National AIDS Commission

Liberia National HIV Prevention Strategy

2017 - 2020

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Abbreviations and Acronyms

Acronym	Description
AIDS	Acquired Immune Deficiency Syndrome
ABC	Abstinence, Be faithful, use Condoms
ANC	Antenatal Care
ARV	Antiretroviral (medicine)
CBO	Community-based Organizations
DIC	Drop-In Centre
eMTCT	Elimination of Mother-to-Child-Transmission
EID	Early Infant Diagnosis
FBO	Faith-based Organization
FSW	Female Sex Workers
GNP+	Global Network of PLHIV
HIV	Human Immunodeficiency Virus
IBBSS	Integrated Bio-Behavioural Surveillance Survey
ISY	In-school youth
KAPB	Knowledge, Attitudes, Practices and Behaviour
LDHS	Liberia Demographic and Health Survey
LIBNEP+	Liberian Network of PLHIV
MCH	Mother and Child Health
MIA	Ministry of Internal Affairs
MOE	Minitry of Education
MGCSP	Ministry of Gender, Children and Social Protection
MOH	Ministry of Health and Social Welfare
MOJ	Ministry of Justice
MSM	Men who have sex with men
MTCT	Mother-To-Child Transmission
NACP	National AIDS Control Program
NDS	National Drugs Service
NGO	Non-governmental organisation
NSP	National (HIV & AIDS) Strategic Plan
OS	Operational Strategy
OSY	Out-of-school youth
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PLHIV	People Living With HIV
PMTCT	Prevention of Mother-To-Child Transmission
PrEP	Pre-Exposure Prophylaxis
PWID	People who inject drugs
PWUD	People Who Use Drugs
SAIL	Stop AIDS Liberia
SDG	Sustainable Development Goals
SGBV	Sexual and Gender-Based Violence
STIs	Sexually Transmitted Infections
SOP	Standard Operating Procedure
TG	Transgender people
ULPIRE	University of Liberia Pacific Institute for Research and Evaluation
UNAIDS	Joint United Nations Programme on AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office against Drugs and Crime
USP	Uniformed services personnel

Contents

Executive Summary

This HIV prevention strategy for Liberia is built on the following principles, based on input from a wide array of stakeholders:

- The approach to HIV prevention is evidence-informed: evidence and verifiable data are underpinning the priorities and operational strategies in the current strategy and evidence also drives future directions.
- The approach to HIV prevention is rights-based: it respects and promotes human rights, while fighting stigma and discrimination.
- The approach to HIV prevention is community driven: it is based on meaningful involvement and participation of key populations and communities in all stages of intervention, including development, implementation, monitoring and evaluation.
- The approach to HIV prevention is multi-sectorial: this strategy recognises that HIV is not only a health problem but acknowledges that also behavioural, social, cultural, legal and religious aspects have an impact on HIV prevalence and incidence. The key development sectors that have a bearing on HIV prevention are: health and community systems strengthening, education, justice, gender, and social protection.

As such this HIV prevention strategy is aligned with the main national and international strategies and policies.

This HIV strategy also takes into account critical social and programmatic enablers, such as:

- Laws, policies, and practices;
- Stigma and discrimination;
- The role of the media;
- Political commitment and leadership;
- Advocacy;
- Human and financial resources;
- Community participation;
- Coordination and management;
- and Research, Monitoring and Evaluation.

This strategy is based on a thorough analysis of existing data about HIV in the general population, including adolescents and youth, and recognises that women, especially young women, are at a disadvantage in Liberia when it comes to HIV. In women, up to the age of 29, HIV prevalence is almost twice the prevalence in men. At the same time this strategy focuses on key populations, such as men-who-have-sex-with-men, transgender people, sex workers, people who inject drugs, prisoners. Key populations have a considerably elevated risk to get HIV, which may be 3-10 times the risk in the general population. People living with HIV are a key population because they play a key role in preventing the further spread of HIV through “positive prevention”. In addition, they suffer considerable stigma in Liberian society, like the other key populations. Liberia also has other groups that have a higher than average risk of acquiring HIV, such as mobile traders and miners, transport workers and staff of the uniformed services – law enforcement agencies and the military. Individuals from these

groups may be (potential) clients of sex workers because the men often spend time away from their families. Thus, these vulnerable groups form a bridge population for the spread of HIV to the general population, as they also have sex with their own partners. The higher HIV prevalence among women in these groups relative to men (e.g. figure 4, p. 21) underscore that the increased vulnerability of women to HIV is augmented in these groups. Compared to key populations, these groups are less stigmatised.

The evidence in this strategy shows that an HIV prevention strategy that includes key and vulnerable populations is of paramount strategic importance for Liberia to achieve its ambition:

A reduction of 50% in new HIV cases by 2020.

At the same time, HIV also affects the general population. Although the term general population suggests one group, in reality the general population can also be approached in a more granular fashion, based on epidemiological evidence.

Available evidence already shows that prevalence is higher in urban than in rural settings. It is also clear that young women are disproportionately affected. Therefore, the strategic focus for HIV prevention is in the general population is to give priority to i) addressing young women and girls and ii) urban areas and high burden counties.

Overall Objective(s)[1]

To stop new HIV infections − in key populations as well as in the general population of Liberia − and keep PLHIV in Liberia alive and healthy.

Specific objectives, including:

- Reduction of new HIV infections among the general population, particularly young women.
- Reduction of new HIV infection among men-who-have-sex-with-men, transgender people, people who inject drugs, sex workers, prisoners, uniformed services personnel, mobile traders, miners and transport workers (by 50%).
- Elimination of HIV related stigma and discrimination, including stigmatisation and discrimination of key populations.

Operational strategies:

Operational Strategy 1: To develop and implement, with meaningful involvement of the populations concerned, evidence-based, comprehensive HIV prevention, protection, treatment, care and support services that are adapted to the needs of the target populations.

[1] Taken from the National HIV & AIDS Strategic Plan 2015-2020

Operational Strategy 2: To create an enabling environment for HIV prevention interventions through focused advocacy, community engagement, community systems strengthening to i) address barriers (social, cultural, religious, political, and legal) to effective interventions and ii) reduce vulnerability, stigma and discrimination related to HIV and to key and vulnerable populations iii) reduce stigmatising and discriminatory attitudes in the general population that hamper effective HIV prevention.

Operational Strategy 3: To strengthen the evidence-base and monitoring systems and to promote the generation of strategic information to improve HIV programming and inform key stakeholders and decision makers.

Operational Strategy 4: To strengthen coordination among stakeholders and strengthen systems to effectively deliver comprehensive HIV prevention services for the general population, particularly for young women, and for key and vulnerable populations.

Subsequent sections in this strategy document outline packages of key interventions that are tailored to each of the target groups, based on the interventions proposed by the National HIV and AIDS Strategic Plan 2015-2020 (NSP):

- Behaviour change communication interventions
- Condom and condom-compatible lubricants promotion and distribution
- Psychosocial support (for youth and key populations)
- Provision of HIV Counselling and Testing (HCT) services (including at friendly health facilities or outreach to hotspots)
- Management of sexually transmitted infections (STIs)
- Ensuring blood safety
- Provision of Post-Exposure Prophylaxis (PEP)
- Prevention of mother-to-child transmission of HIV
- Linking PLHIV into Treatment, Care, and Support

Operational strategy 1

The mainstay of the approaches for key and vulnerable populations will be community, peer-driven interventions that must be based on assessments of the needs, knowledge, attitudes and practices of the target group. Peer-driven links into prevention, care and treatment will be essential to arrive at a more robust treatment cascade. Drop-in centres and case management approaches are ways to provide good quality and integrated services for key populations. For specific groups, innovative prevention services may be introduced if acceptable for the target group, e.g. Pre-exposure prophylaxis with antiretroviral drugs for men-who-have-sex-with-men, transgender people and sex workers. Likewise, comprehensive harm reduction services, including needle and syringe programmes and opioid substitution treatment, will be made available to people who inject drugs, including to those in the prison system.

Operational strategy 2

Operational strategy 2 focuses on documenting and reviewing legislations that may have a negative influence on the HIV response, and establishing legislations and policies that are non-discriminatory, rights-based and gender friendly. A second pillar is the creation of rights-based approaches, empowering key populations to fight stigma and discrimination, while enhancing their access to legal support. This strategy also includes a substantial training component to enhance non-discriminatory, rights-based and gender friendly practices among health care providers and uniformed services personnel. Attention to SGBV is to be part and parcel of this approach.

Operational strategy 3

Since there is a paucity of data on key and vulnerable population as well as on young people regarding their sexual behaviour, sexual and reproductive health needs and HIV knowledge, it is essential to strengthen research and data collection to assist the HIV response. Priority is to be given to research to arrive at accurate size estimates of key populations, and surveys that assess knowledge, attitudes and practices relevant for HIV prevention. Meanwhile, existing data collection such as the integrated bio-behavioural sero surveys (IBBSS) should be enhanced and strengthened. It is important that operational research observe ethical standards and includes affected communities in the design, implementation and publication of the study results; this implies that capacities of communities to be engaged in this type of research has to be built.

Operational strategy 4

Since this HIV prevention strategy is a multi-sectorial one, coordination among stakeholders and strengthening of health- and community systems is pivotal to deliver this strategy. This includes line ministries, the private sector, CBOs (including those of the affected populations, but also faith-based organisations), the UN family (particularly UNAIDS) and the international community. The National AIDS Commission has an important role in overseeing the implementation of this strategy. This strategy includes a performance framework with indicators and targets related to the operational strategies and key and vulnerable populations.

This strategy is a costed one, based on internationally accepted unit costs. The total cost over the strategy period 2017-2020 is around USD 170 million. Specific key population strategies will cost just over USD 11 million over the strategy period, 6.5% of the total budget.

Introduction

In the post-war years, Liberia has set out a course to strengthen its capacity and systems to achieve the Millennium Development Goals and their successors, the Sustainable Development Goals (SDGs). The SDG 3, health, aims to "end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases" by the year 2030. The end of HIV and AIDS by 2030 was reaffirmed in the Political Declaration on HIV and AIDS "On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030", adopted at the UN General Assembly on June 7, 2016.

Liberia has taken up the challenge to respond to these epidemics, including HIV and AIDS. Two strategic plans and several technical guidelines on the subject, published in the recent years, are witness to Liberia's efforts to respond to the HIV epidemic.

Although the epidemic stands at a low level for African standards, there is evidence of a gradual increase of the adult HIV prevalence over the past years from 1.4% in 2007 to 1.9% in 2013. There is also emerging evidence that young women and girls, and key and vulnerable populations, for instance men-who-have-sex-with-men (MSM), sex workers (SW), and people who inject drugs (PWID), have high prevalence rates of HIV.

So far, the approach in HIV prevention has been to respond to a generalised epidemic, whereas the current developments bear characteristics of an epidemic that is concentrated in certain parts of the population. The current epidemiology of HIV in Liberia requires proper attention, reflected in a separate HIV prevention strategy (something the country did not have before) that is targeted to groups at risk, focuses on high prevalence areas and emphasises approaches to reach key and vulnerable populations.

With such an HIV prevention strategy Liberia will be well equipped to realise good quality HIV prevention services for its population, and will thus be able to work towards the end of HIV in Liberia.

Key principles of the HIV prevention strategy

This HIV prevention strategy for Liberia is built on the following principles, based on input from a wide array of stakeholders:

- The approach to HIV prevention is evidence-informed: evidence and verifiable data are underpinning the priorities and operational strategies in the current strategy and evidence also drives future directions.
- The approach to HIV prevention is rights-based: it respects and promotes human rights, while fighting stigma and discrimination.
- The approach to HIV prevention is community driven: it is based on meaningful involvement and participation of key populations and communities in all stages of intervention, including development, implementation, monitoring and evaluation.
- The approach to HIV prevention is multi-sectorial: this strategy recognises that HIV is not only a health problem but acknowledges that also behavioural, social, cultural, legal and religious aspects have an impact on HIV prevalence and incidence. The key development sectors that have a bearing on HIV prevention are: health and community systems strengthening, education, justice, gender, and social protection.

As such this HIV prevention strategy is aligned with the main national and international strategies and policies. On the national level is aligned with the National HIV & AIDS Strategic Plan 2015-2020 (NSP). (National AIDS Commission (NAC) 2014) Liberia's HIV prevention strategy internationally aligns itself with the Sustainable Development Goals for 2030, the UNAIDS 90-90-90 strategy, UNAIDS' Fast-tracking the HIV Response, and uses best practices and WHO guidelines to set the standards for implementation of the HIV prevention strategy.

Local evidence that informs this strategy comes from local research and governmental studies, such as the Integrated Bio-Behavioural Surveillance Survey (IBBSS) (Liberia Ministry of Health and Social Welfare 2013) as well as from community-driven research such as the HIV Stigma Index. (LIBNEP+ 2013) The Literature section at the end of this document lists the publications that are informing this HIV prevention strategy.

This HIV strategy also takes into account critical social and programmatic enablers, such as:

- Laws, policies, and practices;
- Stigma and discrimination;
- The role of the media;
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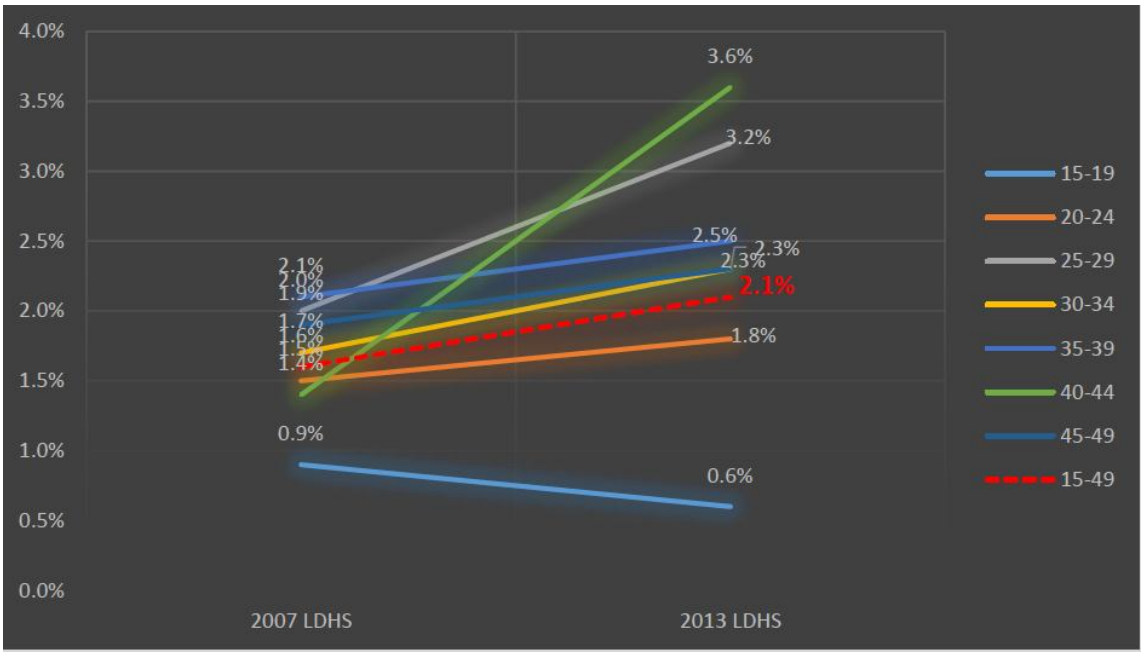
The HIV situation in Liberia

General population perspective

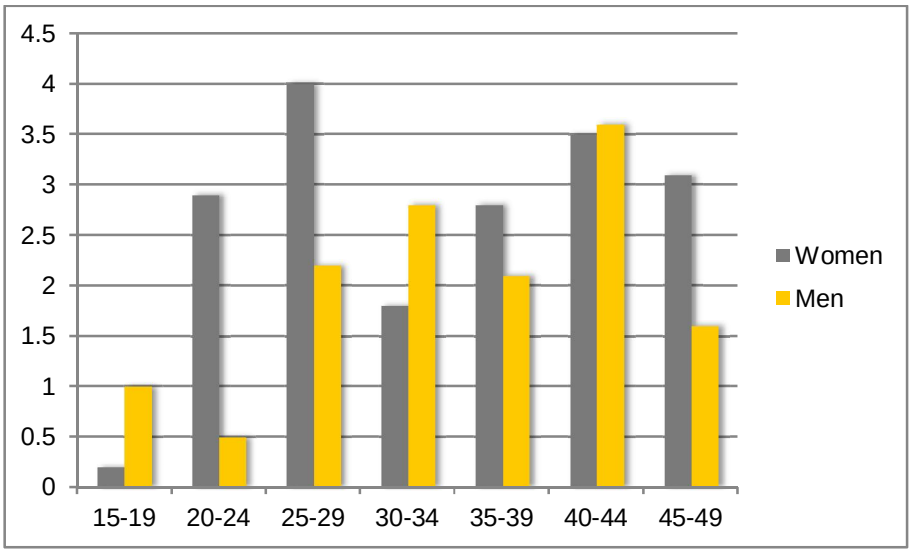
The HIV epidemic in Liberia is considered to be a low-level generalised epidemic. The main modes of transmission are heterosexual contact and perinatal transmission. Blood transfusion, medical transmission and use of non-sterilised needles still occur. The current adult population prevalence of HIV is 2.1%. This is the combined prevalence of the HIV-1 and HIV-2 infections in the country. As depicted in Figure 1 below, there was an increase in all age ranges except for people aged 15 – 19 years where there was a drop in prevalence from 0.9% to 0.6%. Youth in school has a relatively low HIV prevalence (1.1%) with no significant difference between male (1.3%) and female (1.0%) school youth. Among out of school youth (OSY) the prevalence is higher than in in-school youth, being 1.9%; male OSY has higher HIV prevalence (2.3%) than female (1.4%).

Figure 1. Trends in HIV prevalence by age group, Liberia 2007-2013



According to the Liberia Demographic and Health Survey (LDHS) of 2013, (Liberia Institute of Statistic and Geo-Information Services (LISGIS) 2014) the main mode of transmission is sexual. Women and girls are disproportionally affected. The adult HIV prevalence of HIV-1 and HIV-2 combined is 2.4% in women and 1.8% in men.

Figure 2. HIV-1 or HIV-2 Prevalence (%) by age and sex



Source: LDHS, 2013

There are substantial urban-rural differences in HIV prevalence.[2] HIV prevalence in urban settings is 2.6%, with Greater Monrovia showing a peak of 3.2%, whereas in rural settings 0.8% of the adult population of 15-49 years old is living with the virus. The population of Liberia is about equally divided between urban and rural settings.

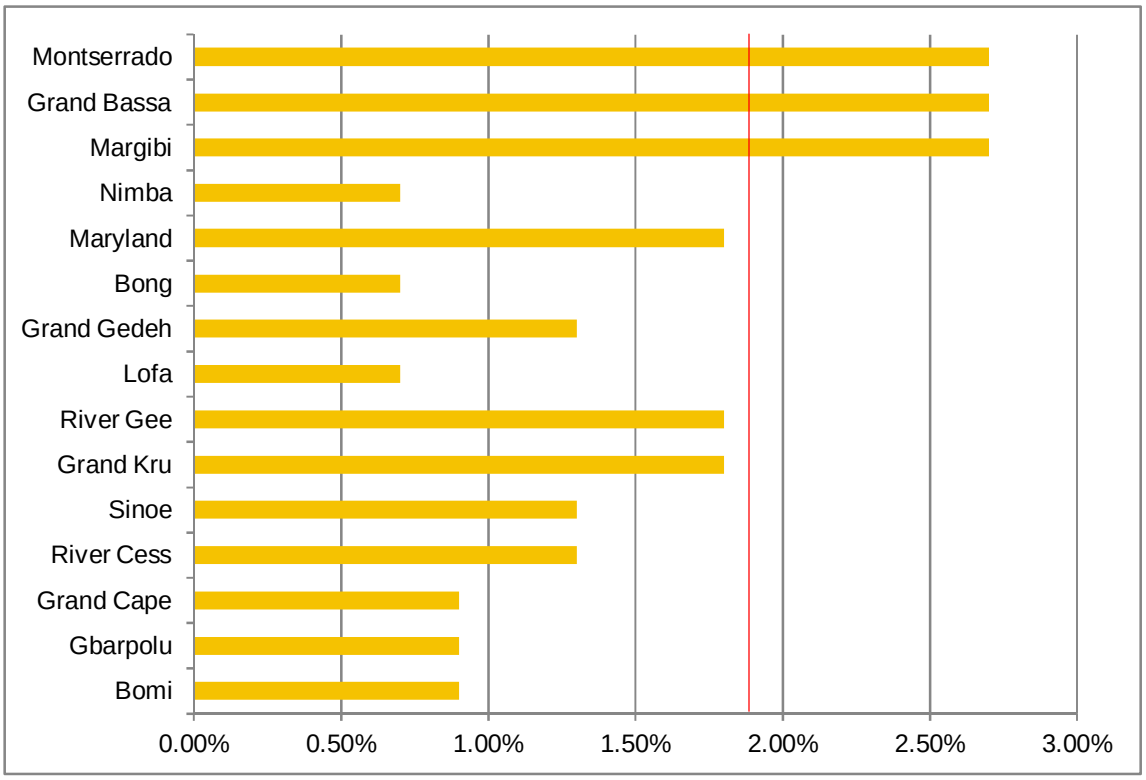
The distribution of HIV across the Liberian counties largely reflects the urban-rural divide. Prevalence is 2.7% in Montserrado county where Monrovia is located (Figure 3, next page). According to the 2008 census, Montserrado county alone harbours almost one-third of the Liberian population. Other counties with an equally high prevalence are Grand Bassa and Margibi.

HIV shows no association with education but there is a positive association with wealth. Prevalence is higher in the wealthier quintiles of the population. For women, HIV prevalence increases from 0.7 percent among those in the lowest wealth quintile to 3.5 and 3.0 percent among those in the highest two wealth quintiles, respectively. For men, HIV prevalence increases from 0.8 percent among those in the lowest wealth quintile to 3.5 percent among those in the highest.

In terms of new infections, the latest available UNAIDS Spectrum Modelling estimates for 2014 reveal there will be 1,789 new HIV infections including 309 in children 0-14 years. There will be 29,538 PLHIV including 2,730 in young people 15-24 years and 4,784 children 0-14 years.

Figure 3. HIV prevalence by county

[2] In this document, HIV without further specification (as in HIV-1 or HIV-2) must be understood as HIV-1



Source: NACP, 2014

Gender perspective

Looking at general population data related to HIV, women − especially young women − are at a disadvantage in Liberia. There are some background characteristics of Liberian women that must be considered when implementing HIV prevention programmes that target (young) women. Evidence from the LDHS for instance shows that 48% of women never attended school, against 33% of men. Literacy rate is 71% among men but 48% among women; young and urban women are more likely to be literate, however. Young women of 15-19 years old have high unmet needs for family planning. Fifty-one percent of nonusers of family planning services did not discuss their needs with a field worker or health staff.

In women, up to the age of 29, HIV prevalence is almost twice the prevalence in men. Prevalence among pregnant women is 5.3%. The UNAIDS Spectrum model predicts that about 57% of the new infections will be in females.

There are societal habits that reflect the vulnerable position of women in general in Liberian society and that have an impact on young women's vulnerability to HIV. For example, in terms of relationships it is very common that young women have sexual relationships with older men who could already have been exposed to HIV or a sexually transmitted infection (STI). The findings of the 2013 LDHS support this line of thought. Eleven percent of women between 15-19 years old had sex with a man who was ten or more years older. Less than 1%

of men had sex with a much older woman. Of young women, 23% had sex before the age of 15; this was the case in 9% of young men. Fifty percent of women and 17% of men reported having an STI or STI symptoms in the 12 months preceding the survey, which is a proxy of increased HIV risk in women.

Condom use in women is lower than in men. Condom use at last sex during the past 12 months was 22.3% in women and 45.2% in men, while 22.3% of young women who had 2 or more sexual partners used condoms the past 12 months. Of young men, 32.4% used condoms. These LDHS data do not so much reflect knowledge of condom use in young women, but more the lack of empowerment to negotiate safe sex among women in Liberian society. Testing for HIV among young men and women is low, but still twice as high in women than in men: 21% of women of 15-24 years who had sex tested for HIV and received results. In men, this is less than half (9.7%) of the percentage in women.

Women are more aware than men that HIV can be transmitted through breastfeeding (71 percent versus 52 percent) and that the risk of mother-to-child transmission (MTCT) can be reduced by taking special drugs (58 percent versus 35 percent). Overall, 51 percent of women and 27 percent of men are aware that HIV can be transmitted through breastfeeding and that taking special drugs can reduce this risk. Compared to older age groups, young women and men have higher MTCT knowledge.

Key and vulnerable populations perspective[3]

There are groups in Liberian society that show higher rates of HIV than the general population. These groups comprise the *key populations*, defined by UNAIDS as groups with elevated risk who are also otherwise stigmatised and marginalised in society such as men-who-have-sex-with-men (MSM), transgender people (TG), (female) sex workers ((F)SW), and people who inject drugs (PWID). In most contexts, prisoners as well as people living with HIV would also be considered as key population. People living with HIV are a key population because they play a key role in preventing the further spread of HIV through "positive prevention". At the same time they suffer considerable stigma in Liberian society. Only 6.6% of women and 14.4% of men express an overall supportive attitude towards PLHIV.

Liberia also has other groups that have a higher than average risk of acquiring HIV, such as mobile traders and miners, transport workers and staff of the uniformed services – law enforcement agencies and the military. Individuals from these groups may be (potential) clients of sex workers because the men often spend time away from their families. Thus, they form a bridge population for the spread of HIV to the general population, as they also have sex with their own partners. The higher HIV prevalence among women in these groups relative to men (e.g. figure 4, p. 21) underscore that the increased vulnerability of women to HIV is augmented in these groups. Compared to key populations, these groups are less stigmatised; they still require tailored approaches in HIV prevention. For the sake of this

[3] Unless stated otherwise, data about key and vulnerable populations come from the IBBS 2013.

document they will be called 'vulnerable populations' in order not to confuse them with the internationally agreed definition of key populations.

There is a paucity of data regarding HIV among most at-risk populations, especially about the key populations as earlier mentioned. There are few prevalence estimates, let alone incidence studies, KAPB research, or accurate information on geographical spread of these populations. The Liberia IBBSS (Liberia Ministry of Health and Social Welfare 2013) has established the most recent data about HIV prevalence among key populations using sound methodologies. In order to prioritise and plan interventions for key and vulnerable populations it is not only important to know prevalence rates; it is important to have an estimate of the size of each of the key and vulnerable populations as well. The only size estimates that have become available for Liberia are from 2011 and comprise MSM, (female) SWs and PWID only. As key populations are stigmatised and marginalised, they tend to hide themselves from the authorities and from research. Hence group sizes are inherently challenging to estimate; the available estimates are believed to underestimate the true population size of each group by several times. For instance, while the MSM population estimate for Liberia is 711 individuals, neighbouring Sierra Leone, which has an HIV epidemic with similar characteristics to Liberia with a slightly larger population size, estimates its MSM population to be 20 000 (National AIDS Secretariat 2015). Estimates for female SW and PWID in Sierra Leone also exceed those for Liberia several times.

While for clarity’s sake the information in this strategy is categorised along key and vulnerable populations, it must be borne in mind that belonging to one group does not necessarily exclude belonging to another. For example, there are MSM who also inject drugs, and SWs may double as mobile traders.

Table 1. key and vulnerable population population size, HIV prevalence and adult sexual behaviours (%)

	Transport Workers	Miners	Mobile Traders (M)	Mobile Traders (F)	Uniform Services	FSW	MSM	PWID
Population size*	25 000	17 000 - 20 000	n/a	n/a	4650	1822	711	457
Source: 2013 IBBSS								
HIV prevalence (%)	4.8	3.8	4.5*****		5.0	9.8	19.8	3.9
Ever had sex (Yes) (%)	95.1	95.1	94.2	95.5	96.4	100	100	91.3
N	*506*	*491*	*313*	*308*	*504*			*300*
Early sex (Sex before age 15)	12.9	9.2	16.3	9.2	8.0	30.5	26.4	23.7
Mean age at first sex						16.3	20.6	16.7
Condom use at last sex (%)	30.4	25.5	36.3	29.6	26.1			
No condom use at last sex with any type of partner (%)	68.8	72.6	62.4	63.9	71.8		60.6	63.1
Had Sex last 3 months (%)	74.6	65.7	74.2	71.4	77.6			
Sex with paying partners last 3months (%)	16.4	14.1	18.6	10.5	9.1			
Sex with non-paying partners last 3 months (%)	72.6	63.0	70.5	70.7	70.3			
N*	*481*	*467*	*295*	*294*	*486*			*274*
Condom use at last sex with paying partner (%)	72.3	54.5	76.4	67.7	47.7	81.8	20.7	58.6
Number of Paying sexual partners last 3 months								
1 (%)	35.4	30.3	34.5	32.3	52.3			15.3
2 (%)	24.1	30.3	18.2	29.0	18.2			25.2
3+ (%)	40.5	39.4	47.3		38.7	29.5		59.5
N*	*79*	*66*	*55*	*31*	*44*			*111*
Sexual behaviours with Non-Paying partners last 3 months (%)						46.3		25.9
Condom use at last sex with Non-paying partner (%)	29.5	18.0	25.5	30.8	28.8			
Number of non-paying sexual partners last 3 months (%)								
1	73.4	77.9	74.0	85.1	79.8			68.5
2	17.5	13.3	13.5	13.0	13.2			15.4
3	9.2	8.8	12.5	1.9	7.0			16.0
N*	*349*	*294*	*208*	*208*	*371*			*162*

*) Not from IBBSS. FSW, MSM, and PWID: Size Estimation of Sex Workers, Men who have Sex with Men, and Drug Users in Liberia (University of Liberia Pacific Institute for Research and Evaluation (ULPIRE) 2011); Transport workers: Liberia Labour Force Survey; Miners: Liberia Labour Force Survey (Liberian Institute of Statistics and Ministry of Labour Geo-Information Services (LISGIS) 2011); Poverty and Social Impact Assessment and Strategy Formulation on Artisanal Diamond Mining Reform in Liberia (Wallace and Lepol 2008).

**) Denominator is number of respondents who ever had sex

***) Denominator is number of respondents who had sex with paying partners last 3 months

****) Denominator is number of respondents who had sex with non-paying partners last 3 months

*****) both sexes

Men-who-have-sex-with-men (MSM)

With 19.8% of the group infected with the virus, MSM in Liberia have a severely high prevalence of HIV. Prevalence increases with age in MSM. Geographically, Montserrado county sees high prevalence rates in MSM. The group of MSM in Liberia is estimated at 711 individuals (University of Liberia Pacific Institute for Research and Evaluation (ULPIRE) 2011). As stated before, this is likely to be an underestimate.

More than 52% of MSM report having first sex with another man when they are 20 years old or younger. This rate is an early warning indication of the vulnerability of adolescent males in Liberia. Many MSM report having commercial sex (81%); some of them double as (male) sex workers. Many MSM also have sex with women (77.9%) so as to show a way of life that is accepted in Liberian society, in which same-sex relationships are a criminal offence and a taboo.

Forty percent of MSM report exposure to any type of violence, and 24.5% of MSM report ever been threatened by the police. Eighteen percent of MSM have been forced to have sex without a condom.

The relatively high comprehensive knowledge about HIV (47% of MSM)[4], might be due to the fact that MSM seem to be rather well-educated and more exposed to media than any other adult key and vulnerable population group. Still, comprehensive knowledge of less than 50% about a health problem that directly affects this group is low in absolute terms. Knowledge about STI symptoms is somewhat higher than about HIV. Over 63% of MSM know two or more STI symptoms in males.

Just under half of MSM know about condoms *and* know where to get one. Seventy-six percent of MSM ever used a condom. More than 95% of MSM who know where to get a condom obtain them from a pharmacy, chemist, clinic or hospital. Condom use with lubricant is reported by 54% of MSM. They use oil, ghee, cream or lotion as well as water-based lubricant, which means that not all lubricant use is condom compatible. An important source to obtain lubricants are again pharmacies and chemists, but less so in clinics and hospitals. Instead, MSM quote shops, markets and friends as additional sources for lubricants.

There is a knowledge behaviour gap in MSM – as in the Liberian population as a whole. Despite the relatively high presence of HIV prevention knowledge, 60.6% of MSM report they did *not* use a condom at their last sex with any type of partner. Only close to one-fifth (20.7%) of MSM report condom use at last anal sex with a paying partner, and 25.4% reports condom use with a non-paying partner.

[4] The Liberia IBBSS defines comprehensive knowledge of HIV as the simultaneous knowledge of the three (3) main prevention methods (condom use, abstinence, and being faithful) and rejection of the two (2) main erroneous transmission methods (mosquito bites and meal sharing).

A little over 65% of MSM report they know the location of a HCT site in their community. Forty-four percent of MSM ever had an HIV test, whereas 38.5% ever had an HIV test and received the result.

Knowledge about treatment is low in MSM. While about four out of ten MSM have heard of medicines that can improve the health of people with HIV, knowledge of the existence of antiretroviral medicines (ARVs) is quite low at 15.5%. Over 11% of MSM think there is a cure for AIDS.

Exposure to peer-driven interventions shows a mixed picture. Nearly half of MSM report having ever discussed HIV/AIDS with a peer educator, but only 19% of MSM ever participated in a peer education session.

Female Sex Workers (FSW)

As may be clear from the previous paragraph, except for female sex workers also MSM (and trans-gender TG)) can be sex workers. About the latter two SW groups there are virtually no data in the country, which is the reason why this paragraph concentrates on female sex workers (FSW) only.

The prevalence of HIV in FSW is 9.8%. (Liberia Ministry of Health and Social Welfare 2013) The FSW population is officially estimated at 1822, (University of Liberia Pacific Institute for Research and Evaluation (ULPIRE) 2011) but is likely to be much larger, as 10% of men report ever paying for sex in the Liberia DHS and 5% report having paid for sex in the 12 months preceding the interview.

FSW start being sexually active at a young age. Before they become 15, just over 30% has had sex. This is the highest proportion of all key and vulnerable populations. Many FSW are also young when they get involved in sex work. More than 62% of FSW report being between the ages of 15-24 when they started such work.

Almost 97% of FSW report having sex with a paying partner during the last 7 days with 73.7% having more than 3 sexual paying partners. The corresponding percentage of FSW reporting having more than 3 sexual non-paying partners during the last 7 days is 17%. A little over 10% of FSW report practising anal sex of which 38.9% do it as a routine.

Sex workers gather at so-called ‘hotspots’, which are often bars or other busy places. About four out of every ten FSW report daily alcohol and drug use. The price for sex can be as low as 50 LD if with condom and as low as 100 LD if the client does not want to use a condom. Female sex workers, like MSM, face harassment from the authorities because of their illegal status and from clients e.g. when trying to negotiate safe sex. Reports of rape are frequent. Over one in every three FSW report having been forced to have sex without a condom. They also suffer frequent physical violence and other abuse; a little less than nine out of ten FSW report ever having suffered violence; over two-thirds have been threatened by the police with

arrest and almost six out of ten FSW have had to provide sexual favours to the police to avoid such arrest.

Of all key and vulnerable populations, surprisingly FSW record the lowest percentage of comprehensive HIV knowledge: just under one in five of all FSW can correctly identify three HIV prevention methods and also correctly quote two misconceptions about HIV transmission. Six out of ten FSW know that a pregnant woman with HIV can transmit the virus to her unborn child, which is higher than other key and vulnerable populations. Compared to women in the general population, where seven out of ten women know this, FSW knowledge seems to be on the low side.

Nevertheless, from all key and vulnerable populations FSW report the highest percentage (81.8%) of condom use at last sex with paying partners. Condom use is not consistent though. Almost half of FSW (46.3%) report condom use at last sex when it comes to non-paying partners. Anal sex with paying partners happens with condom in around seven out of ten cases whereas with non-paying partners this proportion becomes three in ten. Out of those FSW that reported to have practised group sex, 12.5% reported the use of the same condom with more than one woman.

Only one in three FSW know of a HCT site in their community, and also one in three ever had a test and received the result. This is very low compared to other key and vulnerable populations.

People who inject drugs (PWID)

The HIV prevalence in PWID is 3.9%. (Liberia Ministry of Health and Social Welfare 2013) The number of PWID in Liberia is estimated at 457. (University of Liberia Pacific Institute for Research and Evaluation (ULPIRE) 2011) As underlined before, drug use also occurs in the key populations of FSW and MSM, as well as among mobile traders, miners and uniformed personnel. However, the latter three groups report far less drug use than MSM and FSW. Of all FSW who report drug use, a particularly high proportion (36%) reports injecting drugs. Certain types of non-injecting drug use (particularly smoking of crack cocaine) are associated with an increased HIV prevalence. (Weeks and DeCarlo 2009) Therefore, it is important to consider the drug using population as a whole, whereas it is important to differentiate between the types of drugs used. The total number of people who use drugs (PWUD) in Liberia is estimated at 2303 individuals.

Most popular is use of ganja (Marihuana), which is reported in 68% of PWUD. Use of Italian White is reported by 33% of PWUD and 32% of PWUD report cocaine use. Twelve percent of drug users report using heroin. People who inject drugs are reportedly relatively wealthy compared to other key and vulnerable populations, because they need to be able to afford their drug use and get needles and syringes. PWID are young: just over 50% are between 20 and 29 years old.

Almost one in four (23.7%) of PWID report having sex before being 15 years of age. PWID report high rates of anal sex, possible due to the overlap with FSW.

Just less than one in four PWID have comprehensive knowledge about HIV prevention and – transmission. More than 90% of PWID know that needles that have been used by someone else can transmit HIV. This is comparable to other key and vulnerable populations' knowledge about this way of HIV transmission.

Almost six out of ten PWID report condom use at last sex with a paying partner, which is rather low compared to other key and vulnerable populations. One out of every four PWID uses a condom with a non-paying partner, which seems low but is not dissimilar to what other groups report. Only FSW report a much higher proportion of condom use. The proportion of PWID (48.3%) reporting condom use during last anal sex with paying partners was relatively low compared to FSW (72.2%). A relatively high proportion (59.5%) of PWID report having paying partners, again due to the overlap with sex work. Seen in that light, the low rate of reported condom use is a worrying sign.
Over 90% of PWID know where to get male condoms and almost half of PWID know where to get female condoms. These are unusually high proportions compared to other groups. The high knowledge about condom availability, especially female condom availability, can (again) quite possibly be explained by the overlap between FSW and injecting drug use.

Seven out of ten PWID know the presence of a HCT site in their community, which is about average for most key and vulnerable populations. Also the gap of bringing that knowledge into practice is similar to other key and vulnerable populations, since only 28% of PWID ever had an HIV test and received the result.

Uniformed services personnel

Uniformed services comprise immigration officers, police and customs officers. The majority of uniformed personnel are men, although a small number of women do work in this sector. In contrast to other key and vulnerable populations, uniformed services personnel tends to be in the older age categories: over 30% are older than 45 years. Because of the nature of their work they also tend to be have a higher level of education. Over 90% has secondary education or higher.

The total number of immigration, police and customs officers is not reported. Public sources quote the number of police officers in Liberia at 4100, (Interpol 2015) customs officers at 300, (Brooks 2016) and immigration officers at around 2600. (Sonpon III 2016) A prevalence rate of 5.0% characterises the increased risk of exposure to HIV in this group of government staff.

Only 8.0% of uniformed services personnel had sex before the age of 15, the lowest figure among key and vulnerable populations in Liberia. Sex with paying partners is also the lowest among these populations, with 9.1% reporting such activity.

Almost four out of ten uniformed services personnel have a comprehensive knowledge of HIV. Although low by absolute standards, uniformed personnel have the highest percentage of comprehensive knowledge on HIV among the Liberian key and vulnerable populations.

Indicators on condom use and –knowledge are about average in this group. The exception is using condoms with paying partners; although the percentage of uniformed services personnel reporting sex with a paying partner is low, using condoms with this type of partner is also among the lowest among the key and vulnerable populations at 47.7%. Only MSM report a (much) lower percentage.

Approximately seven out of ten (72.5%) uniformed services personnel know the location of a HCT centre in their community. Forty-five percent had an HIV test and has received its result, the highest of the key and vulnerable populations discussed here.

Uniformed services personnel stands out in terms of a relatively high level of education and knowledge about HIV. They do not report particularly low condom use compared to the general population, except for low condom use with paying partners – but sex with paying partners is not frequent in this group. Therefore, there is little detailed insight in what factors exactly result in the high HIV prevalence with uniformed services personnel.

Mobile traders

Mobile traders are men and women involved in small business, often near or across borders. Among mobile traders, about 5% of males and females are adolescents aged 15-19. Among females, more than half (52.6%) were either illiterate or had only primary education compared to 38.7% of their male counterparts.

There is no current estimate of the number of mobile traders in Liberia. HIV prevalence in this group is 4.5%, with a much higher prevalence in women (6.5%) than in men (2.3%). Because the prevalence in mobile trading men is quite close to the general population prevalence, one might even argue that the main vulnerable group is mobile trading women.

Compared to FSW, IDU and MSM, early sex at age lower than 15 years is not frequent, although male mobile traders do report this in 16% of cases; nine percent of women say they had sex before the age of 15. Recent sex with a paying partner is almost twice as high in men as it is in women.

Comprehensive knowledge of HIV prevention and –transmission is as low as it is in the other key and vulnerable populations. About one in four women demonstrates comprehensive HIV knowledge, and about one in three men does so. The share of female mobile traders who have knowledge about MTCT does not differ much from the knowledge about this subject in FSW.

Knowledge about where to get condoms is approximately the same as in other groups. Condom use, whether with a non-paying partner or with a paying partner is slightly higher than in many of the other key and vulnerable populations.

Mobile traders also do not differ much in knowing a HCT site in their community. Like other key and vulnerable populations, this is between 65% (men) and 73% (women). Having had a test and receiving the a result show a large gender difference, in that 28% of men and 45% of women report a complete testing cascade.

Among mobile traders, it is clear that women run a higher risk than men. There is a need for more information about the practices and mechanisms that constitute the vulnerability for HIV infection for mobile trading women.

Miners

Miners in Liberia are mainly gold and diamond miners. Extraction of gold and diamonds occurs through industrial mining by several companies active in Liberia, but many miners work in small-scale artisanal mining.

The average level of education in miners is low. The IBBSS quotes almost half of the miners having maximum primary education; a small study of artisanal miners by UNDP showed that 96% had no more than primary education. (Wallace and Lepol 2008) It is estimated that between 17,000 (Liberian Institute of Statistics and Ministry of Labour Geo-Information Services (LISGIS)) and 45,/8,000 workers (Wallace and Lepol 2008 , Grant 2015), mainly men, are involved in the artisanal mining sector in Liberia. Women assist in certain aspects of the work.

HIV occurs in 3.8% of miners, who have the lowest figures among the key and vulnerable populations when it concerns early sex. Less than one in ten miners have had sex before the age of 15. Around 14% of miners had sex with paying partners the past 3 months, which is somewhat higher than in the average population but not particularly high as compared to other key and vulnerable populations.

Comprehensive knowledge about HIV is rather low, with only one in four miners correctly quoting three HIV prevention methods and dismissing two misconceptions about transmission, but this is still comparable to some other key and vulnerable populations.

One in five miners say they used a condom when they had sex last time with a non-paying partner. With a paying partner this proportion doubles; just over half of the miners use a condom in that case. Both proportions are low. Miners have the lowest condom use with non-paying partners of all key and vulnerable populations, but with paying partners condom use is comparable with e.g. uniformed services personnel in the country. About half of miners ever used a condom. Almost 69% of miners know a place that sells condoms; compared with other key and vulnerable populations this proportion is rather low.

The knowledge on where to get counselled and tested for HIV is present in 63% of miners, whereas only 23% of miners would translate this knowledge into action, i.e. go for a test and also receive the result of that test.

Miners run a higher HIV risk, because they work away from home and family, which is often a risk factor for unsafe sex. Their condom use is low, but precise vulnerabilities have not been further mapped in this group. There are about 4,000 women involved in mining and quarrying in Liberia according to official statistics. Although their proportion constitutes only 23% of the mining population, it is not negligible. The vulnerabilities to HIV of women in this sector have not been studied separately.

Transport workers

Transport workers in Liberia comprise taxi drivers, truck drivers and pen-pen drivers (motorcycle taxis). Like miners and mobile traders, transport workers tend to be young. About half of transport workers are younger than 30 years. Almost half of all transport workers have secondary education, still a substantial 13% have no education at all.

The HIV prevalence among transport workers is 4.8%. The number of transport workers in Liberia is estimated at 25,000. Although it is generally assumed that transport workers are predominantly male, the Liberia Labour Force Survey estimates that 5,000 out of the 25,000 transport workers are women. (Liberian Institute of Statistics and Ministry of Labour Geo-Information Services (LISGIS) 2011) The IBBSS sample has 3% of transport workers recorded as female.

Thirteen percent of transport workers had sexual experience before the age of 15. Sixteen percent had sex with a paying partner the past three months. Thirty percent used a condom the last time when they had sex. Condom use with a paying partner is 72%, which is the third highest of all key and vulnerable populations in Liberia. Condom use with a non-paying partner is second highest of Liberian key and vulnerable populations, but at 29% it is not very high in absolute terms. Seventy-six percent of transport workers know where to obtain (male) condoms, which is not very different from other key and vulnerable populations.

One third of transport workers demonstrate comprehensive knowledge of HIV. Knowledge of MTCT is rather low in transport workers. While typically half or more of other key and vulnerable populations know that a mother can transmit HIV to her unborn baby, around four in ten transport workers know about this way of transmission. One in five transport workers mistakenly believe that AIDS can be cured; less than one in ten has heard of ARVs.

Sixty-eight percent of transport workers know where they can get counselling and a test for HIV in their community. Just 30% actually went for a test and received the result.

Because of their profession, transport workers are at increased risk for HIV. Like other key and vulnerable populations their general HIV awareness is low. Sex with a paying partner is more frequent than in the general population, while condom use with paying partners is relatively high. Still, 69% did not use a condom at last sex with any kind of partner.

People Living with HIV (PLHIV)

An estimated 26,313 adults and 2,339 children were living with HIV in 2015. (Kiazolu, Cooper et al. 2016). Of all couples, 2.8% are serodiscordant, while in 1.1% of couples both partners are living with HIV. (Liberia Institute of Statistic and Geo-Information Services (LISGIS) 2014).

PLHIV form 50% of those present at any HIV-transmission event and yet are a minority of the population. So, it might be argued, programmes targeted at PLHIV may have a disproportionate effect to reduce new cases of HIV.

People living with HIV are a particularly vulnerable group, as they need access to a range of HIV prevention, care, support and treatment services. Stigma in Liberia is substantial, which severely hampers access to these services. In addition, people living with HIV play a key role in preventing the further spread of HIV through "positive prevention". Adherence to treatment and therefore living with an undetectable viral load, reduce the spread of the virus. This can only be achieved by treatment literacy and good adherence among PLHIV, as well as access to good quality treatment (including treatment monitoring) and universal access to PMTCT services.

Although the focus of this strategy document is HIV prevention, high awareness about 'classical' HIV prevention methods as well as treatment as prevention must play a key role when it comes to prevention by PLHIV. Strategies to scale up access to quality antiretroviral treatment are included in the National HIV & AIDS Strategic Plan 2015-2020.

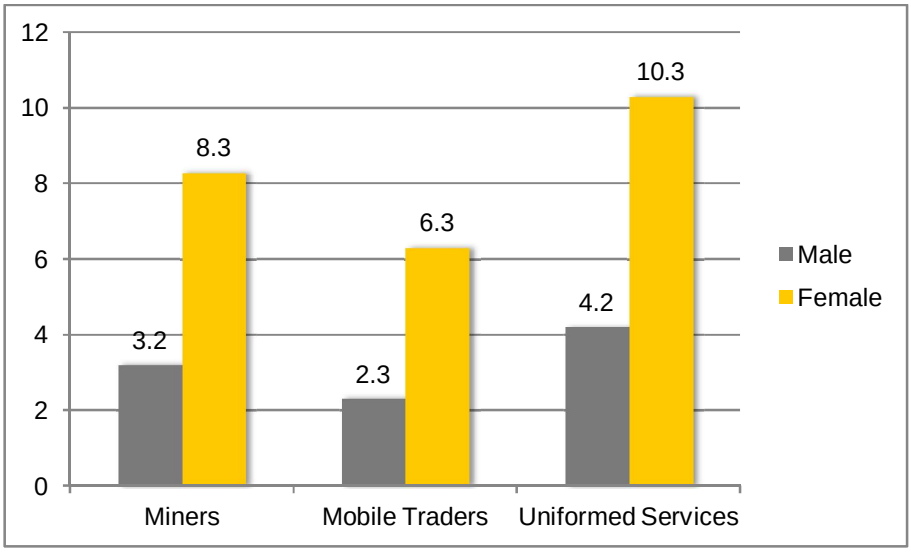
General trends among key and vulnerable populations

In a way, key and vulnerable populations do not stand out compared to the general population in terms of HIV knowledge and awareness. Comprehensive knowledge about HIV prevention and transmission is rather low in Liberia, as is PMTCT knowledge. People know about HIV prevention and particularly condom use, but do not use these prevention methods. There is also awareness about HIV testing, but it does not result in people going for a test and receive the result. Also knowledge about treatment is low.

Common for most key and vulnerable population is the paucity of data about their knowledge, attitudes and practices regarding sexual behaviour and HIV.

Within some groups there are substantial differences by sex, following the trend of the general population, where women are generally at a disadvantage. Figure 4 shows the details.

Figure 4. HIV Prevalence in selected key and vulnerable population by sex



These data are important in what they show but also important in what they don't show, i.e. certain key populations are not included in any official data collection efforts about HIV in Liberia. Methodologically sound HIV prevalence rates among prisoners and transgender people are not available, and data are anecdotal at best. According to the National AIDS Control Program (NACP), prisoners in Monrovia central prison have been tested for HIV and this test did not reveal a higher prevalence than in the general population. The NGO Stop AIDS In Liberia (SAIL) reportedly has done outreach HIV testing among transgender people. Out of the 22 tests administered, 17 came back positive.

HIV prevention: past efforts and achievements

Liberia has included HIV prevention in its earlier HIV strategies. During the immediate post-war years, most HIV prevention focused on interventions among the general population, as population-based HIV-prevalence data were showing signs of HIV spreading among the general population. As a response, Liberia has developed HIV programmes and services directed at the general population, that include:

Information, Education and Communication (IEC) and behaviour change communication (BCC) programmes by the government and NGOs. Associations of people living with HIV, Community-Based Organizations (CBOs), and Faith-Based Organizations (FBOs) actively participate in efforts to raise public awareness about HIV and AIDS.

Condom Promotion. Large quantities of male and female condoms made available by the Global Fund, UNFPA and USAID are distributed through the NACP. Activities promoting the distribution and utilization of condoms are largely carried out by community-based organizations. Some major condoms promotion activities include the social marketing of condoms, the production of print and audio communication materials, improving the quality of care at youth centres, the provision of community based sensitization activities, and the setting up of distribution outlets at community level. Condom distribution has increased from 2.6 million male condoms in 2006 to 8.2 million in 2015. (National AIDS Commission (NAC) 2010, Kiazolu, Cooper et al. 2016)

HIV Counselling and Testing (HCT). Voluntary Counselling and Testing (VCT) is offered in health facilities, community-based services and stand-alone VCT centres. Some non-governmental organisations offer outreach and mobile VCT services in counties that lack VCT centres. Most testing takes place in the context of provider-initiated testing and counselling (PITC). Testing has increased over the years: between June 2007 and December 2008, a total of 81,576 persons were tested for HIV, whereas in 2015 a total of 115,213 individuals were actually tested for HIV and 113,312 (98%) received their results.

Prevention and elimination of Mother-to-Child Transmission (PMTCT, eMTCT). PMTCT is a key programme area in the HIV response in Liberia. The PMTCT services in Liberia are integrated in Maternal and Child Health (MCH) services. Ideally they include various interventions, such as HIV testing and counselling (including Early Infant Diagnosis (EID) using PCR), treatment with antiretroviral drugs (maternal and infant), counselling and support for appropriate infant feeding, access to safe obstetric care and family planning services. PMTCT has been rolled out throughout the counties and include sites based at faith-based, private, and international NGO health facilities and. This has resulted in significant scaling up of the programme through increasing the number of facilities providing PMTCT services from 55 in 2009 to 335 sites in 2015. Successive antenatal care survey results show significant reduction in HIV prevalence among pregnant women from 5.7% in 2006, to 2.5% in 2013. The percentage of pregnant women tested for HIV who know their results increased from 3% in 2007 to 34% in 2013. The percentage of HIV positive pregnant women who

received antiretroviral drugs to prevent mother to child transmission of HIV increased from 2% in 2007, to 42% in 2013 resulting in decreasing the percentage of HIV exposed babies infected with HIV at 6 weeks of birth from about 31.98% in 2010, to 24.63% in 2013. In 2015, a total of 1,358 HIV-positive pregnant women received ARVs/ART to reduce the risk of mother-to-child transmission (MTCT). According to Spectrum estimates, there were about 1,300 HIV-positive pregnant women in need of ARVs for PMTCT in 2015 (Kiazolu, Cooper et al. 2016). In 2015, NACP adopted option B+ to ensure the best results and set steps towards eMTCT.

Blood Safety. The Ministry of Health established a national Blood Safety Programme to coordinate blood safety. It is mandatory that all donated blood is screened for HIV, hepatitis B, hepatitis C, malaria, and syphilis in a quality assured manner. The supply of test kits to public and private laboratories and VCT centres is solely through Ministry of Health and is free of charge. The program estimates that 35,000 units of blood are required to meet the annual national blood transfusion demand. On the average, the Blood Safety Program is able to provide no more than 12,500 units of screened blood for the country annually.

Sexual and Gender-Based Violence (SGBV) plays a role in HIV transmission in Liberia. The prevention of SGBV is therefore important for the government, which has put in place a national task force on SGBV within the Ministry of Gender, Children and Social Protection.. A national SGBV Plan of Action aims to build skills of health professionals; improve documentation and evidence; ensure the required reforms to deal more effectively with cases of SGBV; establish systems and outreach systems for survivors; and set up of social and economic empowerment programmes for women. National treatment protocols specify a service package that includes PEP, STI treatment, emergency contraception, prevention of tetanus and counselling.

Treatment of Sexually Transmitted Infections (STI). National STI management guidelines and protocols were developed in 2005 which were revised in 2009. The guidelines focused on BCC strategies as well as effective and prompt STI case management. STI treatment has not markedly increased. In 2015, based on the WHO syndromic management approach, 139,373 cases of STIs were reported to have been treated, whereas between June 2007 and December 2008 184,000 patients were treated. Self-reporting of STIs did not decrease between 2007 and 2013, based on data from LDHSs in the same years.

Male circumcision. Male circumcision is associated with lower transmission of STIs including HIV.(World Health Organization 2007) Male circumcision is almost universally practiced in Liberia and has an important place as a cultural practice of passage into adulthood. The LDHS both 2007 and 2013 showed that male circumcision is indeed widespread in Liberia, with almost all men being circumcised (98% and 99% respectively).

Next to classical HIV prevention, ART has been scaled-up in the country; provided the ART programme achieves good adherence and therefore patients on treatment have undetectable viral loads, ART will also contribute to prevention of new HIV infections.

Soon after the establishment of the first HIV prevention activities directed at the general population, the first evidence from qualitative studies and field programmes indicated that women and girls were more vulnerable than men, and that key and vulnerable populations faced particularly high HIV risks, such as young girls engaging in transactional sex, sex work and clients of sex workers, MSM and mobile populations.

From 2010 onwards there was a realisation that future focus of HIV prevention efforts must be directed towards these most-at-risk and vulnerable populations. According to the National HIV/AIDS Strategic Framework 2010-2014 II including the following areas::

Strengthening the gender focus of the response, which takes into account the epidemic's clear gender dimensions and differential risks and vulnerabilities of women and girls, men and boys, including sexual and gender-based violence.

Strengthening focus on key and vulnerable populations with HIV-prevention programmes tailored to their specific needs. Key populations at risk include women and girls engaging in sex work, and their clients; mobile men and cross-border mobility; uniformed personnel; prison inmates, MSM and transgender people. This also requires a geographic focus on high prevalence areas and -counties. IEC, HCT, and condom and lubricant distribution that are accessible and acceptable to these groups is to be one of the mainstays of HIV prevention.

Strengthening positive prevention approaches, which build on the active involvement of PLHIV in HIV prevention.

Strengthening the health sector capacity to scale up coverage of key HIV-prevention services, and strengthening their integration into the health system. Priority services include HCT, PMTCT, and STI treatment.

Strengthening the involvement of key non-health government sectors for reaching specific populations with targeted policies and interventions, including the Ministries of Education, Youth and Sport, Defence, Interior (border guards, police) and Labour.

Strengthening the involvement of the private sector in workplace HIV/AIDS interventions.

The Ebola outbreak between March 2014 and May 2015 negatively impacted the HIV response in Liberia. National ART coverage dropped from 34% in 2013 to just 19% in March 2015. Little to no HIV and AIDS services were provided at most health facilities. Uptake of antenatal care and other reproductive health services declined, and are likely to have impacted coverage of PMTCT just like in Ebola-affected neighbouring countries. Many health workers (including program staff) and other resources in the public health sector were redeployed on Ebola Emergency Response (EER) activities for prolonged periods during the outbreak..

In addition, the Ebola outbreak worsened the already weak health and community systems: it generated great fear in the communities and created significant distrust and loss of confidence in the health system that was needed to protect patients and clients from contracting Ebola and/or similar diseases. These weaknesses are presently seriously hindering efforts to restore health services (including HIV and AIDS preventing, treatment, care, and support services) to pre-Ebola levels.

One of the lessons learned from the Ebola outbreak is that the communities play a pivotal role in the response. If they are informed, involved and empowered, and their capacities built, they will become a positive force for testing and counselling and link people into care.

In order to achieve program targets in the near future, therefore, there is a huge and urgent need for strengthening health and community systems needed for restoring health facility level services to pre-Ebola levels and beyond.

In conclusion, despite the emerging evidence about rising HIV numbers in key and vulnerable populations and data about significantly higher prevalence of HIV in a (limited) number of counties, earlier strategies to target HIV prevention interventions towards key and vulnerable populations, or high risk areas, did not materialise. Thus far, HIV prevention interventions have lacked a clear focus in Liberia.

Development of strategies and policies to strengthen targeted HIV prevention efforts to date are hampered by lack of essential and accurate health data to assist evidence-informed policy making, cultural taboos surrounding key populations and by weak health- and community systems that received an extra blow from the Ebola outbreak.

Successful HIV prevention strategies and approaches, in IEC, HCT, condom promotion (including social marketing), and PMTCT, must cater to the needs of key and vulnerable populations, based on evidence, community involvement and capacity building of relevant staff and structures.

HIV prevention: the main strategies

Liberia has a low-level generalised HIV epidemic, with higher rates of infection among young women. The key populations MSM, FSW and PWID have HIV-infection rates 3-10 times higher than in the general population. Apart from the key populations, there are other vulnerable populations in Liberia with higher rates of HIV infection that the general population, but lower rates than the key populations. These groups comprise uniformed services personnel, mobile traders, miners and transport workers. There are also key populations about which virtually no data exist in Liberia: transgender people and prisoners.

The evidence in the previous chapters in this document shows that an HIV prevention strategy that includes key and vulnerable populations is of paramount strategic importance for Liberia.

The aim of the Liberian HIV prevention strategy and of the National Strategic Plan is to achieve a reduction of 50% in new HIV cases by 2020.

At the same time, HIV also affects the general population. Although the term general population suggests one group, in reality the general population can also be approached in a more granular fashion, based on epidemiological evidence.

Available evidence already shows that prevalence is higher in urban than in rural settings. It is also clear that young women are disproportionately affected. The evidence about HIV prevalence in youth points to higher prevalence rates in out-of-school youth compared to in-school youth , especially among boys.

Therefore, the strategic focus for HIV prevention *in the general population* is to give priority to i) addressing young women and girls and ii) urban areas and high burden counties. Next to that, due priority is to be given to HIV prevention in *key and vulnerable populations*; a separate section in this document will highlight the tailored activities that are to be targeted to these populations.

Overall Objective(s)[5]

To stop new HIV infections − in key populations as well as in the general population of Liberia − and keep PLHIV in Liberia alive and healthy.

Specific objectives, including:

- Reduction of new HIV infections among the general population, particularly young women by 50%.
- Reduction of new HIV infection among MSM, TG, PWID, SWs, prisoners, uniformed services personnel, mobile traders, miners and transport workers by 50%.
- Elimination of HIV related stigma and discrimination, including stigmatisation and discrimination of key populations.

[5] Taken from the National HIV & AIDS Strategic Plan 2015-2020

Table 2. Core indicators HIV prevention strategy

Impact Results		Indicators	Baseline Value, Source & Year	Data Sources	Targets 2020
Reduction of new HIV infections by 50% from 1789 in 2014 to 895 by 2020	1.[6]	Percentage women and men aged 15-24 who are HIV infected	1.1%; DHS 2013	DHS	0.5%
	2.	Percentage pregnant women aged 15-24 who are HIV infected	1.8%; ANC Sero Survey 2013	ANC Sero Survey	1.0%
	3.	Percentage of selected key populations who are HIV infected	2013 IBBSS	IBBSS	
		MSM	19.8%		12.5%
		FSW	9.8%		6.0%
		PWID	5%		3.0%
		TG	TBD[7]		TBD[7]
		People in prisons and other closed settings	TBD[7]		TBD[7]
	4.	Estimated total number of new infections annually	1789; NACP Spectrum Modelling 2014	NACP Spectrum Modelling	895
Sexual transmission of HIV infections in adults 15-49 years reduced by 50% from 1386 new HIV infections in 2014 to 693 in 2020	5.	New HIV infections in adults 15-49 years	1386; NACP Spectrum Modelling 2014	NACP Spectrum Modelling	693
		Percentage young women and men 15-24years who are living with HIV	1.1% (women and men) (2013 LDHS)	LDHS 2013	TBD[7]
		New infections in key and vulnerable populations		Notification from sentinel sites; Registries; Prevalence among young members of key populations; Projection modelling	

[6] Numbered items correspond with indicators with the same number in the Liberia HIV and AIDS Response Monitoring and Evaluation Plan.

[7] In the absence of baseline data and other data problems, targets need to be set when accurate data become available. Some of the currently lacking data are expected to become available after the mid-term review of the NSP (2017); the establishment of drop-in centres for key populations will fill some of the data gaps for these groups. Once data gaps have been filled, targets in this performance framework will need to be determined or adjusted to reflect the ambitions in the various HIV prevention objectives and -activities.

Impact Results		Indicators	Baseline Value, Source & Year	Data Sources	Targets 2020
		MSM	TBD[7]		50% of baseline
		FSW	TBD[7]		50% of baseline
		PWID	TBD[7]		50% of baseline
		TG	TBD[7]		50% of baseline
		People in prisons and other closed settings	TBD[7]		50% of baseline
		Uniformed services personnel	TBD[7]		50% of baseline
		Miners	TBD[7]		50% of baseline
		Mobile traders	TBD[7]		50% of baseline
		Transport workers	TBD[7]		50% of baseline
Adults 15+ years are adapting behaviors that reduce the risk of HIV infection from sexual intercourse.	11.	Percentage Adults aged 15-49 years who had 2+ sexual partners in the past 12 months	Women: 6.5% Men:17.6%	LDHS 2013	TBD[7]
	12.	Percentage Adults aged 15-49 years who had 2+ sexual partners in last 12 months and who report using a condom in their last sexual intercourse	Women: 20% Men: 24%	LDHS 2013	TBD[7]
New HIV infections in young people reduced	13.	Percentage young women and men 15-24 years who have comprehensive knowledge on HIV prevention & transmission & reject major misconceptions on HIV prevention & transmission	Women: 67% Men: 59%	LDHS 2013	TBD[7]
	14.	Percentage young women and men 15-24 years who had 2+partners in the last 12 months	Women: 8.6% Men: 12%	LDHS 2013	TBD [7]
	15.	Percentage young women and men 15-24 years who had 2+ partners in the last 12 months and who used a condom during their last sexual intercourse	Women: 5.6% Men: 32%	LDHS 2013	TBD[7]

Impact Results		Indicators	Baseline Value, Source & Year	Data Sources	Targets 2020
	16.	Percentage young women and men aged 15-24 years who had sex before the age of 15 *	Women: 7.2% Men: 8.5%	LDHS 2013	TBD
New HIV infections in key and vulnerable populations reduced		Percentage of key population or key and vulnerable population in sample able to correctly identify ways to prevent HIV and who reject common misconceptions.	2013 IBBSS	IBBSS	
		MSM	37		TBD[7]
		FSW	19.6		TBD[7]
		PWID	23.9		TBD[7]
		Transgender people	TBD[7]		TBD[7]
		People in prisons or other closed settings	TBD[7]		TBD[7]
		Uniformed services personnel	38.4		TBD[7]
		Miners	24.4		TBD[7]
		Mobile traders	32.4 (M) / 26.4 (F)		TBD[7]
		Transport workers	33.5		TBD[7]

The table with core indicators highlights the main available baselines and targets for the specific objectives, derived from the current NSP and from the Liberia HIV & AIDS Response M&E Plan. The main goal is to achieve a 50% reduction of new cases by the end of the strategy period. Concrete targets for key and vulnerable populations can only be set once incidence data for these populations, as well as accurate size estimates for key populations, become available, which is not the case at the time of writing of this strategy. The current establishment of key population-focused drop-in centres and a mid-term review of the NSP are expected to produce most of the currently lacking data on key populations.

Operational strategies:

Operational Strategy 1: To develop and implement, with meaningful involvement of the populations concerned, evidence-based, comprehensive HIV prevention, protection, treatment, care and support services that are adapted to the needs of the target populations.

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.
OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.
OS 1.3: Link target groups, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant group.
OS 1.4: Link target groups, where necessary, to high quality, acceptable and accessible psycho-social support services for each relevant group.

Operational Strategy 2: To create an enabling environment for HIV prevention interventions through focused advocacy, community engagement, community systems strengthening to i) address barriers (social, cultural, religious, political, and legal) to effective interventions and ii) reduce vulnerability, stigma and discrimination related to HIV and to key and vulnerable populations iii) reduce stigmatising and discriminatory attitudes in the general population that hamper effective HIV prevention.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.
OS 2.2: Reduce stigma, discrimination and violence related to HIV and key and vulnerable populations with a focus on healthcare providers and uniformed services personnel.

Operational Strategy 3: To strengthen the evidence base and monitoring systems and to promote the generation of strategic information to improve HIV programming and inform key stakeholders and decision makers.

OS 3.1: Finalise population size estimations and geographic mapping of all key and vulnerable populations, including key populations not mapped so far such as transgender people and prisoners.
OS 3.2: Conduct periodic IBBSS of in-school and out-of-school youth and all key and vulnerable populations, including those key populations not included so far such as transgender people and prisoners.
OS 3.3: Establish routine monitoring of strategy, programmes and service quality, involving those affected by the monitored programmes and services.
OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising affected people's rights and their access to services.
OS 3.5: Build the monitoring and research capacity of implementers and relevant CBOs**.**
OS 3.6: Create a learning programme to document the key results and impact of the HIV prevention strategy or parts thereof, and to disseminate the results nationally, throughout the region, and internationally.

Operational Strategy 4: To strengthen coordination among stakeholders and strengthen systems to effectively deliver comprehensive HIV prevention services for the general population, particularly for young women, and for key and vulnerable populations.

OS 4.1: Engage with the broader community to establish linkages and coordination with networks of PLHIV, key and vulnerable populations, youth organisations, women's organisations, faith-based organisations, trade unions, human rights organisations, private sector, media, and community legal and social support bodies in order to strengthen relevant community systems in the response to HIV.
OS 4.2: Engage with relevant governmental and non-governmental sectors to establish linkages and coordination to remove structural barriers to the use of services and programmes by key and vulnerable populations, young women and other population groups as relevant, and improve their rights.
OS 4.3 Support training and capacity building of key and vulnerable populations, youth service providers, and youth advocates.

HIV prevention: the main activities

The next section outlines a more detailed framework how the different components of the Operational Strategies will be implemented. The general aspects of these operational strategies, i.e. those that are applicable to the general population *and* to key and vulnerable populations, are described first. A next section will focus on the specifics for key and vulnerable populations. The framework does not indicate priorities. Priority interventions will be identified, and interventions will be phased in based on an activity plan for each population group. Additional services may be added over the duration of the strategy (and beyond), as identified by monitoring data and as part of the activity plan. This HIV prevention strategy document will not address eMTCT, as a separate plan for eMTCT has already been drafted (see Annex). This strategy document will also not address male circumcision, as this is considered to be traditionally embedded in Liberian culture and therefore virtually universally applied with 98% of the adult male population circumcised.

Operational Strategy 1: To develop and implement, with meaningful involvement of the populations concerned, evidence-based, comprehensive HIV prevention, protection, treatment, care and support services that are adapted to the needs of the target populations.

The National HIV and AIDS Strategic Plan 2015-2020 (NSP) highlights the HIV prevention policy response. The main proposed direct HIV prevention services are:

1. Behaviour change communication interventions
2. Condom and condom-compatible lubricants promotion and distribution
3. Psychosocial support (for youth and key populations)
4. Provision of HIV Counselling and Testing (HCT) services (including at friendly health facilities or outreach to hotspots)
5. Management of sexually transmitted infections (STIs)
6. Ensuring blood safety
7. Provision of Post-Exposure Prophylaxis (PEP)
8. Prevention of mother-to-child transmission of HIV
9. Linking PLHIV into Treatment, Care, and Support

These services are well described in the National Strategic Plan (NSP). The next paragraphs provide more detailed indicative activities with population groups as starting point, rather than being centred around interventions.

The mainstay of the approaches for key and vulnerable populations will be community, peer-driven interventions that must be based on assessments of the needs, knowledge, attitudes and practices of the target group. Peer-driven links into prevention, care and treatment will be essential to arrive at a more robust treatment cascade.

School health clubs and youth centres (from the Ministry of Youth and Sports) are potentially important providers for peer-driven HIV prevention and comprehensive life skills targeted at both in-school youth and out-of-school youth.

In many communities, key populations but also categories of young people will feel safer seeking services from organisations that have a special focus on their particular psychosocial and legal needs, along with their health needs. These 'one-stop shop' services can provide comprehensive HIV/STI risk reduction and treatment options, as well as services that address the range of other issues these populations face. Clients of these services can identify with their peers, and are likely to be more open towards these peer workers who are naturally more credible and trustworthy to them. In addition, knowledge present in peer workers and their organisations about preferences and behaviour of the target group is likely to be based on recent, local and specific understanding of their situation. CBOs targeting key populations will not automatically have the right capacities to provide these services and, therefore, their capacity must be built to do so. At the same time, health care facilities close to the community, either private or public, are also providers of HIV prevention services. They may be in a good position to adapt their approaches and provide e.g. youth friendly / one-stop shop services in an integrated manner with their other clinical activities.

The introduction and scale-up of drop in centres can be a way to integrate some of the essential services into a one-stop shop for youth groups and, specifically, key populations who often face stigma, discrimination and exclusion. These drop-in centres provide a safe haven to access essential services tailored to their needs. For instance, at such a drop-in centre people can:

- Socialise free from stigma or discrimination.
- Access testing and counselling services.
- Access basic care and –treatment services.
- Access legal services and information regarding their rights.
- Access mental health counselling.
- Access ART adherence support.
- Access other information about HIV, STIs, TB, drug use, healthy lifestyles and other health information.

Case management is an approach that takes the client or patient centre stage, identifies medical and psychosocial needs and builds a network of services around the client or patient by establishing referral links. This approach has been successfully implemented for key and vulnerable populations in various settings, both in high-income as well as in low- and middle-income settings. Health care facilities, drop-in centres (DIC) or CBOs that have adequately trained staff can provide case management.

The following steps are included to roll out peer-driven, community-based approaches utilising DICs and/or case management.

- Develop peer education and outreach worker standard operating procedures (SOPs) and establish case management approaches as part of peer education.
- Develop and implement a standardised peer education training curriculum.

- Prepare DIC SOPs to guide the basic/comprehensive package of services offered through key population or youth friendly DICs.
- Procure relevant prevention related supplies and equipment.
- Identify and refurbish as needed DICs/health care facilities/other facilities in hotspots.
- Explore range of location options to provide greater choice. Start with high prevalence areas: e.g. target greater Monrovia / Montserrado, and then Margibi and Grand Bassa counties, with high HIV prevalence rates and high concentrations of key populations.

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.

Indicative activities:

Operational Research must provide the evidence base to develop and target interventions:

- Size estimates using rigorous methodologies such as respondent-driven sampling techniques or capture-recapture methods.
- Mapping of hotspots where young people and key and vulnerable populations congregate.
- Capacity assessments of CBOs, FBOs, and others who target key and vulnerable populations to do advocacy / community mobilisation, provide services, monitor activities, conduct operational research - depending on the mandate of these organisations.

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Indicative activities:

Size estimates and needs assessment or KAPB study per hotspot or other geographical area should determine priority locations to start the interventions outlined below.

Peer-driven HIV prevention literacy and basic treatment literacy and behaviour change interventions for sexual risk reduction:

- Develop a training curriculum in peer-driven behaviour change interventions that includes comprehensive life skills (for in-school youth, out-of-school youth, and young key and vulnerable populations), sexual and reproductive health and rights (SRHR), including prevention of HIV and STIs. Potential target groups of these trainings are youth CBOs and school health clubs (for in-school youth) and youth centres run by the Ministry of Youth and Sports (for out-of-school youth).

- Roll out of a training programme for relevant CBOs (e.g. those dealing with key or vulnerable populations, and those for PLHIV) and schools in peer-driven behaviour change interventions.
- Provide brief intervention counselling for problematic substance use for population groups with high rates of such substance use.
- Offer other behaviour change interventions on a peer-to-peer basis at all designated programme sites.
- Implement condom promotion and -distribution as per National HIV and AIDS Strategic Plan 2015-2020. Key and vulnerable populations and young people between 15-24 years have priority when it comes to access to free condoms and lubricant.
- Condom promotion and -distribution includes female condoms; expand comprehensive information on condom use and –availability with comprehensive information about the female condom.

Introduce and scale up basic prevention interventions:[8]

- Provide HIV prevention information and –services through mass media outlets, and on social media and the internet. Information i) uses language and style that appeals to the target group and ii) is pre-tested by the target group and adjusted as necessary.
- Offer a quality package of life skills and comprehensive sexuality education, including HIV prevention, to in-school youth from 10-24 years old, adapted to age, cultural context and educational level.
- Based on the mapping developed under OS 1.1, set up a network of youth friendly clinics and/or youth clubs where young people can access good quality information and counselling about comprehensive life skills, sexual and reproductive health and rights (SRHR), including prevention of HIV and STIs.
- Condom promotion and -distribution at places that young people and key and vulnerable populations visit ('hotspots') and other places that are acceptable and accessible to each population group.
- All HIV prevention and behaviour change activities and -programmes and should target young out-of-school women between the ages of 15-24 to decrease their vulnerabilities in getting HIV, whether they are involved in sex work or not. An example of such a prevention and behaviour change activity is the community dialogue (e.g. regarding HIV testing) with girls and women.

Introduce and scale-up outreach free HIV Counselling and Testing (HCT) and free community HCT. Outreach- and community HCT will provide a link to care and treatment services for people who test positive for HIV.

- Provide HIV counselling and testing on outreach basis at hotspots with rapid diagnostic tests, using the mapping developed under OS 1.1, especially for out-of-school youth and key and vulnerable populations.

[8] As male circumcision is almost universal in Liberia, this prevention option has not been included as a priority in the listed prevention activities.

- Community HCT at places that are acceptable and accessible to out-of-school youth and key and vulnerable populations.
- Develop standard operating procedures for outreach HCT.
- Develop a training curriculum for health care personnel involved in outreach HCT as well as for relevant community-based organisations deploying key and vulnerable population activities.
- Training health care personnel in outreach HCT with rapid diagnostic tests in collaboration with relevant community-based organisations deploying key and vulnerable population activities.

Involve the private sector present at these hotspots to gain a better understanding and buy-in of the relevant HIV prevention activities implemented on or near their premises.

- Develop an HIV awareness and training programme for relevant private sector representatives to gain maximum effectiveness and efficiency in HIV prevention activities that include a role of the private sector in delivering these interventions.

OS 1.3: Link target groups, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant group.

Essential elements:

- Antiretroviral treatment
- TB case finding and treatment.
- Hepatitis B testing and -vaccination.
- Hepatitis C testing and -treatment.
- STI diagnosis- and treatment.
- SGBV care and PEP, where applicable.
- Home-based care.
- Palliative care.
- Nutrition support.

Care must be taken to deliver care and support services to PLHIV in a discreet and sensitive manner, i.e. being aware of potential stigmatising effects when certain individuals or households, who haven't disclosed their status, are seen by the community to be receiving extra care or support.

Indicative activities:

- Strengthen community-based support and peer support for pregnant HIV-positive women according to activities outlined in the Liberia National HIV and AIDS Strategic Plan 2015-2020.
- Roll-out of option B+ PMTCT protocol according to activities outlined in the NSP.

- Integration of PMTCT services, or referral to PMTCT, into youth- and key and vulnerable population-focused programmes, in addition to integration into all maternal, new-born and child health facilities as indicated in the NSP.
- Develop clear guidelines and SOPs for health workers and staff of DICs and relevant CBOs.
- Develop training curricula for health workers and CBO staff in these guidelines and SOPs, and offer trainings and refresher trainings at regular intervals.
- Develop guidelines SOPs and trainings, analogous to the above, with regards to SGBV and PEP for relevant sections of law enforcement authorities and prison services, with input and participation from key and vulnerable population focus.
- Based on assessments of utilisation of traditional healers outlined under OS 3, and depending on feasibility, develop a training curriculum adapted for traditional healers to improve their accurate knowledge of HIV infection, transmission, treatment, care and support.
- Create referral networks between essential services, including traditional healers where feasible and acceptable, and ensure regular coordination and communication between all parties to ensure effective and smooth referral processes.

OS 1.4: Link target groups, where necessary, to high quality, acceptable and accessible psycho-social support services for each relevant group.

Indicative activities:

- PLHIV and those who are affected by HIV are linked into peer-driven care and can access adherence and treatment literacy services.
- Diagnosis, support and care of mental health problems.

Table 3. Operational Strategy 1 Performance Framework: To develop and implement, with meaningful involvement of the populations concerned, evidence-based, comprehensive HIV prevention, protection, treatment, care and support services that are adapted to the needs of the target populations.

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
Output	***Behaviour change in-school youth***			
All grade schools in Liberia are benefiting from Life Skills and HIV Prevention Program by 2020	109.[9] Percentage of schools reached with life skills–based HIV education for Grades 1 to 12	43% (MoE 2013)	MoE	100%
	110. Number of school health clubs established	124 (MoE 2013)	MoE & MPCHS	500
	111. Number of schools with trained teachers on life skills and HIV prevention	200 (MoE 2014)	MoE & MPCHS	500
	112. Number of schools teaching sessions on life skills and HIV prevention	N/A	MoE & MPCHS	450
Output	***Testing and Counselling***			
Increased number and percentage of people are tested, counselled and know their results	22. Number and Percentage of women & men who received HIV test in last 12 months & know their results *	209,381 10% 2013 NACP prog Data) , LDHS	(NACP prog Data) , LDHS, IBBSS	367,044 (17%)
	Women 15-49	76.2		TBD[10]
	Women 15-24	71.3		TBD[1010]
	Men 15-49	61.6		TBD[10]
	Men 15-24	50.8		TBD[10]
Increased number and percentage of key and vulnerable populations are tested, counselled and	MSM	65.2		TBD[10]

[9] Numbered items correspond with indicators with the same number in the Liberia HIV and AIDS Response Monitoring and Evaluation Plan.

[10] In the absence of baseline data and other data problems, targets need to be set when accurate data become available. Some of the currently lacking data are expected to become available after the mid-term review of the NSP (2017); the establishment of drop-in centres for key populations will fill some of the data gaps for these groups. Once data gaps have been filled, targets in this performance framework will need to be determined or adjusted to reflect the ambitions in the various HIV prevention objectives and -activities.

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
know their results				
	FSW	28.2		TBD[10]
	PWID	69.0		TBD[10]
	Transgender people	TBD		TBD[10]
	People in prisons or other closed settings	TBD		TBD[10]
	Uniformed services personnel	72.5		TBD[10]
	Miners	64.3		TBD[10]
	Mobile traders	65.2(M) / 72.5(F)		TBD[10]
	Transport workers	67.8		TBD[10]
Increased number of health facilities providing HIV counseling and testing services according to national guidelines	23. Number and percentage of health facilities providing HIV counseling and testing services according to national guidelines	335 (..%) 2013 NACP prog Data)	(NACP prog Data)	669 (..%)
	Percentage of sites where key population-focused programmes provide HTC	TBD[10]	Facility-based assessment/ NACP programme data	TBD[10]
Availability	Sites providing behavioural interventions for sexual risk reduction	TBD[10]	Facility-based assessment/ NACP programme data	TBD[10]
Outcome	***PLHIV***			
People living with HIV are actively involved in preventing the transmission of HIV.	18. Percentage of PLHIV practicing safe sex and other non sexual behavioral practices to prevent HIV reinfection and transmission	N/A	Positive living & Stigma Index surveys	
	19. Percentage of Health Facilities using PLHIV Counselors		MOH Prog	

Results		Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
Increased retention rate of PLHIV not on ART at 12 months follow-up	20.	Percentage of adult & children not on ART retained in care at 12 months of follow-up *	24.7% ART Cohort Study	ART Cohort Study	50%
Increased retention rate of PLHIV on ART at 12 months follow-up	21.	Percentage of adults & children on ART retained in care at 12 months of follow-up *(numbered 6 above)* *	69.9 % ART Cohort Study	ART Cohort Study	85%
Access to ART for key and vulnerable populations living with HIV		Percentage of key and vulnerable populations living with HIV reporting they currently receive ART.			
		MSM	TBD[10]	IBBSS	TBD[10]
		FSW	TBD[10]	IBBSS	TBD[10]
		PWID	TBD[10]	IBBSS	TBD[10]
		Transgender people	TBD[10]	IBBSS	TBD[10]
		People in prisons or other closed settings	TBD[10]	IBBSS	TBD[10]
		Uniformed services personnel	TBD[10]	IBBSS	TBD[10]
		Miners	TBD[10]	IBBSS	TBD[10]
		Mobile traders	TBD[10]	IBBSS	TBD[10]
		Transport workers	TBD[10]	IBBSS	TBD[10]
Access to PMTCT for keyand vulnerable populations living with HIV		Percentage of pregnant women from key and vulnerable populations living with HIV reporting they currently receive ART.	TBD[10]	IBBSS	100%

Results	Indicators	Baseline Value; Source & Year	Data Sources	Target 2020
Outcome	***Specific key and vulnerable populations***			
Increase in key and vulnerable populations reached with and using HIV prevention programs	39. Percentage MSM reporting the use of a condom the last time they had anal sex with a male partner *	19.5%	IBBSS	85%
	37. % FSWs reporting the use of a condom with their most recent client *	81.7%	IBBSS	85%
	Percentage TG reporting the use of a condom the last time they had sexual intercourse *	44.3%	IBBSS	TBD [10]
	Percentage of key and vulnerable population in sample who report using a condom the last time they had anal or vaginal sex.	TBD	IBBSS	TBD[10]
	PLHIV (serodiscordant)	TBD[10]	IBBSS	TBD [10]
	People in prisons or other closed settings	TBD[10]	IBBSS	TBD [10]
	People who inject drugs	44.3	IBBSS	87%
	Uniformed services personnel (paying partner/non paying partner)	47.7 / 28.8	IBBSS	TBD [10]
	Miners (paying partner/non paying partner)	54.5 / 18.0	IBBSS	TBD [10]
	Mobile traders (paying partner/non paying partner)	76.4 / 25.5 (M) 67.7 / 30.8 (F)	IBBSS	TBD [10]
	Transport workers (paying partner/non paying partner)	72.3 / 29.5	IBBSS	TBD [10]
	Percentage of key or vulnerable population who inject drugs and who report using sterile injecting equipment the last time they injected drugs	0	IBBSS	TBD[10]
Output	***Integrated services***			
Availability	Percentage of sites providing defined package of health sector interventions	0	Facility-based assessment/ NACP programme data	TBD[10]

Results	Indicators	Baseline Value; Source & Year	Data Sources	Target 2020
Coverage	Key or vulnerable population reporting they have received a combined set of health sector interventions.	0	NACP programme data/ IBBSS	TBD[10]
	Pre-exposure Prophylaxis			
Availability	Sites where oral pre-exposure prophylaxis (PrEP) for HIV prevention is available for men who have sex with men and transgender people	0	Stakeholder consultation, facility-based assessment	TBD[10]
Coverage	Number of men who have sex with men receiving oral pre-exposure prophylaxis (PrEP) for HIV prevention	0	Programme data	TBD[10]
Private sector commitment, involvement, funding and service delivery of HIV and AIDS prevention, treatment, care and support programmes/ services increased	77. Number of large private sector companies with workplace HIV and AIDS policies and programmes (particularly those in mining and transport)	TBD [10]	NAC/MoL data	TBD[10]
	Condom Promotion			
Male and female condoms are available in the country to meet annual demand for family planning and prevention of STIs including HIV.	43. Number and percentage of male & female condoms procured: male condoms	101,053,944	MOH Prog data	114,076,664
	43. Number and percentage of male & female condoms procured: female condoms	1,123,560	MOH Prog data	1,246,590
Coverage	Percentage of key and vulnerable population reporting they have received condoms and condom-compatible lubricant the past 12 months.	TBD[10]	IBBSS	TBD[10]
	Harm Reduction			
Availability	Sites providing brief intervention counselling for problematic substance use	0	Facility-based assessment/ NACP programme data	TBD[10]
Availability	Sites providing injecting equipment – needle and syringe programmes (NSPs)	0	Facility-based assessment/ NACP programme data	TBD[10]
Availability	Percentage of people who inject drugs reporting sterile needles–syringes are	0	NACP programme	TBD[10]

Results	Indicators	Baseline Value; Source & Year	Data Sources	Target 2020
	readily accessible		data/ IBBSS	
Coverage	Percentage of people who inject drugs reached by NSPs	0	NACP programme data/ IBBSS	TBD[10]
Availability	Sites providing maintenance opioid substitution therapy (OST)	0	Facility-based assessment/ NACP programme data	TBD[10]
Coverage	Percentage of individuals injecting opiates receiving maintenance OST	0	NACP programme data / IBBSS	TBD[10]
	PMTCT			
	Post Exposure Prophylaxis (PEP)			
Outcome	29. Number of people who have accessed PEP services at health facilities	TBD[10]		TBD[10]
	30. Percentage of eligible health facilities with active & quality PEP services (quality - full range of PEP services includes first aid, counselling, HIV testing, provision of ARVs, patient follow-up & support)	TBD[10]		TBD[10]
	Management of Sexually Transmitted Infections (STIs)			
Outcome				
Patients with sexually transmitted infections are managed according to National STIs Guidelines.	31. Number of patients receiving diagnosis and treatment for STIs according to national guidelines	168,865	MOH Prog Data	175,502
	32. Percentage of women accessing antenatal care (ANC) services who were tested for syphilis *	TBD[10]	ANC Study	TBD [10]
	33. Percentage of antenatal care attendees positive for syphilis who received treatment *	TBD[10]	ANC Study	TBD [10]

Operational Strategy 2: To create an enabling environment for HIV prevention interventions through focused advocacy, community engagement, community systems strengthening to i) address barriers (social, cultural, religious, political, and legal) to effective interventions and ii) reduce vulnerability, stigma and discrimination related to HIV and key and vulnerable populations iii) reduce stigmatising and discriminatory attitudes in the general population that hamper effective HIV prevention.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.

Indicative activities:

- Review of legislation and policies, with meaningful involvement of key populations, women and youth, i) to examine the (positive and negative) impact of existing legislation and law enforcement on efforts to address HIV for members of key and vulnerable populations where relevant ii) to examine how accessible the legal system is to them, iii) analysis of how a given change of legislation or policy may affect HIV service access and advocate for change where necessary.
- Organise legal technical assistance for those affected by identified legislation or policies by in order to support the development of advocacy approaches for the areas in need for improvement.
- Establish links with duty bearers, lawmakers, line Ministries and other relevant government bodies who play a role in the policies and laws that are to be addressed.
- Finalise and implement strategies aimed at i) establishing legislation and policies that enable affected populations to protect themselves from HIV and gender-based, sexual and intimate partner violence, ii) changing legislation and policies that negatively impact efforts to address HIV.

OS 2.2: Reduce stigma, discrimination and violence related to HIV and key and vulnerable populations with a focus on healthcare providers, media and uniformed services personnel.

Indicative activities:

- Identify healthy and unhealthy gender norms and traditional beliefs in Liberian society that have a bearing on HIV, gender-based sexual and intimate partner violence.
- Based on the above, develop effective messaging and campaigns to promote healthy gender norms to end gender-based, sexual and intimate partner violence and to mitigate risk and impact of HIV.
- Develop and implement training curricula with regards to gender sensitisation, rights, SGBV and HIV for relevant sections of law enforcement authorities and prison services, involving key populations, women's and youth organisations and media.
- Develop and implement similar training curricula for health care providers.

- Establish policies on non-discriminatory, rights-based and gender friendly practices among health care providers and uniformed services personnel.
- Document stories of stigma, discrimination and violence experienced by key populations or other vulnerable populations to provide the evidence base for further training activities.

Table 4. Operational Strategy 2 Performance Framework: To create an enabling environment for HIV prevention interventions through focused advocacy, community engagement, community systems strengthening to i) address barriers (social, cultural, religious, political, and legal) to effective interventions and ii) reduce vulnerability, stigma and discrimination related to HIV and key and vulnerable populations.

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
Impact				
Stigma, discrimination, and punitive approaches related to HIV reduced. (OC)	Percentage of people with accepting attitudes towards PLHIV			
	Percentage of women (15-49) expressing acceptance attitudes on four indicators	6.6 (2013 DHS)	NAC/DHS	60%
	Percentage of men (15-49) expressing acceptance attitudes on four indicators	14.4 (2013 DHS)	NAC/DHS	60%
	Percentage of sample of service providers / uniformed personnel responding to statements that discriminate or stigmatise key populations	TBD[12]	Survey data	
Stigma, discrimination against people infected and affected by HIV reduced.	118. [11] Percentage of key populations (including PLHIV) who report they have experienced stigma and discrimination from other people is reduced	30% in 2013 2013 Liberia PLHIV Stigma Index Study	PLHIV Stigma Index Study; other surveys	10%
Output				
Increased access to HIV-related legal services.	64. Number & percentage of PLHIV and key populations that accessed legal support when felt stigmatised or segregated against	TBD[12]	NAC/Prog Data	50%
	Percentage of key population-focused programme sites where appropriate medical, psychological and legal support for those who have experienced violence is provided	TBD[12]	Facility-based assessment/ NACP programme data	TBD[12]
Monitoring and reformulation of laws, regulations and policies relating to HIV improved.	65. Number of different laws repealed/ policies reviewed to avoid punitive element and enhance enforcement in combating stigma	TBD[12]	NAC/Prog Data	5 (cumulative)
Increased Legal Literacy ("know your rights") on HIV and human rights.	66. Number of PLHIV and affected populations and vulnerable population trained in HIV and AIDS human rights violations, abuse and protection	1 000 (LIBNEP+)	LIBNEP+	5 000
Lawmakers and law enforcement agents	67. Number of law enforcement staff and Policy makers trained in HIV, Human rights	TBD[12]	NAC/Prog Data	500

[11] Numbered items correspond with indicators with the same number in the Liberia HIV and AIDS Response Monitoring and Evaluation Plan.

[12] In the absence of baseline data and other data problems, targets need to be set when accurate data become available. Some of the currently lacking data are expected to become available after the mid-term review of the NSP (2017); the establishment of drop-in centres for key populations will fill some of the data gaps for these groups. Once data gaps have been filled, targets in this performance framework will need to be determined or adjusted to reflect the ambitions in the various HIV prevention objectives and -activities.

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
sensitised on HIV and human rights.				
Training for health care providers on human rights and medical ethics related to HIV increased/ expanded.	68. Number &percentage of health workers trained in human rights, patient confidentiality and ethics in the context of HIV prevention and care	5 000	NACP/Prog Data	1 0000
Increased participation of communities in reduction of discrimination against women (and sexual and Gender based violence) in the context of HIV.	69. Number of communities that participated in campaigns against discrimination against women (and sexual and Gender based violence) in the context of HIV.	TBD[12]	NAC/Prog Data & stakeholders consultation	500
Increased participation of communities in reduction of discrimination against key populations and PLHIV.	69a. Number of communities that participated in campaigns against discrimination against key populations and PLHIV.	TBD[12]	NAC/Prog Data & stakeholders consultation	TBD[12]
	Media			
Outcome				
Partnership between the mass media and the national HIV response enhanced	70. Number of mass media institutions involved in national response to HIV & AIDS activities	26 (AAMIN 2015)	NAC/AA MIN Data	85
	71. Number of media practitioners writing HIV related articles in major media outlets or platforms	49 (AAMIN 2015)	NAC/AA MIN Data	185
Output				
Regular briefings on HIV and AIDS for the press by responsible national and county HIV and AIDS authorities.	72. Number of press/ media briefings on the national response developments in the last one year	5 (NAC 2014)	NAC/Prog Data	10
Making public service messages and original programming available to other outlets on a rights-free basis.	73. Number and proximity of public service messages accessible to public	30 (NAC 2015)	NAC/Prog Data	150

Operational Strategy 3: To strengthen the evidence base and monitoring systems and to promote the generation of strategic information to improve HIV programming and inform key stakeholders and decision makers.

OS 3.1: Finalise population size estimations and geographic mapping of all key and vulnerable populations, including key populations not mapped so far such as transgender people and prisoners.

Indicative activities:

- Establish methodologies of choice for population size estimates, such as respondent driven sampling or capture-recapture methods.
- Involve representatives of the target group to identify hotspots and other relevant locations where the research can be done.
- Observe ethical standards for informed consent and confidentiality and obtain ethical approval from the relevant bodies.
- Make size estimates per location or geographical unit and thus facilitate improved programming and targeting. The current establishment of DICs for key populations provide a good opportunity and geographical starting point for these size estimates.

OS 3.2: Conduct periodic IBBSS of in-school and out-of-school youth and all key and vulnerable populations, including those key populations not included so far such as transgender people and prisoners.

Indicative activities:

- Repeat IBBSS among key and vulnerable populations, and in-school youth and out-of-school youth at regular intervals.
- Change of national surveys to include a breakdown of out-of-school youth at risk into sub-groups relevant for HIV prevention activities, e.g. young pen-pen drivers, young girls working in bars or restaurants, hawkers etc.
- Involve representatives of the target groups to identify hotspots and other relevant locations where the research can be done.
- Observe ethical standards for informed consent and confidentiality, while seeking ethical approval from the relevant bodies.

OS 3.3: Establish routine monitoring of strategy, programmes and service quality, involving those affected by the monitored programmes and services.

Indicative activities:

- Develop and prioritise outcome and output indicators and -targets with input from all stakeholders, and adjust the performance framework of this strategy and the Liberia HIV & AIDS Response M&E plan accordingly.

- Organise notification of new cases of HIV with relevant background data such as age, and sex, and develop methodologies to estimate HIV incidence by key and vulnerable population.
- Establish baselines and benchmarks for quality.
- Develop quality improvement plans, procedures and checklists.
- Conduct periodic programme reviews and outcome evaluation of progress toward achieving the HIV prevention strategy goals for key and vulnerable populations as well as for the general population.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Indicative activities:

- Change of national surveys to include a breakdown of out-of-school youth at risk into sub-groups relevant for HIV prevention activities, e.g. young pen-pen drivers, young girls working in bars or restaurants, hawkers etc.
- Develop a better understanding, including through operational research, of the utilisation of traditional healers on HIV-related issues by all population groups and how traditional healers can be made into a useful link in the prevention and treatment cascades.
- Develop a better understanding, through operational research, of the level of knowledge of traditional healers on HIV-related issues.
- Conduct patient / client satisfaction surveys on a regular basis.
- Document stories of rights violations, sexual and gender-based violence, stigma, experienced by women and young people to provide an evidence base for policy makers, publications, and training activities.
- Conduct Knowledge, Attitudes and Practices surveys tailored to subgroups of youth, and key and vulnerable populations.
- Involve key and vulnerable populations and their organisations to formulate criteria for quality and research needs.
- Feedback of the results of operational research to result in improvement actions in the relevant programmes.

OS 3.5: Build the monitoring and research capacity of implementers and relevant CBOs.

Indicative activities:

- Establish capacity building activities for staff implementing routine monitoring and quality insurance, and for CBOs of key and vulnerable populations, affected women and youth.
- Build research capacities of key and vulnerable populations, affected women and youth and their organisations to carry out and monitor the implementation of the operational research action plan under OS 3.4.

OS 3.6: Create a learning programme to document the key results and impact of the HIV prevention strategy or parts thereof, and to disseminate the results nationally, throughout the region and internationally.

Indicative activities:

- Develop a dissemination plan for monitoring, evaluation and operational research carried out among the general population and key and vulnerable populations.
- Communicate with policy- and decision makers with results and recommendations from studies, in a language that they can understand.
- Participate and present successes and lessons learned from HIV programming at national and international conferences.
- Establish exchanges and study tours with other countries in the region and in other regions to learn and share experiences.
- Publish research results and knowledge generated through monitoring and operational research in an online repository.
- Publish research and other papers in peer-reviewed journals.
- Carry out formal mid-term and end-term evaluations.

Table 5. Operational Strategy 3 Performance Framework: To strengthen the evidence base and monitoring systems and to promote the generation of strategic information to improve HIV prevention programming and inform key stakeholders and decision makers.

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
Output				
Strengthened leadership, structures, planning, coordination of HIV and AIDS M&E	92. Number of planned Regular M&E/SI Programme review /coordination meetings of M&E TWGs, task forces and Committees at National, Sectorial/ line ministries, county & Networks/ umbrella organisations as relevant for HIV Prevention	4 (NAC 2014)	NAC/Program Data	4
Strengthened systems and increased capacity for routine HIV & AIDS programme Monitoring	93.[13] Number of staff from implementing partners trained on M&E	5 (NAC 2013)	NAC/Program Data	500
	94. Number of national, sectorial, thematic & county progress reports produced that address HIV Prevention and key and vulnerable populations			NAC 2 County 4
Strengthened systems and capacity for HIV and AIDS biological and behavioural surveillance, surveys and research	96. Number of the scheduled /planned surveys, surveillance, assessments, studies rounds and research conducted as per the M&E Plan that include studies on HIV Prevention, particularly among key and vulnerable populations and women, young people.	4 (NAC 2013)		TBD[14]
	97. A National HIV and AIDS Research and Evaluation Agenda available that includes HIV Prevention among key and vulnerable populations and among women and young people			Available
	98. National annualised epidemiological analyses, key and vulnerable population size estimates available			IBBSS and size estimates published
	99. Mid Term Evaluation of NSP (incl. HIV prevention strategy)	0		Available
	100. End of Term Evaluation (2019/20) (incl. HIV prevention strategy)	0		Available
Strengthened systems and	101. A national HIV & AIDS information dissemination and knowledge			Yes

[13] Numbered items correspond with indicators with the same number in the Liberia HIV and AIDS Response Monitoring and Evaluation Plan.

[14] In the absence of baseline data and other data problems, targets need to be set when accurate data become available. Some of the currently lacking data are expected to become available after the mid-term review of the NSP (2017); the establishment of drop-in centres for key populations will fill some of the data gaps for these groups. Once data gaps have been filled, targets in this performance framework will need to be determined or adjusted to reflect the ambitions in the various HIV prevention objectives and -activities.

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
capacity for HIV and AIDS Information dissemination, utilisation, learning & Knowledge Management	management strategy including guidelines for best practices identification and transfer/scale up created			
	102. Number of planned user friendly HIV & AIDS information products at National and County produced, including HIV prevention	TBD[14]		TBD[14]
	Strategic information on HIV Prevention, including information about key and vulnerable populations, women and young people, generated by the M&E system is used for evidence-based planning, management, advocacy and policy formulation.	TBD[14]		TBD[14]

Operational Strategy 4: To strengthen coordination among stakeholders and strengthen systems to effectively deliver comprehensive HIV prevention services for the general population, particularly young women, and for key and vulnerable populations.

OS 4.1: Engage with the broader community to establish linkages and coordination with networks of PLHIV, key and vulnerable populations, youth organisations, women's organisations, faith-based organisations, trade unions, human rights organisations, private sector, media, and community legal and social support bodies in order to strengthen relevant community systems in the response to HIV.

Indicative activities:

- Make a community systems and -structures strengthening plan
- Organise a meeting mechanism to exchange information and common actions to strengthen the community response to HIV. Use existing structures or meetings that already take place, such as annual review meetings, technical working group meetings etc,
- Monitor the implementation of the plan and propose corrective action.

OS 4.2: Engage with relevant governmental and non-governmental sectors to establish linkages and coordination to remove structural barriers to the use of services and programmes by key and vulnerable populations, young women and other population groups as relevant, and improve their rights.

Indicative activities:

- Assess training needs and establish a training curriculum for staff in these governmental sectors on salient issues affecting women, young people and key and vulnerable populations, with involvement of these target groups.
- Implement this training curriculum, revise, and keep up-to-date as necessary.
- Establish a feedback loop of monitoring and operational research results to staff working in the relevant government sectors.
- Establish advocacy targeted to the governmental sectors on policies, procedures and laws that impede access to services for women, young people and key and vulnerable populations and work with these sectors to improve the situation.
- Set up a parliamentarian advocacy group and strengthen the human rights platform in the current governmental structures as channels and targets for the aforementioned advocacy.

OS 4.3 Support training and capacity building of key and vulnerable population and youth service providers and key and vulnerable population and youth advocates.

Indicative activities:

- Assess training needs and establish a training curriculum for staff (and where relevant, volunteers) of women's groups, youth organisations, key and vulnerable population services providers and key and vulnerable population advocates including current standards in HIV prevention, new preventive technologies, human rights and other issues as relevant.
- Implement this training curriculum, revise and keep up-to-date as necessary.

Table 6. Operational Strategy 4 Performance Framework: To strengthen coordination among stakeholders and strengthen systems to effectively deliver comprehensive HIV prevention services for the general population, particularly young women, and for key and vulnerable populations.

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
	Community System Strengthening (CSS)			
Outcome				
Strengthened community systems making significant contributions to achieving the outcome of the national HIV response.	108.[15] Number of CBOs & FBOs whose governance, management, resource mobilisation, & M&E systems have been strengthened	NA	NAC & PSI	7 (300)
	Community Participation in HIV Response (incl. Private sector and CSO involvement)			
High-level meetings with private sector, media, and CSOs held annually	Number of private sector companies engaged in HIV and AIDS partners	5 (NAC/MoL 2015)	NAC/MoL data	20
The CSO, FBO, CBO sector commitment, involvement, advocacy and resource mobilisation and service delivery of HIV and AIDS prevention, treatment, care and support programmes/ services increased	79. Number of CSOs, FBOs, CBOs implementing HIV and AIDS prevention, treatment, care and support programmes/services increased	25 (NACP 2013)	NAC/PSI data	55
The private sector commitment, involvement, funding and service delivery of HIV and AIDS prevention, treatment, care and support programmes/ services increased	77. Number of large private sector companies with workplace HIV and AIDS policies and programmes. (particularly those in mining and transport: see also under key and vulnerable populations services)	2 (MoL 2014)	NAC/MoL data	15
Outcome				
Active community	80. Number of organised community support groups active in HIV and AIDS	5 (2014	NAC Prog Data	35

[15] Numbered items correspond with indicators with the same number in the Liberia HIV and AIDS Response Monitoring and Evaluation Plan.

Results	Indicators	Baseline Value; Source & Year	Data Sources	Targets 2020
participation in the HIV response is strengthened	in prevention, care and support (by counties, Districts & categories)	SHALOM)		
Output				
Traditional and religious leaders in the communities identified and their knowledge on HIV and AIDS effective leadership.	81. Number of key traditional and religious leaders whose capacities have been strengthened to provide leadership for community level HIV activities (by counties, Districts & categories)	850 (2015 NAC/LCC)	NAC/Prog Data	1 000
Umbrella groups and networks of local CSOs and FBOs whose capacities have been strengthened spearhead community level HIV and AIDS activities.	82. Number & percentage of umbrella groups & networks of local CSOs & FBOs whose capacities have been strengthened to spearhead community level HIV & AIDS activities. (by category, counties, Districts)	4(2015 NAC)	NAC/Prog Data	60
	Coordination and Management of the National HIV Response			
Outcome				
Management and coordination capacities for the national HIV response improved.	83. Number of stakeholder TWGs held by NAC at national, sectorial and different constituency (i.e. CSOs, private sector organisations, line ministries and other government departments and agencies) levels and county levels held/ organised/ facilitated	5 (NAC 2014)	NAC data	10
	84. Existence of coordination offices, structures and guidelines for national, sectorial and county and community level HIV and AIDS programmes	5 (NAC 2015)		15

HIV prevention among key and vulnerable populations

Although there are many commonalities in the implementation of the strategy among each key and vulnerable population there are also specific factors and tailored approaches for each of these populations.

The following section highlights specific issues per key and vulnerable population related to some of the operational (sub-) strategies. These issues should be seen additional to those outlined in the general HIV prevention framework. Indicators and targets for key populations are included in the tables in the previous section that refer to each operational strategy.

Men who have sex with men (MSM)

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Additional indicative activities:

- All HIV prevention and behaviour change activities and -programmes and should also target young men ≤ 20 years given early MSM sexual involvement.
- Condom promotion and -distribution should also include distribution of condom compatible lubricants at places that MSM visit ('hotspots') and other places that are acceptable and accessible to MSM.
- Introduction of new preventive technologies for MSM such as Pre-Exposure Prophylaxis (PrEP) with the appropriate ART drugs according to WHO guidelines depending on the outcomes of the assessment under OS1.1.

Because of the overlap between MSM, drug injecting and use of other drugs, a comprehensive harm reduction package must also be made available, including:[16]

- Objective information on drugs, their action, toxicity, and overdose symptoms.
- Needle exchange.
- Opioid substitution therapy (OST) as needed.
- Drug rehabilitation services.
- Overdose prevention and –treatment.

Because of the overlap between MSM and sex work, provide a comprehensive package that targets male sex workers, including:

- Free condoms and condom compatible lubricants.
- Introduction, as necessary, of new preventive technologies for MSM such as Pre-Exposure Prophylaxis (PrEP) with the appropriate ART drugs according to WHO guidelines.

[16] See section on people who inject drugs for more explanation of the harm reduction package

- Access to PEP.
- Access to SGBV care in case of rape.
- Access to STI diagnosis and -treatment.
- Access to quality HIV prevention information tailored to the needs of this group.
- Hepatitis B diagnosis and vaccination.

Cross-cutting elements
In the health care sector, the setting up of a network of MSM-friendly health care providers, – clinics or DICs can contribute to improved access to prevention, treatment and care services. At these providers, MSM can:

- Obtain free condoms and lubricants.
- Access STI treatment.
- Access free counselling and testing.
- Access basic care and –treatment services
- Access information about HIV, STIs, PrEP, and other health information.
- Access SGBV interventions / PEP.

Training of health care personnel:

- In medical needs and health problems specific for MSM.
- New preventive technologies such as PrEP for MSM.
- MSM experiencing (sexual) violence, SGBV interventions and PEP
- Avoiding stigmatisation and discrimination of MSM and encouraging a non-judgmental attitude towards MSM.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.

Additional indicative activities:

- Access to legal services and human rights information for MSM.
- Analogous to MSM friendly health care services, a network of MSM-friendly legal services will help realise improved access of MSM to legal services, where MSM can obtain non-judgmental legal assistance free of stigma and discrimination.
- Consult with MSM to document harassment and/or arrest.
- Identify national laws that criminalise same-sex behaviour and same-sex relationships and review and identify national laws that open up opportunities to non-discrimination or decriminalization of same-sex behaviour or same-sex relationships.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of

stigma, discrimination and other societal issues on exercising their rights and their access to services.

- Carry out research on cultural factors affecting the judgment of same-sex behaviour.
- Base general population information campaigns towards more tolerance for MSM on the results of this research.

Female Sex Workers (FSW)

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.

Additional indicative activities:

- Assess the need and acceptability regarding the use of PrEP among FSW community.
- Assess the need and acceptability to roll out the use of the female condoms among FSWs.

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Additional indicative activities:

- Prioritise those geographical areas where the highest impact is likely given results obtained under OS1.1., e.g. urban areas.
- All HIV prevention and behaviour change activities and -programmes should also target young women between the ages of 15-24 given early start of involvement in sex work of many FSW. These prevention programmes need to be linked to similar programmes for out-of-school youth.
- Enhancing comprehensive knowledge among FSW on HIV prevention and –transmission, with information relevant and tailored to the target group in a language that they can understand. This includes comprehensive knowledge about HIV transmission through injection and sharing injection equipment because of the overlap between FSW and drug injecting.
- Condom promotion and -distribution should also include distribution of condom compatible lubricants at places that FSW visit (‘hotspots’) and other places that are acceptable and accessible to FSW.
- Ensure FSW understand the benefits of 100% consistent condom use.
- Introduction of new preventive technologies for FSW such as Pre-Exposure Prophylaxis (PrEP) with the appropriate ART drugs according to WHO guidelines depending on the outcomes of the assessment under OS1.1.

- Pay special attention to knowledge about HCT, HCT sites and increase accessibility of HCT by implementing community HCT and outreach HCT at hotspots.
- Ensure the implementation of a comprehensive package of SGBV care and PEP.
- Given the frequency of rape in FSW, implement a package of FSW empowerment trainings to negotiate safe sex.

Because of the overlap between FSW, alcohol use, drug injecting and use of other drugs, a comprehensive harm reduction package must also be made available, including:[17]

- Objective information on drugs, their action, toxicity, and overdose symptoms.
- Needle exchange.
- Opioid substitution therapy (OST) as needed.
- Drug rehabilitation services.
- Overdose prevention and –treatment.
- Information about the role of alcohol use in engaging in unsafe sexual practices.

Cross-cutting elements

In the health care sector, the setting up of a network of FSW-friendly health care providers and –clinics or DICs can contribute to improved access to prevention, treatment and care services. At these providers, FSW can:

- Obtain free condoms and lubricants.
- Access STI treatment.
- Access free counselling and testing.
- Access basic care and –treatment services
- Access information about HIV, STIs, PrEP, and other health information.
- Access SGBV interventions / PEP.

Training of health care personnel:

- In medical needs and health problems specific for FSW.
- New preventive technologies such as PrEP for FSW.
- FSW experiencing (sexual) violence, SGBV interventions and PEP.
- Avoiding stigmatisation and discrimination of FSW and encouraging a non-judgmental attitude towards FSW.

OS 1.3: Link target groups, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant group.

Essential elements:

- HBV testing and –vaccination.
- STI diagnosis and –treatment.
- SGBV care and PEP.
- Access to legal services and human rights information for FSW.

[17] See section on people who inject drugs for more explanation of the harm reduction package

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.

Additional indicative activities:

- Analogous to FSW friendly health care services, a network of FSW-friendly legal services will help realise improved access of FSW to legal services, where FSW can obtain non-judgmental legal assistance free of stigma and discrimination.
- Consult with FSW to document harassment and/or arrest.
- Identify national laws that criminalise sex work and review and identify national laws that open up opportunities to non-discrimination or decriminalisation of sex work.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Carry out research on cultural factors affecting the stigma of sex work.
- Base information campaigns towards more tolerance for FSW targeted to the general population on the results of this research.

People who inject drugs (PWID)

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

and

OS 1.3: Link target groups, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant group.

Additional indicative activities:

- Develop national policies and guidelines related to needle and syringe programmes (NSP), and opioid substitution therapy (OST). To maximise impact, NSP guidelines should stipulate that:
    - There be no limit on the quantity of injecting equipment provided by NSPs
    - The return of used injecting equipment is not a prerequisite for clients to receive new injecting equipment.

    - NSPs provide a range of injecting equipment that is appropriate for local injecting practices and substances injected and that is acceptable to the target population.
- OST guidelines should include clear guidance on:
    - Patient assessment
    - Gaining informed consent for treatment
    - Dosing and duration of treatment
    - Provision of psychosocial support
    - Dispensing protocols
    - Patient review and follow-up
    - Provision of OST for pregnant women
- Prioritise those geographical areas where the highest impact is likely given results obtained under OS1.1., e.g. urban areas within high-prevalence counties such as Montserrado, Margibi and Grand Bassa.
- Establish links with HIV prevention activities for other key and vulnerable populations, particularly for FSW.
- All HIV prevention and behaviour change activities and -programmes and should also target young people between the ages of 15-24 given early start sexual activity in PWID. These prevention programmes need to be linked to similar programmes for out-of-school youth.
- Enhancing comprehensive knowledge about HIV prevention and –transmission, with information relevant and tailored to the target group in a language that they can understand. This includes comprehensive knowledge about HIV transmission through injection and sharing injection equipment.
- Implement a comprehensive package of harm reduction for PWID, based on international recommendations, including:
    - Needle and syringe programmes.
    - Opioid substitution therapy and other drug dependence treatment.
    - Overdose prevention and –treatment.
    - Voluntary rehabilitation.
    - HIV testing and counselling.
    - Antiretroviral therapy.
    - Prevention and treatment of sexually transmitted infections.
    - Condom programmes for people who inject drugs and their sexual partners.
    - Targeted information, education and communication, including objective information drugs, their action, symptoms of overdose, and on safe injection.
    - Prevention, vaccination, diagnosis and treatment for viral hepatitis (B and C).
    - Prevention, diagnosis and treatment of tuberculosis.
- Access to legal services and human rights information for PWID.

Cross-cutting elements

In the health care sector, the setting up of a network of PWID-friendly health care providers, –clinics or DICs can contribute to improved access to prevention, treatment and care services. At these providers, PWID can:

- Obtain free condoms.
- Obtain clean needles, syringes and injection paraphernalia.
- Access STI treatment.
- Access free counselling and testing.
- Access basic care and –treatment services
- Access information about HIV, STIs, PrEP, and other health information.

Private sector involvement:

- Especially in urban areas, encourage involvement of the private sector pharmacies in the distribution of needles, syringes and injection paraphernalia in a network of PWID friendly pharmacies.

Training of personnel:

- For health care personnel: medical needs and health problems specific for PWID.
- For health care personnel: new preventive technologies such as PrEP for PWID.
- For law enforcement agencies (police, military): principles of a public health approach to drug use and people who use drugs and essential HIV prevention services for people who use drugs.
- For health care personnel and law enforcement agencies: Avoiding stigmatisation and discrimination of PWID and encouraging a non-judgmental attitude towards PWID.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.

Additional indicative activities:

- Analogous to PWID friendly health care services, a network of PWID-friendly legal services will help realise improved access of PWID to legal services, where PWID can obtain non-judgmental legal assistance free of stigma and discrimination.
- Consult with PWID to document harassment and/or arrest.
- Identify national laws that criminalise drug use and review and identify national laws or regulations that would facilitate a public health approach to drug use and drug injection, as opposed to an approach exclusively based on law enforcement.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper

understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Carry out research on cultural factors affecting the stigma of drug use.
- Ensure information campaigns on drug use are not stigmatising and vilifying people who use drugs, and include information about prevention- and treatment options for people who inject drugs.

Transgender people (TG)

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.

Additional indicative activities:

- Include TG people in routine monitoring and research activities that include other key and vulnerable populations, including IBBSS, mapping of hotspots etc., while realising that TG are a separate group from MSM, with separate needs.
- Assess the need and acceptability regarding the use of PrEP in the TG community.

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Additional indicative activities:

- Condom promotion and -distribution should also include distribution of condom compatible lubricants at places that TG visit (‘hotspots’) and other places that are acceptable and accessible to TG.
- Introduction of new preventive technologies for TG such as Pre-Exposure Prophylaxis (PrEP) with the appropriate ART drugs according to WHO guidelines depending on the outcomes of the assessment under OS1.1.

OS 1.3: Link key and vulnerable populations, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant population.

Essential elements:

- HBV testing and –vaccination.
- STI diagnosis and –treatment.
- SGBV care and PEP.

- Access to legal services and human rights information for TG.

Cross-cutting elements
In the health care sector, the setting up of a network of TG-friendly health care providers and –clinics can contribute to improved access to prevention, treatment and care services. At these providers, TG can:

- Obtain free condoms and lubricants.
- Access STI diagnosis- and treatment.
- Access free counselling and testing.
- Access basic care and –treatment services
- Access information about HIV, STIs, PrEP, and other health information.
- Access SGBV interventions / PEP.

Training of health care personnel:

- In medical needs and health problems specific for TG.
- New preventive technologies such as PrEP for TG.
- TG experiencing (sexual) violence, SGBV interventions and PEP
- Avoiding stigmatisation and discrimination of TG and encouraging a non-judgmental attitude towards TG.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.

Additional indicative activities:

- Analogous to TG friendly health care services, a network of TG-friendly legal services will help realise improved access of TG to legal services, where TG can obtain non-judgmental legal assistance free of stigma and discrimination.
- Consult with TG to document harassment and/or arrest.
- Identify national laws or regulations that criminalise or discriminate TG people. and identify national laws that open up opportunities to non-discrimination of TG people.
- Advocate for change in laws and procedures to include feminisation process and change of sex in legal records if desired by the TG person.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Urgently implement research on size estimate of the TG population, and include TG population in the IBBSS.
- Set HIV prevention targets for TG people based on the results of these studies.

Prisoners and other people in closed settings

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.

Additional indicative activities:

- Include prisoners in routine monitoring and research activities targeted at key and vulnerable populations, such as IBBSS, and implement country-wide coverage of such research.
- Work towards the availability of data broken down by sex.

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

And

OS 1.3: Link target groups, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant group.

Additional indicative activities:

- Deal with most pressing health problems of prisoners (e.g. scabies, other skin infections) first, such that prisoners are open to receiving HIV information without being distracted by these health problems.
- Implement discreet condom and lubricant distribution inside prisons.
- Implement a comprehensive package of harm reduction activities inside prisons based on international recommendations, including:
    - Needle and syringe programmes.
    - Opioid substitution therapy and other drug dependence treatment.
    - Overdose prevention and –treatment.
    - HIV testing and counselling.
    - Antiretroviral therapy.
    - Prevention and treatment of sexually transmitted infections.
    - Targeted information, education and communication
    - Prevention, vaccination, diagnosis and treatment for viral hepatitis (B and C).
    - Prevention, diagnosis and treatment of tuberculosis.

- Make available bleach to clean tattooing equipment and shared shaving tools.
- Provide instructions as to the proper use of bleach.
- Establish continuity of care and referral links outside the prison system for prisoners upon release through individual, peer- or community driven case management approaches.
- Establish linkages and referral systems with social support, mental health, legal and human rights organisations including those that have access inside prisons and other places of detention, and including organisations working with post-release prisoners.

Training of prison staff and prison health care personnel is to address:

- Medical needs and health problems specific for prisoners.
- Prisoners experiencing (sexual) violence, SGBV interventions and PEP
- Assess knowledge about HIV and transmission of HIV, HBV, and HCV
- Based on the assessment, set up a training curriculum about protection of the health of prison staff and prison health care personnel.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.

Additional indicative activities:

- HIV prevention in prisons safeguards human rights of prisoners, including voluntariness of testing and treatment.
- Develop training and information sessions for both prison staff and prison populations to raise awareness about human rights in prison.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Make available an accurate size estimate of the prison population in the country.
- Assess the most pressing health problems among prisoners and ensure these are addressed besides HIV and related infections.
- Assess in more detail the situation encompassing all HIV prevention aspects in prisons, including consensual sexual activity, rape / SGBV, drug use, drug injecting, tattooing, sharing of shaving tools and other sharps, and exposure to blood.

- Include male as well as female prisoners in operational research.
- Implement further steps in HIV prevention based on evidence from these studies.

Uniformed services personnel

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.

Additional indicative activities:

- Make data of routine surveys, such as IBBSS, available broken down by sex.

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Additional indicative activities:

- Condom promotion, knowledge- and use pays special attention to consistent condom use, especially with paying partners.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Make available an accurate size estimate of uniformed services personnel in the country.
- Review existing data, and design and implement targeted research on knowledge, attitudes and practices relevant to HIV in this group, including sex with paying partners, sexual violence and drug- and alcohol use in order to gain a better insight in the drivers of the relatively high HIV prevalence in this group. Develop a comprehensive package of HIV prevention activities for this target group.
- Assess HIV knowledge, attitudes and practices of workers in the prison system (see section on prisoners) and develop a comprehensive package of HIV prevention activities for this target group.

Mobile traders

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Additional indicative activities:

- Pay special attention to the needs of women in targeting of HIV prevention activities, while including both sexes in those activities.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Make available an accurate size estimate of mobile traders in the country.
- Review existing data, and design and implement targeted research (that includes women) on knowledge, attitudes and practices relevant to HIV in this group, including sex with paying partners, sexual violence and drug- and alcohol use in order to gain a better insight in the drivers of the relatively high HIV prevalence in this group.

Miners

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.

Additional indicative activities:

- Include information about both sexes, geographical location, employment status and mining sector (industrial or artisanal mining).

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Additional indicative activities:

- Engage, where relevant, with the private sector, notably mining companies, to develop and implement workplace awareness trainings on HIV.
- Engage, where relevant, with the private sector and labour unions to develop and implement a comprehensive package of HIV prevention services for miners based on current national and international standards as outlined in this HIV prevention strategy.

OS 1.3: Link key and vulnerable populations, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant population.

Additional indicative activities:

- Engage, where relevant, with the private sector to link miners into HIV treatment and care services.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.

Additional indicative activities:

- Review existing regulations and policies that have a negative impact on the HIV situation in the mining industry.
- Establish links, where relevant, with the private sector and labour unions to remove regulations and policies that have a negative impact on the HIV situation in the mining industry.
- Design an advocacy strategy to change identified regulations and policies.

OS 2.2: Reduce stigma, discrimination and violence related to HIV and key populations with a focus on healthcare providers and uniformed services personnel.

Additional indicative activities:

- Establish links, where relevant, with the private sector and labour unions to design and implement campaigns to reduce stigma and discrimination of PLHIV working in the sector.

OS 3.1: Finalise population size estimations and geographic mapping of all key and vulnerable populations, including key populations not mapped so far such as transgender people and prisoners.

Additional indicative activities:

- Include both male and female workers in routine data collection, such as IBBSS.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Design and implement studies that map vulnerabilities of various mining populations by employment status and mining sector (industrial or artisanal mining).
- Review existing data, and design and implement targeted research on knowledge, attitudes and practices relevant to HIV in this group, including sex with paying partners, sexual violence and drug- and alcohol use in order to gain a better insight in the drivers of the relatively high HIV prevalence in this group.

Transport workers

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.

Additional indicative activities:

- Update information to include both sexes, and main transport routes.

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Additional indicative activities:

- Engage, where relevant, with the private sector, notably transport companies, to develop and implement workplace awareness trainings on HIV.
- Engage, where relevant, with the private sector and labour unions to develop and implement a comprehensive package of HIV prevention services for transport workers based on current national and international standards as outlined in this HIV prevention strategy.

OS 1.3: Link target groups, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant group.

Additional indicative activities:

- Engage, where relevant, with the private sector to link transport workers into HIV treatment and care services.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response in the general population, particularly among young women, and among key and vulnerable populations.

Additional indicative activities:

- Review existing regulations and policies that have a negative impact on the HIV situation among transport workers.
- Establish links, where relevant, with the private sector and labour unions to remove regulations and policies that have a negative impact on the HIV situation among transport workers.
- Design an advocacy strategy to change identified regulations and policies.

OS 2.2: Reduce stigma, discrimination and violence related to HIV and key and vulnerable populations with a focus on healthcare providers and uniformed services personnel.

Additional indicative activities:

- Establish links, where relevant, with the private sector and labour unions to design and implement campaigns to reduce stigma and discrimination of PLHIV working in the transport sector.

OS 3.1: Finalise population size estimations and geographic mapping of all key and vulnerable populations, including key populations not mapped so far such as transgender people and prisoners.

Additional indicative activities:

- Include both male and female workers in routine data collection, such as IBBSS.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Design and implement studies that map vulnerabilities of various types of transport workers by geographical location, employment status and transport sector (cargo, taxi drivers, pen-pen drivers).
- Review existing data, and design and implement targeted research on knowledge, attitudes and practices relevant to HIV in this group, including sex with paying partners, sexual violence and drug- and alcohol use in order to gain a better insight in the drivers of the relatively high HIV prevalence in this group.

People Living with HIV

OS 1.1: Update and maintain existing information regarding i) locations where target populations such as out-of-school youth, and key and vulnerable populations concentrate (hotspots), ii) service needs, iii) programme coverage and iv) existing community capacities in order to plan and deliver high quality, acceptable and accessible services with meaningful involvement of each relevant target group.

Additional indicative activities:

- Map and understand prevention service needs of PLHIV from all key and vulnerable populations.
- Map and understand prevention service needs among serodiscordant couples.

OS 1.2: Implementation of a package of high quality, acceptable and accessible HIV prevention services for each relevant target group, including new preventive technologies.

Additional indicative activities:

- Integrate HIV prevention messages and services into HIV care and treatment settings as well as HIV testing and counselling programmes.
- Prevention counselling for PLHIV, including key and vulnerable populations living with HIV.
- Develop and implement a prevention package for serodiscordant couples, including:
    - Partner disclosure and (peer-) support with partner disclosure
    - Prevention counselling for serodiscordant couples
    - Family planning education and –counselling
    - Prevention of HIV related SGBV
- Scale-up PMTCT services for all pregnant women with HIV.

OS 1.3: Link target groups, where necessary, to high quality, acceptable and accessible HIV treatment and care services for each relevant group.

Additional indicative activities:

- Scale-up access to antiretroviral (ARV) treatment for all people living with HIV, including key and vulnerable populations who are found living with HIV who often face the greatest barriers to services, utilising the preventive benefits of treatment without compromising their human rights.
- Access to adherence counselling and other community driven support mechanism for key and vulnerable populations living with HIV.

OS 2.1: Advocacy for changes in HIV policies, procedures and laws that might impede the HIV response among key and vulnerable populations.

Additional indicative activities:

- Support programmes, policies and laws that create shared responsibility among everyone in their role to prevent new HIV infections irrespective of HIV status.
- Remove laws that criminalise transmission of HIV.
- Remove other policies and service practices that hinder access to means of prevention for people living with HIV, including the prevention of mother-to-child transmission.

OS 3.4: Develop and implement an operational research action plan for each key and vulnerable population and other population groups as needed that will help to improve the implementation and quality of the services provided to them, and will help to gain a deeper understanding of the impact of stigma, discrimination and other societal issues on exercising their rights and their access to services.

Additional indicative activities:

- Design and implement studies that map the HIV prevention needs of PLHIV, and particularly prevention needs of serodiscordant couples.

OS 4.1: Engage with the broader community to establish linkages and coordination with networks of PLHIV, key and vulnerable populations, youth organisations, women's organisations, faith-based organisations, trade unions, human rights organisations, private sector, media, and community legal and social support bodies in order to strengthen relevant community systems in the response to HIV.

Additional indicative activities:

- Include positive prevention as an element of community systems strengthening.

OS 4.3 Support training and capacity building of key and vulnerable population and youth service providers and key and vulnerable population and youth advocates.

Additional indicative activities:

- Establish a training curriculum in positive prevention for networks and organisations of PLHIV as well as relevant organisations representing key and vulnerable populations.
- Train networks and organisations of PLHIV as well as relevant organisations representing key and vulnerable populations in positive prevention.

Monitoring, evaluation and data collection

Monitoring, evaluation and data collection centres around **Operational Strategy 3:**
To strengthen the evidence base and monitoring systems and to promote the generation of strategic information to improve HIV programming and inform key stakeholders and decision makers.

The evaluation framework is based on the main objectives of the HIV prevention strategy: reducing the new cases of HIV in the country by 50% from baseline in 2020. Therefore, the high level (impact) indicators monitor HIV incidence, in the general population, in women and young people, and in key and vulnerable populations. Although more difficult to measure, preference is given to measurement of incidence over prevalence, since the latter is a function of many factors. A rise or fall in prevalence is not necessarily a 100% reflection of a rise or fall in incidence. For instance, improved treatment outcomes of HIV will result in more PLHIV surviving, and therefore might (temporarily) result in an increased prevalence.

Other indicators are derived from the four operational strategies: i) Development and access to services, ii) creating an enabling environment, iii) monitoring evaluation and research, and iv) coordination. Indicators are aligned with the 'Liberia HIV and AIDS Response Monitoring and Evaluation Plan' and WHO indicators. (National AIDS Commission (NAC) 2014, World Health Organization 2015)

There are major challenges in the data availability and –collection in order to establish the right data frames to monitor the results of this HIV prevention strategy. For instance, there are data available about the number of new HIV infections per year; these are not broken down by age and sex, nor are there any data about new HIV infections in key and vulnerable populations. Therefore, routine monitoring of new HIV infections must include data broken down by age and sex to adequately monitor (reduction of) HIV incidence in the general population, particularly to monitor the results to reduce HIV among young women and adolescent girls.

Routine data collection will generally not include data about someone's sexual orientation, drug addictions, or whether a person is involved in commercial sex. People are likely to be reluctant to disclose such data when accessing services and if these data would be collected, this mere fact will most certainly deter individuals from key populations in accessing services. Therefore, collecting data about HIV incidence and prevalence in key and vulnerable populations must be organised in a different way, taking into account the sensitive nature of the data collection. This implies involving CBOs delivering services that are focused on the respective key and vulnerable populations, and using tailored methodologies in order to be able to assess relevant baselines and subsequent trends. For example, testing and notification data from sentinel sites accessed by people from key populations may provide a more specific estimate of incidence, but consideration should be given to how representative these data are of the entire key population. Also mathematical modelling can estimate incidence. Modelling tools such as the UNAIDS Spectrum Package can be used to estimate HIV incidence for

various population groups. To produce incidence estimates in key populations and other population groups, these models require reasonably accurate population size estimates that can serve as denominators for calculation of indicators. These models also need information on prevalence, modes of transmission, and data from ART programmes.

Therefore, conducting serosurveys and IBBSS at regular intervals will be important to monitor HIV prevalence. At the same time, such surveys collect information about important behavioural indicators among key and vulnerable populations, and among youth.

Certainly given the sensitive nature of the subject, surveys and other research requires observing high ethical standards regarding informed consent, data management, and –storage.

Not all elements of this strategy can be put into quantifiable indicators. An example is the establishment of law reform with regards to key populations, such as decriminalisation of sex work and same sex relationships. For these type of processes, milestones are formulated and thus progress can be tracked.

Nevertheless, there are also methodologies to monitor the amount of stigma experienced by, for instance, PLHIV. The stigma index developed for PLHIV by GNP+ is a case in point. These methodologies can be adapted per target group and describe stigma and discrimination experienced by key populations.

In order to collect key population specific data, whether quantifiable or not, it is of paramount importance that all target populations are involved in the set up of data collection and that their capacities and skills in monitoring and evaluation be built.

Synergies with other sectors

HIV prevention has links with many sectors in the medical and public health arena. HIV prevention is not a stand alone issue but is linked up, and integrated, with health services that provide ART care, TB prevention and treatment, Sexual and Reproductive Health and the EBV response.

Synergies between these sectors are already implied by linking HIV to ART in treatment as prevention, by including TB case finding and treatment, HBV prevention (and HCV prevention) and by linking sexual and reproductive health issues into the current HIV prevention strategies for key and vulnerable populations, and the general population. Integration of HIV and EVD prevention may provide opportunities especially in the general population. Follow up of EVD survivors has shown persistent virus in semen. This offers opportunities to further promote condom use to prevent sexual transmission of both HIV and EVD. This HIV prevention strategy will support greater coordination and integration in the control of linked epidemics of TB, HBV, HCV and EVD.

Because HIV prevention has so many ramifications beyond the medical and public health sector, it is clear that many other governmental and non-governmental sectors beyond health are to play an important role and hence must be kept involved and informed.

Synergies with these other development sectors have been already described in the Liberia National HIV & AIDS Strategic Plan 2015-2020, and are summarised in table 7. This table from the NSP is adjusted to provide a link with key priorities in this HIV prevention strategy and identify additional key partners in HIV prevention. The narrative focuses on the link with HIV prevention rather than providing the detailed strategies and activities included in the NSP.

Table 7. National HIV response and Synergies with Development Sectors

	Elements in HIV Prevention strategy	NSP 2015-2020 Focus	Synergizing Activity	Development Sector & other key partners
1	Key population and key and vulnerable population focus of health services (including capacity building)	Strengthening key health systems impacting on the national HIV response	Health Systems Strengthening	Health Sector – Ministry of Health and Social Welfare (MOH), WHO, UNAIDS, FBOs, NDS
2	Community involvement in key population and key and vulnerable population focus of health services – including capacity building). Community	Strengthening community systems impacting on the HIV response	Community Systems Strengthening (CSS)	Community Sector – CSOs (especially those of PLHIV, key and vulnerable populations, and youth) , FBOs, Ministry of Internal Affairs / Law Enforcement Agencies, Traditional Council, and Chiefs, Traditional healers. Private sector (e.g. health care providers, condom sociall marketing, pharmacies)

	Elements in HIV Prevention strategy	NSP 2015-2020 Focus	Synergizing Activity	Development Sector & other key partners
	involvement includes private sector			
3	HIV prevention in young people, particularly young women and girls	HIV education for in school youth	School-Based HIV Education	Ministry of Education (MOE), CSOs (youth organisations)
4	HIV prevention in young people, particularly young women and girls	SRH & HIV education for out of school youth	HIV prevention information and services for out of school youth	CSOs (especially those involving youth), Ministry of Youth and Sports
5	Elimination of HIV related stigma and discrimination, including stigmatisation and discrimination of key populations.	Stigma and discrimination against PLHIV	Human Rights and HIV	Legal Sector, Human Rights Sector – Ministry of Justice. Ministry of Health CSOs/FBOs (including human rights organisations and those of PLHIV, key and vulnerable populations) Private sector Law Enforcement Agencies Mass media (newspapers, journals, radio and TV stations)
6	None	Mitigating socioeconomic impact on AIDS-affected households	Social Protection for the Poor, involve PLHIV in income generating activities	Social Protection – Ministry of Gender and Development (MGCSP), Mass media (newspapers, journals, radio and TV stations)
7	Gender Dimension of HIV : focus on young women and girls, SGBV	Gender and HIV	Gender Dimension of HIV	Ministry of Gender, Children and Social Protection (MGCSP) CSOs / FBOs (women, youth) Law Enforcement Agencies (SGBV)
8	Vulnerable populations: uniformed services personnel, miners, mobile traders, transport workers	HIV and the Workplace – Formal Sector	Workplace HIV Programs; occupational health services.	Public Sector Ministries including the Security Forces; Ministry of Transport; Private Sector Firms (transport and trading companies, mining companies); Labour Unions
9	Vulnerable populations: miners, mobile traders, transport workers	HIV and the Workplace – Informal Sector	Workplace HIV Programs	Ministry of Labour, CSOs

Focus of health services on key and vulnerable populations

This corner stone of the HIV prevention strategy links with the Health Systems Strengthening focus of the NSP. The health sector will receive specific capacity building in HIV prevention for key and vulnerable populations. Key partners are obviously found in the health sector. Technical support – notably guideline and policy development, development of SOPs – may be provided by the UN family under the coordination of UNAIDS, with assistance from other International NGOs (INGOs) where necessary. Capacity building of health services staff, including those of private health providers from e.g. faith-based organisations, needs to be initiated coordinated by the MOH. Strengthening procurement systems at the National Drug Service will help create a uninterrupted and predictable supply of prevention consumables (male and female condoms, medicines, vaccines, needles, syringes etc.).

Community involvement in focus

The second cornerstone of this HIV prevention strategy is its focus on community involvement. Key populations tend to avoid services because of their marginal position in society. Each key and vulnerable population has different requirements for HIV prevention, and therefore services must be tailored to their needs. Community-based organisations led by these groups are pivotal to make the HIV prevention strategy for key and vulnerable populations work. While they have a good understanding of the needs of the group they represent, many additional capacity building needs still exist and hence strengthening of the technical and organisational capacities of these organisations is a priority.

Community involvement includes private sector in certain areas, e.g. community based HCT, condom social marketing, condom compatible lubricant social marketing, pharmacy-based outlet of HIV prevention materials etc. Also here, additional capacity building is necessary.

Finally traditional structures with traditional leaders play an important role in rolling out community-based HIV prevention, and therefore they need to be involved and their capacities need to be built.

The same goes for traditional healers, who are often the first point of contact of people when they experience symptoms or seek protection from HIV infection. Proper recognition of the potentially important role of traditional healers, while providing them with some simple tools to work safely and refer when necessary, will help to improve the prevention and treatment cascades.

HIV prevention in young women and girls

Given the current epidemiology of HIV in Liberia, comprehensive life skills, sexuality education and HIV prevention for young people, particularly young women and girls, is important to curb the HIV epidemic in the country. Youth in school is already being reached through educational activities at school, further enhanced through peer-based interventions. The Ministry of Education is a primary partner to enable good quality curricula in this respect. Out-of-school youth is more difficult to engage than in-school youth, but also here peer-based

intervention through relevant CSOs/FBOs and youth clubs of the Ministry of Youth and Sports are likely to have the best effect, with the latter Ministry in the lead.

Elimination of HIV related stigma and discrimination

Key populations have first-hand experience of stigma and discrimination, and hence their organisations play an important role in creating the awareness of other governmental and non-governmental organisations in Liberian society.

The Ministry of Justice is an important partner in implementing policies on respecting human rights of key populations and as a target for advocacy when it comes to changing legislation and policies that criminalise key populations or hamper the HIV response in other ways.

Because of the way law enforcement authorities usually engage with key populations, stigmatising and discriminating behaviour is likely to occur. An integrated curriculum that puts the public health approach centre stage, raises awareness with law enforcement authorities of key populations' rights as full Liberian citizens, HIV prevention issues of these key populations, and awareness of SGBV will gradually bring about a change in mentality and behaviour of these authorities and thus facilitate rights-based public health approaches to HIV prevention for key populations.

Gender Dimension of HIV

Certain gender role patterns in Liberian society are not conducive to empowering women to protect themselves when it comes to sexuality. The epidemiology of HIV, with relative high prevalence in young women and girls, is a reflection of these societal patterns. Other gender inequalities that have an impact on the HIV epidemic in Liberia are: violence against women, gender-related barriers to access services, the caregiving role of women (not giving priority to their own needs), lack of education and economic security for women, and inadequate budget support for gender-sensitive and women-focused HIV prevention programmes. Activities involving the relevant governmental sectors are being implemented to tackle these issues. The most important activities in this HIV prevention strategy would include the focus and empowerment of young women and girls in HIV prevention, and collecting HIV-relevant data disaggregated by age and sex to inform policies and programming. Furthermore, involvement of women's organisations together with the Ministry of Gender, Children and Social Protection (MGCSP) in HIV prevention activities and their development will further strengthen a gender-sensitive approach to HIV prevention.

Vulnerable populations

HIV-at-the-work-place programmes developed under the leadership of the Ministry of Labour, and sectorial or private (occupational) health services will be able to address the elevated HIV prevalence among uniformed services personnel, miners, mobile traders, and transport workers. Labour unions play a role in advocacy to strengthen these programmes if there is a need to do so. This will address the workers that found formal employment in these sectors.

A significant proportion of miners, mobile traders, and transport workers is employed in the informal sector. These groups are more difficult to reach with HIV prevention programmes. Hence, CSOs, organised along trade or faith, must play a role in prevention and service provision where these groups do not turn to the regular health systems. A better understanding of health seeking- and sexual behaviours, beyond what is coming through IBBSS, is needed to tailor HIV prevention efforts to the needs of these target groups.

Key partners' roles and responsibilities

The National AIDS Commission was established in 2010 by an Act of the National Legislature to coordinate and manage the multisectorial national HIV response. As such, NAC will oversee and lead the implementation of this HIV prevention strategy. NAC's Partnership Mandate has facilitated the formation of the 'Government Line Ministries and Agencies HIV and AIDS Coalition' to provide stewardship in mainstreaming and integrating HIV and AIDS into their core functions.

Key governmental partner is the Ministry of Health, through the National AIDS Control Programme (NACP). The Ministry of Health is the Principal Recipient (PR) of two Global Fund grants related to HIV. After the devastating Ebola epidemic, most health facilities have resumed their HIV services, including condom promotion and distribution, HIV counselling and testing, prevention of mother to child transmission, ART care and support for PLHIV, post-exposure prophylaxis, blood safety programmes, and diagnosis and treatment of sexually transmitted infections.

The Ministry of Internal Affairs (MIA) is very instrumental in providing education to local and community leaders on their roles in the national HIV response, for instance by conducting HIV and AIDS awareness and sensitisation for District Commissioners, Town Chiefs and Opinion Leaders. MIA is also a partner in trainings of traditional healers and traditional birth attendants in HIV prevention issues, e.g. PMTCT and referral issues.

The Ministry of Education leads the education sector response to HIV & AIDS using the Life Skills based approach implemented by the School Health Division. Through this approach, school health clubs are being set up, while teachers and students receive trainings on HIV prevention and peer support.

The Ministry of Gender, Children and Social Protection remains a key stakeholder in the national HIV response due to the important role being played by the Ministry in mainstreaming gender in HIV activities. In addition, MGCSP plays a key role in implementing the promoting the SGBV response with partners throughout the country.

The Ministry of Labour plays a key role in promoting HIV at the workplace policies, which is important for selected vulnerable populations that are addressed through the HIV prevention strategy, such as miners, transport workers, mobile traders and uniformed services personnel.

The Ministry of Justice, and especially the section for Human Rights and Protection, plays a key role in protecting and safeguarding the rights of key populations and those living with HIV, and monitor these rights in the light of human rights conventions that Liberia has signed.

Finally, the Government of Liberia is responsible for resourcing the NSP and the HIV prevention strategy. The NSP foresees an increasing contribution of the government's financial resources to the HIV response towards funding 15% of the HIV response from the governmental budget in 2020.

The public, private and CSO/FBO sectors and development partners are all key partners in the national HIV response. The CSO/FBO sector comprises a vast difference of organisations involved in the HIV response, from organisations set up and led by key populations, such as SAIL, and LIBNEP+, to professional societies and faith-based organisations, such as the Catholic Church and the Liberia Council of Churches. Youth and women's organisations are also important partners in mobilising attention for HIV prevention among their membership. CSO and FBOs are pivotal to making the HIV response into a success because they facilitate access to services for key populations and youth. Therefore, under the leadership of NAC, their role and capacities in HIV prevention, care and support will be strengthened in order to further roll out HIV strategies for key populations.

The mass media are important partners to provide the Liberian population with accurate, non-judgmental and non-stigmatising information about HIV and AIDS and key populations. Therefore, mass media outlets and journalists need to have a place at the table when it comes to information and communication about the HIV response in Liberia, while their capacities to produce quality copy about the subject needs to be built.

The UN Family, remains engaged with the national HIV response especially through UNAIDS. UNAIDS works closely with NAC in the areas of capacity building, restructuring of the coordination mechanism of the HIV response, Ebola response, domestic resource mobilisation, monitoring and evaluation and social mobilisation. Also UNDP plays an important role by supporting coordination and capacity building of key population CSOs such as LIBNEP+. UNICEF plays a leading role in supporting the welfare of women and children in Liberia, which is reflected in UNICEF's support for Liberia's PMTCT / elimination of MTCT activities and HCT for pregnant women.

International NGOs are important partners where they co-implement important parts of the HIV prevention strategy. Population Services International (PSI) is the PR for the Global Fund grant on key populations and as such is a key partner in the implementation of this part of the HIV prevention strategy.

International donors are central to HIV prevention because they provide the financial support for HIV prevention where the Government of Liberia is unable to mobilise funds from the national budget. International donors, notably the Global Fund to fight AIDS, tuberculosis and malaria, provided more than 98% of the HIV response in the previous years. Although

and increase in government expenditure for the HIV response is planned, international funding is likely to remain essential in the near future in order to mount a sufficiently equipped HIV response, including HIV prevention capacity.

Resourcing the prevention response

Financial resources required to implement the HIV prevention strategy are summarised in table 8. The unit costs used to calculate the total indicative costs for each service area were derived from unit costs as retrieved from the Avenir Health Unit Cost Repository, with costs as much as possible taken from West-Africa country data, or, when not available, East-Africa country data. (Avenir Health 2010) These costs, which are standardised to 2011 price levels in the repository, are adjusted for average annual inflation rate to levels of 2019 as a mid-point in the current strategy. The 2019 data are then multiplied by four, the number of years this strategy will be in place.

The units are as much as possible derived from the NSP and the National HIV M&E Plan. Calculations for the general population are based on reaching 70% of the target group on average. Population size estimates for key populations are adjusted from the published size estimates, and based on calculations from the 2015 funding request to the Global Fund for HIV prevention among key populations. (Liberia Country Coordination Mechanism 2015) The cost of condoms has been calculated based on numbers of condoms procured as indicated in the Liberia HIV and AIDS M&E Plan, and averaged over the years. (National AIDS Commission (NAC) 2014) The cost of condoms includes procurement, storage, distribution and marketing.

Costing the HIV prevention strategy in the way described has its limitations, as they are derived from cost estimates coming from other countries, and modelled population size estimates for key populations. In the absence of accurate unit costs at Liberian price levels, and given the inaccurate key population size estimates available, the current costing method is the best one available in the circumstances.

The total estimated cost per year for the full HIV prevention strategy is close to USD 42.5 million, which amounts to USD 170 million over a four-year period. Condom programming makes up the bulk of these costs, and does not take into account the possible revenue from condom sales. Condoms programming requires about USD 101 million over the total period. Condom programming serves multiple objectives beyond HIV prevention, and includes EVD prevention, STI prevention and family planning purposes. Implementing the key and vulnerable populations-specific activities will require USD 11 million over four years.

Table 8. Indicative costs HIV prevention strategy, per year and total period

		Unit Cost (USD)	Units	2019	Total (four years)
HIV Counseling and Testing	All			3.619.647	14.478.589
	HCT	9,41	359.459	3.619.647	14.478.589
Blood safety	All			365.472	1.461.888
	Cost per blood unit screened	10,93	31.250	365.472	1.461.888
Sexually Transmitted infections	All			2.240.494	8.961.976
	Cost pp diagnosis and treatment	11,64	179.890	2.240.494	8.961.976
Key populations	All			2.760.268	11.041.070
MSM	Cost pp reached outreach	62,69	8.612	404.375	1.617.499
	Cost PrEP 20% MSM	600	8.612	1.105.781	4.423.123
FSW	Cost pp reached outreach	53,56	5.929	237.850	951.401
IDU	Cost pp reached OST	987,66	857	362.270	1.449.079
	Cost pp reached outreach	15,45	857	7.084	28.335
MSW	Cost pp reached outreach	77,81	1.722	100.381	401.524
Migrant labourer: mobile traders, miners	Cost pp reached outreach	8,6	45.000	289.863	1.159.452
TG	Cost pp reached outreach	125,46	1.000	93.970	375.878
Prisoners	Cost HCT pp	23,54	2.203	49.940	199.759
Transport workers	Cost per client visit (package)	3,4	25.000	63.665	254.660
USP	Cost pp reached	8,6	7.000	45.090	180.359

		Unit Cost (USD)	Units	2019	Total (four years)
Condom Promotion and Distribution	All			25.427.432	101.709.729
	Cost per female condom	1,09	1.246.590	1.453.898	5.815.592
	Cost per male condom	0,17	47.286.117	20.335.534	81.342.137
	Cost per male condom sold through social marketing	0,85	4.000.000	3.638.000	14.552.000
Adolescents and young people	All			4.996.738	19.986.952
	Outreach OSY pp reached	9,57	438.077	3.140.105	12.560.421
	Youth pp reached (ISY, peer)	3,53	702.214	1.856.633	7.426.531
Development synergies	All				
	SGBV	30,13	1.250	28.209	112.837
	Messaging, outreach pp reached	2,37	999.709	1.774.613	7.098.454
Behaviour change			999.709	3.099.958	12.399.831
	Person reached	4,14	999.709	3.099.958	12.399.831
Grand Total				**42.510.009**	**170.040.035**

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