Concern Liberia
HIV&AIDS Programme evaluation

2008-2011

15th May 2012

Jennifer Chapman
Jenny.chapman@tiscali.co.uk

Contents

Acronyms

AIDS	Acquired immune deficiency syndrome
ART	Anti-retroviral Therapy
ARV	Anti-retroviral
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CD	Compact Disc
ELWA	Eternal Love Winning Africa
FG	Focus Group
FGD	Focus Group Discussions
FGM	Female Genital Mutilation
GIPA	Greater Involvement of People Living with HIV & AIDS
HAP	Humanitarian Accountability Partnership
HBC	Home-Based Care
HIV	Human immunodeficiency virus
IEC	Information, Education and Communication
IGA	Income Generating Activity
INGO	International NGO
KAP	Knowledge, Attitude and Practices
LD	Liberian Dollar
LDHS	Liberian Demographic and Health Survey
LIBNEP+	Liberian Network of People Living with HIV
LIWEN	Liberia Women Empowerment Network
M&E	Monitoring and Evaluation
MARP	Most At Risk Populations
MoHSW	Ministry of Health and Social Welfare
MSM	Men who have sex with men
NAC	National AIDS Commission
NACP	National AIDS Control Programme
NGO	Non-governmental Organisation
NSF	National Strategic Framework
OI	Opportunistic Infection
OVC	Orphans and vulnerable children
P4	Programme Participant Protection Policy
PLAL	Positive Living Association of Liberia
PLHIV	People living with HIV&AIDS
PMTCT	Prevention of Mother to Child Transmission
SHALOM	Saving Humanity with Affection, Love, and an Open Mind
SG	Support Group
SGBV	Sexual and gender-based violence
STI	Sexually Transmitted Infections
TB	Tuberculosis
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
YWOSD	Young Women Organized for Sustainable Development

Acknowledgements

I would like to thank the many people who have taken their time to share their experiences and insights on the HIV&AIDS programme. In particular I would like to thank Julia Lysander, HIV&AIDS Programme Manager who accompanied me throughout the evaluation and ensured everything went as smoothly as possible. Veronica Wrokpoh and Emmanuel Carto, HIV&AIDS Officers were also of great help in Grand Bassa and Monrovia respectively.

Executive summary

Introduction

Concern started directly implementing an HIV&AIDS programme in Montserrado, Liberia in 2008 and in Grand Bassa in 2010, building on prior mainstreaming work. The programme has also worked with the partners Eternal Love Winning Africa (ELWA), Light Association, Young Women Organized for Sustainable Development (YWOSD) and, in 2011, the newly formed LIBNEP+. It was planned as a 5 year programme (2008-12) but was terminated at the end of 2011 due to lack of funding.

The **goal** of the programme was to contribute to the reduction of the spread and impact of HIV and AIDS among extremely poor people in Liberia, with the **immediate objective** being to achieve significant improvements in the social support, health and livelihoods of people living with HIV and affected communities, and reduce the susceptibility of key populations of higher risk in selected poor communities in programme counties. The programme had a budget of €991,561 funded by Medicor, IBIS and MAPS.

This evaluation was carried out by an external consultant, supported by Concern staff. It is based on information from documentation, telephone interviews and field work in Liberia during 9-20th December 2011. It has subsequently been updated by using data from a survey carried out by Capstone in early 2012.

The review found the programme is **relevant** to the priorities of the Government of Liberia and meets the needs of communities as expressed in the initial assessment. It is also aligned to Liberia's Poverty Reduction Strategy and broadly aligned to the National Strategic Framework 2010-2014. The programme follows the principle of the 'Three Ones' as far as possible within the current context in Liberia.

Geographical **targeting** of Grand Bassa and Montserrado was due to both counties' relatively high prevalence of HIV, Concern's well-developed HIV mainstreaming activities there, the presence and strong working relationship with the primary HIV partner ELWA, and the lack of service providers. Given these considerations, the choice to focus the initial phase of the work in these counties, and within Montserrado on urban slums, would appear to be sensible.

The main target groups within these areas were people living in extreme poverty and in particular key populations of higher risk: people living with and affected by HIV and AIDS; sex workers; adult transport workers; youth; and children. In general these are appropriate groups to target, though the extent to which they have been systematically reached is unclear due to lack of monitoring data.

Significant changes (impact)

Feedback suggested that Concern is recognised as a leader in the HIV&AIDS response in Liberia, particularly with regard to the GIPA principle. Government stakeholders stressed that Concern collaborates well with the government at both County and National level, and has contributed to the National AIDS Commission's (NAC) increased capacity for coordination.

Output One: The programme has worked to reduce HIV-related stigma and prevent new infections through community mobilisation and awareness activities. Outreach activities are estimated to have reached communities with total populations of around 13,000 in Grand Bassa and 171,000 in Monrovia. Achievements include:

- The setting up and/or training and support of community based focus groups, school health clubs, and peer educators that take the lead in HIV&AIDS outreach work within the communities. Members at all groups visited showed good basic knowledge of HIV&AIDS and were well able to share basic messages on it within the community. However some were less strong on arguing a case or persuading people to change their practices.
- Some anecdotal evidence of decrease in number of sexual partners or increase in condom use.
- Both surveys and field work indicated considerable reduction in stigma (both self and external) over the programme period; whilst there will be a range of factors driving this, discussions suggested a significant contribution was made by the programme.
- The final approval and distribution of a government policy that includes protection for PLHIV against stigma in the workplace and schools, which was supported by Concern and which has the potential for longer term impact.

Though considerable achievements can be seen against this output there remain a number of challenges, some of these are related to the Liberian context of high poverty, unequal gender relationships and lack of quality services in rural areas. High stigma and the strong influence of secret societies also provide challenges to overcome.

In rural areas the remote and dispersed nature of communities can make it difficult for Focus Group members to reach everyone, and condom supply currently relies on Concern. In urban areas high turnover of volunteers means regular training is needed, yet the focus groups mainly rely on Concern for up to date information and training. Data from the Capstone survey of 2012, indicates that knowledge on some specific aspects of HIV&AIDS may have actually worsened over the duration of the programme, though the reasons for this are not clear. There are thus some serious concerns about the sustainability of some of the progress against this output.

Output Two: The programme aimed to improve and strengthen sustainable capacity of local partners and relevant government bodies in HIV and AIDS prevention, care, support, and treatment services in the two counties. It has successfully facilitated ELWA to directly provide a range of services to PLHIV for the programme's duration, though it is unclear how many individual PLHIV have benefited due to monitoring data focusing at the activity level. Anecdotal feedback suggests that improved services have helped reduce mother to child transmission, and loss to follow up and helped increase adherence to ARV. These services have also provided PLHIV with important emotional and psycho-social support that helps them in positive living and prevention of infection of others. Of particular note has been ELWA's children's support group, a first in Liberia.

Whilst there can be no doubt about the impact on individuals' lives as a result of these improved services, there are a number of questions about their sustainability following staff changes at ELWA. Community outreach and peer support is no longer a priority for ELWA leadership and a number of support group members reported that care provision had deteriorated throughout 2011. This output, which should have been about improving services for the long run, whilst paying for them in the short run, appears in practice to have successfully provided important services during the programme's life, without succeeding in developing the capacity and commitment to continue to provide these in the long run.

A more positive picture emerges around the capacity and commitment of other partners such as Light Association and Young Women Organised for Sustainable Development to provide prevention, care and treatment services in the future. There is also a new organisation SHALOM which developed out of the work at ELWA; this was formed in 2011 with the intention of replicating the community based approach to HIV and AIDS piloted during the programme. The HIV&AIDS Programme has also played a key role in the formation of LIBNEP+, Liberia's first national network for People living with HIV&AIDS.

Concern is one of the few INGOs that work at the national level on HIV&AIDS and is recognised as a key partner of the government through its work to support NAC to develop the National Strategic Frameworks 1 and 2. Concern also worked alongside NACP and NAC and others to establish other committees such as the Prevention committee on HIV&AIDS which has the responsibility to coordinate HIV&AIDS messages and media activities. Concern has also been good at building partnerships with government agencies such as the county health teams, and ensuring they are fully informed of the programme, and included where appropriate.

Beyond this, advocacy by Concern and other civil society groups including PLHIV networks is said to have contributed to influencing the Government of Liberia to approve a bill for budgetary allotment for care and support for PLHIV within the national budget, which will provide opportunities for the future.

Output Three: This output focuses on ensuring that people living with and affected by HIV and key populations of higher risk have improved and sustainable levels of nutrition, food and livelihood security. Again it has proved challenging to get consistent information about the scale of work against this output, but the numbers appear to be relatively small. Within Liberia developing sustainable livelihoods in the urban context is quite challenging, and data was not provided as to the extent of success in this, though information received suggests that livelihood gains may be quite fragile. The programme has experimented with farms in Monrovia and Buchannan, but both of these have faced considerable challenges and appear unlikely to be continued. Data is lacking about who received loans under the revolving loan scheme to start small businesses, and the extent to which these businesses are continuing and providing a livelihood, though anecdotal reports suggest at least one thriving business has been started. Due to staff and administrative challenges repayment of the final round of loans has not been made and no new loans are being made.

The picture in terms of knowledge of improved nutrition is clearer. All the members of support groups in Monrovia and Buchannan met showed good knowledge about the importance of balanced nutrition in living positively, though they are not always able to put this knowledge into practice due to poverty.

Accountability and Ownership

All beneficiaries speak positively of Concern and Concern staff and there is good participation in various activities. The level of beneficiary ownership appears to vary however, and some issues related to ownership by beneficiaries were only picked up by the review, suggesting that monitoring could be improved. There appears to be less consultation or participation on overall programme design, given that the same model of focus group outreach by volunteers is being used in all communities, whether urban or rural. Members of focus groups set up by Concern in urban areas had many complaints about the level of volunteer input expected from them without recompense – there was a sense that these were seen as a Concern initiative rather than owned by the community.

Concern Liberia appears to have developed good strong partnerships with most of the partners within the HIV&AIDS programme, and it would appear that overall these were appropriate and effective means to implement the HIV&AIDS programme. Ownership by partners of their own activities is good but inclusion in deciding the strategic direction of the overall programme is less apparent, though all partners were involved in developing the revised logframe and M&E framework. Concern could also at times take a more 'critical friend' approach to challenge partners to think more deeply about their work. All partnerships are currently under challenge due to the abrupt nature of the programme ending: partners were informed of this decision in late November 2011, but were not consulted on ways to make the phase out less disruptive.

It appears that the work of most partners has a rather start-stop nature to it, caused by delays in receiving and agreeing financial and narrative reports before the next tranche of money can be released. Whilst supporting the development of financial capacity is critical, it is important that this doesn't disrupt services that need to be regular.

The challenges in the partnership with ELWA over 2011 highlight some of the challenges and shortcomings with relation to sustainability for the long run including relationships relying on one person, persuading partners to take on activities they are reluctant about and focusing on implementing activities to provide services without sufficient attention to identifying strategic opportunities for the long term.

Strategic action and direction

In general the strategic action and direction has been good, however there are some aspects that could be strengthened. Though the proposal recognises that coordination between actors and between the provision of services in prevention, with those of testing, treatment and care was a key area of work, this has been addressed more through the provision of coordinated testing, treatment and care services at ELWA, the long term sustainability of which is questionable. It would have been useful to address this issue at a more strategic level.

There has been some focus on reaching specific groups such as young single mothers or transport drivers. However other than the focus on youth through work in schools, this has been somewhat sporadic and ad hoc, and most of the focus groups visited, consisted of a cross representation of the local population and appeared to use generalised messages focusing on basic facts intended for the general population.

Efficiency

The total budget over the 4 years was 991,561 Euros, with most of this being allocated for the period 2009-11. The review raised some concerns that approximately 75% of the budget for 2011 was to be spent within the final one quarter of the year; considering the on-going nature of most of the activities this is somewhat high. It appears that the overall cost of the programme is reasonable, though it is hard to make rigorous assessments of efficiency and value for money without better data on coverage/numbers reached and the impact of the work. However the ending of the programme at short notice, and without a phase out plan, though driven by necessity rather than choice, is likely to reduce the overall efficiency of investments already made due to the effect it is likely to have on sustainability.

Cross cutting issues

Gender issues around HIV&AIDS are analysed in the programme documents and understood by programme staff. However baseline information and the subsequent survey were not disaggregated by sex or any other social difference, neither has Concern analysed the gender implications of the new law on stigma and discrimination, despite having advocated for it to be passed. Feedback suggested that in some cases staff are more sympathetic to the challenges faced by PLHIV women than PLHIV men. Working with the disabled is a gap that is recognised by staff who have said they would have looked at it in the next phase of the work.

Programme activities are not systematically adapted depending on those targeted and this would merit further attention.

Mainstreaming

Mainstreaming, both internal and external appears to be a strength of Concern Liberia, and staff at all levels are clearly committed to it. All Concern staff and partner staff receive orientation in HIV&AIDS awareness, risk, vulnerability, prevention and care, and the implications on their work. Programme staff demonstrate high levels of knowledge and positive attitudes towards people living with and affected by HIV&AIDS. Staff report changes in their own behaviours to protect themselves against infection, but comment on some incidences of continuing risk behaviour or avoidance of VCT in others, indicating that not all staff find it easy to put their knowledge into practice. At least two partners have developed their own internal HIV policy and rolled it out with staff.

Each programme is said to have a HIV mainstreaming plan and receive yearly training. Programmes are also designed to take account of the needs of those who are labour constrained or chronically sick and to minimise the risk of HIV transmission, and also integrate HIV&AIDS messages. However many staff are not clear on the distinction between mainstreaming and integration.

Key Lessons

Sustainability: The programme demonstrates how important it is to consider sustainability from the start, rather than leaving it as something to address in an exit strategy adopted towards the end of the programme. HIV&AIDS services are not something that can be provided for a discrete length of time and then stopped, but need to be on-going. CBOs working on HIV&AIDS awareness need to be linked in to systems to ensure their information stays up to date.

Community outreach: The programme demonstrates that it might be useful to explore different approaches in urban and rural areas. Group members could benefit from more focus on support in persuasive arguing skills and planning. The programme also needs to consider how to move on from generalised HIV&AIDS awareness information to approaches more targeted to particular at risk groups.

Nutrition & livelihoods: The programme demonstrates the benefits of linking clinical and home based work on care and information about positive living with support on livelihoods to provide a comprehensive package. Even with the supplementary nutrition many PLHIV met still faced challenges in ensuring they had adequate nutrition to take their medicine. Key lessons here include: the need for any stipends to be received regularly; the need for transparent guidelines on how to deal with the challenges of limited funding forcing targeting based on budget rather than need; the importance of securing tenure before investing in infrastructure development on land; and, the need for a certain level of formal group organisation and accountability before introducing loans.

Monitoring and Evaluation: There are a range of issues emerging around monitoring and evaluation which needs to be strengthened.

Recommendations

The future of the HIV&AIDS programme is currently uncertain. A decision was taken to end the programme at the end of December 2011 due to lack of funds, however staff are still looking into possibilities for new funding. The recommendations are therefore split into ones relevant to different scenarios.

If the programme is not continuing quite a bit could be done to smooth out the ending of the programme and thus increase the chances of benefits being sustained. It is recommended that responsibilities for phase out are included in the work plan of the ACDP, Area Coordinators and the HIV&AIDS Officers over the next 3-6 months. This will not necessarily require a budget other than for staff time. Staff should meet with each partner, CBO, Focus Group and Support Group individually to systematically analyse opportunities for sustainability.

If Concern Liberia continues with an HIV&AIDS programme: The Liberian government recommends that future HIV&AIDS prevention work should be more focussed on high risk groups and less on general awareness. Concern should align itself with these government priorities while working to its strengths, such as working with youth. It is recommended that for a future programme Concern Liberia should focus its work to allow an emphasis on quality and learning, and using that learning to influence wider changes within the Liberian response to HIV&AIDS. Areas where Concern has particular strengths include: working with PLHIV to include them within the response; linking medical care with support to nutrition and community outreach; psycho-social support groups for PLHIV, especially children; and working with traditional and religious leadership.

There are two areas of weakness within the national response that have been highlighted as priorities, the first of which is not a current strength of Concern's, but where it should in any case be developing capacity; if resources were put into developing capacity and understanding in these they would both strengthen Concern's own work, but could potentially

have much wider impact. These two areas are developing standardised data and reporting tools for non-clinical community-based HIV interventions; and, strengthening the gender focus of the response.

It is also recommended that if Concern continues with Focus Groups it consider different approaches for rural and urban areas. If it continues work with school health groups it should focus more on the quality of their activities and encourage them to particularly focus on supporting life skills, gender awareness and behaviour change in youth, rather than taking on responsibility for generalised awareness raising in local communities.

Recommendations for Concern Worldwide: The approach of using focus groups and school anti-AIDS clubs for outreach in Liberia follows a similar design for both urban and rural areas, and is similar to approaches that Concern has used elsewhere despite differing patterns of the disease. It is recommended that Concern carry out a comparative study to assess what has been learned about appropriate community responses to care and prevention in different contexts including factors such as different rates and patterns of HIV prevalence, and what works best in urban and rural contexts.

Mainstreaming is generally going well. In the future it is recommended that:

- Systematic approaches are developed for keeping staff (both HIV&AIDS focal points and other staff) up to date with latest developments.
- Concern Liberia clarifies the difference between mainstreaming and integration and develops clarity as to when integration is appropriate.
- Partners, support groups and focus groups from the HIV&AIDS programme are used where possible for integration activities for other programmes. This can also be used as an opportunity the HIV&AIDS mainstreaming officers to update these groups on the latest information.

Future programming: Overall Concern Liberia's HIV&AIDs programme has been an interesting initiative, working in a difficult and changing context. It has some real strengths, as well as some significant weaknesses. Through this work Concern has built a significant profile and reputation for HIV&AIDs work in Liberia. Concern is strongly encouraged to seek further funding to enable the organisation to build on these foundations.

1 Introduction

1.1 Context

Liberia, on the West Coast of Africa, is a relatively small country of approximately 111,370 sq. km, and an estimated population of 3.2 million. It suffered from fourteen years of armed conflict ending in 2003 which left Liberia among the poorest countries in the world[1]. During the war almost 10% of the population were killed and at least half displaced. Much of the nation's infrastructure was destroyed or severely damaged throughout these years and all levels of government were left in disarray[2]. By the time of the elections in 2005, average income in Liberia was just one-quarter of what it had been in 1987, and just one-sixth of its level in 1979. In 2006 nearly 80% of the population were living below US$1 per day, with a significant proportion in the severe poverty category of less than US$0.50 per day[3].

A lack of reliable data makes it difficult to get an accurate picture of the state of the HIV epidemic in Liberia. The 2007 population-based *Liberian Demographic and Health Survey* (LDHS) showed an HIV rate of 1.5 percent (1.3% HIV-1; 0.2% HIV-2) among the general population aged 15-49, indicating a low-level, generalised epidemic. However this is considerably lower than results from anti-natal testing sites which were 5.7% in 2006, 5.4% in 2007, and 4.0% in 2008. 2011 results are awaited[4].

As in other African countries, the LDHS showed higher HIV rates among women (1.8%) than among men (1.2%), particularly among those 15-24 where rates are three times higher. It also revealed significant differences between urban and rural settings, with HIV being well established in urban areas with a prevalence rate of 2.5%[5] against only 0.8%[6] in rural areas. Differences are also found in the HIV rates among different socioeconomic groups: the rate among the wealthiest group is 2.6% (3.0 for women; 2.2 for men), against 0.7% among the lowest-income group (0.8 for women; 0.5 for men). In addition, results show clear regional differences, with the highest HIV rates in the capital Monrovia (female 2.9%; male 2.3%), followed by the South Eastern B region, (female 2.4%; male 0.8%), while the lowest HIV rate of 0.6% was found in the North Central region (female 0.5%; male 0.7%). More in-depth research is needed to better understand the underlying dynamics of these regional and rural-urban differences in HIV rates.

In Liberia, the primary mode of HIV transmission is through heterosexual contact, followed by maternal to child transmission (MTCT) during pregnancy, childbirth, or breastfeeding; additional significant routes of infection in Liberia include unsafe blood and injection drug use[7].

There is no HIV-prevalence data on specific most-at-risk populations, such as sex workers and men who have sex with men (MSM), though these are expected to have higher rates. TB-HIV co-infection is a major problem: more than one-fifth of TB patients who undergo HIV testing are HIV-positive[8].

Whilst male circumcision rates are high in Liberia and may help to reduce the spread of HIV, the 2007 Liberian Demographic and Health Survey found a statistically non-significant association between male circumcision and HIV infection where circumcised men were slightly more likely to be HIV-positive than uncircumcised men[9]. Other factors are likely to drive the epidemic: sexual and gender-based violence (SGBV) is widespread; poverty and economic dependency on men have driven many women and girls to engage in high-risk transactional sex; and, high labour mobility and population movements during and after the war have been shown to increase the likelihood of multiple sex partners. Youth are particularly at risk with many not living with their parents, large numbers out-of-school, and early age of sexual debut for young women being the norm[10]. Sexually Transmitted Infections (STIs) are a major public health problem and data from 2008 suggests that unprotected sex was the norm, rather than the exception, especially among

[1] IMF, 2008

[2] Livelihoods programme proposal

[3] UN – Liberia National Human Development Report, 2006.

[4] Personal communication NAC. There are a number of possible reasons for the differences in these results: the ANC survey was biased towards urban areas and 9.2% of those interviewed in the DHS survey refused to be tested for HIV, possibly biasing the results.

[5] 2.8% for women and 2.1% for men

[6] 1.1% for women; 0.6% for men

[7] LISGIS 2008 cited in Evaluating HIV and AIDS Knowledge, Attitudes, and Practices in Montserrado County, Liberia, May 2012, New York University Master of Public Health Program, Global Health Leadership Concentration, Capstone in Global Public Health

[8] National Strategic Framework 2010-14, no date given for test results

[9] LISGIS 2008

[10] LDHS, 2007

the most sexually active young population[11]. These factors provide potential for the rapid spread of HIV, without effective HIV-prevention programmes.

The war led to the almost total collapse of the public health-care system with severe consequences for people's overall access to health care, including key HIV prevention, care and treatment services. In 2007, there were only six anti-retroviral (ARV) centres, reaching 1,150 people[12], or about 5%[13] of those who need treatment, and less than 2% of pregnant women were accessing prevention of mother-to-child transmission (PMTCT) services[14]. The situation has improved considerably since then and by 2010 there were 29 Anti-retroviral Therapy (ART) centres (see Table 1).

Table 1: HIV and AIDS Service Delivery 2008 - 2010

Service Delivery Area	2008	2009	2010
Number of sites providing HIV Counselling and Testing services	89	114	176
Number of sites Prevention of Mother to Child Transmission (PMTCT)	29	55	149
Number of sites Anti-retroviral Therapy (ART)	19	22	29
Number of Blood Bank set up and running according to national guidelines	3	5	6
Number of People with Advance HIV infection receiving ART	2017	2970	3906
Number of Pregnant women receiving ARVs prophylaxis to prevent mother to child transmission of HIV	420	690	1174
Number of people tested for HIV and know their status	51,515	243,717	272,390
Number of STI cases treated according to national guidelines	155,758	243,717	275,390
Number of health workers trained in HIV service delivery area	763	1000	1,341
Number of free condoms distributed to high risk population	2,200,000	10,300,000	10,919,798
Number of sentinel sites functioning	15	20	20

However major challenges remain. While access to HIV treatment, care, support and prevention services are now available at an increased number of health facilities, weak health systems, and stigma and discrimination still hamper PLHIV's access to these services and loss to treatment for both PMTCT and ART remains high[15].

There is currently said to be high levels of general awareness of HIV but according to the National Strategic Framework 2010-14 (NSF), comprehensive HIV knowledge remains poor, and denial, stigma and discrimination remain widespread. Furthermore, high awareness has not resulted in safer sex behaviours.

1.2 Concern's HIV&AIDS programme

Concern started implementing an HIV&AIDS programme in Liberia in 2008, building on prior mainstreaming work. It was planned as a 5 year programme (2008-12) working in Grand Bassa and Montserrado County initially, with the expectation that phase two would either expand within these counties or to Lofa and Bong County as appropriate. The decision was made to terminate the programme at the end of 2011 due to lack of funding.

The **goal** of the programme was to contribute to the reduction of the spread and impact of HIV and AIDS among extremely poor people in programme counties in Liberia, with the i**mmediate objective** being to achieve significant improvements in the social support, health and livelihoods of people living with HIV and affected communities, and reduce the susceptibility of key populations of higher risk in selected poor communities in programme counties. There are 3 strategic goals, each with an associated output (see Table 2)

Table 2: Strategic Goal and Outputs

Strategic Goal	Output
Stigma and Prevention Individuals and communities demonstrate commitment, responsibility and capacity (knowledge, skills, means and options) to prevent the spread of HIV and mitigate the causes of stigma against HIV and related issues and to act to reduce discrimination	Reduced HIV-related stigma and increased knowledge, attitude and behaviour towards HIV prevention, treatment and care among key populations of higher risk
Care and Treatment *PLHIV and affected communities living in extreme poverty have increased and*	Improved and strengthened sustainable capacity of local partners and relevant government bodies in HIV and AIDS

[11] LISGIS, 2008
[12] Statistic from Lwopu Bruce, NACP, 18-10-2007 cited in Programme proposal for five year HIV and AIDS programme.
[13] UNAIDS Country Situation Analysis: Liberia http://www.unaids.org/en/Regions_Countries/Countries/liberia.asp
[14] UNAIDS Country Situation Analysis: Liberia http://www.unaids.org/en/Regions_Countries/Countries/liberia.asp
[15] As women go from outpatient visit to pre and post test counselling, the number who follows through on this chain decreases dramatically. (NACP-MOH Annual Report 2010)

equitable access (and uptake) to quality HIV related services as part of comprehensive health services for all, targeting in particular areas where Concern is supporting health programmes	prevention, care, support, and treatment services in selected counties
Nutrition and Livelihood Security *Extremely poor HIV-affected communities and individuals especially women and children have improved levels of nutrition, food and livelihood security.'*	People living with and affected by HIV and key populations of higher risk have improved and sustainable levels of nutrition, food and livelihood security in collaboration with Concern Livelihoods, Concern Health and partners.

The programme had a budget of € 991,561 funded by Medicor, IBIS and MAPS.

Direct implementation by Concern started in 2008 in Monrovia and in 2010 in Grand Bassa. The programme has also worked with the following partners: Eternal Love Winning Africa (ELWA); Light Association, and Young Women Organized for Sustainable Development (YWOSD) and, in 2011, the newly formed LIBNEP+.

1.3 Methodology

This evaluation was carried out by an external consultant, supported by Concern staff. It is based on information from the following:

- Literature review of available documentation[16]
- Review of financial data
- 2 telephone interviews with staff from Concern Worldwide in Dublin
- 7 Interviews with management, HIV&AIDS programme staff, and M&E officer from Concern Liberia
- 2 interviews with government staff at national and District levels
- Visits and discussions with all partners (ELWA, Light Association, LIBNEP, YWOSD) and SHALOM
- 5 separate focus group discussions (FGD) with members from 3 Support Groups
- FGD with members of health clubs and teachers from 4 schools (students and teachers were formed one group in Montserrado, and were spoken with separately in Grand Bassa)
- FGD with focus groups from 6 communities (men and women separately in 2 communities)
- A visit to the farm in Monrovia
- 2 visits to households reached by awareness activities[17]
- 4 FGD and 2 interviews on mainstreaming with programme and support staff in Monrovia and Buchannan
- A feedback and discussion session with Concern Liberia staff

Field work was challenging due to a fairly short time in the field for one evaluator working on their own, which meant that it was not possible to always talk to different social groups separately (men, women or by age). There was also a lack of accurate and clear quantitative data available at the time the field work took place as summarised below:

- The programme did undertake a baseline study in Montserrado in June 2009 of 1710 interviewees, however the wording of some questions invite subjective answers such as 'how much do you know about HIV&AIDS', making comparison with later surveys unreliable. The data was also not disaggregated by sex, age or other social factors.
- Limited pre and post Knowledge, Attitude and Practices (KAP) surveys of 29 (June 2009) and then 60 (August 2010) informants were carried out in Grand Bassa, which give some data from a limited sample of informants, but suffer from similar limitations in the wording of questions and some apparent inaccuracies in analysis[18].
- Data has not been collected on an on-going basis against the indicators in the original logframe. After an internal review the logframe was revised in June 2011 to make the indicators clearer, but again data had not been collected against these new indicators, and it was not feasible within the timeframe of this evaluation to remedy this. Rather than go systematically through the logframe explaining where and why data is not available against each indicator, the approach taken by this review is to use the data that is available to assess progress against the intended outputs.
- Regular reporting has taken place, but data within this focuses on the activity level. It has proved challenging to understand this coverage data as reports tend to count the number of people attending particular outreach activities and as the same people may attend more than one activity there is the potential for double counting. For example the 2010 report states that: '*Door-to-door awareness was carried out in 10 communities in Buchanan and its environs during which 19,374 persons (4,687 male; 6,621 female and 8,066 children) were reached directly.* Yet other documentation suggests that these 10 communities have a **total** population of 6745

[16] See Appendix 1

[17] For a full list of those interviewed see Appendix 2

[18] For examples actual numbers of respondents are not given, but for the question on how HIV is transmitted the % replies for each category (unprotected sex, mother to child transmission, unsterilized needle) add up to 100%, suggesting that the percentages were worked out on total number of answers given rather than on the number of respondents.

inhabitants. Similar problems were evident in the data for other outputs. Given the limited time allocating to writing the report, it has been necessary to use the data that is available to make some educated estimates about likely coverage. Where this has been done the reasoning is explained in footnotes.

Subsequently Concern Liberia worked in collaboration with Capstone to carry out a rigorous KAP survey within the Monrovia programme area, key findings of this have been included in the final version of this report[19].

2 Relevance

According to the National AIDS Control Programme, Ministry of Health (NACP-MOH) Annual Report 2010, since the advent of HIV and AIDS in Liberia, the primary emphasis of the government has been on preventing the spread of the virus. Their multi-pronged approach towards prevention includes Information, Education and Communication (IEC)/Behaviour Change Communication (BCC); HIV counselling and testing; condom promotion and distribution; management of sexually transmitted infections; blood safety and universal precautions; and prevention of mother-to-child transmission of HIV infection. Concern's HIV&AIDS programme is relevant to these priorities and meets the needs of communities as expressed in the initial assessment and field work. It is also aligned to Liberia's Poverty Reduction Strategy.

The current National Strategic Framework 2010-2014 sets out the key areas of focus for the next phase of work as:

1. Strengthening coordination and management of a decentralised, multi-sectoral response
2. Strengthening HIV prevention among most at risk and vulnerable populations
3. Scale up coverage and quality of treatment, care and support for People living with HIV&AIDS (PLHIV), orphans and vulnerable children (OVC) and others affected
4. Availability and use of strategic information for an evidence-informed response
5. Reducing stigma and discrimination of PLHIV as a cross-cutting priority.

The HIV&AIDS programme is also broadly aligned to this strategy 2010-2014 in that it supports these overarching aims, though they have some implications for future strategic direction were the programme to continue (see later comments).

The programme follows the principle of the 'Three Ones[20]' as far as possible within the current context in Liberia; a national HIV database and Monitoring and Evaluation system does not yet exist but is currently at draft stage and is a key priority within the NSF.

Mainstreaming

HIV&AIDS has been both mainstreamed and integrated into Concern's other programmes in Liberia; indeed staff do not seem to be clear on the difference between these[21]. As Liberia has a generalised epidemic[22] mainstreaming is important. Integrating HIV&AIDS activities within these programmes is also relevant in the Liberian context as:

- Establishing health clubs focused on HIV&AIDS information within the education programme supports the draft national HIV policy and strategic plan for the education sector.
- The integrated HIV&AIDS activities in the livelihoods and WASH programmes focuses on reducing stigma and discrimination of PLHIV which might otherwise result in such people being refused access to Concern provided facilities
- In many rural areas there is a lack of other information sources on HIV&AIDS, so it is helpful for Concern to disseminate general information on HIV&AIDS when working in the area.

3 Targeting

Grand Bassa and Montserrado[23] were chosen as priority counties for the programme due to:

- Their relatively high prevalence of HIV: Monrovia had an estimated rate of 2.6% in 2007 (2.9% and 2.3% women/men)[24]. Data for Grand Bassa is included in the South Central Health region which had the third highest rate of 1.4% (2.2% and 0.5% among women and men respectively).

19 Evaluating HIV and AIDS Knowledge, Attitudes, and Practices in Montserrado County, Liberia, May 2012, New York University Master of Public Health Program, Global Health Leadership Concentration, Capstone in Global Public Health.

20 One agreed AIDS action framework, as the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad-based multi-sectoral mandate; and one agreed country-level monitoring and evaluation system

21 External mainstreaming views programmes and projects through an HIV lens and refocuses them to take into account both causes and consequences of HIV and AIDS. This means modifying intended activities if necessary, NOT adding HIV activities. (Concern HIV&AIDS Strategy 2008-12).

22 An epidemic is considered 'generalized' when more than one per cent of the population is HIV-positive.

23 For further information on these Counties see Appendix 3

- Grand Bassa and Montserrado County hold Liberia's two major urban centres, Monrovia and Buchanan City. Urban areas have higher rates of HIV than rural, and are considered to have higher rates of risky behaviour including higher number of sex workers, and transient populations.
- The existence of well-developed HIV mainstreaming activities in the Livelihoods and Health programme in both counties
- The strong working relationship with the primary HIV partner ELWA in both counties
- The lack of service providers among key populations and people living with and affected by HIV in these counties, and, in Grand Bassa, few other NGOs working on HIV&AIDS.

Given these considerations, the choice to focus the initial phase of the work in these counties, and within Montserrado focus on urban slums, would appear to be sensible.

The main target groups within these areas were:

- People living in extreme poverty and within this key populations of higher risk and PLHIV
- People Living with and affected by HIV and AIDS
- Sex Workers
- Adult transport workers
- Youth
- Children

People living in extreme poverty who are HIV positive are clearly a key group for the programme to focus on for support in care, treatment, nutrition and livelihood. It is less clear that people living in extreme poverty are always the most significant group to target for stigma and prevention work. Whilst the poorest are the least able to deal with the consequences of HIV infection and are so most vulnerable to its impact, it is debatable whether the poor in general are always the most at risk of becoming newly infected. The LDHS data of 2007 shows a direct correlation between wealth and HIV status with the lowest wealth quintile the least likely to be HIV+ (0.7% overall compared to 2.6% for the highest wealth quintile). However, particularly in urban areas, staff point out that poverty makes people more likely to adopt risky behaviour such as transactional sex.

The poorest are however the group that the other programmes target so where the HIV&AIDS programme is run alongside, they become the target group. A further complication here is that not all communities accept the idea of forming an HIV&AIDS Focal Group. In Grand Bassa the programme set up 4 focus groups in 2010 and another 2 in 2011. Staff report that there was an intention to set up an additional 2 groups in 2011, but the communities didn't want them. Whilst it is not suggested that focus groups are pushed onto resistant communities, it is quite possible that these are communities with particularly high levels of stigma and denial about HIV&AID, and therefore ones that need work on prevention and stigma most.

Sex workers and transport workers are clear groups that have been identified by the National AIDS Commission (NAC) as priorities for prevention work. Female sex workers and their male clients are considered to be the most important at-risk and bridge populations for HIV transmission[25]. Furthermore, transactional sex was a common survival strategy for many women and girls during the war, and has remained widespread as a means of securing a livelihood. However the extent to which the programme has been able to systematically target these particular groups is less clear (see Section 6).

According to NAC infection rates are beginning to rise in ages 19-24. By the age of 18, 83% of girls and just over 50% of boys are sexually active. Young people are therefore considered to be critical to target with life skills education to both delay sexual debut and install safe sexual behaviour[26]. The national policy is to target all young people; hence focusing on youth and children in prevention work, as this programme does in its work in schools, is appropriate.

Key groups at risk of HIV which were not considered within the programme were men who have sex with men (MSM), men in incarceration, uniformed personnel and people living with disabilities. Given Concern's focus on the poorest, and its lack of experience in working on MSM issues or in prisons, the choice not to target the first three of these groups makes sense; there were plans to work more with people living with disabilities in the next phase.

---

[24] DHS Survey 2007

[25] A 2008 report by the World Bank showed that female sex workers and their male clients were the most important core and bridging populations in the HIV epidemics in West Africa. This also found that 'high-volume sex workers' – a group it suggested who often form a minority of women engaged in the sex trade – account for a large part of commercial sex activity (sex acts), and are therefore one of the key groups that require priority attention.

[26] Andrian-Paul, Stolze &Popovic, 2009

4 Significant changes (impact)

4.1 Overall

Interviews with a range of stakeholders suggested that Concern is recognised as a leader in the HIV&AIDS response in Liberia. They are particularly credited with being one of the first organisations to stress the GIPA principle[27] and to work together with PLHIV to address the epidemic and tackle stigma, some of this work predating the HIV&AIDS programme.

There was limited opportunity to interview government stakeholders during the review process, but those met stressed that Concern collaborates well with the government at both County and National level. The capacity of NAC to coordinate the HIV&AIDS response within Liberia has clearly increased since 2008, and though Concern is only one player in this, it has contributed to this improvement. In particular Concern supported NAC to develop an operational plan for its current Strategy. Concern has also directly contributed towards the setting up of a national network of PLHIV, LIBNEP+ which was identified in the National Framework as a key activity.

4.2 Stigma and Prevention

Output One: Reduced HIV-related stigma and increased knowledge, attitude and behaviour towards HIV prevention, treatment and care among key populations of higher risk.

The programme has worked to reduce HIV-related stigma and prevent new infections through community mobilisation and awareness activities including:

- Establishing or supporting community based focus groups in slum and rural communities that work to educate and inform their local community about HIV&AIDS (direct implementation)
- Supporting ELWA and Light Association peer to peer and house to house outreach work
- Community workshops aimed at key target groups such as religious and town leaders, traditional leaders community officials, low-income men, low-income women, sex workers, transport workers, youth and children (direct implementation & partners)
- Setting up and stocking condom outlets in communities, particularly targeting transport stops, bars, markets, health clinics, partner offices, and other strategic areas (direct and partners)
- HIV and AIDS prevention and awareness events, including large scale sensitization campaigns.
- Age-sensitive child-to-child awareness in schools through school health clubs, and organisation of inter-school awareness events (YWOSD and direct implementation).
- Awareness generation on HIV and AIDS through health and hygiene education sessions in WaSH programme.
- Training media practitioners and broadcasting HIV and AIDS messages through radio phone in talk shows, national TV stations, and community and school video clubs (ELWA, Light Association, YWOSD).
- Development and distribution of Information Education Communication and Behaviour Change Communication materials (IEC/BCC).
- Advocacy (Light Association)
- Supporting and celebrating World AIDS Day.

Outreach activities are estimated to have reached communities with populations of around 13 000 in Buchannan (see Table 3), and 171,000 in Monrovia, though in the latter case it is unlikely the focus groups will have reached all the population of the area. Radio shows led by ELWA in Grand Bassa, and YWOSD and Light in Montserrado targeted an audience of 25,000 in Grand Bassa and 82,000 (7% of Monrovia's population).[28].

Table 3: Population of communities where outreach activities by community volunteers occur

Area	Programme modality	CBOs	Population of communities		
			Female	Male	Total
Grand Bassa	Direct Implementation	6 Focus groups established in WASH or education programme areas, volunteers: Caring for Tomorrows Generation Orphanage Home; Zardun (Tubmansville Public School); Compound #2; Gayegbokon; Gio; Charles Johnson)	1818	1799	3617[29]
	ELWA outreach through peer	6 peer counsellors working in 10 communities: Joe Zohn Community; Zinc camp; Sugar cane com; Juah town community;	3526	3225	6745[30]

[27] Greater Involvement of People Living with AIDS

[28] From 2010 annual report

[29] Taken to be total population of villages in which the Focus Groups are based. As these are rural areas and small villages, it is likely that everyone will be aware of the Focus Group activities. Actual outreach will be more than this as the Focus Groups also visit nearby communities.

[30] Data taken from pre and post KAP survey report 2010. These are total populations for communities where ELWA works, so are likely to be an over estimate of those actually reached with stigma and prevention messages.

	counselling	Bassa community; Moore community; Millionaire quarter; Big Fantee town; Saw mail community; Dirt Hole community.			
	Light Association	Awareness raising activities	1179	1215	2394[31]
Total in Grand Bassa			6523	6239	12762
Montserrado	Direct Implementation	8 communities reached through 8 Focus Groups. 50 Condom outlets set up in these communities. Communities include: Clara Town; Chocolate City; Gaye Town; Gballasua; SKD Community; Chicken Soup Factory; New Kru Town; Topoe Village	n/a	n/a	171,000[32]
	ELWA outreach through peer counselling	7 trained PLHIV working since 2006 as peer educators	n/a[33]	n/a	1,260[34]
	YWOSD	80 organisations receive copies of video, screened on 2 TV stations for 5 months, and at 11 video clubs 10 school health clubs established (2010)[35] in Paynessville, Oldest Congo Town and Old Road	n/a	n/a	82,000[36] 2,000[37]

Focus Groups/Peer Educators

The community based focus groups, school health clubs, and peer educators that have been set up, trained or supported by the HIV&AIDS programme take the lead in outreach work within the communities on education about HIV&AIDS and prevention of stigma. Peer educators are trained PLHIV who receive a stipend each month. Focus Group and Health Club members are volunteers.

8 groups were visited during field work (underlined in the table above), along with peer educators from ELWA. All members showed good basic knowledge of HIV&AIDS including how to prevent it, and how it is transmitted. They could also reject major misconceptions about HIV transmission. They were well able to share basic messages about HIV&AIDS within the community.

> *Looking at community people, at the start they couldn't talk about it… Now they are confident to go into another community and give awareness… They now know that talking about HIV will not get you infected. (Concern staff)*

When asked if there were areas where they did not know enough, a number of group members suggested they did not understand the mechanisms by which mother to child transmission occurs, though they were aware that pregnant women should go for HIV testing and that if found positive could be supported to minimise the risk of transmission.

Whilst members and peer educators knew the facts and were good on knowledge, some were less strong on arguing a case or persuading people to change their practices, a much more challenging area. One peer educator observed in practice, could give accurate information about HIV&AIDS transmission and prevention, but was only able to repeat these when asked the advantages of knowing ones status. Another group hadn't considered that peer to peer education (i.e. young women talking to young women, older men to older men) would work more effectively though they complained that older men tended not to listen to young women.

Survey data of community knowledge, attitudes and practices: Monstserrado

A KAP survey was carried out in 7 communities in Montserrado in 2009, and repeated in 6 of these in 2012 with the addition of two others[38]. These are areas where direct implementation has been taking place. The two surveys are not directly comparable as the initial one targeted respondents aged between 15-50 and the later one anyone over 18. Also

[31] Population data not available so data taken from reports of numbers attending events. As some may attend more than one event this likely to be an overestimate.

[32] Figure from baseline 2009 for 7 communities. Awareness and prevention activities were reported to have reached 151230 in Monrovia in 2011 through all activities, a figure likely to involve some double counting.

[33] These are said to make 420 visits yearly, 35 visits monthly. However it is possible that the same people are visited each month, so this does not give the number of beneficiaries.

[34] Figure provided by Concern staff, source unknown

[35] In Oldest Congo Town: Monrovia Open Bible high School, Tarr town. In Paynesville: Paynesville junior high school, Neezoe; Christian Mission Fellowship intl School, Leo; Paynesville central academy, Neezoe; Patrick Pah Wesleyan Junior high, Neezoe. In Congo Town: Repentence Baptist, Pagco Island; Goodridge High School, Gaye Town. In Old Road: Clarence Momolu High School, Nippy Town; Open Bible School, Tarr Town; Wells Hairston High, VP Road.

[36] Figure provided by Concern staff, source unknown

[37] Figure provided by Concern staff, source unknown

[38] The 2009 survey was carried out in Chicken Soup Factory, Clara Town, SKD Community, Gaye Town, Gballasua, New Kru Town, Gaye Town and Chocolate City. The 2012 survey was carried out in all of these except SKD community and added Doe Community and Topoe Community. The repeat survey was in the communities where the programme has been operational.

questions were not necessarily identical. However if we compare questions that were identical, or very close to it, findings indicate the following:

- The majority of the respondents in the repeat survey (96.9%) had heard of HIV&AIDS. This is slightly down from the 100% who answered yes to this question in 2009.
- In a self-assessment of knowledge 72.4% in 2012 said they knew a little or very little about the disease[39].
- In 2012 16.9% reported they knew 'a lot' about HIV&AIDS, this is up from 10.7% in 2009.
- In 2012 44.7% of respondents stated there was no difference between HIV&AIDS compared to 75% in 2009.
- 59.2% of those surveyed in 2012 believed it was not possible to catch HIV from mosquito bites. This is slightly down from the 65% who said it cannot be transmitted this way in 2009.
- 19.3% of individuals replied that a mother cannot give HIV to her baby, whereas only 2.5% did in 2009.
- In 2012 18.8% said AIDS could be cured compared to 5% in 2009. Furthermore 27.5% of respondents in 2012 believed there is a vaccine.
- In 2012 79.6% responded that they were willing to have an HIV test. This is up dramatically from 35% in 2009. However the 2012 survey found that those who self-report multiple sexual partners are less likely to say that they are willing to have an HIV test in the future.
- 28.4% said they had never used a condom in 2012 compared to 14% in 2009.
- 47.8% of people in 2012 said they had ever refused sex because of unavailability of a condom, this was up from 30% in 2009.
- In 2012, 29% of men and 41% of women (35.5% overall) would not tell any one if they were HIV positive. This has dropped a lot from the 80.5% in 2009.

Table 4 summarises these comparable results in terms of those that have improved and those that have worsened.

Table 4: Changes indicated by before and after KAP surveys

Question	Change in responses[40]
If you had HIV or AIDS would you tell anyone? Those that answered 'No'	Improved by 45%
Would you ever do your HIV test? Those that answered 'yes'.	Improved by 45%
Is there a difference between HIV&AIDS? Those that answered 'No'.	Improved by 30%
Did you ever say no to a man/woman in bed because there was no condom? Those that answered 'yes'.	Improved by 18%
How much do you know about HIV&AIDS: those that answered 'a lot'.	Improved by 6%
Have you ever heard about HIV&AIDS	Worsened by 3%
Is it possible to catch HIV from mosquito bites?: Those that answered 'No'	Worsened by 6%
Can AIDS be cured? Those that answered 'yes'.	Worsened by 14%
Have you ever used a condom? Those that answered 'no'	Worsened by 15%
Can a pregnant woman give HIV to her baby? Those that answered 'no'	Worsened by 17%

The data from the pre and post surveys in programme communities in Monsterrado suggests that there has been considerable shifts around stigma in that a lot more people indicate that they would be prepared to be open about their status (up 45%) and a lot more say they would be prepared to ever do their HIV test (up 45%). The 2012 survey also found a correlation between higher levels of knowledge around HIV&AIDS and reduction in stigma and concluded that *'this finding provides good evidence that improving knowledge can reduce stigma, even if the effects of improving knowledge on behaviour change are less straightforward.'*

However the picture on whether knowledge about specific aspects of HIV&AIDS has improved over the programme duration is much less clear. Considerably more people know there is a difference between HIV&AIDS, however in terms of specific knowledge about transmission in some cases the situation appears to have worsened. Particularly concerning is the situation that 17% fewer respondents who think it is possible for a pregnant woman to pass HIV to her baby.

Data from the 2012 survey that cannot be directly compared with baseline data showed that one third of those surveyed thought was not safe to live with someone who has HIV or AIDS, and one fifth of respondents said they would no longer associate with a close friend who was diagnosed with HIV. These suggest that though stigma may have reduced, considerable levels of stigma remain.

Thirty three percent said that they themselves have multiple concurrent sexual partners and 24% reported that their partner did. Those reporting their own multiple partners were more likely to be young, male and Christian. Those reporting their partners having multiple partners were more likely to be: female; single, widowed or divorced; and

[39] This is more than twice those who claimed little knowledge about the disease in 2009 (32.6%). However as the original data is missing for 2009 it is hard to be totally sure these figures are comparable. On the same page this figure of 32.6% is quotes as the number who said they knew 'very little'.

[40] 'Improved' indicates one of the following: more people gave the factually correct response; fewer people gave the factually incorrect response; more people reported positive behaviours; less people reported negative behaviours. 'Worsened' indicates the reverse.

themselves having multiple sexual partners. Furthermore 56.8% of those surveyed had not used a condom last time they had sex. This suggests that there is still a long way to go in ensuring that improved knowledge leads to reduction in risky behaviour.

However there were indications that improved knowledge on HIV&AIDS does have some influence on behaviour change as higher self-reports of condom use were associated with better knowledge about HIV as well as younger respondents and being men. The survey also found that there is a positive association between knowledge about HIV and both lifetime condom use and willingness to have an HIV test in the future. It is also associated with willingness to accept an HIV+ friend.

Access to condoms appeared to be widespread with 74.5% claiming they could get a condom whenever they needed one, with half of them citing the hospital or clinic as their source, a little over a third the drug store or pharmacy and about one fifth community organisations and NGOs.

Survey data of community knowledge, attitudes and practices: Grand Bassa

Limited pre (June 2007) and post (August 2010) intervention KAP surveys were carried out in ELWA programme areas in Grand Bassa. These contain a number of limitations, and the data must be treated with caution. It found that:

- All respondents (n=60, 32 m & 28 w) had heard about HIV&AIDS, this was up from 95% in the initial survey[41].
- 85% of respondents (n=51, split by sex not available) had heard about HIV counselling and testing centres, this was up from approximately a third[42].
- 35% (n=21) said they knew it was possible to get a confidential HIV test compared to only 2%[43] initially.
- 37%[44] said they would be willing to take a HIV test, up from zero in the initial survey.
- 100% (n=60, 32 m & 28 w) said they could eat and sleep in the same room as an HIV infected person compared to 69% initially.
- The number who said they had ever used a condom increased from 17% (approximately 5 out of 29) to 63%[45].

Whilst the actual percentages should be treated very cautiously and are based on small sample sizes, the data from Grand Bassa does indicate a positive trend in knowledge. The extent to which this knowledge is put into practice cannot be assessed accurately as the positive answers could indicate individuals knowing what answer will please the questioner rather than what they actually do.

Data from field visits

The positive trends shown by the surveys were collaborated by the data collected during the field visit. It was only possible to visit 2 households within the Grand Bassa area, but both those visited had good knowledge about HIV&AIDS transmission and prevention and knew of ELWA's outreach work. One of the women visited said that she sent her children to ELWA's workshops, the other said that she insisted on the use of a condom with her fiancé as she was aware he had other partners. Their knowledge was in marked contrast to that of a relative from a different area that was visiting the first woman. This man had heard about AIDS from the radio, but didn't really believe it was real, and had no intention of using a condom or going for VCT.

Feedback from focus group members and peer educators was that they were observing changes within the community, in terms of knowledge and acceptance that HIV&AIDS exists:

> *I didn't know HIV&AIDS was real. I used to hear about it on the radio and not care about it. (Compound #2)*

They were also more knowledgeable about STIs, both what they are, common symptoms, and the importance of getting them treated:

> *Before no-body used to care less about their health. Now, because of our education, if we notice any symptoms we want to check what it is.'* (Female FG member Compound #2)

[41] NB The date of the baseline survey in Grand Bassa is not given. The sample size in the baseline was said to be 29, so presumably 28 out of 29 said they had heard of HIV&AIDS (i.e. 96.5%). 95% is presumably a rounded figure.

[42] This was up from 35% in the pre KAP survey, but again 35% does not work out to a whole number in a sample size of 29.

[43] 2% of a sample of 29 equates to less than one person. It is possible some refused to answer this question.

[44] Number of informants not given, but 37% does not equate to a whole number out of a sample size of 60. It is possible some refused to answer.

[45] Number of informants not given, but 17% does not equate to a whole number out of a sample size of 60. It is possible some refused to answer.

Focus groups and peer educators also considered that there had been a significant reduction in implement sharing. Adults were said to be aware of the importance of disposing safely of needles or razor blades used for threading hair or cutting fingernails, and children were reported to be told not to play with ones found on the ground. The children we spoke to at the ELWA hospital support group were very aware of this. One midwife, a member of a focus group, said that she now always used a fresh razor blade for cutting the umbilical cord, suggesting she hadn't in the past. There are also anecdotal reports from Concern and partner staff that they have successfully reached out to secret societies and advised them of the need to use new blades when carrying out circumcision. All of those interviewed were also aware of the importance of using sterile equipment for injections, including avoiding the services of the 'black bag' (itinerant doctors who may reuse needles and syringes many times), and ensuring blood is tested before transfusions. This is important as the NAC recognises that nosocomial infections[46] are a possibility in Liberia. Villagers in Gayekebon report that women no longer breast feed another's baby.

Sexual behaviour is both harder to change and to track. Some of those interviewed, both men and women, reported a decrease in their number of partners:

> *Now I stay by myself. I used to run around all over. The group helped me to move around and stop a lot of risky things' (F FG member, Compound #2).*
>
> *The group helped me to be faithful. Before I used to be like a footballer and play anywhere. (M FG member Compound #2)*

More common was the claim that more people were aware of risks and are now more likely to use condoms, at least for sex with someone other than their regular partner. All focus groups visited reported increased acceptability and use of condoms, a typical comment was:

> *When we started the FG we would give out condoms and people would refuse. Now they accept and use them. (M FG Gballasua)*

As the focus groups also distribute condoms they are in a good position to track this. In all the communities visited there was a ready supply of condoms that could be collected discretely from a dispenser or privately from a man or woman chosen by the focus group. In both rural and urban areas men were reported to be much more likely to collect and initiate use of condoms:

> *It is mainly men who come for condoms. Women may be shy. Men are the ones going for walk about[47] so they are the ones to take condoms for protection… I use condom outside as I don't want to bring the sickness inside. (community leader, Gayegboken).*
>
> *Most [girls] say they don't need it. Once in a while we get a young girl who asks. Before it was only boys. Middle aged women won't come. (FG, Gballasua).*

Though condoms are not distributed in schools, feedback from both the schools visited suggested that some students are sexually active. This is substantiated by other data which suggests that sexual debut is early, and that Liberia has the highest rate of teenage pregnancies in the world[48]. One female staff member reported on how she had been approached by 3 girls the previous month who told her that they were happy with the work of the school health club as it was helping them prevent both STIs and pregnancy, through educating them about condoms.

<u>Stigma</u>

Field work indicated considerable reduction in stigma (both self and external) over the programme period, which collaborates the data from the surveys in Montserrado. There will be many factors behind this, a key one being the greater availability of ART. However discussions suggest a significant contribution by the programme. In particular it has encouraged PLHIV to be open about their status and this has helped reduce some of the fear and misunderstandings.

> *Concern has been able to reduce stigma and discrimination in Grand Bassa via the awareness and education programme. They made me to be open about my status and through that I was able to get support from others. (ELWA)*

[46] Ie Hospital acquired

[47] Implying that men are the ones who have extra-marital affairs.

[48] According to Concern documents in Compound 2 in April 2011, out of 100 pregnant women being treated, 25 of them were under 17 years old.

Concern was the first to work on HIV&AIDS. They even broke the stigma. We ate together and travelled together (Light Association)

Reduction in stigma can also be tracked in the changes in people calling in to radio talk shows on HIV&AIDS:

Before they would call and give a threat. Now they call to give input and to ask questions to clear their doubt. (Concern Staff)

A number of informants interviewed during field work suggested that reduced stigma has led to an increase in those going for VCT, and of focus group members met, a significant proportion said they had been tested:

Before stigma was so high that you would not be able to do the test as people would feel you are a certain kind of person. It is not like before (FG Gayekebon)

The programme has not collated trends for VCT testing within the direct programme areas, so it is not possible to triangulate this information. Data available at the national level shows significant increases in VCT across the whole country. It is not useful for our purposes as it only disaggregates by whole county, which will be influenced by many other factors in addition to the Concern HIV&AIDS programme.

Concern has also supported the final approval and distribution of a government policy that includes protection for PLHIV against stigma in the workplace and schools. This has the potential for longer term impact.

Distance to go/challenges

Though considerable achievements can be seen against this output there remain a number of challenges, some of these are related to the Liberian context:

- In rural areas some communities are a significant distance from the nearest services with poor roads, and people may have to travel a long way for VCT. Communities may also be quite spread out, causing challenges for outreach services. Some communities are not covered by radio services, and in any case poorer individuals may not have access to radio. Furthermore some feedback suggests that people who have already had the opportunity to discuss HIV&AIDS are more likely to subsequently listen to programmes about it, others may turn the radio off, or disbelieve the information.
- Focus group members and staff report a lack of confidence that rural clinics will keep medical information confidential, thus discouraging people from finding out their status.
- Widespread poverty and lack of livelihood options mean that people at times struggle to put increased knowledge into practice. For example girls as young as 12-14 are reported to be pressurised by their families or boyfriends to engage in transactional sex, where their youth and lack of confidence makes it harder to negotiate condom use.
- Gender relationships remain unequal, with it being socially challenging for young women to ask men to use condoms, and multiple sexual partners being common, particularly in urban areas: *'Sisters don't pick and choose. They don't tell men about condoms. They don't encourage it. It is picking up gradually, but culturally here, it is hard for women to talk to a man about condoms as the men don't listen' (M FG Gballasua). 'There is pressure on young girls to have more than one boyfriend. The girl may be serious with the man, but the behaviour of the boyfriend to have more than one girl pressures her to do the same. (M FG Gballasua).* The imbalance in numbers of men and women in urban areas is said to make promoting faithfulness challenging: *When we say stick to one faithful partner, most the time they laugh. Women are so available, men say it is not possible to take only one partner.* (W FG member Gballasua). There is said to be peer pressure on young men to have sex. *(M FG Gballasua)*
- Secret societies such as the Poro and Sande Societies have enormous social influence, and are said by some to continue cultural practices which can contribute to the spread of HIV and AIDS (such as multiple partners, or circumcision in non-sterile environments) but are challenging to work with due to their secret nature.
- Denial resulting from widespread discrimination makes people reluctant to come forward for testing, treatment and care. '*If they hear someone is positive they will not come around. It is still a problem with some people. They may not want to affiliate with you.' (community member). 'Some trust no-body. Once you know your status, someone should know. But they are afraid that if they tell the problem to someone they wont keep it secret' (*FG Gayegbokon)
- In February 2011 FGD carried out by the Education programme with teachers found that 36% demonstrated no understanding of child rights or protection issues. When asked about HIV and AIDS 41% of teachers had some understanding but often held misconceptions and many showed signs of stigmatising PLHIV.

Within this context, asking Focus Group members, who work on an entirely voluntary basis, to take a lead in spreading messages around HIV&AIDS faces some challenges:

- The remote and dispersed nature of communities can make it difficult for Focus Group members to reach everyone.
- There is a lack of employment or income earning opportunities in and most of the FG volunteers are unemployed or under employed. This is a particular issue in urban areas where the turnover of volunteers is very high, meaning regular training is needed.

There are thus some serious concerns about the sustainability of some of the progress in this area. Whilst there are indications of an increase in the use of condoms, in many cases the supply of these is reliant on Concern. Communities that are a long way from alterative supplies (e.g. Gayegbokon is a 5 hour walk from the nearest clinic) are unlikely to continue with condom dispensing once the programme ends.

The focus groups themselves appear to have varying likelihood of being sustained post programme. In rural areas members enjoy sessions and show pride in being a member. They report that they benefit from increased confidence and increased status:

> *Before I used to stutter a lot. Since I joined the group I talk fluently. I am meeting new people and talking a lot' (M FG member Compound #2).*
>
> *I am respected by the nearby communities where we go. If I go in uniform, people see me and way they are willing to listen (F FG member Compound #2).*

One rural group that was visited (Gayekebon) have started paying dues and have identified land to plant Cassava; here group cohesion appears high and it looks likely that the group will continue in some form, though the focus on HIV&AIDS messaging may become diluted. The other rural Focus Group visited (Compound #2) hadn't given any consideration to future sustainability.

In urban areas there are more competing demands and opportunities. Here existing groups who approached Concern to seek support seem to take more initiative and ownership and looked likely to continue post programme. Gballasua has raised sponsorship from 2 local businesses, and are in discussions with other possible INGO partners. Chocolate city has got support from the Lutherans till July 2013 to pay a monthly stipend for 2 counsellors, and is in the process of becoming a CBO. However the other two groups visited which had been set up by Concern showed a much less ownership of the initiative, with many volunteers appearing to continue coming to the group through some hope of gaining some material benefit themselves at some point through association with Concern.

Accuracy of the information that is being shared is also a concern, as well as keeping it up to date[49]. As the repeat survey in Monserrado has shown, respondents were actually less accurate in their answers on some key issues such as mother to child transmission in 2012 than they were in 2009. All except two focus groups visited, relied on Concern for up to date information about HIV&AIDs. When the programme ends their lack of access to new information, combined with high turn over of volunteers, means the information they share is likely to become less accurate and out of date over time. Strengthening links to local clinics could help in this regard, though one (Chocolate City) considered themselves to be actually better informed than the clinic: '*we take information to the clinic and empower them.'* The New Kru Town group reported that they had tried to talk with the HIV&AIDS officer at the clinic, who failed to turn up to the appointment. They want Concern to officially introduce them.

The peer educators are paid a stipend each month and most do not have other sources of livelihood. It is unlikely they will be able to continue outreach in a systematic manner once the programme ends and their stipend ceases as they will have to look for alternative livelihoods.

4.3 Care and Treatment

Output Two: Improved and strengthened sustainable capacity of local partners and relevant government bodies in HIV and AIDS prevention, care, support, and treatment services in selected counties.

[49] It should be noted that neither staff nor partners appeared to be aware of the most recent WHO guidelines on breastfeeding for HIV+ mothers. The advice that appeared to be given by support groups was of exclusive breastfeeding for 6 months, followed by total cessation of breastfeeding at 6 months. This advice was replaced in 2010 and WHO guidelines now recommend that HIV-infected mothers of uninfected infants breast-feed for the first year. http://www.medscape.com/viewarticle/762831?src=mp&spon=9&goback=%2Egde_3381406_member_112980441

Activities relevant to this strategy include

- Supporting the capacity development of partners (ELWA, Light Association, YWOSD) through training and exposure visits.
- Supporting the coordination role of NAC and the Grand Bassa and Montserrado County Health Teams
- Contributing to HIV&AIDs sectoral and thematic working groups
- Advocacy for budgetary allotment of care and support for PLHIV and systems to ensure drugs are in-date.
- Coordination meetings of all the support groups in Grand Bassa, and some in Monrovia
- Financial and technical support to ELWA for
    - Family and PLHIV capacity building
    - Training in counselling, awareness raising and care-giving
    - Home-based Care where PLHIV are visited by HBC volunteers drawn from the Support Group
    - Nutrition Education
    - Health Club and play area for OVC
    - PLHIV Support Group
    - Following up those lost to care.

Achievements

The programme has facilitated ELWA to directly provide a range of services to PLHIV over the period of the programme. It has proved challenging to get accurate data on the number of people benefiting from this as reports appear to count each activity of care rather than number of beneficiaries, though this is not consistent[50] (see Table 5). Thus one individual PLHIV who is visited at home 5 times would be counted 5 times. If they also come to a support group meeting every month, and are treated 3 times for opportunistic infections they would show up 20 times in the data.

Table 5: Data for activities in 2010 (from ELWA report)

Partner	Activity	Women	Men	Total	Target[51]
ELWA Monrovia	HBC visits 2010	352	228	580	540
	OI treatment			1167	960 (80 / month)
	Emergency Medical Services			172 (160 adults, 12 children)	120
	Protective supplies for home care			173	72
	Support Group meetings	537 adult 130 children	381 adult, 125 children	918 adults 255 children	600 adults 180 children
	Supplementary rice feeding	76 adult	44 adult	612 children 120 adults	600 children
ELWA Grand Bassa	HBC visits			552 (108 PLHIV & 444 carers)	
	Protective supplies for home care	86	25	111	
	Support Group meetings			40 adults[52]	40 adults
	Supplementary rice feeding			120 children 60 adults	120 children 60 adults

Having set out the data shown above (though not in table form) the 2010 report then concludes that 2559 vulnerable people have benefited, but it not clear how this figure was reached:

> *2,559 vulnerable people reached in Montserrado and Grand Bassa have experienced improved health conditions and have returned to productive life though care, treatment and support, which they received through the intervention, thus reducing the financial strain on their family members.*

From the data available during field work this appears to be somewhat of an overestimate; monitoring and documentation is a key challenge that would need focused attention in any future programme. Assuming the support group met every month as planned the data above suggests an average attendance in Monrovia of 77 for the adults and 21 for the children, though discussions while in the field suggest that this figure varies considerably and on occasions there are up to 150 adult PLHIV and 57 children who come to the Support Groups run by ELWA in Monrovia, though only 50 adults and 50 children are budgeted for in terms of transport and lunches. A further 35 PLHIV are supported by ELWA

[50] Figures given for support group meetings in Grand Bassa give the number of people who come regularly. The same data for Monrovia appears to give the total number of people who attended the monthly sessions over the year.

[51] In many cases money raised from sale of farm produce allowed more to be reached than the target, see Section 4.4

[52] This would appear to be regular members who come each month. The equivalent figure for Monrovia appears to be total number who attended over the year.

and 52 by Light Association in Grand Bassa[53]. As the most vulnerable in each case are referred to the support group, in most cases it will be these support group members who are benefiting from all the care and support initiatives including HBC, medical care, emergency services and protective supplies. Thus it seems likely that there have been less than 300[54] direct beneficiaries of care and support through the programme, though more may have been reached with advice on nutrition through the meetings that have brought together support groups supported elsewhere. Whilst the number would appear considerably less than claimed, the benefits of belonging to a support group appear significant, though systematic data on this has not been collected by the programme, and was not possible within the short time in the field allowed for this review. However feedback gained through focus group discussions and interviews with staff and beneficiaries suggest the following:

- Vulnerable pregnant PLHIV have been supported to take measures to prevent transmission to their baby. One woman, diagnosed as HIV+ whilst pregnant talked about how she didn't have the deposit required to give birth at the hospital, and was unable to ask her husband for it as she didn't dare disclose her status. She reported that the ELWA counselling staff ensured that finance was found through the programme budget.
- Support group membership, combined with support in transport costs to reach the hospital (to collect ARV supplies and attend the SG) is supporting adherence, a major concern in Liberia. This is very significant for those who live outside the urban area, as the cost of monthly transport to collect their drug supply can be prohibitive.[55] *Without lunch and transportation they wouldn't come. Some come very far, e.g. 3-4 hours.'*
- HBC, which ELWA has being doing since 2006, is carried out by 6 trained PLHIV who are paid a stipend each month, supported by hospital staff. Staff consider this a key intervention to prevent loss to follow up, which is often due to despair and feelings of isolation: '*HBC is how we know the patients lost to follow up. Most time patients are lost to follow up when they feel alone. They stop coming and taking medication.'*
- The programme been able to ensure that PLHIV children registered at the hospital are able to receive the care they need. These are a particularly vulnerable group, as for most of them either one or both parents will also be HIV+, and they may be orphaned. Staff comment that '*There are many children at ELWA. We had only one death among 50 positive children. If not for the medical support they had from Concern to pay their bills for the children [it would be very different]. We would get them from their home when they were sick and follow up. Without this we would have had more deaths.'*
- Members testify how the SG helped them to inform their relatives, including spouses, and how difficult this would be without this backing.
- Around half of the women met at the support group at ELWA talked about how they had been rejected by their family or their husband's family and now had to rent accommodation, and how now the support group felt like family to them. For those who are rejected, the support group can be very significant in terms of emotional support: *If I come to the group I feel fine. If I am alone I feel low.*
- The majority of support group members met testified as to how the SG helps them avoid re-infection of themselves and infection of others through advice, information, emotional support and access to condoms. Members talked about how they now choose to abstain or use condoms. One PLHIV woman who had remarried had made it a condition of the union that her new husband would be content to always use condoms, a male PLHIV talked about how he now preferred to have relationships with other female PLHIV as it made talking about issues such as condom use so much easier. In this case the support group was providing the opportunity for him to meet PLHIV women and thus reducing his sense of isolation.
- Support group members talked about how useful the information they learnt about positive living was including: the importance of good nutrition, avoiding smoking and excessive drinking, and getting sufficient rest. It appeared that members were trying to apply this advice in their own lives.

Overall, according to staff: '*The project has helped a lot of patients to stay healthy and prolong their lives and cope with their HIV status.'*

ELWA supported by the programme, started the first children's support group in Liberia. This caters particularly for the needs of children who are themselves positive, or who are the children of PLHIV. Parents of PLHIV report how challenging it can be to persuade young children to regularly take their medicine, and how the group supports them in this. Counsellors report that they are finding a particular need to support PLHIV children when they reach puberty as this can be a very challenging time for them.

[53] These figures come from discussions with staff. ELWA in Monrovia say they have 910 regular PLHIV patients (622 of whom are women) on their books, but not all of these are support group members – as only the more vulnerable are referred. They also have 57 PLHIV children of 0-18

[54] 150 adults maximum in Monrovia + 57 children in Monrovia + 35 ELWA in Grand Bassa + 52 Light Association in Grand Bassa = 294

[55] For some villagers it can cost US$ 10 one way to get to hospital. For ART get one month at a time, thus it can cost for transport alone US$ 240 per year to adhere to ART. This compares with a GNI per capita of US$160 in 2009 http://www.unicef.org/infobycountry/liberia_statistics.html

For those members selected to act as peer educators and HBC volunteers, the responsibility and respect along with the stipend can have an enormous impact on reducing depression and self stigma.

> '*They don't mind discrimination as they have something to do. They get a little money to sustain themselves' (staff)*

Whilst there can be no doubt about the impact on individuals lives as a result of these improved services, there are a number of questions about the sustainability of these services provided by ELWA. It appears that everything was going well in the programme until the end of 2010, and that year the annual report commented on '*noticeable improvement in relationship among client-to-counsellor, client-to-client, and client-to-relatives interactions.'* But in 2011 the key member of staff at ELWA was made redundant and, according to a range of reports from different informants, leadership at ELWA was reluctant to continue with the programme during 2011. Whilst they were persuaded to do so, commitment at the top level now appears to be reduced. This has caused a number of challenges for the programme throughout 2011 that are looked at in more detail later. Indeed a number of support group members reported that care provision had deteriorated throughout the year.

Unfortunately from discussions it seems unlikely that ELWA will continue its community outreach work of HBC and peer support in the same way in the future. Whilst the support group will continue, it is unlikely to be able to continue to supply transport costs or supplementary food. In short, the approximately 300 poor and vulnerable PLHIV who have been supported by the programme will find themselves without much of the support they have got used to from January 2012 onwards. Some members of the support group have grown to depend on the food they get from the group or stipend from being a peer educator or HBC worker and there is a high level of anxiety about the future. This output, which should have been about improving services for the long run, whilst paying for them in the short run, appears in practice to have successfully provided important services during the programme's life, without succeeding in developing the capacity and commitment to continue to provide these in the long run.

A more positive picture emerges around the capacity and commitment of other partners to provide prevention, care and treatment services in the future, some of which are offshoots of the work at ELWA.

Light Association: Light Association are an association of PLHIV established in 2002, originally formed by 14 people receiving counselling at ELWA. They have been supported by Concern since 2004. They now have 5000 members and 25 staff and have successfully accessed funding from a range of donors including Global Fund, UNAIDS, UNFPA and Bristol Meyer Foundation. They focus on awareness raising and advocacy, using live radio and TV shows, and discussions with parliamentarians and religious leaders and have carried out training for journalists. They also run support groups in Grand Bassa and Monrovia. They comment that Concern is one of the few donors who have been supporting advocacy, training of media to understand the way they should report HIV, and training PLHIV in counselling. Light Association, supported by Concern are said to have played a key role in halting the practice of using out of date drugs for ART and OI treatment.

It is evident that Concern have supported Light Association to develop their capacity over the years, and to rebuild the organisation after a leadership crisis and some mismanagement in 2005-6. Staff comment that '*Concern does not just give us money, but goes after us to ensure we have implemented. If there is a set back or any difficulty, they sit round with us to sort it out*.' The organisation now appears to be in a reasonably strong position to continue its work into the future though they comment that the effect of Concern stopping an HIV&AIDS programme will be *'like using two sticks to jump and then you take one away. We need to find another. One arm of the association – advocacy and capacity building will be gone. To find another sponsor will take time'*.

Young Women Organised for Sustainable Development (YWOSD) were established in 2004 as a response to the many problems affecting girls in Liberia. They reach out to vulnerable girls through HIV&AID awareness, micro finance support and skill training. Besides Concern they also receive funding from a Ugandan organisation, The Liberian Education Trust, and receive free Global Fund condoms through NACP. In 2005-8 they worked with Concern to train 525 vulnerable women and girls under the livelihood programme. Since 2008 they have been working with the HIV&AIDS programme on HIV&AIDS awareness in schools and the community. They comment that Concern has been a '*good partner*' and Concern staff report that they have '*demonstrably improved in their capacity to implement effective HIV and AIDS programmes'*.

SHALOM (Saving Humanity with Affection, Love, and an Open Mind) is a new organisation formed in 2011 by staff and support group members from ELWA with the intention of replicating the community based approach to HIV and AIDS piloted during the programme. They are providing psycho-social support to PLHIV and continuing the development of

support groups for young people, particularly adolescents. Whilst SHALOM are not directly supported by Concern, they have been quite successful in raising funding elsewhere. The leadership of SHALOM suggest that they would not exist as an organisation without the Concern HIV&AIDS programme as the exposure that Concern gave the leadership at SHALOM whilst they were working at ELWA gave them the confidence to establish their own organisation: '*We gained a lot of experience with partnering Concern in thinking about the future. We have developed a fundraising strategy. We are also thinking about our own fund generation.'* This shows how some of the capacity developed initially at ELWA is now being put to good use elsewhere.

Liberia Network of HIV Positive (LIBNEP+): The HIV&AIDS Programme, in collaboration with NAC, NACP and three PLHIV associations, has supported the formation of LIBNEP+, Liberia's first national network for People living with HIV&AIDS. The network's primary objective is to ensure a coordinated advocacy approach among associations of people living with HIV and AIDS from across Liberia, and to present a unified voice and the full participation of PLHIVs in advocating for national-level change. LIBNEP+ grew out of a 3 day conference held in April 2011 that brought together representatives from the Light Association, Liberia Women Empowerment Network (LIWEN), and Positive Living Association of Liberia (PLAL), with representatives from nine support groups of PLHIV from across the fifteen counties, and County Health Team HIV/TB focal persons from all 15 counties. Concern Worldwide played a key role in the planning and organisation of the Conference. Since the establishment of this Network, Concern has continued to provide financial support through NAC to support the development of the network. LIBNEP+ are recognised by the government of Liberia as the National network and since June 2011 have had representation on the Board of NAC. They have succeeded in raising funding from UNAIDS with the NAC's assistance. It is too early to judge the sustainability of this initiative, though the executive committee appear strongly committed.

The National AIDS Commission (NAC) and National AIDS Control Programme (NACP): Concern has played a recognised role in supporting NAC to design and strategise implementation by working on the steering and planning committees where they have supported the development of the National Strategic Frameworks 1 and 2. Concern also worked alongside NACP and NAC and others to establish other committees e.g. Prevention committee on HIV&AIDS which has the responsibility to coordinate HIV&AIDS messages and media activities. They have been able to support the national response financially where key gaps became evident, for example Concern financed the hiring of a consultant to develop a national operational plan to implement the first two years of the new Strategic Framework. Dr Camanor, Executive Director of NAC comments that '*Concern is one of the key partners in the National AIDS response. They have played an important role in our own capacity building. They have been one of the active members in the development of the National Strategic Framework.'* He points out that may NGOs work at the county or regional level, but few also work with at the national level to support coordination of the response.

County Health Teams: Concern has also been good at building partnerships with government agencies such as the county health teams, and ensuring they are fully informed of the programme, and included where appropriate.

Beyond this, advocacy by Concern and other civil society groups including PLHIV networks is said to have contributed to influencing the GOL to approve a bill for budgetary allotment for care and support for PLHIV within the national budget, which will provide opportunities for the future.

4.4 Nutrition and Livelihood Security

Output Three: People living with and affected by HIV and key populations of higher risk have improved and sustainable levels of nutrition, food and livelihood security in collaboration with Concern Livelihoods, Concern Health and partners.

Activities under this output include

- The Support Group at ELWA started a farm in Monrovia which was supported by the programme to cultivate rice, cassava, water melon, vegetables pigs and poultry. Proceeds were used to provide food to PLHIV who worked on the farm and SG members, finance SG activities and some kept for restocking the farm. A similar farm was started in Buchanan which provides 35 support group members and families with nutrition and 22 PLHIV have been trained in animal restocking[56]. The farms also provided employment for a small number of people some of whom were PLHIV[57].
- A total of 30 PLHIV have received small loans of 2,000 LD ($28.00) each through the ELWA support group to start up small businesses such as selling shoes, food, and non food items, and wholesale of charcoal[58].

[56] Overall data for additional PLHIV linked to the livelihood programme for support has not been provided

[57] NB interviews suggested this was 10, but the 2010 Medicor report mentions '208 hired daily' which doesn't correlate with what interviewees said.

[58] IBIS 5th Mid-term report March 2011

- Members of support groups in Monrovia and Buchannan have been trained in the importance of good nutrition. This has included support groups not otherwise directly supported by the programme.
- SG members are fed when they come to the group and the 65 most vulnerable are given food to take away (40 children and 10 adults in Monrovia, 15 in Grand Bassa). (ELWA)

Again it has proved challenging to get consistent information about the scale of this work from the documentation. In interview the farm manager in Monrovia suggested that 10 people (8 men and 2 women) worked on the farm and were paid $50 a month, some of these are PLHIV. In addition there is a manager and farm assistant, making 12 in total. This number appears to grow for particular activities e.g. the IBIS report talks of the 20 PLHIV involved in harvesting watermelons. However the 2010 Medicor report refers to '*the 206 farmers that are hired daily by ELWA Hospital Support Group (Agriculture Project)*'.

In addition to those employed, the food from the farm has helped to feed the approximately 200 members of the Support Groups in Monrovia, 50 of whom have also had their nutrition supported by programme funds. However the sustainability of the farm in Monrovia is under considerable doubt at the moment as the lease is up on one piece of land and the other land was being farmed under an informal arrangement and has been reclaimed by its owners. This has left the support group with nowhere to put its remaining pigs. The other livestock has already been eaten and the group is not in a position to restock.

Members of the support group located there want that group to continue and to register as a CBO in their own right. They have worked to develop written by-laws and a constitution and have 75 full members who make a contribution of 20 Lib $ per meeting. They also want to continue with the farm. However they currently lack the funds to register, and have no access to land for farming, and from January 2012 have nowhere to keep the pigs that Concern provided. The timing of the end of the programme is particularly unfortunate for this group whose future looks very uncertain.

Data is lacking about who received loans under the revolving loan scheme to start small businesses, and the extent to which these businesses are continuing and providing a livelihood, though some members of the support group from ELWA who have moved to be with SHALOM are said to have successfully set up a thriving business cooking food for NGO workshops and other events. It appears that information about who received loans was lost during the staff changes at ELWA in early 2011, and that those who received the final round of loans have not paid them back, so new loans are not being made.

Light Association also experimented with a farm, but when visited commented that '*the farm is down completely. When the funding stopped the farm stopped.'* They say they didn't include it in plans for 2011 as it hadn't worked well the year before.

The picture in terms of knowledge of improved nutrition is clearer. All the members of support groups in Monrovia and Buchannan met showed good knowledge about the importance of balanced nutrition in living positively, though they are not always able to put this knowledge into practice due to poverty.

5 Accountability and Ownership

5.1 Role of beneficiaries

All beneficiaries speak positively of Concern and Concern staff and there is good participation in various activities. The level of beneficiary ownership however appears to vary, and some issues related to ownership by beneficiaries were only picked up by the review, suggesting that monitoring by Concern could be improved.

In direct implementation communities, community leaders are consulted as to whether they are interested in setting up an HIV&AIDS focus group. If they are not, then only mainstreaming work on HIV&AIDS continues, showing that communities are certainly consulted on the programme implementation. Once established focus groups are entirely free to plan their own activities. However there appears to be less consultation or participation on overall programme design, given that the same model of focus group outreach by volunteers is being used in all communities, whether urban or rural. Members of focus groups set up by Concern in urban areas had many complaints about the level of volunteer input expected from them without recompense – there was a sense that these were seen as a Concern initiative rather than owned by the community, and that a number of people remained involved in the hope of getting some sort of direct benefit. Volunteers also said they were getting pressure from the wider community to share the benefits they were presumed to receive from their membership. Whilst much of this can be related to the challenges of making a livelihood in the urban slums, similar comments were not received from the focus groups that already existed

within Montserrado and approached Concern for support; these appeared to have a much stronger sense of local ownership.

A number of members of the ELWA support group in Monrovia, particularly those involved in the farm activities, expressed some considerable frustration about the implementation of the programme over the last year since the management changes at ELWA. When the staff member left, the SG treasurer and chair also went and those remaining in the group don't know what happened to contributions they had made or proceeds from the sale of produce. The members of the support group have responded by eating rather than selling their produce, as if they sell the money goes out of their control; this has negative implications for sustainability. It was clear that they currently felt disempowered and would like more control: '*PLHIV are doing the work, but they don't see the money or the accounts.'* A number of SG members stated that they no longer wanted ELWA to run the various projects as they were concerned that if reports to Concern Liberia weren't done on time, payment was delayed, and then they didn't get their allowances.

A summary of accountability against the six HAP benchmark standards is given in table 6.

Table 6: Progress against HAP benchmark standards

Quality management	Quality management is assured through regular visits by programme staff to partners or CBOs (for direct implementation) and by pretesting IEC materials e.g. video. This appears to be adequate in terms of ensuring: • Accurate and non stigmatising information about HIV&AIDS is disseminated. • That focus groups have accurate and up to date information. However more attention needs to be given to supporting and monitoring the quality of processes and group dynamics to prevent or pick up on emerging challenges.
Transparency	Concern is transparent with its partners in terms of sharing information and budgets. However it could do more to support partners to establish, sustain and monitor their own systems that allow their transparency with the CBOs or PLHIV they support.
Beneficiary participation	Beneficiaries do participate in programme activities and take varying amounts of ownership of programme activities.
Staff competencies	Staff are committed and have appropriate attitudes for work on HIV&AIDS, however there are some core competencies that could do with strengthening including: • Ongoing monitoring and evaluation and using this information to inform strategic decision making • Getting the right balance in partnerships so that they are not too prescriptive or directive, but do challenge when necessary
Complaints handling	Concern does not yet have complaints system operating within the HIV&AIDS programme, but one is being trialled in another programme.
Continual improvement	It is hard to conclude that the programme is continually improving overall, given that for key components of the work 2010 seems to have been a more successful year than 2011. Continual improvement needs better M&E which is used for lesson learning and more focus on quality of interventions. To achieve this a more focussed programme to allow attention to quality, learning and documenting the lessons learned is recommended.

Staff and partner level of understanding of P4 appears good. Understanding is more uneven at community level. Urban groups and school based groups appeared to have good understanding of the pertinent issues, but in one rural community the initial reaction to being asked what they would do if a Concern member of staff had a sexual relationship with a local woman was that '*We would tell him about condoms and warn him about risky behaviour*'. They only appeared to feel the need to report it if the relationship was with an underage girl.

5.2 Partnerships

Concern Liberia appears to have developed good strong partnerships with most of the partners within the HIV&AIDS programme, and it would appear that in overall these were appropriate and effective means to implement the HIV&AIDS programme. In general partners were very positive about their partnership with Concern. People talked about how staff were very helpful and always ready to teach things.

Local ownership by partners of their own activities is good: in general they develop their own plans and then approach Concern to support them: '*The budget with Concern was not donor driven. The projects came from us. We allowed them to come from the beneficiaries. We only had to shape it so it became a project with measureable indicators when we took it to Concern' (ELWA).* Inclusion in deciding the strategic direction of the overall programme is less apparent, though all partners were involved in developing the revised logframe and M&E framework.

Furthermore effective partnership is not just about supporting partners to carry out their own ideas, but also about supporting them to think more critically and strategically. Staff report that when the support group at ELWA managed to gain access to additional land for farming and asked for support for this, they didn't think it appropriate to enquire too

closely into the arrangement as they were glad to see this initiative coming from the grassroots. Concern subsequently financed the building of a number of structures on this land, where the tenure was never secure. An approach to partnership that took a more 'critical friend' approach, would not see it as interfering to ask questions about issues of land tenure, and to warn the partner of possible complications in the future if these arrangements are not formalised.

Partners have also been encouraged to work with each other. Some ELWA peer educators were assigned to YWOSD to help with field activities with their allowances then paid by YWOSD.

However all partnerships are currently under challenge due to the abrupt nature of the programme ending: partners were informed of this decision in late November, but were not consulted on ways to make the phase out less disruptive. Staff report that it was not planned for the programme to end in December 2011, so they didn't work out an exit strategy. All of the partners commented that they were concerned that this would leave a gap in services.

> *There will be plenty of deaths in 2-3 months. Who will pay for the medical services? Patients don't have money to pay bills, or feed families. A lot depend on funding from here. (ELWA)*
>
> *It is not a good way to stop the programme. Concern started it and they brought us so far. If they just stop the programme it will be chaos. Concern encouraged us to be brave and strong and speak out for others. Now they are just leaving. (Light Association)*

It appears from a range of comments that the work of most partners has a rather start-stop nature to it, caused by delays in receiving and agreeing financial and narrative reports before the next tranche of money can be released. Whilst supporting the development of financial capacity is critical, it is important that this doesn't disrupt services that need to be regular. One PLHIV, who was also a community volunteer commented that their monthly stipends were often late which disrupted their nutrition: *'People need to buy food for medication. They should rush to do the documents on time. They don't care about us'.*

It was not possible to work out the actual causes of these delays as everyone talked to has a different view. However it does appear that the decision to make Concern's Partnership Advisor redundant, due to lack of funding, has potentially had a knock on effect. One member of staff commented that on paperwork Concern have a standardised approach that they won't adapt depending on the capacity of the partner, and that some partners really struggle.

With the benefit of hindsight, the challenges in the partnership with ELWA over the past year, highlight some of the challenges and shortcomings with relation to sustainability for the long run:

- For the first 2 years of the HIV&AIDS programme the partnership with ELWA was based around a strong relationship with one particular, reasonably senior, member of staff rather than with the organisational leadership as a whole. This led to challenges when this member of staff was made redundant.
- ELWA senior management are reported by numerous informants to have been reluctant to continue with the programme during 2011, and had to be persuaded by Concern to do so. The reasons for this are not entirely clear, and it was not possible to interview the chief executive. This has had both implications for the smooth running of the programme during 2011, and for the future sustainability of this work. ELWA staff said they expect the outreach and home visits to stop, despite the national strategy emphasising the importance of strengthening such services. SG members report that the death rate of members went up this year, which they suggested was due to the HBC system not working so well.
- Partnership with ELWA appears to have focused largely on the implementation of the activities agreed under the HIV&AIDS programme, rather than also looking for strategic opportunities for the long term.

6 Strategic action and direction

As stated in Section 2, the programme is relevant in that it addresses issues of concern to the beneficiaries and is aligned with government priorities. In general the strategic action and direction has been good, however there are some aspects that could be strengthened. Though the proposal recognises that coordination between actors and between the provision of services in prevention, with those of testing, treatment and care was a key area of work, this has been addressed more through the provision of coordinated testing, treatment and care services at ELWA, the long term sustainability of which is questionable. It would have been useful to address this issue at a more strategic level. To systematically map out the opportunities for this would be a task in itself, not something that can be inferred from a short field visit focused on evaluation, but might include:

- Systematically monitoring, assessing and documenting the value to PLHIV of the coordinated testing, treatment and care services and using this data, along with a rigorous cost-benefit analysis, to inform policy dialogue at the national level.

- Looking for opportunities to link partners with other initiatives happening in country to support sustainability. For example ELWA used to get support for supplementary feeding for PLHIV from the WFP, but this stopped in 2011 when WFP turned the programme over to the Liberian MoH to run. ELWA staff are now unclear whether this support will only go to government hospitals or whether they are also eligible. This is the sort of area where Concern could have supported ELWA to think about the long term sustainability of their programmes by supporting them to advocate for these supplies.

There has been some focus on reaching specific groups such as young single mothers or transport drivers. However other than the focus on youth through work in schools, this has been somewhat sporadic and ad hoc, and most of the focus groups visited, consisted of a cross representation of the local population and appeared to use generalised messages focusing on basic facts intended for the general population. This is similar to what has been happening in Liberia overall. The National Strategy suggests that in future peer support groups of specific 'most at risk populations' (MARP) should be formed, i.e. groups of young adolescent women (10-18) or sex workers, or specific drop in centres aimed at particular groups such as young female street based sex workers – a particular vulnerable group. In any future work it will be important to develop a more tailored approach to different population groups and clearer targeting to make best use of limited resources. There are important opportunities for more focus on the connection between HIV infection and gender inequality, particularly when working with young people, which can be connected with life skills approaches. The National Framework states: '*Similarly, the selection of programmes and services should be based on proven (cost) effectiveness in Liberia or other countries in the region, whereby resources allocated to specific groups and services should be proportional to the impact of HIV on those groups. Cost-effectiveness is increasingly important in the context of global economic crisis and diminishing external support.'*

The government plan is that in the future HIV prevention should focus specifically on the *geographic areas* that show the highest HIV-prevalence rates; this includes the main urban centres and border areas. These will not necessarily coincide with areas targeted by Concern's other programmes. Thus, whilst there are distinct benefits in terms of building relationships with the community and cost efficiencies, in running the direct implementation HIV&AIDS programme in parallel with the WASH and FIM programmes, these may not be priority areas to invest scarce HIV prevention resources.

7 Efficiency

The total budget over the 4 years was 991,561 Euros, with most of this being allocated for the period 2009-11[59]. This came from Medicor, IBIS and MAPS funding. At the time of writing data of expenditure was only available for the first 3 quarters of 2011. From the start of the programme up to September 2011 654,256 Euro had been spent with 236,754 Euro remaining in the budget. There were expectations that the majority of this would be used before the end of the programme. This represents 75% of the budget for 2011 to be spent within the final one quarter of the year; considering the on-going nature of most of the activities this is somewhat high.

Table 7 shows the expenditure by major categories. It can be seen that Concern personnel costs took 25.5% of the total costs. This is not unreasonable for a programme that was both partly directly operational and involved staff engagement in key committees at the national level. Direct programme costs took 64.7% of the expenditure during this period, with the majority of this (48.2% of the total) being spent via partners, and 11.6% on direct implementation activities.

Table 7: Expenditure (Euros)

HIV/AIDS Programme : Financial Report 30 September 2011	'08	'09	2010	Jan -Sept 11	Total expenditure to Sept 2011	% of actual expenditure	Remaining Budget
International Staff Costs	0	18,753	28,479	29,875	77,107	11.4	24,063
Local Staff Costs	0	28,882	32,127	33,759	94,768	14.1	13,126
Total Personnel Costs	**0**	**47,635**	**60,606**	**63,634**	**171,875**	**25.5**	**37,189**
Activities subtotal	0	29,348	28,987	19,892	78,227	11.6	12,054
Local Partners subtotal	19,343	107,765	135,329	62,642	325,080	48.2	138,037
Training & capacity building subtotal	2,704	15,712	14,605	-	33,020	4.9	33,725
Total Direct Programme Costs	**22,047**	**152,825**	**178,920**	**82,534**	**436,327**	**64.7**	**183,816**
Total Capital Costs	**7,974**	**0**	**5,271**	**0**	**13,245**	**2.0**	**1,733**
Total Programme Support Costs	**59**	**2,206**	**1,490**	**4,944**	**8,699**	**1.3**	**-1,472**
Head Office Administration 7%	2,106	14,187	17,240	10,578	**44,110**	**6.5**	**5,489**

[59] Year by year budget can be found in Appendix 4

Total Project Costs	**32,185**	**216,853**	**263,527**	**161,690**	**674,256**	**100.0**	**236,754**
IBIS Contribution	32,185	132,547	94,533	100,394	359,659	53.3	
Medicor & MAPS Contribution	0	84,306	168,994	61,296	314,597	46.7	

The planned total costs of the NSF has been calculated at USD 99.3 million over five years (approx 76 million euro[60]), which works out at 15 million Euro per year or 4.7 Euro per head of population per year. This is to cover the cost of prevention, treatment and care for the whole population. If the reach of the Concern HIV&AIDS programme is taken to be roughly 184,000 people[61] and the average annual cost to be around 240,190 Euro[62] then the per year cost per head comes to around 1.3 Euro a year. These figures cannot be compared directly of course: there are other players also working in Grand Bassa and Montserrado on HIV&AIDS, and the overall budget for the NSF covers many aspects of work that Concern's programme does not. However it appears that the overall cost of the programme is reasonable, though it is hard to make rigorous assessments of efficiency and value for money without better data on coverage/numbers reached and the impact of the work.

Table 8 shows the overall expenditure on direct programme costs broken down by type of activity. Here it can be seen that the major costs were support to ELWA at 72,742 Euro or 10.8% of total expenditure; Home Based Care[63] at 69,850 Euro or 10.4% of total expenditure, Livelihood support at 57,391 Euro or 8.5% of total; Community Awareness (GIPA) and Advocacy at 52,916 Euro or 7.8% of the total; and, Community Outreach etc at 51,713 Euro or 7.7% of the total.

It is notable that the row in the budget for technical support to partners on monitoring and evaluation has no expenditure against it. Whilst partners have been very good at collecting data on activities, any analysis of this data, even at the most basic level of numbers of overall beneficiaries reached, is missing. Furthermore the KAP surveys undertaken by partners and staff could have been vastly more useful with a small amount of technical support.

Table 8: Direct programme costs

Direct Programme Costs	**Actual expenditure to Sept 2011**	**% of total expenditure[64]**
KAP Survey	2,122	0.3
Child to Child	12,658	1.9
Community Outreach / Campaigns / IEC Materials / Condoms	51,713	7.7
Community Workshops + Youth Activities	11,733	1.7
Activities subtotal	**78,227**	**11.6**
Home Based Care	69,850	**10.4**
Livelihood Support	57,391	**8.5**
Training, Support and Counselling	19,053	**2.8**
Community Awareness (GIPA) & Advocacy	52,916	**7.8**
Support to Government Line Agencies	3,496	**0.5**
Support to partners ELWA	72,642	**10.8**
Support to partners YWOSD	31,817	**4.7**
Support to Partners LIGHT[65]	-	**-**
NACP / CHT	17,915	**2.7**
Local Partners subtotal	**325,080**	**48.2**
Technical Assistance/Training & Capacity Building	14,073	**2.1**
Intl Workshops and trainings	18,947	**2.8**
Monitoring & Evaluation	-	**-**
Training & capacity building subtotal	**33,020**	**4.9**
Total Direct Programme Costs	**436,327**	**64.7 % of total**

It has not been possible with the data and time available to make any analysis of the cost effectiveness of particular interventions. It may be that generalised HIV&AIDS awareness programmes in areas of low prevalence (i.e. rural poor

[60] www.xe.com on 3 Jan 2011

[61] The approximate populations of the communities reached by the programme from Table 3. This is probably an over estimate as the programme is unlikely to reach the whole of the communities in Monrovia which are quite large.

[62] The mean of expenditure over the two years with data for the full year i.e. 2009 and 2010.

[63] I assume this is the HBC carried out by ELWA?

[64] In each case this is total expenditure up to end of September 2011.

[65] The 2011 Light budget for Grand Bassa in 2011 was allotted to LIBNEP+

areas) are not the most cost effective approach given the data that is beginning to emerge about the pattern of prevalence in Liberia.

One point that does need to be made about efficiency is that the ending of the programme at short notice, and without a phase out plan, though driven by necessity rather than choice, is likely to reduce the overall efficiency of investments already made due to the effect it is likely to have on sustainability.

8 Cross cutting issues

8.1 Gender and other social differences

Gender issues around HIV&AIDS are analysed in the programme documents and understood by programme staff. However baseline information and the subsequent survey was not disaggregated by gender (or any other social difference).

The immense range of challenges facing women around HIV&AIDS are understood by partners and staff and staff are sensitive to their needs and the challenges they face; though overcoming these issues remains difficult. Feedback suggested that in some cases they are less attuned to or sympathetic to the challenges faced by men, particularly PLHIV men. Discussions with the men from support group at ELWA suggested that they felt relatively ignored, and considered that women tended to be the ones who got support: '*It is not the fault of the hospital. Globally everything is focused on women also. All are vulnerable for the disease and they only rescue women. They give a stick to the women and leave the men to drown. We need a stick also, something to hold on to.'* Whilst overall women are likely to be the most vulnerable, this is on average and will not apply in every case. One PLHIV man in the group who had cared for his sick wife until she died of AIDS, is now struggling to bring up two young PLHIV children on his own. Though he gets some support from relatives, he is the only one who can consistently get them to take their medicine, and this constrains his ability to earn a livelihood.

Programme activities are not systematically adapted depending on those targeted, except by some partners or CBOs who appear to take the initiative for this. It may be that different approaches are effective for different groups e.g. more men than women tend to call the radio show, likewise specific approaches may be called for in working with sex workers or their clients. Whilst this has happened to some extent, it has tended to be on a rather ad-hoc rather than strategic manner.

The recent law outlaws stigma and discrimination on the basis of HIV status which is welcomed. However it also criminalises 'wilful' infection of others. As women are often the first to know their status and may find it hard to disclose to their sexual partners for fear of violence or abandonment this puts them in a difficult position; Concern does not appear to have fully analysed the gender implications of this before advocating for the law to be passed and working to distribute it.

Other social difference such as working with the disabled is a gap that is recognised by staff who have said it is a gap they would have looked at in the next phase of the work.

8.2 Mainstreaming

Mainstreaming, both internal and external appears to be a strength of Concern Liberia, and staff at all levels are clearly committed to it.

Internal mainstreaming:

All Concern staff and partner staff receive orientation in HIV & AIDS awareness, risk, vulnerability, prevention and care, and the implications on their work. Programme staff demonstrate high levels of knowledge, and positive attitudes towards people living with and affected by HIV & AIDS.

Staff report changes in their own behaviours to protect themselves against infection, but comment on some incidences of continuing risk behaviour or avoidance of VCT in others, indicating that not all staff find it easy to put their knowledge into practice: '*We have been taught. Everything has been put in place. What is lacking is responsibility. With many social workers, I know those who don't use condoms'.*

Female staff may find it more challenging to discuss with partners and both male and female staff in Grand Bassa would like some sessions including partners: *'It depends on your relationship with your partner if you can talk about it. If the partner was invited it might be better. They may say you are just jealous'.* Staff reported that this had taken place in Monrovia.

ELWA and YWOSD have developed their own internal HIV policy and rolled it out with staff.

External mainstreaming

Each programme is said to have a HIV mainstreaming plan and the HIV Coordinator has been conducting yearly external HIV mainstreaming training for programme staff, in each programme area, aimed at supporting the development of approaches to be used in their specific programme contexts.

Many staff are not clear on the distinction between mainstreaming and integration and tend to assume that integration is a key element of mainstreaming. However, given the context in Liberia, with a generalised epidemic, high stigma and poor health service provision and information, integration would seem to be an appropriate approach. All programmes integrate HIV&AIDS information, with HIV&AIDS and gender awareness training usually done in coordination with the relevant line ministries, the Ministry of Gender and the NACP. In many cases PLHIV from local support groups are also invited to contribute. Training is supported by a variety of materials including: t-shirts, posters, calendars, and music CDs. These messages focus on 'Positive Living', and have been approved by the NACP. Condoms are also made available to beneficiaries. Communities are also sensitised to ensure PLHIV are not excluded from using facilities.

Baselines for all programmes include data about HIV&AIDS, and for the education programme, teacher knowledge of child rights and protection. HIV&AIDS mainstreaming is also expected to be covered in reviews. HIV&AIDS issues are also taken into consideration in the design of programmes. For example the needs of the labour constrained or chronically sick are met through attention to location and design of latrines and boreholes; kitchen gardens and small livestock are promoted for the labour constrained or those with particular nutrition requirements; women are involved in the selection of the activity sites to ensure that they will feel safe walking to them and that they will not be exposed to sexual exploitation or abuse; the education programme works to integrate Child Protection, Child Rights, Equality, HIV and AIDS and life skills in teacher training, and advocates for its inclusion in the curriculum; adult literacy work is said to have a strong health component, which includes HIV and Concern have been asked to be part of committee to adapt a set of South African books which combine HIV awareness with literacy skills for the Liberian context.

All contractors and consultants employed by Concern and local partners are expected to sign and adhere to Concern's Programme Participant Protection Policy (P4) on the protection of programme participants from exploitation. This clarifies the responsibilities of Concern staff, contractors and partners and the standards of behaviour expected of them.

For 2012 the programmes have budgeted for the time of HIV&AIDS officers.

9 Innovation

The HIV&AIDS programme has shown some interesting examples of innovation within the Liberian context:

Child and adolescent focused support groups: The programme initiated the first support group aimed at children and adolescents, and also supported the development of specialist counselling skills appropriate for this age group. Support to positive children will become increasingly important as advances in medical care mean that those born with HIV have longer life expectancy. Children who are HIV+ face particular issues as they reach adolescence and wish to become sexually active in a context of continuing considerable stigma. There are also indications that children's support groups help carers ensure that children adhere to their medication.

Coordinating hospital based care services with support group, community outreach and nutrition and livelihood support: Coordination of different services is a key challenge in Liberia. The work at ELWA, when it was working well, demonstrated the benefits that could be gained from linking different kinds of services and ensuring systematic referral between them.

Involving PLHIV fully in prevention and care services: Concern has taken a lead in Liberia in breaking stigma by fully involving people who are openly living with HIV in various initiatives:

- Inviting PLHIV to give testimony during training and awareness sessions for different programmes
- Supporting organisations and networks of PLHIV and a collective voice for advocacy at the national level
- Demonstrating how PLHIV can be productive members of society through various income generating activities including farming
- Employing PLHIV as home based care workers and peer to peer counsellors for door to door awareness to share their testimony with families.

Running HIV&AIDS programme in parallel with other programmes:

Concern Liberia has an interesting experience of running HIV&AIDS programmes in parallel with other programmes. This can prove useful in that other programmes such as WASH or livelihoods prove a good entry point to build relationships while undertaking work that has clear tangible benefits for the community. These relationships then provide a good basis for talking about issues that have in the past been taboo such as sex and HIV&AIDS. The challenge is that the targeting criteria for the different programmes is not necessarily the same.

Use of Journey of Hope: Concern was one of the first organisations in Liberia to use the Journey of Hope methodology as a means to encourage discussion about HIV&AIDS. Feedback from staff is very positive: '*It gives participants opportunities to make their own choice and encourages open discussion'.*

Engaging community leaders: The programme has had some success in engaging community leaders including religious leaders, leaders in the secret societies and traditional leaders. Some lessons have been learnt about the effective means of doing this.

All of these innovations would have benefited from better monitoring and documentation to develop an evidence base of what works well and why so that they could be used to influence the national response.

10 Key Lessons

10.1 The need to consider sustainability from the start

The programme demonstrates how important it is to consider sustainability from the start, rather than leaving it as something to address in an exit strategy adopted towards the end of the programme. HIV&AIDS services are not something that can be provided for a discrete length of time and then stopped, but need to be on-going. CBOs working on HIV&AIDS awareness need to be linked in to systems to ensure their information stays up to date. Lessons here include:

- It is best to work with existing community structures or groups where possible. If forming new groups such as HIV&AIDS focus groups, ensure that from the start they are linked in with local services such as local clinics or hospitals, and involve clinic staff in any training initiatives to ensure they know at least as much as the focus group. Links are important even if the local clinic lacks capacity on HIV&AIDS; the clinic will still be there in the long run. It is understood that school clubs were formed according to Ministry guidelines and are registered with them, which is positive.
- It is best to work with a range of people within an organisation and to ensure buy-in from the top leadership. That way if one member of staff leaves or falls ill, the programme is not too disrupted.
- Always ensure that when providing direct services (e.g. supplying condoms, paying for OI treatment, paying stipends for HBC, paying transport costs for PLHIV to attend support groups, supplying supplementary nutrition), this is linked in with a strategy for ensuring these services are sustained in the long run. Strategies might include:
    - Rigorous documentation and analysis of the benefit of these services linked with an advocacy strategy to promote their uptake by others.
    - Working to link partners with longer term sources of support (e.g. ELWA with the WFP nutrition support; condom outlets with NACP – which was done to some extent)

10.2 Community outreach

The programme has been quite successful in generating community enthusiasm and, at least initial, enthusiasm to do something about the HIV&AIDS issue. There are valuable lessons here that could be documented about how to engage communities. For example staff commented that in rural areas it works best to have a small discussion with the leaders before talking about HIV with the wider community. There are also lessons about how to work with the secret societies; to do so effectively staff have to be a member themselves and of the same sex. It was found that it is possible to successfully educate members about, for example, the need for sterile implements, as long as this is done in a way that is not deemed to be critical of the cultural practices of the secret society such as FGM.

It depends on the context and issue whether it is better to talk to men and women separately. Both staff and community members talked about the need to talk with couples together, but for secret societies it has to be peer based. *Put women and men together in educating them. If you go differently and she comes educating the man, he may not agree and not listen (female community member)*

The programme demonstrates that it might be useful to explore different approaches in urban and rural areas. The reliance of voluntary work by people without secure livelihood was a particular issue in urban areas where the turnover

in volunteers meant that there was a need for regular training, and the groups set up by the programme did not appear very likely to continue work after the programme ends.

Group members had good knowledge on HIV&AIDS, but could benefit from more focus on:

- Support in developing skills to engage in discussion around issues such as why it is useful to know one's status, and how to deal with arising issues such as how to engage with known PLHIV who are seen to be acting irresponsibly.
- Thinking through how to plan their programme of work including:
    - When to use peer to peer approaches rather than whole group approaches
    - How often to meet: too often and it can take up too much time from other activities for both adults and school children, too infrequently and the group will lose momentum. School clubs should not be meeting every day as one group said they did.
    - When to meet: children should not be missing lessons on a regular basis to attend group activities as they were in one school.
    - Teachers need support to ensure they have ideas on how to make school focus groups interesting.

The programme also needs to consider how to move on from generalised HIV&AIDS awareness information to approaches more targeted to particular at risk groups, and information targeted on areas where surveys show specific knowledge is inaccurate or lacking.

10.3 Nutrition & livelihoods

The programme demonstrates the benefits of linking clinical and home based work on care, information about positive living with support on livelihoods to provide a comprehensive package. Within Liberia developing sustainable livelihoods in the urban context is quite challenging, and data was not provided as to the extent of success in this, though information received suggests that livelihood gains may be quite fragile. Even with the supplementary nutrition many PLHIV met still faced challenges in ensuring they had adequate nutrition to take their medicine or to stop breastfeeding at 6 months. Key lessons here include:

- If PLHIV are paid a monthly stipend for activities such as HBC, peer education or agriculture work it is important that this is received regularly as they rely on this to purchase food with which to take their medication. A number of PLHIV complained that these payments had been held up due to payments to partners being delayed over reporting issues that the PLHIV had no control over.
- Targeting based on funding rather than need can bring challenges for programme staff and needs clear and transparent guidelines on how to deal with it. E.g. ELWA had money to give 20 cups of rice to the 15 most vulnerable each month, but more vulnerable would come. PLHIV suggested that different staff dealt with this in different ways with some taking a first come approach, others trying to stretch supplies to more people, and others sticking to an original list of the most vulnerable.
- The programme should not make investments on land unless it is assured about its security of tenure. In Monrovia, considerable investment was made in building structures on land that was since reclaimed by its original owners, who are now benefiting from these investments as individuals.
- Loans should not be going to a group that has not first set up at a minimum membership criteria, a constitution and group accountability systems to monitor who gets them, and repayment. If groups are loaning their own money/resources this should be encouraged. If Concern is inputting financial resources it should be obligatory. Concern needs to develop its own capacity on standard good practice for savings and loan systems if continuing work with revolving loan funds.

10.4 Monitoring and Evaluation

There are a range of issues emerging around monitoring and evaluation which needs to be strengthened:

- Some issues with the work of one partner in the final year of the programme were not picked up until the final evaluation. Staff suggested that there was some lack of clarity as to who should take up the partnership officer's responsibilities when this post was discontinued due to budgetary restraints. A systematic complaints system is another route by which these difficulties could possibly have been picked up and dealt with earlier
- Questions in KAP surveys need to be worded in unambiguous terms following international best practice; responses should always be disaggregated by gender and preferably also other key factors such as age.
- The quantitative data produced by the programme is hard to interpret and appears to include considerable double counting. Staff need support in developing skills to understand and deal with quantitative data.
- Monitoring needs to go beyond counting activities to also:
    - Tracking quality and coverage of services
    - Supporting partners to develop their own M&E and accountability systems

Data collected should then be used as a management tool to make strategic decisions about the programme, rather than seen mainly as a reporting exercise. Better M&E would also support quality documentation of, and lesson learning from, innovations that could strengthen advocacy.

11 Recommendations

The future of the HIV&AIDS programme is currently uncertain. A decision has had to be taken to end the programme at the end of December 2011 due to lack of funds, however staff are still looking into possibilities for new funding. The recommendations are therefore split into ones relevant to different scenarios.

11.1 If the programme is not continuing

Quite a bit could be done to smooth out the ending of the programme and thus increase the chances of benefits being sustained. If Concern does not continue with an HIV&AIDs programme it is recommended that responsibilities for phase out are included in the work plan of the ACDP, Area Coordinators and the HIV&AIDS Officers over the next 3-6 months. This will not necessarily require a budget other than for staff time. Even though ELWA have now decided not to continue the partnership with Concern it is possible for Concern staff to have discussions both directly with community groups and with ELWA staff where necessary. Staff should meet with each partner, CBO, Focus Group and Support Group individually to systematically analyse what can be done to:

- Sort out any lack of clarity remaining from the staff changes in ELWA in Monrovia, including transparency on finances contributed by PLHIV and from sale of farm produce; whether anything can or should be done about registration of the support group; access to land; and, the remaining livestock.
- Where needed, link Focus Groups with local health centres so that they are recognised by the local HIV&AIDS officers and can get updated information
- Where needed, link Focus Groups with an on-going supply of condoms.
- Introduce to other potential donors
- Register the group if appropriate
- Link the group or members of the group to FIM if appropriate
- Working in schools.

11.2 If Concern Liberia continues with an HIV&AIDS programme

The government recommends that future HIV&AIDS prevention work in Liberia should be focussed much more on high risk groups and less on general awareness. However Concern does not have expertise in working with these groups, other than with youth. Concern should align itself with these government priorities while working to its strengths. It is recommended that for a future Concern Liberia focuses its programme to allow emphasis on quality and learning, and using that learning to influence wider changes within the Liberian response to HIV&AIDS. Areas where Concern has particular strengths include:

- Working with PLHIV to include them within the response.
- Linking medical care with support to nutrition and community outreach. Given the challenges that the programme has faced with the larger scale farms, this might mean looking at kitchen gardens for the most vulnerable to support nutrition and IGA.
- Psycho-social support groups for PLHIV, especially children
- Working with traditional and religious leadership.

There are two areas of weakness within the national response that have been highlighted as priorities, the first of which is not a current strength of Concern's, but where it should in any case be developing capacity; if resources were put into developing capacity and understanding in these they would both strengthen Concern's own work, but could potentially have much wider impact:

- M&E tools for non-clinical community-based HIV interventions where different implementing NGO and CBO partners use non-standardised data-collection and reporting tools, hampering the aggregation of data at higher levels.
- Strengthening the *gender focus* of the response, taking into account the epidemic's clear gender dimensions and differential risks and vulnerabilities of women and girls, men and boys, including sexual and gender-based violence.

It is also recommended that if Concern continues with Focus Groups it consider different approaches for rural and urban areas, and focuses on targeted education addressing certain topic areas in which knowledge is particularly low, rather than generalised awareness raising. If it continues work with school health groups it should focus more on the quality of their activities and encourage them to particularly focus on supporting life skills, gender awareness and behaviour change in youth, rather than taking on responsibility for generalised awareness raising in local communities.

11.3 Recommendations for Concern Worldwide

The approach of using a focus group and anti-AIDS clubs in schools for outreach in Liberia follows a similar design for both urban and rural areas, and is similar approaches that Concern has used elsewhere including in Rwanda and Zambia. However the nature and pattern of the disease is considerably different in each country, suggesting that different approaches might be called for in each case. It is recommended that Concern carry out a comparative study to assess what has been learned about appropriate community responses to care and prevention in different contexts including factors such as different rates and patterns of HIV prevalence, and what works best in urban and rural contexts.

11.4 Mainstreaming

Mainstreaming is generally going well. In the future it is recommended that:

- Now that there is no-longer a HIV&AIDS programme manager, systematic approaches are developed for keeping staff (both HIV&AIDS focal points and other staff) up to date with latest developments.
- Integration appears to be an appropriate approach within Liberia in the current context. However this will not necessarily always be the case. Concern Liberia should clarify the difference between mainstreaming and integration and be clearer as to when integration is appropriate, so it becomes a deliberate choice.
- Partners, support groups and focus groups from the HIV&AIDS programme are used where possible for integration activities for other programmes. This can also be used as an opportunity the HIV&AIDS mainstreaming officers to update these groups on the latest information.

It would be preferable if the Education programme could take over support of the health clubs set up by the HIV&AIDS programme. However discussions with staff suggest this is unlikely to be possible due to the significant budget cuts this programme has had to make.

11.5 Future programming

Overall Concern Liberia's HIV&AIDs programme has been an interesting initiative, working in a difficult and changing context. It has some real strengths, as well as some significant weaknesses. Through this work Concern has built a significant profile and reputation for HIV&AIDs work in Liberia. Concern are strongly encouraged to seek further funding to enable the organisation to build on these foundations.