Sierra Leone

National HIV/AIDS Operational Plan

2011-2012

June 2011

Volume 5

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National AIDS Secretariat
Freetown, Sierra Leone

June, 2011

National AIDS Secretariat

Five for One

Five for One: Represents the **Five** 'Pillars' strategically designed to compliment and feed into one another delivering **One** robust and comprehensive road map for the multi-sector response to HIV/AIDS in Sierra Leone.

The **Five Pillars** will contribute towards the goal of Zero New HIV Infections, Zero Discrimination, Zero AIDS Related Deaths in Sierra Leone guided by and in line with the governments Agenda for Change, the UN Joint Vision for Sierra Leone, the UNAIDS Strategic Outcome Framework and the scaled up the national response towards Universal Access and the MDGs.

Five Pillar Activities:

Know your Epidemic, Know your Response (Modes of HIV Transmission):
The purpose of the Know your Epidemic is to better characterize Sierra Leone's epidemic, to assess the extent to which existing responses address the real drivers, sources of new HIV infections and to recommend strategies to improve the effectiveness of Sierra Leone's response to HIV/AIDS.

Final Joint Programme Review of the NSP 2006-2010:
The final Joint Programme Review is to undertake a comprehensive consultative Review in respect of the NSP 2006-2010. The Joint Programme Review and Know your Epidemic will provide recommendations that will guide the development of a new National Strategic Plan 2011-2015, the new National M&E Plan 2011-2015 and an Operational Plan.

National Strategic Plan on HIV/AIDS 2011-2015
The current (NSP 2006-2010) concludes its time frame tin 2010, therefore a new National Strategic Plan on HIV/AIDS will be developed for 2011-2015 The new NSP will have clear and measurable goals, objectives and priorities that are going to guide the country's future programmes and operational plan that will benefit the response as follows.

National M&E Plan on HIV/AIDS 2011-2015
The current National M&E Plan concludes its time frame in 2010. The new M&E Plan will include a robust Monitoring and Evaluation Framework that will guide the collection, collation analysis and dissemination of strategic information on the HIV/AIDS epidemic and the responses to the epidemic in the country.

National HIV/AIDS Operational Plan 2011-2012
Based on the findings of the Know your Epidemic study, the outcome of the Joint Programme Review and NSP, a national Costed Operational Plan will be developed for the period 2011-2012. The OP will serve as a road map that clearly defines the role and responsibilities of stakeholders in implementing the provisions of the NSP.

FOREWORD

The National HIV/AIDS Secretariat is pleased to make this National Operational Plan on HIV/AIDS 2011 – 2012 available to all our development partners including our numerous stakeholders in the campaign against HIV/AIDS in the country.

There are signs of hope in our collective efforts as the national prevalence among the general population appears to be stabilizing around 1.5% and even gradually decreasing among some population sub-groups like pregnant women. Results from our sentinel surveillance among antenatal clinic attendees showed a decline from 3.9% in 2005 to 3.2% in 2010. This trend is expected to continue in the coming years. Access to free HIV care and treatment will continue to provide relief and hope to our compatriots living with and affected by the disease. Amidst our successes, there are clusters within our population especially, the most-at-risk-populations with prevalence rates higher than the national prevalence. This calls for scaling-up our comprehensive multi-sectoral response in prevention, treatment, care and impact mitigation.

This Operational Plan was developed in collaboration with our development partners and our numerous stakeholders to respond to these challenges. It presents a detailed implementation plan that is gender responsive and results-based for the first and second year of our national Strategic Plan on HIV and AIDS 2011 - 2012. It is built on the six strategic Pillars outlined within the National Strategic Plan 2011 – 2015 namely; Coordination, Institutional arrangements, Resource Mobilization and management; Policy, Advocacy, Human Rights and Legal Environment; Prevention of New Infections; Treatment of HIV and other Related Health Conditions; Care and Support for the Infected and affected by HIV and AIDS and Research, Monitoring and Evaluation.

In implementing this Plan, Government is committed to working closely with development partners within the National Strategic Plan on HIV/AIDS 2011 – 2015, the National Monitoring and Evaluation Plan on HIV/AIDS 2011 – 2015, the Agenda for Change, the UNAIDS Strategic Framework and existing national legislations. This Plan seeks to galvanize and coordinate efforts with other national and international partners, including the Global Fund to Fight AIDS, Tuberculosis and Malaria; the United Nations Family; Bi and Multilateral Partners and Non Governmental and Private Sector Organizations to ensure that investments in HIV and AIDS are complementary to achieving the Zero New HIV Infections, Zero AIDS Related Death, Zero HIV Related Stigma and Discrimination and the Millennium Development Goal in Sierra Leone.

We will continue to create a conducive environment for all stakeholders to contribute to the national effort by engaging with this plan so that together we can transform Sierra Leone to a country of Zero New HIV Infection, Zero HIV-related Discrimination and Zero AIDS-related death.

DR. BRIMA KARGBO
DIRECTOR

ACKNOWLEDGMENT

The National HIV/AIDS Secretariat acknowledges with gratitude the invaluable contribution of a large number of individuals and organizations who made it possible for the Operational Plan to be a success. We wish to particularly thank the UNAIDS Country Coordinator, Madam Mulunesh Tennagashaw for her special skills in mobilizing partners around our FIVE Pillar activities for 2010, one of which is this Operational Plan.

We would also like to express special thanks to the UN Family in Sierra Leone, the World Bank, the Technical Support Facility (TSF) for Western and Central Africa for their support in providing technical and financial assistance to support the process. We further acknowledge the assistance provided by the consultants who facilitated the Joint Programme Review and the Modes of Transmission Study. These reports provided possible scenarios for developing the Operational Plan.

We wish to thank the Consultancy Team, the NAS and UNAIDS Country Office colleagues for contributing many hours of dedicated work.

Thanks are also due to our numerous stakeholders, Government Ministries and Departments and Agencies, civil society organizations, PLHIV networks, District AIDS Committees (DAC), development partners for their participation in at the different stages of the process of developing the OP. Your participation has helped to improve the quality and comprehensiveness of the OP.

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ABBREVIATIONS

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ARG	AIDS Response Group
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASAP	World Bank AIDS Strategy and Action Plan
AWP	Annual Work Plan
BCAASL	Business Coalition Against Aids in Sierra Leone
BCC	Behavioural Change Communication
BSS	Blood Safety Services
CAC	Chiefdom AIDS Committee
CBO	Community Based Care
CCM	Country Coordination Mechanism
CDC	U.S Centre for Disease Control
COMAHS	College of Medicine and Allied Health Sciences
COPSAASL	Coalition of Public Sector Against HIV and AIDS in Serra Leone
CSO	Civil Society Organization
CSW	Commercial Sex Worker
DAC	District AIDS Committee
DAAG	Disability Awareness Action Group
DBS	Dried Blood Spot
DHMT	District Health Management Team
DHO	District Health Officer
DMO	District Medical Officer
DOO	District Operational Officers
DPC	Disease Prevention and Control
DPI	Directorate of Planning and Information
ETWG	Extended Technical Working Group
FAO	Food and Agricultural Organization
FAWE	Forum for African Women Educationists
FSU	Family Support Unit
GF	The Global Fund on HIV/AIDS, TB and Malaria
GIS	Government Information Service
GoSL	Government of the Republic of Sierra Leone
GWT	Gender Working Team
HACSA	HIV and AIDS Care and Support Association
HARA	HIV and AIDS Reporters Association
HBC	Home Based Care
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HR	Human Rights
IDU	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labour Organization
IMC	Independent Media Commission

INGO	International Non Governmental Organization
IOM	International Office of Migration
JPR	Joint Programme Review
KFW	Krebital ftaltfürWieberaufbau (German Development Bank)
KYE,KYR	Know Your Epidemic, Know Your Response
Le	Leone (Sierra Leone currency)
MARPs	Most-at-Risk Populations
MDAs	Ministries, Departments and Agencies
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MELSS	Ministry of Employment, Labour and Social Security
MEYS	Ministry of Education, Youth and Sport
MIALGRD	Ministry of Local Internal Affairs, Local Government and Rural Development
MLGCD	Ministry of Local Government and Community Development
MoD	Ministry of Defense
MoFED	Ministry of Finance and Economic Planning
MoHS	Ministry of Health and Sanitation
MoIC	Ministry of Information and Communication
MoJ	Ministry of Justice
MoT	Modes of Transmission
MoTCA	Ministry of Tourism and Cultural Affairs
MoU	Memorandum of Understanding
MoWHI	Ministry of Works, Housing and Infrastructure
MoYS	Ministry of Youth and Sports
MRU	Manor River Union
MSM	Men who have Sex with Men
MSWGCA	Ministry of Social Welfare, Gender and Children Affairs
NAC	National AIDS Council
NACP	National AIDS Control Programme
NACSA	National Commission for Social Action
NAS	National HIV/AIDS Secretariat
NASSIT	National Social Security and Insurance Trust
NECHRAS	Network of Christian Response to HIV and AIDS in Sierra Leone
NETHIPS	Network of HIV Positives
NGO	Non-governmental Organization
NOW	National Organization for Welbodi
NSP	National Strategic Plan
OHCHR	United Nations Office of the High Commissioner for Human Rights
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PABA	People Affected By AIDS
PEP	Post Exposure Prophylaxis
PHC	Primary Health Care
PHE	Public Health Educators
PHU	Peripheral Health Units
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission
PSM	Procurement and Supply Management
PWD	People Living With Disabilities

PSO	Private Sector Organization
RH	Reproductive Health
RST	Regional Support Team
SEAC	Sexual Exploitation and Abuse Committee
SHARP	Sierra Leone HIV and AIDS Response Project
SL	Sierra Leone
SLANGO	Sierra Leone Association of Non-Governmental Organization
SLDHS	Sierra Leone Demographic and Health Survey
SLLC	Sierra Leone Labour Congress
SPU	State House Patrol Unit, State House
STI	Sexually Transmitted Infections
SWAASL	Society of Women and AIDS in Africa, Sierra Leone Chapter
TBA	Traditional Birth attendants
TFCs	Therapeutic Feeding Centres
TTIs	Transfusion Transmittable Infections
TWG	Technical Working Group
UCC	UNAIDS Country Coordinator
UCO	UNAIDS Country Office
UNAIDS	Joint United Nations Program on HIV and AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nation General Assembly Special Session
UNHCR	United Nations High Commission for Refugees
UNICEF	United Nations Children Fund
UNIDO	United Nations Industrial Development Organization
UNIPSIL	United Nations Integrated Peace Building in Sierra Leone
USG	United States Government
VOW	Voice of Women
WFP	World Food Programme
WHO	World Health Organization

SECTION 1: INTRODUCTION AND BACKGROUND

1.1 Sierra Leone: Socio-Economic and Political Profile

Sierra Leone is located on the west coast of Africa and covers an area of about 71,740 square kilometers (approximately 28,000 square miles). The country is bordered in the north and north-east by the Republic of Guinea, on the north and northeast by the Republic of Liberia and the west and southwest by the Atlantic Ocean.

Administratively, the country is divided into four provinces namely the Western Area, three provinces namely; Northern, Southern and Eastern. The provinces are further divided into fourteen (14) Districts and 149 chiefdoms. The 14 Districts are sub-divided into 19 Local councils following the enactment of the Decentralization Act. Out of the 19 Councils, 6 are City Councils and the remaining 13 are District Councils. Government is at present implementing a devolution plan, which will see the devolution of the central government's functions to the councils. At the moment 19 out of the 34 core functions have been devolved to the councils. To further strengthen the decentralization process, a Chiefdom Governance Act was enacted by the Parliament.

The country's population is estimated at around 5.6 million people with 37.1% residing in urban areas. The results of the previous censuses indicated an annual population growth rate of 1.8 percent per annum during the 1985 to 2004 period. Women account for about 51.5% of the total population with 47.8% of the estimated total population within the age brackets of 15 – 49 years. 47% percent of the population is under age 15 years and adolescents accounts for 19.4% of the estimated population in 2004. The Total Fertility Rate (TFR) has remained at slightly above 6 children per woman and this rate has remained constant for over a decade. This high TFR level has largely contributed to the youthful nature of the population.

Over the years, the urban population has been increasing at a faster rate than the rural, largely as a result of rural neglect and the civil conflict, which ended in 2002. The result of the rural-urban migration has led to an upsurge in movement to the urban centers resulting in some sorts of disintegration in the communal traditions and family bonds that once held the communities together. These communal traditions and family bonds are crucial in providing social protection not only for PLHIVs but the population as well.

Sierra Leone's gross national income (GNI) per capita is US$ 809 (UN HD Report 2010). Based on consumption levels, 66.4% of the population could be defined as 'poor' (47% in urban areas versus 79% in rural areas). The 2010 UNDP Human Development Report ranked Sierra Leone 158th out of 169 on the Human Development Index.

On-going public sector reforms which affected the health sector has made the district health services, the core component of primary health care. They are composed of a network of peripheral health units (PHUs), the district hospital and the District Health Management Team (DHMT). The PHUs are the first line health services, and are further sub-classified into three levels. The maternal and child health posts (MCHPs) are situated at village level for populations of less than 5000. They are staffed by MCH Aides are supported by community health workers (Community volunteers, etc) who are trained. They provide the following services: antenatal care, supervised deliveries, postnatal care, family planning, growth monitoring and promotion for under-five children, immunization, health, education, management of minor ailments, and referral of cases to the next level[1].

Community Health Posts (CHPs) are at small town level with population between 5,000 and 10,000 and are staffed by State Enrolled Community Health Nurses (SECHNs) and MCH Aides. They provide the same types of services that are provided at the MCHPs and in addition prevention and control of communicable diseases and rehabilitation. They refer more complicated cases to the Community Health Centres (CHCs) which are located at Chiefdom level, usually covering a population ranging from 10,000 to 20,000 and staffed with a community health officer (CHO), SECHN, MCH Aides, an epidemiological disease control assistant and an environmental health assistant. They provide all the services provided at the CHP level in addition to environmental sanitation and supervise the CHPs and MCHPs within the Chiefdom.

[1] MOHS (2009): National Health sector Strategic Plan (2010-2015)

The district hospital is a secondary level facility providing back-stopping for the PHUs. It provides the following services: outpatient services for referred cases from PHUs and the population living within its immediate environs, inpatient and diagnostic services, management of accidents and emergencies, and technical support to PHUs. The District Health Management Team (DHMT) is responsible for the overall planning, implementation, coordination, monitoring and evaluation of the district health services under the leadership of the District Medical Officer (DMO). Other members include the medical officer in charge of the district hospital and scheduled officers for various programs and units. Medical services provided by the private sector, faith-based organizations and NGOs are also growing in importance.

Table 1 shows the types, ownership and number of health facilities in Sierra Leone. It shows that there are 1,029 health facilities in all. This is rather inadequate for a population of nearly 6 million. This may probably be partly responsible for the low health indicators in Sierra Leone. For instance, women in Sierra Leone do not receive antenatal care services early during pregnancy. According to the 2008 Demographic and Health Survey, only 30% of women obtained antenatal care in the first 3 months of pregnancy, while 41% made their first visit in the 4th or 5th month, and 17% made the first ANC visit in the 6 or 7 month; 1% of women had their first antenatal care visit in the 8th month of pregnancy or later. Such a trend present challenge for PMTCT services. The challenge is further compounded by the fact that only 42% of the births are attended by skilled health personnel.[2] Infant and child mortality is estimated at 89 and 140 deaths per 1,000 live births, while maternal mortality is estimated at 857 deaths per 100,000 live births[3]. Malnutrition and malaria are the major causes of infant and under-five mortality and morbidity in Sierra Leone.

Table 1: Types, Number and Ownership of Health Facilities in Sierra Leone

S/No	Description of Health Facility	Government	Private	Mission	NGO	Total
1	Community Health Post	176	-	-	-	**176**
2.	Community Health Centre	178	-	-	-	**178**
3.	Maternal and Community Health Post	520	-	-	-	**520**
4.	Clinics	11	45	38	17	**111**
5.	Hospital	30	3	11	-	**44**
	Total	**915**	**48**	**49**	**17**	**1029**

Source: National Health Sector Strategic Plan (2010-2015)

Sierra Leone has commenced the implementation of Universal Access to Primary Education. However, school enrollment and retention still pose some challenges. Some 30% of children of primary school-going age are still out of school[4]. Many of those who eventually access schooling do not complete. Causes of non-attendance and completion include hidden and indirect costs, socio-cultural barriers to girl-child education, child labour and high rate of teenage pregnancy.

[2] UNDP Human Development Report 2010
[3] 2008 Demographic and Health Survey
[4] Poverty Reduction Strategy 2008-2012, An Agenda for Change, January 2009, pp 18, 102

1.2 HIV Epidemiology

Sierra Leone's HIV epidemic has been categorized as mixed, generalized and heterogeneous – meaning that HIV affects different population sub-groups and all sectors of the population through multiple and diverse transmission dynamics. The 2010 HIV Modes of Transmission Study revealed that for all new HIV infections in adults (15-49 years), commercial sex workers, their clients and partners of clients contributed 39.7%; people in discordant monogamous relationships contributed 15.6% and people reporting multiple partnerships and their partners contributed 40%. Of these, multiple sex partnership groups with the casual heterosexual sex group and their partners contributed about 15%. Fisher folks contributed the second highest incidence (10.8%) followed by traders, transporters and mine workers with 7.6%, 3.5% and 3.2% respectively. MSMs and IDUs are slowly emerging in the Sierra Leone society. They contributed 2.4% and 1.4% of the new infections respectively.

HIV prevalence is higher amongst specific groups and various studies have revealed high HIV prevalence amongst a number of key affected groups, including sex workers, mobile populations (miners, fisher folks etc.), men who have sex with men and injecting drug users. A recent study from UNODC estimates that 14% of Intravenous Drug Users (IDUs) lives in Freetown with 47% of them sharing needles. The study further revealed 1.6% of sex workers were IDUs with 87% of them sharing needles. The study concludes that Sierra Leone is the second most exposed country in West Africa after Nigeria to IDU. Some of these groups are marginalized within the Sierra Leonean society. Homosexuality and sex work for example are illegal in Sierra Leone and punishable by law. Therefore these groups are difficult to reach with HIV prevention, treatment and care, and the extent to which these groups are affected has not been fully explored.

Adult HIV prevalence is estimated at 1.5% whilst that of pregnant women attending ante-natal clinics stands at 3.2%. Sierra Leone HIV prevalence peaked during 2005 and, according to the 2007 figures; it has stabilized at 1.5%[5]. This makes Sierra Leone one of the least affected countries in the world by the HIV and AIDS epidemic. This stabilization is thought to be partially due to an increase in HIV awareness and multi-sectoral involvement of implementing and development partners. However, many Sierra Leoneans are still not being reached with HIV prevention, treatment and care services. An estimated 50,000 Sierra Leoneans are living with HIV[6] out of which 4,600 are children[7]. Only 5,552 of the estimated adults living with the virus are receiving treatment and 54 children are currently enrolled on treatment[8]. This indicates that Sierra Leone still has a long way to go in meeting Universal Access targets on HIV treatment, prevention and care.

Women are disproportionately affected by HIV. In 2008 Demographic and Health Survey, HIV prevalence among women was 1.7% while that of their male counterparts was 1.2%. This disparity is even greater in young women aged 15-19. Girls are more likely to become infected with HIV than boys of the same age because of early initiation of sexual intercourse as evidenced from high teenage pregnancy, which is thought to contribute to the higher prevalence of HIV. The mean age at which women start having sexual relations in Sierra Leone is 16 and only 3% of young women and 7% of young men used condoms during their first sexual encounter. The study further estimated 69% of the teenage girls to have had their first child before the age of 18.

The study revealed that HIV is prevalence is three times higher among adolescent girls (1.4%) than boys (0.5%). HIV prevalence was highest for the 23-24 age group, while among young men was highest for the 20-22 age group. Adult HIV prevalence is greater in urban areas (2.5%) than rural areas (1.0%) of Sierra Leone[9]. Since around 60% of the population of Sierra Leone lives in rural areas, the total number of adults living with HIV is expected to be higher rural settings than urban settings.

[5] Ibid
[6] Sierra Leone HIV Modes of Transmission Study, 2010 January 2009, pp 81
[7] UNAIDS, 2009 Global Estimates
[8] NAS M&E Programme Data 2010
[9] Sierra Leone Demographic and Health Survey, 2008, pp 224

1.3 Overview of National HIV Response

HIV prevention has been the mainstay of the national response since the adoption of the multi-sectoral response in 2002. This has been the key aspect of mobilizing the society. The key interventions in the previous National HIV/AIDS Strategic Plan (2005-2009) were to increase the number of people within the sexually active population (especially those aged 15-24 years) that adopt key HIV prevention behaviors, decrease vertical transmission of HIV and adoption of safe blood transfusion practices. The prevention intervention is further complemented with the provision of free treatment to mitigate the impact of the disease on people infected and affected. The aim of the Sierra Leone National HIV and AIDS Strategic Plan (2011 – 2015) is to achieve zero new HIV infection by using new, evidence-based approaches to HIV prevention.

To achieve this, plans were outlined in the six main thematic areas indicated below:

(i) Coordination, Decentralized Response, Resource Mobilization And Management
(ii) Policy, Advocacy, Human Rights and Legal Environment.
(iii) Prevention of New HIV Infections
(iv) Treatment of HIV And other Related Health Conditions
(v) Care And Support for the Infected and Affected By HIV/AIDS
(vi) Research, Monitoring And Evaluation

The key achievements as well as the challenges are discussed under the thematic areas listed above.

(a) Coordination, Decentralized Response, Resource Mobilization and Management

The establishment of the national HIV/AIDS secretariat has no doubt increased coordination efforts at the National level. The District AIDS Committees (DACs) were also established at the district levels to coordinate HIV/AIDS activities at that level. The Chiefdom AIDS Committees (CACs) are yet to be inaugurated in line with the decentralization policies of government. Various coordination platforms have been set up within and amongst the sectors. They include: COPSAASL (for public sector actors), BCAASL (for private sector actors), NETHIPS (for PLHIV), SLANGO (for other CSO actors), Inter-religious Council (for FBOs) and HARA (for media). Capacity needs assessment has been done for only NETHIPS. There is also the NAS interface with other actors through fora such as the NAS-development partners' forum, NAS-Implementing Partner forum. Coordination meetings are found to be largely irregular. In addition there are various technical working groups that also assist in coordinating efforts of the various thematic areas and also render technical assistance where need be. Key challenge is how to effectively coordinate the efforts of the diverse NGOs, CBOs and FBOs is still a challenge.

Currently, Global Fund provides close to about 80% of the resource envelope for the national HIV response. Other bi-laterals who are also contributing resources directly to the national HIV response are the German Government (through KfW) and US Government etc. The EU is also supporting the National HIV response through grants given to some NGOs to implement sexual reproductive health and HIV related activities. The current funding windows especially with the bi-laterals could be conceived as unpredictable because of the present global financial crisis and economic crisis. The UN system has also been providing reasonable level of financial resources and lot of technical assistance for the response. Though Government remains committed to the campaign against HIV and AIDS with increased domestic resources allocation, the response continue to be heavily reliant of external sources. Given financial sustainability, a major concern is the dependence on donor funding for nearly 95% of the national response. The major concern is the almost exclusive dependence on the Global Fund to finance the national response in spite of the high level of political support for national HIV response.

(b) Policy, Advocacy, Human Rights and Legal Environment

Sierra Leone National HIV response has been captured in relevant strategic documents such as the 'Agenda for Change' and Poverty Reduction Strategy Paper II. There is also considerable level of political support for the response at the highest level of government. Sierra Leone is a signatory to International Human Rights Protocols and conventions such as the UN charter on Human Rights, Ndjamena Accord, Convention on the Elimination of forms of Discrimination Against Women (CEDAW), UNGASS resolution, Universal Access etc.

The Prevention and Control of HIV/AIDS Act (2007) was enacted but some aspects of the HIV/AIDS Prevention Act are also considered discriminatory and are being reviewed. The Child Rights Acts as well as three "Gender Acts"; the Domestic Violence Act 2007, the Devolution of Estate Act 2007 and the Registration of Customary Marriage and Divorce Act 2007 which protects the women from domestic violence and other forms of abuse which make them more vulnerable to HIV/AIDS were enacted. Enforcement of these laws is still a key issue as some of the law enforcement agents are not often aware of them. The National HIV policy and the national HIV workplace policy were developed but the dissemination of these policies is still a major gap. Private sector organizations like Zain (now Airtel), Sierra Leone Brewery, National Petroleum and Standard Chartered Bank have workplace policies.

National policies/protocols and guidelines were also developed for the following: ART, HCT, Blood transfusion, PMTCT, Youths, Management of Paedriatic HIV/AIDS and Health-care Waste management, etc. However, there is also no national policy on OVC, home-based care and condom. As it is with laws, popularization of the policies is still a major challenge.

(c) Prevention of New HIV Infections

The response for this thematic area is discussed under the following:

HIV Counseling and Testing (HCT)

HIV Counseling and Testing has been scaled up across Sierra Leone since 2005. Number of HCT sites increased from 19 in 2005 to 543 in 2010. Provider initiated counseling and testing was also introduced during provision of ante-natal services. Number of people who ever got counseled and tested increased from 24,375 in 2005 to 189,903 by close of December 2010. Though the increase might be substantial, a large majority of the Sierra Leoneans are yet to know their HIV status. Estimates from the 2008 Demographic and Health Survey revealed that about 13% of women and 8% of men aged 15-49 years have ever had an HIV test. This is a critical challenge for prevention interventions most especially when HCT is a gateway to prevention.

Prevention of mother-to-child transmission (PMTCT)

Prevention of mother-to-child transmission (PMTCT) intervention was introduced into the national response in 2007. Since 2007 health facilities offering PMTCT services increased from 18 to 543 in December 2010. An estimated 98,870 pregnant were counseled and tested for HIV by December 2010. In early 2010 the Ministry of Health and Sanitation introduced combination therapy to replace single-dosed nevirapine to prevent mother-to-child transmission. The Government also in April 2010 introduced a free healthcare initiative for pregnant and lactating mothers including the under-fives. This initiative will encourage pregnant women testing and to deliver antiretroviral treatment to more children who need it.

Communication Interventions

HIV and AIDS education is an essential component of HIV prevention. The HIV/AIDS curriculum has been mainstreamed into the SRH/Life skills education curriculum for secondary schools but is yet to be effected for primary schools. Several education campaigns to raise awareness about HIV nationwide through print and electronic media were undertaken. Knowledge about HIV/AIDS preventive education is still very low among the populace (19.7% for women and 31.2% for men aged 15-49 years-SLDHS 2008). It is slightly higher among young people aged 15-24 years (women 23.7% and men 32.9%). Targeting of MARPs and their clients (in particular) with key prevention messages is still a major challenge

Condom use

Prevention of new HIV infection is anchored on delaying sexual intercourse among the teenage population, promoting abstinence, and faithfulness to partners as well as the use of condoms. Condoms have been made freely available in health facilities, work places and other places of convenience throughout the country through three main distribution channels namely; the District and Peripheral Health Units, the NGOs and community based networks and social marketing outlets. Female condoms are being gradually provided to increase options available to women within the context of protection against sexually transmitted infections including HIV. Condon distribution is gradually being scaled-up. Between 2005 to December 2010, 10,744,810 condoms were distributed. However, many obstacles still prevent people from accessing condoms or wanting to use the product.

They include low knowledge about condom use, conflicting messages about condom use, many religious leaders expressed opposition to condom use and condom distribution to in-school adolescents is against the education policy. This is in contradiction of the vision of having healthy and educated adolescents and the youth as the future of the country. Therefore, priority ought to be attached to strengthening youth and adolescent sexual reproductive health programmes as a component of the operational plan.

(d) Treatment of HIV and other Related Health Conditions

Treatment as a component of the multi-sectoral response was initiated in 2005 as a pilot to target 500 adult patients at 16 treatment sites within the Government hospitals at the District Headquarter town. Nevertheless, by 2010 the number of adults receiving free antiretroviral therapy had significantly increased to 5,552 with 119 sites offering treatment. The number of people co-infected with HIV and tuberculosis (TB) is gradually increasing. Although the collaboration between the national TB Control Programme and the National AIDS Control Programme are being strengthened, facilities with dual treatment are very limited. It is obvious for many of those requiring ARVs alongside TB treatment are not receiving it. An estimated 14.4% of PLHIVs have TB co-infection. 20.7% and 7.27% of the co-infection were found among men and women respectively.

Pediatric treatment also commenced within the period. By December 2010, 54 children were enrolled and receiving treatment. The overall coverage for children remains extremely low. Majority of the children who need treatment are not accessing it for reasons such as the lack of accurate information about medical care for children and inadequate equipment (only 3 PCR equipment is available for the whole country) to do early infant diagnosis for children under 15 months etc.

However, the introduction of the new treatment guidelines by WHO, the free healthcare initiative by Government for pregnant, lactating and under-fives, the availability of a PCR machines for early infant diagnosis and implementation of the scale-up plan for PMTCT and Pediatric care are bound to increase treatment coverage. Due to these developments, the number of people that are expected to die from AIDS particularly children will decline in the coming years.

The treatment technical working group was established to assist in coordinating treatment efforts. The Laboratory Technical Working Group has been established while the reference laboratory has been equipped to enhance quality assurance and support for diagnosis and treatment. The laboratory strategic plan was also developed.

(e) Care and Support for the infected and affected by HIV/AIDS

NETHIPS-network of people living with HIV/AIDS was established while support groups are established in all districts. Mapping of support groups was done. More PLHIV are now disclosing their HIV status and thus qualify for support in one form of the other. Capacities are still limited in terms of service provision. There is no policy for HBC and OVC though manuals on HBC and OVC were produced. HBC services not standardized and limited in scope. Services primarily concentrated on addressing the immediate material needs of PLHIV- nutritional and HBC kit.

PLHIV are receiving livelihood and nutritional support from the UNAIDS, World Food Programme (WFP) and EU through some NGOs. NETHIPS with assistance of partners have trained members on income-generating activities. However, there are still very limited economic empowerment opportunities for the indigent PLHIV. Very few facilities are available for the chronically ill patients as there are only two hospices in the whole country for the chronically ill patients. There is also limited involvement of health workers in home-based care. Most of the care givers are immediate relatives of PLHIVs who do not have the capacity to provide adequate services.

Situational analysis of OVC was conducted but no concrete plan of action for OVC. Currently only 120 OVC out of the identified 8,000 OVC are being supported by some NGOs. For OVCs, only two out (nutritional and educational) of the seven pillars of support (which includes medical, psycho-social, shelter and protection) are provided.

(f) Research, Monitoring and Evaluation

The National M&E plan for NSP I (2006-2010) was developed but not adequately disseminated. It was also not largely reviewed. The M&E unit have also been producing the relevant information to meet the reporting requirements of the funders such as global fund and to also meet international obligations e.g. UNGASS.

M&E unit at the National level (NAS) have staff with relevant skills but adequacy is a challenge. Inadequate skills are pervasive at the sub-national levels. Capacities of staff have been built over the years but needs upgrading. Institutional capacity to train and retain qualified M&E staff of all cadres is also a challenge. However, NAS has two international advisors placed at Headquarters to build capacity of staff and its partners through mentoring in addition to other on-going efforts.

Key surveys and studies have been by NAS in conjunction with other key stakeholders and it includes: 2006, 2007, 2008 & 10 ANC Sentinel Surveillance (2006, 2007, 2008 and 2010), SLDHS (2008), NASA (2006-2009), HIV Prevalence Among MSM in Sierra Leone Study, Sierra Leone Modes of Transmission Study (2010) HIV Prevalence Among Fisher folks in Sierra Leone Study (2010).

1.4 Key Response Challenges and Gaps

1.4.1 Sustainability of the national response

The 2006/2007 National AIDS Spending Assessment (NASA) documented 98% of the resources for the national response coming from external sources. The Global Fund to Fight AIDS, Tuberculosis and Malaria currently accounts for about 85% – 90% of the external funding. Though Government remains committed to the campaign against HIV and AIDS with increased domestic resources allocation, the response continue to be heavily reliant of external sources. Given financial sustainability, a major concern is the dependence on donor funding for nearly 95% of the national response and the almost exclusive dependence on the Global Fund to finance the national response.

1.4.2 Human Capacity Development and Program Scale-Up

Sierra Leone has made progress in stabilizing the epidemic as well as scaling-up prevention and treatment programming interventions in a resource constrained environment. Though these are all important, very little focus has been placed on human capital development to ensure sustenance of scale-up. Skills for certain areas are concentrated in only few hands to the extent that once they are not around activities may be grounded. While there are on-going efforts to integrate HIV training into curricular of some tertiary institutions there is need to fast-track this. Health facilities (virtually at all levels) seemed to be heavily involved in demand creation activities which further adds to burden of health personnel. There may be the need to shelve the demand creation activities to the civil society organizations so that the health personnel can concentrate on their core duties.

1.4.3 Coordination

One of the tenets of the multi-sectoral response strategy adopted by Government is anchored on the key assumption that the National Response to HIV/ AIDS cannot be implemented by state actors alone. It has to create room for the involvement of diverse players with the belief that it will engender richness and diversity of the inputs as well as the commitment from the various stakeholders with a view to enhancing service delivery. However, the increased and dispersed number of civil society organizations across the country wanting to contribute to the national response makes it challenging to integrate their activities in local/national planning and coordination structures. Similarly, there is also the challenge of quality of in their activities and supervision. There is need therefore to integrate their activities into existing coordination and planning mechanisms, while at the same time establish more of such structures for those whose current interventions cannot fit into present structures.

1.4.4 HIV Stigma and Discrimination

Even though awareness of HIV and AIDS in Sierra Leone is improving slowly, many people living with the virus are still subjected to stigma and discrimination. Studies have shown that people are aware of the basic facts about HIV and AIDS but many lack the in-depth knowledge on the issues of stigmatization and discrimination.

1.4.5 Lack of integrated planning at district level

Even though the District AIDS Committees have been established within the District/City Councils to take responsibility for district and local HIV responses, the district response initiatives show lack of integrated planning in the execution of district level HIV responses. The Councils non-health and District Health Management Team appear to be working in isolation particularly in monitoring the trend of the epidemic. This may be partly responsible for seeing HIV/AIDS as a vertical programme and with little or no progress in mainstreaming of HIV and AIDS into the comprehensive council plans.

1.4.6 Uneven distribution and low condom use

Nationwide condom distribution has been uneven between rural and urban communities in the country. The main distribution outlet for free male condoms still remains the health service outlets. Use of condom is very low with less than 10% of the population reporting the use (SLDHS 2008) and there is also no national condom policy in place. Promotion of effective and consistent condom use faces several challenges because of its cultural and religious sensitivities most especially within the rural context. Furthermore, the uptake of female condoms is quite low due to its low availability and acceptability coupled with its high cost.

1.4.7 Overstretched health care infrastructure

The national response is currently witnessing shortages of skilled health and non-health personnel. The programme has been characterized by the placement of much emphasis on the medicalisation of the HIV service cadre. The introduction of the Free Healthcare initiative by the Government for pregnant, lactating and under-fives has overstretched the health care infrastructure in coping with the additional demand for PMTCT and pediatric care services. The roll-out plan for PMTCT and Pediatric care has not been supported with adequate communication activities for the service providers and the community in general to create demand for services.

1.4.8 The Challenge of reaching Clients of Most-at-risk population (MARPs)

MARPs include the MSM, SWs and their clients and IDUs within the general population and probably IDUs in prison settings. There are no documented effective best practice interventions in the country for the most-at-risk populations identified above. Also, there is a dearth of information about HIV infection and spread among the different population groups thus making it very challenging to track the epidemic as well as to monitor programme implementation and its impact.

Other issues relating to this group are stigma and illegality. Homosexuality is illegal in Sierra Leone and therefore men who have sex with men are ostracized by the society. Although the HIV prevalence rate among the groups is high, their population size is also unknown. There is therefore the need to do size estimation of the MARPs. Regular Integrated biological and behavioural surveys among the population-most-at-risk (Prisoners, IDUs, SWs, and MSM) will help monitor the spread of HIV among the group as well as identify the causal factors for the high prevalence rates within these groups.

1.4.9 Weak Monitoring and Evaluation System

The M&E system for HIV and AIDS is weak. National pool of qualified people in M&E of health and social related projects in the country is very small. Most of those recruited to perform M&E functions have inadequate skills. There is a dearth of data not only on MARPs but studies conducted are not comprehensive enough. Besides, the database maintained by the national authority is virtually limited to capturing information from partners, whose resources are coming from the authority. Interventions by the bulk of the partners are not captured into the system. Therefore the tendency of under-reporting on universal access and MDG Targets is very high.

SECTION 2: NATIONAL HIV/AIDS OPERATIONAL PLAN (2011 – 2012): PROCESS, CONTENT AND PRINCIPLES

2.1 The NSP (2011-2015): Results Framework and Relationship with OP

The overarching result of SLNSP II (2011-2015) is to towards **Zero-new HIV infections, Zero Stigma and Discrimination and Zero AIDS Related Deaths in Sierra Leone by 2015.**

To achieve this, **five impact and outcome level results** are to be achieved by 2015 and they are as follows

1) Coordinating structures at national and decentralized level effectively manage implementation.
2) Laws and policies protecting the rights of PLHIV and orphans are widely applied.
3) Incidence of HIV is reduced by 50%.
4) Morbidity and mortality amongst the PLHIV are reduced.
5) People infected and affected have the same opportunities as the general population

The Sierra Leone National Strategic Plan on HIV/AIDS 2011 – 2015 is based on the principles of three-ones, the UNGASS and MDGs and Universal Targets. It serves as a framework for a broad partnership between the Government of Sierra Leone, civil societies, nongovernmental organizations, development partners and the private sector in order to achieve the set objectives and targets. The plan outlined 6 thematic areas to focus on in the next five years.

a) Coordination, Institutional arrangements, Resource Mobilization and Management
b) Policy, Advocacy, Human Rights and Legal Environment
c) Prevention of New Infections
d) Treatment of HIV and Other Related Health Conditions
e) Care and Support for the Infected and affected by HIV and AIDS and
f) Research, Monitoring and Evaluation

A combination of the results at the output and outcome levels (including intermediary outcomes) as well as strategies and actions will ensure that these results are achieved. The Operational Plan draws largely from the NSP and the focus of the operational plan is the output level results and also outlines in details the activities to be implemented in order to achieve the desired results. In essence the operational plan provides the basis for the implementation of the Strategic plan. The operational plan was also developed based on the six thematic areas above.

2.2 Preparatory activities for National HIV/AIDS Operational Plan Development

The entire process of developing the OP was spearheaded under the leadership of the National HIV/AIDS Secretariat with the active involvement of partners/stakeholders including people living with HIV/AIDS and civil society. The OP was developed between February and March 2011, though the preparatory processes started in 2010. The key activities are as outlined below:

2.2.1 Final Joint Programme Review of the 2006 – 2010 National Strategic Plan on HIV/AIDS.

The review was to give an indication of the level of implementation of the NSP 2006-2010 and the OP 2009 - 2010. The process involved desk/document review, group meetings with sectoral/institutional representatives, individual interviews of key people at the district level on the key six priority areas of the 2006 – 2010 National Strategic Plan from which the OP was developed.

2.2.2. Know Your Epidemic; Know Your Response Study (Modes of Transmission Study)

The aim of the study was to describe and understand the HIV epidemiological situation, prevention response and make recommendations at improving the programming of national HIV interventions. The process involved desk review, field data collection and incidence modeling with all the stakeholders actively involved. The key issues emanating from the study provided the much needed evidence for developing the strategic plan (2011-2015). The Operational Plan sets outs activities which will be undertaken to achieve the objectives under each thematic area within the NSP.

2.3 Guiding Principles for National HIV/AIDS Operational Plan

The Guiding Principles of the OP include:

1. **Commitment by all stakeholders:** Government leadership and accountability towards achieving full implementation of activities in the OP. Commitment of all the other stakeholders including civil society organizations including faith-based organizations, private sector and the development partners
2. **Quality:** Technical and Policy framework to optimize HIV planning, implementation, and M&E.
3. **Decentralisation and Integration**: Decentralisation of service delivery and integration of HIV services into the maternal, nutrition, child, adolescent health and other reproductive health including FP programmes.
4. **Equitable access:** Ensuring equitable and reliable access for HIV services with a focus on districts or communities with high HIV prevalence, MARPs, and others made vulnerable to HIV infection and/or its effects especially on the basis of gender-related disparities.
5. **Health systems:** Strengthening and utilisation of the health systems, including the private health facilities in communities (without government health facilities) to improve service delivery.
6. **Monitoring:** Tracking programme performance and impact, outcomes, and output results
7. **Partnership:** Strengthening partnerships at all levels and in all sectors, including PLHIV associations, development partners, and CSOs and private sector.

2.4 The OP Development Process

The OP is closely aligned with the 2011 – 2015 NSP and the country's Second Poverty Reduction Strategy 2008-2012, which is the medium term strategy for achieving Government's Agenda for Change. It is anchored on the premise of scale-up of programmes and interventions to accelerate progress towards achieving the HIV targets of the Millennium Development Goals (MDGs). The guiding block throughout its development process has been participation and involvement of key stakeholders, ownership and buy-in. The OP development process consisted of the following:

i) Review of National Operational Plan (2009-2010)

The expired National HIV/AIDS Operational was based on the last NSP (2005-2009). However, it was reviewed with a view to drawing out some lessons. The key lesson learnt was that stakeholders were not involved in the development neither was it disseminated and so there was no ownership. It also made coordination and reporting challenging. Though some activities contained therein were implemented by some stakeholders, it was largely picked from the NSP rather than a well-articulated operational plan.

It also has to be said that since the last OP was based on the expired NSP and the entire NSP was reviewed (including the expired OP) most of the activities and strategies to be scaled up , reviewed or discarded were already taken into consideration in developing the current NSP and the OP.

ii) Desk review of relevant Documents:

Relevant documents such the Education Sector Master Plan, 2011 – 2015 Strategic Plan for Adolescent and Young People's Health and Development, scale-up plans on PMTCT and Pediatric care etc. and work plans of the Global Fund, KfW and the UN Family.

iii) Consultations with Stakeholders (February 21 – 26 2011)

Consultations were held with different stakeholders on the process most especially in identifying priority target population and activities for the next two years. This was to avoid the mistakes of the past OP, wherein stakeholders were not aware of the OP. Consultations were held at national and regional levels with MDAs, private sector, civil society organizations, District AIDS Committees, People Living with HIV/AIDS, technical and donor partners notably the UN Team. Consultations continued up to the finalization of the OP.

iv) OP Development (February 1 – 4, 2011)

A three-day residential retreat was organized for key technical people to participate in the drafting of the OP. 35 stakeholders from the public, private sectors, implementing partners (NGOs and CBOs), Network of HIV Positives in Sierra Leone, MARPs Representation and UN Agencies took part. The morning session retreat focused on the principles for results based planning and management; priority setting and evidence based monitoring and evaluation. The retreat identified activities for inclusion in the new National Operational Plan. After the retreat, the team of consultants fine-tuned the framework.

v) Validation and Finalization of the National HIV/AIDS Operational Plan (16 February 2011)

A one-day validation meeting was held with a larger group of stakeholders (60 participants) to review the draft OP framework after the retreat. Stakeholders included people from the UN system, the public and private sectors, bi and multi lateral donor partners as well as implementing partners, PLHIVs groups, MARPs, the media, labour unions etc. Comments from the participants were incorporated to finalize the OP.

2.5 Priority Target Groups

Populations that engage in high-risk sex or are vulnerable to HIV infections based on their occupation, lifestyle and cultural and gender factors are considered priority during the implementation of the OP

a) **MARPs**: The HIV epidemic analysis indicates the significant contribution of female sex workers (FSWs), MSM, the clients of FSWs, fisher folks and IDUs to new HIV infections in the country. Equally are the uniformed personnel. However, this significance was not matched with the appropriate national response: interventions that specifically target these populations are very limited. No guidelines currently exist for targeting MARPs and there is high stigma and discrimination against MARPs due to religious and cultural factors. The NSP prioritizes MARPs for HIV prevention interventions to reduce new HIV infections and also for treatment and care and support services for MARPs who are infected by HIV.

b) **Men and women with multiple partners**: The practice of having multiple sexual partners increases exposure to HIV infection. The HIV epidemic analysis shows a significant percentage of men and women have multiple sex partners. There is a need for this strategic plan to prioritise this population for HIV prevention services.

c) **Pregnant Women**: In order to virtually eliminate the Mother-to-Child Transmission of HIV, there would be scaling up of HCT and PMTCT services for pregnant women and their children.

d) **The Adolescents and Youths:** The adolescent and youths (15-24 years) will be a priority target group in a quest to create a generation free of HIV/AIDS. This is because they have been found to engage in high level of risky behaviours due largely to peer pressure. The HIV prevention strategy will include key strategies targeting the youth with HIV information and education, and testing and counselling services. Major information, education, and communication (IEC) campaign approaches include emphasis on delaying the age at sexual debut by abstaining from sexual intercourse among young people, mutual fidelity among partners, correct and consistent condom use during high-risk sex, and avoidance of drugs and alcohol abuse.

2.6 Priority Interventions

This two- year HIV/AIDS Operational plan (2011-2012) will focus on the following priorities as part or re-prioritization of the NSP (2011-2015) identified priorities:

1) Targeting prevention to those at the highest risk
2) Scaling up of HCT and PMTCT and other prevention services
3) Service decentralization and integration
4) Developing and scaling up a continuum of care services, based on expressed needs, and expanding from the clinical care protocols to include participation of more stakeholders particularly the private sector and civil society sector including faith-based organizations.
5) Creation of more enabling environment through enactment of relevant laws and policies
6) Generating reliable national information on the epidemic (rather than information only on specific donor supported programmes) through undertaking a national population based survey (with biological & BSS components) and periodic studies on issues related to HIV/AIDS/STI and TB. The surveys and studies will provide a better understanding of the dynamics of HIV epidemic and key base line data to facilitate better targeting and more effective resource use for the national response. The plan will also work towards strengthening the routine programme monitoring so as to generate desired output indicators as a basis for indicating programme coverage and performance.
7) Focusing on programme efficiency and effectiveness through better programme management and coordination.
8) Improving health services delivery through health infrastructure expansion and rehabilitation to enable provision of wide range of health care services.
9) Securing adequate funding for implementing the NSP. This is by far the greatest challenge and efforts should be geared towards diversification of funding as Global Fund currently accounts for about 80-90% of total funding while substantial funding gap still exists.

SECTION 3: RESULTS FRAMEWORK FOR THE OPERATIONAL PLAN (2011-2012)

3.1 Introduction

The results framework for the Operational plan (based on the six thematic areas) is presented here and shows in details the relationship between the OP and the National HIV Strategic Plan (2010-2015). While the NSP gave an indication of expected outputs, the OP has gone further to state the output level results, activities and key strategies. However, the OP results framework below gives the impact level, outcome level and output level results as well as the key strategies. The detailed OP matrix containing the activities is contained in Annex 2 of this report.

Table 2: OP Results framework for Thematic Area 1- Coordination, Decentralised Response, Resource Mobilization and Management

IMPACT LEVEL RESULT (from the NSP)	KEY OUTCOME LEVEL RESULTS (population level knowledge & behavioral changes & systemic changes)		OUTPUT LEVEL RESULTS	KEY STRATEGIES
Coordinating structures at national and decentralized level effectively manage implementation	Result: 1.1	**Coordination mechanisms at national and sub-national levels strengthened** • % of DACs and CACs strengthened and fully functional • % of networks strengthened/established and functional	**Key output Indicators & (Targets)** • 19 DACs fully established and functional • Capacity of DACs' enhanced for effective coordination. • 149 CACs established and functional • 149 staff of CACs trained on relevant areas such as HIV/AIDS education, mainstreaming, • BCAASL properly positioned for more effective coordination of private sector activities • National Network of CSOs on HIV/AIDS established and functional. • Capacities of at least 82 members and staff of NETHIPS built in diverse areas • Strategic Plan for NETHIPS developed and disseminated. • Youth Network on HIV/AIDS established and functional	• Mentoring and coaching • Training and re-training of staff or advocacy for staff secondment. • Continuous engagement with the leadership of the councils. • Capacity-building based on needs assessment. • Development of capacity building plan • Development and Implementation of strategic plans
	Result 1.2	**National HIV/AIDS Strategic Plan is funded** • % of the annual funds required by the costed National Strategic Plan that is realized • % of government's contribution to total HIV/AIDS spending annually.	**Key Output Indicators** • Gender Technical Working Group established and functional • GoSL and Local/District councils provide increased funding for HIV/AIDS activities • At least 20 private sector organization fund HIV/AIDS activities • At least 10 faith-based organization provide resources for HIV/AIDS activities	• Increased advocacy and engagement of the stakeholders. • Development of resource mobilization plan and strategy • Gender mainstreaming and identification of 'gender champions'
	Result 1.3	**Effective human and logistical Systems in place** • % of facilities that experienced no stock-out of commodities annually (by ARVs, OI drugs, Male & Female Condoms	**Key output indicators** • Procurement and Supply management (PSM) committee established and functional • At least 7 of the medical warehouses do not experience stock out.	• Recruitment of more qualified personnel • Coaching and mentoring • Task shifting and task alignment

Table 3: OP Results Framework for Thematic Area 2- Policy, Advocacy, Human Rights and Legal Environment

IMPACT LEVEL RESULT (from the NSP)	KEY OUTCOME LEVEL RESULTS (population level knowledge & behavioral changes & systemic changes)	OUTPUT LEVEL RESULTS	KEY STRATEGIES
Laws and policies protecting the rights of PLHIVs widely applied	**Existing laws and policies for social protection of the PLHIV and other vulnerable groups are strengthened** • % PLHIV networks/support groups who report their rights are protected and they are empowered • Prevention & Control of HIV & AIDS Act and other relevant Acts are reviewed/enacted and enforced	**Key output Indicators & (Targets)** • NAC bill signed into law and disseminated. • Labour laws reviewed to include HIV-related issues and is implemented in the formal and informal sectors. • Laws that impedes the social protection of the MARPs, PLHIV and OVC are reviewed • New national HIV/AIDS policy developed and disseminated • New national HIV workplace policy developed and disseminated • HIV workplace committees established in 40 organizations and fully functional • Educational workplace policy on HIV reviewed and disseminated. • 700 persons from different organizations and communities have increased knowledge on HIV and Human Rights	• Capacity-building for relevant stakeholders • Lobbying and advocacy to lawmakers and relevant stakeholders. • Formation of pressure groups such as coalition and alliances. • Development and implementation of advocacy plan for specific issues.

Table 4: OP Results Framework for Thematic Area 3- Prevention of New HIV Infections

IMPACT LEVEL RESULT (from NSP)	KEY OUTCOME LEVEL RESULTS (population level knowledge & behavioral changes & systemic changes)		OUTPUT LEVEL RESULTS	KEY STRATEGIES
Reduced HIV Incidence	Result: 1	**Reduced Sexual Transmission of HIV** • % of general population and MARPs who are HIV infected	**Key output Indicators & (Targets)**	
	Intermediate Result 1.1	**MARPs and clients adopt safe behaviour** • Percentage of MARPs (female sex workers, MSMs, Fisher folks, Uniformed Personnel) who are HIV infected • Percentage of MARPs who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission • Percentage of female sex workers reporting the use of a condom with their most recent client • Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	**Key output Indicators & (Targets)** • 62000 MARPS are reached with comprehensive prevention messages • 12,000 MARPs know their HIV status • 20,000 MARPs use condoms correctly and consistently	• Development of policies on MARPS. • Capacity-building for service providers • Advocacy with authorities to ensure a supportive environment for prevention with MARPs • Improvement of quality of counselling and testing services for MARPs • Outreach programs to MARPs through peer education programs, provision of information on HIV and STIs, referral for HIV testing, condom promotion and STI diagnosis
	Intermediate Result 1.2	**Reduction of Risky sexual behavior amongst general population**	**Key Output Indicator** • Capacities of 150 people built	

		• Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 (disaggregated by age and sex) • Percentage of population who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission (disaggregated by age and sex) • Percentage of population aged 15-49 who had more than one sexual partner in the past 12 months (disaggregated by age and sex) • 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	on BCC and CCE • 700,000 people reached with prevention messages • 340, 000 BCC materials distributed • National Strategy for Prevention of HIV/AIDS amongst adolescents and young people developed and disseminated. • 1,440 teachers trained to provide support for implementation of SRH, HIV and Life Skills education • 1,600 in-school and out-of school youths peer educators are trained on life skills • 308,000 youths are reached with prevention messages • 11 million male condoms and female condoms distributed. • HCT guidelines, protocol and training manual reviewed and disseminated • 2,360 HIV counsellors trained • Additional 440 facilities provide HCT services • At least 564,000 HIV tests are conducted annually	• Development of comprehensive prevention plan and BCC strategy • Greater emphasis on use participatory approaches for community engagement • Development or review of relevant guidelines and training manual • Standardisation of training manuals • Establishment of HCT centres in non-health facilities and community outreaches • Intensification of HCT mobile services • Rehabilitation of existing facilities and HCT service integration. • Promotion of condom social marketing • Outreach programs promoting safe sexual behaviour including HIV/STI prevention education, anti- gender-based violence, family planning, and condom promotion • Community sensitization for promotion of safe sexual behaviours, including HIV testing and condom promotion • Involvement of local authorities and media in community sensitization • Extension of youth friendly HIV prevention and reproductive health services • Integration of sexual and reproductive health and HIV prevention component into schools' curricula • Outreach work and provision of a complete package of prevention with out-of-school youth through peer education, including provision of information on SRH, HIV and STIs, gender based violence, condom promotion, life skills, and referral for HIV testing and STIs • Improvement of quality of counselling and testing services
	Intermediate Result 1.3:	**Quality Treatment of STIs increased** • Percentage of people reporting symptoms suggestive of STIs and seeking treatment from clinical services (disaggregated by sex)	**Key output indicators** • At least 200,000 people are reached with information on STIs • 1050 health care personnel trained on STI management • At least 90, 000 cases of STIs are treated. • 240 health workers trained on family planning	• Enhancing laboratory capacity for STI testing • Integration of STI management into HIV services • Provision of "friendly" STI diagnosis and treatment services for sex workers and their clients, and MSM • Provision of youth-friendly STI screening and referral services for the youth by youth friendly services • Capacity building and creation of linkages
	Result 2	**Biomedical transmission of HIV is reduced** • Percentage of people in the	**Key output indicators and targets** • 1,750 people are trained on universal safety precautions and infection control	• Development/review of appropriate policies and

		general population reporting that last injection was given with a syringe and needle taken from a new, unopened package • Percentage of donated blood units screened for HIV in a quality assured manner	• Additional 280 sharp disposal bins are provided to health facilities • Additional 200 health facilities are provided with PEP kits. • National policy on blood transfusion reviewed and disseminated. • 240 health workers trained on blood safety • At least 10,000people are enlisted as blood donors	procedures and dissemination. • Reinforcement of universal precautions in all public health facilities • Ensure access to PEP for all health care workers and rape survivors • Capacity-building for health workers • Raising awareness of general population on blood exposure risks and about PEP availability • Ensure access to PEP for all exposed people outside of health facility settings
	Result 3	**Vertical Mother-to-Child Transmission of HIV reduced** • Percentage of HIV+ children born to known HIV+ mothers (at six weeks, five months and 18 months)		
	Intermediate Result 3.1	**Transmission of HIV during pregnancy, child birth and breastfeeding reduced** • Percentage of HIV+ pregnant women who received antiretroviral therapy to reduce the risk of mother to child transmission	**Key output indicators and targets** • PMTCT and Paediatric HIV Care guidelines and protocol revised and disseminated • 2,000 HIV positive women take ARV • 2,000 health workers trained and re-trained on PMTCT • Additional 200 health facilities provided PMTCT services. • 98,000 pregnant women are counselled and tested • 600 HIV positive women are provided nutritional Support. • 600 infants are provided with EID services	• Expansion of integrated PMTCT services in all health facilities to ensure national coverage • Strengthening integration of PMTCT services in existing health facilities • Promotion of ANC attendance by pregnant women and delivery by pregnant women at health facilities • Increased male involvement and family approach for PMTCT • Intensification of routine counselling and testing of all pregnant women for HIV during pregnancy (at least at first and last ANC visit) • Intensification of case-finding so that HIV+ pregnant women who initiated PMTCT are followed-up to completion • Reinforcement of linkages between health facilities and community • Reinforcement of nutritional support for pregnant and lactating women and their babies • Reinforcement of OI and STI screening, prophylaxis, treatment and referrals for HIV+ pregnant women • Improvement of OI prophylaxis and treatment for HIV exposed infants.
	Intermediate Result 3.2	**HIV positive women are empowered to take informed reproductive health decisions** • Percentage of women of reproductive age attending HIV care and treatment services whose needs for family planning were met	**Key output indicators and targets** • SRH and HIV prevention services integrated. • 240 health workers trained on family planning and HIV.	• Increase male involvement in family planning

Table 5: OP Results Framework for Thematic Area 4- Treatment of HIV and Other Related Conditions

IMPACT LEVEL RESULT (from the NSP)	KEY OUTCOME LEVEL RESULTS (population level knowledge & behavioral changes & systemic changes)		OUTPUT LEVEL RESULTS	KEY STRATEGIES
Morbidity and mortality among PLHIVs are reduced	Result: 1	**Adult PLHIVs and Children PLHIVs eligible for ART receive it.** • Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.	**Key output Indicators & (Targets)** • 390 health care workers trained on ART • 12, 300 eligible adults receive treatment • 600 health care personnel trained on paediatric HIV management. • 1,600 children receive ART. • Additional sites offering ART services increased by 64. • 2,444 health workers are trained and re-trained to provide quality ART services. • Monitoring of ART services is enhanced	• Capacity-building for relevant health personnel • Service integration and expansion. • Rehabilitation and upgrading of existing facilities • Establishing high quality assurances mechanisms and monitoring • Development of effective referral systems. • Development and review of relevant policy guidelines. • Intensification of case finding of PLHIV with TB • Strengthening of laboratory system and support to National Reference Laboratory
	Result 2	**PLHIVs receive OI prophylaxis, treatment and other co-infection treatment.** • Percentage of people enrolled in HIV care and treatment who receive cotrimoxazole prophylaxis in the last 12 months • Percentage of HIV-positive patients who were screened for TB in HIV care or treatment settings • Percentage of hospitals and health centers offering full package of HIV services (HCT, PMTCT, ART, TB)	**Key output indicators** • 780 health care personnel trained to manage OIs and other co-infections such as hepatitis. • 22,458 PLHIV and HIV infected children receive treatment for OIs • TB and HIV collaboration are better coordinated for service delivery. • 830 workers trained on management of HIV/TB co-infection • 5,600 PLHIV screened for TB. • Laboratory services are better coordinated for effective service delivery. • 192 laboratory technicians trained on HIV related laboratory services • 85 laboratories provide services according to national guidelines.	

Table 6: OP Results Framework for Thematic Area 5- Care and Support For those Infected and Affected by HIV/AIDS and OVC

IMPACT LEVEL RESULT (from the NSP)	KEY OUTCOME LEVEL RESULTS (population level knowledge & behavioral changes & systemic changes)		OUTPUT LEVEL RESULTS	KEY STRATEGIES
People living with HIV and/or affected by HIV/AIDS have same opportunities as the general population.	Result: 1	**People living with HIV and/or affected by HIV/AIDS have improved economic opportunities and social** • Percentage of PLHIV network members applying for credit who accessed credit per year	**Key output Indicators & (Targets)** • Baseline information on socio-economic needs/profile available for PLHIV and PABA • 1,166 PLHIV and 2,280 OVC and elderly care givers acquire relevant skills for business start-up. • At least 861 PLHIV, OVC and elderly care givers are gainfully employed. • At least 200 PLHIV are linked to other sources of economic opportunities and take advantage of them	• Development of linkages with poverty alleviation agencies. • Demand-driven capacity-building for individual PLHIV • Development of public-private partnership .
	Result 2	**Social and economic protection is ensured for orphans and vulnerable children.** • Percentage of OVC aged 0-17 whose households received free basic external support in caring for the child • Percentage of school attendance among orphans and non-orphans aged 10-14	**Key output indicators and targets** • Data base of HIV/AIDS related OVC and OVC service organizations established. • OVC issues are more effectively disseminated, coordinated and implemented. • At least 4,000 OVC access the minimum package of services. •	• Development and wide dissemination of policy guidelines for OVC • Promotion of community and rights-based approaches
	Result 3	**Stigma and discrimination towards PLHIVs is reduced.** • System for officially documenting cases of stigma and discrimination exist • Percentage of population expressing accepting attitudes in relation to people living with HIV	**Key output indicators and targets** • Legal aids schemes identified and instituted for PLHIV and OVC's • Stigma and discrimination study conducted and disseminated. • 840 health workers, 500 law enforcement agents and 112 communities sensitized on stigma and discrimination	• Promotion of community and rights-based approaches • Enactment of relevant laws and wide dissemination of the laws • Strengthening capacity of law enforcement agents for enforcement of laws
	Result 4	**PLHIVs receive care and support according to needs** • Percentage of PLHIVs receiving nutritional support in the last 12 months	**Key output indicators and targets** • 14,400 PLHIV and infected children receive care and support services • 514 persons trained on home-based care • 2,642 home-based care kits and procured and distributed. • Baseline data on nutritional status of PLHIV obtained • At least 7,400 PLHIV receive nutritional support according to national guidelines	• Development of policy guidelines for home based care and the training manual. • Capacity-building and Intensification of recruiting of care givers • Male involvement

Table 7: OP Results Framework for Thematic Area 6: Research, Monitoring and Evaluation

IMPACT LEVEL RESULT (from the NSP)	KEY OUTCOME LEVEL RESULTS (population level knowledge & behavioral changes & systemic changes)		OUTPUT LEVEL RESULTS	KEY STRATEGIES
No impact results since this thematic area plays a systems/ support function	Result: 1	**M&E, research and knowledge management systems at the national and sub-national systems are strengthened** • % of DACs submitting report to NAS at least once a year • Number of HIV/AIDS related researches and studies conducted.		
	Intermediate Result 1.1	**Capacities for M&E increased.** • % of DACs and CACs with designated M&E Officers • % of regions with functional M&E	**Key output Indicators & (Targets)** • Capacity-building plan for M&E developed • 120 various categories of staff are trained on M&E locally and internationally. • Logistical support provided to NAS and DACs for effective M&E. • 3 regional M&E TWG established and functional	• Coaching, mentoring and recruitment • Advocacy for increased involvement of districts and local • Promotion of vertical and cross learning's
	Intermediate Result 1.2	**Research and surveillance activities are enhanced.** • % of HIV stakeholders carrying out researches and surveys	**Key output indicators** • HIV Research and Ethics Guidelines and research agenda developed and disseminated • 80 stakeholders trained on HIV/AIDS research • 12 researches, surveys and studies conducted and disseminated •	• Capacity building • Intensification of getting research results into policy and practice • Operational research to identify risk populations and routine surveillance to monitor trends in behaviour, prevalence,
	Intermediate Result 1.3	**Data quality, information generation and dissemination is improved** • HIV/AIDS databases integrated into existing HMIS • No of specific research and lesson learnt dissemination fora held annually	**Key output Indicators** • HIV/AIDS M&E systems are integrated into Health sector MIS • National HIV/AIDS information dissemination strategy developed and disseminated • At least 12 newsletters and reports printed and distributed • 6 learning and sharing events are organized.	• Promotion of data integrity and Integration with existing systems

SECTION 4: BUDGET AND RESOURCE MOBILIZATION

4.1 Introduction

This section presents the estimation of the cost of the resources Sierra Leone needs to implement her HIV and AIDS multi-sectoral response as captured in the Operational Plan for the next two years (2011- 2012). This response is grouped under the following thematic areas:

i. Coordination, Institutional Arrangements, Resource Mobilisation and Management
ii. Policy, Advocacy, Human rights and Legal Environment
iii. Prevention of New HIV Infections;
iv. Treatment of HIV and other Health Related Conditions;
v. Care and Support of the Infected and affected; and
vi. Research, Monitoring and Evaluation;

Estimates of annual and total costs have been based on targets contained in the OP regarding the coverage of each intervention or programme together with the associated unit costs.

4.2 Costing Methodology

The estimation of the cost of the resources needed for the OP is discussed under the following three broad stages:

i) Preparation of the demographic and epidemiological profile of Sierra Leone

The Spectrum Model was used in deriving the demographic projections as well as data from the preliminary cost estimate of the NSP using the Resources Needs Model.

ii) Detailed costing of the OP

An activity-based costing model (the ASAP Costing Model) was used for the detailed costing of the OP. Each of the activities of the OP contains the major assumptions for their cost. The coverage or access levels for the operations are specified in the OP and NSP while the Unit Costs of the inputs were computed using information from NAS records and in some cases the internet.

iii) The estimation of the financing gap

The financing gap analysis was then conducted to determine the shortfall in the financial resources that will have to be raised if Sierra Leone is to implement all the planned interventions in their entirety.
Generally, the inputs for estimating the cost of the OP were derived from numerous sources, including, but not limited to:

i. Report of the Final Joint Review of the NSP 2006-2010, August 2010-11-09;
ii. Sierra Leone, Demographic and Health Survey, 2008;
iii. National AIDS Spending Assessment (NASA) ;
iv. Global Fund Round 9 Proposal;
v. Sierra Leone Modes of Transmission Study, 2010;
vi. National Health Sector Strategic Plan, 2010-2015;
vii. An operational plan for scaling up paediatric HIV Care in Sierra Leone, UNICEF;
viii. Pillar teams, NAS personnel, NGOs, CSOs, and consultants;
ix. Government ministries and agencies; and
x. Personal communication with service providers

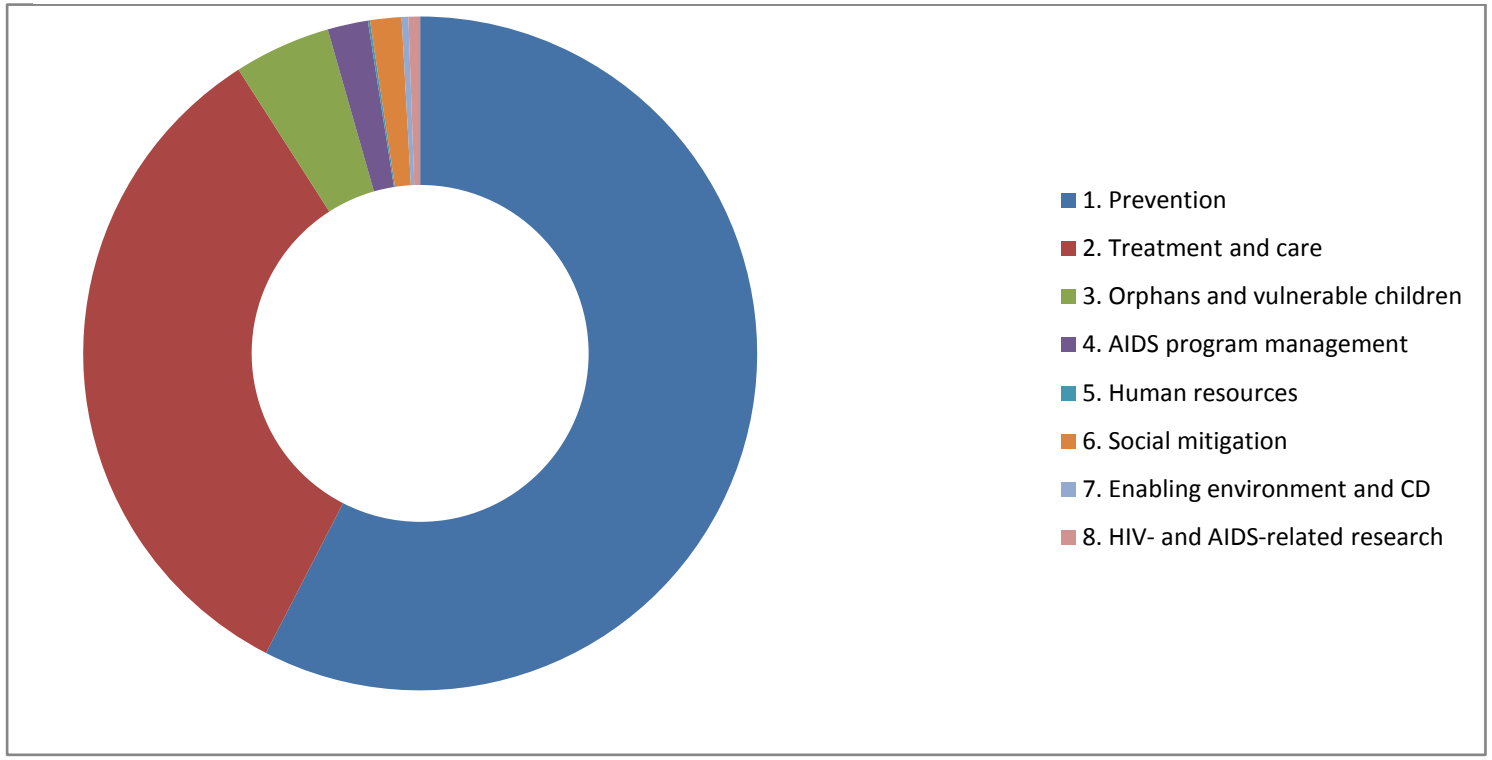
4.3 Total Cost of the OP

The indicative cost of the Operational Plan is about US$ 106 million over the two-year period 2011-2012. The detailed activity costs were analysed in line with the NASA Classification of HIV/AIDS Functions. The total cost for each class of Functions is presented in the table below. However, the detailed cost sheets (in Excel format) are available and should guide in the implementation of the OP.

Table 8: Total cost summary by HIV/AIDS Function

	Cost in national currency (Leones)			Cost in US$			
Total Costs by Function	**Cost 2011**	**Cost 2012**	**Total Cost**	**Cost 2011**	**Cost 2012**	**Total Cost**	**%**
Prevention	85,175,664,964	149,438,660,321	234,614,325,284	19,808,294	34,731,142	54,539,436	52%
Treatment and care	161,602,599,780	177,084,133,304	338,686,733,084	19,991,371	20,137,501	40,128,871	38%
Orphans &vulnerable children	5,142,940,367	12,031,275,000	17,174,215,367	1,196,033	2,797,971	3,994,004	4%
AIDS program management	9,810,480,517	5,029,090,221	14,839,570,737	2,281,507	1,169,556	3,451,063	3%
Human resources	525,083,029	265,838,750	790,921,779	122,112	61,823	183,935	0%
Social mitigation	3,915,674,874	3,901,138,374	7,816,813,248	910,622	907,241	1,817,864	2%
Enabling environment	1,208,174,186	835,897,238	2,044,071,424	280,971	194,395	475,365	0%
HIV/AIDS-related research	3,386,067,725	1,444,023,850	4,830,091,575	787,458	335,820	1,123,277	1%
Grand Total	**270,766,685,440**	**350,030,057,057**	**620,796,742,497**	**45,378,367**	**60,335,448**	**105,713,815**	**100%**

Pictorial presentation of the total cost summary by HIV/AIDS Function



The analysis of the Activity Costs shows that the key cost drivers are Prevention (to which about 52% of the resources are allocated) and Treatment & Care (38%). This appears to be in line with the country's determination to reach zero new infections by 2015 as this will definitely require embarking on aggressive Prevention interventions whilst taking good care of the infected. Certainly if Sierra Leone is to reduce long-term morbidity and costs, then extensive Prevention interventions are vital and a lot of effort must be put in to ensure that they work. For example, if PMTCT functions properly it has the potential of virtually eliminating paediatric HIV cases. Similarly, programmes aimed at the MARPs could reduce the transmission among themselves as well as cross transmission to the general population. Also, an effective Treatment intervention not only improves the quality of life of the infected but reduces their potential to transmit the virus.

From the above analysis therefore, the programme will need to allocate about 90% of the budget to interventions related to Prevention and Treatment & Care if the country is to achieve the set objective of achieving zero new infections by 2015.

4.4 Detailed Cost Allocation.

As discussed above, the activities of the OP have been analysed in line with the NASA Classification of HIV/AIDS Functions. These functions are grouped under the following broad categories:

i) Prevention
ii) Treatment and care
iii) Orphans &vulnerable children
iv) AIDS program management
v) Human resources
vi) Social mitigation
vii) Enabling environment
viii) HIV/AIDS-related research

Each Functional group is further broken down into detailed sub-functions. The table overleaf therefore presents a detailed breakdown of the cost by HIV/AIDS Functions.

Table 9: Detailed cost summary by HIV/AIDS Function

THEMATIC/SERVICE DELIVERY AREA	Le Cost 2011	Le Cost 2012	Le Total Cost	USD Cost 2011	USD Cost 2012	USD Total Cost
1. Prevention.	**85,175,664,964**	**149,438,660,321**	**234,614,325,284**	**19,808,294**	**34,731,142**	**54,539,436**
1.01. Mass media	1,656,046,473	289,069,497	**1,945,115,969**	385,127	67,225	**452,353**
1.02. Community mobilization	632,681,725	731,581,725	**1,364,263,449**	147,135	170,135	**317,271**
1.03. Voluntary counseling and testing	16,085,951,748	17,559,399,164	**33,645,350,912**	3,740,919	4,083,581	**7,824,500**
1.04. Special populations	4,800,000	4,800,000	**9,600,000**	1,116	1,116	**2,233**
1.05. Youth in school	813,903,600	727,290,200	**1,541,193,800**	189,280	147,102	**336,382**
1.06. Youth out of school	1,013,023,746	794,436,346	**1,807,460,091**	235,587	184,753	**420,340**
1.07. Prevention programs for people living with HIV	585,980,207	554,604,962	**1,140,585,170**	136,274	128,978	**265,252**
1.08. Programs focused on sex workers and their clients	195,111,352	66,675,852	**261,787,204**	45,375	15,506	**60,881**
1.09. Programs focused on MSM *(included in 1.08)*	-	-	-	-	-	-
1.10. Harm reduction programs for IDUs	-	-	-	-	-	-
1.11. Workplace Activities	391,802,250	331,793,500	**723,595,750**	91,117	77,161	**168,278**
1.12. Condom social marketing	4,479,357,382	5,386,931,551	**9,866,288,933**	1,041,711	1,252,775	**2,294,486**
1.13. Public and commercial sector condom provision (male)	19,694,057	20,117,268	**39,811,325**	4,580	4,678	**9,258**
1.14. Female condom	-	-	-	-	-	-
1.15. Microbicides	-	-	-	-	-	-
1.16. Improving management of STIs	1,813,690,599	1,249,075,074	**3,062,765,673**	421,789	290,483	**712,271**
1.17. Prevention of mother-to-child transmission	55,767,536,751	119,953,422,377	175,720,959,128	12,969,195	27,896,145	40,865,339
1.18. Blood safety:	679,751,568	629,081,568	**1,308,833,136**	158,082	146,298	**304,380**
1.19. Post-exposure prophylaxis	543,706,533	224,493,678	**768,200,210**	126,443	52,208	**178,651**
1.20. Safe medical injections	226,967,424	451,487,560	**678,454,984**	52,783	104,997	**157,780**
1.21. Male circumcision	-	-	-	-	-	-
1.22. Universal precautions	265,659,550	464,400,000	**730,059,550**	61,781	108,000	**169,781**
1.99. Prevention Other	-	-	-	-	-	-
2. Treatment and care	**161,602,599,780**	**177,084,133,304**	**338,686,733,084**	**19,991,371**	**20,137,501**	**40,128,871**
2.01. Provider initiated testing	-	-	-	-	-	-
2.02. Prophylaxis for Opportunistic Infections	30,960,000	61,920,000	**92,880,000**	7,200	14,400	**21,600**
2.03. Antiretroviral therapy	38,611,001,992	39,279,926,793	**77,890,928,785**	8,979,303	9,134,867	**18,114,169**
2.04. Nutritional support associated to ARV therapy	75,670,665,650	90,554,800,000	**166,225,465,650**	7,200	14,400	**21,600**
2.05. Laboratory monitoring	42,490,696,703	42,986,567,871	**85,477,264,574**	9,881,557	9,996,876	**19,878,434**
2.06. Dental Programs for PLWHA	-	-	-	-	-	-
2.07. Psychological Treatment and Support	132,512,400	20,862,000	**153,374,400**	30,817	4,852	**35,668**

THEMATIC/SERVICE DELIVERY AREA	Le Cost 2011	Le Cost 2012	Le Total Cost	USD Cost 2011	USD Cost 2012	USD Total Cost
2.08. Palliative care	51,600,000	25,800,000	**77,400,000**	12,000	6,000	**18,000**
2.09. Home-based care	596,642,000	500,363,500	**1,097,005,500**	138,754	116,364	**255,118**
2.10. Alternative and informal providers	-	-	-	-	-	-
2.19. Out-patient care NEC	1,463,989,200	1,385,460,000	**2,849,449,200**	340,463	322,200	**662,663**
2.21. Treatment of Opportunistic Infections	2,473,351,835	2,237,473,140	**4,710,824,975**	575,198	520,343	**1,095,541**
2.29. In-patient care NEC	-	-	-	-	-	-
2.30. Patient Transport and Emergency Rescue	-	-	-	-	-	-
2.99. Treatment Other	81,180,000	30,960,000	**112,140,000**	18,879	7,200	**26,079**
3. Orphans and vulnerable children	**5,142,940,367**	**12,031,275,000**	**17,174,215,367**	**1,196,033**	**2,797,971**	**3,994,004**
3.01. Education (OVC)	748,200,000	748,200,000	**1,496,400,000**	174,000	174,000	**348,000**
3.02. Basic Health Care (OVC)	3,511,380,000	11,148,180,000	**14,659,560,000**	816,600	2,592,600	**3,409,200**
3.03. Family/home support (OVC)	-	-	-	-	-	-
3.04. Community support (OVC)	391,300,000	64,500,000	**455,800,000**	91,000	15,000	**106,000**
3.05. Organization costs (OVC)	362,097,867	3,660,000	**365,757,867**	84,209	851	**85,060**
3.06. Institutional Care (OVC)	-	-	-	-	-	-
3.99. Other (OVC)	129,962,500	66,735,000	**196,697,500**	30,224	15,520	**45,744**
4. AIDS program management	**9,810,480,517**	**5,029,090,221**	**14,839,570,737**	**2,281,507**	**1,169,556**	**3,451,063**
4.01. Program Management	4,429,850,234	2,936,160,827	**7,366,011,061**	1,030,198	682,828	**1,713,026**
4.02. Financial Management	72,188,400	72,188,400	**144,376,800**	16,788	16,788	**33,576**
4.03. Monitoring and Evaluation	2,638,809,798	1,726,569,450	**4,365,379,248**	613,677	401,528	**1,015,204**
4.04. Operations Research	-	-	-	-	-	-
4.05. Surveillance (sero-sentinel, behaviour surveillance)	-	-	-	-	-	-
4.06. HIV drug resistance surveillance	-	-	-	-	-	-
4.07. Drug supply systems	1,858,309,900	12,436,000	**1,870,745,900**	432,165	2,892	**435,057**
4.08. Information Technology	209,991,711	-	**209,991,711**	48,835	-	**48,835**
4.09. Program supervision/patient tracking	-	-	-	-	-	-
4.10. Upgrading laboratory infrastructure	-	-	-	-	-	-
4.11. Construction of new health centers	-	-	-	-	-	-
4.12. Other renovations/upgrading	-	-	-	-	-	-
4.99. AIDS Program Other	601,330,473	281,735,544	**883,066,017**	139,844	65,520	**205,364**

THEMATIC/SERVICE DELIVERY AREA	Le Cost 2011	Le Cost 2012	Le Total Cost	USD Cost 2011	USD Cost 2012	USD Total Cost
5. Human resources	**525,083,029**	**265,838,750**	**790,921,779**	**122,112**	**61,823**	**183,935**
5.01. Monetary incentives for doctors	-	-	-	-	-	-
5.02. Monetary incentives for nurses	-	-	-	-	-	-
5.03. Monetary incentives for other staff	-	-	-	-	-	-
5.04. Formative Education - HIV Workforce	354,279,154	132,587,500	**486,866,654**	82,391	30,834	**113,225**
5.05. Training	170,803,875	133,251,250	**304,055,125**	39,722	30,989	**70,710**
5.99. HR Other	-	-	-	-	-	-
6. Social mitigation	**3,915,674,874**	**3,901,138,374**	**7,816,813,248**	**910,622**	**907,241**	**1,817,864**
6.01. Monetary Benefits	-	-	-	-	-	-
6.02. In kind benefits	-	-	-	-	-	-
6.03. Social services	-	-	-	-	-	-
6.04. Income generation	3,915,674,874	3,901,138,374	**7,816,813,248**	910,622	907,241	**1,817,864**
6.99. Social Other	-	-	-	-	-	-
7. Enabling environment and CD	**1,208,174,186**	**835,897,238**	**2,044,071,424**	**280,971**	**194,395**	**475,365**
7.01. Advocacy and communications	182,255,064	95,138,075	**277,393,139**	42,385	22,125	**64,510**
7.02. Human Rights	110,523,750	183,956,250	**294,480,000**	25,703	42,781	**68,484**
7.03. Institutional Development	877,172,373	556,802,913	**1,433,975,285**	203,994	129,489	**333,483**
7.04. Programs focused on Women	38,223,000	-	**38,223,000**	8,889	-	**8,889**
7.99. Community Other	-	-	-	-	-	-
8. HIV- and AIDS-related research.	**3,386,067,725**	**1,444,023,850**	**4,830,091,575**	**787,458**	**335,820**	**1,123,277**
8.01. Biomedical research	-	-	-	-	-	-
8.02. Clinical research	159,465,650	288,465,650	**447,931,300**	37,085	67,085	**104,170**
8.03. Epidemiological research	436,211,075	371,883,200	**808,094,275**	101,444	86,484	**187,929**
8.04. Social science research,	9,675,000	267,675,000	**277,350,000**	2,250	62,250	**64,500**
8.05. Behavioural research	2,084,369,700	516,000,000	**2,600,369,700**	484,737	120,000	**604,737**
8.06. Research in Economics	266,346,300	-	**266,346,300**	61,941	-	**61,941**
8.07. Vaccine related research	-	-	-	-	-	-
8.99. Research Other	430,000,000	-	**430,000,000**	100,000	-	**100,000**

4.5 Financing Gap Analysis

As an important component of the costing exercise, a gap analysis was carried out to determine the shortfall in the financial resources required to implement the planned interventions. This required identifying all the revenue sources for the OP and matching this with the total cost of the interventions identified in the OP to determine the gap. The financial gap estimation was therefore based on the triangulation of different data sources: information obtained from the records of NAS (including the recently signed Global Fund Round 9 Proposal), some of the key stakeholders such as the UN agencies, the relevant Government Ministries and Departments as well as NGOs and CBOs. Interviews with some key stakeholders constituted a secondary source of data for the exercise. The gap analysis is presented in the table below:

Table 10: Funding Gap Analysis

	National Currency (Million Leones)			US $ million			
Total Costs by Function	**Cost 2011**	**Cost 2012**	**Total Cost**	**Cost 2011**	**Cost 2012**	**Total Cost**	**Proportion**
1. Prevention	85,176	149,439	234,614	19.81	34.73	54.54	52%
2. Treatment and care	161,603	177,084	338,687	19.99	20.14	40.13	38%
3. Orphans and vulnerable children	5,143	12,031	17,174	1.20	2.80	3.99	4%
4. AIDS program management	9,810	5,029	14,840	2.28	1.17	3.45	3%
5. Human resources	526	266	791	0.12	0.06	0.18	0%
6. Social mitigation	3,916	3,901	7,817	0.91	0.91	1.82	2%
7. Enabling environment and CD	1,208	836	2,045	0.28	0.19	0.48	0%
8. HIV- and AIDS-related research	3,386	1,444	4,830	0.79	0.34	1.12	1%
Grand total of costs	**270,767**	**350,030**	**620,797**	**45.38**	**60.34**	**105.71**	**100%**
Financing							
GOSL funding	1,290	2,580	3,870	0.3	0.6	0.9	2.30%
Global Fund	59,641	76,626	136,267	13.87	17.82	31.69	80.10%
Domestic: Private sector	430	860	1,290	0.1	0.2	0.3	0.80%
KFW	3,612	2,408	6,020	0.84	0.56	1.4	3.50%
UN Family	11,309	11,309	22,618	2.63	2.63	5.26	13.30%
Total funding available	**76,282**	**93,783**	**170,065**	**17.74**	**21.81**	**39.55**	**100.00%**
Financing Gap	**194,485**	**256,247**	**450,732**	**27.64**	**38.53**	**66.16**	

From the analysis above, the Global Fund will contributing most of the financial resources (80.1%) for the national response. This is followed by the UN System in Sierra Leone (13.3%), KFW (3.5%), the Government of Sierra Leone 2.3%, and the Domestic Private sector (0.8%).

On the whole there is a shortfall of US$66.16 million of the resources required for implementing the OP. On a year-by-year basis, Sierra Leone will need to raise additional US$27.64 million in 2011 and US$38.53 million in 2012 if the country is to achieve its set HIV/AIDS objectives to their fullest extent.

4.5 Financing the OP

i) Resource Mobilization

Over the years the national response to the HIV/AIDS has received substantial funding. According to the 2010 National AIDS Spending assessment (NASA), about 2.7% of the funding came from the Government of Sierra Leone while the Global Fund contributed 95% of the funds. Other contributors were KFW 1.5% and the domestic private sector 0.7%. It is expected that each of these financiers will increase the levels of funding substantially and that new partners will buy into the new NSP/OP.

ii) Sustainability

Sustainability of the OP will depend on two key factors. Firstly, it is crucial that the strategies accurately address the disease profile of the country and the interventions must closely meet the needs of the affected and infected. Furthermore, there must be an effective mechanism to monitor and evaluate the operations. Secondly, there must be reliable and assured sources of resources necessary for the implementation of the interventions. These include not only financial resources but also human and material resources such as essential drugs and commodities, infrastructure, vehicles and equipment.

Most of the financial resources for HIV/AIDS activities are obtained from external funding, with the Global Fund being by far the largest contributor. At the community level, except the faith-based organisations which can secure most of their funds from their religious bodies, most of the civil society organisations (CBOs) depend on external donors for funds to implement their programmes. Another key source of resources is the services of volunteers. However, volunteers need to be trained to ensure their effectiveness.

In view of the fact that huge financial resources are required for the national HIV/AIDS response, the country will continue to require the input of her development partners. But to secure the continued support of the external donors there must be concerted efforts at assuring the partners that their resources will be accounted for and put to good use. NAS is therefore strengthening the management system to reassure the partners that their resources will continue to be used judiciously and properly accounted for.

In addition to the issues pertaining to financial sustainability, NAS is also taking the necessary measures to ensure the sustainability of the programmes. The capacities of communities will be built up through cross-cutting activities to ensure they take ownership of the programmes.

4.6 Financial Management and Auditing Arrangements

As emphasised above, the best way to secure continued funding is to assure the financiers that their resources will be well managed and accounted for. Given the expected scaling up of operations under the OP, management is introducing a robust financial management system that is capable of capturing all the transactions of the programmes, analysing and promptly recording them to facilitate the production of timely, accurate and relevant financial and programmatic reports for planning, managing and controlling the operations. This system will be underpinned by an enhanced system of accounting and internal controls based on a fully integrated computerised financial management system maintained by well qualified and properly trained personnel.

To further strengthen the systems of accounting and internal controls, NAS has introduced an internal audit department, staffed with personnel seconded from the Ministry of Finance. The department's responsibility is to constantly review the systems and processes of the programmes and provide feedback as to the adequacy of the systems and whether they continue to function as planned. In addition to this, statutory audits are carried out on the accounts of NAS every year by an international firm of auditors. This improves the credibility of the financial reports and provides assurance that the spending mechanisms follow the national legal and regulatory framework as well as international best practices.

Also, the implementing agencies have their own accounting systems and auditing arrangements. NAS ensures accountability by including provisions in the Grant Agreement that oblige the implementing agencies to establish credible financial management and reporting systems. They are also required to provide prescribed reports and returns to NAS at specified times.

Sierra Leone will also continue to conduct the National AIDS spending Assessment (NASA) which serves as a useful tool for tracking HIV-related expenditure in the calendar year. The NASA approach is structured to inform a multi-sectoral perspective. NASA reflects actual expenditures associated with the delivery of a service or a product that differentiates commitment and disbursements.

In addition to these, the LFA plays a crucial role in the judicious management of the Global Fund grants that constitute about 95% of the funding for HIV/AIDS in Sierra Leone. The LFA plays an oversight role on behalf of the Global Fund that enhances the Performance Based Funding model. They conduct Progress Reviews quarterly and also vet and recommend disbursements. The other key roles the LFA plays include reviewing the acceptability of auditor, their terms of reference and sub-recipient audit plans. They also review the audit reports and advise the Global Fund accordingly.

Furthermore, NAS and some of the implementing agencies have well established M&E units that engage in periodic monitoring of the activities to ascertain the levels of implementation. The results of these monitoring visits are then shared and used to improve the quality and quantity of implementation.

SECTION 5: COORDINATION AND IMPLEMENTATION MANAGEMENT

5.1 Institutional Framework for Coordination

5.1.1 National Level Coordination

The institutional framework for coordinating the NOP is basically the same as the NSP except that emphasis will now shift to the lower levels for regular updates and reporting to the higher levels. NAS, in line with principles of three ones[10] is responsible for coordinating and providing leadership for the HIV response in the country. It does this by ensuring that all stakeholders align their priorities and strategies with National ones. However for greater alignment, NAS needs to disseminate this plan document.

Currently, there exist various coordination platforms for HIV intervention including information sharing. They are: Partnership forum and Technical Working Groups such as: Donor Partners Consultative Group on AIDS, Expanded Technical working Group, IEC/BCC Steering Committee, Monitoring and Evaluation Technical Working Group, Treatment Technical Working Group and Laboratory Technical Working Group. It is recommended that one of the key strategies will be to strengthen these platforms and establish additional ones recommended. It is expected that these platforms will continue to play increasing role in coordination while NAS and other partners would continue to provide necessary support (technical, financial etc.) and policy guidance for effective functioning.

5.1.2 Regional Level Coordination

The creation of regional offices is an innovative way of strengthening coordination of the national HIV response. These offices should be created and staffed without further delays to be able to play the expected roles which include providing technical assistance and oversight to the District AIDS councils. They are also expected to strengthen monitoring and evaluation activities

5.1.3 District Level Coordination

The District AIDS Committees (19 in all) are responsible for coordinating HIV response at the district levels and their composition is multi-sectoral in nature comprising amongst others the following: District Medical Officer, representatives of MDAs at the district levels, PLHIV, Civil Society Representatives, implementing partners and the community representatives. Given the increasingly role they are expected to play in the current dispensation (including support the CACs) they should be strengthened.

5.1.4 Chiefdom Level Coordination

Plans are on-going to establish Chiefdom AIDS Committees (CACs) in all the 149 Chiefdoms which is the third-tier of government in line with decentralization policy. They would also be responsible for coordinating the HIV/AIDS activities at the chiefdom levels. The terms of reference (ToR) for the CACs is being developed.

5.1.5 Constituents Coordinating Entities

Coordinating entities such as Coalition of Public Sector against HIV and AIDS in Sierra Leone (COPSAASL), Network of HIV positives in Sierra Leone (NETHIPS), Business Coalition against AIDS in Sierra Leone (BCAASL) and the Inter-Religious Council of Sierra Leone (ICSL) will coordinate the activities of their different constituencies during the implementation of the operational plan. The proposed network to be established for NGOs and the youths are also expected to play similar roles as soon as they are constituted.

5.1.6 Key sectors and Line Ministries

Key Line Ministries should also be empowered to coordinate activities of their key sectors other than the coordination of workplace policies within their Ministries. This will go a long way in promoting the mainstreaming of HIV into their activities.

[10] One national coordinating body, one national strategy and one national M&E framework.

5.2 Implementation of the NOP

5.2.1 Implementation Environment

There is a good implementation environment for this NOP given the involvement and commitment of the stakeholders in all the process leading to the development of the plan. This is further enhanced by the track record of implementation as well as political will and commitment at the level of his Excellency, The President. Furthermore, HIV/AIDS also featured prominently in various policies of government such as the 'Agenda for Change' and Second Poverty Reduction Strategy Paper (PRSP II), 2008-2012. Government recognizes the roles of the different stakeholders such as development partners, national and international NGOs, civil society and the private sector as well as the faith-based organizations and communities, and will continue to support them to enhance implementation, coordination and harmonization of donor assistance.

5.2.2 Implementation Arrangements and Roles of Stakeholders

The National HIV/AIDS Operational Plan (2011-2012) will be implemented by a range of stakeholders that includes: NAS, DAC, Key MDAs, Donor partners, Implementing partners, private sector organizations, as well as individual CSOs, FBOs and CBOs**.**

The role of NAS, DAC and CACs will be limited largely to coordination and providing enabling environment for the entire HIV response. NAS will also facilitate the implementation of activities particularly Global Fund supported activities as the principal recipient. CACs and DACs will also support the facilitation of implementation as much as practicable.

Development partners particularly the UN system will also continue to support NAS through the provision of technical assistance. There are also assurances that individual NGOs, CBOs and FBOs and their networks will continue to be supported by the UN system and other development through provision of technical assistance and direct grant support.

Ministries, Departments and Agencies will also continue to coordinate and facilitate the implementation of HIV interventions. They may also engage in direct implementation of activities as much as possible while also engaging in implementation where possible.

The Ministry of Health and Sanitation will continue to coordinate the health sector response through the National AIDS Control Programme (NACP).The Public health approach has been adopted for the treatment programme to include both public and private health facilities. Currently, the NACP is being supported by the Global Fund, DFID and CDC in strengthening the country's health systems. This is expected to continue throughout the implementation of the OP.

NGOs, FBOs and CBOs will be concerned largely with implementation of interventions at the community level. This is because they have structures that are closer to the people or located within the communities. Their roles will include awareness creation, sensitization, advocacy, community engagement and demand creation for HIV services.

5.2.3 Implementation Challenge

The key challenge to implementing this Operational Plan is funding. Currently 80 to 90% of funding for the national HIV response is from external sources. There is therefore the need to embark on rigorous resource mobilization through sustained advocacy efforts. Government should be engaged to increase the level of funding for HIV activities. This should be possible now given that NAS is now an agency of government established by Act of Parliament.

SECTION 6: MONITORING AND EVALUATION OF THE NATIONAL HIV/AIDS OPERATIONAL PLAN (2011-2012)

6.1 Introduction

For effective implementation of the operational plan, a robust M&E system has to be in place to provide timely and reliable information on the implementation of the interventions, the results being realized in form of outputs and outcomes. The M&E is also important to help in making strategic choices on which interventions to scale up, drop or introduce based on evidence generated. This therefore elaborates on the M&E arrangements with specific regard to: the indicators or priority information of interest to the operation plans that must be generated; the data sources from which this priority information will be collected for the construction of input, process, output, outcome and impact indicators; the data collection practices is built in the plan as well as mechanisms for data management, quality assurance, storage, retrieval, reporting and utilization and feedback.

The M&E of the OP will be anchored into the "One National M&E System", the framework of which is contained in the National HIV/AIDS Monitoring and Evaluation Plan (2011- 2015).

6.2 Indicators

The OP M&E will require the full continuum of indicators; input, process, output, to assess the plan delivery process and the outcome and impact indicators to assess the effects of the plan. The main focus of the measurements will be of output and outcome indicators.

A whole range of Output and Outcome indicators have been provided in Section 3- the OP Plan Results Framework. Generic indicators have also been provided in annex 1 of the NSP. The construction of these indicators will be presented in the M&E framework.

6.3 Data Sources

These indicators will be constructed using data from both the routine programme service coverage data and the population based data. The following data sources with the expected frequency of data generation will be key for the M&E plan for the OP.

Table 11: Summary of key Data Sources

Data Source	Lead responsible Institutions	Frequency
Routine Programme Monitoring/ service coverage Data		
Health sector programme activity monitoring data including Biological surveillance (STI, TB,HCT, PMTCT, ART, ANC, FP)	MOH, NAS,	Collected Monthly & aggregated Quarterly
Non health public sector programme activity monitoring data (non-health sector activities)	NAS, MoE, other government ministries, departments and agencies	Quarterly
Routine programme Monitoring Data from other non health and non public sector (CSOs, Private actors) agencies' as Constituent Coordinating Entities (CCE)	NAS, COPAASL, BCAASL, NETHIPs etc	Quarterly
Field Support Supervision Visits (reports)	NAS, NACP, Ministries, CSOs…	Quarterly
Service Statistics and Records	All service providers	Collected Monthly & aggregated Quarterly

Data Source	Lead responsible Institutions	Frequency
Surveys and Surveillance		
(Pop based AIDS Survey) Second generation surveillance	**MOH**, Development Partners, University, **SSL**	Every five years
Behavioural surveillance	NAS-MOH, with SSL	Every two years
Quality of Health care & related HIV Services Survey	MOH	Every two years
Condom availability and quality survey	MOH	Every two years
Workplace Survey	MOLSS	Every two years
Other sources:		
Joint Annual Programme Reviews(JAPR)	NAS, NACP with partners	Annually
• Project/ programme evaluations (mid-term, terminal.) • Baseline surveys, • Formative & operations studies/ research, • Capacity and training needs assessments & Evaluation, • Assessments- thematic programme assessments i.e. in-schools life skills	Implementing or coordinating and supporting partner organizations	Varied –depending on programme

6.4 Data management and Information Flow

The NAS will coordinate the development of data collection tools and reporting formats/ forms for the routine data collection sources with respective partners and service providers at different programme levels. A data management plan will also be developed as part of the M&E framework to guide the collection, data analysis, retrieval and access. The envisaged information flow, reporting and dissemination arrangements will include:

- Monthly reports within projects, sectors and service provider institutions
- Quarterly and annual reports to NAS, NACP, Implementing Partners, Networks and Projects as well as individual NGOs.

6.5 Information Dissemination and Products

Unless the data collected and information produced is disseminated in user friendly formats and products, it may not be useful for informed decision making. The following channels and information products will be utilized to ensure that the data and information available is shared and disseminated for eventual effective utilization:

- Quarterly stakeholder meetings by NAS, NACP; TWGs, and Networks.
- Annual stakeholder programme joint reviews.
- Quarterly HIV/AIDS Bulletin or newsletter.
- Circulation of reports, fliers, brochures, fact sheets, posters, CDs and other IEC materials produced based on generated information.
- NAS HIV/AIDS reference collection/ MOH resource centre and other resource centers with HIV/AIDS corners/ collection at sectors, universities and other selected outlets.
- Websites: NAS, MOH and others.

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Annex 2: SIERRA LEONE NATIONAL HIV/AIDS OPERATIONAL PLAN (2011-2012) MATRIX

SIERRA LEONE NATIONAL HIV/AIDS OPERATIONAL PLAN (2011-2012)

THEMATIC AREA 1: COORDINATION, DECENTRALIZED RESPONSE, RESOURCE MOBILIZATION AND MANAGEMENT

IMPACT : Coordinating structures at national and decentralized level effectively manage implementation

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Activity Code	RESULTS	OUTCOMES/OUTPUTS AND ACTIVITIES	IMPLEMENTATION PERIOD								LEVEL OF IMPLEMENTATION N=National R= Regional D=District C=Chiefdom	RESPONSIBLE SECTOR/ ORGANIZATION	FUNDING SOURCE(S)	ASSUMPTIONS/COMMENTS
			2011				2012							
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
		Sub-Theme: Coordination and Decentralized Response												
		Outcome 1: Coordination mechanisms at national and sub-national levels strengthened												
		Output 1: NAC strengthened.												
1.1.1	Strategic decisions on National HIV/AIDS response taken and implemented.	Conduct bi-annual meetings of NAC	1	0	1	0	1	0	1	0	N	NAC, NAS	GOSL,	50 persons meetings
1.1.2	**Knowledge and skills of NAC members on HIV/AIDS issues upgraded.**	Organize an annual Study Tour for 2 NAC members	0	0	1	0	0	0	1	0	N	NAC, NAS	UN Family	Air Ticket and DSA for 2 for 7 Days
1.1.3		Organize yearly advocacy workshops on diverse issues relating to HIV/AIDS	0	0	0	1	0	0	0	1	N	NAS	UN Family	National Consultant for 7 days, Refreshment, Training for 35 people for 3 days each
		Output 2: NAS Strengthened.												
1.2.1	NAS repositioned for effective service delivery.	Re-structure NAS based on the outcome of the institutional review	0	0	1	0	0	0	0	0	N	NAS		International Consultant for 21 days (Consultancy fee, Air Ticket, DSA etc.)
1.2.2		Recruit 3 Regional Coordinators	0	1	0	0	0	0	0	0	N	NAS	GF	Salaries @ $2k/staff for 21 months
1.2.3		Recruit NAS additional staff	0	0	5	0	0	0	0	0	N	NAS	GoSL, GF	Admini/HR, CDP, CSC, RMM and IT. Average monthly salary is $2K for 18 months

1.2.4	Capacity building plan (including technical assistance plan) for national coordination bodies developed.	Conduct capacity needs assessment of NAS and national coordination bodies (NAS, DACs, NETHIPS, HARA, COOPASL and BCAASL)	0	0	1	0	0	0	0	0	N	NAS	UN Family	International Consultant for 45 days (Fees, Air Ticket, DSA etc.)
1.2.5		Develop and roll-out capacity development and technical assistance plan for the Coordination Bodies	0	0	1	1	0	0	0	0	N	NAS	UN Family	International Consultant for 30 days (Fees, Air Ticket, DSA etc.) and national Consultant for 8 weeks and DSAs
1.2.6	NAS' staff capacity for management and coordination strengthened	Conduct training for NAS Management on the management Technical Assistance including consultants	0	0	1	0	0	0	0	0	N	NAS	UN Family	International Consultant for 14 days (Fees, Air Ticket, DSA etc.), 5 day training for 20 people.
1.2.7		Organize/support participation of NAS in International Learning events such as conferences, study tours, exchanges etc	0	0	1	1	0	1	1	0	N	NAS	UN Family, GF	Air Ticket and DSAs for 2 NAS staff in 2 learning events per year
1.2.8		Provide logistical support	0	0	1	0	0	0	0	0	N	N	GoSL, GF, UN Family	(4 vehicles, 15 Desktop Computers including Accessories and Printers; 6 Laptops and Projectors, one 110 and one 75 KVA) Generators)
1.2.9		Conduct annual Programme Retreat	0	0	0	1	0	0	0	1	N	NAS,	UN Family	3 day residential programme for 30 persons
1.3		Output 3: DACs strengthened												
1.3.1	19 DACs fully established and functional	Review the TOR for setting up of DACs	0	1	0	0	0	0	0	0	N	NAS,	GOSL, UN Family,	Stationery and refreshment for 30 persons
1.3.2		Conduct advocacy meetings with District/City Council Chairpersons	0	1	0	1	0	1	0	1	D	NAS, MOLG	GOSL, UN Family	1 day meeting for 25 persons
1.3.3		Provide logistical support to the DACs	0	0	1	0	0	1			N	NAS, DACs	UN Family	19 motor bikes, 19 laptops and Stationery for 19 DACs
1.3.4		Conduct capacity needs assessment of DACs	0	0	1	0	0	0	0		D	NAS, MOLG	UN Family	Already costed under activity in 1.2.3
1.3.5		Convene Bi-monthly meetings of DACs and HIV IPs at the District level	0	0	2	2	2	1	2	1	D	NAS, DACs	GoSL, UN Family	Refreshment for 50 for 10 meetings

1.3.6	Capacity of DACs' enhanced for effective coordination.	Organize/support participation of DACs in International Learning events conferences, study tours, exchanges etc) on an annual basis.	0	0	1	0	0	0	1	0	D	NAS, MOLG	UN Family	Air Tickets and DSA for 4 DAC members for 7 days
1.3.7		Conduct annual training for Council M&E and Development Planning Officers on mainstreaming HIV and AIDS	0	0	0	1	0	0	0	1	D	NAS, MOLG	GOSL, UN Family	3 day training for 45 people
		Output 4: CACs strengthened.												
1.4.1	149 CACs established and functional	Establish 149 CACs	0	0	0	0	32	37	40	40	C	DACs, NAS,MoLG	GF	Stationery and local per diem of $60/person for 4 NAS staff for 30 days. Refreshment for 149 meetings with 15 persons per meeting.
1.4.2		Provide logistical support to the CACs	0	0	0	0	0	0	1	0	C	DACs, NAS,MoLG	GoSL,, UN Family	Furniture (1 Table and 6 Chairs), 1 bicycles and 5 Reams of paper per CAC for 149 CACs
1.4.3	149 staff of CACs trained on relevant areas such as HIV/AIDS education, mainstreaming etc.	Conduct capacity Needs assessment and develop capacity-building plan for CACs	0	0	0	0	0	1	0	0	C	DACs, NAS,MoLG	GoSL,, UN Family	2 national consultants for 6 weeks. Travel for 2 teams (each team consists of 3 persons including driver) for 14 days. I day validation meeting for 40 people
1.4.4		Train staff of CACs staff on program management and coordination, HIV/AIDS education, mainstreaming etc.	0	0	0	0	0	75	74	0	D	DACs, NAS, MoLG	GoSL,, UN Family	5 day residential training. Two national consultants for 15 days.
		Output 5: Coordinating bodies strengthened by type												
		a) Country Coordinating Mechanism (CCM)												
1.5.1	Capacities of CCM strengthened	Participate in monthly CCM meetings	3	3	3	3	3	3	3	3	N	CCM Secretariat, NAS, MOHS,	GF, GTZ	1 day meeting for 30
1.5.2		Provide support to the CCM Secretariat	0	1	1	1	1	1	1	1	N	CCM Secretariat, NAS, MOHS,	GF, GTZ	1 Computer and Stationery, allowance to CCM Secretariat Personnel
		b) COOPASL												
1.5.3		Convene quarterly meetings of the COOPASL	0	1	1	1	1	1	1	1	N	NAS, MDAs,	UN Family,	1 day meeting for 30

1.5.4	121 COOPASL members trained in diverse areas of HIV	Conduct training for MDAs focal points on mainstreaming HIV/AIDS and Gender into their annual plans	0	0	35	0	0	0	0	0	N	NAS, MDAs,	UN Family,	3 day training
1.5.5		Conduct training for COOPASL Members on Programme management, coordination etc	0	0	40	0	0	0	40	0	N	NAS, MDAs,	NAS, UN Family	2 national consultants for 15 days. 5 day residential training for 40 persons.
1.5.6		Facilitate the participation of 6 MDAs Focal Points in international learning events	0	0	0	3	0	0	3	0	N	NAS, MDAs,	UN Family, GOSL	Air Tickets and DSA for 6 persons for 7days
1.5.7	HIV/AIDS mainstreamed into Ministries' Performance Contract	Conduct Two Trainings targeting the Strategic Planning Unit (SPU) of the Office of the President and Cabinet Ministers on mainstreaming HIV and AIDS into public policy	0	0	0	2	0	0	0	0	N	NAS	GOSL and UN Family	International Consultant for 14 days 2 trainings of 45 persons each
1.5.8		Conduct quarterly Advocacy meetings with the Ministry of Finance on Budget Allocation for HIV/AIDS activities	0	0	2	2	1	1	1	1	N	NAS,	NAS, UN Family	1 day meetings of 15 people
		c) Business Coalition Against AIDS in Sierra Leone (BCAASL)												
1.5.9	BCAASL properly positioned for more effective coordination of private sector activities	Convene quarterly meetings of board members	0	1	0	1	1	0	0	1	N	BCAASL, NAS	Private sector, GF	1 day meeting for 20 persons
1.5.10		Convene monthly meetings of Focal Points	0	3	3	3	3	3	3	3	N	BCAASL, NAS	Private sector	1 day meeting for 35
1.5.11		Organize bi-annual consultative meetings with Private Sector CEOs/ MDs on HIV/AIDS issues.	0	0	0	1	0	0	0	1	N	BCAASL, NAS	UN Family	Meeting for 25 persons
1.5.12		Convene Quarterly meetings with Employers Federation, SLLC and MOLSS on membership mobilization and information sharing and popularizing the ILO Recommendation on HIV and AIDS and the World of Work	0	1	1	1	1	1	1	1	N	BCAASL, SLLC, MOLSS, Employers Federation	BCAASL, UNAIDS, ILO	Refreshment for 30 persons for meetings
1.5.13		Organize Annual General Meeting for BCAASL members	0	0	0	1	0	0	0	1	N	BCAASL	BCAASL	1 day meeting for 50 people

1.5.14		Support participation of 2 persons from BCAASL in one international learning event annually.	0	0	0	1	0	0	1	0	N	BCAASL, Employers Federation, NAS	BCAASL, UNAIDS, GTZ, ILO	Air Tickets and DSA for 7 Days for 2 persons per annum
1.5.15		Provide logistical and institutional support to BCAASL Secretariat	0	0	0	1	0	0	0	0	N	BCAASL	UNAIDS	(one four wheel drive vehicle; one motor bike and 1 laptop)
1.5.16	Private sector HIV/AIDS Strategic and Operational Plan developed and disseminated	Develop Private Sector HIV Strategic and Operational Plan	0	0	1	0	0	0	0	0	N	BCAASL, NAS	UN Family	1 national consultant for 30 days and validation meeting for 50 for 1 day
		d) NATIONAL NETWORK OF CSOs ON HIV/AIDS												
1.5.17	National Network of CSOs on HIV/AIDS established and functional.	Establish and convene quarterly meetings of the network	0	0	1	1	0	1	1	1	N	NNCHA	UN Family,	1 day meeting for 30 people
1.5.18		Conduct Capacity assessment of the network	0	0	0	1	0	0	0	0	N	NNCHA	UN Family	1 National Consultants for 14 days
1.5.19		Conduct training for network members on governance, programme planning and management etc	0	0	0	0	30	30	30	0	N	NNCHA	UN Family	5 day training
1.5.20		Organize Annual Study tour for 2 persons	0	0	0	1	0	0	1	0	N	NNCHA	UN Family including WB and Dev. Partners	Air Tickets and DSA for 7 Days for 2 tours
1.5.21		Provide logistical and institutional support to the network	0	0	0	0	1	0	0	0	N	NAS, NNCHA	UN Family	(1 lap top computer and accessories ; printer, stationeries)
1.5.22		Organize annual general meetings of the network	0	0	0	1	0	0	0	1	N	NNCHA	UN Family	1 day meeting for 50 persons.
1.5.23	Civil Society sector HIV/AIDS Strategic and Operational Plan developed and disseminated.	Develop HIV/AIDS Strategic and Operational Plan for the Civil Society sector	0	0	0	1	0	0	0	0	N	NNCHA	UN Family	1 national consultant for 21 days
		e) Network of PLHIVs (NETHIPS)												
1.5.24	NETHIPS properly positioned to play its coordination and	Convene quarterly national executive meeting	1	1	1	1	1	1	1	1	N	NETHIPS, NAS	UN Family, GF, C Aid	1 day meeting for 25 persons

1.5.25	advocacy roles.	Convene quarterly Board/Advisory council meeting	1	1	1	1	1	1	1	1	N	NETHIPS, NAS	UN Family, GF, C Aid	Meetings for 30 persons
1.5.26		Organize annual general meetings	0	0	0	1	0	0	0	1	N	NETHIPS, NAS	UN Family, GF, C Aid	1 day meeting for 80 persons
1.5.27		Conduct two-day annual programme retreat	0	0	0	0	0	0	0	1	N	NETHIPS, NAS	UN Family, GF, Dev. Partners, C. Aid,	Two day residential retreat for 20 people
1.5.28		Provide logistical and institutional support to the network	0	0	0	1	0	0	0	0	N	NETHIPS, NAS	UN Family, GF, Dev. Partners, C. Aid,	(2 Motor Bikes; 10 Bicycles; 2 laptop computers and 2 Desktops and accessories; 2 Printers; stationeries and computer consumables
1.5.29		Recruit 8 office personnel	0	0	1	0	0	0	0	0	N	NETHIPS	GF, Comic Relief, Dev. Partners	8 staff @$1k
1.5.30	Capacities of at least 82 members and staff of NETHIPS built in diverse areas	Conduct training for NETHIPS on governance, leadership, programme planning and management, coordination etc	0	0	40	0	0	40	0	0	N	NETHIPS, NAS	UN Family, GF	3 trainings for 40persons each
1.5.31		Support participation of 2 persons from NETHIPS in one international learning event annually.	0	0	0	1	0	1	0	0	N	NETHIPS, NAS	UN Family, GF, Dev. Partners, C. Aid,	Air Ticket and DSA for 7 days for 2 persons.
1.5.32	Strategic Plan for NETHIPS developed and disseminated.	Develop Strategic Plan for NETHIPS	0	0	0	1	0	0	0	0	N	NETHIPS, NAS	UN Family	1 national consultant for 30 days. 1 day validation meeting for 40 people
		f) Youth Network on HIV/AIDS												
1.5.33	Youth Network on HIV/AIDS established and functional	Convene Quarterly meetings of the network	0	1	1	1	1	1	1	1	N	Network, NAS	UN Family	1 day meeting for 30 persons
1.5.34		Conduct Capacity assessment of the network	0	0	1	0	0	0	0	0	N	Network, NAS	UN Family	1 national consultant for 14 days and DSA and local travel allowance for 6 days
1.5.35		Conduct training for Youth network on governance, leadership, programme planning and management, coordination, M&E etc	0	0	0	0	25	25	0	0	N	Network, NAS	UN Family	5 day training
1.5.36		Provide logistical and institutional support for the network	0	0	0	1	0	0	0	0	N	NAS	UN Family	1 Motor Bike, 2 Computers including Printer and Stationery
		g) HIV/AIDS Reporters Association (HARA)												

1.5.37		Convene Quarterly meetings of the association	0	1	1	1	1	1	1	1	N	HARA, MOIC, NAS	UN Family	Meeting for 20 persons
1.5.38	At least 60 members of HARA trained on HIV/AIDS reportage and other diverse areas	Conduct relevant trainings for the Association in the areas of HIV prevention, reportage, BCC etc	0	0	0	30	0	30	0	0	N	HARA, MOIC	UNAIDS, UNICEF	3 day residential training
		h) Inter-religious Council of Sierra Leone (IRCSL)												
1.5.39	Capacities of IRCSL enhanced for more effective coordination	Convene quarterly meetings of the Council	0	1	1	1	1	1	1	1	N	IRCSL, NAS	UN Family	1 day meeting for 40 persons
1.5.40		Conduct Capacity assessment of the Council	0	0	1	0	0	0	0	0	N	IRCSL, NAS	UN Family	1 national consultant for 21 days
1.5.41		Conduct training for 30 IRCSL members in area of HIV/AIDS preventive education, advocacy, HIV mainstreaming etc	0	0	0	30	0	0	30	0	N	IRCSL, NAS	UN Family	2 day training
1.5.42		Support participation of 2 persons in International learning event annually.	0	0	1	0	0	0	1	0	N	IRCSL, NAS	UN Family	Air Ticket and DSA for 7 days for 2 persons.
1.5.43		Provide logistical and institutional support for the network	0	0	0	0	1	0	0	0	N	IRCSL, NAS	UN Family	1 Computer and Printer, stationery
		i) Gender Technical Working Group												
1.5.44	Gender Technical Working Group established and functional	Establish Gender and HIV/AIDS Technical Working Group hold periodic meetings	0	0	1	1	1	1	1	1	N	NAS,MOSWGCA	UN Family	1 day meeting for 25 persons
1.5.45		Conduct training for policy makers and program planners on gender - mainstreaming	0	0	0	40	0	40	0	0	N	MOSWGCA, NAS	UN Family	3 Day training for 40 persons
		Coordination mechanisms within and amongst networks (Public sector network, Private sector networks) and with coordinating bodies at National and District levels are strengthened.												
1.5.46		Convene bi-annual meetings of NAS and Development partners	0	1	0	1	1	0	1	0	N	NAS, UNAIDS	GOSL	meetings for 30 persons
1.5.47		Convene Quarterly NAS-IP (ETWG) meetings.		1	1	1	1	1	1	1	N	NAS	GOSL, UN Family	meetings for 40 persons
1.5.48		Convene monthly meeting of NAS Sector Managers	0	6	6	6	6	6	6	6	N	NAS	GOSL	meetings of 15 persons

1.5.49		Convene monthly DACs-IP meetings at District levels	0	2	3	3	3	3	3	3	N	DACs	DACs, GOSL, UN Family	Meetings for 45 persons
1.5.50		Convene annual partnership forum at national and regional levels	0	0	0	1	0	0	0	1	N, R	NAS,UN Family, DACs	UN Family	2 days forum for 200 persons at the National level (40% of this number will come from the regions). 1 day regional partnership forum will be held in each region x 3 regions) with 50 people attending.
1.5.51		Convene bi-annual NAS-DAC meetings	0	0	0	1	0	1	0	1	N	NAS, DACs,NAS	GOSL, UN Family	1 day meeting for 50 persons. DSA for 16 people
1.5.52		Convene Semi-Annual NAS-PSOs meetings	0	0	0	1	0	1	0	1	N	NAS,PSOs	GOSL, UN Family	1 day meeting for 40 persons
1.5.53		Convene Quarterly NAS-Public sector coordination meetings	0	0	1	1	1	1	1	1	N	NAS, PSOs	GOSL, UN Family	1 day meeting for 35 persons
		Sub-Theme: Financial Resources												
		Outcome: National HIV/AIDS Strategic Plan is funded												
		Output 1: Funding from Government is increased												
1.6.1	Resource mobilization plan for the response developed and disseminated	Develop resource mobilization plan	0	0	0	1	0	0	0	0	N	NAS	UN Family	International Consultant for 30 days (Fees, Air Ticket, DSA etc.)
1.6.2	GoSL and Local/District councils provide increased funding for HIV/AIDS activities	Advocate for provision of budget line on HIV/AIDS for key line Ministries	0	0	1	2	1	1	1	1	N	NAS	UN Family	1 day meeting for 30 persons
1.6.3		Advocate to NAC, Parliament, Local Government Finance Dept and Budget Bureau for integration of HIV/AIDS issues into budget of District Councils	0	0	2	2		2	2	1	N	NAS	UN Family	1 day meeting for 30 persons
1.6.4	Resource tracking for HIV/AIDS activities conducted and disseminated.	Develop/adapt resource tracking tools	0	0	0	1	0	0	0	0	N	NAS	UN Family	International Consultant for 30 days and 3 days training of 30 persons
1.6.5		Conduct resource tracking for HIV/AIDS activities annually	0	0	1	0	0	0	1	0	N	NAS	NAS, UN Family	DSA for a team of 6 for 14 days per year

1.6.6	50 key stakeholders are trained on resource tracking	Train 50 stakeholders (NAS, MDAs, DACs, CSOs, FBOs, PSOs etc) on resource tracking.	0	0	25	0	0	25	0	0	N	NAS	UN Family	3 day training
		Output 2: Funding from Development Partners is increased												
1.7.1	At least two new core funders support the HIV/AIDS response in Sierra Leone	Conduct advocacy to new funders.	0	0	1	1	1	1	1	1	N	NAS	NAS, UN Family	1 off-shore (international) advocacy visit for 2 people annually. Other advocacy visits will be meeting for 20 people.
1.7.2		Build the capacities of NAS, Implementing Partners and NGOs on resource mobilization	0	0	50	0	0	50	0	0	N	NAS	NAS, UNAIDS	3 day training
1.7.3		Develop policy on donor funding coordination	0	0	0	1	0	0	0	0	N	NAS	UN Family	1 International and 1 national Consultant for 30 days
1.7.4		Develop jointly financed programs and implementation frameworks	0	0	0	1	0	0	0	0	N	NAS	UN Family	
		Output 3:Funding from Private sector is increased												
1.8.1	At least 20 private sector organization fund HIV/AIDS activities	Conduct 40 advocacy visits to companies, small and medium enterprises for support for HIV/AIDS activities.	0	5	5	5	5	5	5	5	N	NAS, NETHIPS, CSOs, DAC,	GoSL, Private sector	Advocacy visit consisting of 5 people
		Output 4:Funding from FBOs is increased.												
1.9.1	At least 10 faith-based organization provide resources for HIV/AIDS activities	Advocate for funding of HIV/AIDS programme by religious organizations	0	0	2	2	1	2	3	4	N	NAS	UN Family	Refreshment for 14 Advocacy meetings and stationery
		Sub-Theme: Human Resources, Procurement and Logistics Management												
		Outcome 3: Effective human and logistical Systems in place												
		Output 1:Procurement and distribution system improved.												
1.10.1	Procurement and Supply management (PSM) committee established and functional	Establish the Procurement and Supply Management (PSM) Steering Committee	0	1	0	0	0	0	0		N	NAS	GOSL	No cost is assumed
1.10.2		Convene periodic meetings of the	0	1	1	1	0	1	1	1	N	NAS	GOSL	1 day

		Committee												
1.10.3		Review procurement and logistics management processes at NAS	0	1	0	0	0	0	0	0	N	NAS	UN Family, GOSL	1 international Consultant for 21 days
1.10.4	At least 7 of the medical warehouses do not experience stock out.	Develop logistics management Information systems	0	1	0	0	0	0	0	0	N	NAS	UN Family and Dev Partners	
1.10.5		Train HIV counsellors on Logistics management	0	0	30	35	30	0	35	0	N	NAS	UN Family and Dev Partners	3 day training
1.10.6		Train procurement staff on procurement and logistics management	0	0	8	0	8	0	0	0	N	NAS	UN Family, GF and Dev Partners	7 day training.
1.10.7		Conduct quantification exercise for essential drugs and commodities.	0	0	0	1	0	0	0	0	N	NAS	UN Family, GF and Dev Partners	1 international Consultant for 14 days
		Output 2: Community based system developed and strengthened												
1.11.1	100 stakeholders trained on programme planning and management .	Conduct training on Programme Planning and Management for CSOs, FBOs, CBOs , coalitions and Networks	0	0	50	0	0	0	0	50	N	NAS, UNAIDS	UN Family, GF	Two days training
		Output 3:Human Resource capacity strengthened												
1.12.1	All the 19 DACs and 50 CACs have full complement of staff	Advocate for deployment of staff to DAC/CACs	0	1	1	1	1	1	1	1	N			One advocacy activity per quarter to relevant Ministries
		ii) Health Sector												
1.12.2	Increased number of health workers- in - training are familiar with HIV/AIDS issues.	Standardized and harmonize HIV training curricula	0	1	0	0	0	0	0	0	N	NACP, MOHS	GoSL, GF,Dev. Partners	1 International consultant and 1 national consultant for 40 days
1.12.3		Develop task-shifting and task alignment strategies	0	0	1	0	0	0	0	0	N	NACP, MOHS	GoSL, GF,Dev. Partners	International consultant for 4 weeks
1.12.4		Integrate HIV/AIDS curricula into Pre-service training of health personnel at all levels	0	1	1	1	1	1	1	0	N	NACP, MOHS	GoSL, GF,Dev. Partners	Advocacy visits to relevant institutions. 5 person advocacy team. Transport only.

SIERRA LEONE NATIONAL HIV/AIDS OPERATIONAL PLAN (2011-2012)

THEME 2: POLICY, ADVOCACY, HUMAN RIGHTS AND LEGAL ENVIRONMENT

IMPACT Results: Laws and policies protecting the rights of PLHIVs and other vulnerable groups widely applied

Activity Code	RESULTS	OUTCOMES/OUTPUTS AND ACTIVITIES	IMPLEMENTATION PERIOD								LEVEL OF IMPLEMENTATION N=National R =Regional D=District C=Chiefdom	RESPONSIBLE SECTOR/ ORGANIZATION	FUNDING SOURCE(S)	ASSUMPTIONS/ COMMENTS
			2011				2012							
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
		Outcome 1: Existing laws and policies are strengthened for social protection of the PLHIV and other vulnerable groups												
		Output 1: Bills passed/laws amended in parliament and disseminated												
2.1.1	NAC bill signed into law and disseminated.	Hold consultative meetings with parliamentarians and partners for the enactment of the NAC bill into law.	1	2	0	0	0	0	0	0	N	NAS, CSOs,	UN Family	1 day meeting with 60 persons
2.1.2		Print and Disseminate the Revised law	0	0	1	0	0	0	0	0	N	NAS, CSOs, MDAs	UN System	1-day dissemination meeting for 120 participants; print and distribute 10000 copies of HIV law
2.1.3		Organize community conversations on the new HIV law	0	0	0	1	1	1	1	1	R	CSOs, NAS	UN System	At least four regional trainings of at least 25 participants in selected communities for a 7-day training of community facilitators on community conversations
2.1.4		Develop, print and disseminate abridged versions of the law.	0	0	0	1	0	0	0	0	N	NAS, CSOs	UN System	1 national consultant 7 days to develop the abridged version. Print and distribute 5,000 copies

2.1.5	Labour laws reviewed to include HIV-related issues and is implemented in the formal and informal sectors.	Conduct Training of Trainers for 25 participants annually on social protection of HIV and the world of work	0	0	25	0	0	25	0	0	N	MoLSS, NAS, BCAASL, Unions	UN System	5 day training workshop
2.1.6		Train employers and workers organizations to integrate HIV/AIDS issues and relevant provisions on non-discrimination into their collective bargaining agreements	0	0	30	30	0	30	30	0	R	MoLSS, NAS, BCAASL, Unions	GF, UN System	3 day-training
2.1.7		Identify discriminatory clauses/ sections within the existing labor laws	0	1	0	0	0	0	0	0	N	BCAASL, Unions, NAS	UN System, GF	1 national consultant for 21 days meeting. I day validation meeting for key stakeholders of 50 participants.
2.1.8		Advocate for review of labour laws to include HIV services , protection and respect for the rights of PLHIV, labour migrants and their families.	0	1	1	1	1	1	1	1	N	BCAASL, Unions, NAS	UN System, GF	Conduct advocacy to relevant stakeholders once every quarter. Advocacy team consists of 4 persons
2.1.9	Laws that impedes the social protection of the MARPs, PLHIV and OVC are reviewed	Hold consultative meetings for review of laws and policies that disallows MARPS (particularly prisoners) from using condoms	2	2	2	2	2	2	2	2	N	NAS, CSOs	UN System	At least 8 consultative meetings per annum to engage key stakeholders on the law. 30 persons per meeting.
2.1.10		Advocate the strengthening and enforcement of existing policies and laws for social protection of PLHIVs, OVCs, MARPS and other vulnerable groups.	0	1	1	1	1	1	1	1	N	NAS, CSOs	UN Family	Conduct advocacy to relevant stakeholders once every quarter. Advocacy team consists of 4 persons

2.1.11		Advocate to the Ministry of Justice to include violations of the rights of PLHIVs, OVCs, MARPS and other vulnerable groups in the Special Court sittings for GBV.	0	1	1	1	1	1	1	1	N	NAS	UN Family	Hold at least one meeting per quarter with Ministry of Justice. Refreshment only for 20 persons
		Output 2: National policies developed/reviewed and disseminated												
2.2.1	New national HIV/AIDS policy developed and disseminated	Hold consultative meetings on policy review and analysis	0	0	1	1	0	0	0	0	N	NAS	UN Family	2 consultative meetings, duration- 2 days each, 50 participants each.
2.2.2		Develop new National HIV/AIDS Policy	0	1	0	0	0	0	0	0	N	NAS, CSOs	GF, UN Family	1 International and national consultant for 21 days. TWG Meeting (residential meeting) for 20 people for 3 days. One day validation meeting for 80 people
2.2.3		Print and disseminate the National HIV/AIDS Policy	0	0	1	0	0	0	0	0	N, D, C	NAS, DACs, MDAs, CSOs,	GF, UN Family	1 day dissemination meeting for 150 people. 3,000 copies will be printed
		Workplace Interventions												
2.2.4	New national HIV workplace policy developed and disseminated	Review the National HIV Workplace Policy	0	1	0	0	0	0	0	0	N,D	MoLSS, Unions, BCAASL	GF, UN Family	1 national consultant for 21 days. TWG meeting for 2 days for 25 people. One day Validation meeting for 50 persons.
2.2.5		Print and disseminate National HIV Workplace Policy	0	0	1	0	0	0	0	0	N, R,D	MoLSS, NAS, BCAASL, Unions	UN Family	1 day dissemination meeting for 100 people. 1,000 copies will be printed

2.2.6	HIV workplace committees established in 40 organizations and fully functional	Establish and hold quarterly meeting of the Broad based Task Force on implementation of workplace policy	0	0	1	1	1	1	1	1	N	MoLSS, NAS, BCAASL, Unions	GF, UN Family	1 day meeting for 15 persons
2.2.7		Training of 150 members(19 ministries, Department and Agencies, 21 unions that are affiliated with Labour Congress) on mainstreaming HIV/AIDS and Gender into workplace and business institutions	0	0	25	25	25	25	25	25	N	BCAASL, Unions, NAS	GF, UN Family	5 day training workshops.
2.2.8		Conduct advocacy meetings to Workplaces for establishment of Workplace committees.	10	10	10	10	12	12	13	13	N	MoLSS, BCAASL, Unions, Employers Federation, NAS	GF, UN Family	Advocacy teams consists of 4 persons. Cost for transport only.
2.2.9		Conduct orientation sessions for the workplace committee members (10 members per workplacex40.	1	1	1	1	1	1	1	1	N	NAS, MOLSS, BCAASL Unions, Employers Federation	GF, UN Family	2 day non-residential training, 1 training of 50 members per quarter
2.2.10		Train 400 peer educators in the workplaces	50	50	50	50	50	50	50	50	N	NAS, MOLSS, BCAASL Unions, Employers Federation	GF, UN Family	5 day non-residential training workshops
2.2.11		Conduct advocacy to key sectors for integration/mainstreamin g of HIV into existing sectoral workplace policies and NASSIT.	1	1	1	1	1	1	1	1	N	BCAASL, Unions, NAS	UN Family	1 Advocacy event will take place every quarter
2.2.12	**Educational workplace policy on HIV reviewed and disseminated.**	Review and disseminate the educational workplace policy on HIV	0	0	1	0	0	0	0	0		MEST	UN Family	1 national consultant for 10 days. I day validation meeting for 40 people
		Output 3: Knowledge on HIV and human rights increased												
2.3.1	700 persons from different organizations	Train 100 CSOs on Human Rights and HIV	0	25	25	0	0	25	25	0	N	CSOs,NAS	UN Family	3 day training.

2.3.2	and communities have increased knowledge on HIV and Human Rights	Sensitize 250 community, traditional, opinion and religious leaders on Human Rights and HIV	0	50	50	0	50	50	50	50	D	CSOs, DAC, NAS	UN Family	1 day sensitization meeting.
2.3.3		Train 300 persons from Human Rights Commission, Law Enforcement agents on Human Rights and HIV	0	50	0	50	50	50	50	50	N	CSOs, NAS	UN Family	Workshop is of two (2) days duration.
2.3.4		Train CSOs on understanding issues of MARPS and HIV	0	20	0	20	0	20	0	20	N	CSOs, NAS	UN Family	2 days training

SIERRA LEONE NATIONAL HIV/AIDS OPERATIONAL PLAN (2011-2012)
THEME 3: PREVENTION OF NEW HIV INFECTIONS
IMPACT: Incidence of HIV is Reduced by 50% in 2015

Activity Code	RESULTS	OUTCOMES/OUTPUTS AND ACTIVITIES	IMPLEMENTATION PERIOD								LEVEL OF IMPLEMENTATION N=National R= Region D=District C=Chiefdom	RESPONSIBLE ORGANIZATION / SECTOR	FUNDING SOURCE(S)	ASSUMPTIONS/ COMMENTS
			2011				2012							
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
		Outcome 1: Reduced Sexual Transmission of HIV												
		Intermediary Outcome 1: MARPs and clients adopt safe behaviour												
		Output 1: MARPs (Female Sex Workers and their clients, MSM, IDUs, Uniformed personnel) are reached by Comprehensive Prevention Programmes												
3.1.1	**62000 MARPS are reached with comprehensive prevention messages**	Identify organizations working with MARPs	0	1	0	0	0	0	0	0	N	CSOs, NAS	UN System	1 National Consultants for 14 days, Validation meeting for 1 day for 20 people.
3.1.2		Develop and disseminate guidelines on service provision targeting MARPS	0	1	0	0	0	0	0	0	N	CSOs, NAS	UN System, USDOD	I international Consultant for 14 days, TWG meeting for 10 people for 2 days, validation meeting for 1 day for 20 people.
3.1.3		Print and distribute 200 copies of the guidelines	0	0	200	0	0	0	0	0	N, D	NAS, CSOs, Private sector	GF, USDOD, UN System	
3.1.4		Develop BCC strategy for MARPs	0	0	1	0	0	0	0	0	N	NAS, CSOs, Private sector, RSLAF	GF, UN System	TA for 14 days, TWG meeting for 10 people for 2 days, validation meeting for 1 day for 20 people
3.1.5		Train 100 service providers and strengthen the capacity of existing ones on issues dealing with MARPS	0	0	25	25	25	25	0	0	N	NAS, CSOs, Private sector, RSLAF, MDAs	GF, UN System, USDOD	Training is for 3 days

3.1.6		Develop Peer Education Manuals for MARPs	0	1	0	0	0	0	0	0	N	NAS, CSOs,		1 International Consultant and 1 national consultant for 14 days. 1 day validation meeting for 20 people.
3.1.7		Train 1,200 peer educators amongst the MARPS	0	0	200	200	200	200	200	200	N, D	CSOs, RSLAF, NAS, Private sector, MDAs	GF, UN System	Training is for 5 days
3.1.8		Produce and distribute BCC materials targeting MARPS (500 posters and 5,000 leaflets) annually	0	0	1	0	0	1	0	0	N, D	CSOs, RSLAF, NAS, Private sector, MDAs	GF,USDOD, UN System	
3.1.9		Produce and air 32 radio message (8 per quarter) targeting MARPs	8	8	8	8	8	8	8	8	N	CSOs, RSLAF, NAS, Private sector	GF, USDOD, UN System	Production of one radio jingle costs US$170 and airing costs US$2 per slot
		Output 2: MARPS who know their HIV status increased												
3.2.1	**12,000 MARPs know their HIV status**	Train 220 HIV Counsellors to target the MARPs	60	25	0	25	85	0	25	0	N	CSOs, RSLAF, NAS, Private sector	GF, USDOD, UN System	5 day training
3.2.2		Integrate service provision for MARPs into health facilities	10	10	10	10	10	10	10	10	N,D	NAS, CSOs, RSLAF, Private sector, MDAs	GF, USDOD, UN System	This would attract no costs as they would just provide the services after being trained
3.2.3		Organize 112 sensitization meetings per year	28	28	28	28	28	28	28	28	N,D, C	NAS, CSOs, RSLAF, Private sector, MDAs	GF, USDOD, UN System	2 sensitization meetings per district per quarter reaching out to 50 people
3.2.4		Make HCT services available through mobile HCT services	3	3	3	3	3	3	3	3	N,D,C	NACP, CSOs, Private sector	GF, UN System	3 mobile HCT outreach services will be conducted per quarter
		Output 3: Condom and other prevention commodities are available and accessible by MARPs												
3.3.1	**20,000 MARPs use condoms correctly and consistently**	Train 680 peer educators on condom use	80	80	80	80	80	80	80	80	N	NAS, CSOs	GF, UN System	No cost assumed. Integrate into the training of Peer educators above.
3.3.2		Conduct survey on condom use amongst MARPs	0	0	1	0	0	0		0	N, D	NAS, CSOs	UN System	1 national consultant for 21 days. 1 day validation meeting with 20 people.

3.3.3		Organize 48 Sensitization meetings (per year) for MARPS on condom use	12	12	12	12	12	12	12	12	N, D	CSOs, NAS, Private sector, MDAs	GF, UN System, USDOD	No cost assumed. Integrate into the sensitization meetings for HCT above.
3.3.4		Intensify advocacy on HIV prevention in prisons.	1	1	1	1	1	1	1	1	N	CSOs, NAS,	UN system	Advocacy team consists of 5 persons
3.3.5		Distribute condoms to Peer educators to make it available for MARPs	0	0	0	0	0	0	0	0	N, D	CSOs, NAS, Private sector, MDAs, RSLAF,	GF, UN system	No cost is assumed as the figures is embedded in the national figures for condom distribution
		Intermediary Outcome 2: Reduction of Risky sexual behaviour in general population												
		Output 1: General Population Reached by Comprehensive Prevention Programmes												
3.4.1	**Prevention and BCC activities better coordinated**	Establish and hold meeting of National Prevention Technical Working Group-TWG (1 meeting per quarter)	1	1	1	1	1	1	1	1	N	NAS, CSOs, MDAs, Private sector, RSLAF,	UN System	1 day meeting for 40 people.
3.4.2		Hold meetings of the BCC/IEC Technical Working Group (TWG)	1	1	1	1	1	1	1	1	N	NAS, CSOs, MDAs, Private sector	GF	1 day meeting once per quarter
3.4.3		Establish and convene meetings of District BCC/IEC Committee.	0	1	0	1	1	0	1	0	R	NAS, DACs, CSOs, MDAs	GF, UN system	Meeting for 30 people
3.4.4	**Comprehensive prevention plan and BCC strategy developed and disseminated**	Develop a National Prevention Plan	0	1	0	0	0	0	0	0	N	NAS, CSOs, MDAs, Private sector	UN System	1 International and 1 national consultant for 30 days, TWG meeting for 3 days for 36 persons, I day validation meeting for 100 people.
3.4.5		Print and distribute 2000 copies of the Prevention plan	0	0	1	0	0	0	0	0	N, D, C	NAS, CSOs, MDAs	UN System	

3.4.6		Develop the comprehensive BCC strategy	0	0	1	0	0	0	0	0	N	NAS, CSOs, MDAs, Private sector, RSLAF,	UN System	1 International Consultant, 1 national consultant for 30 days, TWG meeting for 2 days for 30 persons, I day validation meeting for 50 people.
3.4.7		Print and distribute 2500 copies of the BCC Strategy (in '000)	0	0	0	2.5	0	0	0	0	N,D, C	NAS, CSOs, MDAs, Private sector, RSLAF,	UN System	
3.4.8		Develop a BCC Training Manual	0	0	0	1	0	0	0	0	N		GF, UN System	1 consultant for 21 days, TWG meeting for 1 days for 20 persons, I day validation meeting for 30 people.
3.4.9		Print 4000 and distribute copies of the training manual (in '000)	0	0	0	4	0	0	0	0	N	NAS	GF, UN System	
3.4.10	**Capacities of 150 people built on BCC and CCE**	Conduct training of trainers (ToT) on BCC for 50 persons at the National level	0	0	0	0	50	0	0	0	N	NAS,	GF, UN System	5 day training assumed
3.4.11		Conduct training of trainers (ToT) on BCC for 5 community members/district for 14 districts	0	0	0	0	0	35	35	0	R	NAS, CSOs	GF, UN System	3 days assumed
3.4.12		Conduct national Training of Trainers on Community Capacity Enhancement	21	0	0	0	21	0	0	0	N	NAS	UN System	1 International Consultant for 21 days. The training is for 10 days
3.4.13		Training of community facilitators on CCE-CC (Community Conversation)	0	25	25	0	0	25	25	0	N	NAS, CSOs	UN System	1 International Consultant for 15 days
3.4.14	**700,000 people reached with prevention messages**	Facilitate Community Conversations on HIV/AIDS issues	1	3	3	3	1	3	3	3	D	NAS, CSOs	UN System	Materials include 10 flip chart markers, 1 ream ofA4 paper, Facilitation fee for 2 facilitators at US$ 50 per facilitators for 2 facilitators

3.4.15		Train duty bearers(opinion, religious and traditional leaders) on community mobilization for HIV/AIDS activities (in '00)	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	D	DACs, CSOs	GF, UN System	1 day training assumed
3.4.16		Conduct community and youth council meetings and outreaches on HIV/AIDS	28	28	28	28	28	28	28	28	R, D	NAS, DACs, CSOs,	GF, UN System	2 per district/quarter. 50 persons/meeting
3.4.17		Celebrate World AIDS Day	0	0	0	1	0	0	0	1	N,D	NAS, DACs, MDAs, CSOs, Private sector	GF, UN System	10,000 round neck t-shirts @$5 each, 5,000 Tennis shirts @ $12 each, 5,000 Fez caps @ $4each, 100 banners @ $50 each, 5,000 posters @ $1.2 each, Venue @ $600, Generator @ Live Band @ $1,350 for 3 days, 5 matching Band for rally @ $1,000, 3,000 Chairs @ $0.25 each, 10 Canopy @$1,200 each for 2 days, Subvention for DACs @ $1,200 each for 19 DACs, Refreshments for 4,000 people @$3 each, Live broadcast @ $2,000.
3.4.18		Develop and air HIV/AIDS Drama on Television	13	13	13	13	13	13	13	13	N	NAS, MIC	GF	Drama to be produced for each week and aired weekly for 52 weeks/year
3.4.19		Produce radio jingles on various aspects of HIV/AIDS e.g HCT, PMTCT, ART, Condom, abstinence etc.	0	16	0	0	16	0	0	0	N	NAS, CSOs	GF, UN System	1 jingle will be developed for each thematic area and in 4 different languages per year. Production of 1 jingle is US$170
3.4.20		Air radio jingles (in '000)	5.04	5	5.04	5	5	5.04	5	5	N	NAS, MIC	GoSL, GF	360 radio jingles/district radio station per quarter. 1 slot is US$2
3.4.21		Produce television spots	4	0	0	0	4	0	0	0	N	NAS, CSOs	GF,	Produce 4 TV spots. 1 per thematic area. Production of each TV

														spots costs US$300
3.4.22		Airing of TV spots (in '00)	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	N	NAS, CSOs	GoSL, GF	2 slots per day per TV station for 2 TV stations
3.4.23	**340, 000 BCC materials distributed**	Develop gender sensitive BCC/IEC materials.	0	15	0	0	0	0	0	0	N	NAS, CSOs, Private sector	GF, UN System	1 three day meeting for 15 persons
3.4.24		Produce and distribute gender-sensitive and age appropriate BCC materials	1	0	0	0	1	0	0	0	N	NAS, CSOs, MDAs,	GF	1 for this activity refers to 30,000 brochures and 30 billboards per year
3.4.25		Produce advocacy materials such as biros, umbrella, keyholders, notepads, armbands etc. with key HIV/AIDS messages(on HCT, PMTCT, stigma	0	1	0	0	0	0	0	0	N,D,C	NAS, CSOs, Private sector	GF, UN System	1 lot refers to 50,000 biros, 25,000 keyholders, 20,000 notepads, 50,000 armbands, 5,000 tea-cups etc.
3.4.26		Establish 4 Regional HIV/AIDS Information Centres	0	0	2	0	0	0	2	0	N,R	NAS	GF, UN System	Set up costs for each centre is rent@ US$3,000 per annum, 10 tables@US$30ea, Chairs @$20ea, 10 Shelves@$5 ea, 2 TV@250 ea, 2 DVD@US$ 150ea, 4 desktop computers and accessories @ US$2,000ea, 1 printer @$200ea, 2 fans@$70 ea, 2 Generators@US$1,500ea, publications (lump sum) @ 3,000
		Output 2: Young People aged 15-24 are at reduced risk of HIV Infection												
3.5.1	**National Strategy for Prevention of HIV/AIDS amongst adolescents and young people developed and disseminated.**	Develop a costed National Strategy for Prevention of HIV/AIDS amongst adolescents and young people	0	0	1	0	0	0	0	0	N	NAS, MOYS, MOE,CSOs	UN System	1 International, 1 national Consultant for 45 days, TWG meeting for 25 persons for 3 days, 1 day validation meeting for 50 people

3.5.2		Print and distribute 1,000 copies of the Strategy document (in '000)	0	0	0	1	0	0	0	0	N, D	NAS, MOYS, CSOs	UN System	
3.5.3	**National Peer Education Manual developed**	Develop a national peer education manual	0	0	0	1	0	0	0	0	N	NAS	UN System	1 National consultant for 21 days, TWG meeting 15 people for 2 days, Validation meeting for 40 persons
3.5.4		Produce and disseminate 1000 national peer education manuals (in '000)	0	0	0	0	1	0	0	0	N, D	NAS, CSOs	UN System	
3.5.5	**1,440 teachers trained to provide support for implementation of SRH, HIV and Life Skills education**	Establish and maintain a data base of teachers trained in SRH/ HIV and Life skills	0	0	1	0	0	0	0	0		MEST, MOYS, CSOs, NAS	UN System	1 International consultant, 2 national consultants, 8 enumerators, TWG meeting for 25 persons for 1 day.
3.5.6		Develop the SRH, HIV and Life Skills Manual		1	0	0	0	0	0	0	N	MEST, MOYS, CSOs, NAS		1 International Consultant and national consultant for 21 days, TWG meeting (residential) for 25 people for 3 days, validation meeting for 1 day for 80 people.
3.5.7		Develop, print and distribute 12,000 copies of the SRH, HIV and Life skills education manual ('000)	0	12	0	0	12	0	0	0	N	MEST, NAS	GF,	
3.5.8		Train 720 teachers and life skill facilitators annually.	0	240	240	240	180	180	180	180	D	MOE, NAS, CSOs	GF, UN System	2 day non-residential training assumed.
3.5.9		Strengthen the capacity of the MEST to supervise monitor and evaluate SRH, HIV and life skills interventions in schools	0	0	40	0	0	40	0	0	N,D	MOE, NAS, CSOs	GF, UN System	3 day training for district education officers and school supervisor at 20 per region x 4 regions
3.5.10	**1,600 in-school and out-of school youths peer educators are trained on life skills**	Train1,600 in-school and out-of-school adolescent/youth peer educators (ratio of 60:40)	200	200	200	200	200	200	200	200	N,D	MEST, MOYS, CSOs, NAS	GF	5 day training assumed.

3.5.11	**308,000 youths are reached with prevention messages**	Establish 200 HIV/AIDS and Health clubs	25	25	25	25	25	25	25	25	N,D	MEST,CSOs, DACs	GF	One-off Support of US$200 is given to 1 club per year.
3.5.12		Build capacities of youth centers to provide information and basic services on HIV and sexual and reproductive health	0	0	28	0	0	0	0	0	N	CSOs, NAS, MOYS, MEST	UN System	Train 28 officers (2 from each district), 2 day training assumed
3.5.13		Produce and distribute youth friendly BCC/IEC materials on HIV/AIDS and sexual and reproductive health.	0	0	1	0	0	0	0	0	N	NAS, MIC, MOE, MOYS, MOHS	GF, UN System	1 lot refers to 5, 000 posters, 30,000 brochures, 14 billboards, 40,000 armbands
3.5.14		Produce radio jingles on various aspects of HIV/AIDS e.g HCT, Condom, abstinence etc targeting youths specifically.	0	12	0	0	12	0	0	0	N	NAS, CSOs	GF, UN System	1 jingle will be developed for each of the 2 thematic areas and in 4 different languages per year. Production of 1 jingle is US$170
3.5.15		Air radio jingles **(in '000)**	2.52	2.5	2.52	2.5	2.5	2.52	2.5	2.5	N	NAS, MIC	GoSL, GF	180 radio jingles/1 district radio station for 14 districts per quarter. 1 slot is US$2
3.5.16		Produce television spots	2	0	0	0	2	0	0	0	N	NAS, CSOs	GF,	Produce 2 TV spots. 1 per thematic area for 2 areas. Production of each TV spots costs US$300
3.5.17		Airing of TV spots **(in '00)**	3.6	3.6	3.6	3.6	3.6	3.6	3.6	3.6	N	NAS, CSOs	GoSL, GF	2 slots per day per TV station for 2 TV stations

3.5.18		Organize Interschool essay competition on HIV/AIDS at the regional and National level.	0	0	0	0	0	0	4	1	N, R	NAS, CSOs	GoSL, GF	4 regional competitions and one national competition. For regional competitions- refreshments for 200 people, honorarium for 6 judges x 4, hall rentage, prizes for schools, transport fares for schools, public address system, 150 chairs, 4 tables, decorations, DJ, generator. At the National level, 10 judges and honorarium, prizes and transport fares for schools, 500 chairs, generator, decorations, refreshment for 500, DJ, public address system,
		Output 3: People Living with HIV including sero discordant couples provided with positive prevention services												
3.6.1	**800 health workers are trained on PHDP**	Develop a training package on Positive Health Dignity and Prevention (PHDP)	0	0	0	1	0	0	0	0	N	NACP, NETHIPS	GF, UN Family	1 International Consultant and 1 national consultant for 15 days. 2 day workshop (non residential) for TWG of 20 persons
3.6.2		Train health care workers, PLHIV, CSOs, MDAs on PHDP and universal precautions.	0	0	0	0	200	200	200	200	N, D	NACP	GF, UN Family	3 day workshop
3.6.3	**All support groups are sensitized on PHDP**	Sensitize PLHIV and support groups on positive living and advantages of disclosure	0	0	0	0	10	10	9	9	N,D	NETHIPS, CSOs	GF, UN Family	1 sensitization session is for 1 day and 40 persons.

		Output 4: HIV infections resulting from sexual or gender-based violence are prevented												
3.7.1	**112 communities are sensitized on actions to take when SBGV occurs**	Develop, produce and disseminate BCC materials for sexual and gender-based violence	0	1	0	0	0	0	0	0	N,D	MSWGCA, CSOs, NAS	UN System	1 lot refers to 5,000 posters, 14 billboards, 10,000 brochures
3.7.2		Sensitize communities on Sexual-based and Gender Violence (including the benefit of PEP particularly for rape survivors)	14	14	14	14	14	14	14	14	D	MSWGCA, DACs,DHMT, CSOs, NACP, MOHS, CSOs, Private sector	UN System	1 sensitization meeting per quarter per district
3.7.3	**320 law enforcement officials are trained on SGBV**	Training 320 law enforcement officials and others on proper advice and referrals for survivors of SGBV.	40	40	40	40	40	40	40	40	D	CSOs, NACP	GF, UN System	1 day training workshop
		Output 5: Increased number of people use condoms correctly and consistently												
3.8.1	**Condom programming better coordinated**	Disseminate the National Condom Programming Strategic Plan	0	1	0	0	0	0	0	0	N	NAS, CSOs	GF, UN System	1 day meeting for 50 people
3.8.2		Convene quarterly National Comprehensive Condom Programming Committee meeting	1	1	1	1	1	1	1	1	N	NAS, CSOs, Private sector	GoSL, UN system	1 day meeting for 20 people
3.8.3		Develop a training manual for female and male condom use	0	0	1	0	0	0	0	0	N	NAS, CSOs, Private sector	GoSL, UN system	1 International and national consultant for 21 days, TWG meeting for 15 people for 2 days and validation meeting for 50 people.
3.8.4	**200 people trained as peer educators on condom use**	Conduct TOT for 200 persons on Condom Use	0	0	0	50	50	50	50	0	N	CSOs, NAS, MOHS	KfW, UN System	3 day training assumed.
3.8.5		Produce and distribute BCC materials on condoms	1	1	1	1	1	1	1	1	N, D, C	NAS, CSOs,	GF, UN System	1 unit refers to 2,000 brochures, 2,000 posters, 20 billboards and 2,500 stickers
3.8.6		Conduct 28 events on condom promotion (2 Per district) annually	7	7	7	7	7	7	7	7	D	CSOs, NAS, MOHS	GF, UN System	This would be in form of rallies/campaigns
3.8.7		Organize 240 radio shows and 60 TV shows on condom promotion (60 radio show and 15 TV shows per quarter) and annually	75	75	75	75	75	75	75	75	N	NAS, CSOs	GF, UN System	Production, recording and editing cost should also be considered

		Output 6: Male and Female Condoms are available and accessible by the general populations												
3.9.1	**Strengthen the capacity of currently existing condom distribution points**	Train the marketing distribution networks on condom social marketing	50	50	50	50	50	50	50	50	N,D	CARE	GF, UN System, KfW	Training is for 2 days
3.9.2		Establish 160 additional condom selling/distribution points through the private/public sector initiatives	20	20	20	20	20	20	20	20	N, D	CSOs	GF, UN System, KfW	
3.9.3	**11 million male condoms and female condoms distributed.**	Procure and distribute male and female condoms **(in millions)**	2	2	2	2	2.8	2.75	2.8	2.8		NAS, CSOs,	GF, UN System, KfW	Male and female condoms will be procured in the ratio of 99.5%:0.05%)
3.9.4		Procure 48 condom dispensers	6	6	6	6	6	6	6	6	N	CSO, NAS	GF, UN System, KfW	
3.9.5		Make condoms available in at least 40 workplaces annually	10	10	10	10	10	10	10	10	N	NAS	GF, UN System, KfW	This is already part of what is to be procured globally
3.9.6		Develop market strategy for introduction of lubricants	0	0	1	0	0	0	0	0	N	NAS, CARE	GF, UN System, KfW	2 day non-residential meeting
3.9.7		Procure and distribute lubricants **(in'000)**	400	400	400	400	550	550	550	550	N	CSOs, NAS	GF, UN System, KfW	This would depend on the number of condoms. 1 lubricant for 5 pieces of condoms
		Output 7: Increased number of people know their HIV status												
3.10.1	**HCT guidelines, protocol and training manual reviewed and disseminated**	Review the HCT guidelines and protocol	0	1	0	0	0	0	0	0	N	NACP, MOHS	UN System	1 international Consultant and 1 national consultant for 21 days, TWG meeting for 15 people for 3 days and validation meeting for 50 people.
3.10.2		Print and distribute the revised HCT guidelines and protocol	0	0	2000	0	0	0	0	0	N, D	**NACP,** MOHS, DACs, MDAs,	UN System	

3.10.3		Revise, print and distribute the HCT training manual	0	1	0	0	0	0	0	0	N, D	NACP, MOHS, MDAs, CSOs	GF, UN System	1 international, I national consultant for 15 days, TWG meeting (non-residential) for 15 people for 2 days, 1 day validation meeting for 50 persons. 1,000 copies will be printed
3.10.4	**2,360 HIV counsellors trained**	Train and re-train HCT Counsellors	250	250	250	250	250	250	250	250	N, D	NACP, MOHS, CSOs, MDAs Private sector	GF, UN System	8 day training is assumed
3.10.5		Train service providers on Youth sensitive HCT services	30	30	30	30	30	30	30	30	N, D	NACP, CSOs, Private sector	GF, UN System	3 day training assumed
3.10.6	**Additional 440 facilities provide HCT services**	Integrate HCT services into health facilities and adolescent/youth friendly HCT centers)	30	30	30	30	30	30	30	30	N, D, C	NACP, MOHS, CSOs, MDAs Private sector	GF, UN System	Recruit 1 staff each for 20% of the health facilities.2 Tables, 1 executive chair, 10 plastic chairs, 1 filing cabinet, 1 wall fans, 1 refrigerator, will be provided for each facility
3.10.7		Establish stand alone HCT centers (including youth friendly HCT centers)	24	24	24	28	24	24	24	28	N	NAS, MDAs, CSOs, Private sector	UN System	About 60% will be for the general population and 40% will be adolescent and youth friendly centers. For adolescent centers include the cost of television, VCD player, games and video tapes. Establishment costs is the same as that for integration.
3.10.8	**At least 564,000 HIV tests are conducted annually.**	Provide logistical support for HCT centers	14	0	0	0	0	0	0	0	N	NACP	GF	14 motorcycles (1 per district) 28 computers and printers (2 per district).

3.10.9		Procure mobile HCT service equipments	0	0	0	4	0	0	0	0	N	NACP	GF,	4 mobile HCT vans (One for each region). In addition, 1 canopy, 6 collapsible chairs, two collapsible tables, 1 megaphone,
3.10.10		Conduct rallies for youths during special events like children's day, international youth day, Muslim and Christian festivals and valentines' day targeting in and out-of-school youths	3	3	3	3	3	3	3	3	N, D	NAS, DACs, CSOs	GF, UN System	500 T-Shirts, 10 banners, Musical instruments, matching band, refreshments for about 500 people, generator.
3.10.11		Print and distribute 12,000 brochure on HCT services ('000)	0	6	0	0	0	6	0	0	N, D	NAS, CSOs	GF, UN System	6,000 per year
3.10.12		Conduct community sensitization (using drama) on HCT in the communities.	40	40	40	40	40	40	40	40	D	DACs, CSOs	GF, UN System	Drama will be staged in open place and charges will be drama, No refreshment needed.
3.10.13		Conduct sensitization workshops opinion, religious (Christian and Muslim) and traditional leaders on HCT	28	28	28	28	28	28	28	28	D	DACs, CSOs	GF, UN System	Each workshop will have a maximum of 40 ppts
3.10.14		Organize 1,440 talk shows on HCT	180	180	180	180	180	180	180	180	N,D	CSOs, NAS, DACs	GF, UN System	1 Talkshow @US$25

		Intermediary Outcome 3: Increase in Quality Treatment of STIs												
		Output 1: Increase awareness of STIs symptoms and demand for STI treatment.												
3.11.1	**At least 200,000 people are reached with information on STIs**	Sensitize communities (particularly the MARPs) on STIs and services available	28	28	28	28	28	28	28	28	N,D	DHMT, DACs, CSOs	GF, UN System	2 communities in each district to be sensitized per quarter
3.11.2		Develop radio jingles on STIs.	0	4	0	0	0	4	0	0	N,D	NAS, MOHS		1 jingle will be developed in 4 different languages per year. Production of 1 jingle is US$170
3.11.3		Air radio jingles (in '000)	2.52	2.5	2.52	2.5	2.5	2.52	2.5	2.5	N	NAS, MIC	GoSL, GF	180 radio jingles/1 district radio station for 14 districts per quarter. 1 slot is US$2
3.11.4		Produce television spots	2	0	0	0	2	0	0	0	N	NAS, CSOs	GF,	Produce 2 TV spots. 1 per thematic area for 2 areas. Production of each TV spots costs US$300
3.11.5		Airing of TV spots	180	180	180	180	180	180	180	180	N	NAS, CSOs	GoSL, GF	1 slots per day per TV station for 2 TV stations
3.11.6		Produce and distribute BCC materials on STIs.	0	0	1	0	0	0	0	0	N	MOHS, NACP, NAS, CSOs	GF, UN System	1 lot refers to 1, 000 posters, 10,000 brochures, 14 billboards,
3.11.7		Develop video clips on STI prevention and treatment	0	1	0	0	0	0	0	0	N	NAS	GF, UN System	Develop STI clips in four local languages
3.11.8		Airing of video clips	0	0	180	180	180	180	180	180	N	NAS	GF, UN System	1 slots per day per TV station for 2 TV stations
3.11.9		Sensitization during social gatherings (Sports)	360	360	180	360	360	360	180	360	N	NAS, NGOs CSOs	GF, UN System	Premier Football matches, School sports meet

		Output 2: Increased availability and accessibility to high quality STI treatment												
3.12.1	**1050 health care personnel trained on STI management**	Review the guidelines and protocols for Syndromic management of STI	0	0	1	0	0	0	0	0	N	MOHS, NACP	GF, UN System	1 International consultant and 2 national Consultants for 21 days, 1 day non-residential meeting for 20 TWG members, Dissemination meeting with 50 people for 1 day.
3.12.2		Print and distribute 1000 copies of the guidelines (in '00)	0	0	0	10	0	0	0	0	N	MOHS, NACP	GF, UN System	
3.12.3		Advocate for integration of STI service provision into health facilities (public and private) and HIV prevention services	0	4	4	0	0	0	0	0	N	NACP, CSOs, MOHS, Private sector	GF, UN System	8 advocacy meetings with relevant policy makers. Max of 15 persons per meeting. Refreshment only
3.12.4		Advocate for the review of the PHC Operational Manual to include the syndromic management of STI including HIV	0	4	4	0	0	0	0	0	N	NACP, CSOs, MOHS	GoSL, GF, UN Family	No cost assumed similar to activity above.
3.12.5		Conduct one-day orientation meeting for 100 health personnel on the RH/STI policy.	0	50	50	0	0	0	0	0	N	NACP, MOHS, CSOs	GoSL, GF, UN Family	1 day non-residential meeting
3.12.6		Train and re-train750 service providers on Syndromic Management of STIs.	0	150	150	150	150	150	0	0	D	NACP, MOHS, CSOs	GoSL, GF, UN Family	2.5 days non-residential training with two facilitators.
3.12.7		Train 28 health personnel on STI surveillance (2 per district.	28	0	0	0	0	0	0	0	N	MOHS, NACP	GoSL, GF, UN Family	3 day residential training with two facilitators
3.12.8		Conduct orientation training for 200 healthcare workers on STI data collection tool	0	100	100	0	0	0	0	0	D	MOHS, NACP	GoSL, GF, UN Family	2 day non-residential training with 2 facilitators
3.12.9		Print and distribute 18,000 STI surveillance forms for data collection.	0	1	0	0	0	0	0	0	N	NACP	GoSL, GF, UN Family	1 lot refers to 18,000 forms
3.12.10	**At least 90, 000 cases of STIs are treated**	Refurbish /renovate 32 STIs clinics	4	4	4	4	4	4	4	4	D	NACP, MOHS	GoSL, GF, UN Family	Refurbishment consists of painting, repair of examination couch, 1 table, 1 chair and 1 wash hand basin.

3.12.11		Procure and distribute the STI drugs (projected no of cases in '000)	11.3	11	11.3	11	12	12.1	12	12	N	NAS	GoSL, GF, UN Family	Year 1 Genital Discharge 31,516, Genital Ulcers 9,005, Inguinal Bulbo & Others 4,502; Year 2: Genital Discharge; 33,804; Genital Ulcers 9,658; Inguinal Bulbo & Others 4,829
		Output 3: All patients have access to quality family planning services												
3.13.1	**SRH and HIV prevention services integrated.**	Advocate for the integration of SRH into HIV prevention and HIV into SRH	0	4	4	4	0	0	0	0	N	MOHS, NAS, CSOs	UN Family	Advocacy meeting for 15 people. Refreshment and transport
3.13.2		Advocate for the review of National Youth Policy to address SRH issues	0	4	4	4	0	0	0	0	N	MOYS, MEST, MOHS	UN Family	Advocacy meeting for 15 people. Refreshment and transport
3.13.3		Develop and disseminate guidelines and protocol on SRH and HIV integration	0	1	0	0	0	0	0	0	N,D	MOHS, DHMT, CSOs	UN Family	1 national Consultant for 21 days. 1 day meeting for TWG for 20 persons. 1 day validation meeting for 40 people. 1,000 copies of the document will be printed and distributed.
3.13.4	**240 health workers trained on family planning**	Train the health service providers on youth friendly service provision for family planning	30	30	30	30	30	30	30	30	N, D	MOHS, NACP, CSOs, Private sector	GF, UN System	2 day non residential training assumed.
3.13.5		Sensitize women on the availability of contraceptives for informed decision-making (2 sensitization event/district/quarter)	28	28	28	28	28	28	28	28	D	MOHS, CSOs	UN Family, DFID	2 sensitization events per district/quarter

		Outcome 2: Biomedical transmission of HIV is reduced.												
		Output 1: Universal medical safety precautions is enhanced												
3.14.1	**1,750 people are trained on universal safety precautions and infection control**	Develop Universal Precautions handbook (including infection control and injection safety)	0	1	0	0	0	0	0	0	N	MOHS, NACP	GoSl, GF, UN family	1 international consultant, 1 national consultant for 21 days. 2 day residential meeting of the TWG members. 1 day validation meeting for 50 people
3.14.2		Print and distribute copies of the Universal Safety Precautions Manual and national medical waste management policy and guidelines	0	2000	2000	0	0	0	0	0	N, R, D	MOHS, NACP	GoSL, GF, UN family	2000 copies of each manual will be printed.
3.14.3		Train Health care personnel (doctors, nurses, laboratory scientists) on Universal safety Precautions	0	0	0	150	150	150	150	150	N,D	MOHS, NACP, Medical and Paramedical Professional Associations	GoSl, GF, UN family, DFID, Private sector	3 day training
3.14.4		Train other categories of health workers (auxiliary staff such as cleaning/laundry staff in health facilities) on universal precautions & infection control	0	0	0	200	200	200	200	200	D	MOHS, NACP,Medical and Paramedical Professional Associations	GoSl, GF, UN family, DFID, Private sector	1 day training
3.14.5	**Additional 280 sharp disposal bins are provided to health facilities.**	Provide medical waste (sharp) disposal bins for all health-care facilities.	70	70	70	70	70	70	70	70	D	MOHS, NACP	GoSL, GF, DFID, EU	1 sharp disposal bin per facility
3.14.6		Train incinerator operators	0	0	0	0	70	70	70	70	D	MOHS, NACP,Medical and Paramedical Professional Associations	GoSL, GF, DFID, EU	1 day training
3.14.7		Develop and produce BCC materials on injection safety and health care waste management	0	0	1	0	0	1	0	0	N	MOHS, NAS, NACP, CSOs	GoSL, GF	1 lot refers to 1000 posters, 6000 brochures

		Output 2: All HIV exposed health workers and other cases in need are provided with PEP services												
3.15.1	**Additional 200 health facilities are provided with PEP kits.**	Distribute PEP kits to all health facilities	25	25	25	25	25	25	25	25	D	NACP, MOHS	GoSL, GF	1 PEP kits contains ARV (5 day dose), Test kits-1, Emergency contraceptive pills-1 pack, Antibiotic-single dose(Azithromycin-500mg)
3.15.2		Conduct one day sensitization in all health facilities on availability of PEP	0	139	139	139	139	0	0	0	D	DHMT, NACP	GoSL, GF	
3.15.3		Establish PEP Committee in all health facilities	0	139	139	139	139	0	0	0	D	MOHS	GoSL, GF	No cost needed
3.15.4		Produce and distribute BCC materials on PEP	0	0	1	0	0	1	0	0	N	NAS, NACP, CSOs	GoSL, GF	1 lot refers to 1000 posters, 6000 brochures
		Output 3: All blood donated for transfusion is screened for HIV, Hepatitis and other TTIs												
3.16.1	**National policy on blood transfusion reviewed and disseminated.**	Review the national Blood transfusion policy	0	0	1	0	0	0	0	0	N	MOHS	GoSL, GF	1 national Consultant for 21 days. 1 day meeting for TWG for 20 persons. 1 day validation meeting for 40 people.
3.16.2		Print and disseminate the policy documents	0	0	0	###	0	0	0	0	D	MOHS	GoSL, GF	
3.16.3		Conduct awareness campaigns/rallies on blood donation	30	30	30	30	30	30	30	30	C	MOHS, CSOs	GoSL, GF	Refreshments and transport for 40 people only
3.16.4	**240 health workers trained on blood safety**	Refresher Training of 240 Health personnel on the rational use of blood	30	30	30	30	30	30	30	30	D	MOHS, CSOs	GoSL, GF, UN Family	2 day training
3.16.5	**At least 10,000people are enlisted as blood donors**	Training of 600 blood donor promoters nationwide	75	75	75	75	75	75	75	75	D	MOHS, CSOs	GoSL, GF, UN Family	2 day training
3.16.6		Scale up airing of jingles on voluntary blood donation nationwide (including Freetown)	2	2	2	2	2	2	2	2	N,D			increase stations covered from 16 to 32 (2 airings per station per day)

3.16.7		Celebrate **national and i**nternational Blood donation day	0	1	1	0	0	1	1	0	N,D,R	MOHS	GoSL, GF, UN Family	500 T-Shirts, Caps 500 , 500 biros, 500 Shields, 500 Badges, 1,000 posters, 10,000 brochures, 20 banners, musical instruments, caravan for rally, generator, US$200 for each district.
3.16.8		Advocate to professional associations of doctors, Nurses, laboratory scientists, etc for compliance with the policies.	2	2	2	2	2	2	2	2	N,D	MOHS, NACP,Medical and Paramedical Professional Associations	GoSL, GF, UN Family	No cost assumed should be mainstreamed into their general meetings
3.16.9	**All blood units donated are properly screened.**	Procure and distribute reagents and other essential commodities for blood transfusion services-screening (in '000 of blood units).	4	4	4	4	4	4	4	4	N, R	MOHS, NAS, Private health facilities	GoSL, GF, UN Family	4,000 test kits for hepatitis B, 4,000 test kits for hepatitis C, 4,000 (Bioline) test kits for Syphilis, 4,000 test kits for syphilis confirmatory test and other reagents will be procured per quarter
3.16.10		Provide appropriate equipment and reagent for blood storage and cross matching (in '000)	7	7	7	7	7	7	7	7	N,R	MOHS, NACP,Private health facilities	GoSL, GF, UN Family	7,000 units of blood transfused per quarter; 7,000 bags (2,000 pediatrics, 5,000 adults) will be required every quarter; a total of 28,000 pairs will be required in a year
3.16.11		Recruit and retain volunteer blood donor clubs (1 per district)	14	14	14	14	14	14	14	14	D	MOHS, NAS, DHMT, CSOs	GoSL, GF	Incentives for blood donor clubs per club per quarter (badges-1,500, certificates-1500, t-shirts-500, shields-100, US$100 as running costs) for active donor promoters after the 50th donation

3.16.12		Produce and distribute BCC materials on blood donation	1	1	1	1	1	1	1	1		MOHS, NACP,Medical and Paramedical Professional Associations	GoSL, GF	1 lot refers to 4,500 brochures, 1,000 posters, 200 caps and 1,000 wrist bands
		Outcome 3: Reduction in Vertical Mother-to-Child Transmission of HIV												
		Intermediary Outcome 1: Reduction in transmission of HIV during pregnancy, child birth and breastfeeding												
		Output 1: Increased availability and accessibility of high quality PMTCT services												
3.17.1	**PMTCT and peadriatic HIV Programmes are better coordinated.**	Conduct technical Review of the PMTCT and peadriatic HIV Programme	1	0	0	0	0	0	0	0	N	NACP, MOHS	GF, UN System	Technical Assistance- 1 International and 1 National consultant for 15 days, 1 day validation meeting with TWG of 20 people.
3.17.2		Conduct quarterly meeting of PMTCT and Paedriatic HIV Care TWG	1	1	1	1	1	1	1	1	N	NACP, MOHS	GF, UN System	1 day meeting for 20 members
3.17.3	**PMTCT and Paedriatic HIV Care guidelines and protocol revised and disseminated**	Review the current PMTCT and Paedriatic HIV Care guidelines and protocol (align with nutrition and RCH guidelines)	0	1	0	0	0	0	0	0	N	NACP, MOHS	GF, UN System	1 International Consultant for 30 days, 2 National Consultant for 30 days, TWG meeting for 20 participant for 2 days, 1 day validation meeting for 30 people.
3.17.4		Produce and distribute PMTCT guidelines	0	###	0	0	0	0	0	0	N,R, D	NACP, MOHS	GF, UN System	
3.17.5		Review, print and distribute the PMTCT training manual	0	0	1	0	0	0	0	0		NACP, MOHS	GF, UN System	1 International Consultant for 15 days, 1 National Consultant for 15 days, TWG meeting (non-residential) for 20 participants for 2 days. 500 copies will be printed and distributed.
3.17.6	**2,000 HIV positive women take ARV**	Provide HIV positive pregnant women with ARV prophylaxis	0	0	0	0	0	0	0	0		DHMT, MOHS	GF, UN System	No cost is assumed here. Part of the Global ARV needs

3.17.7	**2,000 health workers trained and re-trained on PMTCT**	Train and re-train 2,000 PMTCT service providers	250	250	250	250	250	250	250	250	D	NACP, MOHS	GF, UN System	3 day training assumed
3.17.8	**Additional 200 health facilities provided PMTCT services.**	Refurbish/rehabilitate existing and new PMTCT Centres	50	50	50	50	55	55	55	55	D	NACP, MOHS	GF, UN System	This will include the provision of basic equipments, furniture and painting
3.17.9	**98,000 pregnant women are counseled and tested**	Conduct sensitization activities in communities (with PMTCT sites)	40	40	40	40	60	60	60	60	D	DHMT, NACP, MOHS	GF, UN System, USDOD	
3.17.10		Conduct social mobilization activities targeting leaders for utilization of ANC/PMTCT services in all the 149 chiefdoms.	900	900	900	900	900	900	900	900	D	DHMT, NACP		900 leaders will be sensitized per quarter. 1 day training assumed.
3.17.11		Provide logistical support for PMTCT monitoring and supervision.	1	0	0	0	0	0	0	1	N	NACP	GF, UN System	1 lot refers to 1 vehicle and 7 motorcycles
3.17.12		Sensitization for TBAs on PMTCT services and awareness.	225	225	225	225	225	225	225	225	N, D	DHMT, CSOs, NACP	GF, UN System	I day training assumed
3.17.13		Conduct periodic assessment of compliance and quality control	0	1	0	1	0	1	0	1	N,R	NACP, MOHS,	GF, UN System	4 teams of 3 (1 for each region) will do the assessment for 4 days each. DSA for 4 persons (3 assessors, 1 driver) for 3 nights, fuel
		Output 2: All HIV positive pregnant women complete the full PMTCT program												
3.18.1	**600 HIV positive women are provided nutritional Support.**	Provide nutritional Support to HIV positive women	600	600	600	600	600	600	600	600	N, D	NACP, MSWGCA, NAS	GF	These are discreet numbers not cumulative
3.18.2		Provide incentives for mothers who complete the full PMTCT programme	300	300	300	300	300	300	300	300	N, D	NACP	GF	A baby pack is given to each mother on completion of PMTCT

		Output 3: All HIV exposed infants have access to Early Infant Diagnosis (EID) Services												
3.19.1	**600 infants are provided with EID services**	Develop guidelines and training manual for establishing specimen transportation system for early infant diagnosis.	0	0	1	0	0	0	0	0	N, D	NACP, MOHS	GF, UN System, CDC	TA - 1 International and 1 national consultant for 30 days
3.19.2		Conduct Training of Trainers for 20 master Trainers	0	0	20	0	0	0	0	0	N	NACP, MOHS	GF, UN System, CDC	Training (residential) is for 8 days. Done at Central Location
3.19.3		Establish specimen transportation system for early infant diagnosis in 3 pilot sites and scale-up.	0	0	0	3	0	0	3	0	R	NACP, MOHS	GF, UN System, CDC	1 motorcycle, coolers, dried blood spot papers and mobile phone will be purchased for each site.
3.19.4		Conduct step down training for 100 persons	0	0	0	50	0	0	50	0	N	NACP,DHMT	GF, UN System, CDC	5 day training assumed
		Intermediary Outcome 2: HIV positive women are empowered to take informed reproductive health decisions												
		Outcome 1: HIV Positive women have access to quality family planning services												
3.20.1		Advocate for the availability of right mix for contraceptives in the interest of HIV positive women	2	2	2	2	2	2	2	2	N,D	MOHS	GF, UN Family, CDC	Advocacy meeting for 15 people. Refreshment and transport

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THEME 4: TREATMENT OF HIV AND OTHER RELATED HEALTH CONDITIONS

IMPACT: Morbidity and mortality among PLHIVs are reduced

Activity Code	RESULTS	OUTCOMES/OUTPUTS AND ACTIVITIES	IMPLEMENTATION PERIOD								LEVEL OF IMPLEMENTATION N=National R= Regional D=District C=Chiefdom	RESPONSIBLE SECTOR/ ORGANIZATION	FUNDING SOURCE	ASSUMPTIONS/ COMMENTS
			2011				2012							
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
		Sub-theme 1: Anti-Retroviral Treatment												
		Outcome 1: Adult PLHIVs and Children PLHIVs eligible for ART receive it.												
		Output 1: Eligible PLHIV initiating treatment increased by 30%												
4.1.1	**390 health care workers trained on ART**	Develop/review guidelines , policies and standards for establishing treatment sites	0	0	0	1	0	0	0	0	N	MOHS	GF, UN System	1 local consultant for 7 days, 2 day stakeholders meeting for 50 people, 1 day validation, printing of 500 copies
4.1.2		Train 180 Medical, Clinical staff, Nurses, PLHIV and Community Health workers on the WHO IMAI Package	0	0	0	60	0	57	57	56	R	MOHS, NACP	UN System	3 day training
4.1.3		Develop training manuals on Treatment literacy and treatment preparedness	0	0	1	0	0	0	0	0	N	NACP, MOHS	UN System	I International and 2 national consultants for 15 days. One day validation meeting for 15 people
4.1.4		Train 150 persons (health care personnel and PLHIV) on Treatment literacy and Treatment preparedness	0	25	25	25	0	25	25	25	R	NACP, MOHS	GF, UN System	3day -training
4.1.5		Training of 120 health workers (1 PHU x 3 workers x 40 PHUs per year) on ART.	30	30	30	30	30	30	30	30	D	MOHS		Training of 120 health workers (1 PHU x 3 workers x 40 PHUs per year) for 3 days.

4.1.6		Development and distribute BCC materials on Treatment (including Treatment literacy)	1	0	0	0	0	0	0	0	N	NACP,MOHS, CSOs	GF, UN System	1 lot refers to 2500 brochures@$3,2000 T-shirts@$11per T-shirt,2000 caps @$5,4000 poster @$1.21
4.1.7	**12, 300 eligible adults receive treatment**	Procure and distribute ARV drugs	0	0	1	0	0	0	0	0	N,D	NAS	GF	12,300 expected to be on ARV on both first and second line drugs. Add distribution costs to all the sites
4.1.8		Provide comprehensive ART services to those eligible adults.	1	1	1	1	1	1	1	1	N,D	MOHS, PHUs, Private Health facilities, faith-based hospitals, NACP		Provide ART to 12,300 eligible adults PLHIV. Both first and second line regimens. This includes providing HCT, ARV, OI and follow-up.
4.1.9		Home based follow up for ART	1	1	1	1	1	1	1	1	N,D	CSOs, DHMT, Private health facilities	GF	Follow-up to be done monthly. Cost for only the incentives given to social workers. 2 per district
4.1.10		Conduct quarterly monitoring and supervision of ART sites	1	1	1	1	1	1	1	1	N,D	NACP	GF	3 staff (including driver) per region/quarter for 4 regions. DSA for 6 days per region/quarter/team, Cost for fuel, lubricants, per diems, stationery. 7 days/region/quarter for M&E
		Output 2: HIV exposed children follow-up improved according to national guidelines												
4.2.1		Establish centers of excellence on PMTCT for scaling up ART services	0	0	20	20	20	20	0	0	D	NAC, MOHS	GF, UN System	Supply 1 Blood Pressure machine, 1 thermometer and 1 standing scale, cupboard and stationery to 40 sites per year
4.2.2	**600 health care personnel trained on paedriatic HIV management.**	Train 600 service providers on pediatric HIV management; and Institute mechanisms for follow up of HIV exposed and infected children.	75	75	75	75	75	75	75	75	N,D	NACP	GF	3 day training.

4.2.2	**1,600 children receive ART.**	Procure and distribute ARV drugs	1	1	1	1	1	1	1	1		NAS	GF	Procure and distribute first and second line ARV for 1,600 children
4.2.3		Provide comprehensive ART services to eligible children.	1	1	1	1	1	1	1	1	N,D	MOHS, PHUs, Private Health facilities, faith-based hospitals, NACP	GF	Provide ART to 1,600 eligible children on both first and second line regimens. This includes providing HCT, ARV, OI and follow-up
4.2.4		Support monitoring and evaluation systems for PMTCT and Pediatrics HIV care in the context of child survival	1	1	1	1	1	1	1	1	N,D	NACP,MOHS	GF, UNICEF	Fuel for supervision printing of supervisory tools and DSA for 4 supervisors and a driver for 5 days/quarter
		Output 3: Facilities offering ART is increased.												
4.3.1	**Additional sites offering ART services increased by 64.**	Upgrade proposed ART sites based on national guidelines, standards and protocols	8	8	8	8	8	8	8	8	N	MOHS	GF, UNICEF	8 sites per quarter. Supply 1 Blood Pressure machine and 1 standing scale, cupboard and stationery to each of the 32 sites per year
4.3.2		Procure 4 PCR for the all regions	1	0	0	1	0	1	1	0	N	NACP	GF, UNICEF, CDC	2 each will be procured in years 1 and 2,
4.3.3		Procure 4 CD4 machines and accessories	0	0	0	0	0	0	2	2	N	NACP	GF, UNICEF	All four will be procured in year 2. Add installation fee.
4.3.4		Conduct quarterly CD4 monitoring using near patient testing equipment and accessories	1	1	1	1	1	1	1	1	D	NACP	GF, UNICEF	The quarterly monitoring will allow a continuous CD4 testing. DSA for 2 people for a week.
		Output 4: Quality Standards for ART are maintained												
4.4.1	**2,444 health worker are trained and re-trained to provide quality ART services**	Print and distribute 1200 ART national guidelines to both public and private facilities in all districts (in '000)	1.2	0	0	0	0	0	0	0	N	NACP	GF	Cost of printing a copy is $4.85

4.4.2		Coordinate and manage ART partnership working groups at all levels	14	14	14	14	14	14	14	14	N,D	NACP, DHMT	GF	Partnership meetings held on a quarterly basis with refreshment provided for 20 people (per district)
4.4.3		Develop a protocol on Clinical mentoring	0	1	0	0	0	0		0	N	MOHS, NACP		1 international Consultant and 1 national consultant for 15 days. 1 day validation meeting with 20 people
4.4.4		Train 100 health personnel on clinical mentoring including electronic self learning resources	0	0	50	0	50	0	0	0	N	NACP	GF	3 day training
4.4.5		Train & retrain 672 health workers to deliver comprehensive HIV care	168	168	168	168	168	168	168	168	R	NACP,DHMT	GF	3 day training
4.4.6		Conduct on-site training on ART for 250 health workers annually	0	50	100	100	0	50	100	100	R,D			3 day training
4.4.7		Conduct pre-service training on ART for 500 health workers annually.	125	125	125	125	125	125	125	125	R,D	NACP,DHMT	GF	3 day training
4.4.7	**Monitoring of ART services is enhanced**	Training on monitoring and supervision of ART sites (1 focal person/district)	0	0	0	14	0	0	0	0	N	NACP	GF	Training for 3 days
4.4.8		Print and distribute 7,200 copies of supervision tools to ART sites (in'000)	7.2	0	0	0	0	0	0	0	N	NACP	GF	Add distribution costs
4.4.9		Conduct sensitization programmes to focus on confidentiality and reducing stigmatization attached to HIV/AIDS in the health care settings.	210	210	210	210	0	0	0	0	C	DHMT	GF	60 service providers from each district will be trained. 1 day training

4.4.10		Promote formation of PLHIV peer support groups and family members as 'treatment buddies' to support ART treatment and adherence.	0	8	8	8	10	10	10	10	D, C	DHMT, NETHIPS	GF	8 treatment buddies will be formed every quarter in year 1 while 10 will be formed every quarter in the second year. Refreshment and transport for 50 persons per treatment buddy.
4.4.11		Conduct market surveillance and quality control of ARVs and medicine used in supportive care and treatment of Ois and STIs	2	2	2	2	2	2	2	2	N,D	Pharmacy board, MOHS, NACP	GF	This will be done twice every year. 2 teams of three (plus driver) and DSA for 5 nights. Stationery for report-writing.
4.4.12		Recruit 2 data managers to strengthen electronic data base system for monitoring of patients at ART sites	0	0	0	0	2	2	2	2	N	NACP		Provide monthly incentive to two data managers @$250/month/data manager for one year.
		Sub-Theme 2: Treatment of Opportunistic Infections												
		Outcome 2: PLHIVs receive OI prophylaxis, treatment and other co-infection treatment by 2015.												
		Output 1: PLHIVs receive OI and other co-infections prophylaxis and treatment according to needs												
4.5.1	**780 health care personnel trained to manage OIs and other co-infections such as hepatitis.**	Revise guidelines and manual on OIs	0	0	1	0	0	0	0	0	N	NACP		1 week residential retreat of 15 people covering accomodation,2 tea breaks and lunch per p)day,DSA,stationery,printin g of 500 copies of the manual.
4.5.2		Train Health workers on newly revised manual and tools	0	0	0	120	75	75	75	75	R	NACP	GF	Training is 2 days @$ 50.0 per person
4.5.3		Retrain health workers on OI prophylaxis & treatment	0	0	60	60	60	60	60	60	D	NACP,DHMT	GF	Training is for 2 days

4.5.4	**22,458 PLHIV and HIV infected children receive treatment for OIs**	Procure and distribute adult and pediatric essential drugs for Treatment of OIs	1	0	0	0	0	0	0	1	N	NAS	GF	19,631 and 22,458 patients will require OIs in 2010 and 2011 respectively. (30% of the total patients will require treatment for fungal infections, 40% of the total patients will require treatment for Parasitic infections, 20% of the total will require treatment for develop bacterial infections, 10% of the total patients will require treatment for viral infections, All patients (100%) of the total coverage require the supplements)
4.5.5		Rehabilitation of 13 District medical stores	0	13	0	0	0	0	0	0	N	NAS, MOHS	GF, UN Family	Purchase of Solar Refrigerator @ $30,000(UNICEF Estimation) including transportation and Installation for 13 medical stores.
		Sub-Theme 3: Management of TB and HIV and other Co-infections												
		Output 2: PLHIVs co infected with TB receive appropriate treatment for TB												
4.6.1	**TB and HIV collaboration are better coordinated for service delivery.**	Develop a joint comprehensive policy on TB/HIV collaborative activities	0	0	0	1	0	0	0	0	N	MOHS (TB Programme), NACP, CSOs	GF	1 National Consultant for 21 days. 2 day meeting of the TWG for 15 members. One day validation meeting for 50.
4.6.2		Convene periodic meetings of the national TB/HIV technical working Group	1	1	1	1	1	1	1	1	N	NACP and TBCP	GF	There will be a quarterly meeting of 15 TB/HIV Technical Working Group Members. Refreshments only
4.6.3		Develop national guidelines for TB screening and INH prophylaxis	1	0	0	0	0	0	0	0	N	NLTBP, NACP	GF	1 International Consultant and 1 national consultant for 20 days. 1 day validation meeting with 20 people
4.6.4		Printing and distribution of developed national guidelines for TB screening and INH prophylaxis	0	500	0	0	0	0	0	0	N	NLTBP, NACP	GF	This activity plan to print 500 copies of TB national guidelines.

4.6.5	**830 workers trained on management of HIV/TB co-infection**	Train 800 Health workers on TB/HIV co-infections and IPT(Izoniazide preventive therapy)	100	100	100	100	100	100	100	100	N,R	NACP, NLTBCP	GF	1 day training workshops for 100 HCW will be organized quarterly @$25.0 per person
4.6.6	**5,600 PLHIV screened for TB.**	Intensify TB case prevention and detection in PLHIV	0	43	0	0	0	43	0	0	N	NACP, NLTBCP	GF	Refresher training of 27 CHC,12 Hospitals & 4 private clinics per year. 2 day training.
4.6.7		Conduct awareness and sensitization meeting on TB/HIV Co-infection.	0	0	14	14	14	14	14	14	C	NACP,NLTBCP		1 sensitization per community per district every quarter
4.6.8		Expand HCT into all DOT centers	15	15	15	15	15	15	15	15	D	NACP,NLTBCP	GF	Test kits will be provided. 120 ledgers and reporting forms
4.6.9		Develop and disseminate guidelines and standards on cotrimoxazole preventive therapy	0	0	1	0	0	0	0	0	N	NACP	GF	1 national consultant for 2 weeks, stakeholders meeting for 2 days (15 people), 1 day validation (30 people), printing of 1000 copies of the guidelines
4.6.10		Procure and distribute adult and pediatric essential drugs for Treatment of TB/HIV co-infection	0	0	0	0	0	0	0	0	N	NAS	GF	This is already included in the global drugs requirement.
4.6.11		Print National guidelines and action plan on Pharmacovigilance	0	0	1	0	0	0	0	0	N	Pharmacy Board,NACP		500 copies guidelines and 2000 reporting forms will be printed.
4.6.12		Training on pharmacovigilance at ART/PMTCT/PAED. CARE sites	0	0	30	30	30	30	30	30	N	Pharmacy Board,NACP		Trainings is for 2 days
4.6.13		Print and Distribute pharmacovigilance monitoring tools to ART/PMTCT/PAED sites (In '000)	0	0	1	0	0	0	0	0	All levels	Pharmacy Board,NACP	CDC	Print and distribute1000 reporting forms.@$ 0.5 per form

		Sub-Theme 4: Clinical and Laboratory Services												
		Output 1: To strengthen clinical and laboratory services to effectively manage HIVand other associated diseases such OIs and TB												
4.7.1	**Laboratory services are better coordinated for effective service delivery.**	Disseminate the laboratory policy and protocols	0	0	1	0	0	0	0	0	N	MOHS	GoSL, CDC	1 day dissemination meeting for 50 people. Print 500 copies of the policy
4.7.2		Convene periodic meetings of the national Laboratory Technical working Group	1	1	1	1	1	1	1	1	N	MOHS	GoSL, CDC	Quarterly meetings of 20 members of the National Laboratory TWG
4.7.3		Conduct advocacy to Integrate laboratory activities into HIV care and treatment and other clinical services (particularly in integrated sites and private health facilities)	3	3	3	3	3	3	3	3	N,D	MOHS, NACP, Medical and Para-medical Professional Associations		3 advocacy meeting per quarter. Advocacy team consists of 4 members.
4.7.4	**192 laboratory technicians trained on HIV related laboratory services**	Train and retrain Laboratory technicians on the use of the Viral load/PCR machine, CD4 fax count machines, clinical chemistry and haematology analyzers and basic laboratory testing for STIs .	0	30	30	30	30	0	0	0	N	NACP,	GF, CDC	This activity plans to strengthen the laboratory monitoring of ART to ensure quality and safety. (50% of 120 lab Technicians will be trained for 5 days)
4.7.5		Train 10 lab technicians on the use of the viral load/PCR machine and 28 in the use of CD4 cell count machines, clinical chemistry and haematology analyzers.	0	19	19	0	0	19	19	0	N	NACP	GF, ,CDC	10 lab technicians to be trained on the use of the viral load/PCR machine and 28 trained in the use of CD4 cell count machines, clinical chemistry and haematology analyzers.
4.7.6	**85 laboratories provide services according to national guidelines.**	Establish standardized and reliable QC and QA laboratory tests system in 85 health	0	20	30	35	0	0	0	0	N,D	MOHS,NAS	GF	Cost of establishing the QA system in the laboratories.

		facility/ laboratories												
4.7.7		Evaluate new tests for use in the country	0	0	1	0	0	0	0	0	N	NACP, CDC	GF	This activity plans to evaluate and update HIV test algorithms on surveillance, diagnosis and blood screening.(1 international consultant and 1 national consultant for 10 days
4.7.8		Provide support for about 5,000 PLHIVs for laboratory investigations (e.g. monitoring HIV on ART, excluding CD4 count) (in '000)	1.25	1.25	1.25	1.25	1.25	1.25	1.25	1.25	N, D	NACP	GF	Subsidy for patients who are unable to pay(HB,PCV,WBC, Malaria, Blood sugar & X-ray) 144 + Round 4PLWHAs(2016)
4.7.9		Provide laboratory supplies required for laboratory monitoring of ART	0	1	0	0	0	1	0	0	N	NAS	GF	Procurement of laboratory reagents and supplies for a standard package of medical equipments including Viral Load machine/ PCR machines, CD4 machines, clinical chemistry and haematology and analyzer.
4.7.10		Develop protocol on drug resistance monitoring and train 10 staff.	0	0	0	0	0	0	1	0	N	Pharmacy Board,NACP	GF	TA - 1 international and national consultant for 30 days to develop a protocol, train 10 staff for 2 days on monitoring methodology.
4.7.11		Conduct Drug Resistance monitoring	0	0	0	0	0	0	1	0	N	Pharmacy Board, NACP	GF	DSA for 3 staff (including the driver) for 5 days per region for 4 regions.

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THEME 5: CARE AND SUPPORT FOR THE INFECTED AND AFFECTED BY HIV/AIDS

IMPACT: People living with HIV and/or affected by HIV/AIDS have same opportunities as the general population

Activity Code	RESULTS	OUTCOMES/OUTPUTS AND ACTIVITIES	IMPLEMENTATION PERIOD								LEVEL OF IMPLEMENTATION N=National R=Regional D=District C=Chiefdom	RESPONSIBLE ORGANIZATION / SECTOR	FUNDING SOURCE(S)	ASSUMPTIONS/ COMMENTS
			2011				2012							
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
		Sub-Theme 1: Economic Empowerment of PLHIV and PABA												
		Outcome 1. People living with HIV and/or affected by HIV/AIDS have improved economic opportunities and social protection.												
		Output 1: Infected and/or affected persons access to skills and education increased.												
		PLHIV												
5.1.1	**Baseline information on socio-economic needs/profile available for PLHIV and PABA**	Assess the socio-economic needs/profiling of PLHIV and PABA for alternative livelihood support(by sex disaggregated data)	0	0	0	1	0	0	0	0	N,D	NETHIPS,NACP		1 International Consultant and 2 National Consultants for 25 days, 8 enumerators and 4 drivers for 10 days, 1 day Validation meeting for 25 people.
5.1.2	**1,166 PLHIV and 2,280 OVC and elderly care givers acquire relevant skills for business start-up.**	Provide skills training for PLHIV on income-generating activities	113	113	178	178	113	113	178	178	R, D	NETHIPS,NACP	GF, UN Family	Skill training costs and average of US100/trainee.
		OVC												
5.1.3		Provide skills and educational training for older OVCs (particularly girls) and elderly caregivers.	285	285	285	285	285	285	285	285	R, D	CSOs, Training Institutions		Skill training costs and average of US75/trainee.

		Output 2: Infected and affected persons access to employment opportunities increased												
5.2.1	**At least 861 PLHIV, OVC and elderly care givers are gainfully employed.**	Provide quality and comprehensive livelihood start-up kit for PLHIV and PABA	113	113	178	178	113	113	178	178	D	NETHIPS, NAS , CSOs, Private sector	GF	Start-up kits is assumed to cost an average of US$300
5.2.2		Provide livelihood start-up grants/kit for elderly care givers and OVC.	285	285	285	285	285	285	285	285	D	NETHIPS, NAS , CSOs, Private sector	GF	Start-up kits is assumed to cost an average of US$300
5.2.3		Conduct advocacy to organizations for engagement of qualified PLHIV for employment	2	2	2	2	2	2	2	2	N	NETHIPS, CSOs, Private sector	GoSL	4 people to make the visits. Cost for fuel only.
		Output 3: Households of persons infected and/or affected have access to credit and other economic opportunities												
5.3.1	**At least 200 PLHIV are linked to other sources of economic opportunities and take advantage of them.**	Build capacity of CBOs, CSOs and other organizations to design impact mitigation measures.	0	1	0	0	0	0	0	0	N	NAS, INGOs, NGOs	UN, INGOs, NGOs	2 day training for 30 persons
5.3.2		Develop appropriate linkages with Poverty Alleviation agencies and micro-finance institutions-finance to PLHIV	3	3	3	3	3	3	3	3	N	NETHIPS, NAS , CSOs, Private sector	UN Family.	Advocacy team of four to do the visit to relevant agencies and organizations
		Sub-Theme: Orphans and Vulnerable Children (OVC)												
		Outcome 2: Social and economic protection of orphans and vulnerable children is ensured.												
		Output 1: Number of OVC accessing minimum package of services is increased.												
5.4.1	**Data base of HIV/AIDS related OVC and OVC service organizations established.**	Conduct national mapping of HIV and AIDS related OVC	0	1	0	0	0	0	0	0	N	NAS,MSWGCA, NETHIPS, CSOs	UN Family.	4 national consultants (1 per region) for 15 days. Include field visits for 6 days by each consultant.
5.4.2		Conduct mapping of NGOs, PSOs, CBOs providing OVC services.	0	1	0	0	0	0	0	0	N	MSWGCA, NAS, NETHIPS, CSOs	UN Family	1 national consultant for 14 days, Field work for 6 days by 6 people (including 2 drivers), Printing of 200 copies of the report

5.4.3	**OVC issues are more effectively disseminated, coordinated and implemented.**	Develop and disseminate National Policy and guidelines on OVCs	0	0	1	0	0	0	0	0	N	MSWGCA, NAS, NETHIPS, CSOs	UN Family.	1 National Consultant for 30 days, 2 day meeting for 20 TWG members. Field visits for 6 people (including driver) for 6 days, 1 day validation meeting for 50 people. Print 300 copies of the policy.
5.4.4		Develop strategic and advocacy plan for HIV affected children and their households	0	1	0	0	0	0	0	0	N	MSWGCA, NAS, NETHIPS, CSOs	UN Family.	1 International Consultant and 2 National Consultants for 21 days, Field visit for six people (including driver) for 7 days,TWG meeting (residential) for two for 15 persons, 1 day Validation meeting for 40 people.
5.4.5		Review and update the OVCs caregiver manual	0	0	0	1	0	0	0	0	N	MSWGCA, NAS, NETHIPS, CSOs	GoSL	1 national consultant for 14 days, 1 validation meeting for 25, Printing of 300 copies of the manual
5.4.6		Reactivate the OVCs Technical Working Group	0	1	1	1	1	1	1	1	N	NAS,	GoSL	1 day meeting for 20m people. Refreshments only.
5.4.7		Organize biennial conference on Children and AIDS	0	0	0	0	0	0	1	0	N	NAS, MSWGCA CSOs,	GoSL, UN Family	
5.4.8		Produce and distribute biannual children and AIDS newsletter (i.e. 2 times/year)	0	1	0	1	0	1	0	1	N	NAS, CSOs,	GoSL	1,000 will be printed and distributed
5.4.9		Provide logistical support for coordination of OVC and other children's HIV related issues	0	1	0	0	0	0	0	0	N	NAS,	GF, UN Family	1 executive table and chair, 1 Secretary's table and chair, filing cabinet, 2 Desktop computer and accessories, 1 printer, 1 photocopier and scanner, 1 vehicle
5.4.10	**At least 4,000 OVC access the minimum package of services.**	Train 1,400 social workers and care givers in OVC support (100/district)	300	300	300	300	200	0	0	0	D	CSOs,DHMT	GF	1 day training

5.4.11		Provide one-off educational support in school OVCs **(in '000)**	0	0.87	0	0	0	2.9	0	0	N,D	CSOs, MEST	GF	A one-off support of US$200 per child per year will be provided
5.4.12		Provide nutritional support for OVC **(in '000)**	0.5	1	1.5	2	3.2	4.5	5.7	6.9		NAS, CSOs,	GF	Nutritional support of US$120/OVC
5.4.13		Provide other forms of support (medical, psycho-social, shelter) to OVC **(in '000)**	0	0.87	0	0	0	2.9	0	0	All levels	NGOs		Other forms of support at US$180/OVC
		Outcome 3: Stigma and discrimination towards PLHIVs and OVC is reduced.												
		Output 1: PLHIV and OVC have access to legal aid services												
5.5.1	**Legal aids schemes identified and instituted for PLHIV and OVC's**	Support legal aid scheme for PLHIV and OVC	1	1	1	1	1	1	1	1	N	NETHIPS, CSOs		Legal retainership @ US$750 per quarter month
5.5.2		Conduct advocacy to organizations offering free legal services	1	1	1	1	1	1	1	1	N	NETHIPS, CSOs		1 advocacy (four person team)/quarter. Transport only.
		Output 2: Increased acceptance of persons infected/affected in the community												
5.6.1	**Stigma and discrimination study conducted and disseminated.**	Conduct stigma and discrimination study in Sierra Leone	0	1	0	0	0	0	0	0	N,D	NAS	GF, UN Family	1 national consultant for 21 days. Field Visits by 2 teams of 3 each (including the driver) for 7 days. 1 day validation meeting for 25 people.
5.6.2	**840 health workers, 500 law enforcement agents and 112 communities sensitized on stigma and discrimination**	Conduct stigma and discrimination and reduction training for 840 health workers, PLHIV and community representatives	105	105	105	105	105	105	105	105	D	NETHIPS, CSOs, NACP	GF	3 day training
5.6.3		Conduct various sensitization sessions for community members/groups on stigma and stigmatization using appropriate messages and media (1 per district per quarter)	14	14	14	14	14	14	14	14	D	NETHIPS, CSOs, NACP	GF	Transport, refreshment(for 50 persons), stationery for facilitators use only.

5.6.4		Conduct workshops for 500 law makers, law enforcement officers & community leaders on child rights & protection	0	100	100	100	100	100	0	0	N,D	NETHIPS, CSOs, NACP	GF	1 day workshop
5.6.5		Sensitize communities on child rights and social protection (7 communities per district per quarter)	0	0	84	84	84	84	0	0	D	CSOs	GF	1 day sensitization
5.6.6		Develop and produce IEC materials	0	1	0	0	0	0	0	0	N	NAS,NETHIPS	GF	1 lot refers to 1,000 posters and 10,000 brochures
		Sub-theme 3: Care and Support for PLHIV												
		Outcome 4: PLHIVs receive care and support according to needs.												
		Output 1: PLHIV receive psychosocial support, including palliative care.												
5.7.1	**Care and support activities are better coordinated**	Conduct mapping of CBOs, INGOs, FBOs, Support Groups, NGOs providing care and support services	0	1	0	0	0	0	0	0	N	NAS,NETHIPS	UN Family.	1 national consultant for 14 days, Field work for 6 days by 6 people (including 2 drivers), Printing of 200 copies of the report
5.7.2		Develop comprehensive national care and support guidelines	0	0	0	1	0	0	0	0	N	NAS, NETHIPs	UN Family.	TA - 1 International and 1 national consultant for 30 days, TWG meeting for 2 days for 30 people, validation meeting for 1 day for 40 people, printing of 500 copies of the guidelines
5.7.3		Establish National Care and Support TWG and hold regular meetings	1	1	1	1	1	1	1	1	N	NAS	UN Family.	1 meeting/quarter for 20 persons.
5.7.4	**14,400 PLHIV and infected children receive care and support services**	Train service providers to provide care and support for HIV infected children and their households (minimum standards of care)	60	60	60	60	60	60	0	0	N	CSOs, N|ETHIPS	GF	Training is 3 days

5.7.5		Develop tools for monitoring community-based service providers for HIVinfected children and their households	0	1	0	0	0	0	0	0	N	MWSGCA, NAS, CSOs, MOHS	UN Family.	I national consultant for 15 days,
5.7.6		Provide income generation training and support for care givers of HIV infected and affected children	146	146	146	146	146	146	146	146	District,Regional	MWSGCA, NAS, CSOs	GF, UN Family	Training costs is US$75 and start-up kits is US$300/person. Total is US$375/person.
5.7.7	**514 persons trained on home-based care**	Train 420 PLHIV, Social Workers/Volunteers on Home Base Care services	60	60	60	60	60	60	60	0	D	CSOs, NETHIPS	GF	15 staff per district x 14 districts=210. 15 PLHIV per district x 14 = 210. Training is for 3 days
5.7.8.		Train 56 health staff on home based care service and supervision (4 staff per district)	0	0	0	0	28	28	0	0	N	CSOs, NETHIPS	GF	4 staff per district/14 @ $25 x 3 days
5.7.9		Train leaders of support groups in leadership and Management (3 per support group x 38)	57	0	57	0	0	0	0	0	N,R, D	CSOs, NETHIPS, NAS	GF	3 day training
5.7.10		Train of PLHIVS as Counsellors for support groups (1 per support group)	0	0	38	0	0	0	0	0	N	NETHIPS, CSOs, NACP	GF	Training of PLHIVS as Counsellors. 1 per each support group(of 38 groups) for 3 days
5.7.11		Training of PLWHAs on self-care and positive living	206	206	324	324	206	206	324	324	N,D	NETHIPS, CSOs, NACP		3 day training
5.7.12	**2,642 home-based care kits and procured and distributed.**	Provide logistical support to Home Base Care Volunteers (bicycles)	0	0	65	0	0	47	0	0	N	NAS	GF	Each bicycle costs $100. 8/district.
5.7.13		Provide home-based care Kits	264	264	388	388	272	272	397	397	N	CSOs, FBOs,PSOs		

		Output 2: PLHIV receive nutritional support according to needs												
5.8.1	**Baseline data on nutritional status of PLHIV obtained**	Conduct nutritional needs assessment and socio-economic profiling of PLHIV and their households	0	1	0	0	0	0	0	0	N	MOHS, NACP,NETHIPS	UN Family.	1 International Consultants, 2 national consultants for 30 days, Field work for 6 days by 9 people (including 3 drivers) Printing of 200 copies of the report
5.8.2		Review and produce abridged version of the national nutritional guidelines	0	0	0	1	0	0	0	0	N	MOHS,NACP,CSOs	UN Family.	1 national consultant for 7 days. 1 day validation meeting for 50 persons.
5.8.3		Print and distribute 5000 copies of the national nutrition guidelines ('000)	0	1	0	0	0	1	0	0	N	MOHS, NACP, CSOs, DACs	GF	
5.8.4	**At least 7,400 PLHIV receive nutritional support according to national guidelines**	Provide nutritional support for PLWHAs (in '000)	10.1	10.0	10.0	10.1	12.4	12.4	12.4	12.4	D	NETHIPS,NACP	GF	Unit cost ($1 per day for 30 days x 3 months in quarters). PLHIV will exit from the Nutritional support after 9 months.
5.8.5		Provide nutritional support to PLHIV under ART, PMTCT and their families ('000)	19.5	19.5	19.5	19.5	22.4	22.4	22.4	22.4	D	MOHS, NETHIPS,NACP	UN Family.	
5.8.6		Review and produce existing HIV and TB nutrition implementation tools	1	0	0	0	0	0	0	0	N	MOHS, NACP, NLTBP	UN Family.	3 day residential meeting for 20 people. 1,000 copies will be printed.
5.8.7		Sensitize and train partners on tools and programme implementation	0	1	0	0	0	0	0	0	N	MOHS, NACP/WFP	UN Family.	3 day training for 30 members
5.8.8		Distribute non- food items (ration cards, registers, weighing scales, computers & accessories etc) to support groups	0	38	0	0	0	0	0	0	D	WFP	UN Family.	Each of the 38 support groups will get ration cards, scales, computer and accessories and printer.
5.8.9		Conduct joint monthly monitoring and supervision to ensure proper food distribution	3	3	3	3	3	3	3	3	D	WFP/NACP/NETHIPS	UN Family.	3 teams of 3 (9 in all including 3 drivers) for 5 days

SIERRA LEONE NATIONAL HIV/AIDS OPERATIONAL PLAN (2011-2012)

THEME 6: RESEARCH, MONITORING AND EVALUATION

Outcome: M&E, research and knowledge management systems at the national and sub-national systems are strengthened

Activity Code	RESULTS	OUTCOMES/OUTPUTS AND ACTIVITIES	IMPLEMENTATION PERIOD								LEVEL OF IMPLEMENTATION N=National R= Regional D=District C=Chiefdom	RESPONSIBLE ORGANIZATION /SECTOR	FUNDING SOURCE(S)	ASSUMPTIONS/ COMMENTS
			2011				2012							
			Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4				
		Intermediary Outcome 1: Capacities for M&E increased												
		Output 1 : Number and capacities of M&E officers increased												
6.1.1	**Capacity-building plan for M&E developed**	Conduct M&E needs assessment at all levels (National, district and Facility levels) and develop Capacity Building Plan	0	1	0	0	0	0	0	0	N,D	NAS, NACP, CSOs, Health facilities		2 national consultants for 30 days. Field Visits for 6 persons (including 2 drivers) for 7 days. 1 day validation meeting for 20 people.
6.1.2		Develop M&E training manual and Field M&E Managers handbook	0	0	1	0	0	0	0	0	N	NAS, NACP	UN System	1 international consultant, 1 national consultant for 45 working days. 3 day validation meeting for 25 people.
6.1.3	**120 various categories of staff are trained on M&E locally and internationally.**	Conduct Training on M&E for relevant staff(SRs, Counsellors & Dist HIV Focal Points)	0	50	0	50	0	50	0	50	N, D	NAS, NACP, CSOs, Health facilities	Global Fund/UN	100 participants per year for 1 week residential training
6.1.4		Conduct Refresher Training for 20 NAS M&E Staff	0	0	0	0	0	0	0	20	N, D	NAS	GF	1 week residential training for 20 participants, 1 international consultant for 10 days
6.1.5		Conduct Programme & Financial Monitoring Training for NAS & NACP M&E Officers	0	15	0	0	0	0	0	0	N	NAS,	GF, UN Family	5 day residential programme for 15 M&E & Programme staff, 1 facilitator for 10 days

6.1.6		Organize International/Regional M&E training for M&E staff	0	0	2	2	2	1	0	0	N	NAS	GF	International/Regional M&E training for 7 M&E staff, 2 staff per qrt,
6.1.7		Develop data base for trainees and trainers	0	0	0	1	0	0	0	0	N	NAS, MOHS, CSOs	GoSL	1 national consultant for 7 days.
6.1.8		Conduct Program and Financial Monitoring of Implementing partners	0	0	1	1	1	1	1	1	N	NAS		4 trips per year by 2 teams for 7 days. A team comprises 5 members (2 finance, 1 programme, 1 M&E, 1 driver)
6.1.9	**Logistical support provided to NAS and DACs for effective M&E.**	Provide logistical support for NAS and DAC M&E units	0	1	0	0	0	0	0	0	N	NAS	GF	2 vehicles for NAS M&E and 14 motorcycles for the 14 districts.
6.1.10		Develop five year M&E Plan for NSP.	1	0	0	0	0	0	0	0	N		UN Family	Estimated costs of US$50,000
		Output 2: M&E TWG established and functional at Regional level												
6.2.1	**3 regional M&E TWG established and functional**	Convene periodic meetings of the M&E Technical Working group	1	1	1	1	1	1	1	1	N	NAS, MDAs, CSOs	Global Fund	1 day meetings with 25 participants. per year
6.2.2		Establish and hold M&E technical working Group meetings at the Regional level	0	0	3	3	3	3	3	3	D	NAS		TORs to be developed by national TWG. Meetings will hold in each of the 3 regions. M&E TWG in each region consists of 12 persons
6.2.3		Conduct Project review meetings	0	1	0	1		1	0	1	N,D	NAS, CSOs, MDAs,	Global Fund	1 day meeting for 50 people
6.2.4		Conduct Bi annual M&E TWG Support Supervision at district Level	0	1	0	1	0	1	0	3	N,D	NAS, CSOs, MDAs,		Field visit of 3 teams (of 3 persons each including the driver) for 5 days for each team.

		Intermediary Outcome 2: Research and surveillance activities are enhanced.												
		Output 1: Increased capacities to conduct more researches and surveys												
6.3.1	**HIV Research and Ethics Guidelines and research agenda developed and disseminated**	Develop and disseminate HIV Research and Ethics Guidelines	0	0	0	1	0	0	0	0	N,D	NAS, MDAs,CSOs, Academia		1 national and 1 international consultant for 30 days. 2 day meeting for 15 TWG members 1 day validation for 40 people. 500 copies printed and 200 e-copies. Distributed. E-copies to be uploaded on various websites
6.3.2		Develop National Evaluation & Research policy and Agenda	0	0	1	0	0	0	0	0	N	NAS, MDAs, CSOs, Academia		2 day meeting of TWG
6.3.3		Establish HIV/AIDS Evaluation and Research Network/Association	0	0	0	1	0	0	0	0	N	NAS, MDAs, CSOs, Academia		1 network established. Honorarium for 1 national coordinator
6.3.4	**80 stakeholders trained on HIV/AIDS research**	Build capacity of NAS, NACP, SSL, TWG, National Consultants, IPs, CSOs, FBOs etc in HIV/AIDS research	0	0	40	40	0	0	0	0	N			2 training workshops per year for 40 participants for 5 days
		Output 2: HIV/AIDS related research and evaluation studies conducted												
6.4.1	**At least 12 researches, surveys and studies conducted and disseminated**	Conduct Annual HIV & AIDS Epidemiological Projections	0	0	0	1	0	0	0	1	N	NACP, MOHS		2 training workshops per year for 40 participants
6.4.2		Conduct Workplace Surveys	0	1	0	0	0	0	0	0	N,D	NAS, BCAASL, Unions		KAP study estimated at 30000 USD
6.4.3		Conduct and disseminate ANC Surveillance	1	0	0	0	0	0	0	0	N	NACP, CSOs	CDC	Estimated cost of conducting and disseminating ANC Surveillance survey is 30000USD
6.4.4		Conduct Condom Availability, Quality and Condom Use Survey	0	1	0	0	0	0	0	0	N,D	NAS, CSOSs		Medium survey estimated 100,000USD, Technical assistance required from PSI and Measure Evaluation

6.4.5		Conduct National AIDS Spending Assessment Study(Resource Tracking of HIV/AIDS Expenditure)	1	0	0	0	0	0	0	0	N	NAS, CSOSs	UN Family	Data collection for 2010 & 2011 estimated at 20,000 USD based on the previous processes
6.4.6		Undertake Annual Unit cost studies for commodities and products for all Thematic areas and disseminate every two years	0	0	0	1	0	0	0	1	N	NAS, CSOs, MDAs		1 national consultants for 2 15 days. 1 day validation meeting for 25 people
6.4.7		Conduct Baseline surveys on Small & Medium Enterprises(SME) to identify and develop appropriate Programs/interventio ns	0	1	0	0	0	0	0	0	N	NAS, BCAASL, Unions, CSOs		Mapping study estimated at 20,000USD
6.4.8		Conduct Specific Studies on the behaviors of MARPS (Sex Workers, MSMs, Uniform Personnel, Fisher folks, Mobile Migrant, Miners , IDUs, Prisoners, Hair Dressers)	0	0	0	0	0	0	1	0	N	Public/ Private	Unidentified	1 integrated bio-behavioural surveillance conducted. [Sex Workers, MSMs, IDUs, Prisoners] + [Uniform Personnel, Fisher folks, Mobile Migrant, Miners, Hair Dressers]. Estimated Cost of survey is US$120,000
6.4.9		Study on Effective Alternative forms of treatment & prevention of HIV/AIDs	0	0	0	0	0	0	0	1	N	Public	Global Fund	Estimated cost of conducting and disseminating this study is 30000USD
6.4.10		Conduct BSS/KAPB Studies	0	1	0	0	0	0	0	0	N	NAS, CSOs,MDAs	GF, UN Family	Estimated cost is US$30,000

6.4.11		Conduct Second Generation Surveillance(Behavioural & Biological Survey)	0	1	0	0	0	0	0	0	N	NAS, SSL, CSOs, MOHS	GF, UN Family	Estimated Cost of US$450,000
6.4.12		Conduct Impact study on PMTCT - Prevalence of HIV amongst Children born to HIV infected mothers.	1	0	0	0	1	0	0	0	N	NACP, NAS, CSOs	GF, UN Family	I international consultant for 60 days, 2 national consultants for 60 days, 1 day dissemination workshop for 70 participants
6.4.13		Conduct Multi-Cluster Indicator Survey	0	1	0	0	0	0	0	0	N	NACP, NAS, CSOs	UNICEF	Estimated cost is US$80,000
6.4.14		Conduct Drug Efficacy Study & Resistant to ARVs.	0	0	0	0	0	1	0	0	N,D	NACP, NAS, CSOs	80,000	1 international consultant, 2 national consultants, for 60 days, 1 day dissemination workshop for 70 participants
6.4.15		Conduct Socioeconomic impact studies on of HIV/AIDs on specific sectors; education, agriculture, livelihood, workforce etc	0	0	0	0	1	0	0	0	N	NAS, CSOs, Private sector		1 study to cover the different sectors. Estimated costs is $60,000
6.4.16		Conduct Survival rate study Analysis among ART patients(Adults & Children) after 12 months of initiation of treatment	1	0	0	0	0	0	0	0	N,D	NACP, MOHS, NAS, CSOs	GF	Technical assistance required for 1 international consultant and 2 national consultants for 60 days
6.4.17		Conduct Quality Control assessment of HIV Screening Test in the Field	1	1	1	1	1	1	1	1	N,D	NACP, MOHS		4 per year@$2500

		Intermediary Outcome 3: Data quality, information generation and dissemination is improved.												
		Output 1: M&E systems are integrated with the existing Health Management Information Systems (HMIS)												
6.5.1	**HIV/AIDS M&E systems are integrated into Health sector MIS**	Conduct periodic Monitoring and supervision of HIV/AIDS activities of implementing institutions	1	1	1	1	1	1	1	1	D	NAS, DACs, CSOs, MDAs	GF	Per diem for 5 Officials for 7 days per qrt.
6.5.2		Conduct Data Quality Audits/verification	0	0	0	0	0	1	0	0	D	NAS, DACs, CSOs, MDAs, BCAASL	Global Fund	Activity to be Outsourced and funds allocated. Estimated costs is $30,000
6.5.3		Review, align and harmonize HIV M&E monitoring tools to include nutrition supported programs for PLHIV and OVC.	0	0	1	1	0	0	0	0	N,D	NAS, NETHIPS,	GF, UN Family	2 workshops, 70 participants for 2 days
6.5.4		Design information system for HIV nutrition reporting HIV/TB database.	0	0	1	0	0	0	0	0	N	NAS, NETHIPS,	UN Family	1 national consultant for 30 days. Training of 4 database managers for 1 day
6.5.5		Advocate for the integration of HIV M&E systems with HMIS	0	1	1	1	1	1	0	0	N,D	MOHS, NAS	GoSL	1 advocacy meeting per quarter. Refreshments for 30 people
		Output 2: Information sharing amongst stakeholders increase												
6.6.1	**National HIV/AIDS information dissemination strategy developed and disseminated**	Develop a National HIV/AIDS Information Dissemination Strategy/Plan	0	1	0	1	0	0	0	0	N	NAS, MDAs, CSOs, BCAASL		1 international consultant and 1 national consultant for 30 days. 1 dissemination workshop for 70 participants, 1000 hard copies
6.6.2		Set up Editorial/Review Committee and hold periodic meetings	0	1	1	1	1	1	1	1	N	NAS		Regular meetings quarterly meetings. Refreshments for 15 people per quarter
6.6.3	**At least 12 newsletters and reports printed and distributed**	Produce HIV/AIDS Publications (reports, Newsletters, Press releases, fact sheets etc) that provides information on best practices	0	1	0	1	0	1	0	1	N	NAS, CSOs, MDAs, BCAASL	GF	1,000 copies produced every six months

6.6.4		Develop an HIV/AIDS Research Inventory documenting all HIV AIDS related researches	0	0	1	0	0	0	0	0	N	NAS		2 national consultants for 60 days, 500 printed copies, 1000 CDs printed
6.6.5	**At least 6 learning and sharing events are organized.**	Conduct annual program review and planning and disseminate lessons learnt	0	0	0	1	0	0	0	1	N	NAS, NACP, CSOs, MDAs, BCAASL	GF	2 day meeting of 50 people
6.6.6		Facilitate attendance of M&E personnel in International HIV/AIDS Conferences and Workshops	2	0	0	2	0	0	0	0	N	NAS, CSOs, Private sector	GF, UN Family	2 staff per Qrt.- 7 days PD & 1 Return Air Ticket
6.6.7		Conduct Biennial HIV/AIDS Conference	0	0	0	0	0	0	0	1	N	NAS, CSOs, MDAs, Private sector, Unions	GoSL, UN Family	1 national consultant for 30 days. Conference materials for 300 participants, Refreshments for 2 days, Printing of workshop time-table and proceedings (500), 10 banners, radio and television advert (10 slots each), Venue,2 day workshop for 200 participants,
6.6.8		Produce annual country HIV/AIDS Status reports	0	0	0	1	0	0	0	1		NAS, CSOs, MDAs, Private sector, Unions	GoSL, UN Family	1 day dissemination meeting for 150 people. 1,000 hard copies and 2,000 e-copies
		Output 3: HIV/AIDS databases integrated and linked												
6.7.1	**HIV /AIDS database upgraded and capacities for database management enhanced**	Review Existing Data collection and Reporting tools for all programmatic areas - Pretest, Print out and distribute	0	0	1	0	0	0	0	0	N	NAS, MDA,CSOs, BCAASL		1 National consultant for 20 days, 3 day residential programme for 25 persons, 1 day validation meeting for 100 persons
6.7.2		Hold National Workshops on data collection management and quality assurance for staff from M&E Coordinating Organizations	0	0	1	0	0	0	1		N	NAS, MDA,CSOs, BCAASL		2 workshops- 1 per year for 5 days,6 NAS,14distx2 , 2X20 Sectors/SRs=72

6.7.3		Conduct Training for DHMT M&E and District council M&E HIV Counselors on Data Management	0	0	50	0	0	0	0	0	N, D	NAS	GF	1 national consultant for 8 days, 5 day residential training for 50 people
6.7.4		Set up a database for SMEs & Formal Business Houses or Institutions	0	0	1	0	0	0		0	N	BCAASL, NAS, Unions		1 national consultant for 30 days
		Recruit 2 Database Managers and 3 data entry clerks	1	0	0	0	0	0	0	0	N	NAS	GF	2 database managers recruited at national level with support from GF
6.7.5		Train personnel on the use of revised tools	0	0	1	0	0	0	0	0	N	NAS		2 workshops per year to train 50 national & district M&E & programme officers for 5 days (in-house)
6.7.6		Upgrade existing database in line with the revised tools	0	0	1	0	0	0	0	0	N	NAS		1 national consultant for 30 days including training for 4 database managers for 5 days
6.7.7		Advocate for the integration of HIV database into health sector database	0	1	1	1	1	1	0	0	N,D	MOHS, NAS	GoSL	No costs. Link with activity 6.5.5
6.7.8		Procure data management platform (hardware and software including computers, VSAT) for NAS, NACP& DACs M&E Staff	0	0	0	0	0	1	0	0	N, D	NAS		1 VSAT connection & package, 24 months subscription, 14 desktop computers for district M&E officers, 15 HQ desktop computers for M&E officers/programme staff, 2 network printers , anti-virus software and 24 months subscription

Annex 3: LIST OF THE STAKEHOLDERS CONSULTED

ATTENDANCE AT JOINT UN TEAM ON AIDS RETREAT: 23rd -26th Feb, 2011

Name	Agency	Designation	Email
Mulunesh Tennagashaw	UNAIDS	UCC/Chair	tennagashawm@unaids.org
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ATTENDANCE LIST FOR DISTRICT LEVEL CONSULTATION ON DEVELOPING THE NATIONAL OPERATIONAL PLAN 2011 -2012, Moyamba Districts, 23/02/11

No.	NAME	NAME OF ORGANIZATION	DESIGNATION/ POSITION
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3.	Mary J. S. Yambasu	Lets Love One Another Women's Organization	Programme Coordinator
4.	Margaret Sankoh	Evangelical Fellowship of Sierra Leone	Programme Officer
5.	Sylvester Samba	ARG/MOHs	HIV Counsellor
6.	Alfred M. Kargbo	S.L.P	Admin Officer
7.	Princess M. Gbow	Govt. Hospital - Moyamba	Clerk
8.	Alpha V. Koroma	R.S.L.A.F	Counsellor
9.	Titus Bendi	DRIM – SL -Moyamba	Logistics Officer
10.	Lahai K. Macavoray	District Council	HIV/AIDS Focal Point
11.	Wivison Senesie	Moyamba District Council	Chief Administrator
12.	James E. Thomas	Moyamba District Council	Procurement Officer
13.	Richard M. Lavaly	Ministry of Education	Supervisor
14.	Gabriel T. Ndanema	Moyamba District Council	Counsellor
15.	Peter A. Koroma	Moyamba District Council	Human Resource Dev. Officer
16.	Christian D. Squire	M. D. C.	M & E Officer
17.	Kollia Kamara	M. D. C.	Internal Auditor
18.	Philip Byne	Decentralization Secretariat	Resident Technical Facilitator

ATTENDANCE LIST FOR DISTRICT LEVEL CONSULTATION ON DEVELOPING THE NATIONAL OPERATIONAL PLAN 2011 -2012, Bo District, 24/02/11

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6.	Jemaima M. Kombu	NETHIPS	Confidential Secretary
7.	Brima Vongo	AHPRECT	Coordinator
8.	Gassimu Mallah	HELP – SL	Manager Human Security
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14.	Martin R. Sahr	MEST	S/Schools
15.	Hezina Johnson	Restless Development S/L	Assistant Programme - Coordinator
16.	John Koroma	OHRDE	Director
17.	Saidu Conteh	PAGSOH – Bo	Coordinator
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20.	Saffa Andrew Koroma	NUPHA	Vice President
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ATTENDANCE LIST FOR DISTRICT LEVEL CONSULTATION ON DEVELOPING THE NATIONAL OPERATIONAL PLAN 2011 -2012, Pujehun District, 25/02/11

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7.	Patrick S. Alpha	Health Chairman (PDC)	Health Chairman

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National HIV/AIDS Operational Plan

2011 -2012

Sierra Leone Towards
Zero New HIV Infections
Zero Discrimination
Zero AIDS Related Deaths

National AIDS Secretariat

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