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Union Work Progress

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NATIONAL COUNCIL FOR THE FIGHT AGAINST HIV / AIDS, STIs AND EPIDEMICS

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NATIONAL COORDINATION

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EXECUTIVE DIRECTION

2019-2022

NATIONAL STRATEGIC FRAMEWORK AIDS RESPONSE 2019-2022

Version - // - February 15, 2019

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LIST OF ACRONYMS

CSN	:	National strategic framework
HIV	:	Acquired immunodeficiency virus
ARV	:	Antiretroviral
CNLSE	:	National Council for HIV / AIDS, STIs and Epidemics
PNLS	:	National program to fight HIV / AIDS and STIs
STI	:	Sexually transmitted infection
CCN	:	National Coordinating Committee for Global Fund Grants
CCIA	:	Inter-agency coordination committee
DS	:	Health district
ECD	:	District management team
COSA	:	Health Committee
SDG	:	Sustainable development goal
UNDP	:	United Nations Development Program
WHO	:	World Health Organization
UNICEF	:	UNICEF
UNAIDS	:	Joint United Nations Program on HIV / AIDS
DHIS	:	District Health Information System
PNDS	:	National health development plan
Word	:	Study on modes of HIV transmission
CTA	:	Outpatient treatment center
PCR	:	Early detection of HIV in exposed infants
UNHCR	:	Office of the United Nations High Commissioner for Refugees
MICS	:	Multi-indicator country survey
PS	:	Sex professional
MSM	:	Man having sex with other man
PC	:	Prison population
IBBS	:	Integrated Biological and Behavioral Survey
ESIS	:	AIDS indicators seroprevalence survey
UNFPA	:	United Nations Population Fund
SSRAJ	:	Sexual and reproductive health of adolescents and young people
PMTCT	:	Prevention of mother-to-child transmission of HIV
TB	:	Tuberculosis
AES	:	Accident of exposure to blood and biological fluids
Prep	:	Pre-exposure prophylaxis
VSBG	:	Gender-based sexual violence
PEC	:	Supported
Dex / CNLSE	:	Executive direction of the National Council for the fight against HIV / AIDS, STIs and epidemics
GTSE	:	Technical working group on monitoring and evaluation
DDS	:	Departmental health directorates
PNLT	:	National Tuberculosis Control Program
DLM	:	Disease Control Directorate
SIGL	:	Computerized logistics management system
MSP	:	Ministry of Health and Population
PLHIV	:	Person living with HIV
EDS +	:	Demographic and health survey with HIV serology
CDV	:	Voluntary testing counseling
ULS	:	Unit for the fight against AIDS, STIs and epidemics

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PREFACE

In order to ensure the continuity and performance of the fight against HIV / AIDS and STIs, the Congo has undertaken the exercise of developing a National Strategic Framework for the Fight against AIDS and STIs (CSN) for the period 2019-2022. The process that led to the CSN 2019-2022 was an opportunity to take a retrospective and critical look at the systems in place, their operation, their performance and to plan consensually to achieve national and global objectives in terms of AIDS response.

The results and our current achievements remain fragile and deserve that we further strengthen our actions and their performance. This is why this strategic framework is intended to be a revolutionary tool in terms of its orientations, strategies and pillars on which it is based.

The Strategic Framework for the AIDS Response 2019-2022 would not have seen the light of day without the personal commitment of His Excellency Denis SASSOU N'GUESSO, President of the Republic, President of the National Council to Combat HIV / AIDS, the STIs and epidemics (CNLSE). Its development was the occasion for exceptional mobilization, both from national players and partners. I remain convinced that this mobilization will continue and grow in order to allow the Republic of the Congo, under the leadership of the President of the Republic, to meet the elimination of new HIV infections among men. and the elimination of the HIV epidemic by 2030.

Time is running out, new infections persist, and our brothers and sisters continue to die from AIDS. This requires us to speed up the response. Consequently, I invite already, each actor of the response to AIDS and the Congolese population as well as the partners to appropriate this document and to make it the key instrument to overcome the AIDS epidemic and ensure better living conditions for our populations.

By my voice, I can assure you that the Government, under the leadership of His Excellency Denis SASSOU N'GUESSO, will spare no effort to give its full support to the implementation of this Strategic Framework, by mobilizing its own resources but also by mobilizing its development partners.

Mrs Jacqueline Lydia MIKOLO
Minister of Health and Population
1^{time} Vice-President of the National Coordination of CNLSE

THANKS

The AIDS response in the Republic of Congo remains a public health priority. On the basis of an inclusive and participatory process guided by national and international guidelines, the country has just adopted a new National Strategic Framework for the fight against AIDS which will cover the period 2019-2022. It aims to strengthen the response to the HIV epidemic, based on the indisputable advantages of free HIV testing, treatment and biological monitoring programs, the law against HIV / AIDS dear to the President of the Republic who is committed to putting the Congo on the path to eliminating HIV / AIDS by 2030.

This process involved the participation of all representatives of national actors from all sectors (public, community, private, faith-based), technical and financial partners, but also that of key populations and people living with HIV.

It is the place for me to express my gratitude to the staff of the Executive Direction of the CNLSE, the Ministry of Health, as well as to all the national and international technical partners for their selflessness and for the excellent quality of the work that 'they realized. I will not forget all the actors in the fight against AIDS, whether in the public sector, the private sector or civil society for their involvement, to varying degrees, in the process of preparing this strategic framework.

This process was strongly supported by technical and financial partners. It is the place for me to thank the agencies of the United Nations system, in particular UNAIDS, WHO, UNFPA, UNICEF and UNHCR as well as bilateral cooperation agencies (European Union, France , United States) for their remarkable and exceptional contribution.

Together we have provided the Republic of the Congo with a revolutionary tool which will guide our future actions in the direction of better investment to reduce the delay and put the national response on the **the path to achieving the 90-90-90 target and eliminating the HIV epidemic by 2030.** Also, I would like to express my feelings of gratitude to all the natural and legal persons who contributed to its development.

I also express my feelings of gratitude to all the members of the CNLSE steering committee, to civil society organizations, to development partners, to experts and consultants, to the staff of DEX / CNLSE and the Ministry of Health. , for the quality of the work carried out and for the sacrifices made for the development of this Strategic Framework.

It is the place for me to salute the efforts made by His Excellency the Prime Minister, President of the National Coordination of CNLSE and his Excellency the Minister of Health, 1st Vice-President of the National Coordination of CNLSE, to have allowed and supported the progress of this process.

Dr Angélie Serge Patrick DZABATOU-BABEAUX
CNLSE Executive Director

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EXECUTIVE SUMMARY OF THE 2018-2022 CSN

Since 1986, the AIDS response has been a public health issue in the Republic of the Congo, approached cyclically through the development and implementation of a multisectoral and multiannual strategic plan (2003-2007,2009-2013 and 2014 -2018).

The last CSN 2014-2018, structured in three (3) major strategic axes, was implemented thanks to the involvement of several activity sectors (health, other ministerial sectors, civil society, religious denominations, private sector, etc.) .). Funding for activities under the CSN 2014 - 2018 was provided on the one hand by government resources, and the Global Fund, through three (3) major projects of national scope, and on the other hand by other bilateral partners. and multilateral and HIPC funds. Its implementation was punctuated by institutional changes, dysfunctions of national coordination and certain systems, but above all by a national financial crisis which reduced the State's capacities to respect its financial commitments.

Analysis of the dynamics of the epidemic has shown that the Republic of the Congo is experiencing an epidemic which remains generalized, almost stable since 2010, although declining since 2016. It remains generalized, with 3.2% prevalence in adults according to data from the seroprevalence survey and AIDS indicators (ESIS) carried out in 2009 and at 3.14% according to UNAIDS 2018 estimates. Between 2010 and 2016, the prevalence remained stable and began a decline in late 2016 (3% decrease). In addition, prevalence remains high in key and vulnerable groups such as in pregnant adolescents under 15 years of age (3.8%) in 2017, prison populations (3.7%), sex workers (8 , 1%), men who have sex with men (41.2%). Among MSM and PS, HIV prevalence is increasing (+ 58% among MSM and 8% among PS). There are, however, regional disparities of varying importance, affecting in particular the major cities of the country.

New infections remain high with a level in 2017 higher than that of 2010 (7,200 in 2010 and 7,900 in 2017). Young people aged 15-24 contribute to around 29% of new infections, with stability in boys (500 cases per year since 2010) and an exponential increase since 2012 in young girls with a level 4 times higher than that of boys (1900). In addition, the rate of mother-to-child HIV transmission is increasing (15.9% in 2013 and 18.18% in 2017), as are HIV-related deaths (20,100 deaths compared to 31,400 new infections between 2014- 2017)

The analysis of the response to HIV has highlighted the fundamental achievements including, among others: a) the existence of national coordination and an associative and community fabric, b) the establishment of a central purchasing a dynamic of capacity building, c) the existence of a structure in charge of promoting condoms with significant achievements, d) a health system that offers HIV-related services that are becoming more and more more with early detection platforms, viral load platform and a constellation of health facilities that have integrated PMTCT and / or medical care by ARVs in their care package.

Despite the achievements and progress, the analysis of the response also identified the challenges and constraints that remain to be overcome, as well as the program gaps:

In terms of prevention, the problems concern: i) the slow reduction in the prevalence of HIV (-3% over 7 years), the rise in new infections, the high and increasing prevalence among MSM, PS and adolescent girls / young women . The primary causes are a) the low level of reduction of the risks of contamination among MSM and the PS and b) the weak prioritization of the interventions in favor of adolescent girls and young women, which does not allow to reduce their vulnerability to HIV infection.

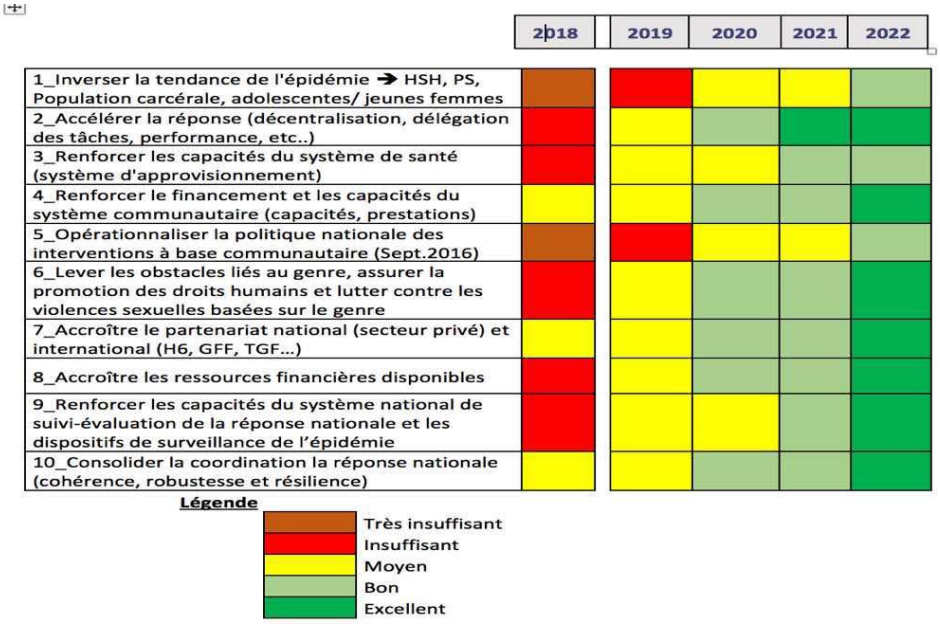
In the field of PMTCT, mother-to-child transmission of HIV is on the rise, placing the country behind the elimination targets. The main causes are a) poor functionality of devices (medical and community) to enlist and keep pregnant women

HIV-positive and children exposed throughout the PMTCT cascade and b) the poor performance of early detection platforms.

In the area of ARV treatment, deaths linked to HIV are on the rise and the survival of PLWHA on treatment remains below expectations. At this level, the review has shown that the main strategies such as detection of HIV-positive people through screening as well as enrollment and keeping children on ARVs encounter difficulties in implementation and effectiveness.

The governance and coordination of the AIDS response during the 2014-2018 period remained generally ineffective due to: i) the poor performance of the supply and distribution system leading to disruption of inputs, ii) the non implementation of quality assurance, iii) the under-funding of health product needs, iv) the low capacity of coordination and operational actors in gender and human rights, which does not allow programming and a capitalization sensitive to gender and human rights, v) the weak capacity for mobilization, management and financial accountability of national coordination, vi) the absence of a strategy for the involvement and participation of community and private sectors funding and implementation,vii) weak functionality of epidemic monitoring and strategic information production systems; and viii) weak strategies for controlling viral suppression.

It is in this context that the development of this strategic framework covering the period 2019-2022 was led by the DEX / CNLS between August and November 2018, with the support and participation of the operational, technical and financial partners of the National response to HIV. This participatory and inclusive process associating the main beneficiaries was conducted in the spirit of a theory of acceleration of the response to catch up and absorb the delay and put the national response on the path of reaching the goal 90- 90-90 and the elimination of the HIV epidemic on the horizon. This theory is based on the following 10 pillars:



The vision of the AIDS response for the period 2019-2022 is in line with that of the country's National Health Policy 2018-2022 which aims "A Congo endowed with an efficient, resilient health system capable of guaranteeing 'universal access to quality health services and optimal health to sustainably support the country's growth and development'. Its following guiding principles among others: strong leadership based on the "Three-Ones", alignment, effective multisectoriality and good

governance, integration of services and synergy, non-stigmatization / non-discrimination, consideration of Gender / Human Rights, strengthening of the national and global partnership for funding, strengthening of the health and community systems as a pillar of the results-based management and accountability response and the alignment of the AIDS response with the dynamics of community health.

The priority targets of the strategic plan are people living with HIV (children and adults), TB / HIV co-infected patients, men who have sex with men, sex workers and their clients, the prison population, HIV-positive pregnant women and adolescent girls and young women (10-24 years old).

The CSN 2019-2022 is built around 3 strategic priorities which are as follows:

- Reduce new infections among vulnerable populations (in this case young girls, young women), key populations and eliminate those in children;
- Achieve the 90-90-90 targets to significantly reduce morbidity and mortality among PLHIV;
- Strengthen governance and resilience of the AIDS response for better local responses based on quality strategic information

The implementation of sectoral strategies to fight against STIs and HIV / AIDS over the period 2019-2022 will be organized according to an approach based on multisectoriality and decentralization around an institutional framework involving the various actors of the national response. The expected impacts of the interventions, three in number, are as follows:new infections are reduced by 50% by by the end of 2022, b) the reduction of at least 62% of HIV-related mortality by the end of 2022 and c) the management, monitoring and evaluation, coordination and governance systems of the HIV response will be strengthened and resilient by the end of 2022.

The budget required has been estimated with the RNM Software at an amount of Seventy-eight million four hundred forty six thousand eight hundred and one Euros (78,446,801) or fifty-one billion four hundred fifty-seven million seven hundred and twenty - eight thousand four hundred fifty nine francs FCFA (51,457,728,459 FCFA).

	2019	2020	2021	2022	TOTAL	%
Prevention	5,165,161	5,900,269	7,031,716	7,918,126	26,015,272	**33.16%**
Key populations	347,049	431,010	520 601	616,426	1,915,086	2.4%
Populations vulnerable	1,057,766	1,261,042	1,768,852	1,986,110	6,073,770	7.7%
Provision of services	3,472,265	3,912,727	4,439,200	5,004,777	16,828,968	21%
Health care	288,081	295,990	303,064	310,812	1,197,448	2%
Care services and treatment	6,660,848	8,239,248	9,981,789	11,860,284	36 742 169	**46.84%**
Governance	2,956,502	3,534,879	4,253,376	4,944,603	15,689,360	**20%**
Total (Euro)	**14,782,511**	**17,674,396**	**21,266,881**	**24,723,013**	**78 446 801**	**100%**
Total (US $)	**16 693 106**	**19,958,759**	**24,015,562**	**27,918,388**	**88 585 815**	
Total (FCFA)	**9,696,691,752**	**11,593,643,789**	**13,950 159,620**	**16,217 233,299**	**51 457 728 459**	

RNM Congo summary (1 US * = 580.88 FCFA, 1 € = 655.957)

The available funding (which can be mobilized) is valued at 25,149,020 € (16,496,675,713 FCFA), representing 32.05% of the total resources required. The funding to be sought is estimated at 53,297,781 € corresponding to 64.95% of the total cost of the CSN 2019-2022.

In order to close the financial gap, the focus will be on advocacy actions with the State, bilateral and multilateral partners, the private sector and civil society organizations. A round table of technical and financial partners, extended to the private sector will be organized and a committee for monitoring commitments set up. The implementation and achievement of the expected results is dependent on the control of risks and the height of the mobilization of financial resources. Also, a risk management plan will be developed for this CSN and it is envisaged a round table of resource mobilization and robust measures to ensure the effective mobilization of funding pledges as well as the use of innovative funding.

The overall coordination of implementation will be ensured by the Executive Direction of the National Council for the fight against HIV, STIs and epidemics (DEX / CNLSE) with the support of its decentralized entities. The monitoring and capitalization of interventions and results will be based on DHIS2 and will have as a frame of reference the 12 components of a functional monitoring and evaluation system recommended at international level.

INTRODUCTION

For the AIDS response, the Republic of Congo has developed and implemented a National Strategic Framework for the fight against HIV / AIDS 2014-2018. The vision of this framework is to make the Congo a country with zero new HIV infections, zero AIDS-related deaths, and zero discrimination in the general population and in particular in the groups most exposed to an emerging Congo by 2025 The priorities were part of universal access to prevention, treatment and care for PLWHA. They revolved around: (i) halving the sexual transmission of HIV, including among young people, men who have sex with men and in the context of the sex trade; (ii) elimination of mother-to-child transmission of HIV and halving of AIDS-related maternal deaths; (ii) improving the quality of life and the medical management of patients on ARVs; (iv) strengthening interventions targeting key populations and vulnerable groups; (v) capitalization of the achievements of the implementation of the strategic framework for combating HIV and AIDS 2009-2013 and (vi) advocacy for the effective financing of the national response.

During the implementation faced difficulties related to events of various nature, duration and impact on the interventions. See table-1:

Table-1 : Summary of historical events between 2014-2018

	Intitulé /Nature de l'évènement	Envergure	Type	2014				2015				2016				2017				2018			
				T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3	T4	T1	T2	T3	T4
1	Conflits armés et crises sociopolitiques	Tout le département du Pool	Sociopolitique et humanitaire																				
2	Déplacements de populations	Tout le département du Pool	Sociopolitique et humanitaire																				
3	Crise économique avec la baisse du cours du pétrole	A l'échelle nationale	Economique																				
4	Reprogrammation du R9 du Fonds mondial	7 départements prioritaires sur 12	Financement																				
5	Mesures suspensives du Fonds mondial	7 départements couverts par le FM	GAS																				
6	Dissolution de la Congolaise des Médicaments Essentiels et Génériques (COMEG)	A l'échelle nationale	GAS																				
7	Mise en place du Comité de Gestion des Approvisionnements et des Produits de Santé Essentiels (CGAPSE)	A l'échelle nationale	GAS																				
8	Mise en place du Comité de quantification des médicaments	A l'échelle nationale	GAS																				
9	Mise en place de la CAMEPS (sans textes valables (vide juridique)	A l'échelle nationale	GAS																				
10	Grève de certains agents du SEP/CNLS (coordination nationale) et de 5 Unités départementales	siège à Brazzaville et Kouilou, Pool, Plateaux, Cuvette-	Coordination																				
11	Mise en place de la politique de sauvegarde additionnelle du Fonds mondial avec perte de statut de PR pour le CNLS	A l'échelle nationale	Financement																				
12	Changement institutionnel du CNLS en CNLSE	A l'échelle nationale	Coordination																				

These events had various consequences on the national response:

Two-speed response (reduction in CNLS capacity and response in the 5 departments) [4]
Reduction of the operational capacities of the actors of the response and of coordination of the response national (departure of key personnel, reduction of personnel, reduction of funding, etc.) [11]
Disorganization of the national response to HIV / AIDS and capitalization difficulties [10]
Reduction in state funding affecting activities and availability of health products [3]
Drastic reduction or even cessation of AIDS response activities [1; 2]
Failure to carry out prevention activities (screening, management of STIs, etc.) [5]
Supply chain dysfunction with stock shortages [6; 7]
Difficulty estimating the country's real needs in health products and mobilizing funds for them health product purchases [8; 9]
Loss of efficiency due to the duplication of roles on the ground between the main players for a certain period of time (CCN CNLSE, PNLS)

In order to ensure the continuity of the response, the National Council to fight AIDS and epidemics led a participatory and inclusive process which led to the development of this new National Strategic Framework for AIDS response for the period 2019 -2022. The process was supported by the Government and the technical and financial partners. The key stages of this process were as follows: a) establishment of the steering committee and thematic groups, b) launch of the process by the Minister of Health in September 2018, c) preparation and validation of the report of the review of the implementation of the CSN 2014-2018, d) preparation and validation of the CSN 2019-2022. The detailed description of the CSN 2019-2022 development process can be found in Appendix 8.5

I. NATIONAL CONTEXT

1.1 Presentation of the country and administrative context

The Republic of Congo is located in central Africa and covers an area of 342,000 km². It shares its borders with 5 countries: Gabon in the West for 1,903 km, Cameroon in the North-West for 523 km, Angola and the enclave of Cabinda in the South for 201 km, the Central African Republic in the North for 467 km and the Democratic Republic of Congo to the East for 2,410 km along the Congo river and the Oubangui river. According to Spectrum, the Congolese population is estimated in 2017 at 4,779,480 inhabitants including 56,072 indigenous people and in 2020 at 5,162,056 inhabitants including 60,560 indigenous people. This population, of which almost 40% is under 15, is predominantly urban (61.8%). Brazzaville (37.1%) and Pointe Noire (19.3%) account for 56.4% of the general population. The population projection and breakdown is as follows:

Table-2 : Population projection and distribution

Demographic indicators	2017	2018	2019	2020	2021	2022
Total population	5,222,633	5,357,538	5,495,701	5,637,035	5,781,530	5,929,334
Male population 15-49 years	479,227	496,164	513,881	532,705	552,107	572,708
Female population 15-49 years	474,948	491,766	509,419	528,185	547,540	568,096
Male population 15-64 years	1,236,494	1,268,932	1,303,468	1,340,254	1,377,946	1,417,184
Female population 15-64 years	1,225,455	1,257,683	1,292,151	1,328,882	1,366,546	1,405,771
School-aged children (primary)	1,376,340	1,416,230	1,453,730	1,488,331	1,519,753	1,548,174
School-aged children (secondary)	954 104	987 704	1,023,254	1,060,703	1,099,894	1,140,603

In secondary education, the gross and net enrollment rates are 65.3% and 44.4% respectively. The urban environment records the highest rates (84.9% against 35.6% for the gross rate and 57.7% and 24.1% for the net rate). It appears from the ECOM that overall 80.4% of people aged 15 and over can read and write in any language.

Law No. 3-2003 of January 17, 2003 establishing the territorial administrative organization structures the national territory in departments, communes, arrondissements, districts, urban communities, rural communities, districts and villages. The national territory is thus structured into 12 departments, 6 municipalities, 19 districts and 86 administrative districts. Each department has a departmental council and each commune has a municipal council. These different councils are the management and development bodies of the resources of these local authorities. Under the terms of Law No. 10-2003 of February 6, 2003 relating to the transfer of powers to local authorities, the departments participate in the establishment of the departmental section of the national health map;

1.2 Socioeconomic situation

The Congolese economy remains very diversified, because mainly focused on the oil industry (around 60% of GDP) and to a lesser extent on wood (5%) and agriculture (3%), the share of other sectors in GDP remaining very marginal. The Congo is therefore largely dependent on the development of commodity prices.

Since 2014, the Congolese economy has suffered the full brunt of the consequences of the drop in oil prices. For the fourth consecutive year, GDP growth is down. This negative development results from the decline in oil GDP (-1.5%) over the 2014-16 period, the other sectors not really taking over (3.3%). After the good performances of 2014 and 2015, all sectors except extractive industries fell by 3.1% in 2016 while inflation, fueled by difficulties in the rail sector, reached 3.6%. According to the estimates updated by this Committee, the GDP growth rate in real terms of Congo over the whole of 2017 would be -1.9% instead of the projected 1% in the meantime. In 2016, GDP growth had already registered a negative performance of -2.8%.

1.3 Context and health situation

Decree No. 2018 - 268 of July 2, 2018, organizes the ministry in charge of health in three hierarchical levels: central, intermediate and peripheral or operational. The health system has three hierarchical levels: central, intermediate and peripheral.

- *The central level* is The role of the central level is strategic, normative and regulatory. It is also responsible for coordinating the entire sector and for mobilizing and allocating resources. The Ministry has several consultation, advocacy and decision-making bodies: (i) the National Health Council, (ii) the PNDS Steering Committee,

(iii) the National Council for Combating HIV / AIDS, Sexually Transmitted Infections and Epidemics (CNLSE), (iv) the National Coordination Committee (CCN) of malaria, tuberculosis and HIV / AIDS projects funded by the global fund, (v) the
inter-agency coordination (CCIA) for immunization and vaccines and various other committees.

- *The intermediate level* is represented by: (i) the 12 departmental health directorates (DDS),

(ii) the 12 departmental population directorates and (iii) the 12 departmental health and population inspections. The latter respectively play the role of technical support to the health districts and of compliance with the regulations of the sector at this level. The territories of
health departments obey the administrative division of the country.

- *The peripheral level* is represented by the DS. Currently the country is divided into 51 health districts according to decree n ° 5369 of August 2, 2017. Each DS is subdivided into several health areas. The DS is managed by a district management team (EDC) and the beneficiary population participates in the management of the health system through management committees (COGES) and health committees (COSA). These are community participation bodies that support the functioning of the health system at the peripheral level.

The main recent health indicators are:

Table-3 : Main health indicators at the end of 2017

Indicators	Value	Year
Synthetic fertility rate	4.9	RGPH 2007
Early pregnancy	26%	MICS 2015
Expected deliveries	140,930	
Infant and child mortality rate (per 1,000 live births)	52 ‰	SPECTRUM
Crude Neonatal Mortality Rate (SDG 3.2.2) (per 1,000 live births)	21 ‰	MICS 2015
Post-neonatal mortality rate (per 1,000 live births)	15 ‰	MICS 2015
Infant mortality rate (SDG 3.2.1) (per 1,000 live births)	36 ‰	MICS 2015

Mortality rate of children under five (per 1,000 live births)		17 ‰	
Maternal mortality ratio (SDG 3.1.1) (deaths per 100,000 live births)		436	
Prevalence delay growth (SDG 2.2.1)	Moderate and severe	21.2	MICS 2015
	Severe	8.2	MICS 2015
Exclusive breastfeeding for children under 6 months		32.9	MICS 2015
Prenatal care coverage		93.2%	MICS 2015
Childbirth in an institution		91.5%	MICS 2015
Incidence of tuberculosis (number of TPM + per 100,000 inhabitants			
Incidence of malaria (parasitaemia in children)		29.7%	MICS 2015
Prevalence of malaria in children 6-59 months		29.8%	MICS 2015
Unmet FP needs		17.9%	MICS 2015

As part of the strengthening of the health system, several activities have been implemented. They mainly concern the availability of services to meet needs in terms of prevention and treatment, the training of providers on various themes, the description and good understanding of the dynamics of health personnel, the permanent availability of essential inputs and supplies. (monitoring relating to purchasing and the supply management system, storage, quality, etc.), financing of the health system, strengthening of the information system, governance, leadership and the development of policies and laws against violence , stigma / discrimination against vulnerable populations.

According to the PSDRHS 2011-2020, human resources for health ... lack of health personnel both in terms of coverage and quality, social and geographic. The main constraints of the health system are: i) poorly motivated health personnel; concentrated in urban centers, ii) ratios of 1 doctor for 13,144 inhabitants, 1 nurse for 2,402 inhabitants and 1 midwife for 982 women of reproductive age, iii) huge disparities between departments and rural and urban areas. Brazzaville and Pointe Noire alone contain nearly 70% of the staff, iv) the aging of executives and v) the low quality and quantity human resources statistics.

The health information system suffers from a lack of personnel and equipment to better fulfill its role. Reinforcement initiatives are underway, in particular the establishment of DHIS2 which should allow better collection and availability of the main health indicators.

The supply system for inputs and health products encounters structural and functional shortcomings which lead to recurrent shortages of certain essential health products. The reform undertaken at the central purchasing level and the improvement of the supply system have not yet produced the desired effects. Quality control and pharmacovigilance remain to be operationalized.

Community participation in the financing, management and implementation of health services remains low overall to guarantee better accountability and responsibility for the communities. To implement community health, the country adopted a community-based intervention policy in 2016. To date, very few health districts have community intermediaries. With the support of Unicef, the tools and supports for community relays were developed. However, its full operationalization constitutes an opportunity for the AIDS response and will require a harmonized operational plan integrating the various services, including those relating to the AIDS response.

Funding is gradually decreasing and is dependent on the economic crisis in the country. Mobilization of external resources. Between 2012 and 2015, the sources of current health expenditure represent respectively: Government (46.50%), households (31.25%) and development aid (20.75%). The proportion of the budget allocated to health has increased since 2013 (12% in 2015 and 11% in 2018), but the implementation rate has decreased from 8.6% in 2014 to 3.8% in 2015.

Priority problems identified in the 2018-2022 PNDS

1. *Insufficient popularization of texts, procedures and management support for the health sector at all levels,*
2. *Insufficient functioning of steering, coordination and partnership bodies at all levels*
3. *Weak capacities in planning, monitoring and evaluation at all levels of the system,*
4. *Insufficient accountability mechanisms in the health sector*
5. *Insufficient leadership at all levels of the health system*
6. *Delay in the implementation of decentralization in the health sector,*
7. *Insufficient involvement of the community and civil society organizations in health management*

II. SYNTHESIS OF THE ANALYSIS OF THE EPIDEMIOLOGICAL SITUATION AND THE RESPONSE TO HIV

2.1 Epidemiological situation of HIV and other co-infections

2.1.1 Situation and evolution of the HIV epidemic in the general population

The modeled data of the epidemic in the Republic of Congo, following the EPP-SPECTRUM methodology, indicates the epidemic is of a generalized type which stands at 3.14% in the population aged 15-49. The main statistical data at the end of 2017 are as follows:

Table 4 : Main HIV statistics at the end of 2017

	Prevalence of HIV among adults aged 15-49	Number of adults and children living with the HIV	Adults and children newly HIV infected	AIDS-related deaths in adults and children
Global	**3.14 [2.6 - 3.6]**	**100,000 [85,000 - 110,000]**	**7900 [6800 - 9200]**	**4900 [3900 - 5800]**
Adults 15 and over	3.03 [2.55 - 3.44]	91000 [77,000 - 100,000]	6200 [5300 - 4800]	3700 [3000 - 4500]
Women 15 and over	4.09 [3.46 - 4.67]	61,000 [52,000 - 70,000]	4100 [3500 - 4800]	2300 [1800 - 2800]
Men 15 and over	1.97 [1.67 - 2.2]	30,000 [25,000 - 44,000]	2100 [1800 - 2600]	1400 [1200 - 1700]
Children 0-14 years old	0.42%	9100 [6400 - 11,000]	1700 [1200 - 2200]	1200 [<1000 - 1500]
Women aged 15-49	4.4 [3.7 - 5.1]	51098 [42849 - 58624]	3607 [3022 4146]	1814 [1418 2213]
Men 15-49 years old	1.9 [1.5 - 2.2]	22112 [17574 - 25533]	1735 [1472 2044]	945 [733 1133]
Girls	2.2 [1.0 - 3.3]	11,000 [4600-16,000]	1682 [884-2203]	144 [54-285]
Young boys	0.6 [0.2 - 0.9]	2800 [1100-4300]	389 [59-555]	72 [41-114]

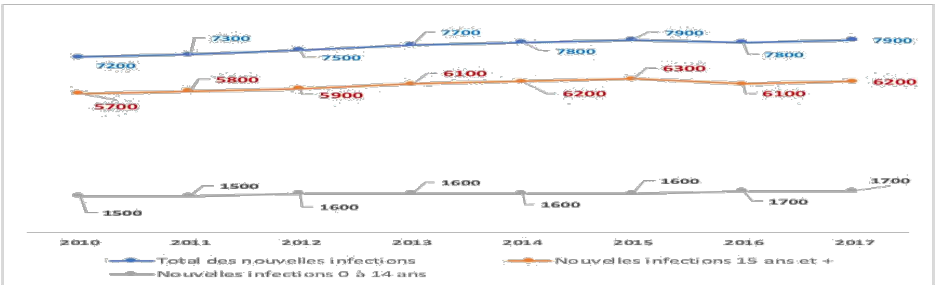
Source: www.aidsinfo.unaids.org

From 2010 to 2016, the prevalence of HIV had stabilized at 3.2% before experiencing a beginning of decline at the end of 2016. In almost 7 years, the gain in reduction in prevalence is 3% . The epidemic remains feminized with a female / male prevalence ratio of 2.3 in adults and 3.6 in young people.

➔ **New infections and modes of transmission**

In absolute terms, we note that the number of new infections increases from one year to the next, as much among the under 15s as among the over 15s. Among 14-24 year olds, there is a stabilization at lower levels in boys, a stabilization at high levels in girls from 10-19 years and on the other hand an increase in the number of new infections among girls of 15-24 year olds from 2012 and throughout the implementation period of the CSN 2014-2018. (See table below)

Graph-1 : Number and evolutionary profile of new annual HIV infections between 2010 and 2017

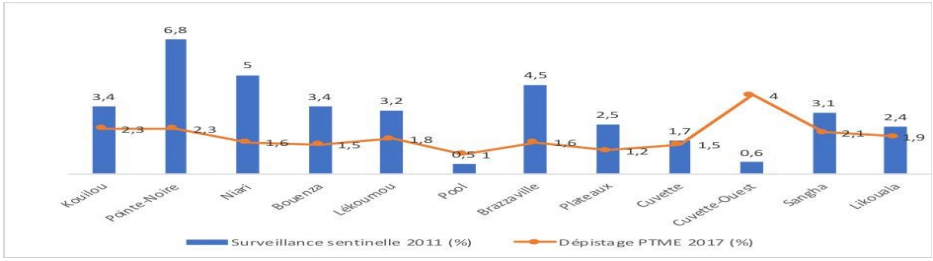


In 2017, the 15-24 age group contributed 29.11% to new infections. There are no recent data to determine the population groups that contribute the most to new infections. Although less recent, the study of the modes of transmission of HIV (MoT) in 20131, shows that the dynamics of HIV infection is characterized by a predominance of new infections within the group of people with occasional heterosexual intercourse (52.2%). Stable heterosexual couples, regular female partners of MSM, as well as clients of social workers, contribute 23.7%, 14.6% and 3.4% respectively. These 4 subgroups represent 90% of new infections in the general population in the Congo.

➔ **Prevalence of HIV in pregnant women and children exposed to HIV**

The prevalence of HIV in pregnant women is estimated at 3.6% [3.0% -4.4%], according to the epidemiological serosurveillance study by sentinel post (CNLS Report 2016). In 2017, the average prevalence rate was 1.8% with regional disparities.

Graph-2 : Geographic disparities in HIV prevalence among pregnant women



Analysis of HIV testing data among pregnant women indicates a variation in HIV status by age. It is higher respectively among the 45 and over age groups (14.3%), followed by those under 15 (3.8%). Between 15 and 39 years of age, the rate of seropositivity increases in the brackets (0.1% among 15-19 year olds, 2.4% among 20-24 year olds, 2.5% among 25-29 year olds, 3, 10% among 30-34 year olds and 3.5% among 35-39 year olds). The rate of seropositivity is low in 15-19 year olds (0.1%) and in 40-44 year olds (1.3%) (Source: PNLS Report 2017)

Of the 215 children born to HIV-positive mothers in the two CTAs, 169 benefited from a PCR at 6 weeks with a report of results. A total of 4 children had a positive PCR result and received early ARV treatment. The transmission rate is therefore 2.3%. Breastfeeding was only practiced in 29% of the cases due to the problems with ruptured ARVs encountered during the year.

[1]SEP-CNLS: Analysis of modes of HIV transmission (MoT), 2013

➔ **Prevalence of HIV among voluntary blood donors**

The blood transfusion is coordinated by the National Center for Transfusion. In total, there are 32 sites that collect blood and secure it for transfusion.

237,721 blood bags were acquired and 209,303 blood bags were secured. All blood bags are tested with four (4) markers (HIV, syphilis, Hepatitis B and Hepatitis C).

However, there are weaknesses in the availability of multiple blood bags (for collection), laboratory reagents and consumables. The haemovigilance system has not really been implemented although the documents are available but awaiting validation. The quality control system has not been in place since 2014. In recent years, blood transfusion services have been disrupted by reduced funding and interruptions of work (strike) of varying duration and scope.

➔ **Prevalence of HIV among refugees and internally displaced persons**

The humanitarian situation is fueled by socio-political unrest in neighboring countries (CAR, DRC) and the events that occurred in the pool in late 2015. In February 2018, during the Ministry of Social Affairs and Humanitarian Action (MASAH) launched IDP registration operations
Pool. The number of displaced people was estimated at 90,000.

The AGDM (Participatory Refugee Assessment) implemented by the HCR2, it emerged that most families push their young people into prostitution to come to the rescue of the family's needs, and some girls recognize the non-use of condoms in exchange of money offered by men during sex, and large numbers of unaccompanied girls or unmarried women live only of survival sex in the urban refugee community than rural.

Data from a blood collection for blood transfusion by the Betou laboratory revealed that 7/10 or 70% of people were not eligible because of their positive HIV test status at first line. At the end of August 2018, 426 refugees living with HIV were receiving ARV treatment, with a predominance among women (297 or 70% against 129 or 30.2% among men). The distribution by place of residence makes it possible to note that 140 (33%) PLWHIV are urban refugees and 286 (67%) are rural refugees. In the first half of 2017, 15 cases of death directly linked to HIV / AIDS due to the rupture of ARVs.

➔ **Prevalence of HIV among adolescents and young people**

This fringe represents 31% of the general population with a dynamic of increase over time. Indeed, the under 15s represents 20.7% of the population in a context of population growth of around 2.8% per year.

Data are available for the 15-24 age group and provided by Spectrum 2018. They indicate a declining prevalence among 15-24 years since 2013 (-5% among boys and -2% among girls between 2013 and 2017) with a higher level, however, among girls. In fact, in 2017, the prevalence among boys aged 15-24 was 0.58% compared to 2.25% among young girls of the same age.

The MICS 2015 survey reveals that 32.58% of young people aged 15-24 have good knowledge of HIV, including 26.7% for adolescent girls aged 15-24 and 45.3% among young adolescents of the same age. .

[2] Report on September 1, 2017 on the statistics of people living with HIV in urban and rural refugees

2.1.2 Situation and evolution of the HIV epidemic in key populations

HIV prevalence in key populations was estimated during the last Behavioral Survey coupled with HIV serology among PS, HS and prisoners in the Republic of Congo3 in 2017. During this study, the following key population sizes are estimated as follows:

Table-5 : Population and HIV prevalence data in key populations

Indicators	Values	Comments / sources
Sex workers		
Estimated population size	9665	Mapping study and estimation of the size of key populations, 2017 concerns: 5 cities (Brazzaville, Pointe-Noire, Dolisie, Ouesso, Pokola)
HIV prevalence	8.1%	Source: IBBS 2017
Men who have sex with men		
Estimated population size	1271	Mapping study and estimation of the size of key populations, 2017 concerns: 2 cities: Brazzaville and Pointe-Noire
HIV prevalence	41.2%	IBBS 2017
Injecting drug users		
Estimated population size	411	Mapping study and estimation of the size of key populations, 2017 concerns: 2 cities: Brazzaville and Pointe-Noire

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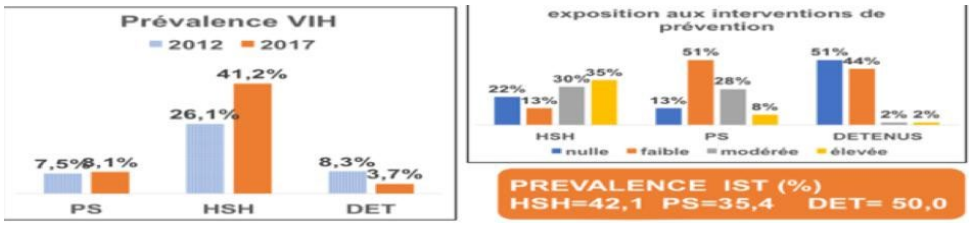
It reveals that the level of prevalence remains far higher than that of the general population, especially among PS and MSM. There is a decrease in the prevalence in the prison population between 2012 and 2017 (8.3% compared to 3.7%) and an increase in PS and MSM. This level of prevalence coexists with a high prevalence of sexually transmitted infections in these three population groups (see graph below).

Graph-3 : Evolving profile of HIV prevalence in key populations and STI situation / interventions



Prevalence levels in 2017 are associated with a low level of exposure to interventions and a high level of sexually transmitted infections.

➔ **Prevalence of Sexually Transmitted Infections (STIs) and Syphilis**

The 2018 IBBS survey highlighted a high incidence of sexually transmitted infections in key populations: 50% in the prison population, 35.4 in sex workers and 42.1% in MSM.

Among adolescents and young people, a survey carried out by the UNFPA4 concerning school pregnancies shows that they are usually associated with STI cases with prejudices and ignorance about the management of adolescent menses.

[3] CNLSE: 2017 behavioral survey coupled with HIV serology among men who have sex with men, sex workers, injecting drug users and prisoners in the Republic of Congo, Final report, May 2018

[4] Final report of the SRAJ Situation Review in Schools in Congo_2015

In the general population, the information system report, although experiencing shortcomings, shows that the frequency is more marked for gonococcal disease and syphilis. The health statistics directories reported 11,508 STI cases in 2015 and 15,834 in 2016. These cases are most often recorded in the cities of Brazzaville (4,068 cases in 2015 and 5,639 cases in 2016) and Pointe-Noire. (3625 cases in 2015 and 6068 cases in 2016).

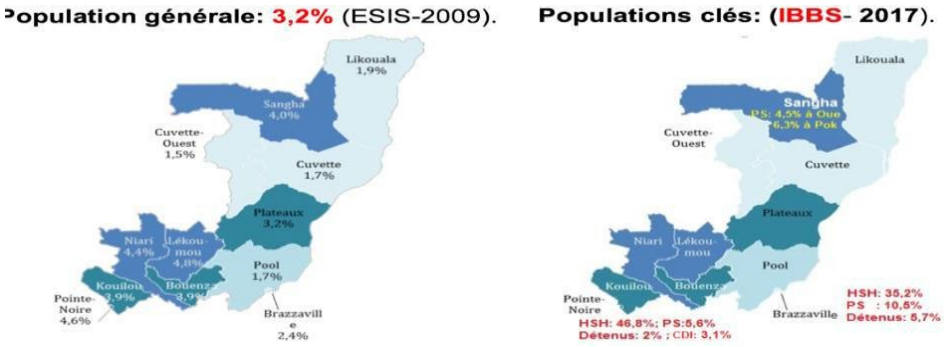
2.1.3 Regional disparities in HIV prevalence

Two studies provide an overview of the disparity in the epidemiological profile of HIV. These are the ESIS study carried out in 2009 in the 15-49 age group and the IBBS survey of key populations carried out in 2017.

The 2009 ESIS study showed a prevalence in women of 4.2% and 2.1% in men. In women, the epidemic was more significant in the 40-44 years (5.1%), 45-49 years (4.8%), 35-39 years (4.5%) age groups, and 30-34 year olds (3.3%). The prevalence of the epidemic was higher in urban areas (3.3%) than in rural areas (2.8%) with an infection ratio of 1.14. Unevenly distributed over the national territory, it is higher than the national prevalence (3.2%) in 6 departments out of 12: Pointe Noire (4.6%), Niari (4.4%), Lékoumou (4.8 %), Sangha (4%), Kouilou and Bouenza (3.8%).

As for the IBBS survey, the prevalence among PS, MSM and the prison population varied from one Department to another. The peak of prevalence is observed in MSM at 46.8% in Pointe Noire, in PS at 13% in Dolisie and in the prison population at 5.7% in Brazzaville.

Graph-4 : Regional disparities in HIV prevalence in the population and among key populations



2.1.4 Situation of HIV-related deaths

The number of HIV-related deaths remains significant. The development is jagged and the annual number of deaths in 2017 is higher than in 2010 (see table below).

Table-6 : Number of annual HIV-related deaths between 2010 and 2017

	2010	2011	2012	2013	2014	2015	2016	2017
Total HIV-related deaths	4600	4500	4200	4500	5100	5300	4800	4900
HIV-related deaths aged 15 and over	3500	3500	3200	3500	4000	4300	3700	3700
HIV-related deaths of 0-14 year olds	1000	1000	1000	1000	1100	1100	1100	1200

Source: Spectrum 2018

Over the 2014-2017 period, cumulatively, the total number of HIV-related deaths is 20,100 compared to 31,400 for new infections (incidence / mortality ratio is 1.46). Analysis of the 2015 cohort shows

that 81.6% of adults with HIV and 92.4% of children on treatment were still alive 12 months after starting their antiretroviral therapy (an overall average of 83% for the survival rate).

Regarding PMTCT, it is estimated that in the absence of ARVs children die within 4 or 5 years of birth. Although the data are not documented, the poor performance of PMTCT suggests the existence of hidden mortality in children.

With regard to deaths linked to TB / HIV co-infection, there has been a gradual increase in the number of cases since 2011 (1,600 in 2011 compared to 2,100 in 2017)[5].

2.1.5 Analysis of the determinants of the HIV epidemic

➔ **The determinants of HIV in the general population**

The main determinants concern in particular: i) ignorance of the serological status of the majority of PLWHIV (30% of PLWHIV screened), ii) the low number of PLWHIV on ARV (29.1%) on the one hand and the low number PLHIV on ART having achieved a viral load (5.5%) and having suppressed viral load on the other hand (28.5%) according to the report of the audit of the active queue in 2017 and

iii) the low systematic use of condoms during risky sexual intercourse (48% in adults aged 15-49 years including 38.3% in women and 58% in men; DHS 2011-2012).

Other factors facilitating transmission include multiple sexual partnerships, interactions with certain bridging populations (PS clients) as well as sexual violence based on gender.

Regarding SGBV, a study carried out by UNFPA in 2016 confirms the persistence of sexual violence with 82% of the victims are under 20 years old, 18% of adults over 20 years old. The median age of the victims is 13-14 years, which is of great importance in terms of exposure to HIV and could explain the high rates of seropositivity in pregnant girls under 15 (3.8%) screened at NPC course in 2017.

In terms of response, we note that the interventions focus little on attitudes of societal tolerance and attitudes of stigmatization among healthcare providers towards victims. It is estimated that 58% of cases are lost to follow-up after the first consultation, which does not promote adequate care, in particular HIV prevention. In addition, the insufficiency of ARVs with recurrent ruptures could weaken the implementation of prophylaxis after exposure to HIV.

➔ **The determinants of HIV in adolescents and young people**

This fringe represents 31% of the general population with a dynamic of increase from one year to another. Indeed, the under 15s represents 20.7% of the population in a context
population growth of around 2.8% per year6. In addition to the fact that the prevalence is significant, we note that adolescent girls are more affected than adolescent boys. PMTCT data from 2017 gives a prevalence of 3.8% among pregnant adolescents under the age of 15.

With regard to young people aged 15-24, the 2015 MICS survey reveals that 32.58% of young people aged 15-24 have good knowledge of HIV, including 26.7% for adolescent girls aged 15-24 and 45.3% among young adolescents of the same age. In the same vein, the box below summarizes the main conclusions of a study conducted in 2015 by UNFPA on the situation of sexual and reproductive health of adolescents and young people (SSRAJ) in 9 departments of the country except, Likouala and Bouenza. This study reveals:

a) Significant higher level of unwanted pregnancies in schoolsin rural areas (70% of schools surveyed observedcases of early pregnancy against

[5] Source: WHO 2016 TB estimates
[6] Final report of the SRAJ Situation Review in Schools in Congo_2015

only 30% in urban areas) 7. They sometimes occur at the primary school level and are associated with cases of sexually transmitted infections.

b) Sexuality girls is a taboo subject in the Congolese family. It is paradoxically not not managed, as in the past, by the paternal / maternal aunt or by the mother, but rather by the media and in "the street", according to the majority of students and parents of students surveyed.

c) Mothers in both rural and urban areas do not prepare their daughters for responsible menstruation management. They make it a taboo subject to such an extent that their offspring learn about the question from fellow students and classmates in the schoolyard or in the neighborhood.

d) Sexuality education (RHS) is a skill that is taught since the primary cycle but which is only introduced in a piecemeal manner because it does not address its "affective" and "emotional" dimension. The ERS does not take into account the specificities of adolescents from minorities such as indigenous peoples, people living with disabilities (PVH), or those based on gender issues.

e) The absence of an appropriate framework for sharing experiences which would offer adolescents, girls and boys, opportunities to better manage their sexuality

Furthermore, teaching HIV in schools has not been continued due to the reduction in funding following the end of phase I of R9 (April 2014), despite the fact that the curricula were developed (loss of trainees, retirement, insufficient funding to ensure coordination and supervision,).

➔ **Determinants of HIV in key populations**

Analysis of programmatic data and the IBBS 2018 survey indicates that the main determinants of the epidemic8 are:

- Stigma and discrimination: the study on the stigma index carried out in 2015 showed that the level of stigma remains significant at 10.3% among MSM and 17.2% among PS;
- Poor knowledge of HIV (47.5% of MSM, 39% of PS and 45% of prisoners have good knowledge of HIV);
- The low systematic use of condoms (64.1% of MSM with male partners and 37.2% with female partners, 81.3% among PS and 50% among prisoners);
- Poor knowledge of HIV status (33.2 among MSM, 15% among PS and 18.9% among PC);
- Low exposure to prevention interventions (24.7 among MSM, 28.4 among PS and 9.7 among PC);
- The weakness of the offer of comprehensive and quality friendly service as well as the incomplete offer of the combined HIV prevention package

➔ **Programmatic determinants of the HIV epidemic**

The effectiveness of a certain number of programs such as screening, ARV treatment, PMTCT (in exposed women and children) should help achieve a reduction in viral load and therefore low transmission of HIV. Unfortunately, their performance remains weak. Analysis of the data indicates that 70% of people living with HIV are not screened, 71% of people living with HIV are not put on ARV treatment and only 2% of PLHIV have confirmed viral suppression. At the PMTCT level, enrollment and wastage in the cascade concern both women and children. In 2017, 91% of HIV-positive women and 97% of expectant children expected to be pregnant did not receive ARV treatment to reduce mother's transmission of HIV à the child.

2.1.6 Critical analysis and priority targets

[7] Unwanted pregnancies are criminalized: article 2 of the Portela Law stipulates that "Will be punished with the same penalties provided for in article 1, all pupil under the age of 21, who, without being engaged will be put into pregnancy ", thus preventing him from continuing his studies. (Article 2 of July 13, 1964). This Law was revised by the 2011 Gate Law whose application is not yet effective

[8] Stigma Index and IBBS 2018

During the 2014-2018 period, the epidemic surveillance systems were not sufficiently functional to ensure the production and promotion of strategic information in order to guide the actors in the response and allow the adaptation of the strategies being implemented in order to be effective.

The poor performance of the national response has not made it possible to substantially change the face of the epidemic. Not only was the regression small (-3% between 2010 and 2017), but it was also increasing among MSM and PS, while remaining overall more significant in large cities. The review showed that adolescent girls and young women are among the targets to which special attention has not been paid, although the situation remains worrying. Indeed, the HIV epidemic has been increasing since 2012 and the prevalence and new infections remain at high levels, representing at least 4 times those of boys of the same age group.

At this rate of decline, the prevalence in 2030 would be 2.94%, which places the country far from elimination. The same is true for the elimination of new infections in children in view of the poor performance of the devices and current strategies. Regarding deaths at this current rate, the country will not be able to meet the reduction in cases of deaths currently on the rise.

Also, for the 2019-2022 period, the epidemiological priorities, alongside the PMTCT targets (HIV-positive pregnant women and exposed children), should concern areas of high prevalence such as large cities, humanitarian situations and targets such as: i) adolescent girls and young women and key populations (MSM, PS and PC). Considering unwanted or early teenage pregnancies and the age group 10-24 years should be considered.

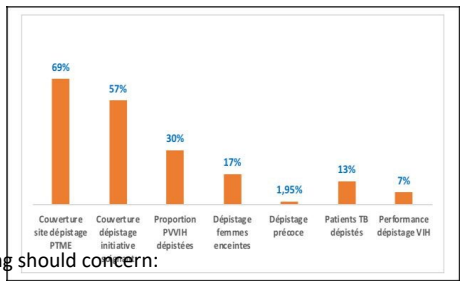
2.2 Synthesis of the analysis of the response to HIV

2.2.1 Reduction of new HIV infections

➔ **HIV testing**

The national HIV testing platform is only offered in healthcare settings and sometimes using mobile units for advanced strategy screening. For PMTCT the proportion of CSIs offering HIV testing is 69%. For early detection of HIV, there are two functional devices located in Brazzaville and Pointe-Noire.

Chart 5 : HIV testing cascade



Community screening is not yet in place and the differentiated strategies were not applied during the 2014-2018 period.

Mobile Units have been underused due to reduced funding and usage strategies, including for example community actors. Furthermore, there is no evidence concerning the performance of the referral of people screened for care structures.

For the 2019-2022 period, the priorities for HIV testing should concern:

	Increase the supply and availability of HIV testing services through involvement community actors and optimal use of existing platforms Ensure screening performance, particularly in terms of targeting populations of pregnant women, children, adolescent girls and young women Strengthen the links and the reference between testing and care services

➔ **The adoption of safer behaviors by key populations in the face of STIs / HIV (PS, MSM, PC)**

Over the 2014-2018 period, interventions in favor of key populations have been strengthened over time thanks to funding from the Global Fund. The complete package of combined prevention services9 for key populations has not been consistent due to the recurrent shortage of health products. These interventions have certainly strengthened the level of knowledge about HIV and low-risk behaviors among key populations. However, there are still some shortcomings that contribute to further exposing these populations to HIV:

Poor knowledge of HIV (47.5% of MSM, 39% of PS and 45% of prisoners have good knowledge about HIV);

The low systematic use of condoms (64.1% of MSM with male partners and 37.2% with female partners, 81.3% among PS and 50% among Prisoners);

Poor knowledge of HIV status (33.2 among MSM, 15% among PS and 18.9% among PC);

Low exposure to prevention interventions (24.7 among MSM, 28.4 among PS and 9.7 among PC).

In addition to these weaknesses, stigma / discrimination10 as well as weak legal protection contribute to distancing key populations from services.

	Increase the supply and availability of adapted services for key populations by fixed and mobile strategies Put in place a combined prevention package around effective strategies to to reverse the trend of the epidemic (including pre-exposure in MSM and screening-treatment in all key populations) Strengthen systematic use of condoms and STI screening / care Maintain an enabling environment by reducing stigma and discrimination both for key populations and stakeholders on their behalf

➔ **The adoption of safer behaviors by vulnerable populations**

The prevalence of HIV among 15-49 year olds did not begin to reduce until 2016 and the epidemic remains general. In addition to the programmatic determinants of the epidemic (section 2.1.5), other behavioral determinants could explain this situation. These include, among others:

Average consumption of condoms (CMCTH2) increased from 2.42 in 2014 to 0.88 in 2017

Lack of knowledge of the serological status of the majority of PLHIV (30% of PLHIV screened); The low systematic use of condoms during unsafe sex (48% among adults 15-49 years of whom 38.3% in women and 58% in men; EDS 2011-2012).

Other factors facilitating transmission include multiple sexual partnerships, interactions with certain bridging populations (PS clients) as well as sexual violence based on gender.

Regarding SGBV, a study carried out by UNFPA in 2016 confirms the persistence of sexual violence with 82% of the victims are under 20 years old, 18% of adults over 20 years old. The median age of the victims is 13-14 years, which is of great importance in terms of exposure to HIV and could explain the high rates of seropositivity in pregnant girls under 15 years of age (3.8%) screened during of the NPC in 2017. Tolerance within communities and insufficient law enforcement increases the risk of insecurity for victims and the feeling of impunity among perpetrators of SGBV, which could help maintain or even increase the number of cases.

[9] During the 2014-2017 period, pre-exposure, screening-treatment were not integrated into the combined package offer in addition to the activities of CCC, screening-STI care and distribution of condoms and / or gels

[10] The study on the stigma index carried out in 2015 showed that the level of stigma remains significant at 10.3% among MSM and 17.2% among PS

➔ **Reducing HIV transmission in children born to HIV-positive mothers**

During the 2014-2018 period, the supply of services gradually increased to 33.7% of health facilities that have integrated the full PMTCT package (screening + ARV for pregnant women and exposed children. The main normative documents have been drawn up along the lines of option B + The program's performance has not lived up to the expectations of the Plan for the elimination of HIV transmission from the mother drawn up and implemented since 2012 See table below.

Table-7 : State of the main PMTCT indicators at the end of 2017 (effective coverage) *

Main PMTCT indicators	Effective coverage			
	2014	2015	2016	2017
Proportion of PMTCT health facilities (Screening)	47.1%	47.1%	59.7%	68.9%
Proportion of PMTCT health facilities (Screening + ARV)	6.3%	6.3%	12.9%	33.7%
Attendance at the NPC	19.66%	24.24%	17.36%	24.47%
Screening during ANC	10.12%	9.39%	11.01%	17.14%
ARV in HIV-positive pregnant women	8.64%	5.23%	9.17%	9.24%
ARV in exposed children	3.57%	2.41%	2.66%	2.60%
PCR in exposed children	2.75%	0.09%	1.56%	1.95%

* Coverage is calculated based on a numerator representing the results obtained and a denominator represented by the total population in need

Regarding women and children on ARV for PMTCT, there is no evidence of continuity of ARV treatment in these women at the end of PMTCT and the early treatment of HIV-positive children born to HIV-positive mothers.

This situation could be explained, among other things, by:

Insufficient synergy and link to RH

The weakness of the device for keeping women and their children in the PMTCT cascade The poor performance of the early detection device

The ineffectiveness of the delegation of tasks

Difficulties in supplying sites with recurrent input shortages and health products

The weakness of the retention system in PMTCT sites and that of the reference site, which does not provide visibility on the continuity of ARV treatment and leads to wastage and the failure to catch up with the lost of sight.

	Increase coverage, availability and quality of PMTCT services, including components SSR Implement the delegation of tasks Strengthen early HIV testing platforms Keep women and children in the PMTCT cascade and in the continuity of ARV treatment Secure funding and supply of health products for PMTCT

➔ **The implementation of universal precautions by health facilities for blood safety and accidents involving exposure to blood / HIV**

The implementation of universal precautions for transfusion safety is ensured by the National Center for Blood Transfusion (CNTS) and all the interdepartmental centers for blood transfusion scattered across the country. In total there are 32 blood collection sites. 237,721 pockets of

blood was acquired and 209,303 blood bags were secured. All blood bags are tested with four (4) markers (HIV, syphilis, Hepatitis B and Hepatitis C).

However, there are weaknesses in the availability of multiple blood bags (for collection), laboratory reagents and consumables. The haemovigilance system has not really been implemented although the documents are available but awaiting validation. The quality control system has not been in place since 2014.

The AES are documented by the CTA as a reference structure in the management of AES in Brazzaville and Pointe-Noire. From 2014 to 2017, we counted and treated:

- 104 cases of accidents involving exposure to sexual secretions, including 20 cases of rape;
- 55 cases of accidents involving exposure to blood or liquid containing blood.

Table-8 : Number of AES and AELB received and processed by CTAs

Indicators	2014	2015	2016	2017
Number of incidents of exposure to sexual secretions	17	13	29	25
Number of accidents involving exposure to blood or liquid containing blood.	16	15	13	11
Number of cases of rape	2	4	9	5

Source: CTA activity reports 2014, 2015, 2016, 2017

In terms of biomedical waste management, the country has a National Biomedical Waste Management Plan drawn up in 2008. Information on the implementation of this plan is not available.

	Strengthen social mobilization for voluntary blood donation Strengthen the technical and operational capacities of blood transfusion services Ensure loyalty and follow-up / support for voluntary blood donors in order to maintain permanent risk reduction Securing the pockets for the 4 markers (HIV, syphilis, Hepatitis B and Hepatitis C) and hemovigilance Update the national biomedical waste management plan (2008)

2.2.2 Reduction of morbidity and mortality of PLWHA

➔ **Antiretroviral therapy**

The number of sites receiving medical care for PLHIV including treatment increased from 70 in 2014 to 77 in 2017, of which only 24 have integrated tuberculosis screening. In addition to this, currently about 15 associations, many of which are networked (RENAPC, FOSIC, COREC Health and Development, AZUR Development), offer various support services in the 12 departments of the country.

The achievement of this objective is very low. The number of adults on ARV treatment increased from 17,894 (21%) in 2014 to 27,397 (30%) in 2017. The number of children on treatment increased from 1,452 (18%) in 2014 to 1,663 (18%)) in 2017. In children, performance remains constant and at the same time raises the relevance of strategies for detection, treatment, quality of treatment (psychosocial monitoring, compliance, etc.). According to available data, the country is not on track to reach the 90-90-90 target, as shown in the table below.

Table-9 : Performance of PLWHA medical care indicators

Situation of the main indicators	2014	2015	2016	2017
Global ARV coverage (<15 years and> = 15 years	20.8%	26.6%	21.1%	29.1%
Comprehensive ARV coverage (<15 years)	18.2%	16.0%	16.6%	18.5%
Overall ARV coverage (> = 15 years)	21.1%	27.7%	21.6%	30.1%
Proportion of the active queue not on ARV (<15 years)	0.0%	0.7%	0.0%	0.0%
Proportion of the active queue not on ARV (> +15 years)	25.9%	6.8%	17.7%	10.0%

Proportion of PLWHA followed having benefited from TB research	2.5%	0.6%	0.9%	ND
Proportion of PLHIV receiving compliance support (<15 years of age)	46.8%	65.5%	33.8%	58.9%
Proportion of PLHIV receiving compliance support (> = 15 years)	14.9%	16.2%	15.6%	12.3%

During the 2014-2017 period, the country experienced recurrent ruptures in ARVs, the longest of which was 7 months in 2017. The ruptures also concern inputs and laboratory reagents for biological monitoring. This situation could be explained by the poor functionality of the Medicines Committee (4 meetings, 3 of which in 2014-2016 and the other in 2018), ii) the poor quality of inventory management linked in part to the lack of control over the active queue and non-compliance with the order / distribution schedule, iii) dysfunctions of the central purchasing office, iv) the limited capacity in terms of input distribution,

v) the absence of a supply security plan linked in part to the difficulty in mobilizing the State contribution, vi) the obsolescence or even the insufficiency of the technical platforms linked to the absence of a maintenance plan and biomedical equipment renewal and vii) weak governance of the purchasing management system, in particular for ARVs. The operationalization of community health is an opportunity to push the agenda on finding the lost of follow-up, adherence to treatment and community distribution of ARVs.

	Increase the offer of care services for adults and children alike sanitary than in community Strengthen the performance and quality of ARV treatment in adults and especially in children Reinforce biological monitoring, in particular the measurement of viral load Drastically reduce the shortage of inputs and support the growing need for ARVs and laboratory inputs / reagents

➔ **Management of TB / HIV and Hepatitis / HIV co-infections**

At the end of 2017, TB / HIV co-infection was estimated at 29% and the management of TB / HIV co-infection remained timid. In terms of service delivery, 37 out of 41 CDTs are functional and provide integrated HIV treatment. In addition, at the level of the 77 functional structures (including 2 CTAs), the search for TB in PLWHIV remains low (less than 500 PLWHIV annually). The prevention of TB in PLWHIV through the use of INH has not yet started. There is no evidence on HIV / Hepatitis co-infection because it does not yet receive special attention, although the programmatic links are known.

Table-10 : Performance of TB / HIV Co-infection Indicators

Indicators	2014	2015	2016	2017
Incidence of tuberculosis (number of cases per 100,000 inhabitants)	382	381	378 **	ND
Tuberculosis screening rate	63%	82.36%	88%	
Therapeutic success rate	76.66%	69.40%	69% **	77%
HIV testing rate among TB patients	12.9%	29% *	38% **	13%
HIV seropositivity rate among TB patients	30%			29.7%
TB / HIV co-infected patients on ART	82 (22%)			272 (72.7%)

*** Source: 2016 country profile Who report 2016.*

The results from the 2014-2018 CSN review highlighted the following problems: i) weak synergy of actions, ii) weak integrated coordination of interventions, iii) weak communication system between the two in terms of sharing of strategic information and integrated co-infection screening system. The enlargement of the missions of the national coordination with the addition of the endemic component offers a window of opportunity to federate the two programs and put in synergy all the available resources (human, material) and mobilizable.

	Strengthen the integration of TB and HIV services and the availability of inputs Implementing INH prevention of TB in PLHIV Strengthen joint TB / HIV programming and supervision Strengthen synergy and coordination between TB / HIV programs

2.2.3 Protecting the human rights of PLHIV and key populations, and gender

In the legal field, the country has an HIV law and two legal clinics, mainly based in Brazzaville and Pointe-Noire. During the 2014-2018 period, the supply of services and benefits slowed down in part to the funding gap. Knowledge of the existence of this service offer and the practical terms of use are quite low. The implementing texts of Law No. 30-2011 of June 3, 2011 have not been taken. SGBV remains a concern.

Despite the achievements, stigma, discrimination and human rights violations remain present both within communities and among health workers. The study on the stigma index carried out in December 2015 highlighted significant levels of stigma and discrimination. This survey reveals that the HIV law was only known by 38.2%, of which 28.9
% certify having read or discussed the content of this law. Regarding human rights, we note the absence

With regard to gender, in general, although being cross-cutting, gender-related aspects did not appear clearly in the CSN 2014-2018 and were not sufficiently taken into account in all strategic areas. The results framework does not include indicators on gender equality that can facilitate understanding of the socio-cultural, economic and epidemiological factors that contribute to the risk and vulnerability of women and girls facing HIV. The coordination of gender and human rights interventions has been limited by the insufficient organization / coordination of initiatives and the weak capacity of the main actors in these two areas. Analysis of the budget allocation shows that 19.13% touched on gender aspects. The weak disaggregation of financial data made it impossible to assess the state of execution of this budget. However, the poor overall execution of the CSN budget (32.61%) also had an impact on the implementation of gender aspects.

	Strengthen the programming capacities and coordination of aspects concerning the gender and human rights Improve the legal environment and reduce stigma / discrimination Reduce gender vulnerabilities among adolescent girls and young women

2.2.4 Governance and coordination of the national AIDS response

Governance underwent an institutional change from the end of July 2017 when the missions of the National Council for the fight against HIV / AIDS (CNLS) were extended to the epidemic component to become the CNLSE. The mission of the CNLSE, the coordination, orientation and monitoring body for the interventions implemented in the fight against HIV / AIDS, STIs and epidemics has experienced major structural and functional disturbances. There are achievements in coordination such as ULS and the implementation of these activities has made available 29 documents out of 75 planned, i.e. a completion rate of 38% during the implementation of the CSN 2014-2018.

During the 2014-2017 period, the coordination of the AIDS response faced various upheavals and events, including the reduction of funding and the availability of key personnel, which impacted their functioning. Also, certain tools necessary for the governance of the response to HIV and AIDS were not available for four years: the country profile, the operational plan; the consolidated action plan; the resource mobilization plan; the strategic plan for partnership with the private sector; the strategic communication plan; and REDES reports, etc.), to ensure effective coordination of the national AIDS response. In addition, the thematic groups also did not function adequately.

Regarding the supply of inputs and health products, the 2014-2017 period was marked by recurrent shortages in reagents, consumables and health products. In addition to insufficient funding, due in part to the difficulty in mobilizing State contributions, the low capacity of the players and the supply chain also contributed to these disruptions. The low quality and completeness of

logistics data from the pick-up sites or the promptness of their dispatch caused delays in the development of distribution plans or quality supply plans.

Financial analysis reveals a dependence on external funding and a weak mobilization of financial resources for the benefit of the response to HIV. Only 32.61% of the necessary resources have been mobilized and external resources represent 65%. Nevertheless, the presence of technical and financial partners (SNU, World Bank, Embassies, etc.) constitutes an opportunity for the mobilization of resources in a context of accountability.

	Strengthen the organization and operational capacities of the CNLSE in order to enable it to effectively fulfill its mission, including accountability Produce and make available the main coordination instruments and tools on time (Country profile, operational plan, consolidated action plan, mobilization plan for resources, strategic partnership plan with the private sector, strategic plan for communication, REDES reports, etc.) Develop and implement an advocacy and resource mobilization plan financial, including innovative financing Strengthen the security of health products and the functionality of the national supply system with a view to reducing shortages

2.2.5 Participation of sector actors in HIV governance

➔ **Public sector response**

The public sector has two sub-components: one health and the other non-health. In the

In the public sector, the coordination of the response to HIV and AIDS takes place at two levels: central and decentralized. At the central level, it is provided by the PNLS and its decentralized structures. In the assessment of the results obtained, the PNLSE and the other sectoral ministries made it possible to improve the performance of the prevention and care and treatment programs. These performances relate essentially to the revision or preparation of guides, the integration of HIV and AIDS in the training curricula, capacity building (equipment and staff) and quality control via supervision, etc.

At the decentralized level, coordination of the response is the responsibility of the UDLS and the ULS focal points. This mechanism made it possible to supervise activities at the departmental level and to guarantee the transmission of strategic information to the central level. At the level of the Ministry of Defense, there is a ministerial memorandum formalizing the teaching of HIV and the organization of BCC activities in the police, army and gendarmerie schools and training centers. From 2005 to 2015, most ministries had budget lines for the AIDS response. These lines are included in the budget allocations of the ministries. However, the registration of financial allocations and mobilization of these lines face a series of difficulties. For example, ULS team governance is faced with a variety of changes (assignment, retirement, etc.). This situation has consequences for the management of programs and projects. At the level of the Ministry of Health, the response to AIDS for the benefit of health personnel and their dependents during this period would also have disrupted the quality of care and treatment of PLWHA.

In education, important achievements exist and can be used to maintain and strengthen measures to prevent and promote HIV-related services. These are: a) the integration of HIV / AIDS and life skills into the curricula; b) the existence of ministerial memoranda formalizing the teaching of HIV and the organization of BCC activities in schools and universities; c) the existence of teaching and didactic materials on HIV and AIDS (guides and teaching programs); (d) the availability of textbooks on HIV and AIDS, reproductive sexual health and human rights; e) the existence of educational tools or supports allowing the teaching of HIV and AIDS to be monitored: f) the existence of a common education sector policy on the HIV epidemic. However, these materials developed over a decade deserve to be revisited and aligned with the factual context. In doing so, the level of knowledge about the prevention of

HIV, the number of new HIV infections, STIs, pregnancies in young people deserve to be listed as a major priority of the AIDS response in schools. In addition to these initiatives

taking SRH into account, an essential component of the national response for the benefit of adolescents. In order to guarantee the pooling of interventions in the school environment, the Support Project for the Improvement of the Education System (PRAASED) with IDA funding is an alternative in the context of the overhaul of school programs. This overhaul will guarantee the pedagogical and didactic sustainability of the fight against AIDS.

	Adapting and innovating the AIDS response in the sector of institutions and ministries Boosting the response to HIV and SSAJ in schools based on methods and innovative approaches Strengthen the effective securing and mobilization of budget lines for the AIDS response at the level of ministries and institutions

➔ **Private sector response**

The response of businesses and the private sector to the response to AIDS is based on the guidelines of the national policy to fight AIDS in the workplace jointly developed and validated by the Ministry of Labor and Social Security, SEP / CNLS, Unicongo and the ILO. Between 2014-2018, the number of companies with policies and programs is estimated at 50 companies in 10 out of 12 departments.

The performance of the response in this sector has been limited by: i) the weak partnership with national coordination in order to mobilize and pool resources and then structure the response from the private sector; ii) insufficient coordination and capitalization of interventions in the private sector; especially employers' organizations; iii) the weak partnership with civil society for the implementation of stakeholders in favor of workers in the private sector and rights holders; iv) the persistence of stigma / discrimination in companies associated with suspicions of respecting confidentiality. The violation of medical confidentiality constitutes a serious violation of human rights.

	Strengthen public-private partnership in order to structure the response of the private sector and mobilize more resources for the national response Strengthen the partnership between the private sector and the organizations of society with a view to increase the offer of adapted HIV and AIDS prevention and care services

➔ **Response from civil society and the community sector**

Between 2014 and 2018, the investment of civil society in the fight against AIDS was devoted to key populations. Contrary to previous planning cycles, performance analysis has highlighted an increased consideration of the needs of civil society organizations in the coordination and implementation of key populations at all levels. These structures participate in coordination bodies (CCN, CNLSE, strategic meetings), in research activities (IBBS, programmatic mapping, Stigma index), in contracting with health training in the provision of prevention and care services HIV and AIDS for key populations.

From 2014 to 2018, the involvement of PLWHIV was mainly observed in the advocacy concerning access to medicines, biological monitoring and inputs. However, the leadership and capacities of community organizations remain insufficient to provide consistent advocacy, quality service provision covering the reduction of vulnerabilities and risks including gender and human rights, HIV testing, PMTCT, treatment. and the continuum of care and capitalization of data and results. The weak capacities of these organizations in mobilizing resources remain insufficient. All these difficulties weaken the community fabric and they do not make it possible to maintain a satisfactory level of commitment and intervention..

	Perform an audit and evaluation of the capacities of civil society organizations by view of building an effective community system Build a system of robust community organizations offering quality HIV services

	Strengthen the capitalization and documentation of interventions and results from community interventions

2.2.6 Use of strategic information for the national response to HIV / AIDS

The national system for monitoring and evaluation of the AIDS response experienced dysfunctions during the 2014-2018 period. The functionality of the epidemic monitoring system made it impossible to produce and make use of certain essential documents such as the country profile as well as strategic information on the epidemic.

In addition to institutional changes, the shortage of qualified personnel and financial resources have impacted the functioning of the Monitoring and Evaluation Unit. Added to this is the non-availability of tools suitable for collection / analysis / triangulation11, the low quality of completeness of the data and the low functionality of discussion and exchange frameworks (failure to set up technical groups).

During the 2014-2018 period, the monitoring and evaluation system did not meet the "Three-Ones" principles. Several systems coexisted and the data was not always harmonized and validated. Community data has been little collected and the circuit is not legible, given the operating difficulties of the UDLS. At the level of the national health information system, the process of setting up DHIS2 is underway.

	Operationalize the monitoring and evaluation groups and frameworks Harmonize and improve monitoring and evaluation tools taking into account the aspects human rights and gender Link the HIV monitoring and evaluation system to that of the SNIS by integrating the major part of health and community indicators Strengthen capacities for production and promotion of the use of strategic information

III. NATIONAL STRATEGIC FRAMEWORK 2019 - 2022

3.1 Vision of the National Strategic Framework to Fight AIDS 2019-2022

The vision of the AIDS response is in line with that of the country's 2018-2030 National Health Policy which aims to

« *A Congo endowed with an efficient health system, resilient and capable of guaranteeing universal access to quality health services and an optimal state of health to sustainably support the growth and development of the country*"

Current progress shows that in the current dynamic, the country will not be meeting the target 90-90-90 and the elimination of the HIV epidemic by 2030. De this fact, as a first step, the country should seek to make up for the delays in the various program areas. This requires, above all, the sustainable strengthening of the robustness and operational capacities of the coordination and implementation structures, including policies and institutional arrangements.

3.2 Values and guiding principles of the CSN 2019 - 2022

This vision is supported by the values of equity, ethics, respect for human rights, national solidarity, sustainability, thoroughness, transparency and accountability.

The implementation of the 2019-2022 CSN will be based on the following guiding principles: strong leadership based on the "Three-Ones", alignment, effective multisectoriality and good governance, integration of services and synergy, not stigma / non-discrimination, taking gender / human rights into account, strengthening the national and global partnership for funding, strengthening the health and community systems as a pillar of the results-based management response and

[11] Audit of the active queue of PLHIV in Congo, MESST, Reports of supervision missions

accountability and alignment of the AIDS response with the dynamics of community health. Details are in appendix-8.1.

The CSN 2019-2022 aligns and is based on: i) the global objectives and commitments in terms of the AIDS response, in particular the objective of eliminating the HIV epidemic by 2030, including the elimination of mother-to-child transmission of HIV, ii) the 2018-2030 national health policy; iii) the national health development plan 2018-2022, iv) the national policy of community-based interventions (2016) and v) the National community health policy on AIDS, tuberculosis and malaria 2018-2030.

3.3 Priority targets for CSN interventions 2019-2022

The profile of the epidemic is marked by the beginning of a reduction in the overall prevalence and a worsening among MSM, PS and adolescent girls and young women. The persistence of vulnerability factors and the difficulties of access and use of care make certain categories of the population of the Republic of Congo priority targets. Also, during the 2019-2022 period, priority will be given to the following population groups:

Table-11 : Priority populations selected in the CSN 2019-2022

	Target type	Base value / year	2019	2022
People living with HIV (<15 years old)	Pop. keys	9106/2017	8,508	8507
People living with HIV (> = 15 years)	Pop. Keys	90 787/2017	96 973	99835
TB / HIV co-infected patients	Pop. keys	2017 /		
Men who have sex with men	Pop. keys	2017/1 911	1,968	2,027
Sex workers and their clients	Pop. Keys	2017/11 084	11,417	11,759
Prison population	Pop. keys	2017/1 189	1,225	1,261
Pregnant women with HIV	Pop. vulnerable		6,878	7,324
Adolescents and young women (10-24 years old) Beneficiaries of service packages	Pop. vulnerable	ND	106,661 (25%)	221,336 (50%)

3.4 Framework and results chain of the CSN 2019-2022

Based on the achievements, shortcomings and intervention priorities, the CSN 2019-2022 targets the following priorities, impacts and effects:

Priority -1			Reduce new infections among vulnerable populations (in this case young girls, young women), key populations and eliminating those in children
	Impact-1		New infections are reduced by 46% between 2018-2022
			Effects
		1.1	At least 80% of key populations (PS, PC, MSM) and vulnerable populations (adolescent girls / young women, Aboriginal populations) engage in lower risk behaviors by 2022
		1.2	Blood transmission of HIV is eliminated (risk = 0%) during the period 2019-2022
		1.3	Mother-to-child HIV transmission rate reduced to at least 5.1% by the end of 2022
		1.4	80% of cases of SGBV reported in adolescent girls and women during the period 2019-2,022 benefited from holistic care (health, legal and psychological, humanitarian situation)
Priority -2			Achieve the 90-90-90 targets to significantly reduce morbidity and mortality in PLWHIV
	Impact-2		HIV-related mortality reduced by 69% between 2018-2022
			Effects
		2.1	60% of adults and children living with HIV know their HIV status and are referred to care / treatment services by the end of 2022
		2.2	50% of adult PLHIV and 40% of children living with HIV are on ARV treatment by the end of 2022

	2.3	The death rate in TB / HIV co-infected patients is reduced by 50% by the end of 2022
	2.4	50% of PLHIV on ARVs have an undetectable viral load at 12 months of treatment in 2022
Priority -3		Strengthen governance and resilience of the AIDS response for better local responses based on quality strategic information
Impact-3		Management, monitoring and evaluation and governance systems for the response to HIV are strengthened and resilient by the end of 2022
		Effects
	3.1	By the end of 2022, the financial execution rate of the CSN is at least equal to 80%
	3.2	Community and private sectors have the necessary capacity (managerial, technical and operational) to implement at least 75% of the response in their sector by the end of 2022
	3.3	By the end of 2022, attitudes of stigma and discrimination are also reduced by 65% well in care than in community
	3.4	During the 2019-2022 period, the health system is strengthened to offer related services quality HIV and adequate availability of inputs and health products
	3.5	During the 2019-2022 period, the national monitoring and evaluation system has the capacities to produce quality data (completeness / timeliness greater than 95%) and promote the use of strategic information
	3.6	Between 2019-2022, CNLSE's capacities and governance system ensure multisectoriality and optimal accountability

3.5 Priority interventions of the CSN 2019-2022

The intervention priorities of the CSN 2019-2022 take into account the shortcomings and achievements of the implementation of the CSN 2014-2018. Analysis of the situation of the HIV epidemic and of the response highlighted important achievements in terms of the national response. Although disrupted by the reduction in funding, the overall architecture of the response to HIV remains in place and can constitute a foundation for strengthening response capacities and program performance.

To do this, the following main problems should be at the center of operational and coordination concerns.

In terms of prevention, the problems concern: i) the slow reduction in the prevalence of HIV (-3% over 7 years), the rise in new infections, the high and increasing prevalence among MSM, PS and adolescent girls / young women . The root causes are a) the low level of reduction of the risks of contamination among MSM and the PS and b) the weak prioritization of the interventions in favor of adolescent girls and young women, which does not make it possible to reduce their vulnerability vis-a-vis to HIV infection.

In the field of PMTCT, mother-to-child transmission of HIV is increasing, placing the country far from the elimination targets. The main causes are a) the poor functionality of devices (medical and community) to enlist and maintain HIV-positive pregnant women and children exposed throughout the PMTCT cascade and b) the poor performance of early detection platforms. These weaknesses are largely due to the recurrent breakdown of inputs (Screening tests and ARV)

In the area of ARV treatment, deaths linked to HIV are on the rise and the survival of PLWHA on treatment remains below expectations. At this level, the review has shown that the main strategies such as the detection of patients of HIV-positive people via screening as well as the enrollment and maintenance of children on ARVs encounter difficulties in implementation and effectiveness.

During the 2014-2018 period, HIV governance remained largely ineffective due to: i) the poor performance of the supply and distribution system leading to disruptions, ii) recurrent health products and not implemented quality assurance, iii) the underfunding of needs in health products, iv) the weak capacity of coordination and operational actors in gender and human rights, which does not allow for programming and capitalization sensitive to gender and human rights, v) weak capacity for mobilization, management and financial accountability of national coordination, vi) absence of strategy for involvement and participation of sectors

community and private sector funding and implementation, vii) weak functionality of epidemic surveillance and strategic information production systems, and viii) weak strategies for controlling viral suppression.

Pillars of response acceleration theory to catch up and reverse the response lag and get the response on track to the 90-90-90 target and the elimination of the HIV epidemic by 2030

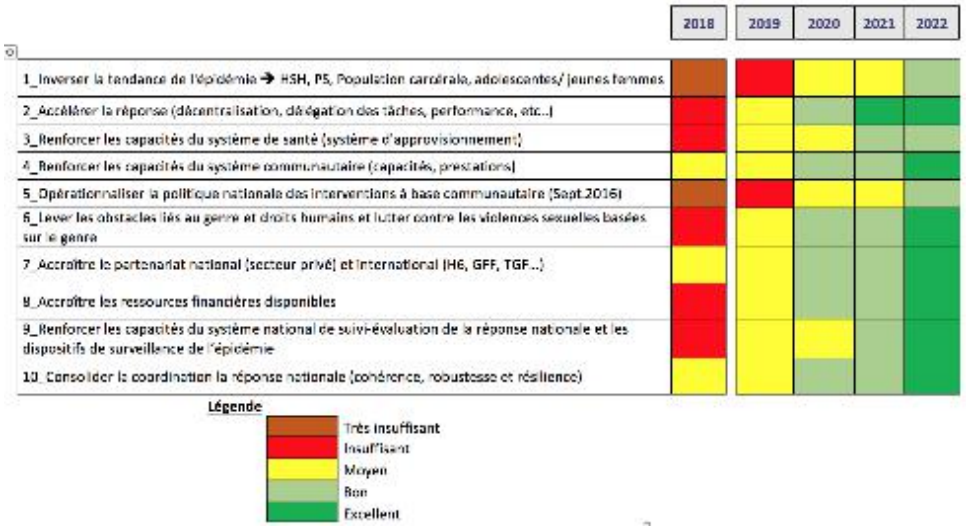


Table-12 : Matrix of priority products and interventions

Priorities	Impact	Effects	Products	Strategies
Priority -1	Reduce new infections among vulnerable populations (in this case young girls, young women), key populations and eliminate those in children			
	Impact-1	New infections are reduced by 46% between 2019-2022		
		At least 80% of key populations (PS, PC, MSM) and populations vulnerable (adolescent / youth women, indigenous people) have lesser behaviors risk by 2022	60% of PS benefit from the combined package of prevention services (awareness, HIV testing, STI care, condoms, referral if necessary)	Capacity development for the combined strategy
				Development and decentralization of user-friendly services
				Intensification of combined prevention activities
				Strengthening of the link / reference for the continuum of care and removal of barriers to access / use of services
			80% of MSM benefit from the combined package of prevention services (awareness, HIV testing, STI care, referral if necessary)	Capacity development for the combined strategy
				Development and decentralization of user-friendly services
				Intensification of combined prevention activities
				Strengthening of the link / reference for the continuum of care and removal of barriers to access / use of services
			94% of PCs benefit from the combined package of prevention services (awareness, HIV testing, STI care, condoms, referral if necessary)	Capacity development for the combined strategy
				Development and decentralization of user-friendly services
				Intensification of combined prevention activities
				Strengthening of the link / reference for the continuum of care and removal of barriers to access / use of services
			At least 60% of the general population (15-49 years) systematically use condoms during risky sex	Integration of HIV, AIDS and sexual and reproductive health during program redesign schools, with the support of INRAP and the Support Project to improve the education system under World Bank financing
				Development of innovative and adapted strategies for people living with disabilities (physical, auditory, visual and mental);
				Development and implementation of innovative communication and information strategies targeting the general population and vulnerable and evidence-based groups (literate and non-literate)
				Implementation of the city and HIV strategy
				Strengthening social marketing of condoms
		HIV blood transmission is eliminated (risk = 0%) for the period 2019-2022	100% of blood relatives are tested and secure	Reinforcement of the supply of transfusion centers with reagents suitable for blood security
			The number of voluntary blood donors is increased and 90% are loyal	Strengthening social mobilization for voluntary blood donation
				Reinforcement of follow-up measures psychosocial support for voluntary blood donors
			HIV risks are reduced by 90% in case exposure among health professionals and	Strengthening of the prevention and management of cases of AES among staff of health and community staff

			key populations	Development of the PrEP and Pep strategy and offer package for MSM and couples serodiscordants
		The rate of HIV transmission from mother to child is reduced to at minus 5.1% by the end of 2022	60% of expected pregnant women are detected during the ANC	Strengthening institutional and community advocacy for PMTCT, including involvement spouses and community leaders Integration of HIV and PMTCT services into SRH services
			At least 80% of pregnant women HIV positive and their newborns are put on ARV treatment	Development and implementation of a service decentralization strategy
				Integration of HIV into the training curricula of professional health schools
				Implementation of the delegation of tasks
				Strengthening community PMTCT
			At least 72% of children born to mothers are diagnosed in both months after birth	Reinforcement of devices to keep women and children in the waterfall
				Strengthening the circuit and strategies for early detection of HIV in exposed children (circuit / networking, quality of samples, transport of samples, reporting of results)
			90% of PMTCT women and their infants HIV infected continue treatment ARV	Reinforcement of mechanisms to ensure the continuity of ARV treatment in women from the PMTCT
				Establishment of decentralized planning and monitoring
			During the period 2019-2022, the framework the elimination of transmission mother-to-child HIV is strengthened and functional	Establishment of a PMTCT working group
				Strengthening program supervision
		80% of SGBV notified in adolescent girls, young women including those in situation humanitarian during the period 2019-2022 benefited from a holistic care (health, legal and psychological)	During the period 2019-2022, the prevention, care and documentation of SGBV cases have a optimal functioning	Strengthening the information and awareness mechanism for parents, victims and communities on the fight against SGBV
				Strengthening the protection of adolescent girls' rights against early marriage
				Development of materials adapted to adolescent girls and young women; Integration of SSRAJ and VSBG Support for interventions in favor of adolescent girls and young women
				Strengthening HIV protection, prevention and care measures in situations humanitarian and emergency, including cases of exposure to risk
				Strengthening the prevention and CEP system for victims of SGBV at all levels
				Reinforcement of case documentation and good practices in prevention and CEP victims of SGBV at all levels
				Strengthening legislative provisions against gender-based violence
Priority -2	Achieve the 90-90-90 targets to significantly reduce morbidity and mortality			in PLWHIV
	Impact-2	HIV-related mortality reduced by 69% between 2019-2022		
		60% of adults and children living with HIV know their status serological and are referred to care / treatment services by late 2022	Capacity in health and community are developed in the field of HIV testing and the link with care services	Review / adaptation of HIV testing guidelines and standards
				Reinforcement of screening on the initiative of the caregiver
				Development of community screening strategies including self-testing, including referral / traceability of people screened positive to health centers
				Development of community screening capacities
		50% of PLWHIV adults and 40% of	60% of adults living with HIV benefit	Updating the acceleration plan for scaling up for medical care

		children living with HIV are under ARV treatment by the end of 2022	quality ARV treatment by the end of 2022	Operationalization of the national delegation of tasks strategy
				Operationalization of differentiated care strategies including the component community
				Strengthening retention measures for ARV patients, including women who have completed PMTCT
			40% of children (under 15) living with HIV are receiving ARV treatment from quality by the end of 2022	Strengthening of family testing "Index testing"
				Active search for children at all entry points into the care system
				Decentralization of pediatric ARV care
			All PLWHIV, especially children, in the need received support and care	Development of a guide to psychological, social and nutritional care for adults living with HIV
			psychosocial burden, including legal	Establishment of a strengthened and functional network of community care organizations
				Setting up and offering suitable / user-friendly services for children / adolescents living with HIV
			Patient retention on sites has improved and the rate of lost to follow-up less than 10%	Harmonization of patient coding and strengthening of the referral / counter system reference
				Strengthening of therapeutic education for PLWHIV and retention measures in the sites of treatment
				Reinforcement of search strategies for missing persons
		The patient death rate TB / HIV co-infected is reduced by 50% by the end of 2022	PLWHIV co-infected with HIV / Hepatitis are diagnosed and supported	Development of a national plan for the prevention and management of hepatitis
				Strengthening of measures to diagnose and manage hepatitis in people living with HIV
				Provision of inputs for the prevention and management of hepatitis in PLWHIV
			The proportion of people living with HIV who seek TB was made reach 100% by 2022	Development and implementation of a joint HIV / TB / Hepatitis plan including integration planning services
				Improvement of tools for managing TB / HIV co-infection and orientation of nursing staff
				Strengthening of regular and joint coordination and supervision of TB and HIV programs
			All PLHIV in need have received the preventive treatment of TB at INH	TB prevention strategy for people living with HIV
				Effective integration of TPI / INH in the sites of medical care of PLWHA (directives, tools, inputs, orientation / staff guide
		50% of PLHIV on ARVs have undetectable viral load at 12 month of salary in 2022	70% of PLHIV have achieved their viral load according to required standards	Reinforcement of technical platforms for biological monitoring (routine check-up, viral load, sequencing resistance
				Development and implementation of a renewal and maintenance plan (preventive and curative) of biomedical equipment
				Dissemination of care and biological monitoring guidelines
				Optimization of diagnostic and biological monitoring platforms including a system for transporting samples and rendering results
				Monitoring biological monitoring and the quality of treatments
Priority -3	Strengthen the	governance and resilience of the AIDS response for better local responses based on quality strategic information		
	Impact-3	The management, monitoring and evaluation and governance systems for the response to HIV are strengthened and resilient by the end of 2022		
		By the end of 2022, the execution rate of the CSN is at least	Percentage of funding for the fight against HIV attributable to the condition is increased to 60% of	Implementation of innovative resource mobilization strategies (mobilization plan, Table round, etc.

		equal to 80%	total expenses	Strengthening of the international partnership for financing the fight against HIV, STIs and epidemics (Global Fund, GF, GAVI, H6 Partnership,...)
				Strengthening of mechanisms for monitoring the mobilization of financial resources and compliance with commitments
				Strengthening of the financial management mechanisms, capacities and tools of the DEX / CNLSE and PNLS
				Annual adjustment of the operational plan for the implementation of the CSN 2019-2022
				Strengthening budget monitoring and accountability (production of detailed annual financial reports, dissemination of the report, establishment / updating of funding gaps, etc.
				Strengthening of monitoring of programming, mobilization and execution of budget lines ULS
				Development of an investment framework to readjust funding in the fight against HIV, STIs and epidemics
		The community sector and private sector have the required capabilities (managerial, technical and operational) to work at least 75% of the answer in their sector by the end of 2022	Percentage of funding allocated to private and community sectors	Mapping of interventions to fight the three diseases (HIV, STIs and epidemics) in the private and community sectors
				Strengthening the coordination of resource mobilization in the private sector, through Public-private partnership (PPP)
			The response in the private sector and community is coordinated and functional to ensure a consistent response and decentralized at community level and in the private sector	Development and implementation of a capacity building plan for society organizations civil
				Establishment and animation of a Platform for the coordination of AIDS response, STI and community epidemics
				Establishment and animation of a Platform for the coordination of AIDS response, STI and epidemics in the private sector
				Strengthening the documentation of activities and funding of AIDS response interventions in the private sector
		By the end of 2022, the attitudes of stigma and discrimination are reduced by 65% as well in care setting than in care community	Prevention and prevention measures and measures fight against stigma / discrimination are reinforced	Strengthening the involvement and awareness of resource people for the protection of rights of PLHIV and key populations
				Development and popularization of guidance / legal protection (law) and implementation documents (implementing texts) on HIV, human rights and gender
				Reinforcement of the appropriation of the law and the implementing texts by the beneficiaries and the rights holders
			Barriers to accessing HIV-related services, STIs, hepatitis, TB are reduced	Strengthening of the multisectoral partnership for the application of protection measures for PLWHIV, key populations and improving access / use of services
				Establishment of community orientation, support and mediation systems for access / use of services (health mediators, orientation and referral tools, etc.)
				Networking of support sites with legal clinics
				Strengthening and supporting the functionality of HIV-related legal services
				Establishment and operation of an observatory on human rights and access / use of services by PLHIV and key populations
				Improved consideration of gender in planning tools, data collection and reporting

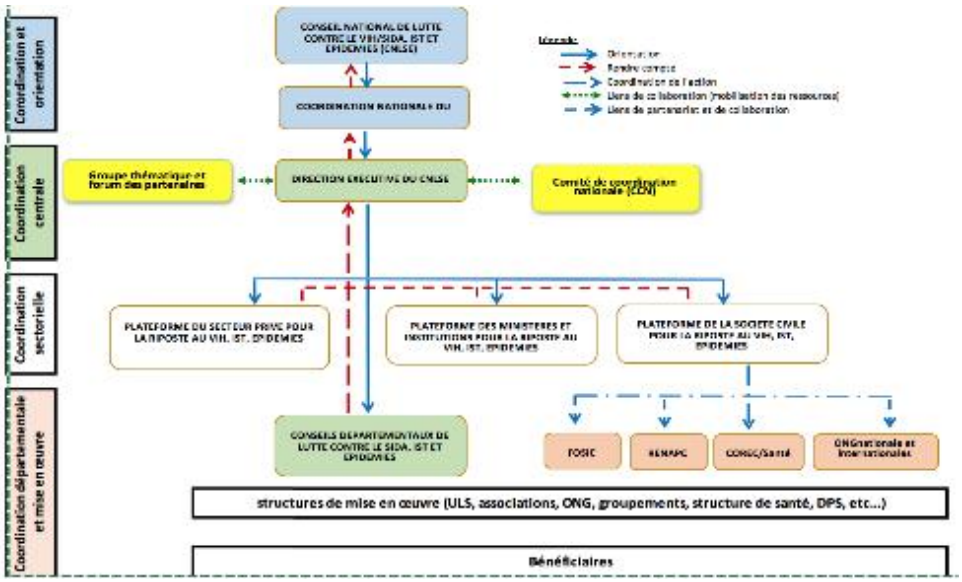
				Establishment and operation of a multisectoral working group on human rights, equality of kind
		During the period 2019-2022, the health system is strengthened for offer HIV-related benefits quality and availability adequate inputs and products health	The supply and management system of HIV inputs is effective	Boosting and strengthening the capacities of the National Committee for Medicines and Other Medicines health
				Operationalization of the Computerized Input Management System (LMIS)
				Reinforcement of storage, management and distribution logistics capacities at central level and decentralized
				Development and implementation of a health product security plan including a resource mobilization for inputs
				Strengthening of the quality assurance measures and measures for health products
			The other pillars of the health system are strengthened to support the response to HIV, STI, epidemics	Integration of HIV indicators (health, private and community) in DHIS2
				Operationalization of community health strategies (strategic plan, operational plan, etc.)
				Strengthening the integration of HIV, STIs and epidemics in the community health package
		During the period 2019-2022, the national monitoring system assessment has the capabilities to produce data from quality (completeness / timeliness greater than 95%) and promote use of information strategic	The monitoring and evaluation system is functional and fulfilled its missions during the bet period implementation of the CSN	Formal establishment and capacity building of the DEX / CNLSE monitoring and evaluation office and PNLS, and civil society
				Establishment and operation of the Technical Monitoring and Evaluation Group (GTSE)
			All required reports and indicators are available on time and are of high quality	Update / revision of data collection and reporting tools
				Improvement of data quality assurance tools and devices
			Strategic information is available and used for planning, management and decision making	Capacity building of actors in operational research and information production strategic
				Development and implementation of a study and research plan
				Production of periodic reports on the national response (financial and programmatic)
				Strengthening the production of strategic information and updating country profiles and tables on board
				Development and implementation of a strategic information dissemination and promotion plan
		Between 2019-2022, the capacities and the governance system of the CNLSE provide multisectoriality and accountability optimal	The normative and orientation documents of the AIDS response are available, updated and adapted to the national and international context	Update / revision of management and governance tools for the national response
				Mid-term evaluation and review of the implementation of the CSN 2019-2022
				Establishment and regular updating of the country profile
				Development and implementation of operational plans (gender, monitoring and evaluation, etc.)
			The national coordination bodies for the response are functional at all levels	Capacity building for female leadership (women parliamentarians, old and new ministers, general managers, etc.) in the response and mobilization of financial resources
				Development and implementation of an institutional support plan for the benefit of DEX with a view to strengthening the managerial and governance capacities of the DEX / CNLSE
				Strengthening synergies between ULS and civil society for the implementation of interventions on the workplace
				Integration of ULS in the organizational charts of ministries, in order to boost advocacy and mobilization of financial resources
				Strengthening of the leadership and functionality of the national coordination bodies, operational and specific
				Improving the visibility and accountability of the response through the production and dissemination of results / acquired from sectoral players

IV. IMPLEMENTATION OF THE NATIONAL STRATEGIC FRAMEWORK 2019 - 2022

4.1 Institutional framework for implementation

With the new CNLSE mission which includes epidemics following the enlargement of the CNLS mission, it is important to adjust the coordination mechanisms. The proposed adjustment takes into account the lessons learned from implementation, the need to rationalize coordination and take advantage of opportunities to integrate, create synergies in order to reduce costs while increasing the efficiency of coordination. The proposed structure is as follows:

Figure 1 : Institutional mechanism for implementing the CSN 2019-2022



➔ **Orientation and coordination bodies** It's about :

The National Council for the fight against HIV / AIDS, STIs and epidemics (CNLSE), created by Decree No. 2017-269 of July 28, 2017, signed by the President of the Republic, it is a body for coordination, guidance and monitoring of the interventions implemented in the context of the fight against HIV / AIDS, sexually transmitted infections and epidemics. The CNLSE is placed under the authority of the President of the Republic. The CNLSE produces an annual report which is sent to the President of the Republic and the Prime Minister.

The National Coordination of CNLSE, is the national coordinating body chaired by the Prime Minister assisted by two Vice-Presidents who are the ministers in charge of health and finance. Its composition is multi-sectoral and takes into account technical and financial partners, civil society, religious denominations, the private sector, PLHIV, actors at the central and decentralized levels. National coordination is convened twice a year in ordinary session upon convocation by its President. However, when circumstances so require, it may meet in extraordinary session at the request of its President.

➔ **Coordination and monitoring bodies**

CNLSE Executive Management, is the technical body of the National Council to Combat

HIV / AIDS, STIs and epidemics. It is led by an Executive Director. Its expandable structure (by order of the Ministry of Health) provide for a Programs Division, an administrative, financial and communication division and departmental units fighting against HIV / AIDS, STIs and
The epidemics

Departmental Councils to fight HIV / AIDS, STIs and epidemics, constitute the technical coordination and monitoring organizations at department level. Their role is also to select community projects in order to submit for funding.

➔ **Operational coordination bodies**

In order to break with the old practices and allow better involvement and synergy between the different sectoral players, the Dex / CNLSE will work on the establishment of a Coordination Platform. The Platforms aim to: i) promote the sharing and circulation of information, ii) coordinate implementation initiatives and interventions, iii) strengthen advocacy, resource mobilization or intervention, iv) strengthen accountability and v) capitalize and disseminate the results in order to promote and give credibility to the sectoral responses concerned. The Platforms that will be implemented are:

The Platform of the private sector and companies for the fight against AIDS, STI and epidemics
The Platform of institutions and ministries for the fight against AIDS, STI and epidemics The Platform of civil society for the fight against AIDS, STIs and epidemics

Each Platform will define its mode of organization and operation. They will constitute consultation entities on which Dex / CNLSE can rely to deepen their thinking and advocacy.

➔ **Specific coordination bodies**

It's about :
The National Commission for the Selection of Community Projects
The National Funding Coordinating Committee (CCN)

The United Nations Theme Group on HIV and the Interagency Coordinating Committee The Technical Working Groups: The main groups to be established are: a) the Group

technical work on monitoring and evaluation (attached to the Monitoring and Evaluation Office), b) the technical working group on Human Rights and Gender (attached to the Programs Division), c) the Committee for monitoring pledges and commitments for funding national response (attached to the Administrative, Financial and Communication Division), d) the technical working group on objectives 90-90-90 (attached to the Office of the Executive Director) and e) the technical working group on antimicrobial resistance (attached to the Office of the Executive Director).

The CSN is implemented by the public sector (health and non-health), the community sector and the private sector.

4.2 Operationalization of the 2019-2022 National Strategic Framework

The implementation of sectoral AIDS response strategies for the 2019-2022 period will be organized according to an approach based on multisectoriality and decentralization around an institutional framework involving the various actors of the national response. It will be done through the following important documents:

The National Monitoring and Evaluation Plan of the CSN 2019-2022: This monitoring plan is used to monitor and evaluate the performance of the national response and to promote orientations and objective decision-making based on the evidence. It gives details on the CSN performance framework, the description of the indicators (operational definitions, collection rhythms, collection methods, means of verification and validation), the overall results reporting and production system. information, data collection methods and tools that will be used as well as the material, informational and human resources that will be mobilized for the production of national HIV information.

The operational plan2019-2022 Implementation Plan: It describes in detail the main priority activities that will be carried out during the period. It takes into account the work plans of projects and programs already available to align them

The resource mobilization plan: it is a guidance document that will serve as advocacy support and mobilization of national and international resources to support the implementation work of the CSN 2019-2022.

Sector plans:The sectors will develop action plans that will take into account the sectoral activities of the regional plans and the priorities defined by the CSN. These plans must take into account the problems and determinants specific to each sector and take care not to encroach on the actions already planned at regional level. The implementation of sector plans will be coordinated by sectoral STI / HIV / AIDS committees

Community sector action plans and projects: community actors develop projects to ensure the implementation of the CSN. Funding for these projects / action plans could be done by the CNLSE via the Community Projects Selection Committee. The actors will also external financial resources

The Global Fund concept notes:Since 2014, the Global Fund has introduced a new funding cycle based on the submission of concept notes and grant renewal requests. Under the aegis of the SCC, the concept notes will be based on the CSN and the Operational Implementation Plan to propose the appropriate activities.

V. MONITORING AND EVALUATION OF THE NATIONAL STRATEGIC PLAN 2019-2022

5.1 Implementation framework for the monitoring and evaluation system

The monitoring and evaluation of the interventions of the CSN 2019-2022 will have as a reference framework, the 12 components of a functional monitoring and evaluation system recommended at the international level. The system provides for the collection and routing of data from the intervention execution sites to the departments, then to the central level through a collection plan. This will take into account the prospects for setting up DHIS2 and SIGL.

In addition to the structures for collecting, processing, analyzing data and producing semi-annual reports, a multisectoral and multidisciplinary technical monitoring and evaluation (GTSE) working group will be set up. This group will also work to ensure data validation and quality assurance.

The data circuit has four levels:

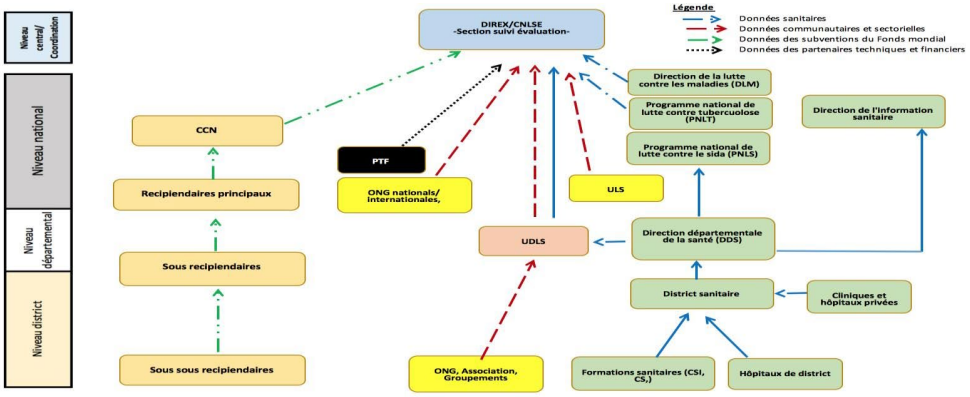
- *The district level* is made up of health structures (district hospitals, CSI, private health facilities), community organizations that act in the field of HIV. Their services will be capitalized in the harmonized tools for collecting data specific to each player. Their data and periodic reports are transmitted and consolidated at the district level before being forwarded to the level of the Departmental Health Directorates (DDS).
- *Departmental level* includes the departmental health directorate and the other sectoral directorates. Managers at this level process and compile all data / information from the district level. To these data are added those transmitted by actors from other sectors (non-health and community ministries). The data are validated at this level with the support and participation of the UDLS Manager. Pending the operationalization of DHIS2, the UDLS will transmit the validated data from each Department to the Monitoring and Evaluation Section of the DEx / CNLSE
- *The national level* includes the DEx / CNLSE monitoring and evaluation section, program evaluation and monitoring services (PNLT, PNLS, DLM), monitoring and evaluation services from NGOs / national / international associations. Those responsible for monitoring and evaluation as well as data managers, at this level, triangulate data received from the regional level, to guarantee its quality. Then, they will transmit their respective data to the Monitoring and Evaluation Section of the DEx / CNLSE, as well as the TFPs, the SCC (data linked to grants from the Global Fund). The data thus processed are subject to validation by the GTSE

to the CMT-SE HIV before being disseminated and used to produce the periodic reports of the national response.

Feedback from central to district level

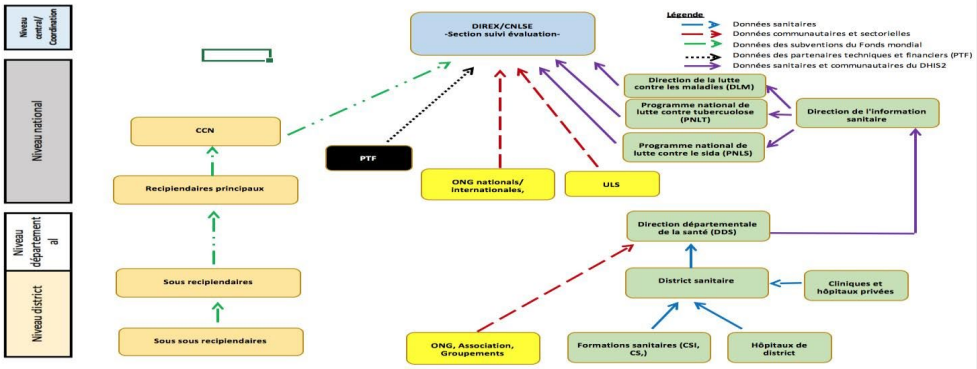
Pending the implementation of DHIS2 and SIGL, the data circuit will be as follows:

Figure 2 : Transient data / information flow before operationalizing DHIS2



Within the Ministry of Health and Population (MSP), a process to set up DHIS2 is underway. Community indicators will be taken into account in DHIS2. The operationalization of this platform will give the Health Information System Division a prominent place in the collection, validation, quality assurance of data and data storage. Also, the data circuit should be modified to adapt to this dynamic, as follows:

Figure 3 : Data / information flow to operationalize DHIS2



A strategy and a system will be developed and implemented for the quality assurance of the data and information collected. The details will be specified in the National Monitoring and Evaluation Plan which is one of the operational documents for the 2019-2022 CSN.

The data reporting intervals are as follows:

Table 13 : Presentation of reporting mechanisms and frequency

Level	Type of	Mode / Transmission medium	Frequency	Deadlines	Comments

	report				
Central	Report of progress quarterly and annual	▪ Physical Mail ▪ Email ▪ DHIS2, SIGL	Quarterly Annual	45 days after quarter or the end of the year	Progress report and gap analysis
Departmental	Report of activities and of results	▪ Physical Mail ▪ Email, if available ▪ DHIS2, SIGL	Monthly Quarterly	15 days after trimester	Narrative report + Data attached
District	Report of activities and of results	▪ Physical Mail ▪ Email, if available	Monthly	5 days after month	Content: data transcribed in reporting tools

5.2 Survey and research data

The review of the implementation of the CSN 2014-2018 highlighted a lack of information and data to assess the impact of the strategies. In addition, programmatic strategies could not be informed by evidence and strategic information.

During the 2019-2022 period, a certain number of studies and research, in particular operational ones, will be carried out on the one hand to update the information, fill the information / data gap and on the other hand to generate strategic information at during implementation.

The GTSE will ensure the quality of the protocols and the results of studies and research. Also, the GTSE will meet to assess the quality of the protocols developed for these studies and is able to request modifications or amendments if necessary. During their implementation, the GTSE will organize itself to set up the monitoring / supervision mechanisms for the works.

At the end of the study or research, the GTSE meets to assess the quality of the data collected and validate the results of the study / research. All data from studies funded by or through the DEx / CNLSE are the property of CNLSE. The DEx / CNLSE will archive data and reports from studies and research.

Table 14 : List of national priorities for study and research

Areas	Thematic
Socio-psychological and behavioral	○ Survey on the quality of life of PLWHIV and families and the satisfaction of users of HIV care services ○ National survey for teaching HIV in schools ○ Qualitative study on the constraints of family HIV testing in the workplace community ○ Stigma Index Survey Update
Support and prevention	○ National Study on the Profile of Primary and Secondary ARV Resistance in PLHIV ○ 12, 24, 36 and 48 month survival study of people on ART ○ Study on resistance and adherence to antiretroviral treatment, seroprevalence of Hepatitis B&C in patients infected with HIV1 followed in the sites of taking in charge of HIV ○ Carry out a study on the problem of cases of lost sight of in PEC sites and PMTCT
Epidemiological	○ National survey of bio-behavioral and biological surveillance (IBBS) with population groups at higher risk of HIV infection ○ Study on the CDV, PEC (Adults and children) and PMTCT cascade ○ National sentinel surveillance surveys of pregnant women ○ HIV / AIDS country profile ○ Demographic and health survey with HIV serology (DHS +) ○ Analysis of the modes of transmission of HIV (MoT)
Socioeconomic	○ Cost-effectiveness studies of the care of PLWHIV
Management	○ National Resources and Expenditure Estimate Study STI / HIV / AIDS (REDES)

	○ Study on the investment framework for the AIDS response

5.3 CSN 2019-2022 performance framework

Table 15 : CSN performance framework 2019-2022

Priorities	Impact	Effects	Indicators	Type Indicators	Basic data Year / Source	Basic data Value	2019	2020	2021	2022
Reduce new infections among vulnerable populations (in this case young girls, young women), key populations and eliminate those in children										
	New infections are reduced by 46% between 2018-2022									
			Number of new infections aHIV during the period of reference by population of 100,000 (HIV I-14)	Impact	2017 / SPECTRUM	159	122	102	84	66
			Estimated percentage of infections aHIV among children born women isHIV positive after deliveryin the past 12 months (HIV 1-6)	Impact	2017 / SPECTRUM	18.18%	8.77%	7.39%	6.02%	5.10%
			Prevalence of HIV among pregnant women	Impact	2017 / PMTCT report	1.80%	1.7%	1.6%	1.5%	1.4%
			Percentage of sex workers living with HIV (HIV I-10)	Impact	2018 / IBBS	8.3%	8.3%	8.2%	8.1%	7.9%
			Percentage of men who have sex with men living with HIV (HIV I-9a)	Impact	2018 / IBBS	41.20%	40.8%	40.1%	39.2%	38.1%
			Prevalence of HIV among people in prison	Impact	2018 / IBBS	3.7%	3.7%	3.7%	3.6%	3.5%
			Prevalence of HIV among young boys aged 15-24	Impact	2017 / SPECTRUM	0.58%	0.54%	0.52%	0.49%	0.45%
			Prevalence of HIV among girls aged 15-24	Impact	2017 / SPECTRUM	2.22%	2.09%	1.96%	1.80%	1.63%
		At least 80% of key populations (PS, PC, MSM) and vulnerable populations (adolescent girls / young women, indigenous populations) have lower risk behaviors by 2022								
			Percentage of sex workers reportingto have useda fatherservative with their last client (HIV 0-5)	Effect	2017 / IBBS	82.3%	85.4%	86.9%	88.5%	90%
			Percentage of men who reportedto have useda fatherhelpful during their last anal report with a male partner (HIV 0-4a)	Effect	2017 / IBBS	64%	74.4%	79.6%	84.8%	90%
			Percentage of girls aged 15-24 who reportedto have useda prédüring their last sexual intercourse in the last 12 months.	Effect	2015 / MICS	46.7%	53%	59%	64%	70%
			Percentage of young boys aged 15-24 who reportedto have useda prédüring their last sexual intercourse in the last 12 months.	Effect	2015 / MICS	49.9%	71%	75%	80%	90%
			Percentage of adolescent girls and young women who have benestringof programs préHIV prevention - packagefinished services (YP-2)	Product	ND	ND	12.6%	14.7%	21.7%	23.6%
			Percentage of sex workers who have benestringof programs préHIV prevention - health services packagéfinished (KP 1-c)	Product	CSN review report 2014-2018	21.7%	41%	51%	60%	70%
			Percentage of men who have sex with men who have benéstringprevention programs of HIV- package of servicesfinished (KP-1a)	Product	CSN review report 2014-2018	38.9%	59%	70%	80%	90%
			Percentage of prison populations with benestringof programs prevention of HIV- package of servicesfinished	Product	CSN review report 2014-2018	91.2%	92.7%	93%	94%	95%
			Percentage of sex workers who tested HIV during the period who know the réresults (KP 3-c)	Product	CSN review report 2014-2018	3.47%	26%	37%	49%	60%

	Percentage of men who have sex with men who have had sex an HIV test during the period report and know the results (KP 3-at)	Product	CSN review report 2014-2018	0.73%	36%	54%	72%	90%
blood transmission of HIV is eliminated (risk = 0%) during the period 2019-2022								
	Percentage of blood products that are tested on all four markers	Product		ND	100%	100%	100%	100%
Mother-to-child HIV transmission rate reduced to at least 5.1% by the end of 2022								
	Percentage of pregnant women who know their HIV status at the HIV guard (PMTCT-1)	Product	CSN review report 2014-2018	17%	34%	43%	51%	60%
	Percentage of pregnant women HIV positive having received some antiretroviral during pregnancy (PMTCT 2.1)	Product	CSN review report 2014-2018	11%	35%	46%	58%	70%
	Percentage of infants exposed to HIV having benefited of one of HIV tracking within 2 months of birth (PMTCT 3.1)	Product		7.79	20%	30%	50%	60%
80% of women and young girls victims of SGBV notified during the 2019-2022 period benefited from holistic care (health, legal and psychological, humanitarian situation)								
	Percentage of women who have had more than one partner in the past 12 years months reporting the use of a preservative during their last sexual intercourse (HIV 0-10)	Effect	2015 / MICS	42.1%	52%	55%	57%	60%
	Percentage of men who have had more than one partner in the past 12 months reporting the use of a preservative during their last sexual intercourse (HIV 0-10)	Effect	2015 / MICS	36.6%	50%	57%	63%	70%
Achieving the 90-90-90 targets to significantly reduce morbidity and mortality among PLHIV								
HIV-related mortality reduced by 69% between 2018-2022								
	Number of deaths binds to AIDS per 100,000 inhabitants (HIV 1-4)	Impact	2018 / SPECTRUM	7112	6,385	5,498	4,650	3,841
	HIV-related mortality rate (100,000 inhabitants)		2018 / SPECTRUM	93	73	48	34	27
	Mortality rate by tuberculosis / HIV (per 100,000 inhabitants) (TB / HIV 1-1)	Impact	2017 / WHO	43	xx	xx	xx	xx
60% of adults and children living with HIV know their HIV status and are referred to services care / treatment by the end of 2022								
	Percentage of people (estimated) living with HIV who have been tracked HIV positive (HIV 0-11)	Effect	CSN review report 2014-2018	32%	43%	49%	54%	60%
	Number of people screened es for HIV and having received their results during the reporting period (HTS-1)	Product	CSN review report 2014-2018	75,336	183,207	222 128	263,259	306,905
50% of adult PLHIV and 40% of children living with HIV are on ARV treatment by the end of 2022								
	Percentage of adults receiving antiretroviral treatment among all adults living with HIV at the end of the reporting period	Product	CSN review report 2014-2018	30%	38%	42%	46%	50%
	Percentage of children receiving antiretroviral therapy among all children living with HIV at the end of the reporting period	Product	CSN review report 2014-2018	18%	27%	31%	36%	40%
Death rate among TB / HIV co-infected patients reduced by 50% by the end of 2022								
	Percentage of people living with HIV cared for (including care PMTCT) in whom signs of tuberculosis have been research s within HIV care or treatment facilities (TB / HIV 3.1)	Product	CSN review report 2014-2018 (2016)	1%	33%	48%	65%	80%

	Percentage of people living with HIV newly enrolled in the HIV care that started pre treatment TB sufferer (TB / HIV 4.1)	Product		ND		20%	30%	50%
50% of PLHIV on ARVs have an undetectable viral load at 12 months of treatment in 2022								
	Percentage of adults and children living with HIV on treatment 12 months after the beginning anti treatment retroviral (HIV 0-1)	Effect	CSN review report 2014-2018	86%	70%	77%	83%	90%
	Percentage of people living with HIV who started therapy antiretrovirals, who have an undetectable viral load at 12 months (<1000 copies / ml) (TCS 3.1)	Product	2017 / Queue audit active	28.5%	33%	35%	38%	40%
Strengthen governance and resilience of the AIDS response for better local responses based on quality strategic information								
The management, monitoring and evaluation and governance systems for the response to HIV are strengthened and resilient by the end of 2022								
By the end of 2022, the financial execution rate of the CSN is at least equal to 80%								
	Percentage of funding for HIV attributable to the state	Product	2018 / Review Report	32.6%	40%	44%	47%	50%
	CSN annual financial execution rate	Product	2018 / Review Report	32.2%	51%	61%	70%	80%
The community sector and the private sector have the necessary capacities (managerial, technical and operational) to implement at least 75% of the response in their sector by the end of 2022								
	Percentage of CSN funding attributable to the private sector	Product	2018 / Review Report	0.35%	2%	3%	4%	5%
	Percentage of CSN funding attributable to the community sector	Product	2018 / Review Report	0.73%	1.5%	2%	2.5%	3%
From here to end 2022, attitudes of stigma and discrimination are reduced by 65% in both care and community settings								
	Percentage of women aged 15 a 49 years old state of discriminatory attitudes a against people living with HIV	Product	2015 / MICS	50.9%	40%	33%	27%	20%
	Percentage of men aged 1549 years old state of discriminatory attitudes a against people living with HIV	Product	2015 / MICS	37.2%	22%	18%	14%	10%
During the period 2019-2022, the health system is strengthened to offer quality HIV-related services and an adequate availability of health products and products								
	Percentage of ARV sites that have experienced a drug shortage antiretrovirals during the pereporting period (TCS-6)	Product	2017 / PUDR	97%	30%	21%	11%	2%
During the 2019-2022 period, the national monitoring and evaluation system has the capacities to produce quality data (completeness / timeliness greater than 95%) and promote the use of strategic information								
	Percentage of entities declaring presenting according their reports in those of leave national directives (M & E-1)	Product	2017 / PUDR	77%	84%	88%	91%	95%
Between 2019-2022, CNLSE's capacities and governance system ensure optimal multisectoriality and accountability								
	Availability rate of essential documents and record keeping CNLSE (country profile, adjusted annual operational plan, annual report, meetings weekly of Dex / CNLSE, GTSE meetings, etc.) of DEx / CNLSE)	Product	2017 / CNLSE report	20%	100%	100%	100%	100%

VI. BUDGET AND FINANCING OF THE CSN 2019-2022

6.1 Modalities for establishing the CSN 2019-2022 budget and financial gaps

The CSN budget was established using the Resource Resource Needs Model (RNM) tool developed by UNAIDS and Future Group International to assist countries in developing the budget for strategic plans.

Three basic hypotheses have been formulated and relate to:

The size of the populations (MSM, PS, Prison populations) was projected on the basis of data from the study on programmatic mapping and estimation of the size of the key populations most exposed to the risks of HIV / AIDS, assuming an annual growth rate of 3 %. The number of pregnant women expected at the ANC was estimated based on the birth rate in the Congo (4%). The other sizes were directly extracted in the Spectrum model which is the reference tool for HIV screenings.

The unit costs adopted are those proposed by UNAIDS in the context of calculating the resources required for the different countries. For some interventions, the proposed costs have been readjusted based on country data. These are essentially the following costs: condoms (male and female), interventions in prison, treatment of diagnosed STI cases, ARV treatment (adults and children), community interventions (PMTCT, care and treatment), PCR, screening , blood security (taking into account the 4 markers), etc. These unit costs cover the entire cost of an intervention. For example, the cost of a patient's ARV treatment intervention includes not only the drugs but also all the expenses related to laboratory monitoring, human resource management, etc. similarly the promotion intervention of condoms include, in addition to promotional activities, the purchase and distribution of condoms.

The targets of the different indicators corresponding to the level of effort to be accomplished, were established until 2022 in accordance with the results chain. These new targets have been aligned with the Congo Catch-up Plan and the three 90s by UNAIDS (test and treat) in order to eliminate the HIV epidemic by 2030. However, they take into account the capacity to mobilization of resources and the current context of the response to HIV.

The different data were integrated into the RNM tool, which made it possible to release the program budget over the next four (04) years. The present budget is expressed in Euro.

6.2 Overall estimate of the CSN 2019-2022 budget and financial gaps

During the period 2019-2022, interventions to fight HIV / AIDS will require Seventy-eight million four hundred forty-six thousand eight hundred one Euros (78,446,801) or fifty-one billion four hundred fifty-seven million seven hundred twenty-eight miles two hundred and forty-four FCFA francs (51,457,728,244 FCFA).

Table 16 : Overview of the CSN 2019-2022 budget (in Euro)

	2019	2020	2021	2022	TOTAL	%
Prevention	5,165,161	5,900,269	7,031,716	7,918,126	26,015,272	33.16%
Key populations	347,050	431,010	520 601	616,426	1,915,087	2.44%
Populations vulnerable	1,057,766	1,261,042	1,768,852	1,986,110	6,073,770	7.74%
Provision of services	*3,472,264*	*3,912,726*	*4,439,199*	*5,004,778*	16,828,968	21.45%
Health care	*288,081*	*295,490*	*303,064*	*310,812*	1,197,447	1.53%
Care services and treatment	6,660,848	8,239,248	9,981,789	11,860,284	36 742 169	46.84%
Governance	2,956,502	3,534,879	4,253,376	4,944,603	15,689,360	20.00%
Total (Euro)	14,782,511	17,674,396	21,266,881	24,723,013	78 446 801	100%
Total (US $)	17,315,521	20,702,935	24,910,999	28 959 345	91 888 800	

Total (FCFA)	**9,696,691,568**	**11,593,643,777**	**13 950 159 460**	**16,217 233,438**	**51 457 728 244**	

Summary RNM Congo (1 US * = 560 FCFA, 1 € = 655.957)

The available funding (available for mobilization) is valued at € 24,597,220 (16,134,718,640 FCFA), representing 31.36% of the total resources required. The funding to be sought is estimated at 53,849,581 € (FCFA 35,323,009,604 or US $ 63,076,803) corresponding to 68.64% of the total cost of the CSN 2019-2022.

Table 17 : Status of funding available and to be sought from the CSN 2019-2022

Budget	2019	2020	2021	2022	Amount	%
Estimate in Euro						
Budget CSN 2019-2022 (Euro)	**14,782,511**	**17,674,396**	**21,266,881**	**24,723,013**	**78 446 801**	**100.00%**
Budget available	9,214,615	8,374,414	3,493,029	3,515,162	**24 597 220**	31.36%
Budget to look for (GAP)	5,567,896	9,299,982	17,773,852	21,207,851	**53 849 581**	68.64%
Estimate in FCFA						
Budget CSN 2019-2022 (FCTA)	**9,696,691,568**	**11,593,643,777**	**13 950 159 460**	**16,217 233,438**	**51 457 728 244**	**100.00%**
Budget available	6,044,391,212	5,493,255,484	2,291,276,824	2,305,795,120	16,134,718,640	31.36%
Budget to look for (GAP)	3,652,300,356	6,100 388,293	11,658,882,636	13,911,438,318	35 323 009 604	68.64%
	37.67%	52.62%	83.58%	85.78%	68.64%	

Summary RNM Congo (1 US * = 560 FCFA, 1 € = 655.957)

6.3 Strategies for resource mobilization

In order to close the financial gap, the focus will be on advocacy actions with the State, bilateral and multilateral partners, the private sector and civil society organizations. A round table of technical and financial partners, extended to the private sector will be organized and a committee for monitoring commitments set up. Each partner must confirm their commitments through an agreement or an official document sent. Added to this is the development of a resource mobilization strategy (internal and external).

The commitment of certain partners to continue their interventions constitutes an opportunity to be seized for the mobilization of the resources necessary for the implementation of the CSN 2019-2022. However, additional efforts for the effective mobilization of internal internal resources (State, private, etc.).

➔ **Mobilization of external resources**

It will be done with traditional donors through funding requests and advocacy missions at regional and international level. The strengthening of the regional and international partnership, the proper functioning of the committee for monitoring declarations and commitments made by the technical and financial partners, close monitoring of the release of the resources made available and the improvement of financial accountability must be considered for the improved mobilization of external resources.

➔ **Internal resource mobilization**

It will be done with the State, private sector actors (formal and non-formal) and civil society organizations through the integration of HIV into development projects, the inclusion of the HIV line in the budget of the State (central and departmental), etc. However, particular emphasis must be placed on strengthening advocacy for the mobilization of resources from the State and the private sector.

A mechanism to monitor compliance with commitments and mobilize resources will be put in place. It will regularly take stock of the state of mobilization, strengthen advocacy for the

release of funding promises and adjust the investment framework of available funding.

6.4 Resource and financial management mechanisms

The management of the financial resources mobilized within the framework of the implementation of the CSN 2019-2022 will obey the procedures in force at national and international level in matters of financial and accounting management. At the national level, these procedures will be defined in the manual of administrative, financial and accounting procedures of the CNLSE. The control system put in place will be strengthened in order to increase the rational and judicious use of available resources.

➔ **Internal control**

The internal control of the resources mobilized will be done through self-control and internal audit. An internal Controller position is provided for in the DEx / CNLSE organizational chart. The self-monitoring will be carried out by the CNLSE which is responsible for the mobilization of resources and the implementation structures. The control procedures will be described in the various administrative, financial and accounting procedures manuals.

While providing information on the quality of the management system and the procedures put in place, the internal audit will be carried out by the control services of the implementation structures. It will ensure compliance with management rules and procedures. These services liaise with the external auditors.

➔ **External control**

In order to improve performance in terms of accountability, external control will be ensured through independent (annual) external audits. It is provided by:

- Independent auditors whose recruitment procedures will be specified in the procedures manuals;
- Specialized state bodies: the Court of Auditors, the General Inspectorate of Finance, the National Commission to Combat Corruption, Bribery and Fraud;
- Any competent person or structure at the request of the State or a technical and financial partner who has contributed to the financing of the response to HIV.

The financial management mode of the national AIDS response strategy will obey the national procedures in force as well as those of the partners involved.

The CNLSE will monitor the financial resources mobilized through the administrative, financial and communication division, which will be responsible for centralizing data on the financial resources mobilized, committed by all projects and programs, whatever the source of funding. The administrative, financial and communication division will establish a financial execution situation (semi-annually and annually) which will be capitalized in the reports (semi-annual and annual).

VII. CONDITIONS OF SUCCESS AND RISK MITIGATION MEASURES

During the 2014-2018 period, several events that occurred during implementation had negative impacts on the availability of services and the performance of the national response. The successful implementation of the 2019-2022 CSN is essential to reposition the national response in the ideal trajectory for the 90-90-90 objectives and the elimination of the HIV epidemic by 2030. This will then require create and maintain throughout the implementation a favorable environment, an adequate availability of resources (technical, financial and logistical) and robust coordination for the strategic and operational management of the national response. These include:

Strengthening the leadership of the CNLSE : This will promote multisectoriality, the effective mobilization of State resources and the favorable environment for the implementation of the provisions

functional institutions

Effective operational management : It translates into enhanced leadership and coordination of the DEx / CNLSE and its branches on the national response, which should encourage engagement

different actors, each playing their role and creating synergies.

An adequate level of funding: This will encourage the implementation of priority interventions

at all levels. In a national and international context characterized by a decrease in resources, the issue of CSN funding is crucial and becomes a critical imperative for achieving the expected impacts. The development of an innovative resource mobilization plan based on international experiences and local models is likely to increase the
availability of financial resources.

Synergy in implementation with national community health policies,which could allow the integration of HIV tasks into the intervention package of community health workers. This integration will lay the foundations for the sustainability of HIV interventions, such as raising awareness among populations, screening in advanced strategy, tracking and finding the lost.

of view, community-based distribution of ARVs as well as adherence to treatment.

A focus on the quality of services, both at the health sector level and at the level of those provided at the community level. This will save money by investing resources

in efficient processes and services with high impact.

The national monitoring and evaluation plan of the CSN 2019-2022,whose architecture and operation should take into account developments in data management systems within the Ministry of Health such as DHIS2 and SIGL. The monitoring and evaluation plan should encourage the adequate availability of strategic information that can inform decision-making and the constant adjustment of programmatic strategies.

In view of the context, the implementation of the 2019-2022 will face risks whose mitigation will be The CSN essential for achieving the intended impacts. following table summarizes the risks and measures mitigation:

Table 18 : Risk analysis and measures table

Type of risks	Level of risk	Reduction measures
Low mobilization of resources financial		○ Strengthening advocacy for the mobilization and regular monitoring of level of funding ○ Development and implementation of a Resource Mobilization Plan ○ Establishment of a Committee to follow up on promises and mobilization funding ○ Development and implementation of a financing strategy innovative, public-private partnership ○ Alignment of targeting and intervention priorities based on level of effective resource mobilization ○ Establishment of a national AIDS fund ○ Capacity building of female leadership (women parliamentarians, former and new ministers, directors general, etc.) in response and resource mobilization financial
Low functionality of CNLSE, DEx / CNLSE, of ULS and PNLS		○ Development of an institutional support plan for the benefit of DEX in to strengthen the managerial and governance capacities of the DEX ○ Securing resources for operation ○ Assessment for the relevance and rationalization of structures ○ Taking into account local opportunities to control costs ○ Development and implementation of a training plan for key personnel ○ Contractualization technical assistance to upgrade the systems and arrangements, transfer of knowledge / capabilities

		○ Integration of ULS in departmental organizational charts ○ Integration of HIV, AIDS and sexual and reproductive health during redesigning school programs, with the support of INRAP and Support project to improve the education system with funding world Bank
Low quality of services	Way at Student	○ Rapid Quality of Service Assessment (RSQA) ○ Staff capacity building: Post supervision training, formative supervision and joint supervision / integrated ○ Improvement of technical platforms and maintenance of devices biomedical
Insufficiency in quality of data	Way at Student	○ Data quality audit (RDQA and OSDV) ○ Capacity building of actors on filling tools and understanding the indicators ○ Periodic data quality analysis ○ Data verification and correction outputs
Low promptness and low completeness of data	Way at Student	○ Update / revision of management and governance tools national response ○ Capacity building of actors on the production of reports ○ Integration of HIV indicators in DHIS2 ○ Active collection outputs of non-transmitted or missing data
Persistence of stigma / discrimination and environment human rights little favorable	Way	○ Capacity building of key human rights actors and gender, including coordination of interventions ○ Implementation and monitoring of interventions to combat stigma / discrimination, discrimination on violence sexual, gender-based, promotion and protection of human rights with a view to removing obstacles linked to poor access to prevention and care services
Situation humanitarian	Way	○ Develop a response plan in humanitarian situations and emergency ○ Continue advocacy for the funding and pursuit of AIDS response activities ○ Integration of ex-combatants and civilian populations in the national response HIV prevention programs

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In the future coordination of the interventions of the national AIDS response 2019-2022, all of the mitigation measures will be taken into account as a priority in the Operational Plan for operational implementation and will be subject to specific monitoring.

VIII. APPENDICES

8.1 Guiding principles of the CSN 2019-2022

The implementation of the 2019-2022 CSN will be based on the following guiding principles: strong leadership based on the "Three-Ones", alignment, effective multisectoriality and good governance, integration of services and synergy, not stigma / non-discrimination, taking gender / human rights into account, strengthening the national and global partnership for funding, strengthening the health and community systems as a pillar of the results-based management and accountability response and the alignment of the AIDS response with the dynamics of community health.

➔ **Respect for the "Three-Ones" and alignment**

The Republic of Congo has adopted the Three Ones principle for governance and management of the response to HIV and AIDS. Indeed, this principle invites national officials and partners to align themselves with effective national coordination based on: (i) a single national strategic framework; (ii) a single national coordination body; and, (iii) a single monitoring & evaluation system.

The CSN is part of the logic of the Sustainable Development Goals aimed at stopping the epidemic of AIDS, tuberculosis, malaria and other communicable diseases by 2030. Also, the CSN is fully consistent with the objectives and guidelines of UNAIDS and its co-sponsors as well as those of the 2018-2022 National Health Development Plan, in particular the improvement in the availability of HIV / AIDS services in all health facilities. At the national level, the CSN is aligned with the commitments made by the national political authorities, in particular the President of the Republic.

➔ **Multisectoriality and good governance**

The response to AIDS requires a multisectoral approach integrating all political and social sectors. Public / private partnership and community participation are also crucial areas of this principle. All the actors involved in the fight against AIDS have a duty to contribute to achieving the objectives of the CSN and to report on their performance, both programmatic and financial, in a transparent manner.

➔ **Integration of services and synergy**

This principle implies that the supply of health services (including HIV and AIDS care) is part of a package of services offered by service delivery points in a non-vertical logic of dispensation and organization of services. The integration of services will reduce costs, accelerate the decentralization of services and bring populations closer to services. This integration also concerns diseases.

➔ **Reducing dependence on external funding**

In past periods, funding for the response to HIV, STIs and epidemics has been heavily dependent on external funding. The country is committed to increasing national funds devoted to the AIDS response in order to increase ownership of the prevention of new infections and the comprehensive care of its population in need. In addition to state funding, efforts will be made to mobilize more financial resources at the community level and in the private sector. To this will be added the rational management of funding in order to reduce operating costs.

➔ **Non-stigma / non-discrimination and ethics**

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It is about respecting strengthening anti-discrimination laws and other laws that protect vulnerable groups and that guarantee respect for privacy and the confidentiality and ethics of research involving human subjects. Non-discrimination and non-stigmatization will encourage the use of services and the involvement and participation of the communities and people concerned.

➔ **Taking gender and human rights into account**

It is a question of guaranteeing universal and equitable access to services and care related to the fight against AIDS to the whole Guinean population while also considering gender inequalities. For this, human rights must
be respected so that barriers to access to services and care are removed and no one is left behind.

➔ **Strengthening of the national and global partnership for the financing of the CSN**

During the 2014-2018 period, the AIDS response was underfunded due to the lack of sufficient resource mobilization. In order to meet the challenges, it is envisaged to put in place innovative resource mobilization strategies (PPP, capacity for financial mobilization of community actors). In addition to this, the country will also put access to the mobilization of external resources by relying on existing global mechanisms such as the Global Fund, the Global financing facility (GFF), GAVI Alliance, the H6 Partnership. All around the Partnership for Mother, Newborn and Child Health (PSMNE) which is a global multi-stakeholder partnership platform which brings together more than 800 member organizations - from various sectors and working on world levels, regional and national to advance SRMNEA. The GFF and the H6 are an integral part of this expanded partnership in support of the Global Strategy. The main mission of the PSMNE is to strengthen alignment, mutual accountability and common advocacy, to contribute to the successful implementation of the Global Strategy.

➔ **Strengthening the health and community systems as a pillar of the response**

During the 2014-2018 period, insufficient capacity in the health system had an impact on the overall performance of the AIDS response. Strengthening the health system will make it possible to offer more services on a permanent basis according to the expectations of the beneficiaries. As for the community system, the structuring strengthening of community organizations will make it possible to offer effective services but also support the health component in certain components such as compliance, retention in sites, etc.

➔ **Linkage with community health interventions**

Supported by WHO and UNAIDS, community health is booming. In Congo, a community-based intervention strategy is available. The linkage of the AIDS response with community health offers an opportunity to integrate HIV services (awareness, screening, referral to services, distribution of community-based health products, maintenance in the PMTCT cascade and retention in sites, etc.). This will rationalize costs and make prevention and care interventions at community level sustainable.

8.2 CSN 2019-2022 results framework

Table 19 : CSN 2019-2022 Results Framework

Budget by impact and effects				Indicators	Annual targets				Total
					2019	2020	2021	2022	
Priority -1	Reduce new infections among vulnerable populations (in this case young girls, young women), key populations and eliminate those in children								
	Impact-1	New infections are reduced by 46% between 2018-2022							
		Effects	1.1. At least 80% of key populations (PS, PC, MSM) and populations vulnerable (adolescent / youth women, populations natives) have behaviors to lower risk by 2022	Number of SPs reached by targeted interventions	4,825	6,139	7,528	8,995	27,486
				Number of MSM affected by targeted interventions	1,203	1,452	1,716	1,994	6,365
				Number of CPs affected by targeted interventions	1,169	1,214	1,261	1,309	4,954
				Number of primary teachers trained	236	263	291	320	1,110
				Number of secondary school teachers trained	147	187	231	278	844
				Number of adolescent girls and young women sensitized	106,661	129,695	196 977	221,336	654,669
				Number of people affected in the workplace	89,255	101,442	114,238	127,718	432,654
				Number of male condoms distributed / sold	17,325,785	18,026,626	18,747,061	19,497,999	73,597,471
				Number of female condoms distributed / sold	911,883	948,770	986 687	1,026,210	3,873,551
				Number of STI cases notified and treated	18,391	24 898	31,843	39,248	114,381
				Number of people benefiting from PrEP / PEP	577	592	607	623	2,399
			1.2. The transmission HIV blood is eliminated (risk = 0%) during the period 2019-2022	Number of blood bags collected and tested (hepatitis B, hepatitis C, Syphilis and HIV)	54,957	56,370	57,815	59,293	228,436
			1.3. The rate of HIV transmission from mother with child is reduced at least 5.1% by the end 2022	Number of pregnant women seen in ANC and tested	75,368	96,633	118,934	142,304	433,239
				Number of pregnant women screened for HIV	2,713	3,479	4,282	5,123	15,597
				Number of HIV-positive women receiving ARVs and having giving birth	2,385	3,325	4,247	5,090	15,047
				Number of exposed children receiving ARVs as part of prophylaxis	2,100	2,926	3,739	4,480	13,245
				Number of pregnant women benefiting from PMTCT community	362	773	1,180	2,049	4,364
				Number of newborns treated with CTX	2,100	2,926	3,739	4,480	13,245
				Number of newborns receiving PCR 2 months after birth birth	467	975	2,077	2,987	6,506

Priority -2	Achieving the 90-90-90 targets to significantly reduce morbidity and mortality among PLHIV								
	Impact-2	HIV-related mortality reduced by 69% between 2018-2022							
		Effe	2.1. 60% of adults and children living with HIV know their status serological and are referred to services care / treatment from here at the end of 2022	Number of SPs benefiting from screening counseling	3,067	4,529	6,075	7,710	21,380
				Number of MSM receiving screening counseling	739	1,134	1,552	1,994	5,418
				Number of pregnant women receiving screening	75,368	96,633	118,934	142,304	433,239
				Number of people benefiting from screening (others populations)	104,033	119,832	136,698	154,897	515,460
				Total number of people screened	183,207	222,127	263,258	306,905	975,496
			2.2. 50% of PLWHIV adults and 40% of children living with HIV are on ARV treatment by the end of 2022	Number of adults receiving ARV therapy	36,953	42 001	47,064	52,025	178,043
				Number of children receiving ARV therapy	2,294	2,663	3,030	3,376	11,364
				Total number of ARV patients	39,247	44,664	50,094	55,401	189,407
				Number of patients receiving care community	5,431	5,604	5,700	5,709	22,444
			2.3. The death rate among co-infected patients TB / HIV is reduced by 50% by the end of 2022	Number of patients treated for TB / HIV co-infection	2,221	2,535	2,806	3,015	10,577
			2.4. 50% of PLHIV under ARVs have a viral load undetectable at 12 months of treatment in 2022	Number of adults with viral load	14,781	21,001	28 238	36,404	100,424
				Number of children with viral load	918	1,332	1,818	2,363	6,431
				Total number of patients with viral load	15,699	22,332	30,056	38,767	106,855
Priority -3	Strengthen governance and resilience of the AIDS response for better local responses based on quality strategic information								
	Impact-3	The management, monitoring and evaluation and governance systems for the response to HIV are strengthened and resilient by the end of 2022							
			3.1. By the end of 2022, the execution rate of the CSN is at less than 80%	Resources mobilized by the State	3,878,676,701	5,101,203,267	6,556,575,021	8 108 616 650	23,645,071,638
				Resources mobilized by private sector actors	193,933,835	347 809 314	558 006 385	810 861 665	1,910,611,198
				Resources mobilized by civil society organizations	145,450,376	231 872 876	348,753,990	486 516 999	1,212,594,242

8.3 Breakdown of the CSN 2019-2022 budget

Table 21 : Breakdown of the CSN 2019-2022 budget by type of intervention (Euro)

Congo	2019	2020	2021	2022	TOTAL	%
Prevention	**5,165,161**	**5,900,269**	**7,031,716**	**7,918,126**	**26,015,272**	**33.16%**
Priority populations						
Sex workers and clients	202,415	257,773	316 354	378,620	1,155,162	1.47%
MSM	120,271	147,936	177,973	210,524	656,704	0.84%
Prison population	24,363	25,301	26,274	27,282	103,220	0.13%
Teenage girls and young women	752,972	914,631	1,378,746	1,549,970	4,596,319	5.86%
Workplace	304,794	346,411	390 106	436,140	1,477,451	1.88%
Provision of services						
Provision of condoms	1,918,667	1,983,970	2,051,410	2,122,066	8,076,112	10.30%
STD treatment	28,042	37,964	48,553	59,843	174,401	0.22%
Screening advice	920 639	1,071,359	1,232,118	1,405,218	4,629,335	5.90%
PMTCT	604,917	819,434	1,107,119	1,417,650	3,949,120	5.03%
Health care					-	0.00%
Blood safety	234,588	240,621	246,789	253,098	975,096	1.24%
PrEP and PEP	53,493	54,869	56,275	57,714	222 352	0.28%
Care and treatment services	**6,660,848**	**8,239,248**	**9,981,789**	**11,860,284**	**36 742 169**	**46.84%**
Antiretroviral therapy	5,092,221	5,793,465	6,496,366	7,183,637	24,565,689	31.32%
Diagnostic examination	1,055,768	1,709,457	2,486,911	3,380,240	8,632,376	11.00%
Community care	124,198	128 140	130,348	130,548	513,233	0.65%
TB / HIV co-infection	388,661	608,186	868 163	1,165,860	3,030,870	3.86%
Governance	**2,956,502**	**3,534,879**	**4,253,376**	**4,944,603**	**15,689,360**	**20.00%**
Multisectoral coordination	177,390	212,093	255 203	296,676	941,362	1.20%
Central management and coordination	650 430	777,673	935,743	1,087,813	3,451,659	4.40%
Health system strengthening (RSS)	354,780	424,186	510 405	593,352	1,882,723	2.40%
Community System Strengthening (CSR)	354,780	424,186	510 405	593,352	1,882,723	2.40%
Human rights and gender	354,780	424,186	510 405	593,352	1,882,723	2.40%
Monitoring evaluation / strategic information	827 821	989,766	1,190,945	1,384,489	4,393,021	5.60%
Financial resource mobilization and accountability	236,520	282,790	340,270	395,568	1,255,149	1.60%
Total Millions of USD	**14,782,511**	**17,674,396**	**21,266,881**	**24,723,013**	**78 446 801**	**100.00%**
Total Millions of FCFA	**9,696,691,752**	**11,593,643,789**	**13,950 159,620**	**16,217 233,299**	**51 457 728 459**	

Table 22 : Breakdown of the CSN 2019-2022 budget by impact and effects (Euro)

Budget by impact and effects				Annual budget				Total budget	%
				2019	2020	2021	2022		
Priority -1	Reduce new infections among vulnerable populations (in this case young girls, young women), key populations and eliminate those in children								
	Impact-1	New infections are reduced by 46% between 2018-2022		4,297,740	4,892,537	5,876,159	6,601,910	21,668,346	27.62%
		Effects	1.1. At least 80% of key populations (PS, PC, MSM) and populations vulnerable (adolescent girls / young women) have behaviors lower risk by 2022	3,405,018	3,768,855	4,445,691	4,842,160	16,461,722	20.98%
			1.2. Blood transmission of HIV is eliminated (risk = 0%) during 2019-2022 period	234,588	240,621	246,789	253,098	975,096	1.24%
			1.3. The rate of mother-to-child transmission of HIV is reduced to at minus 5.1% by the end of 2022	604,917	819,434	1,107,119	1,417,650	3,949,120	5.03%
			1.4. 80% of women and girls victims of SGBV notified during the 2019-2022 period benefited from holistic care (health, legal and psychological, humanitarian situation)	53,217	63,628	76,561	89 003	282,408	0.36%
Priority -2	Achieving the 90-90-90 targets to significantly reduce morbidity and mortality among PLHIV								
	Impact-2	HIV-related mortality reduced by 69% between 2018-2022		7,581,487	9,310,607	11,213,907	13 265 503	41 371 503	52.74%
		Effects	2.1. 60% of adults and children living with HIV know their status serological and are referred to care / treatment services by the end of 2022	920 639	1,071,359	1,232,118	1,405,218	4,629,335	5.90%
			2.2. 50% of adults living with HIV and 40% of children living with HIV are on ARV treatment by the end of 2022	5,216,419	5,921,605	6,626,714	7,314,184	25,078,923	31.97%
			2.3. The death rate in TB / HIV co-infected patients is reduced by 50% by the end of 2022	388,661	608,186	868 163	1,165,860	3,030,870	3.86%
			2.4. 50% of PLWHA on ARVs have an undetectable viral load at 12 month of salary in 2022	1,055,768	1,709,457	2,486,911	3,380,240	8,632,376	11.00%
Priority -3	Strengthen governance and resilience of the AIDS response for better local responses based on quality strategic information								
	Impact-3	Management, monitoring and evaluation systems, governance of the response to HIV are strengthened and resilient by the end of 2022		2,903,285	3,471,251	4,176,815	4,855,600	15,406,952	19.64%
			3.1. By the end of 2022, the financial execution rate of the CSN is at least equal to 80%	236,520	282,790	340,270	395,568	1,255,149	1.60%

		3.2. Community and private sector have capacities necessary (managerial, technical and operational) to implement at least 75% of the response in their sector by the end of 2022	301,563	360 558	433,844	504,349	1,600,315	2.04%
		3.3. By the end of 2022, attitudes of stigma and discrimination are reduced by 65% both in healthcare and in the workplace community	354,780	424,186	510 405	593,352	1,882,723	2.40%
		3.4. During the 2019-2022 period, the health system is strengthened to provide quality HIV services and adequate availability inputs and health products	354,780	424,186	510 405	593,352	1,882,723	2.40%
		3.5. During the period 2019-2022, the national monitoring and evaluation system has the capacity to produce quality data (completeness / promptness greater than 95%) and promote the use of information strategic	827 821	989,766	1,190,945	1,384,489	4,393,021	5.60%
		3.6. Between 2019-2022, the capacities and the governance system of the CNLSE ensure optimal multisectoriality and accountability	827 821	989,766	1,190,945	1,384,489	4,393,021	5.60%
		Total budget	**14,782,511**	**17,674,396**	**21,266,881**	**24,723,013**	**78 446 801**	**100.00%**

8.4 CSN gender budget 2019-2022

Table 23 : Breakdown of the gender budget of the CSN 2019-2022 (Euro)

Congo	2019	2020	2021	2022	TOTAL	%
Prevention	**2,009,733**	**2,511,486**	**3,396,571**	**4,020,186**	**11,937,977**	**90.45%**
Priority populations						
Sex workers and clients	202,415	257,773	316 354	378,620	1,155,162	8.75%
MSM	120,271	147,936	177,973	210,524	656,704	4.98%
Prison population	24,363	25,301	26,274	27,282	103,220	0.78%
Teenage girls and young women	752,972	914,631	1,378,746	1,549,970	4,596,319	34.83%
Workplace	304,794	346,411	390 106	436,140	1,477,451	11.19%
Provision of services						
PMTCT	604,917	819,434	1,107,119	1,417,650	3,949,120	29.92%
Care and treatment services	**124,198**	**128 140**	**130,348**	**130,548**	**513,233**	**3.89%**
Community care	124,198	128 140	130,348	130,548	513,233	3.89%
Governance	**128,036**	**158,378**	**211 615**	**249,044**	**747,073**	**5.66%**
Community System Strengthening (CSR)	64,018	79,189	105,808	124,522	373,536	2.83%
Human rights and gender	64,018	79,189	105,808	124,522	373,536	2.83%
Total Gender Budget (F CFA)	**1,483,752,768**	**1,835,370,121**	**2,452,317,903**	**2,886,065 110**	**8 657 505 901**	
Total Gender Budget (Euro)	**2,261,967**	**2,798,004**	**3,738,535**	**4,399,778**	**13 198 283**	**100.00%**
Total Budget CSN 2019-2022	**14,782,511**	**17,674,396**	**21,266,881**	**24,723,013**	**78 446 801**	**100.00%**
% of gender sensitive budget	**15.30%**	**15.83%**	**17.58%**	**17.80%**	**16.82%**	

8.5 Description of the CSN 2019-2022 development process

The process of drawing up the strategic document for the fight against HIV / AIDS was launched by the Minister of Health and Population, 1st Vice-President of the National Coordination on September 06, 2018 in the presence of all the stakeholders. This report concerns the global review of the implementation of the CSN 2014-2018 which was conducted in a participatory and inclusive manner. It reports on the implementation, the difficulties and obstacles encountered and provides the guidelines for the preparation of the next CSN which should cover the period 2019-2022.

The process was carried out according to a participatory approach involving the various stakeholders in the fight against HIV / AIDS in the Congo (Ministry of Health and Population, Technical and Financial Partners, Civil Society Organization, private sector, etc.). The different phases of this process are summarized in the following table:

Table 23 : Summary of the CSN 2014-2018 review development process

Phases		Details on achievements
1	Stak e in place of committee steering and of groups thematic	The Steering Committee is placed under the aegis of the Minister of Health and Population with the role coordinate the whole process
		Establishment of thematic groups of five (5) and coordinated by the Director Executive of the National Council to Fight HIV / AIDS, Sexually Transmitted Infections and Epidemics (CNLSE): a) Prevention and PEC of HIV (general population, PLWHA, key population and other vulnerable populations; two sub-groups will be formed, namely the sub-group prevention and the care sub-group (care / treatment), b) Prevention of the transmission of Mother-to-child HIV, c) Program and research monitoring and evaluation system, d) Gender and human rights, key populations and strengthening of community systems (CSR), e) Governance, Coordination, financing of the national response and partnership, advocacy, information, education and communication
2	Launch of process	Mobilization of national and international consultants with support from UNAIDS Official launch of the process by the Minister of Health and Population on September 6 2018 at the Ministry of Foreign Affairs
	Framing workshop	A framing workshop was organized on September 12, 2018 in the meeting room of the CCN Congo thematic groups to enable members of the different thematic groups to Appropriate the principles, orientations and contents of the CSN 2014-2018 review as well as the tools / methodology that will be used
	Collect and analysis Datas	The activities carried out consisted of i) the documentary review which made it possible to take stock of all the information and data available concerning the national situation of the respond to HIV / AIDS from 2014 to 2018, to use the results of available surveys, as well as the various reports and all other necessary documents, (ii) the adaptation of the tools for collecting information (frameworks from the different thematic groups and partners), (iii) carrying out additional working sessions with other sectors for the collection of additional information (Ministry of National Defense, UNICONGO, etc.) and (iv) the Processing and analysis of collected data
	The writing of journal report	The CSN 2014-2018 review report was prepared using an interactive and participatory process. Indeed, after the drafting of a first draft of the said report by the team of Consultants international and national, it was submitted for reading, contributions and amendments to managers of the various structures in charge of the response to HIV (PNLS and structures under supervision, as well as to the Representatives of the various Technical and Financial Partners), constituted in Proofreading commission
3	Validation of journal report	The CSN 2014-2018 review report was first presented for pre-validation to a technical subcommittee. Comments were taken into account before the document was validated by the Steering Committee. This validation also concerned the main conclusions and the strategic directions for the CSN 2019-2022.
4	Drafting of the draft of the CSN 2019-2022	
5	Validation of CSN 2019-2022	