS II
Develop/review Terms of Reference and plan of action for TB/HIV collaboration committee	N	NAS/NACP	1	**100**		**100**			GF,	1 term of Reference for TB/HIV Collaboration developed and circulated
Support Regional quarterly meetings of the TB/HIV	R	NAS/NACP	4	2400	**2412**	**2,424**	**2,436**	**2,448**	GF,	4 Regional meetings on TB/HIC conducted by regional

Activity	LEVEL OF IMPLEMENTATION N=National R= Regional D=District	Responsible Person / Department	Target per year	ANNUAL COSTS (USD)					Funding source	OUTPUT
				2016	2017	2018	2019	2020		
Collaboration committee. (4 Regions)										Committees
Conduct Joint Quarterly monitoring of HIV/TB services at service delivery points (3 people)	N	NTBLP /NAS /NACP	4	6000	**6030**	**6,060**	**6,090**	**6,121**	GF,	4 Joint monitoring & supervision of TB/HIV conducted annually
Sub Total				**27,000**	**27,035**	**27,270**	**27,306**	**27,442**		
5.Capacity Building										
Output 5 : Number and capacities of M&E officers increased										
Training of 28 Counselors 5 data entry clerks on data entry and database management programmes for 2 days at national level	R	NAS	1	**40,000**		**40,401**		**40,806**	GF	1 training conducted for District Counselors and data entry clerks
Support Sub Regional Training of 7 NAS and NACP M&E staff on monitoring and evaluation	N	NAS	4	**18,500**	**18592.5**	**18,685**	**18,779**	**18,873**	GF	7 NAS and NACP Staff received appropriate M&E training
Conduct 2- 2 day trainings for SRs/SSRs, partners and local councils on M&E Program reporting and Data Management annually (40 participants)	R	NAS/NACP	2	**12,000**	**12060**	**12,120**	**12,181**	**12,242**	GF	SRs/SSRs, partners and local councils receive training on M&E, Program reporting and Data Management
Support EPP training at national level for district level disaggregation of spectrum data. (15 people for 3 days at national level)	N	NAS	1	**3000**	**3015**	**3,030**	**3,045**	**3,060**	GF,UN Family	15 staff from high burden Districts supported annually for EPP training
Train Staff on use of national Guidelines for recording program data	N	NAS/NACP	1	**3500**	**3518**	**3,535**	**3,553**	**3,571**	GF, GOSL,	Program staff and partners trained on the use of the SOP

Activity	LEVEL OF IMPLEMENTATIO N N=National R= Regional D=District	Responsible Person / Department	Target per year	ANNUAL COSTS (USD)					Funding source	OUTPUT
				2016	2017	2018	2019	2020		
Conduct program review (BCC, PMTCT/EMTCT, HCT and ART) services with partners in 2016 (for 2 days for 50 people) by NACP	N	NAS/NACP/ CSOs	1	**14,000**	**14070**	**14,140**	**14,211**	**14,282**	GF,	1 Technical program review meeting on BCC, PMTCT/EMTCT, HCT and ARTconducted
strengthen the HIV integration in to the DHMT (14 districts)	D	NACP,NAS	4	**14,000**	**14070**	**14,140**	**14,211**	**14,282**	GF, GOSL	An integrated HIV/AIDS data into the DHS
Train 19 Councils HIV focal persons and 15 SRs trained on M&E and HIV reporting	R	NAS	2	**6,000**	**6030**	**6,060**	**6,090**	**6,121**	GF	19 Councils HIV focal persons and 15 SRs trained on M&E and HIV reporting
Sub Total				**111,000**	**71,355**	**112,113**	**72,070**	**113,237**		
Grand Total				**626,700**	**389,992**	**1,072,846**	**780,190**	**854,547**	**3,724,276**	