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LIBERIA

CATCH UP PLAN TO END AIDS 2017-2020: LEAVING NO ONE BEHIND

[Focus, Innovation, Fast track and Impact] F.I.F.I

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Foreword

It is with pleasure that I present the Liberia catch up plan as part of our strategy for fast tracking the country's response to end the AIDS epidemic by 2030. Our focus is to accelerate and get back on track. At the High level meeting on AIDS in New York in June 2016 which ended with a political declaration, Governments noted with deep concern that despite substantial progress over the three decades since AIDS was first reported, the HIV epidemic remains an unprecedented human catastrophe inflicting immense suffering on countries, communities and families throughout the world. As such, Governments Reaffirmed that prevention of HIV must be the cornerstone of national, regional, and international responses to the HIV epidemic and Committed to working towards fast track to achieve the 90-90-90 targets by 2020 and eliminate mother-to-child transmission of HIV while keeping the mothers alive. Liberia was represented in this meeting by the President. Her excellence endorsed the political declaration and committed to attain the fast track target as well as making the elimination of mother-to-child transmission of HIV a reality in Liberia. To align to the global fast track commitments and the elimination of new infections among children and keeping their mothers alive as part of addressing the challenge of the West and Central Africa region being left behind, the NAC was directed by Her Excellency the President to work with bilateral and multilateral partners together with the Ministry of Health recommended the need to develop this catch up plan which focuses on 3 high burden counties to accelerate the delivery of ART and PMTCT services in order for Liberia to catch up and get on the fast track. This plan is about *focus, innovation, fast-track and impact.* The plan will be in two phases: phase 1 will operate in an ''emergency mode'' with a strategic *focus* on Montserrado, Margibi, and Grand Bassa for the next 18 months (2017-2018) and the phase 2 will expand to other high burden counties to ensure that the HIV treatment gap for adults and children is significantly closed. Furthermore, this plan will introduce *innovation*while *fast tracking* for *impact*. If successful, Liberia will be put on the pathway to eliminating mother to child transmission of HIV and to keep their mothers alive and leaving no person living with HIV behind.

We are confident that plan will guide the Government, Partners and stakeholders of resource allocation for sustained impact. Undoubtedly, Liberia has faced severe challenges relating to its current systems of health after the EVD epidemic. However, Government is fully committed to show political leadership and work in partners with our international partners to ensure that the SDG 3 is achieved via universal health coverage in Liberia and our determination and resilience at tackling the HIV epidemic together with other non-communicable diseases will ultimately yield the needed impact. This plan highlights the current status of implementation of the ART/PMTCT programme and areas where progress has been made or has stalled or lagging behind. It sheds light on some of the major bottlenecks that have affected programme implementation and proposes targets, cost efficient strategies and resources that will facilitate achievement of the fast track targets by 2020.

Her Excellency The President of Liberia

Acknowledgement

This National Catch-Up Plan to end AIDS 2017—2020 was developed by the National AIDS Commission and National AIDS & STI Control Program in collaboration with the UN Theme Group in Liberia, our multilateral and bilateral partners, faith based organizations and civil society organizations (CSOs). This plan which is intended to supplement national strategies and quicken the pace of HIV responses tripling treatment coverage in three years could not have been realized without the invaluable contributions of all key stakeholders.

The National AIDS Commission (NAC) profoundly acknowledges the technical support received from the Joint United Nations Program on HIV and AIDS (UNAIDS) towards the compilation of this plan.

The following Ministries: Gender and Development, Education, and Youth and provided valuable technical assistance in aligning their activities with the Catch Up Plan. Special thanks go to the Ministry of Health, the lead agency of government in implementing health activities in the national response to prevent the spread of HIV and mitigate its impact on the population, for their support and collaboration.

Acronyms

AAMIN	Anti AIDS Media Network
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Clinic
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
BCC	Behavior Change Communication
CBO	Community Based Organization
CCM	Country Coordinating Mechanism
CHA	Community Health Assistant
CHT	County Health Team
CHW	Community Health Worker
CPS	Combination Prevention Strategy
CPT	Cotrimoxazole Prevention Therapy
CSO	Civil Society Organization
CSS	Community Systems Strengthening
DHS	Demographic and Health Survey
DOTS	Directly Observed Treatment, Short Course
DP	Development Partners
eMTCT	Elimination of Mother-to-child Transmission
EPHS	Essential Package of Health Services
EVD	Ebola Virus Disease
FBO	Faith-Based Organization
FP	Family Planning
FSW	Female Sex Workers
GF	Global Fund
GFATM	Global Fund to Fight AIDS, TB and Malaria
GOL	Government of Liberia
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRH	Human Resources for Health
HSS	Health Systems Strengthening
IBBSS	Integrated Bio-Behavioral Surveillance Survey
PWID	People Who Inject Drugs
IEC	Information, Education, and Communication
ILO	International Labor Organization
IMR	Infant Mortality Rate
INGO	International Non-Government Organization
ISY	In-School Youth
KAP	Knowledge, Attitude and Practice
KP	Key Population
LCC	Liberia Council of Churches
LCM	Liberia Coordinating Mechanism
LDHS	Liberia Demographic and Health Survey

LIBNEP+	Liberia Network of People Living with HIV and AIDS
LISGIS	Liberia Institute for Statistics and Geo-Information Services
LIWEN	Liberia Women Empowerment Network
LTFU	Lost to Follow-Up
M&E	Monitoring and Evaluation
MDG	Millennium Development Goal
MIA	Ministry of Internal Affairs
MOD	Ministry of Defense
MOE	Ministry of Education
MOGCSP	Ministry of Gender, Children and Social Protection
MOH	Ministry of Health
MOJ	Ministry of Justice
MOL	Ministry of Labor
MoT	Mode of Transmission
MPCHS	Mother Patern College of Health Sciences
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NACP	National AIDS & STI Control Program
NASA	National AIDS Spending Assessment
NBSP	National Blood Safety Program
NDS	National Drug Service
NGO	Non-Governmental Organization
NHPP	National Health Policy and Plan
NSP	National Strategic Plan (2015-2020)
OSY	Out of School Youth
OVC	Orphans and Vulnerable Children
PBC	Performance Based Contract
PEP	Post-Exposure Prophylaxis
PICT	Provider-Initiated Counseling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PSM	Procurement and Supply Management
QA	Quality Assurance
QC	Quality Control
RTK	Rapid Test Kits
SAIL	Stop AIDS in Liberia
SARA	Service Availability Readiness Assessment
SC	Steering Committee
SCT	Social Cash Transfer
SGBV	Sexual and Gender-Based Violence
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TWG	Technical Working Group
UNAIDS	United Nations Joint Program on AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Foundation

USAID	United States Agency for International Development
USD	United States Dollar
VCT	Voluntary Counseling and Testing
WCA	West and Central Africa
WHO	World Health Organization

Executive summary

Liberia has a generalized HIV epidemic with reproductive aged population showing HIV prevalence of 2.1% (2013 LDHS) with an estimated adult HIV population of 30,000 (2015).Significant variations in HIV prevalence exist between and within regions and counties. The epidemic is heterogeneous and variable across the country. The prevalence is higher among females (2.4% especially those above 20 years) compared to males (1.8% especially those above 30 years). Urban dwellers are more impacted (2.6%) than among rural (0.8%) residents and the South Central Region has the highest prevalence of 2.7% among the five regions and Montserrado, Margibi, and Grand Bassa counties have the highest HIV prevalence among the 15 counties and together account for about 70% of the burden of disease in the country. Key populations are disproportionately impact by the epidemic because of their high risk behaviors (Sex workers-9.8%, men who have sex with men19.8%, people who inject drugs-5% etc).

In response to this challenge, the multi-sectoral national AIDs response has an overall vision of getting towards zero New Infection, Zero Discrimination and zero AIDS related deaths. The response is guided by the 2015-2020 National HIV and AIDS Strategic plan which prioritized high impact interventions relating to HIV prevention, treatment care and support. The major interventions include HIV counselling and testing, prevention of mother to child transmission of HIV, treatment with antiretroviral drugs among others.

The Ebola Virus Disease (EVD) outbreak in March 2014, exposed the devastating status of the health system in Liberia and it negatively affected thecapacity of the country to respond effectively with negative consequences on the population at large and economy in general.As of April 2015, a total of 372 health workers had been infected, of whom 184 died.Data from the 2013 LDHS showed that among women of ages 15 - 49 surveyed, 19.1% had been tested for HIV in the past 12 months and received results as opposed to 1.6% reported in 2007 LDHS.The number of people accessing HCT in 2012 and 2013 has reduced by almost half for 2014 and 2015. Program data by county shows that the three high burden counties (Montserado, Margibi, and Grand Bassa) over the period have accounted for about half of all the people tested for HIV and also contributed about 60% of all those testing HIV+ per annum. This may be attributed to the EVD in 2014 as the health sector is yet to recover from its aftermath.

HIV prevalence among pregnant women has consistently been on the downwards trend: from a peak of 5.4% in 2007, 2.6% in 2011 and 2.5% in 2013.Even though DHS data showed that the ANC attendance for four or more time is 78.1%, data from the HMIS showed that HIV testing coverage for pregnant women was just about 35% by end of 2015. The number of health facilities offering PMTCT increased from 55 in 2009 to 335 sites in 2015. This represents 61% of the health facilities. Only 42% of the health facilities provide ARV prophylaxis to HIV+ women and Family planning counselling to HIV+ women was available in 53% of the health facilities.Among the pregnant women who tested HIV positive 2,120 only 1058 (50%) accessed ARV for the elimination of mother to child transmission of HIV by end of 2015.

The number of health facilities offering antiretroviral therapy has increased substantially from 29 sites in 2010 to 54 in 2015 and as a result, there has been a gradual increase in the coverage

of ART. By the end of December 2015, a total of 7,391 (7,002 adults –M=2,202/F=4,800, children=389)out of 30,000 persons living with HIV and AIDS were placed on treatment (ART).

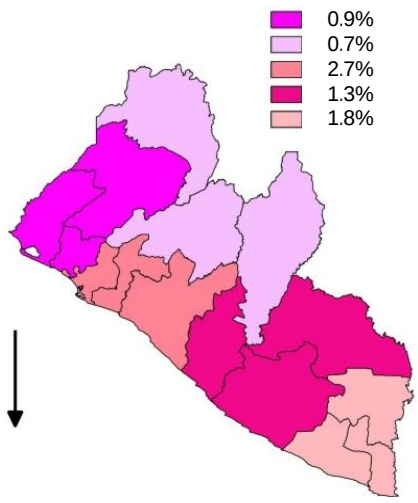
The major bottlenecks relates to inadequate political will, ownership and accountability on the part of program managers in linking their committing to the attainment of the targets in the 2016 Political declaration on AIDS, systemic constraints within the health sector its linkages with community service delivery, serious supply chain management challenges, data quality and funding. All these challenges have affected the absorptive capacity of the country in general with devastating consequences on the people of Liberia.

The slow pace of scale up of ART services has created a huge treatment gap which has resulted in significant morbidity and mortality among persons living with HIV. The West and Central Africa region as a whole has not leveraged the benefits availability of antiretroviral therapy. There are about 4.7 million people who are not on ART and as a result too about 330,000 people died of AIDS by end of 2015. Liberia with about 7,400 people on ART, accounted for almost 2,000 of these premature deaths in the region. This situation is no longer acceptable to the Government of Liberia. Therefore, a call to action has been declared for an end to the business as usual response and to quicken the pace of scale up by tripling the number of people on ART to close the current treatment gap by end of 2020.

The expected outcomes of this catch up plan are a) The Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission is increased from 47% in the three high burden counties to at least 80% by end of 2018 (phase 1) and to at least 95% by 2020 (phase 2) and b) Uptake of ART coverage Increased by 55% (16,000) by end of 2018 and 94% (23,400) by the end of 2020.Overall, this means, a tripling of thecurrent number of people on ART from 7,400 to 23,400by end of 2020.The major outputs are (a) a minimum of 710,000 adults will be tested for HIV in the 3 counties by end of 2018 and an additional 740,000 from 2019 to 2020, (b) a minimum of 170,000 pregnant women will be offered HIV testing in the 3 counties by end of 2018 and an additional 190,000 from 2019 to 2020, (c) at least 95% of all HIV+ mothers and their exposed babies will access antiretroviral therapy (Option B+) to prevent MTCT annually between 2017 and 2020, (d) at least 90% of all HIV exposed babies will access Early Infant Diagnosis for HIV annually, (e) an additional 9000 will be put on treatment in the three counties by end of the first phase in 2018 (this will include about 1,600 pre-ART patients) and an additional 6300 patients will be put on ART in 2019 and 2020 (phase 2). This catch up plan will provide an add-on effect on existing efforts by addressing the major program bottlenecks identified in order to achieve these ambitious targets to leave no one behind in Liberia. The health systems approach to the response will be strengthened in addition to leveraging the community health delivery system which is already in place for TB and Malaria services to deliver HIV-related services such as HIV counselling and testing by community health assistance (which is not currently the case).

This catch up plan will cost about US$19 Million ($10.3 million in phase 1 and $9 million for phase 2).

Section I – Epidemiological profile



Liberia has a generalized HIV epidemic with reproductive aged population showing HIV prevalence of 2.1% (2013 LDHS) with an estimated adult HIV population of 30,000[1](25,000-35,000) by end of 2015. Significant variations in HIV prevalence exist between and within regions and counties. HIV prevalence is higher in urban (2.6%) than in rural (0.8%) areas. The South Central Region has the highest prevalence of 2.7% among the five regions and Montserrado, Margibi, and Grand Bassa counties have the highest HIV prevalence among the 15 counties and together account for about 70% of the burden of disease in the country.

It is noteworthy that in 2013 an Integrated Bio-Behavioral Surveillance Survey (IBBSS) found high HIV prevalence among predominately male key population sub-groups: 19.8% in Men who have sex with Men (MSM); 5% in People Who Inject Drugs (PWIDs), a predominantly male behavior; and 4.8% in transport workers (long distance bus and truck drivers), a heavily male dominated workforce. The prevalence among female sex worker was 9.8%. HIV prevalence is also higher in urban than in rural areas, in females as compared to males, and in key populations(MSM, FSW, PWID, long distance drivers, females).

By end of 2015, spectrum data estimated that 87% of the overall HIV population were adults of which 12% were aged 15-24 years andfemales constituted 53% of all PLHIV in the country. There were 1,596 new HIV infectionsand1,923AIDS related deaths.Between 2010 and 2015, there was a 20% increase in new HIV infections and 24% decrease in AIDS-related mortality among adults 15 years and above. About 97% of the deaths occurred in PLHIV who were not on treatment. TB death among PLHIV per 100,000 PLHIV was 1,065 in 2014. There are 38,462 AIDS-orphans in 2014, equivalent to about 19% of total orphans from all causes.

[1]UNAIDS Spectrum 2015

Section II – Programmatic response and gaps

The national AIDs response is multi-sectoral with the overall vision towards zero New Infection, Zero Discrimination and zero AIDS related deaths. The response is guided by the 2015-2020 National HIV and AIDS Strategic plan which prioritized high impact interventions relating to HIV prevention, treatment care and support. The major interventions include HIV counselling and testing, prevention of mother to child transmission of HIV, treatment with antiretroviral drugs among others. These interventions have been deployed across the country with clear policies, guidelines and standard operating procedures to ensure the delivery of standardized and quality services to all who need.

It is worth noting that following the Ebola Virus Disease (EVD) outbreak in March 2014, Liberia suffered a devastating impact on its health system, the population at large and economy in general.As of 8 April 2015, a total of 372 health workers had been infected, of whom 184 died. Pre-existing structural vulnerabilities included inadequate and poorly motivated health workers, insufficient and unsuitable infrastructure and equipment, weak supply chains and poor quality of care. This led to disruptions in the delivery of routine health services with health facility closures, fears and refusal of health workers to provide routine health services, and community distrust and fears. Coverage of life-saving maternal and child health interventions, in particular, declined dramatically.

The national response is faced with low financial absorption rate of global fund resources resulting in low coverage of all high impact interventions. Below is the distribution of sites by county for the delivery of HIV related services:

Table 1: Distribution of HIV service delivery points by county in Liberia

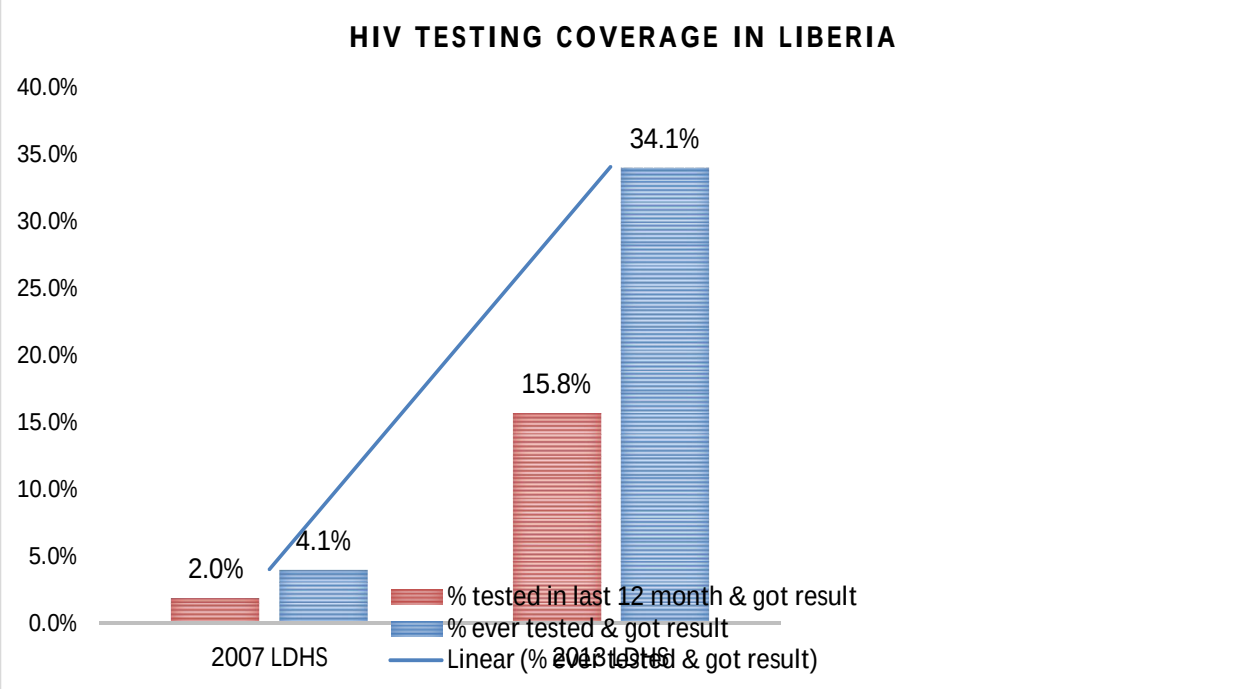
County	Total Facilities	# of facilities offering HCT services	# of facilities offering PMTCT services	# of facilities offering ARV services	# of facilities offering STI services
Bomi	22	20	21	7	22
Bong	42	24	37	7	42
Gbarpolu	17	14	14	3	15
Grand Bassa	28	20	24	2	28
Grand Cape Mount	32	4	30	3	31
Grand Gedeh	24	23	22	2	23
Grand Kru	17	14	5	2	15
Lofa	57	33	47	4	52
Margibi	32	21	15	9	31
Maryland	25	19	17	1	25
Montserrado	261	68	50	21	230
Nimba	72	35	39	10	71

River Gee	19	16	17	3	19
Rivercess	19	15	18	2	19
Sinoe	34	16	30	4	32
Grand Total	701	365	428	84	659

HIV Counselling and Testing

HIV testing is the gateway to treatment with lifelong antiretroviral therapy. The 2013 LDHS showed that among women of ages 15 - 49 surveyed, 19.1% had been tested for HIV in the past 12 months and received results as opposed to 1.6% reported in 2007 LDHS.

Fig 2Proportion of people tested for HIV and know their status



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

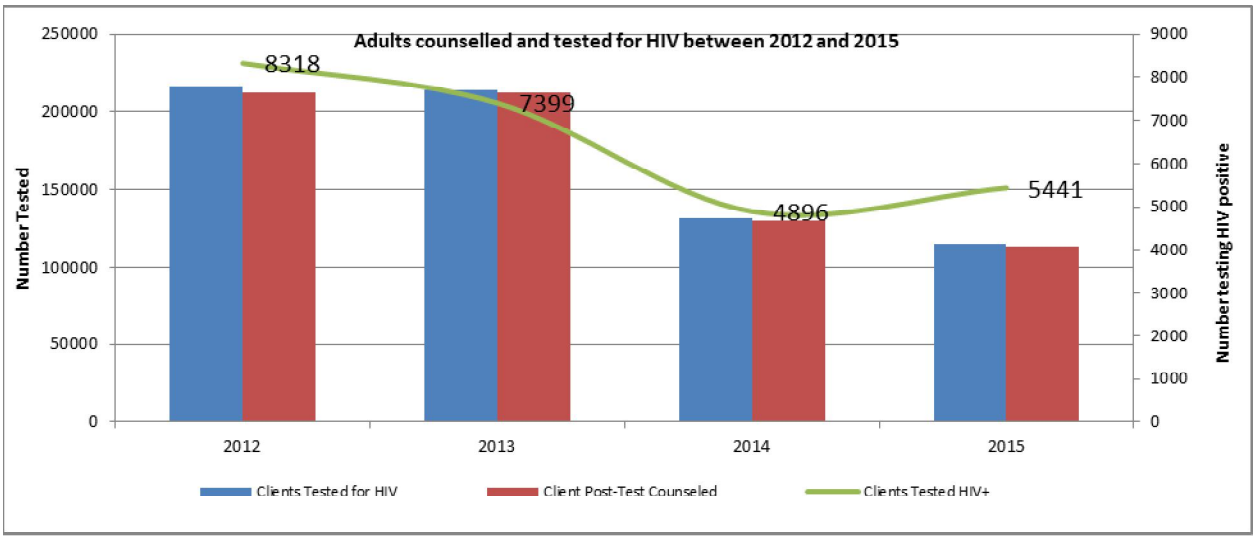
Multi-pronged approaches have been adopted for the delivery of quality HIV Counselling and Testing (HCT) services. These include voluntary counselling and testing, and Provider Initiated Counselling and Testing (PICT). The number of sites providing HCT services from 79 facilities in 2007 to395 in 2015 in all 15 counties. However, this represents only 52% of the health facilities offering HCT services across the different levels of facilities in Liberia, with major disparities across the counties. For instance the least counties were Grand Cape Mount (12%) and Montserrado (26%) whereas Bomi and Grand Gedeh have 92% and 95% respectively.HIV

counselling and testing services were mostly provided in hospitals (88%) and Health centres (73%) while the least were clinics (49%) in less than 50% of the health facility clinics. Public and NGO facilities offered this service in 63% and 58% of the health facilities with majority of facilities (62%) from rural[2].

The number of people accessing HCT in 2012 and 2013 has reduced by almost half for 2014 and 2015.This may be attributed to the EVD in 2014 as the health sector is yet to recover from its aftermath. Unfortunately, the data has not been disaggregated by gender or by age. A further review of the program data by county shows that the three high burden counties (Montserado, Margibi, and Grand Bassa) over the period have accounted for about half of all the people tested for HIV and also contributed about 60% of all those testing HIV+ per annum. The key questions arising from this program data are:(i) Where are all these HIV+ persons? (ii) What is the proportion of people who repeated their HIV test more than once? And (iii) Why are the majority of these HIV+ people in the general population not accessing life-long antiretroviral therapy? (iv) Why are these 3 counties disproportionately impacted by HIV? (v) Have the HIV program use this program data to respond to the unmet needs for these 3 counties?

Below is the distribution of the annual HCT data.

Figure 3: The distribution of the annual HIV Counselling and Testing program data 2012-2015



Community-based Organizations and FBOs have contributed enormously to increasing community sensitization on, participation in, and demand for HCT services that are being provided at MOHSW and private-for-profit and private-not-for-profit health facilities and supplemented by outreach programs on special days such as the World AIDS Day and at key events including major sporting activities.

[2] Liberia Service Availability and readiness Report, 2016.

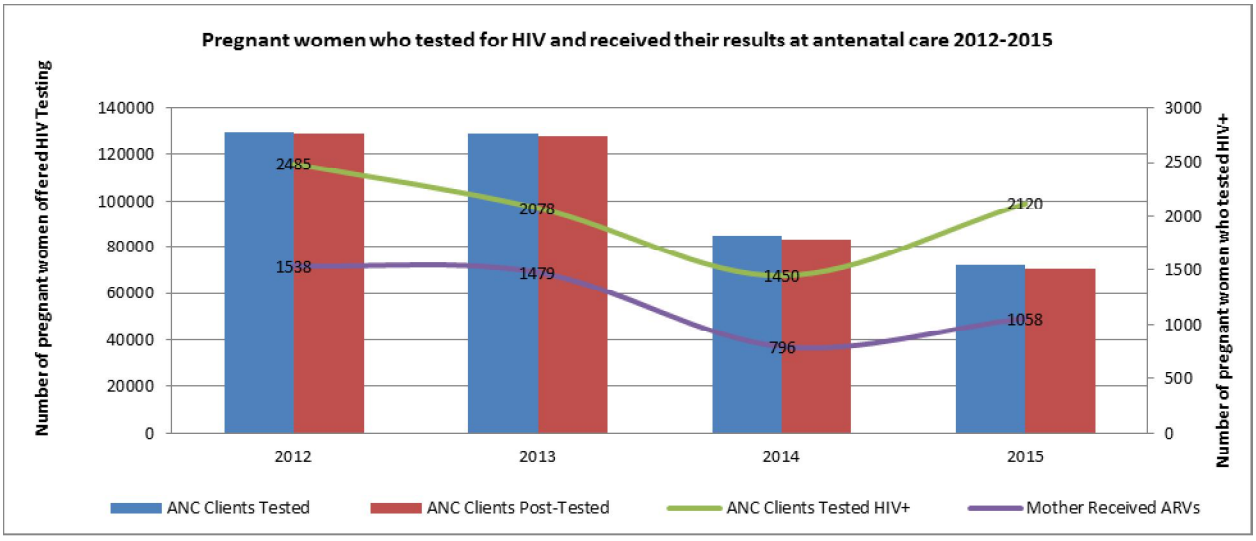
Prevention of mother to child transmission of HIV

HIV prevalence among pregnant women has consistently been on the downwards trend: from a peak of 5.4% in 2007, 2.6% in 2011 and 2.5% in 2013. The rate of decline in HIV prevalence among pregnant women essentially plateaued between 2011 and 2013.

It is generally accepted that the decline in the HIV prevalence among pregnant women was due to the scale up of integrated PMTCT interventions for pregnant women. The counties with the highest prevalence have the greatest needs (Montserado, Margibi, and Grand Bassa). The number of health facilities offering PMTCT increased from 55 in 2009 to 327 sites in 2015. This represents 61% of the health facilities. Only 42% of the health facilities provide ARV prophylaxis to HIV+ women and Family planning counselling to HIV+ women was available in 53% of the health facilities. Not all facilities providing these services were providing ARV prophylaxis to newborns born to HIV+ pregnant women. Infant and young child feeding counselling was done in only 49% of the health facilities. Services for Sexually transmitted infections (STIs) are offered in 94% of the health facilitiesin Liberia with all Reproductive and Sexual Health services delivery point fully covered. Diagnosis of STIs was done in 93% of the health facilities while treatments for STIs were available in 94% of the health facilities.

Even though DHS data showed that the ANC attendance for four or more time is 78.1%, data from the HMIS showed that HIV testing coverage for pregnant women was just about 35% by end of 2015.

Figure 4: Trend of pregnant women who tested HIV+and received ARVs for the prevention of mother to child transmission of HIVat antenatal care (2012-2015)

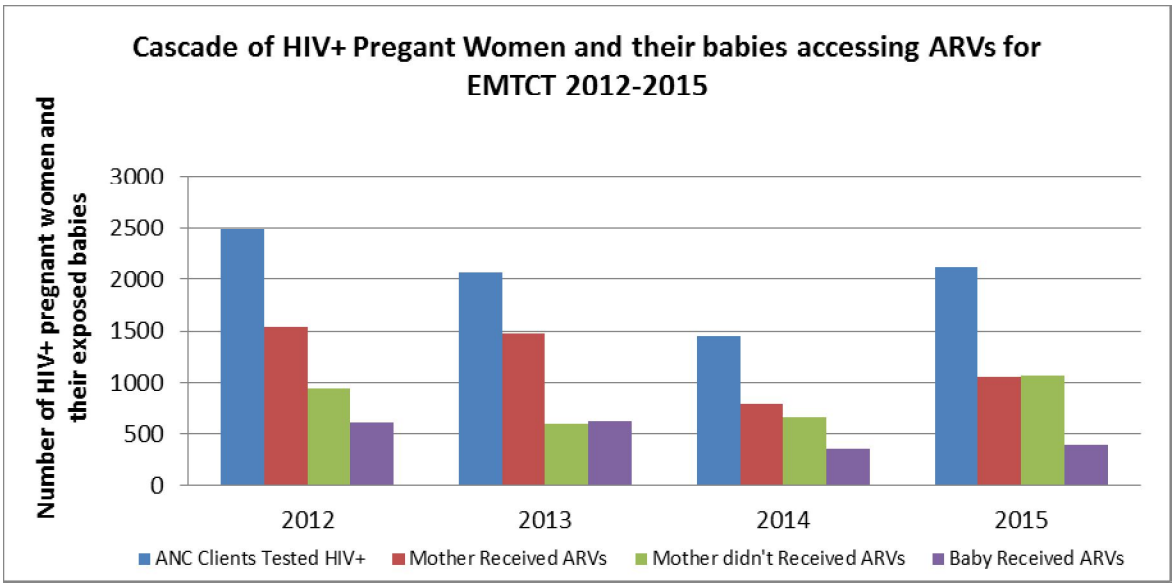


Among the pregnant women who tested HIV positive 2,120 only 1,058 (50%)[3]accessed ARV for the elimination of mother to child transmission of HIV by end of 2015.The three high burden counties with greater unmet needs (Montserado, Margibi, and Grand Bassa) have between 2012

[3] Available NACP program data differs from the published data for Liberia in 2015 (1,358 pregnant women tested HIV+ and 70% receiving efficacious antiretroviral regimen

and 2015 contributed more than 40% of all pregnant women tested for HIV and 60% of all HIV positive pregnant women in the country. Program data further showed that on the average less than half (47%) of all the HIV+ pregnant women identified in these 3 counties received antiretrovirals for the prevention of MTCT.

Figure 5: Cascade of HIV+ pregnant women and their babies accessing ARVs for PMTCT (2012-2015)



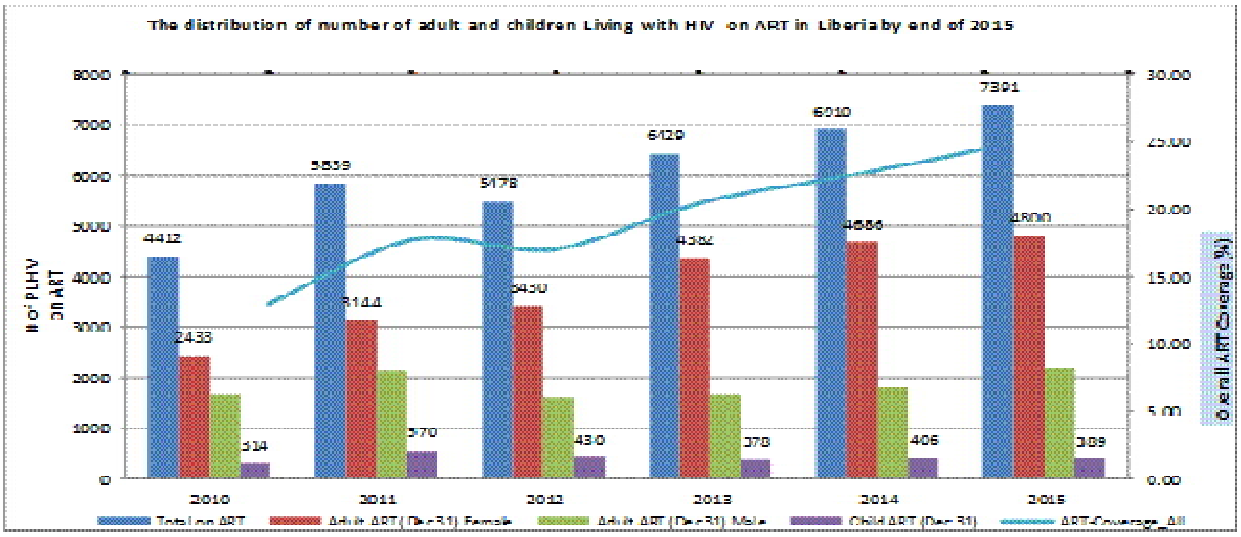
NACP in 2015 adopted Option B+ to ensure that pregnant women and mothers who are tested HIV positive have ART treatment available for their own health and longevity and that their babies are borne HIV negative. The roll-out of the revised guidelinewas delayed due to the outbreak of EVD. The unmet need for family planning is 31.1%. This is critical for HIV positive women who want to space their families or avoid unintended pregnancies.

Antiretroviral Therapy

In the absence of a cure, evidence shows that lifelong antiretroviral therapy has resulted in significant reduction in HIV-related morbidity and mortality among people living with HIV as well as the HIV transmission.

The number of health facilities offering antiretroviral therapy has increased substantially from 29 sites in 2010 to 54 in 2015 and as a result, there has been a gradual increase in the coverage of ART. By the end of December 2015, a total of 7,391(7,002 adults –M=2,202/F=4,800, children=389)out of 30,000 persons living with HIV and AIDS were placed on treatment (ART). The 3 high burden counties hold over 70% of all the PLHIV on ART. Overall, 2,717 patients (of which 60% are in the 3 counties) are in care but not yet on treatment.

Figure 6:Adults and Children with advance HIV currently receiving ART



The growth on treatment has been relatively slow and may not be sufficient to be able to achieve the fast track target by end of 2020. More women than men access treatmentin a ratio of about 3:1 and unfortunately children between 0-14years are being left behind.

About 21% of the health facilities provide Tuberculosis services (TB). Diagnosis for TB was available in only 16% of the health facilities including 1% of facilities using GeneXpert (MTB/RIF and diagnosis by culture). Only 14% of them able to provide prescription of drugs of tuberculosis to patients and 15% of them able to provide drugs to Tuberculosis (TB) patients. TB/HIV co-morbidity has been prioritized in the country. There is a TB-HIV working group which ensuresthat TB-HIV collaborative activities are implemented. About 70% 0f TB patients are screened for HIV.Isoniazid preventive therapy (IPT) has been included as a preventive package for HIV infected patient. This IPT is currently being operationalized in 7 facilities and will be expanded subsequently to cover all the 54 ART sites.

Section III – Analysis of implementation bottlenecks

Policy and Leadership bottlenecks

- There is national commitment to ending AIDS by the Government of Liberia within the context of universal health coverage. However, as a post-conflict country which was impacted negatively by EVD, the health structures are relatively weak to be able to rapidly deliver the needed health outcomes within a short period without the necessary technical and political support. There are health policies and guidelines to ensure proper functioning and management of the health system. There exist task-shifting/task-sharing policies, the WHO option B+ has been adopted but not implemented nationwide, the 2015 WHO treatment guidelines is currently being implemented, free maternal services policy is in place in the public health services delivery points, policies on integration and decentralization of services are in place and Government domestic contribution has been growing steadily.However, the major constraint in Liberia has to do with full implementation of these policies to facilitate the delivery of quality health services for greater health impact. The MOH has recently developed an Investment plan for building a resilient system for health in Liberia and it is hoped that this plan will help breach the current weaknesses in the delivery of health services in the country.

Service delivery models

- The current service delivery model heavily weighs on health sector approach even though in recent times especially after the EVD outbreak the role of community health service delivery has been prioritized to complement health sector service delivery. Community Health Assistants(CHAs) are currently in place and incentivized to support TB, Malaria and HIV service delivery at the community level with strong oversight from the health sector personnel. Currently, these CHWs are not mandated to perform HIV counselling and testing (even though they perform rapid diagnostic tests for malaria). This is a clear missed opportunity to expand the frontiers of HIV testing at the community level in Liberia to achieve the 'first 90' fast track target. Not all PMTCT sites provide full ART services, or TB DOTS point providing ART services and therefore patients have to be referred long distancesto health facilities from their homes. Out of 701 health facilities, PMTCT is provided in 327 facilities. At present there are 104 ART sites delivering ART services.This has contributed to the high dropout rates seen with most HIV-related services. Even though services are supposed to be integrated especially at the Reproductive, Maternal and Newborn Child and Adolescent Health (RMNCAH) platforms, this is not the case in most health facilities leading to missed opportunities for uptake of HIV-related services.

Procurement and supply management (PSM)

- The GoL has challenges in ensuring an appropriate supply chain for the management of health products and technologies. In its 2007-2010 National Health Strategy, the MOH noted that efficient procurement and distributions systems are vital to the provision of

the BPHS. However, factors such as limited road infrastructure, unsuitable storage, limited warehousing capacity, inventory and warehouse management practices, and limited information sharing have led to frequent stock-outs of commodities, uncertain drug quality, and a general lack of confidence. This lack of confidence further undermines the health system as programs see no alternative other than managing their own individual supply chains. This fragmentation adds to the burden on the national system by adding unnecessary, duplicative costs while also contributing to lack of visibility, misallocation of resources, misalignment of supply and demand and general underperformance.The National Drug Service (NDS) has been found to be deficient in asset management, storage capacity, supply management practices, appropriate quantity and quality of trained staff and unclear legal status. At county level, medical supplies face others constraint such as inadequate storage space leading to the use of suboptimal spaces which includes small rooms, verandas and corridors. Warehouse facilities are understaffed and lack necessary equipment to run daily activities. There is no continuous and uninterrupted power supply for most facilities. None of the counties has adequate cold chain facilities; in most cases they use hospital facilities which are already overburdened. Air conditioned facilities are not adequate and in some instances are not available. Last mile distribution is a big challenge due to poor road conditions (only about 10% of the roads to county headquarters are paved)[4].The management of the National Drug Service has been changed for poor performance and an interim management team has been instituted but the constraints of shortages of commodities, procurement of medicines, and reagents with short shelve lives have led wastage and inefficiencies in resource management. In fact, almost all HIV related services are commodity-dependent and so stock-outs causes' serious disruption of services leading to non-performance putting the grant investment at higher risk and failure.

Health management Information System

- The DHIS-2 is currently in operation and captures integrated health data from all health facilities. The challenge is with internet access to provide real-time data access to granular data. Efforts are being made to integrate community based information into the DHIS-2 to capture the totality of health sector and community system indicators. The tools have been developed but the platform is yet to be finalized. There is problem of attrition of trained data managers(due to poor remuneration) and as a result, data is not adequately captured timely. Data quality checks are not regularly done at the county level and therefore the data reported into the DHIS-2 is in-consistent and in-complete. The DQCs are not being done regularly because of bureaucratic red-tapes. There are 5 levels of approval for operational plans and this has to be done per activity. This has led to the slow implementation of quarterly activities. This has led to slow absorption of available resources.

[4] SMCU/UNICEF county depot capacity assessment report –December 2014.

SWOT Analysis of program implementation

Strengths

- There full political buy-in from the level of the president who chairs the NAC Board based on the 3 One's principle. The 2016 Political Declaration on AIDS has fully been adopted and signed by Government of Liberia (GOL).
- Existence of health sector strategy which includes HIV as well an investment plan for resilient and sustainable systems for health
- Availability of unique codes for PLHIV to enable tracking and avoid duplication
- Existence of task-shifting policies
- MoH leadership on the scale up of the HIV response is strong through the National AIDS Control program (NACP), with the Family Health Division playing an oversight role
- The Global Fund has heavily invested into the national scale up of HIV/TB and Malaria and the GOL has incrementally been contributing domestic resources to health service delivery.
- Strong buy-in of bilateral and multi-lateral agencies include support from the Civil Society and networks of PLHIV
- Networks of PLHIV of Liberia are currently involved as sub-recipients for the implementation of the Global Fund grants in Liberia

Weaknesses

- Poor absorption of the Global Fund grant due to bureaucratic red-tapes within the MOH as principal recipient.
- There is **coordination and management function** challenges with the of the Family Health Division of the MoH in the integration of PMTCT into the MNCH platform
- Limited number of HCT/PMTCT/ART sites.
- 29% of Liberians Live beyond 5km from the nearest health facility
- There are over 2,700 patients nationwide who know their HIV status and in care but not on ART. About 1,640 of these patients are in the 3 high burden counties.
- Weak supply chain management systems
- Poor implementation of health policies and guidelines
- Poor data quality and limited internet connectivity at county level
- Service delivery model is largely skewed toward the health sector. There is inadequate community service delivery system for continuum of care for persons living with HIV (PLHIV) unlike for Malaria and TB.
- CHWs do not perform HCT and networks of PLHIV are not actively engaged in community distribution of ARVs to their peers.
- High staff attrition across the spectrum due to low salaries and other conditions of service coupled with the significant loss of health personnel due to EVD.
- Poor supervision of health service delivery and inadequate feedback to the different sites for quality improvement.
- Programming for key populations are weak
- High level of stigma has affected service uptake and utilization
- High STI service availability to support HCT

Opportunities

- Task shifting has been strongly implemented at different levels especially at the decentralized level
- The integrated guidelines for HIV and AIDS care, treatment and support are non-doctor focus. Physician assistants, midwives and nurses are providing nationwide ARV for HIV infected pregnant women and exposed infants and ART for HIV infected mothers. The PMTCT guideline has been updated for the delivery of Option B+.
- The availability of CHWs who work with nurses to promote health awareness in the community, and play a role in the distribution of limited number of medicines and commodities to pregnant women, mothers and children, and to refer those in need of care at a health facility to the appropriate place. CHWs can be quickly trained to perform HCT.
- There is also a mother peer-to-peer group to provide psychosocial support to other HIV positive mothers. There are also PLHIV networks that are supporting retention of newly identified PLHIV in care.
- There is a strong commitment from partners to provide technical and financial resources to ensure the attainment of the 90-90-90 targets by 2020 leaving no one behind.
- Liberia qualifies for the Global Fund new funding cycle 2017-2019 which can support the fast tracking in the country.
- Existence of workplace HIV policies
- USAID is working with Google to improve internet connectivity in the country.

Threats

- Over reliance on international funding for the national HIV response
- Low absorptive capacity of the current grant (based on some of the conditions precedent in place by the Global Fund and this leads to delayed disbursement).
- The currently political commitment to health cannot be guaranteed after the elections in 2017
- Prolonged interruption of internet connectivity may further disrupt the health management information system

Root cause Analysis of major bottlenecks

Table 2: Root cause analysis of program bottlenecks

Programme areas	Implementation issues	Main / root causes	Possible response
HCT	Low utilization of HCT services	• Low personal risk perception • Stigma and discrimination • poor health seeking behavior especially for men • Limited testing points • Stock-out of test kits • Absence of community testing strategies • Long distances for HIV	• Strengthen provider initiated counselling and testing • Family centered HIV testing • Pilot self-testing • Community based HIV testing including mobile even-driven HIV testing strategies • Community sensitization • Improve on reporting to strengthen logistical data and strengthen supply chain management

		testing	
PMTCT	• Low ANC HIV testing coverage •	• Weak coordination and management function of the PMTCT program at national level Mistrust of healthcare workers • Frequent stock-outs of HIV commodities due to poor quantification • Limited geographic access to ANC services with some counties with high unmet need • Weak integration of RMNCAH services • Late presentation at ANC •	• Promote early presentation at ANC during pregnancy (12-14weeks) • Promote pre-pregnancy HIV testing • Strengthen the coordination and management link between family health division and the NACP • Regular supervision to ensure that focused antennal services are delivered in an integrated fashion • Strengthen supply chain management systems • Strengthen integration of PMTCT into RMNCAH platforms • Incentivize performance by health facilities or HCW
	• Option B+ not implemented nationwide	• The EVD disrupted full implementation	• Implement the option B+ policy fully
	• Mother-baby pairs not receiving ARVs • Inadequate access to early infant diagnosis	• Frequent Stock-outs of cartridges and ARVs • Lost to follow up of baby mother pairs •	• Revitalize the use of Mother peer to peer groups to follow up on lost patients • Review the sample collection and transportation to national reference laboratory for EID and strengthen feedback to health facilities and to mothers • Automate the logistic and supply system to improve reporting of consumption data for proper quantification, forecasting and distribution of commodities both at the central and county levels. •
	• Inadequate male involvement in RMNCAH services	• Lack of awareness • Negative social norms • Gender inequalities	• Community sensitization the importance of ''knowing your status'' especially of men via their peers or social/religious groups • Encourage couple testing or family centered service delivery, pilot self-testing, assisted partner notification etc
	• Non-disclosure of HIV status	• Fear of gender-based violence	• Undertake stigma reduction training at the facility level, assisted partner notification etc
ART	• Poor access to HIV testing • Supply chain management challenges	• Limited HCT sites • Poor quantification and forecasting for test kits , medicines and reagents and cartridges for EID • Poor data capture and reporting • Poor supervision	• Adoption and implementation of 2016 WHO test and treat guidelines • Expand outlets for HCT • Strengthen EID (procure the thermo-mixers for the recalibration of GeneXpert equipment to perform EID test) • Strengthen Provider initiated counselling and testing (leverage RMNCAH platforms for pediatric

			HIV testing) • Strengthen data management and reporting especially consumption data
	• Poor quality of care, long waiting times	• Poor supervision • Overcrowding and poor organization of clinic schedules (frequent refills)	• Improve healthcare worker attitudes • Reorganization of services to reduce overcrowding • Conduct regular supportive supervision
	Disparity in access to services: More women than men are on ART including children	• Poor health seeking behaviors of men • Lack of family centered testing especially for children •	• Social mobilization of men • Family centered care • Stigma reduction initiatives
	• Low retention rate at 12 month of initiation on ART (70%)	• Poor quality of care leading lost to follow up • Transportation cost for checkups and refills • Stigma • Inadequate leveraging PLHIV networks to support adherence and retention in care	• Strengthen partnership with PLHIV networks to undertake regular follow up on their peers • Review frequency of refills for stable patients • Sensitize health care workers on stigma reduction
Political commitment and Governance	• Weak Political commitment, ownership/Accountability at the program level leading to poor coordination, weak oversight, ineffective and inefficient implementation of HIV programs	• Lack of interest in HIV • Lack of understanding or knowledge of leadership's mandate to the 2016 Political Declaration signed on by the President to end AIDS • Competition for between agencies for control of resources	• Dissemination of the 2016 Political Declarationto all sectors to ensure that Government of Liberia delivers on the expected results. • Advocate with the Minister of Health to streamline the role of the different agencies and departments responsible for the health sector response. • Hold regular program reviews to track progress on the Political Declaration
Funding and program management	• Low absorptive capacity • Weak coordination with external donors • Data from the National Health Account estimate of 7.44% shows Abuja Declaration of 15% GOL expenditure on health has NOT been met (2011/2012). However, domestic contribution for HIV and AIDS was 14.7% as against 4.7% by the Global Fund in 2011/2012.	• Limited implementation capacities • Numerous safeguard policies/conditions precedent • Low disbursement due to fear of mismanagement/misapplication/corruption etc • As a post conflict country, domestic contribution for HIV has been challenging because of all the economic difficulties faced by the GOL in addressing the needs of the social sector in addition to other development priorities.	• Continue high level advocacy for incremental domestic resources for sustainability of the HIV program. • Develop a resource mobilization strategy • Provision of targeted technical support to unlock implementation bottlenecks • Strengthen coordination and Management capacity assessment • Regular engagement of partners with the Global Fund to instill confidence and facilitate implementation and making the money work

Summary of major bottlenecks

A number of barriers were identified in Liberia that hinders access to quality care and treatment services. The impact of these barriers varies from county and thus requires a differentiated approach based on the county context that may be linked to several factors.

Political Bottleneck

Weak Political commitment, ownership/Accountability at the program level

- There is high level political commitment and leadership to the HIV response. However, commitment, ownership and accountability areless evidentat the implementation level. For instance, if these key political commitment variables were present at the program level, there would be no frequent stock-outs or expiry of HIV commodities.

Programmatic Bottleneck

Weak health and community systems

- The over reliance on health sector approach to the AIDS response, Low utilization of HIV services and weak integration and decentralization of health with active community participation in HIV service delivery across the continuum of care at the community level.

Health sector

- Weak coordination and collaboration between the Family Health Division and the NACP in the implementation of PMTCT/SRH components of the Health Sector HIV response.
- Poor implementation of health policies and guidelines
- Ineffective/inefficient service delivery models (limited geographic coverage of service delivery points)
- PSM constrains (poor quantification and forecasting and distribution)
- HMIS challenges (poor data quality)

Community Systems Strengthening

- Weak community participation in HIV service delivery unlike for Malaria and TB (e.g CHAs do not perform HIV test)

- Inadequate mobilization of community actors HIV service delivery and contribute to community awareness on AIDS and addressing stigma and discrimination

Weak procurement and supply chain management system

- Weaknesses in PSM isdriven by absence of national structures, processes, capacity and support systems for the quantification and forecasting, procurement, distribution and monitoring of logistic systems. This has led to the frequent commodity stock-outs and its ripple effect on delivery of HIV services. There have been changes in the management teams of both the National Drug Service (NDS)and Supply chain management unit of MOH however; the stock situation is still dire.

Poor quality of care

- This is exacerbated by from long waiting times, frequent hospital pharmacy refills, poor adherence and low retention in care and long travel distances to service delivery points are a further limiting universal access to HIV related services.

High levels of stigma and discrimination

- This is expressed in the form of denial of health services, high rates of gender-based violence and gender inequities/inequalities are **reducing access to health and HIV services** (note: more females than males on ART)**.** Punitive laws and policies and exposure to violence, stigma and discrimination deter key populations from fully utilizing available services.

Funding Bottleneck

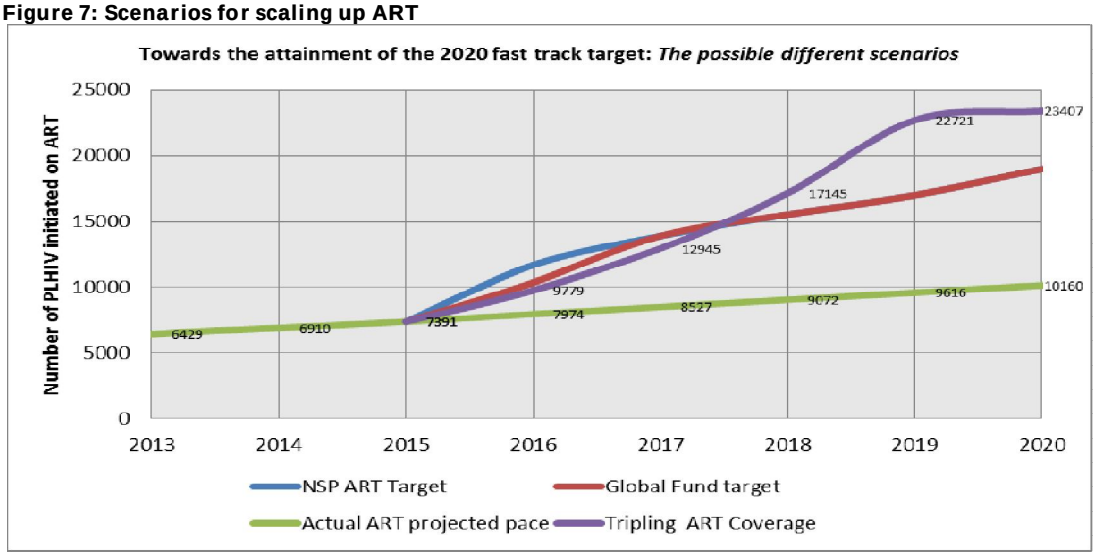
- Complex relationship between Governments and external partners (donors), development partners, leading to underutilization of important external resources.
- Low absorptive capacity of available funds at the county and national levels.
- Data from the National Health Account estimate of 7.44% shows Abuja Declaration of 15% GOL expenditure on health has NOT been met (2011/2012). However, domestic contribution for HIV and AIDS was 14.7% as against 4.7% by the Global Fund in 2011/2012.

Why this catch-up plan?

The slow pace of scale up of ART services has created a huge treatment gap which has resulted in significant morbidity and mortality among persons living with HIV. The West and Central Africa region as a whole has not leveraged the benefits availability of antiretroviral therapy. There are about 4.7 million people who are not on ART and as a result too about 330,000 people died of AIDS by end of 2015. Liberia with about 7,400 people on ART, accounted for almost 2,000 of these premature deaths in the region. This situation is no longer acceptable to the Government of Liberia. Therefore, a call to action has been declared for an end to the business as usual response and to quicken the pace of scale up by tripling the number of people on ART to close the current treatment gap by end of 2020. This is why the catch plan has been developed with the full buy-in from partners and stakeholders.

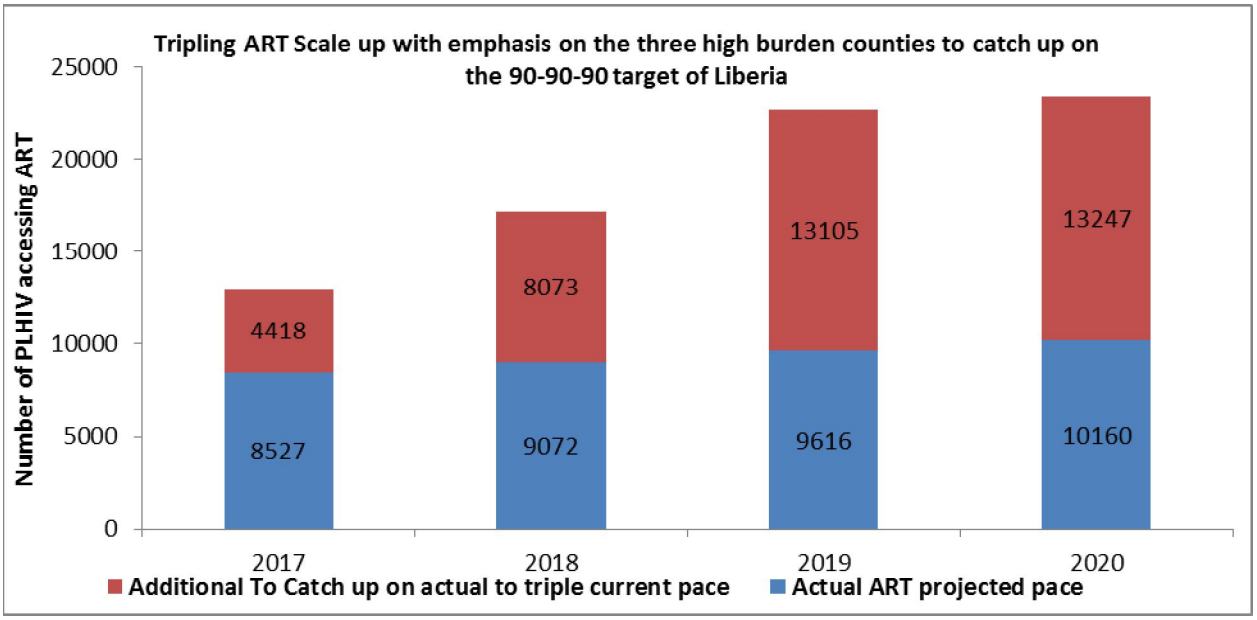
This catch up plan does not replace the current national strategy or any operational plan that is currently being implemented. This catch up is to draw on synergies and to directly complement existing plans with a critical focus on high burden geographical areas and population with the greatest unmet need.
Figure 7 below shows the different scenarios.

Figure 7: Scenarios for scaling up ART



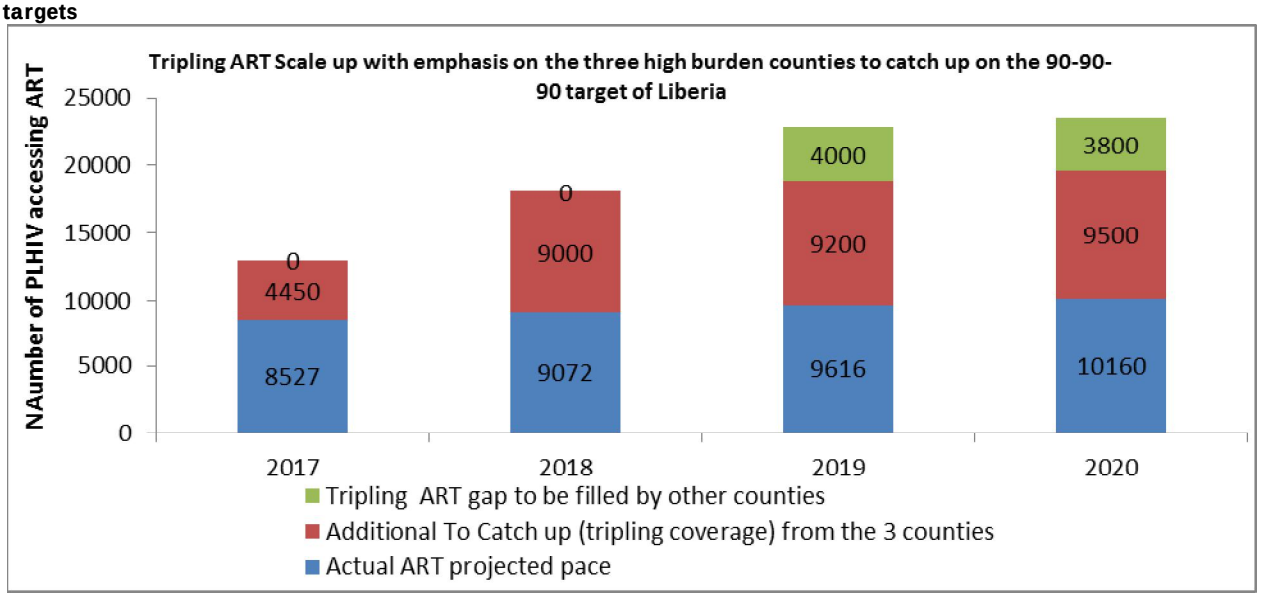
Based on the tripling scenario, there is huge gap that the country has to fill as shown in figure 8below:

Figure 8: The treatment gap based on the scenario of tripling implementation in Liberia



This massive task requires strategic focus and speed in order to maximize impact. The prioritized three high burden countieswill contribute significantly to bring Liberia back on track.

Figure 9:The contribution of the three high burden counties and other counties towards achieving the 2020 targets



After critical analysis of the current state of implementation, major bottlenecks and their associated root causes have been identified and context specific strategies and actions to unlock progress have been suggested for rapid implementation.

The key assumptions under-pinning this catch up plan is as follows:

1. There will be sustained political commitment, ownership, leadership and accountability to ensure that targets in the 2016 political declaration are prioritized and achieved
2. At the operational level, there will be maximum cooperation and coordination of all key actors at all level
3. Flexibility to reconfigure service delivery with critical emphasis on community service delivery where lay providers like CHAs will have the mandate to perform HIV counselling and testing and follow up on patients in partnership with PLHIV peer networks especially in the 3 high burden countiesnamely Grand Bassa, Margibi and Montserrado.
4. HIV service delivery points will expanded with a focus on the populations and locations with the greatest unmet need
5. Serious attention will be given at the highest level to commodity security demonstrated by uninterrupted commodity supply at the last mile (test kits, antiretroviral drugs, early infant diagnosis and Viral load kits) including the establishment of a temporal supply chain management system for at least the 3 counties to avoid service disruptions.
6. Additional resources will be mobilized and/or reprogramming of existing resources to support the plan massive scale up in the 3 counties.
7. The existing bureaucratic red-tapes associated with disbursement of funds by the principal recipients for implementation will be eliminated to ensure effective and efficient absorption of the available resources.
8. There will priority given to the adoption and full implementation of all relevant policies and guidelines especially the 2016 WHO test and start guidelines.
9. There will be the full inclusion and participation of communities, civil society organizations and networks of persons living with HIV to ensure massive community mobilization and support for the achievement of the fast track targets by 2020.

This Catch plan will be implemented in two phases from 2017 to 2020. The first phase will be 2017 and 2018 which will focus strategically on the 3 high burden counties with the aim of reaching the level of saturation of services and then the second phase (2019 to 2020) which will sustain implementation in the 3 high burden counties and also scale up to additional counties with greater unmet needs in order to fast track and attain the 90-90-90 targets by 2020.

Section IV – Results and Strategies for the Catch plan

Expected Outcome (1a): HIV Testing (Phase 1)

A least 27% of the adult population (15+years) will be tested in addition to the national target by end of 2018.

Expected Outcome (1b): HIV Testing (Phase 2)

- **About 28% of the adult population (15+years) will be tested in addition to the national target by end of 2020.**

Expected outcome2: Prevention of Mother to child transmission of HIV

- **The Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission is increased from 47% in the three high burden counties to at least 80% by end of 2018 (phase 1) and to at least 95% by 2020 (phase 2).**

Expected outcome 3 (a): Antiretroviral Therapy (Phase 1)

- **Uptake of ART coverage Increased by 55% (16,000) by the end of 2018**

Expected outcome (3b): Antiretroviral Therapy (Phase 2)

- **Uptake of ART coverage Increased by 94% (23,400) by the end of 2020.**

Major Outputs

- **Triple** the number of people on ART from **7,400 to 23,400**by end of **2020**.A minimum of 710,000 adults will be tested for HIV in the 3 counties by end of 2018 and an additional 740,000 from 2019 to 2020.
- A minimum of 170,000 pregnant women will be offered HIV testing in the 3 counties by end of 2018 and an additional 190,000 from 2019 to 2020
- At least 95% of all HIV+ mothers and their exposed babies will access antiretroviral therapy (Option B+) to prevent MTCT annually between 2017 and 2020.
- At least 90% of all HIV exposed babies will access Early Infant Diagnosis for HIV annually
- An additional 9,000[5] patients (8,000 adults and 1,000 children) will be put on treatment in the three counties by end of the first phase in 2018.

[5]This target includes 1,600 PLHIV in the 3 counties who are in care but not on treatment (Pre-ART)

- An additional 6,300 patients (5,770 adults and 530 children) will be put on ART in 2019 and 2020 (phase 2)

Main Target groups/locations for the Catch plan

The main targets for this plan include but not limited to

- Location/Geography
    - Counties with the highest unmet need for HIV related services (Grand Bassa, Margibi and Montserrado) for the first phase.
    - Urban areas and Hotspots
- Populations to be targeted based on the 2013 DHS and other epidata
    - Focus on women 20-49years (or above), pregnant women, women with STIs and those living in urban areasFocus men aged 30 to 49 years/above
- Key populations: sex workers, MSM/TG, Drug Users, Mine workers, prison population
    -
    - All HIV exposed babies
    - People who know their HIV status but not yet on ART (Pre-ART)

Key partners for operationalizing the Catch plan

- Government partners (NAC, MoH, MoGCSP, MoE, MoYS, MoIA,FHD, NACP, NLTCP, NDU, NDS, County Health Teams, Local Government etc)
- Non-Government Actors (local)
    - Civil Society Organization (including women's groups, Men's groups, youths etc), Faith Based Organizations, Non-Governmental Organizations
    - Networks of Persons Living with HIV
    - Community Health Teams
    - Liberia Coordination Mechanism of the Global Fund (LCM)
- International Partners
    - Bi-latreral Agencies (USAID, SIDA, CIDA, DFID, JICA etc)
    - Multi-Lateral Agencies (WHO, UNAIDS, UNICEF, UNFPA, UN Women, WFP, UNDP, UNOPS, World Bank, African Development Bank, The Global Fund)
    - International NGOs (MSF, CHAI, PSI, Chemonics, PIH etc)

FOCUS AREAS AND KEY RESULTS / ACTIONS

Political Strategy

StrengthenPolitical commitment,Country Ownership and Leadership

The Government of Liberia has signed onto the 2016 Political Declaration on ending AIDS. This is clearly a demonstration of high political will. However, due to the systemic weaknesses experienced during program implementation, the commitment, ownership and accountability to ending AIDS on the part of those who are to provide leadership to solving these challenges is increasingly being questioned. The coordination and management functions of key institutions and sectors responsible for ending AIDS in Liberia needs to be re-emphasized. This will allowfor recommitment to addressing existing bottlenecks which are preventing people from accessing HIV prevention, treatment, care and support services. Missing the 2020 targets in the Political Declaration is not an option for Liberia. Therefore, the importance of political commitment and accountability cannot be overemphasized for the implementation of this catch up.

Key Actions

- The NAC Board to hold a meeting with all sectors to discuss the Catch up plan and also push for sectoral commitments to the implementation of the plan towards the attainment of the 2016 Political Declaration.
- Set up a High Level Steering Committee with relevant partners and chaired by the Minister of Health to oversee the implementation of this Catch plan.
    - Where relevant the Minister will setup sub-committees to handle issues with commodities (test kits, ARVs) and PMTCT/Pediatric treatment.
- The Steering Committee to hold monthly/quarterly review meetings to monitor progress of implementation at the national and county levels with relevant feedback.
- Organize national and county level program inception missions to sensitize partners, county authorities and civil society about the benefits of the program, its implementation arrangements and the definition of the different roles of partners and beneficiaries.
- Continuously identify on-going bottlenecks and advocate for their eliminationduring implementation.
- Identify national and county leaders to act as “Champions” to support advocacy in Liberia, including women and girls, youth, cultural and religious among others.

Key results

- The catch up plan is endorsed by the president
- A High Level Steering Committee set up and operational
- Governance and oversight systems improved for proper coordination at the national and county levels towards the implementation of the Catch up plan
- A national and county level start up meetings organized and roles of key actors clearly defined.
- The President has been fully briefed and implementation bottlenecks addressed.

Programmatic Strategy

Strengthening Governance and Oversight responsibilities of implementing partners for the provision of quality HIV related services

Key Actions

- Hold a start-up meeting with all partners implementing HIV related programs in the 3 counties(and followed by monthly ''Catch-up'' progress meetings) to ensure coordination, harmonization and alignment of strategies to leverage synergies for maximal impact.
- High level advocacy for the Minister of Health to hold an urgent meeting with the Heads of the Family Health Division and the NACP to address the coordination and management bottlenecks affecting the delivery of quality, integrated PMTCT and SRH components of the Health Sector HIV response.
- The Family Health Division in partnership with the NACP to provide monthly updates on the implementation of the PMTCT component of this Catch up planto the Minister.

Key results

- Start-up coordination meeting successfully held to kick off the implementation of the plan followed by monthly ''Catch up'' progress meeting
- The management and coordination between FHD and NACP is strengthened to maximize impact of the Catch up plan.

Strengthening implementation capacity and Service Delivery

The implementation of this plan will focus on the adoption of differentiated models of care within the health and community based service delivery guided by the unmet needs of the high burden counties. Services delivery will be reconfigured to ensure efficiency and program quality improvement.

Key Actions: Health system

Prevention of mother to child transmission of HIV

- **Prong 1:**Expand provision of HIV services for Primary prevention among young women and their partners in the implanting counties
  - Provide regular information on HIV and syphilis prevention and promote HIV testing as a routine service in all RMNCAH services, STI clinics and outpatient clinics.
  - Promote actively through community mobilization early initiation of ANC by pregnant women (between 12 – 14 weeks)
  - In the high burden counties, provide re-testing for HIV negative pregnant women during ANC, labor/delivery and post-natal

- Promote couple/partner HIV/STI testing and counseling for all young women
- Provide STI treatment and routine offer of HIV testing to young women and their partners in adolescent friendly Sexual Reproductive Health service delivery points
- Promote assisted disclosure and safer sex for discordant couples, dual protection; evaluate and prioritize for treatment in line with national guidelines
- Promote condom use/dual protection among young women and men

- **Prong 2:**Close the unmet need for family planning services by expanding services to all HIV+ women who intend to prevent unintended pregnancies
  - Provide Integration of family planning counseling and services including condoms provision into all RMNCAH and HIV services

- **Prong 3:**Expand access to more efficacious ARV regime (Option B+) for HIV infected pregnant women and HIV exposed infants within the RMNCAH platform and Scale up Provision of integrated Care and Treatment with RMNCAH services.
  - Strengthen routine offer of HIV testing to all pregnant women with unknown HIV status in ANC, maternity and post-natal care
  - Provide efficacious ARV/ART for the elimination of MTCT and to keep their mothers alive
  - Implement fully the integration policy for HIV and RMNCAH and all associated task-shifting and decentralization policies to ensure the effective and efficient implementation of PMTCT services.
  - Provide quality infant feeding counseling and support during ANC, delivery, post-natal and immunization clinics including during outreach service provision with the support of CHAs at the community level.

- **Prong 4:**Expand provision of appropriate treatment; care and support to HIV infected mothers and their infants and family
  - Procure and provide Cotrimoxazole prophylaxis to all HIV infected mothers and exposed children
  - Scale up HIV testing (Early Infant Diagnosis) to HIV exposed children according to guidelines
  - Scale up EID services in all PMTCT sites with operational sample transportation system to reference laboratory (in Monrovia via Riders for Health), timely results and feedback systems to health facilities and to the mothers involved.
  - Introduce or expand the use of mobile technology (mHealth) to follow up HIV infected women and exposed childrento ensure continuum of care and accuracy of data (social media, Short Messaging System etc). Other innovative approaches include; integrated HIV/EPI identification of HIV exposed infant, follow up and referral system within the Immunization and growth monitoring services in health facility and outreach.
    - Conduct high level advocacy for the procurement of ''thermo-mixers'' for the recalibration of the GeneXpert machines to conduct EID.
    - Reorganize the EID system with emphasis on proper sample collection and sample transportation from the county level to the central Laboratory for PCR Testing or testing via GeneXpert.

- Review the current turnaround time for EID and the processes involved and make it more effective and efficient.

- Provide ART to infants and children diagnosed with HIV within an integrated RMNCAH platform as a ''one stop shop'' service.
- Establish and operationalize HIV infected mother peer-to-peer (mother support groups) at least a minimum of one at each PMTCT site to conduct follow up and peer support
- Establish Breast feeding support groups at health facilities and communities for continued breastfeeding counseling and support to HIV infected mothers
- Engagement of HIV positive women with personal experience in PMTCT and ART as expert patients and mother peer-to-peer (mentor mothers) to provide education and peer psychosocial support to other women working in support of HCWs at facilities and at community level
- Pilot innovation in PMTCT services delivery by setting targets for the scale up of ART for EMTCT and EID testing to saturation levels among mother-baby pairs in the 3 counties by incentivizing performance.
    - Examples
        - Pilot an incentive mechanism for HCW or health facilities in the 3 counties who are able to achieve at least 95% coverage of ART access by HIV+ mothers and their infants as well as EID at 6-8weeks
- Establish 60new PMTCT sites in the 3 counties to deliver integrated RMNCAH services
- Train 300 midwives in the new PMTCT guidelines (Option B+)

Key results (PMTCT):

- **Prong1:**A minimum of 170,000 pregnant women will be offered HIV testing in the 3 counties by end of 2018 and an additional 190,000 from 2019 to 2020
- **Prong2**: 100% of all HIV positive women needing Family planning to prevent unintended pregnancies access Family planning services by end of 2018 and sustained to 2020.
- **Prong3**: The % of HIV+ pregnant women accessing ART for MTCT in the 3 counties will increase from 47% in 2015 to at least 80% by end of 2018 and at least 95% by end of 2020
- **Prong4**: Annually at least 90% of all HIV exposed infants will access Early Infant Diagnosis for HIV
- 60 new PMTCT established and operational
- 300 midwives trained to deliver integrated PMTCT services
- 380 mother peer-to-peer trained (see community system below)
- An incentive package for high performing facilities and staff offering high quality PMTCT services (>95% of all HIV+ pregnant women receiving a reward)

- **HIV Counselling and Testing.**
    - Intensify efforts in active case finding by focusing on high yield areas and populations at increased risk for HIV. Example, (Key populations FSW, MSM, PWID, prisoners, miners etc), TB patients, STI patients, malnourished children, sick children on admission, HIV exposed infants etc. Target STI clinics, EPI units, TB clinics, in-patient wards for HIV counselling and testing using the Provider Initiated Testing and Counselling. Couple testing and family centered service delivery will be highly encouraged.Where applicable, outreach/mobile HIV testing support will be provided by trained HCW to CSOs for targeted community-based HIV testing.
    - Two innovative initiatives will be piloted: (a) HIV self-testing in the 3 counties (especially for key populations and other groups of interest) with technical support from WHO and UNAIDS. Thelessons learned will inform national policy for nationwide scale up and (b) assisted partner notification/disclosurevia trained counsellors. This will help breach the male: female ART gap at least in these 3 counties.
    - Active Community sensitization and awareness will be conducted to include stigma reduction and know your right campaigns as well as know your status.
    - Train 250 HCW on stigma reduction within health settings
    - Provide technical support to increase capacity for HIV, health and human rights will mitigate stigma, discrimination and violence based barriers to HIV services.
    - The NAC will collaborate with Civil Society PRs and SRs working with key populationsto reach key populations via drop-in centers to access HIV testing services.
    - Scale up HIV testing with additional 50 HCT sites in health facilities in the 3 counties

Key results (HCT)

- A minimum of 710,000 adults will be tested for HIV in the 3 counties by end of 2018 and an additional 740,000 from 2019 to 2020.
- 250 health care workers trained in HCT.
- Additional 50 HCT sites added to the 3 sites by end of 2018

Antiretroviral Therapy

- Adopt and rapidly implement the 2016 WHO ''test and start'' guidelines
- Train 250 HCW to update them on the new guidelines
- Scale up facility based and community based treatment follow up – Motivate for adherence. – Initiate a role model program.
- Prioritize pre-ART patients in care to be on treatment
- Assess and establish additional ART sites especially in the high burden counties and strengthen partnership with private and faith based health facilities to provide treatment

- Deploy a differentiated care model by seeing sick patients more regularly whereas clinically stable patients will have longer refill/monthly scripting. Test other patient led innovative models for pharmacy refills which effective and efficientbased on the county context.
- strengthen treatment monitoring of patients by revitalizing viral load sample collection and transportation to the national reference laboratory for testing with GeneXpert using
- Leverage the support of PLHIV networks to follow up on peers lost to follow up, promote adherence and retention in care
- Prioritize active case finding of infants and children and provide them with ART in line with national guidelines
- Strengthen the quality of care through regular supportive supervision and feedback and training/mentoring/coaching of HCW
- Strengthen data quality by regularly undertaking data quality checks for accuracy, consistency, completeness and timeliness. This is important in informing consumption of logistics and for quantification and forecasting.
- Sensitization of HCW on stigma reduction within health settings to promote continuous service access and retention in care
- Strengthen communication around the benefits of ART and its impact on life expectancy and quality of Life (leverage ICT/new media) and promote adherence and facilitate retention in care

Key results (ART)

- At least by end of 2018 there will be a total of 45 ART sites (i.e additional 5 to the expected 40 sites committed by the Global Fund by 2017) established, equipped and functional in three countiesand a maximum of 50 ART sites by the end of 2020 (i.e a further addition of 5 sites).

- An additional 9,000[6]patients (8,000 adults and 1,000 children) will be put on treatment in the three counties by end of the first phase in 2018.

- An additional 6,300 patients (5770 adults and 530 children)will be put on ART in 2019 and 2020 (phase 2)

- 2016 WHO guidelines adopted and implemented fully
- 250 HCW trained on the new guidelines

TB/HIV Co-morbidity and other co-morbidities (HIV-HBV)

- Intensify efforts in case-finding for HIV in people attending TB care and for TB in people attending HIV care settings.
- Conduct joint planning, budgeting, joint program implementation, joint reviews.
- Co-locate ART and DOTS centers in all the implementing counties

[6]This target includes 1,600 PLHIV in the 3 counties who are in care but not on treatment (Pre-ART)

- Screenat least 90% of all HIV+ persons for Hepatitis B virus (HBV)[7]

Key results (TB-HIV co-infection)

- At least 90% of TB patients who had an HIV test result recorded in the TB register
- At least 90% of HIV-positive registered TB patients given anti-retroviral therapy during TB treatment in all 3 counties annually
- 100% of HIV-positive patients who were screened for TB in HIV care or treatment settings annually in all 3 counties annually
- At least 90% of HIV-positive patients who were screened for HBV in HIV care or treatment settings in all 3 counties annually

Procurement and Supply Management

- Strengthening the procurement and supply management will be prioritized in the 3 counties to ensure, adequate supply commodities (drugs, test kits, etc.) are in place for testing and treatment.

Key Actions (PSM)

- A sub-committee on PSM to be set up by the Minister of Health and will update the Minister monthly on the commodity situation for the implementation of this Catch up plan.
- Advocate for the Minister of Health to set up a sub-committee on commodities and supply chain management to provide monthly update on the stock situation in at least the 3 counties
- Conduct quick assessment and gap analysis in the three counties to inform quantification and forecasting
- Advocate for possible out-sourcing of the supply chain management system in the short-term (e.g to UNICEF or UNOPS) to rapidly respond to the logistics needs of the Catch up plan while at the same time efforts are made to address the systemic challenges faced by the MOH on PSM in the long term. (Note: it is unacceptable for about have of the HIV positive mothers not to have access to ARVs because of logistical challenges)
- Procure three vehicles (one for each county) and motor bikes as per the health districts in the three counties;
- Technical support provided to the MOH for capacity building of personnel in processes for procurement, quantification and forecasting.
- Support the automation of the logistic information system in line with the vision of the MOH.
- Procure adequate quantities of HIV test kits (including for self-testing and cartridges for EID, supplies for HBV), antiretroviral medicines,Family planning

[7]The HBV prevalence among blood donors in Liberia is 6.2%

commodities for HIV+ pregnant women and reagents to support the continuum of care and treatment for all PLHIVs.
- Advocate for County pharmacists and TB HIV Focal persons to be supported and made accountable
- Logistical support for monitoring and supervision

Key results for PSM

- Sub-committee on PSM set up and operational
- Uninterrupted supply of HIV commodities and equipments at the existing and new ART sites in the three counties by end of 2018;
- Equipments are regularly serviced and maintained to ensure functionality;

Key Actions: Community systems

- To ensure countywide active community involvement and participation in the implementation of the catch up plan, there will be the need for county consultations for buy-in and support.
    - Hold meetings with partners currently managing CHAs to agree on how CHAs can be leveraged to support the implementation of the Catch up plan
    - Maximize HIV testing coverage across the 3 counties via targeted community-based HIV testing with the support of CSOs/FBOs and CHAs.
    - Review of the existing policy guide on HIV testing for CHAs and other lay providers (e.g Expert patients in the PLHIV network) to perform HIV testing
    - Develop a community strategy for CHA's role in the scale of HIV testing at the community level, referrals, follow up on patients, adherence and psychosocial support
    - Train 4,000 CHAs in HIV counselling and testing
- Strengthen community systems and structures to deliver the community interventions service HIV care and treatment
    - Identify existing community organizations, civil society activities, local culture group activities and professional organizations that can be used to support and build capacity of community structures in implementing the catch up plan.
        - Hold meetings with partners currently managing CHAs to agree on how CHAs can be leveraged to support the implementation of the Catch up plan
        - To maximize HIV testing coverage across the 3 counties, a targeted community-based HIV testing program will be initiated. The existing policy guide on HIV testing will be reviewed to allow for CHAs and other lay providers (e.g Expert patients in the PLHIV network) to perform HIV testing
        - Develop a strategy for CHA's role in the scale of HIV testing at the community level, referrals, follow up on patients, adherence and psychosocial support
        - Train 4,000 CHAs in HIV counselling and testing

- Use the trained CHAs and Trained Traditional Midwives (TTMs) efficiently and effectively to deliver community based HIV related services including PMTCT and pediatric services and they should refer as necessary to the health facilities
- Train community organizations, PLHIV and civil society organizations, using gender sensitive and rights based approaches, on how to sensitize and capacitate local communities to support and deliver HCT, PMTCT and ART for adults and children.
    - Undertake quarterly community and awareness for Know your Status
    - Sensitize/mobilize and conduct monthly community outreach HIV testing services
    - Hold quarterly meetings between county health teams and traditional leaders
    - Develop referral linkages with the health facilities
- Set up county level Pediatric HIV care and treatment support groups, building on existing mother peer-to-peer groups for PMTCT.
- Engagement of the facility HCWs to monitor and supervise the CHAs and PLHIV networks in the community for effective implementation of the eMTCT plan
- Engagement of CHAs to provide HIV prevention information and promote HIV testing as a routine service in all RMNCAH sites (ANC, Maternity, Postpartum clinics, Child health/immunization clinics, Family planning clinics, STI clinics, outpatient clinics, outreach clinics etc) as well as advocatingfor couple HIV testing and counseling for all young women.
- Support CHWs to create demand for safe delivery services by skilled attendant in health facilities as well as utilization of postpartum care by actively tracking both mothers and infants.
- Engagement of HIV positive women with personal experience in PMTCT and ART as expert patients and mentor mothers to provide education and peer psychosocial support to other women working in support of HCWs at facilities and at community level

Key results (Community systems)

- Strategy and Guideline for community based testing developed and implemented
- 4,000community health assistants (CHAs) are trained (on HIV testing, Enhanced task-shifting, differentiated care models and community service delivery are implemented
- Train 850 Community health Services supervisors (CHSS)
- 380 mother peer-to-peer trained to mentor other HIV+ pregnant women/mothers
- Linkage to care, care delivery, adherence and retention), deployed, supervised and correctly remunerated.
- Community real-time monitoring system to report on availability of drugs, medical supplies and improved quality of care established and functional in at least 3 countries.

Funding strategy

Data from the National Health Account estimate of 7.44% shows Abuja Declaration of 15% GOL expenditure on health has NOT been met (2011/2012). However, domestic contribution for HIV and AIDS was 14.7% as against 4.7% by the Global Fund in 2011/2012.

Key actions (Funding)

- Engage development partners (donors) in Health to discuss and agree on mechanisms to increase the absorption rate of all existing external resources.
- The Government of Liberia to develop a resource mobilization strategy and organize a high level Investment forum to mobilize resources for the implementation of the plan.
- GoL to commit additional resources for the implementation of the catch up plan to ensure sustainability of the national HIV program.
- Utilize this catch up to access additional resources required to scale up in the 3 counties especially from the new funding cycle of the Global Fund (2017-2019).
- Mobilize CSO activism to hold Government and partners accountable with strong linkages to media partners (awareness creation on beneficiaries)
- Hold a high level meeting with the Minister of health to remove the bureaucratic bottlenecks leading to low disbursement of Global Fund resources for grant implementation.

Key Results (Funding):

- A high level donor forum organized to develop a roadmap for absorbing available external resources.
- A resource mobilization strategy developed and operationalized for investment into the plan.
- Domestic resources committed for the implementation of the plan as part of sustainability.
- Additional resources mobilized from the Global Fund for the implementation of the Catch up plan

Section V – Timeline

Table3 : Example of an GANTT implementation matrix

Programme areas	Expected results		Priority actions	Responsibility	Timeline																	
					M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18
HIV Counselling and Testing	**Expected Outcome 1 :**	Output 1.1: A minimum of 710,000 adults will be tested for HIV in the 3 counties by end of 2018 and an additional 740,000 from 2019 to 2020.	Action 1.1.1 Establish 60 new HCT sites	MoH																		
			Action 1.1.2 Pilot HIV self testing in at least one of the 3 counties (among key populations)	MoH/NAC/MoE																		
		Output 1.2: 250 health care workers trained in HCT and stigma reduction within health settings	Action 1.2.1 Conduct training for 250HCW in the new HCT sites and stigma reduction	MoH/NAC																		
		Output 1.3 4,000 community health assistants	Action 1.3.1 Review of the existing policy guide on HIV	MoH																		

Programme areas	Expected results		Priority actions	Responsibility	Timeline																	
					M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18
		(CHAs) are recruited, trained	testing for CHAs and other lay providers and Develop a community strategy for CHA's role in the scale of HIV testing at the community level																			
			Action 1.3.2 Conduct training for CHAs for community-based HIV testing	MoH																		
		Output 1.4 HIV self-test implemented (starting with key populations)	Action 1.4.1 Procure Technical assistance (from WHO/UNAIDS) for the implementation of HIV seilf-testing																			
		Output 1.5 Train 843 Community	Action 1.5.1 Conduct training for CHSS in each	MoH																		

Programme areas	Expected results		Priority actions	Responsibility	Timeline																	
					M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18
		health Services supervisors	county																			
	Expected Outcome 2	Output 2.1 A minimum of 170,000 pregnant women will be offered HIV testing in the 3 counties by end of 2018 and an additional 190,000 pregnant women tested from 2019 to 2020	Action 2.1.1 Establish 100 new integrated PMTCT sites	MOH																		
			Action 2.1.2 Train 300 midwives	MoH																		
		Output 2.2 380 mother peer-to-peer trained to mentor other HIV+ pregnant women/mothers	Action 2.1.3 Mobilize and train mother peer-to-peer groups	MoH																		
		At least 90% of all HIV exposed babies will access Early Infant Diagnosis for HIV annually																				
	Expected Outcome	Output 3.1 • An	Action 3.1.1 Establish 50	MoH																			

Programme areas	Expected results		Priority actions	Responsibility	Timeline																	
					M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12	M13	M14	M15	M16	M17	M18
	3 Increased uptake of ART coverage by 55% (16,000) by end of 2018 and 94% (23,400) by the end of 2020	additional 9,000[8] patients (8,000 adults and 1,000 children) will be put on treatment in the three counties by end of the first phase in 2018. • An additional 6,300 patients (5,770 adults and 530 children) will be put on ART in 2019 and 2020 (phase 2)	additional in the 3 counties																			
		Output 3.2 200 HCW trained on the 2016 WHO guidelines to initiate ART to patients in the new ART sites	Action 3.1.2 Integrated ART training for 200 HCW	MoH																		

[8]Inclusive of 1,600 patients who know their HIV status but not yet on ART (i.e Pre-ART)

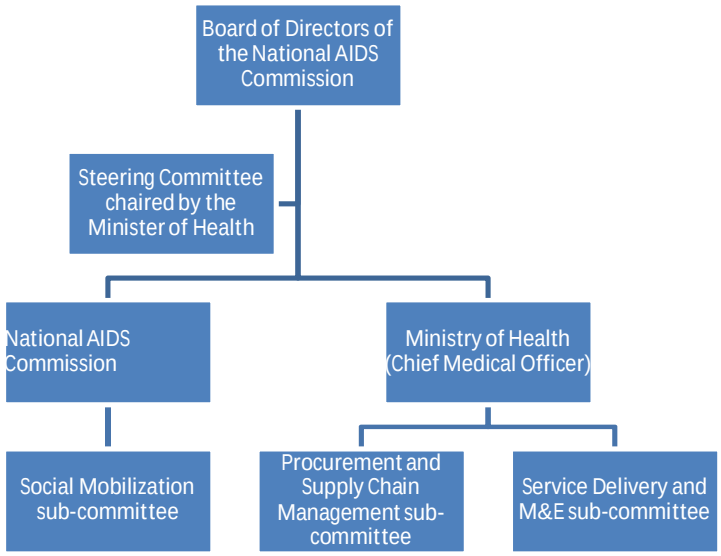
Section VI – Monitoring and evaluation

Governance of the Catch up Plan

The governance arrangement of this catch up plan is such that the Ministry of Health and vice chair of the Board of Directors of the National AIDS Commission, will lead the implementation of the plan and account directly to the Board of the AIDS Commission as well as to the funding partners. Civil Society Organizations and partners working at the community level will play a key role in the implementation of the community component of this catch up plan. A steering committee will be set up chaired by the Minister and will meet on quarterly basis in the first year (due to the urgency associated to this plan by the President). This steering committee will include the National AIDS Commission, National AIDS Control Program, Liberia Country Coordinating Mechanism, UN-partners, USAID and Civil society and Faith-Based Organizations. Sub-committees responsible for logistic and supply chain management, social mobilization and service delivery (HCT, PMTCT, ART) will be set-up and will meet monthly to address implementation bottlenecks and then present a one-pager report to the Minister for urgent action to be taken to unlock progress.The main recipients of funds for the implementation of this will be the MoH/NAC/PSI.

Accountability structure of the Catch up Plan

Figure 10: The accountability structure for the successful implementation of the Catch up plan



Overview of Monitoring and evaluation of the catch up Plan

Under the leadership of the Minister of Health there will be two levels: High level tracking of key performance indicators and operational management of the plan. The high level steering committee chaired by the Minister will review implementation and its associated performance indicators on monthly basis. The different sub-committees will provide updates on the operations whereas the M&E team will specifically provide data on key performance indicators via a dashboard. After the first year of implementation, the monitoring of the plan will revert to quarterly or biannually. The Minister, by her mandate as vice-chair will report on the Catch up to the Board of Directors chaired by the President.

Frequency of Reporting and Mechanism for assessing Results

Table 4: Tracking implementation for Results

	Activity	Responsibility	Frequency/Timeline
1	Supportive supervision to the site and feedback for quality improvement	NAC/NACP/PSI	Monthly
2	Data quality checks (on-site data verification)	NAC/NACP/PSI	Monthly
3	Data analysis and visualization and reporting	NAC/NACP	Monthly
4	Review meetings to validate program results	MOH/NAC	Biannually
5	Publication and dissemination of results	MoH/NAC	Quarterly/Annually
6	Mid-Term and Final Reviews of the catch up plan	NAC/MOH	Mid-term review in 2018 and Final review in 2020

Section VII – Costed workplan

The table below shows the budget summary by key program areas.

Table 5: Budget Summary

	2018	2020
Sub-Total HCT	$3,747,580 (36%)	$2,054,520 (23%)
Sub-Total PMTCT	$2,959,991 (29%)	$4842794 (54%)
Sub-Total ART	$2,702,720 (26%)	$1,492,708 (17%)
Sub-Total M&E	$429,000 (4%)	$279,000 (3%)
Sub-Total Program Management	$450,000 (4%)	$360,000 (4%)
Total	$**10,289,291**	$**9,029,022**

The detailed costed workplan is shown in the table below.

Table 6: Costed Workplan

	Phase 1--Expected Outcome (1a): A least 27% of the adult population (15+years) will be tested in addition to the national target by end of 2018. **Phase 2--Expected Outcome (1b): About 28% of the adult population (15+years) will be tested in addition to the national target by end of 2020.**				
Programme areas	**Expected outputs**	**Priority actions**	**Responsibility**	**Estimated cost (US$) (2018)**	**Estimated cost US$ (2020)**
1. HCT	Output 1.1 HIV Self testing (HST) successfully piloted in the 3	Action 1.1.1: Procure International TA Action 1.1.2 Set up local committee for HST			

	counties	Action 1 .1.3 Procure logistic (test kits) Action 1.1.4 Meetings and trainings	MOH/UN-partners/PSI	350,000	350,000
	Output 1.2 Xx Communities mobilized for HCT	Action 1.2.1 Active Community mobilization and sensitization for HCT via 5 CSOs	NAC	500,000	300,000
	Output 1.3 50 new HCT sites established	Establish 60 new HCT sites in the 3 counties	MOH	600,000	
	Output 1.4 250 HCW trained for HCT	Train HCW to conduct HCT	MOH	100,000	
	Output 1.5 850 CHSS trained	Train CHSS to provide supportive supervision of CHAs	MOH	250,000	
	Output 1.6 4,000 CHAs trained for HCT	Train CHAs on HCT and to support continuum of care of PLHIV	MOH/PSI	600,000	
	Output 1.7 Test kits for HCT procured 710,000 for phase1 and 740,000 for phase 2	Procure test kits	MoH	1,347,580	1,404,520
Sub-total (HCT)				**3,747,580**	**2,054,520**
	Expected Outcome 2:The Percentage of HIV-positive pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission is increased from 47% in the three high burden counties to at least 80% by end of 2018 (phase 1) and to at least 95% by 2020 (phase 2).				
Programme areas	**Expected outputs**	**Priority actions**	**Responsibility**	**Estimated cost (2018)**	**Estimated cost (2020)**
2. PMTCT	Output 2.1 60 new PMTCT sites established	Action 2.1.1 Establish 60 new PMTCT sites	MOH	600,000	
	Output 2.2 380 Mother peer-to-peer recruited and trained	Action 2.2.1 Recruit and train Mother peer-to-peer groups	MoH	60,000	
		Action 2.2.2 Transportation for mother peer-to-peer	MoH	275,000	275,000
	Output 2.3	Action 2.3.1	MoH	115,000	

	300 midwives trained on Option B+	Train Midwives on Option B+			
	Output 2.4 Logistics for PMTCT Procured (Test kits, EID, ARVs)	Action 2.4.1 Procure PMTCT logistics (Test kits)	MoH	293,760	328,320
		Action 2.4.2 Procure PMTCT logistics (ARVs)	MoH	719,100	803,700
		Action 2.4.3 Procure PMTCT logistics (EID)	MoH	38,100	42,582
		Action 2.4.4 Procure PMTCT logistics (Lab reagents for pregnant women)	MoH	360,273	432,007
		Action 2.4.5 Procure PMTCT logistics (Syphilis)	MoH	348,758	389788
		Action 2.4.6 EID Sample collection and transportation	MOH	50,000	50,000
	Output 2.5 50% or more facilities benefited PMTCT incentive scheme for quality work done	Action 2.5.1 Establish an incentive mechanism for facilities who achieve >95% of ARV access to HIV+ pregnant women	MOH	100,000	100,000
Sub-Total (PMTCT)				**2,959,991**	**4,842,794**
	Expected Outcome 3: **Increased uptake of ART coverage by 55% (16,000) by end of 2018 and 94% (23,400) by the end of 2020**				
Programme areas	**Expected outputs**	**Priority actions**	**Responsibility**	**Estimated cost (2018)**	**Estimated cost (2020)**
3. ART	Output 3.1 2016 Treatment Guidelines Adopted and implemented	Action 3.1.1 Organize a retreat to revise and adopt the new WHO 2016 Guidelines	MoH	25,000	
		Action 3.1.2	MoH	100,000	

		Print the revised guidelines			
	Output 3.2 50 additional ART sites established	Action 3.2.1 Establish 50 additional ART sites	MoH	350,000	200,000
	Output 3.3 250 HCW trained on the new WHO ART Guidelines	Action 3.3.1 Provide training for 250 HCW on the revised Guidelines	MOH	137,500	
	Output 3.4 LIBNEP+ is supported to follow up on patients on ART	Action 3.4.1 Contract LIBNEP+ to provide support to PLHIV as part of continuum of care (adherence support, retention in care, track patients lost to follow up etc)	MoH	200,000	100,000
	Output 3.5 Logistics/Commodities procured for 23,400 patients by end of 2020 (Lab test, ARVs etc)	Action 3.5.3 Logistics for Lab test (baseline and follow up) for adult and Children		530,381	468,819
		Action 3.5.4 Logistics for ART for Children		95,467	95,467
		Action 3.5.5 Logistics for ART for Adult		1,103,836	965,856
		Action 3.5.6 Procurement agent fees		222,536	262,566
Sub-total (ART)				**2,702,720**	**1,492,708**
Expected Outcome	**Key performance indicators achieved**				
Programme areas	**Expected outputs**	**Priority actions**	**Responsibility**	**Estimated cost (2018)**	**Estimated cost (2020)**
4. M&E	Output 4.1 Key performance indicators (KPIs) have been tracked adequately	Action 4.1.1 Monthly monitoring/supervision at the program level	MoH/NAC	100,000	100,000
		Action 4.1.2	MoH/NAC	20,000	

		Develop a performance dashboard to track the KPIs			
		Action 4.1.3 Conduct on-site Data quality checks	MoH/NAC	60,000	60,000
		Action 4.1.4 Conduct Data analysis, data visualization and data use fora	MoH/NAC	50,000	50,000
		Action 4.1.5 Organize Biannual program review meetings	MoH/NAC	50,000	50,000
		Action 4.1.6 Conduct Mid-term and End-line program review	MoH/NAC	100,000	100,000
		Action 4.1.7 Build M&E capacity in data collection, collation, analysis, visualization, data use and dissemination	MoH/NAC	70,000	30,000
Sub-total				**429,000**	**279,000**
Expected Outcome	**The Catch up plan has been effectively and efficiently implemented and lessons learned/best practices documented and disseminated**				
Programme areas	**Expected outputs**	**Priority actions**	**Responsibility**	**Estimated cost (2018)**	**Estimated cost (2020)**
5. Program Management	Output 5.1 Catch plan managed effectively and efficiently	Action 5.1.1 Conduct a National launch and then a county level start up meeting	MOH/NAC	20,000	
		Action 5.1.2 County level monthly meetings	MOH/County Health teams/County local governments	15,000	15,000
		Action 5.1.3 Central level quarterly meeting	MOH	10,000	10,000
		Action 5.1.4 Biannual Board meeting	NAC/MOH	4,000	4,000

		Action 5.1.5 Quarterly media briefing	MOH	20,000	20,000
		Action 5.1.6 Engage community radios at county level to mobilize people	NAC	30,000	30,000
		Action 5.1.7 Engage the mobile communication networks to develop a communication package for patient follow up and feedback mechanism of EID results, dissemination of HIV prevention/know your status information via social media	NAC	250,000	200,000
		Action 5.1.8 Procure technical assistance for the development of a resource mobilization strategy followed by the organization of a donor forum	NAC	80,000	
Sub-total				**450,000**	**360,000**
Grand Total				$**10,289,291**	$**9,029,022**