Liberia HIV and AIDS Response Monitoring and Evaluation Plan

Acknowledgment

Foreword

This monitoring and evaluation plan is designed by the National AIDS Commission and partners to ensure that the key indicators for measuring the implementation of the 2015-2020 National Strategic Plan on HIV and AIDS. The M&E plan is therefore a tool for measuring the impact of the epidemic on the vulnerable populations targeted in the M&E plan.

The M&E plan will be used to monitor the progress we make to achieve the universally desirable goals 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.

This plan adopts the 12-components M&E Systems Strengthening Tool (MESST) for an M&E assessment which point to the need to strengthen the institutional competences to attain an effective National HIV and AIDS Multi-sectoral and decentralized One M&E System:

The 2015-2016 NSP underlines the importance of the M&E System in the National Response towards strengthening of monitoring progress in achieving the targets of the NSP 2015-2020. The NSP is built on the expectation that a matching M&E System is able 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).

The Monitoring and Evaluation (M&E) Plan 2015 – 2020 shall serve as a guide and tool for performance measurement of the national response and for monitoring of the effects and patterns of the HIV epidemic. The Liberia National M&E Plan is anchored onto the overall Liberia National social and economic development framework and Policy Framework as explicitly enshrined in the Agenda for Transformation (Aft) which is Liberia's Medium-term development strategy 2012 -2017).

The National HIV and AIDS Strategic Plan 2015 – 2020 and the M&E Plan shall therefore be expected to contribute to "***Pillar III Goal:*** *Improve quality of life (by investing in more accessible and higher quality education; affordable and accessible healthcare; social protection for vulnerable citizens; expanded access to healthy and environmentally-friendly water and sanitation services"*

As is the Agenda for Transformation (Aft), the National HIV and AIDS M&E Plan shall guarantee focus on: multi-sectoral response, multi-thematic interventions, participation by both public and private sectors and all programme and service delivery at the national, the decentralized (county and District) and community levels.

The Commission is grateful to UNAIDS and the Global Fund for their support by providing financial resources and technical assistance for the development of the 2015-2020 NSP and this M&E plan.

Acronym

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
CDO	County Development Officer
CDSC	County Development Steering Committee
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
HLM	UN General Assembly Special Session on AIDS High Level Meeting of 2011
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
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
MEESST	M&E Systems Strengthening Tool
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 Patern 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
NSP	National Strategic Plan (2015-2020)
OIs	Opportunistic Infections
OSY	Out of School Youth
OVC	Orphans and Vulnerable Children
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
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

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1. Background

1.1. Country Context

Liberia is administratively divided into 15 counties: Bomi, Bong, Gbarpolu, Grand Bassa, Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa, Margibi, Maryland, Montserrado, Nimba, River Gee, River Cess, and Sinoe.

The World Bank Report estimated Liberia's population to be 4.2 million people in 2012 having grown from 3.5 million people recorded in the 2008 census. About 43% of the population is below 15 years of age an indicator of 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.

Figure 1: Map of Liberia

The Liberia Demographic and Health Survey of 2013 (LHDS 2013) registered a fertility rate of 4.7, a contraceptive prevalence rate of 20%, and an infant mortality rate of 54 per every 1000 live births. The under-5 mortality rate was reported at 94 per 1000 live births. 75% of the deaths occurred before the first birth day with 28% occurring in the first month of life.

The United Nation's Human Development Index of 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.

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.

1.2. HIV Epidemic Profile

Liberia presently has a generalized HIV epidemic with the general population HIV prevalence of 1.9% (2013 LDHS). The impact of the epidemic continues to be significant. The Spectrum Modeling estimates for 2014 reveal there were about 1,789 new HIV infections including 309 in children 0-14 years. About 57% of the new infections were in females. It was also estimated that there were about 29,538 people living with HIV (PLHIV) including 2,730 in young people 15-24 years and 4,784 children 0-14 years.

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.

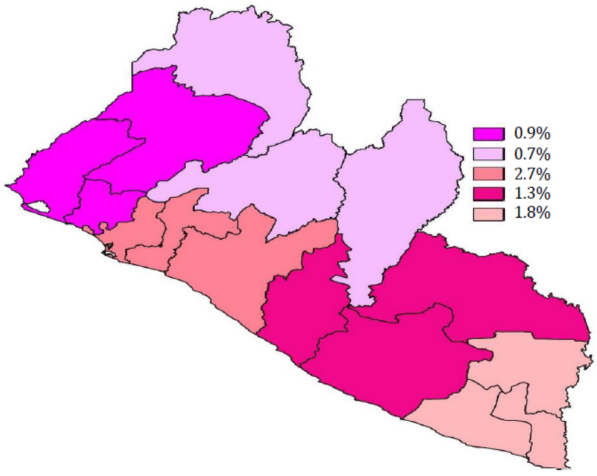


Figure 2: HIV Prevalence by county

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. The prevalence of 1.7% in men in 2013 is significantly higher than the 1.2% recorded in men in 2007.

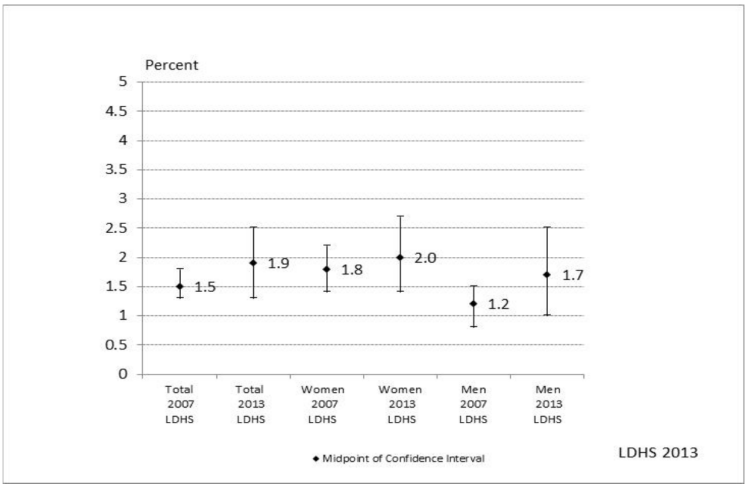


Figure 3: HIV Prevalence in men and women 2007 - 2013

It is noteworthy that the 2013 Integrated Bio-Behavioral Surveillance Survey (IBBSS) found high HIV prevalence in men only or predominately men key population subgroups: 19.8% in men who have sex with men (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.

1.3. National Response

Since 1985, when the first HIV case was reported, the Government of Liberia has taken bold steps, registering gradual progress to stabilize the prevalence of HIV in the country, which was estimated at 1.5% in 2007 and 1.9% in 2013 (2007 & 2013 LDHS), contain the spread and mitigate the impact of HIV and AIDS on the general population.

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.

The national HIV&AIDS response was initially led by the Ministry of Health and Social Welfare (MOHSW) until the establishment of the National AIDS Commission of Liberia through an Act of the National Legislature in 2010.

Box 2: Response Landscape

- Response initially led by the Ministry of Health and Social Welfare (MOHSW)
- National AIDS Commission (NAC) was established by an Act of the National Legislature in 2010
- National Technical Working Groups (TWGs) for HIV Prevention, ART, OVC, PMTCT, Key Populations (MARPs), Research and M&E, and Partnership Forum
- Amended 1976 Public Health Law to include sanctions for violating confidentiality of the HIV status and willful transmission
- Liberia has so far implemented two national strategic frameworks, NSF I (2004-2007) and II (2010-2014).
- "Three Ones of the National Response
    - "One National Plan"
    - "One Coordinating Authority" through establishment of the National AIDS Commission
    - "Building a One Monitoring and Evaluation (M&E) System"

The National AIDS Commission (NAC) was established 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.

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.

In collaboration with donors and multilateral partners, Liberia has developed and successfully implemented two national strategic frameworks, NSF I (2004-2007) and II (2010-2014). The frameworks provided the strategies for the national HIV response and defined the policy direction for the country's HIV interventions.

Liberia has already attained the full complement of three ones by having:

- "One National Plan" and has so far implemented.. successive Strategic Plans and now running the NSP 2015 – 2020;
- "One Coordinating Authority" through establishment of the National AIDS Commission;
- "One Monitoring and Evaluation (M&E) System" realized through implementing a one national M&E Plan.

However, the extent to which the "one Coordinating Authority" being exercised by NAC and 'one M&E System" lead by NAC have been built is not yet adequate.

Liberia has been implementing a multi-sectoral HIV response with national coordination by NAC through five mandates (Programs and Policy, Partnership, decentralization, and Monitoring & Evaluation).

Decentralizing the coordination and management of the HIV response to the counties is on-going. NAC offices have been established in 5 of the 15 counties. The counties with NAC offices are Bong, Bomi, Grand Bassa, , Lofa, and Nimba,. The Ministry of Health (MOH) has established and HIV & AIDS structure at the County level through the County Health Office (CHO) and County Health Teams (CHT). The MOH has both clinical and community HIV & AIDS programme components.

Line ministries have integral HIV & AIDS coordination units/ structures and sector HIV action plans. A number of Key line ministries including the Ministries of Education, Gender and Youth and Sports also have departments implementing HIV & AIDS Interventions. The Liberia Network of PLHIV (LIBNEP+) and Key NGOs also have strong programme presence at county level.

The Government of Liberia (GOL) committed to the ten UN General Assembly High Level Meeting (HLM, 2011) targets and the AU Roadmap for shared responsibility and Global Solidarity on AIDS, TB and Malaria (2012). In 2013, the GOL also developed the Liberia **Agenda for Transformation** (the Medium term Development Framework), which prioritizes HIV&AIDS as a cross cutting theme.

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%.

Liberia is implementing a multi sectoral response lead by the Government of Republic of Liberia mainly through the National AIDS Commission and the Ministry of Health with other central level government ministries and specialized semi autonomous departments providing, to a varying extent, the needed technical and management leadership to the respective sectors.

Other **key actors** in the national response include the following:

- the decentralized government departments within the frameworks of County councils;
- the National and International Civil Society Organizations (CSOs);
- Networks of Persons Living with HIV and support groups
- Faith Based Organizations (FBOs);
- Private sector agencies;
- Cultural and traditional leaders of the respective communities;
- Research and Training Institutions;
- Networks of PLHIV and support groups;
- the Multi-lateral and Bi-Lateral development partners

1.4. National AIDS Response Strategic Plan 2015 - 2020

The NSP 2015-2020 is an expression of the Liberia's commitment to achieving the universally desirable goals 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 National Strategic Plan (NSP) 2015 – 2020 was developed with the following Vision, Goal and Aims:

Vision: To create an AIDS-free society

***Goal of the NSP*:** To stop new HIV infections and keep PLHIV alive and healthy in Liberia.

***Aim of the NSP*:** 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-sectoral approach that is led by NAC and implemented in Liberia

Guiding Principles in the creation of the NSP 2015 – 2020 were as follows:

- 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

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 intervention areas along with selected key social and programmatic enablers will be implemented in synergy with selected key development sectors. The NSP high impact priority intervention areas 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 NSP also has a provision of other priority intervention areas to serve as critical social and programmatic enablers are under the following tracks:

i. Laws, Policies, and Practices;
ii. Stigma and Discrimination;
iii. the Media;
iv. Political Commitment, Advocacy, and Resource Availability;
v. Community Participation;
vi. Coordination and Management;
vii. and Research, Monitoring and Evaluation

The key development sectors elected for enhanced crosscutting elements and synergies articulated in the National Agenda for Transformation (AfT) for Health and Community Systems Strengthening include: Education; Justice; Gender and; Social Protection;

1.5. M&E situational assessment

The adoption of the 12-components M&E Systems Strengthening Tool (MESST) promoted by the UNAIDS and other lead M&E partners such as GF, Measure, World Bank as a choice tool for an M&E assessment is due to its comprehensiveness and requiring a few complementary tools when compared to other MESST tools

The findings point to the need to strengthen the following institutional competences to attain an effective National HIV and AIDS Multi-sectoral and decentralized One M&E System:

i. M&E leadership, structural development, planning, coordination and performance management of HIV and AIDS Monitoring and Evaluation
ii. M&E human resource capacity
iii. Systems and capacity for routine HIV and AIDS programme data collection, management, support supervision and data quality assurance
iv. Systems and capacity for routine logistics and supplies monitoring and quality assurance
v. Systems and capacity for HIV and AIDS financial monitoring/ tracking, budget and expenditure analysis
vi. Systems and capacity for generating HIV and AIDS biological and behavioral surveillance, surveys and research
vii. Systems and capacity for HIV and AIDS Information dissemination, utilization, learning & Knowledge Management

2. Introduction

2.1. Goal of M&E Plan

The NSP underlines the importance of the M&E System in the National Response towards strengthening of monitoring progress towards achieving the targets of the NSP 2015-2020. The NSP is built on the expectation that a matching M&E System is able 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).

The Monitoring and Evaluation (M&E) Plan 2015 – 2020 shall serve as a guide and tool for performance measurement of the national response and for monitoring of the effects and patterns of the HIV epidemic. The Liberia National M&E Plan is anchored onto the overall Liberia National social and economic development framework and Policy Framework as explicitly enshrined in the Agenda for Transformation (Aft) which is Liberia's Medium-term development strategy 2012 -2017).

The National HIV and AIDS Strategic Plan 2015 – 2020 and the M&E Plan shall therefore be expected to contribute to "***Pillar III Goal:*** *Improve quality of life (by investing in more accessible and higher quality education; affordable and accessible healthcare; social protection for vulnerable citizens; expanded access to healthy and environmentally-friendly water and sanitation services"*

As is the Agenda for Transformation (Aft), the National HIV and AIDS M&E Plan shall guarantee focus on: multi-sectoral response, multi-thematic interventions, participation by both public and nonpublic sectors and all programme and service delivery levels; the national, the decentralized (county and District) and community levels.

2.2. Objectives

Based on the M&E systems assessment findings, and in line with the NSP higher outcome, the M&E Plan shall aim to address all the M&E thematic elements international acclaimed by development frameworks in which Liberia is a party.

With respect to all actors in both public and nonpublic sectors, at national, sectoral, decentralized and organizational levels; the M&E plan shall in the next five years aim:

i. To strengthen leadership, structural development, planning, coordination and performance management of HIV and AIDS Monitoring and Evaluation
ii. To Enhance HIV and AIDS M&E human resource capacity
iii. To strengthen **systems and capacity for routine** HIV and AIDS **programme data** collection, management, support supervision and data quality assurance
iv. To strengthen the systems and capacity for routine logistics and supplies monitoring and quality assurance
v. To strengthen systems and capacity for HIV and AIDS **financial monitoring/ tracking**, budget and expenditure analysis
vi. To strengthen systems and capacity for generating HIV and AIDS biological and behavioral surveillance, surveys and research

vii. To strengthen systems and capacity for HIV and AIDS Information dissemination, utilization, learning & Knowledge Management

2.3. Guiding Principles

Based on the above objectives, the development of the National HIV and AIDS Monitoring and Evaluation (M&E) Framework and Plan was underpinned or guided by a number of key principles, factors and considerations including the following:

a) Based on the results outlines in the National Strategic Plan
b) Promote the "three ones" principle in the national response
c) Muti-sectoral thematic focus and Comprehensiveness in coverage
d) Entire coverage and responsive to all Programme levels: The M&E plan provisions shall be applicable at all programme levels right from Community; Service Delivery Points (SDP) by different categories of actors; lower local governments such as county; district; in-country regional; project; sectoral; National as well as regional and international levels.
e) Compliance with the contemporary and technically acclaimed approaches and requirements such as the 12 features of a good M&E system promoted by the UN, World bank and other lead partners in Monitoring and Evaluation and the adequacy for M&E Plan, compliance to the new GFATM new funding Model, and the post 2015/post MDG reporting priorities.
f) Evidence and results based, experiential learning and "best practice" based
g) Partnership and Networks promotion and development
h) In-built resource mobilization and country human resource capacity building, systems strengthening for Sustainability
i) Enabling gender, and equity based programming
j) Promotion of National Leadership and ownership

2.4. M&E Plan development process

The following national HIV response processes and respective documentation served as foundations for the M&E Plan development: the 2013 the Mid Term Review (MTR) for the NSF 2010- 2014; the NSP 2015 – 2020 and the finally the M&E rapid assessment report 2015 as reflected in Figure 2 below.

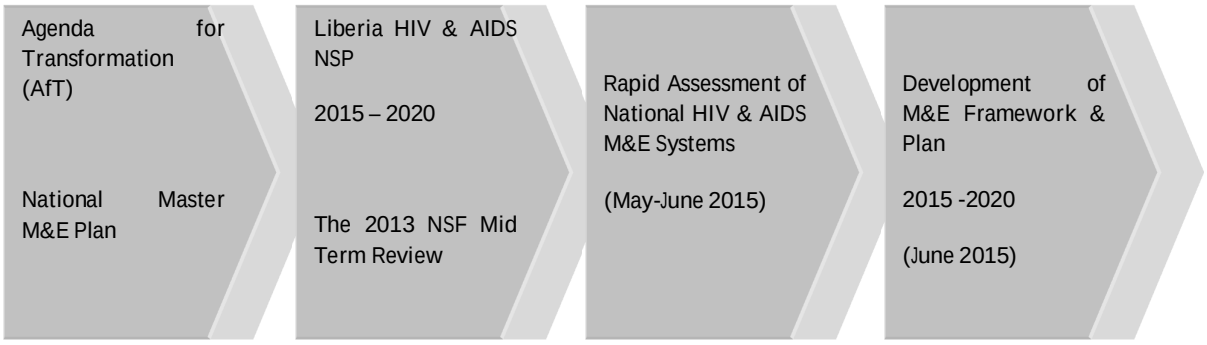


Figure 4: M&E Development Process

The development of the M&E Framework and Plan was undertaken during the months of May and June 2015 through the following four (4) interlinked stakeholder participatory phases as presented in Figure 4:

1. Planning;
2. M&E Systems assessment (situation & response analysis);
3. Re-formulation/development and;
4. Stakeholder Validation

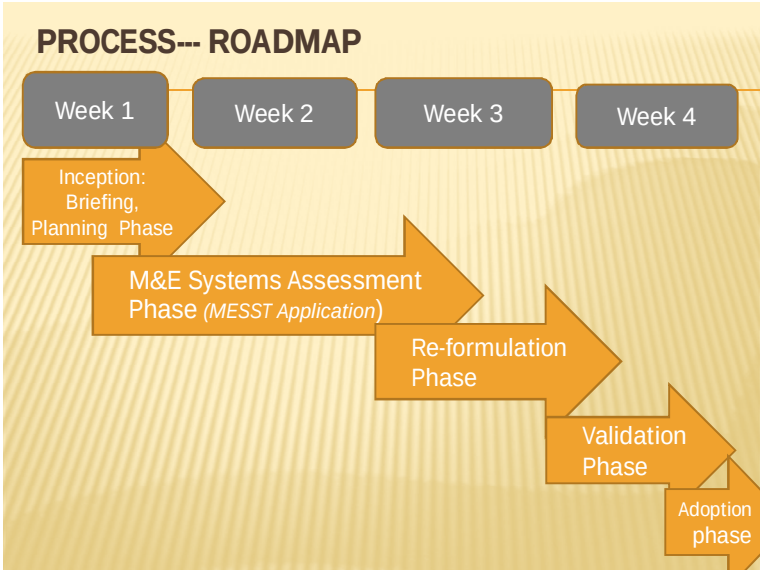


Figure 5: M&E Framework & Plan Development Phases

The process involved:

- Briefings with the NAC, MOH, UNAIDS;
- Review/appraisal of scope and tools for M&E assessment by Technical Working Group (TWG)
- Document review;
- Key informant Interviews at National and County levels with programme managers and service providers;
- Field visits to three counties of Nimba, Bong and Grand Bassa;
- Review/appraisal of the M&E assessment findings by Technical Working Group (TWG);
- M&E Framework and plan drafting
- Stakeholder Validation /Consensus Meetings.

The entire length of the Framework and Plan development process was appraised by the multi-sectoral M&E Technical Working Group (TWG) coordinated by National AIDS Commission.

2.5. Definition of terms and processes

Monitoring and evaluation are complementary processes. Below are some of the key internationally accepted concepts and definitions in relation to HIV & AIDS program monitoring and evaluation.

a) Monitoring: the continuous, routine compilation of data and assessment of on-going activities and/or processes. It aims to provide management and main stakeholders of an on-going intervention with early indication (or lack thereof) towards the achievement of outputs.

b) Evaluation: the periodic assessment of the overall achievements of activities and/or processes. It aims to understand the progress that has been made towards the achievement of an outcome at a specific point in time. All evaluations are linked to outcomes as opposed to outputs.

c) Indicator: a statement that describes the level of performance achieved in relation to a set of aims and/or objectives.

d) M&E results chain: There are five levels – impact, outcome, output, activity and input
   - Impact: refers to the highest level of results, a long term result at behavior or social norm level, which demonstrates cumulative effects of programs or interventions over time on what they ultimately aim to change

- Outcomes: intermediate result at the population level of an intervention's outputs. They often require surveys to measure.
- Outputs: Intermediate Result, Population Level, intermediate effects of an intervention's outputs, such as change in knowledge, attitudes, beliefs, behaviors. Often requires surveys to measure.
- Activities: actions to be done to accomplish a desired output
- Inputs: the resources that are needed to implement the project and its activities. Inputs can be expressed in the form of the people, equipment, supplies, infrastructure, means of transport and other resources needed for a specific project or activity.

2.6. Components of M&E Plan

The national M&E Plan has been structured to address all the key M&E thematic elements international acclaimed by development frameworks in which Liberia is a party. The M&E Plan is cognizant of the following M&E thematic elements

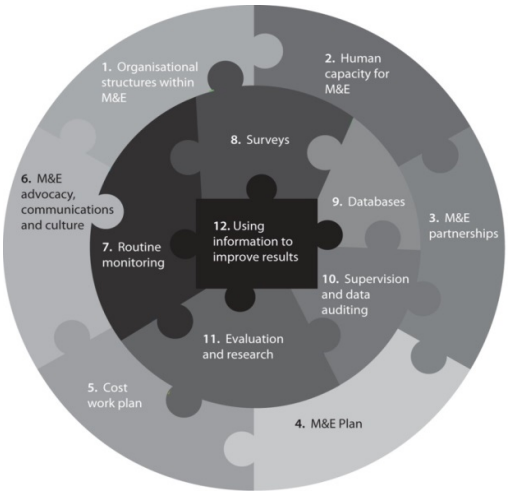


Figure 6: M&E Framework

1. M&E Organizational Structures
2. Human Resource Capacity for M&E
3. Partnerships to plan, coordinate HIV& AIDS M&E system
4. National multi sectoral HIV M&E Plans
5. Costed, National multi-sectoral HIV M&E Work Plans
6. Communication, Advocacy & Culture for HIV M&E
7. Routine HIV Programme Monitoring
8. Surveys and Surveillance
9. National and Sub-national HIV databases
10. Supportive Supervision and Data Auditing
11. HIV Evaluation and Research Agenda
12. Data / Information dissemination and Use

i. Organizational structures with HIV M&E functions

The M&E framework is designed to strengthen leadership and coordination structures to steer the performance assessment and monitoring of the HIV and AIDS response. The framework is premised for the support and sustenance of units responsible for M&E planning and coordination at national, sectoral, county levels as well as other self-regulating networks and individual organizations. The framework provides for a one national coordinating authority, which is the National AIDS Commission (NAC) to lead the M&E of the response through functional relationships.

Strategies to be implemented could include:

- Development of statutory instruments to enforce routine reporting of clinical and non-clinical data
- Establishment of functional M & E sector coordination mechanisms
- Capacity building of sector coordination structures.

ii. Human capacity for HIV M&E

The M&E framework provides for the building and sustenance of human resource capacity with requisite numbers and skills to ensure adequate M&E planning, data collection, data entry, data analysis, interpretation, storage and further management, information packaging and utilization in decision making.

Strategies to be implemented could include:

- Advocate with implementing partners to recruit adequate M&E personnel
- Develop on the job continuous education and mentoring tools for use by M&E staff
- Capacitate M&E people in public, private sector, Civil society and PLHIV
- Mainstream M&E in the training and duties of the nurses at site level as well as Health Information Officers.

iii. Partnerships to plan, coordinate, and manage the HIV M&E system

The framework has in-built partnership structures through technical working groups, technical resource networks with representation from all categories actors in the response. These partnerships will promote participation and buy-in for the M&E plan; ensuring the sustained relevance and strategic appropriateness and; enhance leveraging of the limited M&E resources.

Strategies to be implemented could include:

- Strengthen national and sub-national M & E taskforces
- Create partnerships with organizations and academia to support M&E activities

iv. Multi-sectoral HIV M&E plan

The framework promotes M&E planning at all programme levels. The framework has provisions to guide development of separate or wider programme/plan embedded but explicit integrated M&E workplans at overall national, multisectoral; sectoral thematic/programme; self-coordinating networks; county and individual organizational or project levels.

Strategies to be implemented could include:

- M & E plan always aligned to National HIV and AIDS Strategic Plan.
- Adherence of the M&E Plan to national and international standards for HIV M&E
- Regular review and update of the M & E plan

v. Annual costed national HIV M&E work plan

The M&E plan and other workplans to operationalise this framework shall be costed to ease resource mobilization and implementation of M&E interventions.

Strategies to be implemented could include:

- Stakeholder involvement in development and finalization of costed M&E workplan
- Improve resource mobilization for M&E
- Routine review of the annual workplan.

vi. Advocacy, communications, and culture for HIV M&E

The overall social and economic development framework and indeed this M&E framework has the use of information generated by the various monitoring and evaluation activities and M&E human resource as an integral approach to its execution. This is aimed at promoting the practice and culture of M&E for informed decision making in the national response and across all the development sectors. This culture being promoted by communication and use of priority and strategic information for decision making will also enhance stakeholder prioritization of HIV and AIDS in Liberia's development agenda.

Strategies to be implemented could include:

- Integration of M&E into national communication and advocacy strategy

vii. Routine HIV programme monitoring

The M&E Plan will derive the data needed for the monitoring and evaluation of the response from both routine and not routine data sources. The M&E Plan shall promote use of standardized or common tools for data collection, reporting and data quality assurance. The scope of routine data as a key source will cover all the NSP interventions and matching indicators.

Strategies to be implemented could include:

- Development of instruments to enforce routine reporting
- Identification of all existing data sources and establishment of appropriate links.
- Standardization of data collection processes and tools.

viii. Surveys and surveillance

The National response will require bio and social markers as well as systemic information to generate outcome and impact indicators. These will be undertaken in health sector facilities, non health sector service delivery sites. The M&E plan has scheduled a number of these surveys, some undertaken by a number of sectors.

Strategies to be implemented could include:

- Development of a national calendar of surveys and surveillance
- Strengthening the multi-sectoral coordination of survey and surveillance

ix. National and sub-national HIV databases

The M&E Plan has also provided for enhanced patronage (and establishment) of the available national and sub national data bases. Notable of these are the MOH based DHIS for the Health Sector Management Information System (HMIS), the Education Management Information System, that shall be enriched with HIV and AIDS relevant indicators; other sectoral / line ministry data bases and the an overall- multisectoral Master- HIV and AIDS data base that shall be established at the National AIDS Commission (NAC). These data bases will, to extent possible and desirable, be inter-operable and linked.

Strategies to be implemented could include:

- Develop linkages between databases so that they feed into one national databases
- Establishment of e-health systems

x. Supportive supervision and data auditing

The M&E Plan is built on a premise that all national sector ministries, counties, self-regulating networks; umbrella organizations and major national organizations and projects implementing HIV and AIDS interventions will undertake regular support supervision, data quality assurance and occasional data quality audits. NAC along with the lead sector institutions shall guide the development and ensure the availability of the harmonized tools for supportive supervision and quality assurance and audit. In addition to the individual support supervision, the NAC, MOH and sector or thematic lead agencies will guide and coordinate joint support supervision.

Strategies to be implemented could include:

- Development SOP for support and supervision and data auditing
- Strengthen support supervision and data auditing system

xi. HIV evaluation and research

The multisectoral national HIV and AIDS response to the epidemic shall benefit from the effective development and execution of a priority research agenda. The M&E plan and the operational plan shall strengthen and widen the technical and ethical review structures for HIV and AIDS related research. This will include the building of requisite human and institutional capacities.

Strategies to be implemented could include:

- Create a research agenda
- Development of guidelines for research and evaluation
- Capacity building on evaluation and research
- Institutionalize mechanism for the dissemination of researches and evaluation findings.
- Resources mobilization for research and evaluation
- Promote implementation of OR at all levels

xii. Information dissemination and use

The M&E plan seeks to enhance the generation, packaging, dissemination and utilization of information on the epidemic and response interventions at all levels and for all target audiences and purposes. Different forms of packaging that is audience targeted and purpose oriented are provided for including policy briefs, fact sheets, service coverage charts, patient electronic medical records, progress briefs, regular progress reports, mailing lists and network platforms,

Strategies to be implemented could include:

- Development and implementation of data dissemination plan
- Capacity building of management on data usage for decision making.

3. The Monitoring & Evaluation Systems

3.1. M&E System structure

3.1.1. *National AIDS Commission (NAC)*

The NAC, as the "One Coordinating Authority", and; the Secretariat of the "one Plan of Action", the NSP, shall support the planning, monitoring and evaluation the National HIV and AIDS response in line with the "one M&E System" principle. The NAC shall support the strengthening and sustenance of coordination arrangements in both public and non public sectors and with all the different categories of stakeholders in the national response at all programme levels, on or not on project support or funding.

The NAC shall also be responsible for leading and supporting the mobilization of the strategic, human, logistical and material resources for the implementation of the Monitoring and Evaluation Plan at all programme levels and in all sectors. To develop the "one M&E system the NAC will also be responsible for promotion and popularization of the adopted plan; guiding the development and supporting the partnerships needed for M&E, supporting the development of the standard and harmonized data collection and reporting tools; establishment and sustaining the functioning of a master national HIV and AIDS data base while also supporting the sub national data bases; data bases inter-operability; custodian of all HIV & AIDS related data; guiding the undertaking of HIV and AIDS research; guiding the data management; development of user friendly information products and dissemination and; promotion of utilization of the M&E and information products.

3.1.2. *M&E Strategic Information Technical Working Group (M&E SIM TWG)*

The National HIV and AIDS Multisectoral M&E Technical Working Group (M&E TWG) in collaboration with the various sectoral and thematic TWGs, shall provide the overall technical oversight and strategic direction to the roll out the implementation M&E plan. The TWG will ensure that the implementation of the Plan meets the technical and stakeholders' expectations and not just the NAC and MOH aspirations.

3.1.3. *Ministry of Health (MOH)*

The MOH which is charged with leading the planning, management and coordination of all HIV and AIDS interventions under the health sector shall be responsible for the overall sector technical guidance for M&E and supporting the rest of the implementing partners in the sector.

The MOH will ensure that the huge volume of information from the health sector is fed into the "One National M&E System" of the response coordinated by the NAC. NAC and MOH will also support synchronization and inter-operability between their rich and wide data bases and the other non health/ non HIV response data bases managed by other line ministries and MDAs, Umbrella agencies for completeness and consistence in reporting. The Health Sector HIV & AIDS response M&E plan will be anchored to the NSP and national multi sectoral M&E Plan/M&E plan.

3.1.4. *Other line/sector Ministries*

The monitoring and evaluation of a multi sectoral HIV and AIDS response requires active participation of the key line ministries. The sectoral HIV and AIDS Desks/ Focal Persons/ focal

points, planning and M&E units shall lead the planning, implementation, coordination and monitoring of all HIV and AIDS interventions in the respective sectors.

The respective ministry HIV and AIDS units with the support of the planning units shall coordinate the development and implementation of M&E of HIV and AIDS activities in the sector implementing public and non-public departments and agencies. Key line ministries like those of Education; Youth and Sports; Gender, Children and Social Protection; Labour shall be key sources of information for the computation of output indicators from the routine reporting supported by the respective sector Management Information systems (MIS) such as the EMIS-Education Management Information System. The sector ministries will also be key in leading and coordinating assessments, surveys and research that will generate the data for the computation of outcome and impact indicators relating to their respective sectoral mandates. HIV focal persons must be supported by their respective line ministries and agencies. It is suggested that line ministries include HIV & AIDS activities within their budgets.

3.1.5. *Liberia Institute for Statistical and Geo Information Services (LISGIS)*

LISGIS is the national body mandated to lead and guide the collection, compilation, analysis, validation, quality assurance and dissemination of all official and other statistical information in the country. LISGIS will technically support the Multi-sectoral M&E SIM TWG, MOH M&E TWG and other stakeholders in ensuring that methodologies used in collecting data, generation of representative samples, management of data during research and the monitoring and evaluation of HIV and AIDS activities are compatible with the national and international standards and specifications or technical protocols. LISGIS will play a lead role in questionnaire designs, development of methodologies for surveys, or routine data collection and has to ensure that the NAC, MOH and other lead stakeholders timely update it on the values of the HIV indicators baselines and targets set in the NSP and this M&E Plan. LISGIS will involve the NAC and the M&E SIM TWG in planning for the HIV & AIDS, Reproductive Health and related Social Economic house hold and impact surveys so that the content makes enough provisions for the generation of strategic information needed by the HIV & AIDS response.

3.1.6. *Umbrella agencies*

For effective reach during the implementation of the M&E plan, use shall be made of the wide networks strategic positioning of umbrella agencies and networks that coordinate the various constituencies of actors in the national response.

They shall be involved in creating stakeholder buy-in for reporting; provide alternative assessment of the national response when preparing the GARPR report every two years with an important component in constructing an indicator on national programme effort Index and commitment Policy Index (NCPI). The networks and umbrella organizations shall also be represented by the relevant technical persons in the HIV and AIDS M&E/ SIM TWGs at National, sectoral and County levels. These networks shall also be vital for developing and keeping inventories and data bases and websites to be used as channels for dissemination of the HIV and AIDS information products.

3.1.7. *AIDS Development Partners*

Development partners who include United Nations Agencies, Bilateral and Multilateral agencies, international NGOs shall be expected to support the implementation of the M&E plan through funding, technical assistance, information sharing and mobilization of the supported implementing partners to enhance compliance to the “One National M&E System” in Liberia.

3.1.8. *County HIV and AIDS Partners forum/ Committees (CAC)*

Institutional and Coordination guidelines for the implementation of the National HIV & AIDS response provide for the strengthening of HIV & AIDS stakeholders fora/committees at county level. The CACs, the CHT and sectors identified for sysnergies such as Education, Gender and other line ministries's decentralized departments shall be members and supportive of these committees. The NAC and line ministries will support the functioning of these county level stakeholder Committees to ensure vibrant decentralized response generation and management of strategic information. These structures shall also support evaluation activities normally executed by the national level agencies but implemented at the population level where they have the strategic positioning.

3.2. Data Management

The functionality of appropriate data sources is essential for the timely generation of the data needed for construction of the indicators presented in the performance framework presented in the previous chapter, section three.

The National AIDS Response M&E Plan will make use of both routine and non-routine or periodically generated data; primary and secondary data as well as quantitative and qualitative data. Over the plan period, 2015-2020, it is expected that data will be generated from sources summarized in table 4A below.

Table 1 provides a summary of different categories of data sources; the institutions with lead responsibility for ensuring that the data is collected and analysed; the likely supporting partners; the frequency of collection; the next round of data collection is envisaged for the non-routine sources.

Table 1: Key Data Sources for the National HIV and AIDS M&E Plan

Data Source	Lead Institutions	Likely supporting Partners	Reporting Frequency	Planned
Routine Programme Data				
1. Routine Health sector programme service coverage data - clinical /facility generated data mainly covering: HCT, ART, PMTCT, FP, ANC, Postnatal, OIs, STI, TB, Condoms, Blood Safely, Surveillance, Lab (from HMIS/ DHIS data base)	MOH	GOL, GFATM,	Quarterly	On-going
2. Routine Non-clinical HIV & AIDS public/ govt sector programme data form other line ministries, departments and agencies	NAC	GOL, GFATM,	Quarterly	
3. Routine programme data from non public sector- *(health, non health sector interventions by non public/no govt umbrella organizations and networks ie for CSOs, FBOs, CBOs, PLHIV net works such as LINEP+, LIWEN, any other community programme AIDS reporting)*	NAC and Umbrella organizations	GFATM for SRs and SSRs of on - going grants,	Quarterly	

	Data Source	Lead Institutions	Likely supporting Partners	Reporting Frequency	Planned
4.	Field Monitoring and Support Supervision data by National head offices of both public & non public sectors	NAC, MOH	GOL, GFATM	Quarterly & bi-annually	
5.	Health Sector Sentinel surveillance surveys (sero- surveillance for pregnant women)	MOH	GOL, GFATM	Every 1- 2 years	ANC survey 2015, 2017 & 2019
Non Routine Sources					
6.	Population based Bio and behavioral Surveys such as: Demographic and Health Surveys (LDHS), AIDS Indicators Survey- AIS , IBBSS	LISGIS		3-5 years	LDHS 2018
7.	Integrated Bio and Behavioral Surveillance Surveys for key Populations including Prison population	LISGIS		3-5 years	IBBSS 2016 & 2019
8.	Stigma Index /Survey			2-3 years	2017 & 2020
9.	Quality of Health services delivery and related HIV Services Assessments and Facility Surveys	MOH,		Biennially	
10.	Programme/ Project specific reviews and Evaluations	Projects		Every 2 -3 years	
11.	HIV and AIDS Workplace Survey			Every 2 -3 years	
Other Essential Assessments and Special Studies					
12.	Independent Annual Response Assessment	NAC		1-2 years, End of NSP review in 2016	2015. 2016, 2018, 2019
13.	Mid Term reviews (MTR) & End of NSP term reviews-ETR	NAC	GOL	2-3 yrs, 5 yrs	2017, 2020
14.	Sector Wide Reviews/ Assessments (SWAPS) & Strategic Plan reviews	Sector Ministries		1-2 years	
15.	Assets Inventory, procurement and supply management and Administrative records analysis		GOL	Annually	
16.	Stakeholders and Service Mapping	NAC		Biennial	
17.	HIV & AIDS & Health Accounts, Budget & Expenditure Analysis /studies	MOH, MO Devt Planning		Biennial	
18.	Gender Assessment	NAC, MoGender & Devt			2015
19.	OVC situation reviews	MGD	UNICEF		
20.	Situation of Women and Children	MGD	UNICEF		Last one in 2012, next …
21.	Modes of Transmission (MOT);	NAC, MOH	UNAIDS		2019

	Data Source	Lead Institutions	Likely supporting Partners	Reporting Frequency	Planned
22.	Household - Social Economic Impact Studies (SEIS)	LISGIS	GOL, UNDP?	Every 3 -5 yrs	
23.	Size Estimation of National HIV & AIDS target populations, key Popn Size Estimation of -MSM, FSWs, PWID, and modeling & Projections	NAC, MOH, LISGIS	UNAIDS, WHO	Every two years	
24.	Condom Surveys, Treatment Adherence Cohort studies; Drug resistance studies; PMTCT Study	MOH	UNAIDS, WHO		PMTCT Study 2017, 2020
25.	National AIDS Spending Assessment (NASA)	NAC, Min of Finance	UNAIDS		2017, 2020

The next sub sections elaborate on the the set up and management of the respective data sources, with respect to the data collection, flows into the "one National HIV and AIDS M&E System in Liberia".

3.3.1. *Health Sector Routine Programme Data*

Currently, this the most robust source of data on the National HIV and AIDS Response. The MOH is responsible for monitoring the facility based and other community health HIV services including HCT, ART, PMTCT, FP, ANC, Postnatal, STI, TB, Condoms, blood products safety, Surveillance and Laboratory services. The health sector is also responsible for the OI management, PEP, Universal precautions for infection control, condom distribution and Community /Home Based Care (CHBC). The MOH has its own HMIS data collection tools for routine reporting on each of these services. The MOH is responsible for monitoring services offered in both Government and non-government owned facilities.

All health facilities in the country providing any of these services, regardless of ownership will be required to submit routine reports to the County Health Team offices and to MOH every month this will be part of aggregated quarterly reports. The MOH will continue to enter this data into the DHIS at county level, undertake the needed analysis and generate reports.

For this data source the overall responsibility for support supervision and data quality assurance will lie with the MOH. NAC and development partners working through the M&E / Strategic Information Management (SIM) TWG will support the MOH in support supervision and data quality assurance and occasional auditing.

This data source will also include data from national facilities such reference laboratories, blood bank, referral hospitals that may not be reporting to the CHT, community health workers (CHW) and outreaches under taken by the health facilities.

3.3.2. *Non-health facility programme data*

NAC is reviewing the existing data capture and reporting tools to produce standardized data collection tools and templates to feed into the one M&E system this plan is aiming to make operational. This will enhance the capture of data on all non health facility HIV activities /services implemented by public, NGO and private sector implementing partners. The data collected includes is from non clinical based interventions such including BCC, life skills based

HIV, Education, OVC support programmes, youth / adolescent sexual and reproductive health services in the communities and youth centre, work place programmes development, non faculty condom, Distribution; health and community systems strengthening interventions.

This routine data source requires strengthening and will not be limited to the ministries or NGOs whose activities have been funded through NAC as an SR under GF but will cover all Government Ministries, Departments and Agencies (MDAs) and private sector institutions implementing HIV and AIDS activities. This source will be vital in production of routine data for computation of non clinical output level indicators.

The implementing partners (IP) reporting will include public sector ministries, departments and agencies; NGOs, Self Regulating Entities (SRE) or umbrella organizations, private sector non clinical service providers. These will complete the routine Service Coverage Reporting (SCR) forms or fill the web based/ electronic entry screens on a monthly basis, collate it quarterly basis.

The head or coordinating officers of these IPs will be expected to undertake regular support supervision, quality assurance; track respective sector or constituencies reporting and provide feed back to the IPs under their supervision scope.

NAC will aggregate data, undertake data quality assurance and occasional audits, enter it into the national Master HIV & AIDS data base, do further analysis to generate national output indicators and analytical reports and provide feed back to the implementing partners.

To strengthen decentralization of M&E as a critical part of the response management, the ministries, NGOs, SR/CE reporting will be expected to support their respective county based offices to collate data, do quality assurance, give feed back to respective community level service providers, undertake limited analysis and report to county HIV and AIDS, pillar Steering Committee.

3.3. Data Storage

UNAIDS M&E guidelines supported World Bank, WHO, PEPFAR, Measure and other leading M&E technical leading agencies require national responses to have National and sub national data bases. Notable of these data bases under this plan will be the National HIV and AIDS Master data base LESGIS, the DHIS by MOH and one to be established at NAC. The data bases shall enable easy access with defined access levels and rights and have inter-operability, migration and export of data and to enhance the sharing information. The NAC based/ run/ managed National HIV and AIDS database shall serve as the main national repository for data from both non-clinical and clinical data from routine programme monitoring; population based surveys, surveillance, research, financial monitoring and other relevant sources as shall be overseen by the MESIM TWG.

The national and sub national data bases shall have user friendly procedures or database management protocols to ensure that it's data are updated regularly, consistently and on time and accessed with relative ease even in the largely resource constrained settings with poor connectivity.

The data uploaded shall ensure the necessary desegregation including: by geographical areas, by NSP thematic areas, target /beneficiary population and service provider categories. NAC will

encourage and work towards the creation of geo referenced HIV and AIDS data fed by the Mapping as one of the data sources. Where such data exists, relevant geo referenced data will be used to create maps and data atlases for inclusion in M&E information products for enhanced strategic information management.

All line ministries, umbrella agencies and networks, major projects and programmes coordination units shall be expected and supported to build and run sub national data bases. These data bases shall be fed by data from the respective implementing partners and programmes coordinated. All these sub national date bases shall however make sure they use the national guidelines and definitions and policies and shall be complaint, not contradictory, to the sector lead institutions.

The sub national data bases and data sets shall also use the unique identifiers system of services, providers, locations, beneficiaries developed by the national multi-sectoral M&E SIM TWG to avoid duplication. Once these provisions are made, this will be a strength for the response as it will provide cross referencing and will translate into no significant double entry errors, extra cost or parallel systems

3.4. Data flow and transmission

Given the different data sources and a multiplicity of actors, it is important that simple data, information flows and reporting framework is built and secures the consensus of stakeholders to synchronize and smoothen the M&E function in the response. Figure 4 illustrates the flow of data/ information right from the community level service delivery points to the national repositories of the "One M&E System".

Figure 4 indicates the coordination, reporting and partnerships at the National, sectoral and county levels. The arrangements also provide for the continued reporting and other functional linkages expected between the individual agencies or offices in the field and their mother organizations /offices or sectors to which they are affiliated at national level.

In-built in the information flow framework is the emphasis on feed back at all levels between those who generate and submit the information and those who collate, analyze, store and disseminate the information. NAC will support the establishment and functioning of fast data and information flows in the response through the multi sectoral response set up as elaborated by the NSP and the decentralized system represented by the Counties and umbrella agencies and adoption of relevant technologies.

Figure 4 indicates proposed data and information flows, sharing, data quality assurance and feedback links, coordination of M&E and Research within the Liberia National HIV and AIDS response.

National level: Overall, the NAC shall be the "One National Coordination" and "One M&E authority". To ensure effectiveness and accountability and good governance in execution of the role of the trust holder for "One M&E System", the NAC secretariat shall be supervised and given oversight by Office of the NAC board; the Parliamentary HIV & AIDS Committee and the National HIV and AIDS Partnership forum representing all stakeholders.

The NAC shall, through the auspices of the national M&E & SIM TWG, execute the M&E trust ship and leadership function in regular and close collaboration with MOH, MDP and LISGIS.

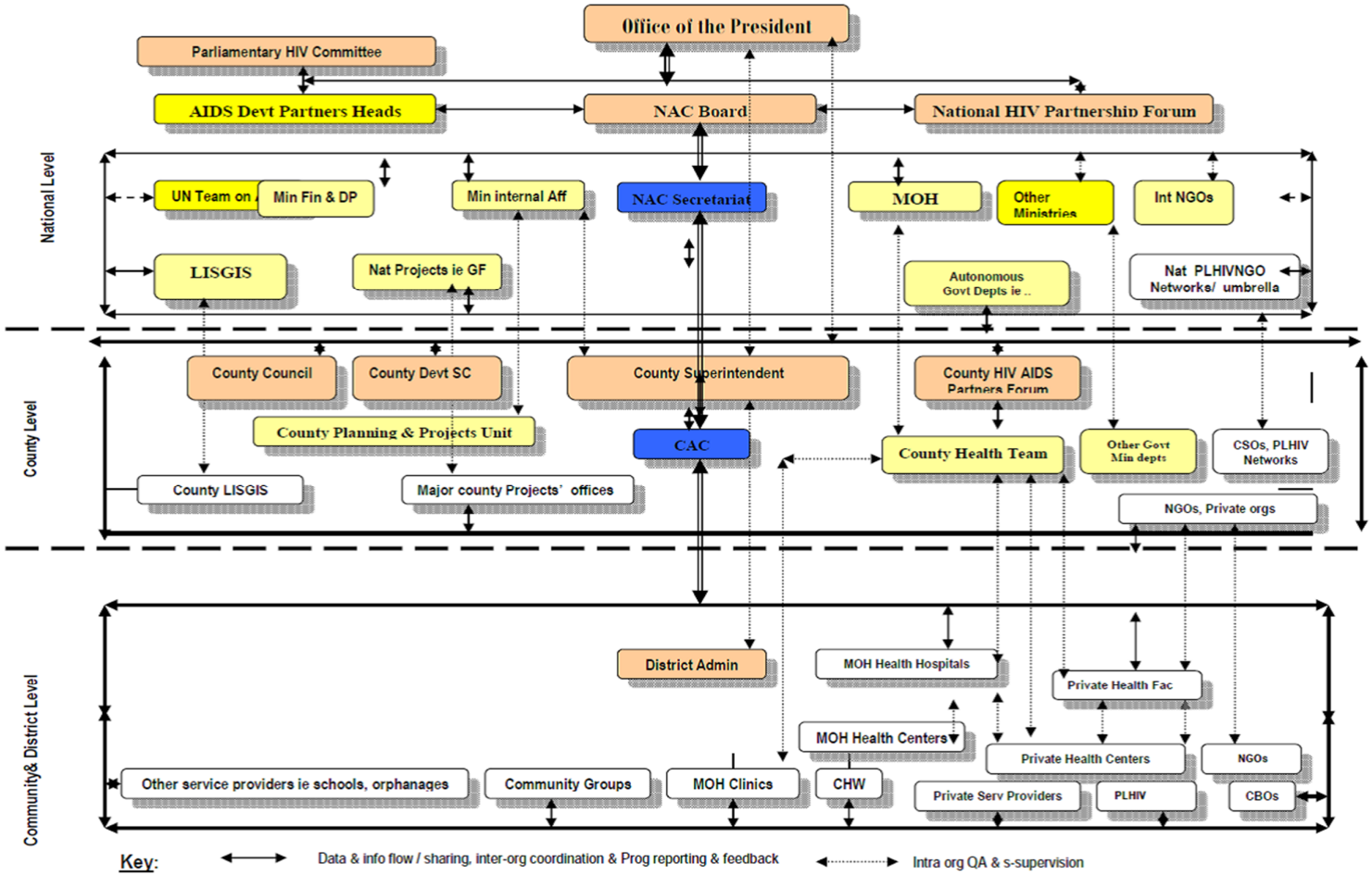
The sustenance of "one M&E system" will also require close articipation and support of the AIDS Development Partners (ADPs); Major National Networks or umbrella agencies coalitions of PLHIV networks; CSOs, FBOs, Private sector coalitions, major national projects and programmes such as the GFATM.

The NAC will receive quarterly reports on pre-provided reporting forms from the National and County level actors for aggregation, analysis for national reporting. This will be based on TWG approved workplan, provide the needed M&E technical logistics and support along with the ADPs to sectors, county and respective umbrella organizations structures/ units responsible for M&E coordination.

County level: At the County level, this semblance of actors will be replicated with the County NAC Coordinator (CAC) closely working with the County Health Team (CHT) under the oversight of the District Council, the County Development Steering Committees (CDSC), the Human Resource Aft Pillar partners meeting under which HIV falls and the County HIV and AIDS Stakeholders' partners Meeting/forum. Close collaboration with the already solidly established County Health Management Team (CHMT), District planning and LESGIS office will be needed for effective delivery of this function.

NAC County AIDS Coordinator (CAC) will be expected to receive quarterly reports on pre-provided NAC reporting forms, or on other synchronized existing forms such as those of MOH, from other County, District and community level based service providers for aggregation, analysis and onward reporting and; provide the actors with needed M&E technical logistics and support along with their respective national level mother offices. An existing HIV and AIDS partners /stakeholders' forum and County planning committee sub committees or task force shall serve as the M&E TWG to avoid a multiplicity and unnecessary duplication of structures.

Figure 4: **Liberia "One M&E System" Data /Information Flow, Reporting & Coordination Arrangements (draft)**



3.5. Data Quality and Supervision

Field monitoring and support supervision will be undertaken by organizations responsible for the HIV and AIDS response coordination including: NAC, MOH, other line ministers, Umbrella agencies; County NAC and County Health Team coordinators and development partners. Major National Project's coordination units such as GF coordination office at MOH, other PRs for Global Fund if in place,. This source will constitute another key source of data for monitoring the response and guiding the needed-re programming. These agencies/ organizations and projects, guided by NAC, will have guidelines for support supervision and quality assurance and will submit reports to NAC for the consideration of the WG through NAC.

The quality of data and information generated by the M&E plan is central to creation of an enabling environment to attain the aims of the NSP. NAC, in collaboration with other National partners will spear head the strengthening of Data Quality Assurance (DQA) through development and adoption of DQA Protocols for the different thematic tracks of the NSP interventions.

Data Quality Assessment focusing on the validity, reliability, integrity, precision, timeliness and completeness of the data being generated will enable organizations, programs and projects to strengthen their data management and reporting systems. Each of the routine and non routine data sources will also have DQA measures specified as part of the tools, templates and protocols. The ME SIM TWG will review the DQA protocols guidelines when need arises but at most every 2 years to ensure sustained relevance, appropriateness and technical compliance. Provision shall also be made for data quality audits that will be occasionally be commissioned by the different MESIM TWGs.

3.6. Data analysis

A standard data analysis and use plan is critical for effective planning, coordination, and implementation of programme activities. The results from the analysis of data should inform all implementers in a timely manner so they can make appropriate changes in program management and resource allocation.

Majority of data analysis is expected to be conducted through Microsoft Excel and PowerPoint. Modelling analysis is done using Spectrum.

An analysis plan is needed to be developed for the M&E plan and its partners in order to guide means of analysing data and transforming it into relevant information. Standard training curricula for data managers, implementers, and M&E staff will be provided at all levels.

4. Research, Studies and Evaluation

4.1. Studies and Surveys

The computation of outcome and impact indicators which are essential for measuring the outcome and impact results of the NSP rely on data generated through surveillance, surveys, operations or implementation research and evaluations. Population and facility based biological HIV surveillance along with the behavioral surveillance are an important component of this HIV and AIDS M&E plan to produce both bio-makers and needed social-behavioral indicators.

Protocols and data collection tools for surveillance and surveys shall be based on international quality, technical and ethical guidelines from WHO, UNAIDS, Measure evaluation, PEPFAR customized into national guidelines. The data from these sources will be submitted through the respective routine reporting systems and technical working groups in case of surveys, operations research and evaluation reports.

5.1.1. *Quality of Health Care Survey*

The MOH, which implements a largest proportion of HIV and AIDS interventions through health facilities, will be undertaking regular surveys of health facilities. These surveys will collect data on both the quantity and quality of these services provided at health facilities. The assessment of the quality of care or of HIV service provision required will be done directly or as out sourced as independent exercises. MOH will be responsible for the quality of health related HIV services survey every two years, resources permitting. The data from this source will also be submitted to NAC as part of one M&E system.

5.1.2. *Thematic Evaluations, Assessments and Service Delivery Surveys*

Specific thematic assessments and evaluations will also be undertaken to generate data that will deepen the understanding of the performance of the different thematic interventions. A specific Evaluation or assessment of ART, PMTCT or HCT programme is likely to produce deeper analysis and understanding of the key sub track beyond what is routinely reported. However, need for deeper investigation will not rule out the wider thematic component or wider response evaluation that examines the inter-relationships within a thematic area or even between different thematic areas.

5.1.3. *Workplace HIV and AIDS Programme Survey*

Workplace surveys covering a sample of public and private sector agencies shall be conducted to assess the adherence to the policy provisions and regularly assess the extent to which HIV and AIDS prevention and care have been mainstreamed in workplaces and programmes. The establishments to be surveys shall be selected on the basis of the size and nature of work force and also selected to provide a representative sample. These surveys undertaken every two years shall be steered by the Ministry of Labor with support of NAC and MOH. The findings will be fed into the one M&E System. The survey will be guided by workplace survey protocols produced by UNAIDS and ILO.

5.1.4. *Demographic and Health and other Integrated Household Surveys*

The response shall also benefit from the LDHS of 2018 and any household social and economic impact studies undertaken by LISGIS**.** These studies have been and shall remain the key source

of impact and outcome indicators values or levels, distribution and shifting trends of the epidemic, and the complex underlying, relational nature of the varying epidemic elements, causative and propagating factors. Population level survey that will generate HIV related outcome and impact indicators as part of wider integrated household surveys with social economic development indicators will be undertaken. These surveys will be undertaken by the LISGIS or sub contracted agencies and will the basis for generation of some of the NSP outcome and impact indicators in the development synergies track. NAC in collaboration with LISGIS, the sector line ministries and partners will ensure that questions on HIV and AIDS are part of tools for the integrated household surveys data collection modules.

5.1.5. *Assets Inventory, Procurement and Supply Management (PSM) records*

NAC guided by the national M&E/SIM TWG will guide all stakeholders implementing the HIV and AIDS interventions to keep records on HIV assets and procurement and supplies management as a vital source of input indicators. This category of data is important for tracking the volume, quality, durability, timely delivery and cost of the inputs as well as the cost-effective use of the different types of logistics. This data will be fed into the National Logistics Information System (LOGIS) data base (housed at.....) and or sub component of the National Master HIV and AIDS data base to be established at NAC as part of the one M&E system. This information shall be reported on/ submitted annually.

5.1.6. *HIV and AIDS Stakeholders and Service Providers Mapping*

A national mapping of HIV and AIDS services/ interventions and Service providers will be conducted every two years. This will build on other inventories and data bases. The counties , sectors and umbrella agencies and will greatly aid the, equitable planning, development, coordination and monitoring of the national response. Mapping information will support the production of geo-service maps to produce an atlas and maps on different services in HIV and AIDS across the country. These amps will be useful for monitoring of service distribution and an analysis of possible relationship with observed levels of different outcome and impact indicators.

5.1.7. *Resource Tracking, HIV & AIDS Accounts, Budget & Expenditure analysis*

A National AIDS Spending Assessment (NASA) was undertaken in 2013 on the expenditure on HIV and AIDS response for the years 2011/2012. Another NASA shall be undertaken in 2017 and finally in 2012. The NASA shall be completed by analysis of Health accounts in the national budget and an analysis of expenditures reported. These studies shall be important sources of indicators on the volume and sources of expenditure on HIV and AIDS, the proportionate distribution of expenditure between the different thematic tracks of the response based on the AIDS spending Categories (ASC), the channels/agents of financing the response, the factors of production spend on and the beneficiary populations. This information is important in determining the political commitment, guiding the realignment of the response resources to the disease burden and deciding between the alternative funding mechanisms against the existing national context and response landscape. .

5.1.8. *Research, Evaluation and Special Studies*

A number of research undertakings in form of operations/ implementation research, investigative, data mining, special studies targeted at various thematic tracks of the response will be undertaken as an important data source. Other investigation will assume an approach of

data mining, meta-analyses and triangulation of the existing data sets to enhance the understanding of the epidemic and the effectiveness of the response. This data source is vital for understanding the enabling and prohibiting factors at play towards the attainment of the planned results or changes contributed to or caused by the response interventions. The National HIV and AIDS M&E/ SIM Technical Working Group (TWG) will spearhead the development of a national HIV & AIDS research and evaluation agenda. This agenda will also incorporate the agenda of the health sector research agenda on HIV. Other research topics will be listed in the HIV & AIDS Research Agenda, such as a study on motorbike drivers and their vulnerabilities to HIV transmission.

5.1.9. *Independent Assessments, Joint Annual, Mid Term and End of term Reviews*

The performance of the NSP will also be derived from annual Independent Response Assessments, Joint Annual Reviews (JAR), Mid Term Reviews (MTR) and End of Term (ETR) or Terminal Reviews. These assessments help to take stock of the progress made along the National operational plans and NSP targets and provide information for more strategic response re-programming.

5.1.10. *HIV Estimates and Projections*

NAC, MOH and LISGIS through the National M&E/ SIM TWG with support from UNAIDS, WHO and other development partners will ensure that current UN provided estimation and modeling tools are used to establish baseline and target values of the M&E Plan. This exercise shall be conducted every year.

5.1.11. *Modes of Transmission (MOT) Study*

A Modes of transmission (MOT) modeling was undertaken in 2004. Another MOT will be undertaken in the second half of the NSP period to estimate the number and patterns of new HIV infections. On the basis of a description of the distribution to the new infections and patterns, priority interventions will be programmed. MOT synthesis will also assess the relative alignment of resource allocation to HIV transmission patterns and AIDS burden and guide the strategic directions of the response.

5.1.12. *Cohort Analysis and Drug Resistance studies*

Other important sources of information for the management of the response will be Cohort analysis and drug résistance surveys. Cohort analysis will be undertaken to generate information on retention of patients on treatment and survival. Drug resistance studies will also be undertaken as vital for informing the policy as regards the planning for what regimens to avail to those on treatment.

5.1.13. *Gender Assessment*

A gender assessment shall be undertaken in 2015 to inform the programming of the response and especially the GF Concept Paper development and development of the national Operational Plan for the NSP on the dynamics of the Gender, HIV, TB and other co-infections. .

5.1.14. *Women and Children Survey*

A UNICEF supported National situation analysis/ study on women and children in 2012. This study, to be conducted again in 2017, was and shall be an important source of information with regard to the demographic variables, other development social economic parameters such as

nutrition; education; disability; human rights; Sexual exploitation and Gender Based Violence (SGBV); inequities in service access and outcomes; HIV knowledge; behavioral changes; life skills (including livelihood skills) on the two of the key vulnerable population groups, the women and children.

5.1.15. *Mid Term reviews (MTR) & End of NSP Term reviews (ETR)*

The NSP 2015 – 2020 shall be subjected to a Mid term Evaluation at the end of 2017. The 2017 MTE shall be an opportunity to re-evaluate the performance of the NSP as per targets in each of the expected results expected results; the strategic alternatives and make choices on which ones to pursue and which ones to drop. The MTR/E, like would be the case with the annual assessments, shall also be an opportunity to realign the response to any new national and global realities. The MTE of 2017 shall replace the independent assessment for that year and will be a deeper and more analytical exercise more than the annual independent assessments.

5.1.16. *Sector Wide Reviews/ Assessments (SWAPS) & Strategic Plan reviews*

To fully comprehend the contributive effect of the different development synergies envisaged in the NSP, the national response actors shall actively take part in the various sector reviews and assessments. The National HIV response shall take key interest in the health; education; gender and development; Internal affairs; Justice, Law and Order sector assessments.

5.1.17. *Stigma Index /Survey*

A stigma Index survey will be under taken to capture the levels and profiling of Sitigma, denial and discrimination related to HIV and AIDS and associated conditions.

5.1.18. *Integrated Bio and Behavioral Surveillance Surveys for key Populations*

Two Integrated Bio and Behavioral Surveillance Surveys for key Populations (2017 and 2019) will be undertaken focusing on SW, MSM, PWID given the proportional influence on the epidemic as indicated by the higher prevalence rates. The surveys will also specially provide data for generation or indicator values on the response interventions targeting key populations. The findings will also assist on re-evaluation of the adopted strategies.

5.1.19. *Population Size Estimation of Key Populations*

The first Population Size Estimation (PSE) of Key Populations in Liberia was conducted in 2013, another PSE study of Key Populations should be conducted in 2018. This study will provide estimates for the sizes of population of the key populations, namely FSW, MSM, and PWID.

5. Information Products, Dissemination and Utilization

5.1. Reports

The M&E plan will ensure that the varying information needs of the different stakeholders are met by packaging the available information to meet the diverse needs. A number of information products, packaged differently for the different audiences will be produced including the following:

Table 2: Reports for dissemination

i. HMIS, non-clinical interventions Service Coverage Reports (Quarterly and Annual Progress Reports) ii. HIV Surveillance reports iii. Brochures, leaflets, fact sheets iv. Information and Assessment reports v. Assets registers and inventory, PSM reports vi. HIV interventions and providers Mapping reports and Mapping Atlas	vii. NASA reports viii. Budget and expenditure analysis reports ix. Assessment and review reports (Joint Annual Review (JAR) reports, Mid Term Review (MTR) Reports x. M&E Calendar & Wall Charts xi. Estimates and projections reports xii. Biennial GARPR Report xiii. Research and Survey Reports

Depending on the indicators being reported upon, the information products above will contain information/data analyzed by sex, age group, social status/ groups and location (Counties and Districts). This will be done to enhance the use of information to manage and plan the response.

Different information needs may emerge that require re-analysis of the existing data or the collection of raw data beyond what is routinely collected. Such requests shall be made in writing to NAC, MOH or other partners in the response which will in turn be considered whether they can be accommodated within available resources based on technical appraisal by the ME/SIM TWG. Depending on the information needs in question and their relevance to the management of the national response, the TWG will assist to commission an activity to generate such information with support from the relevant partners or give the necessary technical guidance to the stakeholders in need of such information.

5.2. Dissemination plan

Harnessing the stakeholder buy-in into the M&E Plan will, to a large extent, depend on the user friendly nature of the information products generated under this plan. There is no point at all in collecting and sharing data/information that is not shared or is availed in a form that cannot be easily used or will not be used.

The ultimate use of information shall serve to direct HIV control efforts at all levels: national, Sectoral, County and the Community levels. Information from the monitoring and evaluation of the national response will be disseminated widely to various stakeholders using different channels that will include the following.

a) The Liberia National HIV and AIDS Partnership Forum that brings together stakeholders' at national, sectoral, non government and County levels will be used to share the information products of this Plan and those sourced from elsewhere. The stakeholders' partnership fora at national and county levels will enable all categories of stakeholders share the HIV & AIDS

Status reports and other resources key for the strategic development and technical references for the national response interventions. It will also be the channel for sharing information on the national response in the preceding implementation period with key focus on the scope of service coverage, the best practices and management of challenging and emerging issues.

b) Quarterly HIV TWG at NAC, coordination and planning meetings with the HIV and AIDS Focal Persons in the ministries at National levels
c) National level quarterly coordination meetings with HIV & AIDS and M&E Focal persons from umbrella agencies that could include: national and international NGOs, networks of PLHIV, AIDS development partners such as the UN Joint Team on AIDS and the research and teaching institutions
d) County level monthly HIV and AIDS partners meeting/forum. These will also be used to monitor progress of implementation of the HIV and AIDS and M&E activities within the county, share any available HIV & AIDS information, identify the lessons learnt, challenges and constraints and then map way forward strategies.
e) Use of the print and electronic media by having airtime and news paper space and pull outs in the widely circulated news papers.
f) Websites and electronic platforms or common email addresses. This will require regularly uploading and updating the NAC, MOH and other selected intranets, websites and repositories
g) The NAC, sectoral (MOH and other line ministries), District, other public and private Resource Centers and reference collections
h) Stakeholder mailing lists—electronic and manual
i) Stakeholder dissemination workshops and Research Conferences
j) Coordination meetings of the umbrella agencies
k) Training Workshops and Seminars
l) National exhibitions at different fairs and days that involve exhibitions
m) Other key National and International stakeholders conferences

5.3. Mechanisms to utilize information

Innovative methods must be used in order to ensure that the information collected by M&E reaches stakeholders, beneficiaries and other partners. Strategies of improving information utilization are:

- Enhance reporting, writing and presentation skills of implementing partners, stakeholders and M&E officers
- Provide ongoing support and mentorship to M&E staff and county level staff to generate specialized reports
- Conduct data needs assessment of partners in order to target the reports produced
- Ensure data sharing and utilization occurs during M&E TWG meeting and weekly Ministry of Information meeting
- Promote the strategic use of information and data at key routine partner meetings, like the LCM
- Liaise with the communication team on innovative and effective methods of sharing information
- Update the NAC website with relevant information and data

6. Implementation of M&E Plan

6.1. Roles and responsibilities of key partners / bodies to M&E

The NAC is responsible for implementing the multi-sectoral response to HIV and AIDS and thus has the mandate for overall plan supervision. At the National and sub-national levels, appropriate institutional arrangements and capacities will be created and resources provided to facilitate participation in M&E at all levels. Table 5 summarizes the institutional framework and roles and responsibilities for operationalizing the M&E plan.

Table 3: Roles and Responsibilities for the Implementation of the M&E Plan

Institution	Responsibility
NAC Management	· Enforcing accountability in the implementation of the national M&E Plan, including policy and program implementation
NAC M&E Team	· Provides overall daily management and oversight of the implementation process of the M&E Plan · Provide technical support to partners and stakeholders on implementation of M&E plan and its tools
HIV TWG	· Provides technical oversight in the implementation of the National M&E Plan
NACP M&E Team	· Monthly and quarterly review meeting to monitor progress in implementing clinical aspects of the M&E plan
Ministries	· Ensure active integration of M&E into the HIV sector and support efforts of the implementation of M&E Plan · Plan and budget for M&E activities in the department · Provide information related to the HIV response as requested in reporting lines and the M&E Plan
CSO, FBO, NGO	· Ensure M&E is mainstreamed in all HIV / AIDS activities · Monitor and evaluate HIV / AIDS activities and report to the NAC M&E unit · Align M&E programs to the national HIV M&E Plan
Development Partners	· Provide technical assistance to implementation of M&E Plan · Assist the NAC M&E unit in mobilizing resources to implement the M&E Plan · Adhere to M&E Plan, workplan and reporting requirements
Health Facilities	· Order and maintain adequate stocks of data collection tols · Proper filing and storage of completed forms · Monthly consolidation of data / statistics as per templates · Timely submission of complete reports to reporting lines
County Coordinators	· Provide oversight on M&E plan implementation and reporting processes

6.2. Communication of Plan

It is important for all stakeholders contributing to the implementation of the M&E Plan to be aware of and familiar with the M&E plan so that they are clear about their role and responsibility in ensuring effective tracking of activities to prevent the transmission of HIV and to treat and care for those living with or affected by HIV and AIDS. The plan will be distributed widely electronically and hard copies to umbrella/coordinating bodies of key stakeholders, individual implementing agencies and health facilities, development partners.

6.3. Technical assistance needs to implement plan

Focal / coordinating units for the implementation of the M&E plan which include: NAC M&E unit; the MOH HIV and AIDS Unit/ NACP; the sectoral ministries' planning and HIV and AIDS Units; the County (CHT, CAC, ministry departments) and which are responsible for M&E; the Secretariats of Stakeholders' umbrella agencies and Networks shall be supported with minimum necessary logistics by NAC and development partners.

The minimum logistics required by the units responsible for coordinating HIV and AIDS interventions to undertake their core functions shall be elaborately defined and reviewed annually by the National MESIM TWG.

Informed by the assessment of needs undertaken every two years, the ME/SI TWG working through NAC or outsourcing to an appropriate service provider shall mobilize and provide logistical and technical support using common M&E plan budget/ funding under the National Operational Plan (NOP) or the identified development partners may provide technical support services directly as long as it's in line with the NOP.

The undertaking of major and specialized M&E/SI activities in the Plan such as surveillance, the ME/SI TWG through NCO shall specifically, as has been the case in the past, solicit technical support from the specialized agencies such as UNAIDS and WHO to help in availing non regular resource persons /technical assistance to assist the such planned undertakings.

In event of availing such non-regular or external technical support, the following considerations are important for execution of effective procurement of the technical assistance:

- the development of a clear scope of work contained in a terms of reference and;
- the assignment be appraised by a national TWG
- shall be undertaken in close partnership with regular technical staff of the host agency and/or national consultant, where possible, so that mentorship and capacity building as well as the national response memory is enhanced for sustained response purposes as long as it does not compromising the objectivity of the exercise in question.

7. Performance Framework

** Denotes global standard indicators from Global AIDS Response Progress Report*

7.1. Impact Level Results and Indicators

NSP Impact Results	Indicators (Core indicators in bold)	Baseline Value, Source & Year	Data Sources	Performance Targets					
				2015	2016	2017	2018	2019	2020
Reduction of new HIV infections by 50% from 1789 in 2014 to 895 by 2020	1. % women and men aged 15-24 who are HIV infected*	1.1%; DHS 2013	DHS				0.7%		
	2. % pregnant women aged 15-24 who are HIV infected*	1.8%; ANC Sero Survey 2013	ANC Sero Survey				1.2%		
	3. Percentage of selected key populations who are HIV infected*	MSM: 19.8% FSWs: 9.8% PWIDs: 5% (2013 IBBSS)	IBBSS		19.0% 9.0% 4.5%			12.5% 6.0% 3.0%	
	4. Estimated total number of new infections annually	1789; NACP Spectrum Modeling 2014	NACP Spectrum Modeling	1789	1611	1433	1255	1077	895
Sexual transmission of HIV infections in adults 15-49 years reduced by 50% from 1386 new HIV infections in 2014 to 693 in 2020	5. New HIV infections in adults 15-49 years *	1386; NACP Spectrum Modeling 2014	NACP Spectrum Modeling	1386	1246	1106	966	826	693
Survival of adults & children on ART improved from 74% in 2014 to 85% by 2020	6. % adults and children with HIV known to be on treatment 12 months after initiation of ART *	74%; ART Cohort Study 2013	ART Cohort Study	78%	80.0%	82.0%	83.0%	84.0%	85%
Elimination of Mother-to-Child transmission of HIV	7. Percentage of infants born to HIV infected mothers who are infected with HIV at six weeks*	9.6%; PMTCT Impact Study 2012	PMTCT Impact Study	5.6%	4.2%	3.0%	2%	1%	0.0%
	8. Percentage of infants born to HIV infected mothers who are infected with HIV at the end of breastfeeding*	24.3% PMTCT Impact Study 2012	PMTCT Impact Study	18.3%	16.3%	14.3%	12%	10%	9.75%
Reduction in Socio-economic effects /impact of HIV &AIDS	9. Current school attendance among orphans and non-orphans (6-10, 10–14, 15- 18 years old, primary school age, secondary school	N/A	H/Hold survey				TBD		TBD

NSP Impact Results	Indicators (Core indicators in bold)	Baseline Value, Source & Year	Data Sources	Performance Targets					
				2015	2016	2017	2018	2019	2020
	age)*								
	10. % of HIV affected Households in extreme poverty	N/A	H/Hold survey				TBD		TBD

7.2. Performance at Outcome and Output Levels

7.2.1. *Preventing New HIV Infections – Non Clinical*

Preventing HIV Infection in the General Population

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Output									
Adults 15+ years are adapting behaviors that reduce the risk of HIV infection from sexual intercourse.	11. % 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%		
	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%		

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

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									

New HIV infections in young people reduced	13. % young women and men 15-24 years who have comprehensive knowledge on HIV prevention & transmission & reject major misconceptions on HIV prevention & transmission *	Female = 67% Male = 59%	LDHS 2013				94% 90%		
	14. % young women and men 15-24 years who had 2+partners in the last 12 months *	Female= 8.6% Male = 12%	LDHS 2013				6.5% 9%		
	15. % 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=5.6% Male = 32%	LDHS 2013				80.% 84%		
	16. % young women and men aged 15-24 years who had sex before the age of 15 *	Men: 8.5% Women: 7.2%	LDHS 2013				4.8% 9%		
	17. % young women and men 15-24years who are living with HIV *	1.1% (women and men) (2013 LDHS)	LDHS 2013				0.6%		

Preventing HIV Transmission by PLHIV

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
People living with HIV are actively involved in preventing the transmission of HIV.	18. % of PLHIV practicing safe sex and other non sexual behavioral practices to prevent HIV re-infection and transmission	N/A	Positive living & Stigma Index surveys						
	19. % of Health Facilities using PLHIV Counselors		MOH Prog						
Output									
Increased retention rate of PLHIV not on ART at 12 months follow-up	20. % of adult & children not on ART retained in care at 12 months of follow-up *	24.7% ART Cohort Study ..Yr	ART Cohort Study	33%	36%	39%	43%	47%	50%
Increased retention rate of PLHIV on ART at 12 months follow-up	21. % of adults & children on ART retained in care at 12 months of follow-up *(numbered 6 above)* *	69.9% ART Cohort Study ..Yr	ART Cohort Study	74%	76%	78%	80%	82%	85%

7.2.2. *Preventing New HIV Infections – Clinical Prevention*

HIV Testing and Counselling

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Output									
Increased number and percentage of people are tested, counseled and know their results	22. Number and Percentage of women & men who received HIV test in last 12 months & know their results *	209,381 10% 2013 NACP prog Data)	(NACP prog Data)	285,192 (13%)	337,756 (15%)	344,858 (16%)	352,101 (16%)	359,495 (16%)	367,044 (17%)
Increased number of health facilities providing HIV counseling and testing services according to national guidelines	23. Number and percentage of health facilities providing HIV counseling and testing services according to national guidelines	335 (..%) 2013 NACP prog Data)	(NACP prog Data)	455 (..%)	498 (..%)	540 (..%)	583 (..%)	626 (..%)	669 (..%)

Blood Safety

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
The Blood Safety Program of the MOHSW is meeting the national need for safe blood (OC)	24. Percentage of donated blood units screened for HIV in a quality-assured manner	100%	MOH Prog Data	100%	100%	100%	100%	100%	100%
	25. % of health districts, Hospitals & Health Centers that have not had any blood stock outs in the last 6 months		MOH Prog Data	7.5%	12.5%%	20%	25%	40%	60%
Output									
35,000 units of safe blood are available for transfusion by 2020	26. Number & % units of safe blood available for transfusion	12,500(36%) ;2013 NACP prog Data	(NACP prog Data)	16,259 (46%)	23,750 (57%)	23,750 (68%)	27,500 (79%)	31,250 (89%)	35,000 (100%)
	27. # & % of relevant staff trained in blood safety & Universal Safety Precautions	3; (2013 NACP prog Data)	NACP prog Data	12	5	5	5	5	5

3 additional blood banks are constructed in the country.	28. Cumulative number of functioning blood banks in the country	2 (Monrovia & Phebe); 2013 NACP prog Data	(NACP prog Data)	3	4	5	5	5	5

Post Exposure Prophylaxis (PEP)

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
Vulnerable populations have access to PEP services	29. Number of people who have accessed PEP services at health facilities	TBD					TBD		
Output									
Increased access to quality PEP services	30. % of eligible health facilities with active & quality PEP services (quality - full range of PEP services includes first aid, counseling, HIV testing, provision of ARVs, patient follow-up & support)	TBD					TBD		

Management of Sexually Transmitted Infections (STIs)

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
Patients with sexually transmitted infections are managed according to National STIs Guidelines.	31. Number of patients receiving diagnosis and treatment for STIs according to national guidelines	168,865	MOH Prog Data	197,440	193,052	188,665	184,277	179,890	175,502
	32. Percentage of women accessing antenatal care (ANC) services who were tested for syphilis *	TBD	ANC Study						
	33. % of antenatal care attendees positive for syphilis who received treatment *	TBD	ANC Study						

7.2.3. *HIV Prevention Programs for Key Populations (KPs)*

Programs for Key Populations

Results	Indicators	Baseline Value, Yr & Source	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
New HIV infections in Key Populations are reduce	34. % FSWs who are living with HIV) *-(taken care of in the impact indicators)**	9.8%	IBBSS		7%			5%	
	35. % MSM who are living with HIV *-(-(taken care of in the impact indicators)**	19.8%	IBBSS		15%			10%	
	36. % PWIDs who are living with HIV *(-(taken care of in the impact indicators)**	3.9%	IBBSS		3%			2.5%	
Output									
Increase in Key Populations reached with and using HIV prevention programs	37. % FSWs reporting the use of a condom with their most recent client *	81.7%	IBBSS		88%			95%	
	38. % FSWs who received an HIV test in past 12 months and know their results *	31.3%	IBBSS		53%			75%	
	39. % MSM reporting the use of a condom the last time they had anal sex with a male partner *	19.5%	IBBSS		52%			85%	
	40. % MSM that have received an HIV test in past 12 months and know their results *	44.4%	IBBSS		61%			77%	
	41. % PWIDs reporting the use of a condom the last time they had sexual intercourse *	44.3%	IBBSS		66%			87%	
	42. % PWIDs who received an HIV test in the past 12 months and know their results *	27.9%	IBBSS		50%			73%	

7.2.4. *Condom Promotion and Distribution*

Condom Promotion and Distribution

Results	Indicators	Baseline Value, 2014 NSP est	Data Sources	Targets (from NSP)					
				2015	2016	2017	2018	2019	2020
Output									

Male and female condoms are available in the country to meet annual demand for family planning and prevention of STIs including HIV.	43. Number and % of male & female condoms procured	Male	101,053,944	MOH Prog data	103,116,269	105,220,683	107,368,044	109,559,228	111,795,131	114,076,664
		Female	1,100,000	MOH Prog data	1,123,560	1,147,150	1,171,240	1,195,840	1,220,950	1,246,590
	44. % of Health Facilities and service outlets that experienced Condom stock outs in the last 6 months	Male	TBD	MOH Prog data						
		Female.	TBD	MOH Prog data						

7.2.5. *HIV Treatment, Care and Support*

Treatment for HIV Positive Pregnant Women (Option B+)

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
HIV infections from HIV positive women delivering in the last twelve (12) months reduced by 2020.	Estimated percentage of infants born to HIV infected mothers who are infected with HIV at six weeks *	13% PMTCT Impact study 2012	MOH Prog data PMTCT Impact study	8.6%	7.7%	6.6%	4.8%	3.9%	1.0%
	Estimated percentage of infants born to HIV infected mothers who are infected with HIV at the end of breastfeeding *	24.6% PMTCT Impact study 2012	MOH Prog data PMTCT Impact study	21.8%	19.4%	17.0%	14.6%	12.2%	9.7%
Output									
The number of HIV positive pregnant women receiving ART (Option B+) increased	45. # & (%) 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%)
	46. # HIV+ pregnant women placed on ART (Option B+) *	664	1,193	1,141	1,092	1,047	1,006	968	932

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
	47. % 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%)
	48. % 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%
	49. % infants born to HIV positive mothers who received antiretroviral 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%)
	50. # &% of health facilities that offer adult and paediatric antiretroviral therapy *	335	373	411	449	486	524	562	600

Antiretroviral Treatment (ART)

Results	Indicators	Baseline Value, Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
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	51. % adults & children with HIV known to be on treatment 12 months after initiation of ART *	74. % 2013 ART Cohort Study	TBD	75%	77%	79%	81%	83%	85%
Output									
Number and percentage of adults and children currently receiving antiretroviral therapy among all eligible PLHIV. Increased	52. percentage of adults (15+ years) on ART *	6,520 (35%)	MOH ART Cohort Study	8859 (46%)	10034 (53)	11585 (62%)	12955 (70%)	14140 (77%)	15,499 (85%)
	53. percentage of children on ART *	378 (10%)	MOH prog data	1,292 (30%)	1,630 (40%)	2,325 (60%)	2,592 (70%)	2,846 (80%)	3,493 (100%)
	54. # HIV exposed children on cotrimoxazole prophylaxis *	NA	MOH prog data	2038 (47.8 %)	2344 (58.3%)	2640 (68.7%)	2922 (79.1%)	3198 (89.6%)	3490 (100%)
	55. Number and percentage of people living with HIV and AIDS receiving nutritional support	NA	MOH prog data	4466 (44%)	5365 (46)	6429 (46%)	6842 (44%)	7134 (42%)	7597 (40%)

Results	Indicators	Baseline Value, Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
	56. Number of health facilities that offer ART *	46	MOH prog data	61	68	74	81	88	96
	57. % of Health Facilities that experienced ARV stock outs over the last 6 months *	TBD	MOH prog data						

HIV - TB Co-Infection Management

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
The HIV/TB co-infection rate reduced (OC)	58. % TB patients that have HIV infection *	16% (2013)	MOH Prog data;			12%			8%
Output									
Number and percentage of HIV positive TB cases that received treatment for both TB and HIV increased	59. Estimated TB cases (All Forms)	12,343	LNTCP	12,791	13,252	13,728	14,217	14,721	15,240
	60. TB Cases expected to be notified (All Forms)	9380	LNTCP	10233	11132	12080	13080	14132	14630
	61. Number (%) of TB patients that were tested and counseled for HIV and know their results	(5989) 77%	79% (7,410)	81% (8,289)	83% (9,240)	85% (10,268)	87% (11,380)	88% (12,436)	90% (13,167)
	62. 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)
	63. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV *	33%	40%	48%	56%	64%	72%	80%	85%

7.2.6. *Critical Social and Programmatic Enablers*

Laws, Policies and Stigma and Discrimination

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
Stigma, discrimination, and punitive approaches related to HIV reduced. (OC)	Percentage of people with accepting attitudes towards PLHIV *	40% (DHS 2013)	NAC/DHS				60%		
Output									
Increased access to HIV-related legal services.	64. # & % of PLHIV that accessed legal support when felt stigmatized or segregated against	TBD	NAC Prog Data	10%	20%	30%	35%	40%	50%
Monitoring and reformulation of laws, regulations and policies relating to HIV improved.	65. Number of different laws repealed/ policies reviewed to avoid punitive element and enhance enforcement in combating stigma	TBD	NAC Prog Data	0	2	1	1	0	1
Increased Legal Literacy ("know your rights") on HIV and human rights.	66. Number of PLHIV and affected populations and vulnerable population trained in HIV and AIDS human rights violations, abuse and protection	TBD	NAC/Prog Data	200	300	500	600	1000	1000
Lawmakers and law enforcement agents sensitized on HIV and human rights.	67. Number of law and Policy makers trained in HIV, Human rights	TBD	NAC/Prog Data	50	200	200	400	400	500
Training for health care providers on human rights and medical ethics related to HIV increased/ expanded.	68. Number &% of health workers trained human rights, ethics in the context of care HIV prevention and care	TBD	NAC/Prog Data	300	500	500	500	500	500
Increased participation of communities in reduction of discrimination against women (and sexual and Gender based violence) in the context of HIV.	69. Number of communities that participated in campaigns against discrimination against women (and sexual and Gender based violence) in the context of HIV.	TBD	NAC/Prog Data	100	200	250	300	500	500

Media

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
Partnership between the mass media and the national HIV response enhanced.	70. Number of mass media institutions involved in national response to HIV & AIDS activities	26 (AAMIN 2015)	NAC/AA MIN Data	35	45	55	65	75	85
	71. Number of media practitioners writing HIV related articles in major media outlets or platforms	49 (AAMIN 2015)	NAC/AA MIN Data	60	85	110	135	160	185
Output									
Regular briefings on HIV and AIDS for the press by responsible national and county HIV and AIDS authorities.	72. Number of press/ media briefings on the national response developments in the last one year	5 (NAC 2014)	NAC/Prog Data	5	10	10	10	10	10
Making public service messages and original programming available to other outlets on a rights-free basis.	73. Number and proximity of public service messages accessible to public	30 (NAC 2015)	NAC/Prog Data	50	50	75	100	100	150

Political Commitment, Private sector and CSO involvement and Advocacy

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
GOL makes adequate funding, staff, and material resources available for the national HIV response (OC)	74. Percentage of HIV response funded by Government funding *	2% (NASA 2012)	NASA	5%	7%	10%	10%	10%	15%
Output									
Participation of High level government officials in key HIV and AIDS functions	75. Number and frequency of high level political leaders engaged in HIV and AIDS functions (AIDS day, Campaigns against SGBV, Stigma reduction, service access, HCT and blood donation...)	75 (NAC 2015)	NAC/Prog data	100	100	100	100	100	100
High-level meetings with private sector, media,	76. Number of private sector companies engaged in HIV and AIDS partners	5 (NAC/MoL 2015)	NAC/MoL data	10	15	20	25	30	20

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
and CSOs held annually	meetings								
The private sector commitment, involvement, funding and service delivery of HIV and AIDS prevention, treatment, care and support programmes/ services increased	77. Number of large private sector companies with workplace HIV and AIDS policies and programmes.	2 (MoL 2014)	NAC/MoL data	5	7	9	11	13	15
	78. % of response funded by private sector companies *	TBD	NASA						
The CSO, FBO, CBO sector commitment, involvement, advocacy and resource mobilization and service delivery of HIV and AIDS prevention, treatment, care and support programmes/ services increased	79. Number of CSOs, FBOs, CBOs implementing HIV and AIDS prevention, treatment, care and support programmes/services increased	25 (NACP 2013)	NAC/PSI data	30	35	40	45	50	55

Community Participation in HIV Response

Results	Indicators	Baseline Value, Yr & Source	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
Active community participation in the HIV response is strengthened	80. Number of organized community support groups active in HIV and AIDS in prevention, care and support (by counties, Districts & categories)	5 (2014 SHALOM)	NAC Prog Data	10	15	20	25	30	35
Output									
Traditional and religious leaders in the communities identified and their knowledge on HIV and AIDS effective leadership.	81. Number of key traditional and religious leaders whose capacities have been strengthened to provide leadership for community level HIV activities (by counties, Districts & categories)	850 (2015 NAC/LCC)	NAC/Prog Data	1000	1000	1000	1000	1000	1000
Umbrella groups and networks of local CSOs and FBOs whose capacities have been strengthened spearhead community level HIV and AIDS activities.	82. # & % of umbrella groups & networks of local CSOs & FBOs whose capacities have been strengthened to spearhead community level HIV & AIDS activities. (by category, counties, Districts)	4(2015 NAC)	NAC/Prog Data	10	20	30	40	50	60

Coordination and Management of the National HIV Response

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
Management and coordination capacities for the national HIV response improved.	83. Number of stakeholder TWGs held by NAC at national, sectoral and different constituency (ie CSOs, private sector organizations, line ministries and other government departments and agencies) levels and county levels held/ organized/ facilitated	5 (NAC 2014)	NAC data	8	10	10	10	10	10
	84. Existence of coordination offices, structures and guidelines for national, sectoral and county and community level HIV and AIDS programmes	5 (NAC 2015)	NAC data	5	8	10	12	15	15
Output									
NAC Board of Directors meetings organized regularly	85. Number of scheduled and emergency NAC Board meetings held in a year	1 (NAC 2014)	NAC data	2	2	2	2	2	2
	86. participation rates of the different constituencies of the board meetings	TBD							
Advocacy and resource mobilization drives/ campaigns undertaken	87. Number of advocacy and resource mobilization drives/ campaigns undertaken and proposals submitted by NAC and other partners	10 (NAC 2013)	NAC data	5	10	15	20	25	30

Funding Resource Needs of the National HIV Response

Results	Indicators		Baseline Value; Source & Year	Data Sources	Targets					
					2015	2016	2017	2018	2019	2020
Outcome										
Domestic sources of funding for the national HIV response increased/ diversified	88. Domestic contribution as a percentage of total spending on national HIV response *		2% (2011/12, NASA 2013)	NASA	5%	7%	10%	10%	15%	15%
		Central Govt	2% (NASA 2013)	NASA	5%	7%	10%	10%	15%	15%

Results	Indicators		Baseline Value; Source & Year	Data Sources	Targets					
					2015	2016	2017	2018	2019	2020
		Counties govt	N/A	NASA	1%	2%	2%	3%	5%	5%
		Private	N/A	NASA	2%	2%	4%	5%	5%	5%
		Communities	N/A	NASA	0.3%	0.9%	1%	1%	1%	1.5%
		Out of Pocket/ individual	45 (NAC 2013)	NAC	0.5%	0.5%	0.5%	0.5%	0.8%	1%
		Cost recovery								
	89. Number of different sources of domestic funding for the national HIV response		(Fund raise & Finance dept)	NASA						
Output										
External sources of funding for the national HIV response increased/ diversified	90. Number of different sources of external (multilateral, bilateral, corporations, foundations, trusts) funding for the national HIV response		(Fund raise & Finance dept)	NASA, NAC prog data						
Different funding mechanisms to scale up national response	91. Number of funding channeled through these different funding mechanisms to scale up national response		3 (NAC 2013)	NASA,	3	5	5	8	10	10

Monitoring, Evaluation and Research

Results	Indicators	Baseline Value, Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Output									
Strengthened leadership, structures, planning, coordination of HIV and AIDS M&E	92. Number of planned Regular M&E/SI , Programme review /coordination meetings of M&E TWGs, task forces and Committees at National, Sectoral / line ministries, county & Networks/ umbrella organizations	4 (NAC 2014)	NAC/Prog Data	4	4	4	4	4	4
Strengthened systems and increased capacity for routine HIV & AIDS programme Monitoring	93. Number of staff from implementing partners trained on M&E	5 (NAC 2013)		50	100	200	300	400	500
	94. # of national, sectoral, thematic & county progress reports produced			NAC 2 County 4	NAC 2 County 4	NAC 2 County 4	NAC 2 County 4	NAC 2 County 4	NAC 2 County 4

Results	Indicators	Baseline Value, Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
	95. A national master data base at NAC & sub national data bases established	0 (NAC 2014)		1	3	5	8	10	15
Strengthened systems and capacity for HIV and AIDS biological and behavioral surveillance, surveys and research	96. # of the scheduled /planned surveys, surveillance, assessments, studies rounds and research conducted as per the M&E Plan	4 (NAC 2013)							
	97. A National HIV and AIDS Research and Evaluation Agenda available			1					
	98. National annualized epidemiological analyses, estimates available								
	99. Mid Tern Evaluation of NSP					1			
	100. End of term Evaluation (2019/20)								1
Strengthened systems and capacity for HIV and AIDS Information dissemination, utilization, learning & Knowledge Management	101. a national HIV & AIDS information dissemination and knowledge management strategy including guidelines for best practices identification and transfer/scale up created			1					
	102. # of planned user friendly HIV & AIDS information products at National and County produced								

7.2.7. *Synergies with Development Sectors*

Health Systems Strengthening

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
The GOL 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.	103. % of Govt annual budget on health sector	9.53%	MoH						15%
Output									
Human Resources for Health	104. % of established Health sector HR filled		MoH						

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Adequate HRH available and equitably deployed.	105. Equitable distributed HRH available		MoH						
Health workers retention policy developed and implemented.	106. Health workers retention policy in place and functional		MoH						
Procurement and Supply Chain Management	107. A functional Health sector PSM system		MoH						

Community System Strengthening (CSS)

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
Strengthened community systems making significant contributions to achieving the outcome of the national HIV response	108. # of CBOs & FBOs whose governance, management, resource mobilization, & M&E systems have been strengthened	NA	NAC & PSI	2 (150)	3 (300)	5 (300))	0 (300)	0 (300)	7 (300)

Education Sector Response *(synergies)* to HIV

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
All grade schools in Liberia are benefiting from Life Skills and HIV Prevention Program by 2020	109. Percentage of schools reached with life skills–based HIV education for Grades 1 to 12	43% (MoE 2013)	MoE	50%	60%	70%	80%	90%	100%
Output									
	110. Number of school health clubs established	124 (MoE 2013)	MoE & MPCHS	120	250	350	450	500	500

	111. Number of schools with trained teachers on life skills and HIV prevention	200 (MoE 2014)	MoE & MPCHS	250	300	350	400	450	500
	112. Number of schools teaching sessions on life skills and HIV prevention	N/A	MoE & MPCHS	200	250	300	350	400	450

Workplace HIV Programs

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Outcome									
The public and private sectors have HIV Workplace policies.	113. # & % of public sector line ministries, agencies & large private companies with functional HIV Workplace Policies and programmes	5 (MoL 2013)	MoL	10	100	200	300	400	500
Output									
Reviewed National Workplace Policy incorporates HIV and AIDS issues.	114. # of public sector line ministries and agencies with HIV and AIDS mainstreamed into policy/mandate and core businesses.	60 (NAC 2103)	MoL & NAC	60	70	80	90	100	100

Mitigating the Socioeconomic Impact of HIV and AIDS

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Basic needs of poor AIDS-affected households are met	115. Number of counties reached with Social Cash Transfers	2	MOGCSP	TBD	TBD	TBD	TBD	TBD	TBD
	116. # & % of PLHIV & other vulnerable H/holds provided with economic support in previous 3 months		DHS 2013						
	117. Number of PLHIV, OVC and / or other vulnerable Households provided with livelihood skills training	40 (MPCHS 2014)	LIBNEP+ & MGCSP	500	600	700	800	900	1000

Stigma and Discrimination

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets					
				2015	2016	2017	2018	2019	2020
Stigma and discrimination against people infected and affected by HIV reduced.	118. % PLHIV who report they have experienced stigma and discrimination from other people is reduced	2013 Liberia PLHIV Stigma Index Study 30% in 2013					20%		10%
	119. % women and men aged 15–49 with discriminatory attitudes towards PLHIV is reduced	30% (DSH 2103)	DHS 2013				15%		10%
Output									
PLHIV and support groups educated on their human rights.	120. Number of PLHIV and support groups trained on advocacy, SDD campaign management and human rights	1000 (LIBNEP+)	LIBNEP+	1000	2000	3000	4000	5000	5000
Health workers trained on confidentiality of information on PLHIV.	121. Number of health workers trained on confidentiality of information on PLHIV.	5000 (NACP)	MoH	6000	7000	8000	9000	10000	10000

Annex: Indicator Definition