NATIONAL HIV/AIDS STRATEGIC FRAMEWORK II

2010-2014

National AIDS Commission
Republic of Liberia

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FOREWORD

The completion of the National HIV/AIDS Strategic Framework II 2010-2014 is a significant milestone in the prevention and control of the pandemic in Liberia. With restoration of peace and increased access to all parts of the country, Liberia faces the greatest threat to the increased incidence and spread of the HIV epidemic throughout the country. We must therefore mobilise all national sectors and partners and other stakeholders for a coherent and effective support to prevent the spread and control the HIV epidemic in Liberia.

Efforts to prevent and control HIV and AIDS remain a high priority on the national development agenda. All government agencies are urged to effectively mainstream and scale up HIV/AIDS programmes in their respective sectors and areas of special advantage. The office of the President, through the National AIDS Commission of Liberia, is committed to strengthening the coordination and management of the national response, monitoring and tracking the utilisation of all resources to ensure that value is added to HIV & AIDS funding for national development. The National Strategic HIV/AIDS Framework (2010-2014) is a policy and strategic document that will guide the National AIDS Commission (NAC), the line ministries, the UN Theme Group on HIV/AIDS, NGOs, CBOs, FBOs, and other stakeholders associated with the prevention, control, care and treatment of HIV/AIDS in Liberia.

Our expectation is that the National HIV/AIDS Strategic Framework (2010-2014) will serve as a basis for strengthening the generation of strategic information on the epidemic and providing a framework for a multi-sectoral response. The movement from a purely health response to a multi-sectoral one is a manifestation of a strong desire by Government to scale up the universal access to treatment, care and support services to all Liberians. This strategy also places emphasis on the need to continuously monitor the trend of the epidemic in order to effectively devise plans and programmes to mitigate the spread of the epidemic.

We applaud our development partners, donors, civil society, the private sector and all other stakeholders for their continuous support to the national response to HIV & AIDS. I take this opportunity to strongly endorse Government's commitment to ensuring that the necessary environment prevails for all partners and stakeholders to actively participate and contribute meaningfully towards the achievement of the goals of the National Strategic Framework. The process of developing a new national multisectoral response has been marked by an all-inclusive effort that involves the National AIDS Commission, line ministries, the UN Theme Group on HIV/AIDS, and other stakeholders associated with the response to the HIV/AIDS epidemic in Liberia. I urge all Liberians of reproductive and sexually active age especially the youth, to take personal responsibility to avoid risky sexual behaviours that endanger personal health and accelerate an upsurge in new infections and the burden of the epidemic. I call upon the three branches of Government – the legislative, judiciary, and executive, to be vigilant in mobilising all resources and all communities to access HIV/AIDS services.

Mrs. Ellen Johnson-Sirleaf
President of the Republic of Liberia
Chair of the National AIDS Commission

PREFACE

The development of the new national multisectoral response has been an all-inclusive process involving the National AIDS Commission, the line ministries, the UN Theme Group on HIV/AIDS, and other stakeholders associated with the response to HIV/AIDS in Liberia. This National HIV/AIDS Strategic Framework II (NSF) (2010-2014) is a coordinated tool for the national response developed from the efforts and experiences of the national HIV/AIDS partnership. The framework sets priorities for the five thematic service areas of Coordination and Management of the Decentralised Response, Infection Prevention and Promotion of Behavioural Change, Treatment, Care and Support, Strategic Information Management, Policy Advocacy and Enabling Environment. It also outlines priorities for strengthening service delivery systems.

A team comprised of international and local consultants and stakeholders worked tirelessly to develop a draft document which was reviewed and commented on by the technical task team and later finalised to produce a document now known as the National HIV/AIDS Strategic Framework II (NSF) (2010-2014 for the national response to the HIV/AIDS epidemic in Liberia. The participatory process through which the NSF was developed has renewed the commitment of the National AIDS Commission of Liberia, and it increased the motivation and thinking about the road map to the country's vision of a population free of HIV. The National HIV/AIDS Strategic Framework II will be a key tool for implementation coordination and oversight of the national response for the next five years. It is my sincere hope that all partners, including donors and implementers will, to every extent possible, align their support and interventions to the priorities of the National HIV/AIDS Strategic Framework II and collectively contribute to the achievement of the targets in the most cost-effective way.

The Government of Liberia is strongly committed to designing effective resource mobilisation strategies and mechanisms for accountability, and their application for greater impact. Mainstreaming gender, sexual, and reproductive health rights will be crucial in enabling strategic positioning to address the phenomena of high discordance rates, the vulnerability of women and high risk groups. It is only through aligning to the National HIV/AIDS Strategic Framework II that the goals and objectives of the national response to HIV/AIDS will be achieved by 2014. This NSF II will prevent new HIV infections and HIV-related deaths and improve the quality of life of men, women and children living with HIV, and will contribute to the attainment of the Millennium Development Goals especially the Sixth Goal… to halt and reverse the AIDS epidemic.

With the establishment of the National AIDS Commission, we urge all of our partners to join us in identifying the means of support and work together as a team to prevent the spread of the HIV epidemic, especially among women of reproductive age and mitigate its impact on our people.

Ivan Camanor, MD, MPH&TM, FWACP
Executive Director
National AIDS Commission

ACKNOWLEDGEMENTS

Numerous organisations and individuals, in the past two and a half years, have been involved in developing and writing this strategic framework. Without their dedication and commitment, this document would not have been completed. It was an honour to work with all of our partners who shared their perspectives, expertise, and resources.

The National Steering Committee acknowledges with profound appreciation the significant financial and human resource contributions of Liberia's international partners, particularly UNAIDS, the Global Fund, UNICEF, WHO, USAID, faith-based organisations and the World Bank (ASAP), to the development of the National HIV/AIDS Strategic Framework. This framework will serve as the blue print for all HIV/AIDS interventions within the Republic of Liberia. We would also like to thank all of the stakeholders and PLHIV who ensured that this framework reflects the multisectoral approach of the national response to this epidemic.

None of this work would have been possible without the support of the staff of the National AIDS and STI Control Programme, who served as the secretariat for the strategic framework development and completion.

Lastly, we thank all who took time from their busy schedules to draft, read and edit this document. The feedback and suggestions were invaluable.

Juanita Ramirez, RN, MSN
Chairperson
National Steering Committee

ABBREVIATIONS USED

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal clinic
ART	Antiretroviral therapy
ARV	Antiretroviral
ASAP	AIDS Strategy and Action Plan
BCC	Behaviour-change communication
BPHS	Basic package of health services
CBO	Community-based organisation
CHT	County health team
CHW	Community health worker
CSO	Civil society organisation
SW	Sex Worker
DHS	Demographic and Health Survey
FBO	Faith-based organisation
FP	Family planning
GFATM	Global Fund to Fight AIDS, TB and Malaria
GoL	Government of Liberia
HCT	HIV counselling and testing
HIV	Human immunodeficiency virus
HMIS	Health management information system
IDP	Internally displaced person
IEC	Information, education and communication
IMR	Infant mortality rate
INGO	International non-government organisation
LDHS	Liberia Demographic Health Survey
LCM	Liberia Coordinating Mechanism
LISGIS	Liberian Institute for Statistics and Geo-Information Systems
LOAF	Liberia Orphans of AIDS Foundation
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MoD	Ministry of Defence
MoE	Ministry of Education
MoG&D	Ministry of Gender and Development
MoHSW	Ministry of Health and Social Welfare
MIA	Ministry of Internal Affairs
MPCHS	Mother Patern College of Health Sciences
MSM	Men who have sex with men
NAC	National AIDS Commission
NACP	National AIDS & STI Control Programme
NDS	National Drug Supply Service
NGO	Non-governmental organisation
OI	Opportunistic infection
OVC	Orphans and vulnerable children
PA	Physician assistant
PEP	Post-exposure prophylaxis
PITC	Provider-initiated testing and counselling
PLHIV	People living with HIV
PPTCT	Prevention of mother-to-child transmission

PRS	Poverty Reduction Strategy
STI	Sexually transmitted Infection
SGBV	Sexual and gender-based Violence
UNAIDS	United Nations Joint Programme on AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Foundation
USAID	United States Agency for International Development
USD	United States Dollar
VCT	Voluntary counselling and testing
WHO	World Health Organisation

EXECUTIVE SUMMARY

The National HIV/AIDS Strategic Framework II succeeds the first NSF, which expired in 2007, to guide Liberia's national HIV response for the period 2010-2014. Key priorities include improving the coverage and quality of existing prevention, care and treatment services, and strengthening the involvement of non-health government sectors, civil society and the private sector. The NSF II priorities are based on an in-depth analysis of 1) Epidemiological data; 2) Drivers of the epidemic and key populations at risk; and 3) Lessons learned from previous programmes and services.

The Epidemiology of HIV in Liberia

The scarcity of reliable HIV-prevalence data makes it difficult to get an accurate picture of the state of the HIV epidemic in Liberia. To date, the 2007 population-based *Liberian Demographic and Health Survey* (LDHS) provides the most reliable data on HIV prevalence among the general population. LDHS results show an HIV rate of 1.5 percent (1.3% HIV-1; 0.2% HIV-2) among the general population aged 15-49, indicating a low-level, generalised epidemic. Overall, the HIV rate among women is higher (1.8%) than among men (1.2%), revealing women's higher vulnerability to HIV infection. The difference in HIV rates between women and men is particularly strong in the younger age groups, with 1.3 percent among females against only 0.4 percent among males in the 15-19 years age group, and 2.0 and 0.7 percent respectively in the 20-24 years age group. This highlights the particular vulnerability of young women and girls. Furthermore, LDHS data reveal significant differences between urban and rural settings, with overall HIV rates in urban areas at 2.5 percent (and 2.9% in Monrovia) against only 0.8 percent in rural areas. This urban-rural divide is further corroborated by results of the two facility-based studies among women attending antenatal care (ANC) clinics in 2006 and 2007, which show a peak prevalence of 10.4 percent in one urban health centre, and rates of 7 percent or more in four out of 13 urban clinics, but lower rates in two rural sites. LDHS data further show higher HIV rates in the eastern and western border regions, which may be associated with trans-border mobility. Thus, the overall HIV prevalence rate of 1.5 percent masks the fact that HIV is in fact *well established* among the general population in urban settings, with an average rate of 2.5 percent. The real extent of the HIV epidemic is further blurred by the lack of any HIV-prevalence data on most-at-risk populations, such as sex workers and MSM. Future studies are likely to reveal much higher rates among these groups, as well as among bridge populations, such as clients of sex workers (including mobile men) and MSM who have female sex partners as well. Furthermore, TB-HIV co-infection is a major problem, as evidenced by the fact that more than one-fifth of TB patients who underwent HIV testing were HIV-positive.

Drivers of the HIV Epidemic

Structural socio-economic and cultural factors increase people's vulnerability to HIV, thus driving the HIV epidemic. The impact of war, poverty and the breakdown of communities, the public health system and other government support systems, have left large parts of the population vulnerable to HIV infection. The war has left the country with an estimated 270,000 dead, a devastated infrastructure, the collapse of the economy and generalised extreme poverty, and the breakdown of critical services, most importantly in the health, education and social support systems.

The vast majority of the population lives in *extreme poverty*, whose dimensions include high unemployment; poor nutrition and food security; and low health and education indicators. Women are particularly vulnerable to poverty, especially in rural areas, because of their more limited access to employment and basic services such as health and education. In addition, poverty and economic dependency on men have driven many women and girls to engage in high-risk transactional sex or even sex work, which places them at high risk of HIV infection. Poverty is also associated with high

labour mobility, which increases the risk of men and women engaging in (often unprotected) sex with multiple sex partners. Furthermore, high percentages of children not living with their parents; large numbers of out-of-school youth; and early age of sexual debut for young women leave children and young people – especially girls – vulnerable to sexual abuse and violence, and HIV infection.

The collapse of the public health-care system during the war hampers people's overall access to health care, including key HIV prevention, care and treatment services. The health system is plagued by a lack of skilled professionals, inadequate facilities and poor logistics and supply systems, especially in rural areas. Low quality of care further decreases the utilisation of the available services. In addition, inadequate observance of universal precautions leaves patients vulnerable to nosocomial infections.

Sexual and gender-based violence (SGBV) is widespread and constitutes a major risk for HIV infection. During the war, many (young) women and girls were victims of sexual violence, including rape, while 'transactional sex' – sex in exchange for goods, money and/or protection – was a survival strategy for many women. After the war, many forms of SGBV and domestic violence – including rape; sexual assault and harassment; incest and sexual child abuse; prostitution, child trafficking and criminal coercion; and intimate partner violence – continue to affect many women.

Key Populations at Risk or Affected by HIV/AIDS

Different factors – socio-economic, cultural, and behavioural – play together to leave specific population groups at particularly high risk or vulnerable to HIV infection, or the impact of AIDS. *Gender* plays a cross-cutting role in all these factors, leaving women – in particular young women and girls – especially vulnerable. While unsafe sex is the dominant route of transmission, HIV is also spread from mother to child, or through unsafe blood transfusions and inadequate observance of universal precautions in health facilities. In this regard, a number of specific population groups are at high risk or more vulnerable to HIV, and require priority attention in the NSF II. Key groups include (female and male) sex workers and their clients; men who have sex with men; orphans and vulnerable children, including street children; men in incarceration; mobile populations (e.g. long-distance bus and truck drivers); and uniformed personnel, including UN peacekeepers.

(Young) Women and Girls – A combination of gender-related factors leaves women and girls particularly vulnerable to HIV and other sexual and reproductive health problems. These include traditional cultural, socio-economic, educational and behavioural factors. Women's vulnerability is strongly linked to their overall disempowered position in society, and their (traditional) economic and social dependency on men. Sexual debut among women is at a younger age than among men. Sexual and gender-based violence (SGBV) are widespread and further contribute to women's HIV vulnerability. Unprotected sex with multiple partners is common, especially among the most sexually active young population, with many (young) women engaging in transactional sex to secure a livelihood. Several studies consistently show low condom use, partly due to women's inability to negotiate consistent condoms in a context of economic dependency, coercion or sexual and gender-based violence.

Women and girls involved in transactional sex or sex work – While women and girls are overall vulnerable to HIV infection, transactional sex and sex work constitute particularly high-risk factors. Female sex workers and their male clients are the most important at-risk and bridge populations for HIV transmission, with high-volume sex workers accounting for a large part of the overall commercial sex activity. During the war, transactional sex was a common survival strategy for many women and girls, ensuring some level of protection and economic support for themselves and their children. After the war, transactional sex remains widespread as a means of securing a livelihood. The line between transactional sex and sex work is often thin. As sex work becomes more organised, exploitation and trafficking of women and girls become a threat.

(Young) Men and Clients of Sex Workers, including Mobile Men – While HIV rates and research show that women and girls are particularly at risk, many (young) men are also involved in

unsafe sex with multiple partners. Culturally-determined gender roles and the impact of war and poverty also affect their vulnerability to HIV. Hence, the active involvement of (young) men is crucial for a successful national response. A particularly important group of men in this regard are (potential) *clients of sex workers*, including mobile men who often spend time away from their families, such as truck and long-distance bus drivers, soldiers and UN peacekeepers, businessmen, and small miners. As they also have sex with non-commercial female partners, they form a key bridge population for the spread of HIV to the general population.

Men Who Have Sex With Men (MSM) – Research among MSM in West Africa reveals HIV rates from 13.5 to 25 percent, much higher than any other group of men considered at high risk. In Liberia, MSM are an extremely marginalised population, facing widespread social ostracism, threat of violence and stigmatisation. As a result of societal pressure and expectations, MSM often eventually marry and end up living "doubles" lives. Data from other West African countries suggest high rates of unprotected anal sex with multiple partners among MSM, while many also have (unprotected) sex with women, thus acting as a bridge population for the spread of HIV to the general population. A special group are prisoners: unprotected sex among *male prison inmates* is common in most countries of the world, including West Africa. After their release from prison, former prisoners may transmit HIV to their wives and other female sexual partners.

Infants Born to HIV-Infected Mothers – In addition to sexual transmission, transmission from mother to child is a major concern as well. Despite increasing availability of PPTCT services, children born to HIV-positive mothers still face the risk of HIV infection, mainly due to weak health systems with inadequate VCT and referral.

People Living With HIV/AIDS (PLHIV) – To date, most PLHIV are unaware of their HIV status, due to inadequate coverage and utilisation of VCT and provider-initiated testing and counselling (PITC). VCT/PITC is a key entry point to other AIDS care and treatment services. While HIV services are being scaled up, weak health systems and stigma and discrimination hamper PLHIV's access to these services.

Orphans and Vulnerable Children (OVCs) – Thirty-five percent of households in Liberia have either foster or orphan children, most of them *not* as a result of AIDS. Although many children are vulnerable in Liberia, children who have been orphaned by AIDS may be especially discriminated against and deprived of basic human rights to education and health.

Liberia's National HIV/AIDS Response to Date

Coordination and management systems – Initial efforts to establish a coordinated response to HIV were ineffective: the *National AIDS & STI Control Programme* (NACP), established in 1987, remained ineffective for many years due to the lack of political support and resources. Similarly, the 2002 *National HIV/AIDS Policy and Legislation* and the first *Multisectoral National Strategic Plan (NSP) of Action 2000-2004* were not implemented for lack of funding. The *National AIDS Commission* (NAC), established in 2000 to broaden the national response beyond the health sector, remained ineffective for years and was only re-established in 2007. The first meaningful implementation of programmes started with the advent the Global Fund Rounds 2 and Round 6: in this context, the Liberian Coordinating Mechanism was established to coordinate inputs of all sectors. To date, the response has remained largely health-sector driven, although other sectors are increasingly involved, e.g. through the development of sectoral HIV policies and workplans in the Ministries of Education, Labour, and Gender and Development. In addition, *civil society organisations* (CSOs), including local and international relief organisations, as well as church-based organisations have played an important role, e.g. in the provision of care and support and treatment through private hospitals. Furthermore, *UN agencies and programmes* have made important contributions to all elements of the national response through technical and financial support. At the county level, County Health Teams play a key role in local coordination. HIV has also been incorporated in national and international policy and development frameworks, such as the *National Health Policy and National Health Plan 2007-2011*; the *Liberia Poverty Reduction Strategy 2008-*

2012; and Liberia has endorsed key international declarations and agreements, such as the *Millennium Development Goals*; the *Abuja Declaration on HIV/AIDS, TB and other related Diseases*; the 2001 *UNGASS Declaration of Commitment on HIV/AIDS*; The Three Ones and the Universal Access targets.

Resource Mobilisation and Financing – HIV funding has mainly come from international development partners, in particular the Global Fund (GFATM), which contributed almost USD 7.7 million through Round 2 (as of 2004), and in late 2006, USD 31.15 million through Round 6. A new proposal for Round 8 was approved recently for an amount of USD 77.7 million, and is expected to start in 2010. While the first programme mainly focused on initiating the response, the subsequent round 6 and 8 programmes comprise major components for strengthening health systems (HSS), to allow effective service delivery of key HIV services by the health sector. The UN Joint Programme (2008-2010) has committed USD 5.5 million for HIV/AIDS in 2008. Additional funds may be needed for the NSF II to allow further expansion of key HIV programmes beyond the health sector.

HIV/AIDS Service Delivery – To date, the national response has been dominated by health sector programmes, with limited involvement of other government sectors, and a limited focus on most-at-risk populations. While support from the Global Fund has allowed scaling up health-sector-based HIV services, their quality, coverage, utilisation and continuity remain suboptimal. Further scale up of services is hampered by the weak capacity of the health system, especially the lack of skilled human resources, weak infrastructure and logistics. Despite these challenges, important achievements have been made in prevention, treatment and care.

HIV-Prevention programmes – 1) *IEC/BCC* interventions have resulted in almost universal awareness of HIV/AIDS, although *comprehensive* knowledge remains low and the impact on behaviour change is limited. 2) Large amounts of male and female *condoms* have been distributed through health facilities, VCT centres, hotels, bars and workplaces. Research shows, however, that consistent and correct use of condoms is still low across the country. 3) *Voluntary counselling and testing* (VCT) services, which constitute a key entry point to prevention and treatment, are provided through a large number of facilities, including antenatal care facilities, STI services, and PPTCT services. Nevertheless, overall VCT utilisation is still low as a result of insufficient promotion and gaps in service provision. 4) *Prevention of parent-to-child transmission*-plus (PPTCT) services are available in 31 sites in 10 counties. In 2009, 32,518 pregnant women were counselled, of whom 562 received PPTCT services. PPTCT is increasingly integrated as part of the basic package of health services (BPHS) in the context of antenatal care. However, low utilisation of ANC care is a major obstacle for the further scale-up of PPTCT coverage. 5) *STIs* are a significant public health problem for Liberia. National STI management guidelines and protocols are in place and over 240 health health-care staff have been trained in syndromic STI management. 184,000 patients were diagnosed and treated for STIs between June 2007 and December 2008. 6) A national *blood safety* programme and national guidelines are in place. Despite occasional stock-outs of reagents in the counties, all blood is screened for HIV before transfusions. However, the proportion of *voluntary* blood donations is still low and needs to be promoted. 7) MoHSW has been promoting the strict application of universal precautions (UPs). Guidelines and protocols on post-exposure prophylaxis (PEP) are in place and UNFPA has provided *rape prophylactic kits* for STI, and PEP for accidental occupational exposure to major health centres and hospitals. The Government has formed the *National GBV Task Force* and the GBV Secretariat within the Ministry of Gender and Development, and has developed a National GBV Plan of Action. 8) There has been a limited number of special programmes and services *for most-at-risk populations (MARP) and vulnerable groups, such as* women and girls, sex workers and their clients, mobile men (e.g. truck drivers), uniformed personnel, prison inmates and MSM. This is partly due to limited research and insufficient knowledge about MARP's specific risks and vulnerabilities. Examples of MARP programmes include training of sex worker (SW) peer educators; however, IEC needs to be better tailored to SW needs and basic

reproductive health-care services should be provided through SW-friendly facilities. 9) Very few activities for *clients of sex workers* have been implemented. Potential SW clients include mobile men such as drivers, uniformed personnel and traders. The UN has put in place a zero-tolerance policy for civilian and military peacekeepers with regard to sexual exploitation and abuse for its 10,000-plus peacekeeping forces. Similarly, the Ministry of Defence is preparing an HIV-control policy and strategy. 10) HIV has been incorporated in the *school health-education curriculum*; guides and student modules on Life-skills-based HIV education are in place and peer educators have been trained. 11) *Workplace HIV programmes* are scarce, given the limited formal employment opportunities. The Firestone rubber company runs a large HIV programme, including ARV treatment for its employees. The recent launch of an HIV/AIDS workplace policy by the MoL aims to further promote workplace programmes.

Treatment, Care and Support – 1) *ARV Treatment* was first introduced in 1999. Currently, 19 sites are providing ARV treatment. Drastic price cuts for ARV drug have facilitated access to ART, but weak health systems, regular ARV stock-outs and a severe shortage of skilled staff hamper a rapid scale-up of ART. 2) NACP provides drugs for *treatment of opportunistic infections* (OIs) to all facilities administering ARVs, but there is no systematic reporting from any of the facilities on the number of HIV-infected cases and the types of OIs diagnosed. 3) *Home-based care and non-medical care and support* for PLHIV, OVCs and affected families is provided by international and local NGOs, FBOs and CBOs and PLHIV support groups, but access is low at the county level. Services include nutritional support, psychosocial counselling, medical care and home visits. However, referral mechanisms between home-based and facility-based care are weak. 4) *PLHIV self-support groups* have been established in hospitals that offer ARV treatment. Also, PLHIV Associations contribute to increased empowerment of PLHIV. Several FBOs provide peer-education and life-skills training for PLHIV, and offer income-generating activities (IGAs). 5) The extended family is the major support mechanism for *orphans and vulnerable children* in Liberia, with 35 percent of households caring for either foster or orphan children. International and local NGOs, FBOs, CBOs and PLHIV associations provide *care and support* to OVCs, including food, psychosocial counselling and financial support for school materials.

Health Systems Strengthening – Due to the collapse of the public health system during the war, HIV service delivery has relied heavily on vertical programmes, which lack effective integration into the health-care system. In this context, there has been increasing attention for *health systems strengthening* (HSS) to ensure adequate capacity and long-term sustainability of the national HIV response. 1) *Human resource limitations* in the health sector – especially in rural areas – have seriously affected the delivery of quality HIV services, while the HIV epidemic has further increased workloads. The MoHSW has established a *Human Resources and Development Unit*, and has introduced a national incentive scheme to ensure minimum staffing levels. The *Health Sector Pool Fund* offers scholarships for local and international training. The Global Fund and other partners have been supporting the health workforce through capacity building of health and social workers. 2) *Infrastructure and Logistics*, including facilities, equipment, utilities, transport, communications and waste management, face serious challenges. Facility-level stock-outs of essential drugs and supplies are common, as effective supply-chain management is hampered by poor road conditions and county-level weaknesses in requisitioning, warehousing and distribution. In response, donors are contributing to the NHP target of 70 percent coverage of all health facilities and laboratories with adequate infrastructure, equipment and logistics by June 2010. 3) Adequate *laboratory support* to health services is hampered by a lack of adequately trained staff, equipment, supplies and infrastructure. MoHSW will establish a Laboratory and Blood Safety Unit to standardise and coordinate laboratory services at the national level, and create a National Reference Laboratory.

Research, Surveillance and M&E – While major challenges remain with regard to reliable information on HIV trends, risk factors and service delivery, key achievements include *HIV sentinel*

surveillance studies among women attending antenatal care in 2006 and 2007, and a strong HIV component in the 2007 *Liberia Demographic and Health Survey* (LDHS). However, apart from small studies, specific HIV-prevalence and behavioural data on most-at-risk populations is not available and therefore an urgent priority. In the health sector, the MoHSW health management information system (HMIS) still faces difficulties in collecting health-service data, while the flow of information between the facility, county and national levels is inadequate. In response, the GFATM has supported standardised data-collection tools, such as patient daily registers for VCT, PPTCT, ART, OI and drugs stock balance and requisition forms. However, gaps and challenges remain with regard to M&E tools for non-clinical community-based HIV/AIDS interventions.

Priority Issues Emerging from Epidemiological, Situation and Response Analyses

Analysis of available epidemiological and cultural-behavioural data, as well as lessons learned in the context of the national response reveal five main strategic areas to be addressed: 1) Effective coordination and management; 2) Strengthening HIV prevention, with a priority focus on most-at-risk and vulnerable populations; 3) Scaling up coverage and quality of treatment, care and support for PLHIV, OVCs, and otherS affected; 4) Availability and use of strategic information for an evidence-informed response; and 5) Reducing stigma and discrimination of PLHIV as a cross-cutting priority. These issues are the basis for the development of the five key NSF objectives and core strategies.

Strategic Framework NSF II (2010-2014)

Key guiding principles and wider policy context of the NSF II – The NSF is based on seven *key principles*, which provide overall direction and reflect the core philosophy underlying Liberia's national response: 1) *Promoting human rights*, with special attention for PLHIV and disempowered, marginalised groups; 2) A *Gender-based approach*, ensuring that HIV interventions meet the specific needs of women and men, girls and boys; 3) *Greater involvement of PLHIV*; ensuring that PLHIV are actively involved and empowered by the national response; 4) *Government leadership* in multisectoral partnerships; recognising the key responsibility and mandate of the Liberian government to protect its citizens from the impact of HIV in close collaboration with other sectors; 5) *Evidence-informed* approaches reflect the available knowledge and understanding of the HIV epidemic and prioritise the most cost-effective interventions; 6) *Sustainability* involves strategies that are integrated in existing programmes and services; can build on existing in-country capacity; and do not fully depend on external resources; and 7) *Accountability* of decision makers for their prioritisation of population groups and services.

In addition to these guiding principles, the NSF II is part of a ***wider policy context*** with regard to health and social rights and development. In this regard it is in accordance with key national and international strategies, such as the *Liberian Poverty Reduction Strategy*; the MOHSW *National Health Policy and Plan 2007-2011;* the *Millennium Development Goals*; the 2001 *UNGASS Declaration of Commitment*; and the UNAIDS-supported *Three Ones* principles.

NSF Goals and Strategic Objectives – The *main goals* of the NSF II are to: 1) To contain the HIV prevalence rate among the general population below 1.5 percent by 2014; and 2) To mitigate the impact of the epidemic on the health and wellbeing of persons infected and affected by HIV/AIDS. In this context, the NSF II has *five strategic objectives*, which address the key issues that emerged from the comprehensive analysis of the Liberian HIV situation: 1) To ensure effective *coordination and management* of a decentralised, multisectoral national response to HIV/AIDS; 2) To *reduce the number of new HIV infections* among most-at-risk populations and vulnerable groups in the general population, with a special focus on women and girls; 3) To strengthen quality, and scale up coverage and utilisation of *treatment, care and support* for PLHIV, OVC, and other affected persons; 4) To strengthen the availability, sharing and utilisation of *strategic information* that will guide the planning and implementation of policies and programmes; 5) To promote *supportive environments* for women,

men and children living with HIV, and reduce HIV/AIDS-associated *stigma and discrimination*.

Core NSF Strategies and Main Activities

The attainment of each objective involves achieving a number of *key results* in terms of behaviour change; improved quality, coverage and utilisation of services; and other major *outcomes*. The core strategies and main activities to achieve these results (per objective) are listed below:

1) Strategies for *improving coordination and management of the response* will focus on a) Strengthening the capacity and functioning of the National AIDS Commission (NAC) as the overall *coordinating body*; b) Strengthening the *active involvement* of government sectors beyond health, and *mainstreaming* HIV/AIDS into their *policies and strategies*; c) Establishing effective public-private *partnerships* for joint programme implementation and information exchange; d) strengthening the mobilisation, disbursement and tracking of *funds* and resources for HIV/AIDS programmes; and e) strengthening the *institutional capacity* of implementing partners, especially in civil society.

2) The core strategies in the field of *infection prevention and behavioural change communication* will primarily focus on a) *Improving knowledge and safer sex practices* among most-at-risk populations and vulnerable groups; and b) *Increased coverage and utilisation of key HIV-prevention services*. Prevention strategies will have a clear focus on most-at-risk populations and vulnerable groups, with special attention for women and girls, and the gender dimensions underlying the HIV/AIDS epidemic. In addition, priority will go to those geographic areas with the highest HIV prevalence, including urban centres. Key populations at risk include women and girls engaging in transactional sex; (female and male) sex workers and their clients; victims of sexual violence; children born to HIV-infected mothers; men who have sex with men; prison inmates; uniformed personnel, and mobile populations. *Strengthening health systems* is an important prerequisite for delivering key HIV-prevention services such as: VCT; PPTCT, with special attention for integration of PPTCT-plus in antenatal care; safe blood transfusion services; Post-exposure prophylaxis (PEP) and universal precautions (UP); and quality syndromic management of STIs. Key prevention strategies (also) involving non-health sectors include targeted IEC/BCC programmes for at-risk groups and the general population; condom promotion and distribution; workplace HIV programmes and policies and the mobilisation of employers through an HIV Business Coalition; Life-skills-based programmes for in-school youth through the formal education system, as well as for out-of-school youth (unemployed or working); and special programmes targeting most-at-risk populations, such as sex workers, MSM, mobile men and vulnerable women and girls.

3) Strengthening the quality, and scale up *coverage and utilisation of HIV treatment, care and support* for PLHIV, orphans and vulnerable children (OVCs) involves strategies in three main areas: a) Strengthening coverage and utilisation of *ARV and OI treatment* services, and their integration into the public health system. A key priority in this regard is improving monitoring of ARV treatment adherence and the development of ARV resistance; b) Strengthening health systems capacity to provide HIV treatment and care; this involves integration of HIV training components into pre- and in-service training of health-care staff; Strengthening supply-chain management of HIV drugs and commodities; and Strengthening the coordination of TB and HIV-related services. c) A third area is strengthening facility- and community-based care and support services for PLHIV, OVCs and other affected persons. This involves strengthening capacity and resources for home-based care and support for PLHIV; Empowerment of PLHIV associations and self-help groups and support for their active involvement in HIV care, support and treatment; as well as comprehensive support to individuals and households affected by HIV/AIDS.

4) Adequate *knowledge and understanding* of the scale, dynamics and distribution of the HIV epidemic is crucial for an evidence-informed national response. To this effect, the NSF II includes

strategies for strengthening the coordination of data collection, access and utilisation for HIV policy and programme planning. The basis for improved strategic data management will be the establishment and roll-out of a *National Surveillance and M&E System and Plan*; this comprises the establishment of a *National HIV/AIDS database*, and effective dissemination of HIV information to all stakeholders. An important aspect will be strengthening the technical capacity of policy makers and programme staff with regard to strategic information management; as well as the development of quality-assurance and M&E tools and mechanisms. Furthermore, a crucial component of this system is a comprehensive *national second-generation surveillance* (SGS) system to ensure reliable data on biological and behavioural trends among the general population and key populations at risk; as well as Special research on key knowledge gaps with regard to drivers and underlying dynamics of the HIV epidemic, especially regarding and most-at-risk populations.

5) In addition to strengthening coordination, management and service delivery in the field of prevention, care and treatment, a key priority for the NSF II is to promote *supportive environments for those infected or affected by HIV* and reduce HIV/AIDS-associated stigma and discrimination. To this effect the NSF II supports: a) Sensitisation of the general public on the rights of citizens infected and affected by HIV; b) Supportive policies and legislation to protect the rights of key at-risk or affected populations, including PLHIV and marginalised groups such as sex workers and MSM. c) Promotion of non-discriminatory policies and practices in workplaces, health facilities, communities and families.

Implementing the National HIV/AIDS Strategic Framework 2010-2014

Institutional framework and arrangements for implementing the NSF 2010-2014 – Successful implementation of the NSF 2010-2014 depends on the effective collaboration of NAC as the overall coordinating body with Ministries and other policy and implementing organisations in civil society and the private sector. A key priority in this regard is strengthening NAC's organisational structure, and the staffing and capacity of the *NAC Secretariat, which* will be responsible for key tasks regarding national coordination, monitoring and evaluation, advocacy and policy guidance. Key partners include a) the MoHSW-based National AIDS Control Programme (NACP); b) the Global Fund's Liberian Coordinating Mechanism (LCM), which play a key role in coordinating the implementation of many of the components of the national response; c) Non-health *Ministries with a unique role in the national response; County-level HIV Focal persons and County health teams; civil society organisations*, including PLHIV associations, churches and faith-based organisations; as well as the *UN Theme Group on HIV/AIDS*, and UNAIDS as the secretariat of the joint UN programme.

Financial resources available and needed – The total cost of the NSF has been calculated at USD 99.3 million (depends on final targets and budget) over five years. A breakdown of the budget according to *costs per Objective* shows that 36 percent of the budget has been assigned to HIV-prevention, while half of the budget (50.5%) has been allocated to treatment, care and support. Almost half of the financial resources needed for implementation of the NSF 2010-2014 are currently already available, or will be available soon, primarily through Global Fund rounds 6 and 8. Nevertheless, a considerable shortfall of 50.9 percent remains.

Monitoring and evaluation of the NSF II – Monitoring and evaluation (M&E) is an integrated element of the National Strategic Framework (NSF) at all levels – impact, outcomes, outputs and activities (inputs/process). For each level, annual targets have been set, the attainment of which will be monitored using objectively verifiable indicators (OVIs), which are in accordance with international M&E standards and local priorities. The *Results and Performance Frameworks* provide an overview of the key results expected in terms of a) the *Impact* on HIV-infection rates and quality of life of PLHIV; b) *Outcomes* in the field of HIV-prevention behaviours; coverage and utilisation of key HIV/services; and effective use of strategic information; and supportive environments. c) key *Outputs* that are expected as a result of implementing the NSF's main strategies.

1. INTRODUCTION

1.1 BACKGROUND

Following the expiration of the National HIV/AIDS Strategic Plan 2004-2007, there is a need to mount a more effective and coordinated national HIV/AIDS response, which will be guided by this new National HIV/AIDS Strategic Framework II (NSF) for the period 2010-2014. The development of the new 5-year national strategic framework comprised a first phase of a comprehensive rapid assessment to take stock of the achievements, challenges and lessons learned with respect to the implementation of the national HIV/AIDS response over the past five years; and the synthesis of recommendations to guide the development of the new National Strategic Framework. The entire process was widely participatory, evidence-based and as contextually relevant as possible, and provided an opportunity for high stakeholder involvement.

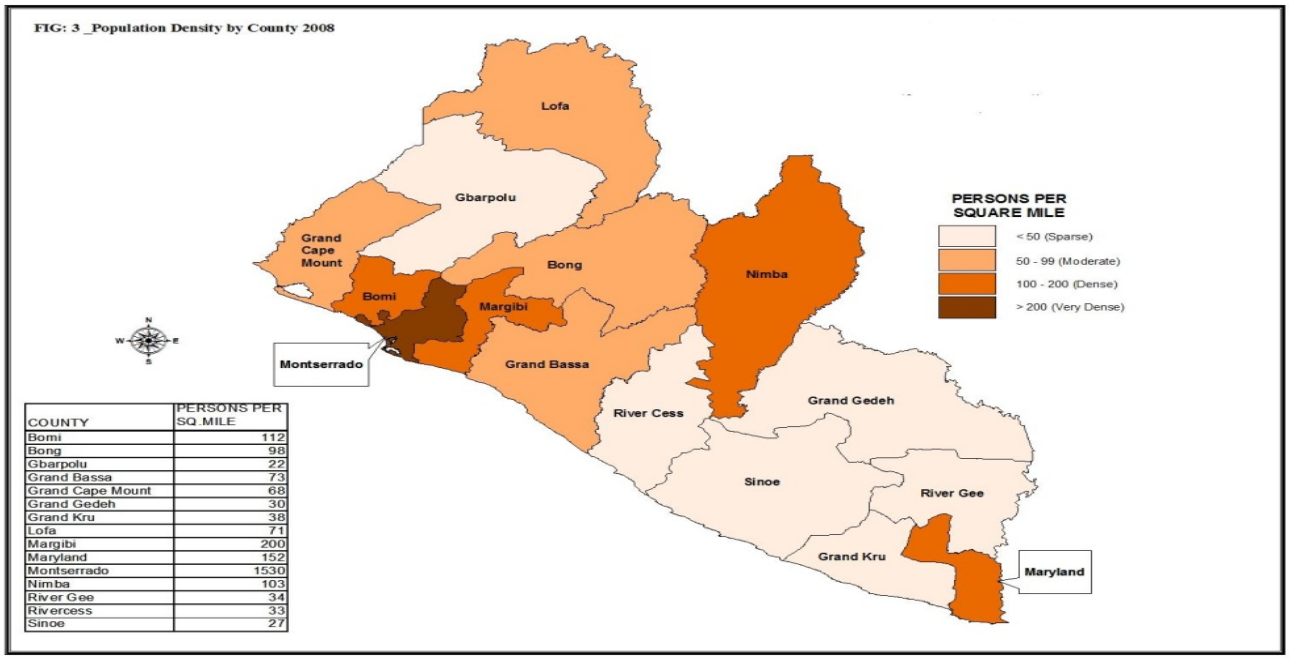
The NSFII 2010-2014 is informed by the available evidence from epidemiological surveillance and social research, as well as the experiences with the national response to date. Chapter 2 describes the epidemiology of HIV/AIDS in Liberia with regard to HIV rates among men, women, different age groups and geographic distribution. In addition, an analysis of the key drivers of the HIV epidemic, and the population groups most at risk or most vulnerable to HIV highlights the priority populations and issues to be addressed. Chapter 3 presents the main achievements, gaps and challenges of the national response to date, with regard to programmes and service delivery, as well as the overall coordination and management, available resources and larger policy frameworks. Based on the joint analysis of the epidemiological data, drivers of the epidemic, most-at-risk populations, and lessons learned from the past responses, Chapter 4 highlights the key strategic issues to be addressed in the context of this NSF II (2010-2014). These form the basis for the Strategic Framework, which is presented in Chapter 5: it describes the key guiding principles of the NSF II, the goals and strategic objectives, and provides a brief description of the main strategies to be implemented with a view to attaining each of the five objectives. Chapter 6, finally, describes the overall institutional framework, an overview of the funding requirements and available funds, as well as the approach to monitoring and evaluation. Operational details are given in the workplan and budget, as well as the Results and Performance Frameworks, which specify the results to be achieved and the targets to be met under this NSF II.

1.2 DEMOGRAPHIC AND HEALTH PROFILE

The preliminary results from the 2008 *Population and Housing Census* indicated a total population of Liberia of approximately 3.5 million (GoL, 2008). In the 2007 *Liberian Demographic and Health Survey* (LISGIS, 2008) young people aged 5-14 years account for 29.5 percent of the population, while the proportion of the population aged 15-49 years is about 36 percent. *Table 1* shows the distribution of the population over Liberia's 15 counties. Montserrado County is the most densely populated county with a population density of more than 1,500 persons per square mile; it has the highest total population (one-third of the national population) on the smallest land area. Monrovia, the administrative capital and business hub of the republic and its environs, has an even higher population density and also highest opportunities for employment, abundant social amenities, better communication and transport connections, and highest physical infrastructure.

Table 1. Population Distribution					
County	Population 2008		County	Population 2008	
	Number	%		Number	%
Bomi	84,119	2.4	Margibi	209,923	6
Bong	333,481	9.6	Maryland	135,938	3.9
Gbarpolu	83,388	2.4	Montserrado	1,118,241	32.2
Grand Bassa	221,693	5.4	Nimba	462,026	13.3
Grand Cape Mount	127,076	3.7	River Cess	71,509	2.1
Grand Gedeh	125,258	3.6	River Gee	66,789	1.9
Grand kru	57,913	1.7	Sinoe	102,391	2.9
Lofa	278,863	8.0			
TOTAL				**3,476,608**	**100**
Source: LIGIS 2008 Preliminary National Population Census Report					

The counties of Margibi, Maryland, Bomi and Nimba have high-density population concentrations. With the exception of Nimba County, the other three have relatively small landmasses with high population totals that condition the high densities. Four counties, Bong, Lofa, Grand Bassa and Cape Mount have moderate population concentrations (50-99 persons per square mile) and generally have



large landmasses and high population totals. These counties were hosts to former mining and agricultural companies, and have, moderate transport and communication facilities. The rest of the country comprising Gbarpolu, Grand Gedeh, Grand Kru, River Cess, River Gee and Sinoe counties are sparsely populated with densities between 22 and 40 persons per square mile. These counties are disadvantaged with difficult relief and poor communication and transport lines, scanty physical infrastructure and social amenities, and generally low employment opportunities.

Following Liberia's civil wars there have been significant population movements and changes in the pattern of settlement, especially in rural areas where the residential households tended to be concentrated to form bigger villages in order to be better protected. Combined with the changes in socioeconomic development, many new communities had been established, while existing ones had

expanded or contracted or even disappeared. Urban areas especially Monrovia expanded, and some areas that were previously considered rural have become urban. The increase in urban population is worth noting, because HIV-prevalence rates are higher in urban areas than rural areas. The annual growth rate of the population is 2.1 percent.

The demographic context has implications for HIV/AIDS programming. Prevention efforts are required almost everywhere, but urban areas and other "hot spots" require additional targeted efforts. The provision of treatment, which requires substantial expansion, was reasonably started in large urban centres, and regions with higher prevalence, and spread to district capitals and beyond as experience and resources become available. The population aged 5-14 years is frequently referred to as a "window of hope," and will require concerted effort to ensure that they remain uninfected.

Since the first incidence of the HIV/AIDS epidemic in the 1980s, the estimated number of people living with HIV in Liberia based on the population-based survey is 53,000 adults. Improvement in the care and treatment of PLHIV, especially with the use of ART and treatment of opportunistic infections (OIs), is expected to lead to improved survival. To date, there are no records of the number of persons who have died of AIDS and related complications. UNAIDS/WHO 2008 report projects the number of annual AIDS deaths below 2000 in 2007.

Table 2: Liberia – Key Statistics

Total population:	**3,476,608**
Gross national income per capita (PPP international $):	**260**[**]
Life expectancy at birth m/f (years):	**43/46**[**]
Probability of dying between 15 and 60 years m/f (per '000 populations):	**498/415** [**]
Total expenditure on health per capita (Intl $, 2006):	**39** [**]
Total expenditure on health as % of GDP (2006):	**5.6** [**]
Infant Mortality rates (IMR) (between birth and first birthday):	**71 per 1000 live births**[##]
Under-Five Mortality (children under five years of age):	**110 per 1000 live births**[##]

2. HIV/AIDS IN LIBERIA

2.1 THE EPIDEMIOLOGY OF HIV/AIDS IN LIBERIA

Reliable data on the spread of HIV in Liberia is scarce. Before 2006, HIV data was available only from case reporting from routine screening of blood donors, in- and outpatients, TB patients and antenatal women (in the context of PPTCT), as well as from clients of VCT services. In 2001, the estimated HIV rate was 12 percent, based on the available data from case reporting. Since then, the number of reported HIV cases kept increasing steadily. However, HIV-case-reporting data is known to be an unreliable source for accurate HIV-prevalence data, given the large probability of selection bias, as it is only based on HIV cases found through passive case finding.

In 2006, the first HIV sentinel surveillance study was held among women attending antenatal care (ANC) services, followed by a second ANC study in 2007. In 2007, HIV was also included in the *Liberian Demographic and Health Survey (LDHS*), which for the first time presented *population-based* HIV data. While the results from these two distinct types of surveys – *facility*-based and *population*-based – show considerable discrepancies, the LDHS data is regarded as more reliable as it is based on a representative sample of the general population in both urban and rural areas, while the ANC studies were among ANC women, predominantly in urban areas. The overall HIV rate found in the LDHS was 1.5 percent, with 1.8 percent among women and 1.2 percent among men aged 15-49, which is used as the basis for the official statistics. Most HIV infection is with HIV-1, while HIV-2 represents only a very small fraction of 0.2 percent. It shows that while HIV prevalence among the general population is still low, it is *above* one percent, indicating a generalised epidemic, with a potential for rapid further spread among the general population, unless adequate measures are taken, targeting the most vulnerable and at risk populations.

Gender differences – Disaggregated LDHS data for gender and age provide a better insight into the underlying dynamics of the spread of HIV. While the overall data already reveal a considerable gender difference, with prevalence among women 1.5 times higher than among men, this gender disparity becomes even more apparent when looking at specific age groups. In the 15-19 years age group, HIV rates are 1.3 percent among females, while only 0.4 percent among males; in the 20-24 years age group this is 2.0 and 0.7 percent respectively. HIV rates for men are 1.7 percent or higher only in the age group 25-34 age group. This data not only shows gender differences, but also the particular HIV risk of young, adolescent women and girls, which reflects a pattern of older men having sexual relations with younger women and girls.

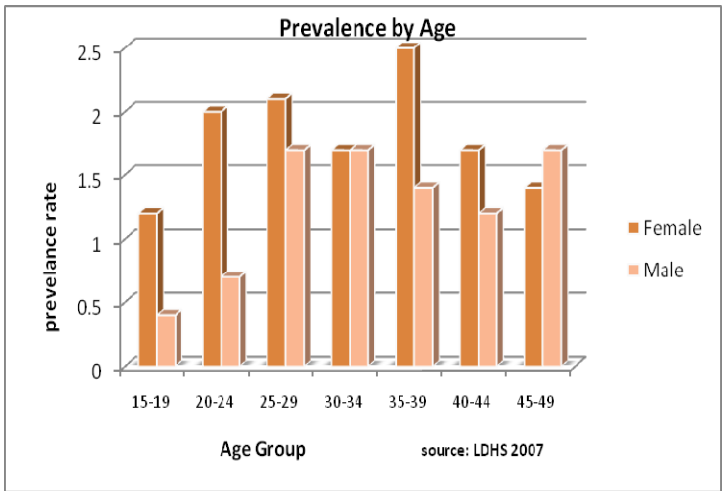


Figure 1. HIV-prevalence rates by gender and age (LISGIS, 2008)

Furthermore, LDHS data show stark differences between *urban and rural* populations: HIV prevalence among the urban population is 2.5 percent (2.8% for women; 2.1% for men), while only 0.8 percent among the rural population (1.1% for women; 0.6% for men). The highest rate was found among women in Monrovia, at 2.9 percent (see Figure 2). These urban-rural differences are also reflected by the HIV rates among different socioeconomic groups, with a consistent relationship between income and HIV rates: the HIV rate among the wealthiest group is 2.6 percent (3.0 for women; 2.2 for men), against 0.7 percent among the lowest-income group (0.8 for women; 0.5 for men). In addition, results show clear regional differences, with the highest HIV rates in the capital Monrovia (female 2.9%; male 2.3%), followed by the South Eastern B region, (female 2.4%; male 0.8%), while the lowest HIV rate of 0.6% was found in the North Central region (female 0.5%; male 0.7%).

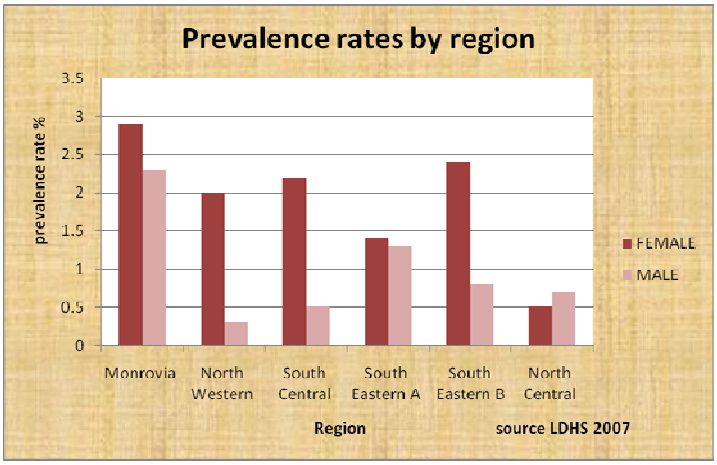


Figure 2: HIV-prevalence rates by gender and region (LISGIS, 2008).

Comparison of HIV-prevalence data with ***high-risk sex behaviours*** does not reveal clear patterns: among women (15-49) there appears to be a relationship between higher HIV rates and behavioural risks such as the number of sexual partners and the number of higher-risk partners in the last 12 months, but for men this relationship is opposite. Similarly, condom use – ever, at last sex or high-risk sex – does not show a clear relationship with HIV rates. Overall, the behavioural LDHS data appears to suffer from reporting bias, as it is difficult to get reliable self-reported data on sexual behaviours. More in-depth research, using qualitative methods may be more appropriate for revealing sexual behaviours.

ANC studies – As mentioned, the LDHS and both ANC sentinel surveillance studies show very different results. The first ANC study in 2006 (10 urban sites in all five health regions) found an overall HIV prevalence of 5.7 percent, while the 2007 (15 sites, including two rural) ANC study showed 5.4 percent among ANC women – both considerably higher than the LDHS data. This may be partly explained by the fact that most ANC study sites were in urban areas, which also showed higher HIV rates than rural areas in the LDHS. In addition, 9.2 percent of those interviewed in the LDHS study *refused* to be tested for HIV, which is a source of potential selection bias if those who are more at risk were more likely to refuse an HIV test. Nevertheless, the ANC data shows interesting patterns, comparable to those found by the LDHS. Comparison of ANC sites shows stark rural-urban differences, varying from 2.6 percent in one rural site, to 10.4 in one urban health centre. HIV rates above 7 percent were found in four urban sites[1] (out of a total of 13 urban sites), indicating that HIV may be firmly rooted in selected urban areas, with the potential of rapid spread among the general population in those areas. A similar difference between urban and rural areas – albeit not as strong – was shown by the LDHS results (see above). Data from both 2006 and 2007 ANC studies also show higher HIV rates in the eastern and western border regions. This might reflect the influence of cross-border trade, as well as commercial and mining activities, and the associated mobility and transactional sex and/or sex work. More in-depth research is needed to better understand the underlying dynamics of these regional and rural-urban differences in HIV rates.

[1] The ANC Sentinel surveillance sites with HIV rates above 7 percent were Senji Health Centre (10.4%); Martha Tubman Hospital (8.5%); J.J. Dossen Hospital (8.0%); and Firestone Health Centre (7.1%).

HIV among most-at-risk populations

To date, the complete absence of HIV-prevalence data among most-at-risk populations (MARP) presents a major gap. No bio-behavioural studies have been conducted among the main MARP groups, including (female and male) sex workers and their clients; men who have sex with men; as well as among other more vulnerable groups, such as mobile populations (e.g., drivers, military). Small-scale behavioural studies among these groups (see below) have revealed particularly high risks for HIV/STI infection, e.g. among street-based sex workers. Therefore, future second-generation surveillance (SGS) studies should include not only the general population, but specifically focus on these MARP groups – especially sex workers and their clients, as well as MSM – which represent a potential bridge population for further spread into the general population.

TB-HIV Co-infection

Data on patients receiving antiretroviral treatment show that there is a large burden of TB among HIV patients enrolling into care and treatment: 21 percent of TB patients who underwent HIV testing were HIV-positive, while 241 out of 4135 HIV patients enrolled are receiving treatment for TB. The emergence of TB, which interrupts normal ART protocols, has led to a high use of *Efavirenz*-based regimens (11%) at increased costs. These data highlight the importance of jointly addressing the twin epidemics of HIV and TB, through services that are integrated in the public health-care system.

2.2 POTENTIAL DRIVERS OF THE HIV EPIDEMIC

Potential drivers of the HIV epidemic include structural socioeconomic and cultural factors that are not easily measured, and which increase people's vulnerability to HIV infection (UNAIDS, 2008). Examples include poverty, unemployment, the post-conflict impact of the war, the collapse of health and social systems, gender inequality, human rights violations, sexual and gender-based violence, and stigma and discrimination. To date, very little research has been done into the link between factors that may drive the epidemic in Liberia and the prevalence of HIV in specific groups or geographic regions. Nevertheless, a wide body of research in other parts of Africa and the world have clearly identified the mechanisms through which these structural factors may drive the spread of HIV and/or hamper an effective national response.

2.2.1 The Impact of War and Extreme Poverty

War – Liberia's recent history has been marked by 14 years of violent conflict, which had its roots in the political and economic exclusion of large parts of the population. The war has had a devastating impact on the country's social, economic and health situation. The war left an estimated 270,000 people dead, created hundreds of thousands of refugees and internally displaced persons (IDPs), and destroyed communities. It led to the destruction of basic governance institutions, physical infrastructure and social capital. The economy completely collapsed, impoverishing much of the Liberian population. GDP fell a catastrophic 90 percent between 1987 and 1995, one of the largest economic collapses ever recorded in the world (IMF, 2008).

Poverty – The armed conflict and years of mismanagement have left Liberia among the poorest countries in the world, with an estimated GDP per capita of USD 190.2 (IMF, 2008). By the time of the elections in 2005, average income in Liberia was just one-quarter of what it had been in 1987, and just one-sixth of its level in 1979. Almost two-thirds of Liberians live below the poverty line, particularly in rural and remote areas of the country. The *dimensions of poverty* include very high

levels of unemployment (up to 85% in the formal sector); low levels of income and consumption; poor nutrition and food security; low health and education indicators; and inadequate infrastructure, with many roads impassable, which seriously constrains economic recovery, as well as the provision of basic services such as health and education. Poverty is further exacerbated by inequities, especially in access to justice and economic opportunities. Women are particularly vulnerable to poverty, especially in rural areas, because of their more limited access to employment and basic services such as health, education, and infrastructure.

The ***HIV/AIDS epidemic*** in Liberia cannot be separated from the overwhelming consequences of the war, including the breakdown of communities and families; large-scale forced migration and displacement; massive and systematic sexual violence, especially against women and girls; the total collapse of health, education and social support systems; and widespread, extreme poverty. The combination of war, violence and poverty has, and continues to drive the HIV epidemic directly and indirectly. Widespread sexual and gender-based violence (SGBV) – including coercion, rape and trafficking of women and girls in prostitution networks – *during and after* the war has put many women and girls at risk of HIV infection.

The dimensions of poverty also exacerbate HIV risks more *indirectly*, especially for women and girls. Massive population displacement in rural areas during the war has led to the collapse of traditional communities and accelerated urbanisation, with almost half of the population residing in urban communities, and Monrovia hosting more than one million inhabitants – double its pre-war population. This move away from rural areas, the collapse of the formal economy and the resulting massive unemployment pose a direct threat to people's food security, which has forced many women and girls to engage in high-risk transactional sex, or even sex work, as poverty may facilitate women to be lured into sex work through human trafficking. Poverty and unemployment have also fuelled labour migration in- and outside of the country, which in turn is associated with higher risk of unsafe sex with multiple partners, including sex workers.

High percentages of children not living with their parents; large numbers of out-of-school youth; and early age of sexual debut for young women render children and young people – especially girls – vulnerable to sexual abuse and violence, including rape, and HIV infection. Poverty and the poor state of institutions and infrastructure also hamper access to education and key HIV-prevention, care and treatment services, such as prevention of mother-to-child transmission, HIV education, antiretroviral treatment, STI treatment and others. This is further exacerbated by the massive exodus of trained professionals from the country, which has led to serious problems in finding skilled health-care workers. As a consequence, knowledge on various aspects of HIV transmission is *low to very low* among different groups, further exacerbating their HIV risk.

2.2.2 Collapse of the Public Health-Care System

The collapse of the public health-care system during the war hampers people's overall access to quality health care, and poses a particular challenge to providing key HIV/AIDS prevention, care and treatment services. Current access to health care is estimated at 40 percent, due to an inadequate number of functioning facilities and a structural lack of skilled staff, especially outside the main urban centres. Liberia currently has 400 health facilities of which nearly 70 percent are managed by international and local NGOs that will begin phasing out as their humanitarian mandates expire. Many functional facilities are currently providing sub-standard care due to a lack of qualified staff (doctors, nurses and certified midwives) and basic necessities such as sufficient power, water, drugs, lab tests, supplies and adequate communications. Today there are only 51 Liberian physicians in the country – compared to WHO-recommended staffing levels of 1,094 – to cover the nation's public health needs: approximately one for every 70,000 Liberians (PRSP, 2008). The equitable distribution

and compensation of staff is likewise problematic. Even though HIV-treatment outlets have significantly increased in the last few years, the coverage of HIV/AIDS-related services – such as PPTCT services, ARV treatment and treatment of opportunistic infections – is still low. Communication between the counties and the MOHSW remains difficult. Landlines are universally unavailable, cellular reception and internet access is uneven and costly, and radios are underutilised. Generators, which remain the predominant sources of electrical power, are liable to frequent breakdowns and fuel shortages. The lack of communication hinders coordination between the MOHSW and the counties, as well as facilities' ability to refer patients and laboratory samples. Poor road conditions exacerbate the situation.

Apart from inadequate access to HIV/AIDS services, the poor state of the health system also represents a direct threat, as the lack of equipment, commodities and training hamper the consistent application of universal precautions, which may lead to *nosocomial transmission* of HIV through unsafe injections, needle-stick injuries, incorrect handling of body fluids and drugs, or in the context of blood transfusions. Inadequate access to post-exposure prophylaxis (PEP) puts health-care staff at particular risk, which in turn may lead to increased fear, stigma and discrimination of PLHIV on behalf of health workers.

While the exact ways and extent to which these potential drivers of the HIV epidemic put different population groups at risk of HIV infection is not clear, their impact is particularly felt by women and girls, as is evidenced by the gender disparities in HIV rates in all age groups and geographic areas.

2.2.3 Violence and Sexual and Gender-Based Violence

President Ellen Johnson Sirleaf*: "Liberia is on the path to national recovery after some 14 years of a brutal civil war that left around half of all Liberian women as survivors of gender-based violence (GBV). However, rates of GBV, in particular domestic violence, remain high. For many Liberian women, the violence they experienced during the conflict period is still occurring."* (Johnson Sirleaf, 2007)

Experiences in Liberia and elsewhere show that sexual and gender-based violence *(*SGBV) typically soars during and after conflict[2]. Several small-scale qualitative studies and abundant anecdotal evidence reveal that SGBV – both *during* and *after* the war – was, and continues to be *widespread* in Liberia. During the conflict, girls and women were subjected to multiple forms of sexual violence, including gang rape, sexual slavery, 'survival' sex in exchange for food, and unwanted pregnancies due to rape. SGBV has a serious and lasting impact on the physical and psychosocial wellbeing of women and girls, including the risk of HIV infection, STIs, unwanted pregnancies or infertility, and other reproductive health problems, as well as strong social stigmatisation.

SGBV during the war

A recent reproductive health survey by UNFPA and CDC in 2007 among 907 women in Lofa County, Northern Liberia (Tomczyk et al, 2007), provided the first scientific evidence of widespread SGBV during *and after* the conflict. The study assessed *five types of sexual violence* (including *"rape by force"* and *"sex in return for services"*) for both *war and post-war* periods. The results reveal that *sexual violence* was extremely widespread during the 1999-2003 conflict in Lofa county, with almost two-thirds (59%) of all women reported at least one sexually violent incident, with 31 percent

[2] At least 50,000 internally displaced women in Sierra Leone were sexually abused by armed combatants during its civil war, according to *Physicians for Human Rights*. More than 250,000 Rwandese women were raped during the 1994 genocide, according to UN sources.

reporting they were raped (vaginal, oral or anal), while almost 36 percent were forced to engage in sex for goods or services such as food, water or protection. The findings also show that violent incidents were not isolated but happened repeatedly to most women: the largest proportion of women reported that attacks of sexual violence had occurred more than four times. Also, almost half of women compelled to have *sex for favours* reported that this happened more than four times. The study revealed a significant difference in the prevalence of violence reported by urban and rural women. Study findings furthermore indicate that during the conflict, *rebels and paramilitary forces* were the most frequently reported perpetrators of sexual and physical violence. In the post-conflict period, a neighbour was the most frequently reported perpetrator of both physical and sexual violence. The most common locations of (sexual and other) violence were the home village/town or when travelling by road.

Another study in six counties on violence against women during and after the conflict, conducted by WHO in 2004 (Omanyondo, 2005), showed that many young girls and women were forcibly taken as 'bush wives', cooks, cleaners and sex slaves for the fighters. Rape and sexual abuse were common forms of violence during the war: almost 75% of female respondents had been raped during the civil war (Bruthus, 2007), while 60% of women suffered emotional or psychological disturbance as a result of the violence; and 90% of women who reported violence needed medical treatment.

SGBV in post-conflict situations

Although the war ended six years ago, and despite the large number of international agencies working on SGBV issues, there is strong evidence of *ongoing* widespread SGBV and domestic violence throughout the country, including rape, sexual assault and harassment, incest and sexual child abuse, prostitution, child trafficking and criminal coercion. E.g. the Association of Female Lawyers of Liberia (AFELL) receives reports of up to six rape cases every day – the tip of an iceberg, as the vast majority of rape cases go unreported. Alleged perpetrators include influential community members such as teachers, religious and traditional community leaders, humanitarian workers and even fathers (Bruthus, 2007). There is general silence and denial by the community or even the affected family, and customs and traditions often take precedence over the formal legal system. Because of stigmatization, many SGBV survivors are unwilling to seek medical or other professional help or even to report the assault. In addition, they are deterred by the difficulty and danger of reporting due to gaps in legal, protection, health and psychosocial services that fail to ensure confidentiality and supportive services that SGBV survivors need.

The 2007 LDHS study shows that 45 percent of women ever experienced *physical* violence since they were 15 years old, while 29 percent had faced violence in the last 12 months. The main perpetrators were current or former husbands/partners: 35 percent of women had experienced spousal violence in the last 12 months. The same study revealed that 10 percent of women said their first sex was forced, against their will. Almost one-fifth of women aged 15-49 had ever experienced sexual violence (LISGIS, 2008). Similarly, a study in 2007 among 600 women and girls in Eastern Nimba and Central Montserrado counties conducted by the *International Rescue Committee (IRC)* and Columbia University's *Programme on Forced Migration and Health* reveals communities rife with gender-based violence (Shiner, 2007), showing that ending the war did not end the violence against women. The study focused on *marital rape; rape outside of marriage; and non-sexual domestic abuse.* Results show that outside of marriage, one-fifth of the sample population in Montserrado County and more than one-quarter of those surveyed in Nimba County had been raped or otherwise sexually abused. Among married or divorced women, more than 72 percent in both counties reported that their husbands had forced them to have sex in the last 18 months. Furthermore, the study revealed that more than one in 10 girls under the age of 17 had been sexually abused in the previous 18 months in both counties.

The Lofa County Reproductive Health survey (Tomczyk et al, 2007) found similarly high lifetime prevalence of ***intimate partner violence*** (IPV), with almost two-thirds (61.5%) reporting that they had been subjected to IPV. Of those responding, approx. 61% had experienced physical violence and one-third sexual violence. Global studies on violence reveal the complex and interrelated risk factors associated with IPV, which include individual, partner relationship, community, and societal factors. In a post-conflict setting such as Liberia, the combined suffering of women due to war-related violence and IPV undoubtedly increases their physical and psychological health risks.

2.3 KEY POPULATIONS AT RISK (OR VULNERABLE) AND AFFECTED BY HIV/AIDS

In the context of extreme poverty, forced migration, sexual and physical violence, and lack of economic opportunities, it is difficult to distinguish clear-cut population groups that are at higher risk or vulnerable to HIV/AIDS. Many social, economic, behavioural, cultural and other factors combine to create circumstances and situations in which women and men, adults and children, are at risk or vulnerable to HIV infection. Overall, though, all these factors put women and girls at much higher risk of HIV and other STIs than men, as many of the risk factors have a strong relation to gender issues, and affect women and girls differently from men. The epidemic in Liberia is mainly driven by unsafe sexual behaviour, which are often influenced by power differences between men and women, although mother-to-child transmission, blood transfusions, and inadequate implementation of universal practices in the health sector are also areas of concern. To date, in Liberia, mapping and biological-behavioural studies have not taken place among groups at higher risk or vulnerable to HIV; these groups include (female and male) sex workers and their clients, men who have sex with men, orphans and vulnerable children, such as street children, prison inmates, mobile populations (e.g. long-distance bus and truck drivers), uniformed personnel, IDPs and refugees and other potentially vulnerable groups. Smaller qualitative studies and assessments among these groups have, however, allowed identifying their specific risks and vulnerabilities, and developing specific HIV/AIDS interventions that meet their needs.

2.3.1 (Young) Women and Girls

Feminisation of the HIV epidemic – As discussed in the previous section, data from the 2007 population-based LDHS study consistently show statistically significantly higher HIV-prevalence rates for women than for men, especially in urban areas and in the (younger) age groups of 15-29 and 35-44 years (LISGIS, 2008), with women showing up to 2-3 times higher HIV rates than men. This data provides strong evidence for the elevated HIV risks facing women and girls. While DHS data show relatively low overall HIV rates, data from the 2007 Sentinel Study among women attending ANC clinics in 13 selected urban and two rural sites show alarming HIV rates of more than 7 percent in four out of 15 sites, with 10.4 percent in Sinje Health Centre. While this data may not be representative for the overall female population in Liberia, it clearly shows that HIV has reached worrying levels in specific urban communities, reflecting the vulnerabilities and risks facing these women.

A combination of gender-related factors – socio-economic, cultural, educational, behavioural and related to limited access to education, health care and employment – renders women and girls particularly vulnerable for HIV and other sexual and reproductive health problems. Rather than seeing them as individual risk factors, it is important to acknowledge that the combined impact of these factors disproportionately affects women and girls in different settings and situations.

Traditional practices, HIV/AIDS awareness and sexual behaviours

Traditional practices – The prevailing patriarchic system in Liberia plays an important role in shaping social norms and behaviours. A number of traditional practices may contribute to HIV risks, although their impact seems to be limited. Under traditional marriage, *polygamy* is allowed and practiced by various ethnic groups in Liberia. A study by UNDP in 2001 found that 30 percent of married men were in polygamous unions (Barh et al., 2001). While strictly faithful polygamous relationships do not encourage HIV infection, a married man in search of a second or third wife could "try out" other women, infecting them if he is HIV-positive, or getting infected himself and spread HIV to his wife/wives. *Widow Inheritance*, the traditional practice of inheriting a deceased brother's wife by another brother is gradually becoming a dying cultural practice. It was based on the belief that a wife becomes part of her husband's family property when she gets married and a dowry is paid for her; while it also provides a safety net for man's wife and children. At present, some ethnic groups still practise widow inheritance, while others are abandoning it, especially in urban areas (Barh et al., 2001). Another traditional practice, *female genital cutting* (FGC) is also still widely practised by several ethnic groups and may contribute to HIV transmission due to inadequate hygiene and the use of unsterile blades, albeit on a very limited scale.

HIV awareness – The 2007 LDHS study found HIV/AIDS awareness in Liberia to be near universal (93% of men; 89% of women), and increasing with educational level. However, *comprehensive knowledge*[3] about HIV/AIDS was low, particularly among women (32% of men; 19% of women), and in rural areas in North-western and South-eastern A regions (21% of men; less than 10% of women). Knowledge about breastfeeding as a way of mother-to-child transmission was relatively high (61% of women; 59% of men). The LDHS study also looked specifically at young people aged 15-24 years, as this group accounts for half of all new HIV infections worldwide. Results show that comprehensive knowledge about HIV/AIDS was slightly higher than among the overall adult group (20% of young women; 27% of young men). Half of young men (52%) and women (49%) knew a source of condoms. A reproductive health survey in 2007 among women in Lofa County found even lower levels (14.5%) of comprehensive knowledge of HIV, while only slightly over half of respondents (55%) said they had ever heard of HIV/AIDS, with no significant difference between younger and older age groups (15-24 and 25-49 years). Perceptions of personal risk of contracting HIV were low, with almost half of women (46%) saying that they had a small chance of contracting the HIV virus.

Early age of sexual debut – Data from the 2007 LDHS study show that a higher proportion of young women (17%) have sex before the age of 15 than young men do (9%); similarly, by the age of 18, 82% of women against 56% of young men have had sex. LDHS findings also show that young women in Monrovia and those with at least some secondary education are least likely to initiate sex before age 15, compared to young women in other regions and those with less education. Early age of sexual debut not only places young women at an earlier and longer life-time risk of HIV and STIs, early pregnancy also limits young women's access to education and employment, and increases their economic dependency on men, which may in turn lead women to engage in – often unprotected – transactional sex.

High-risk sexual behaviours – Findings from the 2007 LDHS study revealed that high-risk sex[4] was more prevalent among younger women and men, as well as among those who were never married. Higher-risk sex is also more prevalent among young people who are better educated and from wealthier backgrounds, as well as among those in urban areas. The 2007 LDHS data further show that women are far less likely than men to report having had two or more sexual partners in the last

[3] Comprehensive knowledge is defined as "Knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the HIV virus, knowing that a healthy-looking person can have the HIV virus, and rejecting the two most common local misconceptions about HIV transmission or prevention".
[4] High-risk sex was defined as "sex with a non-marital partner" in the 2007 LDHS study.

12 months (7 percent for women and 21 percent for men)[5]. Similarly, 33% of women against 52% of men who had had sexual intercourse in the previous 12 months reported having had higher-risk sex[6]. Thus, although women engage less in high-risk sexual behaviour, they are more vulnerable as a result of gender-based dependencies on men.

Condom use – Unprotected sex is known to be the norm, rather than the exception, especially among the most sexually active young population. An often heard statement says that *"Liberians want 'flesh-to-flesh, skin-to-skin' sexual contact"* (News.com, 2005). Condom use at first sex is rare in Liberia (LISGIS, 2008). Among young people aged 15-24 years who have ever had sexual intercourse, only 6 percent used a condom during their first sexual intercourse. Fourteen percent of women who said they had had more than one partner in the last 12 months, said they used a condom during the most recent sexual intercourse: much less than the 22 percent reported by men. Among women who reported having had higher-risk sex in the past 12 months, only 14 percent used a condom at the last higher-risk sex, against 26 percent of men (LISGIS, 2008). Data from a previous LDHS study showed that 90 percent of youth aged 13-19 years indicated that they did not intend to use a condom during their next sexual encounter; more than 75 percent said having multiple sexual partners; and 95 percent said they would not abstain from sexual activity as a strategy to prevent HIV/STIs (LDHS, 2000). *Another study* in 2007 among 709 urban youth aged 15-17 years showed high levels of risky sexual behaviour, while consistent condom use in the past 90 days was low at 16 percent (Harris et al, 2007).

Lack of condom-use negotiation skills among women may be a factor causing differences in condom use by young men and women, and low levels of promotion and availability of female condoms could be another factor. Condom use increases with education level and with wealth. A study in 2001 on socio-cultural factors and HIV/AIDS revealed that many women are still powerless and helpless when confronted with male sexual demands – with one respondent indicating: "*When you the woman try to insist that the men use condoms, it could cost you losing your relationship. So we don't have any choice because we want to keep our relationship"* (Barh et al., 2001). This shows how traditional gender roles act as obstacles for women to participate as equals in sexual decision making, leaving them unable to control their own sexual health, including protection against HIV.

Gender inequality and associated sexual and gender-based violence

Negative impact of gender inequalities, poverty and violence on women's HIV risk – The previous sections have clearly shown that poverty, conflict and traditional gender imbalances constitute powerful drivers of the HIV epidemic, which predominantly affect (young) women and girls. The impact of sexual and gender-based violence (SGBV) may be evidenced by results from the ANC study in 2007, which reveal slightly higher HIV rates for the 30-34 year age group (6.4%) than the overall average (5.3%); the same was observed in the 2006 ANC study (6.8% vs. 5.7%). This may indicate an elevated HIV risk as a result of the widespread sexual violence during the conflict, when these women were adolescents and young women (MoHSW/UNDP/WHO, 2008).

Many studies have shown that SGBV is not unique to conflict situations, but deeply rooted in traditional thinking about gender roles by men and women alike, as is shown by two participants in focus group discussions on the topic (Barh, 2001): (man) *"As heads of homes, men have the right to take decisions regarding when to sleep with their wives and the number of children to have."* And (woman): *"Men make decisions and should have authority. Women are there to procreate, raise decent children and lend support to their husbands."*

[5] It is important to note that the lower levels of multiple partnership, higher-risk sex, and condom use reported by women than men could be real or could be due to shyness among women to report behaviour that may not be widely acceptable.
[6] Sexual intercourse with a partner who neither was a spouse nor lived with the respondent.

Even after the war, for Liberian women and girls, sex is often *not* the result of free choice: they often find themselves in a context of economic dependency on men (transactional sex), coercion (intimate partner violence), and other forms of sexual and gender-based violence, including rape, forced sex work and human trafficking, leaving them unable to protect themselves against unsafe sex and HIV infection.

2.3.2 Women and Girls Involved in Transactional Sex or Sex Work – Victims of Human trafficking

Socio-economic factors and access to education

As discussed in the previous sections, traditional practices and gender norms, inadequate HIV knowledge and negotiating power on sex, and sexual and gender-based violence severely limit women's and girls' control over their own sexual health. In addition, low levels of formal education, lack of access to employment, and extreme poverty and food insecurity further exacerbate women's dependency on men for survival. In this context, many (young) women and girls, and even children, engage in *transactional sex* or *sex work* as a means of survival. A recent report by the World Bank shows that female sex workers and their male clients are the most important core and bridging populations in the HIV epidemics in West Africa (World Bank, 2008). *High-volume sex workers* – who often form a minority women engaged in the sex trade – account for a large part of commercial sex activity (sex acts), and are therefore one of the key groups that require priority attention.

Transactional sex involves providing sexual favours in exchange for money, food or other goods and favours. Women and girls – as well as some boys – involved in transactional sex typically do not identify themselves as sex workers, as they merely consider it a means of providing a livelihood for themselves and their children. Transactional sex is widespread in Liberia (Save the Children UK, 2006) and a major risk factor for HIV infection, STIs and unwanted pregnancies, especially as it takes place in a context of (economic) dependency, which makes it more difficult for women and girls to practice safer sex.

While research on the scope and impact of transactional sex is limited, it is documented by several studies and programme reports. A study by Save the Children UK in 2006 (Save the Children UK, 2006) revealed that transactional sex was a common survival strategy for girls aged 8-18 years in IDP camps and returnee communities, with many girls agreeing to have sex with older men for money, food and clothes. A high proportion of these girls was involved in what they called "man business", while girls aged 12 years and upwards identified as being involved in "selling sex" to men with money or status, including camp officials, humanitarian workers, businessmen, peacekeepers and government employees, while even teachers were frequently mentioned. Most girls cited the lack of economic and livelihood opportunities and chronic poverty as the main reasons for engaging in transactional sex. In some cases, families indicated that it was a means of supporting the wider family to access food or money to purchase food. The widespread nature of the problem meant it affected children in many environments, including entertainment centres, latrines, video clubs, bush land around camps, and even in homes. Discussions with communities showed an alarming trend, with girls and their families increasingly accepting that sex in exchange for goods and services was more and more becoming a common option for children to support themselves and their families.

A Continuum of Transactional Sex, Sex Work and Exploitation

The line between transactional sex, sex work and exploitation of girls and women is often blurred, and a clear classification of the types and patterns of transactional sex and sex work, and those involved in it is not easy. Different local studies identify *three broad categories* of women and girls engaged in selling sex: *prostitutes, hustlers, and homegirls*. These groups can co-exist in the same sphere, such as in or around nightclubs in Monrovia (Jennings et al., 2009).

1) Women referred to as *'prostitutes'* are professional sex workers, who identify themselves as such and are almost always organised by a pimp ('godpa') or madam ('godma'). They make a relatively good living, and as they are visible as sex workers, they tend to be stigmatised. Two main groups exist: a) the so-called "*high class*", which operates in expensive hotels, nightclubs and cinemas and often maintains a restricted clientele; and b) the "*low class*", which operates in cheap motels, market places, motor parks, as well as on the streets. Since 'prostitutes' are more professional and experienced in the trade, they are often better able to negotiate condom use than 'hustlers' and 'homegirls' (Jennings et al., 2009; Barh et al., 2001).

2) The so-called *'hustlers'* are 'survival sex workers', who sell sex intermittently as needed, often to obtain the basics of life or to supplement their income, and do not typically self-identify as prostitutes. They may be married or single, employed or not, or in business. They are mostly not organised, and generally work on the streets on a part-time basis. They are usually less experienced and unable to demand consistent condom use with their clients, and therefore more at risk of HIV/STIs (Jennings et al, 2009; Barh et al., 2001). Reports from internet-based news services paint a bleak picture of the lives of these survival sex workers in Monrovia, selling sex to pay for their own school fees and those of their smaller brothers and sisters (News.com, 2005).

3) *'Homegirls'* are the least well-defined group, whose practices mostly resemble transactional sex. They tend to live in their family home and are not engaged in sex work in any organised or survival context, nor do they self-identify as sex workers. They are typically *not* dependent on sexual transactions for survival, but use transactional sex or relationships with 'boyfriends' to maintain or improve their standard of living. For many 'homegirls', the ultimate goal is a steady relationship with a foreigner, based on mutual benefits (Jennings et al., 2009).

Sexual Exploitation and Trafficking of Women and Girls

As sex work becomes more organised to cater for an increasing demand, exploitation and even trafficking of women and girls becomes a real threat. Several studies and reports reveal that widespread poverty and the presence of large numbers of humanitarian workers and (military) peacekeeping forces have created a breeding ground for sexual exploitation and harassment of women. Monrovia has developed robust entertainment infrastructures catering to peacekeepers and other international actors and local elites (Jennings et al., 2009). Many young girls and women 'offer' themselves to humanitarian workers in order to secure much-needed household income. Interviews with parents showed that some had encouraged daughters to go out and search for food, using their bodies (Munala, 2007). Sex workers say soldiers often rape them without paying and refuse to wear condoms, putting them at the risk of HIV infection (News.com, 2005).

Informal accounts on regional news channels report that young women and girls, some as young as 10, in Liberia and neighbouring countries such as Sierra Leone and Ivory Coast become victims of organised sex trade and face the dangers of drugs, HIV/AIDS and trafficking (News.com, 2005). Criminal networks are known to be involved in regional and international cross-border trafficking of women and girls into sex work in Liberia, as well as to the UK and Western Europe, and from Sierra

Leone and Eastern Europe to Liberia (News.com, 2005).

2.3.3 (Young) Men and Clients of Sex Workers – including Mobile Men

While HIV-prevalence rates and the results of behavioural and social research in the field of HIV and sexual health clearly reveal the gender dimensions of the HIV/AIDS epidemic, with women and girls at considerably higher risk and vulnerability than men, unsafe sex behaviours do not only affect women and girls, but men and boys as well. The same social and cultural norms and expectations that result in women's disempowerment and (economic and social) dependency on men, lead boys and young men to accept the (dominant) gender roles that they learn through traditional and 'post-conflict' socialisation processes. Furthermore, Liberian men and boys are also victims of the impact of war and poverty, with limited or no options to improve their lives. While men are usually the perpetrators of sexual and gender-based violence against women, existing societal norms and the long civil war with widespread violence have left their mark on the lives of many (young) men as well. In this context, strengthening HIV-prevention efforts and protecting women from sexual and gender-based violence requires changing the prevailing gender and sexual norms and attitudes. This cannot be done by focusing on (young) women alone, but this requires the active involvement of men and boys in HIV-education efforts and vocational training in school and out-of-school settings.

Clients of sex workers

As mentioned above, female sex workers *and their male clients* are the most important core and bridging populations in the HIV epidemics in West Africa (World Bank, 2008), and thus require priority attention in the national response to HIV/AIDS. While little specific data is available on male clients of sex workers in Liberia, studies in West Africa show that these clients come from all professions and all walks of life. It is notoriously difficult to obtain accurate data on the proportion of men who have sex with FSWs, with substantial survey under-reporting. In the DHS household-based general population surveys in the region, the proportion of men who report having paid for sex in the last year ranges from 1.3 to 2.9 percent (World Bank, 2008). These data are however almost certainly gross underestimates, due to social desirability bias and selection bias, as surveys of this type miss most men whose work takes them away from home or who live in barracks or other compounds. Mobile men include truck and long-distance bus drivers, soldiers and UN peacekeepers, businessmen, small miners and others. Other data sources and estimation methods suggest that the proportion of men who are clients of sex workers is likely to be up to 10 times higher than the DHS estimates. Research indicates that high percentages of men with high-mobility occupations, and who often spend time away from their families, buy sex from sex workers; these include truck and long-distance bus drivers, seasonal workers, police and army personnel, UN peacekeepers, miners, fishermen. In addition to buying sex from commercial sex workers, these men may also have high rates of sex with non-commercial female partners, forming a "bridge population" between sex workers and the wider population. A negative effect of HIV/AIDS educational campaigns is that they have resulted in men buying less sex from overt, professional sex workers – particularly those working in brothels or other sex work establishments – and more from less obvious sex workers, who are perceived as lower risk, but with whom condom use is much lower.

2.3.4 Men Who Have Sex With Men (MSM)

In Liberia, as in most Sub-Saharan African countries, men who have sex with men (MSM) are an extremely marginalised population, facing widespread social ostracism, threat of violence and

stigmatisation. As a result of societal pressure and expectations, MSM often eventually marry and end up living "doubles" lives – engaging in unprotected (oral and) anal sex with multiple male sexual partners, while at the same time having sexual relationships with women.

In other parts of the West African region, the importance of MSM in the HIV epidemic is increasingly being recognised. HIV prevalence among MSM varies between 13.5% and 25.3% in different countries, much higher than any other group of men considered at high risk. Available data suggest that high rates of unprotected commercial and non-commercial anal sex occur between MSM in West Africa, with high rates of multiple partners. High proportions of MSM are also married and/or have sex with other women, with very low rates of condom use, acting as a bridge for HIV between MSM men and women. In Senegal, where prevalence of 21.5% has been found among MSM in Dakar, assuming that 3% of men engage in male-to-male sex, an estimated 20% of current HIV infections could be due to sex between men (World Bank, 2008).

A recent qualitative study (Martin et al., 2009) on HIV risk behaviours among 25 MSM in Liberia reveals that MSM in post-conflict Liberia are at high risk for HIV/AIDS because of the prevalence of unprotected sex, history of STIs, and limited knowledge of HIV/STIs. It also shows that their lives are characterised by cultural marginalisation, widespread discrimination and social rejection. MSM are concerned about the lack of legislations to recognise, respect and protect their fundamental rights.

Preliminary data from another study on the extent of HIV risk among MSM launched in mid 2009 (amFAR, 2009) document the existence of a sizeable and growing community of MSM in Liberia. Findings highlight their lack of education on HIV and STIs, and high risk of contracting and/or transmitting HIV because of being "closeted". This makes it particularly difficult to reach them with specific HIV-prevention interventions, thus exacerbating the risk of contracting HIV for them and their sexual partners, including their wives and unborn children. While more information is needed to understand the scope and nature of MSM culture in Liberia, both studies show the importance of more openness on MSM and HIV/AIDS, and of legislations to protect their basic human rights.

Men in incarceration

A special group that is often at high risk of HIV/STIs are men in incarceration. As a result of long-term confinement to small spaces with other men and without women, unprotected sex among male prison inmates – including high-risk anal sex, and both voluntary or forced sex, including rape – is common in most countries of the world, including West Africa. The lack of access to HIV/STI education, condoms, and the strong stigma and social rejection surrounding MSM – especially since most prison inmates engaging in sex with men do not self-identify as homosexual – makes it extremely hard to reach them with effective HIV-prevention interventions. In addition, after their release from prison, former prisoners who have been engaged in unsafe sex with other men, may further transmit HIV to their wives and other female sexual partners. The main obstacles for HIV prevention in prisons include a lack of knowledge and understanding of the sexual networks in prisons; the limitations to provide HIV-prevention services and condoms in prisons; and the strong social stigma and discrimination with regard to MSM. Hence, more research is a key step towards strengthening HIV prevention in this field.

2.3.5 Infants Born to HIV-Infected Mothers

While sexual transmission of HIV is the dominant route, transmission from mother to child is a major concern as well. Without measures to prevent parent-to-child transmission of HIV (PPTCT), approximately one in three children born to HIV-infected mothers will be infected by the mother,

either intrauterine, during delivery, or through breastfeeding. Today, PPTCT is one of the most cost-effective HIV-prevention interventions, considerably reducing the risk of vertical transmission. In addition, provider-initiated HIV testing in the context of PPTCT offers an entry point for HIV-infected mothers (and their newborn children, partners and families) to effective ARV treatment, care and support (PPTCT-Plus). With support from donors and UN agencies, the MoHSW is developing a PPTCT policy and guidelines (to be finalised by August 2010), while an increasing number of health facilities are upgraded and health-care staff trained to offer PPTCT services to HIV-infected pregnant women, their partners, children and families. Despite these efforts, children born to HIV-positive mothers still face the risk of HIV infection. Weak health systems hamper effective VCT services, which results in most HIV-infected women being unaware of their HIV status, and not seeking adequate services, including PPTCT. Furthermore, the coverage of PPTCT services is still restricted to a limited number of facilities, while the utilisation of these available services is further hampered by inadequate antenatal care, and low rates of women consistently using ANC services, which makes it difficult to offer PPTCT services to those in need. Hence, an important priority for the NSF-II is to further strengthen health systems and integrate PPTCT-Plus services into Maternal and Child Health services, as an integrated component of the basic package of health services (BPHS).

2.3.6 People Living With HIV/AIDS (PLHIV)

People living with HIV are a particularly vulnerable group, as they need access to a range of HIV prevention, care, support and treatment services. Inadequate or interrupted access to these services presents a direct threat to their health and wellbeing, as well as to those around them, as they may unknowingly transmit HIV to sexual partners or unborn children. While services for PLHIV, including ART, are increasingly available in the country, many of these services depend on a functioning, adequately staffed public health-care system, with accessible and affordable services. However, due to the impact of war and poverty, and despite ongoing efforts to restore the health system, structural problems in terms of staffing, infrastructure and adequate supplies continue to hamper access to key HIV services.

1) The first obstacle to accessing these services is the fact that most HIV-infected people are unaware of their HIV status, since they have never gone for voluntary counselling and testing (VCT). In this regard, key attention is needed for expanding provider-initiated testing and counselling (PITC) in a number of health-care settings, such as antenatal care (PPTCT), STI and TB services, especially in rural areas. 2) VCT and PITC are the main entry points to other AIDS care and treatment services. This requires adequate referral between different departments and programmes, and special training, equipment and reliable supplies without stock-outs of key commodities, such as drugs for ART and treatment of opportunistic infections (OIs) and test kits and reagents. To date, however, referral systems are weak, with HIV services often still operating as stand-alone, vertical programmes, which lack integration into the overall health system. Furthermore, ART, OI treatment and palliative care are only available at a limited number of sites, with low coverage and utilisation, particularly in rural areas. The rapid roll-out of these programmes to additional sites is hampered by a lack of skilled staff and weak procurement and supply-chain systems. In addition, the *sustainability* of expensive ARV and OI treatment beyond the current support by Global Fund and other donors is uncertain. Problems with adherence to ARV treatment not only threaten the health of PLHIV patients, but also lead to the development of resistance: an increasing number of patients requires (even more expensive) second-line treatment, also as a result of TB and other co-infections. 3) In addition to care and treatment provided through the health sector, PLHIV need comprehensive care and support, including nutritional support for those on ARV treatment; TB treatment and home-based medical and other care and support from health professionals and communities. However, poverty and weak community systems make it difficult for families and communities to provide adequate support to PLHIV. 4) HIV-related stigma, discrimination and social rejection pose a serious

threat to PLHIV's wellbeing, as well as their access to work, health, education and other services. Negative attitudes towards PLHIV by health-care workers may keep PLHIV from seeking health care, or health-care workers may refuse to offer them services. This may affect their access to ARV and OI treatment, care and support, as well as PPTCT. Stigma and discrimination may also affect the access of PLHIV to education and work. HIV-infected women face additional stigma, as HIV infection is often associated by society with promiscuity, which is tolerated for men, but not accepted for women. *Summarising*, while access to HIV/AIDS treatment, care, support and prevention services is scaled up to an increasing number of health facilities, weak health systems, and stigma and discrimination hamper PLHIV's access to these services.

In addition to access to these services, PLHIV play a key role in preventing the further spread of HIV. To date, HIV-prevention efforts have placed insufficient emphasis on the active involvement and role of PLHIV in *"positive prevention".*

2.3.7 Orphans and Vulnerable Children (OVCs)

Ten percent of Liberian households have a single orphan and 2 percent have double orphans (UNICEF, 2005). Thirty-five percent of households in Liberia have either foster or orphan children, with the percentage much higher (40%) in urban areas than in rural areas (31%). Rural children are more likely to live with both parents than urban children. The highest proportion of children living with both parents is in the Southeastern A region (56%) and the lowest proportion is in Monrovia (37%) (LISGIS, 2008). An OVC situation analysis report indicates that *many* children are vulnerable in Liberia, and that for most their vulnerability is not due to the impact of HIV or AIDS. However, children who have been orphaned by AIDS often face additional problems, as they may be discriminated against and deprived of basic human rights to education and health as a result of HIV-related stigma and discrimination. But children who have been orphaned by other causes are no less vulnerable, and this is particularly relevant when looking at the needs of OVC in Liberia where relatively few children have been orphaned as a result of AIDS to date. Children who are not orphans may also be vulnerable for other reasons, and where economic conditions are difficult this has ramifications for their education, health, well-being and safety.

3. LIBERIA'S NATIONAL HIV/AIDS RESPONSE TO DATE

After 25 years of instability and a devastating 14-year civil war (1989-2003), Liberia is on its way to development and recovery. Much of the population has been without access to basic services, including health services, for decades, and there is very little reliable data to guide national policies and plans. Despite these challenges, Liberia's national response to HIV/AIDS has seen clear progress, with successful scale-up of key HIV/AIDS services – albeit on a modest scale. The new administration of President Ellen Johnson Sirleaf has shown strong political commitment to addressing HIV/AIDS at the highest level, and HIV/AIDS has been adequately incorporated in the macroeconomic development frameworks. International support, especially through the Global Fund, has been the main source of funding to date. The main challenge for the future is to consolidate and further expand the national response in a sustainable way.

3.1 MANAGEMENT, COORDINATION AND FINANCING

3.1.1 National Management and Coordination Structures

In 1987, the Ministry of Health and Social Welfare (MOHSW) established the *National AIDS & STI Control Programme* (NACP) after the first HIV case in Liberia was reported in 1986. As a result of the war and lack of funding, however, the NACP and the national response remained inactive for many years. In 1999, the NACP and the newly established *Expanded Theme Group on HIV/AIDS* jointly developed the *Multisectoral National Strategic Plan (NSP) of Action 2000-2004.* The NSP was costed at USD 6 million, but could not be implemented due to a lack of resources. A first, unsuccessful attempt to establish a *National AIDS Commission* (NAC) took place in 2000, with the aim to promote a more *multisectoral* response beyond the health sector. Similarly, the *National HIV/AIDS Policy and Legislation*, developed in October 2002, was not successfully enacted.

In 2004, after the NSP 2000-2004 had expired, the first *National HIV/AIDS Strategic Framework (NSF) 2004-2007* was developed. It aimed to promote the active involvement of public and private sectors and included all major prevention, care and treatment components, such as IEC/BCC programmes, HIV prevention among most-at-risk populations, condom promotion, STI treatment; VCT and PPTCT services; blood safety; ARV treatment and treatment of opportunistic infections, and OVC support.

After a dysfunctional period of several years, the NACP was re-established in 2006 to oversee HIV/AIDS programming of the MOHSW. To date, the NACP primarily leads and coordinates the health-sector response to the epidemic, and is a major sub-recipient of the Global Fund with implementation functions in the field of treatment (ARVs, OIs) and PPTCT.

In June 2007, the Liberian *National AIDS Commission* (NAC) was formally reconstituted as the primary national body to coordinate, monitor and mobilise resources for the national response to HIV/AIDS. NAC set up a Steering Committee, which developed draft legislation and an initial strategic framework for HIV/AIDS in 2008. Chaired by the President, NAC aimed to strengthen the multisectoral character of the response beyond the health sector. Till recently, functioning of the NAC has remained suboptimal, as a result of delays in formalising its legal status and the lack of its own Secretariat. The recent appointment in February 2009 of the Executive Director of the NAC Secretariat has marked the beginning of a more effective coordination of a truly multisectoral response.

In addition to these governmental programmes and coordinating bodies, Liberia has implemented Global Fund-supported programmes since 2002. In this context, the so-called *Liberia Coordinating Mechanism* (LCM) was established – with wide membership of all national stakeholders, ministries, UN agencies, NGOs and bilaterals – to oversee and coordinate the implementation of GFATM programmes in the field of HIV, TB and malaria.

3.1.2 Multisectoral Involvement and Coordination

Government Ministries – To date, limited involvement of public and private sectors *beyond the health sector* has hampered the effectiveness of the national response to HIV/AIDS. A comprehensive multisectoral response requires the active involvement of other ministries and agencies, including the Ministries of Education, Gender and Development, Labour, Defence, Transport, Agriculture, Youth and Sports, and Information, Cultural Affairs and Tourism. In addition to their ability to *reach* specific populations (e.g., children and young people, uniformed personnel, truck drivers), Ministries are also major employers in the formal sector, with unique opportunities for large-scale workplace interventions. Moreover, every Ministry and sector will need to address the impact of HIV/AIDS among its own staff and their dependents, including issues such as access to care, support and treatment.

Specific sectoral responses to date include the NACP in MOHSW, which plays a key role in clinical HIV/AIDS services and surveillance. The MOHSW has the most widespread geographical network of health facilities and County Health Teams, and a large number of health-care staff, many of whom are directly involved in HIV/AIDS care, treatment and prevention. The MoE is in the process of developing a sectoral HIV/AIDS policy, strategy and workplan, and has appointed a HIV/AIDS Desk Officer at the MoE School Health Department. MoE has also incorporated life skills education in the school curriculum, as well as training teachers on HIV/AIDS and related issues. The MoYS is conducting HIV/AIDS activities for youths, while MoGD is supporting HIV/AIDS with respect to gender issues in all sectors – especially with regard to SGBV – and has appointed a HIV/AIDS Focal point. Furthermore, the MoL has developed and launched a *Workplace Policy for HIV in 2009*, and is planning a programme to train line and private business organisations on the policy. Finally, the MoD is currently preparing a HIV-prevention and control policy and strategy for the military.

Civil Society Organisations and the Private Sector – To date, *civil society organisations* (CSOs) have played a key role in all aspects of the national response. These include the Catholic and Lutheran churches, faith-based organisations (FBOs), international relief organisations, as well as some private companies. While initially, most CSO activities lacked proper coordination, this has improved with the advent of the Global Fund-based LCM. Experiences have shown the particular need to strengthen local NGOs with institutional and technical capacity building and resources.

UN Agencies – UN agencies and programmes, such as UNAIDS, WHO, UNFPA, UNICEF, ILO, UNIFEM and The World Bank have made important contributions to all elements of the national response through technical and financial support. The UN Theme Group on HIV/AIDS, supported by UNAIDS, aims to guarantee adequate coordination of activities within the UN system and with other stakeholders, although adequate harmonisation is still a challenge.

County level – Effective management and coordination at the county level also remains a particular challenge. County Health Teams are primarily tasked with coordinating HIV/AIDS activities, but the lack of coordination at the central level, the limited integration of NACP as a vertical programme within MOHSW, and the overall limited degree of decentralisation encumbers already understaffed counties with weak infrastructures.

3.1.3 HIV/AIDS in Broader National and International Policy and Development Frameworks

In addition to the HIV/AIDS-specific policies, frameworks and plans mentioned above, HIV/AIDS has also been incorporated as a key priority in other national policies, strategies and plans. The MoHSW has included HIV/AIDS a priority area and *Milestone Indicator for Health* in the *National Health Policy* and *National Health Plan 2007-2011* (MOHSW, 2007), with HIV/AIDS prevention and care/treatment services as part of the Basic Package of Health Services (BPHS), which includes HIV education, condom distribution; home-based care; treatment of opportunistic infections; VCT; PPTCT; blood screening and antiretroviral therapy.

HIV/AIDS was also included in the *Interim Poverty Reduction Strategy* (iPRS) 2006-2008 (GoL, 2006), and more recently, as one of five cross-cutting issues featured under all four 'Pillars'[7] of the *Liberia Poverty Reduction Strategy 2008-2012.* In addition, HIV/AIDS is recognised as a key issue for other LPRS priorities, "Gender" and "Children and Youth".

Furthermore, HIV/AIDS plays a key role in a number of *international agreements and declarations* that have been formally endorsed by the Liberian government. HIV/AIDS is a central issue in the *Millennium Development Goals* (Goal 6) – established in September 2000 – which include goals, targets and baseline indicators to measure progress with regard to HIV/AIDS (GoL; UNDP, 2002). Furthermore, Liberia is a signatory to the *Abuja Declaration on HIV/AIDS, TB and other related Diseases* of the African Union Summit on HIV/AIDS in 2001; as well as the 2001 UNGASS Declaration of Commitment on HIV/AIDS. Liberia has furthermore endorsed the *Three Ones principles* for the coordination of national AIDS responses in 2004, and in June 2006, the UN General Assembly's commitment to scale up towards the goal of *Universal Access* to comprehensive HIV prevention programmes, treatment, care and support by 2010. Most importantly, however, the formal commitments made by the Liberian Government, are increasingly visible in high-level political commitment by the President of the republic and other national leaders, as well as in the establishment of the National AIDS Commission directly under the President.

3.1.4 Resource Mobilisation and Financing for HIV/AIDS

As a result of its ongoing reconstruction phase, Liberia has very limited national revenues. Hence, the government contribution to the national HIV/AIDS response has been restricted mainly to staff salaries and office space within Ministries, and a recent allotment of USD 100,000 for the National AIDS Commission in 2009. The vast majority of available HIV/AIDS funding comes from international development partners, including the Global Fund (GFATM), the UN System, international NGOs, bilateral donors (e.g. USAID, Irish Aid) and smaller donors. The UN Joint Programme (2008-2010) committed USD 5.5 million for HIV/AIDS in 2008. In addition to HIV-specific funding, health-sector funding also (in)directly benefits AIDS activities; e.g., faith-based organisations manage 44 health facilities under the auspices of the Christian Health Association of Liberia (CHAL) (MoHSW, 2007). The main challenge is to ensure sustainable government financing to reduce the current overdependence on external donors. Additional funds may be needed for the NSF II to allow further expansion of key HIV programmes beyond the health sector.

[7] The four pillars of the Liberia Poverty Reduction Strategy are: 1) Security; 2) Economic Revitalisation; 3) Governance and Rule of Law; 4) Infrastructure and Basic Services).

Global Fund-supported Programmes

In June 2004, the first considerable amount of funding, a total of almost USD 7.7 million, became available through the Global Fund in ***Round 2***. As of 2005, this first GFATM programme allowed the Government of Liberia to start implementing key components of the national response to HIV/AIDS, including blood safety, IEC/BCC and condom promotion, home-based care and treatment. The programme also strengthened laboratory capacity and monitoring and evaluation.

In late 2006, a second GFATM programme was approved for a total amount of USD 31.15 million (GFATM, 2009)[8] for a 5-year period of June 2007-2012. This ***Round-6*** programme allowed the further strengthening and scale-up of a more comprehensive national response, including components such as IEC/BCC for HIV awareness and reducing stigma and discrimination; condom promotion; blood safety; STI treatment; VCT; PPTCT; ARV treatment and treatment of opportunistic infections, as well as the integration of TB/HIV; and care and support for PLHIV and others affected. In addition Round-6 support aimed to strengthen health systems by building capacity of public and private health facilities at county and district levels. Experiences to date have shown that a rapid scale-up of HIV/AIDS services is possible if adequate financial and technical support is available: Care and treatment services expanded from only three private facilities offering ART in and near Monrovia in November 2006 to 15 sites in nine counties by 2008. Similarly, the availability of PPTCT services has increased from three facilities in 2006 to 18.

Additional funds for HIV/AIDS will become available in 2009 through the recently approved ***Round-8*** proposal, which amounts to a total of USD 77.7 million. This programme has two major components: an HIV-specific component (USD 51.1 million,) and a component for health systems strengthening (HSS) (USD 19.2 million). The HIV component will support further expansion and improvement of facility-based HIV/AIDS services, in order to promote equitable geographic access to high-quality services. Another priority area is further strengthening of HIV awareness and safer sex behaviours, especially consistent condom use. In addition, the programme will focus on *strengthening community systems*, and effective partnerships between government, NGOs, the private sector and CBOs, particularly with PLHIV associations and support groups. The *HSS* component will 1) Strengthen staffing and human resource capacity in health-care facilities, laboratories and pharmacies; 2) Strengthen infrastructure and equipment of laboratory and blood-safety systems at national and regional levels, and an improved laboratory referral system; and 3) Improve quality assurance and supply-chain management.

In the absence of a coordinated mechanism for tracking financial resources, it is difficult to monitor funding flows, especially since most is not channelled through NACP, but disbursed directly through international NGOs and other implementing partners. The only tracking system is used by the Global Fund, which uses performance-based disbursement.

3.2 HIV/AIDS SERVICE DELIVERY

3.2.1 HIV-Prevention Programmes and Services

Awareness-Raising, IEC and Behavioural Change Communication

Information, education, and communication (IEC) and behaviour change communication (BCC) programmes by government and NGOs have contributed to high levels of general awareness of HIV/AIDS. Common IEC/BCC methods include billboards and posters, T-shirts, brochures and

[8] The original Proposal budget was for USD 44.3 million; The Grant Scorecard indicates an amount of USD 33.6 million.

leaflets in waiting areas of hospitals and health centres, and mass-media campaigns through the network of 21 radio stations across the country and messages to cell-phone users. The umbrella organisation *Media Against AIDS* (MAA) has been involved in a few awareness campaigns, and a biweekly phone-in programme "Staying Alive" has high coverage and response. There has, however, been limited targeting of special groups, such as truck drivers, youth and women.

Despite these efforts, comprehensive HIV/AIDS *knowledge* remains poor, and denial, stigma and discrimination remain widespread. Furthermore, high awareness has not resulted in safer sex behaviours. The effectiveness of IEC/BCC interventions is hampered by the absence of a clear, coordinated BCC strategy, and the failure to tailor IEC messages and methods to the information needs of different population groups. Most messages focus on the most basic facts, while failing to take socio-cultural norms and practices into account. Many media are still not involved, and more sustained support is needed to strengthen their role in HIV/AIDS education agenda setting and advocacy. In addition, there is a lack of coordination between mass-media and more interpersonal BCC approaches in health-care and education settings. While IEC campaigns have shown some success in increasing demand for VCT services and mobilising community support, a more specific focus is needed to promote HIV/AIDS services such as STI treatment, PPTCT and ARV treatment. In addition, IEC should promote a more supportive environment for PLHIV and the reduction of stigma and discrimination.

Condom Promotion

With a high proportion of sexually active young people and high levels of transactional sex, condom promotion has always been a key component of the national response. Large amounts of male and female condoms, made available by the Global Fund, UNFPA and USAID, were distributed primarily through NACP. E.g., in 2007, 2.6 million male condoms were distributed. Recognised condom-distribution outlets include health facilities, VCT centres, hotels and entertainment centres, and workplaces. There are a few youth-friendly centres stocking condoms in Monrovia and some counties. In addition, condoms are sold through a few commercial outlets. A social marketing system for condoms is not yet in place, although a pilot project is ongoing.

Despite these efforts, *correct and consistent use* of condoms is still low across the country. The 2007 LDHS study shows that among young people aged 15-24 years, only 6 percent used a condom during their first sexual intercourse, and only 14 percent of women used a condom at the last higher-risk sex. The availability, accessibility and proper condom education still need more attention. Condom distribution still lacks coordination and there are limited outlets for distribution to communities.

Counselling and Testing

Between June 2007 and December 2008, a total of 81,576 persons were tested for HIV, with a high percentage (72%) of uptake of testing following counselling. VCT services are provided in 89 health facilities (75%), community-based services (14%) and stand-alone VCT centres (11%) in 14 counties. The Christian Health Association of Liberia (CHAL) offers outreach and mobile VCT services in counties that lack VCT centres. Most of the HIV counselling and testing (73%) takes place in the context of *provider-initiated testing and counselling* (PITC) aimed at higher-risk groups (NACP-2, 2009), while 23 percent of people tested had taken the initiative to go for VCT themselves. National VCT guidelines were developed in 2006, and testing protocols and training of counsellors standardised, with all counsellors trained in three recognised training institutions.

Nevertheless, overall VCT coverage is still low as a result of insufficient promotion, gaps in service provision, and the inability of some VCT providers to provide results to clients on the same day. Also, while all donated blood is screened, VCT is not yet offered to all blood donors. Despite

the national guidelines and protocols, the quality of VCT services is still inadequate, with VCT providers that have not been accredited using different algorithms for testing.

Prevention of Mother-to-Child Transmission (PPTCT)

In March 2009, there were 31 sites providing PPTCT services in 10 counties, the majority in Bong and Montserrado counties. Most PPTCT sites are based at mission and private hospitals and international NGOs. The MOHSW aims to further scale up access to PPTCT by integrating PPTCT services into all health facilities providing maternal and child health services as part of the Basic Package of Health Services (BPHS). Integrated guidelines on HIV testing, blood safety and PPTCT have been developed, and an increasing number of ANC attendees now receive HIV counselling and testing. While in 2006 only 629 pregnant mothers completed counselling and testing, this had increased to 32,518 between June 2007 and December 2008, of whom 562 HIV-infected women received PPTCT services.

Further PPTCT scale-up is hampered by the limited capacity of the health system and the decrease of PPTCT utilisation as pregnant women progress through the ANC system through to deliveries. The success of the PPTCT programme is dependent on access to VCT and family planning services, and the use of health-care facilities by pregnant mothers for antenatal care and deliveries. LDHS data show that while almost 79 percent of pregnant women receive antenatal care from a trained health professional (94% in urban areas; 72% in rural areas), only 37 percent of deliveries takes place in health facilities, with the majority (61%) at home, and less than half (46%) of births delivered with the help of a trained health professional and 48 percent by a traditional midwife.

STI Treatment

Sexually transmitted infections (STIs), which are associated with facilitating HIV transmission, remain a significant public health problem. National STI management guidelines and protocols were developed in 2005, and over 240 health health-care staff from public and private facilities were trained in syndromic management of STIs. STI drugs provided by the Global Fund have facilitated free STI treatment: between June 2007 and December 2008, more than 184,000 patients were diagnosed and treated for STIs in accordance with national guidelines. Furthermore, STI patients are provided with free condoms.

Blood Safety

National guidelines (MOHSW, 2005) stipulate that all blood and blood products must be screened for HIV and other transfusion transmissible infections, such as syphilis and hepatitis. The MOHSW established a *national blood safety programme* to coordinate blood safety in the three blood banks located in Nimba, Grand Gedeh and Montserrado counties. The supply of test kits to public and private laboratories and VCT centres is now solely through MOHSW and is free of charge. Despite occasional stock-outs of reagents in the counties, all blood is reportedly screened for HIV before transfusions. Currently, national blood transfusion policy, guidelines and standard operating procedures (SOPs) are being revised alongside an assessment of the current state of blood safety and capacity of health workers. The *Association of Voluntary Blood Donors* (VOBDAL) promotes voluntary blood donations, although some hospitals only use replacement donors. At least 45 laboratory staff from public and private facilities have been trained on safe blood and transfusion practices by VOBDAL and MOHSW in collaboration with WHO.

Universal Precautions and Post-Exposure Prophylaxis (PEP)

MOHSW has been promoting the strict application of universal precautions (UPs), including the safe handling and disposal of sharps, safe decontamination of instruments, safe disposal of contaminated waste and the use of gloves to prevent direct contact with blood and body fluids. The National Protocols for HIV/AIDS and ARV care (June 2006) specify the PEP regimen to be applied after accidental occupational exposure to blood in health-care settings. Furthermore, UNFPA has provided *rape prophylactic kits* for STI, and PEP for accidental occupational exposure to major health centres and hospitals. Training on PEP has been organised for UN staff and implementing partners, and the MSF hospital in Paynesville was contracted by UNFPA to organise RAPE management training. In addition to PEP services for rape victims, the Liberian Government has formed the *National GBV Task Force*, as well as a GBV Secretariat within the Ministry of Gender and Development. A National GBV Plan of Action aims to provide appropriate skills to health professionals; improve documentation and reporting on clinical evidence; reform the legal system to deal more efficiently and expeditiously with violence; establish systems and outreach services for survivors; and ensure that women and girls have access to economic and social empowerment programmes.

Special Programmes for Vulnerable and Most-at-Risk Groups

While many HIV-prevention interventions have been health-system based, activities for specific at-risk groups have been limited. Examples include women and girls, sex workers and their clients, mobile men (e.g. truck drivers), uniformed personnel, prison inmates and MSM. Limited research and the absence of second-generation surveillance among most-at-risk population (MARP) groups have led to inadequate knowledge about their specific risks and vulnerabilities. In addition, it is often difficult to effectively reach them with interventions that are tailored to their needs.

Female sex workers – Specific HIV-prevention programmes among sex workers have been limited, although sex work and transactional sex are well documented and known to be commonplace. Sex workers have been trained as peer educators in HIV/STI prevention. IEC programmes for sex workers should better focus on specific hot spots for sex workers, such as bars, cafes, hotels, military barracks, places where UN peacekeepers go, truck stops, bus stations. In addition, sex workers should have access to 'friendly' STI treatment and other basic reproductive health-care services.

Clients of sex workers – Clients of sex workers have a particular HIV/STI risk, and constitute a bridge population as they may pass on HIV/STI infections to their wives and other sex partners. Sex work is often associated with mobile men, as well as men with a regular income. This includes truck and bus drivers, uniformed personnel (military, police and border guards, UN peacekeepers), cross-border traders and migrant workers, men working on rubber plantations, as well as international or local businessmen.

In response to reports of involvement of UN peacekeeping forces in acts of sexual exploitation and abuse (SEA), in April 2006, the UN system reiterated its zero-tolerance policy for civilian and military peacekeepers with regard to sexual exploitation and abuse, which includes prohibition of "exchange of sex for money or any form of assistance. The zero-tolerance policy is actively enforced through an internal reporting system. Each UN agency has trained focal points who monitors any allegation of sexual exploitation. The military has ongoing activities for uniformed personnel and MoD is developing a strategy for the military. To date, however, there are no programmes for police, immigration, customs and drug-enforcement agencies.

Mobile populations – There have been no studies on the prevalence of HIV among mobile groups in Liberia, such as truck drivers, refugees and IDPs, migrant workers, cross-border traders and others. The African Development Bank funded the *Mano River Basin* sub-regional HIV/STI-prevention project for cross-border populations, internally displaced persons, ex-combatants and host communities. The *OPEC for International Development* funded the strengthening of existing HIV-prevention programmes for refugees, Internally displaced people, returnees and host communities in Liberia. Furthermore, the Ministry of Defence is currently preparing a policy and strategy for HIV prevention and control in the military.

School-based programmes – With support from UNICEF, MoE has developed a draft national HIV/AIDS policy and strategic plan for the education sector. The school health education curriculum is being revised to include an HIV component. The Ministry of Education (MoE) and NACP have developed a teacher's guide and student modules on life skills with support from UNICEF and UNESCO. Furthermore, the MoE Division of School Health has led the efforts to train peer educators and advisers in the counties.

Workplace Programmes – In 2009, the Ministry of Labour (MoL) developed and launched a HIV/AIDS workplace policy, and is currently planning a programme to train line and private business organisations on the policy. In 2003, MoL was supported by UNFPA to pilot a workplace project including education on sexual and reproductive rights, and condom distribution. The Firestone rubber company, which has 6000 workers who live with their families on company property, has a large HIV/AIDS workplace programme, which in 2007 already included ARV treatment for 150 people. However, given the low number of formal employers in Liberia, workplace programmes are limited. Government ministries are the largest employer, but to date, there have been limited workplace programmes. Other employers to be involved in HIV prevention in the workplace may include transport companies, road-construction companies, as well as any major (future) infrastructural investment programme.

3.2.2 Treatment, Care and Support

ARV Treatment and Monitoring

To date there are an estimated 53,000 adults living with HIV in Liberia (LISGIS, 2008). *Antiretroviral therapy* (ART) was started in 1999 at a private facility run by Firestone plantation in Margibi County, followed by two mission hospitals in Monrovia. Drugs were financed through donations and by Government. Since 2006, the Global Fund has become the primary source of ARVs. As of September 2009, there were 19 sites in 10 counties providing ART, with a cumulative number of 2,968 patients who had started ARV treatment. Although less than 2 percent of adult patients was on second-line ART, an increasing number of ART sites is switching patients to second-line treatment, which indicates increasing failure of treatment, due to inadequate ART adherence as well as TB co-infections. Eight CD-4 machines have been installed at public and private health centres, and laboratory technicians trained. While cuts in ARV drug prices each year have facilitated access to ART, weak health systems and a severe shortage of skilled staff are the main challenges for further ART scale-up. In addition, procurement and logistic problems have plagued ART from the beginning, with ARV stock-outs hampering effectiveness of ART. Also, inadequate forecasting has led to large quantities of expired paediatric and second-line ARVs.

Care and Support for the Chronically Ill

In accordance with MoHSW standards, all HIV-diagnostic care and treatment services are to be provided free of charge as part of the BPHS at both private and public facilities. *Opportunistic*

infections (OIs) are treated generally in all facilities. NACP provides OI drugs to all facilities administering ARVs but there is no systematic reporting from any of the facilities on the number of HIV-infected cases and the types of OIs diagnosed.

Impact-mitigation efforts have been initiated by multiple partners in different parts of the country. International and local NGOs, FBOs and CBOs and PLHIV support groups provide home-based care and support (HBC) to PLHIV and their families, including orphans and vulnerable children (OVCs). Services include food, psychosocial counselling, medical services and home visits. However, home-based care is not standardised and integrated into the care and support system: there is a lack of common standards and guidelines, no common programme for training and supply of HBC kits to health-care providers, and no proper coordination and referral systems between VCT sites and HBC providers. In addition, community capacities have not been sufficiently strengthened for provide outreach and support for PLHIV and OVCs, although between June 2007 and December 2008, more than 2000 community service providers were trained in community-based care and support. In general, HBC services are not available in the counties because of stigma, as many patients will not want to be visited at home by health workers. There are two hospices for terminally ill patients, one in Monrovia and one in Maryland County, both operated by the Catholic Church.

PLHIV Support Groups

PLHIV have formed self-support groups in several hospitals where they receive treatment. The *Light Association*, a PLHIV CBO, provides overall coordination and direction. Several FBOs provide peer-education and life-skills training for PLHIV, and organise income-generating activities (IGAs), as well as microcredit programmes for women with HIV. *Concern Worldwide* supports an advocacy and awareness programme to promote greater involvement of PLHIV (GIPA) and peer support, as well as IGAs. The World Food Programme (WFP) has been providing food aid to PLHIV, with plans to expand this to families. WFP also supports IGA training for women living with HIV.

Orphans and Vulnerable Children (OVCs)

The 2004 '*Children on the Brink*' report estimated there were a total of 1.8 million vulnerable children, of whom 230,000 are orphans (13%), and 36,000 are AIDS orphans (16% of all orphans). The extended family is the major support mechanism for vulnerable children in Liberia: 35 percent of households in Liberia have either foster or orphan children (40% in urban area and 31% in rural areas). However, widespread, extreme poverty makes it increasingly hard for families to support OVCs, and a large number of children live in private or church-run orphanages. However, the OVC problem has still not been prioritised in national policies, strategies or even guidelines. International and local NGOs, FBOs, CBOs and PLHIV associations provide *care and support* to OVCs, including food, psychosocial counselling and financial support to purchase school uniforms and materials for OVCs. Relatively few NGOs are working directly with those affected by HIV/AIDS. In 2008, 1,550 AIDS orphans received external care and support through the Global Fund. The *Liberian Orphans and AIDS Foundation* (LOAF), established in 2001, is the largest NGO supporting AIDS orphans (more than 600). LOAF operates in five counties, placing orphans in family homes, and providing nutritional and legal support, funding for schooling and counselling.

3.3 HEALTH SYSTEMS STRENGTHENING (HSS)

To date, health-care facilities of government, churches and international relief organisations have played a key role in providing essential HIV/AIDS prevention, care and treatment services. However,

in the aftermath of the total collapse of the public health system in terms of human *resources, facilities and equipment*, HIV/AIDS service delivery has relied heavily on vertical programmes, which lack effective integration into the overall health-care system. Ultimately, a sustainable response to HIV/AIDS depends on effective health *systems*. In this context, there has been increasing attention and funding for *health systems strengthening* (HSS) to ensure adequate capacity and long-term sustainability of the national HIV/AIDS response.

Strengthening Human Resources

Human resource limitations in the health sector have seriously affected the delivery of quality HIV/AIDS prevention, treatment and care services. In addition, the HIV/AIDS epidemic has further increased workloads; e.g. HIV/AIDS patients currently account for 25-35% of inpatients in the JFK hospital. Staffing problems are particularly acute in rural areas. In response, the National Health Plan (NHP) promotes a coordinated approach to human resources planning, specifying the minimum number and distribution of trained health workers to deliver the BPHS, with a key focus on enhanced staff performance, productivity and retention. In order to support and oversee the effective roll-out of the NHP's human-resource component, the MOHSW has established a *Human Resources and Development Unit*, and has introduced a *national incentive scheme* to ensure minimum staffing levels. In this context, MOHSW intends to employ 964 additional doctors to fully meet the manpower needs of the health sector. Furthermore, the Health Sector Pool Fund has prioritised scholarships for domestic and international training, and support for the School for Nursing and Midwifery.

The Global Fund and other partners have been supporting the health workforce through the provision of top-up allowances, and has supported c*apacity building* of health and social workers in areas such as VCT, ARV treatment, and diagnosis and treatment of STIs and OIs. By the end of 2008, 1450 staff had been trained.

Furthermore, *MOHSW management levels have been strengthened*, with County Health Teams and MOHSW national staff trained in leadership and management. Coordination within the health sector is being improved through a *Programme Coordination Team* for senior MOHSW staff, and a *Health Sector Coordinating Committee* with MOHSW and donors representatives. Furthermore, MOHSW is strengthening information sharing between national and county levels through *Integrated Quarterly Review Meetings.* The World Bank's Health Systems Restructuring Project will support VSAT technology in 7 of the 15 county health teams to improve coordination.

Infrastructure and Logistics

HIV-service provision requires adequate infrastructure and logistics, including physical space, equipment, utilities, transport, communications and waste management. Several bilateral and multilateral donors have been supporting the NHP targets of 70% coverage of all health facilities and laboratories with adequate infrastructure, equipment and logistics by June 2010. The USAID-funded *Rebuilding Basic Health Services (RBHS) project* will support the rehabilitation of 114 health facilities in five counties (USD 53 million over five years). The infrastructure of County Health Teams has also been strengthened.

Effective ***supply-chain management*** is hampered by poor road conditions and county-level weaknesses in requisitioning, warehousing and distribution to facilities. As a result, facility-level stock-outs of essential drugs and supplies for GFATM-supported programmes are common. In response, the National Drug Service (NDS) has set up a network of depots across the country to guarantee the availability of drugs and supplies in health facilities. A technical working group is overseeing the timely procurement and overall coordination of the supply chain system for the Global Fund. NACP has actively participated in the development of Integrated PSM Standard

Operating Procedures (SOPs) and electronic data-management tools. Drug dispensers and pharmacists have been trained and placed in health facilities and counties respectively.

Laboratory Systems

There is currently no national entity to coordinate and supervise blood safety and laboratory services and ensure adequate quality assurance, training and sample transportation. A recent assessment revealed that Liberia's hospital laboratories are unable to support basic health-service delivery, due to lack of adequately trained staff, equipment, supplies and infrastructure. Blood safety practices are currently limited to a handful of facility-based blood bank refrigerators and fall far below international standards. In response, the MOHSW considers establishing a Laboratory and Blood Safety Unit to standardise and coordinate laboratory services at the national level. A National Reference Laboratory will be created to strengthen national laboratory capacity and advanced technical skills. At the county level, County Health Teams have been strengthened with Directors of County Diagnostic Services to oversee all laboratory and blood safety services.

3.4 RESEARCH, SURVEILLANCE AND M&E

To date, collecting reliable information on HIV/AIDS trends, risk factors and the national response has been a major challenge. A *sentinel HIV-surveillance study* was first conducted among women attending antenatal care (ANC) in 2006 and repeated in 2007. Also in 2007, the *Liberia Demographic and Health Survey* (LDHS) was the first *population*-based study since the war that provided information on HIV-prevalence rates and HIV-related behaviours, disaggregated for sex, age and geographical regions. However, there is still a lack of evidence on HIV rates and behaviours among most-at-risk and vulnerable populations, since no systematic bio-behavioural surveillance has been conducted among these groups. In addition, very few special studies have been conducted among these groups, and most evidence comes from anecdotal reports or small-scale, qualitative studies.

Although strengthening the MOHSW health management information system (HMIS) is an important priority in the National Health Plan, the HMIS is still facing major challenges to collect key health-service data and is hampered by a poor flow of information between the facility, county and national levels. However, in the context of the Global Fund Round 6 programme, there have been significant improvements in setting-up a functional M&E system for HIV/AIDS programmes, especially in the clinical field. Standardised data-collection tools have been developed, including patient daily registers for VCT, PPTCT, ART, OI and drugs stock balance and requisition forms. Also, monthly service-delivery reporting forms for all HIV-related clinical interventions have been standardised for all health facilities. Standard Operating Procedures (SOPs) and guidelines on how to complete these tools have been developed, along with training on data recording. However, gaps and challenges remain with regard to M&E tools for non-clinical community-based HIV/AIDS interventions: different implementing NGO and CBO partners are still using their own data-collection and reporting tools, hampering the aggregation of data at higher levels.

4. PRIORITY ISSUES EMERGING FROM EPIDEMIOLOGICAL, SITUATION & RESPONSE ANALYSES

The future direction of Liberia's national response to HIV/AIDS is informed by the review and analysis of various data: 1) Epidemiological data on the HIV prevalence among different population groups and in geographic regions; 2) Information on economic and socio-cultural drivers of the epidemic, and specific behaviours and other factors associated with higher HIV risks and vulnerabilities; 3) Lessons learned with regard to what works and what not, i.e. successful interventions, gaps and challenges. The review of this data in the previous chapters has revealed the *priority strategic issues* that need to be addressed for a successful national response to HIV/AIDS for the period of the next National Strategic Framework 2010-2014. These priority strategic issues can be distinguished in the following five key areas:

1. Effective coordination and management of (a decentralised, multisectoral) national response;
2. Strengthening HIV prevention, with a priority focus on most-at-risk and vulnerable populations;
3. Scaling up coverage and quality of treatment, care and support for PLHIV, OVCs, and other affected persons;
4. Availability and use of strategic information for an evidence-informed response; and
5. Reducing stigma and discrimination of PLHIV as a cross-cutting priority.

4.1 EFFECTIVE COORDINATION AND MANAGEMENT OF THE (DECENTRALISED), MULTISECTORAL NATIONAL RESPONSE

One of the key lessons learned from the national response to date is the need to strengthen the overall coordination and management of the many initiatives and actors involved in the multisectoral response. Activities in the field of prevention, treatment, care and support have been scattered, and have often shown a lack of coordination among the different players; a lack of active involvement of *non-health* sectors; and inadequate *partnerships* between government, civil society organisations and the *private* sector. While this has led to duplication in some areas, there are important gaps in others, which are exacerbated by the limited availability of local funds.

Strengthening the effective coordination and management involves addressing the following strategic issues:

- Strengthening capacity of the National AIDS Commission as the overall coordinating body of the multisectoral response;
- Strengthening sectoral involvement and mainstreaming of HIV/AIDS in (existing) policies and programmes of all sectors and at all levels (*national and county*);
- Establishing public-private partnerships and mechanisms for improved reporting and exchange of information among partners at all levels and in all sectors;
- Improving coordination of resource mobilisation, as well as of allocation and monitoring the disbursement of funds; including more commitment of govt. funds and integration of HIV in government budgets (MoF);
- Strengthening the institutional and technical capacity of civil society organisations – as well as the private sector – to effectively implement HIV interventions (CSS).

4.2 STRENGTHENING HIV PREVENTION, WITH A PRIORITY FOCUS ON MOST-AT-RISK AND VULNERABLE POPULATIONS

To date, HIV-prevention programmes have been characterised by the *lack of a clear focus* on the most at-risk and most vulnerable populations. Most HIV prevention has focused on interventions among the general population, as population-based and ANC HIV-prevalence data are showing signs of HIV spreading among the general population. Despite the lack of hard data, however, there is sufficient evidence from qualitative studies and field programmes that women and girls are more vulnerable than men, and that specific subgroups face particularly high HIV risks, such as young girls engaging in transactional sex, sex workers and their clients, MSM and mobile populations. Prevention interventions have, however, lacked a clear focus on these priority groups, and concrete results are limited.

In order to strengthen the future focus of HIV prevention on these most-at-risk and vulnerable populations, the following strategic issues need to be addressed:

- Strengthening the *gender focus* of the response, which takes into account the epidemic's clear gender dimensions and differential risks and vulnerabilities of women and girls, men and boys, including sexual and gender-based violence;
- Strengthening a *focus on most-at-risk populations* with HIV-prevention programmes tailored to their specific needs. Key populations at risk include women and girls engaging in transactional sex or sex work, and their clients; mobile men and cross-border mobility; uniformed personnel; prison inmates and MSM. This also requires a geographic focus on specific urban (esp. Montserrado County) and border areas;
- Strengthening *Positive Prevention* approaches, which build on the active involvement of PLHIV in HIV prevention;
- Strengthening the *health sector capacity to scale up coverage of key HIV-prevention services*, and strengthening their *integration into the health system*. Priority services include VCT, PPTCT, STI treatment, safe blood transfusion, strengthening UPs (prevention of nosocomial infections) and PEP;
- *Strengthening the involvement of key non-health government sectors* for reaching specific populations with targeted policies and interventions, including the Ministries of Education, Youth and Sport, Defence, Interior (border guards, police) and Labour; and
- Strengthening the involvement of the private sector in *workplace* HIV/AIDS interventions.

4.3 SCALING UP COVERAGE AND QUALITY OF SUSTAINABLE TREATMENT, CARE AND SUPPORT FOR PLHIV, OVCs, AND OTHER AFFECTED PERSONS

While the availability of Global Fund support has enabled the provision of ARV treatment and other treatment, care and support to PLHIV, orphans and vulnerable children (OVCs) and other affected groups, the limited *coverage and quality* of these services, as well as their future *sustainability*, present major challenges to the national response.

Coverage and quality of ART, OI and other treatment, care and support are seriously hampered by the very *limited capacity* of the health system in terms of qualified staff, infrastructure, equipment and inadequate procurement, supply and management (PSM) systems. To date, HIV/AIDS services within the health sector depend too much on a *vertical approach*, which lacks integration within the overall health system. Therefore, *health systems strengthening* (HSS) is a sine-qua-non for

sustaining current care and treatment as well as allowing future scale-ups.

In addition, experiences with ARV treatment have shown the importance of a supportive care environment, whereby PLHIV support groups, communities and families play a key role in providing adequate (home-based) care and support to PLHIV, OVCs and other affected groups. In the context of poverty, however, community resources and capacity are limited, and community systems strengthening (CSS) is pivotal.

While strengthening of community and health systems is essential to allow further scaling up of treatment and care, the *longer-term sustainability* requires further integration of HIV/AIDS-related services into the health-care system, and increased resource-allocation from different government sectors and the private sector, e.g. through workplace programmes.

In this context, *scaling up comprehensive and sustainable* treatment, care and support and improving their quality require addressing the following *strategic issues*:

- *Strengthening health systems* to increase their capacity to scale up coverage of high-quality, comprehensive HIV care and treatment. This involves improved human-resource management (training, recruitment and retention of staff); efficient procurement and supply management (PSM) systems; adequate laboratory support; and integration of HIV/AIDS services into the overall health system. Special attention is needed for strengthening the capacity of peripheral health-care facilities at the county and community level, in accordance with MOHSW policies of decentralisation;
- *Strengthening and supporting community systems* – including PLHIV associations and support groups, communities and families – to provide sustained care and support to PLHIV, OVCs and other affected groups; with special attention for *women living with HIV*, including outreach and reduction of stigma and discrimination;
- *Strengthening linkages, referral and collaboration mechanisms to facilitate scale-up:* this applies to 1) Referral mechanisms *within* the health sector – e.g., between VCT services and specific treatment and care services, including ARV treatment, OI treatment, palliative care, Home-based care and support; TB treatment; PPTCT; as well as rural-urban referrals; 2) Linkages between health and *other governmental* support services, including *social welfare* services for nutritional and educational support, legal support, labour rights etc; and 3) Referral and collaboration between health systems and *community* support systems;
- More focus on *sustainability* is needed to ensure that current investments pay off on the long run; this involves building staff capacity, and ensuring follow-up, on-site support. It also requires integrating HIV/AIDS care and treatment in the basic package of health services;
- *Strengthen monitoring and follow-up of ART patients* and overall quality control, as well as *monitoring drug resistance*. Strengthening linkages between facility-based ARV services and home-based care for patient follow-up and defaulter tracing is an important priority.

4.4 AVAILABILITY AND USE OF STRATEGIC INFORMATION FOR AN EVIDENCE-INFORMED RESPONSE

Many of the problems listed above with regard to prevention, care and treatment are associated with a lack of (hard) evidence and research data to guide policies, programmes and services, and identify the specific roles of different sectors. *Knowing your epidemic* is crucial for ensuring that the right programmes and services effectively reach the population groups most in need of HIV/STI prevention, care, support and treatment. The recent (2007) population-based LDHS study has contributed to improved HIV-prevalence data, but surveillance data needs to be further systematised

and integrated into government systems. Furthermore, HIV surveillance needs to be expanded beyond the general population to include most-at-risk populations. Apart from basic biological and behavioural surveillance data, very limited (qualitative) research has been done into the drivers and underlying mechanisms of the HIV/AIDS epidemic, and little is know about the dynamics of HIV transmission in specific groups and regions of the country.

Similarly, while progress has been made in establishing M&E systems in the context of the various Global Fund-supported programmes, these have mainly focused on clinical interventions and PSM, but important gaps and weaknesses still remain with regard to monitoring *non-clinical, community-based* interventions, as well as assessing the *quality* of services. In addition, more standardisation of data-collection tools and reporting formats is required to allow better integration and collation of data at the national level.

Strengthening the availability and use of strategic information to guide an evidence-informed national response involves addressing the following *strategic issues*:

- Establishing a regular *second-generation surveillance system*, based on current population-based and ANC data, as well as expanding it to include bio-behavioural surveillance of most-at-risk population (MARP) groups (sex workers, mobile men, MSM) on a regular basis;
- Better understanding the dynamics underlying HIV risks among MARP and vulnerable groups, as well as the impact of AIDS on communities and individuals. To this effect, a national research agenda should guide priority research in different areas, with a focus on qualitative data;
- *Knowing "what works"* is crucial for a cost-effective national response. This requires strengthening of programmatic M&E through: a) Automated management information systems (MIS); b) Common M&E tools and improved flow of information; and c) Operational research, with special attention for coverage/utilisation and quality of HIV/AIDS services;
- Improving the *tracking of HIV/AIDS resources* (allocations and disbursements) beyond Global Fund contributions;
- Improved *coordination of data collection, flows and utilisation*; this requires the establishment of a joint *National HIV/AIDS Surveillance and M&E System and Plan*, based on common M&E standards and tools, clear reporting lines, and easily accessible data;
- Improved *integration* of HIV/AIDS data into the health sector's HMIS system;
- Strengthening *M&E capacity* among implementers and coordinating bodies, as well as improving the regular supply of HIV test kits to health facilities to ensure regular facility-based reporting of HIV cases and AIDS deaths.

4.5 REDUCING STIGMA AND DISCRIMINATION OF PLHIV, OVCs AND OTHERS AFFECTED – AS A CROSS-CUTTING PRIORITY

The active involvement of PLHIV in the fight against HIV/AIDS is crucial for preventing the further spread of HIV, as well as the effective coverage of treatment, care and support services. However, stigma and discrimination of PLHIV, OVCs and other affected groups present a major obstacle to the effective delivery of HIV/AIDS-related programmes and services. HIV/AIDS-related stigma and discrimination keep people from wanting to know their HIV status, thus affecting the utilisation of voluntary and provider-initiated counselling and testing services. As a result, most HIV-infected persons do not know their HIV status, while those who know are often driven "underground", afraid of the consequences of disclosing their status to their partners, families, communities and employers.

As a result, stigma and discrimination not only threaten PLHIV's social position as well as their health, labour and other rights, they also present a major obstacle for the effective coverage and utilisation of HIV-prevention services – such as PPTCT, PEP and treatment of TB/HIV co-

infection – and of ARV treatment and treatment of opportunistic infections, and care and support services.

Children who have been orphaned or otherwise left vulnerable by the impact of HIV/AIDS face similar stigma and discrimination, which hampers their psychological and social welfare, as well as their access to care and support with regard to education, food and clothes.

In this context, effectively dealing with stigma and discrimination involves addressing the following priority strategic issues:

- Support the empowerment of PLHIV as a group, and as individuals to enjoy same rights and opportunities as other Liberian citizens, regardless of their HIV status;
- Promote supportive attitudes and environments for PLHIV – with special attention for the particularly vulnerable position of HIV-positive women – in society, communities, and families, as well as in the health sector, workplaces;
- Strengthening the legal protection of PLHIV, including their labour rights and access to health-care;

5. STRATEGIC FRAMEWORK NSF II (2010-2014)

The NSF II 2010-2014 aims to provide *guidance and continuity* to Liberia's national response to HIV/AIDS by responding to the strategic issues identified in the previous chapter. These strategic issues emerged from an analysis of the epidemiological situation, the key factors and drivers of the HIV epidemic, as well as the gaps and priorities of the national response to date.

This section will outline the priority interventions of the national strategic framework 2010-2014; to this effect, it will present:

1. Key guiding principles underlying the national strategic framework;
2. NSF Goals and strategic objectives; and the
3. Key NSF strategies and main activities.

Additional operational details on strategies and activities are presented in a number of Annexes, including the NSF Results Framework; the overall 5-year workplan and 2-year Operational Plan; and the detailed budget.

5.1 GUIDING PRINCIPLES AND WIDER POLICY CONTEXT

The NSF-II 2010-2014 aims to address the priority strategic issues identified in the previous chapter. The approaches and strategies employed in the context of this NSF are based on a) a number of *guiding principles*, which provide overall direction and reflect the core philosophy underlying Liberia's national response to HIV and AIDS. b) Furthermore, the NSF is not a stand-alone document, but builds on, and contributes to a wider context of *global and national development policies and initiatives*.

5.1.1 Key Guiding Principles of the National Response to HIV/AIDS

The strategies and activities of the NSF 2010-2014 are based on a number of core principles, which guide the scale and nature of the response:

1. A ***gender-based approach*** acknowledges that (young) women and men have different vulnerabilities to HIV/STIs; and that HIV/AIDS and sexual and reproductive health problems affect them in different ways and degrees. HIV-prevalence data reveal that HIV/AIDS disproportionately affects women and girls, including young *women* engaging in transactional sex; *female* sex workers and their male clients. Therefore, programmes and services for prevention, treatment and care need to address these gender differences and offer women and men services that are tailored to their needs and situation.

2. ***Promoting human rights*** – The Liberian national response to HIV/AIDS and builds on the fundamental human rights of all Liberian citizens, including the freedom from discrimination on account of race, sex and gender roles; the right to health; the right to participation; and the right to information. Protection of these human rights is particularly important in the context of HIV/AIDS, which disproportionately affects women and girls, as well as marginalised population groups such as people living with HIV (PLHIV), sex workers, and men who have sex with men (MSM), who often face stigma, discrimination, social exclusion and denial of their human rights. In this context, a

human-rights-based approach emphasises the legal obligations of the state in realising the rights of its citizens – including the right to health – as well as the importance of *empowerment and active involvement* of communities and individuals infected or affected by HIV/AIDS.

3. *Greater involvement of PLHIV (GIPA)* – The proportion of PLHIV *known* to be HIV-infected is very low in Liberia: the majority of PLHIV do not know their status, have no access to services and no voice in policies and programmes that affect their lives. However, PLHIV understand their own situation better than anyone else, and their personal experiences should help shape the response to HIV/AIDS. The GIPA principle was formally adopted at the Paris AIDS Summit in 1994, where 42 countries declared *Greater Involvement of People Living with HIV and AIDS* (GIPA) to be critical to ethical and effective national responses to the epidemic. The greater engagement of PLHIV is all the more urgent as Liberia intends to scale up its national response to achieve the goal of universal access to prevention, treatment, care and support services.

4. *Government leadership in multisectoral partnerships* – The responsibility of the Liberian government to protect and foster its citizens' health and human rights requires government sectors to take the lead in the national response to HIV/AIDS. Government leadership means working in close coordination and collaboration with other partners in civil society, the private sector and international partners. Government leadership is also crucial for ensuring long-term *sustainability* of programmes and services, by ensuring that HIV/AIDS is integrated in overall government policies, programmes and budgets. In this context, the NSF-II 2010-2014 is based on the *Three Ones* principles, which involves one agreed national action framework; one coordinating authority; and one national monitoring and evaluation system.

5. *Evidence-informed approaches* – The NSF programmatic priorities are informed by available evidence from different sources, including bio-behavioural surveillance and case reporting; special studies; programmatic M&E data and operations research. An evidence-informed approach involves prioritising those population groups that are most at risk, vulnerable or affected by HIV/AIDS. Similarly, the selection of programmes and services should be based on proven (cost) effectiveness in Liberia or other countries in the region, whereby resources allocated to specific groups and services should be proportional to the impact of HIV/AIDS on those groups. Cost-effectiveness is increasingly important in the context of global economic crisis and diminishing external support. Long-term sustainability of the response depends on the cost-effective use of limited resources and increasing government contributions.

6. *Sustainability* – While the aftermath of the war and widespread poverty will leave the country dependent on external funding for many years to come, sustainability has other dimensions beyond financial independence. In this regard, the mainstreaming of HIV/AIDS in policies, programmes and services of government, civil society and private sectors is an important mechanism to ensure long-term sustainability of the response. This involves integrating HIV/AIDS services in the basic package of health services (BPHS) as well as in policies of other ministries. Furthermore, HIV/AIDS has been integrated in key development frameworks and strategies, such as the Liberian Poverty Reduction Strategy. Sustainability is further enhanced by government ownership of the response, and the active involvement of communities and different sectors, including PLHIV. Finally, capacity building is a major component of the NSF II, which will further ensure sustainable responses through strengthened institutional and technical capacity of government and civil society institutions.

7. *Accountability* – The NSF's focus on cost-effective strategies that are based on evidence entails that policy makers and programme implementers are to be held accountable for the decisions they make with regard to prioritisation of population groups and specific services. Accountability not only relates to transparency of financial decisions, but also with regard to transparent processes in prioritising specific interventions over others.

5.1.2 The National Response to HIV/AIDS in a Wider Policy Context

The principles mentioned above are not unique to the national response to HIV/AIDS, but guide government priorities and actions in a wider range of areas. Thus, the NSF-II is part of a larger policy context with regard to health and social rights and development.

In this regard, the NSF-II is in accordance with the HIV/AIDS section of the *Liberian Poverty Reduction Strategy*, which aims to promote human development by reducing the impact of HIV/AIDS vulnerability, morbidity and mortality. The LPRS proposes a comprehensive, multisectoral national response, led and coordinated by NAC, and based on the NSF as the common framework for all prevention, treatment and care, and impact-mitigation strategies. Furthermore, the NSF-II is in line with the MOHSW *National Health Policy and Plan 2007-2011*, which regard health as a basic human right, and whose mission is to effectively deliver quality health and social welfare services to the people of Liberia, regardless of economic status, origin, religion, gender or geographic location.

At the international level, implementation of the NSF-II 2010-2014 will contribute to attaining the *Millennium Development Goals*, which have been endorsed by Liberia's government – in particular Goal (5) – *"To halt and begin to reverse the spread of HIV/AIDS"* – and Goal (3) – *"To promote gender equality and empower women to protect themselves and their families".* Furthermore, the NSF will support other international commitments by the Liberian government, including its endorsement of the *2001 UNGASS Declaration of Commitment*; *The Three Ones* principles; and the targets of Universal Access to HIV/AIDS prevention, care and treatment.

5.2 NSF GOALS AND STRATEGIC OBJECTIVES

5.2.1 NSF Goals

The NSF has two overall goals to prevent the further spread of HIV and mitigate the impact of AIDS on society:

1 To contain the HIV prevalence rate among the general population below 1.5 percent by 2014;
2. To mitigate the impact of the epidemic on the health and wellbeing of persons infected and affected by HIV/AIDS.

These two goals are further operationalised in five strategic objectives that address the five key intervention areas identified in the previous chapter.

5.2.2 NSF Strategic Objectives

The strategic objectives of the NSF II aim to address the key priority areas that emerged from the comprehensive analysis of the state of the HIV/AIDS epidemic and the national response to date. This analysis revealed five *key intervention areas*, which will be addressed through the following five *strategic objectives*:

1. To ensure effective coordination and management of a decentralised, multisectoral national response to HIV/AIDS;
2. To reduce the number of new HIV infections among most-at-risk populations and vulnerable

groups in the general population, with a special focus on women and girls;
3. To strengthen quality, and scale up coverage and utilisation of treatment, care and support for PLHIV, OVC, and other affected persons;
4. To strengthen the availability, sharing and utilisation of strategic information that will guide the planning and implementation of policies and programmes; and
5. To promote a supportive environment for women, men and children living with HIV, and reduce HIV/AIDS-associated stigma and discrimination.

5.3 KEY NSF INTERVENTION AREAS: STRATEGIES AND MAIN ACTIVITIES

The successful attainment of the NSF's strategic objectives entails the achievement of a number of ***key results*** for each objective. This section provides an overview of the key results for ach strategic objective, and describes the core ***strategies*** and main ***activities*** for producing these results. More operational details are provided in the following Annexes (see below). The numbering of objectives and strategies in this section is consistent with the numbering in the various Annexes.

- ***Annex 1*** – More implementation details are given in the ***5-Year Workplan and Budget***. The *Workplan* presents the core strategies and associated main activities for each objective. The *NSF budget* provides details of the costs of the main services and programmes to be implemented; it also specifies the currently available funds and remaining funding gap for each main activity.
- ***Annex 2*** – The ***NSF Results Framework*** provides more details of the expected key *Results* (in terms of impact and outcomes); the *objectively verifiable indicators* for monitoring these results; and the annual *targets* for the 2010-2014 period.
- ***Annex 3*** – ***The NSF Performance Framework*** presents the expected *Outputs* for each of the NSF's main strategies. For each expected output, indicators, data-collection frequency, and means of verification are specified. It also shows current baseline values and annual targets for the period 2010-2014.

5.3.1 Main Strategies for Objective 1: *Coordination and Management of the National Response*

Objective 1: *To ensure effective coordination and management of a decentralised, multisectoral national response to HIV/AIDS.*

Despite Liberia's recent history of war, violence and the breakdown of government structures as well as society itself, the country has successfully started a national response to the threat of HIV/AIDS. To date, however, this response has been characterised by vertical interventions that lack adequate integration into overall public health and other government systems, as well as a lack of coordination and collaboration between the various sectors – public, civil society, private and the international community. In this context, key issues that need to be addressed to strengthen coordination include the need to: a) strengthen the capacity and functioning of the National AIDS Commission (NAC) as the overall *coordinating body*; b) strengthen the *active involvement* of government sectors beyond health, and *mainstreaming* HIV/AIDS into their *policies and strategies*; c) establish effective public-private *partnerships* for joint programme implementation and information exchange; d) strengthen the mobilisation, disbursement and tracking of *funds* and resources for HIV/AIDS programmes; and 5) strengthen the *institutional capacity* of implementing partners.

The key results or outcomes expected in the context of Objective 1 include:

Expected results Objective 1:

1.a Improved coordination and collaboration among donors, policy makers and implementing organisations in public, civil society and private sectors with regard to service delivery, and programmatic and financial reporting;
1.b HIV/AIDS effectively mainstreamed into policies, guidelines, programmes and services (plans and budgets) of public, civil society and private sectors involved in the response to HIV/AIDS;
1.c Adequate and sustainable resources mobilised for the implementation of NSF II, with increasing contributions from Government budgets;
1.d Strengthened institutional capacity (staffing, management and administration, resources, facilities) of key civil society organisations involved in HIV/STI service delivery.

In order to attain these results, the ***following main strategies*** will be implemented:

1.1 Align and strengthen HIV/AIDS coordinating bodies with a view to strengthening partnerships and collaboration among all key national partners;
1.2 Establish and strengthen coordinating mechanisms among implementing and other partners in all sectors, and at national and county levels;
1.3 Strengthen coordination and reporting of resource mobilisation and allocation, disbursements and financial flows;
1.4 Mainstream HIV/AIDS in policies and services of key Government sectors that engage with most-at-risk and vulnerable population groups; and
1.5 Strengthen institutional capacity (staffing, management and administration, resources, facilities) of key civil society organisations involved in HIV/AIDS service delivery.

Strategy 1.1: *Align and strengthen HIV/AIDS coordinating bodies with a view to strengthening partnerships and collaboration among all key national partners* – To date, many players from different sectors have been involved in planning and implementation of the national response. Several organisations and bodies play a role in coordinating specific aspects of the national response: the LCM oversees the implementation of the AIDS and TB programmes funded by the Global Fund, while NACP plays a key role in coordinating the *implementation* of the AIDS components. However, *coordination* of the inputs of the many players – from Government, civil society, faith-based organisations, PLHIV networks, private sectors UN and other development partners and donors – in HIV/AIDS policy and programming has been weak and requires strengthening of the role and functioning of the *National AIDS Commission* (NAC) as the overall national coordinating authority. To this effect, NAC's *mandate and legal position* as the overall coordinating body will be strengthened, while the staffing and infrastructure of the NAC *Secretariat will be expanded* to support effective implementation of its coordinating roles and functions. NAC secretariat staff will be trained in resource mobilisation, monitoring and evaluation, quality assurance and financial management and tracking.

Strategy 1.2: *Establish and strengthen coordinating mechanisms among implementing and other partners in all sectors, and at national and county levels* – In addition to strengthening NAC's capacity and functions as the overall coordinating authority, coordination and collaboration among partners will be strengthened by agreeing on clear *roles and responsibilities*, which will guide each partner's contribution to prevention, care and treatment programmes and services. This includes *guidelines* on roles, responsibilities and reporting requirements (including tools) for all partners involved, as well as the assignment and training of HIV/AIDS *focal point persons* in each

county to coordinate and oversee local responses. Coordinating mechanisms will involve key players in all sectors (government, civil society, private sector, UN and international partners), as well as at the national, county and local levels. Coordination will take place through joint monitoring visits and quarterly meetings with all partners involved to discuss challenges and lessons learned.

Strategy 1.3: *Strengthen coordination and reporting of resource mobilisation and allocation, disbursements and financial flows* – In addition to strengthening coordination of programme implementation among implementing partners, coordination will be strengthened in the field of resource mobilisation and financial flows. To this effect, 1) a *multi-donor pool funding arrangement* will be established, to ensure that donor funding for HIV/AIDS will be allocated in a coordinated way, in accordance with national priorities. In this regard, 2) *Annual Roundtables* will be held with donors and key stakeholders to monitor and discuss funding gaps, resource requirements and disbursements. 3) In addition, a *resource-tracking mechanism* will be developed to monitor HIV/AIDS public and private resource flows both in- and outside the pooled funding arrangement; as well as a system to report to one central coordinating authority. Furthermore, the *financial arrangements at all levels* will be strengthened to improve resource tracking, accountability and effectiveness; this includes 4) the development of standardised financial reporting tools for all fund recipients; 5) training of accounts officers in all programmes on the financial reporting system; and 6) annual financial audits of the NAC Secretariat and funded programmes.

Strategy 1.4: *Mainstream HIV/AIDS in policies and services of key Government sectors that engage with most-at-risk and vulnerable population groups* – In addition to strengthening intersectoral coordination, an effective national response requires an active role of key government sectors and Ministries, and the development and implementation of specific HIV/AIDS-related policies and strategies at national and local levels. The NSF 2010-2014 will provide the overall context for developing specific *sectoral HIV/AIDS policies* in key government ministries and institutions – including the Ministries of Health and Social Welfare (MoHSW); Education (MoE); Youth and Sports (MoYS); Gender and Development (MoGD); Defence (MoD); Justice (MoJ); Labour (MoL); Transport (MoT); and Finance (MoF). Each Ministry will develop sectoral policies, which will guide the response to HIV/AIDS in specific sectors and institutions. These sectoral policies will guide both internal ministerial strategies with regard to the workforce, as well as strategies and interventions that affect HIV/AIDS programmes for specific population groups. All sectoral policies will specifically address gender and human rights issues.

Special attention will be given to strengthening the integration of existing HIV/AIDS services the *health* sector, in particular in the divisions of Family Health, TB, and STI, at national and county levels, in accordance with the Basic Package of Health Services policy.

A key activity involves the *operationalisation* of national and sectoral policies by different ministries at the *county* level. This entails the development of *local HIV/AIDS workplans by County Health Teams.*

Strategy 1.5: *Strengthen institutional capacity (staffing, management and administration, resources, facilities) of key civil society organisations involved in HIV/AIDS service delivery –* In addition to strengthening overall capacity and coordination among governmental sectors and between national and local levels, this strategy focuses on *strengthening the institutional capacity of implementing partners*, particularly *in civil society* – in support of the planned scale-up of service coverage. Liberia's civil society sector is still relatively young and underdeveloped, with limited institutional and technical capacity. a) A first priority in this field is a series of rapid, *participatory institutional assessments*[9] of the main civil society organisations implementing HIV/AIDS programmes with MARP groups, PLHIV, OVCs and other vulnerable populations (sex workers, MSM, out-of-school youth, uniformed services; prison inmates, migrant labourers), in order to

[9] The institutional assessments will use an NGO Capacity Analysis tool, which has been developed for this specific purpose by the International HIV/AIDS Alliance.

identify their priority needs with regard to institutional strengthening. These assessments will include aspects such as: Organisational structure and governance; Human-resource development and administrative systems; Programme management, monitoring and evaluation and reporting; Financial management systems and sustainability; and Technical expertise.

b) Based on the assessments, *institutional development plans* will be developed, tailored to the needs of each organisation. Key components of these plans will include (internal) organisational strength; HIV/AIDS technical capacity; and the development of partnerships, referral systems and coordination mechanisms. c) Implementation of the institutional development plans will involve *long-term technical assistance by local and international external experts*, who will provide technical support through general capacity-building workshops as well as specific (on-site) assistance tailored to an organisation's special requirements. This will include capacity building to conduct regular internal institutional (self) assessments. An integral part of institutional development is the *strengthening of collaboration with partner organisations* through networks and referral mechanisms, including collective planning and implementation of programmes and services, as well as joint advocacy and resource mobilisation by civil society organisations.

5.3.2 Main Strategies for Objective 2: *Infection Prevention and Behavioural Change Communication*

Objective 2*: To reduce the number of new HIV infections among most-at-risk populations and vulnerable groups in the general population, with a special focus on women and girls.*

Although Liberia's HIV epidemic is still at a low level – 1.5 percent among the general population (LISGIS, 2008) – widespread unsafe sex practices, especially among MARP groups, sexual and gender-based violence, and low coverage of key HIV-prevention services provide a potential for the rapid spread of HIV, unless effective HIV-prevention programmes are scaled up.

Effective HIV prevention requires a clear focus on most-at-risk populations and vulnerable groups, with special attention for women and girls, and the gender dimensions underlying the HIV/AIDS epidemic. Key populations at risk include women and girls engaging in transactional sex; (female and male) sex workers and their clients; victims of sexual violence; children born to HIV-infected mothers; men who have sex with men; prison inmates; uniformed personnel, and mobile populations, such as truck drivers, refugees and internally displaced people, and labour migrants.

To date, *weak health systems* have hampered the effective scale-up of coverage of key HIV-prevention services, including VCT, condom promotion, PPTCT, safe blood transfusion services, and STI treatment. In addition to the key role of the health sector in HIV prevention, the *education sector* plays a central role in reaching young people in schools, while *workplace programmes* in Ministries and the private sector need to be reinforced to effectively reach men with higher HIV risk, such as military and border guards, truck drivers and other men with a regular income, who may engage in paid sex. While HIV-prevention efforts usually focus on preventing people from *being* infected, the active involvement of PLHIV in HIV prevention – "positive prevention" – is crucial to prevent them from *spreading* HIV to others. Furthermore, HIV prevention needs to focus specifically on those *geographic areas* that show the highest HIV-prevalence rates, including the main urban centres and border areas.

The key results or outcomes expected in the context of Objective 2 include:

Expected results Objective 2:

2.a	Increase of comprehensive HIV/AIDS knowledge and safer sex practices among most-at-risk populations and vulnerable groups in the general population;
2.b	Increased coverage and utilisation of key HIV-prevention services by most-at-risk populations and vulnerable groups in the general population.

These expected results reflect increased *knowledge and protective behaviours* among all vulnerable populations; as well as increased *coverage and utilisation* of key prevention services, such as IEC/BCC programmes; VCT; PPTCT services; STI diagnosis and treatment; PEP; safe blood transfusion; as well as life-skills-based education and peer outreach programmes.

Key HIV-prevention interventions for achieving these results include: 1) Information and education programmes aiming to *raise awareness and promote safer sex* and other HIV-prevention behaviours; 2) HIV-prevention programmes and services targeting *specific vulnerable or at-risk populations*, and/or in specific settings (e.g. education, workplace); and 3) Key HIV-prevention services delivered through the *health system*. In this context, and building on *existing* programmes and services, the *following main strategies* will be implemented:

2.1 Development and implementation of targeted IEC/BCC programmes for at-risk groups and the general population;
2.2 Special HIV-prevention services for most-at-risk and vulnerable groups;
2.3 Strengthen life-skills-based HIV-prevention programmes in the Education sector;
2.4 Establish and expand workplace programmes in government and private sectors;
2.5 Strengthening coverage and utilisation of VCT services by the general population, as well as specific vulnerable groups, including the promotion of provider-initiated testing and counselling (PITC);
2.6 Increase the capacity of reproductive health facilities, and scale up the availability and utilisation of high-quality PPTCT-Plus services for pregnant women as integrated part of the BPHS;
2.7 Improving access and quality of syndromic management and monitoring of STI in government and private health-care facilities
2.8 Strengthen effective application of universal precautions (UPs) and post-exposure prophylaxis (PEP) in all health facilities and SGBV Referral Centres
2.9 Strengthen blood donation, screening and transfusion services in public and private health institutions in line with national blood transfusion policies

Strategy 2.1: *Development and implementation of targeted IEC/BCC programmes for at-risk groups and the general population* – Recent studies have shown that *general* HIV/AIDS *awareness* is almost universal, but *specific knowledge* on HIV prevention is low and *unprotected sexual practices are widespread* among the general population and specific groups at risk. E.g., LDHS 2007 data show that 52 percent of men, and 33 percent of women aged 15-49 had engaged in higher-risk sex in the past 12 months; of those, only 26 percent of men, and 14 percent of women reported using a condom. This shows the very high levels of unprotected, high-risk sex, with women and girls being particularly vulnerable. In this context, information, education and communication (IEC) for awareness raising and behaviour change communication (BCC) are key components of a comprehensive HIV-prevention strategy. To date, most IEC/BCC interventions have focused on awareness raising among the *general* population. To improve the impact of IEC/BCC, however, future programmes will focus more on specific most-at-risk populations, such as sex workers and their clients, women and girls engaging in transactional sex, STI clinic attendees, as well as vulnerable groups, especially women and youth.

Effective IEC/BCC programmes need to be tailored to the specific information needs of different

groups, using a mix of mass media and interpersonal communication. Currently, however, there is a big gap in knowledge about these HIV-information needs. Therefore, future IEC/BCC strategies will be based on an assessment of the specific information needs of most-at-risk and vulnerable populations, women and men, adults and young people. Depending on the context and target group, messages will focus on knowledge, skills and behaviours with regard to abstinence, postponement of sexual debut, mutual faithfulness, partner reduction, prevention of sexual violence, and consistent condom use. In addition to promoting individual knowledge and behaviours, IEC/BCC programmes will also focus on community and social norms, e.g. to address sexual and gender-based violence, reduce stigma and discrimination and to create supportive environments for PLHIV, orphans and vulnerable children and others affected by HIV/AIDS.

Specific activities in the context of IEC/BCC programmes include: 1) a review of the current HIV/AIDS Communication Strategy, and 2) an evaluation of current messages and the development of new, harmonised messages for MARP and vulnerable groups, as well as the general population. 3-6) Based on this, new mass-media IEC materials will be developed and distributed among MARP groups, school children and out-of-school youth, and the general public. 7-9) In addition, IEC/BCC capacity building will take place for health-care providers, counsellors, and community-based organisations, as well as life-skills training for young people. 10) Evaluation and operational research will accompany all IEC/BCC programmes to identify best practices and improve messages and media.

Strategy 2.2: *Special HIV-prevention services for most-at-risk and vulnerable groups* – As mentioned, the effectiveness of HIV-prevention programmes to date has been limited due to an inadequate focus on the most-at-risk populations and vulnerable groups. While more targeted IEC/BCC interventions will strengthen HIV/STI-prevention knowledge, skills and protective behaviours (see Strategy 1.1), these need to be complemented by HIV-prevention services that meet the specific needs of different MARP and vulnerable groups.

Specific ***interventions for most-at-risk populations***, including sex workers, adolescent girls (10-18) and young women (18-24) engaging in transactional sex, street children, MSM, and mobile groups will start with 1) the establishment of partnerships with *peer support groups* from each MARP group. In the case of sex workers, pimps and madams will also be involved. These peer support groups will serve as an entry-point for the often hard-to-reach MARP groups, for delivering key HIV-prevention services. 2) Peer educators from all MARP groups will be trained to provide *outreach HIV/STI education*, as well as 3-4) to *distribute male and female condoms* among their peers. 5) A particularly vulnerable and marginalised group are *street-based sex workers* – including very young girls – who engage in sex work as a survival strategy, and who often lack the skills and opportunities to practice safe sex with their clients. Therefore, centrally located *Drop-in centres* will be established for this group, which offer counselling and shelter, basic health care, education and condoms. 6) The drop-in centres will also offer a *voucher programme* for *referral to free client-friendly sexual and reproductive health services*; including HIV/STI counselling and testing; and STI treatment.

Specific ***interventions for vulnerable adolescents and young people*** include: 7) training of youth *peer educators* and counsellors, as well as 8) condom promotion and distribution through community youth clubs. Adolescent girls and young women – including married adolescent girls – engaging in transactional sex constitute a large at-risk group, which is, however, hard to reach with focused interventions. To reach these young women as well as unemployed young men and boys 9) *multi-purpose youth centres* will be established to facilitate peer outreach activities for out-of-school youth with life-skills-based education, counselling on sexual and reproductive health and livelihood skills, as well as condoms. Messages will emphasise delay of sexual debut, partner reduction, and consistent condom use. 10) Youth groups will also be trained to use popular theatre, sports and other forms of entertainment to reach young people include with life-skills education. Additional

educational interventions targeting vulnerable young people include 11) the production and broadcasting of *soap operas* on HIV/AIDS targeting the youth; 12) *Sensitisation of traditional leaders* and elders on HIV/AIDS conduct community reach-out, especially the youth; as well as 13) *Sensitisation of religious leaders* on HIV/AIDS to visitors of churches and mosques, including young people. 14) In accordance with the National Health Plan, health-care staff will be trained to provide client-friendly HIV/STI-prevention services to sex workers, young people (especially girls) and other vulnerable groups in the field of VCT, STI treatment, and reproductive health services, including emergency contraception and referral to ANC and PPTCT services.

Strategy 2.3: *Strengthen life-skills-based HIV-prevention programmes in the Education sector* – While the most vulnerable young women who are involved in sex work are difficult to reach through the formal education sector, many young girls inside schools and colleges are vulnerable to sexual violence and to engaging in transactional sex. *In-school youth* constitute a captive audience that can easily be reached with well-packaged programmes. Thus, the education sector is an important entry point for reaching young women and men with HIV education, in particular through life-skills-based peer education, as well as promotion of HIV counselling and testing, prevention of sexual and gender-based violence, and safer sex and condom use. In addition, schools provide an adequate environment for providing care and support to orphans and vulnerable children *(see Objective 3 strategies)*.

Specific activities planned for the education sector include: 1) the production and dissemination of life-skills HIV/AIDS teacher's guides to schools; and the subsequent training of teachers in these guides in all 15 counties. 3) In addition, students will be involved through the establishment of new and strengthening of existing *school health clubs* and 4) the *training of peer educators* in primary, secondary, vocational and university educational institutions to provide IEC/BCC on HIV/AIDS and STI prevention, care and treatment, with a strong focus on building skills for reducing HIV vulnerability. 5) To this effect, portable user-friendly student life-skills handbooks with an HIV/AIDS component will be developed and disseminated among young people in schools. Finally, where appropriate and acceptable, condoms will be made available in selected school settings.

Strategy 2.4: *Establish and expand workplace programmes in government and private sectors* – Workplace programmes offer an opportunity to effectively reach people and integrate HIV/AIDS prevention and treatment services in existing social and health services of private companies and government employers. Workplace programmes are particularly useful for reaching men who are more difficult to reach through reproductive health-care services. As a result of the war and economic collapse of the country, the private sector is small and government ministries and institutions are the largest formal employer. Nevertheless, one of the largest private employers, the Firestone Rubber Company, has a large HIV/AIDS workplace programme in place, providing HIV-prevention and treatment services. Overall, however, the added value of workplace programmes has not been fully exploited, and needs to be expanded, especially in cases where work situations increase the vulnerability to HIV of employees. Work-related mobility – e.g. for long-distance truck and bus drivers, soldiers and UN peacekeepers, and businessmen – increases the likelihood of men seeking paid sexual services from women and girls. Similarly, a regular salary – which is rare for many Liberian men and women – as well as work-related status and power increase the chance of seeking sexual services in exchange for money or favours.

In the context of the NSF 2010-2014, workplace programmes will be established and expanded in both Government and private sectors. In the context of *Strategy 1.4*, key ministries will *mainstream* HIV/AIDS in sectoral policies and strategies, which will provide a basis for workplace programmes for their employees. Furthermore, the Ministry of Labour (MoL) has recently completed the *HIV Workplace Policy Guide*, and will be working with the *Liberian Chamber of Commerce* (LCC) to incorporate HIV/AIDS into the LCC *World of Work Unit*, which will support the development of

private-sector workplace programmes.

Specific workplace activities will include 1) the development of *workplace HIV/AIDS policies*, which will address the labour rights of HIV-infected employees to work, access to HIV/AIDS prevention and treatment, and stigma and discrimination in the workplace. 2) In addition, *research* will inform the development of workplace-specific IEC materials, which will be disseminated by 3) trained peer educators in both Government and private sector workplaces. 4) Private companies will be encouraged to place *condom-dispensing units* in the workplace, and provide free condoms to mobile employees (e.g. drivers, military). 5) Public and private-sector employers will be supported to conduct quarterly "know-your-status" campaigns with on-site mobile VCT services or referral to other VCT sites. 6) The *public-private partnerships* that have been formed in the context of Objective (1) will facilitate the establishment of referral systems to public and private health-care facilities for VCT and STI and ARV treatment services. 7) Based on positive experiences in other African countries, a *Business Coalition Against AIDS* will be established to sensitise private companies and mobilise support and services to employers regarding HIV education. 8) Similarly, these partnerships will be used for annual forums at national and county level to share experiences ad lessons learned with workplace programmes. 9) Finally, employers will be actively involved in financing and organising World AIDS Day activities at the national and county level.

DAVID: → ADD UN PEACEKEEPERS INTERVENTIONS

Strategy 2.5: *Strengthening coverage and utilisation of VCT services by the general population, as well as specific vulnerable groups, including the promotion of provider-initiated testing and counselling (PITC)* – Voluntary counselling and testing for HIV (VCT) is a critical HIV/AIDS service and a key entry point to HIV/AIDS prevention, treatment and care and support. To date, most VCT (73%) takes place in the context of provider-initiated testing and counselling (PITC) in health facilities or community-based VCT centres, as well as some mobile outreach VCT services, run by government, churches and faith-based organisations or international NGOs. However, overall coverage and utilisation of these VCT services remain low, and as a consequence, the large majority of the estimated 53,000 HIV-infected persons in Liberia is unaware of their HIV status, and is therefore unlikely to seek access to HIV/AIDS treatment, care and support services, nor can they consciously prevent HIV from spreading to their wives or husbands, newborn children or sex partners.

Increasing VCT uptake requires improved promotion, strengthening *coverage* and systematic offering of PITC (e.g. to all blood donors), as well as improving the *quality and client-friendliness* of VCT services, and their linkage to other HIV/AIDS care and treatment services. Key interventions in this regard include: 1) *Establishing new fixed and mobile VCT sites* and further enhancing provider-initiated testing and counselling (PITC). New *mobile units* will offer VCT to areas without access and conduct general awareness campaigns. A pilot study will identify ways of improving referral from these stand-alone, mobile VCT units to ART sites and other HIV/AIDS-related care and treatment. 2) Each year, the MoHSW will upgrade selected health-care facilities with additional services and training, to allow offering VCT services as part of the basic package of health services (BPHS), to be provided through clinics, health centres and hospitals (NHP, 2007). 3) Strengthening referral and networking between VCT sites and local health-care facilities to improve continuity of care for PLHIV; as well as: 4) Establishing effective *referral systems* between VCT sites and health and other care and support services, including ART, home-based care, PLHIV support groups and support for OVCs. 5) In addition to increasing and strengthening VCT facilities, *training, follow-up and refresher training, including on-the-job support*, of new and existing VCT counsellors in public and church-based health-care facilities, and in civil society organisations is essential to ensure the adequate delivery of VCT services. 6) Special attention will be paid to ensuring adequate supplies of HIV test kits and other commodities without stock-outs.

Strategy 2.6: ***Increase the capacity of reproductive health facilities to allow scaling up the availability and utilisation of high-quality, integrated PPTCT-Plus services for pregnant women as integrated part of the BPHS*** – Prevention of mother-to-child transmission of HIV (PPTCT) is one of the most cost-effective health-sector based interventions, which dramatically reduces the likelihood of HIV-infected mothers passing HIV on to their unborn or newborn children. To date, PPTCT services have mainly been provided by mission and private hospitals; although PPTCT coverage has been scaled up considerably in the last few years (from 629 women in 2006 to 32,518 in 2009), further scale-up is hampered by systemic weaknesses of the public health-care sector, including inadequate staffing and capacity of government health services; limited access and utilisation of antenatal care (ANC) services by pregnant women; low awareness of the availability of PPTCT services; lack of integration of PPTCT into sexual and reproductive health (SRH) services; and insufficient access of pregnant women to HIV counselling and testing,

In accordance with the *National Health Plan*, the NSF 2010-2014 aims to strengthen the delivery of *comprehensive PPTCT services* as part of the BPHS at all levels – by clinics, health centres and hospitals – encompassing the four key components of: 1) Primary HIV prevention; 2) Prevention of unintended pregnancies among HIV-infected women, through high-quality SRH services; 3) Prevention of HIV transmission from HIV-infected women to their unborn or newborn children (ARV treatment for PPTCT); and 4) PPTCT-Plus, which entails follow-up and linkages to long-term prevention, treatment, care and support for mothers, children and their families.

To this effect, the NSF will support the *following activities*: 1) Development of a PPTCT-Plus Policy; as well as a 5-year national PPTCT scale-up plan; and updating National PPTCT guidelines to include PPTCT-Plus services (including paediatric AIDS). 2) In accordance with the NHP, each year, MoHSW will upgrade and integrate selected facilities providing ANC services, and strengthen staff capacity to allow the gradual expansion of PPTCT services to additional facilities, and integrate PPTCT as part of the BPHS package. A major focus will be to ensure access to client-friendly VCT for women and girls of reproductive age, and strengthen the linkages between VCT sites and care and treatment programmes for women *(see previous strategies)*. In addition, HIV-infected pregnant mothers will be followed up through community mechanisms to prevent them defecting from ANC visits, and ensure they deliver at health facilities to allow delivery of PPTCT services. 3) In this context, reproductive health-care staff in public and private facilities will be trained to provide PPTCT-*plus* services, through workshops and 4) on-site follow-up training and support by County Health Teams. 5) Strengthening the distribution and storage of ARV drug supplies without stock-outs to ensure uninterrupted delivery of PPTCT-Plus services. 6) Community mobilisation and mass media campaigns will sensitise pregnant women and their partners on the availability of PPTCT-Plus services, and the importance of utilising ANC and reproductive health services, including PITC (opt-in). In this regard, it is vital that ANC facilities can guarantee uninterrupted delivery of high-quality ANC and PPTCT services. 7) Provision of counselling on breastfeeding and alternative options for HIV-exposed infants and young children, including the provision of breast-milk substitute feeding. 8) Finally, PPTCT services will be monitored through an ongoing study to determine the effectiveness of the programme. These studies will review PPTCT programme strategy, KAPB and issues related to loss to follow-up, and low uptake of services. To this effect, 9) DNA PCR equipment and test kits will be procured for early testing of HIV-exposed infants.

Strategy 2.7: ***Improving access and quality of syndromic management and monitoring of STI in government and private health-care facilities*** – Syndromic treatment and monitoring of STIs has been a priority in the context the National Health Policy and Plan, including for HIV prevention. To date, more than 240 health-care staff have been trained in national STI-management guidelines and protocols, and STI drugs have been provided through the Global Fund. However, new priorities in the context of the NSF 2010-2014 include: 1) Updating the existing national STI diagnosis and

treatment guidelines, and the development of new STI training modules and materials, including STI treatment flow charts, accordingly. 2) These new training modules will be used to train workers in public and private health-care facilities, using a TOT approach, as well as on-site follow-up support. In addition to STI management, special attention will be given to adequate referral to other services, such as VCT for HIV. 3) In addition to health-care staff, other STI service providers – including pharmacists, facility-based drug dispensers and private drugstore owners – will receive refresher training on STI medication and dosage protocols. 4) In accordance with the approach to expanding VCT and PPTCT services in health-care facilities, the MoHSW-NACP will develop an *annual expansion plan*, detailing new sites for STI service delivery, which will be upgraded with equipment, drugs and other commodities, to ensure STI services meet the new national standards. 5) Special attention will be given to adequate procurement and distribution of STI drugs, test kits and other commodities. 6) IEC/BCC campaigns will raise awareness on STIs and the availability of STI testing and treatment services, with a key focus on geographic areas with higher STI prevalence, such as border towns in seven counties. Special outreach activities, linked to existing HIV/AIDS education, will take place for higher-risk groups, such as sex workers, truck drivers and other mobile groups.

Strategy 2.8: *Strengthen effective application of universal precautions (UPs) and provision of post-exposure prophylaxis (PEP) in all health facilities and SGBV Referral Centres* – MoHSW has identified *universal precautions* (UPs) as a key priority, which includes the safe handling and disposal of sharps, safe decontamination of instruments and safe disposal of medical waste. UPs will continue to be a priority for the NSF 2010-2014: to this effect, 1) UP guidelines and SOPs will be updated in line with national protocols, and 2) health workers will receive refresher training to further improve strict application of universal precautions in all public and private health-care facilities.

Post-exposure prophylaxis (PEP) has been part of the national protocols for HIV/AIDS care since June 2006 in the context of health-care settings, while PEP has also been provided to rape victims. Application of PEP in relation to needle-stick and other injuries will be continued and expanded under the new NSF. Special attention will be given to PEP for victims of sexual and gender-based violence (SGBV), which continues to be a major problem in Liberia. In this context, the following activities will be implemented: 1) IEC/BCC campaigns and IEC materials will strengthen public awareness on the availability of SGBV services and PEP, and focus on reducing SGBV-related stigma, which is a major obstacle for service utilisation by SGBV victims. 2) Access to PEP and other services will be strengthened by establishing *additional SGBV referral centres* for victims of SGBV, including the training of staff in the emotional and physical needs of victims of SGVB, as well as the updated national PEP guidelines and protocols. These centres will provide SGBV-related services such as counselling, medical care and PEP to a larger number of women, especially outside of Monrovia. In addition, the existing referral system will be strengthened to ensure adequate utilisation of these new facilities. 4) Adequate procurement and distribution of PEP supplies will ensure adequate access to key services for SGBV victims at all SGBV referral centres.

Strategy 2.9: *Strengthen blood donation, screening and transfusion services in public and private health institutions in line with national blood transfusion policies* – Blood safety is a cornerstone of the national health system and an essential element in containing the spread of HIV. The National Blood Safety Programme stipulates that all donated blood must be screened for key transmissible infections, including HIV, in one of the three blood banks in the country, in accordance with national guidelines for safe blood transfusion. However, there is a limited number of hospitals with blood-transfusion facilities, which shows the need to increase the number of these facilities throughout the country, and train additional health-care staff in the rational use and safe handling of blood, blood products and universal precautions. In addition, there is a need to establish a *supervision system* that will follow national standards and protocols for blood collection, testing, storage conditions and distribution procedures that meet international norms on blood transfusion. In this context, the NSF will support the following activities: 1) Renovation of the National and Regional Blood Transfusion Centres and upgrading of their equipment will strengthen the blood

transfusion infrastructure; 2) Training of laboratory technicians in revised and updated blood-safety protocols and guidelines; and additional training for health professionals in safe handling of blood and blood products and UPs, and rational and safe use of blood; 3) Strengthening procurement, distribution and management of supplies for safe collection and distribution of blood and blood products; 4) Strengthening voluntary blood donations through a national Voluntary blood donor campaign, and 5) the observation of the National Blood-Donor Day.

5.3.3 Main Strategies for Objective 3: *Treatment, Care and Support*

Objective 3*: To strengthen the quality, and scale up coverage and utilisation of treatment, care and support for PLHIV, OVC, and other affected persons.*

Easy access to quality treatment, care and support for PLHIV, orphans and vulnerable children (OVCs) and other affected persons is a core element of the national response. In the early stages, access to treatment, care and support was often limited to basic community- and family-based care, with minimal support from the health-care system. Access to ARV and other treatment was extremely limited due to the absence of a functioning health-care system; the prohibitive costs of ARV drugs; and the lack of funding. In the last decade, however, the health system has gone (and continues to go) through a process of reconstruction and strengthening, while the cost of treatment has come down dramatically, and significant amounts of funding for HIV/AIDS have become available through the Global Fund and other donors. While this has allowed increased coverage of PLHIV and OVCs with key treatment, care and support services, these services have lacked integration into the public health-care system and their sustainability is low. Emphasis has been on vertical ART programmes, financed by external donors, while care and support for PLHIV and OVCs have mainly been provided by health facilities run by churches and faith-based organisations. The further scale-up of coverage and utilisation of care and treatment services is hampered by the ongoing weak capacity of the public health system, in particular with regard to skilled staff. In this context, further strengthening requires addressing a number of key challenges:

- Strengthening the access and utilisation of ARV treatment and treatment of opportunistic infections, as well as adequate monitoring of treatment adherence and resistance;
- Strengthening health systems to increase their capacity to provide treatment and care to PLHIV;
- Strengthening comprehensive facility- and community-based (communities, families, PLHIV) care and support for PLHIV and OVCs, including health care, social and psychological support, as well as food and educational support;
- Strengthening linkages and referral mechanisms between prevention, treatment, care and support services, as well as between health and other government sectors and community systems.

The *key results* or outcomes expected in the context of Objective 3 include:

Expected results Objective 3:

3.a Increased number of PLHIV with continued and easy access to *comprehensive AIDS treatment* services in accordance with international best practices;
3.b Increased number of men, women and children infected, or affected by HIV/AIDS receive *comprehensive care and support* services, which meet their specific needs;
3.c *Health systems strengthened* to facilitate scale up of high-quality HIV/AIDS treatment and care, which is increasingly integrated into existing health-care services

In this context, and building on *existing* programmes and services, the following main strategies will be implemented to strengthen quality, coverage and utilisation of HIV/AIDS treatment, care and support services:

3.1 Strengthen coverage and utilisation of ART services, which are well integrated into the public health system;
3.2 Development of monitoring strategies for ARV treatment adherence;
3.3 Integration of HIV/AIDS training components into pre- and in-service training of health-care staff involved in HIV/AIDS treatment and care;
3.4 Strengthen HIV/AIDS supply-chain management as integrated part of essential drugs supply-chain management;
3.5 Strengthen coordination and collaboration between TB and HIV/AIDS-related services;
3.6 Strengthen capacity and provide resources for home-based care and support for PLHIV at facility and community levels;
3.7 Support the active involvement of PLHIV associations and self-help groups in comprehensive care, support and treatment, as well as their empowerment as individuals and as a community; and
3.8 Provide comprehensive support to individuals and households affected by HIV/AIDS.

A) Strengthening service delivery in the field of ARV and OI treatment

Strategy 3.1: ***Strengthen coverage and utilisation of ART services, which are well integrated into the public health system*** – To date, 19 facilities in 10 counties are providing antiretroviral treatment (ART), since it was first introduced at a private health-care facility in 1999. As of September 2009, 2,968 PLHIV had started ARV treatment at some point: a small proportion of the total number in need. A number of key activities will be implemented to further integrate ART services in the public health-care system and scale up their coverage and utilisation. 1) *Upgrading and standardisation of ART training manuals and guidelines* will ensure that quality standards are adhered to by all service providers. Special attention will be given to strengthening adherence of treatment and active follow-up of patients. Revision of guidelines will be done every two years. 2) As the health system, including VCT services, is further strengthened, ART services will need to expand as well. In this context, *additional health facilities* (six each year) in new sites in all counties will be *upgraded* and provided with the necessary *equipment and commodities to* enable improved access to high-quality ART service delivery (from the current 19 sites to 49 in 2014). 3) All health-care staff involved in ART (doctors, nurses, counsellors, midwives, lab technicians, pharmacists) in existing and new health facilities providing ART will be *trained* (through workshops and on-site) in ART protocols (with special attention for paediatric ART), adherence, PITC, nutrition, and avoiding stigma and discrimination of PLHIV. Training will specifically focus on strengthening collaboration and referral between different departments (VCT, PPTCT, ART, OI treatment, home-based care etc.). 4) Adequate *procurement and distribution of ARV drugs* and other supplies will ensure continuity of treatment and monitoring of treatment adherence without stock-outs. 5) Similarly, adequate availability of *drugs for OI treatment* will allow providing comprehensive care and treatment to PLHIV. 6) All health facilities providing ART will be provided with key laboratory equipment and commodities (test kits, reagents) to allow adequate monitoring of treatment. 7) To strengthen integration of ART in the regular health-care system, ART patient-record cards and referral cards will be redesigned and incorporated into regular treatment services. 8) *Nutritional support* will be given to all PLHIV as an integrated component of ARV treatment, to strengthen patients' overall health and ability to deal with possible side effects. In this context, NGOs and CBOs will collaborate with health facilities to develop criteria and identify patients in need of nutritional support. Finally, 9) support will be given to technical working groups on care and treatment (ART, PPTCT and PEP), which will look at improving

coordination among different services.

Strategy 3.2: *Development of monitoring strategies for treatment adherence* – Development of a system for improved patient-tracking and ART-adherence monitoring is a crucial part of ART, as low adherence is a serious concern for patients, which may also lead to the development of resistance to ARV drugs. Information on the number of patients ever leaving the ART programme is difficult to establish, since a significant proportion of non-compliant patients return to the health facility for ART at a later stage, especially when sick. In the first quarter of 2009, the attrition rate of patients on ART was 5 percent (n=126), of whom half died, and half was lost to follow-up (NACP, 2009). In this context, 1) ARV service providers will develop a *system for monitoring ART adherence*, by piloting various adherence strategies to help identify successful interventions for strengthening ART adherence and allow for modification of trainings and health facility intervention strategies. 2) In addition, joint *training sessions on treatment monitoring* will take place for counsellors, facility and community care providers and family members. 3) *Strengthening of the referral system for tracing HIV-infected clients* and family members will allow linking HIV-infected clients to facility-based care, as well as tracing HIV-positive defaulters; 4) To gain greater information about ART patients needs, adherence and health status, a *cohort study will follow ART patients* through their treatment courses to gain greater insight about future programming needs. 5) In addition to this cohort study, ongoing *operations research on ARV-drug resistance* will take place.

B) Strengthening health systems to increase their capacity to provide HIV/AIDS treatment and care

Strategy 3.3: *Integration of HIV/AIDS training components into pre- and in-service training of health-care staff involved in HIV/AIDS treatment and care* – In addition to training health-care staff in health facilities that provide ART services (Strategy 3.1), adequate AIDS care and treatment requires strengthening a) HIV/AIDS-specific knowledge and skills; and b) the *overall* human-resource capacity in the health sector.

To date, *HIV-specific training of health-care staff* has mainly been through ad-hoc, in-service and on-the job training in the context of vertical programmes. To ensure a more systematic integration of HIV training, the *NSF 2010-2014* will support the following activities: 1) Support the MoHSW Training Department – in close collaboration with professional associations – in developing a *standardised National Training Plan* for public and private-sector health-care workers, which will encompass both pre- and in-service training. Training will be generalised to allow integration of health services for outpatients and inpatients as well as laboratory and pharmacy services. Special attention will be given to paediatric HIV care. 2) HIV training modules – meeting minimum BPHS standards – will be incorporated into the *pre*-service curriculum of training institutions for medical doctors, nurses, laboratory technicians and pharmacists to ensure adequate training of all staff. 3) In addition to strengthening pre-service training, staff capacity in public and private health facilities will continue to be strengthened through *in-service training and on-site follow-up mentoring and supervision* at health facilities, to minimise the disruption of services due to health staff frequently attending training workshops. 4) In this context, 45 national mentors will be trained to provide on-the-job training, supervision and support.

Strengthening the Health workforce beyond the NSF 2010-2014 – Beyond the HIV/AIDS NSF 2010-2014, *strengthening the overall health-sector capacity* is a key priority area of the National Health Policy and Plan. Contributions in this field will be made through the Global Fund *Health Systems Strengthening* component. Specific elements include strengthening of medical and nursing curricula; continuing education efforts; the development of an in-country certification course in hospital administration and management; and Master-level scholarships for key health professionals in

management and technical areas. In addition to training, The Global Fund HSS component will also expand and upgrade workforces, including medical doctors, pharmacists and laboratory technicians, especially in underserved rural counties. A pilot programme will train and deploy 800 community health professionals (supported by GAVI) to provide primary health care at the village level.

Strategy 3.4: *Strengthen HIV supply-chain management as integrated part of essential drugs supply-chain management* – While previous efforts to address *procurement and supply-chain management* (PSM) have improved the system, drug shortages are still common at the local, county and even national level. Inadequate communication and reporting remain common problems in ensuring proper inventory of medications and supplies, while quality-assurance efforts are minimal at all levels. In the HIV/AIDS-related field, there is a need to improve the integrated supply-chain management of drugs and commodities that are provided through different sources (e.g. Global Fund, UNFPA and USAID) and in the context of different programmes (e.g. HIV/AIDS, family planning, sexual and reproductive health). In this context, the National Drug Supply Service (NDS) will be strengthening the overall PSM system with support from the Global Fund (Round 8) *Health Systems Strengthening* component. Specific activities include the renovation of warehouses and depots at county and local clinics to expand the capacity for decentralised medical storage; this will decrease shortages of drugs for HIV/AIDS, malaria and TB. In addition, technical assistance will strengthen PSM capacity in the field of HIV/AIDS-drug forecasting and procurement, inventory management and information systems. Furthermore, the purchase of additional vehicles will improve distribution systems.

In addition to strengthening PSM systems and capacity, ***laboratory systems*** will also be strengthened with GFATM support: this includes improving the quality and reliability of diagnostic testing through the development and implementation of *internal quality-management Standard Operating Procedures (SOPs)* within all laboratories, in accordance with the BPHS. In addition, a system for *external quality assurance and quality control* for HIV and CD4 testing (as well as for malaria and TB) will be put in place. *Human resource capacity* will be strengthened to ensure adequate management and maintenance of advanced laboratory and other biomedical equipment.

Strategy 3.5: *Strengthen coordination and collaboration between TB and HIV/AIDS-related services* – Strengthening health systems and improved integration of HIV/AIDS into the Basic Health Package Service (BHPS) are important priorities for the NSF 2010-2014, as shown by strategies (3.3) and (3.4). An important area for improving integration is collaboration between the AIDS and TB programmes, especially given the high burden of TB among HIV patients enrolling into care and treatment; similarly, 21 percent of TB patients who underwent HIV testing were HIV-positive (NACP, 2009-1). Currently, 241 out of 4135 (6%) HIV patients enrolled are receiving treatment for TB. To date, however, the AIDS and TB programmes were run as two parallel GFATM-funded programmes, but efforts are underway to strengthen the linkage between TB and HIV/AIDS care and referral services, such as provider-initiated testing and counselling (PITC) for TB patients to be tested for HIV and vice versa. Additional activities in the context of the NSF-II to strengthen linkages and collaboration between HIV/AIDS and TB staff and facilities include: 1) Training of TB clinical staff on HIV testing and referral, and of HIV/AIDS clinical staff on TB screening and referral; 2) Training of HIV/AIDS and TB programme staff to improve integrated case management and facilitate linkages between the two programmes; and 3) On-site mentoring at the health-facility level to ensure quality TB-HIV services; this includes joint, integrated monitoring and supervision visits by national programme managers.

C) Strengthened facility- and community-based care and support services for PLHIV, OVCs and other affected persons

Strategy 3.6: *Strengthen capacity and provide resources for home-based care and support for PLHIV at facility and community levels* – In addition to strengthening health systems for the delivery of integrated HIV/AIDS treatment, the provision of medical, psychosocial, nutritional and other types of ***care and support*** for those affected by HIV and AIDS – including PLHIV, orphans and vulnerable children (OVCs) and others – is a key, but underdeveloped area. Comprehensive care and support requires the active involvement of facility-, community- and household-based systems, with a particularly important role for strengthening the (self) empowerment of PLHIV as individuals and as a group.

Home-based care (HBC) is an integral part of comprehensive treatment and care for PLHIV, which needs to be standardised and integrated into the wider care and support system. *Key activities* in this regard include: 1) *Strengthening and expanding HBC services* by establishing and strengthening technical and institutional capacities of HBC organisations at county level, e.g. in the field of adherence monitoring and palliative care. This includes support for *hospice facilities* in providing medical and emotional care and support to terminally ill AIDS patients, as well as community outreach and educational activities for PLHIV; 2) *Training of professional health-care providers* in palliative care, counselling and psychosocial support services for facility- and home-based care and support; and 3) the procurement and provision of *HBC kits for health-care workers*; 4) In addition to training professional staff, *training of community care providers* – including peer educators, family members, community leaders and volunteers – and PLHIV-support groups in counselling and psychosocial support services in the context of HBC will complement services by professional staff. Special attention will be given to prevention of burnout and 'caring for carers', as well as close collaboration between professional and community caregivers. 5) *Secondary HBC kits* will be procured and supplied to support these community volunteers.

Strategy 3.7: *Support the active involvement of PLHIV associations and self-help groups in comprehensive care, support and treatment, as well as their empowerment as individuals and as a community* – In addition to strengthening care and support by professional and community caregivers (Strategy 3.6), the active involvement of PLHIV themselves is a key element of strengthening care and support. PLHIV should not be regarded as mere recipients of medical, psychosocial or other types of care and support *provided by others*, but the empowerment of PLHIV as individuals, and their organisation and mobilisation as a group to care for themselves and others are equally important. Given the special vulnerabilities of women living with HIV/AIDS (WLHIV), special attention will be given to WLHIV associations and support groups. The main activities to support and strengthen PLHIV support groups and associations are: 1) *Organisational strengthening of PLHIV Associations* through training in management and leadership skills, as well as basic material support, including technical and office equipment. This will allow PLHIV Associations to provide more effective assistance to existing and newly established PLHIV and WLHIV support groups at community and facility levels. 2) In addition, technical and financial support for the creation of a *national PLHIV association* will contribute to strengthening networking, coordination and collaboration among existing PLHIV/WLHIV associations and other vulnerable groups. This will strengthen their combined power for advocacy and social mobilisation in support of PLHIV/WLHIV rights and in reducing stigma and discrimination. 3) In addition to organisational support, *financial and logistical support* will be given to PLHIV/WLHIV associations and support groups to implement activities in peer education, counselling, ART adherence (e.g. by establishing ART support groups at health facilities), and awareness creation to reduce stigma discrimination. 4) *Training* of PLHIV/WLHIV associations and groups in *technical areas* such as career counselling, advocacy, palliative care, adherence disclosure and nutritional advice will allow them to provide concrete support to PLHIV. 5) Support for *income-generating activities* and training will be provided to PLHIV/WLHIV (through support groups and associations) to strengthen their livelihood and economic viability. Finally, 6) the development of *integrated HIV-related and other support services and*

improved referral systems for PLHIV, will facilitate access to comprehensive quality care and support.

Strategy 3.8: *Provide comprehensive support to PLHIV and individuals and households affected by HIV/AIDS* – In addition to medical care and support for PLHIV, other types of support for PLHIV and those affected by HIV/AIDS – such as orphans, vulnerable children, families and community caregivers – is essential for mitigating the impact on individuals, households and communities. The type of support provided will depend on specific needs, and will be provided to those most in need. Key activities in this field include: 1) A *needs assessment* will be conducted to assess the specific care and support needs of PLHIV, OVCs and others affected; this will be the basis for guidelines and detailed planning of care and support services for PLHIV, OVCs and their caregivers; 2) Provision of *medical care, nutritional, psychosocial, and hygiene and sanitation counselling* to PLHIV and affected people most in need; 3) Provision of *basic support for orphans and vulnerable children* and adolescents most in need and their caregivers. This includes: Medical support; School-related assistance (school fees, school uniforms); Emotional/psychological support (counselling); and Social support (clothing, extra food). Support will be provided based on identification of those most in need by local organisations; 4) Training and support for caregivers and communities caring for PLHIV or OVCs on care and support for PLHIV or OVCs; livelihood and income-generating skills, as well as micro loans; 5) In addition to training, income-generating activities for OVC and families will help them strengthen their livelihood and economic security. 6) Finally, basic home-based care will be provided to OVCs and affected families that are most in need.

5.3.4 Main Strategies for Objective 4: *Strategic Information Management*

Objective 4*: To strengthen the availability, sharing and utilisation of strategic information that will guide the planning and implementation of policies and programmes.*

Knowing and understanding the scale, nature and distribution (geographic, gender, age, population groups) of the HIV/AIDS epidemic is crucial for an evidence-informed national response, tailored to the HIV/AIDS prevention, care and treatment needs of key groups at risk or affected. Currently, strategic information is available from different sources, including a) health-facility-based HIV/AIDS and STI case-reporting systems; b) HIV-prevalence data from studies among antenatal women and the general population (LDHS); c) monitoring and evaluation data on programmes, services and financial spending, mainly in the context of Global Fund-supported programmes; d) as well as a limited number of rapid assessments and small-scale qualitative studies. However, the quality, reliability and availability of these different types of data are often suboptimal. In addition, much of the available information is scattered and lacks proper analysis to adequately inform decisions on policy and programme development, or resource allocation. Also, the availability and accessibility of data are often hampered by a lack of coordination and information sharing. Therefore, strengthening the quality of this data, as well as effective coordination of all HIV/AIDS-related information flows in one national system are needed to meet the information needs of stakeholders at the policy and programme level.

The ***key results*** or outcomes expected in the context of Objective 4 include:

Expected results Objective 4:

4.a Strengthened and functional National HIV/AIDS M&E system in place;
4.b Accurate, strategic information is available and accessible to all stakeholders, and used for evidence-informed policy and programme planning, and resource allocation.

In this context, and building on existing programmes and services, the following main strategies will be implemented to strengthen the availability and use of strategic information:

4.1 Conduct special research on drivers and underlying dynamics of the HIV epidemic; impact and other studies to inform policy and programme planning;
4.2 Establish a comprehensive national second-generation surveillance (SGS) system to allow adequate monitoring of biological and behavioural trends among the general population and key populations at risk;
4.3 Establish and roll out a National Surveillance and M&E System and Plan;
4.4 Establishment of a National HIV/AIDS database, and dissemination of HIV/AIDS data and information using different formats and media;
4.5 Strengthening technical capacity in the field strategic information management among policy makers and programme staff; and
4.6 Development of quality-assurance and M&E tools and mechanisms to assess the effectiveness of HIV services, drugs and capacity building in the health sector;

Strategy 4.1: *Conduct special research on drivers and underlying dynamics of the HIV epidemic; impact and other studies to inform policy and programme planning* – Existing gaps with regard to reliable data on specific most-at-risk populations and vulnerable groups are a major obstacle for developing and implementing an evidence-informed national response to HIV/AIDS. To date, research on the specific risks and vulnerabilities of these groups has been limited; e.g., female sex workers or other MARP groups were not included in the latest LDHS study. In this context, *research* among these groups is a key priority for the NSF 2010-2014; this includes *mapping and size-estimation studies*; qualitative, *in-depth research to identify specific risk behaviours patterns and sexual networks*; as well as *service-needs assessments*. The results of these different studies and assessments will be used to tailor key HIV-prevention services to the specific needs of these different groups. Research is also needed to provide more insight into the nature of sexual dynamics and networks among *MSM*, who constitute a potential bridge group, as they engage in high-risk (anal) sex with men, as well as with wives and other female sex partners. The findings will reveal effective ways of reaching MSM with education, e.g. through anonymous and safe media such as internet-based services. More research is also needed to assess the extent of MSM sex and sexual violence among *men in prisons*.

More research is also needed on the socio-economic and cultural drivers of the epidemic, its impact on individuals and communities, and other factors that influence the course of HIV/AIDS in Liberia. In principle, (service) needs assessments among specific groups will be conducted as part of programme planning (see strategies above). In this context, the following activities will be prioritised: 1) Establishment a *national HIV/AIDS research committee*, which will regularly meet to discuss and identify national research priorities and endorse research proposals. 2) A key output of the national research committee will be an annually updated national HIV/AIDS *research agenda*, which will guide social, behavioural, financial-economic, evaluation and policy research in national priority areas. 3) *Annual advocacy meetings* will be held to create support for the national research agenda among government and development partners; 4) In line with current research priorities, a *series of assessments and surveys* (combining qualitative and quantitative methods) will be done to estimate the size and identify specific characteristics, HIV/AIDS risks and vulnerabilities of key MARP and vulnerable groups (including sex workers and their clients; and young women and girls involved in transactional sex; MSM; mobile populations; and prison inmates); 5) A special study will be conducted to assess the socio-economic impact of HIV/AIDS on the population; 6) A *Mapping study* will be conducted to identify current implementing partners in the public and private sector, and the HIV/AIDS interventions and services they provide; 7) A special study will be conducted to assess community approaches to stigma reduction; and tracking of patients on ART.

Strategy 4.2: *Establish a comprehensive national second-generation surveillance (SGS) system to allow adequate monitoring of biological and behavioural trends among the general population and key populations at risk* – The main sources of data on HIV prevalence, knowledge and risk behaviours include sentinel surveillance studies among women attending antenatal care (ANC) services in 2006 and 2007, and the Liberia Demographic and Health Survey (LDHS) among the general population in 2007. While both studies provide an insight in HIV prevalence and behaviours among the general population and ANC women, bio-behavioural data is not available on key populations at risk, such as sex workers and their clients, MSM, or mobile groups. In addition, to allow proper monitoring of trends over time, bio-behavioural studies on HIV/AIDS need to be institutionalised and conducted on a regular basis. Therefore, the following activities will be implemented to institutionalise these SGS studies and expand them to most-at-risk and vulnerable groups: 1) *Annual sentinel surveillance studies among ANC women* will be conducted; the number of sites will increase annually, from 20 sites in 2010 to 30 in 2014; 2) Every two years, *bio-behavioural surveillance studies* will be conducted among the general population and key populations at risk, disaggregated for sex and age. Sampling of most-at-risk populations will be informed by mapping studies (see previous strategy); 3) In addition, household-based *Multi-Indicator Cluster Surveys* (MICS) will be conducted every two years to monitor the socioeconomic and health situation of children and women; this will provide data on the situation of OVCs and affected families, as well as additional data on women, including on HIV/AIDS. 4) To follow up on the 2007 LDHS study, an *HIV/AIDS module* will be included in the *2012 LDHS*. 5) Finally, a *national STI-prevalence study* – with data on chlamydia, syphilis and gonorrhoea – will be conducted in 2010. STIs may facilitate HIV transmission, especially in women; in addition, STI data provide a proxy indicator for specific groups with unsafe sex behaviours.

Strategy 4.3: *Establish and roll out a National M&E System and Plan* – Previous strategies 4.1 and 4.2 address the overall lack of reliable data, especially on most-at-risk populations, by strengthening data collection through special research, bio-behavioural surveys and HIV-surveillance studies. In addition to addressing these data-collection gaps, the establishment of a *national HIV/AIDS M&E system* is needed to strengthen the overall coordination of data collection, data flows, as well as the availability and strategic use of information for policy and programme decisions. This national system should be based on an overall national surveillance and M&E *Framework and Plan*, which will guide the coordinated management and use of data from all sources: surveillance, programme M&E, special research and financial tracking.

The development and rollout of this joint HIV/AIDS M&E system will involve the following main activities: 1) the development of an *overall M&E framework and costed action plan* for the establishment and rollout of a national HIV/AIDS surveillance and M&E system. The Plan will be based on an in-depth *assessment* of the strengths and weaknesses of existing data-collection systems on HIV/AIDS, STIs and related infections. The *M&E framework* will provide: a) a detailed description of the individual components of the system; b) *National indicators* and guidelines and protocols for data collection, reporting and sharing; aggregation; analysis, publication and utilisation at national and county levels; c) the institutional and coordination framework; and roles and responsibilities of key stakeholders; d) the key expected outputs and outcomes of a national system. The *Action Plan* will describe the key steps to be taken to develop and roll out the system. 2) A key component of the national M&E system is the establishment of an adequately staffed and equipped *National M&E unit* – based at the National AIDS Commission (NAC) – which will be tasked with the overall coordination and implementation of the national surveillance and M&E plan. 3) The M&E Unit will support the development of M&E guidelines for community-based data collection and reporting, and will 4) provide *technical and logistical support to data collection and entry* at national and county levels. 5) Every two years, the NAC M&E Unit will organise efforts to ensure the quality of reported data, including a *data quality audit* through record reviews, and verification and validation of reported

data. 6) The NAC-based M&E Unit will collaborate closely with key national stakeholders through the M&E Reference Group (MERG): the *MERG will hold regular meetings* to discuss and review national guidelines for data collection analysis and dissemination. 7) The M&E Unit and MERG will organise and support a *joint Mid-term review of the national response* in 2012.

Strategy 4.4: *Establishment of a National HIV/AIDS database, and dissemination of HIV/AIDS data and information using different formats and media* – As part of the National M&E plan (see previous Strategy), the NAC M&E Unit will develop strategies for disseminating HIV/AIDS-related information, using various formats and channels: 1) Once the national M&E system is operational, with adequate data collection and reporting from different sources, the M&E Unit will develop a *national HIV/AIDS database*, comprising research reports, surveillance data, and key M&E data on programmes, services and spending of resources (e.g. NASA data). 2) This national HIV/AIDS database will be the basis for the *publication and dissemination* of available information in various formats, including an *annual national HIV/AIDS Report*, which will provide a comprehensive update (electronic and printed versions) on all relevant developments in the HIV/AIDS field. 3) In addition, all data will be made available through the establishment of a *documentation centre and website*, providing access to research reports, statistics, programmatic data etc. Additional information-sharing activities include: 4) A *biennial forum for PLHIV* associations and support groups, which will facilitate the sharing of experiences and strengthen mutual support; and 5) a *National HIV/AIDS Forum* for information sharing and discussion among national and local stakeholders, which will inform future strategic frameworks, policies and programmes at national and local levels.

Strategy 4.5: *Strengthening technical capacity in the field strategic information management among policy makers and programme staff* – The development and strengthening of surveillance and M&E systems builds on the availability of well-trained and skilled M&E staff at all levels. In this context, capacity building will take place in the following priority areas: 1) Train NAC, HMIS (MoH) and LISGIS staff and partners on the CRIS indicators and tools at national and county levels; 2) Train M&E Unit staff at NAC on verification of results submitted from different levels to programme; 3) Build and strengthen the skills of county HIV/AIDS focal persons in M&E techniques and tools (two per county); 4) Train M&E staff at key line ministries on relevant HIV/AIDS indicators and data sources. Additional training on surveillance or M&E will be based on emerging needs.

Strategy 4.6: *Development of quality-assurance and M&E tools and mechanisms to assess the effectiveness of key HIV services, drugs and capacity building in the health sector* – To date, monitoring and evaluation (M&E) of programmes and services have mainly focused on quantitative aspects, such as coverage and numbers of services provided or people trained. However, the *quality* of services has received very little attention. In this context, strengthening M&E and quality-assurance (QA) mechanisms is crucial for improving the effectiveness and quality of services, especially in the health sector, which plays a key role in the national response. In this context, the following activities will be implemented: 1) Development of a *QA checklist;* 2) Training of Quality-Assurance Groups (QAG) for rapid appraisals of the quality of services at the PHCs/CHCs, using QA tools and checklists; 3) Strengthening quality assurance on pharmaco-vigilance; 4) Laboratory evaluation of HIV-testing algorithms; 5) Development of pre- and post-test M&E tools to assess the outcomes of HIV/AIDS training programmes; 6) Client-based survey on interpersonal communication between health-care providers and patients, and quality of service.

5.3.5 Main Strategies for Objective 5: *Policy Advocacy and Enabling Environment*

Objective 5*: To promote a supportive environment for women, men and children living with HIV, and reduce HIV/AIDS-associated stigma and discrimination.*

Since there is a widespread view that HIV/AIDS results from immoral behaviour, a positive diagnosis may have devastating social and health consequences, such as termination of employment, divorce, social isolation, abandonment and ridicule. *Stigma and discrimination* constitute major problems for PLHIV as well as non-infected persons, as they may prevent people from going for HIV testing and thus from knowing their HIV status and taking appropriate preventive and help-seeking action accordingly. Furthermore, stigma and discrimination may keep PLHIV from disclosing their status to family members and sex partners, thus hampering support from families and communities, and increasing the risk of further HIV transmission. HIV-infected children may face social exclusion at schools and in communities. In addition, the low percentage of people knowing their HIV status also blurs an accurate picture of the HIV epidemic for policy makers, hampering effective policies and programmes. Furthermore, stigma and discrimination by health-care workers may keep PLHIV from seeking HIV/AIDS prevention, treatment, care and support services, and may hamper their adherence to ARV treatment. Therefore, reducing stigma and discrimination in all settings – communities, workplaces, health sector – is a cross-cutting priority for creating an overall supportive environment for an effective national response. This involves advocacy, social mobilisation and sensitisation efforts for changing social norms and attitudes, as well as strengthening legal and policy frameworks to protect the health, labour and social rights of PLHIV.

The key results or outcomes expected in the context of Objective 5 include:

Expected results Objective 5:

5.a Supportive societal attitudes to PLHIV, with stigma and discrimination reduced in all settings;
5.b Supportive legal and policy environment for PLHIV, OVCs and others affected.

In this context, and building on existing programmes and services, the following *main strategies* will be implemented to strengthen the availability and use of strategic information:

5.1 Sensitise the general public on the rights of citizens infected and affected by HIV
5.2 Review, development and enactment of policies and legislation to protect the rights of men, women and children living with HIV, as well as people with special vulnerabilities to HIV/AIDS
5.3 Sensitisation and promotion of non-discriminatory policies and practices at workplaces, service delivery points, communities and in families

Strategy 5.1: *Sensitise the general public on the rights of citizens infected and affected by HIV* – Stigma and discrimination by society as a whole, in communities and families affect men, women and children living with, or affected by HIV/AIDS in their daily lives. Addressing social stigma and discrimination requires action at the community and political and legal level. Key activities in this regard include: 1) Annual symposia for political, religious, traditional, business and opinion leaders will provide an advocacy platform for promoting their proactive, public action in support of PLHIV and others affected, and against stigma and discrimination. The symposia will also sensitise them to create supportive environments in their own institutions, organisations and companies. 2) Community gatherings will be held in all counties to promote active community support to women, men and children living with HIV/AIDS, and increase knowledge on PLHIV rights. 3) In addition,

nationwide community mobilisation and empowerment activities will be held nationwide to address gender and rights issues and harmful cultural practices. 4) In addition to activities with leaders and communities, electronic and print mass media will be used to sensitise PLHIV and the general public on the rights of PLHIV.

Strategy 5.2: *Review, development and enactment of policies and legislation to protect the rights of men, women and children living with HIV, as well as people with special vulnerabilities to HIV/AIDS* – In addition to creating supportive attitudes among communities and leaders, stigma and discrimination also need to be tackled through policy and legislative measures that protect the rights of PLHIV and other vulnerable groups. Key activities in this regard include: 1) *Training workshops* to strengthen the capacity to deal with stigma and discrimination of key institutions involved, including the judicial system, Ministry of Gender, the International Federation of Women Lawyers, the Department of Social Welfare and the police; 2) *Advocacy* with key government and non-government sectors to ensure the development and (subsequent) enactment of *legislation, policies, guidelines* to protect and support PLHIV, OVC and other vulnerable groups.

Strategy 5.3: *Sensitisation and promotion of non-discriminatory policies and practices at workplaces, service-delivery points, communities and in families* – In addition to creating supportive attitudes and legal and policy frameworks, stigma and discrimination need to be addressed in specific settings, in particular workplaces, health facilities, schools and communities. The sensitisation of leaders and senior decision makers (Strategy 5.1) will facilitate the development and implementation of such local and sectoral policies and guidelines. Specific activities in this regard include: 1) Training and sensitisation of health-facility staff on non-discriminatory policies. Supportive attitudes of health-care workers are essential, since many key HIV/AIDS prevention, treatment and care services are provided by the health sector. 2) In addition, training of and sensitisation of employees in other ***workplace settings*** is important, since government ministries and institutions are the largest formal employer in Liberia: supportive workplaces provide support to HIV-infected staff, and enable the delivery of HIV/AIDS-related programmes and services, e.g. in the education and military sector.

6. IMPLEMENTING THE NATIONAL STRATEGIC FRAMEWORK 2010-2014

6.1 INSTITUTIONAL FRAMEWORK AND ARRANGEMENTS FOR IMPLEMENTING THE NSF 2010-2014

Successful implementation of the NSF 2010-2014 depends on the effective collaboration of NAC as the overall coordinating body with Ministries and other policy and implementing organisations in civil society and the private sector.

The Liberian *National AIDS Commission* (NAC) has the formal mandate for the overall coordination and supervision of the national response. In this function, NAC will oversee the implementation of the NSF and provide overall policy guidance to all national partners. A key priority of the NSF 2010-2014 is to strengthen the NAC organisational structure, and the staffing and capacity of the *NAC Secretariat* to effectively fulfil its roles and responsibilities. The NAC Secretariat will be responsible for the daily management of key tasks in the field of national coordination, monitoring and evaluation, advocacy and policy guidance in the field of HIV/AIDS. In this regard, the NAC Secretariat will work in close collaboration with the MoHSW-based National AIDS Control Programme (NACP), and the Global Fund's Liberian Coordinating Mechanism (LCM), which play a key role in coordinating the implementation of many of the components of the national response. Staff will include four coordinators on M&E, IEC/BCC, Line Ministries and Civil society.

The *Liberian Coordinating Mechanism* (LCM) – which has representation from different government sectors, civil society and the private sector – oversees the implementation of Global Fund-supported projects, which constitute a major part of the national response to HIV/AIDS. These include the Round-6 programme, which is currently being implemented, and the Round-8 programme, which will start soon. Principal Recipients for Round 6 and 8 are UNDP and MoHSW, respectively. The GFATM Implementation Unit (PIU), which is responsible for the overall implementation, will be based at *the MoHSW, the PR for the HIVAIDS grant.* In this context, the LCM and PIU will closely coordinate their roles and functions with NAC and the NAC Secretariat, to ensure the Global Fund programmes provide an effective contribution to the implementation of the NSF.

The *National AIDS & STI Control Programme* (NACP) of the *MoHSW* is responsible for the coordination and implementation of HIV/AIDS interventions in the public health sector, which constitute an important part of the national response. MoHSW is a major recipient of funds under the GFATM Round-6 programme, and will be the Principal recipient of the Round-8 programme. In this context, NAC and the NAC Secretariat will work in close collaboration with MoHSW and NACP to coordinate the health-sector contributions to the national response in accordance with the NSF 2010-2014.

NAC and its secretariat will also coordinate with *other Ministries* to ensure the development and implementation of sectoral policies and programmes. To date, several Ministries, including the Ministries of Labour, Education, Youth and Sports, Gender and Development, and Defence, have developed policies in the field of HIV/AIDS. NAC will support the operationalisation and implementation of these policies in accordance with the NSF 2010-2014, and help other Ministries mainstream HIV/AIDS in their policies and programmes.

Another priority of the NSF is the assignment of *HIV Focal Persons* at the County level – who will play a key role in coordinating implementation of the NSF at the county level, in close collaboration with the County Health Teams.

Furthermore, NAC will work with UN agencies through the *UN Theme Group on HIV/AIDS*, and UNAIDS as the secretariat of the joint UN programme.

Coordination of programmes and services of *civil society organisations*, PLHIV associations, churches and faith-based organisations (CHAL) will be facilitated through the LCM platform, as well as existing network organisations. As part of the NSF workplan, the establishment of a Business Coalition on HIV/AIDS will facilitate NAC's coordination with the private sector in scaling up HIV/AIDS workplace programmes.

6.2 FINANCIAL RESOURCES AVAILABLE AND NEEDED

Full details of the National Strategic Framework 2010-2014 workplan and associated budget are presented in *Annex 1*. The total cost of the NSF has been calculated at **USD 99.3 million** over five years. *Table 3* shows the *costs by Objective*, which shows that almost two-fifth of the budget has been assigned to HIV-prevention, while half of the budget has been set aside for treatment, care and support. Coordination and management absorb 7 percent, and strategic information management 3.5 percent.

Table 3: Total Costs by Objective (in US Dollars) [DRAFT]

NSP Objective No:	COST	% of total	AVAILABLE	GAP
1. Coordination and Management	7,270,461	**7.3**	3,848,642 (53%)	3,421,819 (47%)
2. HIV Prevention	36,018,464	**36.3**	23,052,844 (64%)	12,965,620 (36%)
3. Treatment, Care and Support	50,183,998	**50.5**	21,582,023 (43%)	28,601,975 (57%)
4. Strategic Information Management	3,461,181	**3.5**	252,010 (7%)	3,209,171 (93%)
5. Policy Advocacy & Enabling Environment	2,338,025	**2.4**	2,500 (0.1%)	2,335,525 (90.9%)
Total Costs	**99,272,129**	**100.0**	**48,738,465 (49.1%)**	**50,533,663 (50.9%)**

Available resources and mobilisation of additional funds

Almost half (49%) of the financial resources needed for implementation of the NSF 2010-2014 is currently already available, or will be available soon. The Global Fund is the major donor, with funds from the last two years of the Round 6 project still available as of 2010, and Round 8 fully unspent. To date, government funds have covered personnel costs of government staff in the MoHSW, NACP, and NAC.

Despite the existing funds available, a substantial shortfall of 51 percent remains, which requires the mobilisation of additional resources over the next five years. The largest shortfall, USD 28.6 million, is in the field of *treatment, care and support*: this represents more than half (57%) of the funds required. This major funding gap for treatment and care is largely the result of shortages in the area

of *comprehensive care and support for PLHIV, OVCs and affected families* (USD 12.1 million); as well as in the field of home-based care and palliative care for PLHIV (USD 3.4 million) and nutritional support for persons on ARV treatment (USD 1.5 million). Another major funding gap exists for ARV drugs: of the required 13.3 million, only USD 7.6 million is available from GFATM funds, leaving a gap of USD 5.7 million (43%): this is mainly the result of recent sharp increased targets for ART coverage, as previous targets (2008) were considered too low.

Big shortfalls in the field of HIV prevention – almost USD 13 million – can be found for special programmes for MWARP groups (USD 3.4 million), HIV prevention in the education sector (USD 3.3 million), and VCT services (USD 2.5 million). The large funding gap regarding strategic information is the result of the NSF's key focus on establishing a joint national M&E system, as well as on promoting second-generation surveillance. The 90% funding gap for policy advocacy and supportive environments reflect the inadequate attention to date for these strategies.

Additional funds for HIV/AIDS will become available in 2009 through the recently approved ***Round-8*** proposal, which amounts to a total of USD 77.7 million. This programme has two major components: an HIV-specific component (USD 51.1 million,) and a component for health systems strengthening (HSS) (USD 19.2 million). The HIV component will support further expansion and improvement of facility-based HIV/AIDS services, in order to promote equitable geographic.

[**INTERNAL NOTE**: As a result of the difficulty to obtain accurate data on available funds from different sources, the [estimated] available funding in the budget may be a considerable **UNDERESTIMATION** of the ***actually available funds***. Therefore, the current "funding gap" of more then USD 50 million may shrink considerably as more complete and accurate financial data become available. E.g., HIV-specific funding from GFATM Round 8 amounts to a total of USD 51.1 million, with another 19.2 million for health systems strengthening. Round 6 funding for 2010-2012 amounts to approximately 21.7 million (last 2 years). This translates into a total of USD 72.8 million (HIV-specific, non-HSS), or almost three-quarters (73%) of the required funds, just from Global Fund contributions. Similarly, the ***estimated total cost*** (required funding) may be higher than the actual need, due to difficulties and uncertainties in establishing unit costs, as well as in setting targets that are in accordance with the limited capacity of the health system: targets may need to be adjusted to lower levels, which would result in lower costs as well. In this context, a detailed assessment of the current situation with regard to funds and resources available, as well as of accurate unit costs and targets is a high priority.

6.3 MONITORING AND EVALUATION OF THE NATIONAL STRATEGIC FRAMEWORK 2010-2014

Monitoring and evaluation (M&E) is an integrated element of the National Strategic Framework (NSF) at all levels – impact, outcomes, outputs and activities (inputs/process). For each level, annual targets have been set, the attainment of which will be monitored using objectively verifiable indicators (OVIs), which are in accordance with international M&E standards and local priorities.

Monitoring results and outputs

The ***Results Framework*** in Annex 2 provides an overview of the key results expected in terms of the *Impact* of implementing the NSF on HIV-infection rates and quality of life of PLHIV; as well as the results expected in terms of the NSF's *Outcomes* in the field of 1) key HIV-prevention behaviours; 2) coverage and utilisation of key HIV/AIDS prevention, care, treatment and support

services; and 3) effective use of strategic information; and 4) supportive environments.

The ***Performance Framework*** in Annex 3 provides an overview of the key *Outputs* that are expected as a result of implementing the NSF's main strategies (programmes and services) ; as well as the output indicators used for monitoring the attainment of the annual targets. Finally, the more specific targets for detailed *activities* are presented in the overall ***Workplan and Budget*** (Annex 1).

Monitoring and evaluation of the NSF will be done in accordance with the national M&E framework and plan (to be developed). To this effect, the NSF includes a number of strategies aimed to develop and roll out a national M&E system, which will allow improved coordination of information flows with regard to programmatic M&E, financial data, as well as trends in HIV and key risk behaviours.

To facilitate comparison of Liberia's M&E data with other countries, and to allow adequate reporting on Liberia's progress towards the commitments made in the context of the 2001 UNGASS Declaration of Commitment, the NSF indicators for monitoring HIV trends, key behaviours and utilisation of key services (*impact and outcomes*) are based on the Guidelines on Construction of Core UNGASS indicators for 2001 reporting.

To further harmonise the NSF Performance framework with international standards on M&E, the indicators used for monitoring *programmatic outputs* are in accordance with the guidelines developed by key international agencies, including UNAIDS, UN agencies, The World Bank and the Global Fund. This also facilitates coordination of data collection and reporting in the contact of the Global Fund-supported programmes.

Data collection and reporting

Monitoring and evaluation of the NSF is a shared responsibility of all stakeholders involved in the national response to HIV/AIDS. The *overall* responsibility for monitoring and evaluating the implementation of the NSF 2010-2014 lies with the *National AIDS Commission (NAC)*. Operational M&E responsibilities lie with the NAC Secretariat, which will be strengthened with a *National M&E Unit*, which will be tasked with the coordination and management of data flows from different stakeholders – service providers, researchers and donors – into the future national surveillance and M&E system. This task comprises not only the aggregation of surveillance, programmatic M&E and research data into a national HIV/AIDS database, but also the meta-analysis of data, dissemination of strategic information to all stakeholders, as well as facilitating its use in the development and regular revision of policies, programmes and the NSF, as well as resource mobilisation and allocation.

The key responsibility for data *collection* and *reporting* to NAC lies with service providers, programme implementers and research institutions – including government ministries and institutions, as well as civil society and private sector organisations. An important role in this regard will be played by the implementing partners and programme-implementation unit (PIU) of the Global Fund-supported programmes and services, as well as the NACP, which oversees the implementation of HIV/AIDS-related services and programmes in the health sector. Implementing partners will report key M&E data to the NAC M&E Unit – either directly or through NACP and/or the Global Fund PIU – in accordance with the reporting guidelines to be developed as part of the National M&E Framework and Plan.

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