PRESIDENCY OF THE REPUBLIC

GENERAL SECRETARIAT

NATIONAL AIDS COMMITTEE

EXECUTIVE SECRETARIAT

NATIONAL STRATEGIC PLAN

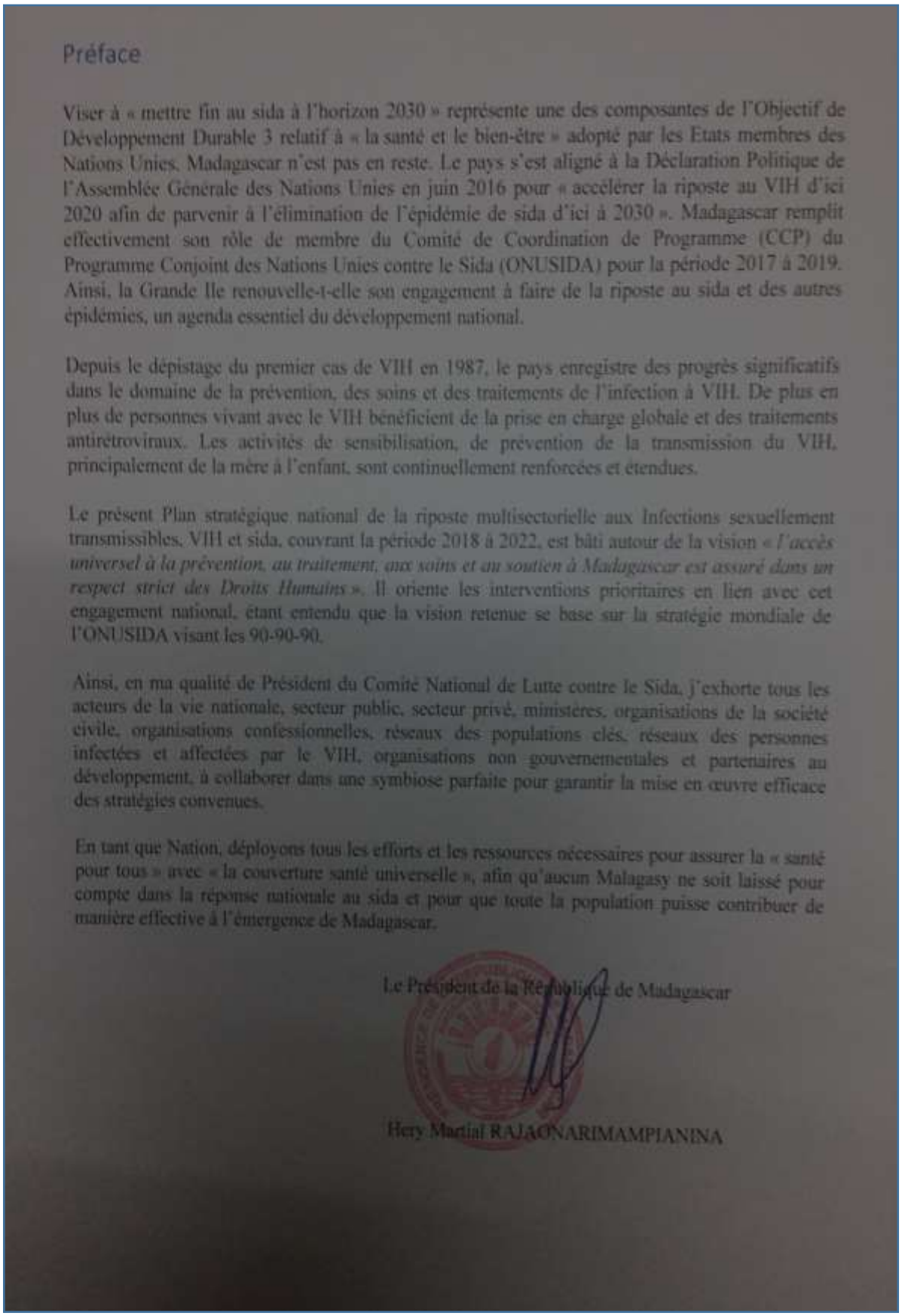
MULTISECTORAL RESPONSE

STI, HIV AND AIDS

2018 - 2022

2018

Preface



Préface

Viser à « mettre fin au sida à l'horizon 2030 » représente une des composantes de l'Objectif de Développement Durable 3 relatif à « la santé et le bien-être » adopté par les Etats membres des Nations Unies. Madagascar n'est pas en reste. Le pays s'est aligné à la Déclaration Politique de l'Assemblée Générale des Nations Unies en juin 2016 pour « accélérer la riposte au VIH d'ici 2020 afin de parvenir à l'élimination de l'épidémie de sida d'ici à 2030 ». Madagascar remplit effectivement son rôle de membre du Comité de Coordination de Programme (CCP) du Programme Conjoint des Nations Unies contre le Sida (ONUSIDA) pour la période 2017 à 2019. Ainsi, la Grande Ile renouvelle-t-elle son engagement à faire de la riposte au sida et des autres épidémies, un agenda essentiel du développement national.

Depuis le dépistage du premier cas de VIH en 1987, le pays enregistre des progrès significatifs dans le domaine de la prévention, des soins et des traitements de l'infection à VIH. De plus en plus de personnes vivant avec le VIH bénéficient de la prise en charge globale et des traitements antirétroviraux. Les activités de sensibilisation, de prévention de la transmission du VIH, principalement de la mère à l'enfant, sont continuellement renforcées et étendues.

Le présent Plan stratégique national de la riposte multisectorielle aux Infections sexuellement transmissibles, VIH et sida, couvrant la période 2018 à 2022, est bâti autour de la vision « *l'accès universel à la prévention, au traitement, aux soins et au soutien à Madagascar est assuré dans un respect strict des Droits Humains* ». Il oriente les interventions prioritaires en lien avec cet engagement national, étant entendu que la vision retenue se base sur la stratégie mondiale de l'ONUSIDA visant les 90-90-90.

Ainsi, en ma qualité de Président du Comité National de Lutte contre le Sida, j'exhorte tous les acteurs de la vie nationale, secteur public, secteur privé, ministères, organisations de la société civile, organisations confessionnelles, réseaux des populations clés, réseaux des personnes infectées et affectées par le VIH, organisations non gouvernementales et partenaires au développement, à collaborer dans une symbiose parfaite pour garantir la mise en œuvre efficace des stratégies convenues.

En tant que Nation, déployons tous les efforts et les ressources nécessaires pour assurer la « santé pour tous » avec « la couverture santé universelle », afin qu'aucun Malagasy ne soit laissé pour compte dans la réponse nationale au sida et pour que toute la population puisse contribuer de manière effective à l'émergence de Madagascar.

Le Président de la République de Madagascar

Hery Martial RAJAONARIMAMPIANINA

Thanks

The development of the National Strategic Plan (NSP) of the multisectoral response to STIs, HIV and AIDS 2018-2022 results from the adhesion of all stakeholders to the planning and implementation cycle of the national AIDS control program in Madagascar. The process of revising and updating the PSN marks the will of all the actors to concretize the vision of the General Policy of the Malagasy State.

The consultations made it possible to capitalize together the gains in the fields of prevention and care while considering new scientific advances, in order to adapt new international strategies and accelerate the national response to AIDS.

At the end of this largely participative, inclusive and consensual process, on behalf of the Executive Secretariat of the National Committee to Fight AIDS, I would like to express here my deep appreciation to all the actors who have contributed directly or indirectly to development of this book, since the final review of the previous PSN, the analysis of the performance of the AIDS program and the revision of the national strategic plan.

My heartfelt thanks go particularly:

- to Her Excellency the President of the Republic of Madagascar, the First Lady of Madagascar who is the godmother of mother and child health and the entire Government of the Republic of Madagascar for their significant support through resource allocation and their high-level involvement in the national AIDS response;

- to senior officials of territorial intervention structures for their availability and attendance at the various stages planned;
- to the Ministry of Public Health of Madagascar through all its central and regional directorates as well as its technical teams;
- to all members of civil society, national and international non-governmental organizations, associations, networks of key populations and people infected and affected by HIV;

- to the National Coordination Body for its precious advice and its continuous encouragement;
- to all development partners who have made every effort to ensure quality technical support and the necessary financial support. Allow me to cite the Agencies of the United Nations System under the mobilization of UNAIDS through its regional and national offices; the Global Fund to Fight AIDS, Tuberculosis and Malaria; the French Government through the French Embassy;

- to all resource persons, national and international experts as well as the members of the reading committee who gave their best to produce quality work.

The actors of the response still count on the commitment and the implication of all for the achievement of the results in terms of impacts and effects of the NHP of the multisectoral response to STIs, HIV and AIDS 2018-2022.

The 2018-2022 PSN does not claim to be an exhaustive document. On the basis of the data and information available, it guides the strategic thinking of the actors of the response with the collaborators, in order to best adapt the interventions in accordance with the dynamics of the epidemic, with the aim of improving the efficiency of actions. In addition, in this spirit, a mid-term review of its implementation is planned to optimize said interventions, in the light of new evidence from national studies and surveys.

Universal access for the entire Malagasy population to prevention, treatment, care and support in equity, respect for gender, and human rights remains our imperative in Madagascar.

Doctor ANDRIANIAINA Harivelo Rijasoa
Executive Secretary of the National AIDS Control Committee

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Abbreviations and acronyms

ARV	: Antiretroviral
CCC	: Communication for Behavior Change
CDV	: Voluntary Counseling and Testing
CDT	: Tuberculosis Diagnosis and Treatment Center
CICLD	: Interministerial Committee for the Coordination of the Fight against Drugs
CIP	: Interpersonal communication
CPN	: Pre-natal Consultation
CTRLS	: Regional Technical Committee to Fight AIDS
CNLS	: National Committee to Fight AIDS
CSB	: Basic Health Center
DEP	: Studies and Planning Department
DHIS2	: District Health Information Software 2
DLIS	: Department of STI and AIDS Control
EDS	: Demographic and Health Survey
ESBC	: Biological and Behavioral Surveillance Survey
SWOT	: Strengths - Weaknesses - Opportunities - Threats
GAM	: Global Aids Monitoring
GESIS	: Health Information System Management
IO	: Opportunistic infections
GT-PSN	: Technical Working Group on the “National Strategic Plan”
STI	: Sexually Transmitted Infections
JICA	: Japanese International Cooperation Agency
MSANP	: Minister of Public Health
MSM	: Man having Sex with Man
OVC	: Orphans and Vulnerable Children
MDG	: Millenium Objectives for development
WHO	: World Health Organization
NGO	: Non-Governmental Organization
UNAIDS	: United Nations Joint AIDS Program
Pcper	: Key Populations Most at Risk
PEC	: Supported
PPE	: Post Exposure Prophylaxis
PSE	: Monitoring and Evaluation Plan
PSI	: Population Services International
PSN	: National Strategic Plan
PMTCT	: Prevention of Mother-to-Child Transmission
PUDR	: Progress Update and Disbursement Request
RDS	: Respondent-Driven Sampling
RGPH	: General Census of Population and Housing
SADC	: Southern African Development Community
CNLS	: National Committee to Fight AIDS
RMA	: Monthly Activity Report
UNICEF	: United Nations International Children's Emergency Fund
HIV	: Human immunodeficiency virus

List of tables and figures

Executive summary

Madagascar ranks among the countries with a low prevalence HIV epidemic, estimated at 0.3% in the population aged 15 to 49 in 2017. Thanks to the efforts of the national program, the prevalence has always been kept below 1% in the general population. However, the epidemic is concentrated in key populations with behaviors that put them more at risk of transmitting the virus. Studies using the Respondent Directed Sampling (RDS) method have reported HIV prevalence in three populations: 14.8% among men who have sex with men, 8.4% among consumers of injecting drugs and 5.6% among sex workers.

Analysis of the available data describes that sexual transmission is the most important route of spread of HIV in Madagascar. In fact, 94.7% of new HIV infections come from practices and behaviors that promote the sexual transmission of HIV. The results of the update on the mode of transmission show that just over half of new infections, 56.8% come from key populations most at risk. According to estimates made with the Spectrum tool in 2017, the number of people living with HIV (PLWHIV) among adults aged 15 to 49 in Madagascar is estimated at 32,000, of which approximately 28,000 PLWHIV, that is, 88% need ARV treatment. Among these patients needing antiretroviral therapy, the number of pregnant women is estimated at 960.

Regarding the 90-90-90 in 2017, innovative approaches must be adopted because only 8.2% of people estimated to be living with HIV know their status. Among 2,914 PLWHA followed at the referral center level, 80%, 2,321 benefit from ARV treatment. 30% of ARV patients have an undetectable viral load.

The 2018-2022 PSN development process is supported by the results of the 2013 PSN final review.
2017. Major achievements were recorded during the implementation of the response until 2017.

The Malagasy State is committed to the response by actively participating in the General Assembly of the United Nations in June 2016 and by adopting the Political Declaration of the High Level Meeting on the acceleration of the response to HIV in order to achieve the elimination of the AIDS epidemic by 2030. Decree number 2017-071 of 02 February 2017 on "reorganization of the National Committee to Fight AIDS" was approved by the Council of Ministers. The proportion of spending from the Malagasy State in the response to AIDS for the year 2017 amounts to 5.5%. The Government significantly supported the mobilization of the resources necessary to ensure the national multisectoral response. The total amount of expenditure in 2017 is 16,776,315,094 Ariary.

On the basis of the three axes of the 2013-2017 PSN, the progress recorded is manifold.

Compared to prevention, a very clear progress in the response targeting key populations with an improvement of knowledge as well as practices to prevent the transmission of the virus is noted.

Regarding the pillars of prevention of mother-to-child transmission, 70% of expected pregnancies are seen in prenatal consultation (CPN). HIV testing is integrated into the ANC package. Option B + has been officially adopted. In 2017, 499,242 pregnant women were seen in ANC, 172,954, or 35% of them tested for HIV and received the result. Finally, 176 pregnant women seen in ANC tested positive for HIV and 60% of them benefited from ARVs to prevent MTCT of the virus.

In overall care, the integration and coordination of therapeutic education and ARV treatment services, as well as psychosocial support, prove to be effective. This has led to an improvement in the quality of care, in the rational management of medical and pharmaceutical products linked to STIs, HIV and AIDS. In 2017, the proportion of PLWHIV still under treatment at 12 months after the start of antiretroviral therapy is 92.23%, if it was 86.42% in 2016. For the monitoring and evaluation of the response, the national system managed by the Technical Monitoring and Evaluation Group using tools with a single circuit is well functional.

Despite the many positive points noted by the evaluation of the response program, several essential aspects require strengthening for a more effective response in achieving the objectives of the 2018-2022 NHP and the elimination of the epidemic in 2030. Indeed , several determinants identified explain the spread of HIV, including the low level of knowledge about prevention, the use of condoms, access to testing and treatment services.

Thus, the strategies selected in the 2018-2022 PSN aim to strengthen:

- coordinating response interventions at all levels for better achievement of objectives;
- communication on HIV infection so that the level of knowledge of the general population and key populations is better to achieve a good awareness of the risk. It will be necessary to target school-going and out-of-school youth in the 10 to 24 age group who are found in significant proportion at the level of key populations;
- coverage of the supply and use of HIV infection testing and management services to achieve the 90-90-90 targets by 2020 and 95-95-95 by 2030;
- prevention of mother-to-child transmission of HIV. Madagascar should be more ambitious by targeting the elimination of mother-to-child transmission of HIV;
- the implementation of new HIV screening strategies and recent WHO recommendations in the management of patients.

The strategic challenges to be faced at these points for improvement relate to the ever-increasing involvement of political authorities in maintaining the AIDS response in the national development agenda, the mobilization of sufficient resources to carry out planned interventions and the performance of the monitoring and evaluation system which should guarantee permanent monitoring of indicators as well as the achievement of the target values of the performance framework.

Built around the vision "Universal access to prevention, treatment, care and support in Madagascar is ensured with strict respect for Human Rights", the national strategic plan for multisectoral response to STIs, HIV and AIDS 2018 - 2022 aligns with UNAIDS global strategy on 90-90-90, to enable Madagascar to accelerate the response to HIV by 2020 in order to achieve the elimination of the AIDS epidemic from here in 2030.

Its implementation will be dictated by the three principles of uniqueness recommending a single framework for action against AIDS, a single coordinating body for the response and a single monitoring and evaluation system.

The following results are expected upon completion of the 2018-2022 NSP:

Impacts:

- Impact 1 - Reduce by at least 75% new infections in key populations, young people aged 10 to 24 and the general population by 2022;
- Impact 2 - The proportion of newborns infected with HIV born to HIV-positive mothers and that of newborns with congenital syphilis are reduced to less than 5% by the end of 2022;
- Impact 3 - Mortality due to AIDS is reduced from 4.4 deaths to 1.5 deaths in 2022 per 100,000 inhabitants.

Effects :

- Effect 1.1. - The risks of sexual transmission of HIV are reduced by at least 75% among PCPERs by the end of 2022;
- Effect 1.2. - 80% of young people aged 10 to 24 have the skills, knowledge and ability to protect themselves from STIs / HIV by the end of 2022;
- Effect 1.3. - 80% of adults aged 25 to 49 have the knowledge and ability to protect themselves from STIs / HIV by the end of 2022;
- Effect 1.4. - The risks of HIV blood transmission are reduced by at least 75% (from 0.27% to 0.06%), by the end of 2022;

- Effect 1.5. - Gender inequalities, all forms of violence against women and girls and discrimination against people living with HIV and key populations are reduced by 50% by 2022;

- Effect 2.1. -At least 80% of pregnant women living with HIV benefit from the package of services aimed at reducing mother-to-child transmission of HIV by 2022;
- Effect 2.2. - Effect 2.2: At least 95% of pregnant women benefited from screening for syphilis in prenatal consultation and having adequate treatment;
- Effect 3.1. - At least 80% of adults and children living with HIV receive ARV as part of comprehensive medical, psychosocial care by 2022;
- Effect 3.2. - At least 80% of adults and children screened for HIV positive on ART have an undetectable viral load by 2022;
- Effect 3.3. - At least 80% of OVC with AIDS and their parents with PLHIV benefit from basic social services by the end of 2022.

The following guiding principles will guide the development and implementation of operational and sectoral plans for the operationalization of the NSP (i) multisectoriality, (ii) integration of services, decentralization, (iii) quality standards, (iv) compliance "three principles of uniqueness", (v) active involvement of PLHIV , key populations most at risk of HIV and communities , (vi) special consideration of young people aged 10 to 24, (vii) test, treat and remember, (viii) good governance, (ix) Human Rights, gender and equity.

The priority targets of the 2018-2022 NHP are (a) populations infected and affected by HIV, (b) key populations most exposed to the risk of HIV infection and (c) populations in a context of vulnerability.

The total cost of requirements for the implementation of the 2018-2022 NHP is estimated at 130,023,683 US dollars.

PART 1 - CONTEXT OF THE MADAGASCAR HIV EPIDEMIC

1.1 Madagascar, Big Island of the Indian Ocean

1.1.1 Geography, administration and demography

Madagascar, a country in Southern Africa, in the southwest of the Indian Ocean, separated from the African continent by the Mozambique Channel, is located between 11 ° 57 'and 25 ° 30' south latitude and between 43 ° 14 'and 50 ° 27' east longitude, straddling the Tropic of Capricorn.

Covering an area of 587,401 Km 2, the Big Island extends over a length of 1,500 km, almost 500 km at its widest point. It includes more than 5,000 km of bathed coastline (the Mozambique Channel to the west, and the Indian Ocean to the east). The territory of Madagascar includes small islands, the most important of which are Nosy Be and Sainte-Marie.

Administratively, Madagascar is subdivided into 6 autonomous provinces, 22 regions, 119 districts, 1,693 municipalities and 18,251 *fokontany (* FKT). Regions and municipalities are decentralized local authorities organized at the level of autonomous provinces.

More than three quarters of the population (80%) live in rural areas where the poverty rate is very high.

Figure 1: Map of Madagascar

Table 1 : Population projection

Year	Total population
2017	24,940,644
2018	25,614,041
2019	26,305,620
2020	27,015,872
2021	27,716,787
2022	29,329,933

GESIS populations, MSANP, 2016

Table 2 : Population by age group

age range	Proportion
Under 15	46.6%
Young people from 10 to 24 years old [1]	32%
Adults 15 to 49	42.8%
Women aged 15 to 49	21.5%
Men 15 to 49	21.3%

[1] *Source: INSTAT and MSANP projections*

The population density at the national level is 21 inhabitants per km². The Malagasy population is characterized by high fertility, with a synthetic fertility index of 4.8 children per woman (DHS 2009). The estimated annual population growth rate is 2.6% in 2016[2].

1.1.2 Society, economy, education and culture

With a Human Development Index (HDI) of 0.512 in 2015, Madagascar ranks among the countries with "low human development" and is 158th position in 188 countries[3].

According to the partnership framework between Madagascar and the World Bank for the period 2017-2021, agriculture is the main source of income in the country. Mining has also become an important pillar of the Malagasy economy and could enormously catalyze development. In addition, the private sector is and will be the engine of growth in the years to come. With a proportion of 91% of the population living below the poverty line (less than 2USD per day), the poverty rate in the urban environment is 48% against 77.3% in the rural environment[4].

In the workforce, women, representing 53% of the farming population and 21% of fishermen, face gender-related challenges. Their ability to run high-productivity businesses, find work in the city, and earn the same wages as men is sometimes hampered.

Despite improvements in the education system, the primary school completion rate remains low. It was 69% in 2012 and 66% in 2015. Increasing this level of completion of primary education is the main challenge to be met by education.

To meet its socio-economic challenges, Madagascar has adopted a National Development Plan (PND) covering the period 2015-2019. The five strategic development axes are: axis 1 - Governance, rule of law, security, decentralization, democracy and national solidarity, axis 2 - Preservation of macroeconomic stability and support for development, axis 3 - Inclusive growth and local roots of development, axis 4 - Formation of adequate human capital for the development process and axis 5 - Development of natural capital and strengthening of resilience in the face of natural disasters.

To finance the implementation of the PND, Madagascar successfully organized in December 2016 a Conference of Donors and Investors (CBI). It was an opportunity for development partners to announce support of 6.4 billion USD for the period 2017-2020, including 2.1 billion USD in undisbursed commitments and 4.3 billion USD in new commitments. In addition, private sector operators have advanced investment projects of 3.5 billion USD.

1.1.3 Health

Under the leadership of the Ministry of Public Health, Madagascar is implementing a Health Sector Development Plan (PDSS) for the five-year period 2015-2019. The priority axes and objectives of the PDSS are based on the six pillars (1) leadership and governance, (2) service delivery, (3) health information system, (4) human resources, (5) inputs, infrastructure and equipment; and (6) the financing system.

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2 *Source: World Bank, 2016*

3 *Human Development Report 2016, UNDP, page 27*

4 *Context of Madagascar 2016, UNDP Madagascar website*

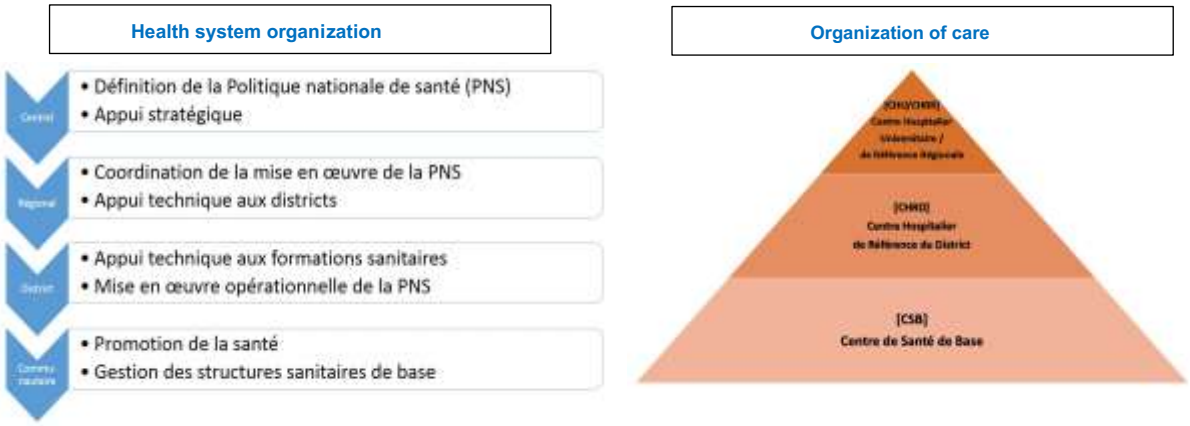
Ultimately, the analysis of each pillar of the health system shows that significant challenges must be met to achieve the objectives of the PDSS in terms of:

i) equity in access to quality preventive and curative care, particularly in the fight against communicable diseases and in the context of the survival of mothers and children;

ii) capacity building of actors at all levels;

iii) sustained involvement of the community, Decentralized Territorial Collectivities (CTD), Civil Society (SC) and Technical and Financial Partners (PTF) and;

iv) equitable, shared and sustainable financing of health sector development costs.



Figures 2 and 3: Organization of the health and care system in Madagascar

The health service supply network is made up of 3,260 public and private basic health facilities including 2,634 public CSBs, 141 district hospitals, 16 regional reference hospital centers, 22 university hospital centers as well as a developed network of community providers . The rest is made up of private health centers. The Ministry of Public Health also has specialized structures directly involved in the national response to AIDS:

- **National Reference Laboratory (** NRL) for the quality control of biological examinations practiced in the country's laboratory network;
- **Pasteur Institute of Madagascar (** IPM) for applied research;
- **Directorate of Blood Transfusion (** SDR) to ensure the availability of blood products secure throughout the national territory;
- **Central Purchasing Center for Essential Medicines and Medical Equipment (SALAMA)** for the supply of essential generic drugs, pharmaceuticals and medical products in Madagascar;
- **National Office for Tobacco Control (OFNALAT) for** coordinate national programs multi-sectoral tobacco control.

The state budget allocated to the health sector was 8.7% [5] **of the national budget in 2011 and 5.29%** [6] **in** 2017. Indeed, a reprogramming at the national level had to be carried out to cover expenses linked to the damage caused by cyclone ENAWO. Currently, the efforts of the Ministry of Public Health are converging towards improving the accessibility of the population to quality and affordable care offers, through Universal Health Coverage (CSU).

[5] Finance Law 2011.

[6] Law # 2017-009 of 04 July 2017, CODE 71, page 89

The table below summarizes the main health indicators for Madagascar.

Table 3 : Main health indicators

#	Indicators	Value
1	Contraceptive use rate (modern among women in union)	33.3 per thousand
2	Prenatal care coverage (consultation by qualified personnel)	82.1 percent
3	Proportion of deliveries attended by skilled health personnel	44.3 percent
4	Maternal mortality ratio per 100,000 births	478
5	Mortality rate of children under 5	62 per thousand
6	Knowledge of tuberculosis	82 percent

Source: INSTAT / ENSMOND 2012-2013, pages 47 and 53.

1.1.4 Framework for the national response to STIs, HIV and AIDS7

The key stages of the national AIDS response in Madagascar since the 1980s followed the following deadlines relating to the various NHPs.

PERIOD	1987	1988 - 1999	2000	2001	2001 - 2006	2007 - 2012
STEPS	Screening for the first case of HIV in Madagascar	1 short term plan and 2 medium term plans	Initiation of the first strategic planning of the national response to AIDS	Declaration of commitment of the Nations United **"Keep your promise"**	PSN 2001-2006 GOALS (i) keep the prevalence rate below from 1% ; (ii) ensuring the well-being of people living with HIV through their care psychosocial and medical.	PSN 2007-2012 VISION "By 2015, Madagascar will be a country where all Malagasy people and in particular young people are aware of the personal risks, are actively involved with the commitment of leaders in the fight against HIV / AIDS. Everyone will have easy access to and use the appropriate prevention methods responsibly. Individual, family and community will provide care and support to those infected and affected by HIV. "

PERIOD	2011	2013 - 2017	2016	2018 - 2022	2023	2030
STEPS	Political declaration of the month of June 2011 at the United Nations GA **"Intensify our efforts to eliminate HIV / AIDS"**	PSN 2013-2017 VISION "Madagascar is a country with zero new HIV infections, zero AIDS-related deaths, zero discrimination and stigma"	Political declaration of the month of June at the GA of United Nations **"Accelerating the response so that HIV is no longer a public health problem by 2020 and eliminate AIDS by 2030 "**	PSN 2018-2022 VISION "Universal access to prevention, care, treatment and support is guaranteed in Madagascar in strict compliance with Human rights "	PSN 2023-2027 VISION "Towards the elimination of AIDS..."	PSN 2028-2032 VISION "Elimination of AIDS in Madagascar "

Figure 4: Milestones in the national AIDS response

Being well in line with the United Nations Sustainable Development Goals (SDGs) stipulating in objective 3.3 that "by 2030, end the AIDS epidemic, tuberculosis, malaria and neglected tropical diseases and fight hepatitis, waterborne diseases and other communicable diseases " [8], Madagascar has the law 2005-040 of February 20, 2006 relating to "fight

[7] Symptoms of the disease were discovered in the first subjects in 1981, the name AIDS was adopted in 1982, but it was not until 1983 that the virus responsible for AIDS could be identified.

[8] http://www.who.int/topics/sustainable-development-goals/targets/fr/ , page 1/3

against HIV / AIDS and protecting the rights of people living with HIV "[9] and its implementing decree. This law governs all actions of the AIDS response throughout the national territory. For a better operationalization of commitments, the national AIDS response is moored to the National Development Plan (PND) 2015-2019 and the General State Policy (PGE) through objective 4.1.2 "fight against epidemics, diseases emerging and non-emerging "[10] in program 4.1 "health to quality standards and accessible to all". This general framework is available in the Health Sector Development Plan (PDSS) 2015-2019 for an effective contribution to the fight against communicable diseases and to decree 2017-071 of February 03, 2017 on "reorganization of the National Committee to Fight against AIDS ". The latter describes the structure of the multisectoral AIDS response from the central level to the territorial intervention structures.

In the context of an epidemic concentrated in key populations: men who have sex with men (MSM), sex workers (PS) and injecting drug users (IDU), to address all the legal aspects of the response , the Ministry of Public Health and the Ministry of Justice, in collaboration with all stakeholders have formalized the decree reorganizing and operating the "Rights and HIV Commission".

Finally, among the opportunities for the national response, the UNAIDS coordination office for Comoros, Madagascar, Mauritius and Seychelles is headquartered in Andraharo, United Nations Joint House, Antananarivo.

1.2 AIDS epidemiology in Madagascar

1.2.1 Epidemiological surveillance

In implementing the "three principles of uniqueness (*three ones)* "[11], the SE / CNLS periodically and according to specific needs, the meetings of the National Technical Monitoring and Evaluation Group (GTSE). The latter brings together experts in monitoring and evaluation as well as research and ensures the review, monitoring and validation of routine data as well as national study reports on STIs, HIV and AIDS in Madagascar. The information analyzed at the level of the GTSE comes from (1) the "GIS - RMA" system[12] »Using GESIS software[13], (2) GeDC software[14] and (3) study reports. MSANP from 2017 launched the effective establishment of DHIS2[15].

The WGSI technically supported by the expertise of all actors in the health and AIDS response, periodically produces the results of strategic analyzes: estimates, projections, modes of transmission and modeling using Spectrum. These results provide a better understanding of the epidemic.

Since 2016-2017, many players in the response to AIDS, including Population Services International (PSI) Madagascar, National Institute of Public and Community Health (INSPC), Doctors of the World (MdM), Aid and Care for the Sick (ASM), etc, invest more in national studies on HIV and AIDS. Major national surveys led by the Ministry of

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[9] *Official Journal of Madagascar # 3029 of May 15, 2006, page 2784*

[10] *National Development Plan 2015-2019, page 65*

[11] *A single framework for action (PSN), a single coordinating body and a single monitoring and evaluation system for the multisectoral response to AIDS;*

[12] *System for monitoring and evaluation of the health sector in Madagascar "Information system for management Monthly activity report";*

[13] *GESIS is software for the management of health information in health systems;*

[14] *Computerized tool for the management of community data on the multisectoral response to AIDS in Madagascar;*

[15] *District Health Information Software 2*

Economy and Planning and the National Institute of Statistics (INSTAT) in Madagascar also integrate the HIV and AIDS component.

Given the concentrated HIV epidemic, national surveys focus on the three groups PS, MSM and CDI, during the period of the PSN 2013-2017. In 2012, a national MDG monitoring study was carried out. The next demographic and health study in Madagascar is planned after the general population and housing census (RGPH) in 2018.

Overall, Madagascar has a “low-prevalence HIV epidemic in the general population aged 15 to 49, as estimated at 0.3% in 2017 and concentrated in the key populations most at risk”.

1.2.2 Programmatic mapping and estimation of the sizes of key populations

1.2.2.1 Vulnerable municipalities.

On the eve of the adoption of the 2013-2017 PSN, a study entitled "Updating the vulnerability of municipalities in Madagascar to the spread of HIV / AIDS" demonstrated that out of a total of 1,549 municipalities, 178 are
11.5% were highly vulnerable municipalities (CFV), 763 or 49.2% of moderately vulnerable municipalities (CMV) and 608 or 39.2% of weakly vulnerable municipalities
(CfV). The distribution of vulnerable communes throughout the island is presented in Figure 5. The results of the said study made it possible to identify the communes considered as being priorities for strengthening the response.

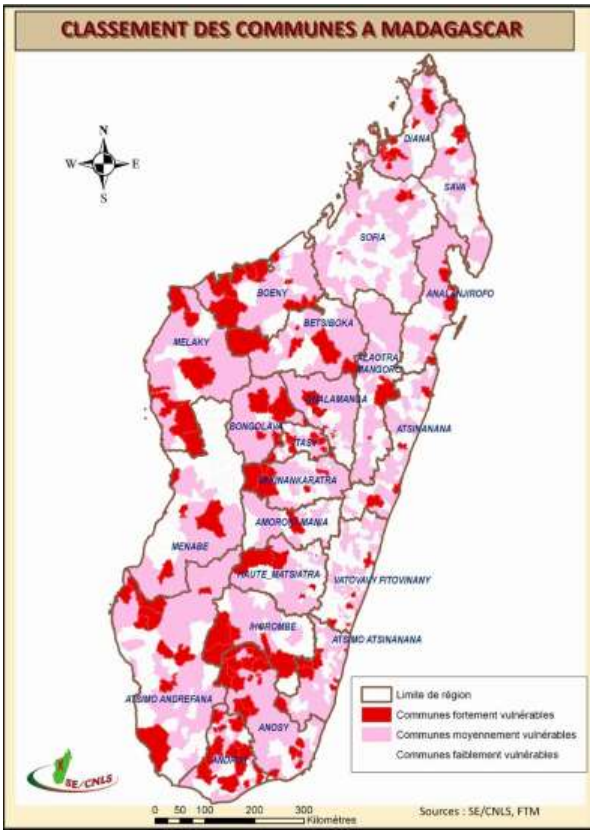

Figure 5: Communes vulnerable to HIV and AIDS in Madagascar, SE / CNLS 2012

1.2.2.2 Sites frequented by PCPERs.

The key populations that could be the source of new HIV infections reside more in the localities where they develop their professional activities. The results of the survey “programmatic mapping and estimation of the sizes of key populations” conducted in 2014 in 37 priority cities [16] displayed that the types of sites frequented by the identified PCPERs are: bar, street, restaurant, nightclub, karaoke, brothel, video room, market, field (football, basketball, pétanque),

[16] *Reference: Annex 6 of the Programmatic Mapping and estimation of the sizes of the key populations, SE / CNLS, 2014*

parking, beach, casino, massage room. Regarding the sites where risky acts are carried out (sexual acts, drug use) the study reports hotels, brothels, family houses, green carpets.

1.2.2.3 Estimated sizes of key populations.

According to the counting method recommended by UNAIDS, the study carried out in 2014 made it possible to have an estimate closer to the reality of the key populations at the level of the sites identified and validated. According to the categorization of localities, the estimated number of PS, MSM and CDI in each city is summarized in table number 4. The study was conducted in 37 priority cities in accordance with the PSN 2013-2017.

Table 4 : Sizes of key populations in Madagascar according to the categories of sites of programmatic mapping and estimation of the sizes of key populations in 2014.

Villes ou Groupes de villes	PS min estimée	PS max estimée	HSH min estimé	HSH max estimé	CDI Min estimé	CDI Max estimé
Groupe 1 : Antananarivo	28,925	35,021	4,126	6,985	1,277	1,781
Groupe 2	31,736	79,396	1,911	5,285	68	181
Groupe 3	18,737	48,464	928	2,425	24	71
Groupe 4	1,720	4,485	67	224	-	-
Groupe 5 : Ranomafana	24	76				
Ensemble	**81,142**	**167,442**	**7,032**	**14,919**	**1,369**	**2,033**

A second edition of the study of “programmatic mapping and estimation of the sizes of key populations” was undertaken in 2017. The same method of counting during the first study in 2014 was adopted during this second study at the level of 42 municipalities. In general, in these 42 Study Communes, 2,380 sites were validated including 1,806 PS sites, 1,019 MSM sites and 919 CDI sites. A total of 128,166 PCPERs were identified, including 114,116 (89.03%) PS, 10,941 (8.54%) MSM and 3,109 (2.43%) CDI.

Figures 6, 7 and 8: PCPER sizes estimated in 2017.

1.2.3 Prevalence of HIV

1.2.3.1 General population aged 15 to 49.

Madagascar has a low prevalence epidemic in the general population aged 15 to 49, estimated at 0.2% in 2016 and 0.3% in 2017. The estimation method used the Spectrum version tool
5.63. HIV prevalence in the general population aged 15 to 49 has always been kept below 1%. During the period 2013-2017, it is clear that the prevalence of HIV remained higher among men than among women in the 15-49 age group. Furthermore, the latest studies confirm a concentrated epidemic in key populations most at risk, at which the prevalence exceeds the threshold of 5%.

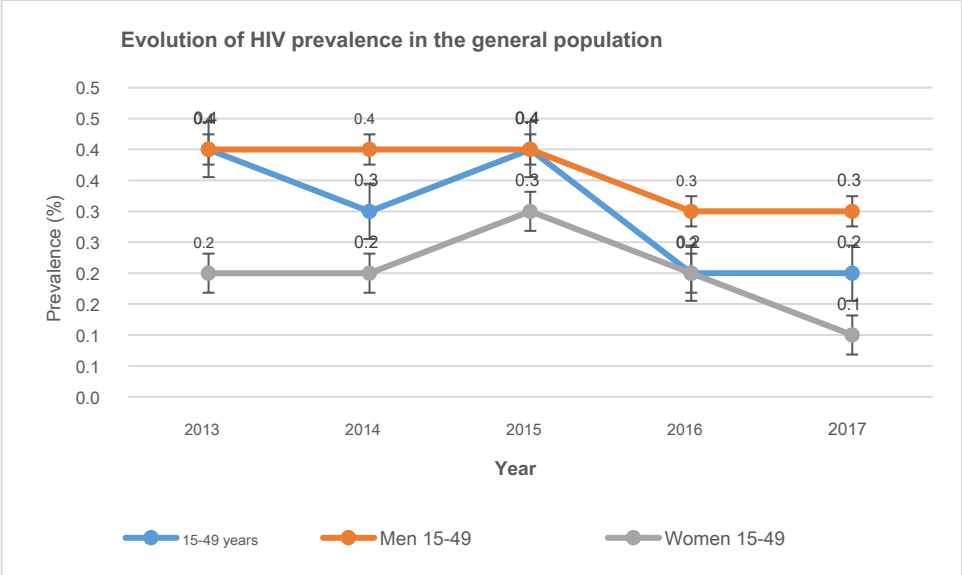

Figure 9: Evolution of HIV prevalence in the general population aged 15 to 49 during the 2013-2017 NHP.

1.2.3.2 Key populations most exposed to transmission risks.

Sex workers. In 2016, the prevalence was one and a half times higher in adult PS than in their younger counterparts, 6.3% versus 4.5%, with no significant difference. There are variations in the prevalence between the cities where PS work, ranging from 0.0% in Antsirabe to 22.7% in Mahajanga. In addition, from 2012 to 2016, a significant increase in the prevalence of HIV among PS was recorded in Mahajanga, 3% versus 23%; in Taolagnaro 0% versus 4.1% in 2016 and in Antsiranana 0% versus 2.9%.

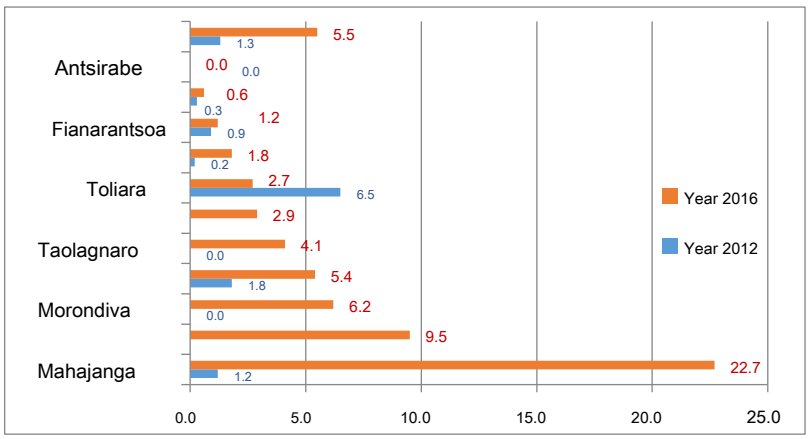

Figure 10: Evolution of HIV prevalence among sex workers between 2012 and 2016 according to the cities of residence.

In the majority of cities with hot spots where sex workers work, the prevalence increases over time.

Men who have sex with men. According to the two studies carried out to date, adult MSM over 25 years of age remain more infected than those under 25: 9.4% versus 19.9% in 2012 and 9.0% versus 28.9% in 2014 If between 2012 and 2014, there was no significant variation in prevalence among young MSM under the age of 25, there was an increase of 45.2% in adults.

There is also a variation according to the cities of residence of MSM. In fact, Antananarivo and Toamasina were the most affected cities in 2014. But in 2016, the situation became more critical in Mahajanga where the prevalence of HIV among MSM rose from 9.3% to 24.0%.

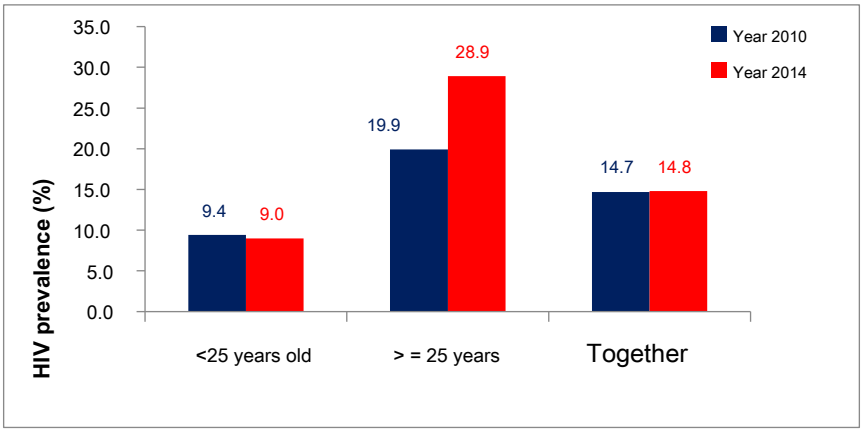

Figure 11: Analysis of HIV prevalence among MSM in 2012 and 2014 by age group.

Injection Drug Users. In this group, variations in HIV prevalence were observed by sex, age and place of residence. In fact, in 2012 and 2016, men were significantly more infected with 10.1% and 9.3% respectively, than women with 4.4% and 0.2%. Depending on age, the prevalence of HIV in adult IDUs is higher than in young people. It is also important to note the 99.7% increase recorded among young people aged 15 to 24 between the two years, with 8.1% versus 3.1% in 2012, while 8.6% versus 9, 5% in 2016.

A significant increase in the prevalence of HIV is observed among injecting drug users residing in Antananarivo, ranging from 8.3% in 2012 to 61.7% in 2016. In Antsiranana, a significant decline in the prevalence of HIV is noted, by 1, 4% in 2012, to 0% in 2016.

1.2.3.3 Other populations

Pregnant women. The present situation took into account the data from the biological surveillance survey in pregnant women aged 15 years or more carried out in 2010 since no other has been done since. Indeed, in the context of a concentrated epidemic, studies have been carried out in key populations of the NHP. While surveillance in women was done at the sentinel site level based on routine data according to the method recommended by UNAIDS. The 2010 survey reports HIV prevalence among pregnant women at 0.09% [0; 0.2]. It is statistically no different from that observed in 2007, 0.18% and in 2005, 0.15%. No disparities between regions and age groups were recorded. However, the highest HIV prevalence was observed in pregnant women aged 20 to 24: 0.16% [0, 1; 0.4].

Adolescents and young people: No seroprevalence study has been performed with this group. The available data come from the Spectrum exercise which gives details according to age groups.

Blood donors. According to data from the National Center for Blood Transfusion (CNTS), the rate of HIV seropositivity in voluntary blood donors is 0.55% based on 148,146 bags tested for HIV in 2017. That of syphilis is 0.70% in September 2017. A total of 6% of the blood bags collected were found to be questionable after the HIV and Syphilis tests. They were all destroyed. It is important to mention that 4.7% of new HIV infections are believed to come from blood transmission in Madagascar.

1.2.4 Prevalence of sexually transmitted infections

The prevalence of syphilis in Madagascar has been estimated at 15.8% with the highest prevalence, 23% reported in Antananarivo. In 2009, a high prevalence of STIs among hidden social workers was noted in Antananarivo. Thirty-two percent of PS (32.0%) were infected with Trichomonas vaginalis and 27% with Neisseria gonorrhoeae, according to their research results. Risk factors for STIs reported were young age, low education, early intercourse and a history of STIs.

1.2.5 Transmission of HIV in Madagascar

1.2.5.1 Sexual transmission

Available data show that sexual transmission is the most common route of HIV spread in Madagascar. In fact, 94.7% of new HIV infections come from practices and behaviors that promote the sexual transmission of HIV. Among the unprotected sexual practices concerned, heterosexual intercourse and sexual intercourse in same-sex men are identified.

1.2.5.2 Blood transmission

Blood transmission of HIV according to current studies is the result particularly of the injecting drug use. According to the report of the World Commission on Drug Policy, in 2012, "the fight against HIV is won when addiction is treated as a health problem". Depending on the updated transmission method, 5.10% of news infections at HIV would come from injections of drugs.

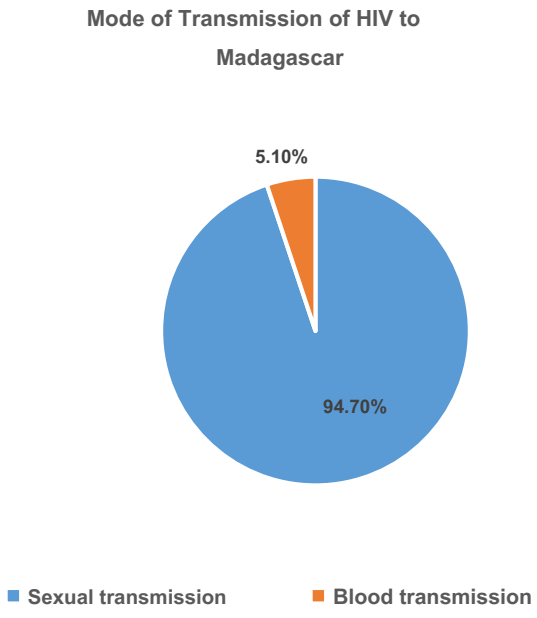

Figure 12: Mode of HIV transmission in Madagascar

Regarding transfusion medicine, blood bags are systematically tested for HIV and syphilis before being made available. of services for transfusion.

1.2.5.3 Vertical transmission of HIV from mother to newborn

Being an essential activity to reach zero new infections, HIV testing is offered to pregnant women in the prenatal consultation activity package. Surveillance at the sentinel sites made it possible to have seropositivity during the implementation period of the 2013-2017 NHP.

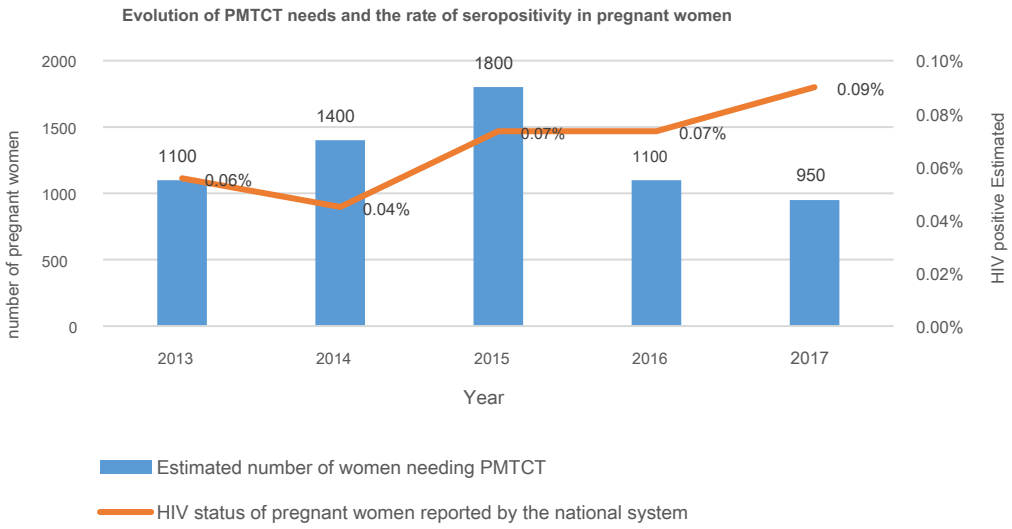

Figure 13: Evolution of PMTCT needs and HIV status among pregnant women during the 2013-2017 NHP.

1.2.6 HIV tuberculosis co-infection

According to data from the “Global Tuberculosis Report 2015” for the WHO country profile, the prevalence of HIV in tuberculosis patients in Madagascar is constantly low, 0.9% since 2000. The incidence of tuberculosis is 236 for 100,000 inhabitants. The incidence of TB tuberculosis co-infection is 15 per 100,000 population. Mortality due to tuberculosis has been steadily decreasing since 2000 to stand at 49 per 100,000 inhabitants. In 2015, HIV TB co-infection caused an increase of 6.3 per 100,000 population, which reduces mortality to 55.3 per 100,000 in tuberculosis patients. And again in 2015, only 33% of TB patients knew their HIV status.

1.2.7 Analysis of new HIV infections

Modeling the modes of transmission according to the tool developed by UNAIDS provides new HIV infections in Madagascar. The results of the modeling in 2017 are presented in the following figure.

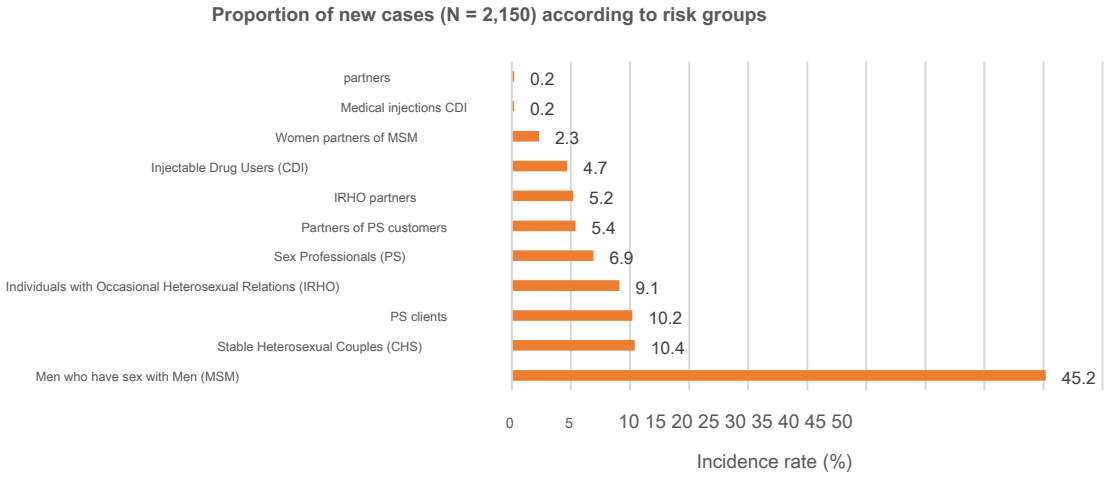

Figure 14: Proportion of new HIV cases by populations at risk by mode of transmission.

Just over half of new infections, 56.8% come from key populations most at risk. A relatively large proportion concerns MSM and their female partners, 47.8% of new infections, or 1023 new cases.

It should be noted that during the biological and behavioral survey among MSM in 2014, the proportion of MSM declaring to be a sex worker is 6.4%. The same study also found that 76.1% of MSM had at least two male sexual partners in the past 12 months.

1.2.8 Estimates and projections

Estimates from Spectrum [17] give trends on the evolution of the AIDS epidemic. Currently, the prevalence of HIV in key populations: PS, MSM and CDI is more than 5%. An upward trend in this prevalence will be feared if no innovation is made in the national response. According to projections from Spectrum, the prevalence of HIV in the general population (male and female) aged 15 to 49 remains at less than 1% until 2022.

Following the analysis of the data generated by Spectrum, if the national strategic plan is effectively implemented in the response to AIDS, from 2018 to 2022, 927 infections would be prevented by PMTCT, 5135 deaths would be avoided thanks to therapy antiretroviral.

According to Spectrum projections from 2017 to 2022, the situation of HIV infection will present itself as follows in Madagascar:

Table 5 : Summary of the main AIDS control indicators

Indicators	2017	2018	2019	2020	2021	2022
Estimated HIV prevalence in the general population aged 15 to 49 (in%)	0.26	0.28	0.3	0.33	0.35	0.37
Estimated number of new people living with HIV in the general population aged 15 to 49	4,946	5,482	5,329	5,460	5,572	5,611
Estimated number of people living with HIV in the general population aged 15 to 49	32,060	36,189	40,302	44,523	48,773	52 993
Estimated number of pediatric PLWHA 0-14	1,280	1,381	1,493	1,636	1,814	2,020
Estimated total number of PLHIV needing antiretroviral therapy	33 909	38,315	42,787	47,426	52 190	57,003
Estimated proportion of coverage of the population eligible for antiretroviral treatment (ARV) (in%)	6.68	26.95	35.21	43.48	51.74	60

Source: Spectrum 2017, SE / CNLS / DLIS / UNAIDS, 2017-2018

1.2.9 Risks of exposure to HIV analyzed in Madagascar

The risk of exposure to HIV is the probability that a person can contract HIV. It is in fact linked to behaviors, not belonging to a group, which put individuals in situations that could expose them to HIV, and certain behaviors create, increase or perpetuate this risk.

1.2.9.1 Paid sexual intercourse and not systematic use of condoms

Based on the updated mode of transmission, taking into account the SPs and their clients, paid sex would be responsible for 17.1% of new infections in 2017. That is to say that about two paid sex in ten are believed to be the source of new HIV + cases. The low rate of condom use is an aggravating factor. According to the study in 2016, 6 PS on

[17] Spectrum version 5.63

10 (62.7%) report having used a condom with their last client. Furthermore, only 4 out of 10 PS (44.20%) declare that they systematically use condoms during sexual intercourse with their client in the past 30 days. This systematic protection rate with clients is significantly higher in Antananarivo (96%), average in Antsirabe (56%) and very low in Nosy Be (7%). Compared to a previous study among PS, a regression of 5.4% without significant difference was observed concerning activities linked to the sex trade. Few health workers know their HIV status because in 2012, 49.5% took the HIV test and know the result. This proportion was 40.2% in 2016. Also in 2016, 48.1% of SPs presented an episode of STIs and used adapted care.

1.2.9.2 Male gay relationships

The study in 2014 reflects that the systematic use of condoms, regardless of the type of partner and sexual intercourse, has not completely entered into the habits of MSM. In fact, just over half, 57.2% had protected anal intercourse in 2014.

Furthermore, the use of condoms during the last anal intercourse was almost systematic in Antsiranana among MSM, 97%. While in the capital, Antananarivo, only 65.2% of MSM who had anal sex (43.5%) used a condom (Figure 12).

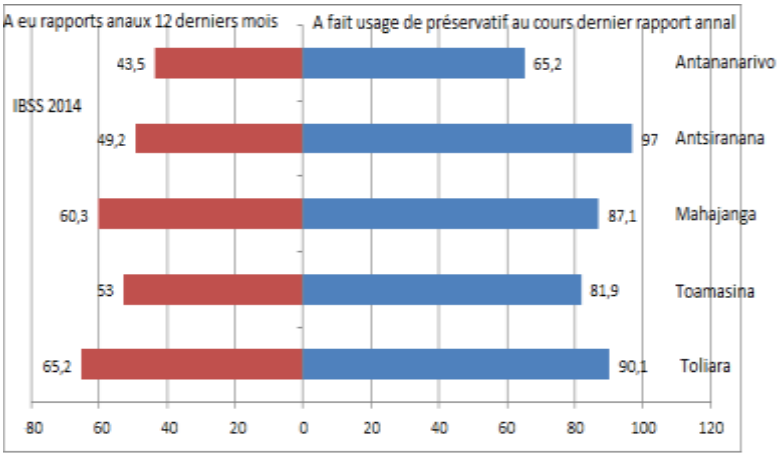

Figure 15: Proportion of MSM who had protected anal intercourse during the last sexual intercourse, by city.

The level of knowledge of HIV infection among MSM is low, around 50% in 2014, there was a considerable decline of around 27% between 2010 and 2014 (26.6% versus 19.3 %). The situation reported is more critical with regard to HIV testing, with a regression of 70.6% between the two years (56.1% versus 16.5%) in terms of MSM having taken the test and having withdrawn the results .

1.2.9.3 Multi sexual partnership and condom use

According to the updated mode of transmission, people who have casual sex and their partners are responsible for 9.1% of new HIV infections.

According to the 2009 DHS results, 14.6% of men and 2.1% of women have had two or more sexual partners in the past 12 months, of which only 7.4% of men and 7.6% of women used a condom during the last report.

The results of the ENSOMD in 2012 show that the proportion of men aged 15-49 who reported having had at least 2 sexual partners in the past 12 months is much higher than that of women (5% against 1%) (16% versus 2% during EDSMD IV). Indeed, among men and women aged 15 to 49 who have already had sexual intercourse, 4.6% of men and 0.6% of women

reported having had at least two (2) sexual partners in the past 12 months. Among these latter groups, 8.3% of men and 9.3% of women reported having used a condom during the last sexual intercourse.

1.2.9.4 Age at first intercourse

The following figure shows the evolution of the age of young boys and girls aged 15 to 24 who have had sexual intercourse before the exact age of 15 and 18. It is clear that early sexual intercourse, especially without the use of condoms, increases the risk of HIV infection among young people.

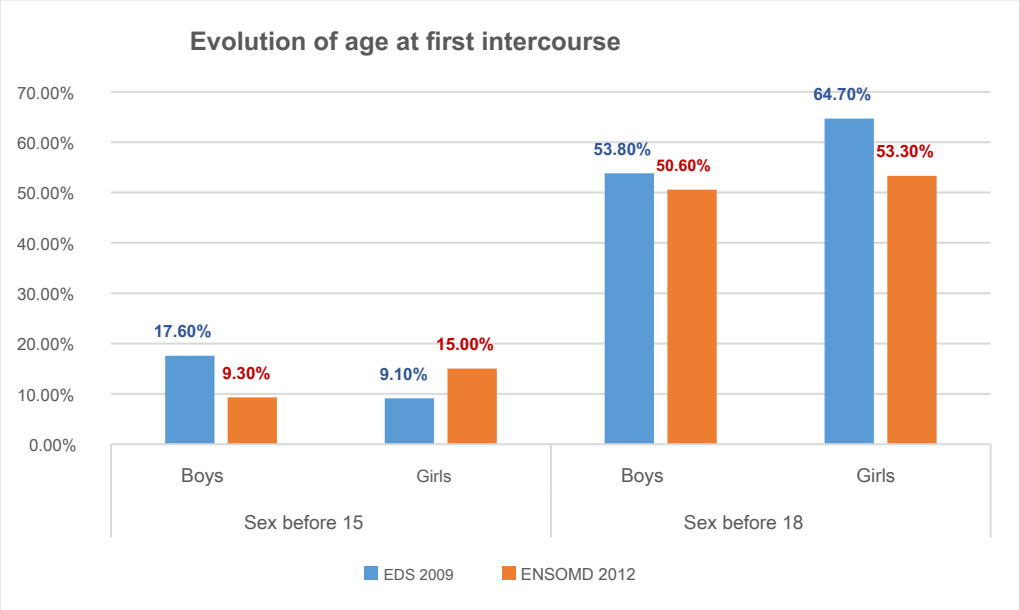

Figure 16: Age at first sexual intercourse of young boys and girls

1.2.9.5 Sharing of dirty syringes

The sharing of contaminated syringes occurs mainly among groups of injecting drug users. The terrible health impact of drug use can be seen in HIV, hepatitis and tuberculosis patients. In 2013, UNODC estimated the overall prevalence of HIV among people who inject drugs at 11.8%. The prevalence of hepatitis C virus infection is also very high among injection drug users, estimated at 51% worldwide in 2011 [18].

According to the results of the updated modeling of transmission modes, injecting drug use is responsible for 5.1% of new infections in Madagascar. The seroprevalence of HIV infection increased from 7.1% in 2012 to 8.4% in 2016 for all injecting drug users. A significant increase in the prevalence of HIV is however observed among injecting drug users living in the city of Antananarivo, ranging from 8.3% in 2012 to 61.7% in 2016 (ESBC 2016). epidemiological surveillance (2012) indicate that, (i) 21.5% injecting drug users used needles / syringes already used by others, (ii) 81.3% had multiple sexual partners in the past 12 months, of which 48.9% reported having used a condom during the last sexual intercourse, (iii) 25.2% of injecting drug users have sex with men, (iv) 19.3% of injecting drug users did not use sterile injection equipment during their last injection.

[18] World Drug Report 2013, UNODC, page 31.

With regard to the program targeting this group, four determinants relating to (1) the use of sterile injection equipment, (2) the systematic use of condoms during risky sexual intercourse, (3) complete knowledge on HIV infection and (4) knowledge of HIV status is monitored during the studies. By comparing the results of research in 2012 and in 2016, it is noted a considerable decrease in values for all of the 4 indicators concerned. Indeed, the very specific risk reduction program represents an important challenge for the response to AIDS, taking into account the legal and legal aspects linked to the use of narcotic drugs in Madagascar.

Table 6 : Indicators of the AIDS response among injecting drug users

Indicators	Study results in 2012	Study results in 2016
Use of sterile material during the last injection	80.7%	68.4%
Consistent use of condoms during unsafe sex	41.8%	41.9%
Complete knowledge of the infection	34.2%	21.5%
Knowledge of HIV status	22.3%	20.9%

Figure 14 shows that the sterile syringe exchange program has improved its effectiveness in Antananarivo and Toamasina between 2012 and 2016.

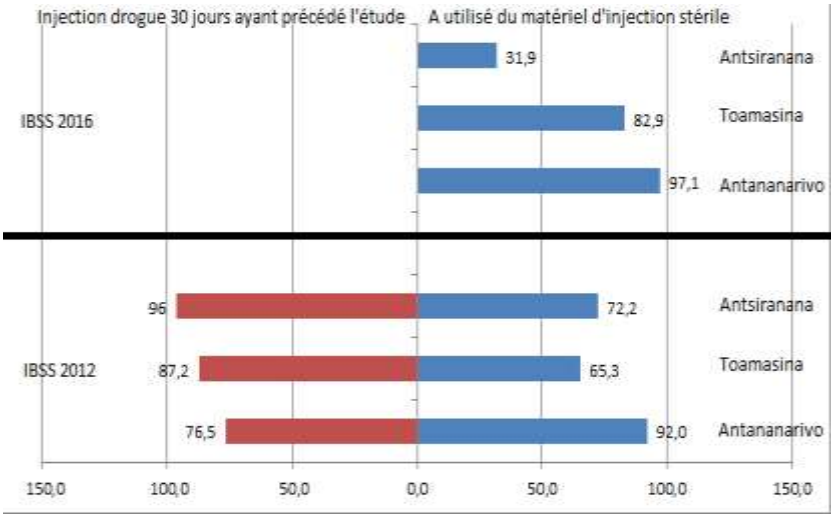

Figure 17: Proportion of injecting drug users who used injection equipment during their drug use in the past 30 days

1.2.9.6 Risk factors for HIV transmission in vulnerable populations

In general, the knowledge, attitudes and practices of other vulnerable populations with regard to HIV infection still remain weak according to research results.

Unmarried adolescents and young people aged 15 to 24 . Knowledge about HIV infection is relatively low regardless of the type of young people. In 2012, only 27.4% of young people knew how to prevent it and 16.3% rejected the misconceptions about HIV infection. Only 3 in 10 adolescents and young people (29.5%) systematically use condoms during unsafe sex. 15.7% of young people took the HIV test and withdrew the result.

Men in uniform (Military) . Overall, 17% of the military said they used a condom the last time they had sex. The city of Antsirabe has the highest rate with 24%, followed by Antsiranana with 22%. This rate is the lowest in Mahajanga, 6%. However, men in the troops show a higher proportion with 22% compared to the two upper grades of which 13% report the use of condoms during the last sexual intercourse.

1.2.10 Major determinants of the AIDS epidemic in Madagascar

The determinants of the HIV and AIDS epidemic are described in this section, the impact of which has already been analyzed by authors such as Over (1992), Bonnel (2000), Stillwaggon (2000, 2006) or Nattrass (2006).). They can thus be grouped into three categories: socio-economic, socio-cultural and epidemiological.

1.2.10.1 Socio-economic determinants

Level of education

The level of education of the population greatly influences the knowledge of the population on HIV and AIDS prevention. According to the ESNOMD2012-2013, among women with no education, 7% (compared to 5%, during the EDSMD-IV) have a knowledge considered to be “complete” against 71% (against 44%, during the EDSMD- IV) among the most educated.

Furthermore, it is among urban men (47%), including those in the capital (47%), among the most educated (70% against 46%, during the EDSMD-IV) that the proportion of those with knowledge considered "complete" is the highest.

In terms of use of HIV testing services, the proportion of women who have already tested and received the test varies from 2% among those with no education to 36% for those with the highest level.

In general, the uneducated male and female populations have less knowledge about HIV and AIDS. Only a very small proportion of them know their status.

Among sex workers, the study in 2016 showed that slightly less than half of them
46.8% reached lower secondary education and 7.7% never attended school. Very little,
0.3% reached university level.

Among MSM, a small proportion, 1.1% say they are uneducated and one more than half, 51% have reached lower secondary education.

With regard to permanent contracts, all permanent contracts declare having attended school. Indeed, only 0.7% is uneducated. About 45.7% reached lower secondary education.

Discrimination and stigma

According to the results of the ENSOMD 2012-2013, 70% of women declared that they would be ready to care at home for a family member who contracted HIV. On the other hand, only 35% would buy fresh vegetables from a trader living with HIV and in only 30% of cases did women say that a teacher living with HIV and who is not sick should be allowed to continue teaching. Finally, the study shows that 37% of women think that it is not necessary to keep the status of a family member living with HIV secret.

Overall, a very small proportion of women (4% versus 5% for EDSMD IV) would show tolerance in the four specific situations mentioned above.

Indeed, whatever the situation, the proportion of tolerant men is slightly higher than that of women: around 5% of men aged 15-49 against 4% of women would be tolerant in the same four situations mentioned above.

The problem of stigma and discrimination remains a major challenge for the country. Few men and women can be considered to have a positive attitude towards PLWHA if the four different situations are considered simultaneously.

Among key populations, when analyzing the 2016 ESBC report among sex workers, the forms of discrimination most frequently reported are insults to their person or their family (75.3%); refusal to mix with them 51.4% and harassment of their children at school 22%. Furthermore, only 1% reported discrimination by healthcare professionals.

Poverty of individuals

The most recent reference data come from the ENSOMD 2012-2013 produced by INSTAT. Here are some important findings from this study.

The proportion of those who have heard of AIDS is lowest among women and men in the poorest quintile.

The proportion of women who have already tested for HIV and received the test varies by economic well-being quintile. The corresponding proportions vary between 21% and 4% among women living in the poorest households to 63% and 20% in the category of the richest women.

With regard to PMTCT, the level of knowledge of the three means of HIV transmission from mother to child is much higher in urban areas (59% of women and 58% of men) than in rural areas (39% and 42% respectively). It increases with the level of education and the standard of living of households.

Furthermore, the majority (63%) of MSM from all survey sites are unemployed. Three-quarters (75%) of MSM from all survey sites with a job declare having a monthly income of less than 150,000 Ariary, A minority of 3.3% of MSM from all survey sites would gain more than 300,000 Ariary per month.

In addition, 78.8% of MSM say that they received money in return for anal sex with a man. While 6.4% report being a sex worker.

Among CDIs, 26.1% declare having a monthly income of less than 100,000 Ariary, 50.8% earn between 100,000 Ariary each month and 7.6% have a monthly income of more than 300,000 Ariary.

Access to information

Compared to the EDS IV, it is noted during the ENSOMD a decrease in the proportion of the population having knowledge on HIV and AIDS.

(1) limiting sexual intercourse to a single uninfected faithful partner and (2) using a condom remain the two main means of HIV prevention known to have been tested. It is in urban areas (78% of women and 82% of men, respectively 81% and 84% during the EDSMD-IV), among the most educated (91% and 89%) and the richest (75% and 77%) that the proportions of women and men who are aware of these two means of HIV prevention are the highest.

In terms of in-depth knowledge of AIDS, among young people aged 15-24 without education, only around 5% of both girls and boys have knowledge considered as "complete" compared to 66% and 73% respectively among the most educated in this group.

Furthermore, the results according to marital status reveal relatively large differences in knowledge. Indeed, the proportions of young people with “complete” knowledge vary from a maximum of 28% (single) to a minimum of 14% (in breakdown) among girls, while these proportions vary from a maximum from 28% (singles) to a minimum of 12% (in

breakdown of union) in boys. Finally, young people living in urban areas have a “full” knowledge of AIDS significantly better than their rural counterparts, with a difference of more than 20 percentage points.

Knowledge of mother-to-child transmission of HIV is important in encouraging women to get tested for HIV when they are pregnant to avoid infection of the baby. For example, during the ENSOMD, series of questions were asked of all the respondents, among other things if they knew that HIV can be transmitted during pregnancy, during childbirth and through breastfeeding. In sum, the percentages of women and men who know all three ways of transmitting the virus from mother to child are 43% and 39% respectively. Overall, almost two-thirds of women (66%) and men (71%) know that the virus can be transmitted from mother to child.

The results of the ENSOMD made it possible to highlight that the levels of knowledge of STIs and HIV in Madagascar deteriorated during the period 2009-2012.

Access to health services

Still based on the results of the ENSOMD 2012--2013, among young people aged 15-24 who had sex in the past 12 months, 4% of girls and 2% of boys said they had carried out a test during the 12 months prior to the survey and received the results. A clear decrease is recorded compared to 2008-2009. The proportions are lower for the youngest people aged 15-19, especially for boys.

The application of article 5 of law 2005-040 [19], on testing a child requiring the consent of one of his parents or a person having authority over him, could constitute a block for health providers to carry out HIV testing.

Speaking of the services themselves, the proportion of health centers that can offer HIV testing is currently 49.1%, 1558 out of a total of 3173 health facilities [20].

Table 7 : Proportion of key populations who have been tested for HIV and who know the results

Key populations	Percentage who took the HIV test in the past 12 months and who know the result	Source
Sex workers	40.6%	ESBC 2016
Men having sex with men	19.3%	ESBC 2014
Injecting drug users	20.3%	ESBC 2016

About 46.3% of tuberculosis diagnosis and treatment centers integrate voluntary HIV counseling and testing. This has the consequence of delaying the diagnosis of cases of tuberculosis-HIV co-infection.

Similarly for PMTCT, a weak supply of services is attributable on the one hand to the low proportion of health facilities offering HIV testing during ANCs and to an insufficiency

[19] *Law 2005-040 of February 2006 governing the fight against AIDS in Madagascar and the protection of the rights of people living with HIV.*

[20] *Source: Integrated GESIS, DLIS / MSANP, November 2017.*

the quality of counseling explaining a proportion of refusal of screening by pregnant women.

Madagascar is not one of the Nations where the “fast-track” of the response to AIDS is closely followed by UNAIDS. However, the country adopted the 2016 political declaration aimed at accelerating the response to achieve the elimination of the AIDS epidemic by 2030.

Thus, compared to the objectives of 90-90-90 of UNAIDS, the situation of Madagascar on behalf of the year 2017 reports 9% for the first 90, 80% for the second 90 and 30% for the last 90[21].

1.2.10.2 Sociocultural determinants

Traditional and cultural practices

Certain practices in well-defined environments could promote or facilitate the transmission of the virus among the Malagasy population. They understand :

- The social tradition of sexual permissiveness, in other words the "sexual license", during the annual events of bath of the relics or "Fitampoha" in Mahajanga in the Boeny Region, the equivalent which is the "Fanompoambe" in Belo-sur-Tsiribihina in the Menabe region and finally the great musical and cultural festival "Donia" in Nosy Be in the Diana Region. According to certain doctrines, these practices enter into a social strategy allowing to have descendants; In some southern regions, parental pressure for the independence of young women or "ampelatovo"
- encourages the practice of the sex trade;

- In the rural communes of Madagascar, the phenomenon of “red light” or “jiro mena” in Malagasy, which is the organization of village festivals without any control of the age of the participants;

- The blood pact or "fati-drà" also promotes blood transmission of HIV; Across the country, polygamous union or
- polygamy is common in the Regions of Melaky, Atsimo Andrefana (8% of the population in both cases), Anosy (10% of the population), and especially Androy (18% of the population) globally concerns around 3% of women aged 15-49 and 1% of men of the same age group. The multipartnership of man who is more culturally tolerated in Malagasy society.
-

1.2.10.3 Epidemiological determinants

Treatment of STIs

The results of this survey show that 2% of women who have ever had sex reported having had an STI in the past 12 months. The reported prevalence is slightly higher among men who have already had sex; 4% reported having had an STI and, taking into account the symptoms, this prevalence reached 6%. In addition, among women, some respondents who did not report having an STI, however reported having symptoms (vaginal discharge / sore or ulcer) that may be indicative of STIs, the prevalence increased from 2% to 3%.

Use of condoms

Compared to the last EDSMD-IV 2008-2009, the ESNOMD 2012-2013 recorded a significant decrease in the proportions of women and men who know that condoms are a means of HIV prevention.

Condom use during first intercourse is more very low among young people. Among women and men aged 15-24 who have already had sex, only 2% of young girls and 4% of young boys (3% and 6% respectively during the EDSMD-IV 2008-2009) have reported using a condom the first time they had sex. These are young people living in urban areas

21 1er and 2th 90: RMA / GSIS, DLIS / MSANP, 2017 - 3th 90: CICM / Faculty of Medicine, 2017.

(5% of women and 10% of men for those living in cities other than the capital), the most educated (7% of women and 10% of men) and those living in a household in the richest quintile (3 % of women and 7% of men) who are slightly more likely to have had protected first sex, but these proportions have decreased compared to those recorded during the EDSMD-
IV.

It should be noted that the use of condoms during the first sexual intercourse is influenced by the knowledge of a place where to get condoms.

1.2.11 Key populations for the epidemic and for the response [22] in Madagascar

With a prevalence low to always less than 1% in the general population since the beginning of the HIV epidemic, the analysis [23] of the epidemiological profile initiated in 2008 gave guidelines for carrying out more specific surveys. Thus, it has been shown during behavioral and biological studies carried out periodically that certain populations with more sexual and blood risk behavior had a higher prevalence: sex workers, men who have sex with men and people who use drugs. injectables. Triangulation analyzes of the information available: routine data, behavioral and biological surveillance studies as well as demographic and health studies have shown that young people aged 15 to 24 constitute a very large proportion among the key populations of HIV infection. .

According to the results of the study of “programmatic mapping and estimation of the sizes of key populations in 2017” [24] PS in Madagascar are found at very diverse sites which are:

1 °) public places with a high attendance of the population - bar, bar-restaurant, epi-bar, restaurant, nightclub / nightclub, casino / games room, karaoke, video room, parking and station, single street , market and high school, and

2) private places with less frequentation - hotel, room / brothel, simple house / home and massage parlor.

1.2.11.1 Sex workers

This group includes adolescents and adults who receive goods or money in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define these activities as income-generating. In Madagascar, men who receive goods or money for anal intercourse are classified in the group of MSM.

The prevalence of HIV among PS is 5.6% and that of syphilis 12.9%.

1.2.11.2 Men who have sex with men

This group includes men who have sex with men regardless of whether they are gay or bisexual.

Malagasy law does not explicitly prohibit same-sex intercourse. However, it is found through daily news that MSM are subjected to violence and stigmatization.

HIV prevalence among these populations is 14.8% according to the latest behavioral study

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[22] *UNAIDS Terminology Guide, Reference, 2015, page 33*

[23] *Madagascar, Towards knowledge of its epidemic, September 2008*

[24] *Preliminary results of the programmatic mapping study and estimation of the sizes of key populations at the level of 42 cities in Madagascar, 2017*

and biological performed in 2014. The prevalence of syphilis among MSM is 6.2%.

1.2.11.3 People who inject drugs

These are adult males or females who have used injection drugs in the past 12 months without any medical prescription. The prevalence of HIV among injecting drug users in 2016 is 8.4%, while that of syphilis is 12.9%, hepatitis B

5.4% and hepatitis C 1.6%.

Since 2010, the method used for behavioral and biological studies in key populations has been “respondent-driven sampling (RDS)” [25].

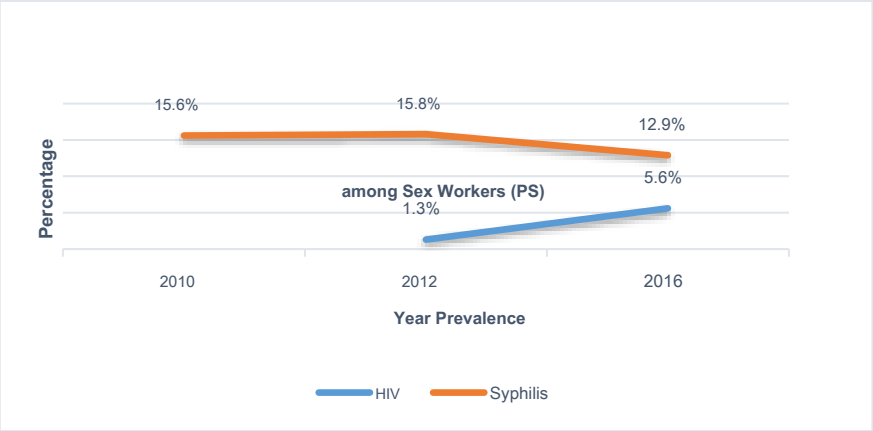


Figure 18: Evolution of the prevalence of HIV and syphilis among sex workers.

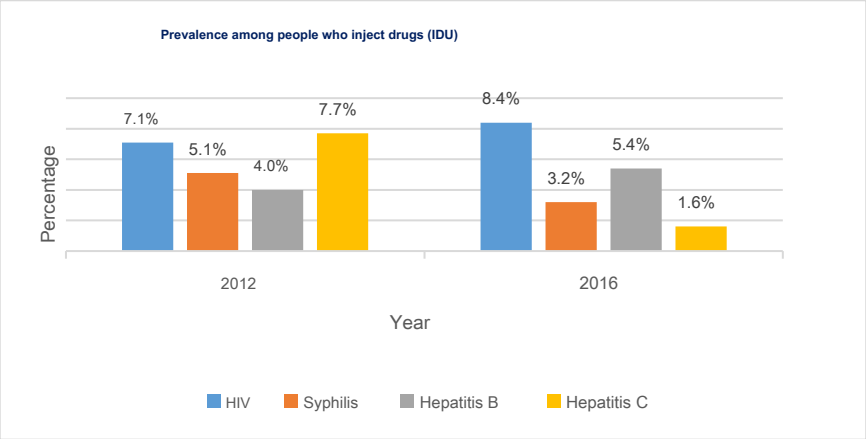


Figure 19: Evolution of the prevalence of HIV, syphilis and hepatitis in IDUs.

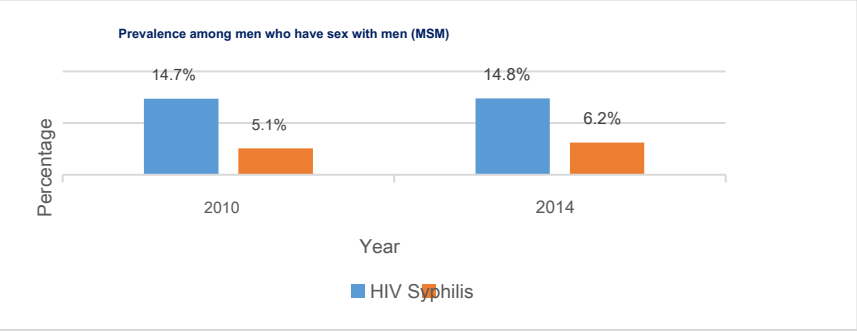


Figure 20: Evolution of the prevalence of HIV and syphilis among MSM.

[25] *The “respondent-driven sampling” method is probabilistic and uses specific software which is the “respondent-driven sampling analysis tool” (RDSAT).*

1.2.12 Other populations at higher risk of HIV infection

Some populations are likely to have unprotected sex with people at higher risk of exposure to the virus[26]. It is this more risky behavior that is discussed here. These include the following populations:

- Clients of sex workers;
- Female partners of MSM;
- People who have casual sex:
- Young people aged 15-24 in school and not in school;
- Mobile populations: miners, truckers, young military recruits, etc .;
- Detained persons;
- Public and private sector workers.

[26] *Reference: UNAIDS Terminology Guide, 2015, page 10*

PART 2 - EVALUATION OF THE PSN 2013 - 2017 AND DEVELOPMENT OF THE PSN 2018 - 2022

The 2018-2022 NHP development process was preceded by an evaluation of the 2013-2017 NHP. The GT-PSN was supported by a team of three experts in programming, monitoring-evaluation and budgeting. It is essential to mention that the preparation of the national AIDS response strategy documents for 2018-2022 benefited from the support of two additional international consultants specializing in monitoring evaluation / analysis of strategic information and prevention of transmission. mother child.

2.1 Final review of the 2013-2017 national strategic plan

2.1.1 Method of evaluation

Through a participatory, inclusive and consensual process, the actors of the national AIDS response, supported by a team, observed several stages. These include meetings, field missions at the regional level, interviews with key and resource people and workshops. The drafting was carried out with remote exchanges with the consultants.

2.1.2 Assessment of the national response from 2013 to 2017

This analysis is carried out with regard to the expected results according to the objectives set for the PSN 2013-2017. In the first part, it will focus on the achievement of products. In a second part, it will examine the level of achievement of the impacts and effects described in the results framework.

2.1.2.1 Major achievements

Several advances have been recorded with the implementation of the 2013 - 2017 PSN in Madagascar. In the programmatic aspects of the response, they are considerable.

In the area of **HIV prevention,** the following improvements are noted:

- ❖ better knowledge of key populations most at risk of HIV and the determinants
  the AIDS epidemic among key populations;
- ❖ better coverage in communication interventions for behavior change in
  the populations most at risk, such as sex workers, adolescents and young people who are not in school;

- ❖ improved HIV prevention among injecting drug users (IDUs), with
  progress of the risk reduction program;
- ❖ enhanced communication and information watch targeting the general population;
- ❖ information and education focused on HIV infection enabling individuals to prevent themselves from
  the infection ;
- ❖ better care for women victims of violence, in particular sexual violence,
  through the activities of programs to combat gender-based violence at the national level;

- ❖ promoting the increased use of the male condom;
- ❖ STI screening and management in the general population as well as key populations in
  particular;
- ❖ improved access to voluntary HIV counseling and testing with better application of the principles
  confidentiality and consent;
- ❖ transfusion safety assurance.

About the **prevention of mother-to-child transmission of HIV,** progress made includes:

- ❖ good antenatal consultation and HIV screening coverage for pregnant women, as well that the availability of antiretroviral prophylaxis (ARV) to prevent mother-to-child transmission of the virus;
- ❖ policy for implementing option B + practiced in pilot sites with a view to upgrading the subsequent scale.

Regarding the **comprehensive care for people living with HIV,** significant progress is also recorded, among others:

- ❖ integration of prevention services in reference centers for the treatment of infection HIV;
- ❖ establishment of TTR (test, treat and retain) pilot centers for immediate management of PLHIV identified;
- ❖ better quality of care and follow-up of PLWHIV through the availability of drugs required ;
- ❖ effective management of HIV tuberculosis co-infection with anti-tuberculosis drugs and antiretrovirals;
- ❖ more effective coordination of the rational management of health inputs with i) integration into the national supply system, ii) the establishment of the Technical Logistics Management Unit (UTGL) and the Logistics Management Committee (CGL), iii) the use of Channel software;
- ❖ improved delivery by the SALAMA Purchasing Center of health products linked to STIs, HIV and AIDS from national to district level of the health system;
- ❖ involvement of members of civil society (networks, associations and NGOs) in psychosocial support for people infected and / or affected by HIV;
- ❖ strengthening of campaigns and advocacy activities in the fight against discrimination and HIV-related stigma;
- ❖ income-generating activities (IGAs) for women and children affected by HIV as well only PS;
- ❖ reorganization and operation of the “Rights and HIV” commission jointly by the Ministry Public Health and the Ministry of Justice to ensure the rights of PCPERs and to find measures facilitating their access to care.

About the **monitoring and evaluation and national coordination** which are very important areas in response management, the following progress should be noted:

- ❖ effective monitoring and evaluation of community activities under the diligence of PSI Madagascar;
- ❖ functional epidemic watch system providing data covering several fields and enabling actors to better understand the AIDS epidemic in Madagascar;
- ❖ single functional monitoring and evaluation system described in the National Monitoring and Evaluation Plan to achieve all the indicators for the multisectoral response;
- ❖ operationalization of the Technical Group for Monitoring and Evaluation of HIV (GTSE) under the coordination of SE / CNLS;
- ❖ availability of a database on the various studies carried out during the period covered by the PSN and for better management of the national response to AIDS;
- ❖ regular production of national and international reports on the AIDS response to Madagascar: GAM for UNAIDS, annual report for SADC and PUDR for FM;
- ❖ involvement of officials at the highest level in the national AIDS response;
- ❖ effective involvement of civil society organizations (CSOs) in several aspects in the national response;

❖ effective collaboration between DLIS / MSANP, the national tuberculosis control program and the SE / CNLS in data management;

❖ clear organization of the decentralized SE / CNLS structures integrated at the level of the Regions;

❖ approval by the Council of Ministers of decree 2017-071 of 03 February 2017 on "Reorganization of the national committee to fight against AIDS (CNLS)" for the management of the response to AIDS.

Despite the aforementioned achievements, significant constraints and difficulties must be observed during the next period of implementation of the response, especially in the face of the challenges as well as the issues of an effective response to achieve universal access to prevention, care and support.

2.1.2.2 Reinforcements necessary for a more effective response

Still in a participatory, inclusive and consensual approach, the analyzes by the GT-PSN members participating in the 2018-2022 PSN development process identified the weak points in the current situation. Based on these observations, needs and areas for reinforcement were put forward for more effective actions in accelerating the response to AIDS in Madagascar.

Regarding the **prevention,** in general, several priority actions have been suggested:

- strengthen communication on HIV targeting the general population as well as the CCC with service / care providers and coordination of the response at different levels: PCPER networks, health system, etc .;
- explore the prevalence of HIV in other populations;
- increase the coverage of interventions targeting MSM, CDI as well as detained persons;
- advocacy to put an end to police repression against CDIs as part of the risk reduction program;
- ensuring gender equality and mainstreaming HIV into the strategy to combat gender-based violence;
- increase the coverage of facilities that can offer HIV counseling and testing in the country;
- implement innovations to increase the proportion of the general population and key populations who have tested for HIV;
- improve coverage of HIV prevention services for schoolchildren; guarantee the integration of the HIV component in actions relating to Reproductive Health; strengthen the technical platform at the level of care offer sites for better quality of services.

In view of **elimination of mother-to-child transmission of HIV,** essential actions have been put forward for the response over the next five years:

- contribute to the increase of CPN coverage in the country;
- improve accessibility PMTCT services by the women (pregnant women, young girls, etc.); ensure the geographic accessibility of pregnant women and newborns living with HIV to antiretroviral drugs;
- scale up the offer of services for women in accordance with option B + and "treat all";
- strengthen the technical platform to allow early diagnosis of HIV infection in newborns born to HIV-positive mothers.

In the area of **comprehensive care** of PLWHIV, the actions proposed aim to improve patient access to available comprehensive services:

- ensure financial and geographic access for poor PLWHA to PEC services for better adherence to treatment;
- preventing the risks of stock-outs in health inputs linked to STIs, HIV and AIDS, mainly ARVs;
- ensure the continuous availability of laboratory analyzes for the biological monitoring of PLHIV by operationalizing the reference system;
- research and implement practical innovative approaches to limit lost-in-sight, carry out active search for patients lost to primary, secondary; advocacy for better involvement of politico-administrative authorities and local
- communities for effective integration of interventions to complete the support package provided to PLWHA (nutrition, legal, etc.).

Finally, considering a comprehensive response to AIDS, concrete suggestions were made for strengthening the **monitoring and evaluation** and some **governance :**

- strengthen the capacity of community actors at peripheral level in terms of monitoring and evaluation and coordination of activities;
- identify effective actions to ensure the transfer of data and reports from the peripheral level;
- improve the completeness of the reports and the quality of the data collected; implement data quality control
- procedures at all levels of the health system and at all stages of the reporting circuit; ensure a database periodically updated at SE / CNLS level; advocate and mobilize donors for a better financial contribution by the
- national party;
-
- mobilize all CSOs for better accountability for their involvement in the national response to AIDS;
- ensure rational management of shortcomings for better coordination and harmonization of the national response;
- strengthen the capacity of health providers for better quality of services especially related to reception, counseling, compliance with protocols ;
- ensure an effective management system for the purchase and inventory of STI, HIV and AIDS products from the central level to the peripheral level to guarantee the permanent availability of the necessary inputs ;
- improve the capacity of national officials in the field of definition, quantification and logistical management of health input needs linked to STIs, HIV and AIDS.

2.1.2.3 Major challenges to be met

Despite the efforts made, the dynamics of the epidemic and the performance of the current response point to many challenges. Interventions for a better impact on the populations deserve to be reinforced while reducing the programmatic and financial gaps. The aforementioned strengths and areas for improvement explain the level of implementation of the control strategy and the importance of the problems with which the response is confronted. Therefore, we can cite the following main challenges.

Package of services and surveillance with key populations:

➢ estimate close to the reality of the sizes of key populations by national studies for a better knowledge of the determinants of the epidemic and for adequate planning of targeted interventions;

➢ development and implementation of the most effective prevention strategies for effectiveness of combined prevention.

Elimination of mother-to-child transmission of HIV:

➢ increased offer coverage , improved accessibility as well as the quality of the offer integrated services for pregnant women in the context of low numbers of health workers;

➢ sensitization of all Malagasy women for the acceptance and use of the package comprehensive HIV and syphilis prevention services to achieve elimination of the AIDS epidemic and congenital syphilis.

Treatment, care and support for people living with HIV:

➢ scaling up of "test, treat and retain" sites for better coverage of HIV testing, a reflection of the achievement of the first 90 of the strategy advocated by UNAIDS;

➢ acceleration of actions in the implementation of the new strategies recommended because having their evidence at the international level, with a view to eliminating the AIDS epidemic by 2030.

Health and community systems:

➢ effective partnership through a real synergy of actions carried out by organizations of the civil society and ministerial public health officials;

➢ integration of routine data management and stakeholder activity reports community and those of the Ministry of Health.

Unique monitoring and evaluation system:

➢ data quality assurance and control at all stages of the reporting circuit with a strengthening the use of information for analysis at both the operational and strategic levels;

➢ planning of surveys and research at national level taking into account all parameters as well as the conditions necessary for their successful completion (financing, methodology, technical assistance, steering committee, etc.) and finally the relevance of the choices of studies to be carried out .

Governance and coordination:

➢ strong mobilization for the resources and / or integration necessary for the proper implementation of the PSN 2018-2022 through innovative financing mechanisms so that Madagascar can implement a response to AIDS with the desired innovations;

➢ mobilization of national authorities and all development actors so that the response multisectoral AIDS figures at the level of national priorities and benefits from the involvement required to contribute to the development of the Malagasy Nation.

2.2 Development of the 2018-2022 PSN

From the year 2017 began the development of the strategic plan for the next five-year period. The said National Strategic Plan (PSN) for the fight against STIs, HIV and AIDS 2018-2022 was developed following a largely participative, inclusive and consensual process by all stakeholders in the national response with the effective support of partners. technical and financial. The actors took into account the international directives relating to global deadlines linked to the Sustainable Development Goals (SDGs) and in line with the Political Declaration of the United Nations General Assembly in June 2016 as well as the vision of UNAIDS, 90 -90-90.

Its development respected the following essential stages:

A) Steering and mobilization committee:

After its establishment, a steering committee made up of national technicians launched work to plan activities and mobilize resources from partners. UNAIDS and the Global Fund therefore supported experts who came on mission to support the national team.

B) Document review, consultation and information gathering:

The information collected during this phase made it possible to assess the achievements of the previous NSP, the obstacles as well as data to set priorities for the period of the next NSP. The aggregated data include primary and secondary sources with documentary reviews, questionnaires and interview tools, "focus group discussions". The review of achievements was also made at the level of territorial structures and made it possible to identify the real bottlenecks that Madagascar faces.

C) Development of the national strategic plan for the multisectoral response to STIs, HIV and AIDS;

During the development phase proper, several working meetings and workshops were held with the participation of all actors of the national response as well as consultants. The objective of the workshops was to agree on strategic directions. This process retraced the vision and the impacts, identified strategic challenges, formulated SWOT analyzes and proposed objectives as well as interventions. The workshops were also an opportunity to build the capacity of certain actors.

D) Review, technical validation and national adoption.

During this finalization phase of the PSN, the information analyzed and the elements consolidated during the previous stages were compiled to draw up the draft of the 2018-2022 PSN. Several versions were thus reviewed and revised through a validation process including an internal review by program managers, actors in the field and a presentation at the "partners forum". The inputs of this validation procedure were used to produce the final version of the PSN. The end result is a clearly articulated NHP with key stages, the implementation of which will serve to effectively contribute to the achievement of zero objectives in the multisectoral AIDS response in Madagascar.

PART 3 - 2018-2022 NATIONAL STRATEGIC PLAN

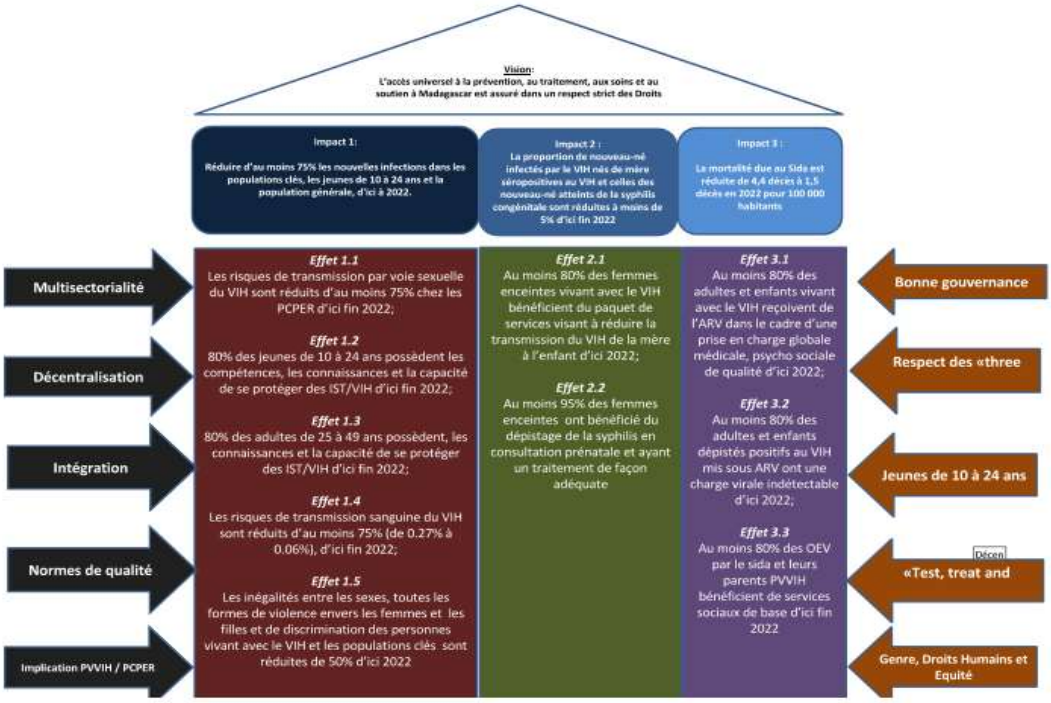


Figure 21: General concept of the 2018-2022 NSP of the multisectoral AIDS response in Madagascar

3.1 Vision

The national strategic plan for multisectoral response to STIs, HIV and AIDS 2018-2022 in Madagascar is designed around the following vision:

"Universal access to prevention, treatment, care and support in Madagascar is insured with strict respect for Human Rights ".

This vision aligns with the UNAIDS 90-90-90 universal strategy to enable Madagascar to accelerate the response to HIV by 2020 in order to achieve the elimination of the AIDS epidemic. here in 2030.

3.2 Impacts and effects

Through the 2018-2022 PSN, the members of the GT-PSN aim to make available to all stakeholders in the multisectoral AIDS response in Madagascar, a national reference document setting the common objectives to be achieved during the period of implementation and describing strategies to achieve effective acceleration of the HIV response.

At the end of the five years, the expected impacts of the NHP relate to:

(1) reduction of new HIV infections in key populations, young people aged 10 to 24 and in the general population;

(2) the reduction in the proportion of newborns infected with HIV born of HIV-positive mothers and that of newborns with congenital syphilis;

(3) reduction of mortality due to AIDS.

The expected effects of the activities to be carried out, according to each impact, are described in the table below:

Table 8 : Impact results and effect results

Impact 1: Reduce new infections by at least 75% in key populations, young people aged 10 to 24 and the general population.	
Effect 1.1	Risks of sexual transmission of HIV are reduced by at least 75% among PCPERs by the end 2022.
Effect 1.2	80% of young people aged 10 to 24 have the skills, knowledge and ability to protect themselves from STIs / HIV by the end of 2022.
Effect 1.3	80% of adults aged 25 to 49 have the knowledge and ability to protect themselves from STIs / HIV by the end 2022.
Effect 1.4	The risks of HIV blood transmission are reduced by at least 75% (from 0.27% to 0.06%), by the end of 2022.
Effect 1.5	Gender inequality, all forms of violence against women and girls and discrimination against people living with HIV and key populations is reduced by 50% by 2022.
Impact 2: The proportion of newborns infected with HIV born to HIV-positive mothers and that of newborns with congenital syphilis are reduced to less than 5% by the end of 2022.	
Effect 2.1	At least 80% of pregnant women living with HIV benefit from the package of services to reduce mother-to-child transmission of HIV by 2022.
Effect 2.2	At least 95% of pregnant women benefited from prenatal screening for syphilis and had adequate treatment.
Impact 3: Mortality due to AIDS is reduced from 4.4 deaths to 1.5 deaths in 2022 per 100,000 inhabitants.	
Effect 3.1	At least 80% of adults and children living with HIV receive ARVs as part of comprehensive medical, psycho-social care by 2022.
Effect 3.2	At least 80% of adults and children screened for HIV positive on ARVs have an undetectable viral load by 2022.
Effect 3.3	At least 80% of OVC with AIDS and their parents living with HIV receive basic social services by the end 2022.

3.3 Alignment

Several conventions and texts adopted by Madagascar as well as official national references govern the implementation of the 2018-2022 PSN, the most important of which are:

i. the Sustainable Development Goals (SDGs) agreed by the member countries of the United Nations, including Madagascar in September 2015, and which represent the global objectives to eradicate poverty, protect the planet and guarantee prosperity for all. The AIDS response falls under target 3.3, which aims by 2030 to end the epidemic of AIDS, tuberculosis, malaria and neglected tropical diseases and to combat hepatitis, water-borne diseases and other communicable diseases. Due to its multi-sectoral nature, it also fits into objectives 3, 5, 10, 16 and 17;

ii. the Political Declaration on HIV / AIDS adopted by the 70th session of the United Nations General Assembly in June 2016 which aims to “accelerate the response to fight HIV and end the AIDS epidemic by 2030”;

iii. Law N ° 2005-040 of February 20, 2006 on "the fight against HIV / AIDS and the protection of the rights of people living with HIV" in Madagascar (OJ number 3029 of May 15, 2006, page 2784) with its decree of application number 2006-902 of December 19, 2006;

iv. the National Health Policy which has, among other objectives, to keep the prevalence of HIV at less than 1% and ensure the well-being of PLWHA;

v. decree 2017-071 of 02 February 2017 on "reorganization of the National Committee to Fight AIDS".

vi. the policy for responding to HIV and AIDS in the workplace in Madagascar.

3.4. Guiding principles

The national strategic plan for the multisectoral response to STIs, HIV and AIDS 2018-2022 will be operationalized through annual national response plans and also sectoral plans.

The development and implementation of these plans is guided by the following guiding principles:

Multisectoriality : the harmful effects of HIV and AIDS are not limited only to the health sector, but impact all sectors of the nation's development and life. As a result, all actors must join their efforts, under the coordination of the CNLS, to fight against this pandemic.

Integration of services ensuring the complementarity of actions and offering efficient and effective services. It will lead to a participatory approach and a partnership increasing the quality as well as the relevance of policies and programs.

Decentralization : the implementation of the 2018-2022 NSP will be done on a decentralized basis and approach. The structures for coordinating the multisectoral response to AIDS at the regional level will be strengthened. The development and implementation of regional plans promoting the effective and inclusive participation of all stakeholders will be the basis of this decentralization. The conditions allowing the transfer of skills, resources and support for the various stakeholders in each region will be strengthened.

Quality standards : particular emphasis will be placed on the quality of all the services that will be provided in order to guarantee their effectiveness. Quality standards will thus be defined and followed, and a human resources skills development program put in place.

Respect for the "three ones" : it is a question of strengthening the national coordination mechanisms and of developing consultation with all the actors with a view to strengthening ownership, alignment, harmonization, results-based management, mutual responsibility.

Active involvement of PLHIV and key populations most exposed to HIV : It is essential to ensure the participation of PLWHIV as well as that of key populations in the planning and implementation of interventions to guarantee their conformity with the needs of the beneficiaries. The involvement of PLWHIV remains essential especially in the implementation of the components relating to positive health.

Special consideration for young people aged 10 to 24 : the universal trend of increasing mortality and an increase in the prevalence of HIV in the population of young people aged 10 to 24 reveals the need for special attention to them. In the Malagasy context, a large majority of the population, 32%, is affected by this age group. Studies have shown that the proportion of young people among the key populations is high.

Test, process and retain : In accordance with WHO recommendations in 2014[27], this approach, based on a treatment cascade analysis, will allow countries to increase the supply of services across the continuum of care and thus accelerate the response effectively, in accordance with UNAIDS 90-90-90.

Good governance : Through this principle, the country must have the capacity to plan and implement an effective response in a favorable environment. Good governance will be based on the leadership and sustained commitment of actors at all levels for rational management and

[27] HIV test-treat-retain cascade analysis, Guide and tools, WHO, 2014

transparent allocation of resources allocated to the response to AIDS.

Human Rights, Gender and Equity : protecting, promoting and respecting these fundamental as well as essential concepts in the response to AIDS will lead to the reduction of inequalities, to fight discrimination, stigma, various types of violence as well as the inadequacies that could constitute a a barrier to universal access to necessary prevention, treatment, care and support.

3.5 Priorities

3.5.1 Priority actions

The priorities of the 2018-2022 NHP were mainly dictated by three complementary and legitimate processes: the application of the UNAIDS global strategy, the analysis of the results of the final review relating to the implementation of the 2013-2017 NHP. and taking into account new international recommendations. For this reason, new screening strategies have been considered in the national context: rapid diagnostic-oriented test (TROD), self-test, community screening, as well as new care approaches: treat all, popularization of the measure. viral load ...

In order to anticipate a possible explosion of the epidemic in Madagascar, the option was resolutely taken to intervene as a priority in areas of high vulnerability and to intervene with key populations most exposed to risks, young people from 10 to 24 years who are found in significant proportion at the level of key populations and finally other vulnerable populations.

Thus, considering the national context, the available evidence, the profile of the epidemic and the vulnerability mapping enabled the members of the Madagascar GT-PSN to agree on the priorities to be retained.

3.5.1.1 **Further promotion of prevention of HIV infection** aimed at (1) the adoption of safer sexual behaviors and practices among key populations, young people aged 10 to 24 and other vulnerable populations (detainees, truckers, men in uniform, etc.), (2) social change, (3) better management (qualitative and quantitative) of STI cases using the syndromic approach and (4) reducing the risk of transmission of the virus among people who inject drugs.

3.5.1.2 **Increased coverage (quality, accessibility and availability) in clinical and community service offerings** , for a continuum of care taking into account the latest WHO recommendations in force as well as new international strategies : TROD, demedicalized HIV screening, self-test, option B +, covering the complete package of: HIV counseling and testing, PMTCT, comprehensive care for PLWHIV (medical and psychosocial), blood transfusion, management of accidents involving exposure to biological fluids (sexual violence, accidental injection from health providers)).

3.5.1.3 **Creating an enabling environment for the multisectoral AIDS response** in essential areas: governance, mobilization of partners and resources both external and domestic, culture of accountability, fight against discrimination and stigmatization, respect for Human Rights, gender… allowing an effective acceleration of actions to fight against the AIDS epidemic.

3.5.1.4 **Strengthening the monitoring and evaluation system and the coordination of the multisectoral response** by formalizing (a) the quality assurance and control mechanism for data, reports, (b) multi-year planning of specific national studies and research on STIs, HIV and AIDS or integrated into national studies in other sectors of development. The strengthening of coordination will concern the effective application of decree 2017-071 on "reorganization of the National Committee to Fight AIDS".

3.5.1.5 **Strengthening of the purchasing and inventory management system** health inputs related to STIs, HIV and AIDS through the training of relevant managers at all levels of the supply chain, the increase in warehouse storage capacity at central and peripheral levels, the establishment of 'management tools using new information and communication technologies allowing rational management and long-term availability of inputs ... All this must be accompanied by an adequate strengthening of the logistics information system.

3.5.2 Priority targets

3.5.2.1 Infected and affected populations

- People living with HIV: adults, children, infants
- Orphans and vulnerable children

3.5.2.2 Key populations most at risk of HIV infection

- Sex workers
- Men who have sex with men
- Injecting drug users

3.5.2.3 Populations in a context of vulnerability

- Pregnant women and newborns
- STI patients
- Tuberculosis patients
- Young people in school and out of school from 10 to 24 years old
- Detained persons
- Clients of sex workers
- Women and children victims of sexual violence
- Men and women aged 15 to 49

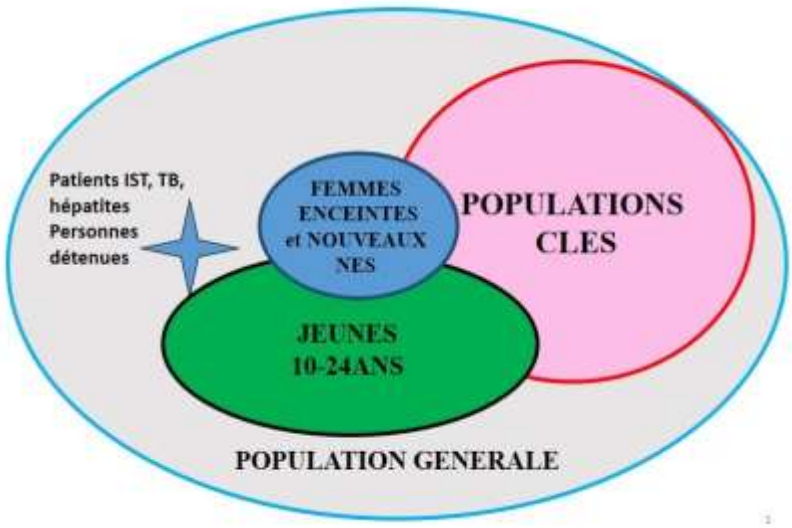


Figure 22: Diagram of the 2018-2022 NHP priority targets

Table 9 presents the estimates of the sizes of the main target populations for the 2018-2022 NHP interventions. The basic data come from the entries made in the HAPSAT software. A linear projection was then carried out for the period covered by the 2018-2022 PSN, using the same calculation assumptions.

Table 9 : Estimated sizes of target populations for PSN 2018-2022.

Target populations	Estimated size		
	in 2017	**in 2018**	**in 2022**
MSM	54,072	55,434	60 882
CDI	17,549	17 991	19,759
PS	76,466	78,884	88,556
Pregnant women living with HIV	1,473	1,359	902
Adults and children living with HIV	35,553	34,369	29,632
Tuberculosis patients	33,502	34 987	40 926
Detained persons	20,653	21,173	23,254
Young people in school and out of school	787 787	807,631	887 007
Women of childbearing age	5,394,906	5,530,802	6,074,384
Women and children victims of sexual violence	2,170	2,225	2,444
AIDS orphans and other vulnerable children	12,756	13,077	14,362

3.6 Results framework

Table 10 : Results framework

Impact / Effect / Product	Indicators	Basic data	Year	Source	2018	2019	2020	2021	2022
Impacts:									
Impact 1: The number of new HIV infections is reduced by at least 75% (*from 29,000 or 7,250)* in key populations most at risk of HIV infection, among young people aged 10 to 24 and the general population by the end of 2022	Prevalence of HIV among sex workers (PS)	5.6%	2016	ESCB	5.1%	4.6%	4.2%	3.8%	3.5%
	Prevalence of HIV in Men Who Have Sex with Men (MSM)	14.8%	2014	ESCB	14.2%	12.3%	10.6%	8.5%	8.1%
	Prevalence of HIV among people who inject drugs (IDU)	8.5%	2016	ESCB	8.3%	7.3%	5.7%	4.9%	3.8%
	Prevalence of HIV among young people aged 10-24	0.2%	2016	Spectrum Estimate	<1%	<1%	<1%	<1%	<1%
	Prevalence of HIV in adults aged 15-49	0.2%	2016	Spectrum Estimate	<1%	<1%	<1%	<1%	<1%
Impact 2: The proportion of newborns infected with HIV born to HIV-positive mothers and those of newborns with congenital Syphilis are reduced to less than 5% by the end of 2022	Estimated percentage of children who have been newly infected with HIV through mother-to-child transmission among HIV-positive women who have given birth in the past 12 months	35.70%	2015	Spectrum Estimate	10.0%	8.0%	8.0%	<5%	<5%
Impact 3: Mortality due to AIDS is reduced from 4.4 deaths in 2018 to 1.5 deaths in 2022 per 100,000 inhabitants	Proportion of people who died from an AIDS-related illness out of 100,000 people	4.40%	2016	Spectrum			1.5%		
Impact / Effect / Product	Indicators	Basic data	Year	Source	2018	2019	2020	2021	2022

Impact 1: The number of new HIV infections is reduced by at least 75% in the key populations most at risk of HIV infection, among young people aged 10 to 24 and the general population by the end of 2022									
Effects:									
Outcome 1.1: The risks of sexual transmission of HIV are reduced by at least 75% among PCPERs, by the end of 2022.	Percentage of MSM who report having used a condom during their last anal intercourse with a male partner	57.2%	2014	ESCB	75.0%		80.0%		90.0%
	Percentage of injecting drug users who report having used a condom the last time they had sex	41.9%	2016	ESCB		65.0%		75.0%	
	Percentage of female sex workers who report having used a condom with their last client	62.7%	2016	ESCB		80.0%		90.0%	
	Proportion of young people aged 10-24 who have had more than one sexual partner in the past 12 months and who report having used a condom the last time they had sex	M: 7.3% F: 8.5%	2012	EDS		M: 15% F: 16%			M: 21% F: 20%
	Proportion of women and children victims of sexual violence receiving prophylactic treatment for HIV transmission among those listed	ND		Blood exposure sheets or Register of associations for the psychoanalysis of victims of sexual violence	80%	90%	100%	100%	100%
Outcome 1.2: 80% of young people aged 10 to 24 have the skills, knowledge and ability to protect themselves from STIs / HIV by the end of 2022	Proportion of young people aged 10-24 who both have the exact knowledge of how to prevent sexual transmission of HIV and who reject the main misconceptions about HIV transmission	M: 25.5% F: 22.9%	2012	EDS		M: 35% F: 34%			M: 51% F: 50%

Outcome 1.3: 80% of adults aged 25 to 49 have the skills, knowledge and ability to protect themselves from STIs / HIV by the end of 2022	Proportion of adults aged 25-49 who have had more than one sexual partner in the past 12 months and who report having used a condom the last time they had sex	M: 9.5% F: 12.3%	2012	EDS		M: 45% F: 44%			M: 73% F: 70%
Effect 1.4: The risks of HIV blood transmission are reduced by at least 75% (from 0.27% to 0.06%) by the end of 2022	Proportion of blood bags tested for quality HIV	100%	2017	CNTS report	100%	100%	100%	100%	100%
	Percentage of people who inject drugs who report having used sterile injection equipment during their last injection	68.4%	2016	ESCB		80%		90%	
	Proportion of cases of accidental exposure to blood in healthcare settings receiving prophylactic treatment among those listed	100%	2017	DLIS report	100%	100%	100%	100%	100%
Outcome 1.5: Gender inequality, all forms of violence against women and girls and discrimination against people living with HIV and key populations are reduced by 50% by 2022	Proportion of women aged 15 to 49 who are or have been married or are in a couple, and who have been victims of physical or sexual violence by a male partner in the past 12 months	65% 2016		Study report (ENDA Indian Ocean and IRD)			25%		
	Percentage of adults aged 15 to 49 who express discriminatory attitudes towards people living with HIV	M: 47.5% F: 49.1%	2012	EDS			M: 57% F: 59%		
IMPACT 2: The proportion of newborns infected with HIV born to HIV-positive mothers and those of newborns with Syphilis congenital are reduced to less than 5 % by the end of 2022									
Outcome 2.1: At least 80% of pregnant women living with HIV benefit from the package of services aimed at reducing mother-to-child transmission of HIV by the end of 2022.	Percentage of pregnant women who know their HIV status	23% 2016		RMA	32.4%	38.8% 45.3%	51.7% 59.9%		
	Percentage of pregnant women living with HIV who have received antiretroviral drugs to reduce the risk of mother-to-child transmission (MTCT)	7% 2016		RMA	49.1%	53.7% 57.7%	61.2% 66.6%		

	Percentage of infants born to women living with HIV who undergo virological testing within two months of birth	ND		RMA	49.1%	53.7%	57.7%	61.2% 66.6%	
	Percentage of women of reproductive age (15 to 49) whose demand for family planning is met with modern methods	33.3%	2012	EDS			55%		
Outcome 2.2: At least 95% of pregnant women have received prenatal screening for syphilis and have had adequate treatment	Percentage of pregnant women receiving prenatal consultation services who have been screened for syphilis (Coverage of syphilis screening among pregnant women in ANC)	28%	2017	RMA	50%	60%	70%	80%	90%
	Percentage of pregnant women receiving antenatal consultations with a positive syphilis serology	4%	2017	RMA	2.5%	1.9%	1.5%	1.2%	0.9%
	Percentage of women seeking antenatal care who test positive for syphilis and treated correctly with a dose of Benzathine Penicillin to reduce MTCT before the fourth month to prevent congenital syphilis	45%	2017	RMA	23.8%	32.0%	40.0%	51.6% 64.3%	
IMPACT 3: Mortality due to AIDS is reduced from 4.4 deaths in 2018 to 1.5 deaths in 2022 per 100,000 inhabitants									
Outcome 3.1: At least 80% of adults and children living with HIV receive ARVs as part of comprehensive medical and psychosocial care by 2022	Percentage of adults and children receiving antiretroviral therapy among all adults and children living with HIV at the end of the reporting period	7%	2016	RMA	9.3%	11.7%	13.9%	15.5% 17.0%	
	Percentage of adults and children living with HIV known to be on antiretroviral therapy 12 months after starting	86.1%	2016	RMA	90.0%	93.0%	95.0%	98.0% 98.0%	

	Percentage of incident cases of HIV-related tuberculosis (TB) that received treatment for both tuberculosis and HIV	22%	2016	Cohort of TB patients Cohort of PLHIV on ARVs	26.0%	28.9%	31.8%	34.7%	37.6%
Outcome 3.2: At least 80% of adults and children screened for HIV positive on ARVs have an undetectable viral load by 2022	Percentage of people living with HIV whose viral load has been suppressed at the end of the reference period	1.2%	2016	RMA	8.3%	10.5%	12.5%	13.9%	15.3%
Outcome 3.3: At least 80% of OVC with AIDS and their parents living with HIV benefit from basic social services by the end of 2022	Proportion of children orphaned by AIDS and children of the most vulnerable parents living with HIV whose household receives free external support for their care	3.9%	2017	Register of associations working with OVC and children living with HIV	6.0%	7.0%	8.0%	9.0%	10.0%

Impact / Effect / Product	Indicators	Data from based	Source Year		2018	2019	2020	2021	2022
IMPACT 1: The number of new HIV infections is reduced by at least 75% in the key populations most at risk of HIV infection, among young people aged 10 to 24 and the general population by the end of 2022									
Effect 1.1: The risks of t sexually transmitted e of HIV are r é at least 75% c h e PCPER, by the end of 2022 .									
Product 1.1.1.1: 112,136 MSM receive full CCC packages by 2022	Number of MSM covered by CCC service packages	19,327	2017	SE / CNLS report	20,293	21,308	22,373	23,492	24,667
Product 1.1.2.1: 9,860 CDI, 812,276 PS receive full CCC packages by 2022	Number of CDIs covered by CCC service packages	1,158	2017		1,932	1,952	1,972	1,992	2,012
Product 1.1.3.1: 812,276 PS receive full CCC packages by 2022	Number of PS covered by CCC service packages	97,000	2017		159 106	160,780	162,456	164,130	165,804
Output 1.1.4.1: 194,437 calls to HIV questions handled by the 511 hotline by 2022	Number of calls received and processed by the hotline 511 regarding questions about HIV	28,953	2016	SE / CNLS report	31,848	35,033	38,536	42,390	46,629
Output 1.1.5.1: 400 cases of victims of sexual violence receiving HIV PEP	Number of women and children victims of sexual violence who have benefited from HIV PEP services	ND			80	80	80	80	80
Effect 1.2: 80% of young people aged 10 to 24 have the skills, know them s ances and the c at ability to p rotere l S T / HIV by fi 2022									
Output 1.2.1.1: 3,094,371 young people aged 10 to 24 in school and out of school, particularly young girls and young PCPER, are covered by information services	Number of out-of-school and out-of-school youth covered by the CCC service package	320,696	2017	SE / CNLS report	589,378	605,291	621,634	633,234	644,834

and STI / HIV education by 2022									
Output 1.2.1.2: At least 90% or 2,784,934 the most vulnerable young people are screened and know their status by 2022	Number of young people tested and withdrawn	206 122	2017	RMA GESIS	530 440	544,762	559,471	569,911	580 351
Effect 1.3: 80% of adults aged 25 to 49 have e s competence s , knowledge and ability to protect yourself from STIs / HIV from here late 2022									
Output 1.3.1.1: 117 companies and 21 departments implement the policy to fight AIDS in the workplace	Number of companies having implemented at least 50% of the activities listed in their annual action plan		2017		77	87	100	117	117
	Number of public ministries other than that of health, having implemented at least 50% of the activities included in their annual action plan		2017		15	17	19	21	21
Output 1.3.1.2: 1,579,379 adults in the informal sector are covered by the CCC STI / HIV service package by 2022	Number of adults 25 - 49 years old covered by the CCC service package	ND			285,828	300,119	315 125	330 881	347,425
Output 1.3.1.3: 157,938 adults in the informal sector, particularly women are screened for STIs / HIV by 2022	Number of adults aged 25-49 who tested for HIV and withheld the results	ND			28,583	30,012	31,513	33,088	34,743
Product 1.3.1.4: 58,019 people inmates receive full CCC packages by 2022	Number of detained persons covered by the CCC service package	8,603	2016	SE / CNLS report	10,500	11,025	11,576	12,155	12,763
Output 1.3.1.5: 126,425,449 of male condoms and 252,861 of	Number of male condoms distributed / sold (in thousands)	15,500	2017	SE / CNLS report	20,252	22,598	25,228	27,858	30,488

female condoms distributed or sold	Number of condoms distributed / sold	214,900	2017	SE / CNLS report	405,044	451,962	504,565	557,168	609,770
Output 1.3.1.6: 883,134 people took their HIV test and withdrew their results (not including pregnant women)	Number of people tested and withdrawn (pregnant women excluded)	355,406	2017	DLIS report	686,582	729,117	780 456	831,795	883,134
Product 1.3.1.7: 1,422,444 STI cases screened and treated using the national syndromic approach	Number of STI cases treated using the syndromic approach	211,812	2017	DLIS report	232 993	256,293	281,922	310 114	341,125
Output 1.3.1.8: 1,491,496 people in the general population sensitized	Number of people who participated in AIDS awareness activities	ND			244,303	268,734	295,607	325 168	357,684
Effect 1.4: The risks of HIV blood transmission are reduced by at least 75% (from 0.27% to 0.06%) by the end of 2022									
Product 1.4.1.1: 168,163 bags of blood secured with the four communicable disease markers distributed	Number of blood bags secured to the four communicable disease markers distributed.	40,000	2016	CNTS 2016 report	58,000	60,900	63,945	67 142	70,499
Product 1.4.2.1: 9,860 CDIs receive sterile injection equipment in quantities suited to their needs	Number of IDUs who receive sterile injection equipment.	1,158	2017	SE / CNLS report 2017	1,932	1,952	1,972	1,992	2,012
Product 1.4.3.1: 150 cases of exposure to HIV in healthcare settings have HIV PEP	Number of cases of exposure to HIV in healthcare settings who have benefited from PEP for HIV.	22	2017	DLIS report 2017	30	30	30	30	30
Outcome 1.5: Gender inequality, all forms of violence against women and girls and discrimination against people living with HIV and key populations are reduced by 50% by 2022									

Output 1.5.1.1: 90,000 people sensitized on gender-based violence against women and girls	Number of population who participated in awareness-raising sessions on gender-based violence against women and girls	ND			18,000	18,000	18,000	18,000	18,000
Output 1.5.2.1: 10 key sectors integrating awareness raising on the specific topic of discrimination and stigmatization against people living with HIV and key populations	Number of key sectors incorporating awareness-raising activities on the specific theme on discrimination and stigmatization against PLWHA and PCPERs	ND			2	4	6	8	10
IMPACT 2: The proportion of newborns infected with HIV born to HIV-positive mothers and those of newborns with congenital Syphilis are reduced to less than 5% by the end of 2022									
Outcome 2.1: At least 80% of pregnant women living with HIV benefit from the package of services aimed at reducing mother-to-child transmission of HIV by the end of 2022.									
Output 2.1.1.1: 3,959,184 women of reproductive age are covered by information on HIV and PMTCT.	Number of women of reproductive age covered by information activities on HIV and PMTCT	585,637	2016	SE / CNLS report 2016	745,764	765,900	786,579	806 987	853 954
Output 2.1.1.2: 768,559 pregnant women perform voluntary screening during the ANC and withdraw their results.	Number of pregnant women taking voluntary screening during ANC and withdrawing their results	221,257	2016	DLIS report 2016	372,882	459,540	550 605	645,589	768,559
Output 2.1.2.1: 1,537 HIV-positive pregnant women receiving ARVs to reduce the transmission of HIV to their children.	Number of pregnant women living with HIV who have received ARVs to reduce mother-to-child transmission of HIV	117	2017	DLIS report 2017	746	919	1,101	1,291	1,537

Output 2.1.2.2: 1,537 children born to mothers living with HIV receive ARVs.	Number of infants of HIV-positive mothers who received ARVs to reduce mother-to-child transmission of HIV	41	2017	DLIS report 2017	746	919	1,101	1,291	1,537
Output 2.1.3.1: 1,537 children born to mothers living with HIV benefit from an early diagnosis of HIV infection and cotrimoxazole prophylaxis.	Number of children born to mothers living with HIV who were diagnosed early with HIV within 12 months of birth.	ND			746	919	1,101	1,291	1,537
Output 2.1.4.1: 2,152 women living with HIV receive family planning counseling and contraceptives to prevent unintended pregnancies	Number of women living with HIV who have received contraceptives or condoms to prevent unwanted pregnancies	ND			1,470	1,615	1,794	1,973	2,152
Outcome 2.2: At least 95% of pregnant women have received prenatal screening for syphilis and have had adequate treatment									
Product 2.2.1.1: 2,797,176 pregnant women screen for syphilis during PNC1.	Number of pregnant women screen for syphilis during PNC1	192,800	2016	DLIS report 2016	372,882	459,540	550 605	645,589	768,559
Product 2.2.2.1: 40,950 pregnant women tested positive for syphilis during CPN1.	Number of pregnant women tested positive for syphilis during PNC1	7,267	2016	DLIS report 2016	9,397	8,616	8,259	7,505	7,173

Product 2.2.3.1: 16,783 pregnant women with syphilis are receiving at least one dose of Benzathine Penicillin to reduce mother-to-child transmission before the 4th month to prevent congenital syphilis	Number of pregnant women under 4 months of pregnancy seen in CPN1 seropositive with syphilis receive at least one dose of Benzathine Penicillin	1,025	2016	DLIS report 2016	2,237	2,757	3,304	3,874	4,611
Output 2.2.4.1: 50,349 pregnant women with syphilis who were treated with the three doses of Benzathine penicillin	Number of pregnant women with syphilis who received 3 doses of benzathine penicillin	4,316	2016	DLIS report 2016	6,712	8,272	9,911	11,621	13,834
IMPACT 3: Mortality due to AIDS is reduced from 4.4 deaths in 2018 to 1.5 deaths in 2022 per 100,000 inhabitants									
Outcome 3.1: At least 80% of adults and children living with HIV receive ARVs as part of comprehensive medical and psychosocial care by 2022									
Output 3.1.1.1: 10,594 adults living with HIV receive ARVs	Active queue of adults living with HIV on ARVs	2,244	2017	DLIS report 2017	3,874	5,509	7,234	8,869	10,594
Output 3.1.1.2: 134 children living with HIV receive ARVs	Active queue of children living with HIV on ARVs	41	2017	DLIS report 2017	107	109	114	120	134
Output 3.1.2.1: 8,809 HIV-positive adults and children still on treatment 12 months after starting antiretroviral therapy during the study period	Number of adults and children who are HIV positive and still on treatment 12 months after starting antiretroviral therapy during the study period	261	2016	DLIS report 2016	2,666	3,702	5,337	7,201	8,809
Output 3.1.3.1: 169 HIV-TB co-infected patients receive	Number of HIV-Tuberculosis coinfected patients receive ARVs as well	97	2016	DLT Report 2016	117	130	143	156	169

both ARVs and TB treatment	that TB treatment								
Effect 3.2: At least 80% d adults and children screened é s positive for HIV put on AT RV have a vs viral harge i not detectable from here 2022									
Output 3.2.1.1: 12,194 adults and children living with HIV have an undetectable viral load	Number of people living with HIV whose viral load was suppressed during the reference period (≤1000 copies / mL)	ND			3,583	5,056	6,613	8,090	9,655
Effect 3.3: At least 80% d es OVC through AIDS and their p at annuities PLHIV b é are in need of services so vs basic ials by the end of 2022									
Output 3.3.1.1: 6,775 adults and children living with HIV benefit from the psychological, social and legal support service package.	Number of PLHIV (adults and children) having benefited from at least one psychological, social and legal support service	2,152	2017	2017 Report	2,482	3,530	4,628	5,677	6,775
Output 3.3.1.2: 5,099 children orphaned by AIDS and their parents living with HIV live in a household that will have received support to ensure their access to basic social services	Number of children orphaned by AIDS and children of parents living with HIV, the most vulnerable, who live in a household that received free outside support to ensure their access to basic social services	452	2017	Madaids Report 2017	683	769	837	889	933

3.7 Implementation strategies

Table 11 : Implementation strategies for the 2018-2022 NHP

Impact / Effect / Product	Indicators	Strategies
IMPACT 1: The number of new HIV infections is reduced by at least 75% (from 29,000 to 7,250) in the key populations most exposed to the risks of HIV infection, among young people aged 10 to 24 and the general population by the end of 2022		
Outcome 1.1: The risks of sexual transmission of HIV are reduced by at least 75% among PCPERs, by the end of 2022.		
Strengthening of the CCC with key populations most exposed to the risks of HIV (MSM, PS, CDI)		
Product 1.1.1.1: 112,136 MSM receive full CCC packages by 2022	Number of MSM covered by CCC service packages	Strengthening the CCC with MSM
Product 1.1.2.1: 9,860 CDIs receive full CCC packages by 2022	Number of CDIs covered by CCC service packages	Strengthening the CCC with CDIs
Product 1.1.3.1: 812,276 PS receive full CCC packages by 2022	Number of PS covered by CCC service packages	Strengthening of the CCC with PS
Product 1.1.4.1: 194,437 HIV-related calls handled by the 511 hotline by 2022	Number of calls received and processed by the hotline 511 regarding questions about HIV	Reinforcement of the capacity of the green line 511
Product 1.1.5.1: 400 cases of victims of sexual violence receiving HIV PEP	Number of women and children victims of sexual violence who have benefited from HIV PEP services	Improving the care of women and children victims of sexual violence
Outcome 1.2: 80% of young people aged 10 to 24 have the skills, knowledge and ability to protect themselves from STIs / HIV by the end of 2022		
Strengthening the knowledge, attitude and practice of young people aged 10 to 24 on STI / HIV and AIDS		
Product 1.2.1.1: 3,094,371 school-aged and out-of-school youth aged 10 to 24, particularly girls and young PCPERs, are covered by STI / HIV information and education services by 2022	Total number of out-of-school and out-of-school youth covered by the CCC service package	Advocacy for the distribution of condoms in schools Effective implementation of comprehensive sex education in schools and out of school, through life skills (lifeskills) CCC on the themes of human rights, early and unwanted pregnancies, gender-based violence, STI / HIV / Hepatitis Peer education- Strat. 1.2.1.5. : Promotion of the use of social networks, green lines for the CCC for young people aged 10 to 24. Reinforcement of youth friendly services and youth associations for all

		levels Networking of youth-friendly services Strengthening of support structures for youth (youth centers, youth spaces, youth corners) Strengthening parents' schools at community level
Product 1.2.1.2: At least 90% or 2,784,934 the most vulnerable young people are screened and know their status by 2022	Total number of youth tested and removed for HIV	Advocacy for the revision of the texts (screening for minors without parental / guardian consent) Education of parents Promotion of HIV testing at community level and in schools Strengthening of collaboration between actors working for HIV testing of young people
Outcome 1.3: 80% of adults aged 25 to 49 have the skills, knowledge and ability to protect themselves from STIs / HIV by the end of 2022		
Strengthening the awareness of target populations with a view to adopting behavior with lower risk		
Product 1.3.1.1: 117 companies and 21 ministries implement the AIDS policy in the workplace	Number of companies having implemented at least 50% of the activities listed in their annual action plan	Strengthening and extending the involvement of the private sector in the fight against AIDS BCC on human rights, STI / HIV / Hepatitis, cervical and anal cancer / vaccines HIV testing STI screening and treatment using the syndromic approach
	Number of public ministries other than that of health, having implemented at least 50% of the activities included in their annual action plan	Strengthening and extending public sector involvement in the fight against AIDS BCC on human rights, STI / HIV / Hepatitis, cervical and anal cancer / vaccines HIV testing STI screening and treatment using the syndromic approach
Product 1.3.1.2: 1,579,379 adults in the informal sector are covered by the CCC STI / HIV service package by 2022	Total number of adults 25 to 49 years of age covered by the CCC service package	Mass CCC or CIP Distribution of male and female condoms
Product 1.3.1.3: 157,938 adults in the informal sector, particularly women, are screened for STIs / HIV by 2022	Number of adults aged 25-49 who tested for HIV and withdrew the results	Intensification of HIV testing in adults Strengthening screening for Hepatitis (B and C) in adults

Product 1.3.1.4: 58,019 detainees receive full CCC packages by 2022	Total number of detained persons covered by the CCC service package	Reinforcement of the CCC in detention centers, awareness raising on the themes of human rights, gender-based violence, STI / HIV / Hepatitis, cervical and anus cancer in prison Advocacy for the integration of HIV prevention in the interventions of associations working in prison
Product 1.3.1.5: 126,425,449 male condoms and 252,861 female condoms distributed or sold	Total number of male condoms distributed / sold (thousands)	Strengthening of the distribution and sale program for male and female condoms Promotion of community-based distribution of condoms
	Total number of female condoms distributed / sold	
Product 1.3.1.6: 883,134 people took their HIV test and withdrew their results (not including pregnant women)	Total number of people tested and withdrawn (pregnant women excluded)	Promotion of availability and use of VCT services Promotion of community-based HIV testing Organization of community dialogues
Product 1.3.1.7: 1,422,444 STI cases screened and treated using the national syndromic approach	Total number of STI cases treated using the syndromic approach	Improvement of the supply and adequate use of STI care services in accordance with the national syndromic approach strategy
Product 1.3.1.8: 1,491,496 people in the general population sensitized	Total number of people who participated in AIDS awareness activities	HIV information and education media campaign HIV information monitoring and surveillance
Effect 1.4: The risks of HIV blood transmission are reduced by at least 75% (from 0.27% to 0.06%) by the end of 2022		
Reinforcement of protection, prevention of populations exposed to the risks of blood transmission		
Product 1.4.1.1: 168,163 blood bags secured with the four communicable disease markers distributed	Total number of blood bags secured to the four communicable disease markers distributed.	Intensify awareness for voluntary blood donors Improved availability of safe blood products
Product 1.4.2.1: 9,860 CDIs receive sterile injection equipment in quantities suited to their needs	Total number of IDUs who receive sterile injection equipment.	Promotion and exchange of injection equipment at CDI
Product 1.4.3.1: 150 cases of exposure to HIV in healthcare settings benefit from PEP for HIV	Total number of cases of exposure to HIV in healthcare settings that have benefited from PEP for HIV.	Reinforcement of prevention and management of HIV exposure accidents in healthcare settings Strengthening of the CCC with hairdressers, tattoo artists, faobe and traditional forazaza as well as the population
Outcome 1.5: Gender inequality, all forms of violence against women and girls and discrimination against people living with HIV and key populations are reduced by 50% by 2022		

Raising awareness of discrimination and stigma towards vulnerable populations		
Product 1.5.1.1: 90,000 people sensitized on gender-based violence against women and girls	Total number of people who participated in awareness-raising sessions on gender-based violence against women and girls	Strengthening of CACs with the general population in the fight against violent acts against girls and women Strengthening of listening and legal advice centers, legal clinic and other associations working in the fight against gender-based violence parent schools place
Product 1.5.2.1: 10 key sectors integrating awareness raising on the specific topic of discrimination and stigmatization against people living with HIV and key populations	Number of key sectors incorporating awareness-raising activities on the specific theme on discrimination and stigmatization against PLWHA and PCPERs	Intensify advocacy in favor of the fight against stigma and discrimination against PLWHA in different sectors
IMPACT 2: The proportion of newborns infected with HIV born to HIV-positive mothers and those of newborns with congenital Syphilis are reduced to less than 5% by the end of 2022		
Outcome 2.1: At least 80% of pregnant women living with HIV benefit from the package of services aimed at reducing mother-to-child transmission of HIV by the end of 2022.		
Reinforcement of the implementation of the ETME acceleration plan		
Product 2.1.1.1: 3,959,184 women of childbearing age are covered by information on HIV and PMTCT.	Total number of women of reproductive age covered by HIV and PMTCT information activities	Strengthening the delivery system for PNC in maternity hospitals Community awareness on the use of maternal and newborn care services
Product 2.1.1.2: 768,559 pregnant women perform voluntary screening during the ANC and withdraw their results.	Number of pregnant women taking voluntary screening during ANC and withdrawing their results	Strengthening and extending the integration of HIV VCT and syphilis screening during the ANC
Product 2.1.2.1: 1,537 HIV-positive pregnant women receiving ARVs to reduce the transmission of HIV to their children.	Number of pregnant women living with HIV who have received ARVs to reduce mother-to-child transmission of HIV	Improved care and monitoring of pregnant women living with HIV
Product 2.1.2.2: 1,537 children born to mothers living with HIV receive ARVs.	Number of infants of HIV-positive mothers who received ARVs to reduce mother-to-child transmission of HIV	Intensified medical care for HIV-infected children born to HIV-positive mothers

Product 2.1.3.1: 1,537 children born to mothers living with HIV benefit from early diagnosis of HIV infection and cotrimoxazole prophylaxis.	Number of children born to mothers living with HIV who were diagnosed early with HIV within 12 months of birth.	Early detection of children born to mothers living with HIV and cotrimoxazole prophylaxis
Product 2.1.4.1: 2,152 women living with HIV receive family planning counseling and contraceptives to prevent unintended pregnancies	Number of women living with HIV who have received contraceptives or condoms to prevent unwanted pregnancies	Integration of the family planning service into the activities of the PLWHIV reference centers
Outcome 2.2: At least 95% of pregnant women have received prenatal screening for syphilis and have had adequate treatment		
Intensified management of syphilis in pregnant women		
Product 2.2.1.1: 2,797,176 pregnant women screen for syphilis during PNC1.	Total number of pregnant women screened for syphilis during PNC1	Strengthening and extending the integration of syphilis counseling and testing during the ANC
Product 2.2.2.1: 40,950 pregnant women tested positive for syphilis during PNC1.	Total number of pregnant women tested positive for syphilis during CPN1	Improvement of the syphilis screening strategy for pregnant women during the ANC
Product 2.2.3.1: 16,783 pregnant women infected with syphilis receive at least one dose of Benzathine Penicillin to reduce mother-to-child transmission before the 4th month to prevent congenital syphilis	Number of pregnant women under 4 months of pregnancy seen in CPN1 seropositive with syphilis receiving at least one dose of Benzathine Penicillin	Improved availability of inputs
Product 2.2.4.1: 50,349 pregnant women with syphilis treated with the three doses of Benzathine penicillin	Number of pregnant women with syphilis who received 3 doses of benzathine penicillin	Intensification of BCC activities for better adherence to treatment Improved access of newborn babies of HIV positive mothers to early diagnosis and treatment of syphilis Improved access of newborn babies of HIV positive mothers to syphilis to early diagnosis and treatment of syphilis
IMPACT 3: Mortality due to AIDS is reduced from 4.4 deaths in 2018 to 1.5 deaths in 2022 per 100,000 inhabitants		
Outcome 3.1: At least 80% of adults and children living with HIV receive ARVs as part of comprehensive medical and psychosocial care by 2022		

Strengthening the implementation of the Test and Treat and Retain strategy		
Product 3.1.1.1: 10,594 adults living with HIV receive ARVs	Active queue of adults living with HIV on ARVs	Revision of the national CEP protocol compared to WHO recommendations Strengthening and widening access to ARVs for adults living with HIV as part of the overall improvement and quality of the offer of comprehensive care services for people living with HIV. Introduction in university medical training of the in-depth module on the global PEC of HIV to generalize the prescription of ARVs Provision of ARVs at the level of medical care centers for PLWHA Management of opportunistic infections
Product 3.1.1.2: 134 children living with HIV receive ARVs	Active queue of children living with HIV on ARVs	Strengthening and widening access to ARVs for HIV-positive children as part of the overall improvement and quality of the offer of comprehensive care services for children. Management of opportunistic infections in HIV-positive children
Product 3.1.2.1: 8,809 HIV-positive adults and children still on treatment 12 months after starting antiretroviral therapy during the study period	Number of adults and children who are HIV positive and still on treatment 12 months after starting antiretroviral therapy during the study period	Improvement in the follow-up of the retention of PLWHIV patients on antiretroviral treatment for at least 12 months of treatment
Product 3.1.3.1: 169 HIV-Tuberculosis coinfected patients receive both ARVs and anti-tuberculosis treatment	Many HIV-Tuberculosis co-infected patients receive both ARVs and anti-tuberculosis treatment	Reinforcement and extension of the CDV in the CDT Improvement of the PEC of the TB / HIV co-infected patients Reinforcement and extension of the screening of TB in the PLWHIV Putting on anti-TB treatment of all the PLWHIV patients tested TB Putting in INH of all the PLHIV patients
Outcome 3.2: At least 80% of adults and children screened for HIV positive on ARVs have an undetectable viral load by 2022		
Operationalization of the follow-up of PLWHIV patients on the viral load at 6 months and at 12 months		
Product 3.2.1.1: 12,194 adults and children living with HIV have an undetectable viral load	Number of people living with HIV whose viral load was suppressed during the reference period (≤1000 copies / mL)	Strengthening of viral load measurement in adults and children on ARVs
Outcome 3.3: At least 80% of OVC with AIDS and their parents living with HIV benefit from basic social services by the end of 2022		
Strengthening of the capacity of workers in the psychosocial care of PLWHA and children orphaned by AIDS		

Product 3.3.1.1: 6,775 adults and children living with HIV benefit from the psychological, social and legal support service package.	Number of PLHIV (adults and children) having benefited from at least one psychological, social and legal support service	Strengthening the involvement of NGOs / CBOs, psychosocial and nutritional care for PLWHA Support for psychosocial care structures Establishment of a reporting mechanism for psychosocial care data at all levels of the national monitoring and evaluation system
Product 3.3.1.2: 5,099 children orphaned by AIDS and their parents living with HIV live in a household that will have received support to ensure their access to basic social services	Number of children orphaned by AIDS and children of parents living with HIV, the most vulnerable, who live in a household that received free outside support to ensure their access to basic social services	Strengthening education and nutritional care for adults and children orphaned by AIDS Establishment of a support mechanism for the protection of the rights of PLHIV

Interventions relating to governance, coordination and monitoring and evaluation,

Concerning the management of the program, below are the priority interventions of the AIDS response governance:

Priority Strategies / Interventions	Main activities
Strengthening of the level of State commitment to the financing of the fight against AIDS	- Advocacy with the government for a substantial budget allocation from the State to the fight against HIV / AIDS - Advocacy at the private sector level to strengthen their financial commitment in the fight against AIDS - Advocacy with technical and financial partners to finance the fight against AIDS complementary to the national contribution - Conduct regular audits to ensure the effectiveness of good management of resources intended for the struggle against AIDS
Reinforcement of all the structures of the coordinating body at central and decentralized level in qualified human resources and in sufficient quantity	- Recruit staff
Make the national monitoring and evaluation system operational and efficient in order to produce strategic information on time and on a regular basis	- Strengthen the capacity of WGSI members - Revise non-health data collection tools - Recruit quality monitoring and evaluation staff - Organize the collection and processing of data in accordance with the defined circuits - Develop and implement the training plan for SE / CNLS monitoring and evaluation unit staff - Develop and implement a data quality supervision and audit plan - Ensure the endowment of regional coordination structures, the DLIS, and the SE / CNLS in resources logistics
Reinforcement of epidemiological, behavioral surveillance and operational research according to the research plan	- Biological and behavioral surveillance survey of key populations every two years - Regularly organize studies on other themes of universal access - Develop and implement an HIV research plan linked to information needs national response strategies

Strengthening and operationalization of coordination structures at all levels	- Implement the initiative to revitalize all the regional coordination bodies and national response - Lead the participatory process of developing multisectoral operational plans - Ensure the regular functioning of the Partners Forum and technical advisory groups - Support the functioning of networks of civil society organizations and the CNT - Organize quarterly coordination meetings between the SE / CNLS and the CTRLS - Mobilize partners through initiatives - structural / events
Strengthening the integration of basic community systems of the national response	- Strengthen the technical and managerial capacity of the networks of CSO voice of the people - Train human resources in community organizations and civil society in HIV prevention at the community level, referral of cases and adherence to treatment.
Efficient coordination of the ordering, purchasing and storage system for inputs and ARV drugs at all levels	- Set up a set of efficient purchasing and inventory management procedures - Strengthen the technical capacity of the quantification committee - Strengthen the SALAMA distribution circuit so that CSBs are regularly served with reagents and ARV and other drugs for OI according to their orders - Supervise and crosscheck on the basis of usage report and confidential register
Strengthening the information watch of the general population through different communication channels	- Organize continuous information watch sessions - Organize with the actors of the response mass communication activities - Organize regular dissemination of research data and results through websites - Promote the response website and develop social networks such as twiter - face book…

3.8 2018-2022 NSP implementation framework

3.8.1 Coordination

According to Decree N ° 2017-071 of 05 February 2017 reorganizing the National Committee to fight HIV / AIDS, The implementation of the 2018-2022 PSN will be done in an organizational and institutional framework comprising organs and structures (i) guidance and decisions, (ii) coordination and monitoring, (iii) execution, (iv) consultation and technical support.

The National Committee for the Fight against HIV / AIDS is the strategic steering, deliberation and supervision body for actions falling within the framework of the fight against HIV / AIDS. It is attached to the Presidency of the Republic.

The National Committee against HIV / AIDS (CNLS) is responsible for:

- Defining the political and strategic orientation of the fight against HIV / AIDS at the national level; Validate
- national reference documents in the fight against HIV / AIDS; Supervise the evaluation of the fight against
- HIV / AIDS;
- Validate the measures proposed with a view to improving the national response to the AIDS pandemic; Validate the reports drawn up
- within the framework of the fight against HIV / AIDS;
- Support the advocacy actions required for the approval of the strategies to be implemented and the search for all the corresponding means;
- Deliberate on all questions submitted to it for approval.

3.8.2 Device

The executing bodies are the directorates / departments of the ministries, health units, educational establishments, civil society organizations, businesses and civil society organizations, non-governmental organizations. These bodies are responsible for the implementation of AIDS programs and projects in the field.

3.8.3 Actors and partners

The United Nations Theme Group on HIV / AIDS brings together United Nations Agencies and other partners (UNAIDS, UNDP, WHO, UNICEF, UNFPA, World Bank, UNESCO, FAO, WFP, UNHCR, Global Fund).

This group is extended to the government represented by the Executive Secretariat of the National Committee to Fight AIDS and to other bilateral partners.

The United Nations Thematic Group for the fight against HIV / AIDS is the instrument of choice for advocacy, resource mobilization and proposes effective coordination of the interventions of all donors and development partners in of fight against HIV / AIDS.

3.9 Monitoring and evaluation of the implementation of the 2018-2022 NSP

The 2018 - 2022 PSN is supported by a National Monitoring and Evaluation Plan for the same period. Developed during several workshops with all stakeholders, following an analysis that highlighted the strengths, weaknesses, opportunities and threats in this essential area, it is based on the 12 components of monitoring and evaluation. It displays all monitoring and evaluation guidelines and describes the PSN monitoring indicators as well as the information circuit.

In addition, it reports on the research agenda with particular emphasis on strengthening the capacity of national actors in monitoring and evaluation.

3.10 Budgetary framework

3.10.1 Estimated budget

Table 12 : Breakdown of the 2018-2022 PSN budget

IMPACT	2018	2019	2020	2021	2022	TOTAL (in USD)	Percentage
IMPACT 1: The number of new HIV infections is reduced by at least 75% (from 29,000 to 7,250) in the key populations most exposed to the risks of HIV infection, among young people aged 10 to 24 and the general population by the end of 2022	15,988,504	16,445,409	17 106 063	17 720 720	18 267 006	85 527 702	66%
IMPACT 2: The proportion of newborns infected with HIV born to HIV-positive mothers and those of newborns with congenital Syphilis are reduced to less than 5% by the end of 2022	2,868,278	1,540,172	3,330,143	2,022,864	3,905,558	13,667,015	11%
IMPACT 3: Mortality due to AIDS is reduced from 4.4 deaths in 2018 to 1.5 deaths per 100,000 inhabitants	2,041,209	2,181,497	3,026,480	3,387,873	4,118,039	14,755,098	11%
Program management	4,455,441	3,529,238	2,635,073	2,903,435	2,550,682	16,073,869	12%
GENERAL TOTAL	**25 355 450**	**23,698,334**	**26,099,778**	**26,036,913**	**28 843 307**	**130 023 683**	**100%**

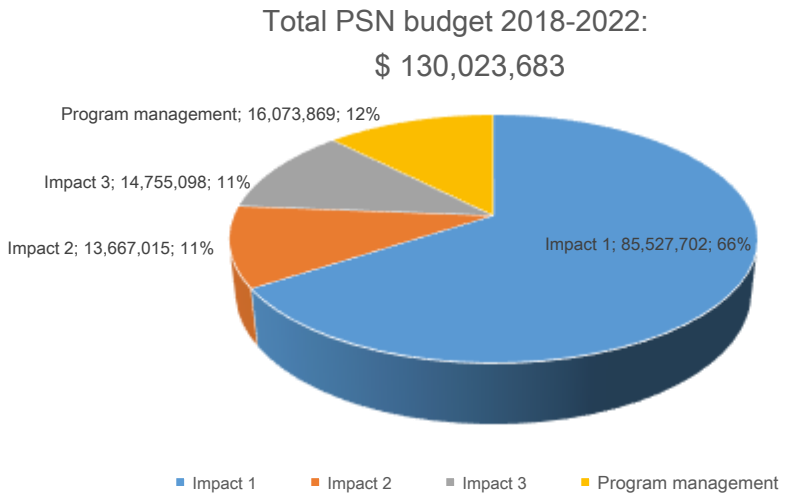


Figure 23: Distribution of the 2018-2022 PSN budget

3.10.2 Estimated budget by outcome and product result

Table 13 : Breakdown of the 2018-2022 PSN detailed budget

Impact / Effect / Product	COSTS (USD) 2018	2019	2020	2021	2022	TOTAL (USD)
IMPACT 1: The number of new HIV infections is reduced by at least 75% (from 29,000 to 7,250) in the key populations most exposed to the risks of HIV infection, among young people aged 10 to 24 and the general population by the end of 2022	**15,988,504**	**16,445,409**	**17 106 063**	**17 720 720**	**18 267 006**	**85 527 702**
Outcome 1.1: The risks of sexual transmission of HIV are reduced by at least 75% among PCPERs, by the end of 2022.	8,200,432	8,236,914	8,378,127	8,414,722	8 556 193	41,786,388
Product 1.1.1.1: 112,136 MSM receive full CCC packages by 2022	84 847	88,980	93 280	97,754	102,459	467,319
Product 1.1.2.1: 9,860 CDIs, 812,276 PSs receive full CCC packages by 2022	8,300	8,417	8,486	8,555	8,624	42,382
Product 1.1.3.1: 812,276 PS receive full CCC packages by 2022	8,027,898	8 112 362	8,196,974	8,281,258	8 365 722	40 984 215
Product 1.1.4.1: 194,437 HIV-related calls handled by the 511 hotline by 2022	15,357	15,357	15,357	15,357	15,357	76,786
Product 1.1.5.1: 400 cases of victims of sexual violence receiving HIV PEP	64,030	11,798	64,030	11,798	64,030	215,685
Outcome 1.2: 80% of young people aged 10 to 24 have the skills, knowledge and ability to protect themselves from STIs / HIV by the end of 2022	3,033,649	3,114,478	3,197,493	3,256,548	3,315,374	15,917,543
Product 1.2.1.1: 3,094,371 school-aged and out-of-school youth aged 10 to 24, particularly girls and young PCPERs, are covered by STI / HIV information and education services by 2022	2,598,089	2,667,158	2,738,096	2,788,578	2,838,832	13,630,753
Product 1.2.1.2: At least 90% or 2,784,934 the most vulnerable young people are screened and know their status by 2022	435,560	447,320	459,397	467,970	476,543	2,286,790

Outcome 1.3: 80% of adults aged 25 to 49 have the skills, knowledge and ability to protect themselves from STIs / HIV by the end of 2022	4,497,666	4,827,588	5,254,817	5,764,529	6 101 120	26,445,720
Product 1.3.1.1: 117 companies and 21 ministries implement the AIDS policy in the workplace	353,775	331,460	365,058	475,792	408,050	1,934,135
Product 1.3.1.2: 1,579,379 adults in the informal sector are covered by the CCC STI / HIV service package by 2022	982,231	1,031,138	1,082,730	1,136,970	1,193,728	5,426,796
Product 1.3.1.3: 157,938 adults in the informal sector, particularly women, are screened for STIs / HIV by 2022	23,470	24,644	25,876	27 170	28,528	129,687
Product 1.3.1.4: 58,019 detainees receive full CCC packages by 2022	34 983	36,545	38,499	40,474	42,341	192 843
Product 1.3.1.5: 126,425,449 male condoms and 252,861 female condoms distributed or sold	2,083,134	2,324,443	2,594,969	2,865,495	3,136,021	13 004 061
Product 1.3.1.6: 883,134 people took their HIV test and withdrew their results (not including pregnant women)	563,772	598,699	640,855	683,011	725,167	3,211,505
Product 1.3.1.7: 1,422,444 STI cases screened and treated using the national syndromic approach	237,920	261,712	287,883	316 672	348,339	1,452,526
Product 1.3.1.8: 1,491,496 people in the general population sensitized	218,379	218,947	218,947	218,947	218,947	1,094,168
Effect 1.4: Effect 1.4: The risks of blood transmission of HIV are reduced by at least 75% (from 0.27% to 0.06%) by the end of 2022	93 001	95 137	97,366	99,694	102,124	487,322
Product 1.4.1.1: 168,163 blood bags secured with the four communicable disease markers distributed	37,419	39,290	41,255	43,318	45,483	206,766
Product 1.4.2.1: 9,860 CDIs receive sterile injection equipment in quantities suited to their needs	25,582	25,846	26,111	26,376	26,641	130,556
Product 1.4.3.1: 150 cases of exposure to HIV in healthcare settings benefit from PEP for HIV	30,000	30,000	30,000	30,000	30,000	150,000
Outcome 1.5: Gender inequality, all forms of violence against women and girls and discrimination against people living with HIV and key populations are reduced by 50% by 2022	163,756	171,292	178,260	185,227	192 195	890,730
Product 1.5.1.1: 90,000 people sensitized on gender-based violence against women and girls	156,712	157,280	157,280	157,280	157,280	785,831

Product 1.5.2.1: 10 key sectors integrating awareness raising on the specific topic of discrimination and stigmatization against people living with HIV and key populations	7,044	14,012	20,980	27,947	34,915	104,898
IMPACT 2: The proportion of newborns infected with HIV born to HIV-positive mothers and those of newborns with congenital Syphilis are reduced to less than 5% by the end of 2022	**2,868,278**	**1,540,172**	**3,330,143**	**2,022,864**	**3,905,558**	**13,667,015**
Outcome 2.1: At least 80% of pregnant women living with HIV benefit from the package of services aimed at reducing mother-to-child transmission of HIV by the end of 2022.	2,586,704	1,194,028	2,916,009	1,537,928	3,328,769	11,563,439
Product 2.1.1.1: 3,959,184 women of childbearing age are covered by information on HIV and PMTCT.	1,758,156	395,303	1,779,222	416 509	1,813,996	6,163,186
Product 2.1.1.2: 768,559 pregnant women perform voluntary screening during the ANC and withdraw their results.	405,176	499,338	598,291	701 501	835 120	3,039,425
Product 2.1.2.1: 1,537 HIV-positive pregnant women receiving ARVs to reduce the transmission of HIV to their children.	288,407	133,464	340,023	187,498	403,323	1,352,715
Product 2.1.2.2: 1,537 children born to mothers living with HIV receive ARVs.	108,296	133,464	159,912	187,498	223,212	812,380
Product 2.1.3.1: 1,537 children born to mothers living with HIV benefit from early diagnosis of HIV infection and cotrimoxazole prophylaxis.	24,469	30,156	36,132	42 365	50,435	183,558
Product 2.1.4.1: 2,152 women living with HIV receive family planning counseling and contraceptives to prevent unintended pregnancies	2,200	2,303	2,430	2,557	2,684	12,175
Outcome 2.2: At least 95% of pregnant women have received prenatal screening for syphilis and have had adequate treatment	281,574	346,144	414,133	484,936	576,789	2,103,576
Product 2.2.1.1: 2,797,176 pregnant women screen for syphilis during PNC1.	271,553	334,662	400,981	470,154	559,707	2,037,057
Product 2.2.2.1: 2,797,176 pregnant women screen for syphilis during PNC1.	2,752	2,524	2,419	2,198	2,101	11 994
Product 2.2.3.1: 16,783 pregnant women living with syphilis receive at least one dose of Benzathine Penicillin to reduce mother-to-child transmission before the 4th month	1,371	1,690	2,024	2,374	2,826	10,285
Product 2.2.4.1: 71,275 pregnant syphilis positive women treated with three doses of Benzathine penicillin	5,898	7,268	8,708	10,211	12,156	44,240

IMPACT 3: Mortality due to AIDS is reduced from 4.4 deaths in 2018 to 1.5 deaths per 100,000 inhabitants	**2,041,209**	**2,181,497**	**3,026,480**	**3,387,873**	**4,118,039**	**14,755,098**
Outcome 3.1: At least 80% of adults and children living with HIV receive ARVs as part of comprehensive medical and psychosocial care by 2022	828,778	953,976	1,207,117	1,561,824	1,701,673	6,253,368
Product 3.1.1.1: 10,594 adults living with HIV receive ARVs	796,323	919,293	1,169,785	1,521,739	1,657,740	6,064,879
Product 3.1.1.2: 134 children living with HIV receive ARVs	15,465	15,828	16,554	17,426	19,386	84,660
Product 3.1.2.1: 8,809 HIV-positive adults and children still on treatment 12 months after starting antiretroviral therapy during the study period (PM 3.1.1.1)	0	0	0	0	0	0
Product 3.1.3.1: 169 HIV-Tuberculosis co-infected patients receive both ARVs and anti-tuberculosis treatment	16,990	18,855	20,777	22,659	24,547	103,828
Outcome 3.2: At least 80% of adults and children screened for HIV positive on ARVs have an undetectable viral load by 2022	856 340	774,796	1,274,811	1,193,765	1,694,898	5,794,610
Product 3.2.1.1: 12,194 adults and children living with HIV have an undetectable viral load	856 340	774,796	1,274,811	1,193,765	1,694,898	5,794,610
Outcome 3.3: At least 80% of OVC with AIDS and their parents living with HIV benefit from basic social services by the end of 2022	356,092	452,725	544,552	632,285	721,468	2,707,121
Product 3.3.1.1: 6,775 adults and children living with HIV benefit from the psychological, social and legal support service package.	179,939	254,349	328,439	402 848	480 771	1,646,346
Product 3.3.1.2: 5,099 children orphaned by AIDS and their parents living with HIV live in a household that will have received support to ensure their access to basic social services	176 152	198,375	216 114	229,436	240,697	1,060,774
Program management	**4,455,441**	**3,529,238**	**2,635,073**	**2,903,435**	**2,550,682**	**16,073,869**
Training	225,625	225,625	225,625	225,625	225,625	1,128,124
Studies and research, Monitoring-Evaluation	2,164,408	1,241,068	346,903	615,266	262,512	4,630,157
Coordination and meetings	76,074	73,211	73,211	73,211	73,211	368,917
Supervision	488,500	488,500	488,500	488,500	488,500	2,442,499
Operation	1,344,786	1,344,786	1,344,786	1,344,786	1,344,786	6,723,930
Audit and technical assistance of the program	156,048	156,048	156,048	156,048	156,048	780,242
GENERAL TOTAL						**130 023 683**

3.10.3 Gap analysis

Compared to the total needs estimated at 130 023 683 US dollars (USD) for the period 2018-2022, the following table presents the distribution of resources already available by source of funding with the funding gap that remains to be filled. The funding gap of 97,086,196.87 USD corresponds to a proportion of 74.67% of the budget necessary for the implementation of the NSP.

Table 14 : Distribution of resources available for financing the 2018-2022 NHP by source of financing.

Funding sources	2018	2019	2020	2021	2022	TOTAL
Malagasy government	$ 2,574,600.12	$ 4,164,007.46	$ 3,971,210.69	$ 3,569,939.43	$ 3,569,939.43	**$ 17,849,697.13**
SE / CNLS Global Fund	$ 1,702,485.00	$ 3,023,714.00	$ 2,888,904.00			**$ 7,615,103.00**
PSI / M Global Fund	$ 1,864,406.00	$ 2,823,558.00	$ 1,633,722.00			**$ 6,321,686.00**
USAID	$ 51,000.00					**$ 51,000.00**
SNU / UBRAF	$ 220,000.00	$ 220,000.00	$ 220,000.00	$ 220,000.00	$ 220,000.00	**$ 1,100,000.00**
TOTAL	**$ 6,412,491.12**	**$ 10,231,279.46**	**$ 8,713,836.69**	**$ 3,789,939.43**	**$ 3,789,939.43**	**$ 32,937,486.13**

3.11 Risk analysis and management

3.11.1 Risk management strategies

The results of the implementation of the 2013 - 2017 NSP lead to the establishment of a risk management mechanism that will allow better implementation of this NSP.

Table 15 : Risk management measures

Risks identified	Preventive mitigation measures	Observations
Prevention area		
Low targeting of interventions	Issue intervention guidelines for key populations, taking into account the packages to be delivered Involve NGOs, CBOs and key populations in the development of guidelines and the implementation of interventions	-
Prevention of mother-to-child transmission of HIV		
Poor coverage of HIV-positive pregnant women	Set up a device so that CSB managers can withdraw the care kit for pregnant women with HIV at the level of the Referral Doctor	-
Processing area		
Persistence and increased loss of follow-up	- Take orders for the delegation of prescribing power to paramedics under the responsibility of the Referral Doctor - Strengthening the skills of paramedics in the management of patients with ARVs	-
Difficulty supply of HIV inputs (frequent interruption of ARVs, laboratory reagents and consumables)	- Boost the HIV input supply plan; - Improve the management of input stocks in health facilities.	-
Area of coordination and resource mobilization		
Insufficient leadership	- Strengthen the coordination capacities of SECNLS and of structures decentralized (departmental and municipal)	-

Insufficient mobilization of national and international partners	- Develop a resource mobilization plan - Hold the sectoral round table of donors; - Monitor compliance with commitments.	-
Monitoring and evaluation and strategic information		
Low quality and data availability	- Build the capacities of actors at different levels; - Validate data at different levels and set up the need for good data completeness and promptness; - Regularly supervise and audit the quality of the data produced and transmitted.	Ensure that monitoring and evaluation has a budget of around 10% of the total budget
Weak culture of monitoring and evaluation	- Make stakeholders aware of the importance of monitoring and evaluation and include it in performance contracts.	-

3.12 Conditions for success

The few conditions listed below are essential for the successful implementation of this National Strategic Plan:

- effective involvement of the country's highest political and administrative authorities;
- strong “leadership” in the national coordination of the multisectoral response;
- synergy and good collaboration from all sectors;
- compliance with the commitments of national stakeholders, authorities and officials, as well as technical and financial partners;
- good governance in the multisectoral response to STIs, HIV and AIDS at all different levels;
- effective integration of the STI, HIV and AIDS component in all national development projects and programs in all sectors of activity;
- flawless accountability at all levels and in all sectors involved in the response;
- mobilization of sufficient resources.

ADDENDUM

The global objectives “90–90–90” constitute the cornerstone for assessing the efforts made to move towards the end of the epidemic of aids in 2030.[28] Ending the HIV and AIDS epidemic requires uninterrupted access to lifelong treatment for tens of millions of people, which requires taking into account the situation of the key populations that are driving the epidemic, building strong and flexible community and health systems; protecting and promoting human rights; and sustainable funding mechanisms capable of supporting lifelong treatment programs for PLHIV. To accelerate the response to AIDS with a view to eliminating the disease in 2030, UNAIDS has defined a strategy in 10 targets for the period 2016-2021 which aligns with the Sustainable Development Goals 3, 5, 10 , 16 and 17. This strategy aims to achieve three essential objectives:

i) the "90 - 90 - 90" targets, ii) the reduction of new infections to less than 500,000 and iii) the elimination of all forms of discrimination by 2020[29].

Madagascar is a country having a epidemic concentrated on the basis of existing data, with a response made up of interventions more targeted to key populations and a performance linked to several political constraints, economic, geographic and socio-cultural. Performance history for the different programs during the implementation of the 2013-2017 NSP objectified results can be improved
compared to forecast. The linear analysis of the system performance history requires setting targets by taking into account the evolution of performance observed from year to year. But being part of the regional and international context which invites to draw up ambitious normative documents, the National Strategic Plan multisectoral response to STIs, HIV and AIDS 2018-2022 sets reasonable objectives with the development of innovative strategies and a consequent mobilization of resources to improve the performance of the system. To do this, the objectives and targets set in the PSN 2018-2022

for the indicators keys linked to impacts 2 and 3 have been reviewed more ambitiously, considering that all the necessary conditions are correctly fulfilled . So, are recommended for recital ion,
the data presented in the table below:

Impact / Effect / Product	Indicators	Basic data	Year	Source	2018	2019	2020	2021	2022
IMPACT 2: The proportion of newborns infected with HIV born to HIV-positive mothers and those of newborns with congenital Syphilis are reduced to less than 5% by the end of 2022									
Outcome 2.1: At least 80% of pregnant women living with HIV benefit from the package of services aimed at reducing mother-to-child transmission of HIV by the end 2022.	Percentage of pregnant women who know their HIV status	23%	2016	RMA	32.4%	38.8%	45.3%	51.7%	59.9%
	Percentage of pregnant women living with HIV who have received antiretroviral drugs to reduce the risk of mother-to-child transmission (MTCT)	7.0%	2016	RMA	23.6%	40.2%	56.8%	73.4%	90.0%
IMPACT 3: Mortality due to AIDS is reduced from 4.4 deaths in 2018 to 1.5 deaths in 2022 per 100,000 inhabitants									
Effect 3.1: At least 50% of adults and children living with	Percentage of adults and children receiving	7%	2016	RMA	17.6%	28.2%	38.8%	49.4%	60.0%

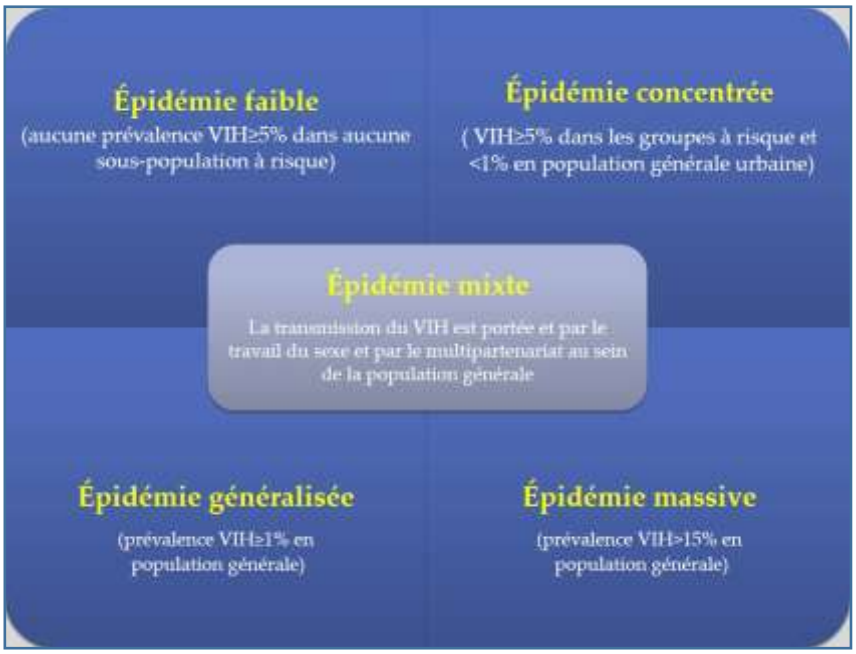
[28] UNAIDS. 90-90-90 An ambitious treatment target to help end the AIDS epidemic.
[29] UNAIDS. Strategy 2016 - 2021: Accelerate the response to end the AIDS epidemic.

HIV receive ARV as part of a comprehensive medical care, quality psychosocial by 2022	antiretroviral therapy among all adults and children living with HIV at the end of the reporting period								
	Percentage of adults and children living with known HIV for to follow a antiretroviral therapy 12 months after starting	86.1%	2016	RMA	90.0%	93.0%	95.0%	98.0%	98.0%
Outcome 3.2: At least 50% of adults and children screened for HIV positive on ARVs have an undetectable viral load by 2022	Percentage of people living with HIV whose viral load has been suppressed at the end of the reference period	1.2%	2016	RMA	11.0%	20.7%	30.5%	40.2%	50.0%

Doctor ANDRIANIAINA Harivelo Rijasoa

Executive Secretary of the National AIDS Control Committee

Annex 1: Types of epidemics of HIV infection and AIDS



Annex 2: Summary of the stages of the evaluation of the 2013-2017 NHP and the development of the 2018-2022 NHP.

# steps	Date / period	Activities	Deliverables obtained
1	07-Aug-17	Document review	List of documents consulted
2	18-Aug-17	Establishment of the GT-PSN and thematic working groups	Group RDT
3	18-Aug-17	Definition of the work methodology	micro plans
4	from August 18, 2017	Consultation of key players and partners	Field visit reports with suggestions and recommendations
5	from August 18, 2017	Analysis of the national response situation	Draft national response analysis report
6	August 21 to 23, 2017	Tool testing by teams in Antananarivo and Miarinarivo	Mission report and tools finalized
7	September 5 to 8, 2017	Analysis of the regional response at the level of the 22 Regions with the organization of mini-workshops and implementation of a coaching system	Response analysis reports by the 22 Regions
8	September 6 to 9, 2017	National evaluation workshop of the NHP 2013-2017	Workshop report on the analysis of the final evaluation of the PSN 2013-2017
9	September 19 to 22, 2017	National workshop to develop the 2018-2022 NHP results framework	Report of the framework development workshop results
10	26-Sep-17	Results framework finalization meeting	Results Framework Draft
11	September 26 and 27, 2017	National workshop for the development of the 2018-2022 Monitoring and Evaluation Plan	Defined indicators and targets
12	from December 4 to 18, 2017	Development of the 2018-2022 PSN budget	2018-2022 PSN Budget Draft
13	December 4 to 18, 2017	Finalization of the drafts of the evaluation reports and of the 2018-2022 PSN	Improved draft of the final review report of the PSN 2013-2017 and draft of the 2018-2022 PSN
14	from 4 to 18 December 2017	Finalization of the drafts of the PSN 2013-2017 final review report, from results framework, 2018-2022 NSP and 2018-2022 PES	Improved document drafts
15	20-Dec-17	Presentation of drafts to members of the partner forum	Comments and suggestions from stakeholders and partners
16	between January to March 2018	Finalization of the drafting (with consideration of member comments)	Improved Drafts
17	23-March-18	Draft documents incorporating comments and budget	Drafts finalized incorporating comments and suggestions from members of the partner forum as well as the budget
18	April to June 2018	Review, proofreading and final drafting of the 2018-2022 PSN and PSE	Finalized version of the 2018-2022 PSN and PSE
19	Jul-18	Formatting of documents and finalization of prefaces, acknowledgments and appendices	Version including the preface, acknowledgments and appendices
20	August-18	Submission to the members of the Reading Committee	Version incorporating comments from members of Reading committee
21	sept-18	Distribution of the finalized version of the 2018-2022 PSN and PSE	PSN and PSE 2018-2022 shared to all parties stakeholders, actors and general population

Annex 3: List of consultants who supported the development of the 2018-2022 NSP

Last name and first names	Expertise	Country
AHOUSSINOU Clément	Monitoring Evaluation and Research	Benign
CONRAD TONOUKOUEN	Prevention of Mother-to-Child Transmission of HIV	Benign
ISSA COULIBALY Malick	Programming	Ivory Coast
RAKOTOBE Andriamihantanoro	Monitoring and evaluation	Madagascar
RANDRIAMANALINA Benja	Financial analysis and budgeting	Madagascar
RATSIMBAZAFY Liva Tiana	Budgeting	Madagascar

Annex 3: List of participants in the development of the 2018-2022 NSP

Last name and first names	Function	Entity
Session: Information meeting and validation of the PSN 2013-2017 evaluation methodology and development of the 2018-2022 PSN		
Place: Meeting room of the Ministry of Economy and Planning Anosy - March 14, 2017		
RANDRIANASOLO H. Pearl	Monitoring and Evaluation Manager SE ONG	AINGA AIDES
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RATEFIHARIMANANA Andosoa	Coordinator	Aid and Care for the Sick
MARIE Isabelle	President	NGO network MAD AIDS
RAZAFIMBAHINY Jaonosy	Coordinator	SERASERA Fanantenana-Line 511 Association
RANDRIAMANATENA Vololona	President	OMASAVE
RANDRIANANTENAINA Hanta	AND / Spros /	DEP / Ministry of Public Health
RAKOTOARISON Herinirina	CGP / DND	
RANDRIANARY Jean Marie	DND	
ANDRIANOMENJANAHARY Josoa	Assistant	SG / Ministry of Public Health
RAFAMANTANANTSOA A. Hasina	RCSNA	National Office of Nutrition
RAHAMEFY Bodomalala	SCRI	Ministry of Finance and Budget
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RAVOMANANA Vincent	General secretary	Analamanga region
ANDRIANARISOA Lalanirina	DDPIA	Ministry of Public Service of Administrative Labor Reform and Social Laws
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RAKOTOMANANTSOA Andrianaivo	MSP	Ministry of Public Security
RABEANDALANA Sandrot	Human Resources Director	Ministry of Education
RAKOTOARINIVO Ando	SMS	Ministry of Education
RABEMAHERY Fiobiana	DDPIA	Ministry of Public Service of Administrative Labor Reform and Social Laws
RASOANIRINA Francia	ACSR	Population Services International Madagascar
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RABEMANANTSOA Jocelyn	Internal Control Manager	Executive Secretariat of the National AIDS Control Committee
RAZAFIMBAHINY Andriamandranto	Head of Coordination Unit at Technical Support	Executive Secretariat of the National AIDS Control Committee
Session: Establishment of the Technical Group "National Strategic Plan 3G- 2018-2022"		
Venue: Meeting room B203 of the SE / CNLS - August 18, 2017		
RAMAROZATOVO Rado Nandrasana	Treasurer	Solidarity Association of MSM
RAFARALAHY Jonas White	Doctor	Presidency of the Republic
RANDRIAMANANTANY Zely Arivelo Director of Transfusion Center	Red chalk	Minister of Public Health
HERINOROTIANA Lalaonirina	IT	NGO MAD'AIDS Network
RAHARISON Volahanta	HIV Advocacy Manager	Doctor of the World
ANDRIAMAHENINA Hery Zo	Technician	Doctor of the World
AGNONA René	Head of Service HIV / AIDS Unit	Ministry of Population, Social Protection and the Promotion of Women
ANDRIANJAFY Vola	Head of Studies and Documentation Service	CICLD
ROBIARIVONY Josiane	Coordinator	CECM
RAKOTONIRINA Emmanuel	President	Serasera Fanantenana Association
RAHATANIARIVO Noro	Host	SISAL
RABARY Onja	Adolescent and Youth Program Officer, and HIV	UNFPA
RAKOTOSEHENO Noro	National Youth Program Coordinator	Ministry of Youth and Sports
ANDRIANJATOVO Andriamiarizo	SEP / DLIS	Minister of Public Health
RABARIJAONA Voahangy Oliva	Project manager	DRSP Analamanga
REJERISON Irene	HIV Focal Point	OSTIE
RANDRIAMANALISOA I, Holiseheno	School Health Project Manager	Ministry of National Education
RARIVOHARILALA Esther	Technical Coordinator	AFSA
RASOANAIVO Balou	MSM Solidarity President	FIMIZORE
RABEMANANA André	Executive Secretary	National coordination body - CCM
RAOELISON Tantely	HIV Program Officer	PSI
RAVELOSON Clarimond	HIV Program Officer	UNAIDS
ANDRIANIAINA Harivelo	Executive Secretary	National AIDS Control Committee

ANDRIANOELINA Miaro Zo	Project Manager	SE / CNLS
RAKOTOMALALA Fara	Monitoring and Evaluation Assistant	SE / CNLS
Session: PSN Assessment 2013-2017		
Location: CHRD Itaosy meeting room - August 24, 2017		
HERINOROTIANA Lalaonirina	IT	OGN MAD AIDS Network
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RASOAMANONTANY Jeritiana Bakoly Midwife Referent		CHRD-Itaosy
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HAJASOA Sylvie Michelle	Referent Social Assistant	Minister of Public Health
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RAZAFINDRAMARY Gisèle	GIS Manager	Minister of Public Health
Location: BMH Isotry meeting room - August 24, 2017		
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Marie isabelle	President	NGO network MAD AIDS
FIRINGA Johnson	Executive director	NGO network MAD AIDS
RABOELINA Mamivololona	Focal point	Analamanga region
HERINOROTIANA Lalaonirina	IT	NGO network MAD AIDS
Session: PSN Technical Group Meeting		
Venue: SE / CNLS meeting room - September 05, 2017		
TIANKAVANA Maxime	Assistant	Solidarity of MSM
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RAFARALAHY Jonas White	Doctor	Presidency of the Republic
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REJERISON Irene	Focal point	OSTIE
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RAZAFINDRAVAO Germaine	President	FIVEMITO
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COULIBALY Malick	International Consultant	UNAIDS
RAKOTOMALALA Aina Tantely	Director of Humanization of Prisons	Ministry of Justice
Session: Evaluation and validation of the National Strategic Plan 3G- 2018-2022		
Location: ESPACE DERA - September 6 to 08, 2017		
RANDRIAMANDROSO Henri Paul	HIV Focal Point	Haute Matsiatra Region
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RAVAONOROLALA Voahangy	HIV Focal Point	Itasy region
RATSARALAHY Arlette	HIV Focal Point	Atsimo Atsinanana Region
RAKOTONIRINA Lalasoa	HIV Focal Point	Analanjirofo region
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VOLAZANDRY Priscilla	HIV Focal Point	Diana region
RATIARAY Viviane	HIV Focal Point	Menabe region
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Elisabeth MONCHAUSSE	HIV Focal Point	Atsimo Andrefana Region
RANDRIAMAHEFA Naina	HIV Focal Point	Vatovavy Fitovinany region
HASSMANY Maholida	HIV Focal Point	Melaky region

RABOELINA Mamivololona	HIV Focal Point	Analamanga region
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RAHANTA HARISOA Bako	HIV Focal Point	Alaotra Mangoro Region
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RASOJIVOLA Emile	HIV Focal Point	Boeny region
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RAKOTOMANGA Aina	Technical Assistant	ASM Befelatanana
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RARIVOHARILALA Esther	Technical Coordinator	AFSA
RAVELOSON Aurore	CSRJ Manager	FISA Madagascar
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RAZAFINDRAVAO Germaine	President	FIVEMITO
ANDRIAMALALA Fenohasina	Representative	NGO Madagascar SAVE
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RANOROMBOLATIANA Dina	CUSE	SE / CNLS
DE MONGE François	Coordinator	MDM
RAKOTOMALALA Fara	Monitoring and Evaluation Assistant	SE / CNLS
RAKOTONIAINA Faniry		SE / CNLS
Session: Development workshop of the National Strategic Plan 3G- 2018-2022		
Location: ESPACE DERA - September 19 to 22, 2017		
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RAKOTONIRINA Lalasoa	HIV / AIDS Focal Point	Analanjirofo region
RAKOTOMANGA Yves Marie	HIV / AIDS Focal Point	Vakinakaratra region
RAKOTONDRAMIARINA Henitsoa	HIV / AIDS Focal Point	Bongolava region
RATIARAY Viviane	HIV / AIDS Focal Point	Menabe region
RAMANARIVO Lucien	HIV / AIDS Focal Point	Ihorombe region
FELACK Christian	HIV / AIDS Focal Point	Atsinanana region
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RATEFINANAHARY Mamy	HIV / AIDS Focal Point	Sava region
RAHANTAHARISOA Bako	HIV / AIDS Focal Point	Alaotra Mangoro Region
RASOLOFOARIMANANA Benjamina	HIV / AIDS Focal Point	Anosy region
RASOJIVOLA Jean Emile	HIV / AIDS Focal Point	Boeny region
RABOELINA Mamivololona	HIV / AIDS Focal Point	Analamanga region
Elisabethe Monchaussé	HIV / AIDS Focal Point	Atsimo Andrefana Region
VOLAZANDRY Priscilla	HIV / AIDS Focal Point	Diana region
TSARALAHY Arlette	HIV / AIDS Focal Point	Atsimo Atsinanana Region
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TONOUKOUEN Conrad	Consultant	SE / CNLS
RAKOTOJAONA Hajanirina	IT specialist	Executive Secretariat of the National AIDS Control Committee
RAZAKARIVONY Bruno	Storekeeper	Executive Secretariat of the National AIDS Control Committee
ANDRIANOELINA Miaro Zo	Project Manager	Executive Secretariat of the National AIDS Control Committee
RAZANAMAHEFA Feno	Administrative Assistant	Executive Secretariat of the National AIDS Control Committee
RAZAFINDRABE Herman	Warehouseman	Executive Secretariat of the National AIDS Control Committee
ANDRIANIAINA Harivelo	Executive Secretary	Executive Secretariat of the National AIDS Control Committee
ANDRIANJAFIMAHENINA Djeda	Assistant RH Manager	Executive Secretariat of the National AIDS Control Committee
RAVELOSON Clarimond	HIV Program Officer	UNAIDS
RASOLOARISON Ony	Program Officer	UNDP
RAKOTOMAVO Mamy	Technician	SALFA
RAKOTOMANGA Aina	Technician	Aid and Care for the Sick
TIANKAVANA Maxime	Member	Solidarity of MSM
RAZAFIMANINTSONY Léa	National Coordinator	Afriyan Madagascar
RAHARISON Volahanta	Advocacy Manager	MDM
RANDRIAMANELINA Janie	President	AFSA
RAKOTONIRINA Emmanuel	President	Fifafi Analamanga
RARIVOHARILALA Esther	Technical Coordinator	AFSA
BEATO SIRVENT Béatrice	General Coordinator	MDM
DE MONGE François	HIV coordinator	MDM
RAZAFIMBAHINY Jaonosy	Coordinator	SERASERA Fanantenana Association
RAVELOHANTA Mananarisoa	Coordinator	AINGA AIDS
RAHANTANIERIVO Noro	IEC Manager	NGO Sisal
RANDRIANA Zoé	IEC Technical Manager	ECAR
HERINOROTIANA Lalaonirina	IT	NGO MAD AIDS Network

RANAIVOLOLONA Isabelle	PEPS	AFSA
TANAMASOANDRO ANDRIAMIALISOA	President	ASSOFRAMA
RANDRIANASOLO Jean Bruno	Vice President	ASSOFRAMA
MASINJAKA Seheno Denisa Aimée	PEPS	AFSA
RAKOTOARISOA Mialy Nirina Valisoa	Technician	TGT Tanà
ANDRIATSIRIMBOHITRA Lova Koloina	Technician	TGT Tanà
REJERISON Irene	Focal point	OSTIE
RAKOTONJANAHARY Nirinambinintsoa	Technician	OSTIE
RAZAFIARISOA Jeannine	Vertical Programs Coordinator	Central Purchasing - SALAMA
RAVELOSON Aurore	CRS Manager	FISA Madagascar
ROBIARIVONY Josiane	Technical Coordinator	CECM

Annex 4: List of participants in the 2018-2022 PSN validation workshop

#	Last name and first names	Function	Organization
1	AGNONA René	Technician	MPPSPEPF
2	ANDRIAMAHERILALA Jean Aimé	Pair Educator	AMBATOVY project
3	ANDRIAMALALA Fenohasina	Member	NGO Madagascar SAVE (OMASAVE)
4	ANDRIAMOSE Lisiariso Vero	Technician	Komitim-Pirenena Miady amin'ny Sida at FJKM (KPMS / FJKM)
5	ANDRIANARIVO Rado	SCLS / SG Technician	Minister of Public Health
6	ANDRIANIAINA Harivelo	Executive Secretary	Executive Secretariat of the National AIDS Control Committee
7	ANDRIANIRINA Lovasoa Mbolamanana	SPIS / DLIS Chef	Minister of Public Health
8	ANDRIANJAFIMAHENINA Djeda	Assistant in charge of RH Management Executive Secretariat of the National Committee	of Fight against AIDS
9	ANDRIANJATOVO Andriamiarizo	DLIS Database Manager	Minister of Public Health
10	ANDRIATIANA Minosoa Ny Aina	Technician	AIRTEL Company
11	BERNACH Hanta	SAAES-DAT	MID
12	BOURRASSEAU Anthony	Consultant	Expertise France
13	DE MONGE François	HIV coordinator	Doctors of the World
14	Elisabeth TURK	Technician	KPMS / FJKM
15	FITIARIVONY Roberto	IT Maintenance Assistant	Executive Secretariat of the National AIDS Control Committee
16	HAMA Dimby	General secretary	Interministerial Coordination Committee for the Fight against Drugs
17	HARIJAONA Henintsoa	Technical assistant	Directorate of Blood Transfusion
18	HARIMANANA Aina	Technician	Pasteur Institute of Madagascar
19	HARRY ZO Jessica	Assistant	NGO MAD AIDS Network
20	INWOLEY André	Consultant	Expertise France
21	JUDE PADAYACHY	Country Director	UNAIDS
22	Justin Vuthanael	Technician	AMBATOVY project
23	LEMANARINA Armand	DPSR / MEP	Ministry of Economy and Planning
24	MAHAVANY Nicole	Director / PLMT	Minister of Public Health
25	MANANTSOA Yves	DND / DCSSM	Department of Defense
26	MARIE isabelle	President	NGO MAD AIDS Network
27	MOSA Milasoa	Director of STI and AIDS Control	Minister of Public Health
28	RABEARISOLO Andréa	Management Assistant	Executive Secretariat of the National AIDS Control Committee
29	RABEMANANTSOA Jocelyn	Internal Control Manager	Executive Secretariat of the National AIDS Control Committee
30	RABENOELINA Noro	Technician	AIRTEL Company
31	RAFARAHANTA Vony	SCST	MFPRTLS
32	RAFARALAHY Jonas White	Doctor	Presidency of the Republic
33	RAFENOHARISOA Brigitte	Technical Assistant to the DVSSE	Minister of Public Health

34	RAHANTAVELONANTENAINA	President	NGO Madagascar SAVE (OMASAVE)
35	RAHARIMBOAHANGY Volatiana	DSFA technician	Minister of Public Health
36	RAHARISON Volahanta	Advocacy Manager	Doctors of the World
37	RAHARIZO Miarimbola	Technical Assistant to the SG	Minister of Public Health
38	RAHERIARISOA Gilbert	Warehouseman	Executive Secretariat of the National AIDS Control Committee
39	RAHERIMAMPIONONA Hanitra	SCPSST	MFPRATLS
40	REJERISON Irene	HIV focal point	OSTIE
41	RAJOELINA Aro	Director of Health Districts	Minister of Public Health
42	RAKOTOARISOA Arthur	Monitoring and evaluation	Association of Samaritan Women (AFSA)
43	RAKOTOBE Liva	Technical Manager	Executive Secretariat of the National AIDS Control Committee
44	RAKOTOJAONA Hajanirina	IT specialist	Executive Secretariat of the National AIDS Control Committee
45	RAKOTOMAHEFA Zo Ary Lalaina	Technician	FIMIZORE
46	RAKOTOMALALA FARA	Monitoring and evaluation assistant	Executive Secretariat of the National AIDS Control Committee
47	RAKOTOMANAMISATA Naritiana Technician		Interministerial Coordination Committee for the Fight against Drugs
48	RAKOTONDRABE Nandonavalona	Procurement and Logistics Manager	Executive Secretariat of the National AIDS Control Committee
49	RAKOTONIRINA Emmanuel	President	FIFAFI Analamanga
50	RAKOTONIRINA Nomenjanahary	Assistant in Procurement and Logistics	Executive Secretariat of the National AIDS Control Committee
51	RAKOTONOMENJANAHARY Mbola	Technician	TELMA Foundation
52	RAKOTOSOA Herivola	Project Manager	Executive Secretariat of the National AIDS Control Committee
53	RAKOTOSON Clairant	Head SSEPDS / DEP	Ministry of Public Service of Administrative Labor Reform and Social Laws
54	RAKOTOVAO Cyril	DLMNT Technical Assistant	Minister of Public Health
55	RAMAHAVONJY Jimmy Cellin	RH Program Director	PSI Madagascar
56	RAMAHEFARISON Danielle Anselme	Technician	Ministry of Education
57	RAMAROZAKA Corinne	Study manager	Ministry of Finance and Budget
58	RAMASY Rado	Technical Assistant to the SG	Minister of Public Health
59	RANDRIAMANALINA Benja	Consultant	Executive Secretariat of the National AIDS Control Committee
60	RANDRIAMANANTENA Vololona	President	NGO Madagascar SAVE (OMASAVE)
61	RANDRIAMIANDRISOA Edelin	President	National Coordination Body
62	RANDRIAMIHAMINA Mamitiana	General secretary	ORANGE company
63	RANDRIAMILAHATRA Emma	Head of Department for Performance Monitoring at the DLIS	Minister of Public Health
64	RANDRIANARILANTONIRINA	Head of Epidemiological Surveillance at the DLIS	Minister of Public Health
65	RANDRIATSARA Haja	Head of Department of PEC at DLIS	Minister of Public Health
66	RASAMIMANANA Nivo Nirina	National Coordinator	SALFA
67	RASOAHARILALA NIRINA	National Coordinator	Voahary Salama

68	RASOANAIVO Balou	President	FIMIZORE
69	RASOANARIVO Jasminah	Technical Manager	Executive Secretariat of the National AIDS Control Committee
70	RASOARIMALALANARIVO Frank	Chief of Blood Safety	Directorate of Blood Transfusion
71	RASOLOFOZAFY Hanitriniaina	DGEHU Technical Assistant	Minister of Public Health
72	RASOLONJATOVO Ny Toky	Technical Manager	Association Aid and Care for Sick Befelatanana
73	RATEFIHARIMANANA Ando	President	Association Aid and Care for Sick Befelatanana
74	RATOVONDRAHONA Christian	Technical Manager	NGO Sambatra Izay Salama (SISAL)
75	RATSIFANDRIAMANANA Lanto	School manager	CHU Mental Health Anjamasina
76	RAVAOHARIMALALA Nadia	Database Manager	Ministry of Youth and Sports
77	RAVELOJOELIANDRIAMBELO Haritafika A	OFNALAT Director	Minister of Public Health
78	RAVELONIRINA Anne Marie Ange	STI, HIV and AIDS Manager	Analamanga region
79	RAVELOSON Aurore	Technician	FISA Madagascar
80	RAVELOSON Clarimond	Program Officer	UNAIDS
81	RAVOAVISON René	Technician	KPMS / FJKM
82	RAZAFILALAINA Hyacinthe	Technician	Minister of Public Health
83	RAZAFIMANANTSOA Tiana	Program Officer	UNICEF
84	RAZAFIMANDIMBY Andriamandranto	Head of Coordination and Technical Support Unit	Executive Secretariat of the National AIDS Control Committee
85	RAZAFINDRABE Herman	Warehouseman	Executive Secretariat of the National AIDS Control Committee
86	RAZAFINDRADAMA Masy	Technician	ECAR / CES
87	RAZAFINDRAKOTO Vio	Technician	TELMA Foundation
88	RAZAFINISOA Nombana	Program Officer	International Labor Office
89	RAZAFINJATOVO Zohasina	Technician	UNDP
90	RAZAFITSIAROVANA	Monitoring and Evaluation Manager	National Office of Nutrition
91	RAZANAMAHEFA Feno	Administrative and Financial Assistant	Executive Secretariat of the National AIDS Control Committee
92	RAZANAMANANA Edwige	DLMT Technician	Minister of Public Health
93	ROBINSON Liva	Technician	ORANGE company
94	WINIFRED FITZGERALD	External Relations, Sustainability Division	AMBATOVY project
95	RANOROMBOLATIANA Dina	Head of Monitoring and Evaluation Unit	Executive Secretariat of the National AIDS Control Committee

Annex 4: 2018-2022 PSN reading committee members

Last name and first names	Function	Entity
RATSIMBASOA Arsène	General secretary	Minister of Public Health
RAMIHANTANIARIVO Herlyne	General manager	Minister of Public Health
PADAYACHY Jude	Country Director	UNAIDS
DEZE Charlotte	Global Health Advisor	French Embassy
RAZAFINDRAFITO Hajarijaona	Health Systems Strengthening Senior Advisor	USAID Madagascar
RIBAIRA Yvette	Chief of Party / Technical Director	MAHEFA MIARAKA / USAID
NKURUNZIZA Emery	Deputy Resident Representative	PSI Madagascar
MARIE Isabelle	President	MAD'AIDS network