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Country Progress Report, 2012

Republic of Liberia

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FOREWARD

The Government of Liberia, under the leadership of her Excellency, President Ellen Johnson Sirleaf has achieved tremendous success in the fight against the HIV and AIDS epidemic. The intention of the government is explicitly expressed in the Liberian Poverty Reduction Strategy (PRS) 2008 to 2011 a national development blueprint-where ôPrevention and Management of Nutrition, HIV and AIDS disordersô is one of the key priority areas. The National HIV and AIDS Strategic Framework 11 guide the implementation of the national response. In order to ensure that the HIV and AIDS agenda is implemented as intended, all Public sector institutions continue to mainstream HIV and AIDS as part of agenda.

With the support of our development and cooperating partners, Liberia has been able to scale up its HIV and AIDS prevention, care, treatment and support program to unprecedented levels. Whilst there were 916 patients alive and on treatment in 2006, the number of patients alive and on treatment reached 5,839 as at the end of December 2011 representing 30.6% (5,839/19,111) coverage for HIV positive patients needing ART while 48% HIV positive pregnant women were reached for those needing ARV to prevent mother to child transmission.

Further increases are expected once Liberia begins full implementation of the new WHO guidelines. HIV Prevention programs are also being scaled up as evidenced by the decrease in prevalence among antenatal attendees. Liberia has also been successful in mobilizing grassroots for HIV and AIDS action. This has been facilitated through community based organizations (CBOs) that the government has allowed to implement. This arrangement has gone a long way towards expansion of service coverage, particularly in the areas of HIV prevention and impact mitigation.

I want to reiterate the governmentôs dedication to fulfilling her commitments to national, regional and international protocols and conventions, including the Declaration of Commitment on HIV and AIDS, for which this report is specifically intended.

This reports thus highlights the gains that Liberia has attained in the past two years, as well as areas for which more work will need to be done for us to win the fight against the HIV and AIDS pandemic.

Dr. Ivan F. Camanor
Executive Director

National AIDS Commission
Republic of Liberia

LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral therapy
ARV	Antiretroviral
BCC	Behavioral Change Communication
BPHS	Basic Package for Health Services
CBO	Community-based Organization
CD4	Cluster of Differentiation Four
CHAL	Child Health Association of Liberia
CRIS	Country Response information Systems
CSO	Civil Society Organization
CSS	Community Systems Strengthening
CSW	Commercial sex worker
DBS	Dried Blood Spot
DNA	Deoxyribonucleic Acid
DSW	Department of Social Welfare
DU	Drug users
EID	Early Infant Diagnosis
EPP	Estimation and Projection Package (Spectrum)
FBO	Faith-based Organization
FHI	Family Health International
FSW	Female Sex Workers
GBV	Gender -Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund For AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People affected by AIDS
GTZ	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	Inject able Drug Users
IEC	Information Education Communication
ILO	International Labour Organization
IPV	Intimate Partner Violence
IRC	International Rescue Committee
LDHS	Liberia Demographic Health Survey
LISGIS	Liberia Institute of Statistics and Geo-Information Systems
LIBR	Liberia Institute for Biomedical Research
M&E	Monitoring and Evaluation
MARPs	Most- at- risk Populations
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goal
MIS	Management Information Systems
MoD	Ministry of Defense
MoE	Ministry of Education
MoF	Ministry of Finance
MoG&D	Ministry of Gender and Development
MoHSW	Ministry of Health and Social Welfare
MoL	Ministry of Labour
MoT	Modes of Transmission
MSF	Medicines 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 of Libaria
NACP	National AIDS and STI Control Program

NASA	National AIDS Spending Assessment
NBTS	National Blood Transfusion Services
NCPI	National Commitment and Policy Instrument
NGO	Nongovernment Organization
NHA	National Health Accounts
NSF	National HIV Strategic Framework II 2010-2014
OVC	Orphans and Vulnerable Children
PCR	Polymerase Chain Reaction
PEP	Post- exposure Prophylaxis
PICT	Provider Initiated Counseling and Testing
PIU	Program Implementation Unit
PLHIV	People Living with HIV
PMTCT	Prevention of Mother- to- Child Transmission of HIV
PRS	Poverty Reduction Strategy
PSI	Population Service International
PSM	Procurement and Supply Management
SE	Size Estimate
SGBV	Sexual and Gender- based Violence
SGS	Second Generation Surveillance
SIM	Strategic Information Management
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 Peace Mission in Liberia
UP	Universal Precautions
USAID	United Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

1. Status a Glance

1.1 Report Preparation Process

At the United Nations General Assembly Special Session (UNGASS) on HIV and AIDS held in June 2001, Liberia was one of 189 member states that adopted the Declaration of Commitment on HIV and AIDS, a framework for halting and beginning to reverse the HIV epidemic by 2015. In 2010, Liberia renewed its commitment

by endorsing the 2011 Political Declaration on HIV/AIDS and its new targetsð by 2015 to reduce sexual transmission of HIV and HIV infection among people who inject drugs by half, to increase the number of people on treatment to 15 million, to halve TB-related deaths in people living with HIV, and to eliminate new HIV infections among children. In order to monitor the progress in achieving the concrete, time-bound targets set out in the 2001 Political Declaration on HIV and AIDS, countries make biennial report on progress made towards achieving the 7 targets based on a set of 30 core indicators at the national level. This country AIDS progress report which contains data for Liberia for the period of January 2010 through December 2011 identifies challenges that need to be addressed. It also makes recommendations to ensure targets are achieved. The National AIDS Commission (NAC) was the lead institution for the development of this report. NAC in collaboration with NACP/MOH&SW and UNAIDS engaged all relevant partners from public and civil society sectors, NGOs and UN agencies to gather relevant inputs and views as well as the International development partners.

Part A of the National Commitment and Policy Instrument (NCPI) Questionnaire was completed by NAC staff, the Ministry of Health and Social Welfare (MOH&SW), the National AIDS Control Program (NACP), the National Blood Safety Program (NBSP) and other sectoral ministries as well as UN agencies and NGOs. Under the leadership of NAC and NACP/MOH&SW, an international consultant and two Research Assistants were contracted to collect and compile the data for validation. AIDS expenditure data were collected from all major HIV donors and implementers in the country. The exercise was harmonized with the National Health Accounts (NHA) data at the MOH&SW. Data collection for UNGASS indicators 1 to 6 was carried out by the NAC and the Joint United Nations Program on HIV and AIDS (UNAIDS) in collaboration with major actors in all key area of the national HIV

response in the country and with reference to key national documents such as the LDHS (2007), Program reports (2008-2011) and the new National HIV Strategic Framework II -2010-2014.

Data for Part B of the NCPI Questionnaire were collected by distributing the questionnaire to all of the main NGOs working on HIV and AIDS including Network of People Living with HIV (LIBNEP+), several human rights organizations, the UN agencies and other development partners/donors. Following preparatory consultations with different constituencies, several stakeholders had a consensus meeting in March 2012 to validate the responses to the questionnaire.

1.2 STATUS OF THE EPIDEMIC

HIV prevalence in the general population aged 15-49 in Liberia is 1.5%. HIV prevalence in urban areas is put at 2.5 percent (and 2.9% in Monrovia) and is much higher than in rural areas at 0.8 percent; and HIV prevalence among women (1.8%) is significantly higher than in men (1.2%) [*Source: LDHS (2007)*].

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

While the overall data (LDHS-2007) 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 (1.3% among females and 0.4 % among males of 15-19 years; and 2.0% among females and 0.7% among males of 20-24 years).

Key populations at risk including vulnerable and ómost at riskô populations for HIV infections are young women and girls, sex workers and their clients, men who have sex with men (MSM), injectable drug users (IDUs), prisoners; uniformed personnel, mobile populations (truck drivers), refugees, returnees and IDPs. A size estimate study (MARPS) was conducted in 2011 which provided estimates of these groups.

1.3 POLICY AND PROGRAMMATIC RESPONSE

The NCPI Questionnaire provides information on policy and strategy development and implementation over the past two years. Part A of the questionnaire covers aspects of the policy development and implementation including strategic planning, political support, prevention, treatment, care and support, and monitoring and evaluation (M&E). There was high stakeholder involvement in the development of the NSF II 2010 - 2014 and the strategy is well prioritized. There is budgetary allocation by Government to HIV and AIDS interventions and the National AIDS Commission is engaged in HIV and AIDS response at policy and multi-sectoral coordination level. With regard to prevention, various prevention interventions are being scaled up , including counseling and testing services using multiple strategies beyond the stand alone VCTs, and a PMTCT. There is also a continuing involvement of MARPs in the national response and prevention efforts are targeted towards priority populations. Liberia has a strategy to scale up treatment, care and support for adults and children. There is an increase in the number of people on ART due to efforts in scaling up access to these services.

Part B of the questionnaire covers human rights, civil society involvement, prevention, treatment, care and support. Civil society representatives, UN agencies and developing partners reached consensus regarding responses covered in this section. The overall consensus was an improvement in policies, laws, and regulations in place to promote and protect human rights in relation to HIV and AIDS during this reporting period. Understanding of HIV in relation to human rights issues has improved, with greater integration of human rights into HIV and AIDS response. Also, more organizations are advocating for the rights of PLHIVs, MARPs and other vulnerable groups. Civil society organizations in Liberia are highly involved in planning, advocacy and implementation for HIV and AIDS interventions. Achievements in prevention, treatment, care and support were reported as significant, as well as the level of political support.

1.3.1. LIMITATIONS OF THE REPORT

The last Liberia Demographic and Health Survey (LDHS) with an HIV module took place in 2007. Another LDHS planned for 2012 is ongoing at the time of the writing of this report. Therefore, for the indicators based on population survey, namely indicators 1.1 - 1.6 and 7.2, information were not available. This will be updated as soon as the LDHS 2012 results are released. So far no Integrated Bio- behavioral surveillance survey (IBBSS) had been done in Liberia to inform the indicators on most at risk populations, in particular sex workers, MSM, IDUs. However, there is a plan to conduct IBBSS in phase 2 of the existing Global Fund HIV grant. Nevertheless, a major development in this direction was the size estimate (SE) study done on MARPS in 2011 to estimate the size of this group for future programming. For indicator 3.3, preliminary results from the PMTCT impact study estimate the rate of mother-to-child transmission at 13.7%, and reasons for lost to follow up (LFTU) component of the PMTCT is currently on-going. Modeling through spectrum projections (EPP) is also being considered to obtain more robust estimates for this indicator.

1.3.2. OVERALL RATING IN THE NCPI QUESTIONNAIRE

Stakeholders in Liberia feel that some of the ratings in the NCPI tool are subjective, and this makes it difficult to compare the ratings over the years to assess progress. For instance, when evaluating overall efforts in HIV prevention, the perspective of stakeholders in 2010-2011 was informed by a deeper understanding of the HIV epidemic in Liberia and therefore different than the perspective of the evaluation in 2008-2009.

1.4 OVERVIEW OF UNGASS INDICATOR DATA

Overview of UNGASS Targets and Indicator Data

	2010 Report		2012 Report		Data Sources and Remarks
Targets & Indicator	2008	2009	2010	2011	
Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015					
Indicators for the general population					
1.1 Percentage of young women and men aged 15ï 24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	**Men = 27.2%** 15-19 yr = 20.9% 20-24 yr = 34.2% **Women= 20.5%** 15-19 yr = 18.1% 20-24 yr =22.8%	-	-	-	Liberia Demographic and Health Survey (LDHS 2007)
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	**Men = 8.5 %** 15-19 yr = 8.6 % 20-24 yr = 8.3 % **Women = 17.2 %** 15-19 yr = 18.7% 20-24 yr = 15.8%	-	-	-	Liberia Demographic and Health Survey (LDHS 2007)
1.3 Percentage of adults aged 15ï 49 who have had sexual intercourse with more than one partner in the past 12 months	**Men = 21.4%** 15-19 yr = 15.9 % 20-24 yr = 26.8 % 25-49 yr = 63.3 % **Women : 7.1%** 15-19 yr = 11.6% 20-24 yr = 8.0 % 25-49 yr = 18.2 %	-	-	-	Liberia Demographic and Health Survey (LDHS 2007)
1.4 Percentage of adults aged 15ï 49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their	**Men = 22.3%** 15-19 yr = 28.9 % 20-24 yr = 27.4 % 25-49 yr = 61.7 % **Women = 13.5%**	-	-	-	Liberia Demographic and Health Survey (LDHS 2007)

	2010 Report		2012 Report		Data Sources and Remarks
Targets & Indicator	2008	2009	2010	2011	
last intercourse	15-19 yr = 10.6 % 20-24 yr = 22.1 % 25-49 yr = 27.3 %				
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	**Men= 2.3%** 15-19 yr = 0.4 % 20-24 yr = 2.9 % 25-49 yr = 8.0 % **Women = 1.6 %** 15-19 yr = 1.7 % 20-24 yr = 2.1% 25-49 yr = 4.4%	-	-	-	Liberia Demographic and Health Survey (LDHS 2007)
1.6 Percentage of young people aged 15-24 who are living with HIV	**LDHS** **All = 1.1%** 15-19 yr = 0.9% 20-24yr = 1.4% **Men = 0.5%** 15-19yr = 0.4% 20-24yr = 0.7% **Women = 1.6%** 15-19yr = 1.2% 20-24yr = 2.0% **ANC Sentinel Survey 2008** **All = 3.6%** 15-19yr = 3.2% 20-24yr = 3.9%	-	-	**ANC Sentinel Survey 2011** (Preliminary data) **All = 2.0%** 15-19yr = 1.3 % 20-24yr = 2.7 %	Liberia Demographic and Health Survey (LDHS 2007) ANC Sentinel Survey 2008 ANC Sentinel Survey 2011 (Preliminary data)
Indicators for sex workers					
1.7 Percentage of sex-workers reached with HIV prevention programs	-	-	716 (PSI hype shows) 48 (PSI Peer education session)	155 (PSI hype shows) 424 (PSI Peer education session) A size (SE) estimate study among MARPs done in 2011	PSI M&E program data (2010 & 2011) Ministry of Health and Social Welfare- NACP

	2010 Report		2012 Report		Data Sources and Remarks
Targets & Indicator	2008	2009	2010	2011	
				revealed that there at least 1822 Female sex in Liberia	(2011)
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	-	-	-	-	Indicator data not available
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results	-	-	-	-	Indicator data not available
1.10 Percentage of sex workers who are living with HIV	-	-	-	-	Indicator data not available
Indicators for men who have sex with men					
1.11 Percentage of men who have sex with men reached with HIV prevention programs	-	-	-	A size (SE) estimate study among MARPs done in 2011 revealed that there at least 711 MSMs in Liberia	Ministry of Health and Social Welfare- NACP (2011)
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	-	-	-	-	Indicator data not available
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	-	-	-	-	Indicator data not available
1.14 Percentage of *men who have sex with men* who are living with HIV	-	-	-	-	Indicator data not available
Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015					
Indicators					
2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe	-	-	-	A size (SE) estimate study among MARPs done in 2011 revealed that there at least 621 (58% of drug	Ministry of Health and Social Welfare- NACP (2011)

	2010 Report		2012 Report		Data Sources and Remarks
Targets & Indicator	2008	2009	2010	2011	
programs				users) injectable drug users in Liberia	
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	-	-	-	-	Indicator data not available
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	-	-	-	-	Indicator data not available
2.5 Percentage of people who inject drugs who are living with HIV	-	-	-	-	Indicator data not available
Target 3.Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths					
Indicators					
3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	**All = 18.2%** 420/2,313 **2 or 3 ARV combined = 15.6%** 360/2,313 **ART (HAART) = 2.6%** 60/2,313	**All = 13.1%** 270/2,067 **2 or 3 ARV combined = 11.2%** 231/2,067 **ART (HAART) = 1.9%** 39/2,067	**All = 31.6%** 590/1,866 **2 or 3 ARV combined = 25.9%** 484/1,866 **ART (HAART) = 5.7%** 106/1,866	**All = 48%** 809/1684 **2 or 3 ARV combined =35.4%** 597/1684 **ART (HAART) = 12.6%** 212/1684	Numerator: NACP M&E programe data (2008-2011) Denominator: Liberia Spectrum Projection (EPP) 2011 of mothers needing PMTCT Annual Percentage coverage is non-cumulative

	2010 Report		2012 Report		Data Sources and Remarks
Targets & Indicator	2008	2009	2010	2011	
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	**10.1%** 234/2313	**11.7%** 242/2067	**15.2%** 283/1866	**20.5%** 346/1684	Numerator: NACP M&E EID programe data (2008-2011) Denominator:Liberia Spectrum Projection (EPP) 2011 of mothers needing PMTCT
3.3 Mother-to-child transmission of HIV (modelled)	-	-	-	* (preliminary data from PMTCT Impact Study done by NACP- 13.7%	* 19 facilities covered in study covering ANC facilities with mother peer attendees of 200 per site.
Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015					
Indicators					
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	**Total Coverage = 13.6%** Adult Men & Women (15yr+) = 1,829 Adult Men = Adult Women= Coverage 1,829/11,038 = 16.6% Children (<15yr)	**Total Coverage= 20.5%** Adult Men & Women (15yr+) = 2,704 Adult Men = Adult Women= Coverage 2,704/10,832 = 25% Children(<15yr) = 266 Male Children=	**Total Coverage = 22.2%** Adult Men & Women(15yr+) = 4,098 Adult Men = Adult Women= Coverage 4,098/15,443= 26.5% Children (<15yr) = 314	**Total Coverage = 30.6%** Adult Men & Women(15yr+) = 5,269 Adult Men = Adult Women= Coverage 5,269/14,961= 35.2% Children(<15yr) = 570 Male Children= Female Children=	Numerator:NACP M&E programe data (2008-2011) Denominator:Liberia Spectrum Projection (EPP) 2011 of adults and children needing ART * Adult and children coverage data be disaggregated by sex

	2010 Report		2012 Report		Data Sources and Remarks
Targets & Indicator	2008	2009	2010	2011	
	= 188 Male Children= Female Children= Coverage 188/3,785 = 5.0 % **Total on ARVs 2,017** **Total in need of ARVs 14,823**	Female Children= Coverage 266/3,660 = 7.3% **Total on ARV 2,970** **Total in need of ARVs 14,492**	Male Children= Female Children= Coverage 314/4,423 = 7.1% **Total on ARV 4,412** **Total in need of ARVs 19,866**	Coverage 570/4,150 = 13.7% **Total on ARV 5,839** **Total in need of ARVs 19,111**	* Children data to be disaggregated by age: <1yr 1-4 yr 5-14yr
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) of PLHIV who initiated ART in Period Nov 2008- Nov 2009 Male = 57% (162/286) Female = 63% (398 /613) Adults (15+yr) = 62% (513/823) Children (<15yr)= 62% (47/76) Lost = 243 Stopped = 4 Died = 81	-	MoHSW (2010): Cohort study of Patients enrolled in HIV treatment and Care in Liberia
Target 5.Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015					
Indicators					
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Numerator 401 *Denominator * Disaggregate by	Numerator 549 Denominator	Numerator 962 Denominator = 283 (8% of TB patients	Numerator 1386 Denominator	Numerator: NACP M&E program data (2008-2011) Denominator:(estimated number of incident TB all types in HIV+): WHO,

	2010 Report		2012 Report		Data Sources and Remarks
Targets & Indicator	2008	2009	2010	2011	
	sex and age (<15yrs, 15+yrs)		were HIV positive in 2010)		www.who.int/tb/country/en
Target 6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries					
Indicators					
6.1 Domestic and international AIDS spending by categories and financing sources					NASA (and NHA)
Target 7.Critical enablers and synergies with development sectors					
Indicators					
7.1 National Commitments and Policy Instruments (NCPI) (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programs, stigma and discrimination and monitoring and evaluation)			See annex on 2012 report	See annex on 2012 report	Rapid Assessment and Participatory consensus meetings
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	**Physical violence in past 12 months** **All = 28.8%** 15-19 yr = 23.2 % 20-24 yr = 29.9% 25-49 yr = 90.8 % **Ever experienced sexual violence** **All = 17.6%** 15-19 yr = 13.1 % 20-24 yr = 13.0%	Gender ministry	Gender ministry	Gender ministry	Liberia Demographic and Health Survey (LDHS 2007)

	2010 Report		2012 Report		Data Sources and Remarks
Targets & Indicator	2008	2009	2010	2011	
	25-49 yr = 60.1%				
7.3 Current school attendance among orphans and non - orphans aged 10ï 14*	MoE/UNICEF	MoE/UNICEF	MoE/UNICEF	**Total orphans in school= 4274** Boys = 2284 Girls = 4274	MoHSW - Social Welfare department)
7.4 Proportion of the poorest households who received external economic support in the past 3 months	Social welfare/ Gender	Social welfare/ Gender	Social welfare/ Gender	Social welfare/ Gender	

2. Over view of the AIDS Epidemic

2.1 CONTEXT

Map 1:

Liberia is Africaôs 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 boarders with Guinea in the north, Cote Dôlvoire in North East, Sierra Leone in West, and the Atlantic Ocean in the south. The Country is divided into 15 counties, with a 2007 census count of 3.5 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 total country population. The population is relatively young, with 29.5% of the entire population aged 5-14 years, while the proportion

[1] Population and Housing Census 2008, LISGIS

of population aged 15-49 years is about 36%. Life expectancy at birth is 45 years and fertility rate 5.2 children per woman and one of the highest in sub-Saharan Africa.
The Government is focused on increasing production and reducing poverty while creating an environment of good governance.

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 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 basic 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.

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 prenatal transmission; although blood transfusion, medical transmission and use of dirty needles still occurs. Many factors fuel the spread of the epidemic. These include, the widespread norm of multiple and concurrent sexual relationships; womenôs low socio-economic status; increasing levels of poverty leading to commercial sex work; lack of open discussion about sexuality; high incidence of sexually transmitted infections (STIs); cultural and religious believes, and stigma and discrimination, among others.

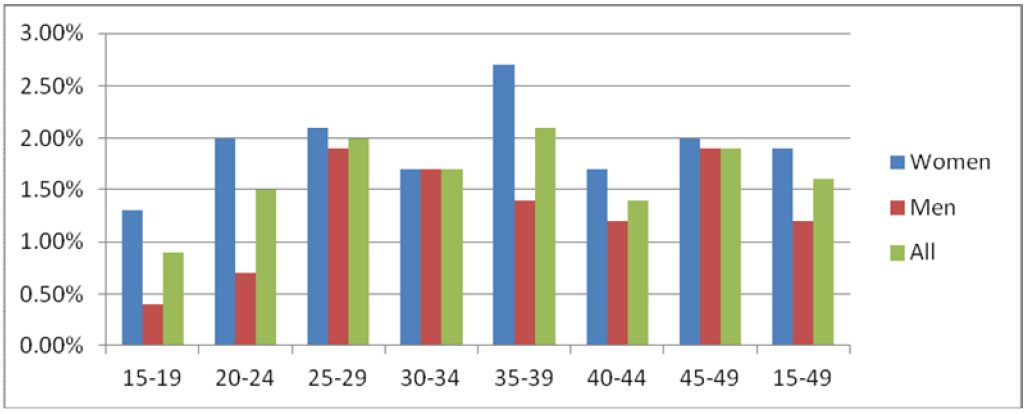
HIV and AIDS epidemic is a social problem, as much as a medical one. The fault lines are wide open channels creating a superhighway for the spread of HIV and AIDS. Partner reduction and consistent and correct use of condoms creates cracks in this highway to slow down or even reverse the rate of transmission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

2.2 HIV PREVALENCE IN THE GENERAL POPULATION

The 2007 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 1.5 percent (1.3% HIV-1; 0.2% HIV-2) in the general population aged 15-49, indicating a low-level generalized epidemic. Overall, the HIV prevalence in women is higher (1.8%) than in

men (1.2%), revealing womenôs 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 three times higher than in men in the 15-24 year age group (see Figure1).

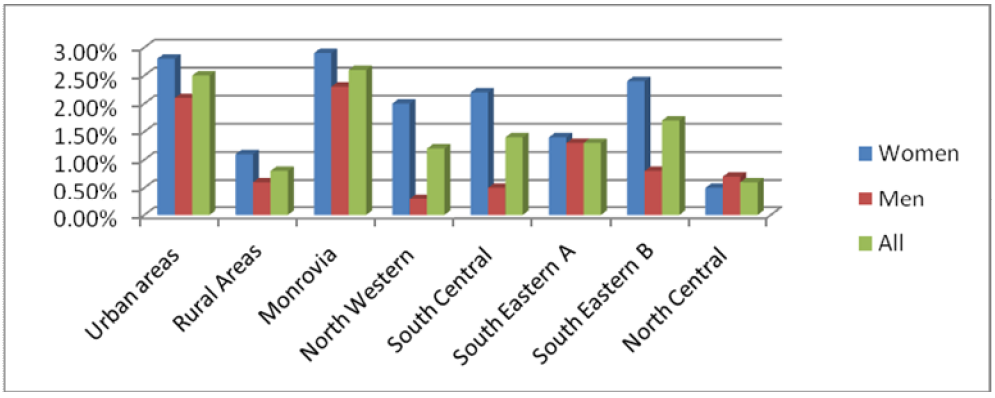
Figure 1: HIV Prevalence by Age and Sex



Source: LDHS (2007)

Furthermore, LDHS-2007 reveals significant difference between urban and rural settings, with overall HIV prevalence in urban areas at 2.5 percent (and 2.9% in Monrovia) against only 0.8 percent in rural areas. It further shows higher HIV prevalence in the eastern and western border regions, which may be associated with trans-border mobility. Thus, the overall HIV prevalence of 1.5 percent masks the fact that HIV is *well established* among the general population in urban settings, with an average prevalence of 2.5 percent (Figure 2).

Figure 2: HIV prevalence by urban, rural and regions



Source: LDHS (2007)

HIV prevalence data are also sourced from sentinel surveillance of pregnant women attending antenatal clinics (ANC). HIV prevalence among pregnant women declined from

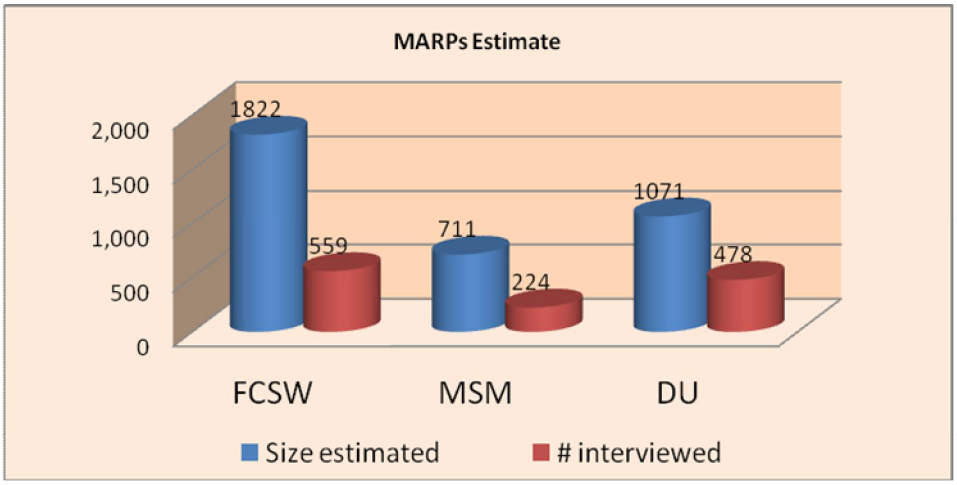
5.7% in 2006 to 5.4% in 2007 and then to 4.0% in 2008 respectively. Preliminary data from the 2011 ANC survey shows a further decline in prevalence to 2.6%.

2.3 HIV AMONG MOST-AT-RISK POPULATIONS

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), uniformed personnel, infants born to HIV infected mothers, HIV sero-discordant couples and PLHIV.

The real extent of the HIV epidemic is blurred by the lack of any HIV-prevalence data on most-at-risk populations. However, evidence suggests that large portions of the population are at risk of contracting HIV due to high-risk behavior. A size estimate study was done in 2011 among sections of MARPs in Liberia to estimate the number of female sex workers (FSW), men who have sex with men and drug and substance users located in various hot spots in the country (Figure 3). An Integrated Bio- behavioral Surveillance Survey (IBBSS) is planned to be carried out in phase 2 of the existing Global Fund HIV grant to inform the next country AIDS progress report.

Figure 3: Size Estimate of Selected MARPs



Source: Size Estimation study among MARPS (2011)

SEX WORKERS (INDICATORS 1.7, 1.8, 1.9 AND 1.10)

The HIV risk perception survey conducted in 2008 in four counties indicates that 33% of respondents received money or were given gifts for sex (40.9% of females and 27.5% of

males) while the use of preventive measures such as condoms was not generally practiced (LISGIS 2008).

A size estimate study done in 2011 among MARPs in Liberia estimated the number of female sex workers at 1,822 persons. Key results demonstrating high risk to HIV included:

- Majority 84% of FSWs are adolescents and young women aged below 30 years. 4% are adolescents aged 13-15 years.
- 10% of FSWs had sex with another woman; 6.8% in the past 12 months and 3.2% beyond the 12 months. The risk of exposure to HIV through lesbianism needs to be explored
- 52% of FSW had used at least one drug and 21% had used a hard drug in the past 12 months.

MEN WHO HAVE SEX WITH MEN (MSM) (INDICATORS 1.11, 1.12, 1.13 AND 1.14)

A Size estimate study done in 2011 among MARPs in Liberia estimated the least number of men who have sex with men (MSM) at 711 persons. Key results demonstrating high risk to HIV included:

- 78% MSMs are adolescents and young men aged below 30 years, including 20% who are between 16 and 20 years old.
- 81% MSM reported having had paid sex (FSW) with another man during the last 12 months. Thus, MSM practice very much ñtransactionalò sex.
- 78% of MSM reported sexual practices with women. 59% said they sometimes have sex with women and for 19%, this was a regular practice. Therefore, 78% of MSM have sex with both men and women.
- 83% of MSM had used at least one drug and 21% had used a hard drug in the past 12 months

DRUG USERS AND INJECTING DRUG USERS (IDUS) (INDICATORS 2.1, 2.2, 2.3, 2.4 AND 2.5)

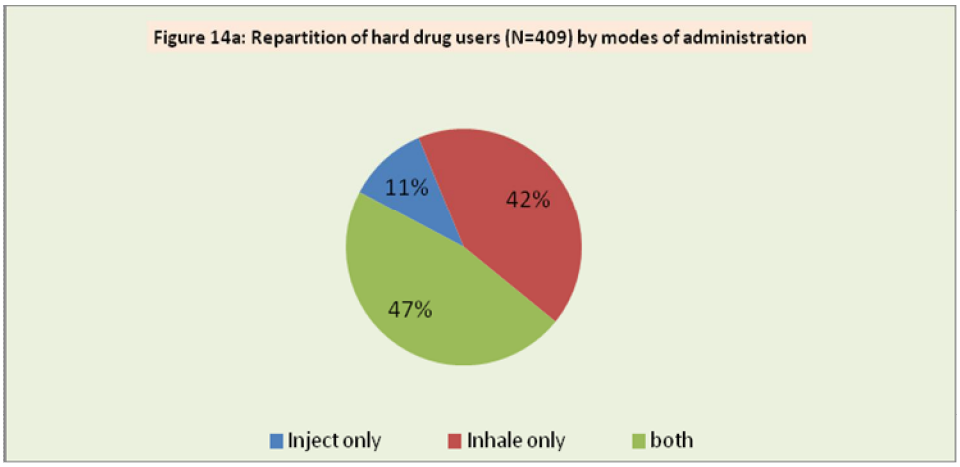
A Size estimate study done in 2011 among MARPs in Liberia estimated the least number of drug users (DU) at 1,071 persons (and including FSW and MSM who use drugs this number reaches 2,303 persons) . Key results demonstrating high risk to HIV included:

- 61% DUs are adolescents and young people aged below 30 years.

- 34.2% of those who used substances reported the use of hard drug during the past 12 months
- Overall, 58% (457) of hard drug users are injecting drug users. 11% of hard drug users only inject the drug, 42% only inhale while 48% both inject and inhale drugs.
- Many drug users regularly engage in other HIV high risk behaviors including high risk transactional sex , gay, bisexual and heterosexual sex
- Significantly more CSWs only inject (36%) as compared to MSM (4%) and initially sole drug users (2%).

Figure 4 illustrates the modes of drug administration among in MARPs in Liberia.

Figure 4: Mode of Drug Administration



Source: Size Estimation study among MARPS (2011)

YOUNG WOMEN AND GIRLS

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

CLIENTS OF SEX WORKERS

Clients of sex workers are the most important core and bridging populations in the HIV epidemics in West Africa (World Bank, 2008). Data from LHDS (2007) among men aged 15-49 years revealed that 2.5% had paid for sex intercourse within past 12 months. In this sub-population only 47.6% reported use of condom in their last paid act of sex which underscores the degree of high risk behaviour among clients. In Liberia the clients come from all professions and all walks of life especially mobile men who include truck and long-distance bus drivers, soldiers and UN peacekeepers, businessmen, small miners and others. In addition to buying sex from commercial sex workers, these men may also have high risk sex with non-commercial female partners, forming a ñbridge populationò between sex workers and the wider population.

MEN IN PRISON

A special group that is often at high risk of HIV/STIs are men in incarceration. As a result of long-term confinement to small spaces with other men and without women, unprotected sex among male prison inmates ï including high-risk anal sex, and voluntary or forced sex, including rape ï is common in most countries of the world, including West Africa. In addition, after their release from prison, former prisoners who have been engaged in unsafe sex with other men may further transmit HIV to their wives and other female sexual partners.

HIV SERO-DISCORDANT COUPLES

In Liberia 1.9% of heterosexual couples are HIV sero-discordant (LHDS 2007), putting the HIV-negative partner in these discordant couples 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. Among 0.7 percent of cohabiting couples, the man is infected and the woman uninfected, while in 1.2 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-infected mothers will be infected by the mother, either intrauterine, during delivery, or through breastfeeding. An estimated 1,866 and 1,684 infants were exposed to HIV in 2010 and 2011 respectively (2011, EPP-spectrum projections) through mother to child transmission. 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 deliveries, which makes it difficult to access and utilize PMTCT services to those in need.

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 35,835 and 33,671 adults and children were living with HIV in 2010 and 2011 respectively (2011, EPP-spectrum projections). 15,443 and 14,961 adult PLHIV were in need of ART in 2010 and 2011 respectively; while 4,423 and 4,150 children were in need of ART in 2010 and 2011 respectively. 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 PLHIVôs access to these services. In addition to access to these services, PLHIV play a key role in preventing the further spread of HIV through ñpositive preventionò.

2.4 SEXUAL AND GENDER- BASED VIOLENCE (SGBV) AND RISK TO HIV (INDICATOR 7.2)

The 2007 LDHS study shows that 45 percent of women ever experienced physical violence since they were 15 years old, while 29 percent had faced violence in the last 12 months. The main perpetrators were current or former husbands/partners: 35 percent of women had experienced spousal violence in the last 12 months. Almost one-fifth of women aged 15-49 had ever experienced sexual violence (LISGIS, 2008). Similarly, a study in 2007 among 600 women and girls in Eastern Nimba and Central Montserrado counties conducted by the International Rescue Committee (IRC) and Columbia Universityôs Program on Forced Migration and Health reveals 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 percent in

both counties reported that their husbands had forced them to have sex in the last 18 months. Furthermore, the study revealed that more than one in 10 girls under the age of 17 had been sexually abused in the previous 18 months in both counties.

The Lofa County Reproductive Health Survey (Tomczyk et al, 2007) found similarly high lifetime prevalence of intimate partner violence (IPV), with almost two-thirds (61.5%) reporting that they had been subjected to IPV. Of those responding, approximately 61% had experienced physical violence and one third sexual violence. Where as 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 womenôs physical and psychological health risks particularly to HIV and other STIs.

3. National Response to the AIDS Epidemic

3.1 NATIONAL COMMITMENT

National AIDS Spending Assessment (NASA) is a comprehensive and systematic resource tracking method used to measure the flow of resources in the national response to HIV and AIDS as well as the National Health Account (NHA). However, Liberia is on the footpath of developing the NASA and NHA. The full realization of these processes will be fully attained during the implementation of the 2nd phase of the round 8 GFATM program in Liberia, which hopes to start in the second quarter of 2012.

Therefore we employed a methodology to secure information. The process entails reaching out to AIDS spending institutions where the funding sourcing questionnaires were supplied to attract accurate data. The categories listed below indicate the sources we reach out to in order to source the information supplied in the funding sourcing matrix.

- Who finances the AIDS response?
- Who manages the funds?
- Who provides the goods and services?
- Which intervention was provided?
- Who benefits from the funds?
- What was brought to realize the intervention?

To this end, the funds are tracked from the financing source ï public, private or foreign ï through the different providers to the ultimate beneficiaries (target groups). The data collection process captures both health and non-health spending related to HIV and AIDS. In order to measure the actual spending, to avoid double counting of the transactions, we categorize between funders and implementing partners. The entry process was basically calculated from the Aids funding institutions.

3.1.1. SOURCES OF DATA AND DATA COLLECTION

A questionnaire was designed with the following components: origin of funds, destinations of funds and use of funds against AIDS spending categories and beneficiary population. Survey respondents were actors involved in the response to HIV in Liberia. They were categorized according to the NAC, Bilateral, United Nation Agencies, Social Security, Global Fund, Not-for-Profit Institutions, Multilateral, and Corporation etc. The survey was administered to all financing sources: Government of Liberia that channels funds through the Ministry of Finance and Economic Planning, donors, UN agencies, bilateral agencies, the GFATM, the African Development Bank (ADB). Other public institutions that were administered the questionnaire (as financing agents) include line ministries (Ministry of Health, Ministry of Education, Ministry of Internal Affairs, Ministry of Youths and Sports, Ministry of Labor, Ministry of Gender and Development and the Ministry of Agriculture) and public institutions (National AIDS Commission, National AIDS Control Program). Additional financing agents in the survey were non-governmental organizations, faith based organizations and community based organizations. Expenditure data from hospitals and health centers was captured at financing agent level (what the hospitals and health centers reported back at financing agent level as amount spent). A detailed list is available on the full report. A questionnaire in three parts was administrated to financing sources and financing agents. The response rate was as follows: 23 out of 30 financing sources and agents partners.

3.2 DIFFERING FINANCIAL YEARS

Some organizations use differing financial calendars than the government (January to December for 2010 and 2011). In these cases, we took expenditures incurred in the calendar period corresponding to the government fiscal year.

The private sector, corporations and out-of-pocket expenditures

The survey did not collect data from the private sector and corporations and out-of-pocket/households, therefore, the survey results underestimate the total expenditures for 2010 and 2011

FINDINGS AND INTERPRETATION

SOURCES OF FUNDING FOR 2010 AND 2011

The financing of the HIV and AIDS response in Liberia is mainly through international partners and the government. International partners are the Global Fund, bilateral agencies, UN agencies, and other donors.

AIDS SPENDING CATEGORIES IN 2010 AND 2011

This section presents a breakdown with respect to AIDS spending categories in 2010 and 2011 and the relative weight of each

Breakdown by AIDS Spending Categories in Liberia for the period 2010-2011

Spending Categories	2010	2011	% variation from 2010 2011
Prevention Programs			
Care and Treatment Component			
Program Management and Administration Strengthening			
Incentives for Human Resource Management			
Orphans and vulnerable children			
HIV and AIDS related research			
Voluntary counseling and testing (VCT)			

3.2.1. POLICY AND STRATEGY IMPLEMENTATION

Liberia recently developed a couple of major policy and strategy documents. These include the Basic Package of Health Services ï meant to increase access to health, and more recently, the Essential Package of Health Services as part of the 10 year health plan. Additionally, as part of the Poverty Reduction Strategy (PRS), a cross cutting thematic component was devoted to mainstreaming HIV and AIDS in overrall development strategy. As part of this process, a National HIV and AIDS Workplace policy was developed, adopted and is being implemented by the Ministry of Labor and its tripartite partners. And finally, a National Strategic Framework 11, 2010 ï 2015 is being implemented under a multi-sectorl platform.

3.3 PROGRAM IMPLEMENTATION

3.3.1. PREVENTION

3.3.2. KNOWLEDGE AND BEHAVIOUR CHANGE (INDICATORS 1.1, 1.2, 1.3)

Since the advent of HIV and AIDS in Liberia, the primary emphasis has been on preventing the spread of the HIV epidemic. The multi-pronged approach towards prevention 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.

As per LDHS (2007), 18.1% of girls aged 15-19 and 22.8% of girls aged 20-24 correctly identified ways of preventing the sexual transmission of HIV and rejected major misconceptions about HIV transmission, as did 20.9% of boys aged 15-19 and 34.2% of boys aged 20-24.

One of the HIV prevention strategies with young people is delaying age of sexual debut. LDHS (2007) showed that 17.2% of girls aged 15-24 and 8.5% of boys in the same age range had had sexual intercourse before the age of 15.

An additional prevention strategy in Liberia is the reduction in the number of sexual partners, in particular concurrent partners. LDHS 2007 showed that 7.1 % of women and 21.4% of men aged 15-49 years had sex with more than one partner in the last twelve months; while 52.2% of men and 33.3% of women aged 15-49 years had engaged in higher risk sex in the past 12 months. 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 2007.

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

Throughout 2010 and 2011 efforts were made to increase public awareness regarding 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 PLHIV,

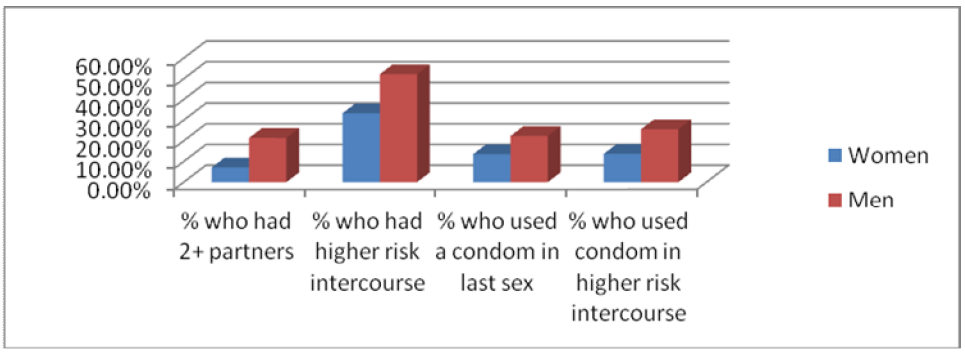
Community-Based Organizations (CBOs), and Faith-Based Organizations (FBOs) actively participated in efforts to raise public awareness about HIV and AIDS.

Over 22,000 radio messages on HIV and AIDS awareness was aired nationwide in 2010 and 2011. An additional 5,700 jingles were aired on local radio stations as well each year. There were also some entertaining for formative radio talk shows and forum during 2010-2011. Over 20 forums were hosted on local radio stations each year. Mobile phone SMS is another strategy being used for HIV information dissemination. Through Lonestar communication network; - Liberiaôs most popular mobile phone company, the Program send out 60,000 SMS on HIV testing each year. These messages were developed in collaboration with partners

3.3.3. CONDOM PROMOTION AND DISTRIBUTION (INDICATOR 1.4)

Data from the LDHS (2007) show low levels of condom among the general population. Among women who had more than one sex partner in 12 months before the survey, only 13.5% said they used condom during the most recent sexual intercourse, far lower than the 22.3% reported by men. Among women who reported having had higher-risk intercourse in the past 12 months, only 14% used a condom at the last higher-risk sex and 26% of the men (Figure 5).

Figure 5: Higher risk sex among women and men



Source: LDHS 2007

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, ôStar,ô 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 11,805,597 pieces of male and 1,140 pieces of female condoms were distributed during 2010 and 2011. 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.

Distribution/sales of condoms in 2010 and 2011 [*Source: NACP quantification data 2011]*

SECTORS		2010	2011
NACP(Free Condoms)	Male Condoms	3,534,767	8,270,830
	Female Condoms	1,140	
Total			

3.3.4. HIV TESTING AND COUNSELING IN THE GENERAL POPULATION (INDICATOR 1.5)

Among women of ages 15 - 49 surveyed in LDHS 2007, 1.6% had been tested in the past 12 months and received their results. Among men of ages 15 - 49 surveyed, 2.3% 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, 2007*]. Among youth respondents, only 1.9 % of girls and 1.6% of boys aged 15- 24 years had been tested for HIV and received the result.

NACP developed national guidelines on HCT in 2006 aimed at standardizing testing protocols and the training of counselors. These tools are important for linking and diagnosis of clients for appropriate care and treatment. Liberia has adopted a multi-pronged approach to provision of 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 during the period under reporting from 98 sites to a total of 216 sites in all 15 counties.

The number of sites providing VCT increased considerably in the years. In 2009, there were only 98 sites offering VCT. By end of 2011, a total of 216 VCT sites were functioning. The number of tests conducted at VCT sites is also on the rise. During 2009 the number tested was 63,674; during 2010 the number was 133,264 while in 2011 the number was 79,934 showing a steady rise in number of people tested. The number of tests performed in VCT sites and for which a result was given was over 98 % of all tests. Table 1 shows the HVT testing during per country in 2010 and 2011 this reporting period.

Table 1: HIV counseling and testing result per county

	2010				2011			
County	Pretest	Tested	Post-test	Tested HIV Positive	Pre-test	Tested	Post-test	Tested HIV Positive
Bomi	1,126	1,121	1,114	72	1,516	1,517	1,376	79
Bong	8,692	6,901	6,874	171	6,081	6,015	6,013	203
Gbarpolu	141	141	141	6	198	198	198	4
Grand Bassa	15,631	13,755	13,697	475	9,045	6,640	6,487	160
Grand Cape Mount	1,478	1,428	1,417	80	1,727	1,640	1,640	79
Grand Gedeh	6,566	3,864	3,809	291	3,565	2,137	2,058	139
Grand Kru	186	185	185	9	641	493	490	13
Lofa	4,569	4,568	4,537	263	7,551	7,169	7,066	187
Margibi	9,382	8,544	7,702	301	5,211	4,985	4,809	190
Maryland	3,157	2,700	2,693	198	1,680	1,680	1,682	152
Montserrado	70,404	61,631	61,129	4,797	32,603	29,959	29,498	2,233
Nimba	37,833	24,102	23,747	1,076	15,472	13,194	13,166	462
River Gee	1,654	1,656	1,654	133	1,957	1,980	1,957	161
RiverCess	875	758	752	36	941	872	852	46
Sinoe	2,107	1,910	1,858	83	1,806	1,455	1,433	75
Grand Total	**163,801**	**133,264**	**131,309**	**7,991**	**89,994**	**79,934**	**78,725**	**4,183**

Source: NACP Annual report 2010 & 2011; * in 2010 there was a big HCT outreach lasting one week to commemorate the World AIDS day. This led to high numbers tested in 2010.

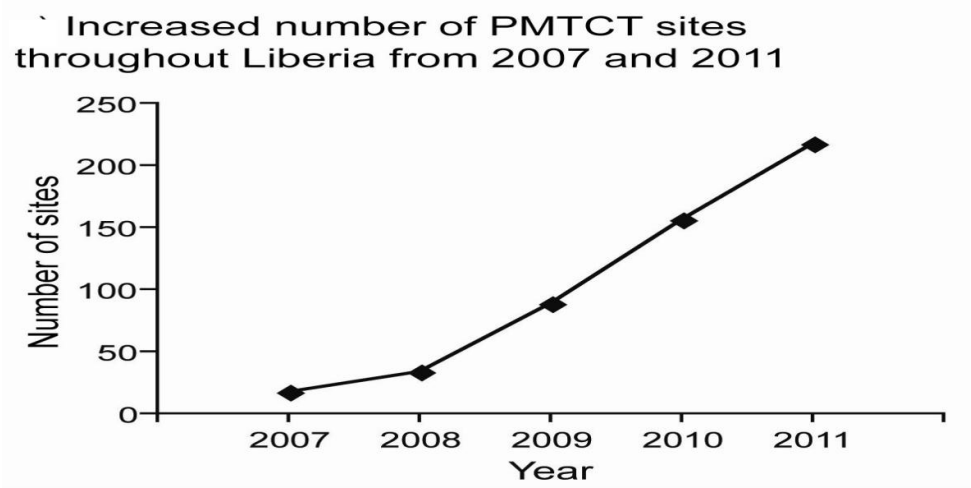
3.3.5. PREVENTION OF MOTHER-TO-CHILD TRANSMISSION (INDICATOR 3.1 AND 3.2)

The NACP is steadily increasing its PMTCT coverage to create access to every pregnant woman accessing antenatal services in Liberia. Liberia revised the national PMTCT guidelines in accordance to the 2010 WHO recommendations and adopted Option A which includes providing HIV positive women with ARVs from 14 weeks of pregnancy, during labor and breastfeeding including ARV prophylaxis for the exposed infant[2]. The revised guidelines are currently being roll out to existing and new facilities providing PMTCT services. 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.

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

The number of health facilities offering PMTCT increased from 55 in 2009 to 156 and 230 sites in 2010 and 2011 respectively (Figure 6). At present there is at least one PMTCT site in every county in Liberia representing an increase of 47 % in coverage.

Figure 6: Number of PMTCT sites.



Source: NACP Program data (2011)

Although few of pregnant women get the four WHO recommended ANC visits, nearly all women come at least for one antenatal care visit, which has been 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 counselling with informed consent was initiated is currently included in national PMTCT guidelines. Rapid HIV testing with same-day return of results is also currently provided. The number of pregnant women tested for HIV reached é 20,640 in 2010 and 2011 respectively. Nearly all women tested received their results in 2011.

Table 2: HIV Pregnant women who received ARVs for PMTCT (Jan 2010- Sept 2011)

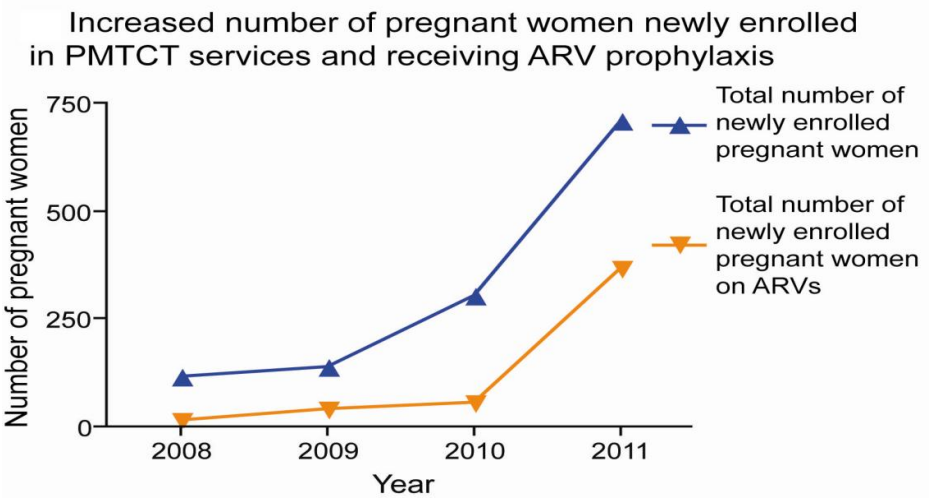
County	2010			2011			
	Women who received ARVs to	Live birth to HIV positive women	Children received ARVs	Women who received ARVs/ART		Live birth to HIV positive women	Children received ARVs
				2 or 3 ARV	ART		

	reduce the risk of MTCT			combined			
Bomi	5	9	9	6	0	1	0
Bong	47	36	19	21	0	15	9
Gbarpolu	0	12	1	1	0	2	2
Grand Bassa	33	19	14	5	10	14	8
Grand Cape Mount	4	4	1	1	0	25	4
Grand Gedeh	35	19	15	16	14	16	14
Grand Kru	1	1	0	0	0	0	0
Lofa	3	6	2	63	6	25	18
Margibi	19	11	4	2	2	4	1
Maryland	2	3	0	25	6	16	17
Montserrado	242	234	191	142	211	137	101
Nimba	64	63	27	33	8	90	16
River Gee	12	9	7	28	4	52	16
RiverCess	7	3	4	1	3	4	4
Sinoe	10	8	8	1	5	4	1
Grand Total	**484**	**437**	**302**	**345**	**269**	**405**	**211**

Source: NACP Annual reports 2010 and 2011

During 2010, 590 HIV-positive pregnant women received ARVs to reduce the risk of mother-to-child transmission (MTCT), and this number increased 809 in 2011. According to EPP/Spectrum estimates, there were about 1866 and 1684 HIV-positive pregnant women in need of ARVs for PMTCT in 2010 and 2011 respectively, revealing an estimated increase in coverage from 31.6% to 48% towards the target of 85% coverage for 2014 (NSP 2010-14). Most importantly, 106 and 212 pregnant women who were eligible for HAART treatment were initiated during pregnancy in 2010 and 2011 respectively. However, many of PMTCT sites are not yet equipped to initiate HAART. Figure 7 illustrates these increases in trends of PMTCT utilization.

Figure 7: PMTCT Access and Utilization among HIV pregnant women



Source: NACP Program data (2011)

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 being used by the program to reduce new HIV infections among children. Children exposed to HIV are offered EID using DNA PCR (DBS) using a reference laboratory in South Africa. According to EPP/Spectrum estimates, the proportion of HIV exposed infants accessing EID has progressively increased from 10.1% (234/2313) in 2008; 11.7% (242/2067) in 2009; 15.2% (283/1866) in 2010 to 20.5% (346/1684) in 2011.

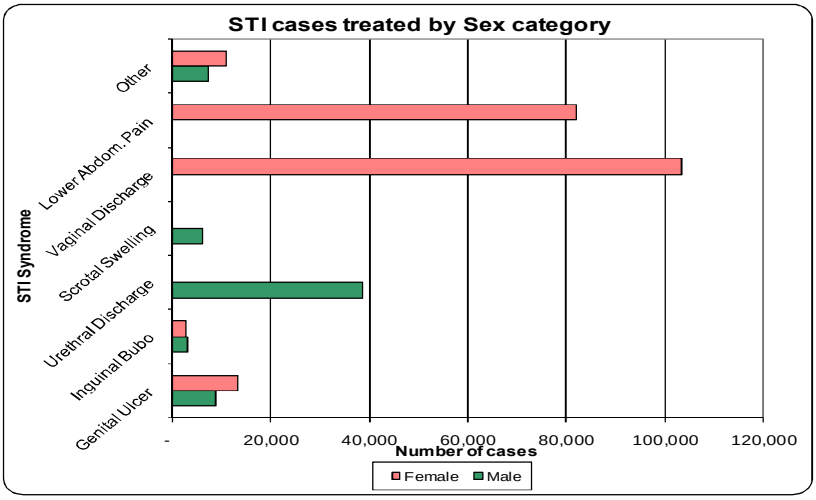
3.3.6. MANAGEMENT OF SEXUALLY TRANSMITTED INFECTIONS

Sexually transmitted Infections (STIs) are major public health problem in Liberia. The HIV pandemic has focused a greater attention on the prevention and control of STI. There is a strong correlation between the spread of conventional STI and HIV transmission. Both ulcerative and non-ulcerative STI have been found to increase the risk of sexual transmission of HIV. The advent of HIV and AIDS makes STI 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 and realistic approach to STI prevention and control by developing the 2nd edition guidelines (syndromic and etiologic management) in August 2009. The guidelines, which also focused on BCC strategies as well as effective and prompt STI case management were distributed to all health workers receiving the STI syndromic management training.

In 2010, based on the WHO syndromic approach, 276,011 cases of STI were reported (an increase from 244,348 cases of STI were diagnosed and treated in 2009). Figure 8 below shows the occurrence and distribution of STI treated in 2010.

Figure: 8 STI Syndromes by Sex Category (n = 276011)



Source: NACP Annual report 2010

3.3.7. PREVENTION AMONG MOST-AT- RISK POPULATIONS (CSW, MSM, IDUS) (INDICATORS 1.7-2.5)

Information available on behaviours for most-at-risk populations (MARPs) in Liberia is still limited. A size estimate study was done among MARPs in Liberia in 2012 and estimated the numbers of selected MARPs sub-populations operating from various hotspots in Liberia. An IBBSS to include MARPs sub-populations is planned in Phase 2 of the GFATM Round 8 HIV grant.

Population services International (PSI) has been conducting prevention programs among young people aged since 2009 and particularly focusing on CSWs. Program Activities include outreach visits made at night in hot spots and hype-shows in which they conduct HIV awareness sessions, social marketing and distribution of free condoms. A total of 764 and 579 CSW were reached in 2010 and 2011 respectively through these activities.

3.3.8. PREVENTION AMONG VICTIMS OF SEXUAL AND GENDER-BASED VIOLENCE (Indicator 7.2)

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 person to another. The

National treatment protocols[3] 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 rape prophylactic kits for STI, and PEP for accidental occupational and sexual exposure to major health centers and hospitals. 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 the legal system to deal more efficiently and expeditiously with violence; establish systems and outreach services for survivors; and ensure that women and girls have access to economic and social empowerment programs.

3.3.9. MALE CIRCUMCISION

Male circumcision has been shown to be associated with lower transmission of STIs including HIV (WHO and UNAIDS, 2007). Male Circumcision is widely practiced in Liberia and often serves as a rite of passage to adulthood. The LDHS (2007) showed that male circumcision is indeed widespread in Liberia, with almost all men being circumcised (98%). This is true for all ages, residence status and by level of educational achievement.

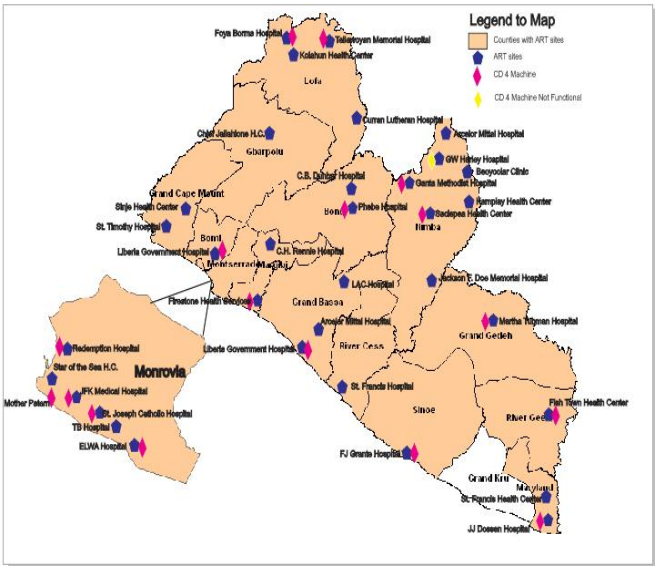
3.4 TREATMENT, CARE AND SUPPORT

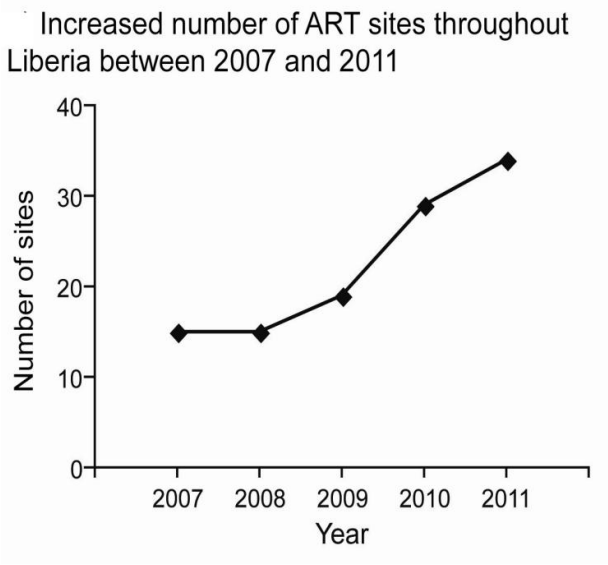
3.4.1. HIV TREATMENT: ANTIRETROVIRAL THERAPY (INDICATORS 4.1 AND 4.2)

The number of health facilities offering antiretroviral therapy (ART) in Liberia has increased substantially from 22 in 2009 to 29 in 2010 and 39 in 2011. Figure 9 below shows the distribution and scaling-up of ART sites in Liberia. Efforts have been made to ensure access to ART in all districts.

Figure 9: Distribution and trends of ART and CD4 sites by 2011

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

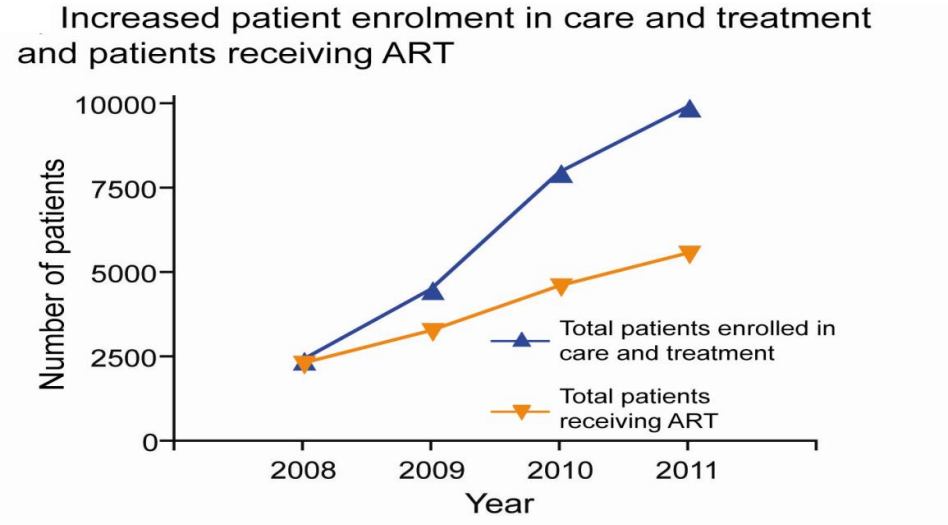




Source: NACP Program data and Annual Report 2011

ART coverage has also increased steadily. According to NACP data and EPP/Spectrum estimates, in 2008 there were only 2,017 (13.6%) PLHIV on ART; in 2009 there were 2,970 (20.5%) PLHIV on ART; in 2010 there 4,412 (22.2%) and in 2011 the number of PLHIV on ART rose to 5,839 (30.6%). In 2011, 69% of patients were women. Figure 10 below shows the number adults and children receiving ART between 2010 and 2011.

Figure 10: Number of PHIV on ART by December 2011



Source: NACP Program data (2011)

The number of children on treatment reached 570 by December 2011, a coverage of 13.7% according to EPP/Spectrum estimates. Measures have been put in place to scale up paediatric care and treatment, such as decentralization of sites in all counties, training of providers (using trainings of trainers) and quality improvement through better supervision and

mentorship. Overall, among all PLHIV on ART in Liberia 8% are children as shown in table 3 below.

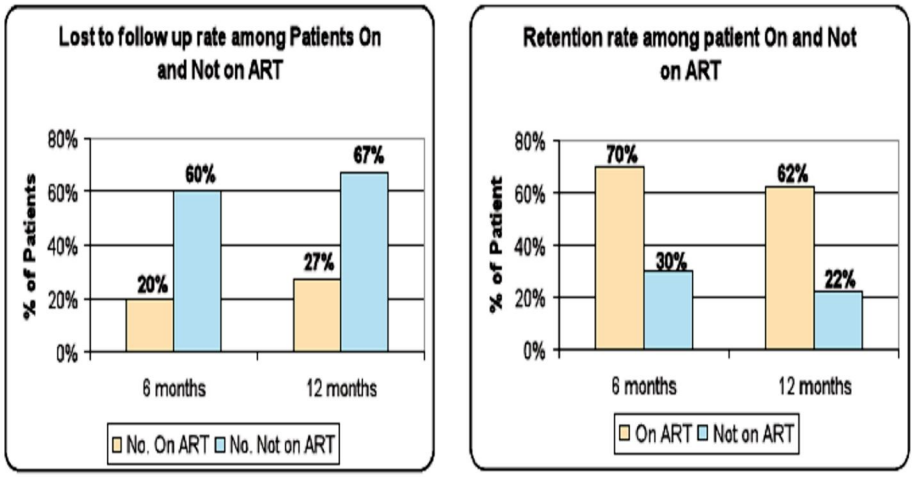
Table 3 : Distribution of PLHIV on ART by Age and Sex

Patients on ART	n	%
Adults, age 15 and over	965	92%
Children	88	8%
Female	727	69%
Male	326	31%

Source: NACP-Cohort Study (2010)

According to results of a cohort study done among PLHIV in HIV care and treatment in Liberia (2010)[4], the number of ART patients retained in care after 6 months is estimated at 70% while at 12 months its is 62%. Among those not on ART this is even lower: 30% at 6 months and 22% at 12 months as shown in the figure below (Figure 11).

Figure 11: Retention and Lost to follow-up rates among PLHIV in care



Source: NACP-Cohort Study (2010)

By sex 44% of among PLHIV on treatment after 12 months are female while 18% are male. By age 57% are adults aged 15 years and above while 5% are aged below 15 years.

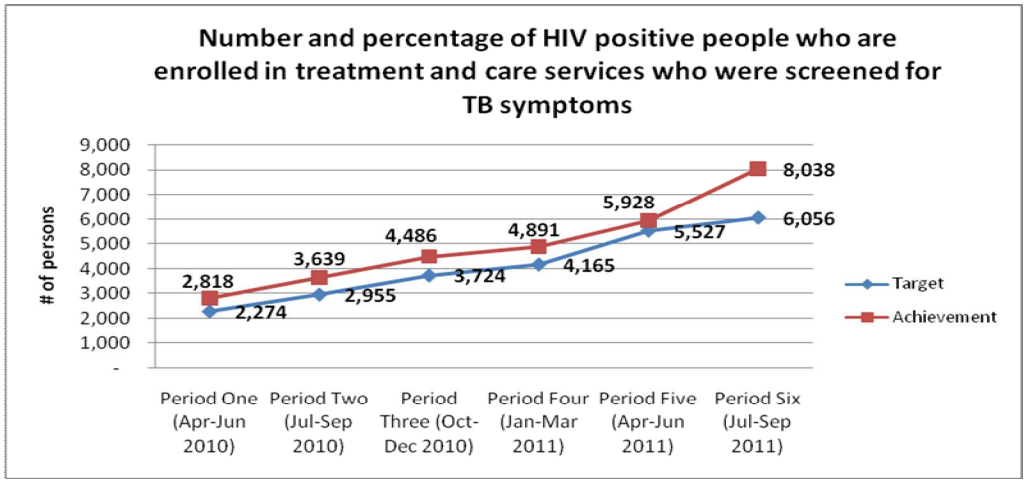
[4] MOHSW/NACP(2010): A Cohort study of Patients enrolled in HIV Care and Treatment in Liberia.

3.4.2. CO-MANAGEMENT OF TUBERCULOSIS AND HIV TREATMENT (INDICATOR 5.1)

HIV and TB collaborative efforts are major priorities for improving the quality care currently being 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.

In response to making Liberia an HIV/TB co-infection free society, lot of emphasis has been made on systematic screening of all HIV patients who are enrolled into Care and Treatment for TB and vice versa as a major part of their routine care services. During the period under review, a total of 8,038 HIV+ patients were screened for TB. In 2010, 962 patients were treated for TB/HIV co-infections while in 2011, the number was 1,386. Figure 12 below illustrates the progress made in TB screening among PLHIV during 2010 and 2011.

Figure 12: Number of PLHIV enrolled in Care who received TB Screening



Source: NACP Annual report (2011)

3.5 IMPACT ALLEVIATION

3.5.1. SUPPORT FOR CHILDREN AFFECTED BY HIV AND AIDS AND SCHOOL ATTENDANCE OF ORPHANS (INDICATOR 7.3)

The Global Fund through its implementing partners, like the Samaritan Purse has providing educational support and livelihood to OVCs. In 2011 support was given to a total of 4, 274 orphans consisting of 2,281 boys and 1,990 girls (Table 4) living in 106 orphanages in 11 counties through direct payment from the Ministry of Health Office of Financial Management (OFM) 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.

Table 4: Total number of Children profiled in 106 0rphanages in 11 counties

County	# Orphanages	Boys	Girls	# of Children
Montserrado	58	1,267	1,001	2,268
Grand Bassa	12	220	223	443
Nimba	8	172	223	395
Margibi	8	186	214	400
Bong	9	245	185	430
Bomi	4	86	64	150
Cape Mount	2	32	15	47
Maryland	2	40	27	67
Sinoe	1	5	2	7
Gbarpoulu	1	15	12	27
Rivercess	1	16	24	40
Total	**106**	**2,284**	**1,990**	**4,274**

Source: MOHSW (SW- 2011)

3.5.2. ECONOMIC SUPPORT TO HOUSEHOLDS IMPACTED BY HIV (INDICATOR 7.4)

Impact mitigation to persons infected and affected by AIDS- Support to Income generating activities

The Global Fund through its implementing partners like the Samaritan Purse supported the training of PLHIV in income generating skills to help them improve their livelihood. The income generated from these small projects has helped the caregivers, families infected and/or affected to settle family needs.

This not only helped in a practical business sense but again helped to foster and improve self-confidence and well-being.

Support to LIGHT Association and Provision of Palliative Care

In Liberia, like in other parts of the world, stigma and discrimination constitute one of the greatest barriers to address effectively the HIV epidemic. In tandem with

the global initiative of Greater Involvement of People Affected by AIDS (GIPA), LIGHT Association the then umbrella organization for PLHIV now Liberia Network of People Living with HIV (LIBNET+) in the country with operational cost supported and financed by the Global Fund implements **Source: NACP Annual report(2010)** activities including small income generating support, advocacy meetings, mass media mobilization campaigns conducted through radio stations to delivered HIV and AIDS information and created awareness campaign including farming and internet café services, in a bit to curb stigma and discrimination, and to reduce the misconceptions about HIV and AIDS in the general population. During these years the Global Fund provided quarterly funding of US$36,000.00 to support LIGHT Associationõs activities.

4. Best Practices

4.1 HIV Clinical Mentoring Program in Liberia

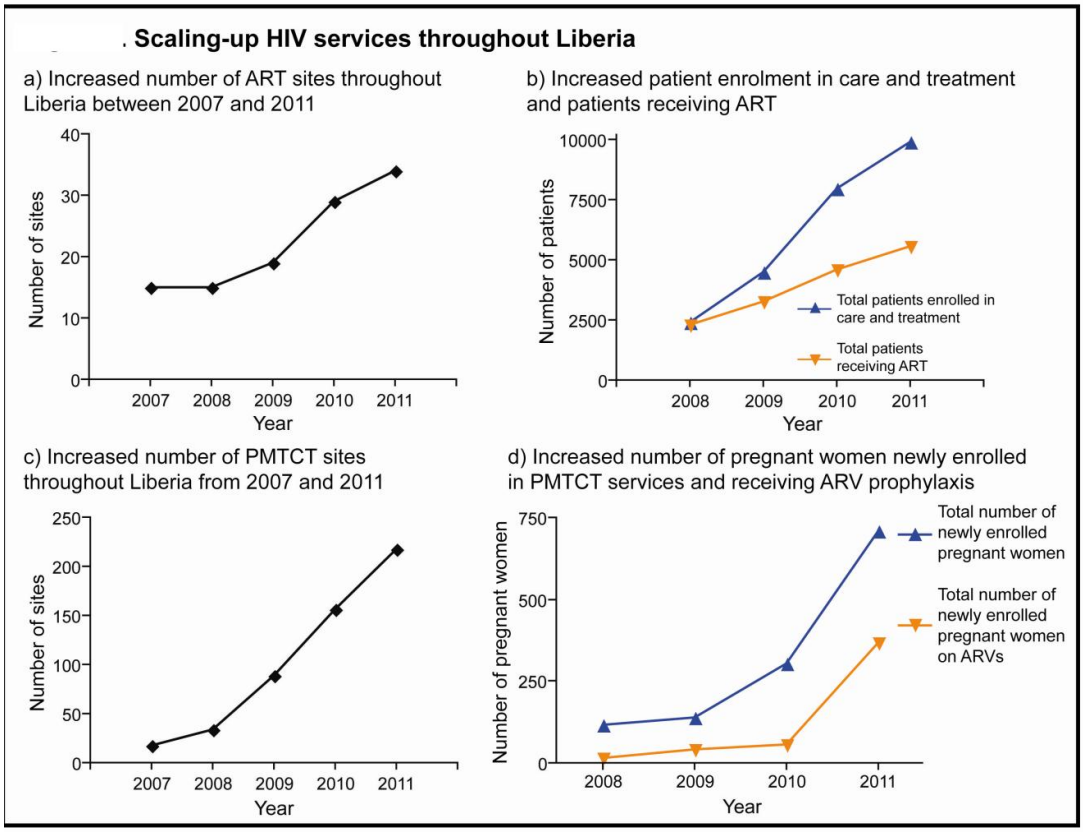
The major challenges of scaling-up of HIV services are maintaining and improving the quality of the services provided to PLHIV. With a lack of HIV knowledge and experience amongst Liberian clinicians, clinical mentoring has proved to be the most effective approach to improve the quality of care.

As one of the key supporters of the Liberian NACP/MOH&SW in updating and producing Integrated Guidelines for HIV prevention, care and treatment in 2007, CHAI- Liberia initiated a Clinical Mentor Program to as a way of disseminating quality implementation of the guidelines.

Source: NACP Program data (2011)

Over the past five 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. Between 2009 and 2011, the number of PMTCT and ART sites rose exponentially throughout Liberia. Subsequently, there was an increase in the number of patients enrolled in care and treatment including those receiving ART. Additionally, the years 2009 to 2011 witnessed a clear increase in number of newly enrolled pregnant women in PMCTC services and of those receiving ARV prophylaxis. Figure 13 below shows the overall impact of the Clinical Mentor Program.

Figure 13: Impact of the Clinical Mentor Program



Source: Source: NACP Program data (2011)

In order to take ownership of the Clinical Mentor Program initiated by CHAI-Liberia, NACP hired ten Liberian clinical mentors in 2010 and 2011 through funds secured from the GFATM. The clinical mentors were responsible for providing care among HIV patients

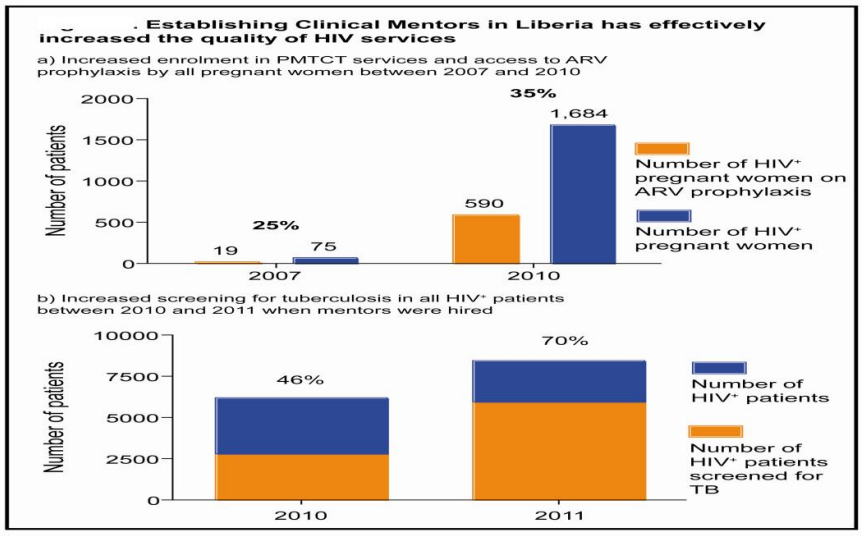
receiving care and treatment in the additional sites, with a particular focus on improving the quality of HIV services.

Source: Source: NACP Program data (2011)

The percentage of pregnant women on ARV prophylaxis and HIV patients screened for TB has increased considerably between 2007 and 2011 as shown

In figure 14 below:

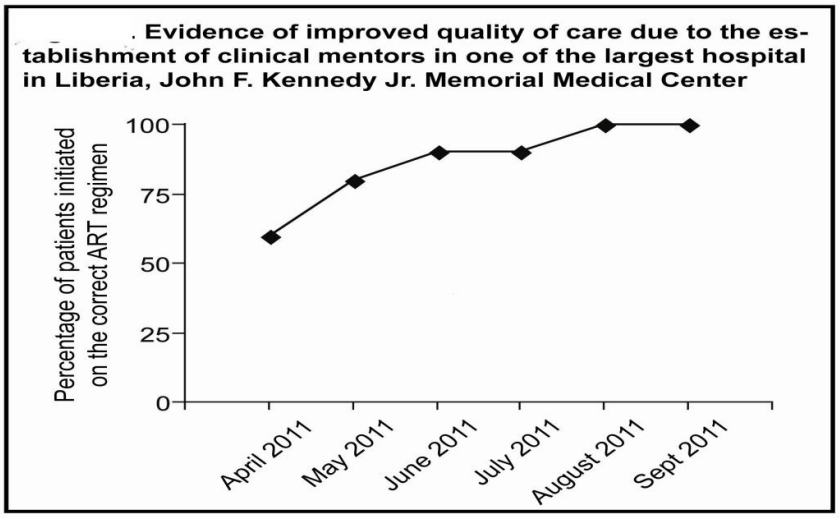
Figure 14: Impact of Clinical Mentor Program on PMTCT and TB/HIV Activities



Source: NACP Program data (2011)

The presence of clinical mentors in health care facilities has improved the HIV services in those facilities. For example, at John F. Kennedy Jr. Memorial Medical Centre, the largest hospital in Liberia, the clinical mentors have increased the monthly percentage of patients initiated on the correct ART regimen since the Clinical Mentor program was initiated in April 2011.

Figure 15: Percentage of PLHIV initiated on ART between April-Sept'2011



Source: NACP Program data (2011)

Future plans for mentor program include introducing a monitoring system for the Clinical Mentor program to track its success; supporting the Clinical Mentoring Program logistically and through continuous education to update and sharpen the HIV clinical management skills of both the Clinical Mentors and health facility staff all over Liberia.

4.2 PALLIATIVE AND HOME-BASED CARE BY THE CATHOLIC HIV/AIDS PROGRAMS

Palliative and home-based care interventions to PLHIV are still in infant stages. In the year 2008, NACP in collaboration with partners, produced standard guidelines to be used both in health facilities and community settings. The Global Fund provides financial support to the Catholic Church HIV/AIDS program to run a hospice center, in Monrovia

Source: NACP Annual report (2010)

(Montserrado County) and Harper (Maryland County). Both are catering for 250 AIDS patients (infant and adults) at a time. The service provided involves the medical management of opportunistic infections, neurological or other complications of HIV/AIDS to comprehensively address symptoms and suffering throughout the continuum of care. Beyond care for children infected and affected by HIV and AIDS, included as well are those neglected by their parents and/or families. Many of these neglected patients after admission are discharge to their various homes when medical and social conditions improve. A cumulative number of 1,411 patients were admitted from 2008 to 2010.

5. Major Challenges and Remedial Actions

The NSF (2010-2014)[5] and draft UNGASS report of 2010, identified a number of areas as challenging and need priority action to lead to the achievement of the Global AIDS reporting targets. These are listed below and briefly discussed along with proposed remedial actions.

5.1 Effective Coordination and Management of (a decentralized, multi-sectoral) national Response:

Key lessons learned from the national response to date is the need to strengthen the overall coordination and management of the many initiatives and actors involved in the multi-sectoral response. Activities in the area of prevention, treatment, care and support are coordinated among the different players. However, moderate involvement of non-health sectors; and inadequate partnerships between government, civil society organizations and the private sector remain integral parts of the many challenges. Remedial actions to strengthening the effective coordination and management include:

- Strengthening capacity of the National AIDS Commission as the overall coordinating body of the multi-sectoral response;
- Strengthening sectoral involvement and mainstreaming of HIV in (existing) policies and programs of all sectors and at all levels (national and county);
- Establishing public-private partnerships and mechanisms for improved reporting and exchange of information among partners at all levels and in all sectors;
- Improving coordination of resource mobilization, as well as of allocation and monitoring the disbursement of funds; including more commitment of government funds and integration of HIV in government budgets (MOF);
- Strengthening the institutional and technical capacity of civil society organizations (CSS) ï as well as the private sector ï to effectively implement HIV interventions in prevention, treatment, care and support.

5.2 Strengthening HIV Prevention, with a Priority Focus on Most-at-risk and Vulnerable Populations:

Most HIV prevention has focused on interventions among the general population, as population-based and ANC HIV-prevalence data are showing decreasing trends (e.g.: 4.0% in 2008 and 2.6% in 2011). Survey data showed that women and girls are more vulnerable than men and boys (LDHS-2007), and that specific subgroups face particularly high HIV risks, such as young girls engaging in transactional sex, sex workers and their clients, MSM, IDUs, and mobile populations.

[5] NSF II (2010-2014): Priority Issues Emerging from Epidemiological, Situation and Response analysis.

In order to strengthen the future focus of HIV prevention on these most-at-risk and vulnerable populations, the following remedial actions are being implemented:

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

5.3 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 PLHIV, 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 PLHIV support groups, communities and families play a key role in providing adequate (home-based) care and support to PLHIV, OVCs and other affected groups. In the context of poverty, however, community resources and capacity are limited, and community systems strengthening (CSS) is pivotal. While strengthening of community and health systems is essential to allow further scaling up of treatment and care, the longer-term sustainability requires further integration of HIV-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:

ÅStrengthening health systems to increase their capacity to scale up coverage of high-quality, comprehensive HIV care and treatment. This involves improved human-resource management (training, recruitment and retention of staff); efficient procurement and supply management (PSM) systems; adequate laboratory support; and integration of HIV services into the overall health system. Special attention is needed for strengthening the capacity of peripheral health-care facilities at the county and community level, in accordance with MoHSW policies of decentralization;

ÅStrengthening and supporting community systems ï including PLHIV associations and support groups, communities and families ï to provide sustained care and support to PLHIV, OVCs and other affected groups; with special attention for women living with HIV, including outreach and reduction of stigma and discrimination;

ÅStrengthening linkages, referral and collaboration mechanisms to facilitate scale-up: this regards to:

1) Referral mechanisms within the health sector ï 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, labour rights etc; and

3) Referral and collaboration between health systems and community support systems;

ÅMore focus on sustainability is needed to ensure that current investments pay off on the long run; this involves building staff capacity, and ensuring follow-up, on-site support. It also requires integrating HIV care and treatment in the basic package of health services;

ÅStrengthen 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.

5.4 REDUCING STIGMA AND DISCRIMINATION OF PLHIV AS A CROSS-CUTTING PRIORITY.

The active involvement of PLHIV 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 PLHIV, OVCs and other affected groups present a major obstacle to the effective delivery of HIV-related programs and services. HIV-related stigma and discrimination help to keep people from wanting to know their HIV status. This affects the utilization of voluntary and provider-initiated counseling and testing services. As a result, most HIV-infected persons do not know their HIV status, while those who know are often driven ñundergroundò, afraid of the consequences of disclosing their status to their partners, families, communities and employers. As a result, stigma and discrimination not only threaten PLHIVôs social position as well as their health, labour and other rights, they also present a major obstacle for the effective coverage and utilization of HIV-prevention services ï such as PMTCT, PEP and treatment of TB/HIV co-infection ï and of ARV treatment and treatment of opportunistic infections, and care and support services.

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

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

6. Support From the Country's Development Partners

6.1 KEY SUPPORT RECEIVED FROM DEVELOPMENT PARTNERS

Liberiaגs commitment to the HIV response is mainly supported by donors and partners. As a result of the ongoing process of reconstruction, Liberia has very limited national revenues. To date, government funds have covered personnel costs of government staff in the MoHSW, NACP, and NAC. The vast majority of available HIV funding comes from international development partners, including:

- The Global Fund (GFATM): In late 2006, a second GFATM program was approved for a total amount of USD 31.15 million (GFATM, 2009) for of a 5-year period of June 2007-2012. This Round-6 program allowed the further strengthening and scale-up of a more comprehensive national response, including components such as IEC/BCC for HIV awareness and reducing stigma and discrimination; condom promotion; blood safety; STI treatment; VCT; PMTCT; ARV treatment and treatment of opportunistic infections, as well as the integration of TB/HIV; and care and support for PLHIV and others affected. In addition Round- 6 support aimed to strengthen health systems by building capacity of public and private health facilities at county and district levels.

Additional funds for HIV became available in 2009 through the Round-8 HIV grant, which amounted to a total of USD 77.7 million. This program had two major components: an HIV-specific component (USD 51.1 million) and a component for health systems strengthening (HSS) (USD 19.2 million). The HIV component supported further expansion and improvement of facility-based HIV services, in order to promote equitable geographic access to high-quality services.

As of February 2010, almost half (49%) of the financial resources needed for implementation of the NSF 2010-2014 were already available, or had been formally committed. The Global Fund was the major donor, with funds from the last two years of the Round 6 still available as of 2010, and Round 8 was still fully unspent. By March 2012, after successfully implementing the consolidated Round 6 & Phase 1 of Round 8, Liberia is currently submitting a funding request for Phase 2 of Round 8, after a reprogramming exercise to propose interventions that are more relevant to present context of the epidemic and implementation experience.

- The UN Joint Program (2008-2010) committed USD 5.5 million for HIV in 2008.
- Bilateral donors (e.g. USAID, Irish Aid) and smaller donors.
- In addition to HIV-specific funding, health-sector funding also (in) directly benefits AIDS activities; e.g., faith-based organisations manage 44 health facilities under the auspices of the Christian Health Association of Liberia (CHAL) (MoHSW, 2007).

There are many Implementing partners and many are funded by donors listed above. Technical assistance has been provided by a number of partners, notably, UNAIDS, the United Nations Development Program (UNDP), the World Health Organization (WHO), the USG, and the GTZ.

6.2 ACTIONS NECESSARY TO THE ACHIEVEMENT OF UNGASS TARGETS

For the Country AIDS Progress report (UNGASS) targets to be met, partners should sustain their support to the national response in a harmonized and coordinated way. The National HIV Strategic Framework II 2010-2014 has been developed with wide participation of all HIV stakeholders and is informed by priorities articulated in the Liberia Poverty Reduction Strategy (PRS-2006) and galvanizes the linkages between the countryøs development strategies, which already well-integrate HIV issues. The support of all partners support is aligned to national priorities. Among the most important innovations of the National Strategic Framework II are the targeting of most-at-risk populations (MARPs) for prevention efforts and the increased involvement of non- health sectors and of civil society organizations-community systems strengthening (CSS) in the national HIV response. At the international level, efforts should be made to accelerate the harmonization process and to optimize reporting requirements from countries. This would save time and resources and allow limited staff to concentrate on actual work at country level. On a positive note, in Liberia there is now a national list of standard HIV indicators used by all development partners in the country and harmonized with PRS, MDGs, Universal Access, UNGASS, and Global Fund proposed Indicators. The M&E systems have greatly improved especially in terms of coordination and alignment of stakeholders to the national reporting system. For the HIV resource tracking, harmonization between NASA and NHA will be expedited.

7. Monitoring and Evaluation Environment

7.1 OVERVIEW OF CURRENT MONITORING AND EVALUATION SYSTEM

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

The national level multi-sectoral HIV&AIDS response is managed and coordinated by NAC. The overall responsibility for monitoring and evaluating the implementation of the NSF 2010-2014 lies with the National AIDS Commission (NAC). A NAC M&E Unit manages the implementation of the M&E Plan in all Government sectors, civil society organizations and private businesses. At the national levels there are also several development partner organizations which provide technical, financial and material support for implementing M&E activities at national levels. NAC and development partners have staff responsible for various M&E related functions.

In 2010, after the development of the NSFII 2010-14, a Liberia National Multisectoral HIV and AIDS M&E Plan 2010-14 and Operational Plan were developed. The M&E plan describes how to assess the degree to which interventions are contributing to the achievement of national HIV NSF II targets, while consistently monitoring trends in HIV prevalence and HIV related behaviours in the population as well as trends in HIV service delivery

The National M&E system is primarily divided between health facility-based and community-based components of monitoring and evaluating the national response, and is decentralized from the national to district levels.

The health facility-based components of the M&E system are led by MOHSW mainly through the NACP, HMIS, Blood safety program and other departments undertake monitoring, surveys, surveillance and research related to clinical HIV&AIDS issues.

The community-based components of the M&E system generally refer to non-facility-based interventions at the community level. Monitoring, surveys, surveillance, research and documentation related to community based non-clinical HIV&AIDS interventions is managed by LISGIS, therefore LISGIS has M&E Officers who are placed at the head office and in all counties. Within the counties, the M&E functions are undertaken by County M&E Focal persons who work closely with the LISGIS M&E Officers. Organizations implementing HIV&AIDS interventions have community outreach officers who undertake monitoring and data collection. Within health facilities monitoring and data collection is done by staff who deliver clinical based HIV&AIDS services.

National umbrella organizations of civil society and private businesses also monitor and report collectively on the HIV&AIDS work being 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

sector ministries like MOHSW, MOF, MOL, MOE and MoG&D 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 ï including government ministries and institutions, as well as civil society and private sector organizations. An important role in this regard is played by the implementing partners and program-implementation unit (PCU) of the Global Fund-supported programs and services, as well as the NACP, which oversees the implementation of HIV-related services and programs in the health sector. Implementing partners report key M&E data to the NAC M&E Unit ï either directly or through NACP and/or the Global Fund PCU ï in accordance with the reporting guidelines developed as part of the National M&E Framework and Plan.

7.2 CHALLENGES FOR IMPLEMENTATION AND REMEDIAL ACTIONS PLANNED

Many of the challenges to effective and efficient implementation of the NSF II that were indentified in section 5 of this report with regard to prevention, care and treatment are associated with a lack of (hard) evidence and research data to guide policies, programs and services, and identify the specific roles of different sectors. Knowing your epidemic is crucial for ensuring that the right programs and services effectively reach the population groups most in need of HIV/STI prevention, care, support and treatment. While the population-based LDHS (2007) study contributed to improved HIV-prevalence data, surveillance data needs to be further systematized and integrated into government systems. Furthermore, HIV surveillance needs to be expanded beyond the general population to include most-at-risk populations. Apart from basic biological and behavioural surveillance data, very limited (qualitative) research has been done into the drivers and underlying mechanisms of the HIV epidemic, and little is known about the dynamics of HIV transmission in specific high risk groups and regions of the country.

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

The following remedial actions are being taken to strengthening the availability and use of strategic information to guide an evidence-informed national response[6]:

ÅEstablishing a regular second-generation surveillance system, based on current population-based and ANC data, as well as expanding it to include bio-behavioral surveillance of most-at-risk population (MARP) groups (sex workers, mobile men, MSM) on a regular basis. An IBBSS and modes of transmission (MOT) study are planned in phase 2 of the current GFATM HIV grant;

ÅBetter understanding the dynamics underlying HIV risks among MARP and vulnerable groups, as well as the impact of AIDS on communities and individuals. To this effect, a national research agenda will guide priority research in different areas, with a focus on qualitative data.

ÅKnowing ñwhat worksò is crucial for a cost-effective national response. This will be through strengthening of programmatic M&E through:

a) Automated management information systems (MIS);

b) Common M&E tools and improved flow of information; and

c) Operational research, with special attention for coverage/ utilization and quality of HIV services;

ÅImproving the tracking of HIV resources (allocations and disbursements) beyond Global Fund contributions. A National AIDS Spending Assessment (NASA) exercise is planned in Phase 2 of the current GFATM HIV grant; and this will be harmonized with the National Health Accounts (NHA);

ÅImproved 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;

ÅImproving integration of HIV data into the health sectorôs HMIS system; and

ÅStrengthening M&E capacity among implementers and coordinating bodies, as well as improving the regular supply of HIV test kits to health facilities to ensure regular facility-based reporting of HIV cases and AIDS deaths.

ÅMapping 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

[6] NSF II (2010-2014): Priority Issues Emerging from Epidemiological, Situation and Response analysis.