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# HIV Situation and Response Assessment USAID/Monrovia



August 2007

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**August 2007**

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Liberia is at a crossroads in so many ways, and the challenges are formidable. However, the dedication and spirit of everyone we met on this assignment puts success well within reach. We hope we have helped in some small way to move Liberia and USAID forward to control the spread of HIV/AIDS nationwide.



## ACRONYMS

|                |   |
|----------------|---|
| <b>AID/W</b>   | USAID/Washington  |
| <b>AHA</b>     | Africa Humanitarian Action                                |
| <b>AIDS</b>    | Acquired Immune Deficiency Syndrome                       |
| <b>ANC</b>     | Antenatal clinic  |
| <b>ARV</b>     | Anti-retroviral   |
| <b>AWARE</b>   | Action for West Africa Region                             |
| <b>BASICS</b>  | Basic Support for Institutionalizing Child Survival       |
| <b>BCC</b>     | Behavior change communication                             |
| <b>BGH</b>     | Bureau for Global Health (USAID/W)                        |
| <b>BPHS</b>    | Basic package of health services                          |
| <b>CHAL</b>    | Christian Health Association of Liberia                   |
| <b>CHT</b>     | County health team  |
| <b>DfID</b>    | Department for International Development (Britain)        |
| <b>ELWA</b>    | Eternal Love Winning Africa                               |
| <b>FBO</b>     | Faith-based organization                                  |
| <b>GAVI</b>    | Global Alliance for Vaccines and Immunization             |
| <b>GFATM</b>   | Global Fund for AIDS, TB, and Malaria                     |
| <b>GOL</b>     | Government of Liberia                                     |
| <b>HIV</b>     | Human Immunodeficiency Virus                              |
| <b>ICRC</b>    | International Committee for the Red Cross                 |
| <b>IEC</b>     | Information, education, communication                     |
| <b>IMC</b>     | International Medical Corps                               |
| <b>IRC</b>     | International Rescue Committee                            |
| <b>LDHS</b>    | Liberia Demographic Health Survey                         |
| <b>LIBR</b>    | Liberia Institute for Biomedical Research                 |
| <b>LOAF</b>    | Liberian Orphans AIDS Foundation                          |
| <b>M&amp;E</b> | Monitoring and evaluation                                 |
| <b>MDM</b>     | Médecins du Monde   |
| <b>MIS</b>     | Management information system                             |
| <b>MOHSW</b>   | Ministry of Health and Social Welfare                     |
| <b>MSF</b>     | Médecins Sans Frontiers                                   |
| <b>NAC</b>     | National AIDS Commission                                  |
| <b>NACP</b>    | National AIDS Control Program                             |
| <b>NGO</b>     | Non-governmental organization                             |
| <b>OFDA</b>    | Office of Foreign Disaster Assistance (USAID)             |
| <b>OVC</b>     | Orphans and vulnerable children                           |
| <b>PEPFAR</b>  | President's Emergency Plan for AIDS Relief                |
| <b>PHN</b>     | Population, Health, and Nutrition (Office, USAID/Liberia) |
| <b>PMI</b>     | President's Malaria Initiative                            |
| <b>PMTCT</b>   | Prevention of mother-to-child transmission                |
| <b>STI</b>     | Sexually transmitted infection                            |
| <b>UNAIDS</b>  | Joint United Nations Program on HIV/AIDS                  |
| <b>UNDP</b>    | United Nations Development Program                        |
| <b>UNFPA</b>   | United Nations Population Fund                            |
| <b>UNICEF</b>  | United Nations Children's Fund                            |
| <b>USAID</b>   | United States Agency for International Development        |
| <b>VCT</b>     | Voluntary counseling and testing                          |
| <b>WHO</b>     | World Health Organization                                 |
| <b>YMCA</b>    | Young Men's Christian Association                         |



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# EXECUTIVE SUMMARY

## Introduction

Liberia presents a challenge in the worldwide fight against HIV/AIDS. Fourteen years of civil war and injustice have taken a heavy toll on the country's infrastructure, including its health system. The government of Liberia estimates 354 health facilities are presently functioning and another 200 do not provide even basic services. Human resources represent a critical shortcoming of the system and evidence suggests that more than 70 percent of Liberia's health services are delivered by international non-government organizations (NGOs) and local NGOs (staffed by Liberians).<sup>1</sup> The health system has been strengthened by a large influx of NGO emergency assistance aimed at providing a basic package of health services (BPHS) nationwide.

Epidemiologically, Liberia is on the brink of a generalized epidemic. Liberia Demographic Health Survey (LDHS) data indicate that 1.5 percent of Liberians 15 to 49 years old are infected with HIV. Prevalence in women is 50 percent higher than in men (1.8 percent versus 1.2 percent). Women ages 20 to 29 and 35 to 39 have the highest infection rates (2.0 percent and 2.5 percent, respectively), and women in the 15 to 19 and 20 to 24 age groups present a 300 percent greater prevalence than men of the same age. Although these latter data must be viewed carefully, women appear to be at higher risk than men in Liberia.

The National AIDS Control Program (NACP) calculated a 5.7 percent HIV prevalence from its 2006 antenatal clinic sentinel survey, which only included pregnant women. The NACP intends to expand the ANC survey in 2007 and 2008 to include more sites in order to monitor the HIV prevalence profile in the urban setting. Important information can be obtained in future years from an expanded, HIV sentinel surveillance effort in Liberia.

Access to HIV and other health services is meager at best. Low levels of HIV/AIDS services represent a critical development challenge for treatment, prevention and care in the near and medium terms. Lack of sound prevention practice, knowledge of status, stigma, denial, human capacity, minimal laboratory support, gender disparities, and generally overstretched systems define the development challenge in Liberia, particularly for the health sector and HIV/AIDS.

An initial, sustained commitment over the next five years of targeted HIV resources is politically and technically required in order to prevent the spread of the virus, particularly in girls and youth in general. USAID needs to be a partner in this commitment. The purpose of this assessment is to help the Mission further define its role as a major development partner in the fight against HIV/AIDS.

## Current Response

The NACP is the operational focal point for HIV/AIDS prevention and control in Liberia. NACP's objective is to guide, facilitate, and coordinate the overall response to HIV/AIDS in Liberia. The NACP works closely with the recently revitalized National AIDS Commission (NAC), which is in the Office of the President and represents the intersectoral policy body of the government of Liberia (GOL). A new strategy is planned for 2007 building upon the 2004 National Strategic Plan. Reducing new infections and limiting the impact of HIV in Liberia comprise the present strategic goal. The NACP works in tandem with the United Nations Development Program (UNDP) in the administration of resources from the Global Fund for AIDS, TB, and Malaria (GFATM). The GOL signed a GFATM Round-6 grant in February 2007 for \$33 million (Phase 1 = \$12 million). Although broad, GFATM resources cannot meet all the needs. Major concerns of

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<sup>1</sup> Sheperd-Banigan, M., Joseph, S.C., Aitken, I., Baer, F., Crystal, P., Hessler-Radelet, C., Silimperi, D., 2007. Health Systems Transition and the Transition Gap in Liberia. Arlington, VA, USA. Basic Support for Institutionalizing Child Survival (BASICS) for the United Agency for International Development, 31pp.

the NACP include duplication of effort among donors and a progressively disjointed response to the pandemic.

A review of the HIV/AIDS stakeholders portrays an environment that has a strong potential to expand and fill many of the HIV/AIDS service delivery gaps that presently exist in Liberia. Health services are provided, for the most part, by NGOs and faith-based organizations (FBOs) and are supported by various bi- and multi-lateral organizations. USAID is a major player in the health sector, and the U.S. government supports more than 60 clinics through combined activities. Coordinating efforts and integrating assistance is required given the dearth of human resources across the systems.

A number of bilateral and multilateral donors provide HIV/AIDS support through NGOs and FBOs. Thus, the non-governmental sector represents a powerful opportunity for expanding HIV/AIDS prevention, care, and treatment. Although many local NGOs exist, oversight by international NGOs remains a requirement in the medium term. FBOs reach broad segments of the population and have been working throughout the civil war. Many are linked to hospitals and/or health centers and oversee the operation of clinics as well. The Christian Health Association of Liberia (CHAL) offers an important option for outreach of integrated HIV/AIDS services and greater integration within the health system in general. Africare supports 37 clinics and wants to expand its HIV/AIDS services significantly. The private sector also has potential in Liberia. A number of concessions engaged in rubber production and mining could be engaged to reach large numbers of workers, families, and communities with HIV/AIDS services.

USAID/Liberia's response to HIV/AIDS is in its nascent stages. It is utilizing the emergency and transition NGO platform to begin addressing key areas, such as expanding prevention and care. Elements of a planned USAID FY 2007 support package include care and support; blood safety; efforts promoting abstinence, behavior change, and condom use (ABC); and systems support. These general areas of support are appropriate in the near term, but are limited in scope and outreach, given available resources. USAID is on the cusp of greater HIV/AIDS engagement in Liberia and is poised to address more fully a number of important gaps as a major donor in FY 2008 and beyond.

## **Gaps and Priorities in HIV/AIDS Response in Liberia**

Poverty and high rates of illiteracy present strong barriers to reaching many Liberians and contribute to the fragility of the State. Roads, electricity, governance, communication, physical plants, logistics, equipment, and supplies all require attention. USAID cannot address all of the challenges that face Liberia, but USAID can and should address some of the gaps in the health system and, in particular, seize opportunities in the HIV/AIDS arena.

The new administration of President Sirleaf imparts political commitment to HIV/AIDS at the highest levels. The 2004 National Strategic Plan of Action for HIV/AIDS identified the following areas where gaps existed in the GOL's response:

- General prevention
- Information, education and communications (IEC)
- Surveillance
- Blood safety
- Sexually transmitted infection (STI) management
- Programs for people living with HIV/AIDS
- Care and support for orphans and vulnerable children (OVCs)
- Systems management (including institutional development and coordination)

Gaps in these priorities remain today, and it is incumbent upon the nation and donor community to address these issues in the near and medium terms.

Liberia's unique situation as an emerging democracy argues for a more flexible, development-oriented approach to programming. This approach would maintain direct and attributable results from each funding account, but cost-share, in a "wrap-around" manner, crosscutting interventions. Government policy specifically identifies program integration within a basic package of health services (BPHS) and specifically includes STI and HIV/AIDS prevention. Thus, resource integration would be welcomed by the GOL.

The entire monitoring and evaluation (M&E) system for health in Liberia requires support and expansion. Government, donor, NGO and consultant reports consistently raise M&E as a major constraint to program implementation and effective decision making. M&E is linked directly to an appropriate and functioning surveillance and reporting system, and to logistic planning at the central and county levels. An overhaul of the management information system (MIS) is in order. This will serve the GOL, donors, and other stakeholders well when instituted.

## Opportunities

The following opportunities argue for expanded development assistance in the HIV/AIDS arena for Liberia.

- **Optimum timing for improving U.S.-Liberia relations.** With the recent democratic election of a President of Liberia and the stabilization of the country, the time is right for the U.S. government and USAID to commit to the future development of Liberia in a variety of areas, including health care. USAID can and should provide a continuum of assistance to address the challenges in the health sector and particularly those faced in the HIV/AIDS arena.
- **Radio messaging.** Radio messages supporting prevention and care initiatives can be very effective in changing behaviors and supporting care initiatives. Numerous public and private radio stations exist in Monrovia and in the counties, and outreach stretches to the community level. Cost is surprisingly low.
- **Private sector.** There is an important private sector in Liberia. The platform of international NGOs is strong and a number of mines, rubber plantations, and other industrial entities exist. Local NGOs, particularly FBOs, represent a network of outreach that can expand service delivery. Furthermore, corporate concerns, such as the Firestone Rubber Company, may be interested in collaboration to bolster HIV/AIDS control efforts, especially in prevention and fighting stigma.
- **HIV epidemic curve.** Liberia may still be on the early part of the epidemiologic curve, where intervention could yield great returns in preventing future infections and saving the country from huge costs of care. Currently, HIV prevalence is significant in urban areas. War and poverty promote transactional and violent sex, which are important factors in the spread of the virus. Epidemiologically, a window of opportunity exists, but it is closing quickly.
- **USAID's comparative advantage.** USAID enjoys a broad comparative advantage in the HIV/AIDS arena. There is a strong U.S. commitment to HIV/AIDS prevention and control in Africa, as exemplified by programming from the President's Emergency Plan for AIDS Relief (PEPFAR). USAID and partner U.S. government agencies have demonstrable prowess in all the major interventions for HIV/AIDS prevention, care, and treatment, including mass media, target group interventions, behavioral change communication (BCC), voluntary counseling and testing (VCT), MIS, and M&E. A huge bank of experience and expertise lies within the U.S. system and within USAID's centrally based technical projects. The Mission has a large selection of available central projects and mechanisms to access in order to meet present and future HIV/AIDS challenges in Liberia. USAID's comparative advantage is anchored in prevention (a primary focus of this assessment), linking behavioral change with communication. USAID has the ability to support large prevention networks and link them with other thought-focused programming, information sharing, and best-practice dissemination.

## Constraints

USAID/Liberia should consider policy, management, and structural constraints during the design of the USAID/Liberia HIV/AIDS Program, including:

- **Political stability and security.** Transitional states are fragile by definition. Positive government performance is critical to success, not only in the health sector itself, but also in other sectors that can affect health care delivery.
- **Use of planned budget increases for health.** There is a strong GOL intention to increase health resources over the next five years. However, translating intentions into action remains worrisome.
- **Complacency resulting from new LDHS results.** Although the new LDHS results are good news for Liberia, they must not lead to complacency by the government, people, or donors.
- **Human resources and GOL support.** Fourteen years of civil war have taken a deep toll on Liberia's capacity to manage, plan, and implement. A key issue in this area is the GOL's commitment to establish GOL positions and support those positions via budget line item adjustments.
- **Roads, weather, topography and geographic isolation.** Logistics in Liberia are difficult at best. In the rainy season, roads become quagmires and are often impassable. Isolated areas in the southeast represent a particular problem and these areas remain underserved.
- **Prevalence of poverty and unemployment.** Poverty and unemployment are major barriers to Liberia's development agenda. They are pervasive, with approximately 75 percent of Liberians living on less than \$1 per day and an unemployment rate of approximately 85 percent.

## Key Findings and Recommendations

### Prevention

- **Findings:** Awareness of HIV/AIDS is high, but less than 10 percent of Liberians know if they have the disease.<sup>2</sup> Attitudes towards protection and practice of healthy behaviors remain low, and risk is generally under-perceived by high-risk groups and the general population. Stigma and denial are pervasive and sharp gender differences in attitudes, risk, and empowerment exist. Polygamy is widely practiced. Serial monogamy, transactional sex, and sexual violence contribute to transmission. Youth and girls are at particular risk.
- **Recommendations:** USAID should provide comprehensive prevention support and expand positive behavior change through multimedia-based ABC messaging. The Mission should begin to support this activity with FY 2008 funds, prior to the final design of a new HIV/AIDS activity. Costs remain low for prime-time radio messages and a concerted effort can reach many segments of the population.

### Potential to expand the local network of providers

- **Findings:** A network of health care sites has been set up throughout the country by local and international NGOs during the emergency period. However, HIV/AIDS services are rudimentary in most of the sites. This argues strongly for an expansion of ABC messages, VCT, post-test counseling, follow-up, care (including home-based and OVC care) and treatment in these sites.

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<sup>2</sup> MOHSW/NACP, 2007. Draft Report of the Joint Review of the Liberia HIV/AIDS National Response. NACP/Dr. Nancy Bannerman, 45pp.

- **Recommendations:** USAID should continue to support the network established by Office of Foreign Disaster Assistance (OFDA) and others, and expand HIV services under the new program.

#### Human capacity

- **Findings:** The dearth of human capacity across the entire Liberian system is a major challenge to progress in the near and medium terms. In particular, Liberians in country lack the necessary technical and administrative skills to implement programs to address HIV/AIDS. Critical gaps in human capacity exist at the central and county levels. Management and planning training for NACP, NAC, CHT, and NGO/FBO staff will help to strengthen service delivery, program efficiencies, monitoring, and evaluation.
- **Recommendations:** USAID should invest in a major training component within the HIV/AIDS program. Starting in FY 08, the PHN Office should help the NACP and NAC improve their management and coordinating skills. In later years, assistance should extend to the county health teams and local networks therein. An integrated approach to training with options for sharing resources within the PHN accounts should be explored. USAID can and should invest in all levels of pre- and in-service training to ensure the delivery of HIV/AIDS services over the program period.

#### Data for decision making, monitoring, and evaluation

- **Findings:** The Liberian health system lacks an efficient, streamlined, functional management information system. The HIV/AIDS element of the MIS would focus on general ABC prevention efforts including IEC messages and BCC impact, surveillance information, VCT outreach, counseling follow-up, laboratory data on treatment, adherence, and resistance profiles.
- **Recommendations:** USAID should assume the donor lead in MIS technical and programmatic assistance, given its comparative advantage in this area.

#### VCT

- **Findings:** Less than 10 percent of Liberians know their HIV status. About 90 percent of those tested do not return for results, according to the NACP.<sup>3</sup> Most county health teams do not provide VCT and lack the counseling capacity for follow up.
- **Recommendations:** USAID should prioritize its annual investment in VCT based on geography of HIV, need, and other donor support. The CHAL network presents a particular opportunity for expansion of VCT. Support would include commodities, diagnostic training, counseling training, site strengthening, IEC messages, and training.

#### Policy Dialogue

- **Findings:** The GOL is open to receiving assistance in making key policy decisions regarding HIV/AIDS service delivery and support. The NAC is in the process of developing a New National Strategic Plan for HIV/AIDS and has already requested assistance from USAID.
- **Recommendations:** USAID should support policy dialogue with the GOL, particularly with the NAC and NACP. The Mission also should consider ways to engage the Ambassador in key HIV/AIDS policy issues and events. Participation in World AIDS Day, discussion of HIV/AIDS issues at meetings with the President, speeches at various opening events, OpEd articles in the press, etc., could be considered.

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<sup>3</sup> MOHSW/NACP, 2007. Draft Report of the Joint Review of the Liberia HIV/AIDS National Response. NACP/Dr. Nancy Bannerman, 45pp.

Innovative and attractive ideas should be presented to the Ambassador in writing on a semi-annual basis to place HIV/AIDS advocacy and policy support on his monthly agenda.

## Summary

The stark realities of Liberia's transition represent formidable challenges to effective and efficient programming in HIV/AIDS, but progress is possible and problems can be avoided. A bold and comprehensive approach to HIV/AIDS prevention and control is justified and highly desired by the GOL. The GOL embraces technical assistance, particularly U.S. technical assistance, and wants USAID to become a full development partner. It makes sense for USAID to assume a major partner role. Americans are welcomed and thus, USAID has a tremendous comparative advantage to provide technical assistance and implementation support at all levels of the system, from the communities and clinics to the Office of the President.

## **I. INTRODUCTION**

Promoting health, including preventing and treating HIV/AIDS, is included in the Foreign Assistance Objective of “Investing in People, restoring or establishing the provision of basic social services such as health.” The United States enjoys a unique historic relationship with Liberia that began more than 160 years ago. The democratic transition and revitalized stability of the country argues for an enhanced U.S. presence. Increased assistance in HIV/AIDS programming is one important conduit to continuing our strong ties with Liberia, bolstering their new democracy, and improving the well-being of millions of Liberians.

## **II. CURRENT SITUATION OF LIBERIA’S HEALTH SECTOR, LDHS INDICATORS, AND HIV/AIDS**

### **Health System Overview**

Fourteen years of civil war and injustice have taken a heavy toll on Liberia. About 85 percent of Liberians are currently unemployed and 75 percent are living in poverty. The country suffers from poor roads and a weak infrastructure.

The health system suffered greatly as well. The GOL estimates that although 354 health facilities are presently functioning, another 200 do not provide even basic services. Human resources represent a critical shortcoming of the system and anecdotal evidence suggests that more than 50 percent of Liberia’s health services are delivered by expatriates.

The health system was strengthened by a large influx of NGO emergency assistance during the war aimed at providing a BPHS nationwide. However, emergency NGOs are transitioning out and future assistance is moving into recovery and development modes. Donors will have to adjust to the transition as well, and begin to provide a continuum of development assistance to deepen Liberia’s capacity to provide basic preventive and curative services.

Table 1 presents estimates and approximations (~) of health system data reported in the National Health and Social Welfare Plan (2007–2011).<sup>4</sup> Access to health services is about 40 percent and about 75 percent do not have access to clean water or appropriate sanitation. Data imply there are about 6 doctors per 100,000 and about 57 total health providers per 100,000.

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<sup>4</sup> Government of Liberia, 2007. National Health and Social Welfare Plan (2007-2011). Ministry of Health and Social Welfare, Monrovia Liberia, February 2007, 21pp.

**Table I: General Health System Statistics—Liberia**

| Element                              | Number    |
|--------------------------------------|-----------|
| Total Population                     | 3.27M     |
| Area (sq kilometers)                 | 111,370   |
| Population Growth Rate               | 2.4%      |
| Population Doubling Time             | ~29 years |
| Literacy                             | <40%      |
| Population Living Below Poverty Line | ~75%      |
| Functional Health Facilities         | 354       |
| Functional Hospitals                 | 18        |
| Functional Health Centers            | 50        |
| Functional Health Clinics            | 286       |
| Facilities Run by FBOs/CHAL          | 44        |
| Non-Functional Health Facilities     | ~200      |
| Access to Health Services            | ~41%      |
| Access to Safe Water                 | ~24%      |
| Access to Safe Sanitation            | ~26%      |
| Total Full-Time Health Workforce     | ~4,000    |
| Total Part-Time Health Workforce     | ~1,000    |
| Number Doctors                       | ~168      |
| Number Registered Nurses             | ~453      |
| Number Physician's Assistants        | 273       |
| Number Certified Midwives            | 297       |
| Nurse Aides, other professionals     | ~700      |

Source: National Health and Social Welfare Plan (2007-2011)

Table 2 presents estimates and approximations from the 2007 LDHS, which was performed by the Liberian Institute for Statistics and Geo-Information Services with the support of Macro International.<sup>5</sup> Data were collected between December 2006 and April 2007. The survey canvassed men and women ages 15 to 49 from over 7,000 households. In addition to questionnaire data, consensual blood samples were obtained and analyzed at the National Laboratory for HIV of the Ministry of Health and Social Welfare (MOHSW) at JFK Memorial Hospital in Monrovia.

<sup>5</sup> Liberian Institute of Statistics and Geo-Information Services, 2007. Liberia Demographic and Health Survey 2007 – Preliminary Report. LISGIS & Macro International Inc., Monrovia, Liberia and Calverton, Maryland.

**Table 2: Preliminary Data from Liberia Demographic Health Survey – July 2007\***

| Element   |           |
|---|-----------|
| Total population  | ~3.27M    |
| Number of women   | ~1.635M   |
| Number of men   | ~1.635M   |
| Total fertility rate  | 5.2       |
| Total fertility rate rural  | 6.2       |
| Total fertility rate urban  | 3.6       |
| Contraceptive prevalence rate   | 11.4%     |
| Modern contraceptive prevalence rate                                      | 10.2%     |
| Urban (total) contraceptive prevalence rate                               | 18.7%     |
| Rural (total) contraceptive prevalence rate                               | 7.7%      |
| Maternal mortality ratio***   | 580/100K  |
| Antenatal visit to professional****                                       | 79.3%     |
| Women delivered at facility   | 37.1%     |
| Infant mortality rate   | 72/1,000  |
| Under-5 mortality rate  | 111/1,000 |
| Full Immunization coverage  | 39%       |
| DPT3 coverage   | 65.7%     |
| Measles coverage  | 63.3%     |
| Polio (3 doses)   | 49.3%     |
| Diarrhea case receiving any oral rehydration therapy at facility/provider | 58.0%     |
| Households with one mosquito net (insecticide-treated or not)             | 30.4%     |
| Preventive malaria treatment during pregnancy                             | 83.2%     |
| Malaria treatment for children under 5                                    | 58.5%     |
| Height for age below 2 standard deviations                                | 38.7%     |
| Weight for height below 2 standard deviations                             | 7.3%      |
| Weight for age below 2 standard deviations                                | 18.8%     |

\*General Information based on LDHS 2007. These data are for USAID internal use only.<sup>6</sup>

\*\*Many of the numbers in this table are approximations (~) and should not be considered as hard data. They are presented to add supplemental perspectives to recent LDHS data.

\*\*\*Source: National Health and Social Welfare Plan (2007–2011)

\*\*\*\*Doctor, nurse, midwife, physician's assistant

For the purposes of this report, a male to female ratio of 1:1 was assumed. This may be skewed by the civil war and other factors, but recent census data are unavailable. The LDHS calculated total fertility at 5.2, with rural fertility close to 70 percent greater than urban fertility. Modern contraceptive prevalence is only 10.2 percent, implying a significant unmet need. Most women deliver at home, yet antenatal visits to a health-trained professional are high (approximately 80 percent). Maternal mortality is also high (580 deaths per 100,000 births), implying poor service, unrecognized high-risk pregnancies, and lack of referrals. Surprisingly, infant and under-5 mortality rates are low, but only 40 percent of children ages 0 to 24 months are fully immunized. Use of oral rehydration salts is moderate. Malaria services are mixed, with 83 percent of mothers receiving preventive therapy but a low rate of usage of insecticide-treated nets and treatment for children under 5 years of age. Chronic malnutrition is pervasive and compromises child health in general.

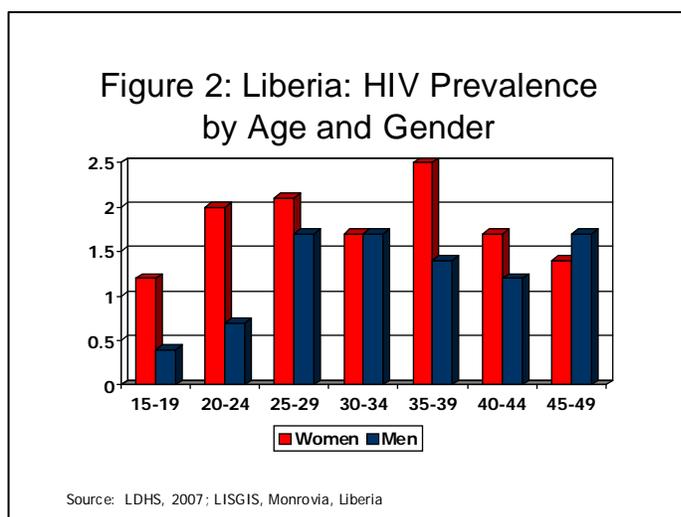
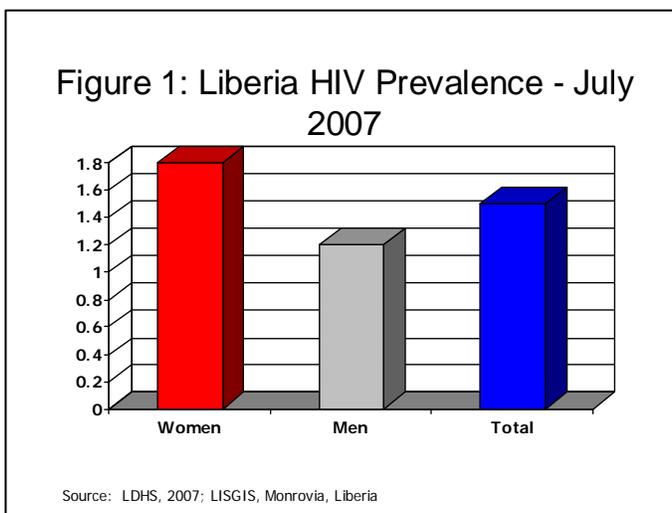
Clearly, tremendous challenges face Liberia today, but these challenges will not disappear and cannot be adequately addressed by emergency investments. Liberia's population is currently estimated at about 3.3 million, and with a growth rate of 2.4 percent, will double to 6.5 million by 2037. Sound and continuous development interventions are in order in both the public and private sectors to promote healthy behavior, treat disease, and manage illness both now and in the future.

<sup>6</sup> Ibid.

## HIV/AIDS Overview

The 2006 National Communication Strategy for HIV Prevention states the general nature of HIV in Liberia is characterized by predominantly heterosexual transmission between older men and younger women, particularly among mobile populations in border towns and urban commerce centers. Knowledge is high, but perceived risk is low, characterized by risky sexual behaviors.<sup>7</sup> Low age of sexual debut and multiple sexual partners are commonplace. Consistent condom use is low and barriers are many. The 2007 Draft Joint Review of the Liberia HIV/AIDS National Response<sup>8</sup> states an early age of sexual debut for young women and high rates of transactional sex (fueled by poverty and food insecurity) drive the epidemic. Sexual coercion and violence, children not living with their parents, out-of-school youth, and drug and alcohol abuse are additional contributing factors to transmission. Even with recalculated prevalence estimates, the risk of explosive HIV transmission is real.

This assessment examines data on HIV/AIDS prevalence from two primary sources—the LDHS and the NACP HIV Antenatal Clinic Sentinel Site Survey.



LDHS data indicate HIV prevalence is 1.5 percent in Liberians ages 15 to 49 years. This is about 26 percent of the prevalence estimated by the 2006 NACP antenatal clinic survey. Prevalence in women is 50 percent higher than men (1.8 percent versus 1.2 percent), as seen in Figure 1. Figure 2 further indicates women aged 20 to 29 and 35 to 39 have high infection rates (2.0 and 2.5, respectively). Prevalence in women in the 15 to 19 and 20 to 24 cohorts presented a 300 percent greater prevalence than males of the same age. These latter data must be viewed carefully. However, as in other countries, women appear to be at higher risk than men in Liberia and represent a critical challenge for treatment, prevention, and care in the near and medium terms.

Approximately 68 percent of Liberia's population lives in rural areas.<sup>9</sup> It is estimated that 40 percent of Liberia's population live within 40 miles of Monrovia. Urban HIV prevalence exceeds rural prevalence by a ratio of three to one

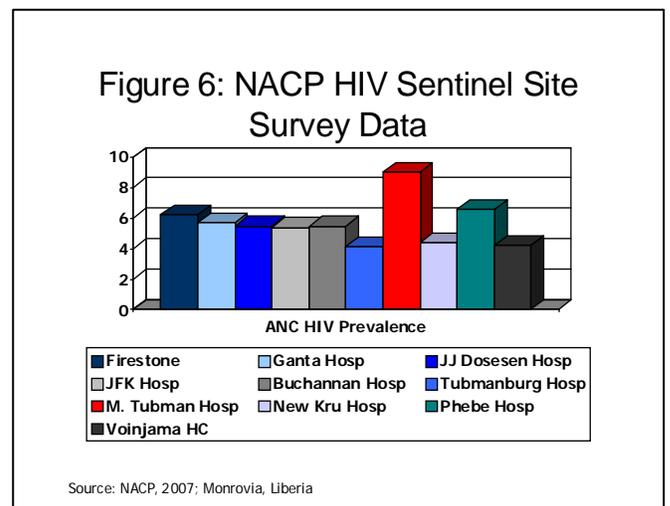
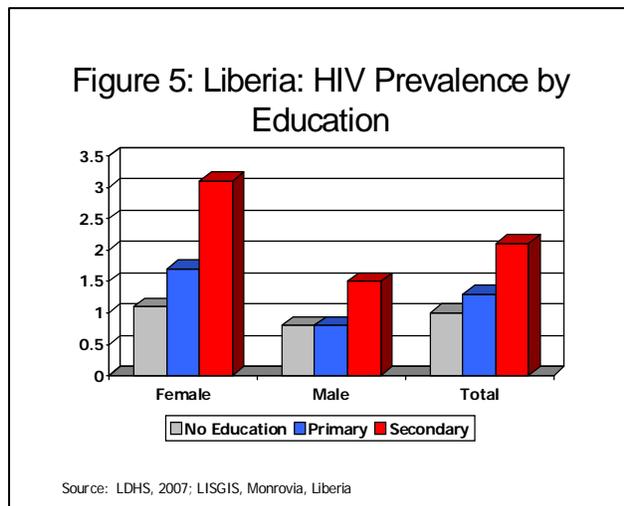
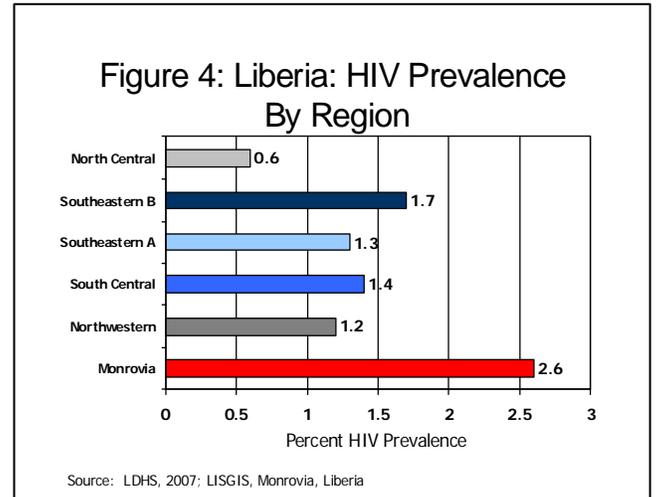
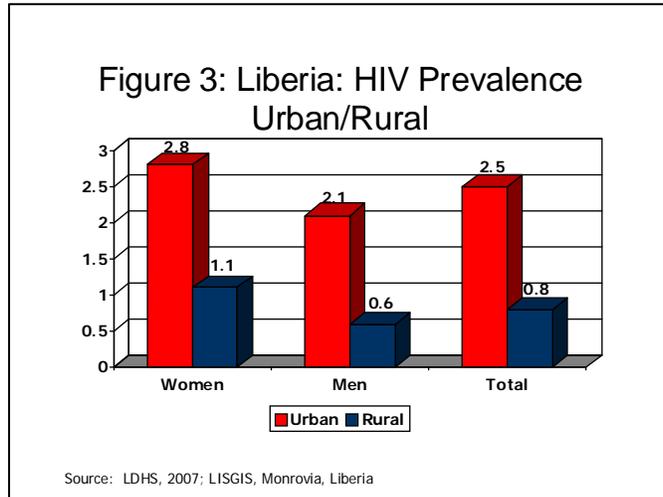
<sup>7</sup> MOHSW, Government of Liberia, Communications Unit, 2006. Liberia HIV/AIDS Situation Analysis (In Preparation for Development of a National Communication Strategy, April 2006, 42pp.

<sup>8</sup> Government of Liberia/NACP, 2007. Draft Report of the Joint Review of the Liberia HIV/AIDS Response (Dr. Mercy Bannerman), 45pp

<sup>9</sup> National AIDS Control Program (Government of Liberia), 2007. HIV Sentinel Survey Among Pregnant Women Attending Antenatal Care 2006. WHO, Monrovia, Liberia.

(Figure 3). Similarly, county prevalence data are skewed toward counties with higher urban concentrations or those close to the Ivory Coast Border (Figure 4).

Education level appears to be proportional to HIV infection in Liberia. Women and men with secondary education presented higher rates of infection than those with primary or no education. Disturbingly, women with secondary education levels presented the highest prevalence (3.1 percent) (Figure 5).



In contrast to the LDHS, the NACP calculated a 5.7 percent HIV prevalence from its antenatal clinic sentinel survey conducted in 2006.<sup>10</sup> However, the NACP survey only included pregnant women drawn from 10 antenatal clinics. As noted in Figure 6, the prevalence rate ranged from four percent at Tubmanburg Hospital in Bomi County, to nine percent at Martha Tubman Hospital in Grand Gedeh County. This high rate of infection in antenatal women in Grand Gedeh may be due to cross-border influences from the Ivory Coast and the large draw of the NGO-supported hospital. (See Figure 7 for the location of the clinics.) Although rural women attend antenatal clinics, attendees are primarily urban and often from younger age groups. The NACP intends to expand the antenatal clinics survey in 2007 and 2008 to include more sites so it can monitor the HIV prevalence profile in the urban setting.

It is important to stress that the value of the NACP antenatal clinics survey is not diminished by the larger LDHS, and important information can be obtained in future years from an expanded, HIV sentinel surveillance effort in Liberia. Broadening surveillance, through expanded antenatal clinics and VCT sites, will deepen the understanding of HIV transmission in Liberia and further inform programmatic investments.

Table 3 on the following page presents some extrapolated HIV information that may be considered in the design of an HIV/AIDS program. Given the LDHS-estimated prevalence of 1.5 percent, total HIV infections are estimated at about 26,000, of which 6 percent are children. About 15,000 adult women are infected versus about 10,000 men, defining a clear risk for HIV infection in Liberian women. About 5,200 people probably require anti-retroviral (ARV) medicines in Liberia, but only an estimated 1,000 people are presently receiving them nationwide.

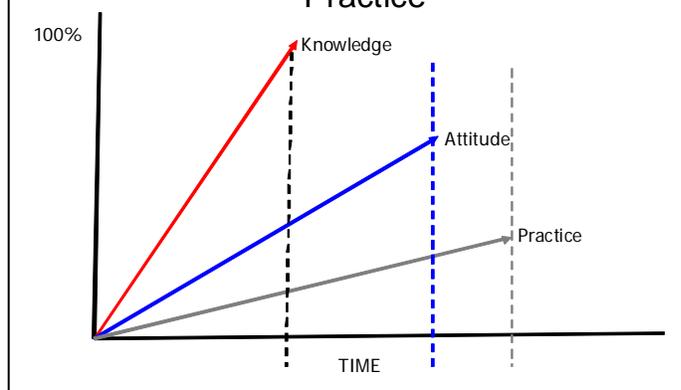
Voluntary testing and counseling is underutilized and lacks outreach in most counties. Increasing the number of sites will improve surveillance, expand service, and reduce stigma. Although knowledge of HIV/AIDS is high throughout Liberia, practice of healthy behaviors requires attention. As illustrated in Figure 8,<sup>11</sup> basic knowledge can be increased fairly rapidly, but changing attitudes and practice will take more time and requires consistent, clear, and appropriate messaging to all risk groups. All stakeholders agree Liberia drastically needs greater dissemination and distribution of solid information to promote healthy behaviors and prevent HIV infection.

**Figure 7: Location of NACP HIV Sentinel Sites**



Source: NACP, 2007; Monrovia, Liberia

**Figure 8: Knowledge, Attitude, Practice**



As illustrated in Figure 8,<sup>11</sup> basic knowledge can be increased fairly rapidly, but changing attitudes and practice will take more time and requires consistent, clear, and appropriate messaging to all risk groups. All stakeholders agree Liberia drastically needs greater dissemination and distribution of solid information to promote healthy behaviors and prevent HIV infection.

Liberia's capacity to process HIV-related laboratory information is limited and requires immediate attention. A comprehensive, functioning national reference laboratory does not exist. Strengthening existing sites as a national reference laboratory and/or a training

<sup>10</sup> Ibid.

<sup>11</sup> This graph is for informational purposes only and is not based on empirically collected data.

and applied research facility would greatly enhance Liberia’s response to the pandemic and to other diseases nationwide.

**Table 3: Extrapolated HIV Information**

| Element   | Number** |
|---|----------|
| Estimated number sexually active                            | ~1.635M  |
| HIV prevalence  | 1.5%     |
| Total infections (adults & children)                        | ~25,995  |
| Estimated adult HIV infections                              | ~24,525  |
| Estimated children infected (~6%) of total                  | ~1,470   |
| HIV prevalence in women                                     | 1.8%     |
| Number of women infected                                    | ~14,715  |
| HIV prevalence in men                                       | 1.2%     |
| Number of men infected                                      | ~9,810   |
| Estimated antenatal prevalence                              | 5.7%     |
| Estimated total requiring ARVs (20% of total infected)      | ~5,200   |
| Number of VCT sites <sup>12</sup>                           | 73       |
| Accredited VCT sites  | 33 (45%) |
| Number of ARV sites   | 11       |
| Number of CD4 machines                                      | 5        |
| Number of CD4 machines in storage                           | 4        |
| Number of people on ARVs <sup>13*</sup>                     | 916      |
| Knowledge of condom use as a prevention for HIV among women | 49.8%    |
| Knowledge of condom use as a prevention for HIV among men   | 71.2%    |
| Percentage of condom use for last intercourse among women   | 13.9%    |
| Percentage of condom use for last intercourse among men     | 25.2%    |
| Number of functioning national reference laboratories       | 0        |

\*Data are cumulative, but deaths, defaulters and/or new cases are not taken into account.

\*\*Many of the numbers in this table are approximations (~) and should not be considered as hard data. They are presented to add supplemental perspectives to recent LDHS data.

A sustained initial commitment over the next five years of targeted HIV resources is politically and technically in order. Complacency and inaction by the U.S. and/or the Liberian governments will result in the spread of the virus, particularly in girls and youth in general. This may have repercussions far beyond the health sector.

<sup>12</sup> Government of Liberia/NACP, 2007. Draft Report of the Joint Review of the Liberia HIV/AIDS Response (Dr. Mercy Bannerman), 45pp.

<sup>13</sup> Ibid. Page 22



### **III. CURRENT RESPONSE TO HIV/AIDS IN LIBERIA— STAKEHOLDER ROLES**

#### **GOL Response to HIV/AIDS**

The NACP was established in 1987 and is the operational focal point for HIV/AIDS prevention and control in Liberia. NACP's objective is to guide, facilitate, and coordinate the overall response to HIV/AIDS in Liberia. The NACP works closely with the recently revitalized National AIDS Commission, which is in the Office of the President and represents an intersectoral policy body of GOL. A new strategy is planned for 2007 and the NACP is presently organizing reviews of various "theme documents" that will inform the design of the 2007–2012 Revised National Strategic Plan. The NACP is the primary sub-recipient (sub-grantee) of the UNDP in the administration of GFATM resources. The GOL signed a GFATM Round-6 grant in February 2007. Phase 1 is for \$12 million and covers a two-year period (June 2007–May 2009). Phase 2, contingent on the success of Phase 1, will provide \$21 million for an additional three years, bringing the total grant to \$33 million.

Reducing new infections and limiting the impact of HIV in Liberia comprise the present strategic goal of the 2004 National Strategic Plan. It is assumed that these priorities will remain national priorities under the new Strategic Plan. Major concerns of the NACP include duplication of effort among donors and a progressively disjointed response to the pandemic. Operational priorities include:

- Expanded IEC and positive BCC. The NACP acknowledges the power of radio in Liberia and endorses expanded radio messages to inform the population and promote positive behaviors.
- Expanded HIV/AIDS services. The National Communication Strategy reports there is a widespread willingness to be tested. Presently, 73 VCT sites exist, but only 33 are accredited by the NACP. Quality is an issue and the NACP wants to significantly improve diagnosis, counseling, and case management in the future.
- Stigma reduction.
- Blood safety.
- Improved clinical management of sexually transmitted infections (STIs) and opportunistic infections. Only a handful of county hospitals serve as primary clinical sites for HIV/AIDS case management. Liberia lacks a functioning National Reference Laboratory, and this is a priority for the GOL as well as NACP.
- Improved program management and coordination. A major challenge is reporting HIV/AIDS data in the counties. Numerous forms exist and a consolidation of reporting forms and reporting periods is needed.

The NACP also wants to strengthen its capacity to monitor and evaluate program impacts and to assess and disseminate best practices to county health teams (CHTs). Most of these priorities fit well with U.S. government and USAID priorities in the HIV/AIDS arena.

The NACP recognizes the opportunity and need for strong and viable public-private sector partnerships, and welcomes broader participation of private concerns such as the rubber plantations and mines in the fight against HIV/AIDS.

## **B. Donor and NGO Support to HIV/AIDS in Liberia**

Table 4 on the following page presents a snapshot of donors and NGOs involved in HIV/AIDS in Liberia. The table is illustrative, and the depth of involvement and potential varies with each entity. However, Table 4 portrays an environment that has a strong potential to expand and fill many of the HIV/AIDS service delivery gaps that presently exist in Liberia. Health services are provided for the most part by NGOs and FBOs and are supported by various bilateral and multilateral organizations. USAID is a major player in the health sector, and the U.S. government supports more than 60 clinics through combined activities. Transitioning assistance from emergency to development assistance represents a major challenge and responsibility for the donor community. Furthermore, coordinating efforts and integrating assistance is required, given the dearth of human resources and infrastructure across the systems.

For HIV/AIDS, implementing the “three ones” is a necessary early step in effective HIV/AIDS programming. USAID enjoys significant leverage and traction with the NACP and can assist in helping to define specific donor and NGO niches for HIV/AIDS assistance. However, the prime responsibility rests with the NACP and, to a fair extent, the Joint United Nations Program on HIV/AIDS (UNAIDS). A greater coordinating role for both the NACP and UNAIDS is critical to successful HIV/AIDS efforts in the future. As noted, the UNDP administers the GFATM Round 6 grant at present. Although broad, GFATM resources cannot meet all the needs. BCC, laboratory support, capacity building diagnostic supplies, management, M&E, and policy development will likely require additional support.

NGOs, FBOs, and the private sector represent a powerful opportunity for expanding HIV/AIDS prevention, care and treatment. Many local NGOs exist, but they are ill prepared to manage large programs technically or financially. Oversight by international NGOs remains a requirement in the medium term.

FBOs reach broad segments of the population and have been working throughout the civil war. Many are linked to hospitals and health centers and oversee the operation of clinics as well. CHAL offers an important option for outreach of integrated HIV/AIDS services and greater integration with the health system in general. Africare supports 37 clinics and wants to expand their HIV/AIDS services significantly.

The private sector also has potential in Liberia. A number of concessions engaged in rubber production and mining could be engaged to reach large numbers of workers, families, and communities with HIV/AIDS services. For example, the Firestone Rubber Plantation at Harbel employs more than 7,000 workers and has an outreach of over 70,000. Engaging some of the major corporate sector concerns may result in significant economies of scale and the delivery of HIV/AIDS services to large segments of the population.

**Table 4: Major Health /HIV/AIDS Partners in Liberia**

| <b>GOL</b>   | <b>Bilateral*</b>  | <b>Multilateral</b>   | <b>Local NGOs**</b>  | <b>Local FBOs***</b>  | <b>Private Concerns</b>  | <b>Inter-national NGOs****</b>   |
|--|--|---|--|---|--|--|
| <ul style="list-style-type: none"> <li>• NAC</li> <li>• NACP (MOH)</li> <li>• MOH/BCC</li> </ul> | <ul style="list-style-type: none"> <li>• USAID</li> <li>• DfID</li> <li>• Irish Aid</li> <li>• JICA</li> <li>• Swiss AID</li> <li>• Others?</li> </ul> | <ul style="list-style-type: none"> <li>• Global Fund (UNDP)</li> <li>• UNICEF</li> <li>• UNAIDS</li> <li>• UNFPA</li> <li>• WHO</li> <li>• EU</li> <li>• Others?</li> </ul> | <ul style="list-style-type: none"> <li>• CHAL</li> <li>• MERCI</li> <li>• YMCA</li> <li>• LNRCS</li> <li>• LOAF</li> </ul> | <ul style="list-style-type: none"> <li>• Catholic Church</li> <li>• Methodist Church</li> <li>• Lutheran Church</li> <li>• Episcopal Church</li> <li>• ELWA</li> <li>• SDA Church</li> <li>• Baptist Church</li> <li>• Muslim Clinic/ Hosp</li> </ul> | <ul style="list-style-type: none"> <li>• Firestone Rubber</li> <li>• LAC</li> <li>• Guthrie Rubber</li> <li>• Cavalla Rubber</li> <li>• Private Providers</li> </ul> | <ul style="list-style-type: none"> <li>• Merlin</li> <li>• Africare</li> <li>• MSF</li> <li>• IRC</li> <li>• ICRC</li> <li>• SCF-UK</li> <li>• AHA</li> <li>• World Vision</li> <li>• IMC</li> <li>• MDM</li> <li>• AWARE</li> </ul> |

\* DfID = Department for International Development (Britain)

\*\* CHAL = Christian Health Association of Liberia, which is a local coordinating NGO that administers support to multiple FBOs. LNRCS = Liberian National Red Cross Society. LOAF = Liberian Orphans AIDS Foundation

\*\*\* ELWA = Eternal Love Winning Africa. MSF = Médecins Sans Frontiers. IRC = International Rescue Committee. ICRC = International Committee for the Red Cross. AHA = Africa Humanitarian Action. IMC = International Medical Committee. MDM = Médecins du Monde.

### **C USAID/Liberia's Response to HIV/AIDS**

USAID/Liberia's response to HIV/AIDS is in its nascent stages. It is using the emergency and transition NGO platform to begin addressing key areas, such as expanding VCT, prevention, and care. Elements of a planned USAID FY 2007 support package include care and support, blood safety, ABC efforts, and systems support. These general areas of support are appropriate in the near term, but are limited in scope and outreach, given available resources. USAID is on the cusp of greater HIV/AIDS engagement in Liberia and is poised to address more fully a number of important gaps as a major donor in FY 2008 and beyond. Table 5 presents a compendium of leadership within the HIV/AIDS arena. The assessments of leadership are preliminary and based on brief discussions. However, USAID/PHN Office can further define leadership niches in follow-on discussion with GOL and donor partners.

**Table 5: Synopsis of Role of USAID and Other Donors in HIV/AIDS Prevention, Care, and Treatment**

| HIV/AIDS Program Element   | USAID Role Major/Minor | MOHSW Donor Partner             | Lead Partner with GOL*       |
|--|------------------------|---------------------------------|------------------------------|
| Prevention (BCC, mass media, materials, best practices, policy, etc.)  | Major                  | GFATM**                         | USAID<br>GFATM               |
| Social Marketing (Condoms, other materials)  | Major                  | DfID***?,<br>GFATM?, EU?        | USAID                        |
| Local Prevention, Care, Treatment Network Support  | Major                  | EU, DfID,<br>GFATM, WHO,        | Unknown                      |
| Technical and Management Support to the NACP   | Major                  | GFATM, WHO                      | UNAIDS (needs strengthening) |
| Monitoring and Evaluation  | Minor                  | WHO, GFATM                      | WHO, UNAIDS                  |
| Policy Dialogue, Legal, Regulation   | Major                  | WHO,                            | USAID, WHO                   |
| Voluntary Testing and Counseling (Delivery and Quality)  | Minor                  | GFATM, WHO,<br>DfID?<br>UNICEF? | WHO, GFATM                   |
| Stigma & Denial Reduction, (Linked to prevention and social marketing)   | Major                  | WHO, GFATM,<br>EU?              | USAID?                       |
| Gender/Women's Issues  | Minor                  | UNICEF, WHO,<br>UNFPA?          | Unknown, UNFPA?              |
| Cross-Sectoral Linkages (RH, MCH to HIV Services)  | Minor                  | WHO, UNDP,<br>UNICEF            | WHO?, UNDP?                  |
| National Reference Laboratory and Training, Applied Research Institute Support   | Minor                  | WHO?,<br>GFATM, EU?,<br>Swiss?  | WHO, GFATM?                  |
| Blood Safety   | Minor                  | GFATM, WHO,<br>Swiss?           | WHO                          |
| OVC Care and Support   | Minor                  | UNICEF, GFATM                   | UNICEF?                      |
| Prevention of Mother-to-Child Transmissions (PMTCT)  | Minor                  | UNICEF, GFATM                   | UNICEF                       |
| Training, Human Resource Development   | Major                  | WHO, DfID, EU,<br>GFATM         | WHO? (more coordination)     |
| Public-Private Partnerships  | Minor                  | Unknown                         | USAID                        |
| Care to Persons Living with HIV/AIDS   | Minor                  | GFATM, WHO,<br>IrishAid?        | Unknown                      |
| Management Information Systems   | Major                  | WHO, GFATM,<br>DfID?            | DfID?, USAID                 |
| DHS Follow-Up  | Major                  | WHO                             | USAID                        |
| <p>* Donor leadership must be further discussed at a donor forum to finalize this category. Attribution of leadership is illustrative for the purpose of this concept paper.</p> <p>** GFATM = Global Fund for AIDS, TB and Malaria. The Fund is administered by UNDP at present. *** DfID = Department for International Development (Britain).</p> |                        |                                 |                              |

## IV. GENERAL OBSERVATIONS

### A. Gaps and Priorities in HIV/AIDS Response in Liberia

As mentioned, 14 years of civil war have taken a heavy toll in Liberia in terms of human capacity, infrastructure, service delivery, and administrative and management capabilities. Poverty and high rates of illiteracy present strong barriers to reaching many Liberians and contribute to the fragility of the State. Roads, electricity, governance, communication, physical plants, logistics, equipment and supplies all require attention. Clearly, USAID cannot address all of the gaps that face Liberia, but USAID can and should address some of the gaps in the health system, and particularly seize opportunities in the HIV/AIDS arena.

The new administration of President Sirleaf imparts political commitment to HIV/AIDS at the highest levels. The 2006 Interim Policy Reduction Strategy included HIV/AIDS and noted the following as priorities:

- Outreach of services
- Nationwide awareness campaigns
- Provider training
- Universal precautions
- VCT
- Prevention of mother-to-child transmission
- ARV therapy
- Home-based care
- Appropriate legal framework for persons living with HIV/AIDS as priorities.<sup>14</sup>

The 2004 National Strategic Plan of Action for HIV/AIDS<sup>15</sup> identified the following gaps in the Government's response:

- General prevention
- IEC
- Surveillance
- Blood safety
- STI management
- Programs for people living with HIV/AIDS
- Care and support for orphans and vulnerable children
- Systems management, including institutional development and coordination

These gaps and priorities remain today and it is incumbent upon on the nation and donor community to address these issues in the near and medium terms.

Priorities for investment correlate with the present gaps in the national HIV/AIDS response. The depth and breadth of human capacity will affect the success of all HIV/AIDS (and other health) interventions. An expanded and unified approach to strengthening technical and management capabilities is essential.

Expanded prevention, through awareness building and wide-scale ABC messaging, is in order. In fact, much of USAID's focus should be on prevention and maintaining low prevalence through safe behavior and BCC, improved M&E, and management. A national reference laboratory, a training and applied research institute, and expanded diagnosis and counseling services are needed to identify infected individuals and provide

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<sup>14</sup> Ibid. Page 15

<sup>15</sup> Government of Liberia, 2007. The National Multi-Sectoral Strategic Plan for the Prevention and Control of STI/HIV/AIDS. MOHSW/National STI/HIV Control Program, August 2004.

appropriate counseling, case management, and treatment. Ensuring a safe blood supply nationwide is essential and closely linked to laboratory strengthening and diagnosis. Although the numbers of orphans affected by AIDS may be relatively low, identifying these children and including them in an overall approach to vulnerable children is appropriate. Improving service delivery through better management, administration, planning, monitoring, and evaluation will strengthen the system and promote Liberian leadership in HIV/AIDS service delivery. A number of policy priorities also face the GOL, such as budget levels, remuneration for providers, and issues concerning case diagnosis and management. The National AIDS Commission will have to address these issues in the near- and medium-terms.

### B. Integration of USAID/Liberia PHN Office Resources—Economies of Scale

USAID must disburse resources according to State Department and Agency guidance. However, Liberia’s unique situation as an emerging democracy and the devastating impact of its 14 years of civil war argues for a more flexible, development-oriented approach to programming. This approach would maintain direct and attributable results from each

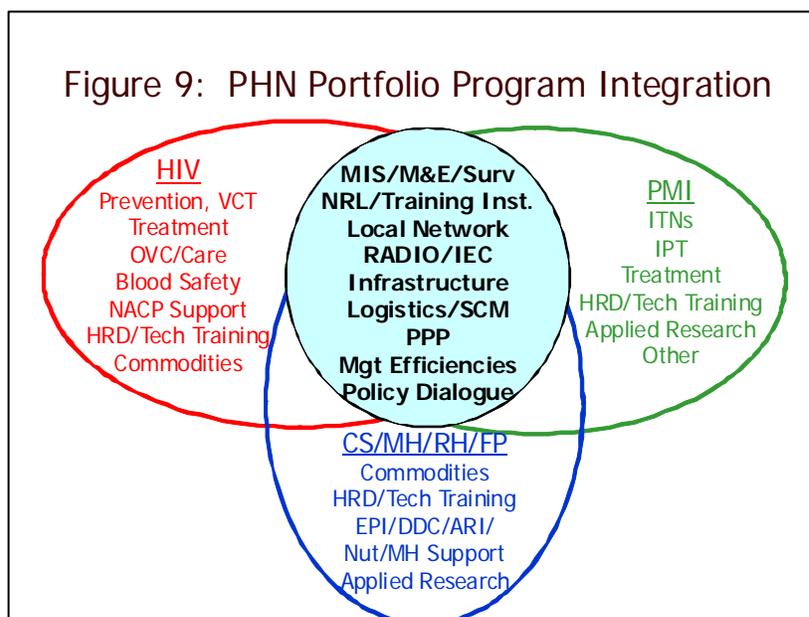
funding account, but cost-share, in a “wrap-around” manner, crosscutting interventions. Government policy specifically identifies program integration within a BPHS and specifically includes STI/HIV/AIDS prevention within the BPHS.<sup>16</sup> Thus, resource integration would be welcomed by the GOL.

USAID/Liberia has an important opportunity to maximize economies of scale and integrate its resources, staff, and overall effort to provide a cogent, practical, and successful PHN Office assistance package for the GOL. Presently, major areas of planned support include:

- HIV/AIDS
- Malaria control (via the President’s Malaria Initiative [PMI])
- A package of child survival, maternal health, reproductive health, and family planning

USAID could maximize its investment in the health sector, achieve specific subsector goals and objectives, and institute a comprehensive assistance package for the GOL by pooling resources for a number of common elements that are GOL priorities and essential to the success of each subsector effort as well. These common support elements include:

- Management information systems
- M&E
- Surveillance
- A national reference laboratory and a training and research institute
- Mass media IEC (radio)



<sup>16</sup> Government of Liberia, 2007. National Health and Social Welfare Plan (2007-2011). Ministry of Health and Social Welfare, Monrovia Liberia, February 2007, 21pp.

- Infrastructure
- Logistics and supply chain management
- Management and administrative skill building  
Policy dialogue

This approach would avoid program duplication and redundancy while focusing on the cornerstone of Liberia's BPHS strategy—the integration of services. Given the status of Liberia's health system and human capacity constraints, integrating appropriate interventions and maximizing PHN Office efficiencies and resources makes good sense.

Figure 9 above presents a graphic description of how USAID might maximize its investment in the health sector, achieve specific subsector goals and objectives, and institute a comprehensive assistance package for the GOL.

### C. Status of M&E for HIV/AIDS in Liberia

The entire M&E system for health in Liberia requires support and expansion. Government, donor, NGO, and consultant reports consistently raise M&E as a major constraint to program implementation and effective decision making. M&E is linked directly to an appropriate and functioning surveillance and reporting system, and to logistic planning at the central and county levels. An overhaul of the management information system is in order. This will serve the GOL, donors, and other stakeholders well when instituted. USAID can play an important role in standardizing and streamlining data collection. Because the Agency enjoys an important comparative advantage in data collection system design and in transferring appropriate technology at the field level, USAID should consider support to M&E through flexible, wrap-around funding.

### D. Opportunities and Constraints

**Opportunities.** The following opportunities argue for expanded development assistance in the HIV/AIDS arena for Liberia.

- **Optimum Timing for Improving U.S. Government-GOL Relations.** With the recent democratic election of a president of Liberia and the continuing stabilization of the country, the time is right for the U.S. government and USAID to commit to the future development of Liberia in a variety of areas, including health care. The GOL is sympathetic to U.S. priorities and is open to many areas of support. Liberia's policies, plans, strategies, and priorities for health are in concert with U.S. priorities, and action now will promote political stability as well as improve the health of many Liberians. Liberia is entering the next phase of its development as a stable, democratic government. USAID can and should provide a continuum of assistance to address the challenges in the health sector and particularly those faced in the HIV/AIDS arena.
- **Radio Messaging.** Radio messages supporting prevention and care initiatives can be very effective in changing behaviors and supporting care initiatives. Numerous private radio stations exist in Monrovia and in the counties, and outreach stretches to the community level. A new BCC strategy for HIV emphasizes expanded radio messages, but resources are required to move the plan to action. The United Nations Mission in Liberia, NGOs, FBOs, and others run local stations that broadcast in local languages and English and are important stakeholders in this arena. Cost is surprisingly low. For example, one week of programming a 30-minute drama twice per week—including additional, one-minute infomercials—costs less than \$25 at a county station.<sup>17</sup> Maximizing the radio network for HIV/AIDS (and other health

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<sup>17</sup> MOHSW, Division of Health Promotion, 2007. "Health Is Our Wealth" Drama at \$22.50 per week. Personal communication, J.K. Ofori and T. Doegmah, 7/25/07

messages) makes good sense at this time. USAID should consider this remarkable opportunity and apply its deep experience, expertise, and resources to promote effective behavior change messages nationwide.

- **Private Sector.** There is a broad and deep private sector in Liberia. The platform of international NGOs is strong and can be expanded to increase service delivery. Local NGOs, particularly faith-based organizations, represent a network of outreach that can continue to assist the GOL in expanded service delivery. Furthermore, corporate concerns, such as the Firestone Rubber Company, may be interested in jointly supporting HIV/AIDS control efforts for their workers, families and surrounding communities.
- **HIV Epidemic Curve.** Liberia may still be on the early part of the epidemiologic curve regarding HIV transmission. High rates of male circumcision and dispersed populations may have limited transmission. However, HIV prevalence is significant in urban areas and the negative impacts of war and poverty on transactional and violent sex have been severe. Out-of-school youth and a departure from traditional family values may increase risk and transmission in the near term. Girls and women routinely present higher prevalence in all age groups, and this disparity causes concern. Epidemiologically, a window of opportunity exists, but it is closing quickly.
- **Outreach of the Church.** As Table 4 suggests, the role of the church is formidable in the delivery of health services. Many FBOs are engaged in HIV/AIDS prevention, care, and treatment, and some of the largest FBOs are the ones sponsored by the Catholic and Lutheran Churches, as well as Eternal Love Winning Africa (ELWA) (mid-Baptist). CHAL presently coordinates a network of 39 clinics and 5 hospitals throughout Liberia. Plans for expansion are underway. FBOs can play an important role in the expanded delivery of prevention, care, and treatment services in Liberia.

**Constraints.** USAID/Liberia should consider the following policy, management, and structural constraints during the design of the USAID/Liberia HIV/AIDS Program.

#### Policy Constraints

- **Political Stability and Security.** Transitional states are fragile by definition. The challenges to the Government are monumental and continuing positive change is essential. Health is only one conduit. Government achievement—or lack thereof—in health as well as road improvement, governance, utility supply, revenue generation, transparent expenditures, and service delivery will determine whether the country can successfully move forward with its development.
- **Use of Planned Budget Increases for Health.** Sustained, adequate resources for health are a noted challenge in the 2007 National Health Plan. There is a strong GOL intention to increase health resources over the next five years. However, translating intentions into action remains worrisome and will require frank dialogue with the GOL during the program period.
- **Salaries and Remuneration Incentives.** Poor salaries and delayed payment compromise the delivery and quality of health services. This issue requires immediate attention by the GOL and stakeholders in the near term.
- **Complacency Resulting from New LDHS Results.** Although the new LDHS results are good news for Liberia, they must not lead to complacency by the Government, people, or donors. Pockets of high risk still exist. Knowledge of HIV transmission and healthy practices are limited. Transactional sex puts young women and girls at particular risk. Limiting further transmission will provide hope and protection, two key elements for success in a new democracy.
- **Training (External and Internal).** National training institutions receive minimal support and cannot meet the human capacity need for the coming decade. Scholarships are rare and many professionals continue to deliver services without the benefit of updated training.

### Management Constraints

- **Human Resources and GOL Support.** Fourteen years of civil war have taken a deep toll on Liberia's capacity to manage, plan, and implement. However, the Government is pushing forward to develop its capacity in many areas. It is relying on donor resources to help train cadres in the public and private sectors. The GOL envisions a guided transition to 100 percent implementation by Liberians in the future. A key issue in this arena is the GOL's commitment to establish positions and support those positions via budget line item adjustments.
- **Transparency and Accountability.** Corruption is a worldwide problem and should be addressed over the life of the USAID/Liberia HIV/AIDS program. Maintaining sound vouchers, financial records, and flow of resources in both the public and private sectors will be challenging. NGO systems can help smooth the process by examining lessons learned, both positive and negative. However, this issue requires additional and continuous attention centrally and in the counties for both NGOs and the public sector.
- **Management Information Systems.** As noted, Liberia requires a functioning, integrated management information system. Presently, no adequate system exists and this compromises decision-making and impacts management and operational efficiency.

### Structural Constraints

- **National Reference Laboratory and Training and Research Institute.** There is no national reference laboratory in Liberia. Diagnosis and feedback often take too much time and compromise the clinical response. Similarly, no field training site outside Monrovia exists for pre- and in-service training and applied research.
- **Standardized Guidelines.** Although some guidelines exist for health care providers, many do not. Furthermore, guidelines are not disseminated and in-service training is a burgeoning priority. Protocols are also lacking and international NGOs require increased guidance from the MOHSW.
- **Roads, Weather, Topography, and Geographic Isolation.** Logistics in Liberia are difficult at best. In the rainy season, roads become quagmires and are often impassable. This is particularly problematic for isolated areas in the southeast, which remain underserved. Striking a practical balance for HIV programming between need and likely impact requires careful consideration.
- **Prevalence of Poverty and Unemployment.** Poverty and unemployment are major barriers to Liberia's development agenda. They are pervasive, with approximately 75 percent of Liberians living on less than \$1 per day and an unemployment rate of approximately 85 percent. Creating jobs through open public-private partnerships is critical across all sectors. This issue cannot be ignored in Liberia's system transition, and programs will need to pursue innovative remuneration schemes to demonstrate progress and avoid systemic discontent.

### **E. USAID's Comparative Advantage in HIV/AIDS Assistance**

USAID enjoys a broad comparative advantage in the HIV/AIDS arena. There is a strong U.S. commitment to HIV/AIDS prevention and control in Africa, as exemplified by PEPFAR programming. USAID and partner agencies have demonstrable prowess in all the major interventions for HIV/AIDS prevention, care, and treatment, including technical assistance and implementation support in:

- Mass media
- Targeted group interventions
- BCC

- VCT
- Management information systems
- Monitoring and evaluation

A bank of experience and expertise lies within the U.S. government and within USAID centrally based technical projects. The Mission has a large variety of central projects and mechanisms that can be accessed in order to meet present and future HIV/AIDS challenges in Liberia. USAID’s comparative advantage is anchored in prevention. USAID has the ability to support large prevention networks and link them with each other thought-focused programming, information sharing, and best-practice dissemination. However, choosing a manageable and correct set of collaborating agencies will be important.

## **F. Geographic Focus**

USAID HIV/AIDS programming will follow the epidemiology of HIV in Liberia to maximize effort and impact. Population distribution and demographics as well as gender variation in infection and potential risk will be considered. Much of the NGO assistance in Liberia focuses on the counties in the north-central corridor (Monserato, Bong, Nimba, Lofa). Clearly, urban and peri-urban areas require attention. However, the Mission should explore the Southeastern B Region described in the LDHS, which presents an estimated 2.4 percent prevalence rate. Underserved counties—such as Maryland, Sinoe, River Gee, and Grand Bassa—should be considered for general prevention support such VCT, network expansion, and ABC efforts through IEC media messaging. HIV-related activities should avoid geographic duplication and saturation and address gaps in service delivery based on epidemiological need, outputs, and programmatic economies.

## **G. Cross-Cutting Considerations**

USAID/Liberia has fertile ground for pursuing cross-cutting initiatives linked to HIV/AIDS prevention and control and to the health sector in general. There is a significant opportunity to fully engage the Education Office in HIV/AIDS efforts. School-based programs, out-of-school youth initiatives, IEC outreach, and condom social marketing all have links to education outreach. LDHS data correlate level of education with higher HIV prevalence and, thus, high school and university programs could be considered as well. Links to governance efforts might also be explored relative to accountability, financial tracking, and authorities for hiring and firing. Economic growth may have traction in expanding the private for-profit sector role in HIV/AIDS, such as the overtures already underway with Firestone Rubber. Links to the agricultural sector are less clear at present. However, as the program matures, greater opportunities may arise with expanded outreach and awareness. The PHN should consider ways to collaborate within the Mission and how HIV/AIDS resources might be best used through cross-sector cooperation.

## V. FINDINGS AND RECOMMENDATIONS

### A. Key Findings and Recommendations

#### Prevention and Awareness

**Findings:** Data indicate awareness of HIV/AIDS is high, but too few Liberians practice healthy behaviors to prevent infection. Risk is under-perceived by high-risk groups and this is likely a major driver of transmission. LDHS data show that only 14 percent of women and 25 percent of men used condoms during their last high-risk intercourse. Multiple partners are frequent and higher for men than women. Polygamy is widely practiced. Serial monogamy, transactional sex, commercial sex, and sexual violence also contribute to transmission. Youth, specifically girls, are at particular risk.

The presence of external military forces exacerbates the complexity of the problem. Sexual violence is common and gun violence remains a threat in some parts of the country.

Stigma, denial, and knowledge of status were echoed themes in all discussions with stakeholders. Stigma remains at all levels of the system and many organizations struggle with preventive messaging and the realities of sex before marriage. Stigma and denial are pervasive and sharp gender differences in attitudes, risk, and empowerment exist. Generally speaking, individual and cohort HIV/AIDS risk perceptions are low. Less than 10 percent of Liberians know their status and complacent, fatalistic attitudes permeate much of the society. About 90 percent of those who are tested do not return for their results, according to the NACP.<sup>18</sup>

Most CHTs do not provide VCT and lack counseling capacity to follow up. IEC human capacity and effective materials, especially for youth, are in short supply.

**Recommendations:** USAID should provide comprehensive prevention support and expand positive behavior change through multimedia-based ABC messaging. USAID should assume the role as the lead agency in the IEC arena, with the Mission beginning its funding of this activity with FY 2008 funds. As noted above, a solid opportunity exists to expand a nationwide ABC campaign. This approach could be coordinated in the MOHSW's Division of Health Promotion, but anchored in a network of county and centrally based radio stations in the private and public sectors. Radio should be the primary medium for this activity since costs remain low for prime-time radio messages and a concerted effort can reach many segments of the population. Specific messages for various sub-regions of Liberia could be developed and transmitted in English and local languages. USAID could review the many messages previously created for other African countries and tailor them to the Liberian situation and target groups. The Mission could supplement this with technical assistance, training, focus group message testing, and delivery of information through various media to youth, girls, schools, communities, and high risk groups. Other media outreach also could be explored, including school-based programs, outpatient clinic videos and information sessions reaching out-of-school youth, and targeted IEC for high-risk groups, such as mobile and border populations and commercial sex workers.

In addition, USAID should provide expanded VCT linked to its support for the BPHS and follow-on support for OFDA-funded service delivery sites. The FY 2008 level should be somewhat conservative and expand significantly in later years as appropriate. USAID should prioritize its annual investment in VCT based on geography of HIV, need, and other donor support. VCT expansion requires support from multiple donors. The CHAL network presents a particular opportunity for expansion of VCT. FBOs have excellent outreach and can provide care as well as counseling and treatment when needed. Elements of support would include commodities, diagnostic training, counseling training, site strengthening, IEC messages, training and client materials and other support to ensure solid VCT outreach and client draw.

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<sup>18</sup> MOHSW/NACP, 2007. Draft Report of the Joint Review of the Liberia HIV/AIDS National Response. NACP/Dr. Nancy Bannerman, 45pp.

### Potential to Expand the Local Network of Providers

**Findings:** Liberia's shattered health system relies on an existing network of health care sites set up throughout the country by local and international NGOs during the emergency period. These clinics are public sector sites supported by NGOs for the most part and provide a BPHS in concert with the GOL's Strategic Plan. However, HIV/AIDS services at most of these sites are rudimentary. Expanding these sites in terms of service delivery, management, and accountability is reasonable. Expanding services to underserved populations is a GOL priority, and the NACP fully endorses a strengthened local network anchored in local NGOs. Remuneration of providers is problematic and represents one of the major policy constraints that will require attention over the life of the project.

**Recommendations:** The Mission should continue to support the network established by OFDA and others, and expand HIV prevention, care, and treatment services under the new project. The existing network is an anchor of service delivery and can serve as one of the keystones for future HIV-related efforts nationwide. An expanded local network will promote sustained effort and investment from the GOL and other donors, including FBOs, who are eager to expand their HIV services.

USAID should merge its funding and efforts for HIV with those for PMI, child survival, maternal health, and reproductive health as a way to assist in expanding the network of sites and services provided. The services should include an expansion of ABC messages, VCT, post-test counseling, follow-up, care (including home-based care), and treatment.

### Human Capacity

**Findings:** The dearth of human capacity across the entire Liberian system is a major challenge to progress in the near and medium terms. The health system is no exception. There are too few trained and competent health care providers. Significant investment in pre- and in-service training is required to address critical gaps in human capacity at both the central and county levels. Although LDHS data suggest success in the delivery of basic services such as immunizations and the treatment of malaria and diarrhea, more needs to be done to adequately address HIV/AIDS, which requires trained personnel.

Management is a key component of successful service delivery so training needs to include areas such as planning, budgeting, administration, and reporting. Management and planning training is needed for NACP, CHT and NGO/FBO staff to help to strengthen service delivery, program efficiencies, monitoring, and evaluation. USAID can access formidable amounts of technical and training assistance from Bureau of Global Health (BGH) central projects, and the NAC has already requested office and study tour support from USAID/Liberia.

**Recommendations:** USAID should invest in a major training component within the HIV/AIDS program. Innovative and creative approaches are necessary to begin to develop a cadre of Liberians who can assume responsibility for the provision of basic preventive and curative care, as well as program management. Given the realities of staffing patterns and the low numbers of health care providers, Liberia cannot afford to train individual providers in just one discipline. Thus, it makes sense to take an integrated approach to training, sharing resources within the PHN Office accounts to train individuals to deal with multiple medical areas. USAID should invest in all levels of pre- and in-service training to ensure the delivery of HIV/AIDS services over the program period.

USAID has an important opportunity to support key aspects of HIV/AIDS management and governance in general, through management support to all HIV/AIDS stakeholders. Starting in FY 08, the PHN Office should help the NACP and NAC improve their management and coordinating skills. In later years, assistance should extend to the CHTs and local networks therein. This assistance should include bottom-up support for training, study tours, and semi-annual best-practices workshops to improve technical, administrative, and management capacity at all levels of the health system. Technical assistance can be accessed through various BGH projects, such as AIDSTAR and the Africa 20/20 project. Assistance should begin with FY 2007 funds and continue through 2012.

## Data for Decision Making, Monitoring and Evaluation

**Findings:** One of the dramatic deficiencies of the Liberian health system is the lack of an efficient, streamlined, functional management information system. The GOL needs to be able to track data efficiently in a number of areas, including:

- Surveillance of major diseases, including HIV/AIDS,
- Supply-chain information from CHTs on supplies, gaps and stock-out timeframes
- Information on personnel, including salaries and work scopes
- Quarterly profiles of stakeholder activities, expenditures, and pipelines

As a result, the MOHSW is unable to make rapid and informed decisions on health interventions, program outputs, logistic and supply needs, and priorities in general. Information sharing suffers, which in turn affects the quality of technical and fiscal planning. The GOL recognizes management information systems as a primary priority and is seeking assistance from the donor community to help central offices (such as the NACP) and county teams strengthen their capacity.

**Recommendations:** USAID should assume the donor lead in technical and programmatic assistance for management information systems, and use it to maintain and strengthen relations with the MOHSW, the NACP and the NAC. The GOL greatly appreciated the LDHS investment and the arrival of the new PHN Office Team Leader has brought USAID to the forefront of health (and HIV/AIDS) participation at the stakeholder table. USAID should pool resources from across the entire PHN Office portfolio for management information systems support for all health care initiatives. It should also ensure that sufficient data will be collected on elements specifically related to HIV/AIDS, such as:

- General ABC prevention efforts, including IEC messages and BCC impacts
- Surveillance information
- VCT outreach
- Counseling follow-up
- Laboratory data on treatment, adherence, and resistance profiles

Many other practical items also can be tracked to better inform decision makers and implementers on the success or shortcomings of their efforts.

## Policy Dialogue

**Findings:** Major policy and regulatory concerns face the GOL in the HIV/AIDS arena, including awareness building, BCC messaging, drug supply, blood supply, prioritizing geographic investments, and managing the transition from emergency to development. The GOL is open to receiving assistance in making key policy decisions regarding HIV/AIDS service delivery and support. The National AIDS Commission (NAC) is in the process of developing a New National Strategic Plan for HIV/AIDS and has already requested assistance from USAID. USAID has a unique role to play as a trusted colleague, honest broker, and important partner. The bank of technical expertise available to the Mission is formidable and can help the GOL significantly in the design and implementation of a cogent HIV/AIDS program.

**Recommendations:** USAID should support policy dialogue with the GOL, particularly with the NAC and NACP, and consider using FY 2007 funds to open the process to ensure input into policy formation. The Mission should access varied technical assistance to help the GOL in multiple areas of dialogue, as appropriate. Donor forums could also serve to identify policy issues and problems and, thus, help to inform an annual GOL policy agenda.

The Mission should also consider ways to engage the Ambassador in key policy issues and events, including participation in World AIDS Day, discussion of HIV/AIDS issues at meetings with the President, speeches at opening events, and Op Ed pieces in the press. Innovative, appropriate, and attractive ideas should be

presented to the Ambassador in writing on a semi-annual basis to ensure that HIV/AIDS advocacy and policy support remain on his agenda. This high-level engagement by the Embassy could help to avoid complacency regarding HIV/AIDS and move critical agenda items forward.

## **B. Other Findings and Recommendations**

### National Reference Laboratory, Technical Training, Applied Research Support

**Findings:** A functioning national reference laboratory does not currently exist,<sup>19</sup> nor is there a main site where field research and technical training can occur. We understand that the GFATM may provide some support to a national reference laboratory under the Round 6 grant, but additional support is needed and desirable. Having both a national reference laboratory and a field training and research site will help improve Liberia's diagnostic, disease research, and case management capacity across all health care areas. Two such sites have been discussed with the GOL—the John F. Kennedy Memorial Hospital (JFK) and the Liberia Institute for Biomedical Research (LIBR). Both sites have important potentials and advantages.

JFK, located in Monrovia, is the major national referral hospital and the premier teaching hospital for Liberia. It is the site of the Maternity Hospital and the Tubman National Institute of Medical Arts, which includes the Schools of Nursing, Physician's Assistants, and Environmental Health. JFK already provides a range of HIV/AIDS services and laboratory services, but both require expansion and better quality control.

LIBR is located about an hour and a half north of Monrovia in Charlesville, three kilometers from the Robertsfield Airport. The LIBR is not functioning at present, but is receiving a modicum of support from the New York Blood Center to maintain care of laboratory animals. LIBR sits on 115 acres of land and has a main building that houses 28 wet laboratories, most of which are in disrepair. It also contains offices, a defunct health center, a garage, a generator, a kitchen, a conference and training center that can accommodate 50+ people, and animal holding cages. It also has four houses and a few small apartments, with total space for about 15 resident personnel. A defunct clinic is also on the compound (see Appendix I).

**Recommendations:** USAID should provide pooled support from across the entire PHN Office portfolio to make JFK a national reference Laboratory and LIBR a training institute and applied research center. This recommendation presents many challenges, given the current state of each facility, but establishing a national reference laboratory in the capital and revitalizing an indigenous institute outside Monrovia is appealing. Prior to finalizing the decision to support either JFK or the LIBR, the Mission should ensure that the GOL fully endorses both sites, has a shared vision for the potential utility of these sites, and is committed to budget and staff support in the medium term. A letter from the MOHSW requesting specific support for JFK and the LIBR should be obtained prior to a final decision by the Mission. Other donor resources could also be brokered for JFK and LIBR.

Concerning LIBR, Mission seed money could be allocated not only for refurbishment of the facility, but also for garnering offshore interest from research and training institutions, such as U.S. and other countries' universities. Initial links to these institutions might include applied research questions concerning HIV/AIDS, malaria and other health interventions. Fieldwork could be conducted in concert with the Firestone Hospital on the plantation and surrounding environs. Clinical services, provider training and research could be carried

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<sup>19</sup>A national reference laboratory was functioning in the 1970s but collapsed in the 1990s. The function of a national reference laboratory is to provide confirmatory testing for both the public and private sectors. National reference laboratories also monitor quality of services and serve as a regulatory agency for training institutions and private providers. They often have accreditation authority and provide monitoring services to maintain quality and performance to standards for diagnostic and general laboratory protocols. Typical elements include: clinical laboratory services for communicable diseases, water quality control, quality assurance for diagnostics and pharmaceuticals, provision of expert opinion for programs and institutions, applied research on locally produced alcohol and foodstuffs to ensure safety, and training for medical, laboratory and paramedical providers. Overall, national reference laboratories serve as a quality control instrument that sets and guarantees national standards and operating procedures.

out though the health center on the grounds.<sup>20</sup> Out years could attract more institutions through a collaborative grants program. Potential support might also come from foundations and research institutions, such as Fogerty and the National Institutes of Health. The Mission could catalyze discussion by various local partners to discern the level of interest in the LIBR and potential commitment.

#### Interagency Coordination and Communication

**Findings:** Inter-agency coordination appears to be lacking, leading to a disjointed approach to HIV/AIDS and reduced efficiencies. The NACP appreciates the need for better coordination and has identified redundancy of donor efforts as a major concern. Internally, the UN branches are unclear on the respective priorities and activities of their sister Agencies. The UNAIDS Office is somewhat isolated because the Director, located in Freetown, Sierra Leone, spends much of his time there. The UN Theme Group is limited to UN Agencies only. Although informal donor gatherings provide a forum for open discussion, key stakeholders lack a consistent forum to discuss HIV/AIDS priorities, activities, challenges, and programs.

**Recommendations:** USAID should help the NACP improve coordination in HIV/AIDS programming. USAID could play a catalytic role by suggesting a monthly meeting of major donor and NGO stakeholders at NACP headquarters and developing a set agenda for each meeting. As appropriate, USAID could garner technical assistance as a secretariat until the role of UNAIDS gels.

USAID could also suggest a monthly luncheon that includes the NACP, the NAC, and a single, high-level representative from the each key donor and stakeholder. This relaxed, rotating-host forum could be used to discuss key issues concerning HIV/AIDS programming from the GOL, donor, and NGO perspectives. It would have the benefit of a higher-level participation, and an action-oriented agenda. Each hosting organization could set the agenda for its respective meeting in concert with the GOL.

#### County Team Needs

**Finding.** Service delivery occurs at the county level and the bulk of the emergency assistance to date has been delivered through the CHTs. During the transition period, CHTs will require support to maintain and expand HIV/AIDS services. Currently, only rudimentary services exist, and they are delivered at some of the larger facilities, such as Phebe, Firestone, and Ganta hospitals. Health centers generally do not provide VCT and many of the international NGOs are ill equipped to provide appropriate pre- and post-test counseling. A significant but coordinated investment is required.

Per Table 4, donor assistance is spread out among the counties. Some mapping of donor effort exists, but a cogent, objective, and operational review by all stakeholders is not available to our knowledge. Donors should maximize investments in the counties by defining a clear division of labor, geographic niches, resources, and programming.

**Recommendations:** The USAID/Liberia PHN Office should promote county program definition and avoid redundancy through routine meetings with the NACP, NAC, donors and other stakeholders. Monthly discussions and quarterly updates of HIV/AIDS activities, coordinated by the NACP and UNAIDS would help to avoid redundancy and standardize HIV/AIDS services nationwide.

The PHN Office needs to identify focus counties based on both HIV prevalence and existing, planned, and potential service delivery sites. It should also work with all stakeholders to define geographic and programmatic niches to push the HIV/AIDS control agenda forward.

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<sup>20</sup> Participating institutions could include JFK, the College of Medicine, the University of Liberia, and Firestone Hospital, as well as other interested parties.

### Public-Private Partnership Possibilities

**Findings:** As noted previously, an important opportunity exists to engage further the private corporate sector in Liberia. The GOL recognizes the potential of corporate concerns and is open to future collaboration. Companies fully appreciate the impact HIV/AIDS may have on their workforce and want to expand prevention, care, and treatment services. However, in many workforce environments, human capacity and materials are in short supply beyond clinical management.

**Recommendations:** USAID should provide seed money to expand corporate engagement in HIV/AIDS prevention and control. Memoranda of understanding could be developed to have corporations contribute support to mass media ABC messaging on HIV/AIDS, production of printed materials, video messaging in clinics, and expanded counseling, testing, care and treatment. The Mission could support applied research to define best practices and intervention impact.

USAID should also use public-private partnerships as a way to implement large-scale demonstration activities for HIV/AIDS and expanding efforts from there. The Firestone Rubber Plantation at Harbel, Liberia may be a good place to begin. Discussions with senior hospital management and the Firestone Acting Medical Director indicate Firestone would welcome a co-investment in HIV/AIDS prevention and control and is willing to explore collaborative opportunities that could be examined to better understand case management, cost and service delivery practices. Cost-sharing of expanded efforts will contribute to sustainability in the long term.

### Blood Supply and Medical Transmission

**Findings:** Liberia lacks a comprehensive and quality-controlled blood screening capacity. Major hospitals such as JFK, Phebe and Ganta provide reasonable screening capabilities, but an expanded network of safe supply is warranted. Medical transmission is a concern as well, given the lack of protective equipment and supplies for first-line workers. Medical waste disposal requires attention and regulation on site. Positive blood is discarded, but patient follow-up varies depending on the availability of trained personnel.

**Recommendations:** USAID should support blood bank safety at functioning facilities and help mitigate medical transmission by providing technical assistance, equipment, supplies, and training. USAID should also conduct a review of the blood safety system to identify and prioritize facilities that require strengthening, especially in underserved areas such as the Southeast.

### Orphans and Vulnerable Children

**Findings:** Liberia has many orphans as a result of the consequences of its civil war. Extrapolated LDHS data on HIV/AIDS suggest there are from 1,500 to 2,500 infected children. However, the actual number of affected children may be three to five times greater. More investment is needed to provide for their care and support.

**Recommendations:** USAID should include programs targeted to these children as part of its overall plans to expand Liberia's prevention, care, and treatment network, especially through local FBOs. USAID should open a proactive dialogue with CHAL and other NGOs to better measure the extent of HIV/AIDS among children and to explore how to expand support to them through existing, home-based platforms. These efforts should be linked to other general community outreach and care activities to avoid stigma. USAID should promote extended family care and support rather than institutional approaches such as orphanages.

### Drug Supplies

**Findings:** Meetings with the UNDP overseer of the GFATM Round 6 grant implied that ARVs and other opportunistic infection drugs were covered for Liberia for the next two years. If the performance-based grant is continued for the full five years at the \$33 million level, we anticipate enough drugs will be available to treat persons living with HIV/AIDS in need. The new LDHS data suggest that about 26,000 Liberians may be infected with HIV. We estimate that less than 10,000 Liberians will require ARVs over the next five years.

The GFATM grant should be able to address this need. However, there may be additional need in the future. The GFATM grant has minimal resources for supply-chain management (\$100,000) and some modest resources for condoms and condom social marketing (3 million condoms and \$20,000 for social marketing). USAID can and should fill these gaps in the future. UNICEF is covering PMTCT and will likely cover those costs and pediatric treatment with GFATM funds.

**Recommendations:** USAID/Liberia should supply ARVs and other opportunistic infection drugs as appropriate to avoid program disruption. These drugs should be used for specific USAID county efforts and administered within the GOL/WHO guidelines relative to type of drug and protocol for use.



## **VI. SUMMARY**

HIV remains a threat to the development of Liberia. Women are at particular risk and systemic deficiencies are pervasive. The dearth of human capacity, poverty, and underemployment can easily thwart progress.

The U.S. has a critical role to play in Liberia's present and future stability, particularly in addressing the health care challenges presented by HIV/AIDS. Sustained support for prevention, treatment, and care should come from a coordinated effort by a number of different agencies, including USAID/Liberia, the U.S. Mission to Liberia, the State Department's Bureau of Foreign Assistance, USAID/Washington, and the Office of the Global AIDS Coordinator.

The recommendations above impart an optimistic view of addressing HIV/AIDS in Liberia. The stark realities of Liberia's transition represent formidable challenges to effective and efficient programming in HIV/AIDS, but progress is possible and problems can be avoided. The GOL embraces technical assistance, particularly from the U.S., and wants USAID to become a full development partner. Since American assistance is welcomed, USAID has a tremendous comparative advantage to provide technical assistance and implementation support at all levels of the system, from the communities and clinics to the Office of the President. A bold and comprehensive approach to HIV/AIDS prevention and control is justified and highly desired by the GOL. USAID can and should be a major partner.



## **VII. APPENDICES**

Appendix A – Scope of Work

Appendix B - Persons Contacted

Appendix C - References

Appendix D – Draft Concept Paper

Appendix E – Draft Logical Framework for New PNP Design

Appendix F – Email Draft—Program Priorities for FY 08 Budget

Appendix G – Draft HIV Program Budget—FY 2008—USAID/Liberia

Appendix H – Memorandum—LDHS and HIV Programming Options

Appendix I – Profile: Liberian Institute for Biomedical Research

Appendix J – Methodology



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