



Republic of Liberia



NATIONAL HIV & AIDS STRATEGIC PLAN
2015 - 2020

July 2014



Republic of Liberia



NATIONAL HIV & AIDS STRATEGIC PLAN 2015 - 2020



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Acronyms and Abbreviations

AAMIN	Anti AIDS Media Network
AFL	Armed Forces of Liberia
AfT	Agenda for Transformation
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BCC	Behavior Change Communication
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CD4	Cluster of Differentiation 4
CHT	County Health Team
CHW	Community Health Worker
CPS	Combination Prevention Strategy
CPT	Cotrimoxazole Prevention Therapy
CSO	Civil Society Organization
CSS	Community Systems Strengthening
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment, Short Course
DP	Development Partners
eMTCT	Elimination of Mother-to-child Transmission
EPHS	Essential Package of Health Services
FBO	Faith-Based Organization
FP	Family Planning
FSW	Female Sex Workers
GARPR	Global AIDS Response Progress Reporting
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund to Fight AIDS, TB and Malaria
GOL	Government of Liberia
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IBBSS	Integrated Bio-Behavioral Surveillance Survey
IDP	Internally Displaced Persons
PWID	People Who Inject Drugs
IEC	Information, Education, and Communication
ILO	International Labor Organization
IMR	Infant Mortality Rate
INGO	International Non-Government Organization
ISY	In-School Youth
KAP	Knowledge, Attitude and Practice
KP	Key Population
LCC	Liberia Council of Churches
LCM	Liberia Coordinating Mechanism
LDHS	Liberia Demographic and Health Survey
LIBNEP+	Liberia Network of People Living with HIV and AIDS
LISGIS	Liberia Institute for Statistics and Geo-Information Services
LIWEN	Liberia Women Empowerment Network
LTFU	Lost to Follow-Up

M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MIA	Ministry of Internal Affairs
MOD	Ministry of Defense
MOE	Ministry of Education
MOGD	Ministry of Gender and Development
MOHSW	Ministry of Health and Social Welfare
MOJ	Ministry of Justice
MOL	Ministry of Labor
MoT	Mode of Transmission
MPCHS	Mother Pattern College of Health Sciences
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NACP	National AIDS & STI Control Program
NAEC	Nutrition Assessment Education and Counseling
NASA	National AIDS Spending Assessment
NBSP	National Blood Safety Program
NDS	National Drug Service
NGO	Non-Governmental Organization
NHPP	National Health Policy and Plan
NSF	National HIV & AIDS Strategic Framework II (2010-2014)
NSP	National Strategic Plan (2015-2020)
OIs	Opportunistic Infections
OSY	Out of School Youth
OVC	Orphans and Vulnerable Children
PA	Physician Assistant
PBC	Performance Based Contract
PEP	Post-Exposure Prophylaxis
PICT	Provider-Initiated Counseling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
QA	Quality Assurance
QC	Quality Control
RBHS	Rebuilding Basic Health Services
RTK	Rapid Test Kits
SAIL	Stop AIDS in Liberia
SC	Steering Committee
SCT	Social Cash Transfer
SGBV	Sexual and Gender-Based Violence
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UNAIDS	United Nations Joint Program on AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Foundation
USAID	United States Agency for International Development
USD	United States Dollar
VCT	Voluntary Counseling and Testing
VNRBD	Voluntary Non-Remunerated Blood Donation
WHO	World Health Organization

Foreword

The Government of Liberia through the National AIDS Commission and the Ministry of Health and Social Welfare, in partnership with implementing partners, international and national agencies, and non-governmental and civil society organizations, has made steady progress in containing the spread of HIV and mitigating the impact of the epidemic on the general population through the implementation of the National HIV Strategic Framework II 2010 – 2014 (NSF II). The NSF II provided the framework for ensuring successful coordination and management of the national HIV response. Prevention activities, testing and treatment services have been scaled up and expanded to ensure universal access to HIV and AIDS services. Involvement of multi-media and civil society organizations in the national response has increased the public's knowledge and awareness of HIV and AIDS with special emphasis focused on youth and key populations. As the operational timeline of the NSF II is set to expire by December 2014, the country has developed a six-year results-based third generation National Strategic Plan 2015 – 2020 that is consistent with the UNAIDS Investment Framework to drive the national HIV decentralized multi-sectoral response.

As an evidence-based national strategic plan, the NSP 2015 – 2020 is informed by the NSF II Mid-term Review, Liberia Demographic and Health Survey 2013, Liberia 2011 United Nations General Assembly Special Session on HIV and AIDS and 2012 Global AIDS Response Progress Reporting, and a number of HIV related research and studies including the National AIDS Spending Assessment, Integrated Bio-Behavioral Surveillance Survey, Stigma Index Study, Gender Assessment, ART Cohort Study and Mode of Transmission Study.

The strategic plan focuses on preventing new HIV infections in order to maintain a low HIV prevalence in the next six years. The NSP aims to reduce new HIV infections by 50% by 2020; intensify the provision of quality and accessible HIV prevention information and services for key populations; and also accelerate actions to eliminate mother-to-child transmission of HIV by 2020, including placing positive mothers on lifelong antiretroviral therapy (Option B+) as the preferred regime of treatment for HIV positive pregnant women.

The Government remains committed to the international obligations as enshrined in the 2011 Political Declaration on HIV, the Universal Access and UNAIDS Three Zeros: zero new HIV infections, zero discrimination and zero new AIDS related deaths.

Mrs. Ellen Johnson Sirleaf
Chairperson, National AIDS Commission Board of Directors
President, Republic of Liberia

Acknowledgement

This National Strategic Plan 2015—2020 for the national response to HIV in Liberia was developed by the National AIDS Commission in collaboration with the UN Theme Group in Liberia, our multilateral and bilateral partners, faith based organizations and civil society organizations (CSOs). This strategic plan, which will provide guidance for implementation of the national response to the epidemic, could not have been realized without the invaluable contributions of all key stakeholders.

Special thanks go to the Global Fund, UN Theme Group, SIDA and EU for financial and technical support for the development of this document.

To the USAID, we are grateful not only for technical support in the development of this document but also for contributions towards its validation.

The following Ministries: Gender and Development, Education, Labor, National Defense and Justice, provided valuable technical assistance in aligning the NSP with the Agenda for Transformation and Vision 2030. We are also grateful to the Legislative Joint Standing Committees on Health for their support throughout the development of this plan. Special thanks go to the Ministry of Health and Social Welfare, the lead agency of government in implementing health activities in the national response to prevent the spread of HIV and mitigate its impact on the population, for their support and collaboration. MOHSW and LISGIS provided most of the health and other relevant data which formed the basis for developing the key strategies and actions in the NSP. We thank LISGIS for making available the statistics from the 2013 LDHS.

We appreciate the excellent partnership with the Press Union of Liberia and the Anti-AIDS Media Network, which was manifested through press coverage of our activities throughout this process. We look forward to sustaining this collaboration during implementation of the plan.

The input of the CSOs in the development of this plan ensured that all thematic areas of intervention were comprehensively addressed. For this we are grateful to all our partners including: LIBNEP+, SAIL, Catholic HIV Program, Sisters of Charity Hospice, Samaritan's Purse, SHALOM, AHF-Liberia, ESTHER-GIP, PSI, ACTIONAID, Lutheran Church HIV Program, and UMAGBO.

We acknowledge with special thanks the collaborative effort of the NACP, FHD, NLTCP, NDU, PCU and NBSP for their technical input in reinforcing the objectives of this National Strategic Plan.

Finally, we want to thank the NSP Secretariat who worked diligently under the able leadership of Clarence Pearson, Sr. of the National AIDS Commission, Chairman, and Sonpon Blamo Sieh of the National AIDS and STIs Control Program, Co-chairman. Other members of the Secretariat are: T. Lincoln Reeves, Julius Togba, Julia Mulbah Lysander and Solomon Hinneh of the National AIDS Commission; Ibrahim B. Dukuly and Momolu T. Massaquoi of the Program Coordinating Unit at the Ministry of Health and Social Welfare; and Moses Badio, Murphy Kiazolu, Dr. Julia Toomey Garbo and M. Janjay Jones of the National AIDS and STIs Control Program.

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Chairman
National AIDS Commission

Structure of the NSP 2015 – 2020

The key elements of the NSP 2015-2020 are detailed in the following sections:

Section 1 - Impact Results of the NSP: discusses reduction of new HIV infections by 50% from its 2014 value of 1789 and improving the survival rate of adults and children on ART from 74% in 2014 to 85% in 2020.

Section 2 - Preventing new HIV infections (Non-Clinical): describes the targets of behavioral change interventions within the general population and young people 15-24 years. This section also includes interventions for reducing the transmission of HIV by PLHIV to people who are not infected by HIV.

Section 3: Preventing new HIV infections (Clinical): articulates interventions around the clinical response, with emphasis on HIV testing and counseling (HCT), which is the entry point for accessing all other HIV and AIDS services, Blood Safety, Post-Exposure Prophylaxis (PEP), and Management of Sexually Transmitted Infections (STIs).

Section 4 - Preventing HIV in Key Populations (KPs): deals with providing HIV prevention information and services for Key Populations (Women and girls, FSWs, MSM, and PWIDs).

Section 5 - Condom Promotion and Distribution: stresses national condom needs for the sexual reproductive health program within the general population including young people as well as condom-compatible lubricants as part of the HIV and AIDS programs.

Section 6 - Treatment, Care, and Support for PLHIV: key components include treatment for HIV positive pregnant women (WHO Option B+), care of people living with HIV, Antiretroviral Treatment (ART), and management of TB-HIV co-infections.

Section 7 - Critical Social and Programmatic Enablers: speaks to selected key enablers including political commitment and advocacy; community participation; coordination and management of the response at the central and decentralized levels; funding resource needs of the HIV response; and research, monitoring and evaluation.

Section 8 - Synergies with Development Sectors: Key development sectors include strengthening key health and community systems impacting on HIV response; HIV education for in-school youth (ISY); SRH & HIV education for out-of-school youth (OSY); stigma and discrimination against PLHIV and KPs; mitigating socioeconomic impact on AIDS-affected households; Gender and HIV, and HIV in the workplace, formal and informal sectors of the economy.

Section 9 - Costing of the NSP 2015-2020: discusses the method and processes in determining value for all activities in the NSP. It describes funding mechanisms and identifies strategies for resource mobilization for the NSP and how the accountability for the funding can be strengthened.

Process for the Development of the NSP 2015-2020

The National AIDS Commission (NAC) requested a third generation National Strategic Plan (NSP) 2015-2020 and identified priority HIV and AIDS thematic modules that are evidence-based and results-driven to form the basis of developing the NSP. These modules were incorporated into the AIDS Investment Framework on which the NSP is constructed. The NAC formed a steering committee to provide guidance and oversight and a secretariat to provide technical and logistical support for the development of the NSP.

The consultant developed a concept note encompassing all the NAC requirements but modeled along the internationally recognized AIDS Investment Framework. The concept note was presented to senior management of the NAC, the steering committee and key stakeholders for concurrence and endorsement.

The endorsed concept note grouped the national HIV response into three key categories. These categories are: Priority High Impact HIV Activities, Critical Social and Programmatic Enablers, and Synergies with Key Development Sectors in the country.

The NAC formed eight (8) technical working groups (TWGs) (Appendix A) comprising technical staff from key public, private, and civil society organizations to provide expert support, input, and guidance for drafting the NSP. The TWGs are: Prevention of HIV Infection; Care and Treatment; Human Resources for HIV and AIDS; Program Management, Coordination, and Strengthening of Health Care System; Development Sector (Enabling Environment and Orphans and Vulnerable Children (OVC).

Guided by the international consultant, the TWGs held several meetings and produced consensus on identified HIV and AIDS thematic areas used in drafting the NSP. The consultant also worked with the secretariat to supplement the work of the TWGs. This team was the main source of data and information for the development of the NSP.

Two drafts of the NSP were produced: a) a zero draft which was circulated to stakeholders for their comments and inputs; b) the first draft with the comments incorporated was discussed separately with senior management of NAC and MOHSW/NACP.

Following the discussions with NAC and NACP, the international consultant further refined the draft document. The NAC circulated this draft to stakeholders for review in preparation for the validation meeting on the NSP. The draft was also given to the costing consultant for developing the budget and narrative for the NSP. The draft NSP 2015-2020 was validated at a Stakeholders' Retreat Validation Workshop on 1st - 4th July 2014.

Desk review of pertinent documents (Appendix D) was carried out. The results from the desk review and information from interviews and discussions with key individuals and stakeholders informed the synthesis of the situation of HIV and AIDS in Liberia and the national response.

The NSP was developed between January 2014 and July 2014. The process for developing the plan involved extensive consultations with stakeholders, development partners, civil society organizations, faith-based organizations and central level technicians. The stages in the development of the NSP are as follows:

- 1. Establishment of the National NSP Secretariat:** A NSP Secretariat was established, with the leadership of the National AIDS Commission, to guide the process for developing the strategic plan. The Secretariat was instrumental in seeking technical support and providing overall leadership to the process.
- 2. Preparation of the National Strategic Plan road map:** A road map for the strategic plan was developed and agreed upon with the NSP Secretariat. This road map which served as a guide was explained to all stakeholders and partners involved in the planning exercise at the launch of the NSP process.
- 3. Analysis of the Epidemic:** The epidemic analysis was conducted to synthesize available data and identify the key aspects of the epidemic. The analysis provided the evidence on which the plan was developed.
- 4. NSP Technical Review Retreat:** A retreat to identify priorities and build technical consensus around thematic areas in the NSP, brought together stakeholders from government, UN and civil society organizations.
- 5. Technical Working Groups (TWGs):** Theme groups provided professional guidance and oversight on specific service delivery areas of the multi-sectoral national HIV response. Members of the NSP Secretariat were assigned to serve as rapporteurs to various meetings held by the TWGs during NSP development.
- 6. Design of the Strategic Plan:** The strategic plan was designed based on the identified priorities and set the targets for the NSP. The design process was participatory.

Background Information

Geographic and Administrative Profile

Located in West Africa, Liberia is bordered by Guinea to the north, Côte D'Ivoire to the east, Sierra Leone to the west, and the Atlantic Ocean to the south. The tropical rainforest and plateaus occupy 45% and 27% respectively of its surface area of 37,240 square miles. With Monrovia as its national capital, the country has 15 administrative counties: Bomi, Bong, Gbarpolu, Grand Bassa, Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa, Margibi, Maryland, Montserrado, Nimba, River Gee, River Cess, and Sinoe.

Demographic Profile

Liberia's population has grown from about 3.5 million people recorded in the 2008 census to an estimated 4.2 million people in 2012 by the World Bank Report. With about 43% of the population below 15 years of age, the country has an extremely young population. The Bank report also estimated life expectancy at birth at 60 years (61 females and 59 males) and 60% literacy rates for adults and 77% in youth. About 50% of the population lives in urban areas. The LHDS 2013 report reveals a total fertility rate of 4.7, a contraceptive prevalence rate of 20%, and infant mortality rate of 54/1000 live births. The under-5 mortality rate is reported at 94/1000 live births: 75% of the deaths occurred before the first birth day with 28% occurring in the first month of life.

Economic Profile

Since 2003, the country has enjoyed peace, two democratic elections, and nearly a decade of economic recovery. The Liberia Poverty Reduction Strategy of 2008–2011 provided the stimulus for growth to a struggling and weak economy, rehabilitated some infrastructure, and generally reduced the punishing burden of poverty for many Liberians. However, the United Nation's Human Development Index 2012 shows Liberia remains one of the poorest countries in the world. The World Bank estimated the country's gross domestic product (GDP) per capita in 2012 was US\$655; about 82% of people are self-employed with 49% engaged in subsistence agriculture. Many challenges to high and sustained economic growth remain and include enormous institutional and human capacity deficits and weak infrastructure especially roads and power.

Health Systems

Since 2003, the health sector has made steady recovery and progressed from its post-conflict emergency status to reconstruction and normal development. The GOL and faith-based organizations provide most of the facility-based care while civil society including faith-based organizations provides much of the community based care. Under the National Health Policy and Plan 2007-2011, functional health facilities increased by 64 percent, from 354 to 550, and facilities offering basic services increased from 36% in 2008 to 84% in 2011. The health workforce also increased from around 5,000 to about 8,000. However, most of the benefits of the health services are skewed in favor of urban than rural populations. Significant under financing of the health sector is resulting in inadequate M&E of the delivery of health service, ineffective procurement and supply chain management system, and the provision of poor quality services.

HIV and AIDS Situation in Liberia and Analysis of the National HIV Response

HIV Epidemic Situation

Liberia presently has a generalized HIV epidemic with the general population HIV prevalence of 1.9% (2013 LDHS). The South Central Region has the highest prevalence of 2.75% among the five regions and Montserrado, Margibi, and Bomi Counties have the highest prevalence among the 15 counties. HIV prevalence is also higher in urban than in rural areas, in females as compared to males, and in key populations relative to the general population.

The impact of the epidemic continues to be significant. The Spectrum Modeling estimates for 2014 reveal there will be 1,789 new HIV infections including 309 in children 0-14 years. About 57% of the new infections will be in females. There will be 29,538 PLHIV including 2,730 in young people 15-24 years and 4,784 children 0-14 years. About 56% of PLHIV are female. The 2013 LDHS reveals the HIV prevalence is 1.9% (2% in women and 1.7% in men), up from 1.5% in 2007. The HIV prevalence amongst pregnant women has decreased from a peak of 5.4% in 2007 to 2.5% in 2013; this is mirrored by a moderate decrease in the mother-to-child HIV transmission rate at the cessation of breastfeeding from 37% in 2009 to 29% in 2013. An estimated 2,330 PLHIV (including 52% female and 311 children) will die from AIDS-related causes with 97% of the deaths occurring in PLHIV not on treatment. Cumulatively, there will be 38,462 AIDS-orphans in 2014, equivalent to about 19% of total orphans from all causes.

National HIV Response Analysis

The national HIV response provides a comprehensive range of services aimed at preventing new infections, providing treatment and care for PLHIV, and mitigating the socioeconomic impact of the disease on people infected and affected by HIV. Greater efforts have been made in providing services geared toward preventing new HIV infections and providing HIV treatment, care, and support services than in mitigating the socioeconomic impact of the disease outside of efforts at reducing stigma and discrimination against people living with HIV.

Liberia has been implementing a multisectoral decentralized HIV response with national coordination by NAC through five mandates (Programs and Policy, Partnership, Decentralization, and Monitoring & Evaluation). The NAC currently coordinates the decentralized response through its offices in 5 counties and through coordination arrangements using focal persons that are staff in the Ministry of Internal Affairs in two counties and in the Ministry of Gender and Development in one county. Over the last five years, NSF II 2010-2014 has guided the national HIV response. During this period, the response has been almost totally dependent on external funding sources: the 2012 NASA indicates the GF and the UN System in Liberia together contributed 98% of the funding for the national response; domestic funding is only 2%. The media, especially radio and print, are contributing immensely to the national HIV response by covering key events as well as providing information, education, and communication on HIV prevention, treatment, care, and support.

Liberia amended the 1976 Public Health Law by adding Chapter 18 on HIV and AIDS, which, includes sanctions for violating confidentiality of the HIV status of PLHIV and willful transmission of HIV, and prohibition of discrimination and vilification of persons on the basis of actual or perceived HIV status. The object of the legal reform is to protect the human rights of people infected and affected by HIV and AIDS. To this end, The Ministry of Justice has established an HIV and Human Rights Platform to advocate and coordinate stakeholders' response to HIV related human rights issues and violation and creates a legal environment for enforcement. Additionally, the work of the Sexual and Gender Based Violence Task Force and the Social Cash Transfer Program of the MOGD are playing key roles in efforts to prevent HIV infection from SGBV and mitigating the socioeconomic impact on poor households, which are both important risk factors for HIV infection.

Information on sexual behavior is important in designing and monitoring intervention programs to control the spread of HIV. In the past decade, Liberia has conducted two demographic and health surveys to provide this information: the Liberia Demographic and Health Survey (LDHS) of 2007 and 2013. Since 2007, the national HIV response has intensified its HIV prevention program messages and efforts on three important aspects of behavior: using condoms; limiting the number of sexual partners or staying faithful to one partner; and delaying sexual debut in young persons (abstinence).

General Population

Knowledge, Attitudes and Practices -Knowledge of HIV prevention methods has increased since 2007 among women. According to the 2007 LDHS, 44% of women knew that HIV could be prevented by using a condom and by limiting sexual partners; this compares with 68% in 2013. Among men, there is a slight increment in the percentage (66% in 2007 and 68% in 2013).

HIV and AIDS awareness is almost universal and 75% of women and men age 15-49 know that consistent use of condoms is a means of preventing the spread of HIV. Eighty-nine percent (89%) of women and 78% of men know that limiting sexual intercourse to one faithful and uninfected partner can reduce the chances of contracting HIV. The proportion knowing both that using condoms and limiting sexual intercourse to one uninfected partner can reduce the chances of contracting HIV is 68% among both women and men.

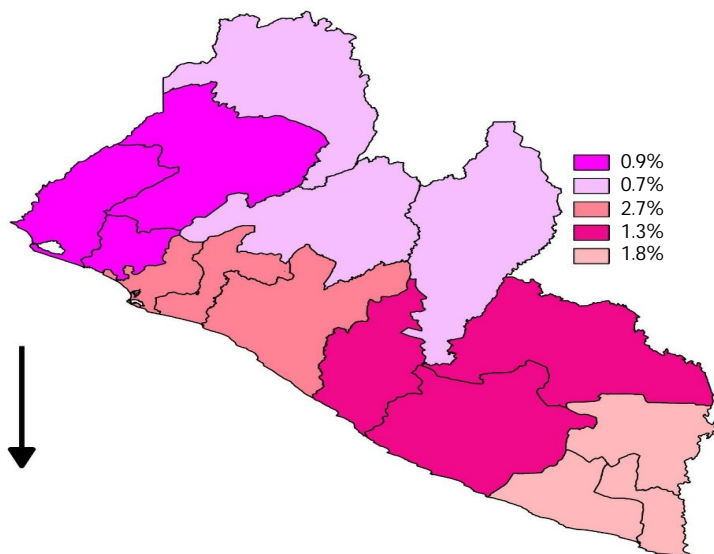
Eighty four percent (84%) of men who have been married previously are most likely to be aware of HIV prevention methods. Among women who have never been married, 72% know that using condoms and limiting sexual intercourse to one uninfected partner reduces the risk of HIV infection. However, only 36% of men who have never been married know that using condoms and limiting sexual intercourse to one uninfected partner reduces the risk of HIV infection.

By residence, women living in Greater Monrovia are more likely to be knowledgeable about HIV prevention methods than their counterparts residing in other urban or rural areas. The same pattern is true for men. Knowledge about HIV prevention varies across counties, with the lowest percentages in Grand Bassa for women (42%) and Lofa for men (41%). Better educated respondents are more knowledgeable of HIV prevention methods than other respondents.

Seven percent (7%) of women and 18% of men reported that they had two or more partners in the past 12 months with 20% of women and 24% of men reported using a condom at the last sexual intercourse. While women have a mean of 4 lifetime partners, men have 13.

HIV Prevalence – The national HIV prevalence is 1.9% but significant geographic variations exist between urban and rural areas, between regions, and between counties. HIV prevalence in urban areas (Female-2.7% and Male-2.5%) is almost three times that in the rural areas (Female-1.0% and Male-0.7%). Greater Monrovia, where about 30% (1.2 million of 4.1million) of the population of Liberia lives, bears the greater burden of the epidemic (Female-3.0% and Male-3.4%) than any area in the country.

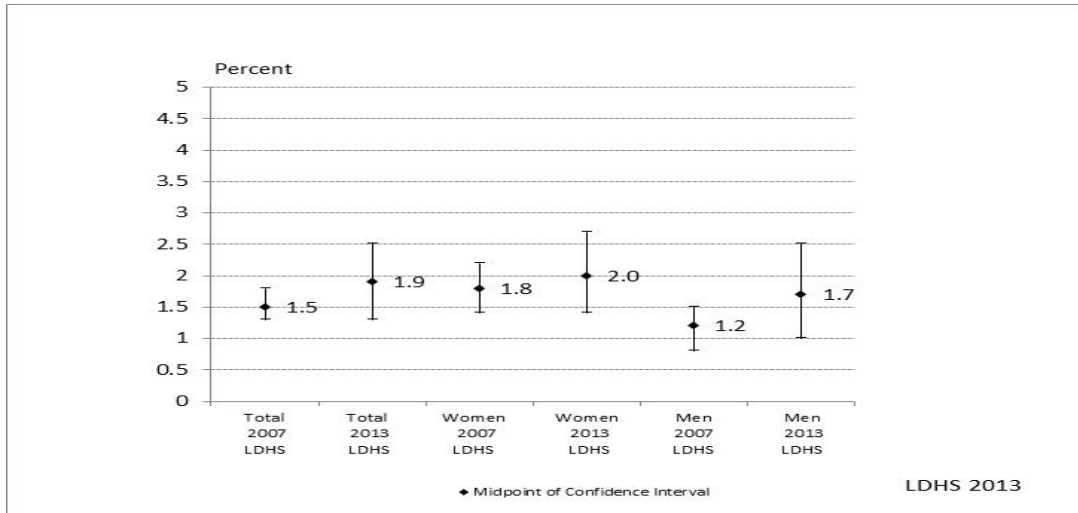
Figure 1: HIV Prevalence by County LDHS 2013



Among Liberia's 5 regions, South Central Region has the highest HIV prevalence of 2.75% aggregate for both male and female; the South East B and the South East A have aggregate prevalence of 1.75% and 1.3% respectively. The North West and North Central Regions have aggregate prevalence of less than 1%: North West has 0.8% and North Central has 0.7% aggregate prevalence. In terms of counties (Fig 1) Montserrado, Margibi, and Bomi counties have the highest prevalence whilst Nimba, Bong, and Lofa Counties have the lowest.

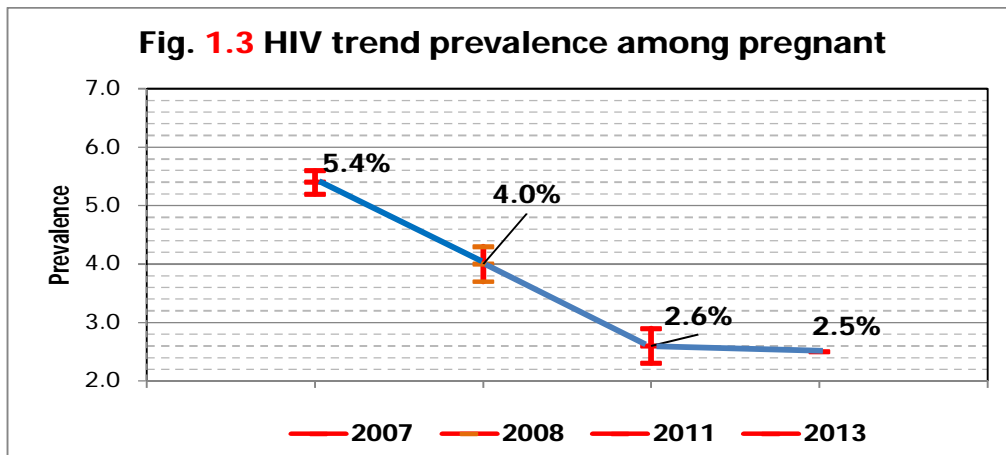
The HIV prevalence in the general population according to the 2013 LDHS is higher (1.9%) than the 1.5% in the 2007 LDHS. Fig 2 compares the 2007 LDHS and the 2013 LDHS HIV prevalence results. The 2013 HIV prevalence of 1.7% in men is statistically different from the 2.0% in women. However, the prevalence of 1.7% in men in 2013 is significantly higher than the 1.2% recorded in men in 2007. It is noteworthy that the 2013 Integrated Bio-Behavioral Surveillance Survey (IBBSS) found high HIV prevalence in men only or predominately men key population sub-groups: 19.8% in MSM; 5% in People Who Inject Drugs (PWIDs), a predominantly male behavior; and 4.8% in transport workers (long distance bus and truck drivers), a heavily male dominated workforce.

Figure 2: HIV Prevalence in men and women 2007 - 2013



Pregnant Women

The NACP regularly carries out HIV prevalence studies in pregnant women attending antenatal clinics. Since 2007, the trajectory of the trend in HIV prevalence in pregnant women has consistently been downward: from 5.4% in 2007, then declining to 4.0% in 2008, 2.6% in 2011, and 2.5% in 2013 (Fig. 3). The rate of decline in HIV prevalence among pregnant women virtually flatlined between 2011-2013 as compared to that between 2007 and 2011. The rapid decline in the HIV prevalence among pregnant women occurred at the time of rapid expansion of the HIV prevention interventions for pregnant women and the results could be due to the impact of successful HCT and PMTCT programs.



Young People 15-24 years

The 2007 Liberian Demographic and Health Survey (LDHS) reported that the HIV prevalence nationwide was 1.5%. The prevalence was found to be higher in urban areas than rural areas, and higher among females than males. The rates of infection were three times higher among adolescent females (ages 15–19) compared to males (1.3% vs. 0.4%) and almost three times higher among young females (ages 19–24) compared to young males (2.0% vs. 0.7%). The 2007 LDHS also report that

13% of females ages 15–24 have experienced sexual violence; and 39% of female adolescents ages 15–19 report they have been victims of physical violence. The survey also reported that 4.4% of young women and 3.4% of young men aged 15–24 had ever been tested for HIV.

Many Liberian youths engage in individual behaviors that heighten their risk for HIV, including transactional sex resulting in multiple and concurrent partnerships, and low levels of condom use. The 2010 UNAIDS Global Report revealed that among Liberian youth who had sex with a non-marital and non-cohabiting partner in the last 12 months, that 22% of males and 14% of females reported condom use at last sex.

Given that more than half of the population in Liberia is young (< 24 years), preventing HIV infection among them is critical. The data on the factors that enhance young people's risk of getting HIV are scarce and the available evidence suggests that a milieu of structural and individual risk factors have the potential to increase youth's vulnerability to HIV. The national HIV response targeted young people with HIV prevention information and services in its 2010-2014 National Strategic Framework for HIV. But HIV prevention information and services for young people has been poorly coordinated and often have small geographic coverage. Large-scale national or sub-national data and information on the outcome and impact of these services are not available. There is also very little published information about HIV in youths in Liberia.

The paucity of data on youth sexual behavior risk for HIV, a multi-partner study was commissioned to identify what the risks are. A large 2012 study¹ on youth sexual behavior and HIV risks was published recently and provides an indication of the youth sexual behavior that increases their HIV infection risks. The study found that among young people 15-24 years, 91% of females and 86% of males reported being sexually active; 56% of females and 47% of males reported they initiated sexual activity before the age of 15. Among the sexually active females, 71% reported they had received money or a gift for sex and 56% of males reported they had given money or goods for sex. Twenty percent (20%) of females and 6% males reported that their first sexual encounter was forced and 15% of females and 6% of males reported they had been forced to have sex in the past year. Multiple partnerships were common amongst both sexes with 81% females and 76% males reporting one or more sex partners in the past four weeks. Less than 1% reported having experiences with injecting drugs and only 1% of males reporting have sex with men. While knowledge of HIV and AIDS was high, prevention behaviors including HIV testing and condom use were low.

The 2013 Liberian Demographic and Health Survey (LDHS) reported that the HIV prevalence nationwide was 1.9%. The prevalence was found to be higher in urban areas than rural areas, and higher among females than males. The survey also reveals 67% of young women and 59% young men aged 15-24 years know that HIV can be prevented by using condoms and limiting sexual intercourse to one uninfected partner. The Survey also found that 8.6% young women and 12% young men had 2 or more partners in the last 12 months and 25.6% young women and 32% young men reported using a condom during their last sexual intercourse.

¹Informing HIV prevention efforts targeting Liberian youth: a study using the PLACE method in Liberia, Donna R McCarragher et al *Reproductive Health* 2013, 10:54

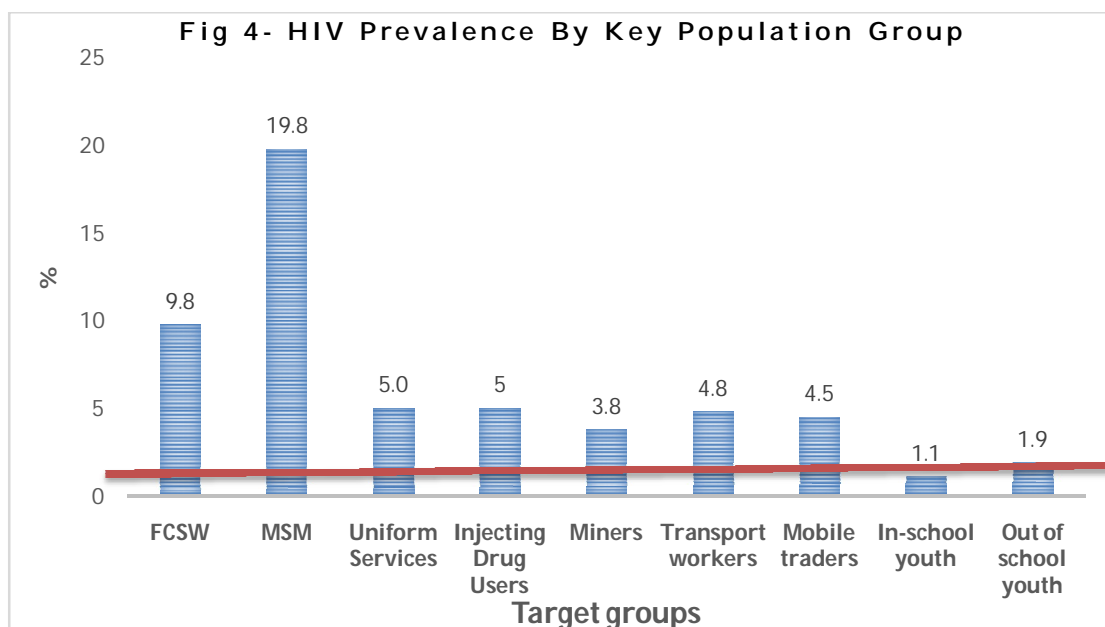
Key and Vulnerable Populations

The national HIV response has always identified certain population groups including FSWs, MSM, and People Who Inject Drugs (PWID), previously known as injecting drug users (PWIDs) as the Key Populations (KPs) driving the epidemic in Liberia. The National HIV and AIDS Program regard young people as vulnerable to HIV infection and have targeted them with HIV prevention information and services.

A 2011 Size Estimation Study of FSWs, MSM, and PWID in Liberia estimated that there are 1822 FSWs, 711 MSM, and 457 PWID. However, many informed opinions consider these as grossly underestimated and regard them as the tip of the iceberg. People below 30 years of age make up the bulk of the 3 key population groups: 84% of FSWs are below 30 years of age including 4% teenagers 13-15 years old, 78% of MSM are below 30 years of age with about 20% between the ages of 16 and 20 years, and 61% of PWIDs are also below 30 years of age.

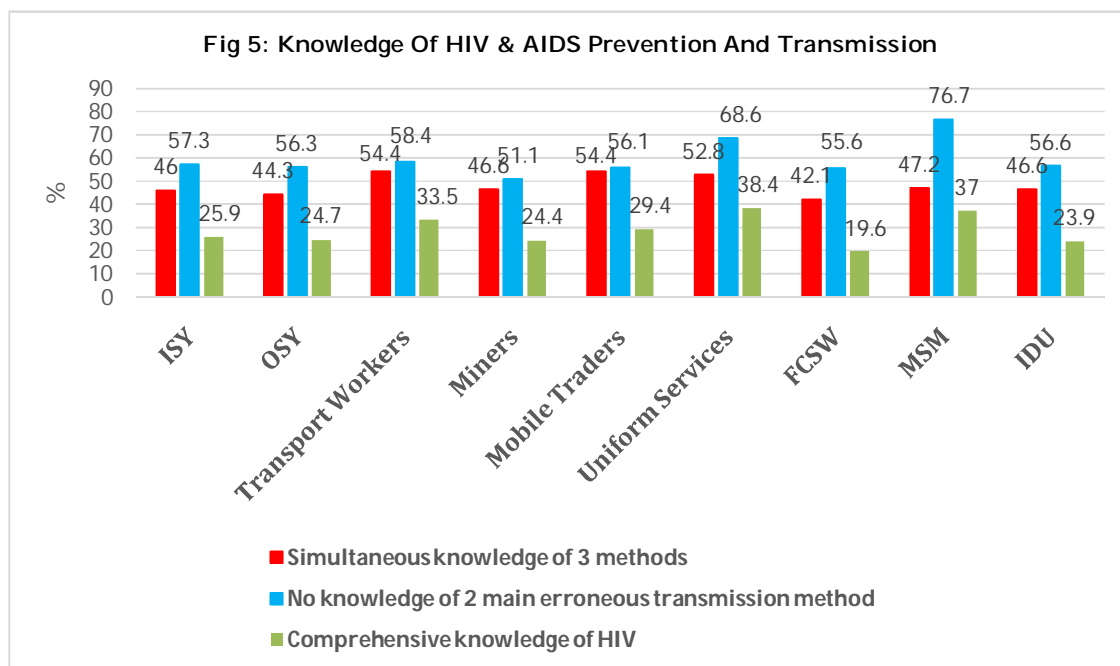
Evidence for the assertion that FSWs, MSM, and PWID are KPs is provided by the 2013 IBBSS that showed not only higher HIV prevalence in these population groups than in the general population but also a wide variation in prevalence between the groups. The study also clearly identifies young people, especially out-of-school youth (OSY) as vulnerable to HIV infection.

There is wide variation in HIV prevalence between the KP groups. Fig. 4 shows the HIV prevalence in the 2013 IBBSS study groups. Dramatically, MSM have the highest HIV prevalence (19.8%) followed in a distant second place by FSWs (9.8%), and then the uniform service (Immigration, Police, and Customs) and PWIDs each have HIV prevalence of 5%. Other KPs that have HIV prevalence of below 5% are transport workers (4.8%), and mobile traders (4.5%). With prevalence just below the 1.9% in the general population, the youth, particularly out of school youth, are a vulnerable group for HIV infection.



The 2013 IBBSS also reveals low level of comprehensive knowledge of HIV and AIDS among KPs and vulnerable groups (Fig.5). No knowledge of the two main erroneous transmission methods and simultaneous knowledge of three methods of HIV transmission were generally below average. It is particularly noteworthy that many MSM have no knowledge of at least two important erroneous transmission

Figure 2: Knowledge of HIV&AIDS Prevention and Transmission - Source: 2013 IBBS Liberia



methods of HIV; yet they have the highest HIV prevalence among the KPs.

The 2013 Spectrum Modeling Estimates indicate that among FSWs, 28.2% have been reached with HIV prevention programs, 81.7% reported using condom with their most recent client, 31.3% received an HIV test in the last 12 months and know their results, and 9.8% are living with HIV. Among MSM, 19.5% reported the use of condom the last time they had anal sex with a male partner, 44.4% received an HIV test in the last 12 months and know their results, and 19.8% are living with HIV. For PWIDs, 44.3% reported the use of a condom the last time they had sex, 27.9% received an HIV test in the last 12 months and know their results, and 3.9% are living with HIV.

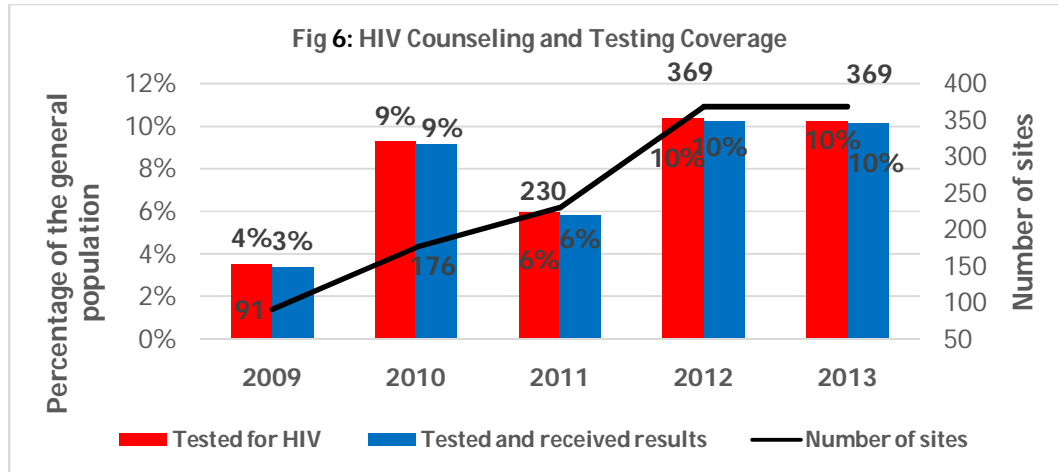
HIV Counseling and Testing (HCT)

The national HIV response gives top priority to providing HCT services as it considers the services as the gateway to HIV and AIDS prevention, treatment, and care and support services in the country. In pursuant of this policy, Liberia has greatly scaled up its HCT program by increasing the number of facilities delivering HCT services from 91 in 2007 to 335 in 2013.

Community-based Organizations and FBOs have contributed enormously to increasing community sensitization on, participation in, and demand for HCT services that are being provided at MOHSW and private-for-profit and private-not-for-profit health facilities and supplemented by outreach programs on special days such as the World AIDS Day and at key events including major sporting activities.

The Ministry of Youth and Sports also runs 5 counseling and testing centers for young people in Margibi and Grand Bassa Counties.

Despite challenges including shortage of trained staff particularly in rural areas, stigma surrounding HIV and AIDS, transport difficulty in accessing services, and the occasional stock-out of rapid test kits for HIV, the HCT program provided full HIV Counseling and Testing services to about 61,000, 171,700, 113,000, 205,500, 209,500 clients representing 3% of the population in 2009, 9% in 2010, 6% in 2011, and 10% in both 2011, and 2012. Fig 6 shows the HCT scale-up between 2009 and 2013.

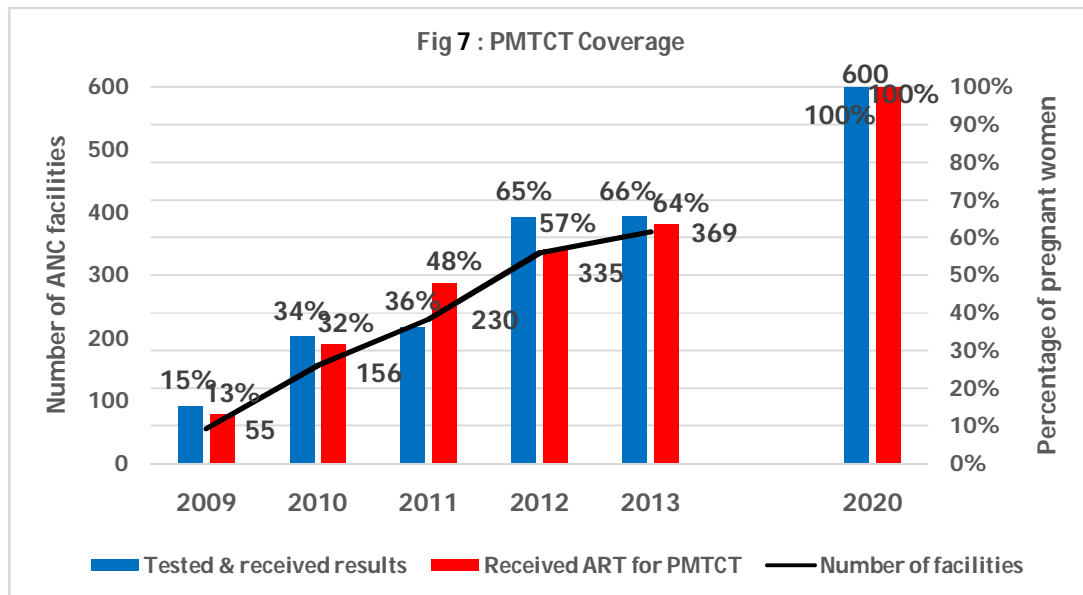


Prevention of Mother-to-child Transmission of HIV (PMTCT)

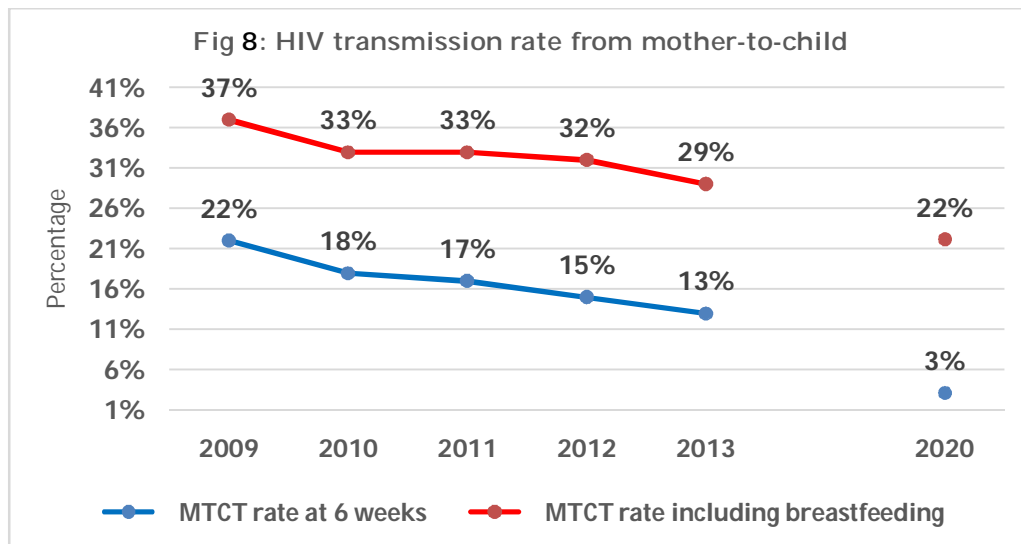
The national HIV response has identified PMTCT as one of the key priority program areas and has put a lot of effort into the implementation of the PMTCT program. This has resulted in significant scaling up of the program through increasing the number of facilities providing PMTCT services from 55 in 2009 to 320 in 2011 and 335 in 2013. MOHSW, FBOs, and large private sector firms provide PMTCT services in health facilities under their management.

Community-based organizations, including support groups and volunteers, are playing critical roles in generating demand for PMTCT services, assisting HIV positive pregnant women to adhere to care and treatment, and tracing clinic appointment defaulters. Despite challenges of shortage of trained staff, transport difficulty experienced by pregnant women in accessing services, stigma and discrimination against HIV and AIDS, and lack of overt male involvement, the program has enabled increasing numbers of women to receive HIV Counseling and Testing and antiretroviral drugs (ARVs) to prevent mother-to-child transmission of HIV annually as shown in Fig 7. The percentage of pregnant women who were tested and know their results increased more than fourfold from 15% in 2009 to

66% in 2013 with corresponding increase in the percentage that received ARVs to prevent mother-to-child transmission of HIV from 13% in 2009 to 64% in 2013.

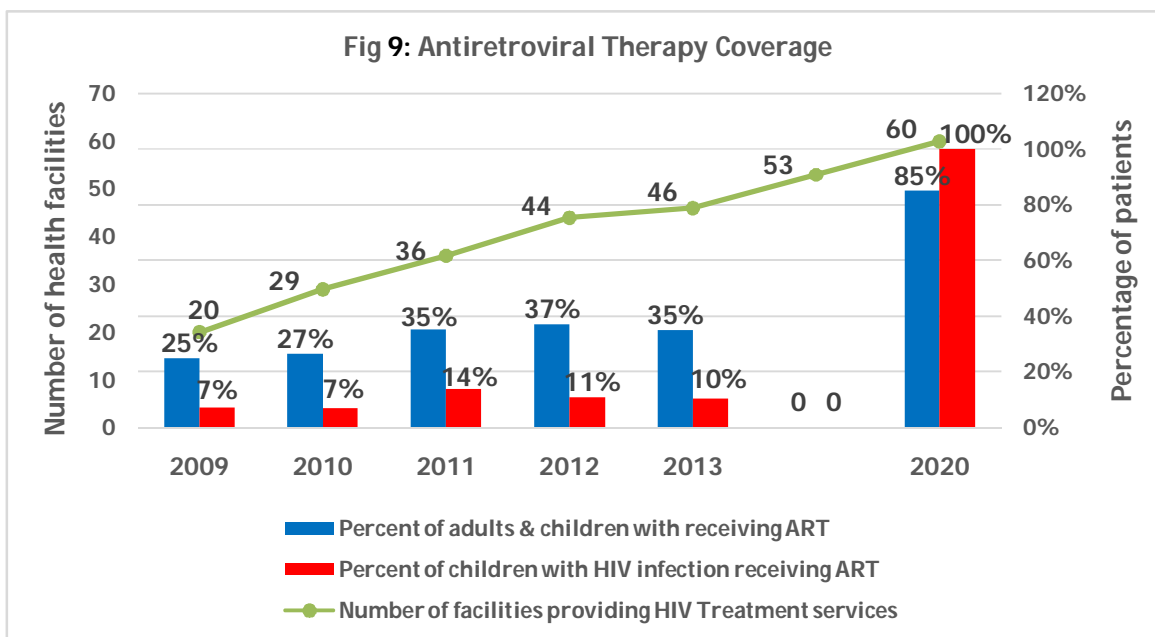


To date, the PMTCT program performed creditably by reducing the mother-to-child transmission rate for HIV at 6 weeks from 22% in 2009 to 13% in 2013 but in relation to the transmission rate including the breastfeeding period that reduced from 37% in 2009 to 29% in 2013 as shown in Fig.8. As breastfeeding is universal in Liberia, the program must intensify its efforts if it is to achieve the goal of eliminating new infections in children.



Antiretroviral Treatment (ART)

Together with HIV Prevention, the Antiretroviral Treatment (ART) Program is at the core of the National HIV and AIDS Control Program since the response to the epidemic started, in earnest, in the late 1980. The aim of the ART program is to achieve universal access to ARVs for at least 85% of eligible adults and all children in need of ART according to national guidelines. However, the number of facilities providing ART has remained low, increasing slowly from 20 facilities in 2009 to 46 in 2013. The ART coverage for both adults and children is not adequate; this is especially true for children (Fig.9). The adult ART coverage increased slowly, from 25% in 2009 to 35% in 2013. The ART coverage in children remains at a minimum, having increased to 10% in 2013 up from a low of 7% in 2009.

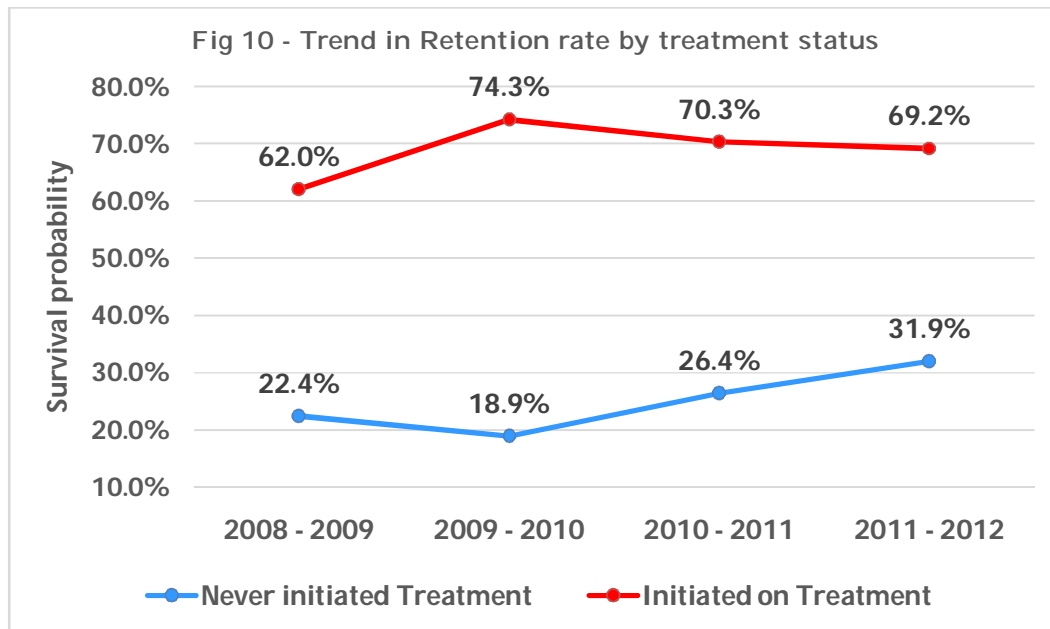


Lost to follow up (LTFU) is a continuing and serious challenge for the Care and Treatment Program. Not only is the ART program unable to reach its annual targets but it is also suffering from huge lost to follow up (LTFU) amongst PLHIV on ART and PLHIV in Care. The lost to follow up for patients on ART and patients not on ART are both large and unacceptable (Fig. 10). Patients not on ART are more likely to be lost to follow than those on ART. Between 2009 and 2012, the LTFU for patients on ART has been in a narrow band range of between 38% and 28% whilst that for patients not on ART is between 81% and 79%.

For patients on ART, an adherence level of 95% or more is required for continued viral suppression to prevent drug resistance through multiplication of mutant viruses. Lost to follow up by patients on ART very likely means the patient will not adhere to treatment and therefore mutant viruses could develop. This will jeopardize the ART program.

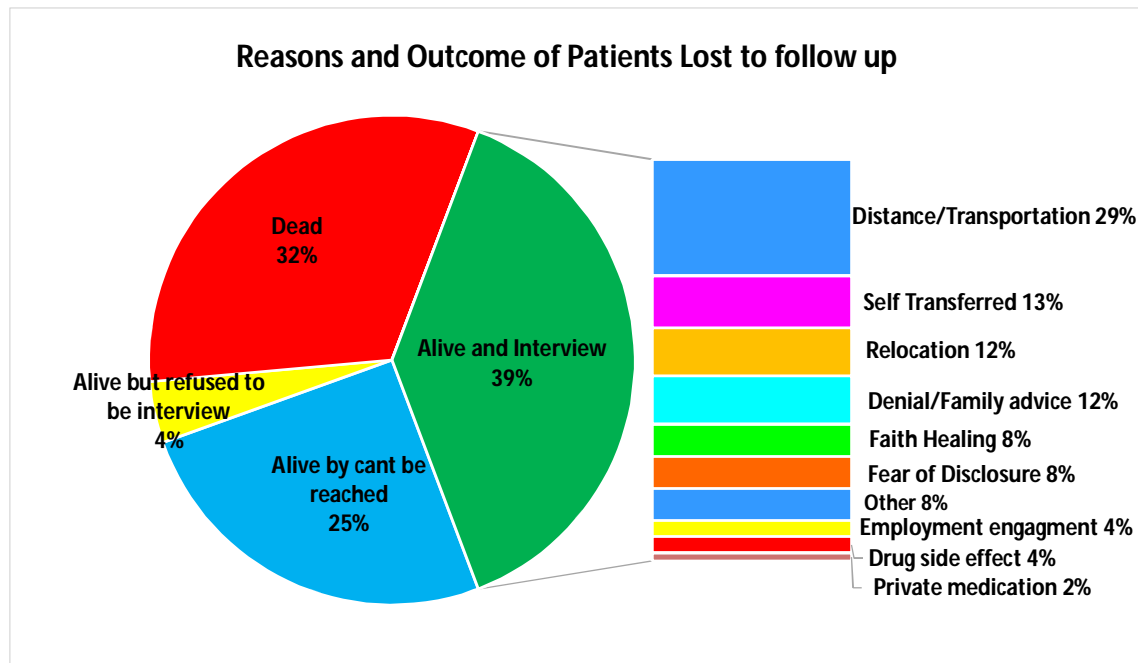
A MOHSW/NACP ART Cohort Study report provided evidence that LTFU is a serious challenge to the national HIV response. The study found that at 12 months of follow up, about 20% of the treatment group was LTFU and 9.4% had died and

67% of the non-treatment group was lost to follow up and 19% had died. At 12 months of follow up, the survival estimates among patients initiated on ART was 70% compared to 25% of patients not on ART.



Further enquiries (Fig11) into the LTFU revealed that 32% of PLHIV had died and 68% were alive. Some of those alive were tracked and interviewed and the most frequent reasons for LTFU include: distance from health facility providing ARVs (29%), self-transferred, relocation, and denial/family advice (37%) often indicate stigma and discrimination, and attending a faith healing facility (8%).

Fig11 - Reasons and Outcomes for LTFU



The Care and Treatment Program faces other serious challenges especially from the weak procurement and supply chain management system. These include stock out of drugs and test kits, lack of nutritional supplements to HIV positive babies and their mothers, weak health system (HR, lab services, poor quality of care, poor data quality, and inadequate monitoring and supervision) and high attrition of trained staff.

Mitigating the Socioeconomic Impact of HIV and AIDS

Similar to other countries in Sub-Sahara Africa, people infected and affected by HIV and AIDS in Liberia bear a disproportionately bigger burden of the socioeconomic impact of HIV and AIDS on the society. These impacts include stigma and discrimination against people infected or affected by HIV and AIDS including OVC, exacerbation of the gender inequality in society, and increased poverty on AIDS-affected households.

Stigma and discrimination against people living with HIV (PLHIV) and people affected by AIDS (PABA) are some of the most serious, pervasive, and persistent challenges hindering the attainment of the targets of the national HIV response. PLHIV face many forms of stigma and discrimination including marital problems, verbal abuse, physical assault, violence, psychological torment, harassment, and loss of employment. HIV and AIDS stakeholders including networks and associations of PLHIV are carrying out stigma and discrimination reduction activities including media campaigns in the country. Additionally, the GOL enacted legislation in 2010 that prohibits vilifying and/or discriminating against a person because of his or her perceived or real HIV status.

These actions notwithstanding, the Report of the 2013 Midterm Review of the National Strategic Framework II (NSF II) for HIV and AIDS 2010-2014, through key informant interviews and focus group discussion, noted the continuing existence of

significant stigma and discrimination against people infected and affected by HIV and AIDS at home, in the community, and in the workplace. Similar findings were also reported in the 2013 PLHIV Stigma Index Study including children thrown out of school, denied health and dental service, dismissed because of HIV, changed job description, lost job because of HIV status, and change of residence due to HIV status.

HIV and AIDS is exacerbating some existing gender inequalities in the country and increasing the burden of HIV and AIDS disproportionately on women and girls than on men and boys. Gender inequality driving the higher impact of HIV and AIDS on women than men continue to exist despite the efforts being made by HIV and AIDS and other development programs to bridge the gender gap. Persisting gender inequalities that increase the impact of HIV on women and girls include: gender norms related to masculinity that encourage men to have more sexual partners and older men to have sexual relations with much younger women; women face barriers to HIV and AIDS services due to their lack of access to and control over resources, child-care responsibilities, restricted mobility, and limited decision-making power; and women and girls have increased risk of HIV infection relative to men and boys, in part, because they are generally less well educated and have less control over the family resources including loss of inheritance especially under customary marriage.

The national HIV and AIDS response program is helping to enroll and keep OVC including girls in school and providing assistance to strengthen survival strategies of AIDS-affected household many of which are headed by women and orphans. Many CSOs are providing basic needs including food, clothing, and home-based care to AIDS-affected families to mitigate the effects of poverty brought on by HIV and AIDS. Additionally, Liberia has passed legislation that provides for women married customarily to have the same inheritance rights as widows of statutory marriage.

The GOL is making efforts to develop and implement social protection programs that will protect poor households including those affected by HIV and AIDS. In the context of the crosscutting pillar in the Aft, the GOL is committed to reducing the spread of HIV and AIDS and mitigating its impact on PLHIV and their families. To this end, GOL, with support from UNICEF, has been implementing a conditional social cash transfer program in 2 counties since 2012. The MOGD, with support from development partners, is implementing this program that has the potential to be expanded to all counties in the country.

Coordination and management of the national HIV response

The National AIDS Commission (NAC) was established by an Act of the National Legislature in 2010 to provide leadership and coordinate, manage, and mobilize resources for the multi-sectoral, decentralized HIV response. The NAC's Secretariat in Monrovia coordinates and supports the work of national coordination arrangements including the NAC Board of Directors, the Technical Working Groups (TWGs) for HIV Prevention, ART, OVC, PMTCT, Key Populations (MARPs), Research and M&E, and Partnership Forum.

It also coordinates the national HIV response activities with the Country Coordinating Mechanism (CCM) of Liberia. The Secretariat is responsible for policy and programs, M&E, partnerships, decentralization, and resource mobilization. These mandates are still young and are not functioning optimally yet.

Decentralizing the coordination and management of the HIV response to the counties is on-going and offices have been established in 8 of the 15 counties. The counties with decentralized offices are Bong, Bomi, Grand Bassa, Grand Kru, Lofa, Nimba, Maryland, and River Gee. The Decentralization mandate at NAC has employed and placed staff in 5 counties; in the other 3 counties, non-NAC staffs provide coordination as focal persons from MOGD in Grand Kru and from Ministry of Internal Affairs (MIA) in Maryland and River Gee Counties.

Inadequate funding continues to adversely affect progress towards reaching the targets of the national HIV response. The National AIDS Spending Assessment (NASA) in 2010/11 and 2011/12 indicates that external sources (mainly Global Fund and the UN System in Liberia) provide about 98% of the expenses while domestic sources contribute only about 2%. Inadequate funding is impacting negatively on efforts to improve both the coordination and management and effective implementation of HIV and AIDS programs.

The major program implementation challenges impeding the country's move toward its commitment of getting to zero new HIV infections, zero discrimination, and zero AIDS-related deaths are stigma and discrimination against people infected and affected by HIV and AIDS and inadequate pro-poor nationwide social protection programs. Stigma and discrimination keeps people including key and vulnerable populations away from knowing their HIV status, increases lost to follow up of people with HIV in care and on treatment, and in conjunction with inadequate social protection programs, increases AIDS-related deaths.

Human Resources

Chronic shortage of staff, high attrition of trained staff, and inability to meet WHO guidelines on minimum staffing norms are impacting negatively on the national HIV response. In the short term, shortages are being addressed through task-shifting and task-sharing alongside clinical mentorship from experienced staff to improve the quality of services. Additionally, the Global Fund is supporting the salaries and personal emoluments of more than 200 HIV and AIDS staff. Novel steps are being employed to retain health workers in rural health facilities including recruiting students from rural areas, exposing all students to rural working conditions during their training, and providing cash and transportation incentives.

Long-term solutions include health-training institutions increasing production of trained staff by increasing student intake and graduating quality trained health workers. In order to increase performance, central and county health teams visit health facilities and monitor the quality of work health workers are doing. Motivation for health workers is a challenge as there is no compensation for additional tasks or extra hours done. However, the Ministry has created some opportunities for career advancement, including master-level scholarships and specialized training in surgical procedures for medical doctors.

Funding of the national HIV response

The GOL was unable to meet its commitment on the Abuja Declaration to allocate 15% of national budget to the National HIV response; the best it has done is about 2% with a commitment to achieve the 15% counterpart financing by 2020. Funding for the multi-sectoral national HIV response is almost completely

externally driven and health sector centered. With no GOL budgetary support, no public sector ministries, departments and agencies (MDAs) have significant HIV and AIDS programs; the MOE, MOGD, and the Ministry of Defense that have HIV and AIDS programs are dependent on external funding.

The national HIV response is almost totally dependent on external sources of funding to implement its programs. The Global Fund and the UN system in Liberia have been meeting virtually all the annual expenses of the national HIV response. For example in 2012, the Global Fund provided about 81% and the UN system about 17% of the expenses while the government and small domestic sources contributed less than 2% of the expenditure. The GF provides a performance based grant and release of funds have been delayed on a number of occasions because the PR (the MOHSW) was not able to meet some Global Fund conditions precedent on time resulting in delays in implementation of program activities.

With so many competing needs for the very limited government resources, Liberia will continue to depend on external funding for its HIV and AIDS program for a long while yet. The political commitment to do more is very obvious but the opportunity to increase domestic funding is limited. Willingness to pay in the context for the New Funding Model (NFM) of the Global Fund grant will be a testing time for Liberia.

Strategic Orientation of the NSP 2015-2020

Vision

To create an AIDS-free society

Goal of the NSP

The Goal of the NSP 2015-2020 is to stop new HIV infections and keep PLHIV alive and healthy in Liberia.

Aim of the NSP

The aim of the NSP is to provide a results-based framework for driving the decentralized, multi-sectoral national HIV and AIDS response within which all HIV and AIDS evidence-based interventions are guided by the multi-sectorial approach that is led by NAC and implemented in Liberia.

NSP Guiding Principles

The following principles support and provide highlights to the strategies:

- ✘ A multi-sectoral approach characterized by advocacy and strategic partnerships
- ✘ Evidence-based and targeted interventions for HIV care, treatment and support services
- ✘ Meaningful involvement of PLHIV in all aspects of the response
- ✘ Participatory approaches for planning, monitoring and evaluating of the response
- ✘ Accountability and transparency to the national response
- ✘ Ensure rights-based approach to the national response

Key Elements of the NSP

The NSP 2015-2020 is an expression of the Liberia's commitment to achieving the universally desirable goal of "*Zero New HIV Infections, Zero AIDS-Related Deaths, and Zero Discrimination*". It is premised on the evidence of the epidemic in the Liberian context and driven by the country's determination to achieve sustainable results in a resource-constrained environment. The UNAIDS Investment Framework informs the choice of the priority interventions, critical social and programmatic enablers, and the synergies with development sectors in the NSP.

Five high-impact priority HIV activities along with selected key social and programmatic enablers will be implemented in synergy with selected key development sectors. The high impact activities are:

- 1) Targeted Behavior Change Interventions,
- 2) Condom Promotion and Distribution,
- 3) HIV and AIDS Program for Key Populations
- 4) Elimination of Mother- to-Child Transmission of HIV, and
- 5) Treatment, Care, and Support for People Infected and Affected by HIV and AIDS

The critical social and programmatic enablers are: Laws, Policies, and Practices; Stigma and Discrimination; the Media; Political Commitment, Advocacy, and Resource Availability; Community Participation; Coordination and Management; and Research, Monitoring and Evaluation. The selected key development sectors are: Health and Community Systems Strengthening; Education; Justice; Gender; Social Protection; and HIV Sector in the crosscutting elements of the National Agenda for Transformation (AFT).

Section One

Impact Results of the NSP 2015-2020

Impact Result # 1: Reduction of new HIV infections by 50% by 2020

The focus of this strategic plan is prevention of new HIV infections in order to maintain a low HIV prevalence in the next six years. New HIV infections are estimated at 1,789, including 309 in children 0-14 years in 2014. The NSP seeks to reduce new HIV infections by half (895) by 2020 through intensifying the provision of quality and accessible HIV prevention information and services for key populations and accelerating actions to eliminate mother-to-child transmission of HIV (eMTCT) by 2020 including implementing Option B+ as the preferred regime of treatment for HIV positive pregnant women.

Impact Result # 2: Reduced morbidity and mortality amongst PLHIV

The composite proxy indicator to reducing morbidity and mortality amongst PLHIV is the percentage of adults and children known to be alive 12 months after initiation of ART. Keeping PLHIV in care will reduce morbidity associated with opportunistic infections and keeping PLHIV eligible for treatment on ART will reduce AIDS-related deaths. Estimates from Spectrum shows 97% of AIDS-deaths will occur in patients **not** on ART and only 3% of deaths occur in patients on ART. The national HIV response will initiate ART on the higher CD4 cell count of 550 in 2015, up from 350 in the previous years. This will reduce morbidity and mortality amongst PLHIV.

Table 1.1: Impact Results Indicators and Targets

	Impact Result	Indicator	Baseline		Target 2020
			Value	Source and Year	
	Reduction of new HIV infections by 50% from 1789 in 2014 to 900 by 2020	% women and men aged 15-24 who are HIV infected	1.1%	Demographic and Health Survey 2013	0.6%
		% women aged 15-24 who are HIV infected	1.8%	ANC Sero Survey 2013	1.0%
		Percentage of selected key populations who are HIV infected	MSM: 19.8% FSWs: 9.8% PWIDs: 5%	2013 Liberia IBBSS	MSM – 10% FSWs – 5% PWIDs – 2.5%
		Estimated number of new infections annually	1789	NACP Spectrum Modeling 2014	579
	Survival of adults and children on ART improved from 74% in 2014 to 85%	% adults and children with HIV known to be on treatment 12 months after initiation of ART	74%	ART Cohort Study 2013	85%

	Impact Result	Indicator	Baseline		Target 2020
			Value	Source and Year	
	by 2020				
	Elimination of Mother-to-Child transmission of HIV	Percentage of infants born to HIV infected mothers who are infected with HIV at six weeks	9.6%	PMTCT Impact Study 2012	0.0%
		Percentage of infants born to HIV infected mothers who are infected with HIV at the end of breastfeeding	24.3%	PMTCT Impact Study 2012	9.75%

Mitigating the socioeconomic impact of HIV and AIDS on people infected and affected by the epidemic is a critical enabler for achieving the impact results of reducing new HIV infections and HIV and AIDS associated morbidity and mortality. Reducing stigma and discrimination against people infected and affected by HIV and AIDS, providing social protection services for and reducing poverty in AIDS-affected households are key interventions that facilitate reducing new HIV infections and reducing morbidity and mortality amongst PLHIV.

Section Two

Preventing New HIV Infections

Preventing new HIV infections is one of the two impact results of the national HIV response. It is an important component of the national HIV response and is treated under two sub-themes in the NSP: the Non-Clinical HIV Prevention and the Clinical HIV Prevention.

The major activities within Non-Clinical HIV Prevention are: a) behavior change communication interventions for the general population, young people, and people living with HIV and key populations; b) HIV prevention information and services for key populations (Section 4); and c) condom promotion and distribution (Section 5).

The activities for HIV Clinical Prevention are: HIV counseling and testing (HCT), ensuring blood safety, post-exposure prophylaxis (PEP), and management of sexually transmitted infections (STIs).

Preventing New HIV Infections: Non-Clinical

Behavior Change Communication Interventions

Behavior change communication interventions (BCC) are targeted at four distinct groups: general population, young people, and people living with HIV and key populations. The focus of these interventions is to prevent HIV negative persons from contracting the infection and to reduce the risk of transmitting the virus from infected to non-infected individuals.

1. Preventing HIV Infection in the General Population

Introduction

The NACP Spectrum modeling for HIV prevalence and AIDS estimates shows that there will be 1,789 new HIV infections in 2014 in the total population in Liberia. About 56% of these new infections will be in women. Liberia is determined to achieve the global commitment to reduce sexual transmission of HIV by 50% and is working towards achieving this by 2020.

Sexual transmission remains the most predominant mode of transmitting HIV infection in Liberia among adults 15+ years. People who inject drugs (PWID) are a universally recognized source of HIV transmission. The practice of needle sharing among PWID exists in Liberia; however, the size of the contribution from needle sharing to total new HIV infections in the country remains unknown. PWID infected with HIV and engage in unprotected sexual intercourse with uninfected partners have increased risk of transmitting HIV to their partners.

Achievements and Challenges

The NSP 2015-2020 has identified combination prevention strategy (CPS) as the overarching framework for preventing sexual transmission of HIV infections in the general population. Its goal is to consolidate and deepen efforts at reducing the transmission of HIV by implementing a combination of behavioral, biomedical, and structural interventions that are carefully selected to effectively respond in the context of the epidemic in Liberia. It includes behavior change messages and

activities that promote abstinence, delay of sexual debut, mutual fidelity in sexual relations, multiple partner reduction, correct and consistent condom use, treatment of STIs, reduction of harmful social and traditional practices including female genital cutting and rites of passage that involve blood-letting, and reduction of stigma and discrimination against people infected and affected by HIV and AIDS. Stakeholders from key government ministries, departments, and agencies at national and county level and the many civil society organizations (CSOs) including CBOs and FBOs are involved in activities that prevent HIV infection in the general population.

Attitudes and behavior change are not mirroring the existence of universal awareness of, and improving knowledge about, HIV and AIDS in the country. For example, knowledge of HIV prevention methods has increased since 2007 among women: knowledge of condom use and limiting sex partners increased from 44% in 2007 LDHS to 68% in 2013 LDHS. Yet condom use among women is low and concurrent multiple sexual partnerships are still common. Also most people know where to go and get tested for HIV, but voluntary counseling and testing (VCT) as a client initiated mechanism is not as frequently used as provider initiated counseling and testing (PICT). And despite the existence of a law prohibiting vilification and discrimination against PLHIV and intense campaigns and activities to reduce stigma and discrimination, the 2013 PLHIV Stigma Index Report shows that stigma and discrimination remain common.

Outcome

- **Sexual transmission of HIV infections in adults 15-49 years reduced by 50% from 1386 new HIV infections in 2014 to 693 in 2020**

The outcome will be tracked using the indicators and targets in Table 2.1.

Table 2.1: Sexual Transmission of HIV Outcome Indicators and Targets

Indicator	Baseline	Target	
		2017	2020
New HIV infections in adults 15-49 years	1386 (2014 NACP Spectrum Modeling)	719	693

Output

- **Adults 15+ years are adapting behaviors that reduce the risk of HIV infection from sexual intercourse.**

The indicators in Table 2.2 will be used to monitor behavior change in the general population in relation to sexual transmission of HIV.

Table 2.2: Sexual Transmission of HIV in General Population - Indicators

Indicator	Baseline	Target 2018
% Adults aged 15-49 years who had 2+ sexual partners in the past 12 months	Women – 6.5% Men – 17.6% (2013 LDHS)	Women = 5% Men = 12%
% Adults aged 15-49 years who had 2+ sexual partners in last 12 months and who report using a condom in their last sexual intercourse	Women – 20% Men – 24% (2013 LDHS)	Women = 70% Men = 78%

Strategies

Combination Prevention Strategy for sexual transmission of HIV will be used. The package of combination strategies is:

- Promotion of abstinence, delaying sexual debut, mutual fidelity, partner reduction, and avoidance of drug use.
- Promotion of condoms use, STI services, management of messages and programs to reduce injecting drug use.
- Strengthening the capacity of communities and local organizations to reduce HIV transmission.
- Promotion of HCT

Major Activities

The major activities will include the following:

HIV Prevention Information and Education: Activities and training to promote abstinence including delay of sexual activity, promoting fidelity (mutual faithfulness) in sexual relationship, reduction of multiple concurrent sexual partnerships, eliminating harmful social and community norms including female genital cutting, wife inheritance, sexual and gender based violence as part of a balanced prevention message approach, with condom social marketing and messages concerning the correct and consistent use of condoms in high risk sex. Activities will also educate individuals on the availability of routine, confidential testing and counseling, which must adhere to the approved national policies, guidelines, and protocols.

HIV Prevention Services: Promotion and distribution of male and female condoms, STI services, management of messages and programs to reduce injecting drug use, and messages and programs to reduce other health risks of persons engaged in high-risk behaviors.

Promote Community Involvement: Expand the capacity (training and technical skills acquisition, materials, and funding for HIV activities) of communities and local organizations to reduce HIV transmission through evidence-based, targeted, prevention programs that focus on changing social norms to promote the delay of sexual debut, abstinence, fidelity, multi-partner reduction, condom use, and reduction of stigma and discrimination against people living with HIV and AIDS and other marginalized groups.

2. Preventing HIV infection in Young People (15-24 years)

Introduction

More than two decades since the advent of the HIV epidemic in Liberia, the 2007 LDHS revealed only 27.2% young women and 21.8% of young men correctly identified ways of preventing HIV and rejected major misconceptions about HIV transmission while 17.2% of young women and 8.5% of young men had sexual intercourse before the age of 15 years. The survey also found that the prevalence of HIV in young people was 1.1%: young women had higher prevalence (1.6%) than young men (0.5%). The national HIV response therefore targeted young women and men as priority area for program intervention.

The 2013 LDHS shows HIV prevalence of 2% and 1.7% in women and men ages 15-49 years respectively. The HIV prevalence in young people 15-24 years is 1.8%. The survey also reveal 67% of young women and 59% young men ages 15-24 years know that HIV can be prevented by using condoms and limiting sexual intercourse to one uninfected partner. The survey also found that 8.6% young women and 12%

young men had 2 or more partners in the last 12 months and 25.6% young women and 32% young men reported using a condom during their last sexual intercourse.

The NACP 2014 HIV Prevalence and AIDS Estimates Report shows that young people ages 15-24 years will contribute about 34% of the 1,386 new HIV infections among all persons aged 15-49 years. HIV prevalence in young people 15-24 years is 1.8% and young people constitute about 9% (2,730) of the total HIV population of about 29,538 among persons aged 15-49 years in Liberia. Two out of every three young people living with HIV are women.

Achievements and Challenges

The major players providing HIV prevention information and services include the MOHSW ASRH Program, the Ministry of Youth and Sports, and the Ministry of Education HIV Prevention Education based on life skills for youth in school. Many CSOs are providing HIV prevention information and services for youth; however, most of these services are part of larger programs often of short duration targeting the general population including youth. There are no easily available data sources that quantify the number of youth that are reached with these programs nationwide, instead there are many reports of small projects in the country. PSI is one of a few NGOs that has a specific program targeting young people in school and out of school in at least 6 counties and that documents the program results.

While the MOHSW Adolescent Sexual Reproductive Health (ASRH) Program integrates HIV information and services into their Family Planning and Reproductive Health Program, the MOYS provided HIV prevention information and services for youth including HCT at 5 facilities in Margibi and Grand Bassa counties. The MOE HIV prevention education for young people is a school-based program that has incorporated HIV and AIDS education into the school curricula for grades 1 to 12 throughout the country. The PSI weekly interactive radio program "Let's Talk About Sex" in Monrovia, which has been running since 2009, has a very large youth listenership; PSI also runs the Healthy Actions Project, which, in collaboration with USAID's Advancing Youth Project, provides FP/SRH education and VCT services in 6 counties in addition to working with youth clubs and training youth peer educators. Additionally, PSI has launched Star brand condom, Liberia's first socially marketed condom that is available through private and public outlets.

Outcome

- **New HIV infections in young people reduced**

NACP estimates there are 476 new HIV infections in young women and men 15-24 years in 2014. Sixty-four percent of the new infections are in young women.

Output

Young people 15-24 years are adapting behaviors that reduce their risk of HIV infection

The outputs will be tracked using the indicators and targets in the Table 2.3

Strategies

- HIV Prevention Information and Services for young people
- Capacity building of organizations with a focus on youth

Table 2.3: Preventing HIV in young people impact Indicators and Targets

Indicator	Baseline	Target 2018
% young women and men 15-24 years who know HIV can be prevented by using condom and limiting sexual intercourse to one uninfected partner	Female = 67% Male = 59% (2013 LDHS)	94% 90%
% young women and men 15-24 years who had 2+partners in the last 12 months	Female= 8.6% Male = 12% (2013 LDHS)	6.5% 9%
% young women and men 15-24 years who had 2+ partners in the last 12 months and who used a condom during their last sexual intercourse	Female=25.6% Male = 32% (2013 LDHS)	80.% 84%
% young women and men aged 15-24 years who had sex before the age of 15	Men: 8.5% Women: 7.2% (2007 LDHS)	4.8% 9%
% young women and men 15-24 years who are living with HIV	1.1% (women and men) (2013 LDHS)	0.6%

Major Activities

The main activities are:

- **Build the capacity of youth organizations and CSOs with a focus on supporting activities for young people.**

Youth organizations supporting HIV services for young people need their capacities (training, funding, material support, and technical assistance) built to enable them provide accurate youth-friendly HIV prevention information and services. Capacity will be built to provide integrated adolescent sexual and reproductive services (ASRH).

- **Provide HIV prevention information and services for young people**

Train young people as peer educators using technologies that they are using to reach their peers with HIV prevention information on abstinence, being faithful, condom use, and drug use avoidance (ABCD). This information will be provided through interpersonal communication, multimedia, mass communication and social media.

- **Offer youth-friendly services at clinics in public and private health facilities.**

Clinics that offer quality services in a non-judgmental, respectful and welcoming environment would encourage youth to return for information and services as needed. This will demonstrate Liberia's commitment to changing the landscape for the provision of accessible care to youth.

3. Preventing HIV Transmission by PLHIV

Introduction

Advances in HIV treatment have dramatically improved the life expectancy and quality of life of people living with HIV. Expanded access to HIV counseling and

testing, and antiretroviral therapy have helped to transform HIV into a chronic disease. These advances magnify the urgent need to decrease HIV transmission.

With an estimated 29,538 people living with HIV in the country in 2014, the prevention of HIV transmission is of critical importance. As PLHIV live longer, it becomes increasingly important to prevent and control the spread of HIV.

Achievements and Challenges

As part of the national HIV response, people living with HIV should either be on treatment or in care. All PLHIV are urged to join support groups. PLHIV not on ART are in care, placed on cotrimoxazole preventive therapy, and are followed up at regular intervals at the health facility where they are examined and checked for opportunistic infections including TB, and counseled on the need to prevent the transmission of HIV to others and should adopt safer sex practices including condom use. They also have their CD4 cell count done at regular intervals. Patients on ART have a similar regimen as those not on ART. The challenges for PLHIV in care and PLHIV on ART are similar: they both face stigma and discrimination and lost to follow up when they fail to keep three consecutive clinic appointments for a variety of reasons. PLHIV in care are more likely to be lost to follow up than PLHIV on ART.

Outcome

- **People living with HIV are actively involved in preventing the transmission of HIV.**

Output

- **Increased retention rate of PLHIV not on ART at 12 months follow-up**
- **Increased retention rate of PLHIV on ART at 12 months follow-up**

The indicators and targets in Table 2.4 will be used to track the output

Table 2.4: Retention Rate of PLHIV at 12 months

Indicator	Baseline		Target					
	2013	2014	2015	2016	2017	2018	2019	2020
% of adult and children not on ART that are retained in care at 12 months of follow-up	24.7%	29%	33%	36%	39%	43%	47%	50%
% of adult and children on ART that are retained in care at 12 months of follow-up	69.9%	72%	74%	76%	78%	80%	82%	85%

Strategy

The Positive Health, Dignity, and Prevention (PHDP)

Formerly called Prevention with Positives, PHDP will be the cornerstone strategy for caring for PLHIV. The aim of PHDP is to keep PLHIV in good health as well as prevent transmission of HIV to uninfected sexual partners. The strategy encompasses three interrelated systematic delivery of a range of combination behavioral, and sociocultural services within local communities. The other two components are: preventing illnesses including opportunistic infections (OIs), malaria, TB and other diseases, and practicing self-care and positive living through a range of basic lifestyle practices including: reducing or eliminating alcohol and tobacco use, maintaining good hygiene, eating a healthy diet and maintaining emotional and mental well-being.

Major Activities

The major activities include the following:

PLHIV Support Groups

The main activities are:

- Training and mentoring of PLHIV support group members and community volunteers (CVs) to incorporate PHDP into community-level activities
- Work with local PLHIV support groups to train and mentor group members in PHDP and supportive communication with peers.
- Build capacity of PLHIV support groups and community volunteers to discuss sensitive subjects such as safer sex, condom use, and fertility desires among HIV-infected individuals.
- Strengthen referral procedures for FP, PMTCT, TB, STI, mental health, and other PHDP-related services at health facility and community level.

Facility level activities for individual PLHIV will include:

- Assessment of adherence to ART and support for adherence counseling.
- Condoms and lubricant and risk-reduction counseling.
- Assessment of partner status and provision of partner testing.
- Assessment for sexually transmitted infections and provision of treatment.
- Assessment of family planning needs and provision of family planning services.
- Enrolment of PLHIV in community-based programs such as home-based care and support groups.

Community level activities:

Community level activities will focus on the following:

- Stigma and discrimination reduction against people infected and affected by HIV and AIDS.
- Support communication about HIV and sex, disclosure to partners, and access to services.
- Addressing structural factors to include efforts to reduce and eliminate cultural and traditional barriers to care and support for PLHIV at community level.

Section Three

Preventing New HIV Infections – Clinical Prevention

The clinical prevention of HIV infection is provided in clinical settings by trained clinical staff. The services are provided at health facilities run by the MOHSW, FBOs, companies, and individuals. They are also provided as outreach activities. The main service delivery areas for the clinical prevention of HIV infection are HCT, Blood Safety, PEP, and STIs.

1. HIV Counseling and Testing (HCT)

Introduction

As the gateway to clinical HIV and AIDS services including PMTCT, ART, and mitigation services, the provision of quality HCT services is a top priority for the national HIV response. The CSOs, FBOs, and the county and district health teams are among key stakeholders involved in the process of generating demand for HCT services within communities through interpersonal communication and awareness and sensitization campaigns at community meetings and gatherings, on the radio and TV, and in the print media. To ensure increased and sustained demand for the HCT services from the communities, stakeholders work closely with motivated community leaders from traditional authorities and faith-based organizations.

The HCT program provides pre-test counseling, testing, and post-test counseling services to clients principally through provider initiated counseling and testing (PICT) approaches using trained counselors and clinicians at public and private health facilities. This is supplemented by voluntary counseling and testing (VCT) and the occasional outreach and special events program.

Achievements and Challenges

The NACP revised the national HCT guidelines in 2012 to standardize testing protocols and training of counselors. The HIV counseling and testing services are delivered through multiple service delivery points including outpatient and inpatient departments of health facilities, antenatal care clinics, maternal and child health clinics, family planning clinics, and TB clinics. Since 2009, the NACP has scaled-up the provision of HCT services: 369 sites were providing HCT services in 2013, up from 91 sites in 2009. The percentage coverage of people who were tested and counseled for HIV and who know their test results increased from 3% in 2009 to 10% in 2013. The HIV rapid test kits (RTKs) are supplied by the NACP. Clients receive the test results the same day. The program has ensured adequate availability of rapid test kits and stock outs occur only occasionally.

The biggest challenge to the HCT program includes referral and linkages to care and treatment programs and the acceptance of positive HIV status. The fear of stigma and associated discrimination keeps many people from finding out about their HIV status, even when key populations like FSWs and MSM know they are at risk of HIV infection. Many clients also fear healthcare workers will disclose their HIV status, thus bringing them more stigma and discrimination in the community. The PLHIV Stigma Index Report points to the stigma and discrimination PLHIV endure at the hands of family, friends, and colleagues, thus making going for an HIV test unattractive. In 2010, the GOL passed legislation that prohibits vilification

and discrimination against a person because of his or her perceived or real HIV status as well as health workers leaking information about the HIV status of clients. These efforts notwithstanding, stigma and discrimination prevent people from getting an HIV test.

Outcome

Number of people tested, counseled and know their status

Output

- **Number and percentage of people who are tested and counseled and know their results**

The key outputs of the HCT program will be:

- Number of health facilities providing HCT services
- Number of men and women who were tested and counseled for HIV and who know their results

The outputs will be tracked using the indicators and targets shown in Table 3.1.

Table 3.1: HCT Output Indicators and Targets

	Indicator	Baseline (2013)	Targets					
			2015	2016	2017	2018	2019	2020
	Percentage of women and men who received HIV test in last 12 months and know their results	209,381 10% (2013 NACP Data)	285,192 (13%)	337,756 (15%)	344,858 (16%)	352,101 (16%)	359,495 (16%)	367,044 (17%)
	Number of health facilities providing HIV counseling and testing services according to national guidelines	335 (2013 NACP Data)	455	498	540	583	626	669

Strategies

- **Maintaining existing HCT sites and establishing new ones**

All existing sites will be effectively maintained to provide quality HCT services. New sites will be established in both urban and rural areas where existing facilities are few in relation to the need. To further enhance HIV and TB collaboration, HCT services will be established in some DOTS centers used by the TB program. Additionally, the project will work to increase HCT coverage through outreach programs to communities including hard to reach rural areas.

- **Ensuring the delivery of quality HCT services**

Clinicians and counselors providing HCT services will receive in-service training and mentoring support including training on provider initiated testing and counseling and confidentiality of client information. Rapid test kits and other commodities will be provided to ensure no stock outs occur. Referral services between the HCT program and other HIV programs including TB, ART, PMTCT, and support groups and community-based services will be enhanced.

- **Expansion of the HCT quality assurance**

The HCT quality assurance system will be expanded to cover all the health facilities providing HCT services. This system is critical in ensuring QA of HCT services on a wider scale. The expansion of the system will improve the QA skills of staff at the

central and decentralized levels and will require additional staff at the county and district levels to supervise the HCT services including the system for specimen testing in reference laboratories and observing HCT sessions.

- **Community participation in the provision of HCT services**

The program will facilitate and support capacity building for CBOs, including community volunteers, support groups and FBOs to generate demand at the community level for the HCT services. Capacity building will reflect the needs of participating organizations and will include training, material and other in-kind gifts and donations, and funding for community based activities.

2. Blood Safety

Introduction

The Blood Safety Program in the MOHSW is responsible for ensuring the availability, safety, quality, and security of blood supply to meet the national blood transfusion requirements. The program estimates that 35,000 units of blood are required to meet the annual national blood transfusion demand. It is mandatory that all donated blood is screened for HIV, hepatitis B, hepatitis C, malaria, and syphilis in a quality assured manner. The program has only two blood banks in the country: one is located in Monrovia, Montserrado County in the Western Region and the other is in Phebe Hospital, Bong County in the Central region.

On the average, the Blood Safety Program is only able now to provide no more than 12,500 units of screened blood for the country annually. The program aims to meet the national blood transfusion requirements mainly from voluntary non-remunerated blood donation (VNRBD) sources in the near future. The two blood banks obtain VNRBD-blood mainly from students. Paid donors are overwhelmingly the most predominant source of blood supply for the 37 facilities that do blood transfusion. These facilities collect, screen, and store the blood for transfusion.

Achievements and Challenges

About 290 health workers including laboratory technicians, registered nurses, midwives, physician assistants, and physicians from various health facilities have been trained in blood safety and blood use. Thirty-seven health facilities do blood transfusion in the country. However, the program is not always able to meet requests for blood from these facilities which therefore have to collect and screen much of the blood they need. In 2012, only 36% (12,647) of the national requirements of 35,000 blood units were available for transfusion. In addition to supplying the health facilities with safe blood, the program also provides facilities with blood donor registers.

Two blood banks are insufficient to serve the country and plans to build additional three facilities have been on the drawing board for a long time now. The Global Fund has approved funding for building two additional blood banks and land has been secured for that purpose in Voinjama, Lofa County, the North West Region and in Zwedru, Grand Gedeh County, the South-East Region. Funding has yet to be acquired for the blood bank to be located in Harper, Maryland County, the Southern Region.

The Blood Safety Program is clearly unable to meet the requests for blood from the health facilities, in part, because of insufficient funding to do intensive and

extensive social marketing to increase its VNRBD base, which is mainly from students. Additionally, because of logistical problems the program is not able to carry out its responsibility for quality assurance for blood that is screened at the health facilities. The program has only two old vehicles that are very often not in good condition.

Outcome

- **The Blood Safety Program of the MOHSW is meeting the national need for safe blood.**

Output

- **35,000 units of safe blood are available for transfusion by 2020**
- **3 additional blood banks are constructed in the country.**
- **Ag-Ab Combo HIV screening test adopted as the primary method for screening blood for HIV**

ELISA is the screening method for screening blood for HIV. Ag-Ab. Combo techniques that detect HIV infection in the window period should be the preferred screening method.

- **Capacity at the Blood Safety Program strengthened**

Staffs at the program have received no training in blood safety and laboratory practice in recent times. Staff should update their knowledge and skills through training. New vehicles are needed for supervision to ensure quality assurance at all facilities that offer blood transfusion services.

The output will be tracked using the indicator and targets shown in Table 3.2

Table 3.2: Blood Safety Output Indicators and Targets

	Indicators	2013 Baseline	2015	2016	2017	2018	2019	2020
	Cumulative number of functioning blood banks in the country	2 Blood Banks: Monrovia and Phebe	3	4	5	5	5	5
	Number (%) units of safe blood available for transfusion	12,500 (36%)	16,259 (46%)	23,750 (57%)	23,750 (68%)	27,500 (79%)	31,250 (89%)	35,000 (100%)
	Ag-Ab Combo test kit introduced as primary HIV screening method	Not Available						
	Number of vehicles bought for quality assurance work	2 (Often not roadworthy)	3	0	2	0	0	0
	Number of program staff trained in blood safety	3	12	5	5	5	5	5

Strategies

- Social mobilization campaigns for voluntary non-remunerated blood donation (VNRBD). The social mobilization campaigns will target population groups with low-risk of HIV infection as the major source of donated blood for transfusion. As people are reluctant to donate blood voluntarily, blood drives within schools are the major source of blood in the country. This will be supplemented by walk-in donations and family replacements. There is therefore a need to establish and provide adequate resources for a vibrant national social marketing campaign to increase VNRBD and ensure the availability of safe blood in the country. Providing adequate human, material, and financial

resources will strengthen the National Blood Transfusion Program in the MOHSW.

- Strengthen laboratory quality assurance system.
- Build the capacity of the NBSP.
- Improve the management of laboratory equipment, services and maintenance
- Develop a network of communication and referral linkage services within a tiered laboratory system.
- Develop an integrated monitoring and evaluation system for all diagnostic services.
- Construction of blood banks

Blood banks are vitally important for storing adequate quantities of safe blood. Three of the five regions do not have blood banks. New blood banks will be constructed in Voinjama, Lofa County to serve the North West Region, in Zwedru, Grand Gedeh County to serve the South East Region, and in Maryland County for the Southeastern Region.

- Blood safety

Effective and efficient screening, storage, and distribution of blood to health facilities and a robust quality assurance at all facilities by trained staff are essential for blood safety. The Blood Safety Program will acquire and use Ag-Ab Combo approach that detects HIV infection in the window period as the tool for screening blood for HIV. The program will also ensure all blood collected and screened at the health facilities are safe through a robust quality assurance program. Staff will be trained and provided with adequate transport to conduct robust quality assurance at all facilities countrywide.

Major Activities

The major activities will include:

- Conduct social marketing campaigns to recruit and retain voluntary non-remunerated blood donors as the major source of donated blood.
- Procure Ab-Ag Combo equipment and commodities for screening all donated blood for HIV.
- Build three additional blood banks in the country.
- Procure one Real-time Viral Load machine with necessary reagents and consumables.
- Provide training for the staff of the Blood Safety Program.
- Provide training for laboratory staff in modern blood safety and screening techniques including Ag-Ab Combo screening for HIV.
- Provide robust quality assurance for blood screening at the health facilities.
- Procure adequate amounts of consumables needed for blood drives
- Strengthen the working relationship with hospitals in closest vicinity to blood donor centers
- Work with hospitals to implement a system to ensure blood is not sold
- Develop a plan for donor recruitment and retention
- Maintain laboratory equipment including service contracts procurement
- Procure and distribute PEP
- Train on blood safety and quality assurance and control.
- Review existing EQA program for HIV and CD4 testing.
- Develop an integrated laboratory management information system that will tie in with the supply chain system.
- Scale up automated services with Eliza at facilities doing blood transfusion.
- Conduct quality assessment on test kits for screening blood and related products for transfusion.

3. Post Exposure Prophylaxis (PEP)

Introduction

The main targets of the PEP program are healthcare workers who have occupational risk of HIV infection from dealing with HIV positive patients and/or handling HIV infected materials; and victims of rape, sexual violence, and defilement who are at an increased risk of HIV infection following forced sex that causes lacerations and abrasions.

The magnitude of needle prick injury in health workers in the program is not known. However, strict observance of universal precautions in infection control by program staff makes this an infrequent occurrence at health facilities. Proper disposal of medical waste, particularly blood and blood products, tissues, and sharps is an important measure to control infections, including HIV. The health facilities have proper waste disposal facilities including bins and incinerators.

Achievements and Challenges

NACP has developed treatment protocols² that specify the PEP regimen and package of services to be given to survivors of sexual assault and rape. The package includes emergency contraception, prevention and treatment of STI, prevention of tetanus, HIV post-exposure ARV prophylaxis, and counseling. The UNFPA has provided rape prophylactic kits for STI and PEP for accidental occupational and sexual exposure to major health centers and hospitals in the country and has contracted the MSF hospital in Paynesville to organize RAPE management training for the HIV and AIDS stakeholders in the country. The MOHSW is strengthening health sector capacity to integrate PEP into health facilities providing PMTCT and ART services.

The Global Fund is supporting the construction of incinerators for health facilities. About 18 incinerators have been built under this program. The MOGD recorded nearly 2,500 cases of sexual and gender-based violence in 2013; nearly 50% of the SGBV were reported as rape cases. It is not known how many of these rape victims received PEP services.

Many health workers are unaware of the increased risk of HIV infection from their professional work. Even when they are exposed to HIV infection risk including needle pricks, they very often do not seek PEP. Some survivors of rape, sexual violence, and defilement are not aware that PEP services are available and the police who handle these cases may not refer survivors for PEP within 3 days after the assault in order for survivors to benefit optimally from the ARV prophylaxis.

Outcome

- **The delivery of PEP services at health facilities has improved**

PEP is needed to prevent HIV infections from accidental occupational incidents among health care workers and especially for survivors of rape, gender-based violence, and defilement. The occurrence of rape, sexual violence, and defilement

²Integrated guidelines for Prevention, Testing, Care and Treatment of HIV and AIDS in Liberia (Third Edition 2010)

remains very high in the country. The HIV and AIDS program will intensify efforts to provide PEP services to the rape survivors and to occupational incidents that increase the risk of HIV infection.

Output

- **Increased access to quality PEP services**

There are currently 335 PMTCT and ART health facilities that have the capacity to deliver PEP services in the country. PEP facilities should always have trained staff and ARVs available at all times. The referral system between health facilities providing PEP services, police stations and facilities without PEP services will be strengthened to ensure people who need PEP services receive them.

Strategies

- **Strengthen the integration of PEP services with PMTCT and ART services**

PMTCT and ART trainings should include PEP and facilities providing PMTCT and ART services should provide PEP services.

- **Awareness creation and sensitization on the need and availability of PEP services**

Widely disseminate information, education, and communication on the availability of PEP services especially to health workers and the police

- **Strengthen training and provide resources for PEP**

Integrate universal infection prevention measures into the training for health workers; train clinicians providing PEP services on the national guidelines; and train the police on referral procedures for rape and sexual violence survivors to health facilities for PEP.

- **Proper disposal of medical waste**

Bins will be provided for proper disposal of sharps and incinerators for the proper disposal of medical waste.

- **Improving data on PEP**

This will include working with the SGBV Task Force of the MOGD and the police on standardizing data collection protocols on PEP.

4. Management of Sexually Transmitted Infections (STIs)

Introduction

Sexually transmitted infections are a major public health problem in Liberia. There is a strong correlation between the spread of conventional STIs and HIV transmission. STI is often referred to as the superhighway for HIV transmission. Both ulcerative and non-ulcerative STIs have been found to increase the risk of sexual transmission of HIV. The HIV pandemic has focused greater attention on STIs, making effective management and control of STIs a priority area in HIV prevention programming.

Achievements and Challenges

Liberia adopted in August 2009 a comprehensive approach to STI prevention and control by developing the 2nd edition of the guidelines for syndromic and etiologic management of STIs; standard operating protocols for STIs were also developed to

improve the quality of STIs management. The guidelines focused on BCC strategies as well as effective and prompt STI case management. About 436 health facilities have been capacitated and 473 health workers trained to manage STI cases, using the syndromic approach. Contact tracing is a major challenge as STI patients are not willing or able, especially if they are females, to convince the partners to come for counseling and treatment. Using the WHO syndromic management approach some 168,865 cases of sexually transmitted infections were diagnosed and treated in 2013.

Outcome

- **Patients with sexually transmitted infections are managed according to National STIs Guidelines.**

Output

- **Number of patients receiving diagnosis and treatment for STIs according to national guidelines.**

Table 3.3: STIs Output Indicators and Targets

	Indicators	2013 Baseline	Target					
			2015	2016	2017	2018	2019	2020
1.	Number of patients receiving diagnosis and treatment for STIs according to national guidelines	168,865	197,440	193,052	188,665	184,277	179,890	175,502

Strategies

Syndromic management of STIs according to National STIs Treatment and Control Guidelines.

Major Activities

The major activities include the following:

- Train healthcare providers on the revised national STI management guidelines.
- Provide STI services as part of integrated healthcare services at all service delivery points.
- Procure and distribute drugs for treatment of STIs
- Identify and remedy bottlenecks to improve quality and accuracy of STI data
- Monitor and supervise health workers to ensure STIs are managed according to the national guidelines.
- Develop and implement an effective contact tracing system.
- Conduct a nationwide culture and sensitivity testing of STI etiological agents, preferably every 4-5 years. This will provide guidance in revising the syndromic management of STI, which should be done periodically.
- Re-enforce IEC material and BCC messages on the link between STI and HIV at all STI clinics.

Section Four

HIV Prevention Programs for Key Populations (KPs)

Introduction

Evidence from countries within the West Africa region indicates FSWs, MSM, and people who inject drugs (PWID) are key drivers of the HIV epidemic. The Liberia national HIV response therefore started providing HIV prevention information and services for these groups in 2010 while plans were developed to carry out a study to estimate the sizes as well as determine the HIV prevalence among the key populations.

Achievements and Challenges

In 2011, the NAC commissioned a size estimation study of FSWs, MSM, and drug users that reported there are 1822 FSWs, 711 MSM, and 457 PWIDs in Liberia. About 20% of MSM regularly, and 60% sometimes, have sex with women. Many people consider this study has grossly underestimated the sizes of all three groups of KPs. In 2012, the NACP supported three CBOs to start providing HIV prevention information and services to FSWs, MSM, and PWIDs while planning to determine the HIV prevalence in these and other groups thought to be most at risk for HIV infection.

The 2013 NAC-supported Integrated Bio-Behavioral Surveillance Survey (IBBSS) confirmed MSM, FSWs, and PWIDs as key populations with HIV prevalence of 19.8%, 9.8%, and 5.0%, respectively, which are much higher than the 1.9% general population prevalence in the 2013 LDHS. Other groups identified as KPs in the 2013 IBBSS are uniform services with HIV prevalence of 5%, transport workers (long distance bus and truck drivers) 4.8%, mobile traders 4.5%, and miners 3.8%. It is noteworthy that the first three KP groups are engaged in activities that stigmatize them. The work of the last four groups takes them away from home; and their HIV acquisition is most likely due to being clients of sex workers. The IBBSS also reveals that out of school youth (OSY) and in school youth (ISY) have HIV prevalence of 1.9% and 1.1% respectively; the out of school youth prevalence is the same as in the general population but the in school youth is lower.

Whereas access to HIV prevention information and services by key population groups whose work frequently takes them away from home can be described as average, KP groups engaged in activities that stigmatize them have poor access. Though deemed inadequate, the security sector (Armed Forces of Liberia, Liberia National Police, Bureau of Naturalization and Immigration, and Bureau of Corrections) receives support to provide HIV prevention information and services to their staff. Mobile traders, transport workers, and miners access HIV prevention information and services that are provided to the general population.

Stigma and discrimination, very limited experience and weak capacity of local civil society service providers are the main reasons why MSM, FSWs, and PWIDs have poor access to HIV prevention information and services. The NACP had subcontracted Reach and Integrated Community Development Center, the Network for Community Development Inc. and Stop AIDS in Liberia to provide KP services. Local civil society organizations (CSOs) that have the potential to provide HIV prevention information and services for MSM and other key populations and PLHIV if their capacities are strengthened include: Stop AIDS in Liberia (SAIL) and All Plus

both are providing services to MSM and other KPs; Health Education and Advocacy for Key Populations which provides services to FSWs and other KPs; LIBNEP+ provides services to PLHIV and KPs; LIWEN an advocacy and empowerment group with a focus on women and HIV and AIDS; and PSI which provides outreach & HIV prevention education to FSWs.

Data is not readily available on access to HIV prevention information and services especially for MSM and PWIDs. Currently, FSWs are receiving more focus from the national response than MSM or PWIDs. But even for FSWs, only 28.2% have been reached with HIV programs in 2013.

Outcome

- **New HIV infections in Key Populations are reduced**

The NSP 2015-2020 seeks to provide targeted information and services to reduce new HIV infections in 7 key population groups with high HIV prevalence identified as the key drivers of the epidemic. KPs have not been a major focus of previous national HIV frameworks and the specific contribution of KPs to the total new infections will be determined by the proposed Liberia Modes of Transmission (MoT) Study. Preliminary work shows key populations are ready to participate in the national HIV response. Adequate investment in funding and time in efforts to reduce stigma and discrimination especially against MSM, FSWs, and PWIDs will yield the desired outcome of reducing new HIV infections in key populations.

Output

- **Proportion of each specific Key Population group reached with HIV prevention programs**

Specific HIV prevention information targeting the different information needs of each KP group will be provided. The program will provide HIV counseling and testing, provision of condoms and lubricants, and treatment of STIs as common services for all key population groups. The indicators and targets in Table 4.1 will track the output.

Table 4.1: KP Impact Indicators and Targets

	Indicators	2013 Baseline	2016	2019
1.	% FSWs reporting the use of a condom with their most recent client	81.7%	88%	95%
2.	% FSWs who received an HIV test in past 12 months and know their results	31.3%	53%	75%
3.	% FSWs who are living with HIV	9.8%	7%	5%
4.	% MSM reporting the use of a condom the last time they had anal sex with a male partner	19.5%	52%	85%
5.	% MSM that have received an HIV test in past 12 months and know their results	44.4%	61%	77%
6.	% MSM who are living with HIV	19.8%	15%	10%
7.	% PWIDs reporting the use of a condom the last time they had sexual intercourse	44.3%	66%	87%
8.	% PWIDs who received an HIV test in the past 12 months and know their results	27.9%	50%	73%
9.	% PWIDs who are living with HIV	3.9%	3%	2.5%

Strategies

- **Providing HIV prevention information and services for key populations**

HIV prevention information and services to meet the needs of each specific KP group will be provided. The HIV prevention information and services needs of the different key population groups are similar in the delivery approach but different in contents. Therefore, the provision of the information and services will reflect the unique requirements of each KP group. The key information and services that will be provided for each KP group are shown in Table 4.2.

Major Activities

The major activities for key populations are shown in Table 4.2

Table 4.2: HIV Prevention Information and Services for Key Populations

	KP Group	Provide HIV Prevention Information	Provide HIV Prevention Services	Key Service Providers
	MSM	Peer Education; Use of information communication technologies including telephone, SMS, Twitter, Facebook, Foursquare	Condom and condom-compatible lubricants promotion and distribution, psychosocial support, STI treatment, provision of HCT services at friendly health facilities or outreach to hotspots	CSOs
	FSWs	Peer Education; Use of information communication technologies including telephone, SMS, Twitter, Facebook, Foursquare	Condom and condom-compatible lubricants promotion and distribution, promotion and distribution of female condoms, psychosocial support, STI treatment, provision of HCT services at friendly health facilities or outreach to hotspots	CSOs – including health education and advocacy for KPs
	Uniform Services	Peer Education; Use of information communication technologies including telephone, SMS, Twitter, Facebook, Foursquare,	Condom provision, psychosocial support, STI treatment, provision of HCT services at health facilities for uniform services	Ministry of Defense, Liberia National Police, BNI, Bureau of Corrections
	PWIDs	Peer Education; Use of information communication technologies including telephone, SMS, Twitter, Facebook, Foursquare,	Condom provision, psychosocial support, STI treatment, provision of HCT services at KP friendly health facilities or outreach to hotspots	CSOs
	Transport Workers	Peer Education; Use of information communication technologies including telephone, SMS, Twitter, Facebook, Foursquare,	Condom provision, psychosocial support, STI treatment, provision of HCT services at health facilities or truck stops	Work through Ministry of Transport & Transport Associations
	Mobile Traders	Peer Education; Use of information communication technologies including telephone, SMS, Twitter, Facebook, Foursquare,	Condom provision, psychosocial support, STI treatment, provision of HCT services at health facilities or marketplace	Work through Liberian Marketing Association
	Out of School Youth (OSY)	Peer Education; Use of information communication technologies including telephone, SMS, Twitter, Facebook, Foursquare,	Condom provision, psychosocial support, STI treatment, provision of HCT services at youth friendly health facilities or outreach site	CSOs MOYS
	In school Youth (ISY)	School-based HIV prevention information – causation, transmission, and prevention	activities of School Health Clubs	Ministry of Education

Section Five

Condom Promotion and Distribution

Introduction

Consistent and correct condom use reduces the risk of sexually transmitted infections including transmission of HIV. In Liberia, there are taboos, cultural, and religious factors that inhibit discussions of sex. These factors hinder condom promotion, distribution, and use. These factors notwithstanding, condoms are widely distributed free of charge by NACP, Family Health Division of MOHSW, Family Planning Association of Liberia, and other implementers in health facilities. Line ministries have HIV focal persons who distributed condoms to the adult population and high-risk groups. A private investor has obtained government approval to start manufacturing condoms for sale in the country.

PSI, an international NGO, has developed and has been implementing social marketing strategies of condom distribution. It has distributed large quantities of condoms to commercial pharmacies and medicine stores since 2010. Its brand "Star Condom" is of high quality, and is popular among key youth audiences. However, distribution is limited to a few counties - Montserrado, Cape Mount, Bassa, Bong, Margibi, and Nimba. With modest additional funding, the number of Star condoms purchased could easily double or triple, as it is the preferred brand in Liberia.

Achievements and Challenges

The Liberia condom policy expired in 2013 and quantification of the total national condom requirements has not been carried out for 2015-2020. There are plans to develop a new condom policy which will be used to guide quantification of the national condom needs.

Data from the 2013 LDHS shows that condom usage, although still low among the general population, is an improvement on the 2007 LDHS findings: in 2013 LDHS, 20% women who had more than one sex partner in past 12 month reported using a condom, up from 13.5% in 2007 LDHS. Similarly, 24% of men who had more than one sex partner in the past 12 months reported using a condom, about the same as the 2007 LDHS of 22.3%.

Activities promoting and distributing condoms are largely conducted by public health facilities and community-based organizations who are promoting its dual utility: preventing unwanted pregnancies and preventing sexually transmitted infections including HIV. Some major condom promotion activities include social marketing of a Liberian branded 'Star' condom by PSI, the production of print and audio communication materials, community based sensitization activities, and the setting up of distribution outlets at community level.

About 9 million pieces of male condoms were distributed in 2013. Some of these distributions were done through condoms dispensing points set up in communities around the country in addition to facility based condom dispensing points at almost all public health facility in Liberia.

Condom promotion and distribution interventions in Liberia are primarily focused on the male condoms. Female condoms are relatively new and are not in demand. Generally, female condom distribution is very limited in the country.

There are peculiar challenges with the female condom. In most relationships, men take the lead in when and how to have sex. It is therefore difficult for women to initiate sex and discuss sexually related topics. Thus, inserting a female condom in advance can have negative connotations that a woman is stepping outside her gender role. Some obstacles for using female condoms are its large size and difficult to use. Others include the delay in the insertion of the female condom and decrease in sexual pleasure and enjoyment. Limited supply, lack of education, and awareness are also some hindrances for using female condoms.

Outcome

- Male and female condoms are available and accessible at all times to meet the needs for family planning and for preventing STIs including HIV.

Output

- Adequate numbers of male and female condoms are available in the country to meet annual demand for family planning and prevention of STIs including HIV.

National Condom Requirements

In the absence of a national condom policy and quantified needs for 2015-2020, the total national condom requirements are estimated based on the quantified national needs by USAID DELIVER project that is the main provider of almost all male condoms in Liberia. The USAID DELIVER project estimated that about 11 million pieces of male condom were needed in Liberia in 2014 to meet both family planning and HIV program needs. This figure is used as the baseline for estimating the male condom needs in subsequent years by taking into account the annual population growth rate of 2.1%. Female condoms were then estimated at 10% of the annual male condom estimates (Table 5.1). These estimates will be revised using the estimates that will result following the development of the new condom policy.

Table 5.1: Estimated Male and Female Condoms 2015-2020

No.	Year	Estimated Male Condom Need	Estimated Female Condom Need	Total Estimated Condom Need (Male + Female)	Estimated Lubricants
1.	2014	101,053,944	1,100,000	102,153,944	78,000
2.	2015	103,116,269	1,123,560	104,239,829	89,700
3.	2016	105,220,683	1,147,150	106,367,833	105,300
4.	2017	107,368,044	1,171,240	108,539,284	124,800
5.	2018	109,559,228	1,195,840	110,755,068	148,200
6.	2019	111,795,131	1,220,950	113,016,081	175,500
7.	2020	114,076,664	1,246,590	115,323,254	206,700

Informed opinion and program staffs believe the size estimation of the MSM population, and other key populations in the country, is grossly underestimated at 711. There is a need to re-estimate the sizes of the MSM and other key populations as soon as possible so as to appropriately quantify and procure the national condom-compatible lubricant requirements for the period 2015-2020.

Strategies

- **Awareness creation and sensitization**

Awareness of and sensitization about condoms are critical if it is to be used correctly and consistently. Clients need to know the dual protective roles of the condom: preventing pregnancy and preventing sexually transmitted infections including HIV. They need to know that condoms are available free of charge and can also be bought in particular outlets. Community-based distribution sites for condoms must be notified to clients.

- **Condom quantification and quality control**

There is a need to quantify the requirements and place a procurement order to meet the national condom needs for both family planning and STIs prevention including HIV. Condom stock-outs should be avoided. Quality control must be performed on all condom batches brought into the country to ensure they are of high quality. Female condoms must be included in the quantification and procurement. Condom-compatible lubricants for MSM and FSWs should be quantified and procured.

- **Condom promotion and distribution**

Print, audiovisual, interpersonal and peer mechanisms should be used to promote the condoms. Social marketing techniques are invaluable in condom promotion. Condoms must be properly stored, to avoid degrading the product, and distributed to health facilities and to community-based outlets including condom vending machines, hotels and guesthouses in the country.

Major Activities

The main activities include:

- **Condom quantification and procurement:** Ensure the availability, accessibility, and affordability of male and female condoms to meet the needs for both the family planning and STI prevention programs including HIV.
- **Condom distribution:** Improve the coordination and equitable promotion and distribution of male and female condoms in urban and rural communities.
- **Condom Social Marketing:** Support the roll out of the condom social marketing program in the country.
- **Improve perception of condoms as necessary and acceptable for HIV prevention** by addressing socio cultural taboos, barriers, and beliefs that hinder the acceptability of condoms.

Section Six

HIV Treatment, Care and Support

The Care and Treatment program in the NSP 2015-2020 comprises care of HIV positive pregnant women and their HIV exposed babies, care and support of people living with HIV, antiretroviral treatment (ART) for AIDS patients, and treatment of HIV/TB co-infected patients.

1. Treatment for HIV Positive Pregnant Women (Option B+)

Introduction

Programs to prevent the transmission of HIV from mother to child (PMTCT) can reduce the rates of transmission to below 5% of all HIV exposed babies³. The NSP 2015-2020 has therefore prioritized elimination of mother-to-child transmission of HIV (eMTCT) as a high priority high impact intervention to be vigorously pursued. Following intense stakeholder consultations and in line with its determination to eliminate HIV infection in children, Liberia has opted to implement the WHO **Option B+** from the beginning of 2015 and is committed to eliminating mother-to-child transmission of HIV by 2020.

Important advantages of Option B+ include: further simplification of its current Option B regimen and service delivery and harmonization with ART programs, protection against mother-to-child transmission in future pregnancies, a continuing prevention benefit against sexual transmission to serodiscordant partners, and avoiding stopping and starting of ARV drugs. Preparatory work is already underway to ensure a successful start of the implementation of Option B+ in 2015.

Achievements and Challenges

Liberia has greatly expanded PMTCT services, primarily with funding from Global Fund, by training clinical staff to provide quality PMTCT services and increasing the number of facilities providing PMTCT services from 55 in 2009 to 230 in 2011 and to 369 in 2013. The NACP, in collaboration with other implementing partners, is the main provider of PMTCT services. Five HIV Sentinel Surveys (HSS), conducted at antenatal clinics in 2006, 2007, 2008, 2011, and 2013 have shown consistent declines in HIV prevalence from 5.7%, 5.4%, 4.0%, 2.6%, and to 2.5% respectively.

As a means to further reduce HIV prevalence, the NACP in collaboration with partners and with funding from Global Fund has introduced the provision of food and nutritional supplements for women enrolled in the PMTCT program, including support for exposed infants.

PMTCT coverage has been rather slow to pick up and NACP Annual Reports reveal that full PMTCT coverage was 13% in 2009, 48% in 2011, 57% in 2012, and 64%⁴ in 2013. The PMTCT program faces major challenges including 15-20% home deliveries, stigma and discrimination that prevent pregnant women from accessing PMTCT services, high lost to follow-up of HIV positive pregnant women in care, inability of PMTCT program to consistently track defaulting clients, breakdown of

³ WHO Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants WHO Geneva Switzerland 2010

⁴ Liberia Country Progress Report 2013 for the GARPR 2013

CD4 machines, and until 2013, lack of early infant diagnosis capability in the country necessitating test samples to be sent to South Africa.

The provision of nutrition support to mothers receiving PMTCT will encourage and enable them to follow medical regimen and adherence to treatment. The combined impact of food and medical care will reduce the effect of HIV and promote a return to productive life. It will possibly extend the period from HIV infection to illness.

Outcome

The percentage of child HIV infections from HIV positive women delivering in the last twelve (12) months reduced by 2020.

The outcome will be tracked by using the indicators and targets in Table 6.1

Table 6.1: eMTCT Outcome Indicators and Targets

	Indicator	2013 Baseline	2015	2016	2017	2018	2019	2020
1.	Estimated percentage of infants born to HIV infected mothers who are infected with HIV at six weeks	13%	8.6%	7.7%	6.6%	4.8%	3.9%	1.0%
2.	Estimated percentage of infants born to HIV infected mothers who are infected with HIV at the end of breastfeeding	24.6%	21.8%	19.4%	17.0%	14.6%	12.2%	9.7%

Output

- **The number of HIV positive pregnant women receiving ART (Option B+)**

The Output will be tracked using the indicator and targets shown in Table 6.2

Table 6.2: eMTCT Output Indicators and Targets

	Indicators	2013 Baseline	2014	2015	2016	2017	2018	2019	2020
	# (%) pregnant women who are counseled and tested for HIV and know their results	120,895 (64%)	133,903 (68%)	144,752 (72%)	171,859 (82%)	188,807 (88%)	209,683 (94%)	218,479 (100%)	223,067 (100%)
	# HIV+ pregnant women placed on ART	664	1,193	1,141	1,092	1,047	1,006	968	932
	Percentage of women living with HIV provided with ARV drugs for themselves or infants during breastfeeding period	NA	45%	1,141 (72%)	1,092 (82%)	1,047 (88%)	1,006 (94%)	968 (100%)	932 (100%)
	# (%) infants born to HIV positive women receiving a virological test for HIV within 2 months of birth	94% (2013)	95%	95%	96%	97%	98%	99%	100%
	# (%) infants born to HIV positive mothers who received antiretrovirals to reduce the risk of mother-to-child transmission of HIV	NA	1,193 (72%)	1,141 (72%)	1,092 (82%)	1,047 (88%)	1,006 (94%)	968 (100%)	932 (100%)
	Facilities Scale up	335	373	411	449	486	524	562	600

Strategies

- **Roll out and scale up Option B+ implementation countrywide in a phased manner.**

The implementation of Option B+ will start at the beginning of 2015 in a phased manner targeting the 335 health facilities providing PMTCT services countrywide. Preparatory work currently underway to prepare the country to start implementing Option B+ include training healthcare providers on Option B+, production and distribution of standard operating procedures, inspecting health facilities to ensure their preparedness to implement Option B+, and ensuring ARVs and other commodities are procured for distribution to participating facilities.

- **Strengthen coordination among stakeholders** (Family Health Division, NLTCP, NACP, PLHIVs and Associations)
- As a part of the nutrition package, **health staff will be trained on the Nutrition Assessment Education and Counseling (NAEC)** approach as part of the care, treatment and support package for HIV. The provision of education and counseling services is particularly important in relation to infant and young child feeding, where international guidance explicitly acknowledges the need to prevent HIV transmission must be balanced with the need to prevent mortality from other causes.

Major Activities

The major activities of the strategy will include the following:

- Assess Liberia's readiness to implement Option B+.
- Finalize an eMTCT scale-up plan.
- Generate demand for eMTCT services at the community level.
- Train clinical staff on Option B+.
- Implement provider initiated counseling and testing (PICT) services at all ANC clinics and supplement this with outreach services.
- Provide lifelong ARV to HIV positive pregnant women.
- Provide ARV prophylaxis and cotrimoxazole prophylaxis to HIV exposed infants according to national guidelines.
- Operationalize the Integrated MNCH/eMTCT intervention package which includes client follow-up through breast feeding period in the existing activities package of community workers (TBAs, TTMs and PLHIVs).
- Provide early infant diagnosis for HIV exposed babies according to national guidelines and provide care and treatment for HIV infected infants.
- Strengthen the follow-up of women diagnosed HIV positive through the mother peer to peer to ensure adherence to treatment and retention in care.
- Intensify positive living messaging and counseling among eMTCT clients including education on the model HIV law.
- Estimate percentage of child HIV infections from HIV positive women delivering in the last 12 months.
- Train all staff in care and treatment on NAEC approach.
- Provide nutrition support to all PMTCT beneficiaries.
- Provide food commodities for PMTCT household members.
- Provide support for formula feeding to exposed infants.

2. Care for People Living with HIV

Introduction

The NACP report indicates about 34,805 people were living with HIV in 2013. By the end of December 2013, it is estimated that 18,387 PLHIV were eligible for treatment. This number comprises 9,958 PLHIV (60%) in care and 35% (6,429) of the eligible patients were placed on ART.

A key objective of PLHIV in care is to prevent opportunistic infections and the development of full-blown AIDS in those not on ART. Regular clinic attendance and adherence to treatment will ensure PLHIV receive care that will reduce the risk of progressing to AIDS or developing opportunistic infections. Patients who comply with the care guidelines live healthy lives.

Lost to follow-up is recorded when a patient has not attended clinic for three consecutive follow up appointments. The common reasons for LTFU are: patient lives too far from facility providing care, stigma and discrimination against patient or family on account of his or her HIV status, and patient has dropped out and is often attending alternative therapy elsewhere, usually at a faith healing facility.

Achievements and Challenges

All patients in care are put on cotrimoxazole preventive therapy (CPT) to prevent opportunistic infections. Trained clinical staff and counselors provide psychosocial support and lifestyle counseling (cessation of drinking and smoking, need for exercise and healthy diet, safer sex, condom use, and fertility desires, and family planning), and assessment of partner status and provision of partner testing to all patients in care. Physical examination, screening for TB and laboratory tests including CD4 count are carried out. PLHIV are advised to join support groups of their peers.

Support groups provide assistance with patient care at the health facility and spearhead community level activities providing support to PLHIV in care. Support groups and family members of the patient provide support at home including dealing with stigma and discrimination, adherence to treatment and attending to all clinic appointments.

The major challenges include stigma and discrimination leading to inability of PLHIV to access HIV services including failure to adhere to treatment and lost to follow up. The 2009 NACP ART Cohort Study shows that 66.8% of patients not on ART are lost to follow up at 12 months follow-up. A lower but still high LTFU (24%) was observed for PLHIV on ART. The most common reasons cited by patients for LTFU are: long distance between home and health facility providing ARV drugs, stigma and discrimination, and stopping treatment because they are attending faith healing facility.

Outcome

- **PLHIV not on ART that are retained in Care increased by 2020**
- **PLHIV on ART that are retained in Care increased by 2020**

The outcome is tracked by using the indicators and targets in Table 6.3

Table 6.3: PLHIV not on ART Outcome Indicators and Targets

	Indicator	2012/13 Baseline	2017	2020
1.	% of adult and children not on ART that are retained in care at 12 months of follow-up	24.7%	39%	50%
2.	% of adult and children on ART that are retained in care at 12 months of follow-up	69.9%	78%	85%

Output

- # PLHIV not on ART that are retained in care at 12 months follow-up appointment
- # PLHIV on ART that are retained in care at 12 months follow-up appointment

Strategies

a) Preventing PLHIV not on ART from being lost to follow up at 12 months

There are many reasons why patients in care are lost to follow-up. These may include patients who feel they are healthy and do not need to attend the follow up clinics and others who drop out due to stigma and discrimination. Clinical caregivers must anticipate these possibilities and pre-empt their occurrence with advice and support. Regular follow up will enable clinicians to take early action to address morbidities including psychological problems before they become serious.

b) Cotrimoxazole Prophylaxis

PLHIV have increased risk of opportunistic infections (OIs) such as pneumocystis Jirovecii pneumonia (PCP), candidiasis, Kaposi's sarcoma and toxoplasmosis. PCP is the most common OI occurring in HIV infected persons and is the leading cause of death in infants with HIV. Patients on cotrimoxazole prophylaxis can prevent the development of PCP.

The outcome is tracked by using the indicators and targets in Table 6.4

Table 6.4: PLHIV not on ART Outcome Indicators and Targets

Indicator	Baseline		Target					
	2013	2014	2015	2016	2017	2018	2019	2020
% of adult and children not on ART that are retained in care at 12 months of follow-up	24.7%	29%	33%	36%	39%	43%	47%	50%
% of adult and children on ART that are retained in care at 12 months of follow-up	69.9%	72%	74%	76%	78%	80%	82%	85%

Major Activities

Key activities under the strategies are:

- Counseling on adherence to clinic appointments and prescribed drugs.
- Tracking PLHIV not on ART at first and second missed clinic appointments.
- Put PLHIV on cotrimoxazole prophylaxis.
- Do CD4 cell count at least twice a year.
- Provide ARV drugs.
- Intensify positive living messaging and counseling among clients including education on the model law.
- Strengthening facility to community linkages through PLHIV community counselors and CHWs.

- Strengthen supervision and monitoring of supply chain system to ensure constant and regular availability of drugs and commodities.
- Train health care staff in the provision of psychosocial counseling.
- Strengthen supervision and monitoring of health facilities for quality of care and data integrity.
- Strengthen referral linkages for sample transportation for HIV, EID, Viral Load, etc.
- Scale up CD4 testing to all integrated sites.
- Conduct proficiency testing for quality control of enrolled facilities conducting HIV testing.

3. Antiretroviral Treatment (ART)

Introduction

The provision of high coverage, high quality, and sustainable HIV treatment is an important mechanism for reducing morbidity and mortality among adults and children living with HIV/AIDS as well as preventing new HIV infections in the community⁵. With access to quality care and treatment, PLHIV can expect to live long, healthy, and productive lives. People with HIV can reduce the risk of infecting their sex partners by more than 90% if they start treatment with antiretroviral drugs when their immune system is still relatively healthy.

Thus anti-retroviral therapy is both a treatment and a HIV prevention strategy. To achieve this double benefit from ART, Liberia has adopted the policy to initiate ART at the CD4 count threshold of 500 from 2015 rather than at the current 350-threshold regimen. This decision also conforms to the new WHO guidelines that advise countries to examine the local context and if found appropriate, to adopt CD4 cell count threshold of 500 for initiation of ART.

The NACP, in collaboration with other implementing partners, has been the main provider of ART services in the country and the Global Fund is the main source of funding for the ART program. NACP and FBOs with hospitals concentrate on providing facility-based ART services while CSO organizations including FBOs provide community and home based support services for the ART program.

Achievements and Challenges

Using a CD4 count threshold of 350 for initiation of ART, Liberia has rapidly expanded its ART program by increasing the number of ART sites from 20 in 2009 to 36 in 2012 and to 46 in 2013. However, the ART program results relating to HIV patients eligible for ART is steadily increasing. The ART coverage for adults (15+ years) has increased modestly over the last 5 years: 25% in 2009, and 35% in 2013. The coverage in children (0-14 years) is really very low: 7% in 2009, and 10% in 2013.

Adult ART coverage is low and pediatric ART coverage is even lower. The reasons for this include stigma and discrimination, CD4 count machines not working, inadequate number of trained clinical staff despite a successful clinical mentoring program, and LTFU. Reasons for LTFU include stigma and discrimination, attending alternative and complementary treatment usually at faith healing facility,

⁵ High Coverage ART Associated with Decline in Risk of HIV Acquisition in Rural KwaZulu Natal, South Africa in *Science Magazine* 22 Feb 2013 by Frank Tanser et al.

poverty, patients live far away from ART facility, and adverse reactions to the ARV drugs.

Outcome

- **Percentage of adults and children with HIV known to be on treatment 12 months after initiation of ART increased from 74% in 2013 to 85% in 2020.**

The outcome will be tracked using the indicators and targets in Table 6.5.

Table 6.5: Patients on ART Outcome Indicators and Targets

	Indicator	2013 Baseline	2015	2016	2017	2018	2019	2020
1.	% adults and children with HIV known to be on treatment 12 months after initiation of ART	74. % 2013 ART Cohort Study	75%	77%	79%	81%	83%	85%

Output

- **Number and percentage of adults and children currently receiving antiretroviral therapy among all eligible PLHIV.**

The Output will be tracked using the indicators and targets in Table 6.6.

Table 6.6: ART Output Indicators and Targets

Indicators	2013 Baseline	2015	2016	2017	2018	2019	2020
Number and percentage of adults (15+ years) on ART	6,520 (35%)	8859 (46%)	10034 (53)	11585 (62%)	12955 (70%)	14140 (77%)	15,499 (85%)
Number and percentage of children on ART	378 (10%)	1,292 (30%)	1,630 (40%)	2,325 (60%)	2,592 (70%)	2,846 (80%)	3,493 (100%)
# HIV exposed children on cotrimoxazole prophylaxis	NA	2038 (47.8%)	2344 (58.3%)	2640 (68.7%)	2922 (79.1%)	3198 (89.6%)	3490 (100%)
Number and percentage of people living with HIV and AIDS receiving nutritional support	NA	4466 (44%)	5365 (46)	6429 (46%)	6842 (44%)	7134 (42%)	7597 (40%)
Number of health facilities that offer ART	46	61	68	74	81	88	96

Strategies

a) The main strategy is to Scale-up ART program.

Key activities for this strategy are:

- Generate demand for ART services and increase adherence to ART.
- Train clinicians on ART and orient them on new CD4 threshold count policy of 500 to initiate treatment.
- Reduce stigma and discrimination to generate demand for and maintain PLHIV on treatment.
- Increase ART sites from 46 in 2014 to 96 by 2020.
- Improve quality of lab services including CD4 count and in-country availability of early infant diagnosis (EID) of HIV capability.
- Improve the system for tracking adherence – early warning for would be defaulters to increase retention.
- Strengthen ARV drugs resistance monitoring and improve pharmacovigilance.
- Strengthen ARV drugs and HIV commodities supply to ART sites.

b) Palliative Care

Services for PLHIV in home-based care are still in infant stages. In 2008, NACP in collaboration with partners produced standard guidelines to be used both in health facilities and community settings.

c) Home-based Care

Family members, support groups, and community volunteers provide community and home-based care and support for PLHIV. Support services include psychosocial support, treatment adherence support, and in some cases support with household chores.

d) Institutional Care

The Global Fund provides financial support to the Catholic Church HIV and AIDS Program to support hospice services (Home of Peace and Joy) in Monrovia, Montserrado County and in Harper, Maryland County. Since 2013, the Government of Japan and AIDS Healthcare Foundation (AHF) are providing financial support to People Associated for People's Assistance (PAPA) which runs the Home of Dignity—Care Home in Virginia, Montserrado County.

PLHIV with complications are often admitted to the hospice in very poor health, often abandoned by their families. The hospice provides services for seriously ill PLHIV patients including: ART, medical management of opportunistic infections and AIDS complications, feeding and psychosocial support. Many of these neglected patients are discharged to their various homes when medical and social conditions improve.

The national HIV response will continue to provide ARV and other drugs to these facilities.

Major Activities

- Provide training for family members and care givers of PLHIV in the provision of home-based and palliative care.
- Provide basic home based health care kits to family members and care givers.
- Train health care staff in the provision of psychosocial counseling.
- Provide nutritional support to homes and institutions offering palliative and end on life care.
- Revise and operationalize the guideline on home-based and palliative care.

4. HIV - TB Co-Infection Management

Introduction

TB is one of the most serious opportunistic infections in PLHIV. It is the commonest cause of AIDS-related deaths and it is globally responsible for a quarter of the deaths in PLHIV. HIV is the strongest risk factor for developing tuberculosis disease in those with latent or new mycobacterium tuberculosis infection. The lack of political commitment and investment in collaborative TB-HIV interventions are

undermining the effects of HIV programs⁶. TB and HIV services can be effectively integrated if national programs undertake joint planning and supervision of HIV and TB activities and all staff providing services are properly trained, mentored, and work together as a team.

Prior to the implementation of the Global Fund HIV and TB supported programs in Liberia, the HIV and AIDS and the TB programs in the MOHSW had virtually no collaborative activities. With very inadequate funding, both programs had parallel implementation pathways; referrals between the two programs were often dysfunctional or weak at best. However, the situation has improved significantly since the Global Fund started supporting HIV and TB programs in the country nearly a decade ago; both programs are increasingly fostering improved HIV/TB collaborative services.

The collaboration is premised on the desire of both programs to mutually reinforce positive outcomes. Collaborative TB/HIV programs would reduce the burden of TB on HIV, and would reduce the HIV burden on TB.

Achievements and Challenges

Global Fund funding has ensured that many TB staff members were trained in HCT. HIV and TB clinical staff were trained in improved management of HIV/TB co-infections, better linkages between the two programs, and strengthening the quality of HIV/TB collaborative services. National AIDS Control Program and National Leprosy and TB Control Program established a joint HIV/TB Technical Working Group at the national level to provide guidance, technical assistance, direction, and general oversight on HIV/TB collaborative activities. Fifteen HIV/TB focal persons were employed and deployed to each of the 15 counties to spearhead county level HIV/TB collaborative activities including integrating HIV and TB activities at the facility level. In 2013, 130 health facilities were equipped for HIV and TB management. Global Fund grant also supported the inclusion of HIV data into revised TB data collection tools.

The quarterly scheduled meetings of the HIV/TB TWG do not take place regularly because of competing priorities. At the county level HIV/TB collaboration is not working because there, county development coordination is a function of the County Development Coordination Committee and HIV and TB are not often prominent on the agenda. This situation is likely to change once NAC establishes its Decentralization Office in each county. HIV and TB county level activities can be coordinated by the NAC Decentralization Office.

Frequent shortages of HIV rapid test kits (RTKs) seriously hinder efforts to test all TB patients for HIV. TB drugs are also stocked-out frequently due to under quantification of needs by the program. This problem is being addressed through more accurate and robust quantification of drug requirements with early procurement of adequate buffer stocks. The MOHSW has approved the Isoniazid Preventive Therapy (IPT) for the TB program and the HIV/TB TWG is now working out the logistics. Currently there is an IPT pilot program being conducted.

All PLHIV in care are screened for TB and the TB program tests all patients with TB for HIV. For 2013, the TB program reported that 7822 TB cases were notified, 5989 (77%) were tested for HIV, and 16% (948) were HIV positive. About 73% (693) of

⁶Towards Universal Access: Scaling up Priority HIV and AIDS interventions in the health sector – Progress Report 2009; WHO, UNAIDS and UNICEF

TB/HIV co-infected patients were put on IPT but only 33% (316) receive ART. The NSP 2015-2020 prioritizes HIV/TB collaborative activities in order to decrease the burden of TB on HIV and vice versa.

Outcome

The HIV/TB co-infection rate reduced.

The indicators and targets in Table 6.7 will track the outcome.

Table 6.7: HIV/TB Outcome Indicators and Targets

	Indicator	2013 Baseline	2017	2020
1.	% TB patients that have HIV infection	16%	12%	8%

Output

- **Number and percentage of HIV positive TB cases that received treatment for both TB and HIV.**

The Outputs will be tracked using the indicators and targets in Table 6.8

Table 6.8: HIV/TB Co-infection Output Indicators and Targets

	Indicators	2013 Baseline	Targets						
			2014	2015	2016	2017	2018	2019	2020
	Estimated TB cases (All Forms)		12,343	12,791	13,252	13,728	14,217	14,721	15,240
	TB Cases expected to be notified (All Forms)		9380	10233	11132	12080	13080	14132	14630
	Number (%) of TB patients that were tested and counseled for HIV and know their results	77% (5989)	79% (7,410)	81% (8,289)	83% (9,240)	85% (10,268)	87% (11,380)	88% (12,436)	90% (13,167)
	Number (%) TB patients that are HIV positive	16%	15% (1,112)	14% (1,160)	13% (1,201)	12% (1,232)	11% (1,252)	10% (1,244)	8% (1,053)
	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV	33%	40%	48%	56%	64%	72%	80%	85%

Strategies

The main strategy is:

Strengthening HIV and TB collaborative activities.

Major Activities

The main activities of the strategies are:

- Build the capacity of the HIV/TB Technical Working Group to provide technical guidance and direction.
- Conduct joint HIV and TB program planning, monitoring and supervisory visits to service delivery sites.
- Generate demand for HIV and TB services at community level including reducing stigma and discrimination.
- Train clinicians and lab technicians on HIV TB collaborative activities.
- Screen all PLHIV for TB and refer all suspected cases of TB to the TB program.
- Provide HCT services to all TB cases and refer all HIV positive TB cases to the HIV program for further management. HCT services expanded to all TB Directly Observed Treatment Short Course (DOTS) sites.
- Prevent stock-out of HIV and TB drugs at treatment facilities.
- Reduce lost to follow-up.

Section Seven

Critical Social and Programmatic Enablers

The following critical enablers are covered in this section: laws, policies, and practices; stigma reduction; mass media; political commitment and advocacy; community participation; coordination and management of the national HIV response; and funding resource needs of the national HIV response.

1. Laws, Policies, and Practices

Introduction

The Liberian Constitution protects every individual's fundamental rights and freedoms including the right to privacy and freedom from discrimination. HIV related laws, policies, and practices have direct impact on how PLHIV and key populations access and use HIV prevention, treatment, care, and support services. The National AIDS Commission was established by an Act of the National Legislature in 2010 to coordinate and facilitate the national HIV response, and to provide unhindered access to HIV prevention, treatment, and care, for all people irrespective of ethnicity, belief, or sexual orientation.

Achievements and Challenges

In 2010, the National Legislature amended the Public Health Law (1976) to provide for the control of HIV and AIDS. The law prohibits vilification and stigmatization of PLHIV and penalizes willful transmission of HIV. Additionally, the Ministry of Justice has established a Human Rights Unit that provides legal support for economically vulnerable population groups and has also developed the National Human Right Action Plan (NHRAP), which encompasses the rights of key populations. In spite of these provisions, Liberia has prohibitive laws that criminalize same-sex conduct and an environment of sustained homophobia. These seriously hinder access by key populations to HIV and AID services, and thus challenge the effectiveness of the national HIV response.

2. Stigma and discrimination reduction

Introduction

Stigma, discrimination and violations of the human rights of others are major barriers to effective national responses to HIV. Because of stigma and discrimination, many people are afraid to get tested for HIV, to access HIV prevention and treatment services, to disclose their HIV status, and to participate in national HIV responses. Consequently, there is the need to protect the human rights of people living with HIV and members of vulnerable and key populations by reducing stigma and discrimination and increasing access to justice. This does not only reduce the personal suffering associated with HIV, but also helps to create social and legal environments that empower and encourage people living with or at risk of HIV infection to access and use HIV services. This is critical to achieving universal access to HIV prevention, treatment, care and support, and to halt and reverse the epidemic and mitigate its impacts.

Achievements and Challenges

Much has been achieved in the efforts to reduce stigma and discrimination against people living with or at risk of HIV infection in the last decade but very much more remains to be done. Stigma and discrimination reduction campaigns continue to be mounted in the mass media by the public sector and civil society, through speaking engagements and performing arts by celebrities, and through spirited and determined efforts of PLHIV associations and networks and groups working to improve access HIV prevention, treatment, care, and support for key populations. However, the Liberia PLHIV Stigma Index Study 2013 shows stigma and discrimination continue to be a big hindrance to access to HIV prevention, treatment, care, and support services.

Outcome

Stigma, discrimination, and punitive approaches related to HIV reduced.

Outputs

1. Promote reduction of stigma and discrimination.
2. Increased access to HIV-related legal services.
3. Monitoring and reforming laws, regulations and policies relating to HIV improved.
4. Increased Legal Literacy ("know your rights") on HIV and human rights.
5. Lawmakers and law enforcement agents sensitized on HIV and human rights.
6. Training for health care providers on human rights and medical ethics related to HIV increased.
7. Increased participation of communities in reduction of discrimination against women in the context of HIV.

Strategies

- **Stigma and discrimination reduction.**
- **Advocacy on the rights of people infected and affected by HIV.**

Major Activities

Major activities of the strategies are:

- Community interaction and focus group discussions involving people living with HIV and members of populations vulnerable to HIV infection.
- Use of media, including advertising campaigns, entertainment designed to educate as well as to amuse ("edutainment"), and integration of non-stigmatizing messages into TV and radio shows.
- Engagement with and sensitization of religious and community leaders and celebrities, legislators, law enforcement agencies, and other development sectors.
- Measurement of HIV-related stigma through the People Living with HIV Stigma Index.
- Peer mobilization and support developed for and by people living with HIV aimed at promoting health, wellbeing and human rights.
- Promotion of the enactment and implementation of laws, regulations, and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support for all.
- Awareness-raising campaigns, that provide information about rights and laws related to people infected and affected by HIV, through the media, community mobilization and education, peer outreach, and telephone hotlines.

3. The Media and HIV

Introduction

The media is a very powerful tool in the formation of opinions. The broadcast media has tremendous reach and influence particularly with young people, who represent the future and are key to a successful national HIV response. Effective partnership between the national HIV response and the media is important in harnessing the benefits accruing from a well-informed, socially responsible, and ethical media to proactively disseminate accurate, objective, balanced, and non-judgmental information to the general population and to specific population groups. The mass media can be instrumental in breaking the silence surrounding HIV and AIDS and creating an environment that encourages discussion of how to reduce societal norms and practices that increase HIV infection risk and how individuals can reduce their personal HIV infection risk by adapting safer behaviors. In its role as a watchdog, the media has the responsibility to report on and hold government accountable for its funding commitments for the national HIV response.

Achievements and challenges

Generally, over the years, the mass media has been a very constructive and engaging partner in the national HIV response. The print media, the radio, and television have been at the forefront of debunking myths and misconceptions about HIV while providing accurate information on the causation, transmission, prevention, and treatment for HIV. For example, in 2011, a network of 22-25 local radio stations reached large sections of the population in both urban and rural areas with HIV and AIDS messages in English and in 16 local languages in all the 15 counties in the country. Mobile phone companies are providing opportunities for the national HIV response to disseminate HIV messages on smart phones especially to technologically savvy young people.

Outcome

Partnership between the mass media and the national HIV response enhanced.

Outputs

- Regular briefings on HIV and AIDS for the press by responsible national and county HIV and AIDS authorities.
- Constructive coverage of national HIV response activities in the press.

Strategy

- Strengthen partnership with the media in the national HIV response.

Major Activities

The mass media is vital in the national HIV response in Liberia and is already undertaking impressive work on HIV, but much more needs to be done. The NAC and NACP and other stakeholders in leadership positions should:

1. **Support training and updates to media practitioners on HIV and AIDS.**
2. **Invite press to cover key HIV activities in the country:** these include festivities such as the World AIDS Day Celebrations and dissemination of important HIV research and study findings such as the LDHS, the IBBSS, and the HIV Sentinel Surveys.

3. **Work with the Press Union of Liberia** to facilitate the media making AIDS programming a key part of their output and, indeed, their corporate strategy. This can be done in a number of ways, including:
 - a) Giving the epidemic prominent news coverage.
 - b) Dedicating airtime to HIV/AIDS public service messages.
 - c) Supporting the broadcasting of HIV/AIDS special programming.
 - d) Supporting the development of AIDS storylines in existing programming.
 - e) Making public service messages and original programming available to other outlets on a rights-free basis.

4. Political Commitment and Advocacy

Introduction

The GOL is committed to providing effective political leadership for a comprehensive national HIV and AIDS response and is determined to fully implement the commitments and achieve the goals and targets of the United Nations 2001 Declaration of Commitment on HIV and AIDS and the 2006 Political Declaration on HIV and AIDS. The GOL is also committed to the 2001 Abuja Declaration on HIV and AIDS, Malaria, TB, and Other Infectious Diseases, which was reconfirmed in 2013 in Abuja on the theme: "Ownership, Accountability, and Sustainability of HIV/AIDS, Tuberculosis, and Malaria Response in Africa".

In this context, the GOL is committed to providing leadership in mobilizing resources to enable the following commitments to be met by 2020:

- Reduce sexual transmission of HIV by 50%.
- Eliminate HIV infection among children.
- Reach 29,538 people with life-saving antiretroviral drugs.
- Reduce TB deaths in people living with HIV by 50%.

The GOL is also committed to: closing the national AIDS funding gap by increasing funding from domestic sources; eliminating gender inequalities and sexual and gender-based violence; eliminating stigma and discrimination; eliminating parallel systems for HIV related services to strengthen integration of the HIV response in public health and development efforts; as well as establishing and strengthening social protection systems for poor households including those affected by HIV and AIDS.

Achievements and Challenges

The GOL is committed to ensuring the targets in the NSP 2015-2020 are met. Political commitment is demonstrated by the fact that the President of the Republic of Liberia continues to be the Chair of the Board of Directors of the National AIDS Commission (NAC), which was reconstituted in 2010. The NAC coordinates the multi-sectoral decentralized national HIV response. Decentralization is proceeding and 8 counties out of 15 now have decentralized coordination capacity. However, this capacity needs further strengthening.

The establishment of the SGBV Unit and the Gender and HIV Desk within the Ministry of Gender and Development (MOGD) with a SGBV Task Force, passage of legislation making rape an unbailable offense, and an Act that provides inheritance rights to women married under customary law demonstrate the government's commitment to reduce gender inequality and gender-based violence. Additionally,

government has enacted legislation that prohibits vilification and discrimination against a person because of his or her perceived or real HIV status.

Mainstreaming of HIV and AIDS is taking place in government ministries, departments, and agencies (MDAs) and large private sector companies have or are in the process of enacting HIV workplace policies. Under “The Agenda for Transformation (AfT): Steps Toward Liberia Rising 2030”, the blueprint for the country’s development, GOL plans to rebuild the public health system by constructing health facilities, training specialize healthcare workers (physician assistants, certified midwives, nurses, doctors), procuring the essential and necessary medical and drug supplies and equipment for the health system, and increasing coverage to comprehensive and basic emergency obstetric and newborn care as well as PMTCT.

The government also plans to strengthen social protection systems that protect vulnerable groups, such as people living with HIV, persons with disabilities and orphaned children who face risks of violence, exploitation, discrimination, abuse and neglect. These plans are slowly being implemented: the health system and health indicators are improving, PMTCT is one of the top priority programs of the national HIV and AIDS Control Program, and the government has started implementing a social cash transfer program to provide cash to households that are below the poverty line and are labor constrained, including AIDS-affected households.

As a low-income country, Liberia has many competing needs for its limited financial resources. Donor support is therefore a significant source of development financing; thus about 98% of HIV and AIDS spending is from external sources. However, government is acutely aware of the need to make appropriate budget allocations in order to take national ownership of programs including the national HIV response.

Since the establishment of the Anti AIDS Media Network (AAMIN) in 2011, as a coordinating body on HIV and AIDS in the media, the national response has experienced progressive and consistent interaction with the media through training and dialogue. The NAC in collaboration with AAMIN has developed an HIV and AIDS media guide to enhance the capacity of media personnel for effective and accurate reporting on HIV and AIDS issues. However, there is a need to strengthen the institutional capacity of AAMIN and technical support to media personnel.

Outcome

- **GOL honors its political commitments in relation to the national HIV response.**

Output

The key outputs from political commitment and advocacy are:

- **Products of high-level meetings with the Executive branch of government** – the GOL makes adequate funding, staff, and material resources available for the national HIV response.
- **Products of high-level meetings with the Legislature** – the Legislature approves adequate budget and pass necessary legislation for the national HIV response.
- **Products of engagements with private sector, media, and CSOs** – the private sector increases its involvement including funding for HIV and AIDS; the media provides increased visibility and space for discussion, information, education,

and communication on the national HIV response; and CSOs increase participation in providing HIV and AIDS prevention, treatment, care and support services.

Strategy

- Mount interpersonal and multimedia advocacy to drum up and sustain political commitment for the national HIV response.

Major Activities

The main activities include the following:

- **High Level Advocacy Meetings with the Executive branch of government** – especially Office of the President and Ministry of Finance: Key stakeholders including associations and networks of people living with HIV and development partners including the UN system and bilateral and multilateral agencies in consultation with NAC, will include HIV and AIDS in their discussions with high level government operatives including the President of the Republic of Liberia, and public officials at the county and district level.
- **High Level Advocacy Meetings with the Legislature** – NAC will spearhead multi-stakeholder consultative meetings and engagements with Members of Legislature, especially the Joint Committees on Finance and Health to advocate for their support in mobilizing public sector funding resources for the national HIV response.
- **Intensive engagement with the media, civil society, and the private sector:** Under the coordination and leadership of NAC, HIV stakeholders will participate in intensive engagement with the media to keep the issue of HIV and AIDS in the public discourse, with communities for support on AIDS-related issues, and the private sector for additional funding for the national HIV response.

5. Community Participation in HIV Response

Introduction

Community participation in HIV response activities is central to achieving universal access to HIV prevention, treatment, care, and support. Without effective community participation, gains made by the multi-sectoral approach to the national HIV response, especially the health sector cannot be sustained. Community participation is critical for generating demand for services and providing community and home based care and support for people infected and affected by HIV and AIDS.

Key aspects of the national HIV response that are more effectively addressed at the community level include: dispelling myths surrounding HIV and AIDS, reducing stigma and discrimination against PLHIV, reducing gender inequalities, and providing community and home-based care for PLHIV and OVC. Key players providing leadership in community level HIV response include traditional councils and religious leaders. Community Support Organizations are playing critical roles in providing HIV and AIDS services at the community level.

Achievements and Challenges

International NGOs including ActionAid Liberia, Plan Liberia, Population Services International (PSI), Samaritan Purse, and Shalom are spearheading community

capacity building and enhancement that are enabling increased and better community awareness of and participation in HIV prevention activities, as well as providing care and support for people infected and affected by HIV and AIDS. Local CBOs and FBOs are the major players driving direct community level action on HIV and AIDS. They work with community volunteers and support groups to provide HIV prevention information and services including BCC and provision of IEC materials, condom promotion and distribution, HIV counseling and testing, and psychosocial and material support for PLHIV and OVC. They also undertake activities that reduce stigma and discrimination against people infected and affected by HIV and AIDS.

The Liberia Network of People Living with HIV (LIBNEP+), Tiyatien Health, Stop AIDS in Liberia (SAIL), and Liberia Women Empowerment Network (LIWEN) are some of the large local CBO actors. The Christian HIV and AIDS Network of Liberia, Lutheran Church in Liberia HIV and AIDS Program, Catholic Church HIV and AIDS Program, and the Union of Muslim Associations of Gbarpolu and Bomi Counties HIV and AIDS Program are some of the key FBO programs that are supporting community level HIV responses. Further, Sisters of Charity and Home of Dignity provide home-based and palliative care at the community level.

Community level HIV activities face many challenges. Often driven by the zeal and urge to help, many CBOs are severely under-resourced and therefore have weak organizational capacity to manage and deliver services. INGOs and FBOs that are not recipients of Global Fund HIV grants are not monitored by the Liberia Coordination Mechanism (LCM) of the Global Fund and do not report the results of their activities to the NAC or the NACP for inclusion in the reports of the national HIV response.

Outcome

- **Active community participation in the HIV response is strengthened**

Outputs

The main outputs are:

- **Number of key traditional and religious leaders whose capacities have been strengthened to provide leadership for community level HIV activities.**
- **Traditional and religious leaders in the communities will be identified and their knowledge of HIV and AIDS strengthened to enable them provide effective leadership for community level HIV and AIDS activities.**
- **Number of large umbrella groups and networks of local CSOs and FBOs whose capacities have been strengthened to spearhead community level HIV and AIDS activities.**

Strategies

- **Build capacity of traditional and religious leaders to provide leadership and stewardship for community participation in HIV response.**

Building the capacity of traditional and religious leaders on HIV and AIDS will enable them to provide leadership and guidance that reduce harmful traditional norms and practices and religious beliefs that drive the HIV epidemic while promoting those that strengthen HIV prevention, treatment, care and support activities.

- **Capacity strengthening for CSOs and FBOs to spearhead HIV and AIDS activities at the community level.**

Strengthening the technical, financial, management, and material capacities of CBOs and FBOs to enable them to deliver quality and sustainable community level HIV and AIDS activities.

Major Activities

The major activities will include; that will be provided by CBOs and FBO, community volunteers and support groups include:

- Generating demand for HIV prevention, treatment, care and support services.
- Reducing stigma and discrimination associated with HIV and AIDS.
- Promote and distribute condoms and lubricants.
- Counseling and support for care and treatment adherence.
- Care and treatment defaulter tracing, follow up of HIV positive mother and baby, and TB screening and follow up.
- Provide support for stopping substance abuse and establish linkage to support services.
- Provide psychosocial support and assistance for the basic needs of positive individuals and HIV and AIDS affected households.
- Provide linkage to other community based-health services.

6. Coordination and Management of the National HIV Response

Introduction

The National AIDS Commission was established in 2010 by an Act of the National Legislature to coordinate and manage the national HIV response. The national HIV response is driven by the international best practice of the 3-Ones Principles: One National Coordinating Authority (the National AIDS Commission), One National Strategic Plan (the NSP 2015-2020), and One National Monitoring and Evaluation Plan (the Liberia National HIV M&E Plan 2015-2020). The 30 member multi-sectoral National AIDS Commission Board of Directors, chaired by the President of Liberia, formulates HIV and AIDS policy for the country and has oversight responsibility for the National AIDS Commission, which is tasked with the responsibility of coordinating and managing the national HIV response.

Achievements and Challenges

Since its establishment in 2010, the National AIDS Commission has been successfully managing and coordinating the activities of the multi-sectoral HIV response. Located in Monrovia, the NAC reports to the NAC Board of Directors and has responsibility for the day-to-day management of the national HIV response. The Chairman heads the Commission, which has four other Commissioners with Mandates for Policy and Programs, Partnership, Monitoring and Evaluation, and Decentralization. The Commissioners have coordinators who assist them to coordinate and manage their respective Mandates. There is also a Communication Coordinator who supports the other mandates and reports directly to the Chairman of the Commission. The Secretariat of the Commission is headed by an Executive Director who manages the finance and administration of the Secretariat and staff for the resource mobilization for the national HIV response.

The various Mandates have shared responsibility for advocacy and resource mobilization for the national response including high-level advocacy and resource mobilization from the GOL, the private sector, and the development partners. All mandates make technical contributions into the planning and development of

major national HIV and AIDS surveys and research studies, and preparing annual and special reports (such as GARPR) of the national HIV response.

A Coordinator assists each of the four Commissioners to effectively discharge their mandates. Even though NAC recognizes the need to keep a lean level of staffing at its Secretariat, the existing staff levels is significantly below what is recommended in the Policy Regulations of NAC. There is a compelling need to increase the number of staff in the Mandates as well as strengthen technical and management skills of the Coordinators and Commissioners. As funding to NAC increases and the national HIV response expands, the Secretariat will need to recruit a senior finance officer to assist with financial reporting and accountability, and a Communications Officer to improve communications on, and visibility of, the national response with the general public including program beneficiaries and the multi-sectoral partnership.

The national level coordination arrangements are the NAC Board of Directors, the Partnership Forum, and various National Technical Working Groups (TWGs). The NAC Board of Directors is serviced by the Secretariat and meets twice a year. Partnership Forum is held semi-annually to review, plan and share progress of the national HIV response to avoid duplication as well as foster optimum use of limited resources. The multi-sectoral TWGs provide technical guidance and direction for HIV and AIDS programs that are implemented in the country.

Partnership Mandate

The public, private and CSOs sectors, and development partners are all key partners in the national HIV response. Activities by all the partners must be coordinated to produce optimal results. The Partnership Mandate at NAC is responsible for coordinating the multi-sectoral partnerships for the national HIV response and organizes the semi-annual Partnership Forum. In addition to organizing the Partnership Forum, the Partnership Mandate has facilitated the formation of the Government Line Ministries and Agencies HIV and AIDS Coalition to provide stewardship in mainstreaming and integrating HIV and AIDS into their core functions. The NAC conducted a 4-day workshop supported by UNICEF to support efforts at developing sector specific HIV workplace policies for eight (8) ministries and two (2) agencies.

The Partnership Mandate has also constituted the HIV and Human Rights Platform to promote and protect universal access to HIV prevention, treatment, care and support services. The Platform has 30 members drawn from public, private and CSOs. The group meets quarterly.

Policy and Program Mandate

One of the primary functions of NAC Program and Policy Mandate is to coordinate the functions of the technical working groups (TWGs) that provide technical guidance and direction for HIV and AIDS programs that are implemented in the country. Some key TWGs for the national response are coordinated by NACP. The current TWGs are: Treatment, Care and Support and PMTCT; HIV & AIDS Prevention; M&E; Finance and Fundraising; and Human Rights and HIV and AIDS. The Program and Policy Mandate at NAC will coordinate the TWGs. The Mandate ensures public awareness and education of the HIV Law of Liberia, and advocate for its implementation.

Meanwhile, the Program and Policy Mandate is working together with Liberia Development Alliance (LDA), a high level coordination mechanism for the implementation of Liberia AfT, to ensure the implementation of the HIV sector under the crosscutting issues pillar of the AfT, Liberia's long-term vision of socioeconomic transformation and development. The HIV sector of the AfT encapsulates the GOL's commitment to reducing the spread of HIV and AIDS and mitigates its impact on persons living with HIV and AIDS and their families. The Mandate in collaboration with partners developed an HIV and AIDS Sector Work Plan and is leading to the development of the NSP 2015-2020.

The Decentralization Mandate

The Decentralization Mandate is responsible for coordinating the decentralized multi-sectoral HIV response at the county, district, and community levels. It has established 5 County Offices in Bong, Bomi, Grand Bassa, Lofa, and Nimba. In 3 other counties, non-NAC staff provide coordination of the county HIV response as focal persons from MOGD in Grand Kru and from Ministry of Internal Affairs (MIA) in Maryland and River Gee Counties.

The Mandate plans to recruit and deploy a staff member in each of the remaining counties to support decentralization of the HIV response to the district and community levels. Meanwhile, the mandate is working closely with the County Development Coordinating Committees to ensure HIV and AIDS issues are addressed at the county levels especially in counties where it does not have staff.

The Strategic Information Management Mandate

The M&E Mandate is responsible for ensuring the national HIV response is evidence-based, effectively monitored, evaluated, and documented. This requires ensuring data and information from all partners in the national response are collected on time, robustly monitored for quality, and accurately analyzed in order to produce Strategic Information of the highest caliber to guide program planning and decision making. The Mandate has facilitated a number of critical HIV related studies including the 2013 IBBSS and collaborated with LISGIS for the 2013 LDHS on HIV and AIDS.

A 2013 UNAIDS assessment of the M&E Mandate found human capacity, sub-national databases, and supervision and auditing" are continuing critical needs of the Mandate that need to be addressed. The Mandate plans to place an M&E staff in each of the 5 regions in the country to coordinate M&E within the regions and an additional staff at the NAC to deal with the increased volume of data and information that is expected to be generated by the regions.

Outcome

- **The NAC management and coordination capacities for the national HIV response improved.**

This outcome will be tracked by periodic reviews of NAC Secretariat and the midterm and final evaluations of the NSP 2015-2020.

Output

The main outputs include:

- **Organizing meetings of the Board of Directors.**

- Organizing and coordinating the TWGs.
- Carrying out advocacy and resource mobilization.
- Organizing national NSP midterm and final evaluations.
- Coordinating surveillance, surveys, and other research studies and assessments.
- Monitoring and reporting on the national and decentralized HIV response.

Strategies

The key strategies are:

- **Strengthening capacity for the coordination of the national HIV response.**
Strengthening NAC's capacity to coordinate the national HIV response will ensure programmatic activities of all stakeholders are aligned to and harmonized with the national Strategic Plan for HIV and AIDS 2015-2020.
- **Strengthening capacity for the management of the national HIV response.**
Strengthening NAC's capacity to manage national HIV response will ensure effective and efficient implementation of the NSP 2015-2020.

Major Activities

The main activities of these strategies are:

Coordination of the National HIV Response

- Hold biannual Partnership Forums.
- Assume responsibility for coordinating the TWG meetings.
- Coordinate international and national HIV and AIDS commemorations and activities.

Management of the National HIV Response

- Provide oversight responsibility for the implementation of the national HIV response.
- Hold biannual meetings of the NAC Board of Directors.
- Provide strategic information and prepare reports on the national HIV response.
- Spearhead advocacy and resource mobilization for the national response including advocacy and resource mobilization from the GOL, the private sector, and development partners.

7. Funding Resource Needs of the National HIV Response

Introduction

All the interventions in the NSP need adequate resources and funding with timely release and disbursement. This is a prerequisite for effective implementation of the NSP 2015-2020. The NAC has primary responsibility for mobilizing resources for the national HIV response.

Achievements and Challenges

The National AIDS Spending Assessment (NASA) for 2010/11 fiscal year showed Global Fund contributed 81.1% and the UN system 16.8% of the spending for HIV and AIDS activities in the country. The GOL and non-UN development partners contributed 0.9% and 0.5% respectively.

The NASA 2010-2012 Report (Table 7.1) shows AIDS spending increased by 9% between 2010 and 2011 fiscal years, from about US\$ 15.95 million in the 2010/2011 fiscal year to US\$17.34 million in 2011/2012 fiscal year with marginal variation in funding sources for the two fiscal years. Internal domestic sources of

funding increased from 0.4% in 2010/11 to 1.2% in 2011/12. External sources of funding for the national HIV response decreased marginally from 99.6% in 2010/11 to 98.8% in 2011/12. The Global Fund provided approximately 80% of the external funding in both fiscal years.

Table 7.1: HIV and AIDS Expenditure by Source of Funding and Beneficiary Liberia NASA 2013

Sources of Funds	2010/2011		2011/2012	
	Amount (US\$)	%	Amount (US\$)	%
Total Spending	15,959,266		17,368,448	
Source				
Public Funds	40,476	0.3	142,193	0.8
Private Funds	17,354	0.1	63,209	0.4
International Funds	15,901,436	99.6	17,163,046	98.8

Further analysis of the report reveals about 58% of expenses is incurred on program support activities and about 48% on direct program activities. About 27% of the funds were expended on HIV prevention activities, the largest expense among the direct program activities and 12% on ART.

Outcome

- Domestic sources of funding for the national HIV response increased

Output

- The domestic funding of the national HIV response increasing.

The Output will be tracked using the indicators and targets in Table 7.2

Table 7.2: Domestic contribution Outcome Indicators and Targets

	Indicator	Target						
		2011/12	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20
1.	Domestic contribution as a percentage of total spending on national HIV response	2%	5%		10%			15%

Strategies

- Increasing domestic funding for the NSP 2015-2020

The three basic sources of domestic funding are the public sector, the private sector (private-for-profit and private-not-for-profit), and the individual sources for meeting the cost of HIV and AIDS services. Increasing domestic funding will require increased contributions from all of these sources. As the economy grows, it will be plausible to expect increased contributions from these sources of funding, especially from public sources.

Major Activities

The key activities of this strategy are:

- Advocate to increase GOL funding to the national HIV response.
- Develop National HIV Resource Mobilization Strategy with a focus on increasing domestic funding, consolidating existing external funding sources, and establishing new external funding sources.
- Operationalize the National Resource Mobilization Strategy.

8. Research, Monitoring and Evaluation

Introduction

The NAC has responsibility for monitoring and evaluating as well as providing guidance and oversight for multi-sectoral reviews, assessments, research, and studies on the national HIV response. The M&E Mandate has primary responsibility for these functions. However, similar to other mandates at the NAC, the M&E Mandate has a small and under-resourced capacity with a Commissioner as its head, one M&E Coordinator, and one M&E Officer. Much of the data and information for monitoring the national HIV response are found at the Ministry of Health (NACP and Family Health Div.) and LISGIS. Data on the involvement of other sectors in the national HIV response is scarce.

Achievements and Challenges

In 2011, NAC commissioned the Size Estimation of Sex Workers, MSM, and Drug Users in Liberia in response to the commonly held belief that these groups are key to driving the epidemic but their population sizes are not known. The study estimated that there are 18,722 FSWs, 711 MSM, and 457 PWID in the country. Even though many informed opinions considered the sizes to be grossly underestimated, the study provided important insights into the sexual behavior of these population groups as well as identified key “hotspots” that may be used as outreach sites for the delivery of HIV prevention information and services for KPs.

In 2013, the NAC and others conducted an Integrated Bio-Behavioral Surveillance Survey (IBBSS) that, for the first time, determined HIV prevalence in vulnerable populations, namely, MSM, FSWs, Uniform Services, PWID, transport workers, mobile traders, miners, out-of-school youth (OSY) and in-school-youth (ISY). The survey showed MSM, FSWs, uniform services, mobile traders, transport workers (long distance bus and truck drivers), and miners have HIV prevalence much higher than that in the general population. Based on this evidence, the national HIV response now recognizes these population groups as Key Populations driving the HIV epidemic in the country. This information is absolutely critical in providing direction and guidance as Liberia prioritizes HIV prevention information and services for key populations in the NSP 2015-2020.

The NAC collaborated with the Liberia Statistical and Geo-Information Services (LISGIS) that conducted the 2013 Liberia Demographic and Health Survey (LDHS). NAC has widely disseminated the HIV and AIDS findings in the 2013 LDHS report. This information is very valuable to current activities of the national HIV response. It is also contributing to HIV policy and program reviews and discourse as well as critically informing the development of the NSP 2015-2020.

The National HIV M&E Plan for the NSP 2015-2020 will incorporate key indicators that will capture information and data from CBOs and others providing HIV and AIDS services at the community level. This will provide a comprehensive picture of the national HIV response.

The NAC M&E Mandate has not been very active in providing strategic information, technical support and guidance on M&E program improvement, in part, because it is understaff. Also, it does not have enough funding to allow it to intensively engage with implementers including building their capacity to collect, collate, analyze, and use information and data at the local level decision-making and transmitting this

data to national level for aggregation and analysis to provide a comprehensive picture of the extent of the epidemic and impact of the national response.

Strengthening the M&E Mandate for the NSP 2015-2020

The NSP 2015-2020 places premium on strengthening the capacity of the M&E Mandate to collect, verify, analyze, and use data from implementing partners and in collaboration with research findings, provide strategic information for the national HIV response as well as provide technical support and guidance to implementing partners. A strengthened M&E Mandate will provide data and information needed to guide policy, planning, coordination, and implementation of the HIV response; assess the effectiveness of the HIV response and measure overall performance; identify gaps and emerging M&E needs for program improvement; and develop a systematic approach to data quality assurance. The M&E Mandate will also play a central role in the development of the accompanying National HIV M&E Plan for the NSP 2015-2020. This Plan will be aligned with the twelve components of good HIV M&E system that UNAIDS currently promotes as international best practice.

Outcome

- **A strengthened M&E Mandate at the NAC is contributing to improvements in policy, planning, coordination, and implementation of and reporting on the national HIV response.**

A strengthened M&E mandate is vital to monitoring progress towards achieving the targets of the NSP 2015-2020. The mandate will be strengthened by recruiting additional staff to enhance monitoring of program activities, training of implementing partners in M&E, and coordinating national level HIV and AIDS research.

The availability of quality SI and program data, trained M&E staff, and improvements in policy, planning, coordination, implementing, and reporting arenas of the national HIV response will indicate how the M&E Mandate has been strengthened.

Output

Key outputs include:

- **Additional six M&E technical staff recruited: 5 posted to the 5 regions and one at the NAC.**
- **An electronic database that captures data and information from all implementing partners is developed and maintained.**
- **The National HIV M&E Plan 2015-2020 is developed and operationalized.**
- **Staff from implementing partners, especially from the CSOs, are trained in M&E.**
- **Routine monitoring of NSP implementation by partners is carried out.**
- **Data audit and quality assurance is carried out.**
- **National HIV and AIDS Program reviews, assessments, surveys, and studies are carried out.**

Strategies

- **Development of National M&E HIV Plan**

The goals of the National HIV M&E System are to track the epidemic, drivers of the epidemic, effectiveness & efficiency of response (results of services/interventions), and determine extent of response (who is doing what, where).

- **Build an electronic database that captures the national HIV response data and information from all participating sectors.**

NAC M&E mandate must be the central repository of all data from the multi-sectoral HIV response. The mandate should issue a 1-2 pager six monthly factsheet with strategic information about the epidemic and the national HIV response that should be sent electronically to all stakeholder organizations to assist them review and plan their activities accordingly.

- Recruiting additional M&E staff.
- Routine monitoring of program activities and data verification and audit.
- Training of HIV program implementers in M&E.
- Coordination of various national research studies and assessments.

The outputs are tracked using the indicators and targets shown in Table 7.3

Table 7.3: Research and M&E Output Indicators and Targets

	Indicators	Baseline	Target					
			2015	2016	2017	2018	2019	2020
	National HIV M&E Plan developed and reviewed/evaluated	2014 National HIV M&E Plan developed			M&E Plan Review			
	Number of M&E staff employed at NAC		2	2	2			
	Develop and maintain a national electronic database containing response data from all implementing partners.		x	x	x	X	x	X
	Number of staff trained in M&E		13	13	15	20	20	20
	Monitoring and supervisory visits made to program sites by senior staff		x	x	x	X	x	X
	Number of data verification exercises undertaken		x	x	x	X	x	X
	Number of data audits carried out		x	x	x	X	x	X
Surveys, surveillance, and other studies or major reviews carried out								
	Size Estimation of MSM, FSWs, PWID,	2011 KP Size Est.		KP Size				KP Size Estimate
	Liberia Demographic and Health Survey (LDHS)	2013 LDHS				LDHS 2018		
	IBBSS Key Populations	2013 IBBSS		2016 IBBSS			2019 IBBSS	
	National AIDS Spending Assessment (NASA)	2013 NASA	NASA	NASA	NASA	NASA	NASA	NASA
	Midterm Evaluation of NSP				MTE			
	Final Evaluation of NSP							Final Eval.
	PMTCT Study	PMTCT Study 2011			PMTCT Study			PMTCT Study
	ART Cohort Study	2013 Cohort Study	Cohort Study		Cohort Study		Cohort Study	

	Indicators	Baseline	Target					
			2015	2016	2017	2018	2019	2020
	Gender Assessment	2013/2014						
	PLHIV Stigma Index	2013 Stigma Index			Stigma Index			Stigma Index
	Planned Mode of Transmission Studies	2014 MoT					2019 MoT	
	Sero-Surveillance Survey among pregnant women	2013 ANC Survey	2015 ANC Survey		2017 ANC Survey		2019 ANC Survey	

Major Activities

The main activities associated with the strategies are:

- Develop National HIV M&E Plan.
- Strengthen capacity of M&E Mandate at NAC.
- Conduct routine HIV program monitoring.
- Conduct trainings for M&E staff of implementing partners.
- Carry out data verification and audit.
- Coordinate and collaborate in conducting key research studies and assessments: Demographic and Health Survey, IBBSS, KPs size estimation, NASA, NSP Midterm and Final Evaluations.

Section Eight

Synergies with Development Sectors

Introduction

Since the results of effective synergies are greater than the sum of the individual parts, the NSP has identified key development sectors (Table 8.1) with which the national HIV response will work in synergy. This list is not exclusive and the national HIV response will form other synergies as and when necessary.

Table 8.1: National HIV response and Synergies with Development Sectors

	NSP 2015-2020 Focus	Synergizing Activity	Development Sector & Key Partners
1.	Strengthening key health systems impacting on national HIV response	Health Systems Strengthening (HSS)	Health Sector – Ministry of Health and Social Welfare (MOHSW), WHO, FBOs, NDS, Development Partners
2.	Strengthening key community systems impacting on the HIV response	Community Systems Strengthening (CSS)	Community Sector – CSOs, Ministry of Internal Affairs, Traditional Council, and Chiefs
3.	HIV education for in school youth (ISY)	School-Based HIV Education	Education – Ministry of Education (MOE)
4.	SRH & HIV education for out of school youth (OSY)	HIV prevention information and services for OSY	CSOs, Ministry of Youth and Sports (MOYS)
5.	Stigma and discrimination against PLHIV	Human Rights and HIV	Legal Sector – Ministry of Justice
6.	Mitigating socioeconomic impact on AIDS-affected households	Social Protection for the Poor, involve PLHIV in income generating activities	Social Protection – Ministry of Gender and Development (MOGD)
7.	Gender and HIV	Gender Dimension of HIV	Social Protection – Ministry of Gender and Development (MOGD)
8.	HIV and the Workplace – Formal Sector	Workplace HIV Programs	Public Sector Ministries including the Security Forces; Private Sector Firms
9.	HIV and the Workplace – Informal Sector	Workplace HIV Programs	Ministry of Labor, CSOs

1. Health Systems Strengthening

Introduction

The health sector response is at the core of the national HIV response. It is important that the health systems are strong, as any weaknesses in the systems will have a negative impact on the national HIV response. The key health systems to support the implementation of the NSP include the Healthcare Financing, Human Resource, Health Infrastructure, Procurement and Supply Chain, and Monitoring and Evaluation.

Achievements and Challenges

The 14 years of civil war (1989-2003) devastated Liberia's healthcare system. Most health professionals either fled the country or died during the fighting and health facilities were trashed, burned down, or looted. Only 89 physicians and 329 nurses remained in the country by 1998. Thus, in 2010, with a population of 3,518,437, there were 1.3 clinical health workers per 1000 population, far below the World Health Organization (WHO) recommendation of 2.2 health workers per 1000 persons in order to assure 80% coverage of deliveries supervised by skilled birth attendants.

By 2005, two years after the peace agreements were signed, the health sector was still in disarray and depended heavily on international humanitarian aid. Without oversight and coordination, this aid was distributed according to disparate donor priorities that did not necessarily match priority needs of the health sector. As a result, the health system was barely functioning, with only an estimated 40% of Liberians able to access basic health services. Many health facilities had no electricity, no communication, only intermittent access to clean water, and frequent stock outs of essential drugs and health commodities.

Since 2003 the health sector has made a steady recovery and has progressed from emergency status to reconstruction and normal development. Designed to restore basic health services that had been destroyed during the conflict and to lay the foundations for a system that can provide accessible and affordable quality health care services to all Liberians, the National Health Policy and Plan (NHPP) was implemented as the Basic Package of Health Services (BPHS). Under the NHPP, under-5 mortality rates declined and under-5 malaria prevalence fell to 32 percent in 2011 from 66 percent in 2005. The number of functional health facilities increased by 64 percent, from 354 to 550, and facilities offering the Basic Package of Health Services (BPHS) increased from 36 percent in 2008 to 84 percent in 2011. The health workforce also increased from around 5,000 to about 8,000.

However, these gains remain skewed in favor of urban populations who can afford private health care provisions. For instance, 85 percent of urban households are within one hour's walk to a health facility while two-thirds of rural households travel more than an hour to reach a health facility. For childbirth, 63 percent of deliveries in urban areas are facility-based compared with 25 percent in rural areas; similarly 77 percent of urban deliveries are done by skilled service providers compared to only 32 percent of rural deliveries. Other challenges abound. Generally, there is low coverage, low quality, unpredictable financing, and poor use of health services. Malaria still accounts for 38 percent of the outpatient attendance and 42 percent of inpatient deaths in Liberia.

Plans for Improving Healthcare for All Liberians

In 2011, the MOHSW published the National Health and Social Welfare Policy and Plan (NHSWPP), which sets the sector strategy for 2011–2021. The goal is to improve the health and social welfare status of the population of Liberia on an equitable basis. The Essential Package of Health Services is the cornerstone of the policy and plan. It builds on the successes of the BPHS and provides a comprehensive set of services.

The challenges noted in the NHSWPP include the continuing poor state of the nation's health, and social welfare systems that crumbled during the civil war; the still depleted health-sector work force; poor road conditions hampering delivery of services and supplies; unpredictable financing due to low budget allocations and uncertain development partner funding; and imbalance between the size and staffing of facilities and the catchment populations they are supposed to serve. Current workforce growth is skewed towards nurses and nurse aides, and there is low retention of skilled workers due to unattractive conditions of service and salary.

The NHSWPP sets out three general objectives for health:

(a) Increase access to and utilization of quality health and social welfare services, delivered close to the community, endowed with the necessary resources and offering a comprehensive package of interventions of proven effectiveness.

(b) Make health and social welfare services more responsive to people's needs, demands and expectations by transferring management and decision-making to lower administration levels, ensuring a fair degree of equity.

(c) Make health care and social protection available to all Liberia's population, regardless of an individual's position in society, at a cost that is affordable to the country.

i. Healthcare Financing

Introduction

According to the Country Situation Analysis Report of July 2011: the overall expenditure on health has been steadily increasing in Liberia over the years: US\$100 million, US\$126 million, and 240 million in 2007/08, 2010/10, and 2011/12 respectively. Household contribution to total health expenditure has increased from 35% in 2007/08 to 51% in 2011/12, whereas GOL contribution to health expenditure has remained at 15%, and external sources have decreased from 47% to 32%.

Review of the MOHSW Annual Report for 2012 indicates that the percentage of the national budget for health has remained around 10% for the 3 fiscal years between 2010 and 2012: namely 7.68%, 10.77%, and 9.53% for 2009/10, 2010/11, and 2011/12 respectively. A review of the National Health Accounts (NHA) shows government health expenditure, as percentage of total government expenditure was 8%, 7%, and 7% in 2007/08, 2009/10, and 2011/12 respectively.

Thus GOL expenditures on health are consistently lower than what all countries in the Economic Community of West African States (ECOWAS) including Liberia assented to in the Abuja Declaration of 2006 which commits governments to allocate at least 15% of the total annual government spending to health.

Outcome

GOL allocation to health sector increased to 15% by 2020.

Output

The budgetary allocation to the health sector as a proportion of the national budget increased from 9.53% in 2011/12 to at least the 15% Economic Community of West African States target in 2019/2020.

Strategies

- **Advocacy with GOL to increase funding to the health sector.**

The MOHSW will advocate for GOL to increase its budgetary allocation with a target of reaching the Abuja commitment of 15% by 2020.

ii. Human Resources for Health

Introduction

In 2009, the HR Census team recorded 9,196 health and social welfare workers.⁷ This number includes a clinical workforce of 5,989 workers and 3,207 non-clinical workers (35%) which consists of: cleaners, drivers, and administrative and security

⁷ This number includes the 428 workers who were absent from work at the time of the survey. These workers have not been included in the further analysis of the workforce. The figure 9,196 includes trained and untrained traditional midwives but excludes other traditional and alternative health practitioners, full-time staff working in training institutions and community health volunteers.

staff. The clinical workforce includes nurse aides (1,589) and all categories of nurses (1,393) constituting 17.3% and 15.2%, respectively, making them the next biggest groups in the sector workforce. Other clinical workers are: certified midwives (412), physician assistants (PAs) (286), and social welfare workers (182) count for 4.5%, 3% and 2% of the total workforce, respectively (World Bank 2010a: 6). In 2006, the Rapid Assessment team recorded a workforce of 4,970 full-time and part-time health and social welfare workers (MOHSW 2006). A comparison with 2009 is not straightforward because the 2006 Assessment excluded traditional midwives and non-clinical workers.

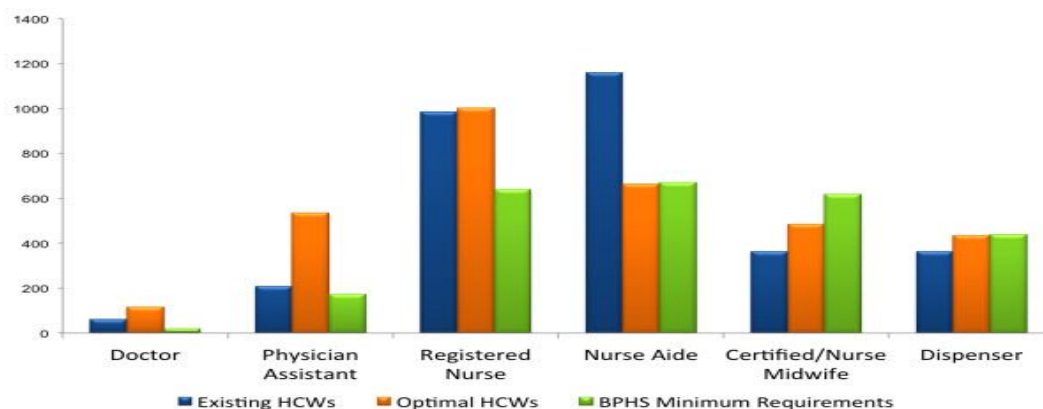
Human capital is a problem due to lack of education and skills, especially among the population that missed out on schooling during the war. The goal of the Agenda for Transformation (AfT), the current GOL blueprint for development, is to improve quality of life by investing in more accessible and higher quality education; affordable and accessible quality healthcare; social protection for vulnerable citizens; and expanded access to healthy and environmentally friendly water and sanitation services. The AfT seeks to improve the health and social welfare status of the population of Liberia on an equitable basis.

Achievements and Challenges

The Basic Package of Health Services (2007-2011) was the GOL blueprint for improving facility-based health services in the country, including providing the needed human resources. It focused on building management capacity at the central and county levels to enhance a coordinated approach to delivery of health services. The plan envisaged a coordinated approach to human resource planning, increasing the number of trained health workers, and enhancing health worker performance, productivity and retention.

A 2011 comparative study of the human resource needs for essential cadres of health workers in the health facilities between existing (2011) staffing levels, the EPHS Minimum Requirements, and Optimal Health Workers based on WHO recommended minimum requirements (Fig 8.1) shows an over capacity in nurse aides, under capacity in doctors, physician assistants, and certified nurse midwives, and about adequate capacity in registered nurses and dispensers. This study showed the EPHS human resource plan had resulted in the recruitment of more nurse aides and less doctors, PAs, and certified midwives at the health facilities. Health worker numbers, performance, productivity, and retention, while still poor overall, are certainly much better in the urban than rural areas.

Figure 8.1: Liberia HRH Comparative Analysis 2011



Source: Varpilah et al: Human Resources for Health 2011 9:11

In addition to being concentrated at hospitals, nurses are concentrated in urban areas, particularly the capital. A 2008 National Census shows approximately one-third of the population of 3.47 million lives in Montserrado. Anecdotal evidence and informed opinions suggest more than half the clinical service providers are concentrated in Montserrado, most of them in Monrovia.

To improve performance, MOHSW, under EPHS, focused on developing strong leadership and oversight, as well as in-service training. With limited resources to invest in pre-service training and the need to improve the quality of services immediately, MOHSW created in-service training modules for the EPHS which every facility clinical worker is required to complete. Two clinical supervision programs are implemented to ensure facility mentoring and monitoring. Each County Health Team (CHT) is staffed with a clinical supervisor whose job it is to provide monthly supervision and assistance to each facility in the county. Additionally, central MOHSW teams are deployed to provide mentoring to the facilities once a year. Logistical challenges such as the constant disrepair of vehicles mean supervision does not currently happen as often as it should. Without increased compensation for additional tasks or years of service, and no opportunities for advancement, motivation for nurses to improve performance is an ongoing challenge.

Liberia has been using task-shifting to increase service availability with limited HR since 1958 when the Physician Assistants school was created to address the shortage of physicians in the country at the time. In recent years, however, the severe shortage of health workers at all levels has heightened the urgency of shifting tasks from highly trained providers to available staff with less training. As a result, throughout the war and in the years immediately following it, widespread informal task-shifting took place. MOHSW has begun formalizing task-shifting to ensure quality and safety. Many of the essential clinical tasks are being task-shifted to nurses because of shortage of physicians and physician assistants.

Outcome

- **Adequate HRH available and equitably deployed.**

Output 1

- **Training modules developed**
- **Training of health workers scaled up.**

Strategies

Scale up training of health workers and ensure deployment of adequate numbers of health professionals. This process of scale up should include:

- Regularizing the status of training institutions.
- Reviewing of training curricula.
- Training of preceptors.
- Admission and training of participants.

Output 2

Health workers retention policy developed and implemented.

Strategies

Implement GOL staff retention strategy

Create the necessary conditions and incentives (*adequate staff housing and associated utilities and access to transport*)

Health Workforce Development for NSP 2015-2020

Most of the benefits of the EPHS are skewed toward urban populations, who have shorter distances and commuting time to health facilities, better coverage and quality of services relative to rural populations.

As part of the Agenda for Transformation (AFT) 2011-2017, the MOHSW in coordination with the Civil Service Agency is in the process of implementing the plans for expanded HRH in a systematic way. This will increase and retain qualified health workers by providing more attractive pay and working conditions, including incentives for those working in difficult locations. Government will deploy social workers at health facilities in rural areas and contract out institution-based social services.

The MOHSW has costed plans for training specialized health care workers (PA, CMs, Nurses, and Doctors) and increasing coverage for comprehensive and basic emergency obstetric and newborn care as well as PMTCT.

The MOHSW will also coordinate with county health teams to build networks of community health volunteers and increase awareness of the availability and need to use community health facilities and programs, such as immunization, insecticide-treated bed nets, trained and certified midwives, and emergency care for children with fever.

iii. Health Infrastructure

The MOHSW in coordination with the Ministry of Public Works (MPW) has a costed plan for the construction of health facilities. In this context, the GOL will give priority to establishing a decentralized network for health services comprising:

- Health service delivery points for populations of less than 3,500 within 5 kilometers.
- Health clinics for populations between 3,500 and 12,000 people, and equip 150 health clinics with solar refrigerators to ensure the stability of vaccines.
- Health centers serving populations up to 40,000.
- County hospitals for up to 200,000.

These facilities will provide the following services:

- Primary health care including nutrition promotion at health service delivery points (SDPs);
- Plus in-patient, emergency and basic OB-GYN services at health clinics;
- Plus general surgery, pediatrics, and general medicine at the level of county hospitals;
- Plus tertiary services at the four regional referral hospitals and the national referral hospital—John F. Kennedy Medical Center.

iv. Procurement and Supply Chain Management

The GOL, in partnership with development partners and NGOs, created the NDS as a self-sustaining private-not-for-profit entity with a mandate to provide drugs and medical supplies to the public and NGO health sector through a revolving drug fund mechanism. The procurement and supply chain management system is among the most challenging systems to strengthen in Liberia.

The capacity of the NDS was also built by UNDP when it transitioned its position as the Principal Recipient of the Global Fund to the MOHSW. The Global Fund grant has facilitated the building of a network of warehouses across the country for storage of health related goods and to guarantee the availability of drugs and supplies in health facilities. Due to continuing weakness of the NDS, its procurement and supply functions are confined to warehousing and distributing the pharmaceutical and health products to the counties once a clearing agent clears them with customs. Global Fund funded drugs are procured through the Voluntary Pool Procurement mechanism in Geneva.

As peace and stability are consolidated and the economy is growing, the road network is improving. This will contribute to improving the supply chain especially in difficult to reach rural areas. The ongoing decentralization of the public sector, if accompanied with adequate allocation of resources to the decentralized counties, would contribute to improving supply chain management at the county level.

Strategies

- Strengthen collaboration with the NDS and SCMU for the purpose of collecting accurate and reliable supply and consumption data.
- Strengthen coordination between the county diagnostic officers and pharmacists.

Activities

Incorporate laboratory reagents and consumables in the LMIS and HMIS to inform decision for quantification and procurement.

Continued mentoring of laboratory technicians and county diagnostic officers.

v. Monitoring and Evaluation System

Introduction

The Monitoring and Evaluation Unit of the MOHSW, established in 2008 to provide leadership for a comprehensive decentralized monitoring and evaluation system in the country, as stipulated by the National Health Policy 2007-11, has been working tirelessly to improve the quality of health data collection, collation, analysis, and use. Significant funding support, notably from the Global Fund, the World Bank, and GOL, and technical assistance from USAID and WHO, have increased the visibility of the M&E Unit and improved its performance in the last five years.

Achievements and Challenges

Financial support from the World Bank Health Systems Reconstruction Project (HSRP) and technical support from WHO and UNDP have enabled the MOHSW to implement a wide area network and utilize ICT technology to monitor and improve health services, including data collection and reporting, through the use of portable or handheld devices. The MOHSW M&E Unit has facilitated the development of a performance framework containing 15 indicators for the Performance-based Contract (PBC) that is being used by the MOHSW to measure the performance of NGOs hired to deliver health services in the country.

Countrywide data verification exercises undertaken by the MOHSW HMIS Unit have shown that even though there is some improvement in data quality, poor data quality continues to be of great concern as evidenced by huge disconnect between data within the county and central level database, the facility monthly paper base reporting forms and health facility ledgers. Remedial actions are being taken and

include providing further training and mentoring support to the PBC contractors to improve data quality.

The convergence of three different sources of funding support has bolstered county level M&E systems. The Global Fund is paying the salaries and has bought motorbikes for 15 M&E Officers stationed in all 15 counties to help improve data quality and county level planning processes. The World Bank has provided all the M&E Officers with laptops, and the GOL Pool Fund has provided modems for internet connectivity to facilitate prompt data transfer between the county and central levels.

Further capacity enhancement for the county level M&E system has been facilitated by USAID-funded RBHS project that supported the training of the county M&E officers, data officers, and county registrars in the use of different tools and methods for data collection and validation. This enhanced capacity has significantly improved data quality and increased the coverage and scope of data reported from the counties to the central level. The MOHSW provided computers, printers and copiers to County Health Offices to support timely data collection and reporting.

There is a need to intensify robust data verification and deepen the data quality assurance exercises and oversight responsibilities being carried out by the MOHSW at the national level and increase support for the county level M&E system including the provision of adequate funding and material resources including office accommodation, stationery, transport and training and deployment of additional staff to all counties for an effective decentralized M&E system.

Outcome

- **A strengthened and well-coordinated Monitoring and Evaluation (M&E) system** involving MOHSW, NAC, and other stakeholders that ensures accurate monitoring of the progress towards desired health and non-health outcomes and objectives and which provides accurate strategic information for planning and program implementation.
- **Strategic information derived from the HIV M&E System used for national and sector planning and decision-making.**

Output

National HIV M&E System strengthened to provide high quality strategic information for timely decision-making and action to continuously strengthen the national multi-sectoral response to HIV.

Strategies

- Institutionalize capacity strengthening for HIV M&E within the line ministries and other implementing partners.
- Establish a national data quality assurance system for HIV that is implemented at all levels and at all sectors.

The M&E key outputs include the following:

- Conduct an assessment of sector HIV reporting system.
- Develop an action plan to strengthen M&E systems based on the assessment report.
- Review and revise data collection and reporting tools,
- Introduce electronic database system at PHC level.

- Develop and disseminate national data quality assurance guidelines.
- Train M&E focal points on the data quality assurance systems and tools.
- MOHSW/NAC/ M&E Unit routine monitoring activities carried out effectively and efficiently.
- Data verification, audit, and quality assurance exercises carried out.
- M&E national and county level staff trainings carried out.

2. Community System Strengthening (CSS)

Introduction

Community participation in HIV response activities is central to achieving universal access to HIV prevention, treatment, care, and support. Without effective community participation, gains made by other sectors of the national HIV response cannot be sustained. The major providers of community-based activities are community-based organizations, faith based organizations, and NGOs. Key players providing leadership in community level HIV responses include religious and traditional leaders, traditional healers and birth attendants.

Achievements and Challenges

Community participation has been the critical factor in generating demand and providing community-based care and support for HIV and AIDS services. CBOs, FBOs, support groups, and community volunteers are spearheading HIV activities as essential components of the national HIV response including: dispelling myths surrounding HIV and AIDS; reducing stigma and discrimination against PLHIV; tracking lost-to-follow up of patients on care and treatment; condom promotion and distribution; reducing gender inequalities; and providing community and home-based care for PLHIV and OVC. CBOs are almost always under-resourced and have weak systems including governance, administration, finance, and staff with little or no training or skills.

Outcome

Strengthened community systems making significant contributions to achieving the outcome of the national HIV response.

The overall outcome of community systems strengthening is to enable community-based organizations, leadership, and social structures as well as non-government organizations play key roles in the achievement of health and HIV response outcomes. Community systems strengthening is aimed at putting in place an effective system for delivering health and HIV services through community level linkages and processes in a manner that complements and links with the health and other development sectors.

Output

Key community systems that will be strengthened include the following:

- **Governance and accountability systems improved.**
- **Management systems for HIV and AIDS activities strengthened.**
- **Resource mobilization capacity for HIV and AIDS activities improved.**
- **M&E of HIV and AIDS activities strengthened.**

Strategies

- Capacity building for CBOs and FBOs

Capacity building for CBOs and FBOs will include the following:

- Strengthening management, accountability, and leadership of CBOs and FBOs.
- Training of CBOs and FBOs in strategic and operational planning and in community-led M&E.
- Building skills in service delivery, advocacy, leadership, and fund raising for CBOs and FBOs.
- Training in monitoring and documenting community-based activities and effective communication and advocacy to policy makers and decision makers.
- Strengthening resource mobilization skills for CBOs and FBOs.
- Provide support for establishing and strengthening community networks, linkages, partnerships and enhancing coordination mechanisms with the district and county officials.

The output result will be tracked using the indicators and targets in Table 8.2

Table 8.2: CSS Output Indicators and Targets

	Indicator	Baseline	Targets					
			2015	2016	2017	2018	2019	2020
	CBOs and FBOs whose governance, management, resource mobilization, and/or M&E systems have been strengthened for community HIV activities	NA	2	3	5	0	0	7

Major Activities

The HIV and AIDS activities to be provided by community-based organizations are:

- Create demand for HIV prevention services with particular emphasis on family health approach including couples counseling and testing and linkage to care in the context of discordant couples.
- Reduce stigma and discrimination associated with HIV and AIDS.
- Trace treatment defaulters.
- Follow up HIV positive mother and baby.
- Promote and distribute condoms and lubricants at community level.
- Support treatment adherence counseling and community-based adherence.
- Provide TB screening and follow up.
- Mobilize and refer for PMTCT, HCT, Treatment, Care and Support.
- Provide support and linkages to support services for substance abuse.
- Provide linkages to other community-based health services including access to clean water and sanitation, nutrition assessment counseling and support (NACS), food security, and other social support mechanisms.

3. Education Sector Response to HIV

Introduction

HIV prevention information has been incorporated into the school curriculum for Grades 6 to 12. Teachers and peer educators have been trained and are spearheading the HIV prevention program in the school system. Training manuals

for teachers and peer educators have been developed and are being used for the HIV Prevention Education based on Life Skills program for schools. The training manuals have modules on HIV and AIDS comprising sessions on:

1. Meaning of HIV and AIDS
2. Window Period
3. ABCDE of Prevention and Implications of Preventive Behavior
4. Prevention and Control of HIV and AIDS
5. Facts about Condoms
6. Male Condom Use
7. Female Condom Use
8. Practices that Promote the Spread of HIV
9. Stigma and Discrimination

Other modules dealing with important HIV risk factors are Relations and Gender Norms and Construction.

Achievements and Challenges

About 2000 (43%) of Liberia's 4600 plus schools are presently benefitting from the Life Skills and HIV Prevention Program. Teachers' guides to teaching HIV have been developed and health clubs have been established in schools. School health clubs have been established to facilitate student learning about HIV prevention. Lack of funding is preventing the roll out of the Program to other schools.

The Life Skills and HIV Prevention Program in schools has not been evaluated. However, behavioral study in more than 800 students in Monrovia suggest that adolescents are at significant risk for HIV and other sexually transmitted diseases: 36% of respondents were sexually experienced and 34% had first sex at ages 14 or younger; 66% of first sexual encounters were unprotected, and 16% were described as "forced". Also, females were more likely to have older boyfriends and sex resulting in pregnancies while males were more likely to have a greater number of sexual partners.

Outcome

All grade schools in Liberia are benefitting from Life Skills and HIV Prevention Program by 2020.

Output

- **Percent of grade schools in Liberia that have Life Skills and HIV Education program (Table 8.3)**

Table 8.3: MOE Output Indicators and Targets

	Indicators	2013 Baseline	2015	2016	2017	2018	2019	2020
	Percentage of schools reached with life skills-based HIV education for Grades 1 to 12	43%	50%	60%	70%	80%	90%	100%

Strategy

- Roll out Life Skills and HIV Protection Program in all grade schools.

Major Activities

The main activities are:

- Procure learning materials for training in Life Skills and HIV Protection Program for grade schools.
- Train teachers on Life Skills and HIV Protection Program for grade schools.
- Trained teachers train school children in grade schools as peer educators.
- Trained peer educators reach other students with Life Skills and HIV protection program.

4. Workplace HIV Programs

Introduction

HIV Workplace Programs are playing critical roles in the national HIV response by providing HIV prevention information and limited services. The information provided enables clients to seek HCT and PMTCT services from health facilities providing these services. Government ministries, departments, and agencies and private sector companies are the major providers of HIV workplace program services.

Achievements and Challenges

The National HIV Workplace Policy, developed in 2008, is now outdated. However, the Ministry of Labor is seeking funding from the International Labor Organization (ILO) to update the document. The public and private sectors will then use the updated National HIV Workplace Policy as a guide to developing sector specific workplace policies.

The Partnership Mandate at the National AIDS Commission has facilitated the formation of the Government Line Ministries and Agencies AIDS Coalition to provide stewardship in mainstreaming and integrating HIV and AIDS into their core functions. The NAC conducted a 4-day workshop supported by UNICEF to support efforts at developing sector specific HIV workplace policies for eight ministries and two agencies. These Ministries and Agencies have developed Draft Workplace HIV Policies, which will be finalized and launched as soon as the Ministers and Managing Directors give their final approval.

HIV prevention efforts by private companies are essential to protecting productivity, profitability, economic growth, and efficiency. They also influence norms and combat stigma and discrimination in the workplace as well as fostering a broader sense of corporate social responsibility. The Rubber Sector developed its workplace policy in 2012 but it has not yet been launched. Some large private sector companies like Firestone and the Liberia Agricultural Company (LAC) have health facilities providing HIV and AIDS services to their staff and people from the surrounding communities.

A number of government ministries have established HIV workplace programs for their staff and have mainstreamed HIV and AIDS into their core functions. Many line ministries have HIV focal persons who spearhead HIV prevention information and services to staff including creating awareness on HIV and AIDS and distributing condoms. However, the lack of government funding is seriously affecting the effectiveness of mainstreaming HIV in the ministries. The lack of GOL funding notwithstanding, some key line ministries are doing the best they can under the circumstances. These include:

1. Ministry of Health and Social Welfare

The MOHSW is the key player in the national HIV response and spearheads the massive health sector response to the epidemic. The MOHSW is the principal recipient of the Global Fund HIV grants and the NACP is the major implementer of the HIV and AIDS programs in the country.

2. Ministry of Gender and Development

Through its Sexual and Gender-based Violence Task Force and the Social Cash Transfers Program, the MOGD is playing key roles in efforts to prevent HIV infection from SGBV and is mitigating the socioeconomic impact on poor households, which are both important risk factors for HIV infection.

The MOGD reviewed the 2010 Agenda for Country Action for Women, Girls, Gender Equity and HIV and identified gaps to be addressed in the next country agenda. The Ministry also launched a nationwide anti-rape campaign to stop the ongoing horrific SGBV.

3. Ministry of Justice

The Ministry is key to protecting the human rights of PLHIV. It is responsible for operationalizing the legislation that prohibits vilification and discrimination of a person based on his or her real or perceived HIV status. Fear of or actual stigma and discrimination is one of the most powerful deterrents to the utilization of HIV and AIDS prevention, treatment, care and support services.

The Ministry of Justice has established an HIV and Human Rights Platform to advocate and coordinate stakeholders' response to HIV related human rights issues and violations, and creates a legal environment for the enforcement of the HIV law. Currently, the Platform is working with the Inter-Religious Council of Liberia to ensure religious communities are informed and engaged in the national HIV response.

4. Ministry of Labor

Through a consultative process, the MOL is reviewing the National HIV and AIDS Workplace Policy to ensure it is aligned to the new ILO standards. Meanwhile the Ministry works with Liberian Business Coalition against AIDS and various ministries to create HIV/AIDS awareness in the workplace and has been providing condoms to the ministries.

5. Ministry of Education

See separate section on Education Sector Response to HIV above.

6. Ministry of National Defense and the Security Sector

The Security Sector: Armed Forces of Liberia (AFL), Liberia National Police (LNP), Bureau of Naturalization and Immigration (BNI), and Bureau of Corrections, receive support to provide HIV prevention information and services to their staff. Six hundred and seventy officers from the AFL, the LNP, BNI, and Bureau of Corrections were trained as trainers in 2012 to spearhead HIV and AIDS prevention activities within their agencies. In 2013 all the agencies received funding to implement HIV and AIDS prevention activities.

The Ministry of National Defense HIV/AIDS Prevention Program was established in 2008. The AFL Medical Officer and trained peer educators are coordinating the Ministry's HIV and AIDS activities. The program conducts general HIV awareness and sensitization among its staff and provides HCT, PMTCT, as well as care and

support services for soldiers and their families. The Ministry is in the process of conducting a military IBBSS.

Outcome

- **The public and private sectors have HIV Workplace policies.**
- **HIV and AIDS mainstreamed into core businesses of public sector line ministries and agencies.**

Outputs

- **Reviewed National Workplace Policy incorporates HIV and AIDS issues.**
- **HIV Workplace Policies developed by public sector ministries and agencies and large private companies.**
- **HIV and AIDS mainstreamed into core businesses of Line Ministries.**

Strategies

- **Strengthening the prevention of HIV infections in the workplace**

The NAC Partnership Mandate will identify and support the development of workplace HIV policies in the public and private sector organizations as well as support the mainstreaming of HIV and AIDS into the core businesses of line ministries and agencies.

5. Mitigating the Socioeconomic Impact of HIV and AIDS

Introduction

The major socioeconomic impacts are stigma and discrimination against people infected and affected by HIV and reducing poverty in AIDS-affected households. The main beneficiaries are PLHIV and OVC. Data from the 2013 Spectrum modeling of HIV and AIDS in Liberia estimates there are about 30,000 people living with HIV comprising 58% women and 42% men. There are also about 200,000 orphans from all causes including 38,500 AIDS orphans.

Liberians infected and affected by HIV have suffered stigma and discrimination since the advent of the epidemic. The 2007 LDHS found that only 13% women and 22% men expressed accepting attitudes toward PLHIV. The 2013 Midterm Review of the National Strategic Framework (NSF) II revealed that stigma and discrimination remains a major challenge for HIV and AIDS prevention, treatment, care and support. The 2013 Liberia PLHIV Index Study estimates up to 30% of PLHIV reported experiencing stigma and discrimination. PLHIV recounted that stigma and discrimination manifested in diverse forms including verbal insults, physical assaults, psychological harassments, gossips and innuendos, loss of friendship and companionship.

Other manifestations of stigma and discrimination include loss of employment and income, and being forced to change residence. AIDS-affected households are often poor and unable to undertake farming, feed and shelter the family, access healthcare, and send the children to school. Thus, the key socioeconomic conditions that people infected and affected by HIV and AIDS suffer from are stigma and discrimination and poverty.

Achievements and Challenges

Since the advent of the epidemic about three decades ago, the extended family, CBOs, and FBOs have been playing critical roles in mitigating the socioeconomic

impact on individuals and AIDS-affected households including: assisting with household chores and farming; providing psychosocial support, food, shelter, and home-based care. Under Global Fund funding, Shalom and Samaritan Purse have been supporting OVC including paying school fees and providing school uniforms.

In order to reduce the impact of poverty on poor households, including poor AIDS-affected households, the GOL is supporting a number of social safety-net interventions. These include School and Supplementary Feeding programs and Social Cash Transfers (SCT). Since 2009, the MOGD, with support from the European Union and UNICEF, has been implementing the Liberia Cash Transfer Program in Bomi and Maryland Counties, benefitting about 15,000 individuals in 3,800 households. The SCT intervention is increasingly complementing in-kind transfers and yielding net positive effects on local agricultural production and market development. Beneficiaries indicate SCT constitutes a timelier, more predictable and more flexible response to poverty reduction.

Stigma and discrimination remains a huge challenge and the national HIV response has been mounting stigma and discrimination reduction campaigns. Anti-stigma and discrimination activities are being implemented by a large number of stakeholders including the government-appointed HIV and AIDS Ambassador; GOL ministries, departments, and agencies including the Anti-Discrimination Platform of the Ministry of Justice, the MOGD, and the MOHSW; CSOs including LIBNEP+, LIWEN, Light Association; and FBOs such as Lutheran, Methodist, and Catholic Church AIDS Programs.

Major national activities on stigma and discrimination reduction include mass media campaigns through the network of radio stations across the country and messages to cellphone users that have huge coverage and response. Events such as the World AIDS Day Commemoration on December 1st and the now defunct Global AIDS Week in May funded by Global Fund, complement the longer duration interventions.

In 2010, Liberia amended the Public Health Law, Title 33, Liberian Code of Laws Revised (1976) to create a new Chapter 18 providing for the “Control of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome” of May 15, 2010. It specifically includes clauses on: sanctions for violating confidentiality about PLHIV and willful transmission of HIV, and prohibition of discrimination and vilification of persons on the basis of actual or perceived HIV status. The legal reform protects the human rights of people infected and affected by HIV and AIDS. Enforcement of the law will contribute to eliminating stigma and discrimination against people infected and affected by HIV.

Outcome

- **Stigma and discrimination against people infected and affected by HIV reduced.**
- **Basic needs of poor AIDS-affected households are met.**

The Outcomes will be tracked using the indicators and targets in Table 8.4.

Table 8.4: Socioeconomic Mitigation Indicators and Targets

Indicator	Baseline	Target	
		2017	2020
% PLHIV who report they have experienced stigma and discrimination from other people	2013 Liberia PLHIV Stigma Index Study	20%	10%

	Indicator	Baseline	Target	
			2017	2020
	reduced	30% 2013		
	% women and men aged 15–49 who report discriminatory attitudes towards PLHIV	TBD		

Output

National stigma and discrimination reduction campaigns undertaken.

Nationwide anti stigma and discrimination campaigns carried out, involving HIV Ambassadors, national celebrities, HIV-focused CSOs including networks or associations of PLHIV, umbrella religious bodies, traditional and community leaders, via multiple communication channels: talks and discussions at gatherings, on radio and TV, in the print media, and use of information communication technology (ICT).

PLHIV and support groups educated on their human rights.

Provide IEC materials, conduct support forums that provide opportunities for PLHIV to meet and share experiences, and hold talks and discussions with HIV and AIDS and human rights experts and organizations.

Health workers trained on confidentiality of information on PLHIV.

Training of health workers on confidentiality of patients' medical information and records emphasized in all pre-service trainings. Workshops, mentoring, and on the job training will be additional means of training health workers on confidentiality especially for those providing HIV and AIDS services.

Ministry of Justice: Work with the Judicial Service to reduce discrimination against PLHIV.

People who discriminate against or vilify PLHIV are being prosecuted. The national HIV response will provide: support to build the understanding of the Police and Judiciary about HIV and AIDS; material support to the Police Unit dealing with sexual and gender-based violence, rape, and defilement; support to HIV-focused CSOs to educate PLHIV on the anti-discrimination legislation, and establish mechanisms for reporting complaints on discrimination via in-person reporting and dedicated SMS and web-based services. The national HIV response will work in synergy with the Ministry of Justice to fully implement the provisions of the HIV anti-discrimination and rape legislation and with the MOGD to reduce SGBV.

MOGD: Collaborate with MOGD to advocate for the roll out of conditional social cash transfers to other counties.

While the extended family, individuals and organizations, will continue to provide support for needy AIDS-affected families, the preferred national HIV response in the coming years is to work towards integrating the basic needs of poor AIDS-affected households into broader national pro-poor social protection programs. In this regard the national response will work in synergy with the MOGD to ensure poor AIDS-affected households benefit from the conditional social cash transfers.

LDHS and Liberia PLHIV Stigma Index Survey carried out.

The NAC will ensure that appropriate survey questions on HIV and AIDS and stigma and discrimination are included in the Liberia National Demographic and Health Survey. The findings of the LDHS on HIV and AIDS will be shared with PLHIV support groups and networks, and also with key stakeholders and policy makers.

The national HIV response will undertake PLHIV Stigma Index survey every 2 years using international best practice methodology customized to the Liberian context of the epidemic. The reports will be shared with all PLHIV support groups and networks, and widely disseminated to all stakeholders and policy makers.

The Output will be tracked using the Indicators and Targets in Table 8.5

Table 8.5: Stigma and Discrimination Indicators and Targets

Indicator	Baseline	Targets					
		2015	2016	2017	2018	2019	2020
All year national anti-stigma and discrimination campaign carried out as a partnership program of NAC and networks and umbrella organizations of PLHIV	x	x	x	x	x	x	X
Number of counties reached with Social Cash Transfers	2	TBD	TBD	TBD	TBD	TBD	TBD

TBD = To Be Determined.

Strategies and Major Activities

Stigma and discrimination reduction

The NSP 2015-2020 enjoins all stakeholders to undertake interventions to reduce stigma and discrimination against PLHIV using a mix of methods including community capacity enhancements; and political, religious, and traditional leaders supporting stigma and discrimination reduction activities. The NAC will coordinate stakeholders to launch and sustain nationwide stigma and discrimination reduction campaigns with intense media involvement and engaging HIV Ambassadors and national celebrities from diverse walks of life.

Support for CSOs to provide the basic needs of poor AIDS-affected households

Support for CBOs and FBOs will include training and appropriate skills development in providing pro-poor services including HCBC; provision of material, financial and technical support; and assistance for strengthening organizational governance and systems. Some development partners including USAID do provide funding to CSOs to support the basic needs of OVC including AIDS-related OVC.

Protecting the human rights of PLHIV.

Many public entities and CSOs are involved in protecting the human and legal rights of PLHIV. The public sector entities include the GOL Commission on Human Rights, the Police, and the Judiciary. The Association of Female Lawyers is one of a few CSOs providing services for human rights. The capacities of these organizations will be strengthened to better protect the human and legal rights of PLHIV and persons subjected to sexual and gender based violence. Capacity building will include training and technical assistance on HIV and AIDS and related stigma and discrimination, and the provision of material and funding support.

Scale-Up Social Protection program (Conditional Cash transfer)

Evaluation of the SCT in Bomi has demonstrated its importance in addressing poverty in poor households. Maryland County is also benefitting from the SCT now. The SCT program should be rolled out to other counties in a phased manner.

6. Gender and HIV

Introduction

Eliminating gender inequality is a national policy in all spheres including AIDS. Education, health, and the economy are among many spheres of national life that are making efforts to eliminate gender inequality. However, it is in the legal sphere where much visible efforts are being made to address gender inequality in the country. Watershed gender inequality issues that are being addressed include granting the same inheritance rights to women married customarily, as those of statutory marriage. They are now entitled to one-third of personal property outright and hold onto a life estate of one-third of real property until death or remarriage.

A new law making rape an unbailable offence; the establishment of a special court to try rape cases; and the establishment of a Women and Children's Section in the Liberia National Police are government's efforts to bridge the gender gap. These efforts have created relatively more conducive environment in post conflict Liberia that are the building blocks for reducing gender inequality and improving decision-making and other roles of women.

Despite prudent legislation redressing some gender inequalities, many forms of gender inequalities including sexual and gender-based violence and poor knowledge by women of their rights continue to be major challenges.

The prevalence of HIV in pregnant women has been declining over the years, from 5.7% in 2006, 4.0% in 2008, 2.6% in 2011 and 2.5% in 2013. However, women constitute about 60% of people living with HIV and contribute about 56% of new HIV infections in Liberia.

Key drivers of Gender Inequality and HIV infection Risk

Gender inequalities are key drivers of the HIV epidemic in Liberia. These drivers include the following:

1. Gender norms related to masculinity and femininity

Gender norms related to masculinity encourage men to have more sexual partners and older men to have sexual relations with much younger women. This may contribute to the higher infection rates of 65% among young women (15-24 years) compared 35% in young men as revealed in the HIV Prevalence and AIDS Estimates Report 2013. Norms related to femininity can prevent women, especially young women, from accessing HIV information and services.

2. Violence against women

Alcohol consumption can play a key role in sexual risk taking and gender-based violence that exacerbates HIV transmission. There are multiple interrelationships among alcohol use with gender-based violence and HIV/AIDS indicating the need for a comprehensive HIV prevention strategy comprising alcohol policy and violence

prevention programming, complemented by health education and care programs to reduce hazardous alcohol consumption. Alcohol screening and treatment programs for alcohol use disorders should be integrated with HIV/AIDS care.

Forced sex contributes to HIV transmission due to tears and lacerations resulting from the use of force. Gender-based violence is often fuelled by alcohol. Women, who fear or experience violence, lack the power to negotiate sex, refuse unprotected sex or ask their partners to use condoms. Fear of violence can prevent women from learning and/or sharing their HIV status and accessing treatment.

Women in Liberia are subjected to physical, sexual, and emotional violence in the home, within the communities, and in the workplace. The MOGD received and documented 2,493 complaints of violence against women in Liberia in 2012, indicating a high level of sexual and gender-based violence (SGBV). Most informed opinions consider this number as the tip of the iceberg since most cases of SGBV go unreported. Sixty percent of the sexual and gender-based violence falls in the category of rape: comprising rape, statutory rape, and sexual assault. Rape, a nonbailable offense in Liberia, is a potent exposure to HIV infection if the offenders are HIV positive.

The Liberian Government has formed the National GBV Task Force, as well as a GBV Secretariat within the Ministry of Gender and Development. A National GBV Plan of Action aims to provide appropriate skills to health professionals; improve documentation and reporting on clinical evidence; reform the legal system to deal more efficiently and expeditiously with violence; establish systems and outreach services for survivors; and ensure that women and girls have access to economic and social empowerment programs.

3. Gender-related barriers in access to services

Gender-related barriers in access to services prevent Liberian women and men from accessing HIV prevention, treatment and care. Women may face barriers due to their lack of access to and control over resources, child-care responsibilities, restricted mobility, and limited decision-making power. Socialization of men may mean that they will not seek HIV services due to fear of stigma and discrimination, losing their jobs, and of being perceived as "weak" or "unmanly".

4. Women and caregiving

Women assume the major share of caregiving in the family, including care for those living with and affected by HIV. This is based on the assumption that women "naturally" fill the role of caregiving and men the role of breadwinners in the family. Women are often so pre-occupied with caregiving for others that they do not have enough time to care for themselves, including going for HCT and other HIV and health services at health facilities.

5. Lack of education and economic security for women

Lack of education and economic security affect millions of women and girls, whose literacy levels are generally lower than men and boys. Many women, especially those living with HIV, lose their homes, inheritance, possessions, livelihoods and even their children when their partners die. This forces many women to adopt survival strategies that increase their chances of contracting and spreading HIV. Educating girls makes them more equipped to make safer sexual decisions. Liberia has passed legislation providing for women married customarily to have the same inheritance rights as those of statutory marriage. This addresses the inheritance

issue but does not address the power imbalance in marriage where men control the economic resources.

6. Inadequate budget support for women-focused HIV and AIDS programs

The national HIV response collects and uses sex and age disaggregated data to monitor and evaluate impact of the program on different populations. However, not many specific and dedicated efforts are being made to build capacity of key women-focused organizations to address gender inequalities, facilitate meaningful participation of women's groups and women living with HIV, and allocate resources for program elements that address gender inequalities.

Proposed gender sensitive HIV activities

- i. HIV and AIDS programs to address harmful gender norms and stereotypes that include working with men and boys to change norms related to fatherhood, sexual responsibility, decision-making and violence, and providing comprehensive, age-appropriate HIV and AIDS education for young people that addresses gender norms.
- ii. Develop programs that address violence against women by offering safer sex negotiation and life skills training, helping women who fear or experience violence to safely disclose their HIV status, working with the Ministry of Justice and MOGD to facilitate access to comprehensive medico-legal services for victims of sexual violence and strengthen and enforce laws that eliminate violence against women.
- iii. Improve access to services for women and men by supporting efforts to build the capacity of women-focused organizations e.g. LIWEN and Health Education and Advocacy for Key Populations (FSWs support), removing financial barriers in access to services, bringing services closer to the community, and addressing HIV-related stigma and discrimination, including in health care settings.
- iv. Support women in their care-giving roles by offering community-based care and support, including increasing men's involvement.
- v. Promote economic opportunities for women (e.g. through microfinance and micro-credit, vocational and skills training and other income generation activities), protect and promote their inheritance rights, and expand efforts to keep girls in school.
- vi. The national HIV response will continue to collect and use sex and age disaggregated data to monitor and evaluate impact of programs on different populations. The program will make great efforts to build capacity of key stakeholders to address gender inequalities, facilitate meaningful participation of women's groups, young women, and women living with HIV in the national HIV response, and allocate adequate resources for program elements that address gender inequalities.

Section Nine

Costing of the NSP 2015-2020

Approach

The costing of the NSP was carried out using unit cost and the National AIDS Spending Assessment (NASA). Unit cost approach was used in estimating the resources needed for the direct intervention areas of the NSP: (i) Prevention of New HIV Infections; and (ii) Treatment, Care and Support.

The National AIDS Spending Assessment (NASA) for 2011/2012 was used for the remaining sections (program support) of the NSP which are: (i) Political Commitment and Advocacy; (ii) Coordination and Management; (iii) Research, Monitoring and Evaluation; (iv) Health Systems Strengthening; (v) Procurement and Supply Chain Management; and (vi) Community System Strengthening.

The basic method of resource estimation was first to estimate the number of people in need of HIV and AIDS-related services in the target group. A coverage target was then established which is the Universal Access target, to estimate the population that would actually use the service. The next step was to estimate the unit cost of providing the intervention or service and this was used to calculate the total cost of the intervention. Unit cost estimates were obtained from field studies in other West African countries, as Liberia has not yet developed any specific unit costs for its interventions.

Estimates for the various program support areas under the NSP were obtained from the NASA for 2011/2012 conducted in 2013. The assessment yielded the following estimates of the expenses for program support given as percentage of the direct expenditure areas:

1. Enabling Environment (including advocacy), 1.21%;
2. Program Management, 12.55%;
3. Operations Research, 0.72%;
4. Monitoring and Evaluation (M&E), 10.52%;
5. Drug Supply System, 32.81%;
6. Program level Human Resources, 55.30%; and
7. Upgrade of Infrastructure, 8.68%.

The large percentage for program level human resources may be due, in part, to the fact that many of the health staff working in the HIV and AIDS program area are paid by the program primarily from the external funding it receives. Thus if the Government of Liberia were able to absorb all or some this cost as part of the national budget for healthcare, the percentage may decrease.

Estimated Financial Resources Needed – NSP Costing Results

This sub-section discusses the estimated cost of the NSP. It presents the cost by the main priority areas of the NSP as shown in Table 9.1 and summarized in Figure 1. For Prevention of New Infections and Treatment, Care and Support the cost data is disaggregated by intervention area. The total cost estimated for the NSP for the period 2015 to 2020 is US\$189,107,447 increasing from US\$28,751,500 in 2015 to US\$34,483,180 in 2020.

The cost of the direct intervention of the NSP (2015 – 2020) is 46.25% of the total estimate and indirect cost forming the remaining 53.75%. Prevention of new infections makes up the largest share (67.81%) of the cost of the direct intervention estimate and 31.36% of the total cost estimate. HIV Testing and Counseling (HTC), Sexually Transmitted Infections (STIs), and Condom promotion and distribution (including lubricants) are the cost drivers of the prevention program. Treatment and Care makes up 14.89% of total cost and is driven mainly by Antiretroviral Treatment and Care for HIV Positive Pregnant Women (Option B+).

The indirect cost component of the total estimate is made up of Critical Social and Programmatic Enablers, 11.18% and Synergies with Development Sector, 42.58%. Synergies with Development Sector are driven mainly by Health system Strengthening made up of Human Resources, Health Infrastructure and Procurement and Supply Chain Management. The other component is mitigating the Socio-economic Impact of HIV and AIDS.

Table 9.1: Liberia – Costing of National HIV/AIDS Strategic Plan (NSP), 2015-2020

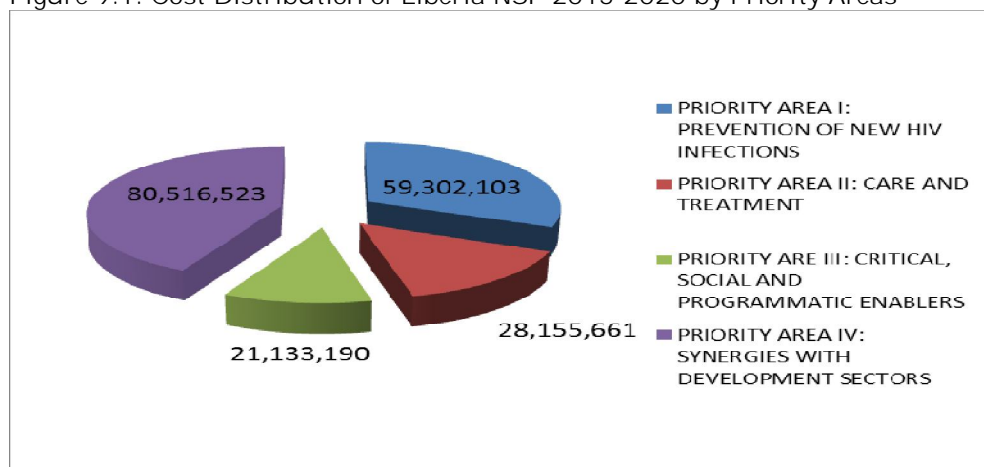
LIBERIA NSP 2015-2020 ESTIMATED COST (US\$) BY PRIORITY AREAS AND INTERVENTION							
Vision: To create an AIDS-free society.							
Goal of the NSP: The goal of the NSP 2015-2020 is to stop new HIV infections and keep PLHIV alive and healthy in Liberia.							
Aim of the NSP: The aim of the NSP is to provide a result-based framework for driving the decentralized, multi-sectoral national HIV and AIDS response within which all HIV and AIDS evidence based interventions are guided by the multi-sectorial approach that is led by NAC and implemented in Liberia.							
PRIORITY AREA I: PREVENTION OF NEW HIV INFECTIONS							
NSP 2015-2020 INTERVENTIONS	2015	2016	2017	2018	2019	2020	TOTAL
Intervention 1: HIV Counseling and Testing	1,853,748	2,195,414	2,241,577	2,288,657	2,336,718	2,385,786	13,301,900
Intervention 2: Blood Safety	331,375	191,375	209,750	153,125	171,500	79,669	1,136,794
Intervention 3: Sexual Transmitted Infections	1,974,400	1,930,520	1,886,650	1,842,770	1,798,900	1,755,020	11,188,260
Intervention 4: Key Populations	180,000	180,000	180,000	180,000	180,000	180,000	1,080,000
Intervention Area 5: Condom Promotion and Distribution	4,711,562	4,945,774	5,220,591	5,536,048	5,892,172	6,289,002	32,595,149
Sub-total for prevention of new HIV infections	9,051,085	9,443,083	9,738,568	10,000,600	10,379,290	10,689,477	59,302,103
PRIORITY AREA II: CARE AND TREATMENT							
Intervention 6: Care for HIV Positive Pregnant Women (Option B+)	1,380,128	1,547,660	1,643,616	1,778,311	1,828,766	1,852,223	10,030,704
Intervention 7: Care for PLHIV that are not on ART	120,000	120,000	120,000	120,000	120,000	120,000	720,000
Intervention 8: Antiretroviral Treatment	1,977,913	2,292,630	2,737,905	3,033,573	3,284,281	3,657,584	16,983,886
Intervention 9: HIV/TB Co-infection Management	53,879	60,060	66,742	73,970	80,834	85,586	421,071
Sub-total for care and treatment	3,531,920	4,020,350	4,568,263	5,005,854	5,313,881	5,715,393	28,155,661

	3,531,920	4,020,350	4,568,263	5,005,854	5,313,881	5,715,393	28,155,661
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PRIORITY AREA III: CRITICAL, SOCIAL AND PROGRAMMATIC ENABLERS							
Intervention 10: Political Commitment and advocacy	148,624	146,536	154,382	160,016	165,022	169,858	944,438
Intervention 11: community participation in the national HIV response	270,000	270,000	270,000	270,000	270,000	270,000	1,620,000
Intervention 12: Coordination and Management of the National HIV Response	1,541,517	1,519,859	1,601,233	1,659,669	1,711,590	1,761,753	9,795,621
Intervention 13: Research, Monitoring and Evaluation	1,380,610	1,361,213	1,434,093	1,486,428	1,532,930	1,577,857	8,773,131
<i>Sub-total for critical, social and programmatic enablers</i>	3,340,751	3,297,608	3,459,708	3,576,113	3,679,542	3,779,468	21,133,190

PRIORITY AREA IV: SYNERGIES WITH DEVELOPMENT SECTORS							
Intervention 14: Health System Strengthening	11,888,721	11,721,689	12,349,273	12,799,947	13,200,384	13,587,253	75,547,267
Intervention 15: Mitigating the Socio-economic Impact of HIV and AIDS	939,023	898,011	854,234	807,208	759,191	711,589	4,969,256
<i>Sub-total for synergies with development sectors</i>	12,827,744	12,619,700	13,203,507	13,607,155	13,959,575	14,298,842	80,516,523
TOTAL RESOURCES NEEDED	28,751,500	29,380,741	30,970,046	32,189,722	33,332,288	34,483,180	189,107,477

Figure 9.1: Cost Distribution of Liberia NSP 2015-2020 by Priority Areas



Financial Gap Analysis

In addition to resources from the Government of Liberia, funding for HIV and AIDS in Liberia has received an immense support from the Global Fund. According to the NASA, over the last two years, 2010/2011 and 2011/2012 there has been an increase in funding for HIV and AIDS related programs from US\$15.95 million in 2010/2011 to US\$17.37 million in 2011/2012.

Commitment by donors during the NSP period 2015 to 2020 is only from 2015 to 2017. These commitments are by the GF and the UN System from 2015 to 2017. USAID's commitment is only for 2015 but assumed to be the same in 2016 and 2017 (Table 9.2). For the funding gap analysis, it was assumed that the Government of Liberia resources are expected to remain constant at US\$905,136 and donors at US\$18,967,061 Liberia will face a US\$67,398,817 shortfall in funding the National Strategic Plan (NSP) over the years 2015 to 2020. Due to lack of information on the resources from the public sector (mainly businesses and households), the financial gap analysis excluded it. Table 9.3 shows that the resource gap will decrease from US\$9,895,829 in 2015 to US\$9,508,544 in 2016 and then increase to US\$11,097,849 in 2017 and then increased over the period from 2018 to 2020 from US\$12,317,525 in 2018 to US\$14,610,983 in 2020.

Appendix A: Technical Working Groups

LIST OF MEMBERS OF THE NATIONAL STRATEGIC PLAN 2015-2020 TECHNICAL WORKING GROUP

I HIV PREVENTION – NON-CLINICAL AND CLINICAL PREVENTION		
1	Marilyn Luke Urey, Chairperson	PSI
2	T. Lincoln Reeves, Repertoire	NAC
3	Baryard Gehyigon	RICDC
4	Queenie Nah	NACP/MOH
5	Deontee H. Farley	SWEAG
6	Sheikh Idrissa Swaray	UMABGCO
7	Cecelia Roberts	LIWEN
8	George Kingsley	APA
9	Harry Smith	SWEAP
10	Thomas Kollison	MPCHS
11	Berline Djabou	Eye Association
12	Baryard Gehyigon	RICDC
13	Queenie Nah	NACP/MOH
14	T. Lincoln Reeves	NAC
15	Marilyn Luke Urey	PSI
16	Deontee H. Farley	SWEAG
17	Sheikh Idrissa Swaray	UMABGCO
18	Cecelia Roberts	LIWEN
19	George Kingsley	APA
20	Harry Smith	SWEAP
21	Thomas Kollison	MPCHS
22	Berline Djabou	Eye Association
23	Baryard Gehyigon	RICDC
24	Queenie Nah	NACP/MOH
25	T. Lincoln Reeves	NAC
26	Marilyn Luke Urey	PSI
27	Deontee H. Farley	SWEAG
28	Sheikh Idrissa Swaray	UMABGCO
29	Cecelia Roberts	LIWEN
30	George Kingsley	APA
31	Harry Smith	SWEAP
32	Thomas Kollison	MPCHS
33	Berline Djabou	Eye Association
II. TREATMENT AND CARE		
1	Julia Toomey Garbo- Chair	NACP
2	Julia Mulbah Lysander- Repertoire	NAC
3	Mercy S. Johnson	SHALON INC
4	Dr. Maima Kawah-Baysah	Redemption Hospital
5	Sam Doepoh	GIP ESTHER
6	Matthew B. Powell	LCL AIDS Program
7	Siennesh Zez-Tamba	NACP
8	G. Moses Jackson	NACP
9	D. Emmet N. Potter	LICELE
10	Wokie Cole	LIWEN
11	Muttie L. G. Jallah	Catholic Church
12	Moses K. Jeuronlon	WHO
13	Catherine Cooper	NLTCP/ MOHSW
14	Kukor S. Weah	WFP
15	Steve Z. Korvah Jr.	UNICEF
16	Cuallau Jabbeh-Howe	MOHSW
17	Josephine Godoe	Light Association
18	Elevanie Nyankesha	UNICEF Regional Office

LIST OF MEMBERS OF THE NATIONAL STRATEGIC PLAN 2015-2020 TECHNICAL WORKING GROUP		
19	Reuben T. Willie	SAIL
20	Chinnie V.M. Sieh	MOHSW
21	Harria L. Garsuah	MOHSW
III. ORPHAN AND VULNERABLE CHILDREN&		
1	Pate Chon, Chairperson	SHALOM
2	Solomon Hinneh, Repertoire	NAC
3	Kukor S. Weah	World Food Program, WFP
4	Love Gibson	Samaritan Purse
5	Berline Djabou	Eye Association
6	Steven Korvah	UNICEF
IV. MANAGEMENT, COORDINATION AND STRENGTHENING HEALTH CARE SYSTEM		
1	Sonpon Sieh, Chairperson	NACP
2	Murphy V. Kiazolu, Repertoire	NACP
3	David Z. Logan	MOHSW/PCU
4	Isaac Ahemesah	UNAIDS
5	Steven Korvah	UNICEF
6	Moses Jeuronlon	World Health Organization, WHO
7	Maybe Livingstone	UNFPA
8	Mr. Tolbert Nyenswah	MOHSW
9	John T. Harris	NDU
10	John Dogba	Laboratory & Blood Safety
11	Charles Moniba	Supply Chain/NACP-MOHSW
VI. HUMAN RESOURCES		
1	Mathew Flomo, Chairperson	MOHSW
2	Ibrahim Dukuly - Repertoire	MOHSW
3	Deputy Minister Planning	MOHSW
4	Sylvester Urey	NAC
5	Victoria Borbor	PCU/ MOHSW
6	Mr. James Beyan	Personnel Division/MOHSW
VII. SOCIAL PROTECTION		
1	Vivian Cherue - Chairperson	MOHSW
2	Grace Yeanay Mayson- Repertoire	AHF-Liberia
3	Kutaka D. Togbah	Ministry of Justice
4	Joejoe Baysah	LIBNET+
5	Steven Korvah	UNICEF
6	Mamie Free	SHALOM
VIII. ENABLING ENVIRONMENT/DEVELOPMENT SECTOR		
1	Sonpon Sieh - Chairperson	MOHSW/NACP
2	Murphy Kiazolu, Repertoire	MOHSW/NACP
3	Thomas Kollison	Mother Pattern
4	Steven Korvah	UNICEF
5	Kutaka D. Togbah	Ministry of Justice
6	James Kolubah	MOGD
7	Stephen McGill	SAIL
VIII RESEARCH		
1	Moses Badio - Chairperson	MOHSW
2	Julius Togba, Repertoire	NAC
3	Murphy V. Kiazolu	NACP
4	Commissioner Njoh	NAC
5	M. Janjay Jones	NACP
6	Ernest Dunbar	NACP
7	Jamee Tegli	PIRE Liberia
8	Hh Zaizay	Consultant

Appendix B: NSP Development Secretariat

LIST OF THE NATIONAL STRATEGIC PLAN 2015 - 2020 SECRETARIAT		
Name	Organization	Role & Expertise
1. Rev. Clarence R. Pearson, Sr.	NAC	Chairperson, Program and Policy
2. Sonpon Blamo Sieh	NACP	Co-chairperson, Program Manager
3. Mrs. Yah Zolia	MOHSW	Team Member, Health Development Planning
4. Moses Badio	MOHSW	Team Leader, Strategic Information Management / Epidemiologist/Statistician
5. Julius Togba	NAC	Team Member, Strategic Information Management/M&E Coordinator
6. Julia M. Lysander	NAC	Team Member, Decentralization Coordinator
7. Ibrahim B. Dukuly	MOHSW	Team Member, Program
8. Momolu T. Massaquoi	MOHSW	Team Member, Program
9. Victoria F. Borbor	MOHSW	Team Member, Finance
10. T. Lincoln Reeves	NAC	Team Member, Communication/IEC & BCC Coordinator
11. Solomon Hinneh	NAC	Team Member, Partnership Coordinator
12. Murphy Kiazolu	NACP	Team member, program/M&E data Specialist
13. M. Janjay Jones	NACP	Team Member, HIV & AIDS Statistical Analyst
LIST OF MEMBERS OF THE NATIONAL STRATEGIC PLAN 2015-2020 TECHNICAL SUPPORT TEAM		
Name	Organization	Role & Expertise
1. Ibrahim B. Dukuly	MOHSW	HIV Program Specialist, Facilitation
2. Dr. Julia Toomey Garbo	NACP	HIV Treatment and Care Specialist, Facilitation
3. Victoria Borbor	MOHSW	HIV and AIDS NSP Costing, Facilitation
4. A. Sylvester Urey	NAC	HIV and AIDS NSP Costing, Facilitation
5. Isaac Ahemesah	UNAIDS	Technical Advisor
5. David Z. Logan	PCU/MOHSW	HIV Program Specialist, Facilitation
6. Stephen K. McGill	SAIL	HIV Program Specialist on Key Population, Facilitation

Appendix C: Participants at NSP Validation Retreat

LIST OF PARTICIPANTS AT THE NATIONAL STRATEGIC PLAN 2015 - 2020 VALIDATION RETREAT JULY 1-4 2014			
#	NAME	ORGANIZATION	Cell #
1	Julius J. Togba	National AIDS Commission, NAC	0886592977
2	Ibrahim B. Dukuly	Ministry of Health and Social Welfare, MOHSW	0886551009
3	Sheikh Idrissa Swaray	United Muslim Association Gbarpolu and Bomi Counties, UMAGBCO	0886546790
4	Momolu T. Massaquoi	Ministry of Health and Social Welfare, MOHSW	0886557385
5	Kukor S. Weah	World Food Program, WFP	0886571440
6	Zoe K. Ziankahn	Ministry of Education, MOE	0886561671
7	Ernlee Bee Barbu	Population Services International, PSI	0886569053
8	William K. Zaza	Liberia Network of People Living with HIV, LIBNEP+	0776513980
9	M. Janjay Jones	National AIDS and STIs Control Program, NACP	0886521885
10	Sonpon Blamo Sieh	National AIDS and STIs Control Program, NACP	0886774166
11	Rev. Clarence R. Pearson	National AIDS Commission, NAC	0886469604
12	Charles Moriba	National AIDS and STIs Control Program, NACP	0886451089
13	Joseph Gbassie	National AIDS and STIs Control Program, NACP	0886579722
14	Isaac Ahemesah	Joint United Nations Program on HIV/AIDS, UNAIDS	0886575289
15	Necus Andrews	Anti-AIDS Media Network, AAMIN	0886849173
16	A. Sylvester Urey	National AIDS Commission, NAC	0886617453
17	T. Lincoln Reeves	National AIDS Commission, NAC	0886569071
18	Julia Toomey Garbo	National AIDS and STIs Control Program, NACP	0886400737
19	James Kolubah	Ministry of Gender and Development, MOGD	0776382498
20	Dr. Wilfred S. Boayue	National AIDS Commission, NAC	0888096690
21	Pate K. Chon	SHALOM	0886533816
22	Moses Badio	Ministry of Health and Social Welfare, MOHSW	0777449575
23	Murphy V. Kiazolu	National AIDS and STIs Control Program, NACP	0886130865
24	Bondo Nomior	US Embassy	0777029848
25	Dr. Ochie Ibe	United States Agency for International Development	0777187950
26	Gebah Fofana	National AIDS and STIs Control Program, NACP	0776192210
27	Lwopu M. Bruce	National Blood Safety Program, NBSP/MOHSW	0886553322
28	John B. Dogba	National Diagnostic Unit, NDU/MOHSW	0886515712
29	Thomas Kollison	Mother Patern College of Health Sciences, MPCHS	0886404277
30	Togba T. Yango	National AIDS Commission, NAC	0886404277
31	Joejoe Baysah	Liberia Network of People Living with HIV, LIBNEP+	0886474448
32	Leroy N. Wilson	National AIDS Commission, NAC	0886370553
33	David Z. Logan	Ministry of Health and Social Welfare/Global Fund, MOHSW /GF	0886923614
34	Josephine Godoe	Light Association	0886875345
35	Stephen K. McGill	Stop AIDS in Liberia, SAIL	0886966725
36	Steven Z. Korvah, Jr.	United Nation Children Fund, UNICEF	0886519902
37	Dr. Ivan F. Camanor	National AIDS Commission, NAC	0886425795
38	Dr. Felix A. Asante	Costing Consultant	
39	Dr. Pat Youri	National Strategy Plan (NSP) Consultant	

**LIST OF PARTICIPANTS AT THE
NATIONAL STRATEGIC PLAN 2015 - 2020 VALIDATION RETREAT
JULY 1-4 2014**

#	NAME	ORGANIZATION	Cell #
40	Solomon Hinneh	National AIDS Commission, NAC	0886565368
41	Solomon Watkins	Anti-AIDS Media Network, AAMIN	0886427519
42	Sr. Thavaleela	Mother Patern College of Health Sciences, MPCHS	0886557006
43	Victoria Borbor	Ministry of Health and Social Welfare, MOHSW	0886554551
44	E. Orlind Cooper	Press Union of Liberia, PUL	0770586264
45	Keith Morris	RAL	0886649279
46	Kutaka D. Togbah	Ministry of Justice, MOJ	0886567610
47	Grace Yeanay Mayson	AIDS Healthcare Foundation, AHF	0886533526
48	Hh Zaizay	National Strategic Plan (NSP) Gender Consultant	0886557278
49	Clarence Carter	Program Coordinating Unit, PCU/MOHSW	0886549996
50	Michau Meriam	National AIDS and STIs Control Program, NACP	0777181549

Appendix D: List of Reference Documents

- 1) "It's Nature, Not a Crime"- Discriminatory Laws and LGBT people in Liberia: Human Rights Watch Nov 2013
- 2) 12 Components Monitoring and Evaluation System Assessment UNAIDS Geneva 2009
- 3) Abuja Declaration on HIV and AIDS, TB, and Other Infectious Diseases 2001
- 4) Agenda for Transformation – Steps Toward Liberia Rising 2030
- 5) AIDS Investment Framework – UNAIDS 2012
- 6) An Act to Amend the Public Health Law to create a new chapter 18 providing for the control of HIV and AIDS
- 7) An Act to Establish the National AIDS Commission of 2010
- 8) Declaration of the Special Summit of African Union on HIV/AIDS, TB, and Malaria: "Abuja Actions toward the Elimination of HIV and AIDS, TB, and Malaria in Africa by 2030"
- 9) Draft HIV and AIDS Decentralization Strategy 2011
Health Financing Unit, MOHSW 2014
- 10) High Coverage ART Associated with Decline in Risk of HIV Acquisition in Rural KwaZulu Natal, South Africa in *Science Magazine* 22 Feb 2013 by Frank Tanser et al.
- 11) High Level Political Commitment on HIV and AIDS UNAIDS June 2011
- 12) HIV and AIDS Data System Mapping and Harmonization in Government Ministries and Agencies
- 13) Informing HIV prevention efforts targeting Liberian youth: a study using the PLACE method in Liberia, Donna R McCarraher et al *Reproductive Health* 2013, 10:54
- 14) Integrated Bio-Behavioral Surveillance Survey (IBBSS) among MARPs in Liberia 2013
- 15) Liberia ART Cohort Study Report - November 2013
- 16) Liberia Demographic and Health Survey 2013 Preliminary Report
- 17) Liberia Global AIDS Response Progress Report (GARPR) 2013
- 18) Liberia National Aids Spending Assessment (NASA) 2010/11 - 2011/12
- 19) Liberia PLHIV Index Report Draft 2013
- 20) Mid-term Review of Liberia's Response to HIV Program Period 2010-2012, National AIDS Commission Liberia 2013
- 21) National AIDS Commission of Liberia 2013 Annual Report
- 22) National AIDS Control Program (NACP) Quarter 13 Report
- 23) National Health Accounts of Liberia, THIRD ROUND: Health Spending 2011/2012
- 24) National Health and Social Welfare Policy and Plan 2011-2021
- 25) National HIV and AIDS Policy – Rubber Sector Republic of Liberia
- 26) National HIV Response Update May 2014 – NAC Liberia
- 27) National HIV Strategic Framework II 2010-2014, National AIDS Commission
- 28) National Strategic Plan for Comprehensive Condom Planning in Liberia 2009-2013
- 29) Organizing Framework for a Functional National HIV Monitoring and Evaluation System: UNAIDS MERG
- 30) Policy Regulations National AIDS Commission Republic of Liberia
- 31) Rebuilding Human resources for Health – Case study from Liberia at <http://www.human-resources-health.com/9/1/11>
- 32) Size Estimation of Sex Workers, Men who have Sex with Men and Drug Users in Liberia: National AIDS Commission Liberia 2011
- 33) Spectrum HIV and AIDS Estimates and Projection for Liberia 2014
- 34) The People Living with HIV Stigma Index November 2013 Liberia
- 35) Transformation of HIV from pandemic to low-endemic levels: a public health approach to combination prevention: April 14, 2014 [http://dx.doi.org/10.1016/S0140-6736\(13\)62230-8](http://dx.doi.org/10.1016/S0140-6736(13)62230-8)
- 36) Transformative Transfers: Evidence from Liberia's Social Cash Transfer Program
- 37) UN Joint Program of Support on HIV and AIDS Republic of Liberia
- 38) Key Programs to Reduce Stigma and discrimination and increase access to Justice in the national HIV response

