Liberia HIV&AIDS Response Progress Report

April 2016

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change Communication
BPHS	Basic Package for Health Services
CBO	Community-Based Organization
CD4	Cluster of Differentiation Four
CHAI	Clinton Health Access Initiative
CHAL	Christian Health Association of Liberia
CRIS	Country Response Information Systems
CSO	Civil Society Organization
CSS	Community Systems Strengthening
DBS	Dried Blood Spot
DNA	Deoxyribonucleic Acid
DSW	Department of Social Welfare
DU	Drug Users
EID	Early Infant Diagnosis
eMTCT	Elimination of Mother-to-Child Transmission
EPP	Estimation and Projection Package (Spectrum)
EVD	Ebola Virus Disease
FBO	Faith-Based Organization
FHI	Family Health International
FSW	Female Sex Workers
GBV	Gender -Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Affected by AIDS
GIZ	German Technical Services
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	Health Systems Strengthening
IBBSS	Integrated Bio-Behavioral Surveillance Survey
IDPs	Internally Displaced Persons
IDUs	Injecting Drug Users
IEC	Information, Education and Communication
ILO	International Labor Organization
IPV	Intimate Partner Violence
IRC	International Rescue Committee
LDHS	Liberia Demographic Health Survey
LISGIS	Liberia Institute of Statistics and Geo-Information Services
LIBR	Liberia Institute for Biomedical Research

M&E	Monitoring and Evaluation
MARPs	Most- at- risk Populations
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MIS	Management Information Systems
MoD	Ministry of Defense
MoE	Ministry of Education
MoFDP	Ministry of Finance and Development Planning
MoG&D	Ministry of Gender Development Child and Social Protection
MoH	Ministry of Health
MoL	Ministry of Labor
MoT	Modes of Transmission
MSF	Medicins Sans Frontiers
MSM	Men who have Sex with Men
MTCT	Mother-to- Child Transmission
MTR	Mid-Term Review
MVC	Most Vulnerable Children (including orphans)
NAC	National AIDS Commission
NACP	National AIDS and STI Control Program
NASA	National AIDS Spending Assessment
NBTS	National Blood Transfusion Services
NCPI	National Commitment and Policy Instrument
NGO	Nongovernmental Organization
NHA	National Health Accounts
NSF	National HIV Strategic Framework II 2010-2014
NSP	National HIV and AIDS Strategic Plan 2015-2020
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post- exposure Prophylaxis
PICT	Provider Initiated Counseling and Testing
PCU	Program Coordination Unit
PLHIV	People Living with HIV
PMTCT	Prevention of Mother- to- Child Transmission of HIV
PRS	Poverty Reduction Strategy
PSI	Population Services International
PSM	Procurement and Supply Management
SE	Size Estimate
SGBV	Sexual and Gender- Based Violence
SGS	Second Generation Surveillance
STI	Sexually Transmitted Infection
SW	Sex Worker
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV&AIDS
UNICEF	United Nations Children Fund

UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV&AIDS
UNHCR	United Nations High Commission for Refuges
UNMIL	United Nations Mission in Liberia
UP	Universal Precautions
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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1. STATUS AT A GLANCE

1.1 STAKEHOLDERS INCLUSION AND REPORT WRITING PROCESS

The report writing process was directed by the National AIDS Commission (NAC) and facilitated by the Joint United Nations Program on HIV and AIDS (UNAIDS) and the National AIDS Control Program (NACP). This report was written using information from diverse sources, namely, National surveys (Demographic and Health Survey (DHS), Integrated Bio-behavioral Surveillance Survey (IBBSS), ART Cohort study, the National AIDS Control Program (NACP) 2015 annual data validation, the National Strategic Plan (NSP) 2015-2020, and a review of the 2013 National Commitments and Policy Instrument (NCPI) Questionnaires.

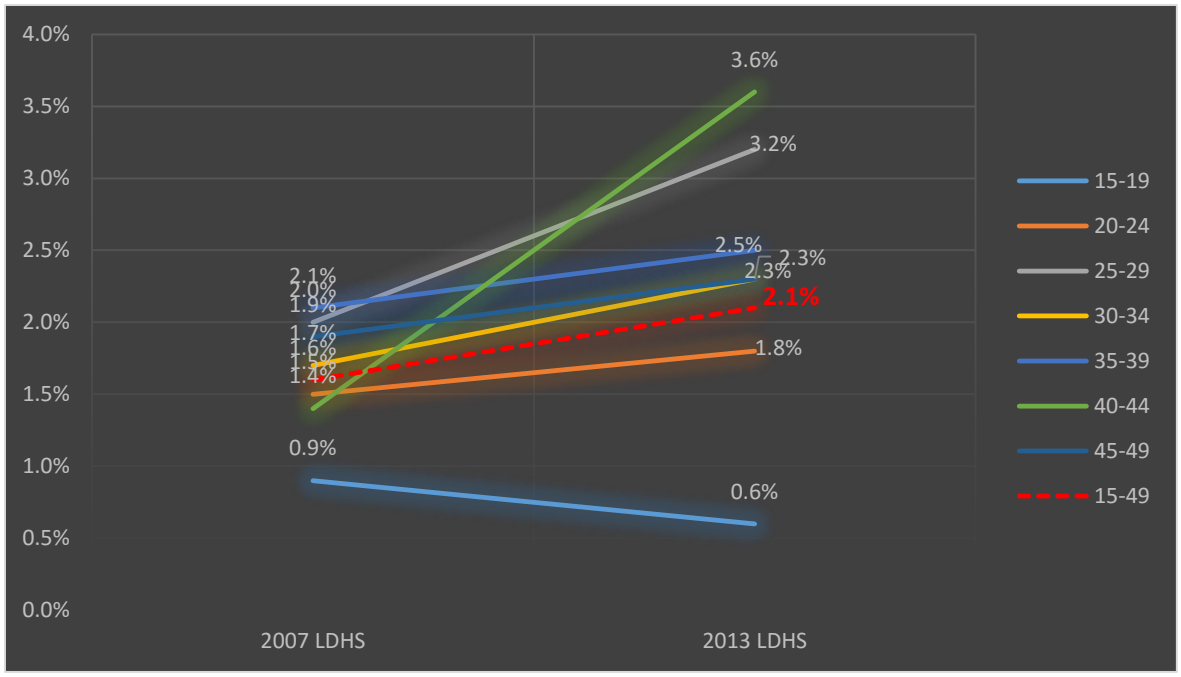
In addition, the annual data validation exercise of NACP provided a detail set of indicators for the health response to HIV including the revised estimates from the Spectrum projection software version 5.4 which provides updates of national statistics whose findings have been integrated in this report.

A validation workshop was held on April 7, 2016 to discuss its contents. The stakeholders included a wide cross-section of participants from national and sub-national governments, development partners, faith based organizations, private sector, network of people living with HIV, key population, community based organizations and media organizations.

1.2 THE STATUS OF THE EPIDEMIC

Between 2007 and 2013, the HIV prevalence in the general population aged 15-49 in Liberia increased from 1.5% to 2.1%. HIV prevalence in urban areas is put at 2.6 percent (3.2% in Monrovia) and is much higher than in rural areas at 0.8 percent; and HIV prevalence among women 2.4% (increased from 1.8%) is significantly higher than in men 1.9% (increased from 1.2% in 2007) [Source: LDHS (2013)]. As depicted in Figure 1 below, there was an increase in all age range except for people age 15 – 19 years where there was a drop in prevalence from 0.9% to 0.6%.

Figure 1 Trend of HIV Prevalence by age



Source: LDHS 2007 & 2013

Five successive antenatal clinic surveillance (ANC) surveys have been conducted in 2006, 2007, 2008, 2011 and 2013 showing decline in prevalence rate of 5.7%, 5.4%, 4.0%, 2.6% and 2.5% recorded, respectively.

Similar to analysis drawn from the 2007 LDHS conducted, the overall data (LDHS-2013) 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 specifically at young women in the age group 15-24 years where prevalence among females is three times higher than males (1.4% among females and 0.45% among males of 15-24 years).

An Integrated Biological and Behavioral Surveillance Survey (IBBSS) among most at risk populations to determine the prevalence of HIV and syphilis, including risk behaviors, perceptions and attitudes was conducted in 2013. The HIV prevalence was dramatically high among MSM (19.8%). They are closely followed by FSW (9.8%) and Uniform services personnel (5.0%). Youth in school had the lowest HIV prevalence (1.1%) with no significant difference between male (1.3%) and female (1.0%). Similar trend was observed among out of school youth (OSY) with the prevalence being 1.9% and no significant difference between male (2.3%) and female

(1.4%). Injecting drug users (IDUs) was predominantly male occupational group with the HIV prevalence of 3.9%, whereas Miners recorded a prevalence of 3.8%. Among Transport workers and Mobile traders, a considerably high prevalence of 4.8% and 4.5% was recorded.

A cohort study of HIV positive patients enrolled into Care and Treatment was conducted in 2013 to determine the retention rate, factors which are associated with lost to follow up and outcome of patients lost. Adherence and factors which influences poor adherence to ART will also be examine. At 12 months of follow up, the Kaplan-Meier survival estimates for retention among patients initiated on ART was 69.9% compared to 24.7% among patients not on ART. These rates dropped to 56.8% among ART patients and 14.3% among patients not on ART as the follow up period double. At 36 months of follow up, the retention rate among ART patients was 48.7% compared to 9.4% among patients not on ART.

1.3 POLICIES AND PROGRAMMATIC RESPONSES

In response to the recent Ebola virus disease (EVD) outbreak of 2014 and 2015 which shock the bed-rock foundation of the nation, the people of Liberia through the Ministry of Health has vowed, "Never again shall we be affected in such a way" through the development of a National Investment Plan for Building a Resilient Health System (2015-2021). The Investment Plan provides an overall framework for restoring the gains lost to EVD and provides health security for the people of Liberia. Additional and a more focused National HIV and AIDS Strategic Plan 2015-2020 provides guidance to the national HIV and AIDS response.

The National Strategic Plan 2015-2020 developed in 2014 replaces the National Strategic Framework 2010-2015 and provides a more ambitious action plan and targets. The NSP 2015-2020 was propounded based on the following:

Vision: To create an AIDS-free society

Goal of the NSP: The goal of the NSP 2015-2020 is to stop new HIV infections and keep people living with HIV alive and healthy in Liberia

Aim of the NSP: The aim of the NSP is to provide a result-based framework for driving the decentralized, multi-sectoral national HIV and AIDS response within which all HIV and AIDS

evidence based interventions are guided by the multi-sectoral approach that is led by NAC and implemented in Liberia.

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

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

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

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

1.4 OVERVIEW OF GARPR AND HEALTH SECTOR INDICATORS

Liberia continues to track progress made in achievement of the agreed ten targets in the 2011 Political Declaration on HIV and AIDS. Table 1 below shows the trend of indicators linked to the ten agreed targets. Information at our disposal including the programmatic data of 2015 and the 2013 Liberia Demography and Health Survey were vital in tracking the progress made.

Table 1: Country Progress on Ten Targets

Target 1. Reduce sexual transmission of HIV by 50% by 2015 General Population								
Indicator	**Gender**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	Male	27.2%					28.5%	Liberia Demographic and Health Survey (2007 & 2013)
	15-19 yrs.	20.9%					19.0%	
	20-24 yrs.	34.2%					40.6%	
	Female	20.5%					35.7%	
	15-19 yrs.	18.1%					34.6%	
	20-24 yrs.	22.8%					37.1%	
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	Male	8.5%					9.1%	Liberia Demographic and Health Survey (2007 & 2013)
	15-19 yrs.	8.6%					8.9%	
	20-24 yrs.	8.3%					9.4%	
	Female	17.2%					23.1%	
	15-19 yrs.	18.7%					23.3%	
	20-24 yrs.	15.8%					22.9%	
1.3 Percentage of adults aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	Male	21.4%			9.5%		17.6%	Liberia Demographic and Health Survey (2007 & 2013)
	15-19 yrs.	15.9%					4.4%	
	20-24 yrs.	26.8%					22.1%	
	25-49 yrs.	63.3%					20.1%	
	Female	7.1%					6.5%	
	15-19 yrs.	11.6%					8.6%	
	20-24 yrs.	8.0%					8.6%	
	25-49 yrs.	18.2%					5.0%	
1.4 Percentage of adults aged 15–49 who had more than one Sexual partner in the past 12 months and who	Male	22.3%			20.7%		23.6%	Liberia Demographic and Health Survey (2007 & 2013)
	15-19 yrs.	28.9%					21.6%	
	20-24 yrs.	27.4%					35.2%	
	25-49 yrs.	61.7%					21.0%	

report the use of a condom during their last intercourse	Female	13.5%					19.6%	
	15-19 yrs.	10.6%					27.1%	
	20-24 yrs.	22.1%					23.6%	
	25-49 yrs.	27.3%					10.4%	
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	Male	2.3%					12.4%	Liberia Demographic and Health Survey (2007 & 2013)
	15-19 yrs.	0.4%					3.6%	
	20-24 yrs.	2.9%					9.6%	
	25-49 yrs.	8.0%					16.2%	
	Female	1.6%					19.1%	
	15-19 yrs.	1.7%					13.1%	
	20-24 yrs.	2.1%					24.9%	
	25-49 yrs.	4.4%					19.5%	
1.6 Percentage of young people aged 15-24 who are living with HIV	All	1.1%					1.2%	Liberia Demographic and Health Survey (2007 & 2013)
	15-19 yrs.	0.9%					0.6%	
	20-24 yrs.	1.4%					1.8%	
	Male	0.5%					0.8%	
	15-19 yrs.	0.4%					1.0%	
	20-24 yrs.	0.7%					0.5%	
	Female	1.6%					1.6%	
	15-19 yrs.	1.2%					0.2%	
	20-24 yrs.	2.0%					2.9%	
	ANC women	3.6%			1.8%			Antenatal Care Survey (2011 & 2013)
	15-19 yrs.	3.2%			1.2%			
	20-24 yrs.	3.9%			2.4%			
Target 1. Reduce sexual transmission of HIV by 50% by 2015 **Sex workers**								
Indicator	**Gender**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
1.7 Percentage of sex-workers reached with HIV prevention programs					28.2%			2013 Integrated Biological and Behavioral

								Surveillance Survey among MARP
1.8 Percentage of sex workers reporting the use of a condom with their most recent client					81.7%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results					31.3%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP
1.10 Percentage of sex workers who are living with HIV					9.8%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP
Target 1. Reduce sexual transmission of HIV by 50% by 2015 **Men who have sex with men**								
1.11 Percentage of men who have sex with men reached with HIV prevention programs								Indicator data not available
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner					19.5%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results					44.4%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP

1.14 Percentage of *men who have sex with men* who are living with HIV					19.8%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP

Targets 1 and 2. Size estimations for key populations			
Key population	**Size estimation performed?**	**Latest estimation performed**	**What was the size estimation (%)**
Female Sex workers	Yes	2011	1,822
Men who have sex with men	Yes	2011	711
Drug Users	Yes	2011	2,303
Injecting Drug Users	Yes	2011	457

Target 2. Reduce transmission of HIV among people who inject drugs by 50% by 2015							
Indicator	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programs							Indicator data not available
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse				44.3%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected							Indicator data not available

2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results				27.9%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP
2.5 Percentage of people who inject drugs who are living with HIV				3.9%			2013 Integrated Biological and Behavioral Surveillance Survey among MARP

Target 3.Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths.								
Indicator	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	All	**18.2%** (420/2313)	13.1% (270/2067)		64% (874/1375)		**107.7%** (1358/1261)	Numerator: NACP M&E program data Denominator: Liberia Spectrum Projection (EPP) of mothers needing PMTCT Annual Percentage coverage is non-cumulative
	2 or 3 ARVs	**15.6%** (360/2313)	11.2% (231/2067)				**88.4%** (1115/1261)	
	ART (HAART)	**2.6%** (60/2313)	1.9% (39/2067)				**19.3%** (243/1261)	
3.2 Percentage of infants born to HIV-positive women receiving a virological test for		10.1% 234/2313	11.7% 242/2067		44% 604/1375		Not Available	Numerator: NACP M&E EID program data Denominator: Liberia

HIV within 2 months of birth								Spectrum Projection (EPP) of mothers needing PMTCT
3.3 Mother-to-child transmission of HIV (modeled)			13.7%		33%		0.41	PMTCT impact study Spectrum modelled
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015								
Indicator	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	All	**22.2%** (4412/ 19866)	**30.6%** (5839/ 19111)		**38%** (6429/ 17158)	**26.2%** 6334 / 24206	25.8% (7391 / 28652)	Numerator: NACP M&E program data Denominator: Liberia Spectrum Projection (EPP) of adults and children HIV population
	Adult	**26.5%** (4089/ 15443)	**35.2%** (5269/ 14961)			**27.1%** (5985 / 22082)	**26.6%** (7002 / 26313	
	Children	**7.1%** (314/4423)	**13.7%** (570/ 4150)			**16.4%** (349 / 2124)	**16.6%** (389 / 2339)	
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	All	**62%** (560/899)			**74.2%**			MoH : Cohort study of Patients enrolled in HIV treatment and Care in Liberia
	Male	**57%** (162/286)			**69.5%**			
	Female	**63%** (398/613)			**76.1%**			
	Adult	**62%** (513/823)			**74.2%**			
	Children	**44.7%** (34/76)			**73.6%**			
Target 5.Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015								

Indicator	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV		962	1,386				154	
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries								
Indicator	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
6.1 Domestic and international AIDS spending by categories and financing sources								See NASA & NHA
Target 7.Critical enablers and synergies with development sectors								
Indicator	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
7.1 National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs,				See annex	See annex on 2013 report		NA	Rapid Assessment and participatory consensus meeting

stigma and discrimination and monitoring and evaluation)								
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	All Physical	28.8%					N/A	Liberia Demographic and Health Survey
	15-19yrs	23.2%						
	20-24yrs	29.9%						
	25-49yrs	90.8%						
	All Sexual	17.6%						
	15-19yrs	13.1%						
	20-24yrs	13.0%						
	25-49yrs	60.1%						
7.3 Current school attendance among orphans and non - orphans aged 10–14*					7,570	7,570		
7.4 Proportion of the poorest households who received external economic support in the past 3 months								
Target 8. Eliminating stigma and discrimination								
Indicator	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
8.1 Discriminatory attitudes towards people living with HIV								

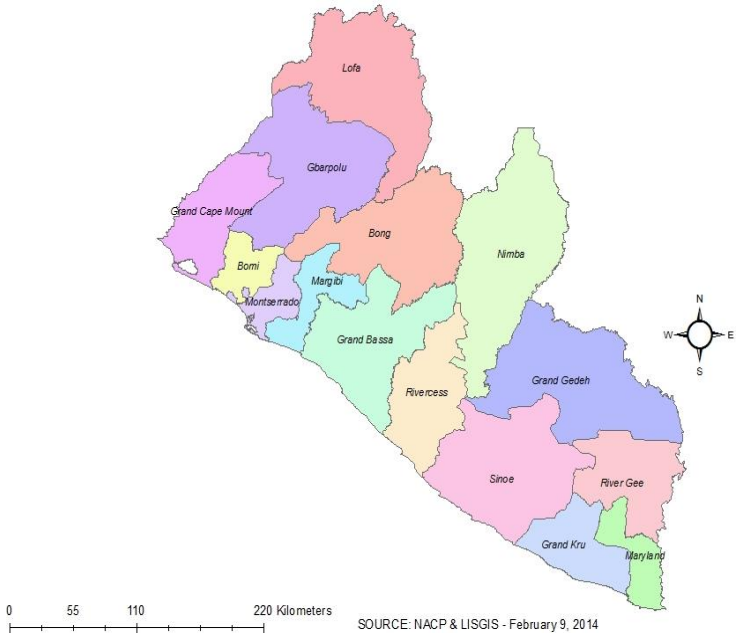
Target 9. Eliminate travel restrictions								
Indicator	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
Target 10. Strengthening HIV integration								
Indicator	**Category**	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**Remarks**
10.1 Current school attendance among orphans and non-orphans aged 10–14*								
10.2 Proportion of the poorest households who received external economic support in the last 3 months								

2. OVERVIEW OF THE AIDS EPIDEMIC

2.1 LIBERIA CONTEXT

Liberia is Africa's oldest republic. It covers an area of about 43,000 square miles and lies between latitude 7 and 8 north and longitude 9 and 10 east, in the west coast of Africa. It borders Guinea in the north, Cote d'Ivoire in the north East, Sierra Leone in the west, and the Atlantic Ocean in the south. The Country is divided into 15 counties, with a 2008 census count of 3.49 million inhabitants[1]. Montserrado County, where the Capital Monrovia is situated, is the most densely populated, with a population density of more than 1,500 persons per square mile and inhabits one-third of the country's total population.

Map 1: Political Map of Liberia



The population is relatively young, with 29.5% of the entire population aged 5-14 years, while the proportion of population aged 15-49 years is about 36%. Life expectancy at birth is 45 years and a fertility rate is 5.2 children per woman is one of the highest fertility rates in sub-Saharan Africa.

The Government is committed to an environment of good governance and reducing poverty. To address the economic and political crisis, in 2005, a general presidential and parliamentary election was held. President Ellen Johnson Sirleaf was inaugurated as the first woman President in Africa

[1] Population and Housing Census 2008, LISGIS

in 2006 and later re-elected for a second term in 2011. Currently, the government faces many key challenges, on the top of the agenda is securing access to essential health services and youth unemployment. The introduction of the Basic Package for Health Services (BPHS) in 2005, now Essential Package for Health Services (EPHS) is aimed at integrating the national health system to address key public health problems.

The HIV and AIDS epidemic is a significant public health and development problem in Liberia. The primary modes of HIV transmission in Liberia as elsewhere in sub-Saharan Africa are heterosexual contact and perinatal transmission; although blood transfusion, medical transmission and use of dirty needles still occur. Many factors fuel the spread of the epidemic. These include, the widespread norm of multiple and concurrent sexual relationships; women's low socio-economic status; increasing levels of poverty leading to sex work; lack of open discussion about sexuality; high incidence of sexually transmitted infections (STIs); cultural and religious beliefs, and stigma and discrimination, among others.

HIV and AIDS epidemic is a social problem, as much as a medical one. The fault lines are wide-open channels creating a superhighway for the spread of HIV and AIDS. Partner reduction and consistent and correct use of condoms creates cracks in this highway to slow down or even reverse the rate of transmission over time. Without appropriate interventions, the risks of transmission, including mother-to-child transmission will continue to the next generation.

2.2 HIV PREVALENCE

2.2.1 Antenatal Care Survey among Pregnant women

A sentinel surveillance on pregnant women attending ANC facilities was held in 2013 in Liberia. This was the fifth round of a routine surveillance being implemented in the country since 2006.

The table below shows the estimates for the median HIV prevalence, by region. At national level this has reached 2.5% with the highest prevalence emanating from the Eastern and Western regions.

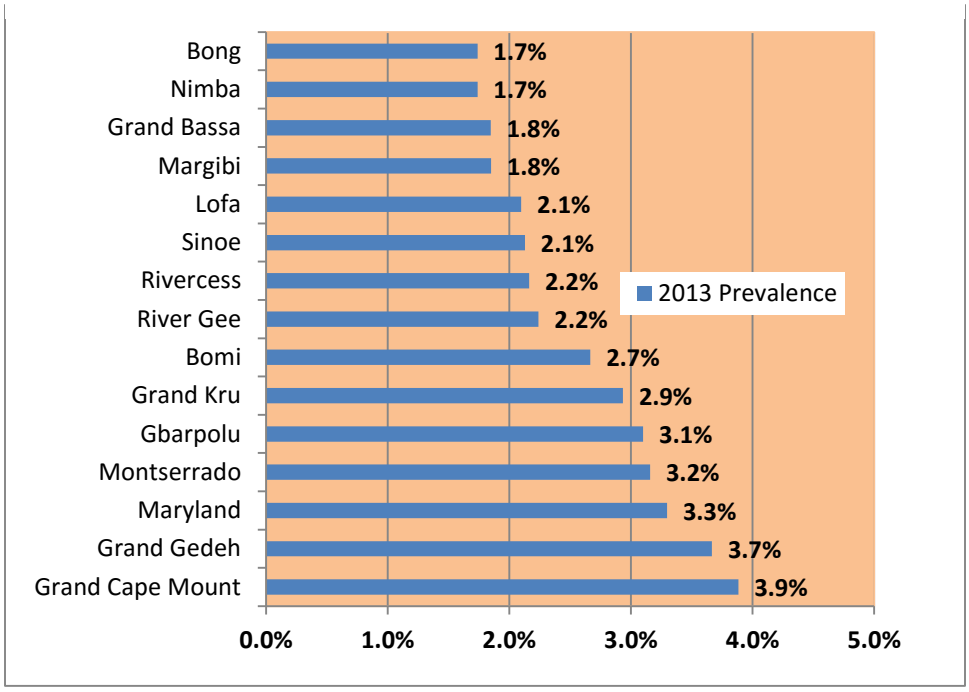
Table 2 HIV prevalence in pregnant women by regions

Regions	County	Eligible Sample Tested	Tested HIV Negative	Tested HIV Positive	Prevalence
Eastern	Grand Gedeh	709	683	26	
	Rivercess	555	543	12	2.8%
	Sinoe	329	322	7	
North Western	Bong	702	690	12	
	Lofa	1287	1260	27	1.9%
	Nimba	978	961	17	
South Eastern	Grand Kru	443	430	13	
	Maryland	637	616	21	2.9%
	River Gee	491	480	11	
Southern	Grand Bassa	866	850	16	
	Margibi	595	584	11	2.6%
	Montserrado	1995	1932	63	
Western	Bomi	300	292	8	
	Gbarpolu	258	250	8	3.2%
	Grand Cape Mount	309	297	12	
Grand Total		**10454**	**10190**	**264**	**2.5%**

For the purpose of the ANC surveys the Country is divided into five regions. Namely: Western, Southern, North-western, South-eastern and Eastern regions. Regional prevalence was calculated based on outcomes from sites within their locale. The analysis per region produced a prevalence of a minimum of 1.9% in the North Western region and maximum 3.2% in the Western region. In comparison to the 2011 ANC survey, the 2013 ANC survey showed the same two (North-western-1.5%, Western-4.2%) regions to have had the lowest and highest HIV prevalence respectively. However, the difference with respect to the regional prevalence in the two surveys is that the minimum in 2013 was 0.4% higher than that of 2011, and the maximum was1.0% less than the prevalence in 2011.

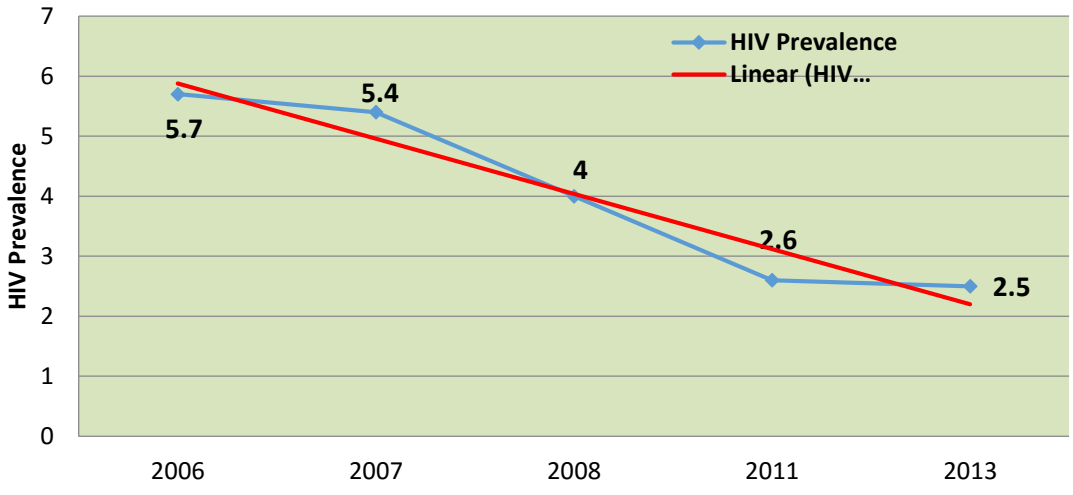
At county level, the HIV prevalence ranged from 1.7% in Bong (0.8% in Nimba in 2011) to 3.9% in Grand Cape Mount (6.3% in 2011). Grand Cape Mount and Grand Gedeh counties have consistently being in the highest bracket with respect to HIV prevalence. Maryland County also recorded a high prevalence of 3.3%. Gbarpolu County which has failed on many occasion to meet the minimum sample size until 2013 recorded a prevalence of 3.1% and ranked 5th from top to bottom.

Figure 2: HIV Prevalence among ANC client by County



Source: ANC 2013 Report

Figure 3: Trend of HIV Prevalence among ANC clients

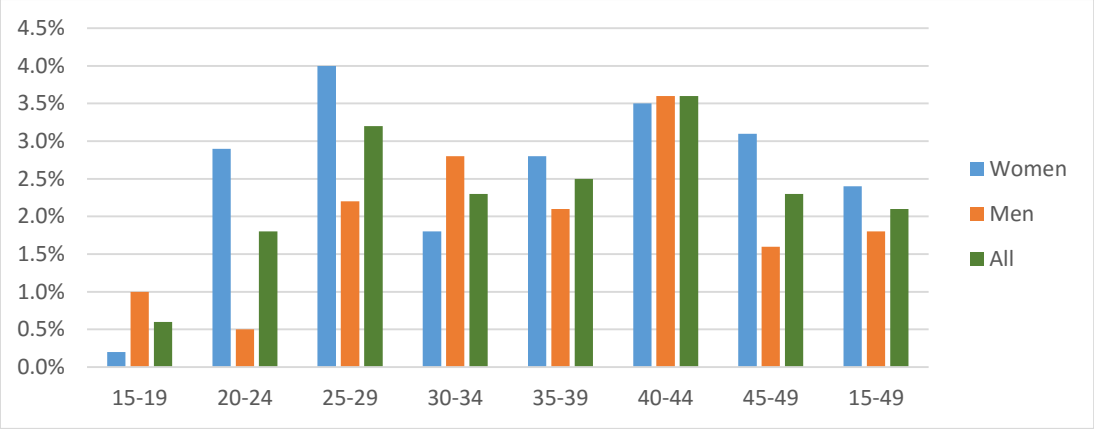


The national HIV prevalence of Liberia is moving along a downward slope since the inception of the HSSS in 2006. There has been a steady decline in prevalence from 5.7% in 2006 to 2.5 in 2013. Like the 2011-ANC survey, the prevalence of the 2013-ANC study represents a 29% decrease from that of 2008-ANC, which was the last of the first three surveys conducted simultaneously to determine a baseline for the antenatal care (ANC) study in Liberia.

2.2.2 HIV Prevalence in General Population

The 2013 Liberian Demographic and Health Survey (LDHS) provides the most reliable data on HIV prevalence in the general population. LDHS results show an HIV prevalence of 2.1 percent[2] (1.9% HIV-1; 0.3% HIV-2) in the general population aged 15-49, indicating a generalized epidemic. Overall, the HIV prevalence in women is higher (2.4%) than in men (1.8%), revealing women's higher vulnerability to HIV infection. The difference in HIV prevalence between women and men is particularly strong in the younger age groups, with HIV prevalence in women about three times higher than in men in the 15-24 year age group (see Figure1).

Figure 4 HIV Prevalence by Sex and Age

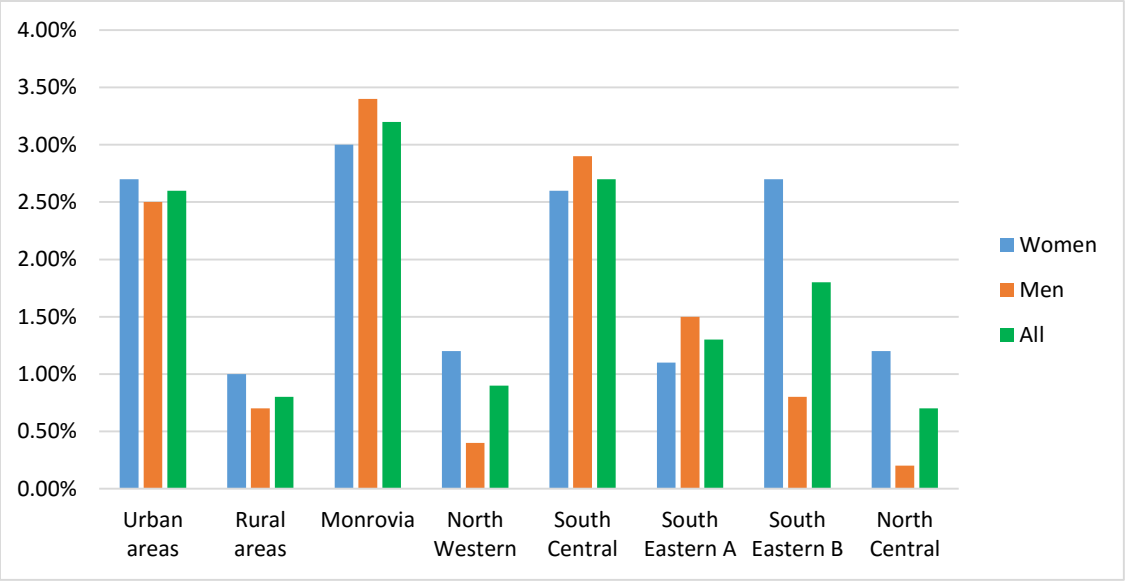


Source: LDHS (2013)

Furthermore, LDHS-2013 reveals significant difference between urban and rural settings, with overall HIV prevalence in urban areas at 2.6 percent (3.2% in Monrovia) against only 0.8 percent in rural areas. It further shows higher HIV prevalence in the southern border regions, which may be associated with trans-border mobility. Thus, the overall HIV prevalence of 2.1 percent masks the fact that HIV is *well established* among the general population in urban settings, with an average prevalence of 2.6 percent (Figure 3).

[2] According to the LDHS 2013 report, further analysis of the HIV prevalence do not include HIV-2 infection because "only a tiny fraction of women and men age 15-49 are infected with HIV-2"

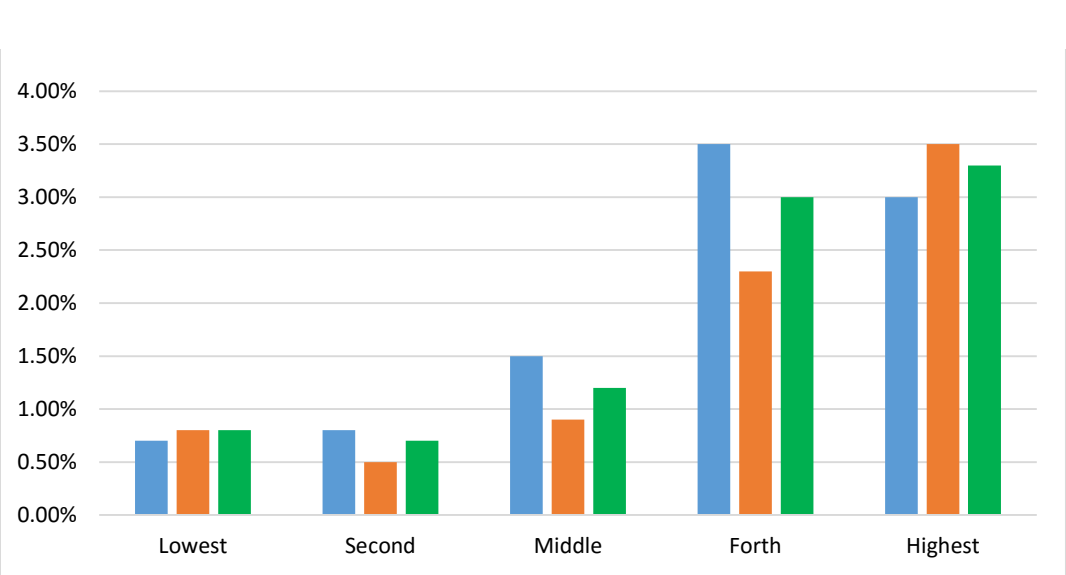
Figure 5: HIV prevalence by urban, rural and regions



Source: LDHS (2013)

Another interesting result from the 2013 LDHS and previous surveys is the prevalence of HIV in relations to peoples' economic status. Results show that HIV prevalence is higher in more wealthy people than in poor population and it shows and increase as people's economic status increase.

Figure 6 HIV prevalence by Economic status



Source: LDHS (2013)

2.2.2 HIV among Most-at-risk population

Most-at-Risk populations (MARPs) in Liberia include (female and male) sex workers and their clients, men who have sex with men, orphans and vulnerable children, including street children, men in prisons, injecting drug users, mobile populations (e.g. long-distance bus and truck drivers).

Knowledge of HIV and AIDS: A minimum of 88% and a maximum of 94% of the targeted populations reported having ever heard of HIV or AIDS. While these proportions are very similar to those reported in the LDHS 2007 and 2013 and could be seen as high, they remain low as compared to other neighbouring countries.

Knowledge of HIV and AIDS prevention methods: Knowledge of HIV prevention methods is not impressive. Among the three main prevention methods, condom use is the most known by about 80% of the respondents, with a minimum of 77% among male OSY and a max of 87% among male ISY and IDUs. The second most known prevention method in all the groups less the OSY is being faithful to one uninfected sexual partner.

Comprehensive knowledge of HIV and AIDS: Comprehensive knowledge of HIV among all of the target population was relatively low especially among FSW. Female sex workers recorded the lowers percentage of 19.6 and Uniform services personnel and MSM recorded the highest percentage of 38.4 and 37.0 respectively.

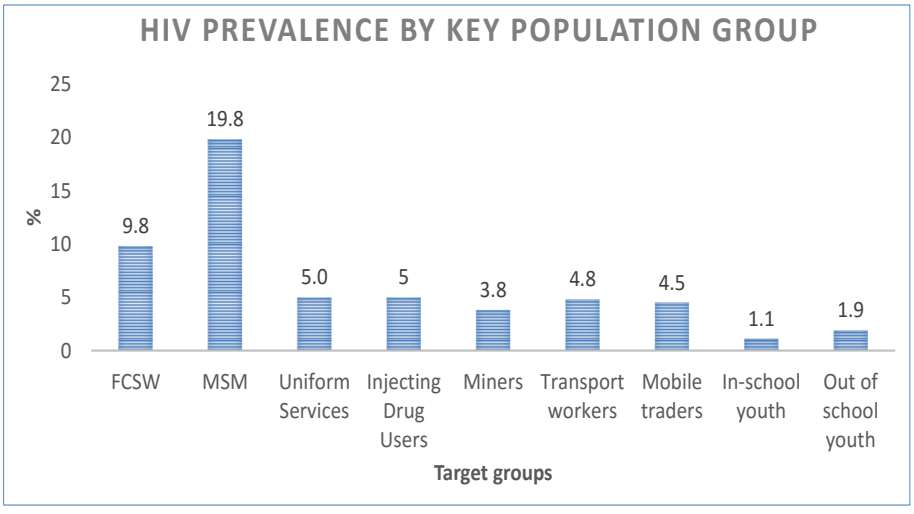
Knowledge of PMTCT: Overall, the average level of knowledge of prevention of mother-to-child HIV transmission was about 50% signifying a relatively low knowledge among all of the key target groups.

Voluntary Counselling and Testing: Apart from FSWs among which only 28% reported knowing a VCT centre in their community, over 55% of all target groups reported the knowledge of a VCT site in their community.

Stigma and Discrimination: Attitude towards HIV positive people: A higher percentage (80.7 and 76.3) MSM and Uniform services personnel indicated that they would be willing to share a meal with People Living with HIV (PLHIV) whereas less than 40% of ISY expressed willingness to share a meal with people living with HIV. An overwhelming majority of both MSM and Uniform services personnel indicated they would be willing to care for family members living with HIV and AIDS within the household, and that people living with HIV should not be quarantine. Only 13.4% and a little 28.7%of MSM and Uniform services personnel indicated that people living with HIV should be quarantine. On average, responses from other target groups indicate a high level of stigma and discrimination.

Knowledge about AIDS treatment: About 20% of MARPs erroneously think that AIDS can be cured and less than half of respondents between 34% of FSW and 53.5% of Uniform Services reported that they ever heard of medicines to improve the health of PLWHA.

HIV and syphilis test acceptance rates: HIV prevalence is dramatically high among MSM (19.8%). They are closely followed by FSW (9.8%) and Uniform services personnel (5.0%). Youth in school had the lowest HIV prevalence (1.1%) with no significant difference between male (1.3%) and female (1.0%). Similar trend was observed among OSY with the prevalence being 1.9% and no significant difference between male (2.3%) and female (1.4%). Injecting drug users was predominantly male occupational group with the HIV prevalence of 3.9%, whereas Miners recorded a prevalence of 3.8%. Among Transport workers and Mobile traders, a considerably high prevalence of 4.8% and 4.5% was recorded.



Knowledge of STI symptoms: Abdominal pain, Genital discharge, and Itching were the most common knowledgeable STIs symptoms in women among all target groups. All male dominant target groups besides ISY and OSY reported more than 60% of knowledge of at least more than two STI symptoms in men. These percentages were far lower among ISY and OSY that reported 23.4% among ISY boys and 38.3% among OSY boys.

STI exposure last 12 months: FSW reported the highest exposure to STI symptoms over the past 12 months with 41.1% reporting abnormal genital discharge and 34.6% reporting genital ulcer/sore. IDUs also reported high percentage of 35.1% and 27.9% for having abnormal genital discharge and genital ulcer/sore during the last 12 months.

Sexual Experiences and Behavior of youth MARPs: Among ISY, 73.5% reported ever having sex compared to 83.2% among OSY. Of these numbers, boys reported a higher percentage of early sex before age 15 compare to girls in both groups. Twenty percentage of boys in school reported having sex before age 15 compare to 16.3% of girl in the same category. OSY also recorded 21.7% of boys and 19.4% of girls reported having early sex before age 15. The median age of first sex for both boys and girls among ISY and OSY was 16 years. Among ISY, condom use at last sex with commercial partners was higher among male (72.4%) compare to female (63.6%). The same trend was recorded among OSY with male reporting 71.2% and 38.7% among female respectively.

Sexual Experiences and Behavior of adult MARPs: Among adult MARPs reporting early sex before age 15, FSW recorded the highest percentage of 30.5% followed by 26.4% among MSM and 23.7% among IDU. Condom use at last sex was less than 50% for most of the adult MARPs (excluding FSW and MSM) whereas proportion increases once a paying partner is involved. FSW reported the highest (81.8%) proportion of condom use with a paying partner closely followed by 76.4% among Mobile Traders male. A significantly low rate (20.7%) was recorded among MSM.

Sexual Behaviors with Paying Partners: Both IDUs and Mobile Traders reported the highest percentage of having 3+ paying and non-paying partners during the last 3 months.

MSM Sexual behaviours: More than 52% of MSM reported having first sex with another man at aged ≤ 20 years. This rate is an early warning indication of the vulnerability of adolescent male in Liberia.

Female Sex Workers Sexual behaviours: Almost 97% of FSW reported having sex with a paying partner during the last 7 days with 73.7% having more than 3 sexual paying partners. The corresponding percentage of FSW reporting having more than 3 sexual non-paying partners during the last 7 days was 17%.

Sexual practices of Injecting Drug Users: Among IDUs, 14.6% reported practising anal sex. Almost half of IDUs (48.3%) reported the use of condom during the last anal sex with paying partners. A proportion of 15% of IDUs reported ever practising group sex with paying partners with the 56.1% reporting the usage of condom during last group sex.

Sexual violence, Blackmail and discrimination: Among FSW, 87.4% reported any type of violence compared to 40.2% among MSM. More than half (68.7%) of FSW and 24.5% of MSM reported ever been threatened by the police with 59.8% of FSW providing sexual favour to avoid arrest. More than a quarter (35.6%) of FSW and 18.4% of MSM have been forced to have sex without a condom.

Knowledge about availability; Use of Condom and Lubricants: About 67% of ISY and half of OSY reported knowing a male condom while only about 50% of all youths reporting knowing where to get a male condom if needed. Knowledge of female condom was very marginal (<1%) among adult MARPs. Knowledge of a male condom was also relatively low (lowest among MSM 67.6%; less than 70% among youths and around 90% among other adults) and almost half of youth and 1/3 of adult respondents do not know where they can get a male condom. About 50% of miners and 30% of other adult respondents reported never using a condom. Among those who know of a male condom, generally about ¾ of adults know where to get one.

Exposure to HIV Interventions: Almost 75% and 62.5% of OSY reported listening to radio at least once a week. For exposure to TV during the same period of time only 43% of ISY and 25% of OSY declared watching TV. Youths are not very exposed to newspaper and only 42% of ISY and 19% of OSY reported reading a newspaper at least once a week. Talking of adult MARPs exposure to media, MSM seem to be more exposed to media than any other adult MARP group. Very marginal respondents reported been exposed to newspapers. Youth respondents were more exposed to UNMIL and local county radios as well as REAL TV and LOVE TV stations. Adult MARPs reported been more exposed to ELBC, UNMIL and Local radio station as well as Power and Real TV. Less than 50% of adults respondents reported ever seen an advertisement in the

media on HIV and only about 30% of them reported ever hearing or seeing a specific advertisement on VCT in the media. Less than one third of youths reported ever hearing of a voluntary counselling and testing centre and fewer reported ever seeing or hearing an advert on VCT. For those who ever heard or seen any advert on VCT, the majority reported radio as the media through which such information was received. Regardless of the group (young or adults), more or less than 80% of respondents who never heard of a VCT centre reported their willingness to use it if its services were available. About 50% of ISY and less than 40% of OSY reported ever seeing a condom demonstration. Very marginal proportions reported ever participating in HIV peer education. Less than one over ten youth reported ever been exposed to radio group peer education. Proportions of adult MARPs who reported ever seeing a condom demonstration vary between 47% among transport workers to 59.7% among uniform services. Very marginal proportions reported ever participating in HIV peer education. As for the participation in radio group peer education, between 0% and 5% reported ever been exposed to such activities, which is relatively similar to the participation in community drama and/or discussing HIV and AIDS related issues with a peer educator.

HIV Sero-discordant Couples

According to the Liberia DHS of 2013 2.8% of heterosexual couples are HIV sero-discordant [increased from 1.9% (LDHS 2007)], putting the HIV-negative partner in these discordant relationships at high risk for HIV infection. These discordant couples are at high risk for HIV transmission, especially if they do not mutually know their HIV status or do not use condoms consistently. In 1.7 percent of cohabiting couples, the man partner is infected and the woman uninfected, while in 1.1 percent of couples, the woman is infected and the man is not.

Infants Born to HIV-Infected Mothers (Indicators 3.1, 3.2 and 3.3)

Without measures to prevent mother-to-child transmission of HIV (PMTCT), approximately one in three children born to HIV positive mothers will be infected by the mother, either intrauterine, during delivery, or through breastfeeding. Children born to HIV-positive mothers in Liberia still face the risk of HIV infection. A somewhat moderate health system hampers effective VCT services, which results in most HIV-infected women being unaware of their HIV status, and not seeking adequate services including PMTCT. The utilization of these available services is further hampered by low rates of women consistently using ANC services and health facility to deliver,

which makes it difficult to access and utilize PMTCT services. This is further compounded by the high rate of lost to follow up and denial.

People Living with HIV (PLHIV) (Indicators 4.1 and 4.2)

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. An estimated 26,313 adults and 2,339 children were living with HIV in 2015 respectively (2015, Spectrum projections). While access to HIV treatment, care, support and prevention services is being scaled up to an increasing number of health facilities, weak health systems, and stigma and discrimination hamper people living with HIV access to these services. In addition to access to these services, people living with HIV play a key role in preventing the further spread of HIV through "positive prevention".

2.4 SEXUAL AND GENDER-BASED VIOLENCE AND HIV INFECTION RISK

Gender inequality including denial of women's and girls' rights to protect their sexual and reproductive health and body autonomy remains the most pervasive form of inequality with direct implication for women's risk of acquiring HIV. The 2007 LDHS[3] shows that 45% of women ever experienced physical violence since they were 15 years old, while 29% had faced violence in the last 12 months. The main perpetrators were current or former husbands/partners: Thirty five percent (35%) of women had experienced spousal violence in the last 12 months. Almost one-fifth of women aged 15-49 had ever experienced sexual violence (LISGIS, 2008). The most recent LDHS did not cover IPV, however it highlights women's and men's attitude toward wife beating. According to the 2013 LDHS, 10.7% of women feel it is justified if a man beats his wife for refusal to having sex, while only 4.1% of men feel it is justifiable. On the overall, 42.5% of women believe that a husband is justified in beating his wife for at least a specific reason (if she burns the food, if she goes out without telling him, if she neglects the children, if she argues with him, or if she refuses to have sexual intercourse with him), while only 24% of men believe that a husband is justified in beating his wife for at least one of these same five reasons. Similarly, a study in 2007

[3] LDHS 2013 did not flagged intimate partner violence

among 600 women and girls in Eastern Nimba and Central Montserrado Counties conducted by the International Rescue Committee (IRC) and Columbia University's Program on Forced Migration and Health revealed communities rife with gender-based violence (Shiner, 2007). 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% 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, approximately 61% had experienced physical violence and one-third sexual violence. Whereas most of these studies did not explored the direct correlation between SGBV and risk to HIV infection among the survey respondents, sexual and gender based violence undoubtedly increases women's physical and psychological health risks particularly to HIV and other STIs.

3. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

3.1 PREVENTION PROGRAMS

3.1.1 Information Education and Behavior Change Communication

The multi-pronged approach towards prevention of HIV and AIDS in Liberia includes information, education and communication (IEC), behavior change communication (BCC); HIV counseling and testing (HCT); condom promotion and distribution; management of sexually transmitted infections; blood safety and universal precautions; and prevention of mother-to-child transmission (PMTCT) of HIV infection. Since the identification of the first HIV and AIDS case in Liberia, the primary emphasis has been on preventing the spread of the HIV epidemic.

Recent DHS report from the country indicates an increase in the number of young boys and girls having a comprehensive knowledge of HIV. Accordingly, 35.7% of girls age 15 – 24 years have comprehensive knowledge of HIV as opposed to 20.5% reported in 2007; meanwhile boys between the ages of 15 – 24 also recorded but a marginal increase in comprehensive knowledge of HIV from 27.2% in 2007 to 28.5% in 2013. Meaning, they are aware that the consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the risk of getting HIV, that even a healthy-looking person can have HIV and they also rejected the two most common local misconception about HIV transmission and prevention.

Delayed sexual debut is one of the many HIV prevention strategies that are being used in Liberia targeting young people. LDHS (2013) showed that 23% of young girls aged 15-24 years and 9% of young boys within the same age range are engaged in sex before age 15; an increase from 17.2% of girls and 8.5% of boys reported in 2007 LDHS. An additional prevention strategy in Liberia is the reduction in the number of sexual partners, in particular concurrent partners. LDHS 2013 showed that 6.5% of women and 17.6% of men aged 15-49 years had sex with more than one partner in the last twelve months (a decrease from 7.1 % of women and 21.4% of men in 2007); Given the moral considerations in having multiple sexual partners, it may be that the actual number of people having more than one partner was largely underreported through the population based survey in 2013.

NACP is making tremendous efforts to prevent new HIV infections by broadening prevention messages that emphasize the predominant modes of HIV prevention in Liberia which are; abstinence from sex (A), reducing to one the number of sexual partners (B) and using condoms correctly and consistently (C).

In 2015, efforts were made to increase public awareness of HIV and AIDS through many channels: mass media (radio messages), health talks at the various service delivery points, school health clubs, and community based drama group performances. Civil society organizations, such as NGOs, associations of people living with HIV, Community-Based Organizations (CBOs), and Faith-Based Organizations (FBOs) actively participated in efforts to raise public awareness about HIV and AIDS. Most of these activities had been dormant due to the Ebola virus disease (EVD) outbreak in the country.

3.1.2 Promotion and Distribution of Condoms

It was established in the LDHS (2013) that 75.1% of women and 75.0% of men identifies condom usage as a means of preventing HIV transmission. However, data from the LDHS (2013) also show low levels of condom usage among the general population. Among women who had more than one sex partner in 12 months before the survey, only 19.6 % said they used condom during the most recent sexual intercourse, far lower than the 23.6% reported by men.

Activities promoting the distribution and utilization of condoms are largely carried out by community-based organizations. Some major condoms promotion activities includes; the social marketing of a Liberian branded condom, 'Star,' the production of print and audio communication materials, improving the quality of care at youth centers, the provision of community based sensitization activities, and the setting up of distribution outlets at community level.

A total of 8,199,230 pieces of male condoms were distributed 2015. Some of these distributions are done through condoms dispensing points set up in communities around the country in addition to facility based condom dispensing points at almost all health facility in Liberia. Facility-based condom distribution accounts for about 29.7% of the total condoms distributed in 2015.

Table 3: Facility-based condom distribution per county

County	Condoms Distributed for non-FP	FP - Female Condoms Distributed	FP - Male Condoms Distributed	Total Condoms Distributed at Facility
Bomi	68,351	548	47,388	116,287
Bong	142,760	3,440	107,559	253,759
Gbarpolu	28,949	1,430	16,786	47,165
Grand Bassa	81,930	121	146,533	228,584
Grd Cape Mount	28,474	96	33,128	61,698
Grand Gedeh	45,559	1,640	64,968	112,167
Grand Kru	39,394	269	3,041	42,704
Lofa	130,197	3,227	123,457	256,881
Margibi	151,835	3,156	180,721	335,712
Maryland	8,127	365	11,816	20,308
Montserrado	55,593	13,338	526,157	595,088
Nimba	94,486	288	100,917	195,691
River Gee	57,328	0	722	58,050
Rivercess	27,776	145	15,773	43,694
Sinoe	50,709	243	16,622	67,574
Liberia	**1,011,468**	**28,306**	**1,395,588**	**2,435,362**

3.1.3 HIV Counselling and Testing in the General Population

Seeking an HIV test may be more difficult for young people than adults because many young people lack experience in accessing health services for themselves and there are often barriers to young people obtaining services. The Ministry of Health through NACP has however made significant strides to make HIV counselling and testing readily accessible and available to all.

The 2013 LDHS showed that among women of ages 15 - 49 surveyed, 19.1% had been tested for HIV in the past 12 months and received results as opposed to 1.6% reported in 2007 LDHS. Among men of ages 15 - 49 surveyed, 12.4% (2.3% in 2007 LDHS) had been tested in the past 12 months and received their results. Women and men in urban areas with secondary-level education or higher and with greater wealth were much more likely to have had a test in the last 12 months and received the results [*Source: LDHS, 2013*]. Among youth respondents, only 18.3% (1.9 % in 2007) of girls and 6.2% (1.6% in 2007) of boys aged 15- 24 years had been tested for HIV and received the result.

Liberia has adopted a multi-pronged approach to provide HIV Counseling and Testing (HCT) services. HCT is provided through voluntary counseling and testing, and through Provider Initiated Counseling and Testing (PICT). The Program has increase the number of sites providing HCT services from 79 facilities in 2007 to 395 in 2015 in all 15 counties.

Table 4 Clients receiving HIV Counselling and Testing in 2015

County	Client Pre-test Counselled for HIV	Client Tested for HIV	Client Post Test Counselled for HIV	Client Tested HIV Positive
Bomi	3,829	3,828	3,875	81
Bong	12,610	12,526	12,525	211
Gbarpolu	1,511	1,453	1,453	19
Grand Bassa	9,257	9,278	9,277	193
Grand Cape Mount	2,074	1,964	1,952	98
Grand Gedeh	4,206	4,001	3,851	190
Grand Kru	684	673	667	17
Lofa	10,981	10,939	10,772	144
Margibi	5,769	5,416	5,240	163
Maryland	4,041	4,020	4,004	256
Montserrado	43,513	39,007	37,857	2,835
Nimba	18,658	16,793	16,578	953
River Gee	1,775	1,773	1,748	107

Rivercess	1,747	1,689	1,667	57
Sinoe	1,911	1,853	1,846	84
Liberia	**122,566**	**115,213**	**113,312**	**5,408**

During 2015 a total of 122,566 persons were offered the opportunity to be tested for HIV having attended a health facility for various reasons. Of said amount, a total of 115,213 (94%) were actually tested for HIV and 113,312 (98%) received their results. An overall HIV positivity rate of 4.7% was recorded; meanwhile, the highest rate of 7.3% was recorded in Montserrado while Gbarpolu County had the lowest positivity recorded (1.3%).

Table 5: Client receiving HIV Counselling and Testing by Age and Sex

Sex	Age range	Client Pre-test Counselled for HIV	Client Tested for HIV	Client Post Test Counselled for HIV	Client Tested HIV Positive
Male	>=25 years	19,304	18,472	18,430	1,069
	15 - 24 years	4,627	4,080	4,081	61
	<15 years	1,093	1,022	1,018	83
	Sub-total	**25,024**	**23,574**	**23,529**	**1,213**
Female	>=25 years	13,729	12,650	12,508	1,723
	15 - 24 years	6,285	5,460	5,429	270
	<15 years	1,701	1,638	1,637	80
	Pregnant	75,827	71,891	70,209	2,122
	Sub-total	**97,542**	**91,639**	**89,783**	**4,195**
Grand Total		**122,566**	**115,213**	**113,312**	**5,408**

3.1.4 Prevention of Mother-to-Child Transmission of HIV

The National AIDS Control Program in close collaborations with the Family Health Division of the Ministry of Health continues to increase PMTCT coverage to create access to every pregnant woman accessing antenatal services in Liberia. In accordance with the WHO 2013 recommendations, although late, NACP in 2015 adopted Option B+ to ensure that pregnant women and mothers who are tested HIV positive have ART treatment available for their own health and

longevity and that their babies are borne HIV negative. The roll-out of the revised guidelines were delayed due to the outbreak of EVD. The PMTCT services in Liberia are integrated into Maternal and Child Health (MCH) services. They includes various interventions, such as HIV testing and counseling, preventive treatment with antiretroviral drugs (maternal and infant), counseling and support for appropriate infant feeding, access to safe obstetric care and family planning services. The number of health facilities offering PMTCT increased from 55 in 2009 to 335 sites in 2015.

Table 6 HIV Pregnant women and New born receiving ARV

County	ANC Client Initiated on ARV	Client Initiated on ARVs in Labor	ANC Clients on ART	Live Birth to HIV Positive Women	Neonates placed on ARVs at Birth
Bomi	10	7	3	10	8
Bong	45	14	1	14	14
Gbarpolu	2	11	0	12	3
Grand Bassa	9	3	5	12	6
Grand Cape Mount	15	3	4	5	3
Grand Gedeh	35	19	3	20	20
Grand Kru	3	3	1	4	4
Lofa	20	7	5	10	7
Margibi	211	6	4	8	6
Maryland	23	17	90	26	26
Montserrado	169	105	113	172	175
Nimba	131	23	9	19	19
River Gee	34	17	2	17	16
Rivercess	10	8	1	4	6
Sinoe	154	1	2	1	1
Liberia	**871**	**244**	**243**	**334**	**314**

Although few pregnant women make the four WHO recommended ANC visits, nearly all women make at least one antenatal visit, which is used as an excellent opportunity to provide PMTCT services. In order to increase the uptake of HIV testing among pregnant women, provider-initiated testing and counseling, with informed consent, is currently included in the National PMTCT Guidelines. Rapid HIV testing with "same-day" results is currently provided.

In 2015, a total of 1,358 HIV-positive pregnant women received ARVs/ART to reduce the risk of mother-to-child transmission (MTCT). According to Spectrum estimates, there were about 1,300 HIV-positive pregnant women in need of ARVs for PMTCT in 2015.

Early Infant Diagnosis (EID) using DNA PCR

Early infant diagnosis (EID) is an integral part of the PMTCT strategy in Liberia and a key strategy used by the program to reduce new HIV infections in children. Children exposed to HIV are given EID using DNA PCR (DBS). According to Spectrum Estimates, the proportion of HIV exposed infants accessing EID has increased progressively from 15.2% (283/1866) in 2010 to 20.5% (346/1684) in 2011. However, due to the inception of the Ebola virus disease in Liberia, all EID services came to a standstill. Laboratories being used for EID testing were transformed to EVD testing sites. All efforts to revive the service in 2015 proved futile.

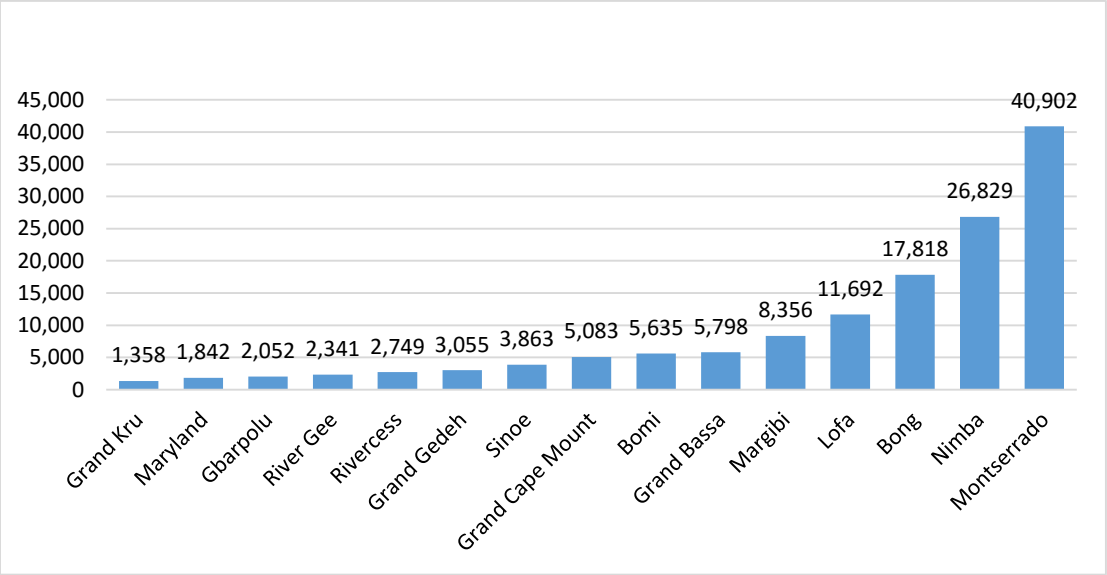
3.1.5 Management of Sexually Transmitted Infection

Sexually Transmitted Infections (STIs) are major public health problem in Liberia. LDHS 2013 clearly demonstrates the severity of STI cases being reported. Among women who had ever had sexual intercourse, the percentage reporting having an STI and/or symptom of an STI in the past 12 months is 30.2% while in the men category 12.9% was recorded. The HIV pandemic has focused greater attention on the prevention and control of STIs. There is a strong correlation between the spread of conventional STIs and HIV transmission. Both ulcerative and non-ulcerative STIs have been found to increase the risk of sexual transmission of HIV. The advent of HIV and AIDS makes STIs prevention a priority health problem. STI is a window for HIV transmission, often referred to as the superhighway for HIV transmission.

Liberia has adopted a comprehensive approach to STI prevention and control by developing the 2nd edition of the guidelines for syndromic and etiologic management in August 2009. The guidelines focused on BCC strategies as well as effective and prompt STI case management.

In 2015, based on the WHO syndromic management approach, 139,373 cases of STIs were reported to have been treated. Montserrado County accounts for 29% of the total STI cases treated followed by Nimba (19.2%).

Figure 7 STI case treated by county



Source: HMIS 2015

3.1.6 Prevention Program for Sexual and Gender-based Violence Victims

Sexual and gender- based violence (SGBV) including rape increases the risk of HIV transmission through sexual intercourse. Sexual violence often results in traumatic lesions of genital mucous membranes, which allow HIV to move easily from one person to another. The National treatment protocols[4] specify the PEP regimen and package to be given to survivors of sexual assault and rape victims. The package includes emergency contraception, prevention and treatment of STI, prevention of tetanus, HIV post-exposure prophylaxis (ARVs) and counseling. Furthermore, UNFPA has provided, to major health centers and hospitals, rape prophylactic kits for STI, and PEP for accidental occupational and sexual exposure. Training on PEP has been organized for UN staff and implementing partners and the MSF hospital in Paynesville was contracted by UNFPA to organize 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

[4] Integrated guidelines for Prevention, Testing, Care and Treatment of HIV and AIDS in Liberia (Fourth Edition 2014)

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.

Table 7: Rape cases reported in 2015

County	Total Rape cases reported	Rape cases follow-up	Rape cases reported within 72 hrs.	Rape cases reported after 72 hrs.	Rape cases treated with pep
Bomi	15	9	4	7	4
Bong	92	50	39	61	35
Gbarpolu	0	0	0	0	0
Grand Bassa	30	1	13	16	3
Grand Cape Mount	0	0	0	0	0
Grand Gedeh	15	19	16	3	17
Grand Kru	0	0	0	0	0
Lofa	5	0	3	2	0
Margibi	67	52	21	31	17
Maryland	5	1	5	0	5
Montserrado	394	208	149	185	78
Nimba	55	61	28	38	26
River Gee	10	7	1	9	1
Rivercess	2	0	2	0	0
Sinoe	0	0	0	0	0
Liberia	**690**	**408**	**281**	**352**	**186**

During the year under review, a total of 690 rape case were reported at health facilities in Liberia, 281 of which were reported within 72 hours (a time allowed for the administration of PEP). A total of 186 cases received PEP treatment based on eligibility.

3.1.7 Male Circumcision

Male circumcision is a common practice in many parts of sub-Saharan Africa for traditional, health and other reasons. Male circumcision has also been shown to be associated with lower transmission of STIs including HIV (WHO and UNAIDS, 2007). Like in most sub-Saharan countries in Africa, male circumcision is widely practiced in Liberia and often serves as a rite of passage to adulthood. The LDHS both 2007 and 2013 showed that male circumcision is indeed widespread in Liberia,

with almost all men being circumcised (98% and 99% respectively). This is true for all ages, residence status and level of educational achievement.

3.2 TREATMENT, CARE AND SUPPORT

In 2004, Liberia launched her first national Antiretroviral Therapy (ART) program in its public health care sector. This was made possible through the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM). People living with HIV and AIDS who attends both public and private sector program in Liberia do not need to pay for HIV related treatment services including laboratory investigations. The ART program first started in four facilities; involving two referral hospitals and two other district hospitals. It has now expanded to 54 sites by the end of December 2015.

3.2.1 HIV and AIDS Treatment: Antiretroviral Therapy

Antiretroviral therapy has been shown to reduce HIV-related morbidity and mortality among people living with HIV and also curbs onward HIV transmission. Studies have shown that early initiation, regardless of an individual's CD4 cell count, can enhance treatment benefits and save lives. Liberia as a country is slowly gearing towards treatment for all (test and treat) first starting with pregnant and lactating women, sero-discordant couples and all children less than five years of age. The number of health facilities offering antiretroviral therapy (ART) in Liberia has increased substantially from 4 sites in 2004, 22 in 2009, 29 in 2010, 39 in 2011 to 54 in 2015. Correspondingly, the Country have also witness a gradual increase in the coverage of ART.

County	Children <15 yrs in Care	Non-pregnant females > 14 yrs. in Care	Pregnant females in Care	Males > 14 years in Care	Total in Care & on ART	Children <15 yrs on ART	Non-pregnant females > 14 yrs. On ART	Pregnant females on ART	Males > 14 years on ART	Total on ART
Bomi	25	86	0	26	**137**	2	68	0	22	**92**
Bong	39	171	1	44	**255**	11	118	0	30	**159**
Gbarpolu	4	15	0	8	**27**	1	12	0	6	**19**

Grand Bassa	23	156	4	71	**254**	9	130	3	59	**201**
Gr. Cape Mount	9	41	0	14	**64**	0	18	0	4	**22**
Grand Gedeh	66	320	31	93	**510**	10	250	16	77	**353**
Grand Kru	0	3	0	2	**5**	0	3	0	1	**4**
Lofa	56	195	10	47	**308**	12	138	2	32	**184**
Margibi	47	166	11	98	**322**	13	147	3	157	**320**
Maryland	58	292	22	76	**448**	12	197	9	54	**272**
Montserrado	667	3901	252	1938	**6758**	292	3132	87	1594	**5105**
Nimba	85	491	33	145	**754**	19	335	5	116	**475**
River Gee	29	96	5	32	**162**	0	52	2	17	**71**
Rivercess	30	6	9	38	**83**	7	3	5	13	**28**
Sinoe	9	79	6	28	**122**	1	62	3	20	**86**
LIBERIA	**1147**	**6018**	**384**	**2660**	**10209**	**389**	**4665**	**135**	**2202**	**7391**

3.2.2 HIV and Tuberculosis Treatment Co-management

HIV and TB collaborative efforts are major priorities for improving the quality of care currently provided in Liberia. Each disease makes the other worse, leading to more deaths. The care of co-infected patients requires coordination and integration of HIV and TB activities. A 2009 sero-prevalence survey of HIV among TB patients revealed a TB/HIV co-infection rate of 22.3%.

In response to making Liberia an HIV/TB co-infection free society, emphasis has been placed on systematic screening of all HIV patients who are enrolled into Care and Treatment for TB and HIV as a major part of their routine care services.

3.3 HIV AND AIDS IMPACT MITIGATION

The Ministry of Health through its implementing partners, like the Samaritan Purse with support from the Global Fund is providing educational support and livelihood to OVCs. In 2012 and 2013 support was given to a total of 7, 570 orphans in 11 counties through direct payment from the Ministry of Health Office of Financial Management (OFM) SHALOM and the Samaritan Purse.

The support provided to OVCs is mainly through payment of educational grants, including procurement of school materials and provide access to medical and psychological care services. However, as attentions shift to more impactful interventions in the fight against HIV, these activities are waning down.

3.4 DIFFERING FINANCIAL YEARS

The NAC recognizes that to strengthen coordination of programme implementation among implementing partners, coordination needs to be strengthened in the field of monitoring and evaluation especially in the assessment of financial flows. Therefore, a National AIDS Spending Assessment (NASA) was conducted for the period 2010/2011 to 2011/2012 to monitor HIV/AIDS public and private resource flows both in- and outside the pooled funding arrangement and hopefully institutionalize a system to report to one central coordinating authority. Conducting the NASA provides the needed information to assess the use of resources for HIV and AIDS related activities and also plan effectively for future activities.

The focus of the study was at the national level. Data collection covered the external sources of funds for HIV and AIDS, government contribution and funds made available by private entities in the years 2010/2011 to 2011/2012. The study employed the NASA methodology which allows for the systematic, periodic and exhaustive accounting of the level and flows of financing and expenditures, in public, international and private sectors to confront the HIV and AIDS epidemic.

Figure 4.1 Sources of Funds for HIV and AIDS Expenditure, 2010/2011 - 2011/2012 (US$)

Results from the NASA study shows an increase in growth of the funds made available for HIV and AIDS related activities, increasing by 9 percent from 2010/2011 to 2011/2012. The National AIDS Assessments estimates that the total expenditure on HIV and AIDS activities in Liberia was **US$15,959,266** and **US$17,368,448** for the periods 2010/2011 and 2011/2012 respectively. The largest proportion of the funds as indicated was sourced from international organizations accounting for about 99.2 percent of the total funds spent on the average within the two year period. Public funds accounted for 0.6 percent of the total funds within the period under consideration with private funds accounting for 0.2 percent. In both years, majority of the funds were spent on Programme Management and Administrative Strengthening, Human Resources and Prevention.

Table 4.3 Total Spending on Key Priorities or Intervention Areas, 2010/11 – 2011/12 (US$)

Key Areas of Expenditure	2010/11	(%)	2011/12	(%)
Prevention Programmes	4,319,660	**27.1**	4,765,865	**27.4**
Treatment and Care	1,892,749	**11.9**	2,158,466	**12.4**
Orphans and Vulnerable Children (OVC)	448,633	**2.8**	921,629	**5.3**
Programme Management and Administration	5,719,629	**35.8**	5,423,259	**31.2**
Human Resources	3,340,117	**20.9**	3,829,099	**22.0**
Social Protection and Social Services (excluding OVC)	172,926	**1.1**	186,423	**1.1**
Enabling Environment	63,073	**0.4**	83,707	**0.5**
HIV and AIDS Related Research	2,479	**0.02**	0	**0.0**
Total	**15,959,266**	**100.0**	**17,368,448**	**100.0**

The NASA assessment groups beneficiary populations of the HIV and AIDS related programmes and activities into five broad areas (People living with HIV, specific 'accessible' population, other key population, most at risk population and general population). The analysis showed that, the specific 'accessible' population group benefitted from the majority of funds spent on HIV and AIDS related activities (45 percent on average in both years). This was followed by the general population and then the PLHIV group. Most at Risk Populations (MARPs) benefitted the least at 0.02 percent in both study periods. To better assess which groups are truly benefitting from the

available resources it is recommended that the target population be clearly specified by implementers during the NASA.

4. BEST PRACTICES

4.1 MOTHER-TO-MOTHER PEER PROGRAM

One of the key impediment of the HIV and AIDS program is the high attrition of people living with HIV who after being diagnosed are enrolled into HIV care and treatment program due to either lost to follow-up or denial. A cohort study conducted in Liberia showed that at 12 months of follow up, the Kaplan-Meier survival estimates for retention among patients initiated on ART was 69.9% compared to 24.7% among patients not on ART. These rates dropped to 56.8% among ART patients and 14.3% among patients not on ART as the follow up period double. At 36 months of follow up, the retention rate among ART patients was 48.7% compared to 9.4% among patients not on ART. To address this dilemma, the mother-to-mother peer program was introduced. At least two mothers who had successfully completed a PMTCT process were recruited at a health facility to serve as support and encouragement to their peers. In addition to improving retention in care, this scheme also provided a sort of ownership of the program to people living with HIV.

4.2 TASK SHIFTING

The shortage of well-trained health workers is a global problem, but low and middle income countries, where HIV and AIDS are taking the greatest toll, feel the crisis most acutely and Liberia is of no exception. In addition to increasing the uptake of medical students in school, which is a long term solution to this dilemma, task shifting has proven to work best at this moment we the general populace are in need of well-trained staff to provide clinical care and support. As it stands, the doctor to patient ratio in Liberia is very low. Only about 4 of the current 54 sites offering HIV care and treatment have doctors who actually work in the unit. Task shifting seemed the only and best option and has worked well with little damage to the quality of care being provided to people

living with HIVs. Under the care of Nurses and few Physician Assistants, Liberia has been able to enroll and retain over ten thousand (10,000) HIV positive people in care with over seven thousand (7,000) of them on antiretroviral drugs.

4.3 HIV CLINICAL MENTORING PROGRAM

The major challenges of scaling-up of HIV services are maintaining and improving the quality of the services provided to people living with HIV. With a lack of HIV knowledge and experience amongst Liberian clinicians, clinical mentoring has proven to be the most effective approach to improve the quality of care.

As one of the key supporters of the Liberian NACP/MoH in updating and producing Integrated Guidelines for HIV prevention, care and treatment in 2010, Clinton Health Access Initiative (CHAI) Liberia initiated a Clinical Mentor Program as a way of disseminating quality implementation of the guidelines.

Over the past 4 years, Liberia has undertaken a robust scaling-up of HIV services by increasing the number of ART and PMTCT sites throughout the country, which has boosted HIV counseling, testing, PMTCT and ART services among communities. In order to sustain the Clinical Mentor Program, NACP hired ten Liberian clinical mentors in 2010 through funds secured from the GFATM with plans to hire additional nine in the near future. The clinical mentors were responsible for providing care to HIV patients receiving care and treatment in the additional sites, with a particular focus on improving the quality of HIV services.

The presence of clinical mentors in health care facilities has improved the HIV services in those facilities. For example, at John F. Kennedy Memorial Medical Centre, the National referral hospital in Liberia, the clinical mentors have increased the monthly percentage of patients initiated on the correct ART.

Future plans for Clinical Mentor Program will include a monitoring system for tracking progress and strengthen clinical skills for clinical mentors and other health providers.

5. MAJOR CHALLENGES AND REMEDIAL ACTIONS

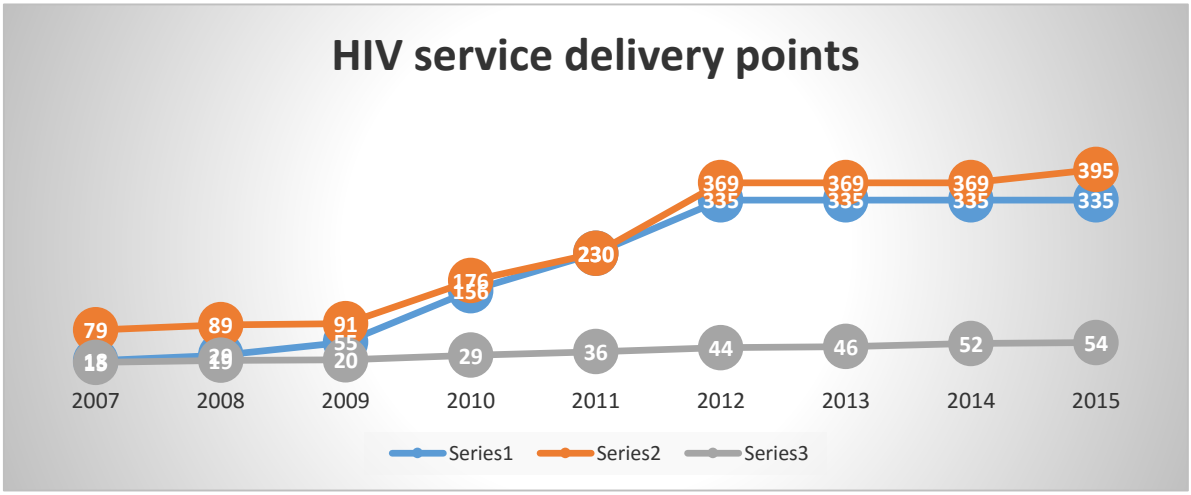
5.1 KEY CHALLENGES REPORTED IN 2013 AND PROGRESS MADE

Between 2013 and the end of 2015 a lot of improvements have been made to offset majority of the challenges listed in the 2013 GARPR report. Although hindered by the outbreak of EVD in 2014 and 2015, strategic goals were yet accomplished. Key among those challenges addressed are:

Effective Coordination and Management of a Decentralized, Multi-sectoral National response – The overall capacity of the National AIDS Commission has been strengthened; the involvement of all sectors and mainstreaming of HIV in existing policies were prioritized; public –private partnership established as well as civil society organizations' capacity built.

Strengthening HIV Prevention, with a Priority Focus on Most-at-Risk and Vulnerable Population – HIV prevention with emphasis on MARPs and vulnerable population was adequately addressed in the NSP 2015-2020 based on evidence of the high vulnerability and the risk of HIV infection. Current proposed strategies and grants lay a lot of emphasis on the prevention of HIV young people, including FSWs, MSMs and of course the general population.

Scaling up Coverage and Quality of Treatment, Care and Support for PLHIV, OVCs, and Other Affected Persons – A lot of strives were made in this direction; however, there is a lot to



be done in term of scaling up coverage, strengthening of the health systems capacity and community systems strengthening. Between 2013 and 2015, coverages were increased but marginally.

Reducing Stigma and Discrimination of PLHIV as a Cross-cutting Priority – Remains an issue that needs to be addressed adequately.

5.2 OUTSTANDING CHALLENGES OF 2015 AND REMEDIAL ACTIONS PLANNED

The challenges highlighted below, though mostly reported in the 2013 progress update still remain as issues that need to be addressed.

Reducing Stigma and Discrimination of PLHIV as a Cross-cutting Priority - The active involvement of people living with HIV in the fight against HIV 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 people living with HIV, OVCs and other affected groups present a major obstacle to the effective delivery of HIV-related programs and services. HIV-related stigma and discrimination prevent people from wanting to know their HIV status. This affects the utilization of voluntary and provider-initiated counseling and testing services. As a result, many individuals 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 threaten HIV-positive people's social position as well as their health, labor and other rights, they also present a major obstacle for the effective coverage and utilization of HIV-prevention services – such as PMTCT, and treatment of TB/HIV co-infection.

Children who have been orphaned or otherwise left vulnerable by the impact of HIV face similar stigma and discrimination. Stigma and discrimination hamper their psychological and social welfare, as well as their access to care and support, education, and other social services. Therefore, effectively dealing with stigma and discrimination involves undertaking the following remedial actions:

- Supporting the empowerment of people living with HIV as a group, and as individuals to enjoy the same rights and opportunities as other Liberian citizens.
- Promoting supportive attitudes and environments for people living with HIV.
- Strengthening the legal protection of people living with HIV, including their labor rights and access to healthcare.

Scaling up Coverage and Quality of Treatment, Care and Support for PLHIV, OVCs, and Other Affected Persons - While existing national response has scaled-up the provision of ARV treatment and other treatment, care and support to people living with HIV, orphans and vulnerable children (OVCs) and other affected groups, the still low coverage and quality of these services, as well as their future sustainability, present major challenges to the national response. HIV services 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.

In addition, experiences with ARV treatment have shown the importance of a supportive care environment, whereby support groups of people living with HIV, communities and families play a key role in providing adequate (home-based) care and support to people living with HIV, 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-related services into the health-care system, and increased resource-allocation from different government sectors and the private sector, e.g. through workplace programs.

Remedial actions for scaling up comprehensive and sustainable treatment care and support and improving their quality include:

• Strengthening health systems 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 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 MoH policies of decentralization;

• Strengthening and supporting community systems – including associations and support groups of people living with HIV, communities and families – to provide sustained care and support to people living with HIV, 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:

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; PMTCT; 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, labor 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 in the long run; this involves building staff capacity, ensuring follow-up, and on-site support. It also requires integrating HIV care and treatment in the Essential 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.

System for Early Infant Diagnosis – Since to outbreak of EVD, there has been a complete halt on early infant diagnosis. The laboratory that was being used for testing samples collected from infants around the country was being used for EVD testing and completely off limit.

Other key challenges includes:

1. Lack of adequate resources to implement the strategies captured in the NSP 2015-2020
2. Delayed disbursement of available funds
3. Low staff retention or High staff turn-over
4. Inadequate supply chain management

6. SUPPORT FROM LIBERIA'S DEVELOPMENT PARTNERS

6.1 KEY SUPPORT RECEIVED FROM DEVELOPMENT PARTNERS

Like in most low income countries, donors and partners support Liberia's commitment to the HIV response. As a result of the ongoing process of reconstruction, Liberia has very limited national revenues. To date, government funds have covered personnel costs at the MOH&SW, NACP, and NAC; with commitment to enhance its contributions. The vast majority of available HIV funding comes from international development partners, including:

- The Global Fund (GFATM) provides the majority of the funds
- The UN Joint Program on HIV and AIDS
- Bilateral donors (e.g. USAID)

6.2 ACTIONS NEEDED BY DEVELOPMENT PARTNERS TO ENSURE TARGETS ACHIEVEMENT

If Liberia must achieve the targets set in the 2011 Political Declaration on HIV and AIDS, our development partners will have to do the following:

- ✓ Support the country's strategies as aligned in the National Strategic Plan 2015-2020,
- ✓ Harmonize and coordinate their support
- ✓ Continued and sustained support to the NAC and its implementing partners
- ✓ Support operational research and surveillance
- ✓ Support the monitoring and Evaluation framework

7. MONITORING AND EVALUATION ENVIRONMENT

7.1 OVERVIEW OF THE MONITORING AND EVALUATION (M&E) SYSTEM

Monitoring and Evaluation (M&E) is an integrated element of the National Strategic Framework II (NSF). For each level, annual targets have been set, the attainment of which will be monitored using objectively verifiable indicators, which are in accordance with international monitoring and evaluation standards and local priorities. Monitoring and evaluation of the NSF is a shared responsibility of all stakeholders involved in the national response to HIV.

The national level multi-sectorial HIV&AIDS response is managed and coordinated by National ADIS Commission. The overall responsibility for monitoring and evaluating the implementation of the NSP 2015-2020 lies with the NAC.

In 2010, a National Multi-sectoral HIV and AIDS M&E Plan 2010-14 and Operational Plan were developed – a revised version is pending validation. The M&E plan describes how to assess the level of intervention and achievements of the national NSF II targets, while consistently monitoring trends in HIV prevalence, service delivery and HIV related behaviors in the population.

The Ministry of Health and Social Welfare leads the health facility-based components of the M&E. Within health facilities monitoring and data collection is done by staff that deliver clinical based HIV&AIDS services. Monitoring, surveys, surveillance, research and documentation related to community based non-clinical HIV&AIDS interventions are managed by LISGIS. Within the counties, County M&E Focal persons work closely with the LISGIS M&E Officers. Organizations implementing HIV&AIDS interventions have community outreach officers who undertake monitoring and data collection.

National umbrella organizations of civil society and private businesses also monitor and report collectively on the HIV&AIDS work undertaken by their constituency members.
Sector ministries are responsible for coordinating the HIV&AIDS activities within their respective sectors. Within each of these sectors, an M&E focal person manages and coordinates all M&E

activities including for HIV&AIDS interventions. Furthermore, some ministries generate information on indicators in this M&E Plan.

The key responsibility for data collection and reporting to NAC lies with service providers, program implementers and research institutions – including government ministries and institutions, as well as civil society and private sector organizations. The NACP plays an important role by supporting and overseeing programs and services in the health sector. Implementing partners report key M&E data to the NAC M&E Unit –directly or through NACP and/or the Global Fund PCU – in accordance with the reporting guidelines of the National M&E Framework and Plan.

7.2 IMPLEMENTATION OF A COMPREHENSIVE M&E SYSTEM CHALLENGES AND REMEDIAL ACTIONS

Many of the challenges listed in the 2013 GARPR report with regards to the implementation of a comprehensive monitoring and evaluation systems have been addressed to some extend but there are still room for improvement. Non-clinical and community-based interventions data collection and reportage remains a challenge. And even within the clinical or facility-based interventions, the information gap is huge especially in the absence of a bio-medical data or electronic patient database at facility-level.

The following remedial actions are still being taken to strengthening the availability and use of strategic information to guide an evidence-informed national response[5]:

• Establishing a regular second-generation surveillance system, based on population ANC data, and bio-behavioral surveillance of most-at-risk population. The first IBBSS was conducted in 2013 and a Modes of Transmission (MoT) study is pending later this year or 2017 as it stands.

• Knowing "what works" is crucial for a cost-effective national response. This will be through strengthening of programmatic M&E through:

[5] NSP (2015-2020): Priority Issues Emerging from Epidemiological, Situation and Response analysis.

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/ utilization and quality of HIV services;

• Improved coordination of data collection, flows and utilization; by establishing a Joint National HIV Surveillance and M&E System and Plan, based on common M&E standards and tools, clear reporting lines, and easily accessible data;

• 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.

• Mapping of community based systems and tools to strengthen and make functional the community based reporting through the Country Response Information System (CRIS). These efforts will involve all stakeholders and implementing partners at community level.