GLOBAL AIDS RESPONSE PROGRESS REPORT

2014

NATIONAL AIDS SECRETARIAT

PRIME MINISTER'S OFFICE

MARCH 2014

ACRONYMS AND ABBREVIATIONS

Acronyms and Abbreviations	
ADSU	Anti-Drug and Smuggling Unit
AHC	Area Health Centre
AIDS	Acquired Immuno Deficiency Syndrome
AF	Action Familiale
ANC	Ante Natal Care
ART	Antiretroviral Treatment
ARV	Antiretroviral (anti-HIV drug)
BCC	Behaviour Change Communication
CAC	Collectif Arc en Ciel
CBO	Community Based Organization
CD4	Cluster Difference 4
CHC	Community Health Centre
CHL	Central Health Laboratory
COR	Council of Religions
CSW	Commercial Sex Worker
CYC	Correctional Youth Center
FBO	Faith Based Organization
FGD	Focus Group Discussion
FSW	Female Sex Worker
GF	Global Fund
GFATM 8	Global Fund to Fight AIDS, Tuberculosis and Malaria Round 8
HCT(HTC)	HIV counselling and testing
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
JAR	Joint Annual Review
IEC	Information Education Communication
IBBS	Integrated Behavioural and Biological Surveillance Survey

Acronyms and Abbreviations	
KABP	Knowledge Attitude Behaviour and Practice
KAP	Key Affected Populations
MARP	Most At Risk Population
M&E	Monitoring and Evaluation
MEF	Mauritius Employers Federation
MFPWA	Mauritius Family Planning and Welfare Association
MIE	Mauritius Institute of Education
MOGE	Ministry of Gender Equality
MOH&QL	Ministry of Health and Quality of Life
MOL	Ministry of Labour
MSM	Men having Sex with Men
MST	Methadone Substitution Therapy
MTR	Mid Term Review
MYS	Ministry of Youth & Sports
NAC	National AIDS Committee
NAS	National AIDS Secretariat
NASA	National AIDS Spending Assessment
NATReSA	National Agency for the Treatment & Rehabilitation of Substance Abusers
NDCCI	National Day Care Centre for Immuno-suppressed
NEP	Needle Exchange Programme
NGO	Non Governmental Organization
NMSTC	National Methadone Substitution Treatment Centre
NSC	National Steering Committee
NSF	National Strategic Framework
NWC	National Women's Council
PBB	Project Based Budgeting
PCR	Polymerase Chain Reaction
PI	Prison Inmates

Acronyms and Abbreviations	
PILS	Prevention Information et Lutte contre le SIDA
PLHIV	People Living With HIV & AIDS
PMO	Prime Minister's Office
PMTCT	Prevention of Mother to Child Transmission
PWID	People Who Inject Drugs
RAU	Rodrigues AIDS Unit
RRA	Rodrigues Regional Assembly
RYC	Rehabilitation Youth Center
SADC	South African Development Community
SDP	Service Delivery Points
SLO	State Law Office
SOP	Standard Operating Procedures
SRH	Sexual & Reproductive Health
STI	Sexually Transmitted Infection
TB	Tuberculosis
TOR	Terms Of Reference
TWG	Technical Working Group
UNAIDS	Joint United Programme on HIV & AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
VCT	Voluntary Counselling & Testing (for HIV)
WHO	World Health Organization

FOREWORD

The Republic of Mauritius is signatory to the 2011 Political Declaration on HIV/AIDS and is striving to meet the Millenium Development Goals. The 2014 Global AIDS Response Progress Report provides valuable information on the status of the country's programmatic achievements towards respecting these solemn commitments.

The methodology adopted in the compilation of this Report was consultative and highly participatory. The writing team solicited contribution from key partners, namely, Civil Society Organisations, the public sector, the Private Sector, the United Nations and People Living with HIV.

Respondents included policy makers and programme managers of various national and international agencies. Following data collection, stakeholders were invited to register on-line in order to view data entered on the system.

The findings of this report highlight the fact that, although the country has made significant progress in a number of areas, namely PMTCT coverage and Harm Reduction among Key Populations, as well as data collection, analysis, and its use to monitor and evaluate programmes, we still need to make progress to improve our performance at each step of the HIV treatment cascade, starting from HIV testing, through enrolment and retention in care, right up to achievement of viral load suppression.

A major lesson learnt during the GARPR preparation is the importance of maintaining a strong M&E system in order to track progress made in the implementation of HIV programmes. There is therefore need to continuously strengthen the M&E system in the country, at every service-delivery point, as well as at programme management level.

It is hoped that policy makers and program managers will refer to this report so as to improve programme implementation and achieve the desired impacts of the programme, namely, reduced HIV transmission, reduced morbidity and mortality and reduced stigma and discrimination.

I want to thank everyone from Government Ministries, Civil Society and UN organizations who provided valuable input during the compilation of the report. All participants who attended the Validation Workshop are greatly acknowledged for their valuable input into the process.

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Prime Minister's Office
Mauritius

AKNOWLEDGEMENT

This 2014 Global AIDS Response Progress Report was prepared by the National AIDS Secretariat with the support of all our partners involved in the fight against HIV and AIDS.

This report is based on contribution made by all key stakeholders involved in the national Response. Data were provided by the MOH&QL, departments such as the AIDS Unit, National Day Care centres for the immunosuppressed, Harm Reduction Unit, MSM and CSW programmes, National TB programme and Central Health Laboratory and the Health Statistics Office. Lines ministries, namely Ministry of Education and Research, Youth and Sports, Social Security, Labour and Industrial Relation, Gender and Family Development and the NGOS/Civil Society/Private Sector have also made valuable contribution.

Technical and managerial support was granted throughout the reporting process by the National AIDS Coordinator, Dr Mrs A.Pathack.

Data was compiled, consolidated and analysed and reported by the following team:

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SECTION 1: STATUS AT A GLANCE

A. THE INCLUSIVENESS OF ALL STAKEHOLDERS IN THE REPORT WRITING

The report writing process commenced with the formation of the Global AIDS Response Program Reporting Steering Committee by the National AIDS Secretariat in February 2012. This steering committee was tasked with supporting the compilation of the country report and ensuring submission to meet the deadline of the 31st March 2014. The M&E team and the programme officer of the NAS were responsible for data collection, analysis, planning and report writing.

Stakeholders from Government and civil society organisations contributed to this report by providing data and reviewing the report till its finalization. The whole process was monitored by the steering committee. The NAS team worked with the GARPR guidelines for the construction of core indicators to define specific data needs. Where necessary, additional data was sourced from Line Ministries, Civil Society organisations, private sector players and other key members of the civil society.

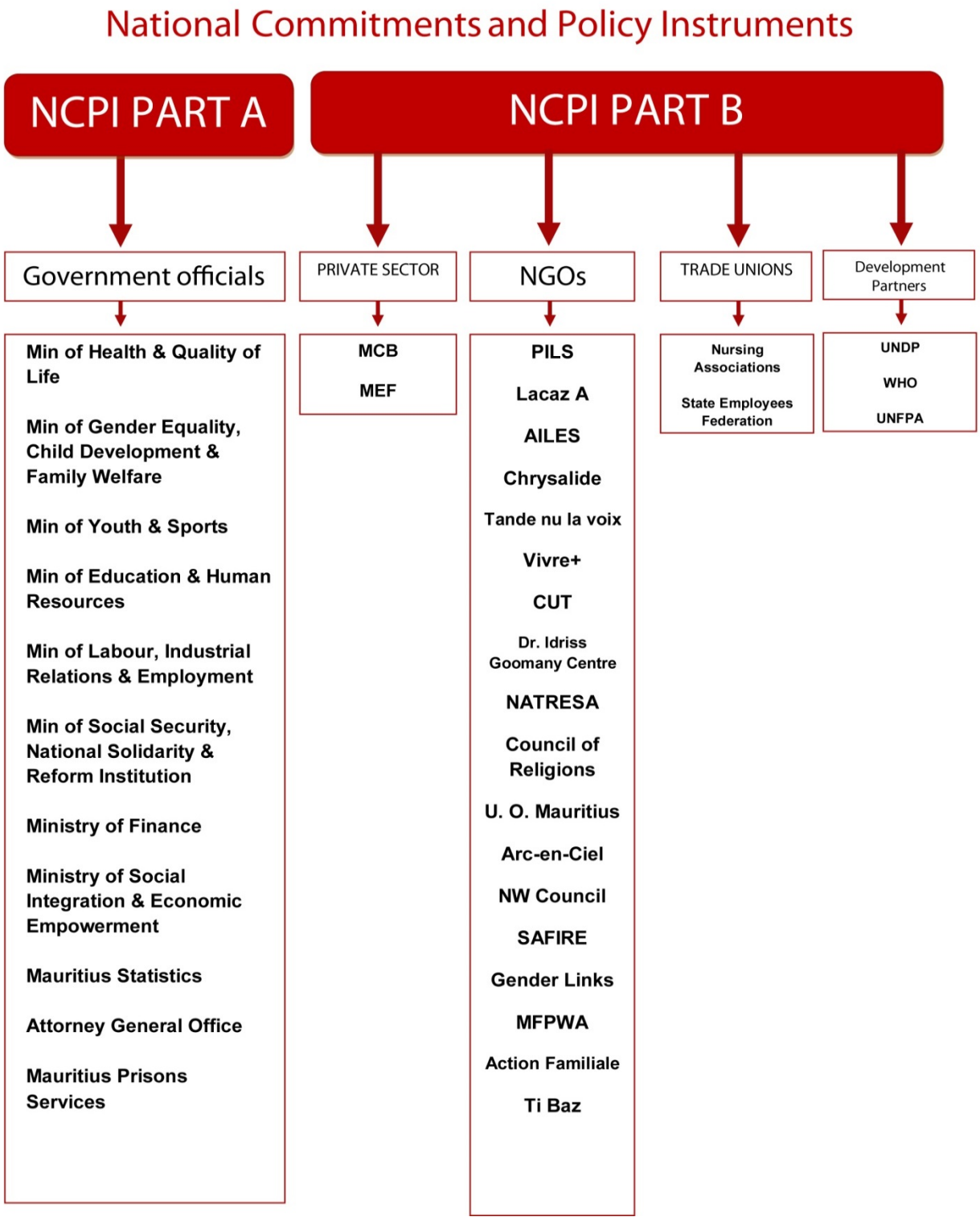
The NCPI questionnaire was circulated in the first week of February among stakeholders contributing to the response to HIV, to enable them to prepare responses.

Part A of the NCPI questionnaire was completed by NAS, Ministry of Health and Quality of Life and all line ministries involved in the fight against HIV. Part B was administered to representatives of civil society, CBOs, FBOs, bilateral partners and Private Sectors. Responses to the questionnaires were collated and agreement obtained on unified responses to NCPI questions at the Validation workshop.

The compilation of the report started with a desk review of background documents on the HIV epidemic and response the Republic of Mauritius. Documents reviewed included the following:

- Strategic documents: National HIV and AIDS Strategic Framework (NSF) 2013-2016.
- Programmatic Reports: Quarterly PUDR (Programme Update and Disbursement Request)
- Integrated Biological and Behavioural Surveys among Key populations (PWID, CSW and MSM)
- Modes of HIV Transmission Report 2013
- Universal Access Report 2012
- Stigma Index Report 2013.
- HIV estimates 2013

The final version of the report was shared among all stakeholders through mail, comments were incorporated and final validated report was submitted to the Prime Minister's Office prior to submission to UNAIDS.

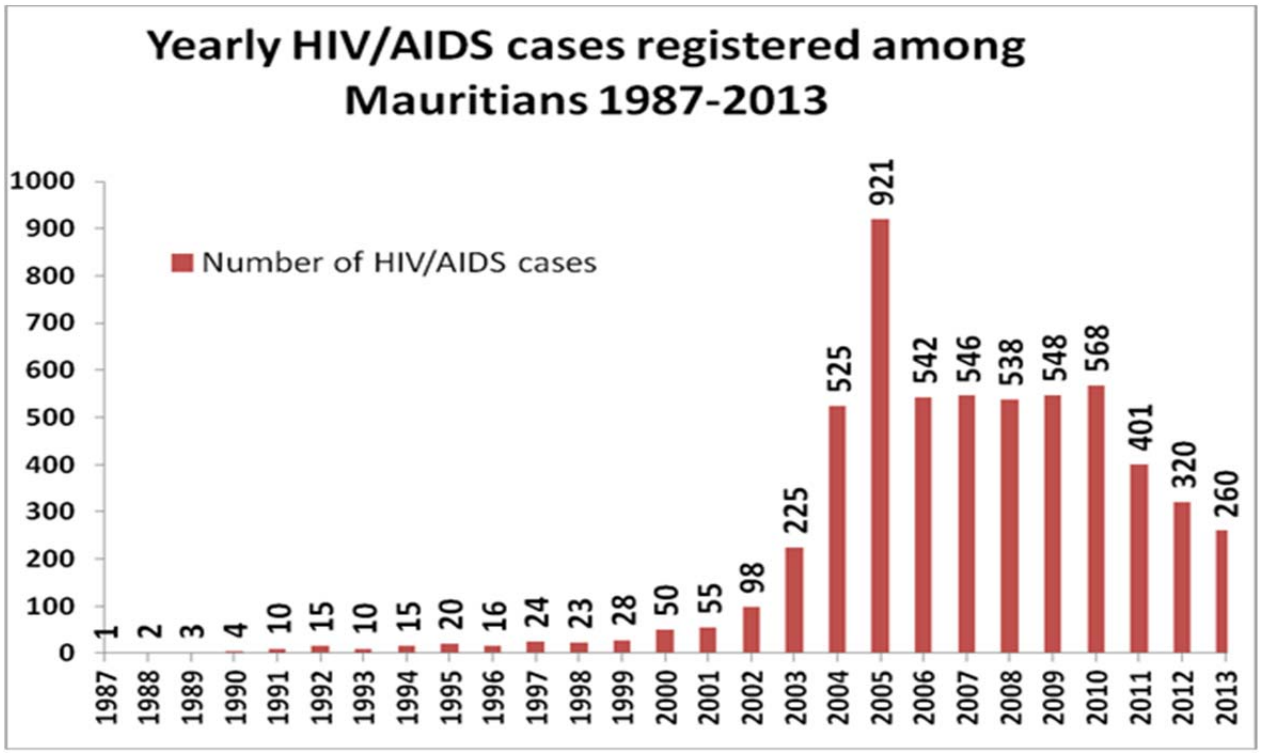


B. STATUS OF THE EPIDEMIC

For the twenty-six years period since 1987 when the first case of AIDS was reported in Mauritius till December 2013, there is a total number of 5,678 detected cases. In the year 2000, only 2% of the newly detected cases were due to Intravenous Drug Use and this percentage gradually increased to 92% in 2005 (National HIV Surveillance). Following the introduction of Harm Reduction strategies in 2006, namely the Needle Exchange Programme and the Methadone Substitution Therapy, transmission among PWID has decreased to 68.1% in 2011, 47.2% in 2012 and 38.1% in 2013.

In the year 2005, a peak in the number of cases was observed with 921 cases registered mainly among Prison Inmates. Subsequently the yearly number of cases has decreased from 401 cases in 2011 to 320 in 2012 and 260 in 2013 bringing the number of monthly detected cases from 46 in the year 2006 to 2010 to 33 in 2011, 27 in 2012 and 20 in 2013(National HIV Surveillance).

Fig 1: Yearly HIV and AIDS registered cases.



Source: National HIV Surveillance

Although the PWID contribute to the spread of HIV and the epidemic in Mauritius is of a concentrated nature, heterosexual transmission, sexual transmission among MSM and FSW remains a possible key driver as there is this low personal risk perception among the population in general. Other key drivers may include multiple partners, stigma and discrimination and poverty in certain areas.

C. POLICY AND PROGRAMMATIC RESPONSE

Mauritius being a small country with a population estimated at 1,259,838 million as at December 2013. HIV and AIDS remains a threat to the development of the country. The Republic of Mauritius has enacted a number of laws and policies to guide the multi-sectoral response to HIV and AIDS. The policies have been well articulated and draw on a number of documents including the following:

- **The National HIV and AIDS policy 2010** was developed by the NAS for the control of AIDS. This policy document provides regulations and guiding principles on topics ranging from prevention of new infections and behavior change, treatment, care and support for infected and affected persons, advocacy, legal issues and human rights, monitoring and evaluation, research and knowledge management and policy implementation by various stakeholders in the national response.

HIV and AIDS is a dynamic and rapidly-changing field, about which new knowledge is constantly emerging. This policy will therefore be under regular review for its applicability and effectiveness in the light of the most recent information, as well as responses.

It is expected that the National Policy will evolve over time with new scientific knowledge, information and experience gained under the leadership of the National AIDS Secretariat. Changes in our societal attitudes and behaviours will also be critical. The policies and guidelines will therefore be revised periodically to ensure that they reflect needs and changes in societal behaviour and culture. The National AIDS Secretariat will ensure that changes are made following broad consultation with the nation**.**

- **Gender and Sexuality**

It is important to understand the linkages between gender, sexuality and HIV and AIDS. Constructions of gender reflect culture, community and self-image, affecting women, men and transgendered people. Sexuality also plays a role in describing the experiences of people living with, or at risk of HIV and AIDS. The role of sexuality and sexual orientation is an important aspect of how HIV and AIDS is experienced and conceptualized.

Gender equality is one of the guiding principles of our strategic framework and it is translated by regular consultation with the Ministry of Gender equality, National Women Council, LGBTI NGOs.

In the Mid Term Review of the NSF 2006-2011, one of the priorites identified for 2013-2016 is a Gender equality based approach in the area of access to medical care and patient follow-up for male and female prison inmates

- **Institutional Barriers and Socio-Cultural Dimensions**

Effective coordination and institutional management is at the centre of an effective national response to the epidemic. The National AIDS was set up under the Prime Minister's Office in 2007 to highlight the high level commitment of Government to fight the HIV and AIDS epidemic.

Civil society responses play a significant role in strengthening the multi-sectoral response to HIV and AIDS.

As such no research /study on Institutional Barriers and Socio-cultural dimensions have been undertaken in Mauritius to guide our response. However IBBS study among the KAPs (15-49 yrs) and Knowledge Attitude Behaviour and Practices study among the population aged 12-49 years old has highlighted the main socio-cultural issues that may impact on the spread of HIV epidemic in Mauritius. These are:

- Age at first intercourse
- Early sexual debut
- Multiple partners
- Commercial Sex work
- Clients of CSW
- IDUs and partners of IDUs
- Sharing of injecting equipment during illicit drug use
- Low utilization of condoms
- Stigma and discrimination
- Gender issues

- **HIV Testing, Prevention and Support**

HIV Testing

An average of 83,000 tests are being carried out annually, half of which are among blood donors while 20% are among pregnant women. The rest comprises of testing low risk group such as patients undergoing cardiac surgery and renal dialysis, migrant workers, KAPs. VCT accounts for very few at the rate of 1000 per annum.

The shift towards provider-initiated HCT comes as one of the measures to reach members of the community as well as KAP.

The imperative of expanding the number of clients counseled and tested for HIV comes as a result of the constant fear of the diffusion of the epidemic from the KAP towards the general population. 5,768 people have been detected out of an estimated 8,000 -10,000 HIV infected people. Some 4,000 have been registered at the National Day Care Centres and the Prisons while around 3000 are being regularly followed up. Furthermore, 50% of those initiated on ARVs each year are being diagnosed at the AIDS Stage.

Under these circumstances, a vast campaign to increase testing capacities has been identified as a top priority and a National HIV counseling and testing Strategy in Mauritius 2011-2012 has been elaborated outlining the following objectives:

1. To expand access to HCT beyond formal health-care settings into community, private sector and non-health care environments

2. To reach and diagnose a maximum of people living with HIV at an early stage of HIV infection so as to ensure appropriate referral to treatment.

A training module has been designed and submitted to the Ministry of Health and Quality of life to train NGO's members on HIV Rapid Testing so as to increase community testing.

- **Stigma and Discrimination**

AIDS-related stigma is not static. Levels of stigma are hard to measure as it changes over time as infection levels, knowledge of the disease and treatment availability vary. Self-stigma and fear of a negative community reaction can hinder efforts to address the AIDS epidemic by perpetuating the wall of silence and shame surrounding the epidemic.

In the Mid Term Review of the NSF 2007-2011 carried out in 2010, one of the priorites identified was to " Improve the quality of life of PLWHA, address stigma and discrimination and create an enabling environment for HIV prevention", taken on board in the NSF 2013-2016. To reinforce this strategy, Institutional mechanism and human rights aspects are also taken into

consideration to mitigate the worst effects of stigma and discrimination. The Stigma Index Survey carried out in 2013 has helped collecting evidence –based data for advocacy and the development of appropriate strategies to eliminate Stigma and discrimination.

Human Rights :

As an active member of the Human Rights Council, Mauritius is recognized for its strong commitment to the promotion and protection of human rights and rule of law at all levels.

The HIV and AIDS Act which was passed in December 2006, established legal provision for the observance of a rights- based approach to HIV and related issues, in particular to protect PLWHA from stigma and discrimination. The Act clearly stipulates that any negative attitude towards people infected and affected with HIV is punishable by law.

This ACT also sets out unequivocal provision for the introduction of harm reduction strategies including Needle Exchange programme and Methadone Substitution therapy.

As highlighted above, the National Response is a multisectoral one where the GIPA concept is fully applied. PLWHA and service users are being regularly consulted for policy and strategy development through Focus Group Discussion.

Equal opportunities ACT : The new legislation adopted in December 2008and reviewed in 2012 prohibits any form of discrimination, directly or indirectly. It is meant to ensure that every Mauritian gets equal opportunities to achieve his goals in every field. He is thus protected from being wronged because of his age, ethnic origin, colour, race, physical state, caste, marital status, political opinions, belongings or sexual orientation

Two structures have been set up - an Equal Opportunities Division and an Equal Opportunities Tribunal. The first is to deal with the elimination of discrimination and the promotion of equality of opportunity and good relations between persons of different status, while the second will hear complaints referred to it, issue interim orders and determine whether the complaint is justified.

Programmatic Response

The most effective prevention programs are those that use a combination of strategies to achieve maximum impact. The National response of the Republic of Mauritius comprises of:

- Behavioural Change Programme for different target group
- Condom promotion and distribution

- HIV testing
- Prompt diagnosis and treatment of other STIs
- Antiretroviral therapy and regular review of protocols.
- Prevention of Mother to child transmission
- Post-exposure Prophylaxis for Health Care Workers; Rape Victims.
- Harm Reduction programme
- Blood supply safety
- Infection Control In Health Care Setting
- Management of Co-infection (TB, Hepatitis B&C)

The Republic of Mauritius being a welfare state, all services provided are free at user end.

❖ **Support**

The Government of Mauritius has a high level of commitment towards improving treatment, care and support for people living with HIV/AIDS. Economic and psychosocial support include:

- Economic aid for PLWHA who are not able to work.
- Transport refund for those who attend the National Day Centres for treatment and follow-up
- Milk substitution for babies born to HIV positive mothers
- Psychological support provided in collaboration with NGOs
- Treatment literacy to improve adherence.

D. INDICATOR DATA IN AN OVERVIEW TABLE

TARGET/INDICATOR		2011	2012	2013
Target 1 : Reduce sexual transmission of HIV by 50% by 2015 ***General population***				
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	38.3% (KABP 2011)		

1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	3.0 % (15-24) 4.2% (15-49) KABP 2011		
	TARGET/INDICATOR	**2010 / 2011**	**2012**	**2013**
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	3.0 % (15-24) 4.2% (15-49) KABP 2011		
1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	85.7% (15-24) 55.9% (15-490 KABP 2011		
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	6.9% (15- 49) KABP 2011		
1.6	Percentage of young people aged 15-24 who are living with HIV	0.3% ANC Data	0.72% ANC Data	0.78% ANC Data
Sex workers				
1.7	Percentage of sex workers reached with HIV prevention programmes	77.6% IBBS FSW 2010	80.5% IBBS FSW 2012	
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	88% IBBS FSW 2010	86% IBBS FSW 2012	
1.9	Percentage of sex workers who have received an HIV test in the past	69.2% IBBS FSW 2010	67.8% IBBS FSW 2012	
1.10	Percentage of sex workers who are living with HIV	28.9% IBBS FSW 2010	22.3% IBBS FSW 2012	
Men who have sex with men				
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	43.6% IBBS MSM 2010	85.6% IBBS MSM 2012	
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	52.9% IBBS MSM 2010	50.9% IBBS MSM 2012	
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	89 % IBBS MSM 2010	94.1% IBBS MSM 2012	
1.14	Percentage of men who have sex with men who are living with HIV	8.1% IBBS MSM 2010	20% IBBS MSM 2012	
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015				

2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	30 IBBS PWID 2011		44 IBBS PWID 2013
	TARGET/INDICATOR	**2011**	**2012**	**2013**
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	25% IBBS PWID 2011		38.2% IBBS PWID 2013
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	89.2% IBBS PWID 2011		83.8% IBBS PWID 2013
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	80.1% IBBS PWID 2011		25.2% IBBS PWID 2013
2.5	Percentage of people who inject drugs who are living with HIV	51.6% IBBS PWID 2011		44.3% IBBS PWID 2013
Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths				
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission		96.0% PMTCT Registers	95.8% PMTCT Registers
3.1 a	Percentage of women living with HIV receiving antiretroviral medicines for themselves or their infants during breastfeeding	NA	NA	NA*
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth			32% (PMTCT Registers)
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months			2.9 % Spectrum 2013
Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015				
4.1	Percentage of adults and children currently receiving antiretroviral Therapy			19.2% ART registers

	TARGET/INDICATOR	2011	2012	2013
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy			79.5% ART Registers
Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015				
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV			100% National TB Programme
Target 6 :Close the global AIDS resource gap by 2015 and reach annual global investment of US$ 22 − 24 billion in low- and middle-income countries				
6.1	Domestic and international AIDS spending by categories and financing Sources	NASA 2011	NASA 2012	
Target 7: Eliminating gender inequalities				
7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months *All indicators with sex-disaggregated data can be used to measure progress towards target 7*			See Narrative
Target 8 :Eliminating stigma and discrimination				
8.1	Discriminatory attitudes towards people living with HIV	36.3% KABP 2011		
Target 9:Eliminate travel restrictions				
9.1	*Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed*			
Target 10:Strengthening HIV integration				
10.1	Current school attendance among orphans and non-orphans aged 10–14			See Narrative
10.2	Proportion of the poorest households who received external economic support in the last 3 months			See Narrative
Policy questions (relevant for all 10 targets)				
	National Commitments and Policy Instruments (NCPI			Attached

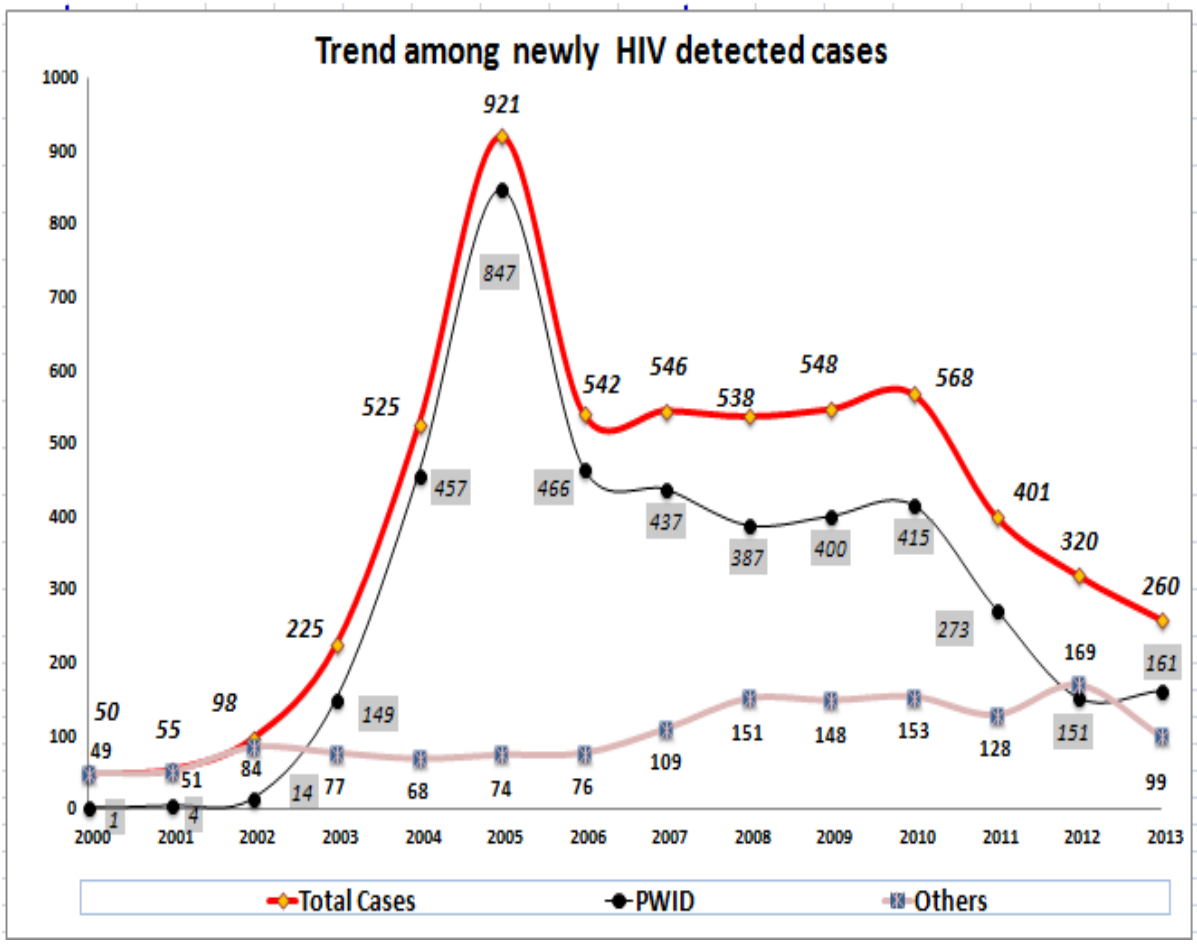
NA= Not applicable

SECTION 2: OVERVIEW OF THE AIDS EPIDEMIC

In 2013 the prevalence of HIV among adults of 15 years and above in Mauritius was 1.02% with an estimated number of 10,000 People Living with HIV and AIDS. As of December 2013, a total of 5,768 cases of HIV and AIDS had been detected cumulatively, out of which 1241 (21.5%) are females, and there remains approximately 5000 or so undetected cases. Approximately 726 deaths due to HIV and AIDS have been reported since 1987. The HIV epidemic is concentrated in Port Louis, the capital of Mauritius, and the regions with higher prevalence figures lie in the north and north-east regions of the country.

The epidemic was IDU driven with 92% detected cases among PWID in 2005 but fortunately this has been reduced to 38.1% in 2013.

Figure 2: Number of PWID among new detected cases.



Source: National HIV Surveillance

New Infections by Modes of transmission

In 2013, Mauritius used the "Modes of Transmission" model (MoT) to estimate the number of new infections that are likely to occur, and in which population group. The model is a mathematical tool that was developed by UNAIDS to help countries estimate the proportion of new HIV infections that will occur over the coming year through key transmission modes using basic epidemiological and behavioral data as input. According to the output generated by the model, the total number of new infections was estimated to be 1,042. 44% of new infections would occur in PWID, 36% in MSM, 75 in clients of SW, 6% in partners of IDU and 3% in stable heterosexuals.

HIV prevalence among the Key populations

People Who Inject Drugs (PWID)

Based on a population size estimation exercise, the estimated size of the PWID population in Mauritius was about 10,000, which is about 0.7% of the island's population of 1.3 million (IBBS 2011). The PWID population had the highest prevalence of HIV of 50.3% in 2013. Most of the PWID were between 20-49 years old, which is also the prime working age. Only 7% of PWID in 2011 were female; 93% of those surveyed were male. Only 1.8% of PWID were under 19 years, and over 20% were over 50 years. Despite this, 45% of PWID reported first starting injecting drug use under the age of 20. 77.4% of PWID live in Port Louis. The interventions to reduce HIV among People Who Inject Drugs also cater for different population types including prison inmates and commercial sex workers who can also be injecting drug users.

Female Sex Workers (FSWs)

Female sex workers have the second highest prevalence of HIV currently following PWIDs, at 26.3% (IBBS FSW 2012). Sex workers operate in varied settings including massage parlours, discotheques, and escort services and via the internet. There is not much data on male sex workers (IBBS FSW 2012). The median age of SW in 2012 was 31, and the age range was 16-63 years. The number of SWs between 15-19 years represents 8% of the population, which is two times higher than in 2010. 61.3% of the sample surveyed reported completing primary education or less. The maximum number of SWs reported living in Port Louis (37.3%), but as Figure 3 illustrates, all 9 districts of Mauritius have SWs. The median age for sexual intercourse with any

partner is 15 years and that for commercial sex is 19 years. 80% of those surveyed reported to have used condoms during their last sexual encounter with any sex partner (IBBS FSW 2012).

Men who have Sex with Men (MSM)

Men who have sex with men (MSM) had an HIV prevalence of 15.6% in the most recent survey (IBBS, 2012). 31.5% of the MSM surveyed reported residing in Port Louis, the capital and region of highest HIV prevalence in Mauritius, and a close 30.5% reported residing in Plaines Wilhems.

Over 85% of MSM reported living with someone. 75% of MSM earned income through employment, and a small percentage of 2.6% earned their income through selling sex. 54% of those surveyed reported having vaginal sex with a female, with 47.4% doing so in the last 6 months. Approximately 33.3% of MSM reported having sex with a man from another country, suggesting that cross-border spread of HIV is a threat. Only about half of those surveyed reported to have used a condom. 11.5% reported using injection drugs, among whom 28.7% reported sharing needles. (IBBS MSM 2012)

Prison Inmates

The Mauritius Prisons Service comprises 6 Prisons for males, 2 female prisons and one correctional institution for the 16-18 age groups. With a turnover of more than 6000 prison inmates annually, an average of 2600 detainees are incarcerated at any point in time, out of whom approximately 750 are HIV infected. A high proportion of inmates are already HIV infected at entry - 13.5% of entrants were positive in 2013, mainly due to the fact that many inmates were PWID. Many of these prisoners were convicted for drug-related crimes. The prisons remain the main point of detection of HIV cases especially among PWIDs until last year- (35.5% of all new HIV cases in 2008 were detected in prison, 40% in 2009 and 23.4% in 2012).

People Living With HIV

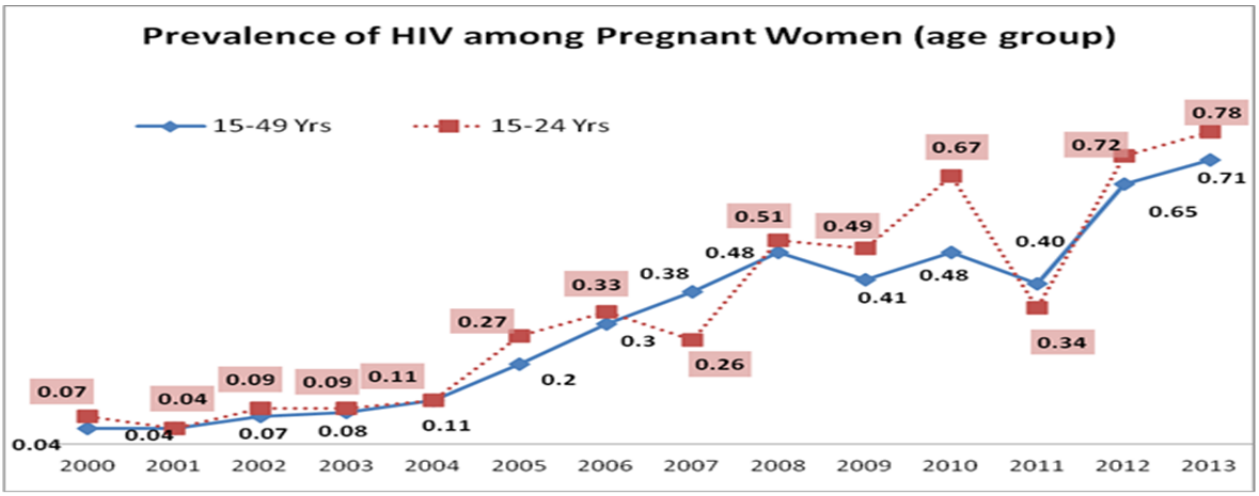
There are 10645 PLHIV in Mauritius according to estimates. As at December 2013, 5768 HIV positive cases were detected, of whom around 2500 are registered with the treatment services.

Some 1750 are considered to be adherent to ARV. Around three quarter of PLHIV is PWID. Weak adherence to treatment and loss to follow up are some of the challenges the national program faces with respect to PLHIV, very likely due to persisting myths associated with ARV, lack of faith in HIV treatment, HIV related stigma and discrimination and perceived marginalization of key populations within the health care setting. PLHIV continue to have risky behaviour putting their sexual and injecting partners at risk of infection: according to the IBBS PWID 2013, 66% of PWID ever shared a needle and among these, 50% are HIV positive. New detected cases among previously sero-discordant couples demonstrate unsafe sexual behaviour of PLHIV.

Youth and risk behaviours:

The HIV prevalence among young people aged 15-24 years is measured using the data collected at ANC clinic as proxy. Trend analysis of HIV prevalence in this age group has shown an increased from 0.34% in 2011 to 0.72 % and 0.78 % in 2012 and 2013 respectively. However, the youth population in Mauritius is extremely vulnerable to HIV because of high-risk behaviours such as unsafe sexual practices and accessibility of Drugs. There is also a low personal risk perception among the youth as the epidemic is concentrated among the Key populations.

Fig 4: HIV prevalence among youth aged 15-24 yrs using ANC data as Proxy



Source: Consolidated Data, NAS 2013

SECTION 3: NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Target 1 : Reduce Sexual transmission of HIV by 50%by 2015. *General Population*

1.1 Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Question	Numerator: Number of respondents aged 15-24 years who gave the correct answer to all five questions	Denominator: Number of all respondents aged 15-24	Percentage of young women and men aged 15-24 who gave the correct answer to all five questions
1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?	208	472	49.9%
2. Can a person reduce the risk of getting HIV by using a condom every time they have sex?	136	472	32.8%
3. Can a healthy-looking person have HIV?	318	472	76.4%
4. Can a person get HIV from mosquito bites?	236	472	56.6%
5. Can a person get HIV by sharing food with someone who is infected?	252	472	60.5%
Final: All questions answered correctly	**183**	**472**	**38.8%**

Source : KABP 2011

It is be noted that according to KABP 2011, 94.6% (94.3% male and 95% female) declared having heard of HIV. Knowledge of the modes of transmission among respondents is as follows:

- Sexual transmission 89.9% (94% male, 85.9% female)
- Mother to child 6.4% (9.8% male, 6.2 % female)
- Blood transfusion 45.9% (32.9%, 59.9% female)
- Injecting drug Use 60.7% (64.1% male, 58.2 % female)

1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15.

Sex	Age	Numerator: Number of respondents who report the age at which they first had sexual intercourse before the age of 15	Denominator: Number of all respondents	Percentage of respondents who report the age at which they first had sexual intercourse before the age of 15
Male	15 -19	2	131	1.2%
Male	20-24	1	111	1.4%
Female	15 -19	1	140	0.2%
Female	20-24	0	90	0%
Total	15 -24	4	472	0.8%

Source: KABP 2011

1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months.

Sex	Age	Numerator: Number of respondents who have had sexual intercourse with more than one partner in the last 12 months	Denominator: Number of all respondents	Percentage of respondents who have had sexual intercourse with more than one partner in the last 12 months
M	15-19	2	113	1.5%
M	20-24	9	111	8.1%
M	25 -49	36	444	8.1%
F	15-19	1	140	0.7%
F	20-24	2	90	2.2%
F	25 -49	9	483	1.9%
Total	15 49	59	1399	4.2%

Source: KABP 2011

1.4 Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse

Sex	Age	Numerator: Number Of respondents who reported having more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	Denominator: Number of all respondents who reported having had more than one sexual partner in the last 12 months	Percentage of Respondents who reported having more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex
M	15-19	2	2	100%
M	20-24	8	9	88.9 %
M	25 -49	17	36	47.2%
F	15-19	0	1	0 %
F	20-24	2	2	100%
F	25 -49	4	9	44.4%
Total	15 49	33	59	55.9 %

Source: KABP 2011

1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results

Sex	Age	Numerator: Number of respondents aged 15-49yrs who have been tested for HIV during the last 12 months and who know their results	Denominator: Number of all Respondents aged 15-49	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results
M	15-19	3	131	2.3%
M	20-24	12	111	10.8 %
M	25 -49	27	444	6.1 %
F	15-19	4	140	2.9%
F	20-24	8	90	8.9%
F	25 -49	42	483	8.7%
Total	15 49	96	1399	6.9%

Source: KABP 2011

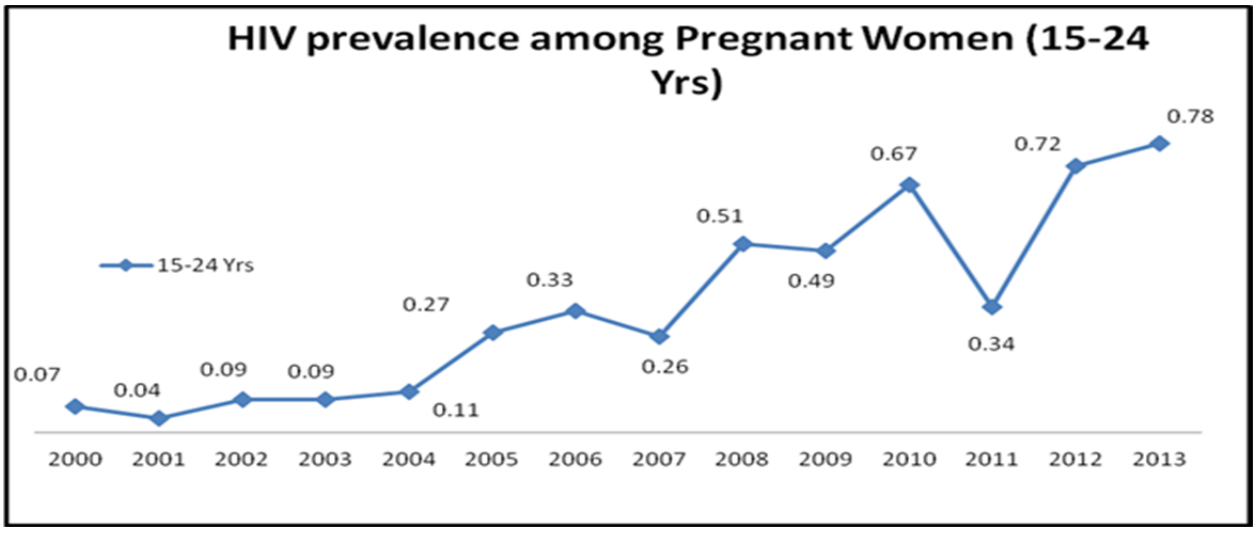
In general 63.8% of the population that knew of HIV, believed that they could have a confidential HIV test done. Gender wise, there was no difference in the frequency on respondents of the sexes who thought it was possible to have a confidential HIV test.

Various factors have been identified for the low uptake of HCT:
(1) socio-economic factors such as age, marital status, educational level, occupation, household wealth, and area of residence;
(2) social factors such as fear of unsolicited disclosure, fear of stigma and discrimination, client-counsellor dynamics including lack of confidentiality ;
(3) proximity and access to VCT site;
(4) HIV knowledge including prior knowledge of VCT sites and HIV risk perception and HIV risk behaviour ; and
(5) health status.
To increase voluntary counseling and testing, a National HIV Counselling and Testing Strategy was put into place in 2011. Following this a series of training on HIV Rapid test was carried.

1.6. Percentage of young people aged 15-24 who are living with HIV

Fig 5: Prevalence of Pregnant Women (15-24 yrs)

Actual data from ANC were used as proxy to determine the prevalence of HIV among youth aged 15- 24 which amounts to 0.71%.



HIV surveillance Data, MOH&QL

The HIV prevalence among the youth aged 15-24 was 0.4 in 2008 -2011, but a gradual increase of 0.6% and 0.7% in 2012 and 2013 respectively was observed and during the validation workshop, partners have highlighted the importance of innovative strategies to reach this young population.

SEX WORKERS

The IBBS FSW 2012 is the second HIV IBBS Survey conducted among FSW in Mauritius. The primary objective of this survey was to provide information on the prevalence of HIV and associated risk behaviours among FSW in Mauritius to inform programmatic and Policy strategies. This second IBBS also provide a second set of data that has been used to analyse trend of behavior change.

To date efforts to address the need of FSW in Mauritius, have been limited but has been expanding. For our Investment Case, the National AIDS Secretariat is organizing a country dialogue with all those concerned to brainstorm on a comprehensive package for FSW in line with study findings and recommendations.

1.7. Percentage of sex workers reached with HIV prevention programmes

	All sex	**Males**	**Females**	**< 25**	**+25**
Numerator: Number sex workers who replied "yes" to both questions	322	0	322	79	243
Denominator: Total number of sex workers surveyed	400	0	400	99	301
Percentage: Percentage of sex workers reached with HIV prevention programmes	80.50	0	80.50	79.80	80.73

Source: IBBS FSW 2012

1.8 Percentage of sex workers reporting the use of a condom with their most recent client

	All sex	**Males**	**Females**	**< 25**	**+25**
Numerator: Number of sex workers who reported that a condom was used with their last client	344	0	344	84	260
Denominator: Number of sex workers who reported having commercial sex in the last 12 months	400	0	400	99	301
Percentage: Percentage of sex workers reporting the use of a condom with their most recent client	86.00	0	86.00	84.85	86.38

1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results

	All sex	**Males**	**Females**	**< 25**	**+25**
Numerator: Number of sex workers who have been tested for HIV during the last 12 months and who know their results	78	0	78	24	54
Denominator: Number of sex workers included in the sample	115	0	115	32	83
Percentage: Percentage of sex workers who received an HIV test in the past 12 months and know their results	67.8	0	67.8	75.00	65.06

Source: IBBS FSW 2012

1.10 Percentage of sex workers who are living with HIV

	All MSM	**Males**	**Females**	**< 25**	**+25**
Numerator: Number of sex workers who test positive for HIV	97	0	97	11	86
Denominator: Number of sex workers tested for HIV	400	0	400	99	301
Percentage: Percentage of sex workers who are living with HIV	22.3	0	22.3	11.11	28.57

Source: IBBS FSW 2012

Sex-workers and their clients:

It is very important to understand the characteristics of sub-typology of sex workers. There is a lack of knowledge about the sub typology and how to reach each different sub-group. The risk associated with particular sub-typology varies. The outreach and service packages need to be different for each typology like street based sex workers, home based sex workers, Parlour etc. Based upon the typology, the outreach and service package should be determined.

Reaching out to the paid clients and the regular partners of sex workers is still a big challenge in HIV program across the world. The clients are from any walk of life from different sectors and profile. The client profile for each sub-typology of sex workers and each spot vary.

Geo-mapping will help to under and develop client profiles for each spot which will help in developing strategies to reach out to paid clients. Partners of sex workers can be reached as part of outreach design.

MEN WHO HAVE SEX WITH MEN (IBBS 2012)

1.11 Percentage of men who have sex with men reached with HIV prevention programmes

	All MSM	< 25	+25
Numerator: Number MSM who replied "yes" to both questions	291	94	197
Denominator: Total number of MSM surveyed	340	108	232
Percentage: Percentage of MSM reached with HIV prevention programmes	85.59	87.04	84.91

Source: IBBS MSM 2012

1.12 Percentage of men reporting the use of a condom the last time they had anal sex w

	All MSM	< 25	+25
Numerator: Number of MSM who reported that a condom was used the last time they had anal sex	173	63	110
Denominator: Number of MSM who reported having anal sex with a male partner in the last 6 months	340	108	232
Percentage: Percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner	50.88	58.33	47.41

Source: IBBS MSM 2012

1.13 Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results

	All MSM	< 25	+25
Numerator: Number of MSM who have been tested for HIV during the last 12 months and who know their results	127	38	89
Denominator: Number of MSM included in the sample	135	41	94
Percentage: Percentage of MSM who received an HIV test in the past 12 months and know their results	94.07	92.68	94.68

Source: IBBS MSM 2012

1.14 Percentage of men who have sex with men who are living with HIV.

	All MSM	**< 25**	**+25**
Numerator: Number of MSM who test positive for HIV	57	9	48
Denominator: Number of MSM tested for HIV	340	108	232
Percentage: Percentage of MSM who are living with HIV	16.76	8.33	20.69

Source: IBBS MSM 2012

Percentage of MSM who are living with HIV is estimated to 20% (Adjusted weighted with a C.I 12.7, 27.3)

MSM/TG population:

The definition of MSM and other sub-groups under MSM should be defined carefully like penetrator and receiver in anal sex. Usually the MSM community has their own code words and languages and it is important to understand the community dynamics.

MSM estimate has always been a challenge since there is an overlap between pleasure circuit and commercial. Also the definitions of getting paid in cash or gift leads to another level of challenge of defining the most at risk among MSM. Community consultations with the community helps to define the MSM sub-typology and focus on most at risk groups in the local context.

The discussion with the MSM Peer Educators indicates that there is presence of Male sex workers in Mauritius. It is important to know their size, risk and profile to develop specific strategies to reach out to this important sub-population of MSM.

It is also observed that the MSM who are testing at VCT are not captured as MSM on many occasions do not reveal their MSM status due to stigma.

The MSM has a trend of changing their boyfriend frequently and they are not using condoms regularly, which is risky and should be considered during outreach and counselling. There is no focused program for Transgender. The stigma for MSM is high among health professionals and need to be addressed.

It is noted that Transgender population is also present in Mauritius. However the present understanding of the size, risk and vulnerabilities of this community is minimal.

TARGET 1 AND 2
SIZE ESTIMATIONS FOR KEY POPULATIONS

1. Population Size Estimate for Key Populations

Key Populations	Size Estimation Performed	If yes, when was the latest estimation performed?	If yes, what was the Size Estimation?
a) Men who have sex with men including Transgender people	Yes	2012	9,000
b) People who inject drugs	Yes	2009 2011 2013	10,000 10,000 5,000
c) Female Sex workers	Yes	2010 2012	2,000 Street-based 9,000 All Categories
d) Other Key Populations	No		
e) Comments: The third size estimation carried out in 2013 among PWID is half those found in previous estimation due to the fact that more than half of the PWID are enrolled in the Methadone Maintenance Therapy (MMT). With regard to sex workers, only female sex workers were selected and the variance lies in the typologies. Only street SWs were captured in the first estimation. MSM include Transgender People.			

Source: IBBS MSM/FSW 2012; IBBS PWID 2013

2. Definition used of the key population:

- **A person who injects drugs**: Men or women who have injected any time within the past 6 months irrespective of being on MMT.
- **Sex worker**: "female adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally".
- Note: The definition of sex worker is broad and includes those who occasionally exchange sex for gifts.
- **Men who have sex with men**: "Men who have sex with men is an inclusive public health term used to define the sexual behaviors of males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular 'community'. The words 'man' and 'sex' are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male to male sex takes place."

- **Transgender persons**: " individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth. The term transgender describes a wide range of identities, roles and experiences which can vary considerably from one culture to another.

3. Method used

The method utilized were two approaches for gathering the multiplier data i.e distribution of the unique object and use of service data:

A. Unique Identifier

The first technique used to determine the multiplier within the RDS/IBBS survey in Mauritius was the 'unique object technique.' The 'first multiplier' component of this approach was determined through the distribution of a unique and memorable object to population studied through existing peer outreach activities in Mauritius. The 'second multiplier' was enumerated during the RDS by asking each participant if they had received the unique object during the distribution period.

B. Service Data

The second approach utilized to determine the multiplier was the use of "service data". The 'first multiplier' within this technique was gathered by compiling the data from service providers on the number of one-time visits by the key population studied during the previous twelve months leading up to the RDS survey. The 'second multiplier' component of this approach was enumerated during the RDS questionnaire through questions asking whether participants had exposure to a particular service.

4. Site specific estimates for all available estimates

Survey sites were identified in a non-randomized manner thus could not generate specific estimates for the different areas/districts in the country. However, in the continuous effort to provide accurate data, the country is proposing to start a programmatic mapping and size estimate for the 4 above-named key populations shortly.

TARGET 2: REDUCE TRANSMISSION OF HIV AMONG PEOPLE WHO INJECT DRUGS BY 50% BY 2015

2.1 Number of syringes distributed per person who injects drugs per year by needle and syringe programmes

Numerator : Number of needles and syringes distributed in past 12 months by NSPs	719,427
Denominator: Number of people who inject drugs in the country	5000
Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes	144

Source: NEP (MOH&QL)

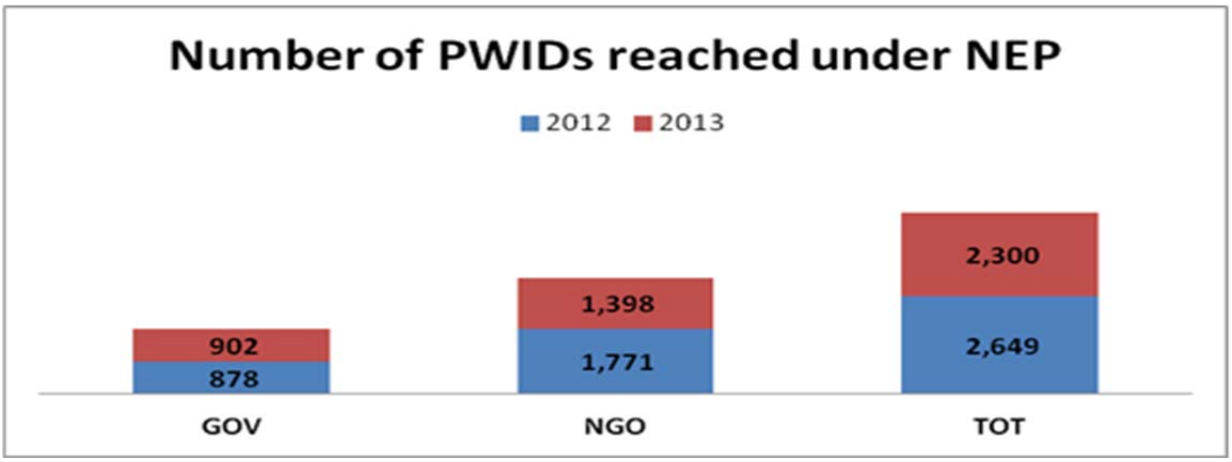
The IBBS 2011 and 2013 highlighted that 50% of PWID bought their syringes in private pharmacies.

Challenges met during implementation of NEP programmes

- Due to police harassment, PWIDs feel exposed when accessing the NEP sites
- There are a number of complaints reported with respect to the quality of material.
- Due to the lack of appropriate legislation or policy decision many PWIDs are in prison with no access to syringes
- MWID (Minors who inject Drugs) do not have access to any services.

To increase the target to 80% in 2015, the Republic of Mauritius envisages strengthening existing programmes and embarking on new initiatives. These include:

- A national coordination and response of the Drug Issues.
- Systematic communication in respect of the sites for NEP
- Re-establish the Harm reduction committee at NAS level.
- Decriminalisation of distribution and utilisation of syringes by working closely with the ADSU (Anti- Drug smuggling Unit)
- Implement extensive Harm reduction in prison
- Conduct frequent Harm reduction awareness programme in the community so as to mitigate Stigma and discrimination.



Source:Consolidated Data ,NAS

2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse

	All	Males	Females	<25	25+
Percentage of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	38.2	35.6	62.6	17.0	39.8
Numerator: Number of people who inject drugs who reported that a condom was used the last time they had sex	250	214	36	14	236
Denominator: Number of people who inject drugs who report having injected drugs and having had sexual intercourse in the last month	710	651	59	59	651

Source IBBS PWID 2013

2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected.

	All	Males	Females	<25	25+
Percentage of people who inject drugs reporting the use of sterile injecting equipment the last time they injected.	83.8	84.0	82.1	65.6	85.3
Numerator: Number of people who inject drugs who report using sterile injecting equipment the last time they injected drugs	619	569	50	54	565
Denominator: Number of people who inject drugs who report injecting drugs in the last month	727	667	60	70	657

Source IBBS PWID 2013

2.4 Percentage of people who inject drugs who have received an HIV test in the past 12 months and know their results

	All	Males	Females	<25	25+
Percentage of people who inject drugs who received an HIV test in the past 12 months and know their results	25.2 %	24.4%	33.3%	27.1%	25%
Numerator: Number of people who inject drugs who have been tested for HIV during the last 12 months and who know their results	183	163	20	16	167
Denominator: Number of people who inject drugs included in the sample	727	667	60	59	668

Source IBBS PWID 2013

2.5 Percentage of people who inject drugs who are living with HIV

	All	Males	Females	<25	25+
Percentage of people who inject drugs who are living with HIV	44.3	42.5	61.8	14.3	47.2
Numerator: Number of people who inject drugs who test positive for HIV	315	276	39	9	306
Denominator: Number of people who inject drugs tested for HIV	713	653	60	59	654

Source: IBBS PWID 2013

The HIV prevalence among PWID was 47.4% in 2009 and 51.6% in 2011.

Mauritius has a good initiative and program for PWID such as Needle Exchange Programme and Methadone Substitution Therapy. There is a need to increase the coverage and systems for follow up the clinical services with outreach. The partners of IDUs need to identified and targeted with HIV prevention services

It is noted that the stigma for PWID is high among health professionals at Government hospitals. This negative attitude can create a barrier between services offered and PWID community. Continuous capacity building of staff is of utmost importance if quality services are to be provided.

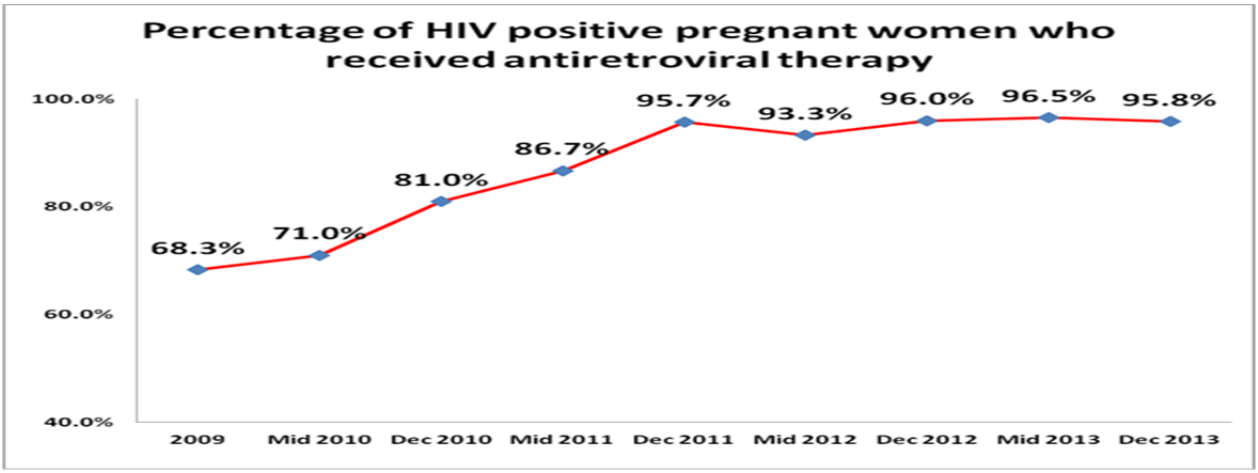
There is an immediate need to develop protocol for overdose management for PWIDs and for methadone management.

From different sources the critical issues raised is that a sizable population of FSW community is also PWIDs. This demands to develop strategies to address the dual-risk among these groups.

TARGET 3: ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN BY 2015 AND SUBSTANTIALLY REDUCE AIDS-RELATEDMATERNAL DEATHS

3.1 Percentage of HIV-positive pregnant women who receive antiretroviral medicine to reduce the risk of mother-to-child transmission.

Fig 5: Percentage of HIV-positive pregnant women receiving antiretroviral



PMTCT Registers, MOH&QL

Disaggregation according to the six general regimens described in the table below.

1. Newly initiated on ART during the current pregnancy	78
2. Already on ART before the current pregnancy	11
3. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B)	89
4. Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A or WHO 2006 guidelines)	2
5. Single dose nevirapine (with or without tail) ONLY	0
6. Other (please comment: e.g. specify regimen, uncategorized, etc.)	0

3.1a Percentage of women living with HIV who are provided with antiretroviral medicine for themselves or their infants during the breastfeeding period.

Percentage of women living with HIV who are provided with antiretroviral medicine for themselves amount to 100%. According to the new protocol once put on antiretroviral therapy during the pregnancy period, they are being maintained on treatment after delivery irrespective of CD4 count.

According to the PMTCT protocol, HIV positive pregnant women are counselled not to breastfed their babies. They are being provided with formula milk for the first year and artificial milk as supplement in the second year.

Pathway of babies born to HIV positive women:

Regular follow-up at NDCCI's offering the following services:

- Prophylactic treatment (Co-trimoxazole)
- Supply of formula milk in the first year and full-creamed milk in the second year.
- Vaccination programmes
- Detection of early clinical stages of AIDS and initiation of ARV's
- Diagnostic test for HIV

3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 3 months of birth.

Total number of babies born to HIV positive mother as from January to December 2012 amounts to 79 including a pair of twins. Out of these 79 babies there were 2 still birth and 2 babies passed away. Total number of babies eligible for PCR was 75, but only 61 have undergone testing. Out of 61 babies tested, only 24 babies have been tested within 3 months.

	Data Value
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	32%
Numerator: Number of infants who received an HIV test within two months of birth, during the reporting period. Infants tested should only be counted once	24
Test result - Positive	0
Test result - Negative	24
Test result - Indeterminate	0
Test result – Rejected by Lab	0
Test result - Other	0
Denominator: Number of HIV-positive pregnant women giving birth in the last 12 months	75

Source: NDCCI, MOH &QL

3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months

	Data Value
Percentage: Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	2.9
Numerator: Estimated number of children who will be newly infected with HIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women	2
Denominator:Estimated number of HIV positive women who delivered in the previous 12 months	69

Source: Spectrum 2013

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TARGET 4: REACH 15 MILLION PEOPLE LIVING WITH HIV WITH LIFESAVING ANTIRETROVIRAL TREATMENT BY 2015

4.1 Percentage of adults and children currently receiving antiretroviral therapy

	Total	Males	Females
Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	19.2	20.9	14.5
Numerator: Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period.	1830	1457	373
Denominator :Estimated number of adults and children living with HIV National criteria for ART eligibility varies by country. To make this indicator comparable across countries global reports will present the ART coverage for adults and children as a percent of all people living with HIV.	9546	6966	2580
Denominator :Estimated number of eligible adults and children (using national eligibility criteria)	4870	3593	1277
Number : Persons newly initiating antiretroviral therapy during the last reporting year	392	290	102

Source: ART Register, NDCCI, MOH &QL

It is to be noted that when new treatment Protocol will be in place , more people will be put on ART.

4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy.

Patients initiated on ART as from January to December 2012 known to be on treatment after 12 months.

	Male	Female	Total
Total number of patients initiated on ART Jan- Dec 2012	324	66	390
Patients passed away	11	3	14
Patients loss to follow-up	62	4	66
Patients still on treatment after 12 months of treatment	251	59	310
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	77.5	89.4	79.5

Source: ART Register, NDCCI, MOH &QL

TARGET 5: REDUCE TUBERCULOSIS DEATHSIN PEOPLE LIVING WITH HIV BY 50%BY 2015

5.1 Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV

REPUBLIC OF MAURITIUS	**Population 2012 = 1.2 million**	
Estimates of TB burden * 2012	**Number (thousands)**	**Rate(per 100 000 population)**
Mortality (excludes HIV+TB)	0.012 (0.012–0.012)	0.97 (0.96–0.98)
Mortality (HIV+TB only)	<0.01 (<0.01–<0.01)	0.48 (0.39–0.54)
Prevalence (includes HIV+TB)	0.48 (0.24–0.81)	39 (20–65)
Incidence (includes HIV+TB)	0.26 (0.21–0.31)	21 (17–25)
Incidence (HIV+TB only)	0.014 (0.011–0.017)	1.1 (0.92–1.3)
Case detection, all forms (%)	49 (41–60)	

(Data from http://www.who.int/tb/country/en)

It is to be noted that:

1. The Republic of Mauritius does not form part of high TB burden countries.
2. All TB patients are tested for HIV and if found positive are put on antiretroviral therapy.
3. All PLHIV following treatment at the Day Care Centre do a yearly routine chest x-ray

	Total	**Males**	**Females**
Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	100%	21.2	14.3
Numerator: Number of people with HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year	23	18	5
Denominator: Number of reported TB cases in People living with HIV	23	85	35

Source: National TB Programme, MOH &QL

TARGET 6: CLOSE THE GLOBAL AIDS RESOURCE GAP BY 2015 AND REACH ANNUAL GLOBAL INVESTMENT OF US$22-24 BILLION IN LOW AND MIDDLE-INCOME COUNTRIES

6.1 Domestic and international AIDS spending by categories and financing sources

To see NASA Report 2012 (Annex 1)

TARGET 7 : ELIMINATING GENDER INEQUALITIES

7.1 Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months.

Violence against women and girls touches Mauritius as every other nation. Gender-based violence also has a range of economic effects at the national level, such as foregone foreign

investment and reduced confidence in a given country's institutions. To highlight the importance of eliminating GBV we have to consider the costs incurred for substantial medical and legal services as a result of injury and abuse. Or calculate the costs of lost household productivity and reduced income stemming from the forfeit of paid working days. No country or part of the world is immune to these costs. According to the Ministry of Gender and Family welfare, the annual cost of GBV in Mauritius surpasses US$46 million.
The Ministry of Gender Equality and Family Welfare is putting a lot of effort to eliminate this problem.

Table - Number of types of Domestic Violence, January to December 2013

Type of problem	**New cases 2013**		
	Male	**Female**	**Total**
Damage to property	8	41	49
Emotional abuse (by spouse)	2	18	20
Harassment by spouse	17	286	303
Illtreatment by spouse	19	194	213
Illtreatment by others	26	98	124
Physical assault by spouse/partner	40	704	744
Physical assault by others living under the same roof	29	156	185
Psychological violence	3	59	62
Rape	1	7	8
Sexual abuse by spouse	0	7	7
Sexual harassment by spouse	0	5	5
Sodomy (marital)	1	8	9
Threatening assault by spouse	28	349	377
Threatening assault by others	22	67	89
Verbal assault by spouse (harassment, abuse, humiliation)	36	479	515
Verbal assault by others living under the same roof	32	137	169
Other, specify	2	8	10

Source : Gender Statistics Unit

TARGET 8: ELIMINATING STIGMA AND DISCRIMINATION

8.1 Percentage of women and men aged 15-49yrs who report discriminatory attitudes towards people living with HIV.

Age group	male	%	Female	%
15-19 yrs	51	38.9	34	24.3
20-24 yrs	41	36.9	21	23.3
25-49 yrs	234	52.7	127	26.3
Total 15-49 yrs	326	47.5	182	25.5
Grand total M&F	508/1399= 36.3 %			

Target 10: STRENGHTENING HIV INTEGRATION

10.1 Current school attendance among orphans and non-orphans aged 10–14

Mauritius has long achieved the goals of Universal primary education and gender parity in enrolment as well as access to all children irrespective of their Status (Orphans, Vulnerable children).

The government has placed emphasis on access to free secondary schooling and more recently on increasing access to tertiary education. All students who attend primary, secondary and tertiary institution are entitled to free transport.

Key factors that have contributed to progress:

- Free and compulsory education for all up to the age of 16
- Free transport (bus facilities) to all school children
- Free text books to all primary school children
- A pre-vocational program for pupils who fail the CPE to ensure that they can enroll in vocational programmes
- Free meals for students in ZEP schools
- Student book loan scheme for secondary students
- Provision of Examination fees for students in need.

MDGs Goal 2: Achieve universal Primary education (MDG's report 2013)

	Ensure that by 2015, children everywhere, boys and girls alike , will be able to complete a full course of primary schooling	Total	M	F
1	The net enrolment ratio in primary school	99%	98%	100%
2	Proportion of pupils srating grade 1 who reach last grade of primary	98.7%	97.5%	97.2%
3	Literacy rate of 15-24 years old	98.1%		

Source: Ministry of Education and Human Resources

10.2 Proportion of the poorest households who received external economic support in the last 3 months

Mauritius does not have a situation of extreme poverty as defined by the UN (US$1.0 per day or US$1.25 in PPPterms). The country remains with less than 1% of its population living in extreme poverty for more than 1 decade (Statistic Mauritius). But the country is seeing a growing proportion of its population living in relative poverty, from 7.9 in 2006/7 to an estimated 9.4% in 2012 (Statistic Mauritius, Household budget Survey 2012)

To ensure the effectiveness of its poverty abatement programmes, the Government has created the Ministry of Social Integration and Economic Empowerment with the objectives of economically empowering vulnerable families so that they can integrate into mainstream society.

Achievements in 2013

Social Housing

- 97 concrete-cum Corrugated Iron Sheet (CIS) housing units constructed and 350 vulnerable families provided with (CIS) houses.
- Upgrading of houses (provision of toilets, bathroom, septic tanks and minor renovation works) for 210 families including 12 families residing at Balisage, Roche Bois, Pamplemousses, Bois Marchand and Morc. Ilois, Tombeau Bay.
- Building materials provided to 450 beneficiaries in Rodrigues for the construction of concrete houses

Child Welfare and Family Empowerment

- 1 Child Day Care Centre operational at La Valette, in addition to the 8 centres already in operation.
- 25,000 children of vulnerable families, including 6,000 in Rodrigues provided with school materials.
- 1,306 students of Pre-Primary and Primary Schools provided with meal, transport and accompagnement scolaire.
- Ongoing Programme to provide 3000 youth with junior life skills training.
- 3555 vulnerable people provided with life skills training.
- 10 and 13 learning corners set up for needy children in deprived regions in Mauritius and Rodrigues respectively with 200 beneficiaries trained in IC3 Computer courses.
- 3 recreational centres providing facilities such as indoor games, learning corner, petanque court and children playground, green space and kiosks set up at Camp La Boue, Camp Accacia and Camp Raffia.
- Training courses offered to 626 beneficiaries in the development of arts and sports, to identify hidden talents in vulnerable children and to give the vulnerable children the opportunity to enhance their full potential in performing arts.
- Basic functional literacy and numeracy courses offered to 580 beneficiaries in Mauritius and Rodrigues.
- Remedial education provided to 687 students of Standard V and VI to bring vulnerable children on the same footing as their mainstream counterparts and to follow up on their educational performance.

Training and Placement

- 2,932 unemployed persons below SC level trained and 348 of them placed, of which 50% have secured employment.
- 47 persons enrolled under the Circular Migration for employment in Canada and France.
- 7 Job fairs held across the island to provide direct interaction between employers and unemployed, with the possibility of the securing job opportunities. 604 have obtained employment directly from job fairs.

Other activities

- Entrepreneurship courses delivered for 60 women at Petit Sable in August 2013.
- Signature of an MOU for the operation of a shelter for the homeless (25 male beneficiaries) in August 2013. The shelter will be operational in the course of 2014.

- Life Enhancement Education Programme carried out in 9 pockets of poverty in the North as from June 2013.
- Cleaning campaign including distribution of bins and plants,carried out in 2 pockets of poverty, namely Bonne Veine and 16eme Mile, Forest Side in October 2013.
- Launching of cow rearing project in the pocket of poverty of Panchavati in November 2013.
- Health Promotion Campaign held at Batimarais for breast cancer, eyes and cardio-vascular check-up in November 2013.
- Sports and Fun organized for 200 vulnerable children of the districts of Grand-Port and Savanne in November 2013.

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SECTION 4 : BEST PRACTICES

Introduction

The People Living with HIV Stigma Index is a research initiative - driven and implemented by people living with HIV - to measure stigma and disctimination relating to HIV. It has been developed and is the result of a partnership between the International Planned Parenthood Federation (IPPF), two networks of people living with HIV: the Global Network of People Living with HIV (GNP+) and the International Community of Women living with HIV (ICW), and The Joint United Nations Programme on HIV/AIDS (UNAIDS).

The rigorous quantitative and qualitative research conducted enable country to build an evidence base for better informed policies, more effective programmes, increased advocacy and will be an empowering experience for the people living with HIV involved in the process. It will generate a wide range of knowledge and best practices.

This tool has been developed to help measure stigma and discrimination and the impact of interventions, and to document the well-being of people living with HIV over time. Some of the key areas explored in the research include the causes of stigma and discrimination; access to work and services; internal stigma; rights, laws and policies; effecting change; disclosure and confidentiality, treatment; having children; and overcoming stigma.

The tool is available on line, and countries need to adapt accordingly to be able to capture data pertinent to their need.

PEOPLE LIVING WITH HIV IN MAURITIUS AND AIDS STIGMA INDEX

HIV-related stigma and discrimination that PLWHIV face in all areas of life is a known fact and the way it is imposed on people who are already excluded or have unequal status in society, make their daily life very difficult. These people also have the fewest resources to cope with and at the same time, fear of stigma and discrimination prevents them from seeking information, adopting preventive behaviour, getting tested, disclosing their sero-status and accessing treatment.

In Mauritius strategies to eliminate Stigma and discrimination were based on anecdotal information and all partners involved in the fight against HIV and AIDS believe that it was high time to measure the complex dimensions of HIV-related stigma and Discrimination that will allow us to measure the nuances and changes over time and it will be a useful resource for analyzing what is and what is not working in the national responses to HIV.

ACTIVE PARTNERSHIP

Over the world, carrying out the stigma Index Survey is essentially An NGO’s initiative but in Mauritius the National AIDs Secretariat took the lead.

Who were our Main partners?

NGOs involved in the fights against HIV (PILS, VISA G, VIVRE+, Lacaz A, Chrysalide) Ministry of Health and Quality of Life who is the main implementer of services. All our partners, feel that issues of stigma and discrimination, denial and ignorance will continue to have an impact on HIV treatment, care and support if not addressed accordingly. Empirical data is important to support advocacy and to remove all misconceptions and hopefully will help us moe on to more effective policy and programme.

Who funded the project?

NAS provided the financial support and mobilise technical assistance from our international partners. The overall budget amount to US$ 30,000.

Who gave support ?

Technical support was provided by UNAIDs; Fullbright Scholar, Miss D.Dethier

The PLWHIV stigma Index Study was initiated with the following objectives

- Measure the types and extent of HIV related stigma and discrimination at the individual, family, community and national levels (i.e. a baseline study) to be able to measure change over time.
- Explore experiences of internal stigma and the effect this has on decision making.
- Explore perceived stigma and discrimination in relation to access to work, health (e.g. HIV testing, treatment and SRH services and education

- Explore the knowledge of people living with HIV of existing HIV related legislation and policies.

- Identify the extent to which HIV positive people are informed of their rights and access mechanisms for rights violations.
- Use results to involve people living with HIV through advocacy and empowerment to define and shape policies, interventions and programmes which meet the specific needs of HIV positive people

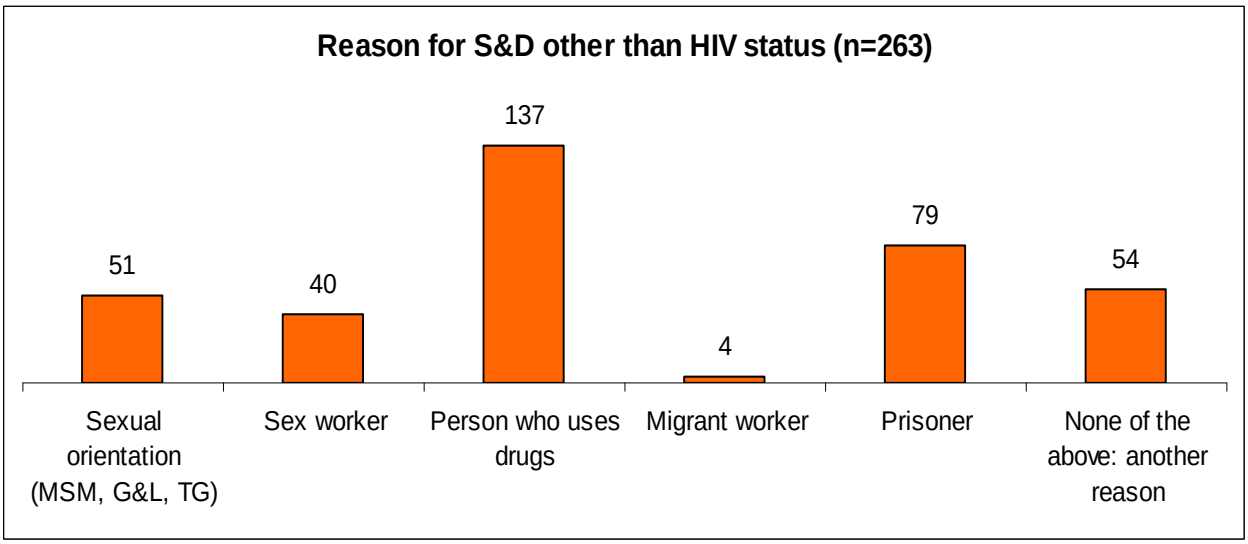
ACTION INITIATED

1. Study coordination : The National AIDS Secretariat provided coordination by setting a steering committee.
2. Ethical considerations discussed and documented in the methodology
3. The dratfing of the concept paper and submission to the Ethics committee
4. Questionnaire adaptation: the questionnaire was translated in creole
5. Recruitment and training of Interviewers among PLWHIV
6. Data collection
7. Data analysis
8. Data validation and dissemination among all partners.
9. Report writing and dissemination of results

MAJOR FINDINGS

Majority of the respondents who participated were male (62.7%, n=250) out of a sample of 399 respondents, mostly between 30 to 49 years old, Single (43.4%, n= 173) with 58.7% primary and 33.9% secondary education. Among the respondents, 56.1% were reported being unemployed whereas 35% were employed. Male respondents were more likely to be self-employed, part time, than female respondents.

The study shows that HIV-related stigma and discrimination, is most notably especially internal stigma as well as discrimination in healthcare settings. These are the major barriers for PLHIV to access HIV prevention, treatment and care services in Mauritius. With a concentrated HIV epidemic, many PLHIV face layered stigma, related to their perceived or actual belonging to one or more key population groups. Concerning their experience of stigma and discrimination in the previous 12 months, 26% of respondents reported having been verbally insulted/ harassed/ threatened ; 22% physically harassed and/or threatened and 18% physically assaulted at least once in the last year.



Source : Stigma Index Survey, Mauritius 2013

WHY THIS PROJECT A "BEST PRACTICE"?

- It is a first of its kind in the region.
- In Mauritius the National AIDS Secretariat took the lead.
- Evidence has been obtained to:
  - inform the development and implementation of national policies that protect the rights of people living with HIV; and
  - shape the design of programmatic interventions so that they consider the issue of HIV-related stigma and discrimination within their content.
- The process has been an empowering one for people living with HIV, their networks and local communities.

WHAT WERE THE PARAMETERS THAT MADE THIS PROJECT A SUCCESS?

The Main parameter for success was that the survey was carried out by PLHIV for PLHIV. It aimed to collect information about the experiences of PLWHIV related to stigma and Discrimination and their rights. It is an important tool that facilitate the collection of qualitative data among a target group who usually do not come forward easily. The project in Mauritius demonstrates that this initaitive could be a collaborative one (GVT/NGOs)

WHAT WERE THE LESSONS LEARNED ON THIS PROJECT

1. A better informed and evidence based understanding of stigma and discrimination
2. This process allowed us to discover a pool of resource persons among PLHIV for future projects.
3. The Interviewers participated during the analysis and validation process, thus the empowerment of PLHIV has been a success.
   The next Stigma Index need to be carried out essentially by PLHIV network as an indication of successful empowerment

WHAT WERE THE FUTURE PERSPECTIVE?

The National Strategic Framework 2013-2016 details the plan to address issues relating to stigma and discrimination.The data/results are available so that it can be used as a national, regional and global advocacy tool to fight for improved rights for PLIV

SECTION FIVE : MAJOR CHALLENGES AND REMEDIAL ACTION

Progress on key challenges identified in the 2012 report

Several challenges were identified in the 2012 report that the country must work towards in improving the quality and access of HIV and AIDS interventions and services.

1. **Mobilization of funds for a robust National Response** : The Government of Mauritius is providing 72% of the total HIV and AIDS budget. Private sector contribution amounts to 2 % while external sources accounts for 26 % with 21% from the GFTAM to support expansion of HIV collaborative activities over a period of five years (2010-2014). Mauritius has continuously received an "A" rating for its performance.
   One of the mandate of the National AIDS Secretariat is to mobilise resources and Since the setting up of NAS in 2007, constant efforts have been made to mobilise financial and technical resources for a robust National Response.

2. **Absence of evidence-based data to inform strategies to mitigate Stigma and Discrimination:** In January –June 2013 the country carry out its first Stigma Index Survey. It is usually an NGO initiative, but in Mauritius, the NAS facilitate the process through mobilization of funding and human resources. This survey provided us with much needed evidence-based information and the recommendations were used to address issues identified.

3. **Budgetted Research and Evaluation strategy:** Mauritius has a well -established Research Agenda. The country has been implementing a robust surveillance among key population(PWID,FSW,MSM) by carrying Integratted Behavioural and Biological Survey every two years.

4. **A costed programme of HIV prevention for Rodrigues:** In 2012 after consultative meetings with the Rodriguan authority a costed NSF for Rodrigues was drafted, and it has been endorsed by the Rodrigues Regional Assembly but the challenges is about the implementation of the programme.

Challenges in the Current Reporting Period

Although the country has made substantial efforts and progress in improving the National Response to HIV, some challenges still remain. Regular peer review and evaluation of the National Response allow the country to constantly re-engineer its responses. Some of the challenges identified are as follows:

1. **Behavior change communication and prevention interventions in the hard to reach population**
    - HCT coverage is still inadequate among the key population. There are still weaknesses in the assurance that referred clients actually access services to which they are referred to. This is one of the challenges that contribute to the continual loss of clients between services points.
    - The prevention and follow-up programmes and services for Commercial Sex Workers and Men Having Sex with Men are quite limited and in need of reinforcement.
    - NGOs members are still waiting for a formal training on HIV Testing Rapid and the possibility to get the approval from the Ministry of Health to carry out testing in the community.
2. **Treatment , Care and Support**
    - Treatment as prevention
    - PReP for sero-discordant couples
    - Services quality
    - To increase Adherence Rate
3. **Methadone Maintainance Therapy**
    - To address issues of overcrowding at dispensing site and follow-up of clients.
    - Decentralisation of Methadone service in other Prisons.
    - Providing ART at Methadone Dispensing site
4. **Monitoring and Evaluation**
    - M&E: Quality Data and Service Delivery point analysis
    - An evaluation of the system

SECTION 7: SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

According to the Analysis of Matrix on Financing sources by Financing Agents in NASA (2012), the government remains the major source of HIV and AIDS funding in the country. The total spending on HIV/AIDS in Mauritius for the year 2012 from all sources of funding was Rs 225,015,695 (US$7.434 million). The main source of funding was the Government of Mauritius (public) accounting for Rs 161,248,617 8 (US$5.4million) (72%). The funding by the government has increased over the past years from Rs 141.9m in 2010 to Rs 161.2, due to increased number of patients under MST programme and ART. Spending over the period was dominated by Prevention with expenditure in the Harm Reduction Programme being the major component of the AIDS spending category. Total expenditure on prevention amounted to Rs 86.5million (US$ 2.98 million) (39.5%). This was followed by spending on Care and Treatment at Rs 68.9million (US$2.37million) (32%), Program management at Rs 50.245 million (US$1.73 million) which accounted for 23% of total expenditure.
Public funds were spent mainly on Care & Treatment, followed by programme management and prevention. Funds from international sources were spent mainly on prevention and program management.

Contribution by Financing Source

	2012	
Financing Source	**Value (MRU)**	**Value in (USD)**
DOMESTIC SOURCES		
Public Fund-National Funding Resource	161,148,617	5,371,621
Private Sector Contributions	3,666,238	122,208
MULTILATERAL/Bilateral		
European Union	1,683,193	56,106
The Global Fund to Fight AIDS, Tuberculosis and Malaria	46,643,370	1,554,779
UNAIDS	3,093,378	103,113
United Nations Development Programme (UNDP) & UNFPA	592,000	19,733
World Health Organization (WHO)	2,768,610	92,287

US Government(GMS)		
World Bank		
Indian Ocean Commission	600,000	20,000
Ambassade de France & Fight AIDS Monaco		
INTERNATIONAL NGO'S		
Alliance	233,706	7,790
SIDACTION	1,508,760	50,292
Other NGO's	1,077,823	35,927
TOTAL	**223,015,695**	7,433,857

Source :NASA 2010

As portrayed above a number of international development partners are currently supporting the Republic of Mauritius to implement programme to mitigate the impact of the epidemic. Their support is both at a strategic level as well as at an operational level.

WHO

The core strategic areas of WHO support in 2012-2013 in line with national HIV/AIDS Strategic Plan and the pursuit of the expected results agreed upon are as follows:

- Financial support for prevention activities For e.g
    - Young Peer educators on life skills
    - Awareness in secondary Schools (Health Club)
    - Training of Nursing staff on Management of care and support to PLWHA
    - Support peer educators programme (CSW, MSM)

UNDP / UNAIDS

UNAIDS is mandated to provide technical support to assist in the implementation of National AIDS programmes. Main areas of support has been technical support through the TSF

UNFPA

UNFPA supports a broad spectrum of initiatives to prevent the transmission of HIV. Main achievements in 2012-2013 have been :

- The mainstreaming of HIV in the Sexual and Reproductive Health services.
- Capacity building through training of Health Care Workers.
- Training of midwives on PMTCT protocol

Global Fund R8

The Republic of Mauritius has achieved a successful phase 1 with an A1 rating.
For the phase 2, (2012-2014), an enveloppe of EU 2,969,010 has been approved to facilitate implementation of high impact capacity building, Scaling –up of services and the development of a robust Surveillance, Monitoring and Evaluation system.

Actions that need to be taken by Development Partners to ensure achievement of targets.

In a limited resource environment, it is hoped that Mauritian's development partners will continue supporting HIV/AIDS efforts through different sectors. Apart from the interventions above, areas requiring immediate support include

- An in depth review of Monitoring and Evaluation system.
- Media campaign to sustain fight against stigma and discrimination and to accelerate prevention activities.
- Surveys to gather timely data for a strategic response
-The strenghtening of the health system with the mainstreaming of HIV and AIDS and allied issues at Primary Health Community level.
-Operational Research to improve quality of Services.

SECTION 8: MONITORING AND EVALUATION ENVIRONMENT

The Republic of Mauritius subscribes to the "three ones" Principles which also guided the development of the M&E plan.

- One agreed HIV and AIDS action framework that provides the basis for coordinating the work of all
- One national AIDS coordinating authority with a broad-based multi-sectoral mandate
- One agreed country level M&E system

The development of the M&E plan completes the "three ones". The plan enables the National AIDS Secretariat to systematically monitor implementation of the strategic plan and measure progress towards the achievement of national targets and international commitments in the fights against HIV and AIDS

Global and Regional Commitments

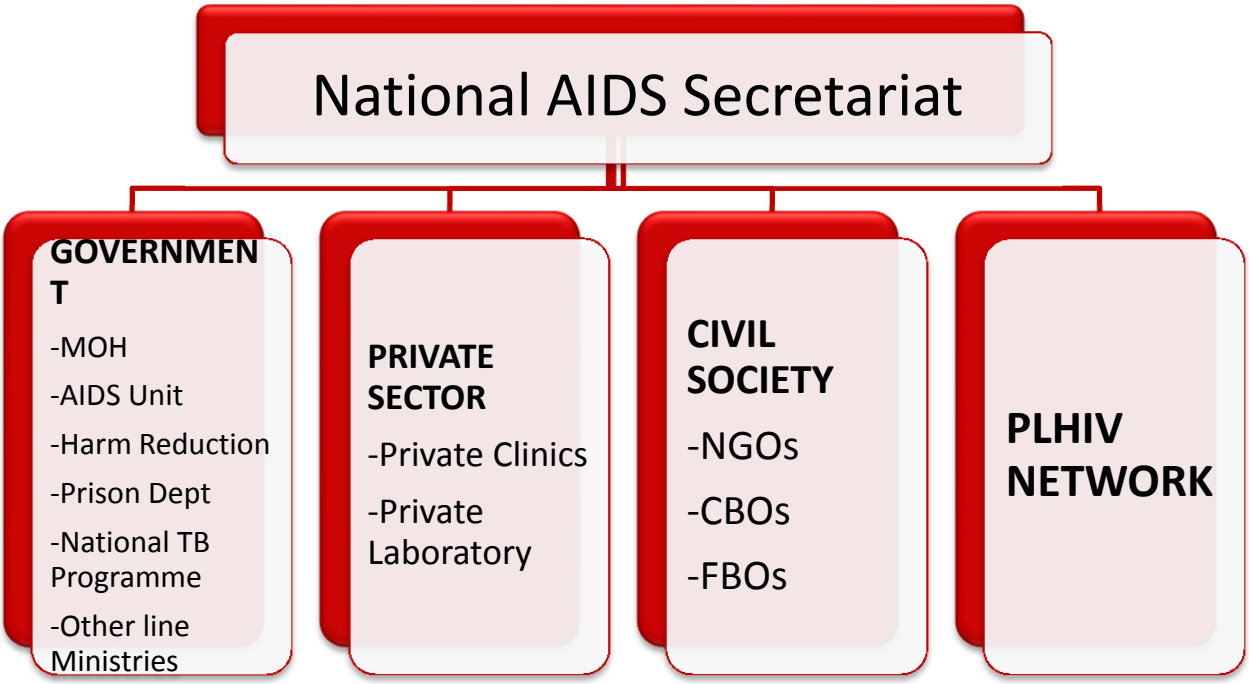
The Republic of Mauritius is a signatory to several international and regional commitments and declarations on which the country is supposed to be reporting regularly. These include:

- Millennium Development Goals
- Global AIDS Response Progress Report (UNAIDS)
- Universal Access (WHO/UNICEF/UNAIDS)
- Ten Targets
- Global Fund to fight AIDS, Tuberculosis and Malaria(GFTAM 8)
- Southern Africa Development Community (SADC)
- African Union (AU)
- United Nation Office On drugs and Crimes
- Indian Ocean Commission

The indicators selected nationally cater for reporting to these global and regional commitments, in addition to National Monitoring and Evaluation requirement.

Goal of the M&E Plan

The National M&E plan is aligned with the strategic priority areas of the results based NSF 2013-2016. The overall goal of the National M&E plan is to provide a systematic approach to tracking activities related to the NSF strategic areas. The plan spells out by programme areas, details of what information is needed including: indicators data sources, collection methods, flow, analysis, use and reporting, feedback as well as responsibilities of implementing partners and



National Monitoring and Evaluation Coordination Structures

stakeholders. It outlines strategies for addressing each of the 12 components of a functional M&E system.

Objectives of the M&E Plan

The objectives of the M&E plan are to assist NAS, implementing partners and stakeholders to:

- Guide policy and planning of the National Response
- Strengthen coordination of all partners and stakeholders working in the area of HIV and AIDS
- Ensure yearly operationalization of the NSF by the implementing partners
- Monitor effectiveness of programme through Joint Annual Review and Mid-Term Review
- Facilitate data dissemination among implementing partners and stakeholders
- Guide Resource Mobilization

Partnerships to plan, coordinate and manage the HIV M&E system

It is important that all stakeholders in HIV M&E work together. The country has been successful in establishing and maintaining M&E partnership through regular reporting and sharing of evidence-based information at National, regional and International level. Further consolidation of partnership will be done through the regular meeting of all relevant stakeholders during the M&E

technical committee. To avoid duplication of effort, NAS has established communication mechanisms with various technical committees that provide regular technical support in M&E both in-country and internationally.

National Monitoring and Evaluation committee

NAS is supported at national level by a multi-sectoral and multi-disciplinary M&E committee. The M&E committee facilitates participation of all stakeholders (Government, donors, NGOs and Civil Society) in national monitoring and evaluation activities. It also guides NAS on monitoring and evaluation issues as well as facilitates coordination, quality and standards in M&E. It also advises on the operational research needs of the country.

Coordination (Sectors responsible for the National Response)

The different sectors of the National Response are coordinated by different players who collect specific data. These are as follows:

SECTOR	COORDINATING BODY	FUNCTIONS
Health Sector	Ministry of Health and Quality of Life	The Ministry of Health and Quality of Life collects data from all health- facility- based interventions, both private and public. The Health Statistics Unit is responsible for collecting all health information while HIV and AIDs intervention data is collected by the AIDS Unit. Data are generated from Harm Reduction Unit, National TB programme, Ante-Natal surveillance sites, Blood transfusion Unit, Central Health Laboratory, Prisons Institutions. With proper alignment the private medical sector should report to the National M&E system through the Ministry of Health.
Civil Society	PILS as NGO's PR and other NGOs involved in HIV prevention	Monitoring and Evaluation in the civil society sector has been facilitated by the NGO PR (PILS). However data is currently flowing from Individual organisations directly to NAS
Private Sector	Mauritius Employers Federation	A coordinating mechanism for the private sectors shall be set up with strengthening capacity to function
Public	Lines Ministries/	Data flows from these ministries directly or

Sector	Ministry of Labour and Industrial Relations/ Ministry of Education and Research/Ministry of Gender Equality	via MOH&QL to the National M&E system.
PLWHIV	Vivre +	This organization needs strengthening and capacity building to be able to function fully as a coordinating body for all PLWHIV activities.

Evaluation, Surveillance and Research

Assessment of the extent to which objectives of the strategic plan (NSF) are met requires an array of periodic evaluation. These evaluations are critical to collection of specific outcome and impact indicators as well as evaluating some fundamental attributes of programs such as efficacy, equity, relevance, appropriateness. The evaluation component therefore has to be strategically planned for utilizing national surveys and surveillance, project evaluations and other similar researches.

Below are the surveillance systems and national surveys which will be utilised for the evaluation of the national response to HIV and AIDS in Mauritius.

Description of Surveillance systems and National Surveys

SURVEYS/ SURVEILLANCE/ EVALAUTION STUDY	**DESCRIPTION**
1. ANC sentinel Surveillance	It is a primary data source for HIV prevalence estimates among pregnant women. ANC data are also used as proxy to determine the HIV estimates among the population in general and among youth aged 15- 24 yrs. It is an on-going activity.
2. Blood donors sentinel Surveillance	Blood donor is a free and voluntary service. HIV testing is mandatory when giving blood. It is an on-going activity.
3. STI's sentinel Surveillance	It summarises the epidemiology of sexually transmitted infection and also help in identifying vulnerable population group. Data collected on an annual basis enable national STI/HIV and AIDS programme managers to conduct efficient planning, Monitoring and Evaluation of interventions activities.
4. National TB Programme	All TB clients are tested for HIV.A close collaboration with the two programme has been developed so as to monitor co-infection HIV/TB. Data collection is done on a quarterly basis. In order to improve the surveillance there is a need to put into place a protocol to ensure that all HIV patients are screened for TB.

5. Integrated Behavioral and Biological Survey for Key Population: PWID,SW, MSM, PI)	IBBS are nationally coordinated and conducted in collaboration with the MOH &QL and civil society. It collects data on health risk behaviours, preventive health practices and health care access. IBBS data are widely used for policy development and Advocacy at both National and International level. IBBS for key populations will be carried out every 2-3 years.
6. KABP study 15-49 yrs old	Assessment of HIV related knowledge, attitudes, beliefs and practices and collection of evidence-based data to inform strategies to reduce the spread of HIV and AIDS will be done every 4- 5 years.
7. Know your Epidemic Study/MOT	Know your epidemic, Know your response has become a rallying cry for an intensified focus on HIV prevention. Modes of Transmission survey will be carried out every 2 years to collect evidence-based data.
8. Stigma Index Survey	Measure the types and extent of HIV related stigma and discrimination at the individual, family, community and national levels to be able to track change over time. To provide support to the Civil Society for carrying out the survey on a 2- 3 years basis.
9. Operational Researches	OR encompasses a wide range of problem solving techniques and methods applied in the pursuit of efficient decision-making. OR to be carried out as and when required so as to improve access and quality service provided.
10. HIV Drug Resistance Monitoring	The purpose of implementing an HIVDR monitoring system is to assess the extent to which ART programmes are functioning to optimize prevention of HIVDR..Central Health Laboratory in collaboration with the AIDS Unit, has to put into place the required protocol to guide Monitoring and Reporting of HIVDR..
11. Mid-term and Joint Annual Review of the NSF	Mid-term and Joint annual Review refers exclusively to the comprehensive, periodic, systematic assessment of the overall national response to the HIV epidemic carried out jointly with relevant stakeholders and partners and as an integral part of a national HIV strategic programming cycle. However, the Joint Review of the national response should clearly build on, and be informed by, reviews of specific HIV projects, specific sectoral responses, or reviews of discrete elements of the overall HIV response, all of which may also be expected to be carried out jointly with relevant partners and stakeholders.
12. National AIDS Spending Assessment	NASA describes the flow of resources spent in the HIV response from their origin to the beneficiary populations. It provides decision makers with strategic information that allow countries to mobilize resources, have a stronger accountability and a more efficient and effective program implementation. NASA is a tool within the national monitoring and evaluation framework and is a recommended measurement tool to track HIV spending at country level to report to GARPR indicator 6.1.
13. Demographic and Health Survey (DHS)	Demographic and Health Surveys (DHS) are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators. Advocacy to development partners for

	mobilization of funds to carry out the DHS.

WAY FORWARD

An M&E system needs to be constantly reviewed and updated. The following strategies have been identified to improve the M&E environment prior to an in-depth review scheduled at the end of 2014.

- Strengthening of instruments to enforce routine reporting
- Establishment of a functional M&E sector coordination mechanisms
- Capacity building of sector coordination structures
- Mainstreaming M&E into Health Information System
- Advocate with implementing partners to recruit adequate M&E personnel or to have dedicated M&E staff
- M&E plan aligned to National HIV and AIDS Strategic Plan
- Develop linkages between databases so that they feed into one national data base
- Development of an electronic laboratory data base
- Reconstitute and capacitate M&E taskforce on data analysis and use.
- Periodic review of the national M&E indicators
- Develop a data dictionary to ensure standardization of indicators

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