Liberia: HIV Epidemic Situation

Introduction

Since the 2008 National Population Census, Liberia's population has grown from about 3.5 million to an estimated 4.3 million people in 2015 according to World Bank data. This Report estimates about 43% of the population is below 15 years of age, life expectancy at birth is 60 years (61 females and 59 males),and literacy rates of 60% for adults and 77% in youth. Liberia is divided into 15 Counties. About 50% of the population lives in urban areas of which about 30% lives in Montserrado County, which contains Monrovia, the capital city and economic center of the country. The Liberia Demographic and Health Survey (LHDS) 2013 report reveals a total fertility rate of 4.7, a contraceptive prevalence of 20%, and infant mortality rate of 54/1000 live births. The under-5 mortality rate is reported at 94/1000 live births: 75% of the deaths occurred before the first birth day with 28% occurring in the first month of life. In 2012 the United Nation's Human Development Index 2012 indicates Liberia remains one of the poorest countries in the world and the World Bank estimated the country's gross domestic product (GDP) per capita was US$655 and about 82% of people are self-employed with 49% in subsistence farming. Serious challenges to achieving high and sustained economic growth remain and include enormous institutional and human capacity deficits and weak infrastructure especially roads and power (Agenda for Transformation (AfT) – pg.21-22}.

Current HIV and AIDS Epidemiology

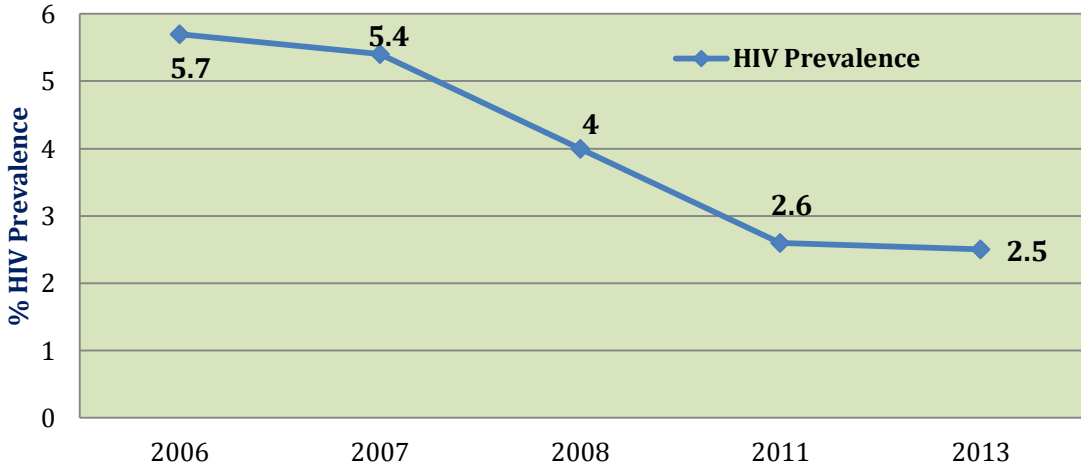
Currently, Liberia has a generalized HIV epidemic with general population prevalence of 1.9% (2% in women and 1.7% in men) (2013 LDHS). The Spectrum Modeling Estimates for 2014 reveal there are 1,789 new HIV infections including 309 in children 0-14 years. About 57% of the new infections are in females. The Modeling estimates there are 29,538 PLHIV including 2,730 in young people 15-24 years and 4,784 children 0-14 years. About 56% of PLHIV are females. The 2013 LDHS reveals the HIV prevalence is 1.9%, up from 1.5% in 2007 LDHS. An estimated 2,330 PLHIV (including 52% females and 311 children) died from AIDS-related causes with 97% of the deaths occurring in PLHIV not on ART. Cumulatively, there were 38,462 AIDS-orphans in 2014, about 19% of orphans from all causes. Selected data from National HIV Prevalence and AIDS Estimates are shown in Table1.1.1

Table 1.1.1: Selected Data from National HIV Prevalence and AIDS Estimates 2014

	HIV Indicator	Adults	Children	Total
1.	HIV Population	24,745	4,784	29,538
2.	HIV Prevalence	1.9%		1.9%
3.	New HIV Infections	1480	309	1789
4.	AIDS Deaths			2,330

The NACP regularly carries out HIV prevalence studies in pregnant women attending antenatal clinics. Since 2007, the trajectory of the trend in HIV prevalence in pregnant women has consistently been downward: from 5.4% in 2007, then declining to 4.0% in 2008, 2.6% in 2011, and 2.5% in 2013 (Fig. 1.1.1). The rate of decline in HIV prevalence among pregnant women virtually flatlined between 2011-2013 as compared to that between 2007 and 2011. The rapid decline in the HIV prevalence among pregnant women occurred at the time of rapid expansion of the HIV prevention interventions for pregant women and the results could be due to the impact of successful HCT and PMTCT programs.

Figure 1.1.1 - ANC HIV Prevalence



Key and Vulnerable Populations

Based on evidence from other countries, the national HIV response identified certain population groups including FSWs, MSM, and People Who Inject Drugs (PWID) and prisoners as the key populations (KPs) driving the epidemic and regarded especially out of school youth as vulnerable to HIV infection Even though there was little concrete knowledge and understanding of the HIV risk behaviors and sizes of these key populations, the NACP, nevertheless provided financial and technical support for the provision of HIV prevention information and services especially to FSWs, MSM, and out of school youth. Stigma and discrimination and fear of harassment significantly hindered FSWs and MSM effectively forming groups and associations to spearhead the delivery of HIV prevention and treatment services that are often sporadic and ill-coordinated. The impact of these services has not been evaluated.

A 2011 Size Estimation Study of FSWs, MSM, and PWID in Liberia estimated that there are 1,822 FSWs, 711 MSM, and 457 PWID. However, many informed opinions consider these as grossly underestimated and regard them as the tip of the iceberg. People below 30 years of age make up the bulk of the 3 key population groups: 84% of FSWs are below 30 years of age including 4% teenagers 13-15 years old, 78% of MSM are below 30 years of age with about 20% between the ages of 16 and 20 years, and 61% of PWIDs are also below 30 years of age.

The 2013 Integrated Bio-Behavioral surveillance Survey (IBBSS) shows key and vulnerable population groups (MSM 19.8%); FSWs 9.8%; uniform services 5%; people who inject drugs 5%; transport workers 4.8%; mobile traders 4.5% and miners 3.8%) have much higher HIV prevalence relative to the general population prevalence of 1.9%. Prisoners were not included in this study but have been identified for inclusion in TB in prisons study some time later.

Geographic Variations and HIV Burden

Significant HIV prevalence variations exist between and within regions and counties. HIV prevalence is also higher in urban (2.6%) than in rural (0.8%) areas. Among Liberia's 5 regions, South Central Region has the highest HIV prevalence of 2.75% aggregate for both male and female; the South East B and the South East A have aggregate prevalence of 1.75% and 1.3% respectively. The North West and North Central Regions have aggregate prevalence of less than 1%: North West has 0.8% and North Central has 0.7% aggregate prevalence. In terms of counties, Montserrado, Margibi, and Bomi counties have the highest prevalence whilst Nimba, Bong, and Lofa Counties have the lowest. Montserrado, Grand Bassa, Margibi, Nimba, Maryland, and Bong Counties have high disease burdens and collectively account for 82% of the HIV burden in the country.

Region	County	Projected 2015 County Populations		HIV Prevalence	HIV Burden	% National HIV Burden
		Number	% National			
North Western	Bomi	97,291	2%	0.90%	876	1%
North Western	Gbarpolu	96,423	2%	0.90%	868	1%
North Western	Grand Cape Mount	146,975	4%	0.90%	1,323	2%
South Eastern A	River Cess	82,707	2%	1.30%	1,075	2%
South Eastern A	Sinoe	118,425	3%	1.30%	1,540	2%
South Eastern B	Grand Kru	66,048	2%	1.80%	1,189	2%
South Eastern B	River Gee	77,248	2%	1.80%	1,390	2%
North Central	Lofa	320,218	8%	0.70%	2,242	3%
South Eastern A	Grand Gedeh	144,872	4%	1.30%	1,883	3%
North Central	Bong	385,701	10%	0.70%	2,700	4%
South Eastern B	Maryland	157,764	4%	1.80%	2,840	4%
North Central	Nimba	528,595	13%	0.70%	3,700	5%
South Central	Margibi	242,794	6%	2.70%	6,555	9%
South Central	Grand Bassa	263,811	7%	2.70%	7,123	10%
South Central	Montserrado	1,291,035	32%	2.70%	34,858	50%
	National	**4,019,907**	**100%**	**1.90%**	**70,161**	100%

Source: Population figures are projections from 2007 National Census using annual growth rate of 2.1%; HIV prevalence data from NACP Report 2014

HIV Risk Factors Analysis

Low comprehensive knowledge of HIV: Comprehensive knowledge about AIDS is low in Liberia: 37 percent of women and 34 percent of men know that use of condoms and having just one uninfected faithful partner can reduce the chances of getting HIV, know that a healthy-looking person can have HIV, and reject the two most common local misconceptions about HIV transmission or prevention.

Multiple Concurrent Sexual Partnerships: Seventy-one percent of women and 52 percent of men age 15-49 know that HIV can be transmitted by breastfeeding. In addition, 58 percent of women and 35 percent of men know that a mother taking special drugs during pregnancy can reduce the risk of mother-to-child transmission. Seven percent of women and 18 percent of men had two or more sexual partners during the 12 months preceding the survey. Among respondents who had two or more partners in the past 12 months, 20 percent of women and 24 percent of men reported using a condom during their most recent sexual intercourse. The mean number of sexual partners in the lifetime of Liberian women and men is 4.3 and 13.1 respectively (2013 LDHS).

Condom use and unprotected casual sex: Correct and consistent condom use is key to preventing HIV transmission and acquisition especially in casual sexual relations. High-risk behaviours, including the lack of condom use, remain significantly high. In addition, with issues bordering around multiple and concurrent sexual partners and the presence of high mobile populations, the potential spread of HIV among special target groups remains a significant public health concern(Pg.9 IBBSS 2013). Five percent of men had paid for sexual intercourse in the past 12 months; among these men, only 61 percent reported using a condom during their most recent paid sexual intercourse (2013 LDHS). According to the IBBSS 2013-pg. 26), condom use among KPs at last sex with non-paying partners was less than 50%; condom use with paying partners was high among FSWs (81.8%), mobile male traders (76.4%) but low amongst MSM (20.7%)

HIV Key populations that may have disproportionately low access to prevention, treatment, care and support services include FSW, MSM, and PWID. Legal barriers are the common thread enjoining FSW, MSM, and PWID to have low access to services: All these groups are breaking/have broken the laws of the land in one-way or the other and also suffer much stigma and discrimination in the general

population, even sometimes from health care providers. FSW, MSM, and PWID are often targeted by law enforcement agencies and are liable to arrest, prosecution, and imprisonment or fine and so they are afraid to access services particularly at public facilities.

Young people 15-24 years have very poor health seeking behavior, as they believe they are healthy and do not have any need for health services. Very often, young people loath to attend public health facilities that also cater for adults and children as they feel they are neither adults nor children. In the absence of adolescent-friendly health facilities, young people are less likely to attend facilities where they feel uncomfortable.

Persons whose jobs take them away from home for long periods of time e.g. police and the military personnel on operations away from base, long distance truck and bus drivers and their assistants, and mobile traders, often have low access to health services as the jobs often leave them with little time during their travels to seek health services.

a) Key human rights barriers and gender inequalities that may impede access to health services.
Laws, policies and socio-cultural and economic norms and practices greatly underpin and influence how human rights barriers and gender inequalities impede access to health services.

Key human rights barriers that may impede access to health services

The Constitution of Liberia provides for equal rights to all citizenry (1986 Constitution of the Republic of Liberia, Chapter Three (3). Combating human rights abuses and advancing the welfare of all Liberians, irrespective of sex, ethnicity, geographical location, political affiliation and socioeconomic condition a key goal of the Agenda for Transformation (AfT) (Pg. 141), the primary development strategy of the country. The principles of the Constitution and AfT mandate all Liberians have unhindered access to health services as a basic right. Whilst these are laudable, the Constitution criminalizes sexual activities of KPs (FSW and MSM) that makes them to be afraid of arrest, prosecution, and imprisonment as well as stigma and discrimination that drive them underground, which then impede their access to health care services including HIV prevention, treatment and care. However, efforts are being made by stakeholder organizations and some civil societies to ensure FSW and MSM have unhindered access to health services: the law enforcement agencies, the judicial service, and the Independent National Commission on Human Rights are being assisted to have better understanding of the situation of FSW and MSM as key drivers of the HIV epidemic and the need to create an enabling environment that facilitates KP access to health care including HIV prevention information and services.

Gender inequalities that may impede access to health services

Eliminating gender inequality is a national policy in all spheres including AIDS. Education, health, and the economy are among many spheres of national life that are making efforts to eliminate gender inequality. Much has been accomplished especially in legislative arena since the advent of democratic governance after the prolonged civil conflict including inheritance rights for women, making rape an unbailable criminal offence, and enacting legislation prohibiting vilification and discrimination against a person because of his or her perceived or real HIV status, a situation that perhaps is affecting more women than men. However, much more needs to be done as many challenges to reducing gender inequalities remain.

Gender inequalities are key drivers of the HIV epidemic in Liberia. Gender-related barriers in access to services prevent Liberian women and men from accessing HIV prevention, treatment and care services. These drivers include:

i. Gender norms related to masculinity and femininity

Gender norms related to masculinity encourage men to have many sexual partners and older men to have sexual relations with much younger women. This may contribute to the higher infection rates of 65% among young women (15-24 years) compared 35% in young men as revealed in the HIV

Prevalence and AIDS Estimates Report 2013. Norms related to femininity can prevent women, especially young women, from accessing HIV information and services. On the other hand, socialization of men may mean that they will not seek HIV services due to fear of stigma and discrimination, losing their jobs, and of being perceived as "weak" or "unmanly". Women are designated the primary care providers for their children and family. These responsibilities may prevent women from accessing HIV prevention, treatment, care, and support services.

ii. Power-relations

Women constitute about 60% of people living with HIV and contribute about 56% of new HIV infections in Liberia. This situation, in part, is because in spousal or partner relations, decision making powers are with the man: in many instances women cannot negotiate safe sex with promiscuous spouses and partners, may need to ask permission from spouses/partners to access HIV services, and may need to ask spouse/partner for transport to HIV care facilities, which request may be denied.

iii. **Violence against women**

Women in Liberia are subjected to physical, sexual, and emotional violence in the home, within the communities, and in the workplace. Sexual and gender based violence (SGBV) is often fuelled by alcohol. Women, who fear or experience violence, lack the power to ask their partners to use condoms or refuse unprotected sex. Fear of violence can prevent women from learning and/or sharing their HIV status and accessing treatment.

The Ministry of Gender and Development (MoGD) received and documented 2,493 complaints of violence against women in 2012. About 60% of the sexual and gender based violence falls in the category of rape comprising rape, statutory rape, and sexual assault. Rape is a potent exposure to HIV infection if the offenders are HIV positive; it is a non-bailable offense in Liberia.

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

iv. Lack of education and economic security for women

Lack of education and economic security affects millions of women and girls, whose literacy levels are generally lower than men and boys. Many women, especially those living with HIV, lose their homes, inheritance, possessions, livelihoods and even their children when their partners die. This forces many women to adopt survival strategies that increase their chances of contracting and spreading HIV. Liberia has legislation that provides for women married under customary law to have the same inheritance rights as widows of statutory marriage. Women with no or little education often do exercise this right because they ignorant of the law or too poor to pay for legal services.

Proposed gender sensitive HIV activities

1) HIV/AIDS program will work especially with community structures to address harmful gender norms and stereotypes. This involves working with men and boys groups and associations to change norms related to fatherhood, sexual responsibility, decision-making and violence, and by providing comprehensive, age-appropriate HIV and AIDS education especially for young people that addresses gender norms.
2) Programs will address violence against women by offering safer sex negotiation and life skills training, helping women who fear or experience violence to safely disclose their HIV status, working with the Ministries of Justice and Gender Development to facilitate access to comprehensive medico-legal services for victims of sexual violence and strengthen and enforce laws that eliminate violence against women.
3) Programs will improve access to services for women (and men) by supporting efforts to build the capacity of women-focused organizations e.g. LIWEN and Health Education and Advocacy for Key Populations (FSWs support), removing financial barriers in access to services, bringing

services closer to the community, and addressing HIV-related stigma and discrimination, including in health care settings.

4) The national HIV response will continue to collect and use sex and age disaggregated data to monitor and evaluate impact of programs on different populations. The program will make great efforts to build capacity of key stakeholders to address gender inequalities, facilitate meaningful participation of women's groups, young women, and women living with HIV in the national HIV response, and allocate adequate resources for program elements that address gender inequalities.

b) The health systems and community systems context in the country, including any constraints

Liberia's 14-year civil conflict (1989 to 2003) left the health system in tatters: health infrastructure was destroyed and the human resources for health decimated. Since 2005, the country has made great effort to rebuild the health system through reform and introduction of the basic package of health services (BPHS) under the National Health Policy and Plan 2007 – 2011 and later the Essential Package of Health Services (EPHS) under the National Health Policy and Plan 2011 - 2021, both of which defined the type of services to be delivered at every level of care, inclusive of the minimum levels of resources required to provide the package of services including human resources for health, infrastructure, equipment, and drug availability. The current health system functions comprises: 1) policy, planning, and resource mobilization and allocation at the national level and 2) a three-tier decentralized service delivery system at County, District, and Community levels implementing the health sector plan. The service delivery system is pluralistic with a variety of direct service providers (government, civil society including faith-based organizations (FBOs), and local and international non-governmental organizations (NGOs), and the private sector). Currently, all government provided services don't attract any user charges.The community system is very weak: community healthcare services are neither well coordinated nor integrated – with many vertical programs being implemented by different actors. With very little GoL funding, community-based public health sector activities are very limited; the major actors are FBOs, local CBOs, and a few international NGOs. As a result of these challenges, the linkages with facility based health services areweak.

During the last decade, with support from development partners, the health systems have improved considerably resulting in modest gains in the health status of the Liberian people. The total number of health facilities has increased from 618 in 2010 to 725 in 2014, according to the HMIS data. In 2014, there were 35 hospitals, 51 health centers, and 639 clinics, as well as 137 pharmacies. Overall, 22% of the health facilities were private-for-profit of which nine out of ten were located in Montserrado and Margibi Counties. The total number of clinical health workers increased from 1,396 in 1998 to 4,653 in 2010. The overall total workforce also grew by approximately 19% from 8,072 in 2011/12 to 9,589 in 2012/13[1]. As of October 2014 there were over 10,000 health workers (October 2014 MOH database of public sector health workers) that were either on Civil Service payroll and/or receiving donor-funded incentives. There were up to 5,000 health workers not on the government payroll.

Many health system challenges remain and were cruelly exposed and made worse by the 8-month (August 2014-March 2015) EVD epidemic. The current key challenges as evidenced from various[2] reports include continuing huge deficits in health human resource especially professional staff, inadequate number of health infrastructure made worse by unequal distribution skewed in favor of urban areas, very ineffective procurement and supply chain management (PSCM) resulting in frequent stock out of drugs and other essential consumables, and weak health management information system (HMIS) that contributes to poor planning and inequitable distribution of resources skewed toward hospitals. These challenges are heavily underpinned, in part, by inadequate funding of the public health sector.

Potential priorities identified in the *Liberia Investment Plan March 2005 (Draft) Report*include addressing the major weaknesses existing before the epidemic (the inadequate health workforce that was further impacted by the epidemic, the weak data and surveillance system, the inadequate laboratory and diagnostic system, weak community engagement, inadequate procurement and supply

[1] MOH National Health Operational Plan 2013/2014

chain system and pharmaceutical regulation, and the dysfunctional health infrastructure) or those exacerbated by the epidemic and also to render the health system resilient to similar shocks in the future. Adequate investments must be made in critical social and health systems enablers (strengthening governance and leadership at central, county, district, and community levels) in building sustainable and resilient health systems.