

# Global AIDS Response Progress Reporting (GARPR) - 2013



## Country progress Report 2013 Republic of Liberia



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## **Foreword**

The 2013 AIDS Response Progress Report for Liberia presents the major highlights of the progress made in the fight against HIV and AIDS for the period from 2012 to 2013. The compilation for this report is part of my Government's commitment to the 2011 United Nations General Assembly Political Declaration to achieve; Zero new HIV infections, Zero Discrimination and Zero AIDS Related Deaths. This report will also provide a good baseline for monitoring progress towards the associated targets that call for the reduction on sexual transmission of HIV; increasing the number of people on treatment; halving TB-related deaths amongst people living with HIV; and, elimination of new HIV infections among children by 2015.

With the support of our partners, Liberia has been able to scale up its HIV and AIDS prevention, care, treatment and support programs to unprecedented levels. In 2006, nine hundred and sixteen (916) individuals were treated with ARVs. By the end of December 2013, the numbers of persons receiving treatment had risen to 6,429. Further increases in the total number of individuals on ART are expected as Liberia transitions to fully implement the 2013 World Health Organization (WHO) Treatment Guidelines.

HIV prevention programs are also being scaled up as evidenced by the decrease in the prevalence rate among antenatal attendees. Liberia has also been successful in mobilizing grassroots organizations to become actively involved in disseminating information on HIV and AIDS. Collaboration with these organizations has enhanced the expansion of service coverage, particularly in the areas of HIV prevention and impact mitigation.

I want to emphasize the Government of Liberia's 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 report highlights the gains that Liberia has attained in the past two years, as well as areas in which more work will need to be done for us to win the fight against HIV.

Ivan F. Camanor, MD  
Chairman  
National AIDS Commission  
Republic of Liberia

### **List of acronyms and abbreviations**

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change Communication
BPHS	Basic Package for Health Services
CBO	Community-Based Organization
CD4	Cluster of Differentiation Four
CHAI	Clinton Health Access Initiative
CRIS	Country Response Information Systems
CSO	Civil Society Organization
CSS	Community Systems Strengthening
CSW	Commercial Sex Worker
DBS	Dried Blood Spot
DNA	Deoxyribonucleic Acid
DU	Drug Users
EID	Early Infant Diagnosis
EPHS	Essential Package for Health Services
EPP	Estimation and Projection Package
FBO	Faith-Based Organization
FSW	Female Sex Workers
GBV	Gender -Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GIPA	Greater Involvement of People Affected by AIDS
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HSS	Health Systems Strengthening
IBSS	Integrated Bio-Behavioral Surveillance Survey
IDUs	Injecting Drug Users
IEC	Information, Education and Communication

ILO	International Labor Organization
IRC	International Rescue Committee
LDHS	Liberia Demographic Health Survey
LISGIS	Liberia Institute of Statistics and Geo-Information Services
LIBR	Liberia Institute for Biomedical Research
M&E	Monitoring and Evaluation
MARPs	Most- at- risk Populations
MDA	Ministries, Departments and Agencies
MDG	Millennium Development Goals
MIS	Management Information Systems
MoD	Ministry of Defense
MoE	Ministry of Education
MoF	Ministry of Finance
MoG&D	Ministry of Gender and Development
MoH&SW	Ministry of Health and Social Welfare
MoL	Ministry of Labour
MoT	Modes of Transmission
MSM	Men who have Sex with Men
MTCT	Mother-to- Child Transmission
MTR	Mid-Term Review
NAC	National AIDS Commission
NACP	National AIDS and STI Control Program
NASA	National AIDS Spending Assessment
NCPI	National Commitment and Policy Instrument
NGO	Nongovernmental 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
PCU	Program Coordination Unit
PLHIV	People Living with HIV
PMTCT	Prevention of Mother- to- Child Transmission of HIV

PRS	Poverty Reduction Strategy
PSI	Population Services International
PSM	Procurement and Supply Management
SE	Size Estimate
SGBV	Sexual and Gender- Based Violence
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Program on HIV&AIDS
UNICEF	United Nations Children Fund
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
UNGASS	United Nations General Assembly Special Session on HIV&AIDS
UNHCR	United Nations High Commission for Refuges
UNMIL	United Nations Mission in Liberia
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

## **1. Status at a Glance**

### **1.1 Report Preparation Process**

This report was written using information from diverse sources, namely, National surveys (Demographic and Health Survey (DHS), Integrated Bio-behavioral Surveillance Survey (IBBSS), ART Cohort study, the National AIDS Control Program (NACP) 2013 annual data validation, report on Mid-term Review (MTR) of the National Strategic Framework (NSF) 2010-2014, and discussion from the National Commitments and Policy Instrument (NCPI) Questionnaires.

The MTR had been conducted in 2013 during which information was collected, analyzed and consolidated from program reports, annual performance reviews and annual surveys covering the period 2010-2014; these were supplemented with those from national and county level consultations including key informant interviews, focus group discussions and meetings. In addition, the annual data validation exercise of the National AIDS Control Program provided a detail set of indicators for the health response to HIV including the revised estimates from the Spectrum projection software version 5 which provides updates of national statistics whose findings have been integrated in this report.

The National AIDS Spending Assessment (NASA) 2011-2012 including the NCPI report data gathering and validation involved desk reviews, consultations with public sector agencies, civil society organization (CSO) networks and bilateral agencies, United Nations (UN) organizations and other development partners during which the questionnaire Part A (for Government) and Part B (for CSOs, Bilateral Agencies and UN Organizations) for the NCPI. Questionnaires were synthesized by the consultants and the generated draft report for final validation at a national stakeholder's workshop.

The report writing process was directed by the National AIDS Commission (NAC) and facilitated by the Joint United Nations Programme on HIV and AIDS (UNAIDS) and the NACP. A validation workshop was held on March 25, 2014 to discuss contents. The stakeholders included a wide cross-section of participants from national and sub-national governments, development partners, faith based organizations, private sector, the network of people living with HIV, community based organizations including the media.

## 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 (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)*]. The 2013 demographic and health produced some preliminary results about HIV knowledge and behavior but indicator of the HIV prevalence is still pending. A trend analysis on the HIV prevalence will be shown in the next round of the GARPR.

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

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).

An Integrated Biological and Behavioral Surveillance Survey (IBBSS) among most at risk populations to determine the prevalence of HIV and syphilis, including risk behaviors, perceptions and attitudes was conducted in 2013. The HIV prevalence was dramatically high among MSM (19.8%). They are closely followed by FCSW (9.8%) and Uniform services personnel (5.0%). Youth in school had the lowest HIV prevalence (1.1%) with no significant difference between male (1.3%) and female (1.0%). Similar trend was observed among OSY with the prevalence being 1.9% and no significant difference between male (2.3%) and female (1.4%). Injecting drug users was predominantly male occupational group with the HIV prevalence of 3.9%, whereas Miners recorded a prevalence of 3.8%. Among Transport workers and Mobile traders, a considerably high prevalence of 4.8% and 4.5% was recorded.

A cohort study of HIV positive patients enrolled into Care and Treatment was conducted to determine the retention rate, factors which are associated with lost to follow up and

outcome of patients lost. Adherence and factors which influences poor adherence to ART will also be examine. At 12 months of follow up, the Kaplan-Meier survival estimates for retention among patients initiated on ART was 69.9% compared to 24.7% among patients not on ART. These rates dropped to 56.8% among ART patients and 14.3% among patients not on ART as the follow up period double. At 36 months of follow up, the retention rate among ART patients was 48.7% compared to 9.4% among patients not on ART.

### **1.3 Policy and Programmatic Response**

The NCPI Questionnaire provided 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-sectorial 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 PMTCT sites. There is also a continuing involvement of MARPs in the national HIV 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 development 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**

HIV prevalence from the 2013 Demographic and Health Survey (LDHS) was not available to be inclusive in this report to enable the country compare and monitor the trend. As such, indicators 1.1 - 1.6 and 7.2, information was not available. This will be updated as soon as the LDHS 2013 results are released.

### **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 2012-2013 was informed by a deeper understanding of the HIV epidemic in Liberia and therefore different than the perspective of the evaluation in 2010-2011.

#### 1.4 Overview of GARPR Indicator Data

**Table 1: Overview of GARPR Targets and Indicator**

Targets & Indicator	2011 Report		2013 Report		Data Sources and Remarks
	2010	2011	2012	2013	
<b>Target 1. Reduce sexual transmission of HIV by 50 per cent by 2015</b>					
<b>Indicators for the general population</b>					
1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission*	<b>Men = 27.2%</b> 15-19 yr = 20.9% 20-24 yr = 34.2% <b>Women= 20.5%</b> 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	<b>Men = 8.5 %</b> 15-19 yr = 8.6 % 20-24 yr = 8.3 % <b>Women = 17.2 %</b> 15-19 yr = 18.7% 20-24 yr = 15.8%	-	-	-	Liberia Demographic and Health Survey (LDHS 2007)
1.3 Percentage of adults aged 15–49 who have had sexual Intercourse with more	<b>Men = 21.4%</b> 15-19 yr = 15.9 % 20-24 yr = 26.8		-	9.5	Liberia Demographic and Health Survey (LDHS 2007)

than one partner in the past 12 months	% 25-49 yr = 63.3 % <b>Women : 7.1%</b> 15-19 yr = 11.6% 20-24 yr = 8.0 % 25-49 yr = 18.2 %				
1.4 Percentage of adults aged 15–49 who had more than one Sexual partner in the past 12 months and who report the use of a condom during their last intercourse	<b>Men = 22.3%</b> 15-19 yr = 28.9 % 20-24 yr = 27.4 % 25-49 yr = 61.7 % <b>Women = 13.5%</b> 15-19 yr = 10.6 % 20-24 yr = 22.1 % 25-49 yr = 27.3 %	-	-	20.7	Liberia Demographic and Health Survey (LDHS 2007)
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	<b>Men= 2.3%</b> 15-19 yr = 0.4 % 20-24 yr = 2.9 % 25-49 yr = 8.0 %	-	-		Liberia Demographic and Health Survey (LDHS 2007)

	<b>Women = 1.6 %</b> 15-19 yr = 1.7 % 20-24 yr = 2.1% 25-49 yr = 4.4%				
1.6 Percentage of young people aged 15-24 who are living with HIV	<b>LDHS</b> <b>All = 1.1%</b> 15-19 yr = 0.9% 20-24yr = 1.4% <b>Men = 0.5%</b> 15-19yr = 0.4% 20-24yr = 0.7% <b>Women = 1.6%</b> 15-19yr = 1.2% 20-24yr = 2.0% <b>ANC Sentinel Survey 2008</b> <b>All = 3.6%</b> 15-19yr = 3.2% 20-24yr = 3.9%	-	-	<b>ANC Sentinel Survey 2013</b> (Preliminary data) <b>All = 1.8%</b>	Liberia Demographic and Health Survey (LDHS 2007)  ANC Sentinel Survey 2008  ANC Sentinel Survey 2011 ANC Sentinel Survey 2013 (Preliminary data)
<b>Indicators for sex workers</b>					
1.7 Percentage of sex-workers reached with HIV prevention programs	-	-		28.2	2013 Integrated Biological and Behavioral Surveillance Survey among MAPR
1.8 Percentage of sex workers reporting the use of a condom with their most recent client	-	-	-	81.7	2013 Integrated Biological and Behavioral Surveillance Survey among MAPR
1.9 Percentage of sex	-	-	-	31.3	2013 Integrated Biological and

workers who have received an HIV test in the past 12 months and know their results					Behavioral Surveillance Survey among MAPR
1.10 Percentage of sex workers who are living with HIV	-	-	-	9.8	2013 Integrated Biological and Behavioral Surveillance Survey among MAPR
<b><i>Indicators for men who have sex with men</i></b>					
1.11 Percentage of men who have sex with men reached with HIV prevention programs	-	-	-		Indicator data not available
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	-	-	-	19.5	2013 Integrated Biological and Behavioral Surveillance Survey among MAPR
1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	-	-	-	44.4	2013 Integrated Biological and Behavioral Surveillance Survey among MAPR
1.14 Percentage of <i>men who have sex with men</i> who are living with HIV	-	-	-	19.8	2013 Integrated Biological and Behavioral Surveillance Survey among MAPR
<b>Target 2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015</b>					
<b><i>Indicators</i></b>					
2.1 Number of syringes	-	-	-		Indicator data not available

distributed per person who injects drugs per year by needle and syringe programs					
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	-	-	-	44.3	2013 Integrated Biological and Behavioral Surveillance Survey among MAPR
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	-	-	-	-	Indicator data not available
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	-	-	-	27.9	Indicator data not available
2.5 Percentage of people who inject drugs who are living with HIV	-	-	-	3.9	Indicator data not available
<b>Target 3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS-related maternal deaths.</b>					
<i>Indicators</i>					

3.1 Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	<b>All = 18.2%</b> 420/2,313 <b>2 or 3 ARV combined = 15.6%</b> 360/2,313 <b>ART (HAART) = 2.6%</b> 60/2,313	<b>All = 13.1%</b> 270/2,067 <b>2 or 3 ARV combined = 11.2%</b> 231/2,067 <b>ART (HAART) = 1.9%</b> 39/2,067		<b>All = 64%</b> 874/1375	Numerator: NACP M&E program data (2013) Denominator: Liberia Spectrum Projection (EPP) 2012 of mothers needing PMTCT  Annual Percentage coverage is non-cumulative
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	<b>10.1%</b> 234/2313	<b>11.7%</b> 242/2067		<b>44%</b> 604/1375	Numerator: NACP M&E EID program data (2013) Denominator: Liberia Spectrum Projection (EPP) 2012 of mothers needing PMTCT
3.3 Mother-to-child transmission of HIV (modeled)	-	13.7	-	33%	Spectrum projection
<b>Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015</b>					
<b>Indicators</b>					
4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy*	<b>Total Coverage = 22.2%</b> Adult Men = Adult Women= Coverage 4,098/15,443= 26.5% Children= Coverage 314/4,423 =	<b>Total Coverage = 30.6%</b> Adult Men = Adult Women= Coverage 5,269/14,961= 35.2% Children		<b>Total Coverage = 38%</b> Adult Men = Adult Women= Coverage 6,429/17,158= 38%	Numerator: NACP M&E program data (2013) Denominator: Liberia Spectrum Projection (EPP) 2012 of adults and children needing ART

	7.1% <b>Total on ARV 4,412</b> <b>Total in need of ARVs 19,866</b>	Children= Coverage 570/4,150 = 13.7% <b>Total on ARV 5,839</b> <b>Total in need of ARVs 19,111</b>			
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	<b>All = 62%</b> (560/899) of PLHIV who initiated ART in Period June 2008- May 2009 Male = 57% (162/286) Female = 63% (398 /613) Adults (15+yr) = 62% (513/823)			<b>All = 74.2%</b> of PLHIV who initiated ART in Period Jan. 2011- Dec 2012 Male = 69.5% Female = 76.1% Adults = 74.2% Children = 73.6% Died = 81	MoHSW (2012): Cohort study of Patients enrolled in HIV treatment and Care in Liberia
<b>Target 5.Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015</b>					
<b>Indicators</b>					
5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	Numerator 962 Denominator = 283 (8% of TB patients were HIV positive in	Numerator 1386  Denominator			Data not available for 2013

	2010)				
<b>Target 6. Reach a significant level of annual global expenditure (US\$22-24 billion) in low- and middle-income countries</b>					
<i>Indicators</i>					
6.1 Domestic and international AIDS spending by categories and financing sources					NASA (and NHA)
<b>Target 7. Critical enablers and synergies with development sectors</b>					
<i>Indicators</i>					
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 2013 report	See annex on 2013 report	Rapid Assessment and Participatory consensus meetings

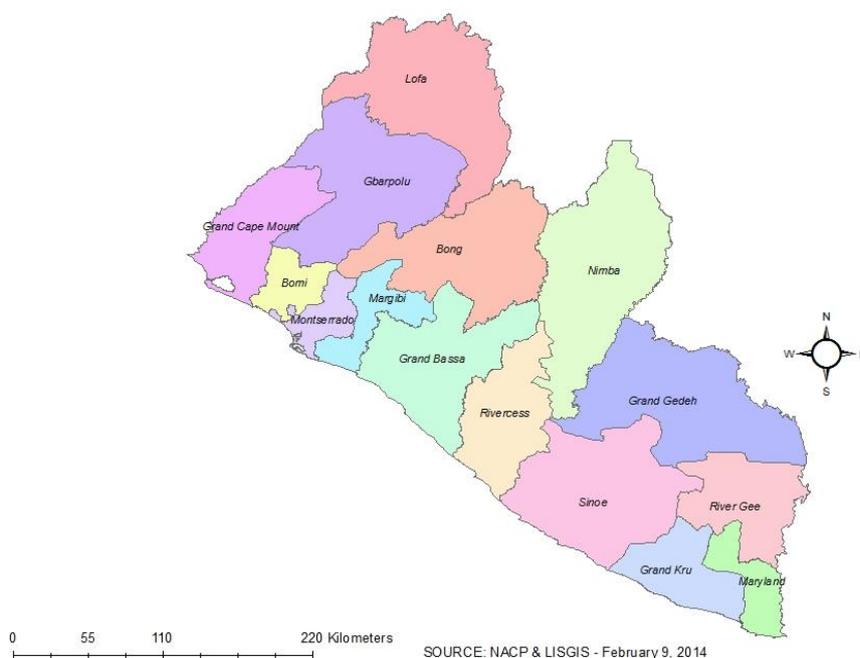
7.2 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	<b>Physical violence in past 12 months</b> <b>All = 28.8%</b> 15-19 yr = 23.2 % 20-24 yr = 29.9% 25-49 yr = 90.8 % <b>Ever experienced sexual violence</b> <b>All = 17.6%</b> 15-19 yr = 13.1 % 20-24 yr = 13.0% 25-49 yr = 60.1%	Gender Ministry	Gender Ministry	Gender Ministry	Liberia Demographic and Health Survey (LDHS 2007)
7.3 Current school attendance among orphans and non -orphans aged 10–14*	MoE/UNICEF	MoE/UNICEF	MoE/UNICEF	Total orphans in school= 7,570	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. Overview of the AIDS Epidemic

### 2.1 Context

#### Map 1: Map of Liberia outlining the 15 political sub-divisions

Liberia is Africa's oldest republic. It covers an area of about 43,000 square miles and lies between latitude 7 and 8 north and longitude 9 and 10 east, in the west coast of Africa. It borders Guinea in the north, Cote d'Ivoire in the north East, Sierra Leone in the west, and



the Atlantic Ocean in the south. The Country is divided into 15 counties, with a 2008 census count of 3.49 million inhabitants<sup>1</sup>. Montserrado County, where the Capital Monrovia is situated, is the most densely populated, with a population density of more than 1,500 persons per square mile and inhabits one-third of the country's total population.

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

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

<sup>1</sup> Population and Housing Census 2008, LISGIS

essential health services and youth unemployment. The introduction of the Basic Package for Health Services (BPHS) in 2005, now Essential Package for Health Services (EPHS) is aimed at integrating the national health system to address key public health problems.

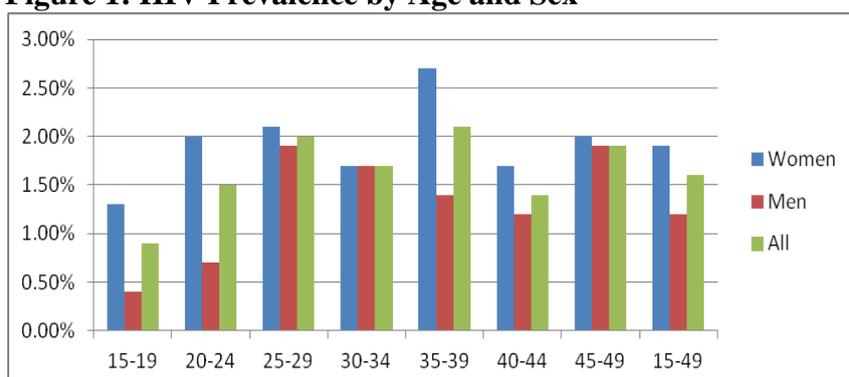
The HIV and AIDS epidemic is a significant public health and development problem in Liberia. The primary modes of HIV transmission in Liberia as elsewhere in sub-Saharan Africa are heterosexual contact and perinatal transmission; although blood transfusion, medical transmission and use of dirty needles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

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

## 2.2 HIV Prevalence 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 generalized epidemic. Overall, the HIV prevalence in women is higher (1.8%) than in men (1.2%), revealing women’s higher vulnerability to HIV infection. The difference in HIV prevalence between women and men is particularly strong in the younger age groups, with HIV prevalence in women three times higher than in men in the 15-24 year age group (see Figure1).

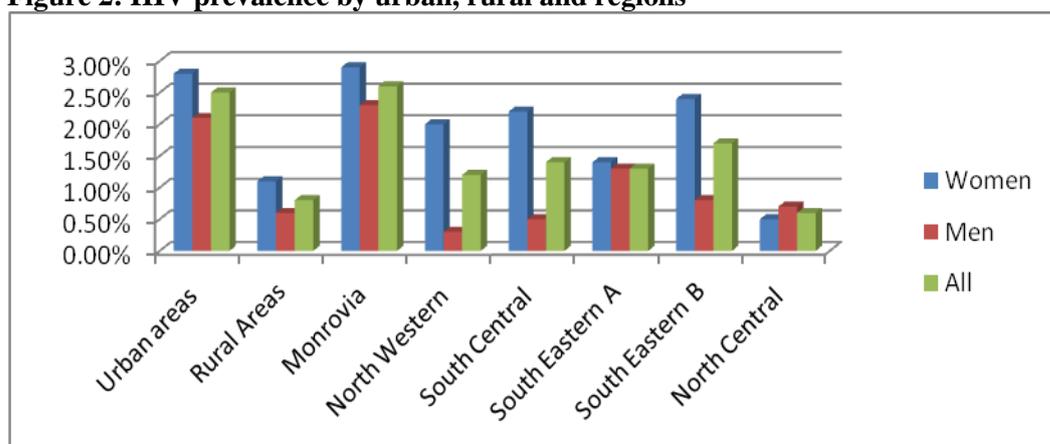
**Figure 1: HIV Prevalence by Age and Sex**



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 (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 2.6%. Preliminary data from the 2013 ANC survey shows a further decline in prevalence to 2.5%.

### 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).

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

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

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

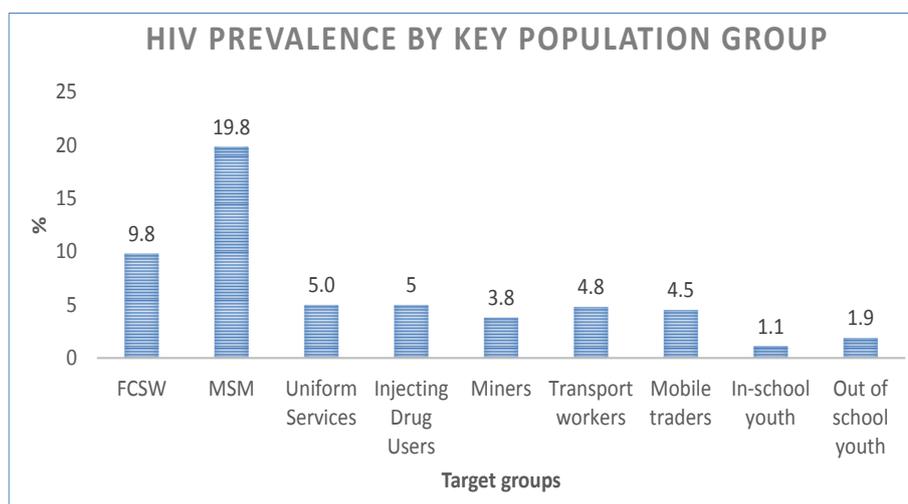
**Knowledge of PMTCT:** Overall, the average level of knowledge of prevention of mother to child HIV transmission was about 50% signifying a relatively low knowledge among all of the key target groups.

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

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

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

**HIV and syphilis test acceptance rates:** HIV prevalence is dramatically high among MSM (19.8%). They are closely followed by FCSW (9.8%) and Uniform services personnel (5.0%). Youth in school had the lowest HIV prevalence (1.1%) with no significant difference between male (1.3%) and female (1.0%). Similar trend was observed among OSY with the prevalence being 1.9% and no significant difference between male (2.3%) and female (1.4%).



Injecting drug users was predominantly male occupational group with the HIV prevalence of 3.9%, whereas Miners recorded a prevalence of

3.8%. Among Transport workers and Mobile traders, a considerably high prevalence of 4.8% and 4.5% was recorded.

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

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

**Sexual Experiences and Behavior of youth MARPs:** Among ISY, 73.5% reported ever having sex compared to 83.2% among OSY. Of these numbers, boys reported a higher percentage of early sex before age 15 compare to girls in both groups. Twenty percentage of boys in school reported having sex before age 15 compare to 16.3% of girl in the same category. OSY also recorded 21.7% of boys and 19.4% of girls reported having early sex

before age 15. The median age of first sex for both boys and girls among ISY and OSY was 16 years. Among ISY, condom use at last sex with commercial partners was higher among male (72.4%) compare to female (63.6%). The same trend was recorded among OSY with male reporting 71.2% and 38.7% among female respectively.

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

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

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

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

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

**Sexual violence, Blackmail and discrimination:** Among FCSW, 87.4% reported any type of violence compared to 40.2% among MSM. More than half (68.7%) of FCSW and 24.5% of MSM reported ever been threatened by the police with 59.8% of FCSW providing sexual

favour to avoid arrest. More than a quarter (35.6%) of FCSW and 18.4% of MSM have been forced to have sex without a condom.

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

**Exposure to HIV/AIDS Interventions:** Almost 75% and 62.5% of OSY reported listening to radio at least once a week. For exposure to TV during the same period of time only 43% of ISY and 25% of OSY declared watching TV. Youths are not very exposed to newspaper and only 42% of ISY and 19% of OSY reported reading a newspaper at least once a week. Talking of adult MARPs exposure to media, MSM seem to be more exposed to media than any other adult MARP group. Very marginal respondents reported been exposed to newspapers. Youth respondents were more exposed to UNMIL and local county radios as well as REAL TV and LOVE TV stations. Adult MARPs reported been more exposed to ELBC, UNMIL and Local radio station as well as Power and Real TV. Less than 50% of adults respondents reported ever seen an advertisement in the media on HIV and only about 30% of them reported ever hearing or seeing a specific advertisement on VCT in the media. Less than one third of youths reported ever hearing of a voluntary counselling and testing centre and fewer reported ever seeing or hearing an advert on VCT. For those who ever heard or seen any advert on VCT, the majority reported radio as the media through which such information was received. Regardless of the group (young or adults), more or less than 80% of respondents who never heard of a VCT centre reported their willingness to use it if its services were available. About 50% of ISY and less than 40% of OSY reported ever seeing a condom demonstration. Very marginal proportions reported ever participating in HIV peer education. Less than one over ten youth reported ever been exposed to radio group peer education. Proportions of adult MARPs who reported ever seeing a condom demonstration vary between 47% among transport workers to 59.7% among uniform

services. Very marginal proportions reported ever participating in HIV peer education. As for the participation in radio group peer education, between 0% and 5% reported ever been exposed to such activities, which is relatively similar to the participation in community drama and/or discussing HIV/AIDS related issues with a peer educator.

### **HIV Sero-discordant Couples**

In Liberia 1.9% of heterosexual couples are HIV sero-discordant (LDHS 2007), putting the HIV-negative partner in these discordant relationships at high risk for HIV infection. These discordant couples are at high risk for HIV transmission, especially if they do not mutually know their HIV status or do not use condoms consistently. 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 positive mothers will be infected by the mother, either intrauterine, during delivery, or through breastfeeding. Children born to HIV-positive mothers in Liberia still face the risk of HIV infection. A somewhat moderate health system hampers effective VCT services, which results in most HIV-infected women being unaware of their HIV status, and not seeking adequate services including PMTCT. The utilization of these available services is further hampered by low rates of women consistently using ANC services and health facility to deliver, which makes it difficult to access and utilize PMTCT services. This is further compounded by the high rate of lost to follow up and denial.

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

People living with HIV are a particularly vulnerable group, as they need access to a range of HIV prevention, care, support and treatment services. Inadequate or interrupted access to these services presents a direct threat to their health and wellbeing, as well as to those around them, as they may unknowingly transmit HIV to sexual partners or unborn children. An estimated 24,205 adults and 6,196 children were living with HIV in 2013 respectively (2012, Spectrum projections). Fourteen thousand nine hundred and eighty three (14,983) adult and 3,601 children were in need of ART in 2013. 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 PLHIV's access to these services. In

addition to access to these services, PLHIV play a key role in preventing the further spread of HIV through “positive prevention”.

#### **2.4 Sexual and Gender- Based Violence (SGBV) and Risk of HIV Infection (Indicator 7.2)**

The 2007 LDHS study shows that 45% of women ever experienced physical violence since they were 15 years old, while 29% had faced violence in the last 12 months. The main perpetrators were current or former husbands/partners: Thirty five percent (35%) of women had experienced spousal violence in the last 12 months. Almost one-fifth of women aged 15-49 had ever experienced sexual violence (LISGIS, 2008). Similarly, a study in 2007 among 600 women and girls in Eastern Nimba and Central Montserrado Counties conducted by the International Rescue Committee (IRC) and Columbia University’s Program on Forced Migration and Health revealed communities rife with gender-based violence (Shiner, 2007). Results show that outside of marriage, one-fifth of the sample population in Montserrado County and more than one-quarter of those surveyed in Nimba County had been raped or otherwise sexually abused. Among married or divorced women, more than 72% in both counties reported that their husbands had forced them to have sex in the last 18 months. Furthermore, the study revealed that more than one in 10 girls under the age of 17 had been sexually abused in the previous 18 months in both counties.

The Lofa County Reproductive Health Survey (Tomczyk et al, 2007) found similarly high lifetime prevalence of intimate partner violence (IPV), with almost two-thirds (61.5%) reporting that they had been subjected to IPV. Of those responding, approximately 61% had experienced physical violence and one-third sexual violence. Whereas most of these studies did not explored the direct correlation between SGBV and risk to HIV infection among the survey respondents, sexual and gender based violence undoubtedly increases women’s physical and psychological health risks particularly to HIV and other STIs.

### **3. National Response to the AIDS Epidemic**

#### **3.1 National Commitment**

The NAC recognizes that to strengthen coordination of programme implementation among implementing partners, coordination needs to be strengthened in the field of monitoring and evaluation especially in the assessment of financial flows. Therefore, a National AIDS Spending Assessment (NASA) was conducted for the period 2010/2011 to 2011/2012 to monitor HIV/AIDS public and private resource flows both in- and outside the pooled funding

arrangement and hopefully institutionalize a system to report to one central coordinating authority. Conducting the NASA provides the needed information to assess the use of resources for HIV and AIDS related activities and also plan effectively for future activities.

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

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



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

majority of the funds were spent on Programme Management and Administrative Strengthening, Human Resources and Prevention.

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

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

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

### **3.1.1. Policy and Strategy Implementation**

Liberia recently developed a couple of major policy and strategy documents. These include the Essential Package of Health Services – 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 Country’s Agenda for Transformation (AFT), a cross cutting thematic component was devoted to mainstreaming HIV and AIDS in overall development strategies. 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 – 2014 is being implemented under a multi-sectorial platform.

## **3.2 Prevention Programs**

### **3.2.1. Knowledge and Behavior 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 the 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 engaged in 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 prevent new HIV infections by broadening prevention messages that emphasize the predominant modes of HIV prevention in Liberia which are; abstinence from sex (A), reducing to one the number of sexual partners (B) and using condoms correctly and consistently (C).

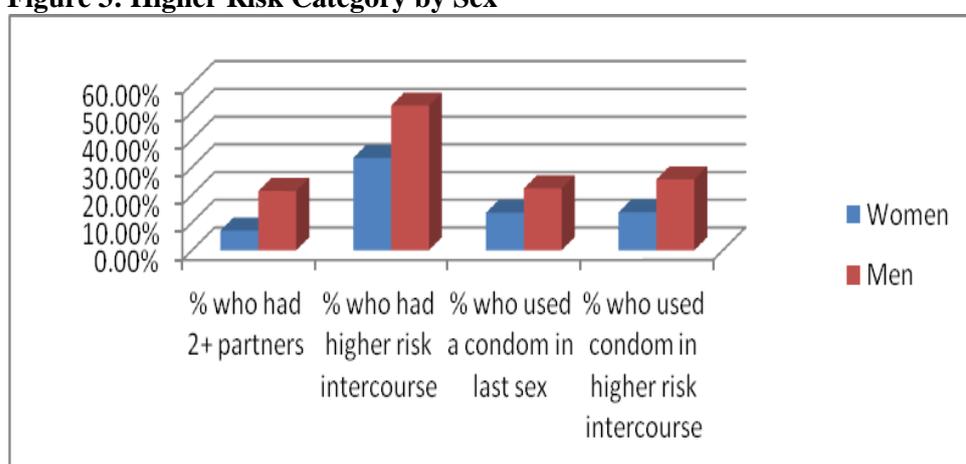
Throughout 2012 and 2013 efforts were made to increase public awareness of HIV and AIDS through many channels: mass media (radio messages), health talks at the various service delivery points, school health clubs, and community based drama group performances. Civil society organizations, such as NGOs, associations of PLHIV,

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

### 3.2.2. Condom Promotion and Distribution (Indicator 1.4)

Data from the LDHS (2007) show low levels of condom usage among the general population. Among women who had more than one sex partner in 12 months before the survey, only 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 3: Higher Risk Category by Sex**



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, ‘Star,’ the production of print and audio communication materials, improving the quality of care at youth centers, the provision of community based sensitization activities, and the setting up of distribution outlets at community level.

A total of 21,305,979 pieces of male condoms were distributed during 2012 and 2013. 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.

**Table 2: Distribution of Condoms**

SECTORS	2012	2013
NACP (Free Condoms)	12,199,623	9,106,356

[Source: NACP quantification data 2013]

### **3.2.3. HIV Counseling and Testing (HCT) 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 revised the national guidelines on HCT in 2012 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 provide HIV Counseling and Testing (HCT) services. HCT is provided through voluntary counseling and testing, and through Provider Initiated Counseling and Testing (PICT). The Program has increase the number of sites providing HCT services in 2013 to 365 in all 15 counties.

**Table 3: HIV Counseling and Testing per County**

County	2012				2013			
	Pretest	Tested	Post-test	Tested Positive	Pre-test	Tested	Post-test	Tested Positive
<b>Bomi</b>	1995	1983	1931	133	2176	2126	2124	128
<b>Bong</b>	5852	5825	5787	205	4853	4830	4804	188
<b>Gbarpolu</b>	644	557	559	36	590	561	556	25
<b>Grand Bassa</b>	5445	4710	4695	234	4470	4464	4448	187
<b>Cape Mount</b>	3003	2966	2923	95	1803	1747	1725	156
<b>Grand Gedeh</b>	2615	2601	2576	288	2355	2355	2232	248
<b>Grand Kru</b>	673	658	648	56	518	518	517	52
<b>Lofa</b>	7781	6631	6490	234	6464	6488	6385	188
<b>Margibi</b>	2589	2502	2448	145	3402	3406	3406	246
<b>Maryland</b>	3760	3753	3735	237	2846	2846	2844	271
<b>Montserrado</b>	37390	37277	35108	3301	40326	40226	39913	2900
<b>Nimba</b>	13924	13749	13696	642	12275	12139	12137	499
<b>River Gee</b>	828	818	821	127	995	994	991	124
<b>Rivercess</b>	1313	1260	1240	34	1130	1131	1123	28
<b>Sinoe</b>	1254	1159	1138	66	624	622	620	84
<b>Grand Total</b>	<b>89066</b>	<b>86449</b>	<b>83795</b>	<b>5833</b>	<b>84827</b>	<b>84453</b>	<b>83825</b>	<b>5324</b>

*Source: NACP Annual report 2012 & 2013*

#### 3.2.4. 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 and ARV prophylaxis for the exposed infant<sup>2</sup>. The revised guidelines have been rolled 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.

The number of health facilities offering PMTCT increased from 55 in 2009 to 335 sites in 2013.

<sup>2</sup> Integrated guidelines for Prevention, Testing, Care and Treatment of HIV and AIDS in Liberia (Third Edition 2010)

**Table 4: HIV Pregnant women who received ARVs for PMTCT 2012 - 2013**

	County	2013		
		ANC clients on ARV	ARVs received at del	Pregnant women ART
Although few pregnant women make the four WHO recommended ANC visits, nearly all women make at least one antenatal visit, which is used as an excellent opportunity to provide PMTCT services. In order to increase the uptake of HIV testing among pregnant women, provider-initiated testing	Bomi	36	12	0
	Bong	76	34	7
	Gbarpolu	0	0	0
	Grand Bassa	35	7	5
	Grand Cape Mount	43	9	2
	Grand Gedeh	14	5	3
	Grand Kru	6	1	0
	Lofa	25	17	3
	Margibi	34	9	6
	Maryland	18	1	4
	Montserrado	169	75	67
	Nimba	39	36	11
	River Gee	27	18	2
	Rivercess	10	1	2
	Sinoe	5	0	0
	<b>Total</b>	<b>537</b>	<b>225</b>	<b>112</b>

and counseling, with informed consent, is currently included in the National PMTCT Guidelines. Rapid HIV testing with “same-day” results is currently provided.

During 2013, 874 HIV-positive pregnant women received ARVs to reduce the risk of mother-to-child transmission (MTCT). According to Spectrum estimates, there were about 1,616 HIV-positive pregnant women in need of ARVs for PMTCT in 2013.

### **Early Infant Diagnosis (EID) using DNA PCR**

Early infant diagnosis (EID) is an integral part of the PMTCT strategy in Liberia and a key strategy used by the program to reduce new HIV infections in children. Children exposed to HIV are given EID using DNA PCR (DBS) using a reference laboratory in South Africa. According to Spectrum Estimates, the proportion of HIV exposed infants accessing EID has increased progressively from 15.2% (283/1866) in 2010 to 20.5% (346/1684) in 2011.

### **3.2.5. Management of Sexually Transmitted Infections**

Sexually Transmitted Infections (STIs) are major public health problem in Liberia. The HIV pandemic has focused greater attention on the prevention and control of STIs. There is a strong correlation between the spread of conventional STIs and HIV transmission. Both ulcerative and non-ulcerative STIs have been found to increase the risk of sexual transmission of HIV. The advent of HIV and AIDS makes STIs prevention a priority health

problem. STI is a window for HIV transmission, often referred to as the superhighway for HIV transmission.

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

In 2013, based on the WHO syndromic management approach, 168,865 cases of STIs were reported.

### **3.2.6. 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 one person to another. The National treatment protocols<sup>3</sup> specify the PEP regimen and package to be given to survivors of sexual assault and rape victims. The package includes emergency contraception, prevention and treatment of STI, prevention of tetanus, HIV post-exposure prophylaxis (ARVs) and counseling. Furthermore, UNFPA has provided, to major health centers and hospitals, rape prophylactic kits for STI, and PEP for accidental occupational and sexual exposure. Training on PEP has been organized for UN staff and implementing partners and the MSF hospital in Paynesville was contracted by UNFPA to organize RAPE management training. In addition to PEP services for rape victims, the Liberian Government has formed the National GBV Task Force, as well as a GBV Secretariat within the Ministry of Gender and Development. A National GBV Plan of Action aims to provide appropriate skills to health professionals; improve documentation and reporting on clinical evidence; reform 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.

### **3.2.7. 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

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<sup>3</sup> Integrated guidelines for Prevention, Testing, Care and Treatment of HIV and AIDS in Liberia (Third Edition 2010)

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 level of educational achievement.

### 3.3 Treatment, Care and Support

#### 3.3.1. 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 47 in 2013.

The number of children on treatment dropped to 378 by December 2013, a coverage of 10% according to Spectrum Estimates. Measures have been put in place to scale up pediatric care and treatment, such as, decentralization of sites in all counties, training of providers and quality improvement through better supervision and mentorship.

A second ART cohort study was conducted in 2013. The objectives of this study was to determine the retention rate, factors which are associated with lost to follow up and outcome of patients lost. Adherence and factors which influences poor adherence to ART will also be examine.

Results from the study shows a 12 months retention among patients initiated on ART was 69.9% compared to 24.7% among patients not on ART. These rates dropped to 56.8% among ART patients and 14.3% among patients not on ART as the follow up period double. At 36 months of follow up, the retention rate among ART patients was 48.7% compared to 9.4% among patients not on ART. (See table 2)

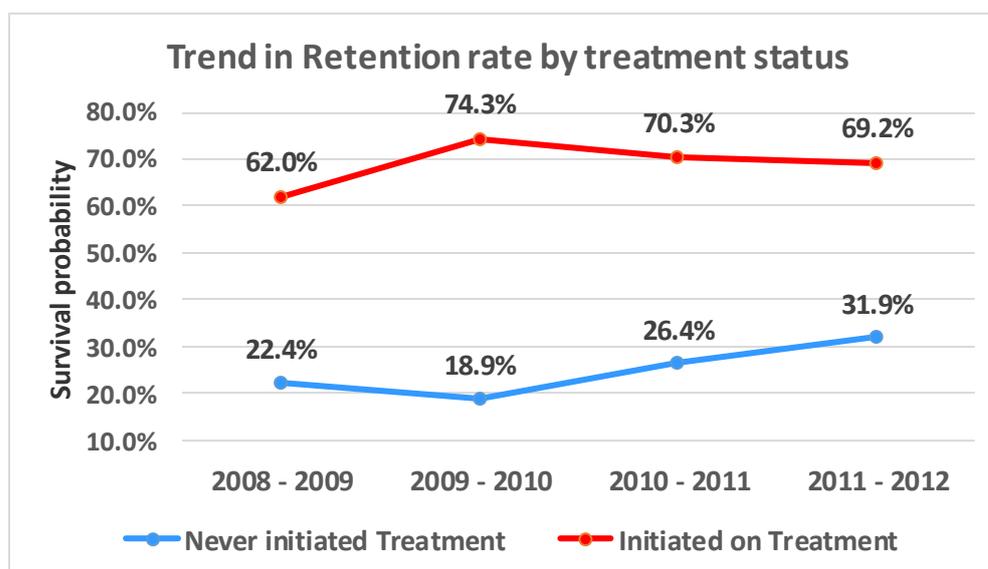
#### **Kaplan-Meier Survival estimates at different intervals for the entire cohort**

Duration of Follow up	Mortality %		Lost to follow up %		Retention %	
	Not on ART	On ART	Not on ART	On ART	Not on ART	On ART
6 months	13.6	6.54	50.9	8.96		
12 months	19.1	9.4	66.8	19.8	24.7	69.9
18 months	23.7	11.4	73.2	25.6		
24 months	27.4	13.2	77.3	30.6	14.3	56.8
30 months	28.5	15.3	80.3	34.6		
36 months	31.7	17.2	83.4	36.5	9.4	48.7

Further disaggregating the data by annual cohorts, the retention rate at 12 months of follow up varies per year. There is a gradual increase in annual retention among patients not initiated on ART. Using the 2009 cohort study result as baseline values, retention dropped to

18.9% at the end of 2010 and later substantially increase to 26.4% at the end of 2011 and 31.9% in 2012. In contrast, the retention rate for the patients on ART significantly increase from 62% in 2009 to 74.3% at the end of 2010 and later dropped to 70.3% at the end of 2011 and 69.2% at the end of 2012.

### Trend in Retention rates by treatment status

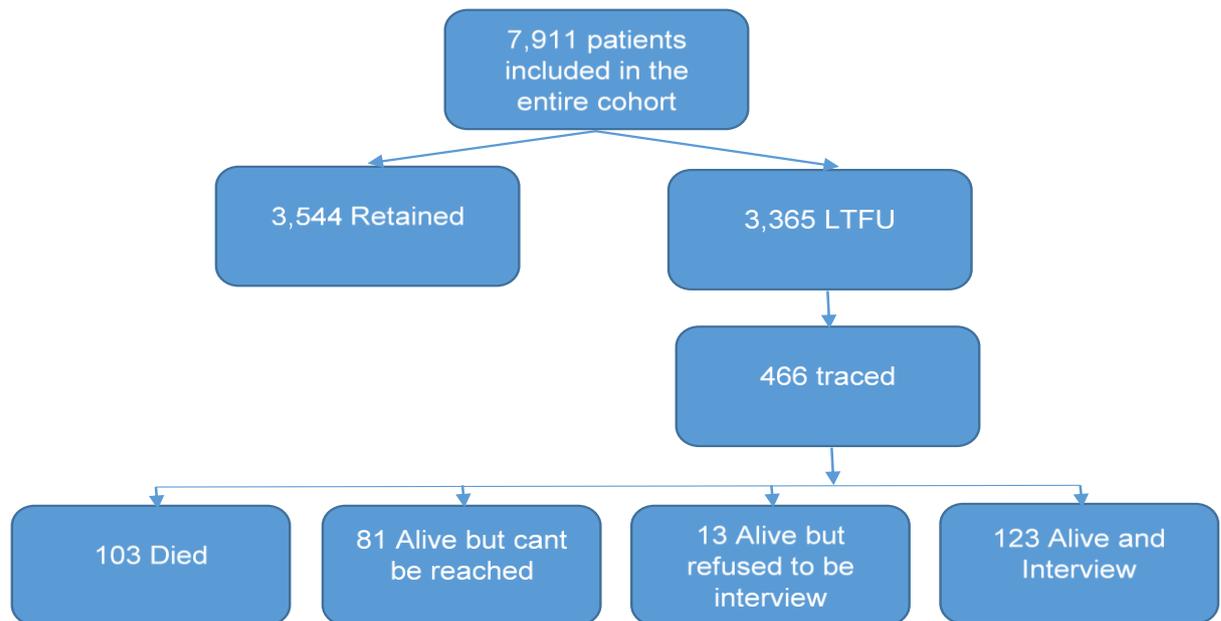


Comparing the difference in the lost to follow up rate per treatment status was highly significant using the log rank test ( $P < 0.0001$ ). Among patients not initiated on ART, more than 50% of the losses occurred in the first 3 months of follow up. This could be due to opt out after initial assessment. But due to the definition of lost to follow up (not seen in clinic after 3 months), the magnitude is very strong at this 3 months during the follow up period.

### Reasons and outcome of patients lost to follow up

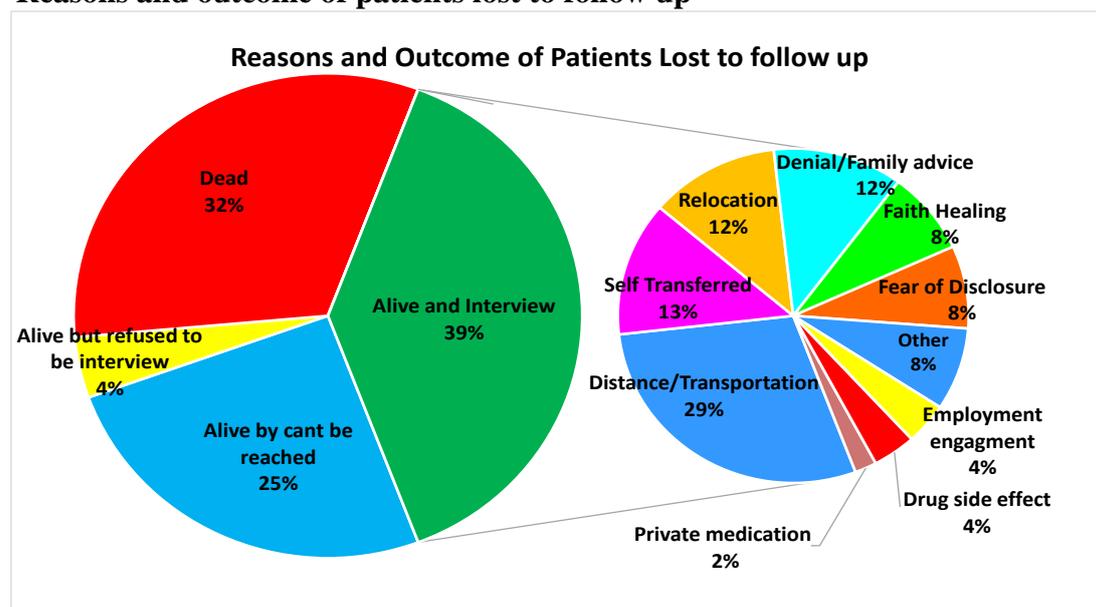
During the entire 36 months of follow up, 3,365 patients got lost to follow-up of which 466 were successfully traced. Out of the 466 patient successfully traced, 103 were found to be dead, 81 were alive but could not be reached, 13 were found alive but refused to be interviewed, and 123 were physically interviewed.

## Description of the outcome of patients lost to follow up



Among those interviewed, the reasons for leaving the program was investigated and 29% of respondents cited long distance to clinic or financial difficulty with transportation cost. This was followed by 13% of respondents who reported self-transfer and were actually accessing Care and Treatment at other facilities. Relocation to other communities or denial each contributed 12% of the reason lost to follow up. It is worth noting that healed of HIV including fear of disclosure each contributed a significant proportion of 8% as reasons for exiting the program. (See figure 6).

## Reasons and outcome of patients lost to follow up



## **Co-management of Tuberculosis and HIV Treatment (Indicator 5.1)**

HIV and TB collaborative efforts are major priorities for improving the quality of care currently provided in Liberia. Each disease makes the other worse, leading to more deaths. The care of co-infected patients requires coordination and integration of HIV and TB activities.

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

### **3.4 Impact Mitigation**

#### **3.4.1. 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 is providing educational support and livelihood to OVCs. In 2012 support was given to a total of 7, 570 orphans in 11 counties through direct payment from the Ministry of Health Office of Financial Management (OFM) SHALOM and the Samaritan Purse. The support provided to OVCs is mainly through payment of educational grants, including procurement of school materials and provide access to medical and psychological care services.

## **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 proven to be the most effective approach to improve the quality of care.

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

Over the past 2 years, Liberia has undertaken a robust scaling-up of HIV services by increasing the number of ART and PMTCT sites throughout the country, which has boosted HIV counseling, testing, PMTCT and ART services among communities.

In order to sustain the Clinical Mentor Program, NACP hired ten Liberian clinical mentors in 2010 through funds secured from the GFATM. The clinical mentors were responsible for providing care to HIV patients receiving care and treatment in the additional sites, with a particular focus on improving the quality of HIV services.

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

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

#### **4.2 Palliative and Home-Based Care by the Catholic HIV and 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 and AIDS program to run a hospice center, in Monrovia (Montserrado County) and Harper (Maryland County). The service provided involves the medical management of opportunistic infections, neurological or other complications of HIV and AIDS. Beyond care for children infected and affected by HIV and AIDS, as well as those children 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.

### **Major Challenges and Remedial Actions**

The NSF (2010-2014)<sup>4</sup> and GARPR report of 2013 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.

#### **4.3 Effective Coordination and Management of a Decentralized, Multi-Sectorial 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-sectorial response. Activities in the area of prevention, treatment, care and support are coordinated among the different players. However, moderate involvement of non-health

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<sup>4</sup> NSF II (2010-2014): Priority Issues Emerging from Epidemiological, Situation and Response analysis.

sectors; and inadequate partnerships between government, civil society organizations and the private sector remained an integral part 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-sectorial response;
- Strengthening sectorial 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, and the monitoring of funds disbursement; including more commitment of government funds and integration of HIV in government budgets
- Strengthening the institutional and technical capacity of civil society organizations (CSO) – as well as the private sector – to effectively implement HIV interventions in prevention, treatment, care and support.

#### **4.4 Strengthening HIV Prevention, with a Priority Focus on Most-at-Risk and Vulnerable Populations:**

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. Most HIV prevention has focused on interventions among the general population. Population-based and ANC HIV-prevalence data are also showing decreasing trends.

In order to strengthen the future focus of HIV prevention of the 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 epidemic's clear gender dimensions and differential risks and vulnerabilities of women and girls, men and boys, including sexual and gender-based violence;
- Strengthening a focus on most-at-risk populations with HIV-prevention 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 Labor; and
- Strengthening the involvement of the private sector in workplace HIV interventions.

#### **4.5 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:

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

#### **4.6 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 prevent people from wanting to know their HIV

status. This affects the utilization of voluntary and provider-initiated counseling and testing services. As a result, many individuals do not know their HIV status, while those who know are often driven “underground”, afraid of the consequences of disclosing their status to their partners, families, communities and employers. As a result, stigma and discrimination threaten PLHIV’s social position as well as their health, labor and other rights, they also present a major obstacle for the effective coverage and utilization of HIV-prevention services – such as PMTCT, and treatment of TB/HIV co-infection.

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

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

## **5. Support from the Country’s Development Partners**

### **5.1 Key Support Received from Development Partners**

Donors and partners support Liberia’s commitment to the HIV response. As a result of the ongoing process of reconstruction, Liberia has very limited national revenues. To date, government funds have covered personnel costs at the MOH&SW, NACP, and NAC. The vast majority of available HIV funding comes from international development partners, including:

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

### **5.2 Actions Necessary to the Achievement of GARPR Targets**

For the Country AIDS Progress Report targets to be met, partners should sustain, harmonize and coordinate their support to the national response. The National HIV Strategic Framework II 2010-2014 was developed with participation of all HIV stakeholders and is informed by priorities articulated in the Liberia Poverty Reduction Strategy (PRS-2006). All interventions

are aligned to the national priorities that are identified in the National HIV Strategic Framework II (2010-2014). This roadmap clearly identifies targets and indicators for a comprehensive national monitoring and evaluation.

At the international level, efforts should be made to accelerate the harmonization process to optimize reporting requirements for all countries. This would save time and resources and allow staff to concentrate on the national priorities.

## **6. Monitoring and Evaluation Environment**

### **6.1 Overview of Current Monitoring and Evaluation System**

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

The national level multi-sectorial HIV&AIDS response is managed and coordinated by National ADIS Commission. The overall responsibility for monitoring and evaluating the implementation of the NSF II 2010-2014 lies with the NAC.

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

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

National umbrella organizations of civil society and private businesses also monitor and report collectively on the HIV&AIDS work undertaken by their constituency members.

Sector ministries are responsible for coordinating the HIV&AIDS activities within their respective sectors. Within each of these sectors, an M&E focal person manages and coordinates all M&E activities including for HIV&AIDS interventions. Furthermore, some ministries generate information on indicators in this M&E Plan.

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

## **6.2 Challenges for Implementation and Remedial Actions Planned**

Many of the challenges to effective and efficient implementation of the NSF II that were identified 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 interventions. 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 behavioral 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 Procurement and Supply Chain Management (PSM), but important gaps and weaknesses still remain in 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<sup>5</sup>:

- Establishing a regular second-generation surveillance system, based on population ANC data, and bio-behavioral surveillance of most-at-risk population. The first IBBSS was conducted in 2013 and a Modes of Transmission (MoT) study is pending later this year.
- Knowing “what works” 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;
- Improved coordination of data collection, flows and utilization; by establishing a Joint National HIV Surveillance and M&E System and Plan, based on common M&E standards and tools, clear reporting lines, and easily accessible data;
- Strengthening M&E capacity among implementers and coordinating bodies, as well as improving the regular supply of HIV test kits to health facilities to ensure regular facility-based reporting of HIV cases.
- Mapping of community based systems and tools to strengthen and make functional the community based reporting through the Country Response Information System (CRIS). These efforts will involve all stakeholders and implementing partners at community level.

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<sup>5</sup> NSF II (2010-2014): Priority Issues Emerging from Epidemiological, Situation and Response analysis.