GLOBAL AIDS RESPONSE

FULL COUNTRY PROGRESS REPORT

Seychelles

Reporting for the Period:

January 2012 – December 2013

Submission date: 15th April 2014

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ACRONYMS AND ABBREVIATIONS

ACP	AIDS Control Programme (Ministry of Health)
AIDS	Acquired Immuno-Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASFF	Alliance of Solidarity for the Family
AU	African Union
BCC	Behaviour Change Communication
CDCU	Communicable Disease Control Unit
CEDAW	Convention on the Elimination of all Forms of Violence against Women
CRC	Convention on the Rights of the Child
CSO	Civil Society Organisations
DA	District Administrator
DAC	Drug and Alcohol Council
DD	Dublin Declaration
EU	European Union
EMTCT	Eliminate Mother-To-Child Transmission
FAHA	Faith and Hope Association
FBOs	Faith Based Organisations
GARP	Global AIDS Response Progress
GBV	Gender Based Violence
HAART	Highly active antiretroviral therapy
HASO	HIV and AIDS Support Organisation
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immune- Deficiency Virus
HRI	Harm Reduction International
HTC	HIV Testing and Counselling
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
IEC	Information Education and Communication
IOC	Indian Ocean Commission
LUNGOS	Liaison Unit for Non-Governmental Organisations of Seychelles
M&E	Monitoring and Evaluation
MFA	Ministry of Foreign Affairs
MoH	Ministry of Health
MSM	Men who have sex with men
NAC	National AIDS Council
NAS	National AIDS Council Secretariat
NBS	National Bureau of Statistics
NCC	National Council for Children
NGO	Non-Governmental Organisation

NSF	National Strategic Framework
NSP	National Strategic Plan
OHU	Occupational Health Unit (Ministry of Health)
PEP	Post Exposure Prophylaxis
PLHIV	People living with HIV
PoA	Plan of Action
PMTCT	Prevention of Mother-To-Child Transmission
PWID	People who inject drugs
RBM	Results Based Management
RDS	Respondent-Driven Sampling
SADC	Southern Africa Development Community
SBC	Seychelles Broadcasting Corporation
SDD	Social Development Department
STI	Sexually Transmitted Infections
SW	Sex worker
TOT	Training of Trainers
UA	Universal Access
UN	United Nations
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organisation

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NAMES	**POST**
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Mrs. Brenda King – Hospital Administrator
Mrs. Sabrina Mousbe- Manager HIV &AIDS Prevention & Control Programme

Finally, gratitude goes to **Dr. Jude Gedeon, the Public Health Commissioner** and **Dr, Shobha Hajarnis Director General Public Health Authority**, **Dr. Anne Gabriel the ex-TAC Chairperson and new NAC Chief Executive Officer,** for their commitment, leadership invaluable support provided in the report delivery.

1.0 INTRODUCTION

BACKGROUND

Seychelles is faced with a concentrated epidemic; HIV prevalence remains relatively low, with 0.87% in the general population. The pandemic is a concentrated one, as indicated from the IBBS 2011 conducted with two key populations (MSM and PWID) which showed prevalence rates of 14% and 4% respectively. The HIV prevalence among 15 to 24 years is also low (0.76%). This result was obtained from the IBBS 2012 conducted in the general population and tests at outreach activities

The *Seychelles Global Response Report 2012-2013* has brought together various national experts, civil societies, private sectors from a wide variety of national HIV AIDS Response fields with aim to ensure the provision comprehensive information, through a muti-sectoral approach. The country progress reports represent the most comprehensive data on both the status of, and response to the Seychelles epidemic. The Seychelles is submitting the fourth Global Response Report previously known as the UNGASS and a mid-term review for 2012. They have been useful in identification of areas of progress as well as those which need further attention to improve the work being done.

During the initial reporting process, the National Aids Council of the Seychelles was undergoing a transition period based on the new enactment of the entity. This was compounded by the release of new instructions of the reporting of 2013 and new indicators. Taking into consideration the limited human resources of the country, no financial support was activated by the UNAIDS, though request was submitted to support the country in succeeding in its reporting for GARPR 2013, by providing financial support for a National Consultant. For effective completion of the report, the Seychelles sought an additional fifteen days to finalise and validate the report before submission on the 15th f April 2014.

In the data compiling process and report writing, it became evident that existing data on certain indicators non health indictors are not easily obtainable or available in the format recommended by GARPR Guidelines on the Construction of Indicators namely for gender inequalities, NCPI and the NASA., however there has great improvement in this area compared to the first reporting in 2008.

It also became clear during the process of data assembling and report writing that the existing information systems is not geared to the collection of all data required in the format recommended by GARPR Guidelines on the Construction of Indicators. Nevertheless, this process can serve to sensitise us to data requirements and the need to construct information systems to address this specific data requirement.

There is a need to continuously engage various partners to include Commitment of Declaration Indicators into existing periodic surveys and routine data collection. Indicators and data elements recommended for both the public and the private sector should take into account data

requirements of the GARPR Guideline for the Construction of Indicators. Similarly, routine data collection of the Ministry of Education, Employment and Social Welfare Agency should take into account data requirements on financial support, basic life skills and HIV & AIDS in workplaces.

This year countries had to report on twelve new WHO indicators of the same value to the DD, UA and GARPR, it would be of significant importance for the report to be simplified by the joint UN system to avoid duplication.

The process of compiling this report was instrumental in renewing this engagement. During the process it was also noted that though the country compiled and prepared the three previous UNGASS reports, 2003 , 2005, 2007, 2009- mid-term review in 2013 these reports were not included in the aggregated International UNGASS and GARPR reports.

Organisation of the exercise

Role of the GARPR Writing team

THE GARPR steering team coordinated the whole process and support the country GARPR reporting. This greatly eased the exercise since the members of the steering committee was already a member of the writing team to some aspects of the reporting, especially those who were forming part of the NCPI and the costing team. However, the steering committee work has shown some limits, especially in relation to the limited availability of the members for attending meetings and for providing technical inputs. Therefore, the meeting was being limited to a maximum of three, and the coordinator is also the country editor. Members of the writing team were also selected from the Steering Committee with specific responsibilities based on their expertise. Each member had the responsibility to present specific indicators of the report during the validation meeting held on the 11th April 2014.

In the framework of this exercise, the steering committee has the following tasks and responsibilities:

Validation of the methodology of the exercise
Facilitation of the NAC work within respective sectors (access to informants and documents)
Validate the NCPI report
Validation of the spending matrix
Validate the country GARPR indicators before their entry online

STEPS OF THE EXERCISE

- Structure the GARPR technical support and coordination framework
- Finalize the roles and responsibilities in the assignment of the national consultant
- Identify key documents and data sources for the exercise
- Develop methodologies and tools for the exercise
- Develop detailed Project Work Plan, schedule of key stakeholder interviews and field visits

- Develop the schedule of steering committee meetings (for methodology validation, and for NCPI & indicators validation)
- Desk review + Work and consultations on the NCPI
- Data collection for the spending information from all the stakeholders
- Data collection for the GARPR indicators
- Conduct the validation for the NCPI, the spending data and the GARPR indicators

Due to the unavalaibilty of a national or international consultant, the methodology including the stakeholders to meeting/visits comprised of:

- National structures (NAC, DFHN, AIDS Programme,)Technical bodies (TAC, epidemiology and statistics units,…) NGOs, International partners and UN organizations Faith Based Organizations Private Sector Organizations, Health sector structures including health Centers, the youth centre, CDCU, private practitioners, etc. At least one district HIV&AIDS Committee ,Community based organizations and structures People living with HIV and Women living with HIV, Representatives of key populations

Taking into consideration the above methodology, the following timeframe proposed was implemented

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV&AIDS

Timeframe Implemented

Activity	Timeframe	Dates	Responsible
Finalisation and validation of the GARPR development TORs Seychelles and submitted to UNAIDS.	5 days	05th -09th February	Core team
Revamp the Steering Committee	5 days	10th -14th February	Core team
Preliminary Meeting with the Steering Committee	1 day	14th -Feb	Core team
Meeting with reporting team on new reporting tools, guidelines and indicators	10 days	15th -20th February	Core team
Downloading of reporting materials from websites as and when it was uploaded	14 days	21 Feb- 06th March	Core team
Desk reviews	7 days	07th – 12th March	Writing team
Meeting with TAC Committee	1/2 day	13th March	Core writing team
Advocacy to the NAC Board	1/2 day	13th March	Core Team
Meeting with NCPI respondents	1 day	14th March	Core team
Review of indicators team headed by the Country editor	2 days	07th -14 March	Core writing team
Meetings with Steering Committee	3 days	28th Feb -18th March	Core writing Team
Desk review + Work and on the NCPI including interviews	15 days	01-07th March 2014	Steer/Core/Writing Team

Data collection/collation analysis of the spending information from all the stakeholders	15 days	14 – 31 March 2014	Writing team
Data collation, analysis of NASA/GARPR indicators	15 days	14th – 31st March	Writing team
Update of Spectrum files	15 days	14th – 31st March	writing team
Cont - Desk reviews + Work and on the NCPI(Outstanding forms)	7 days	13th – 25th March	Writing team
Pre-validation processes (NCPI, spending data and UNGASS indicators) TAC/Steering committee	3 days	26th – 29th March 2014	Writing team
Data processing and up loading into reporting tool	16 days	30th 2014	Writing team
Organisation of validation stakeholders meeting	07th days	07th -10th April	writing team
Stakeholders meeting	1 day	11th April 2014	All
Final approval of validated reports	1 day	12th-13th April 2014	All teams
Production of final version of narrative report	5 days	14th -20th April 2014	Core writing team
Final input into the reporting tool	2 days	14th -15th April 2014	writing team
TOTAL	days		

2.0 STATUS AT A GLANCE

Inclusiveness of the stakeholders in the report writing process;

To support the processes of the activities, the Multi- sectoral Steering Committee was reactivated and provided the technical assistance the progress of the exercise. In addition, the National AIDS Council Board monitored the progress and Technical Advisory Committee on HIV&AIDS and STIs (TAC) was consulted and provided their technical input during the whole process.

The GARPR report 2013 was compiled by the Directorate of Family Health and Nutrition of which AIDS Control Programme is one of the sixth Programme. The process was conducted by a work team coordinated by AIDS Prevention and AIDS Programme. The country editor being the Director of the section and the team comprised members from National AIDS Council, Diseases Prevention and Control (DSRU) and Health Statistics Unit, Communicable Diseases Control Unit (CDCU), Ministry of Finance, Pharmaceutical Unit, PMTCT staff, Civil Society, Social Security Unit of the Ministry of Social Welfare Agency under the guidance and management of the Public Health Department newly revamped to the Public Health Authority. To facilitate efficient coordination and input od indicators into the platform core writing team was established and it comprised of the Country editor, the Manager of the AIDS Control Progamme, the Doctor

in Charge of CDCU and the Hospital Administrator who is also trained in NASA and member of the TAC.

This report has been compiled with participation and involvement of the Public Sector |(various \government Ministries and Departments), Civil Society, Private \Sector and UN team, the National Social Behaviour Change Communication Committee. In producing the report, we also relied mainly on existing data from the Ministry of Health of Health, Finance, Education and Agency for Social Protection. These included data sourced from the National Statistics Bureau, Health Statistics Unit, CDCU, DSRU and Health Statistics Reports.

I. STATUS AT A GLANCE

Table 1 - Status at a glance
INCLUSIVENES OF STAKEHOLDERS

Activity	Timeframe	Dates	Responsible
Preliminary Meeting with the Steering Committee	1 day	14th Feb 2014	Core team
Meeting with TAC Committee	1/2 day	13th March	Core writing team
Meeting with NAC Board	1/2 day	13th March	Core Team
Meeting with NCPI respondents	1 day	14th Mach 2014	Core team
Stakeholders meeting	1 day	11th April 2014	All

STAUS OF THE EPIDEMIC
Table 2.Staus at a glance of the epidemic 2012 and 2013

2012	**2013**
New Cases January to December 2013	New Cases January to December 2012
New HIV Cases - 29 (15M/14F)	New HIV Cases - 47 (31M/16F)
New AIDs cases - 10 (4M/6F)	New AIDs cases - 21 (16M/5F)
AIDS deaths - 8 (6M/4F)	AIDS deaths - 8 (4M/4F)
MTCT - 10	MTCT - 7
HAART - 46 (20M26F)	HAART - 39 (20M/19F
Hep C - 114 (119M/22F)	Hep C - 97 (81M/16F)
Co-Infection HC/HIV 6 (5M/1F)	Co-Infection HC/HIV- 5 (1M/5F)
TB - 18 (11M/7F)	TB - 23 (16M/7F)

THE POLICY AND PROGRAMMATIC RESPONSE;

The Seychelles has recently developed some *National Strategies for the Prevention and Control*

of HIV and AIDS and STIs 2012-2016 in Seychelles, which comprises of the following documents:

Table 3: Available policy and programmatic Response

• The National Policy on HIV and AIDS and STIs 2012
• The National Strategic Framework (2012)
• The National Costed Operational Plan(2012)
• The National Multi-Sectoral Monitoring and Evaluation Framework(2012)
• The National HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour (KAPB) and Biological Surveillance Study Report for Seychelles 2013
• Strategy 2012 on Introduction of Medically-Assisted Therapeutic Services for Key Population in Seychelles:
• Draft Sexual Reproductive Health Policy
• The Situation Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles final report 2013
• The report 2013 *on* Assessment the efficiency of the management of treatment for people living with HIV and AIDS Report of the Auditor General
• The National Social Behaviour Change Communication Framework2013
• The National HIV Testing and Counselling Guidelines 2013
• National HIV AIDS Workplace Policy 2013
• National AIDS Council ACT 2013
• National AIDS Council ACT 2013

NATIONAL COMMITMENT AND ACTION;

Domestic and international AIDS spending by categories and financing sources: (NASA) Funding matrix uploaded
National Composite Policy Index: (NCPI) Separate document uploaded

STATUS AT A GLANCE (cont)

Table 4: The indicator table

TARGET 		**Reduce sexual transmission of HIV by 50% by 2015**		
No.	Indicators	GENERAL POPULATION	%	Source

1.1	Young People: Knowledge about HIV prevention	% of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	88%	IBBS -2013 GARPR)
1.2	Sex before the age of 15	% of young women and men aged 15-24 who have had sexual intercourse before the age of	4.6%	IBBS-2013 GARPR)
1.3	Multiple sexual partners	%of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	8.5%	IBBS-2013 GARPR)
1.4	Condom use at last sex among people with multiple sexual partnerships	% of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	51.3%	IBSS-2013 GARPR)
1.5	HIV testing in the general population	% of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	72.3%	IBBS-2013 GARPR)
1.6	HIV prevalence in young people	% Percentage of young people aged 15–24 who are living with HIV	1%	IBBS-2013 GARPR)
		KEY POPLATION		
		Sex Worker		
1.7	Sex Workers Prevention Programmes	% of sex workers reached with HIV prevention programmes	< 1%	No IBBS done yet
1.8	Sex Workers condom Use	% Percentage of sex workers who received an HIV test in the past 12 months and know their results	< 1%	No IBBS done yet
1.9	HIV testing in Sex Workers	% of sex workers who have received an HIV test in the past 12"months and know their results	<1%	No IBBS done yet
1.10	HV Prevalence in Sex workers	%of sex workers who are living with HIV		No IBSS done yet
		Men Having Sex With Men		
1.11	Men having sex-Prevention Programmes	% of men who have sex with men reached with HIV prevention programmes	62%	GARPR IBBS/RDS 2011
1.12	Men who have sex with men: condom use	% of men reporting the use of a condom the last time they had anal sex with a male partner (Question asked was with different partner)	N/A	GARPR IBBS/RDS 2011
1.13	HIV testing in men who have sex with men	%of men who have sex with men that have received an HIV test in the past 12 months and know their result	27.3%	GARPR IBBS/RDS 2011

1.14	HIV prevalence of Men Having Sex with Men	% of men who have sex with men who are living with HIV	13.2%	GARPR IBBS/RDS 2011
1.16.	Testing and counselling in women and men aged 15 and older	Number of pregnant women aged 15 and older (out of the total number above) who received testing and counselling in the past 12 months and received their results	1626	Sentinel sites Surveillance
1.16.1	HTC in women and men 15 yrs and older	% of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months	100%	Sentinel site Surveillance
1.17.	**SEXUALY TRANSMITTED INFECTION IN KEY POPULATION**			
1.17.1	ANC –Testing for Syphilis	% of women accessing antenatal care (ANC) services who were tested for syphilis	100%	Sentinel site Surveillance
1.17.2	ANC-Positive Syphilis tests	% of antenatal care attendees who were positive for syphilis	0%	Sentinel site Surveillance
1.17.3	ANC – Positive test received treatment	% of antenatal care attendees positive for syphilis who received treatment	0%	Sentinel site Surveillance
1.17.4	Sex Worker –Active Syphilis	% of sex workers with active syphilis	6.9%	Outreach Programme
1.17.5	men who have sex with men who tested positive for syphilis	% men who have sex with men (MSM) with active syphilis	6.8	Sentinel site Surveillance
1.17.6	Adults with Syphilis	Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 month	57	Sentinel site Surveillance
1.17.7	Reported congenital Syphilis	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months	0%	Sentinel site Surveillance
1.17.8	Recorded gonorrhoea in men	% of men reported with gonorrhoea in the past 12 months	146	Sentinel site Surveillance
1.17.9	Recorded men with urethral discharge	Number of men reported with gonorrhoea in the past 12 months	252	Sentinel site Surveillance
1.17.1	Recorded adults with genital discharge	Number of adults reported with genital ulcer disease in the past 12 months	35	Sentinel site Surveillance
	MALE CIRCUMCISION			
2.0				
2.1				N/A Indicator
2.0		**Reduce transmission of HIV among people who inject drugs by 50% by 2015**		
2.1	PWID-Prevention Programmes	Number of needles and syringes distributed per PWID per year by needle and syringe	0%	GARPRUA/DD Programme not

		programmes		introduced yet
2.2	PWID – Condom use	%of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	3.8%	GARPR/UA IBBS/RDS 2011
2.3	PWID - safe injecting practices	% of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	0%	GARPR/UA IBBS/RDS 2011
2.4	PWID-HIV testing in	% of people who inject drugs who received an HIV test in the past 12 months and know their results	100%	GARPR/UA/DD IBBS/RDS 2011
2.5	PWID- HIV prevalence	% of people who inject drugs who are living with HIV	5.8%	GARPR/UA/DD IBBS/RDS 2011
2.6	PWID- Estimated Opiates user	Estimated of opiate users(non an injectors) if available)	1283 (2.3% of adult population)	GARPR/UA/DD IBBS/RDS 2011
2.7	PWID-Opiates sites	Number of opioid substitution therapy (OST) sites	1	Programme
3.0	ELIMINATE NEW HIV INFECTIONS AMONG CHILDREN	**Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**		
3.1	PMTCT	% of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission	100%	GARPR/UA
3.1 a	PMTCT during breastfeeding	% of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period	100%	GARPR/UA
3.2	Early Infant Diagnosis	% of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	0% (Viral load at birth, 3months)	GARPR/UA
3.3	MTCT modelled	% Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	2%	GARPR/UA
3.4	Pregnant women and their HIV Status	% of pregnant women who know their HIV status (tested for HIV and received their results-during pregnancy, during labour and delivery, and during the post-partum period	100% 7 tested 3 known + 4 new	UA

		(<72 hours), including those with previously known HIV status)		
3.5	MTCT and male partner	% of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	Data Not available	UA
3.6	MTCT and ART	% of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	100% (7)	UA
3.7	Infants initiated on ART prophylaxis	% of infants born to HIV-infected women provided with antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks	100% (3 infants)	UA
3.9	Infants started CTX , 2 mths	% of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	100% (3 infants)	UA
3.10	Distribution of feeding practices	Distribution of feeding mixed practices for infants born to HIV-infected women at DPT3 visit	3	UA
3.11	Pregnant women attending ANC	Number of pregnant women attending ANC at least once during the reporting period	1630(100 %)	UA
4.0	15 MILLION ACCESSING TREATMENT	**Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015**		
4.1	HIV Treatment-Anti-retroviral therapy	% of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	58%	GARPRU A/DD
4.2a	ART ; 12 months retention	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	37% Loss to follow up-7 Stopped ART -8 Died - 3	GARPRU A/DD
4.2b	ART-24 months retention	% of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy	70% Loss to follow up 2 Stopped 4 Died 3	GARPRU A/DD
4.2c	ART-60 months retention	% of adults and children with HIV known to be on treatment 60 months after initiation of antiretroviral therapy	72.5% Loss to follow up 0 Stopped 0 Died 3	GARPRU A/DD/ EURO4

4.3a	Health facilities offering ART	number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)	8 including PEP	UA
4.3b	Health facilities offering Peadiatric ART	Number of health facilities that offer paediatric antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)	8 including Children ward	UA
4.4	ART stockouts	% of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV drug in the last 12 months	8	UA
4.6a	HIV Care	Number of adults and children enrolled in HIV care at the end of the reporting period	576	UA
4,6b	HIV Care	Number of adults and children newly enrolled in HIV care during the reporting period	47	UA
4.7	**Viral load suppression**			
4.7a	Viral Load	% of people on ART tested for viral load who have a suppressed viral load in the reporting period	80%	UA
4.7b	ART tested for viral load	% of people on ART tested for viral load (VL) with VL level ≤ 1000 copies/ml after 12 months of therapy	79%	UA
5.0		Reduce tuberculosis deaths in people living with HIV by 50% by 2015		
5.1	Co-management of tuberculosis and HIV treatment	% of estimated HIV-positive incident TB cases that received treatment for both TB and HIV	4%	GARPR/UA
5.2	Newly enrolled active TB	% Percentage of adults and children living with HIV newly enrolled in care who are detected having active TB disease	2%	UA
5.3	New enrolment on IPT	% of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	0% Indicator N/A	UA
5.4	HIV and TB assessment	% of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	100 %	UA
6.0		**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	AIDS Spending	Domestic and international AIDS spending by categories	$ 2.8M	GARPR/DD
7.0		**Eliminating Gender Inequalities**		
7.1	Prevalence of intimate partner violence	Proportion of ever married partnered women aged 15-49whoexperienced physical or sexual violence from a male intimate partner in the past 12 months	No survey conducted	
8.0		**Eliminating stigma and discrimination**		
8.1	Discriminatory attitudes towards people living with HIV	% of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV % or respondents who answered "NO"	79.6%	GARPR
9.0		**Eliminate HIV-related restrictions on entry, stay and residence**	**Data collected by UNAIDS**	
10.0		**Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age)**		
10.1	Orphans and School attendance	**%** Current school attendance rate of orphans aged 10-14 primary school age, secondary school age	100%	GARPR
10.2	Orphans	**%** Current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent	100% Denominator (1)	GARPR

11 OVERVIEW OF THE EPIDEMIC

Data is from the Disease and Surveillance Response Unit of the Ministry of Health. The Unit was set up in 2012 be responsible to carry out the surveillance of communicable diseases and eventually non-communicable diseases as well. The surveillance of the epidemic is conducted at sentinel points, such as the Communicable Disease Control Unit (CDCU), antenatal clinics, Occupational Health Unit (OHU) and the blood bank in the Ministry of Health and reveals that there is an increasing trend in HIV infections. The Seychelles response to the pandemic dates back to 1987 when the first HIV infection was detected and the first recognized full-blown AIDS

case was reported in 1992.

Table 5: Cumulative data from 1987 to December 2013

Local Situation from 1987 to 2013			
	Total	Male	Female
Cumulative HIV Cases	578	334	244
Cumulative AIDS Cases	261	163	98
Cumulative Deaths	116	70	46
Cumulative HIV Positive Pregnancies	98	-	98
Living with HIV & AIDS	376	209	16
Cumulative Cases on HAART	218	118	100
Left Seychelles	89	55	34
Cumulative Loss to Follow- Up Cases	77	42	35
Cumulative Drop–outs on HAART	39	20	19

Source: Ministry DSRU- Ministry of Health

Indicator 4: ***Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy***

Table 5b: Percentage of adults and children with advanced HIV infection receiving ART (Source: Patient Register,

Year	Number of adults and children with advanced HIV infection who are currently receiving ART at the end of the reporting period	Estimated number of adults and children with advanced HIV infection
2007	<15 Female: 4 <15 Male: 3 15+ Female: 39 15+ Male: 51 Total: 97	<15 Female: 4 <15 Male: 3 15+ Female: 39 15+ Male: 51 Total: 97
2008	<15 Female: 6 <15 Male: 3 15+ Female: 45 15+ Male: 59 Total: 113	<15 Female: 6 <15 Male: 3 15+ Female: 69 15+ Male: 83 Total: 161
2009	<15 Female: 6 <15 Male: 3 15+ Female: 55 15+ Male: 75 Total: 139	<15 Female: 6 <15 Male: 3 15+ Female: 57 15+ Male: 80 Total: 146
2010	15 Female: 5	15 Female: 5

	<15 Male: 3 15+ Female: 60 15+ Male: 88 Total: 156	<15 Male: 3 15+ Female: 60 15+ Male: 88 Total: 156
2011	15 Female: 2 <15 Male: 3 15+ Female: 81 15+ Male: 95 Total: 181	15 Female: 2 <15 Male: 3 15+ Female: 81 15+ Male: 95 Total: 181
2012	15 Female: 3 <15 Male:4 15+ Female: 97 15+ Male: 111 Total: 215	15 Female: 3 <15 Male: 4 15+ Female: 97 15+ Male: 111 Total: 215
2013	15 Female: 3 <15 Male: 4 15+ Female: 100 15+ Male: 111 Total: 218	15 Female:3 <15 Male: 4 15+ Female: 100 15+ Male: 111 Total: 218

Situation in 2012

A cumulative of 104 (63M/41F) HIV &AIDS deaths has been reported since 1993 to 2012, 61% of deaths occurred in males and 39% in females. In 2012, 9 (6M/4F) AIDS related deaths have been reported, 11% of the cases died of carcinoma of the colon, 11% of Myocardial Infarction and 78% died of other AIDS related complications

Situation in 2012			
New HIV Cases	-	47	(31M/16F)
New AIDs cases	-	21	(16M/5F)
AIDS deaths	-	8	(4M/4F)
MTCT	-	7	
HAART	-	39	(20M/19F
Hep C	-	97	(81M/16F)
Co-Infection HC/HIV	-	5	(1M/5F)
TB	-	23	(16M/7F)

Source: DSRU Ministry of Health

Local Situation from 1987 to 2012

Table 6: Local situation 1987 to 2012

Cases	Total	Male	Female
Cumulative HIV Cases	531	305	226
Cumulative AIDS Cases	240	145	95
Cumulative Deaths	104	63	41
Cumulative HIV Positive Pregnancies			92
Living with HIV & AIDS	340	190	150
Cumulative Cases on HAART	192	101	91
Left Seychelles	87	53	34
Cumulative Loss to Follow- Up Cases	90	55	35
Cumulative Drop–outs on HAART	24	15	9

Source: DSRU Ministry of Health

HIV

New cases of HIV & AIDS are continuously being reported every year though there has been a 45% reduction in the number of new cases reported for 2012 compared to 2011.There were 29 new cases reported for 2012(15M/14F) compared to 42 new cases in 2011, the age group most affected was the 21 to 25 years representing 24% of the new cases followed by the 16 to 20 years representing17% of the new cases

As of December 2012, a cumulative of 531 (305M/226F) HIV & AIDS cases have been reported which represents 57% males and 43% females. Currently 340 (190M/150F) cases are living with HIV&AIDS representing 56% males and 44% females.

During 2012, 29 (15M/14F) new cases tested positive for HIV, age ranging from 9 months old (the youngest a female) to 74 years old (the eldest a male), 52% of the cases were males and 48% were females. There were 90 (55M/35F) cases that did not access the service for over 6 months representing a 26.5% of loss to follow-up (LTFU).A cumulative of 192 (101M/91F) cases is currently on Highly Active Antiretroviral Therapy (HAART) and 24 (15M/9F) cases have defaulted treatment. All age groups are affected by HIV and the most affected to date from 1987 to 2012 is the 31 to 35 years representing 19% of the cases.

AIDS Deaths

The first AIDS case was reported in 1993, a cumulative of 240(145M/95F) AIDS cases has been reported to date representing 60% males and 40% females. For the year 2012, 10 (4M/6F) new AIDS cases were reported, a 50% reduction in the number of new AIDS cases for 2012 compared to 20 cases in 2011, 2 were newly detected HIV cases and 8 were cases who have defaulted treatment and review over the years and who reported in late stage of AIDS.

A cumulative of 104(63M/41F) HIV &AIDS deaths has been reported since 1993 to 2012, 61% of deaths occurred in males and 39% in females. In 2012, 9 (6M/4F) AIDS related deaths have been reported, 11% of the cases died of carcinoma of the colon, 11% of Myocardial Infarction

and 78% died of other AIDS related complications.

AIDS mortality from 1993 to 2000 was on the increase but a gradual decline was noted from 2001 when the Highly Active Antiretroviral Therapy (HAART) was introduced and accessible to all HIV & AIDS clients eligible for treatment as per WHO guidelines.
Before the introduction of Highly Active Antiretroviral Therapy (HAART), the AIDS related mortality was relatively high, 12 deaths (15%) out of 80 PLWHA in 2001 and which dropped drastically to 7 deaths out of 206 PLWHA (2.7%) in 2005 to 9 deaths (2.64%) out of 340 PLWHA in 2012. The AIDS mortality remains a challenge since 90 (26.5%) cases of known HIV & AIDS clients are not adhering to treatment and follow-up, hence reporting in late stage of AIDS with opportunistic infections.

Hepatitis C
Since 2002 to 2012 a cumulative of 297 cases of Hepatitis C has been detected, 241(81%) were males and 56(19%) were females. there are 18 (13 males/5 females) cases of HIV & Hepatitis C Co-infection. For the year 2012, 141(119M/22F) new cases of Hepatitis C cases were detected representing an increase of 188% in new reported cases compared to 2011 and 6 (5M/1F) new cases of HIV & Hepatitis C Co- infection was also reported.

There is a gradual increase in the incidence of Hepatitis C reported cases from 4 per 1000 tests in 2008 to 24 per 1000 tests in 2010 and 50 per 1000 tests in 2012.Out of the 297 cases, 294 (99%) were Intravenous Drug Users. From 2008 to 2012, 35 % of the Hepatitis C cases were reported from the Mental Health Services, 30% from the Prison and 21% from the CDCU. An increase of 22.4% in the number of Hepatitis C tests conducted in 2012 compared to 2011.

PMTCT
A total of 92 cases of HIV positive pregnancies reported from 1987 to 2012, 69(75%) cases have benefited from the PMTCT program since its introduction in 2001 from monotherapy to tritherapy today.
Throughout 2012, 10 HIV positive pregnancies were reported of which 6 new reported cases of HIV for 2012, representing an increase of 67% in new HIV positive pregnancies for 2012 compared to 2011. Before the PMTCT era, 8 out of the 23 babies born from HIV positive mothers were infected with HIV representing 35%of mother to child transmission, conversely 3 out of the 69 babies born from HIV positive mothers were infected representing 4% of mother to child transmission after the PMTCT program was introduced.
An increase of 67% in new reported cases of HIV positive pregnancies in 2012 (10 cases) compared to 2011(6 cases),

The HIV incidence amongst ANC attendees within the 15 to 24 year age group decreased generally from 2005 to 2008, in 2009 the highest incidence of 1.12 positives per 100 HIV tests was reported followed by a decline in 2010 to 0.48 positives per 100 HIV tests and has gradually increased to 0.54 positives per 100 HIV tests in 2012.
Of note, an increase of 33% in the number of new HIV positive pregnancies and 1.5% increase in the number of ANC attendees within the age group of 15 to 24 years were reported for 2012 compared to 2011.Amongst the 10 new HIV positive pregnancies reported for 2012, 40% of the cases were within the 15 to 24 year age group.

HAART

A cumulative of 192(101M/91F) HIV & AIDS cases are currently on Highly Active Antiretroviral Therapy (HAART) from 2001 to date, which represents 53% males and 47% females. Defaulters who are supposed to be on treatment represent 11% (15M/9F)of the total number of eligible cases.

In 2012, 46 (20M/26F) HIV&AIDS cases were initiated on Highly Active Antiretroviral Therapy (HAART), representing 43% in males and 57% in females respectively when compared to 37 cases in 2011.

Since 2008 to 2012, drop outs in HAART has been observed by year of initiation ranging from 25% of the new cases initiated on HAART in 2003 to 17% in 2008, 19% in 2010 and 4% in 2012.

Tuberculosis

A cumulative of 557 confirmed tuberculosis cases have been reported from 1979 to 2012, 396 (71%) cases were males and 161 (29%) were females. There were 26 tuberculosis related deaths out of 557 cases since 1980 and 28 cases of HIV & TB Co –infection reported from 2000 to 2012. No data available for the previous years.

In 2012, 18(11M/7F) newly confirmed tuberculosis cases , 17(94%) cases of Pulmonary TB and 1(6%) case of Extra Pulmonary TB was reported. There has been a reduction of 14% in the total number of cases reported in 2012(18 cases) compared to 2011(21cases), 22% of the new cases were expatriates and 1 HIV & TB Co- Infection was also reported, a male.

Reported cases were more predominant amongst males than females and no cases of MDR or XDR TB have been reported to date.

Situation in 2013

Over the past 26 years since the first HIV case was diagnosed in Seychelles, a cumulative of 578 (334M/244F) HIV & AIDS clients which represents 58% males and 42% females have been reported. Currently, 376 (209M/167F) cases are living with HIV & AIDS representing 60% males and 40% females.

New Cases January to December 2013			
New HIV Cases	-	47	(31M/16F)
New AIDs cases	-	21	(16M/5F)
AIDS deaths	-	8	(4M/4F)
MTCT	-	7	
HAART	-	39	(20M/19F
Hep C	-	97	(81M/16F)
Co-Infection HC/HIV-		5	(1M/5F)
TB	-	23	(16M/7F)
TB Co-infection	-	1	(M)

Source: Ministry DSRU- Ministry of Health

HIV AND AIDS LOCAL SITUATION

Table 7: Local Situation from 1987 to 2013

Cases	Total	Male	Female
Cumulative HIV Cases	578	334	244
Cumulative AIDS Cases	261	163	98
Cumulative Deaths	116	70	46
Cumulative HIV Positive Pregnancies	98	-	98
Living with HIV & AIDS	376	209	16
Cumulative Cases on HAART	218	118	100
Left Seychelles	89	55	34
Cumulative Loss to Follow- Up Cases	77	42	35
Cumulative Drop–outs on HAART	39	20	19

Source: Ministry DSRU- Ministry of Health

HIV

Over the past 26 years since the first HIV case was diagnosed in Seychelles, a cumulative of 578 (334M/244F) HIV & AIDS clients which represents 58% males and 42% females have been reported. Currently, 376 (209M/167F) cases are living with HIV & AIDS representing 60% males and 40% females.

For the year 2013, 47 (31M/16F) new clients have tested positive for HIV with age ranging from 9 months old (the youngest a female) to 69 years old (the eldest a male), the median age amongst the newly reported cases was 31 years old.

Out of the 346 (209M/167F) clients living with HIV & AIDS, 77 (42M/35F) cases did not accessed the service for over six months representing 22% of loss to follow-up (LTFU). A cumulative of 218 (118M/100F) clients are currently on Highly Active Antiretroviral Therapy (HAART) representing 58% people living with HIV and AIDS are currently on treatment. Of note, 39 (20M/19F) clients representing 15% of clients eligible for treatment as per WHO recommended guidelines defaulted treatment for more than three months in 2013. The year 2013 reported the second highest number of new cases, 47 compared to 51 cases in 2009, an increase of 62% in new cases compared to 29 cases in 2012.

Males are more predominantly affected in all age groups throughout the years except the 0-19 year old age groups whereby there are more females. Age groups 25 to 39 years are more primarily affected but now with improvement in management of HIV and AIDS we have an increasing number of clients aging with the disease.

AIDS

The first AIDS case was reported in 1993, a cumulative of 261(163M/98F) AIDS cases has been reported by December 2013 representing 62% males and 38% females. There were 21(16M/5F) new cases reported in 2013, an increase of 110% compared to 10 new cases in 2012, 10 were

newly detected HIV cases and 11 were cases who have defaulted treatment and review over the years and who reported in late stage of AIDS.

A cumulative of 116 (70M/46F) HIV and AIDS deaths has been reported since 1993 to 2013, 60% of deaths occurred in males and 40% in females. There were 8 (4M/4F) AIDS related deaths reported in 2013 compared to 9 cases in 2012. Of note, 75% of the cases were newly diagnosed HIV and AIDS clients in 2013 and 25% of the cases were those who have defaulted treatment and follow-up, the youngest a 9 months old female and eldest a 69 year old male.

A cumulative of 116 (70M/46F) HIV and AIDS deaths has been reported since 1993 to 2013, 60% of deaths occurred in males and 40% in females. There were 8 (4M/4F) AIDS related deaths reported in 2013 compared to 9 cases in 2012. Of note, 75% of the cases were newly diagnosed HIV and AIDS clients in 2013 and 25% of the cases were those who have defaulted treatment and follow-up, the youngest a 9 months old female and eldest a 69 year old male.

PMTCT

A cumulative of 98 HIV positive pregnancies have been reported from 1987 to 2013, of which 74 (76%) have benefited from the PMTCT program since its introduction in 2001 from monotherapy to tritherapy today.

For the year 2013, 7 new HIV positive pregnancies were reported, a reduction of 30% compared to 2012. Before the PMTCT era, 8 out of the 23 babies born from HIV positive mothers were infected with HIV representing a mother to child transmission rate of 35% compared to 2 out of the 74 babies since the introduction of PMTCT program representing a mother to child transmission of 3%.

Two babies were reported HIV positive at 9 months of age in 2013 and both their mothers tested HIV negative at 36 weeks gestation. There is a possibility that they could have been infected either late in pregnancy, during delivery or whilst breastfeeding hence further emphasize the need of testing of both partners.

Highly Active Ante-Retroviral Therapy (HAART)

From 2001 to 2013, 257 (138M/119F) HIV & AIDS clients were initiated on Highly Active Antiretroviral Therapy (HAART), which represents 54% males and 46% females. However, increasing number of treatment drop out cases are reported every year.

As of December 2013, a total of 39(20M/19F) HIV & AIDS clients representing 15% who are eligible for treatment have defaulted treatment for more than three months. There has been a fluctuating trend in the incidence of drop-outs from 8% in 2005, 10% in 2008, 17% in 2011, 27% in 2012 and 18% of cases initiated on HAART in 2013 respectively.

In 2013, 61 (38M/23F) HIV & AIDS clients were initiated on Highly Active Antiretroviral Therapy (HAART), representing 62% in males and 38% in females respectively, an increase of 33% in new cases compared to 46 in 2012. Of the 61 new cases initiated on HAART in 2013, 11(7M/4F) cases representing 18% have defaulted treatment for more than three months.

Hepatitis C

From 2002 to 2013, a cumulative of 394 cases of Hepatitis C were detected, 322(82%) males and 72(18%) females. Out of the 394 cases, 27(18M/9F) were HIV and Hepatitis C co-infection and 6(3M/3F) Hepatitis C related deaths.

For the year 2013, 97(81M/16F) new cases of Hepatitis C were detected representing a reduction of 45% in new reported cases compared to 2012.The age group most affected was the 20 to 29 years representing 51.5% of the total cases reported for 2013, the youngest was a 15 year old female and the eldest a 52 year old male. There were 5 (1M/4F) new cases of HIV & Hepatitis C co- infection, 1 Hepatitis C related death (1F) and 2 Hepatitis C related pregnancies reported.

There was a gradual increase in the incidence of Hepatitis C reported from 24 per 1000 tests in 2010 to 50 per 1000 tests in 2012 followed by a rapid decline to 26 per 1000 tests in 2013. Out of the 394 cases reported to date, 391 (99%) cases were confirmed to be Intravenous Drug Users. An increase of 30% was also observed in the number of Hepatitis C tests conducted in 2013 compared to 2012. From 2008 to 2013, 37% of the Hepatitis C cases were reported from the Mental Health Services, 30% from the Prison and 19% from the CDCU.

Tuberculosis

A cumulative of 580 confirmed tuberculosis cases have been reported from 1979 to 2013, 412 (71%) cases were males and 168 (29%) were females. There were 31 tuberculosis related deaths out of 580 cases since 1976 and 31 cases of HIV & TB Co –infection reported from 2000 to 2013. No data available for the previous years.

In 2013, 23(16M/7F) newly confirmed tuberculosis cases were reported , 20(87%) cases of Pulmonary TB and 3(13%) cases of Extra Pulmonary TB were reported, an increase of 28% in the total number of cases compared to 2012. Of note 35% of the new cases were expatriates. There was 1 HIV & TB Co- Infection reported, a male, and 5 (4M/1F) tuberculosis related deaths of which 60% were Seychellois. No cases of MDR or XDR TB have been reported to date.

Modes of Transmission

According to data collected from tests conducted throughout 2011, the mode of transmission is as follows: 86% is heterosexual 14% is MSM.

Indicator1.5: HIV testing in general population

Percentage of women and men aged 15 to 49 years received an HIV test in the past 12 months

There were 899 (407 males, 492 females) respondents aged 15-49 in the KAPB and biological survey of 2013. In all 72.3% in that age group received an HIV test in the past 12 months and know their results, 58.0% among the males and 84.1% among the females. The highest were among females aged 25-49 years which was 98.6% and the lowest were among males age 15-19 years, 12.8%.

Data from the DSRU indicate that the HIV incidence has remained constant at 5 per 1000 HIV tests for the year 2006 to 2008 but increased to 6 per 1000 HIV tests in 2009. From 2010 to

2012, there was a decreasing trend in the incidence. The incidence for 2013 was 5 per 1000 HIV tests.
A fluctuating trend in the number of HIV conducted between 8000 and 10000 tests. A total of 9547 HIV tests were conducted for 2013, an increase of 2% compared to 2012. HIV tests were conducted in all VCT centers, Wards, Antenatal Clinics and the Blood Transfusion Center.

Other Sexually Transmitted Infections

Indicator 1.17: Percentage of antenatal care attendees who were positive for Syphilis

All pregnant women who attended ANC services were tested negative for syphilis, however the test was not offered during the KAPB Study in the general population.

Compared to the last reporting period, data from the DSRU shows the trend of STs is on the increase.

Syphilis

An increase of 53% in new syphilis cases and a reduction of 4% in the number of RPR/TPHA tests performed for 2013 compared to 2012. The incidence of syphilis is calculated per 10000 RPR/TPHA. A significant increase in the incidence of syphilis has been observed over the past four years from 60 per 10000 RPR/TPHA tests in 2010 to 91 per 10000 RPR/TPHA tests in 2013, a growing epidemic.

Gonorrhea

The incidence of Gonorrhea has generally been on the increase over the years from 1 per 100 tests in 2006 to 13 per 100 tests in 2009, 22 per 100 tests in 2011 and 19 per 100 tests in 2013, a reduction of 6% compared to 2012. A total of 5967 tests for Gonorrhea were conducted from 2005 to 2013 with 812 positive cases representing a case detection rate of 14%.
The year 2013 reported 201 (146M/55F) Gonorrhea cases, an increase of 20% in positivity and 23% increase in the number of tests conducted as compared to 2012. The youngest affected was a 14 year old and eldest a 62 year old, both males, age group more predominantly affected was the 15-29 years, representing 58% of the total reported cases

Amongst the 201 positive gonorrhea cases detected in 2013, antimicrobial sensitivity testing was conducted for Ciprofloxacin, Ceftriaxone and Cefixime.
Of note, 76% of the positive cases were resistant to Ciprofloxacin and 78% of the positive cases were sensitive to Ceftriaxone.

Chlamydia

A total of 3828 tests for Chlamydia Trachomatis were conducted from 2005 to 2013 with 590 positive cases reported representing a case detection rate of 15%. A gradual increase in the incidence for Chlamydia Trachomatis was observed from 6.53 per 100 tests in 2008 to 14.65 per 100 tests in 2011, 14.66 per 100 tests in 2012 and 27.21 per 100 tests in 2013, an increase of 86% in 2013 compared to 2012.The year 2013 also reported an increase of 50% in the number of tests conducted compared to 2012. The youngest was a 14 year old and eldest a 68 year old, both males. The age group most predominantly affected was the 15-29 years, representing 58% of the total positive reported cases. To note that 3 cases of opthalmia neonatorum due to Chlamydia were also reported in 3 neonates.

III. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Seychelles is a democratic republic consisting of 155 islands located in the Western Indian Ocean, 55.6 degrees east of Greenwich meridian and 5 degrees south of the equator. The total land area is 455km2 and the Exclusive Economic Zone (EEZ) comprises of 1.3 million km2 of ocean. The archipelago is largely composed of granitic and coralline islands. The geopolitical location of the Seychelles is in Eastern Africa with 100% boundaries consisting of more than 600 km of coastlines and the country is relatively isolated.As a Small Island Developing State (SIDS), has generally positive key development indicators, especially literacy rate for both sexes (94%), low maternal and infant mortality rates, life expectancy at birth of 74.2 years for both sexes and a high proportion of the population with access to potable drinking water (95%) and with access to sanitation (97%).

In 1990, the mid-year estimate of the population of the Seychelles was 69,507, with a birth rate of 23.1 and a death rate of 7.7 By 1995, the population had grown to 75, 304, with a birth rate of 21.0 and a death rate of 7.0. The population continued to grow until it reached 80, 410 in 1999. Since then, the Seychelles an average of 1,500 persons have been added to the population annually. The population also dropped from 2002 from 82,781 to 82,475 in 2003. For the next three years, it stayed around 82, 000 people due to fluctuations in the number of migrant workers and increase in emigration.

STRUCTURES IN PLACE

National Coordination

Seychelles has a concentrated epidemic and the country have developed coordination structures and strategic documents and plans and to a certain extent put in place national monitoring and evaluation systems. Based on the evaluation of the National HIV/AIDS Policy 2001 and the National Strategic Plan 2005-2009, the Seychelles has recently developed a new policy on HIV and AIDS and STIs and a National Strategic Framework for the period 2012-2016 to tackle the issues around coordination, prevention, treatment, care and support, Impact Mitigation and Human Rights Protection and they are supported by Coordination and Communication, Resource Mobilisation, Human Resource and Monitoring and Evaluation and monitoring and evaluation of HIV AIDS response.

Given its political commitment to all required international obligations by signing treaties, conventions and / or committing itself to various requirements, such as those laid out in political declarations and UNAIDS strategic plans. Hence, the country adheres to principles and targets, such as those of the MDG, the "Three Ones" Principles and "Getting to Zero", Universal Access and UNGASS Declarations 2001 and 2011.

The Coordinating Mechanism is also guided by the country's various international commitments, such as the the first UN General Assembly Special Session (UNGASS) on HIV/AIDS in 2001 adopted a Declaration of Commitment, the "Three Ones" and "Getting to Zero"; the principles to

access the Global Fund and other financial international funding sources.
Strong leadership is the key to success and is noted amongst the ten points in the Declaration. Moreover, the "Three Ones" Principle also calls for one national coordinating body.

National AIDS Council
The National AIDs Council (NAC) strengthens the country's response to HIV/AIDS in Seychelles. This was formed in May 2002. It is the highest National Authority on HIV/AIDS in Seychelles. As such the President of the Republic is the Patron. The Minister for Health is also the Minister for HIV and AIDS. In December 2013, the NAC bill as approved by the National Assembly of Seychelles.

President of the Republic of Seychelles James Michel has appointed a New Chief Executive of the National AIDS Council of Seychelles as from January 2014, in accordance with the National AIDS Council of Seychelles amendment act 2013, section 21. Its main role is to support NAC and provide guidance and assistance to all organisations involved in the multi-sectoral national response, namely in prevention and behaviour change, treatment and care, impact mitigation and human rights protection, coordination and resource mobilization, monitoring and evaluation and finally costing of various national and multi-sectoral HIV and AIDS and other STIs –related plans, consists of a costed action plan and monitoring and evaluation framework to ensure that progress is adequately measured.

Interventions in terms of prevention has moved gradually from general one size fits all messages to more targeted interventions albeit being conducted more by NGOs rather than the Ministry of Health. The latter has also partially succeeded in getting the nation and key stakeholders to see that HIV and AIDS are not the sole responsibility of the Ministry, but that the issue is a national one, with the potential to wreak havoc with national development goals

AIDS Control Programme
The AIDS Prevention and Control Programme (also referred to as AIDS Programme is a unit with fulltime AIDS Programme Manager, a Health Promotion Officer under the Public Health Division in the Ministry of Health. It is responsible for advocacy and prevention aspects of HIV&AIDS, reaching a wider community. However, it is much involved in planning, facilitation, coordination, implementation, monitoring and evaluation of activities.. For the past years until January 2014, the AIDS Programme also held the NAC Secretariat, though not operating to the maximum.

Now that the NAC bill as been enacted, the AIDS Control Programme is responsible for the biological aspect of the national response to HIV&AIDS. It is based within the Ministry of Health and only retain its mandate to provide technical expertise and lead the HIV&AIDS response in the health sector.

Communicable Diseases Control Unit (CDCU)
In 2001 antiretroviral therapy was firstly introduced in the Seychelles and many HIV-infected individuals have accessed free treatment.

The government commitment to provide care support to the infected and affected of HV and AIDS saw the establishment CDCU. The main treatment centre falls under the portfolio of the Ministry of Health, is the sole specialist referral centre in the Seychelles for the management of all sexually transmitted infections (STIs) which include HIV and AIDS, management of Tuberculosis, Leprosy, Hepatitis B and C, and traveler's health. The duties of the CDCU are not confined only to the management of people living with HIV and AIDS but also sensitisation programmes on treatment adherence.

The Civil Society (including NGOs, Faith-Based Organisations) and the Private Sector are involved in the national response, represented in various structures and are consulted before any interventions. Apart from the ancient CSO into the national response, we have seen four new organisations that joint in 2012-2013, namely:

- Centre D'Accueil de La Rosiere (CAR) – FBO
- Light Amidst my Path (LAMP) – NGO
- Everlasting Love Ministry (ELM) – FBO
- National Council for the disabled- NGO

The Technical Advisory Committee for HIV&AIDS (TAC) Based
Members are health professionals of the Ministry of Health who meets fortnightly to discuss issues pertaining to care and support, testing, treatment, surveillance and other guidelines. Main issues are research and surveillance; care and counselling; Blood Safety; Provision and Difficulties with antiretroviral therapy; Resource mobilisation; STI management; community activities; IEC; laboratory; and others e.g Contact Tracing; Confidentiality.

(a)EXISTING POLICY ENVIRONMENT

International Commitments
On the international level, the Seychelles is a signatory to eight major human rights treaties, including the ***International Covenant on Civil and Political Rights (ICCPR),*** the ***International Covenant of Economic, Social and Cultural Rights (ICESC),*** the ***Convention on the Rights of Persons with Disabilities*****, the** ***Convention on the Rights of the Child (CRC)*** and the ***International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)*** **.**Specific to HIV and AIDS, the country has also committed itself to the **"*Three Ones*"** principles (one national HIV and AIDS coordinating authority, one national HIV and AIDS action framework, and one monitoring and evaluation framework). Further commitment is given through adherence to the UNAIDS 2011 – 2015 Strategy: Getting to Zero. **"*One of the key thrusts is to advance human rights and gender equality for the HIV response. It is considered essential to address the issue of social and legal environments that fail to protect against stigma and discrimination or to facilitate access to HIV programmes continue as they block universal access. In particular, greater efforts are needed to realize and protect HIV-related human rights of women and girls, of PLHIVs, key populations, populations at higher risk and most vulnerable communities*"**

Other international obligations are to the ***Millennium Development Goal*****s HIV and AIDS related commitments and the** ***2011 UN General Assembly Special Session on AIDS (Political***

Declaration on HIV/AIDS : Intensifying our Efforts to Eliminate HIV/AIDS).

Furthermore and closer to home, the ***WHO Country Cooperation Strategy 2008-2013*** addresses all health issues in Seychelles with some priority areas, such as non-communicable diseases linked to lifestyles (diet, exercise and work). It further notes that **"*there is a need to strengthen the surveillance systems and implement an effective monitoring and evaluation system. An HIV observatory will go a long way towards strengthening information support and strategic information intelligence to inform policy, decision making and response*".** Moreover, the strategy document suggests that present challenges related to HIV and AIDS prevention and treatment include the sustainability of services, as well as long-term adherence and possible resistance development to ARVs in the future. There is also concern about reported incidence of some STIs such as gonorrhoea, genital warts, genital herpes, and syphilis, although the number of cases remains low, and their link to HIV and AIDS as indicators of possible drivers of the pandemic.

The ***Republic of Seychelles: Progress Report on Declaration of Commitment on HIV and AIDS 2013*** provides a comprehensive assessment of the current situation, with a relatively good treatment, care and support programme in place, while still experiencing problems with being able to foster consistent behaviour change in the general key populations.

National Commitments

In 2012 and 2013, there was still no specific legislation relating to HIV and AIDS and PLHIV. However, the ***Seychelles Health Strategic Framework 2006-2016*** is based on the principles of ***Health** By **All** **and** **Health For All.***

The Seychelles has recently developed its ***National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs 2012-2016,*** which comprises of the following documents:

The National Policy on HIV and AIDS and STIs 2012
The National Strategic Framework (2012)
The National Costed Operational Plan (2012)
The National Multi-Sectoral Monitoring and Evaluation Framework (2012)

The National HIV& AIDS and STIs Policy is aligned and incorporate International Obligations and Alignment with Human Rights instruments:

One of the main considerations for the development of the National Policy is the major human rights instruments signed by the Seychelles. All of them have certain obligations that the country need to abide to once it ratifies the treaty. These include the following:

The ***International Covenant on Civil and Political Rights (ICCPR)***, which give all citizens of all countries the right to self-determination, equality before the law, right to a fair and public trial before a competent tribunal, right to marry and form families with whomever they want, freedom of thought, expression, conscience, movement and to dispose of personal assets as seen fit by the individual. The rights to freely associate with others and form groups are also enshrined in the Covenant. The non-discrimination principle on the basis on race, colour, nationality, religion, status and gender is also expressed therein.

The ***International Covenant on Economic, Social and Cultural Rights (ICESCR)*** which give all citizens of all signatory countries the right to work in decent conditions, with equal pay for equal work, the right to education, especially primary which should be free, compulsory and accessible to both genders, the right to decent standard of living, environment and health, and freedom to promote and express their cultural values and identity.

***The Convention on the Rights of the Child (CRC*)** which stipulates that children have special rights as well as some of those enshrined in the ICCPR and the ICESCR, such as the right to play, to have their best interests given primary consideration, to protection from abuse and exploitation and to be provided with alternative care when families cannot provide it.

Other Instruments are:
The ***Convention on the Elimination of All Forms of Discrimination***
The ***Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and Optional Protocol of CEDAW,*** **as well as** ***General Recommendations No. 19***
The ***International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families***
The ***African Charter on Human and Peoples' Rights***
African Charter on the Rights and Welfare of the Child
The ***MDG Declaration***
HIV and AIDS related commitments are:
The 2001 UN General Assembly Special Session on AIDS **(*UNGASS Declaration of Commitment on HIV/AIDS)***
2000 - UN MDGs declaration to strengthen National response
2001 - Abudja declaration on Universal Access HIV/AIDS/TB/Malaria/STIs – 2001
2003 - Maseru Declaration
2006 - Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Supporting Africa in 2010.
2006 - UN General Assembly *Universal Access Declaration*
2011 - Women, Girls, Gender Equality and HIV: progress towards Universal Access – Windhoek – 2011.
The 2011 UN General Assembly Special Session on AIDS (Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS)

The ***National Policy on the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles 2012,*** which lays the foundation and principles on which are based all further actions. The core values of the National Policy are: ***Respect for, protection and fulfillment of human rights,*** as stipulated in national and international instruments, *Integration of programmes and services*, for better networking and for building effective local and international partnerships and ***Pragmatism*** with emphasis on the central role of the body of scientific evidence in programmatic actions. The main goal of the Policy is to ***"halt new infections and reverse the trend of HIV and AIDS and sexually transmitted infections, and to care for and support those living with HIV and affected by AIDS".***

The ***National Strategic Framework on HIV and AIDS and STIs 2012 – 2016,*** which gives the

main priority areas for action. These are Prevention and Behaviour Change, Treatment and Care, Impact Mitigation and Human Rights Protection and they are supported by Coordination and Communication, Resource Mobilisation, Human Resource and Monitoring and Evaluation.

The ***National Costed Operational Plan,*** which gives the programmatic actions to be undertaken for the coming five years, with special emphasis on 2012.

The ***Multi-Sectoral Monitoring and Evaluation Framework for HIV and AIDS and STIs*** **2012-2016** with health and non-health sector indicators, aligned to international obligations (UNGASS, AIRIS-COI, and Universal Declaration) and national ones.

Whilst these international and national obligations have been factored into the national HIV and AIDS policy document, the NCPI shows, great improvement, on the existing national strategies compared to two years ago. The main ones have been listed below.

Government Officials

It was clear for most government officials which period is covered by the national multi-sectoral strategy for HIV and AIDS. Few of them seem aware that there was no Strategic plan in place in 2012 and 2013.

It is notable that there is the lack of multi-sectoral strategies with a budget for specific HIV activities, which has also been the case in 2012-2013

Overall, responses indicate an average of 8 out of 10 for overall strategy and national planning. However, there are limited substantial comments and examples to support that from the responses.

Civil Society

Most CSO representatives were involved in the development of the new strategic plan and there is a trend of increasing involvement from the previous NSP. However, this participation is still viewed as low and ineffective. Some CSOs found limited representation when it comes to budgeting for the national strategic plan on HIV/AIDS and STIs 2012-2016.

In summary, commitment to international and national obligations has been generally satisfactory, especially in terms on inclusiveness in national documents. However, there was no strategic plan being used in 2010 and 2011. Review of both documents and drafting of the new strategic plan has involved more CSO representatives.

HIV AIDS Workplace Policy 2012

HIV and AIDS is a terrible threat to the world of work. Virus strikes the most productive segment of the labor (age from 16 to 45 years), skills are disappearing sometimes difficult to replace, slow productivity, and reduce earnings are some consequences of the spread of HIV/AIDS. They pose a threat to fundamental rights at work because of discrimination, exclusion and stigmatization of people infected or affected may suffer. Stigma, discrimination and the threat of job loss suffered by people affected by HIV or AIDS are barriers to voluntary HIV virus, which increases their vulnerability and undermines their right of access to social benefits.

Despite of effort made in Seychelles to eradicate HIV&AIDS, it has been noticed that few actions were targeted workplaces. For too long, the issue of HIV/AIDS and that the disease requires care was raised by health experts for entrepreneurs only in terms of public health, the assumption that "talk of AIDS the workplace is in the interests of workers". Based on the New HIV& AIDS STI Policy 2012-2016, business leaders and all stakeholders solicited the availability of clear action plan targeted workplace.

(B) PREVENTION, KNOWLEDGE AND BEHAVIOUR CHANGE

***Indicator 4.1:** Percentage of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse.*

There were 76 (53 males, 23 females) respondents aged 15-49 in the KAPB and biological survey of 2013 who had more than one partner in the past 12 months... In all 51.3% in that age group used a condom during their last sexual intercourse, 50.9.0% among the males and 52.2% among the females. The highest were among males aged 15-19 years which was 63.6% and the lowest were among males and females age 20-24 years, 40% "*Only 68% of respondents believe that condoms can protect you from HIV… The figures were slightly higher in 2003, with 76% of males and 77% of females believing that condoms can protect from HIV transmission*."

The perception regarding condoms may need to be changed so that they are seen as both necessary and useful for prevention of pregnancy and transmission of diseases

In 2012 and 2013, the issue of behaviour change communication and prevention strategies remains predominant in the national response to the epidemic. The continued rise in the number of new PLHIV is a sign that much needs to be done in this area. The focus of interventions is still on the general population and young people. Sessions have been conducted in schools, workplaces and districts on demand from various groups and organisations by the AIDS Control Programme, the Social Development Department, the Youth Health Centre and the Drug and Alcohol Council. These are not regularly scheduled activities.

Key populations and vulnerable groups are not targeted directly. There have been attempts by some NGOs to become more proactive in addressing the needs of PWID, SW and MSM. Notable actions have been as

Use of 10 Targets Tracking Tool (based on the completed report)
USE OF 10 TARGETS TOOL

TARGET 1: REDUCE SEXUAL TRANSMISSION OF HIV BY 50% BY 2015

The Government of the Republic of Seychelles has shown continued commitment to improving the national response to HIV through leadership and through the allocation of resources to support interventions at various levels. There has been considerable progress in the development of HIV programmes, strategies and policies. Seychelles has a concentrated epidemic and the country have developed coordination structures and strategic documents and plans and to a certain extent put in place national monitoring and evaluation systems.

General population

The HIV and AIDS pandemic in Seychelles is a concentrated on, with a prevalence of 0.87% in the general population (KAPB Study Final Report, 2013).
Conducting a KAPB helped to better understand the HIV epidemic in Seychelles by providing two types of essential data: KAPB and biological surveillance of the general population. This is in line with the principles of *Result-Based Management*, which have also been incorporated into the national strategic plan for HIV and AIDS and STIs[3]. A key component of any action national prevention and control programme is to *Know Your Epidemic*. The KAPB Study 2012 has gone a long way in ensuring just that: Seychelles stakeholders and partners having comprehensive knowledge and understanding of the key drivers of the epidemic in the country.

Such data also helps to realign policies, the priories and programmatic actions of the strategic plan which is also scheduled for mid-term review in 2014. Moreover, the information guides national, regional and community IEC campaigns conducted by stakeholders and partners, such as the National AIDS Control Programme (ACP) and the Disease Surveillance and Response Unit (DSRU) of the Ministry of Health, the Ministry of Education (Personal and Social Education – PSE, and Students' Welfare Unit – SWU) and other government agencies and NGOs, such as HIV and AIDS Support Organisation (HASO), Faith and Hope Association (FAHA) and the Alliance of Solidarity for the Family (ASFF).

In reference to indicators 1.1 to 1.6, overall there were 263 (128 males, 135 females) respondents aged 15-24 in the KAPB and biological survey of 2012, 4.6% in that age group had sexual intercourse before the age of 15 years, 1.6% among the males and 7.4% among the females.

There were 899 (407 males, 492 females) respondents aged 15-49, 8.5% in that age group had sexual intercourse with more than one partner in the past 12 months, 13.0% among the males and 4.7% among the females. The highest were among males aged 20-24 years which was 20.0% and the lowest were among females age 25-49 years, 3.9%.
There were 76 (53 males, 23 females) respondents aged 15-49, who had more than one partner in the past 12 months... In all 51.3% in that age group used a condom during their last sexual intercourse, 50.9.0% among the males and 52.2% among the females. The highest were among males aged 15-19 years which was 63.6% and the lowest were among males and females age 20-24 years, 40%.
There were 899 (407 males, 492 females) respondents aged 15-49 in the KAPB and biological survey of 2012. In all 72.3% in that age group received an HIV test in the past 12 months and know their results, 58.0% among the males and 84.1% among the females. The highest were among females aged 25-49 years which was 98.6% and the lowest were among males age 15-19 years,12.8%.
In the same study , 649 women aged 15-24 were ante-natal attendees. Six (0.92%) were living with HIV,0.86% were in the age group 15-19 years and 0.95% were in the age group 20-24 years.
In that perspective, the *National Strategic Framework for the Prevention and Control of HIV and AIDS and STIs 2012 – 2016* focuses on developing programmatic actions that address specifically the needs of key populations, whilst pursuing with multi-sectoral approach interventions geared towards the general population.

Major Progamme Implemented

The HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour and Biological Survey in the general population, aged 15 to 64 years,
The sample is composed of 1691 persons living in Seychelles at the time of the study, who are aged between 15 and 64 years. The sample is also stratified according to age, gender and district of residence. The main methods of data collection are a face-to-face interview through the administering of a pre-tested questionnaire to have information on levels of knowledge, the kinds of attitudes, and the behaviour patterns of respondents, and a biological sample (blood) from each respondent to test for HIV and other STIs, with a rapid test in a laboratory setting.

National policies, programmatic actions by civil society and the state as well as intensive prevention and awareness campaigns for the general population have contributed to improved levels of knowledge about HIV and AIDS. In recent years, the national television has also produced a few films on situations regarding the pandemic rather than relying exclusively on foreign productions. This has increased interest in the subject and may have improved the level of knowledge and reduced stigma and discrimination.

Development of a National Strategic Framework for social and behaviour change communication for HIV&AIDS and STIS 2014-2016. The framework is aligned to, and complements National Policy and Strategic Framework for HIV/AIDS and STIs 2012-2017 with a view to contribute towards achieving national goals, resolutions adopted under UN High Level Political Declaration to Eliminate HIV and AIDS, 2011 including Universal Access targets. It also further demonstrates our commitment to continue strengthening national AIDS response.

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

Key Population

Integrated behavioral and biological surveillance (IBBS)

The first round of an integrated behavioral and biological surveillance (IBBS) survey conducted from June to August 2011, among Injecting drug users (IDU) and men who have sex with men (MSM) in the Republic of Seychelles. The primary objective of these surveys were to provide information on the prevalence of HIV infection and associated risk factors among IDU and MSM to inform programmatic and policy responses and to provide a baseline from which to monitor epidemic trends. While the prevalence of HIV infection in the Seychelles remains below 1% in the general population, prevalence is expected to be much higher among high-risk groups such as female sex workers, MSM and IDU.

The Seychelles IBBS surveys were carried out by the Ministry of Health, Victoria, Seychelles, in collaboration with the Projet d´Appui à l´Initiative Régionale de prévention du IST/VIH/SIDA dans les Etats membres de la Commission de l'Océan Indien (AIRIS-COI project), National AIDS Trust Fund, and World Health Organization (WHO). Funding for technical support was

provided by AIRIS-COI, United National Office of Drugs and Crime (UNODC) and WHO.
RDS is a chain-referral sampling method specifically designed to obtain probability-based samples of 'hidden' and hard-to-reach populations that are socially networked. After providing informed consent, respondents completed an interview and provided blood specimens to be tested for HIV, syphilis and Hepatitis B (HbsAg) and C (HCV).

IDU
This surveillance survey used respondent-driven sampling (RDS) to obtain a final sample of 346IDU in Seychelles. Eligible participants were males and females who reported injecting illicit drugs in the last six months, aged 18 years and older, residing in Seychelles and speaking Creole or English.

KEY FINDINGS

Socio demographic results: The majority of IDU have employment, have a secondary education, are single or unmarried, are living with a partner, and are Catholic. Twenty percent of IDU are female.

Biological test results: HIV prevalence among IDU in Seychelles was 5.8%. Only 0.7% of IDU were found to be infected with Syphilis and 0.1% infected with Hepatitis B (HbsAg). However, 53.5% of IDU were infected with Hepatitis C (HCV). Among female IDU, 4.6% were HIV seropositive. Sixteen percent (95% CI. 2.8, 59.4) of HIV seropositive IDU were also infected with HCV.

High-risk sexual behaviours: The median age of sexual debut for IDU was at 15 years. IDU have multiple types of sexual partners, including occasional and commercial partners. The median number of sexual partners of the opposite sex was two and condoms use was inconsistent.

Alcohol and drug use: Among the 30% of IDU who reported consuming alcohol, 46% did so weekly or more often. Almost all IDU reported using illegal non-injection drugs. Smoking cannabis or heroin were the most frequently used drugs in the six months prior to the survey.

High-risk injection drug use practices: IDU in Seychelles inject heroin, specifically *tanmaren* and *white* heroin. There was almost an even split between IDU who reported injecting once a week or less (54%) and more than once a week (but not daily) (46%). High percentages of IDU share needles and syringes previously used by someone else as well as give, lend or sell needles or syringes to someone else after already using them. In addition, high percentages of IDU share cookers, vials and containers, cotton and filters, and/or rinse waterand draw up drug solutions from common containers shared by others.

Low HIV transmission knowledge: Few IDU had correct knowledge (as determined using an aggregated scale of knowledge questions) of HIV transmission. However, IDU had good knowledge of some individual sexual risks and injection risks. Sixty three percent of IDU reported ever having had an HIV test. Among that Sixty three percent, 48% had a test in the past twelve months, and among those so tested, 89% received their test results.

Low treatment access and utilization: Although 41% of IDU reported ever receiving treatment or "help" for injecting drug use, very few received detoxification or maintenance with methadone.

High stigma and discrimination: IDU in Seychelles suffer from high levels of stigma and discrimination. Sixty eight percent of IDU reported being refused a service in the past 12 months because of their injection drug use. Just over 50% of IDU had been arrested in the past twelve months.

The Seychelles have many people who inject illicit drugs: Approximately 2.3% (or 1, 283) of the adult population in Seychelles inject drugs. Females comprise 257 of the adult IDU population in Seychelles.

Major Programme Implemented

Introduction of National Medically-Assisted Therapeutic Strategy(MAT) Providing Treatment Options for People Who Inject Drugs. The program takes a biological, psychological, social and spiritual stance using a multidisciplinary team which includes physicians', psychiatrists, nurses, psychologists, and other supporting staff. The program follows an integrative and holistic treatment approach, which is in line with best practice models of abstinence.
The programme consists of a two-week residential induction phase which allows the staff of the centre to conduct HTC and to promote the use of condom and to discuss other issues affecting the clients. However, there is no safer injecting practices and no NSP. As for the latter, it is done on an individual level by one or two individuals on an ad-hoc basis with persons that they know well.

So far, there has been no central and national approval for NSP with PWIDs. So far, there have been 328 for the past two years, men accounts for 84.5% (278) and women 15.2%. Out of this total 0.9% (3) were male minors below the age of 18years. The demand for such services is high as the more people are on the waiting list. The service is well established for people living with addiction There s a need to expand the service (Introduce outpatient services)
The support of stakeholders is visible through donation of a gym and other equipments for rehabilitation of clients. Efficient service delivery through training of staff in basic addictology for all staff working with the addictology unit by the Ministry, IOC UNODC, WHO and SADC.

Sex with females:
Most men self-identified as bi-sexual or heterosexual, indicating active sex with females, including partners considered being wives and girlfriends. Among those who reported having sex with a female in the past six months, 41.7% reported having ≥4 female sex partners. Less than half of MSM used a condom during intercourse with their last non-paid female sex partner.
Commercial sex workers are the bridges in HIV/AIDS epidemic linking concentrated epidemics to the general population. Therefore sensitisation of the CSW is a key aspect in HIV/AIDS prevention and control. One of UNAIDS strategy plan is to provide access and services to commercial sex workers as a means of disease prevention and management. Devoting sensitisation campaigns and offering access to health care services to target groups has additional benefit for disease prevention and management, as with CSW you can offer service to injecting drug users who are commercial sex workers.

Programmes Implemented

Sex worker

April 2013 a team of, one doctor and 2 nurses set out on the streets of Victoria, alongside a nongovernmental organisation 'NOU LA POU OU', to identify hot spots where prostitutes use to pick up clients. On the first evening 5 prostitutes were identified, counselled, condoms and CDCU bookmarks distributed, as well as blood drawn for HIV, Hepatitis B, C, and RPR/TPHA. On the second day, similar activities, 6 CSW were registered.

A total of 11 prostitutes were reached through the 2 days. The target was 25-30 CSW, so a third night was dedicated to continue the outreach activity. On the 26th of April again similar activity of which 5 more CSW was reached. Therefore a total of 16 CSW (15 females and 1 male) agreed to participate and 3 refused. The youngest CSW was 18 and oldest 36 years old.

RESULTS: The majority of the CSW welcomed the idea of enrolling them to care and the outreach program. During counselling some of the constraints identified, most of them had condoms 3-4, stating that the police stopped them if they have more condoms. Although they were using condoms with clients, they were having unprotected sex with their stable partners and they were sharing needles with whomever; most of them asked if they could have a needle and a syringe. 15/16 i.e. 94% were injecting drug users (IDU). One tested HIV positive, 14/16(87.5%) were hep c (+). No one tested positive for syphilis or Hep B. In all 192 condoms were distributed. Out of the 16 only one CSW came for her results at CDCU, at the same time she was screened for other sexually transmitted infections, her results were normal.

Overall the outreach activity was well received by the CSW. Blood sample and counselling were being done on street corners; safety and privacy were at risk. The incidence of Hepatitis C is 87.5 % among the CSW and HIV incidence 6 % among CSW. Out of the 5 objectives stated above, only 4 were achieved. Enrolment to services and access to treatment failed as only one CSW came for results and she has been referred to the methadone substitution unit (WELLNESS CENTRE).

Even though the sample size is small, the level of HIV and Hepatitis C is alarming among CSW, especially since CSW is the bridge between the concentrated epidemics to the general population. The IDUs and CSW are vital target groups in disease prevention and control campaigns and should not be ignored; action now can prevent a HIV and Hepatitis C outbreak in the general population. The outreach activity should be ongoing with the support of the government until a more permanent program aim at targeting commercial sex worker is in place either through an NGO or linked to the AIDS prevention program, like in other countries.

(C) CARE, TREATMENT AND SUPPORT

The Communicable disease Control Unit (CDCU) of the Public Health Department which falls under the portfolio of the Ministry of Health, is the sole specialist referral centre in the Seychelles for the management of all sexually transmitted infections (STIs) which include HIV and AIDS, management of Tuberculosis, Leprosy, Hepatitis B and C, and traveller's health. The

Unit has been in operation since the first case was detected in 1987 and has well laid down guidelines and procedures. The Unit has not experienced stock out during the reporting period.

TARGET 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths.

PMTCT

In 2012, a total of 1,672 and 1,630 in 2013 of women attended antenatal clinics and delivered out of these total A cumulative of 98 HIV positive pregnancies have been reported from 1987 to 2013, of which 74 (76%) have benefited from the PMTCT program since its introduction in 2001 from monotherapy to tritherapy today.

For the year 2013, 7 new HIV positive pregnancies were reported, a reduction of 30% compared to 2012. Before the PMTCT era, 8 out of the 23 babies born from HIV positive mothers were infected with HIV representing a mother to child transmission rate of 35% compared to 2 out of the 74 babies since the introduction of PMTCT program representing a mother to child transmission of 3%.

Two babies were reported HIV positive at 9 months of age in 2013 and both their mothers tested HIV negative at 36 weeks gestation. There is a possibility that they could have been infected either late in pregnancy, during delivery or whilst breastfeeding hence further emphasise the need of testing of both partners.

The Republic of Seychelles has demonstrated increasing commitment to and investment maternal health and wellbeing of Seychellois women and children. There has been progress in policy, investment of domestic resources, health systems strengthening, and universal Maternal and Child healthcare. These actions continue to improve maternal and child health indicators in the country.

Maternal mortality is very low in Seychelles In some years (2006, 2007, 2009 and 2011 and 2012), the rate is zero. The figure of 133 in 2010 represents 2 deaths. Nearly 100% of births in most years are attended by skilled health professionals According to MGD report 2013; Seychelles had progressed well recording zero maternal deaths over some years. Maternal mortality rate (per 100,000 live births) 0 133 0 0 / 1 death registered in 2013.

The PMTCT programme is perhaps the most effective one in the national response to HIV and AIDS. Due to the small population, it targets 100% of women attending antenatal clinics and educational sessions. In 2013, the Social Development Department of the Ministry of Social Affairs and Community Development with the collaboration of the Drug and Alcohol Council have been conducting these educational and parenting sessions on alcohol and drugs, psychosocial support in the preparation for the birth of the child and discussions of any social and psychological issues the women and their partners bring to the sessions. These are done over and above the normal antennal sessions that the women and their partners attend.

Programmes Implemented.

A number of factors have led to progress in achievement of this target. These include:

- **Free primary health care**, with a good distribution of regional health centres on the three main islands.
- **Training and deployment of midwive**s, with enhanced skills in a variety of health matters, including drugs and alcohol abuse and nutrition.
- Availability of **free family health services** (contraceptives, antenatal clinics) and nutritional support to mothers.
- **Free HIV Testing and Counselling (HTC) and Antiretroviral drug** (ARVs) for HIV positive mothers.
- **Strong Prevention of Mother-to-Child Transmission (PMTCT) programme,** which may be able to move to Elimination of Mother-to-Child Transmission EMTCT as monitoring of mothers and children tend to be comprehensive.
- **A solid antenatal, delivery and postnatal programme. School Health Programme** including Health-Promoting Schools components, which is a special programme that focuses on making the school as holistic healthy as possible, encourages school to look at health of the school in terms of its overall environment, both physical and psychological, to promote healthy attitudes and behaviours in school personnel, parents, the community and students.
- **Availability of health professionals at childbirth**.
- **Antenatal supplemented by parenting and psychosocial support** sessions (Drug and Alcohol Council, 2013).

- Development of the **Reproductive Health policy 2012** focuses on aspects of women and men's health and in particular issues pertaining to access to information and services for reproductive and sexual health. Women's health and the health of the family is a major factor that affects the country's population issues and services are put in place to target such issues.

- **Launching of CARMMA 2013,** The Government of the Republic of Seychelles commits to join other AU member states and launched CARMMA on the 21st of November 2013, in line with national priorities and AU resolution to advance health of women and children in Africa. The launched of the campaign in Seychelles w focused on awareness building, advocacy, mobilizing support and adopting a ROADMAP to implement agreed priority high impact interventions that will improve Maternal, Neonatal and Child health (MNCH) including adolescent health in Seychelles in line with National Health Framework 2006-2016.

- **CARMMA roadmap** for Accelerated Reduction of Maternal, Neonatal and Child Mortality and Morbidity in Seychelles 2014-2015. A roadmap was developed as a product of a series of national stakeholder consultations and expert synthesis. The ROADMAP outlines set of strategies and interventions that form basis of commitment to further improve maternal, neonatal and child health including adolescent and men's health outcomes, accelerate progress towards achieving health related MDGs by 2015 and sustain the achievements in the long term
  The Roadmap has 5 main components namely: Maternal, Men's, Youth, and Neonatal and

Child Health.

- A **Sexual and reproductive health monitoring and evaluation framework** has been developed in line with the national reproductive health strategic plan. The M&E framework will be used as a tool in the monitoring and evaluation of RH services in Seychelles

- **Family Planning Procedure Manuals 2007**, reviewed on the existing Family Planning procedure manual started in August 2012 and completed, printed and disseminated in 2013. Various people concerned reviewed different sections of the manual including the nurses who will be using it on a daily basis.

- **Procurement of Equipments** namely weighing scales and blood pressure apparatus for both Family Planning and Ante Natal clinics, School health nurses on Mahe and Inner Islands. These are facilitating early diagnosis and referrals of clients.

- Capacity building on **"Minimum Initial Service Package" (MISP)**.The impact of the flood occurred in January 2013following heavy rainfall saw a significant number of displaced family including pregnant women. Therefore a national rapid needs assessment for reproductive health in critical situations with the technical support of UNFPA. Based on recommendations, a three days training of 30 health workers and social workers were capacitated on Minimum Initial Service Package (MISP) training

- Parallel to the training **UNFPA made a donation of reproductive health kits to Seychelles at a value of $ 2,125 000.** The donation complimented the existing reproductive health services being offered especially following the recent flood affecting the country early 2013. The RH kits included different contraceptives, drugs and disposable equipments. The donations were handed over by the UNFPA regional Director to the Minister for Health on Tuesday 23rd April in a short ceremony assisted by MOH representatives and the WHO Liaison Officer.

- Additionally in 2013 the Youth **Health Centre of the Ministry of Health in collaboration with the Sexual Reproductive Health Programme** has set forth the process to develop a **National Adolescent Sexual Reproductive Health Policy.** Proposal was submitted and approved in fourth quarter 2013. Available documents gathered and desk review started in December 2013. Development of the situation analysis and the development of the policy itself will be done during 2014.

However, despite the marked achievements in the fertility transition, Seychelles experiences high adolescent fertility, which is 54 births per 1,000 females, aged 15 to 19. About 32% of all first pregnancies are occurring among 15 to 19 year old. Teenage pregnancy is still relatively high even with the numerous programmes available in the country:

Child Health

In 2012, there were a total of 7, 079 children in the age group 0-4 years, which represented

8.02% of the total population of Seychelles. Over the past 10 years, the average total number of births has been around 1,533 births per year. In fact, the Seychelles presently has the lowest mortality in Africa and is following the WHO guidelines and protocols for Maternal and Child Health. The under-five mortality rate per 1000 live births is already low and had dropped from 16.5 in 1991 to 12.8 in 2012 and 15.7 up to December 2013.The decline in death rate and infant mortality rate (IMR) per year had started since the 1970s. For example, the death rate dropped from 8.5 in 1971 to 7.4 in 2010 and IMR declined from 33.2 in 1971 to 10.8 in 2012 and 16.5 in 2013.

Programme Implemented

The relatively good results have been due to strong supportive government policies regarding child and maternal health, with strong antenatal and breast-feeding programmes, coupled with free health care.

- The antenatal and post-natal programmes include more than just sessions on nutrition and taking care of the baby, but since the beginning of 2013, they now also include **sessions on drug and alcohol abuse and psychosocial support for the expectant mothers.**

- The Ministry of Health also has a section that provides **Information, Education and Communication (IEC) materials and conducts advocacy and awareness campaign**s. Thus, a lot of advocacy is also continually done to inform mothers of the type and level of care they need to provide their children. The prospective and on-going **Child Development Study** conducted by the Ministry of Health in collaboration with the University Of Rochester, New York, has also helped to increase awareness and services for parents who are expecting babies and are raising children.

- The **Child Health Programmes in Community Health Services have been well established**, comprising of developmental assessment programmes as well as Immunisation Programmes. All babies are delivered in health care settings managed by Health professionals.

- Strengthening **Personal and Social Education (PSE)** Personal and Social Education (PSE) in schools which discusses reproductive health and rights with all students in state schools, the Youth Health Centre and its services for young people aged 14 to 24 years.

- The **presence of NGOs working in the field of gender and empowerment of women, peer education and counselling programmes** which have seen more than 600 teenagers trained in drugs and alcohol and reproductive health education.

- **Free family planning services** and distribution of **condoms in health centres and offices**. School health programmes provided by the Ministry of Health has some input into life skills and empowerment programmes for in-school students and out-of-school youths is the mandate of Youth Health Centre (YHC.
- **Revision of the postanatal guidelines for women and their babies** issue. The guideline

aims to identify the essential core (routine) care that every woman and her baby should receive in the first 6-8 weeks after birth, based on the best evidence available. Although for most women and babies the postnatal period is uncomplicated, care during this period needs to address any deviation from expected recovery after birth. This guideline gives advice on when additional care may be needed and these recommendations have been given a status level.

- **Survey and creation of data base on children aged 0-8 years** having special needs. The proposal is to conduct a survey of all children aged 0-8 years with special needs and create a data base with detailed information pertaining to these children. The results of the study is strengthened capacity to develop, adapt and implement national child survival strategies for the achievement of universal coverage of cost effective child survival intervention towards achievement of MDG 4 and 6.

- The **Infant Feeding Policy** has been developed in the context of national policies, strategies and programmes and numerous global initiatives in infant and young child feeding. An Infant Feeding Policy for Seychelles Hospital and other Child Health Services provides a framework to standardize procedures and improve practices by eliminating all practices that discourage breastfeeding as the norm. It also helps to support advocacy and resource mobilization to support breastfeeding practices

- Introducing the **revised School Health Screening Programme**. Change has made for the screening of secondary four students. These changes include the introduction of Human Papiloma Virus vaccine, Breast Self Examination (BSE) for girls, Testicular Self Examination for boys, hearing test (for implementation in the near future), and screening for Sexually Transmitted Infections and HIV testing. The implementation of the programme will be directed by the administration of written consents from parents and or guardians
- Implementation o the new **WHO guidelines on PMTCT since 2012**

TARGET4. Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015

Treatment of HIV is still free and easily accessible to persons who meet the set WHO guideline. The PMTCT programme remains strong, even if with the advent of heroin-dependent mothers there is some risk of higher child mortality, given their non-attendance of antenatal sessions. PWIDs and MSMs have the highest prevalence of HIV and STIs, especially Hepatitis C, which pose particular challenges for behaviour change communication, treatment, follow-up and psychosocial support.

The national target for access to treatment is 100% for all who are eligible using WHO guidelines. However, adherence and clinic attendance can be an issue for some of the patients.

The efficiency of the management of treatment for people living with HIV and AIDS.

In 2012 there were 92% of adults and children who received antiretroviral therapy among all adults and children living with HIV, comparatively in 2013 which was 83%. Therefore there has

been 9% decrease for the year 2013.

- In March **2013 an audit was conducted on the activities performed by the CDCU in providing treatment, care and support to PLHWA**. The focus of the audit was based around the effectiveness with which the services are provided in ensuring adherence to treatment. The audit covered the period from January 2008 to March 2013.

- In reference to the audit Report Assessing the efficiency of the management of treatment for people living with HIV and AIDS2013 by office of the Auditor General, As of March 2013, 97 (60 Males /37 Females) cases did not access the service for over six months representing 28 per cent of loss to follow-up amongst the people living with HIV and AIDS and a cumulative of 37 (19 Males/ 18 Females) cases defaulted treatment representing 16 per cent of the HIV and AIDS clients eligible for treatment. Similarly, six new AIDS cases and three AIDS related deaths were reported for the first quarter of 2013.It has been noted in the DSRU report[1] that 60 per cent of the new AIDS cases reported for the first quarter of 2013 were known HIV individuals who had defaulted treatment and follow-ups over the years.

It was recommended for the unit to integrate in its calendar of activities additional programmes specific to adherence to treatment in respect to HIV and AIDS. This would ensure that the objective of treatment compliance can be targeted amongst HIV and AIDS individuals who are already on treatment and those who will eventually start treatment, as well as the general public which can also benefit through such programmes.

In the last year, the country has experienced no stock-out of ARVs. The total treatment cost per patient per year varies between US$730 – US$3112 per client (US$1 =SR11.50) with at least 48% of the national HIV budget allocated to treatment.
However some of the national programmes have been very successful and can be used as examples of best practices. Indeed, standards were maintained and even improved in some areas of programming. These include the following:

- **P/EMTCT where access is 100%** in most years for both antenatal and post-natal service delivery for both mother and child, with access to HTC, ART, nutritional support and good follow-up.

- **Regionalisation of the service** to population of the inner island.
- **Universal free (ARVs) treatment** for all PLHIV. Recently, the Ministry of Health has acquired a PCR in 2013
- **Revision of the Sexual Assault Guidelines in 2012**

Post Exposure Prophylaxis
The Ministry of Health developed the PEP guidelines since the year 2000, provides post-exposure prophylaxis (PEP) to all health care workers exposed to potential HIV-infected material

during the course of duty. Administration of PEP requires testing of both source and exposed individuals. This service is offered to health professionals and cadres such as police and fire officers, who are exposed to the risk of HIV infection when executing their duties and also to victims of sexual violence.

- PEP **guidelines have been reviewed and upgraded**. The PEP after sexual assault guidelines was developed in 2005 and implementation and is in progress.

TARGET5. REDUCE TUBERCULOSIS DEATHS IN PEOPLE LIVING WITH HIV BY 50% BY 2015

The number of new TB cases detected in Seychelles varies every year and the age ranges of new patients also remain an issue of concern. More young people are being infected with TB and unlike in highly endemic countries, TB in Seychelles is not associated with poverty or HIV. People from Seychelles travel a lot and mostly to highly TB endemic countries and there is a need to establish if there could be any link. Furthermore Seychelles has an influx of expatriate workers coming also from high burden countries, and every year we detect a significant number of these expatriate with active TB.

Program Implemented

- **Treatment guideline is according to WHO protocols** and it is free. Until to date there is no case of MDR TB recorded and that could be due to the proper application of the DOTS strategy.

- The number of Health Centers on the Island and their demographic location **allows for proper DOTS implementation** thus reduces the possibility of non compliance. For the past years there has been no rupture of stock of TB treatment.

- Seychelles has a **central laboratory facilities and well trained personnel with experience in the screening of specimen for TB**. We have the facility of Gene Xperts which facilitate prompt diagnosis and adequate treatment.

- Patient detected with active **Pulmonary TB are being isolated in the main hospital** for treatment until their sputum is clear of AFB. They can then continue DOTS in their respective clinic and do their follow-up at the Communicable Diseases Control Unit (CDCU) the only unit managing all TB cases.

- Considering the size of the country, **tracing of close TB contacts is very feasible**.

- For every single case of Pulmonary TB detected, tracing and screening of close contacts is done and those with latent TB are being put of **prophylactic treatment with Isoniazid.**
- TB control program in Seychelles is **fully funded by the government** but benefitted also with technical support from SADC and WHO.

(D) IMPACT ALLEVIATION

TARGET 8: 8. ELIMINATING STIGMA AND DISCRIMINATION

The ***National Policy on HIV and AIDS and STIs 2012*** notes that the ***"****impact of HIV and AIDS in Seychelles cannot be under-estimated. The individuals who have contracted the HIV virus all have families, friends, school or work colleagues and neighbours. Apart from the burden of disease estimated to be about SR5 million annually just for the provision of ART, there are other human costs, such as mental anguish and stress. The other financial costs are the laboratory services and the care provided by health professionals. The psychological distress leads to poorer school performance and lower productivity, and in some cases, at the advanced stage of AIDS, to the loss of a student or a worker.*"

A number of issues pose particular challenges for the national response to HIV and AIDS in the Seychelles. These include:

- Increasing numbers of new cases of HIV and AIDS annually.
- The change in the modes of transmission from heterosexual to PWID and MSM, with social contacts and bridges between these key populations and the general population, increasing the risk of further transmissions.
- The risk of HIV Infection for individuals is relatively high especially as there is little sign that people have changed their behaviour in spite of their knowledge about HIV and AIDS.
- Health-seeking behaviour in men remains low, especially as services tend not to be adapted to their needs.
- The treatment for hepatitis C is difficult and costly, placing more pressure on health financing systems and programmes.
- There are still poor levels of adherence to medications in some patients (5%). This may lead to more resistant forms of the virus, and treatment will become even more difficult.
- There are already signs of drug resistance in certain patients.
- As a result of HIV and AIDS, there is an increasing number of dependents on social services and social welfare assistance, placing severe pressure on the limited human and financial resources for these departments.
- Expenditure is increasing, for ARVs and the management of complications such as opportunistic diseases. Thus, ensuring that funds are available and sustainable on regular annual budget is now a major issue.

Table 8: Impact Alleviation - Summary of Findings of the National Review of the National Workplace Policy 2007

STRENGTHS	WEAKNESSES
• The Constitution of Seychelles guarantees many rights in Chapter 3: ***Part I: Seychellois Charter of Fundamental Rights and Freedoms*** • There is strong legislative framework for employment and labour, such as the***Employment Act 1995*** • The ***National Strategic Framework on HIV and AIDS and STIs 2012-2016*** has been developed and accepted by the National AIDS Council • Human rights is the foundation of all HIV and AIDS policy and framework documents • The National Policy on HIV and AIDS in the Workplaces had been developed • The Tripartite Committee has been created • The necessary partners or organizations have been created: the ***Federation of Employers Association***, the ***Seychelles Federation of Workers' Union (SFWU)***, the ***Employment Tribunal*** and more recently, the ***Office of Migrant Workers and Itinerants*** • The HIV and AIDS issue is at the forefront of national awareness • National programmes have been developed to address the issue of key populations, such as People Who Inject Drugs (PWID) • Workplaces are now more interested in developing HIV and AIDS policies	• Discriminatory laws: for example, S19(1)(a) of the ***Immigration Decree 1981*** may consider a person 'who is infected or inflicted with or is a carrier of a prescribed disease' as a prohibited immigrant. • The ***National Strategic Framework on HIV and AIDS and STIs 2012-2016*** has been disseminated and action-plans have not yet been developed for implementation of proposed actions. • The human rights of migrant workers living with HIV are not respected as they may be refused entry in the Seychelles on the basis of their HIV test. • The national HIV and AIDS policy for the workplace is relatively unknown and not widely disseminated. • The Tripartite committee meets rarely • Some of the organizations have weak structures and are generally inactive • HIV and AIDS in the workplace is still considered as a taboo subject and is rarely discussed openly • Key populations (migrant workers, sex workers, women and children) have less access to services, such as reproductive health counselling, testing and support. While these services may be available, their delivery may not be at accepted levels of customer care and service and may even be discriminatory and derogatory.
OPPORTUNITIES	**THREATS**
• The Seychelles undertook a review of the legislative environment for HIV and AIDS and included migrant workers and other key populations in the assessment. • The ***Corporate Social Responsibility (CSR)*** tax which has been introduced in 2013 provides greater possibility of funding for	• The high prevalence of HIV and AIDS in key populations such as MSM and PWID may create more stigmatisation and discrimination. • Seychelles is now classified as high middle income country and this can limit the amount of financial and technical assistance offered.

HIV and AIDS related workplace programmes. • There is now greater synergy between various sectors, such as HIV and AIDS and substance abuse and social work as organisations work together to address needs of key populations (MSM, SW, PWID, migrant workers, women). • The annual conference on HIV and AIDS in the Indian Ocean region creates contacts and possibilities for technical and financial support for national HIV and AIDS workplace programmes.	• There may be local donor fatigue, especially with the introduction of the CSR, which some businesses consider as a tax on tax. • With fear, stigma and discrimination still present in the country and subsequently in the workplace, there may be calls for more discriminatory actions against PLHIV including workers. • Internal migration for work and movements within workplace may lead to disarray and loss of institutional memory to ensure follow-up and sustainability of programmes undertaken.

The recent Legal Assessment report, Stigmatizing and discriminatory policies and practices continue to affect people living with HIV, despite the constitutional right of every person to equal protection of the law and freedom from discrimination under Article 27 of the Constitution. The GCHL's recent investigation into HIV, law and human rights reported that around the world, people living with HIV continue to feel the impact of stigma, discrimination, marginalization and abuse, both verbal and physical, in their homes, families, communities and in public institutions. In the Seychelles, CSOs working with people living with HIV and affected populations have provided anecdotal evidence of the kinds of stigma and discrimination experienced, including:

- HIV testing for purposes of marriage (in the case of marriage to foreigners);
- HIV testing for purposes of application for a dependent's permit (in the case of foreigners);
- HIV testing and denial of insurance and/or bank loans to people living with HIV;
- Discrimination in schools against children affected by HIV and AIDS;
- Discrimination in places of worship;
- Pre-employment HIV testing and denial of employment in certain employment sectors (e.g. hotel industry, airlines,) and of certain categories of employment (e.g. foreign / migrant workers);
- Dismissals from employment on the basis of HIV status;
- Stigmatizing and discriminatory treatment in access to health care services;
- Instances of HIV testing without voluntary and informed consent and without adequate pre- and post-test counseling (e.g. in health care services; for people who use drugs on entry into rehabilitation; for prisoners, on entry into prisons); and
- Breaches of confidentiality

According to participants in these focus group discussions, stigma and discrimination leads to increased isolation, self-stigma and fear amongst affected populations and makes people unwilling or afraid of accessing HIV testing, prevention, treatment, care and support services. The National HIV Policy and NSF provide the most detailed expositions of the rights of affected

populations to HIV prevention, treatment, care and support services without discrimination. Notably, HIV policies and plans provide for the specific prioritization of the rights of key populations at higher risk of HIV exposure (such as MSM, people who use drugs, sex workers, and prisoners, migrants and young people). These broad policies are furthermore supplemented by health guidelines on treatment for HIV. However, there may be a need for stronger protection for these rights in law, as well as for further training and strengthening of implementation, in order to ensure that these rights in policy translate into provision for the needs of affected populations.

National Strategic Framework for the Control and Prevention of HIV and AIDS and STIs 2012-2016 has taken this issue into consideration and together with the recommendations of the legal assessment study; there are propositions to amend laws to reduce stigma and discrimination for all persons and especially for the key population groups.

The NCPI questions on Human Rights also support the findings and recommendations of the Legal Assessment report. Most respondents (n=15) indicate there is existing non discrimination law or regulation which specifies protection of people living with HIV. Law or regulation implies a policy enforceable in a court of law.

Respondent also confirm that the country has no specific non discrimination legislation or regulation which specifies protections for specific populations. Most respondents (n=18) agree the country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations including MSM, people who inject drugs,, prison inmates, sex workers, and transgender people.

However strong recommendations are for Laws, regulations, policies and guidelines need to provide equitable access to HIV-related health care services in order to ensure effective responses to HIV and AIDS. Access to HIV prevention, treatment, and care and support services should be available to all people without discrimination and in particular should prioritise access for key populations at higher risk of HIV exposure. This requires developing appropriate HIV laws and policies as well as ensuring training for health care workers on non-discrimination and on the provision of HIV-related health care to key populations.

Programmes Implemented

- **Legal Assessment Framework 2013** aimed to improve availability of information and evidence on legal and regulatory aspects in the context of HIV and AIDS for purposes of advocacy and making recommendations for creating and strengthening an enabling environment that promotes an effective national AIDS response in accordance with National Strategic Plan for HIV and AIDS and STIs 2012-2016.

- Development of a **draft post LEA action plan 2014-2019** developed to address the recommendations based on the result of the assessment

- National policies, **programmatic actions by civil society** and the state as well as

intensive prevention and awareness campaigns for the general population have contributed to improved levels of knowledge about HIV and AIDS.

- In recent years, the national television has also **produced a few films on situations regarding the pandemic** rather than relying exclusively on foreign productions. This has increased interest in the subject and may have improved the level of knowledge and reduced stigma and discrimination. Still more needs to be done to reduce ignorance, stigma, discrimination and prejudice.

Appendix 3: NCPI. NATIONAL COMMITMENTS AND POLICY INSTRUMENT (NCPI)

Process used for NCPI data gathering and validation

ANALYSIS AND SUMMARY OF RESPONSES TO NATIONAL COMPOSITE POLICY INSTRUMENTS (NCPI) QUESTIONNAIRE (PART "A' AND "B")

Purpose of NCPI review process

The process aims to gather information to know the progress, challenges on overall policy, strategy, legal and programmes implementation environment for the HIV/AIDS response in Seychelles. The National Composite Policy Instruments (NCPI) relates to critical enablers, i.e. those elements that entail supportive and protective policy and legal environment for scale up of national multi sectoral HIV/AIDS Prevention, Treatment and Care and Support. It is part of UNGASS reporting exercise which is a commitment by the member states under the terms of the 2011 Political Declaration. UNGASS emphasizes that effective national Response to HIV and AIDS should be measured by achievement of tangible, time-bound targets. Therefore, there is a need for systematic monitoring of the progress in implementing commitments.

Respondent identification, recruitment and data collection process

A sample of 40 potential respondents was identified from different contact lists of relevant sectors and units within the government, and outside the government including Civil Society Organizations and United Nation Organizations. Out of this total 20 responded through the submission of completed questionnaire either before or after the half day workshop. It is notable that most respondents make up a sample of informants from within and outside the government who could be having with some sort of familiarity with scope of issues and knowledge around national response to HIV and AIDS.

The potential respondents were contacted and standardized self administered questionnaires posted to them. The respondents were expected to complete and post back completed questionnaires to the contact person in AIDS Control Program Office. Posting back the completed questionnaire also indicated consent by the identified persons to participate in the exercise. A section of the respondents posted back completed questionnaires while others completed their questionnaires, in a stakeholders meeting organized to build consensus on the

process of the NCPI data gathering and validation process.

Describe the process used for resolving disagreements, if any, with respect to the responses to specific questions

A half day workshop was organised for sensitisation on the purpose, objectives and possible outcome of the exercise. There was an interactive participation where they had the opportunity for clarifications.

Highlighted concerns, if any, related to the final NCPI data submitted (such as data quality, potential misinterpretation of questions and the like)

The NCPI process has gathered important views on a number of areas useful in understanding the current country situation. There are consistent views from both part A and B questionnaires including remarkable progress in access to treatment services e.g. ARVs, but also limitation in treatment access to certain population groups. Generally, there are more shared than conflicting views on trends of national HIV/AIDS response. Not to say there is absolute agreement in all areas, but even yet the points teased out in this summary will require further corroboration with evidence from desk reviews of other documents, and validation considering not all respondents share same views on even some of the most pronounced trends.

It is also important to acknowledge that, the sample of the participants in this process are relatively few, therefore, the views and general trends identified should only be interpreted carefully within reasonable scope and generalized only after triangulation with findings from desktop reviews of existing policy documents and validation with national stakeholders

(e) TARGET 6. CLOSE THE GLOBAL AIDS RESOURCE GAP BY 2015

Closing the Resource Gap

Seychelles is a recipient of ODA and not a donor country. Between 2009 and 2012 and in the context of the macroeconomic reform programme, the EU disbursed a total envelope of €17 million in the form of budget support to the Seychelles Government under the General Budget Support programme (Central Bank Report, 2012).

Since the economic crisis caused by external debt of more than 150% of GDP and the adoption of the IMF-driven comprehensive reforms in 2008/2009, the Government's economic policy has been consistent with the maintenance of a fiscal policy in line with its objectives of reducing public debt and aims to attain primary fiscal surpluses of 6.7% of GDP in 2012 (above the budget target of 4.7%). This has been largely achieved as the budget surplus has averaged 3% of GDP. The Seychelles' economic outlook is considered generally good with real GDP growing from 2.8 to a projected 3.2 in 2013 and 4.3 in 2014. Current account as a percentage of GDP is stable and expected to remain so, from 2011 to 2014, with an average -26.5%.

The government's commitment to the provision of health services together with education has always been given top priority. This is illustrated by the share of the yearly budget allocation of

the national budget to the Ministry of Health in 2012 was 11, 9% and slightly increased to 12.62% in 2013.
For effective calculation of expenditure incurred in HIV and AIDS during 2012 2013, the National AIDS spending (NASA) model applied used. It is a methodology to measure and track resources of the national responses to HIV. It is used to estimate HIV expenditure. It compared with Resource Needs Estimates to reflect possible financing Gaps NASA measures ALL spending on HIV and AIDS. Finance from ALL sources: public, external, and private, individuals in relation to findings for health, social mitigation, education, human rights and labor. The exercise was undertaken by a team trained in Mauritius in 2011.

The total expenditure of HIV and AIDS in local currency in was **SR26, 928,518 in 2011. SR 66,149,168 in 2012 and 35,002,177 in 2013.** The **government spent SR 34,334,946 (98%) in 2013, SR 58,629,430 (88.6%) in 2012 and SR26, 051,550 (96.9%) in 2011**. Most of the spending tends to be on **Administration: SR16, 534,745 (63.8%) in 2011 compared to 2012 when there was nearly 50% reduction SR6, 549,675 and in 2013 SR 3,004,120.** There has also been a reduction in the spending on **Treatment and Care, from SR11, 714,724 in 2011 to SR 8,183,955 in 2012 and in 2013 SR 2,184,644,** Communication and BCC, risk reduction and social mobilization, social protection, risk reduction and prevention activities for vulnerable group and This has been principally because there were fewer people on treatment due to low incidence and the treatment cost has reduced. **Enabling environment is the leading expenditure for 2013 with SR17, 351,977 compared to SR81, 407 in 2012.**
The government accounts for 90% the expenditures of HIV and AIDS where as other multi-lateral partners including private sectors accounts to less than 10% of the total expenditure. During the exercise data from Civil Society other than the National AIDS Trust Fund on HIV/AIDS still remains a challenge. This will be improved through the development of proper reporting mechanism following the institutionalization of the investment framework by the National AIDs Council.

Programme Implemented

To reflect the national character of the epidemic and action against HIV and AIDS, a **National AIDS Trust Fund** has been established in March (S.I. 6 of 2002) under the **Public Finances Act (*Cap 188A*).** It was created to coordinate action on the part of government, non-governmental organizations, the private sector, community groups and individuals. The government of Seychelles contributes annually to the fund. Based on the low national HIV prevalence and being a middle income country, the Seychelles has not benefitted from the Global Fund grant.

Therefore to scale up the HIV AIDS response in Seychelles, the establishment of the National Funds on HIV and AIDS are measures of the Government Commitment to fight HIV. It is additional fund from government. The **government contribution amounts to US$ 100,000 annually from 2008.** It is specifically for **prevention, treatment, care, support, enabling environment, research, monitoring and evaluation. The source of fund is derived from revenue collection levied from, business, personal income** tax, value added Tax (VAT) of commodities and services, Gainful Occupational Permit (GOP) from migrant employee, selling

of assets, Social Security and other taxes

The purpose of the National AIDS Trust Fund is to attract, manage and disburse additional resources through a multi-sectoral partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV/ of the AIDS in Seychelles, and contributing to the achievement Millennium Development Goals (MDGs).
Throughout the five years the **NATF has received 70 applications of community projects for funding of which 86%** were approved of which the minimum implementation stage ranged from one week to three years. The total amount of funds disbursed amounts to USD.

TARGET7. ELIMINATING GENDER INEQUALITIES

Gender inequalities
Seychelles has a good record of gender equality, with the achievement of MDG 3: the elimination of gender disparity in primary and secondary education in all levels of education by 2015. Even if there is relatively little data for this indicator, there are mechanisms in place to track Gender Based Violence (GBV), such as the monitoring that takes place at institutions such as the Police Department for self-initiated reports, Social and Probation Services for service provider initiated reports and the Family Tribunal, which also records GBV in its cases. The **Gender Secretariat** has also developed a ***Costed National Action for Gender Based Violence for the Republic of Seychelles*** and it also monitors issues such as Gender-Based Financing and Budgeting.
The data collected from various institutions do not permit to know the proportion of ever-married or partnered women aged 15-49 who have experienced physical or sexual violence from a male intimate partner in the past 12 months. Estimates may be as high as 50%, given the number of cases registered. The national strategic framework focuses on women living with HIV and AIDS, as one of the populations that need special attention. Regulatory framework is available with clear laws such as the ***Family Violence Act 2000, Employment Act 1995*** and the national action plans, but the gap is in the enforcement of the legislation and implementation of the national action plan.

However there has been a gradual increase in the proportion of women in national parliament without the use of quotas. One more woman selected for proportional representation will make up 50% of proportion of seats held by women in the national assembly. In some cases for positions, such as for director-general and district administrators, women are almost on par with men or are more represented. Still, in positions with more decision-making power and authority, such as government ministers and chief executive officers, there are fewer women (27% and 36% respectively). For key positions in the central government, there were 63.7% women compared to 36.3% men in 2012. It is noted that parastatal organizations are employing fewer women every year, with 37.3% in 2012, 38.2% in 2010 and 41.4% in 2009.

The ***Draft National Policy on Gender*** which uses the ***SADC Protocol Gender and Development*** targets to be achieved by 2015 also provides some guidelines about what Seychelles needs to do to improve the participation and empowerment of men and women in socioeconomic development of the country. In the Draft Policy, the government makes a commitment to '*ensure*

that economic policies and programmes are gender responsive, address poverty and increase decent work and entrepreneurial opportunities equally for women and men.' The main objective is to '… *ensure women and men have full and equal access to, control over and ownership of the benefits of socio-economic growth and development*

It is also important to note that HIV prevalence is higher in males than females in Seychelles, contrary to the pattern on the African continent. This issue needs to be effectively addressed, as the perception of gender issues is still focused on women and girls, even when data shows that men are at a disadvantage in education, life expectancy and burden of NCD and in HIV and AIDS. Again the Gender Secretariat notes that "*Gender is everybody's business, not an issue that concern only women or the Ministry holding the portfolio responsibility*."

Programmes Implemented

Seychelles has been very active in promoting women's rights and now gender issues in general. It has met its **international obligations through accession on 5th May 1992 without any reservations to the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).** Annually the Gender Secretariats organized activities to commemorate16 days of violence against gender.

The **Constitution of Seychelles 1993** itself is gender-blind and gender neutral. In Article 30, it focuses on the rights of working mothers; in Article 31, it emphasizes the rights of minors and in Article 32, it makes provision for the protection of families. Other instruments and national laws and policies speak to gender equality in the workplace, in the home and in public life.

- The **Beijing Declaration and Platform for Action (BPFA*)* was adopted in 1995;**

- The **Employment Act of 1995 amended in 2006 specifically forbids discrimination in the workplace based on gender in Section 46 A (1**). It also makes harassment an offence under Section 2.

- The **Family Violence (Protection of Victims) Act 2000** gave the Family Tribunal, established in 1998 under the Children Act, power as a paralegal entity to address the issue of gender-based violence and other forms of family violence as well as to administer child maintenance, care and custody of children.

- The **Commonwealth Plan of Action for Gender Equality 2005- 2015** was adopted and implemented.

- The Gender Secretariat was established as a permanent structure in the Social Development Division and it developed the **National Action Plans** for Gender-Based Violence and is lobbying for gender-based / sensitive budgeting.

- Civil society is actively engaged in gender issues with a wide variety of non-governmental organizations including community-based organizations conducting nation-

wide programmes: WASO for economic empowerment, Alliance of Solidarity for the Family (ASFF) for reproductive rights, Entreprendre au Feminin Océan Indien Seychelles chapter (EFOIS) for women craft workers and artisans, Seychelles Association of Women Professionals (SAWOP) assisting in personal development of their members and SOROPTIMISTS Seychelles which help to fund charitable activities and groups.

- The **Government Dedicated Fund for school children** to help address the issue of poverty. In all state schools, there are special programmes (Dedicated Fund) to assist children from poorer backgrounds with obtaining school uniforms, bus passes to travel to and from school and midday meals, which cost SR2 or US17 cents per meal.

- There are many national social programmes undertaken through the Agency for Social Protection. **Ordinary citizens who need assistance can apply directly to the Agency for Social Protection (ASP)** or they can be referred by various service providers, such as social workers, school counselors and district administrators. The ASP assesses means and distributes money as needed.

- Probation Services and at times the MPower Centre (a local NGO working with young vulnerable women) seek to **assist just-released prisoners** in finding shelter and work. There is also an aftercare committee.

TARGET 10: STRENGTHENING HIV INTEGRATION

Orphans school attendance

The right to education is a constitutional right and is also enshrined in the Education Act (2004) with ten years of compulsory education. Consequently, the country continues to make progress on this target with consistent net enrolment of around 99%. Both girls and boys orphans and not are regularly sent to school by their parents and / or guardians and registration for primary education is done eagerly each year. Most pupils complete their primary education.

A small number of primary pupils may be absent for long periods. When persistent absenteeism occurs, there are mechanisms at school and at national levels to look for these children and their parents. Based on the assessment of the Ministry of Education and Social Services, the children and their parents are offered support (financial, psychosocial and advisory) as needed.

The trend of primary school enrollment from 1991 to 2012 averages 99%. Enrollment ratio in some years is above 100, notably from 2010 to 2013. There seems to be no discernible inequalities for this target. Parents readily enroll their children for primary school. Indeed, they also seek to enroll their children for kindergarten or crèche which is not part of the compulsory education requirement as dictated by the Education Act (2004). The trend of primary school completion rate from 1991 to 2012 is also relatively high, with averages above 100% for both sexes.

Programmes Implemented

- There are various social programmes such as the **Dedicated Fund (government) through which parents can seek assistance**. The Fund is allocated to all state schools to ensure that no child is deprived of necessities that would affect their attendance to school. It is used for the following purposes: school meals, provide snacks mid-morning breaks, school uniform and its accessories, pay for tailoring if necessary, stationery and assistance with bus fares. Cases are identified through self-referrals, district administrators, parents and teachers and parents have to apply for the assistance.

- Additionally all vulnerable children and their families are assisted through the **National Security Fund.**

- Orphan who have lost are either cared for by family members and **assisted financially by the government or are placed in foster homes**

MAINSTREAMING OF HIV AIDS

The **workplace Policy 2013**, adopted **recommendation 200** on the ***International Labour (ILO) Conference in Geneva in 2010.*** By adopting the recommendation, the tripartite constituents indeed agreed to have a national policy that serve as a frame of reference for national stakeholders and reference for partners. Furthermore, the implementation of a national policy in the workplace was an urgent need for a synergy of action in response to the pandemic of HIV and AIDS and helps Seychelles to intensify its actions in all sectors of activities.

The policy was formulated and implemented within the framework of the National Policy for HIV and AIDS 2012 Existing laws and policies to ensure that those infected with HIV or those living with HIV are not subjected to discrimination need to be enforced.

Programmes Implemented

- All HIV AIDS **workplace focal persons trained in HIV& AIDS mainstreaming**
- **Outreached HTC posts** integrated into national community social activities including workplaces
- Conduct **massive national sensitisation campaigns** through media
- Training of **key health professionals and non health people,** as well as civil Societies, Private sectors, to help address various issues in the HIV and AIDS national response Strengthen the actions and presence of various civil society organisations in this area
- Training on **Prevention and management of Reproductive health** issues of non health actors.
- **Sensitisation of parliamentarians by civil societies.**

However, there is still much to be done as there is still discrimination in laws, application of laws and policies and attitudes of various segments of society towards key populations and others. Whilst the prevention programmes have been effective in raising awareness, they have been less so in changing behaviour patterns for a number of Seychellois. Therefore, the national response needs to move to targeted interventions for key populations.

1V BEST PRACTICES

Political Leadership

The Seychelles has given its political commitment to all required international obligations by signing treaties, conventions and / or committing itself to various requirements, such as those laid out in political declarations and UNAIDS strategic plans. Hence, the country adheres to principles and targets, such as those of the MDG, the "Three Ones" Principles and "Getting to Zero", Universal Access and UNGASS Declarations 2001 and 2015.

- There is also strong symbolic political leadership through the national coordinating organisation is the National AIDS Council (NAC). The **patron of organisation by the President who attends all meetings and makes public statements** of support to the objectives and programmes of the national response. He has also spoken about the link between HIV and the needs of key populations and vulnerable groups. National media coverage is given to each meeting, with follow-up news items and special programmes on national radio, television and written press. NAC is also being restructured so that it has more power, credibility and resources to coordinate, communicate, monitor and evaluate national programmes.

- **NAC has become a statutory body** with an act of parliament to guide its works. The law has been enacted being a separate entity of the AIDS Control Programme of the Ministry f Health.

- NAC will coordinate the national response through a variety of multi-sectoral sub-committees to ensure that actions are implemented as per the priority areas of the new national strategic plan.

- Political leadership is also shown through the **creation of the National AIDS Trust Fund** which is entirely made up of government provided funds. Both state and non-state actors are able to apply for funding for their projects and programmes. The Fund is administered by locals and membership of the Board includes NGOs. Projects are submitted and scrutinised according to set criteria before selection.

- Other strong political leadership is indicated through **universal access to free treatment and care, including the use of overseas treatment and social welfare assistance to PLHIV.** However, stakeholders feel that this might have been even stronger if all leaders and all parties committed themselves openly and publicly to the giving symbolic and/or real support to the national response to HIV and AIDS.

Infrastructure development

Seychelles has invested and built modern infrastructure to house some of its key programmes. In its ***Country Cooperation Strategy 2008-2013,*** the World Health Organisation notes that: "*Over the last four decades Seychelles has made remarkable progress in health development through comprehensive healthcare infrastructure.*" **The *National Plan of Action on National Development 2005 - 2015* (*NPASD)*** also highlights the relatively good care and support available generally. There are regional health centres and hospitals on inner-lying islands, Praslin and La Digue. Some examples of other infrastructures involved in treatment, care and support for PLHIV and people affected by HIV are as follows.

- The **Youth Health Centre (YHC),** which plays a pivotal role in providing access to services for all young people, is housed in modern and well-equipped building. Moreover, with the **National Youth Centre (NYC)** adjacent to it, there is more discretion for the young people coming in for sexual and reproductive health issues, as there are so many activities taking place that it is difficult for passers-by to pinpoint exactly for which reasons the youth are visiting the YHC. However, the space may be too small to accommodate all the programmes run therein.

- The **NGO, ASFF, operates its men's health centre** in spacious and pleasant surroundings which are also discreetly located. Facilities for training, counselling and medical examinations are available. ASFF is seeking to develop a strategic partnership with the International Planned Parenthood Federation (IPPF).

- Planned infrastructure which may require a close government and NGO partnership are the following, which are presently under discussion and may offer proper facilities for NGOs to conduct targeted interventions with PWID, SW and MSM. These are as follows:

- A **drop-in centre for street-based sex workers –** the programme is being designed by the Social Affairs Division of the Ministry of Community Development, Social Affairs and Sports;

- A **drop-in centre for "homeless" and indigent people.** Both proposals follow results of studies conducted by the Social Development Department in 2010 and 2011 on sex workers and homelessness in Seychelles.

- Recently, the **Centre d'Accueil de la Rosière has acquired a nun's residence in a quiet secluded area outside of the capital to use as its rehabilitation centre.** It is undergoing renovations and will be able to accommodate at least 14 persons for drug and alcohol rehabilitation services

- The recently build new **Wellness Centre at Les Cannelles offering a second chance for a for drug addicts to embark on the first ever MAT programme.** The service is

providing clients with a safe drug free environment where client's are able to detox , explore and identify what personal changes they require to make in themselves and their environment to enable them maintain a drug free lifestyle.

A supportive policy environment

The issue has already been discussed in the previous chapters; suffice to say, that much effort has been devoted to ensure that alignment with international and national obligations is maintained, not only in policy documents, but also in implementation of programmes. The new national policy and strategic plan have included robust standards of procedures, service for and behaviour in working with PLHIV, PWID, MSM, SW, migrants and prison inmates, amongst others. NGOs wishing to implement harm reduction activities with any key population group can do so and are able to obtain financial aid from the National AIDS Trust Fund (NATF) and technical assistance from the AIDS Control Programme employees.

- There are **mechanisms available for PLHIV** and any other person affected by HIV to **seek redress for alleged violations of their rights**. There is, however, a need to inform people of their rights and responsibilities

Programmes Implemented

Some of the national programmes have been very successful and can be used as examples of best practices. Indeed, standards were maintained and even improved in some areas of programming. These include the following:

- **EMTCT where coverage is 100%** in most years for both antenatal and post-natal service delivery for both mother and child, with **access to HTC, ART, nutritional support and good follow-up.**
- **Universal free (ARVs) treatment for all PLHIV**. Recently, the Ministry of Health has acquired a PCR.
- Blood and blood product safety, with rigorous procedures and measures in place for testing.
- There is **good integration of HIV/AIDS with TB management.** Moreover, HTC is also integrated in the health system and it is possible to **access services at all entry points** in the district and main public health centres.
- The **Ministry of Education** has established **a curriculum, the Personal and Social Education Programme (PSE)** which has its own trained teachers for secondary schools. In this programme, HIV and STIs are addressed in an age-appropriate manner. However, the programme is still not an examinable subject. The various other weaknesses of the programme have been addressed in the new national strategic plan for 2012 to 2016.
- The **Youth Health Centre** and partners conduct **outreach programmes with integrated HTC in post-secondary institutions.**
- The **Social Welfare Agency** provides **financial assistance to PLHIV** who require such. Confidentiality is maintained and the programme is available to all PLHIV without

discrimination based on age, gender or race.

- The **Social Development Department** has developed a **draft national gender policy** and a plan of action which include taking into account the power dynamics of relationships and their role in mitigating or exacerbating the impact of HIV and AIDS and how they may also lead to greater incidence of HIV.

MONITORING AND EVALUATION

Since 2009, the Seychelles have been developing its national multi-sectoral monitoring and evaluation system, with national indicators as well as those recommended from various international instruments (UNGASS, GARPR, and Universal Access). The M&E Framework is now ready and has been included in the national strategic plan 2012-2016. Its development has been a proactive and involved participatory process with national stakeholders and assistance from international agencies, such as UNAIDS.

The set of national indicators focus on all priority areas of the national response to HIV, have both health and non-health criteria and makes provision for all activities to have some form of monitoring and evaluation to track progress. For the first time, the standards have not only been set for government organisations, but also for all civil society organisations that wish to access public funding, such as provided by the NA.

V. MAJOR CHALLENGES AND REMEDIAL ACTIONS

(a) Progress made on key challenges reported 2012 Country Progress Report

Implementation of targeted programmatic actions for key populations More civil society organisations are getting engaged in developing targeted programmes for key populations (men's health centre, including MSM – ASFF, peer education work - FAHA). For the moment, the actions are timid, but there is momentum building for targeted programmatic actions for key populations. The major events precipitating such projects or programmes are the publication of the results of the RDS survey on MSM and PWID, the finalisation of the national strategic plan for the period 2012-2016 and the holding, in Seychelles, of the AIRIS-COI Colloquium on HIV and AIDS in the region.

Stigma and discrimination towards MSM, SW and PWID are also presently hampering access to services which have been well-integrated in the national health system. However, with the centralisation of HIV and AIDS management at the CDCU, some key population members are still reluctant to approach the site for medical and psychosocial services. It might be important to consider some decentralisation of services.

Need for more outreach programmes Government and civil society organisations still have services on site with specific opening hours. This situation makes it harder for key populations to seek assistance. Some NGOs (ASFF, FAHA), faith-based organisations (Roman Catholic and Church of England Youth Groups) and government agencies (YHC, Students' Support Services of the Ministry of Education) have started to train peers to provide targeted behaviour change

communications. For now, the work is limited mostly to young people, especially those who are out-of-school. The church groups have started being present in key sites where SW gathers.

Drop-outs and non-adherence to treatment Defaults and non-compliance to treatment continue to be serious issues, as they are compounding the difficulties of management of clients. A number of clients are still reporting in late stage AIDS. Some have already developed resistance to the medicines, leading to treatment failure. This is an issue that needs to be addressed urgently as it also impacts on prevention and the goal of having "zero new infections". It also has an impact on sustainability of programmes as more people may contract HIV.

It is now clear that studies need to be conducted to better understand the social, psychological and economic dynamics that are fuelling defaults and non-adherence to treatment. This situation is somewhat baffling when one considers that treatment is free, psychosocial support and nutritional assistance are integral part of the management of PLHIV.

Patients coming in late stage of the disease, This issue is similar to the one mentioned above and both are linked. With drop-outs and non-compliance, there are more patients that coming in with late stage of AIDS. Treatment is more difficult if not ineffective, placing further strain on the health system and affecting sustainability of programmes.

Client-initiated HTC Most HTC is still initiated by the service provider. To increase client-initiated HTC, perhaps there may be a need to have decentralised anonymous HTC services provided in non-health settings and by non-health professionals. In this way, the national response becomes even more multi-sectoral and addresses more adequately the needs of the public. In fact, more provider-initiated HTC should also be encouraged at various entry points into the health system, both public and private.

Sustainability of funding, As the incidence of HIV increases, there may come a time when it is difficult or impossible to sustain the level of programming in treatment, care and support. This is an urgent issue as the Seychelles epidemic shows no sign of slowing down now that evidence have shown that the Seychelles is already facing concentrated epidemic.

Access to service by minors-The KAPB study has shown that minors are not only engaged into early sexual relationship but taking risky sexual and illicit drug practices. The rate of teenage pregnancy is alarming. Reproductive health services including contraceptives HIV and hepatitis testing are not accessible

Empowering peers-Peers of various key populations, vulnerable groups and others are still rarely used in programming at all levels – design, testing or piloting, implementation and monitoring and evaluation. Service delivery is still done by interested and dedicated individuals, but who are not peers of their clients. This issue is also linked with the need to have more outreach programmes for key populations and vulnerable groups.

Unprotected sex The rates of abortions and STIs continue to increase indicating that unprotected sex is still an issue.

Denial and risk-taking behaviour- Stakeholders note that there is a pervasive attitude of laissez-faire and denial around the issue of HIV and AIDS. Information is disregarded or discarded. People still engage in unsafe sexual practices and behaviours. The issue is not ignorance as KAPB studies do show quite widespread knowledge and understanding of HIV and AIDS. In spite of this, behaviour and lifestyle changes do not follow. There is thus a need to boost behaviour change communication interventions to reduce the levels and types of reckless behaviour.

Gender inequalities- In spite of the tremendous strides made by Seychellois women in recent years, there are still unequal power dynamics in relations which impact on the incidence of HIV. Women and girls still have problems negotiating issues like condom use, HTC and contraceptives with their male partners. There is thus a need to address these issues with girls and boys in family education programmes, in PSE in schools and various other forms of interventions in communities.

(b) Challenges faced throughout the reporting period (2012-2013)

Inadequate Human resource Capacity:
Since the establishment of the AIDS Control Programme, it also house the NAC Secretariat with very limited staffing only a Programme Manager and a Health Promotion Officer, the Secretary was posted to another section of the Ministry of Health. The Director of Family Health and Nutrition Programme is overseeing five major programmes of the Ministry of Health namely: EPI, Chid Health, School Health Maternal Health, Family Planning (Reproductive Health), Nutrition and HIV AIDS Control Prevention Programme. The director has been also acting as the National Coordinator for HIV AIDS until January 2014 when the new CEO was nominated. For the past four UNGASS then the GARPR reporting the Director has been the country editor and writer of the narrative reports. Henceforth, the capacity to sustain timely reporting has been one of the major challenge faced, with no incoming financial assistance from UNAIDs for technical assistance be it local or international

Stigma and discrimination towards key populations and some vulnerable groups
HIV and AIDS are still considered as pariah conditions, even if reactions to PLHIV and people affected by HIV are gradually improving. There were still only two persons who had publicly disclosed their positive status: one is now deceased and the other is less active for the moment. There is still no specific law for HIV and AIDS. The only strong documents are the Constitution, the Employment Act, and the Workplace Policy. It has been acknowledged that it is very difficult to prove workplace discrimination because the employer can simply use any other reasons to explain the dismissal.
Stigma and discrimination towards MSM, SW and PWID are also presently hampering access to services which have been well-integrated in the national health system. However, with the centralisation of HIV and AIDS management at the CDCU, some key population members are still reluctant to approach the site for medical and psychosocial services. It might be important to consider some decentralisation of services.

Needle exchange programmes

The Harm reduction policy especially the introduction of needle exchange programme has been one major political concern, there is an urgent need to amend the Misuse of Drugs Act (1995) as being in possession of drug paraphernalia is illegal The new National Strategic Framework for the Control and Prevention of HIV and AIDS and STIs 2012-2016 has taken this issue into consideration and together with the recommendations of the legal assessment study; there are propositions to amend laws to reduce stigma and discrimination for all persons and especially for the key population groups.

Strengthen programmes for Maternal Care

The population that is becoming less accessible is the heroin-dependent mothers as they are less reliable in terms of keeping appointments and coming for follow-up visits for them and their children. However, there are plans by the Ministry of Health, the Drug and Alcohol Council and civil society organizations to have greater access to them through treatment facilities and outreach programmes, including on site work in the streets and areas where drugs are sold.

There is also a need to have early identification programmes and medical services for vulnerable women and their partners during the period of pregnancy and the early years of raising the baby, such as screening for drugs and alcohol just as is presently done for HIV, hepatitis C and other blood-borne viruses. These programmes must also include psychosocial support for parents-to-be and their children.

There is also an urgent need to provide services for heroin-dependent mothers and their babies to prevent having new generations of Seychellois falling prey to the scourge of drug dependence and its related health economic and social problems.

Access to Reproductive Health Services by 15-17 years

Evidenced based data from the IBBS 2013 shows that some minors are sexually active and the CDCU has records of minors infected with HV and Hepatitis C. The issue of contraceptives and HTC for 15 to 17 year olds remains an unresolved one, with this population being unable to access contraceptives, condoms even if the age of consent for sex is 15 years or the girl has had a baby before. Three emerging priorities are noted: reducing drug use amongst the age group of 15 to 25 years and thus reducing the number of heroin-dependent mothers, increasing targeted and well-delivered reproductive rights and health education sessions for adolescents and reducing child sexual abuse, which can account for the pregnancies of those younger than 15 years.

Need for more outreach programmes

Government and civil society organisations still have services on site with specific opening hours. This situation makes it harder for key populations to seek assistance. Some NGOs (ASFF, FAHA), faith-based organisations (Roman Catholic and Church of England Youth Groups) and government agencies (YHC, Students' Support Services of the Ministry of Education) have started to train peers to provide targeted behaviour change communications. For now, the work is limited mostly to young people, especially those who are out-of-school. The church groups have started being present in key sites where SW gathers.

The Ministry of community Development also engaged into outreach programmes for the sex workers.

Drop-outs and non-adherence to treatment

Defaults and non-compliance to treatment continue to be serious issues as depicted by the audit assessment of 2013. They are compounding the difficulties of management of clients. A number of clients are still reporting in late stage AIDS. Some have already developed resistance to the medicines, leading to treatment failure. This is an issue that needs to be addressed urgently as it also impacts on prevention and the goal of having "zero new infections". It also has an impact on sustainability of programmes as more people may contract HIV and the switch from one regimen to another.

The CDCU should make sure to implement the recommendations of the reports .It is now clear that studies need to be conducted to better understand the social, psychological and economic dynamics that are fuelling defaults and non-adherence to treatment. This situation is somewhat baffling when one considers that treatment is free, psychosocial support and nutritional assistance are integral part of the management of PLHIV.

Patients coming in late stage of the disease

This issue is similar to the one mentioned above and both are linked. With drop-outs and non-compliance, there are more patients that coming in with late stage of AIDS. Treatment is more difficult if not ineffective, placing further strain on the health system and affecting sustainability of programmes.

Client-initiated HTC still rare

Most HTC is still initiated by the service provider. To increase client-initiated HTC, perhaps there may be a need to have decentralised anonymous HTC services provided in non-health settings and by non-health professionals. In this way, the national response becomes even more multi-sectoral and addresses more adequately the needs of the public. In fact, more provider-initiated HTC should also be encouraged at various entry points into the health system, both public and private.

Sustainability (funding issues)

As the incidence of HIV increases, there may come a time when it is difficult or impossible to sustain the level of programming in treatment, care and support. This is an urgent issue as the Seychelles epidemic shows no sign of slowing down.

Empowering peers

Peers of various key populations, vulnerable groups and others are still rarely used in programming at all levels – design, testing or piloting, implementation and monitoring and evaluation. Service delivery is still done by interested and dedicated individuals, but who are not peers of their clients. This issue is also linked with the need to have more outreach programmes for key populations and vulnerable groups.

Unprotected sex

The rates of abortions and STIs continue to increase indicating that unprotected sex is still an issue.

Denial and risk-taking behaviour
Stakeholders note that there is a pervasive attitude of laissez-faire and denial around the issue of HIV and AIDS. Information is disregarded or discarded. People still engage in unsafe sexual practices and behaviours. The issue is not ignorance as KAPB studies do show quite widespread knowledge and understanding of HIV and AIDS. In spite of this, behaviour and lifestyle changes do not follow. There is thus a need to boost behaviour change communication interventions to reduce the levels and types of reckless behaviour.

Gender inequalities
In spite of the tremendous strides made by Seychellois women in recent years, there are still unequal power dynamics in relations which impact on the incidence of HIV. Women and girls still have problems negotiating issues like condom use, HTC and contraceptives with their male partners. There is thus a need to address these issues with girls and boys in family education programmes, in PSE in schools and various other forms of interventions in communities.

(c) Concrete remedial actions that are planned to ensure achievement of agreed targets.

It is important to note that all these issues are addressed with *proposed* programmes and activities in the national strategic plan 2012-2016. However, concrete actions presently undertaken are few and far between to effectively deal with the complex and varied situations related to these issues. In the table below, some of these actions are presented.

Table 9: Concrete remedial actions

Challenges	Concrete Remedial Actions
Adequate Human resource in HIV Coordination	NAC Secretariat MUST be equipped with a FULL team for effective coordination of the response
Implementation of targeted programmatic actions for key populations	Harm reduction measures clearly highlighted in the new national strategic plan 2012-2016 Civil society encouraged to apply for project grants, through the NATF and international donors, to implement clean needles, syringes and other equipment for PWID NGOs and FBOs have begun pilot programmes targeting MSM and SW Amend the Misuse of Drugs Act (1995) Study in the SW and prison
Stigma and discrimination towards key populations and some vulnerable groups	Proposal to have a HIV and AIDS Act Inform the general population and key groups of their rights and how to seek redress for alleged violations of these .
Strengthen programmes for	Study the population group to know the extent of the

Maternal Care	issue Review the ANC protocol
Access to Reproductive Health Services by 15-17 years	Undertake a youth study on sexual reproductive health Implementation the SRH minor protocols
Need for outreach programmes	Some CSOs have limited peer education programmes. There is a need for these to be scaled up.
Drop-outs and non-adherence to treatment	Implement the audit report recommendations of 2013 by the auditor general. Study proposed on causes of drop-outs, defaults and non-compliance to treatment
Patients coming in late stage of the disease	Same as above
Client-initiated HTC still rare	Proposal to have provide-initiated HTC in all entry points Decentralisation of treatment services More involvement of NGOs in HTC, e.g., ASFF
Sustainability (funding issues)	Focus on targeted prevention for key populations to reduce incidence to ensure that the epidemic does not increase Advocacy to Global Fund
Empowering peers	Peer education training by NGOs (ASFF, LAMP, ELM, Youth Alive) and YHC
Unprotected sex	Targeted prevention with key populations, including peer education and outreach activities, focusing on behaviour change communication, HTC and adherence to medication
Denial and risk-taking behaviour	Same as above
Gender inequalities	National Gender Policy National Gender Plan of Action National Gender-Based Violence Plan of Action

V1 Support from Country Development Partners

During the past two years, the Seychelles has received some support, both technical and financial, from various multi-laterals and bilateral partners as well as various other international organisations, such as the Harm Reduction International (HRI) previously known as the International Harm Reduction Association (IHRA). The information below has been collected from stakeholders and as some did not respond on time, it is possible that there are gaps in this section, as assistance received may not have been accurately recorded. It is also important to note that Seychelles, as a middle-income country, does not qualify for much of the international aid available for strengthening of the national response to HIV and AIDS.

Contributions from Development Partners

Table10. Contribution from UNAIDS

UNAIDS contribution to the national response to HIV and AIDS and STIs	
YEAR	PROGRAMES
2012	***Technical Support*** • A UN Volunteer Technical Advisor (UNVTA) on HIV/AIDS, Mr. Jacques Sindayigaya worked in Seychelles from December 2009 to February 2012 helping in strengthening Seychelles' response to HIV/AIDS. He was based at the Seychelles hospital • Technical support given in the formulation of the new national HIV/AIDS strategic framework 2012-2016, the monitoring and evaluation framework 2012 and the cost operational plan 2012-2016. • UNAIDS partially supported the formulation of the Modes of Transmission Study (MOT) for 2011 and since the exercise is not completed yet, the follow up will be undertaken in 2012 • UNAIDS gave technical support and funding for the drafting of the national strategic plan for HIV&AIDS and STLs 2012-2016 • UNAIDS funded the participation of some (5) Seychellois to the HIV/AIDS colloquium in 5 for 2012 held in the Comoros 5 in Mauritius in 2013
2013	• Supported 1 participant from Social Department to attend the SECOND HIGH LEVEL MEETING OF THE Global POWER Africa Network • Training of 2 participants in HIV "Regional HIV&AIDS Estimates and Projections workshop" for countries of the Middle East and North Africa Region • Supported one participant for Regional Meeting on the Investment Approach and Investment Cases for HIV • Technical support for the Legal the development of the Legal Assessment framework

Table 11: Contributions from WHO

WHO contribution to the national response to HIV and AIDS and STIs	
2012	• Financial support for Sexual reproductive health strategies including men's health programme supported • Men's study • Procurement equipments - Scales 50 scales BP apparatus and accessories • Develop costed minimum maternal and newborn service package • Capacity building of 30 participant stakeholders

2013	• Technical support for training of HTC health professional and development of HTC tools • Promotion of Child Health programme supported • Sustenance BFHI activities • Support of 2 for review and planning of FRH Programmes
Table 12: Contributions from UNFPA	
UNFPA contribution to the national response to HIV and AIDS and STIs	
2012	*Integration through the annual POA* Funding • Training on management and delivery of user friendly RH/FP services • Training in integration of HIV and RH/FP services at the community level • Developing of BCC materials (including for people living with disability) • Review of family planning procedure manual • Developing of Monitoring and Evaluation Framework for National RH Strategy • Advocacy for mainstreaming/integrating population issues in national and sectoral plans and policies *Gender Equality* • Trainings in GBV and care for victims for the police, health, social services, judiciary, prisons and education sectors • Validation of National Gender Policy and development of National Gender Plan of Action • Consultative Workshop for Costing National Gender Plan of Action • Advocacy for mainstreaming gender issues in national and sector plans and policies • Developing national media plan on GBV *Youth Adolescent Sexual & Reproductive Health and HIV* • Advocacy for decentralization or services • Training in integrated Youth friendly RH/FP/HIV services and service quality assurance • Advocacy meetings for review/harmonization of restrictive laws in access to contraceptive among young people below 18 years • Peer/life skill education and community outreach events for hard to reach youth populations including youths and adolescents in school • Developing BCC materials targeting change in risky behaviours (i.e. multiple concurrent sexual partnerships, lack of/inconsistent condom use at high risk sex, drug use, early initiation of sex) among youths and adolescents • Skill building workshops for youths in Peer education, networking and project leadership skills *HIV Services* • Training on provider initiated HIV Testing and Counselling (HTC) for service providers especially non health service providers • Validation, printing and dissemination of national HTC guideline

	• Review and updating HIV and STI guidelines
2013	*Integration* • Training in integration of HIV and RH/FP services at the community level • Advocacy for increased and sustained resources (financial and human) for RH/FP services and essential commodities • Training in evidence based planning, monitoring and evaluation among the RH/FP service providers • Training workshop on designing male oriented RH/FP services. *Youth Adolescent Sexual & Reproductive Health and HIV* • Developing and adoption of National Minimum Standards for Youth Peer Education for RH/FP/HIV • Training of PSE teachers in management and delivery of RH/FP/HIV information in learning sessions • Technical assistance in conducting Knowledge, Attitudes, and Practices national survey related to risks of pregnancy and transmission of HIV and STIs among youths aged 15-24 years • Developing Adolescent and Youth Sexual &Reproductive Health and Development Policy, and implementation plan
Table 13:Contributions from SADC	
	SADC contribution to the national response to HIV and AIDS and STIs
2012	*Technical Support* • TB Managers meeting and partnership Forum • Monitoring & Evaluation meeting • Annual Review Meeting Member States HIV & AIDS Mainstreaming Focal Persons Forum • Regional Technical Meeting on HIV Related Indicators for Selected Non Health Sectors- • Regional HIV and AIDS Research agenda • HIV Prevention and Research Meeting • Meeting to Review Year One of Implementation of HIV Funds Projects • Regional Consultation on Key Population meeting
2013	• SADC Regional Consensus and Validation Meeting SADC Book of Best Practices for Child and adolescent HIV, TB and Malaria Continuum of Care and Support" • Development of joint proposals for the sadc hiv and aids fund round ii
Table 14: Contributions from UNDP	
	Funding • Supported the implementation of the Legal Assessment Framework
Table 15: Contributions from ARASA	
2012	• Training of Trainers on HIV, TB, advocacy and Human Right, Monitoring and Evaluation. (2 participants)

	• Financial assistance for local advocacy projects
2013	• Training of Trainers on HIV, TB, advocacy and Human Right, Monitoring and Evaluation. (2 participants). • Financial assistance for local advocacy projects.
Table 16: Contribution from UNODC	
2013	Training of TRIP-NET for 30 participants

V11 MONITORING AND EVALUATION ENVIRONMENT

Overview of the current Monitoriing and Evaluationsystem

With the National AIDS Council, the National AIDS Control Programme and the Disease Surveillance and Response Unit, there is continual monitoring of the progress made in the national response to HIV and AIDS. The national strategic framework is also a tool to help monitor programmatic actions and indicators of success. Since the first case of HIV was discovered in 1987, the country has made great strides in developing strategies in all priority areas to address the pandemic. In policy development, there are now two generations of national strategic plans and national policies.

The national workplace policy is being reviewed and a new one will soon be drafted. The national strategic framework also consists of a costed action plan and monitoring and evaluation framework to ensure that progress is adequately measured.
The surveillance of the epidemic is conducted at sentinel points, such as the Communicable Disease Control Unit (CDCU), antenatal clinics, Occupational Health Unit (OHU) and the blood bank in the Ministry of Health and reveals that there is an increasing trend in HIV infections.

The Seychelles has recently developed its ***National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs 2012-2016,*** which comprises of the following documents:

- The National Policy on HIV and AIDS and STIs 2012
- The National Strategic Framework (2012)
- The National Costed Operational Plan(2012)
- The National Multi-Sectoral Monitoring and Evaluation Framework(2012)

The national strategic plan is also based on surveillance and research data. For the first time, the priorities have been decided as a result of the data obtained from the respondent-driven sampling study on People Who Inject Drugs (PWID) and Men Who Have Sex With Men (MSM) conducted in 2011. Therefore, the activities of the plan are research-informed.

The National Strategic Framework 2012-2016 has furthermore prioritised the needs of key populations at higher risk of HIV exposure, in response to the limited prioritisation within the previous national plan of the specific needs of affected populations such as young people, MSM, people who inject drugs, sex workers and migrants.

The current HIV/AIDS programmes aim at the primary prevention of HIV infection, and the provision of care and support to PLHIV and those persons affected by HIV. These encompass sensitization and education through IEC activities, PMTCT, HTC, surveillance, blood screening and safety, accessibility to post exposure prophylaxis, provision of ARVs, treatment of opportunistic infections, and support of PLHIV.

Data collection has greatly improved with a number of studies and exercises recently conducted to ensure that the Seychelles knows its epidemic: the study on migrant populations and seafarers, the National Policy and Strategic Plan reviews of 2011, the MOT study in the same year as well the NASA, followed by the RDS Survey on PWID and MSM and lastly the KAP Study of 2012. Now, there is clearer indication of spending patterns on HIV and AIDS, the state of the epidemic (whether it is generalised or concentrated) and the key populations that need greater attention and intervention in the national response programmes.

However, since then a national multi-sectoral costed M&E framework has been prepared, with clear definitions of set targets, necessary calculations, data needed to measure the set targets, clear indicators for all levels of results (impact, outcomes, outputs, activities and inputs), reporting periods and international and national commitments. The framework is part of the national strategic plan for the period 2012 and 2016. All activities have some form of budgeted M&E incorporated to measure their success.

Moreover, NAC should also have an M&E unit operated by trained and qualified personnel to help monitor and evaluate the national response. Support is further provided by the Ministry of Health Disease Surveillance and Response Unit which collects, collates and maintains data on all diseases reported to health centres in the country, including HIV and its related morbidity and mortality. This is in line with the national development plan which places focus on the need to collect data and to ensure that statistics are properly kept so that progress on all national targets, including health ones, are noted and used for future planning.

Challenges faced in the implementation of a comprehensive M&E system;

The NCPI indicates that while all the M&E framework and structures are in place, some national stakeholders are unaware of all the work that has been done and all infrastructures established to have a robust M&E for HIV and AIDS and STIs. It would seem that for now only a select few technicians and policy-makers are aware of all that is available. Therefore, there is a need for proper communication to all stakeholders about the history of the work done and what is proposed in the National Monitoring and Evaluation Framework, so as to build consensus amongst stakeholders.

Other challenges noted by stakeholders in the NCPI are limitations in human resources and technical capacity, lack of information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations. Overall in the NCPI, there are limited comments and responses to questions on M&E, possibly indicating low awareness, participation in M&E planning activities, or lack of such. It would be worth it to explore the details further with national stakeholders.

However, evidence shows that most respondents to the NCPI have been present for various meetings in relation to the development of the national multi-sectoral monitoring and evaluation framework both in 2010 for the preliminary work and in 2011 for the finalisation of the document. However, many seem to have forgotten their involvement which may imply that the process has not been meaningful enough for them to retain institutional memory of it.

Remedial actions planned to overcome the challenges

The NAC has the responsibility to coordinate and communicate about the national response. Steps are already being taken to educate national stakeholders about the National Multi-Sectoral Monitoring and Evaluation Framework. This is important as the projects and programmes will be judged as effective and viable based on the measures taken from set targets and indicators. NGO programmes and projects seeking funding will be judged on these same fundamentals.

The national strategic plan is being launched in April 2012 and this will be another opportunity for members of the public and national stakeholders to be made aware not only of the goals and objectives, but also the set international and national indicators that will be used to track progress. National media always cover such events extensively and NAC must seize the opportunity to do what is necessary to acquaint people with the M&E framework.

Need for M&E technical assistance and capacity-building.

With one national coordinating body and its M&E activities, all data types and sources in the national M&E system will thus flow to NAC M&E Unit, be they from sentinel sites, research from CSOs or academia, surveillance data, routine project and programme data. Technical assistance and facilities and resources for training to build capacity are needed in the following areas:

- Epidemiology Statistics, storage and use of strategic information
- Health and social research methodology / tools already in use by other organisations and countries
- Policy planning and development
- Capacity-building

With the new M&E framework, all partners are now expected to collect data on their project and programme activities, using the national set of indicators and definitions as their guidelines. Civil society actors will need assistance in project writing and management using these new sets of procedures, rules and formulae. Some training in management and use of data for programming is also required for both state and non-state actors.

ANNEXES

ANNEXE 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

Dates	Tasks
07Febth – 30th March	Desk reviews/ consultation/development of TORS
29th March – 12th April	Collection of data for Indicator 6 (NASA)
15th -28 - March	Meeting with stakeholders/Collection of information for NCPI
29th March	Data analysis, compilation Draft Completed Circulate 1st draft for Feedback
12th April-	All Feedback on Draft given Final Draft Completed Narrative Report, NCPI, and CRIS Circulated for Approval
13th April	Validation workshops of the entire Country indicators
14th – 21st April	Entry of the Country Progress Report in the online reporting system

Endorsement of the report

In endorsing the national report, a meeting was organised and hosted by the AIDS Control Programme to achieve agreement and consensus on the documents. The following committee members participated actively and the document was unanimously endorsed: Central Management Committee, UNFPA Implementing Partners, Technical HIV AIDS Advisory Committee, National AIDS Council, SBCC Committee and Technical Advisory Committee Members of HIV/AIDS and STIs, participated in the meeting and the document was amended and unanimously endorsed.

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the 2011 Declaration of Commitment on HIV/AIDS

Table1. Timeframe Implemented

Activity	Timeframe	Dates	Responsible
Finalisation and validation of the GARPR development TORs Seychelles and submitted to UNAIDS.	5 days	Feb.5th -9th	Core team
Revamp Steering /SBCC Committee- Produce list/ TOR/Invitation/Communication for meeting on 20th & 27th Feb	3 days	Feb.10th-12th	Core team
Consultation with core team on new reporting tools, guidelines and indicators	6 days	Feb 13th-19th	Core team
Downloading of reporting materials from websites as and when it was uploaded	15 days	Feb-20-06th Mar	Core team
Perusal of guidelines/ HIV related documents	6 days	Mar 07th -12th	Writing team
Review of indicators team headed by the Country editor	2 days	13th &14th Mar.	writing team
Desk reviews + Print + Dessiminate + Meeting + Interviews Work and on the NCPI questionnaire+ analysis+ Production of Draft analytical report	14 days	15th -28th Mar.	Core Team
Data collection/collation analysis of the spending information from all the stakeholders	14 days	29th Mar -12th April	Core team
Data processing and up loading into reporting tool	10 days	13th Apr-10th Apr	writing team
Organisation ,validation of data in stakeholders meeting	3 days	11th -13th Apr	writing Team
Production of final version of narrative report	7 days	14th -20th April	Steer/Core/Writing Team
Final input into the reporting tool	1 day	21st April	Writing team
Total	**75 days**		

ANNEXE1b
NAC Board members Advocacy meeting dated 11th March 2014

No.	Name	Title	Organisation
1	Ms Anna-Lisa Labiche	Clinical Psychologist	Allied Health Professional
2	Ms Fatoumata Sylla	Director General Youth Department	Office of the President
3	Dr Jude Gedeon	Public Health Commissioner	Public Health Authority
4	Ms Marie Jenny Marie	Senior Nursing Officer	Maternity Unit
5	Mrs Peggy Vidot	Principal Secretary	Ministry of Health
6	Bishop Denis Wiehe	Bishop	Roman Catholic Church/Chairman Seychelles Inter-faith Council (SIFCO)
7	Dr Haresh Jivan	Private Doctor	Private clinic
8	Mr Marco Francis		Seychelles Chamber of Commerce and Industry
9	Dr Anne Gabriel	Chief Executive Officer	National AIDS Council (NAC)
10	Mrs Marie-Nella Azemia	Chairperson	Liaison Unit of Non-Governmental Organisations (LUNGOS)
11	Ms Beryl Pillay	Journalist	Seychelles Broadcasting Corporation (SBC)
12	Dr Jastin Bibi	Director Epidemiologist and Statistic	Ministry of Health

ANNEX 1c: HIV AIDS Technical Advisory (TAC) agreement and consensus of GARPR Indictors Meeting dated 11th March 2014

Names	Title
Dr. Anne Gabriel	CMO Community (CMOCH) – Chair
Mrs. Sabrina Mousbe	Acting AIDS Program Manager (ACPM)
Dr. Shobha Harjanis	Director General Public Health department (DGPH)
Dr. Cornelia Atsyor	WHO Liaison Officer (WLO)
Mr. Philip Palmyre	Director Public Health Lab (DPHL)
Mr. Prosper Kinabo	Director Clinical Lab (DCL)
Mrs. Sheryn Raoul	Health Promotion Officer HIV/AIDS (HP ACP)
Ms. Peggy Azemia	Reproductive Health Program Manager (RHPM)
Mrs. Jeanine Faure	SNO Disease Surveillance & Response Unit (SNO DSRU)
Dr. Daniella Malulu	CIC Mental Health (MH)
Mrs. Brenda King	Health Care Administrator (HCA)
Ms. Georgette Furneau	Nurse Manager Communicable Disease Control Unit (NM CDCU)
Mr. Joachim Didon	Senior Statistician
Dr. Louine Morel	Communicable Disease Specialist (CDCU Dr)
Dr. Jastin Bibi	Director Epidemiology & Statistic Unit (D Epi/Stats)
Ms. Rosie Bistoquet	Director Family Health & Nutrition (DFHN)
Ms. M. Michelle Lai Lam	Representing Pharmacist
Dr. Meggy Louange	Director Occupational Health & Communicable Disease (DOHCD)
Ms. Chantal Melanie	Nurse In charge Youth Health Centre (NIC YHC)
Ms Christine Bradburn	Nurse Manager Community Health (NM CH)

ANNEXE 1d .Stakeholders Validation Committee Members

NAMES	**POSITIONS**	**Organisation**
Peggy Vidot (Mrs.)	Principal Secretary for Health-	MOH
Suresh Menon (Dr)	Chief Executive Officer- Health service agency	MOH
Jude Gedeon (Dr)	Public Health Commissioner	MOH
Cornelia Atsyor (Dr)	WHO- Liaison Officer- Seychelles Country Office	WHO
Shobha Hajarnis (Dr)	Director General – Public Health Authority	MOH
Anne Gabriel (Dr)	Chief Executive Officer (NAC)	NAC
Rose-Mary Elizabeth (Mrs)	LUNGOS Chairperson- CSO	NGO
Annalisa Labiche (Ms.)	Psychologist- Chairperson- Allied Health Professional/NAC Board Member	MOH
Beryl Pillay (Ms.)	Journalist	Media
Marie-Jenny Camille (Ms)	Senior Midwife – NAC Board Member	Nurses Council
Jastin Bibi (Dr)	Director Disease Surveillance Unit and Statistic	MOH
Justin Freminot (Mr)	Chairperson HASO	CSO

Meggy Louange (Dr.)	Director Occupational Health/CDCU	MOH
Daniella Malulu(Dr)	Consultant In Charge Mental Health/Head of Wellness Centre	MOH
Georgette Furneau(Ms)	Manager CDCU	MOH
Brenda King (Mrs.)	Hospital Administrator/TAC Member	MOH
Josie Chetty (Ms)	Senior Pharmacist _TAC Member	MOH
Sheryn Raoul (Mrs.)	HIV AIDS Health Promotion Officer	MOH
Brigitte Gbilimou (Mrs)	Provisional Psychologist	MOH
Celia Ponzo (Ms)	Nutrition- health Promotion Officer	MOH
Suzanne Pierre (Ms)	Senior Social Worker	Social Department
Christine Benoit (Priest)	Anglican Church	CSO
Doreen Hotive (Mrs.)	Health Promotion Officer	WHO
Georges Madeleine (Mr)	Manager Health Promotion Unit	
Chantal Melanie(Ms)	Ag, Nurse Manager-Youth Health Centre	MOH
Genevieve Ali (Ms)	Member	National Council for the Disabled
Joanne Vel (Mrs)	Nurses- ASFF	NGO
Desiree Hermitte (Mrs)	Student welfare Officer	Ministry of Education
Joachim Didon(Mr)	Senior stayistician-TAC Member	MOH
Rosie Bistoquet (Ms)	Director- Family Health & Nutrition Unit	

ANNEX 2: Data sources and References

1) Ministry of Health Diseases Response Surveillance Unit (DSRU) annuals 2012-2013
2) Sentinel site data from the Communicable Disease Control Unit (CDCU)
3) Policy and national programme data from the Ministry of Health AIDS Control Programme (ACP)
4) Reproductive Health Programme Annual Reports
5) Child and school Health Programmes annual reports
6) Youth Health Programme annual reports
7) Ministry of Health (2011) *Injection (sic) Drug Use Integrated Biological and Behavioural Surveillance Survey Round 1*
8) Ministry of Health (2011) *Men Who Have Sex With Men: Integrated Biological and Behavioural Surveillance Survey Round 1*
9) Ministry of Health and Social Services, Social Development Division (2006) *National Plan of Action on National Development 2005 – 2015*
10) Ministry of Health (2001) *National Policy for the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles*
11) National AIDS Council (2012) *National Policy for the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles*
12) National AIDS Council (2012) *National Strategic Framework for HIV and AIDS and STIs 2012 – 2016*
13) National AIDS Council (2012) *National Costed Operational Plan on HIV and AIDS and STIs*
14) National AIDS Council (2012) *National Multi-Sectoral Monitoring and Evaluation Framework for HIV and AIDS and STIs*
15) UNDP *Seychelles Common Country Assessment Report 2010*
16) Ministry of Foreign Affairs (2012) *Draft Report of the Implementation of the International Covenant on Civil and Political Rights (Seychelles)*
17) National AIDS Council (2011) *Final Report on the Evaluation of the HIV/AIDS NSP 2005-2009, Updating of the National Policy on HIV/AIDS and Other STIs, and Road Map for NSP 2011-2015*
18) Ministry of Health (2012) *Domestic and International AIDS Spending by Categories and Sources*
19) National Bureau of Statistics (2011) *Population and Housing Census 2010: Preliminary Results*
20) National Bureau of Statistics (2011) *Population and Vital Statistics: No. 2 of 2011*
21) Ministry of foreign Affairs (2013) Seychelles Millennium Development Goals Status Report 2013
22) Situation Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles final report 2013
23) Ministry of employment (1995) Seychelles employment act 1995
24) Ministry of Legal Affairs (2013) *Assessing the efficiency of the management of treatment for people living with HIV and AIDS Report of the Auditor General*
25) Ministry of Health (2013) The HIV, AIDS and STIs Knowledge, Attitudes, Practice and

Behaviour (KAPB) and Biological Surveillance Study Report for Seychelles
26) Ministry of Health (2013) Social Behaviour Change Communication Framework
27) Ministry of health (2012) Introducing Medically-Assisted Therapeutic Services in Seychelles:
28) Ministry of Health and social Development: Report on situational analysis of the institutional response to domestic violence
29) Ministry of Foreign Affairs: Seychelles Millennium Development Goals Status Report 2013
30) Ministry of Employment National HIV AIDS Workplace Policy 2013
31) National AIDS Council ACT 2013

ANNEXE 3: SEYCHELLES ANALYSIS AND SUMMARY OF RESPONSES TO NATIONAL COMPOSITE POLICY INSTRUMENTS (NCPI) QUESTIONNAIRE (PART "A' AND "B")

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted
for questions, if any: Sabrina Mousbe
Postal address: Ministry of Health, Mont Fleuri, Mahe, Seychelles
Tel: + 248 438 8186
E-mail: sabrina.mousbe@health.gov.sc

Date of submission: 15th April 2013

PURPOSE OF NCPI REVIEW PROCESS

The process aims to gather information to know the progress, challenges on overall policy, strategy, legal and programmes implementation environment for the HIV/AIDS response in Seychelles. The National Composite Policy Instruments (NCPI) relates to critical enablers, i.e. those elements that entail supportive and protective policy and legal environment for scale up of national multi sectoral HIV/AIDS Prevention, Treatment and Care and Support. It is part of GARPR reporting exercise which is a commitment by the member states under the terms of the 2011 Political Declaration. The GARPR emphasizes that effective national Response to HIV and AIDS should be measured by achievement of tangible, time-bound targets. Therefore, there is a need for systematic monitoring of the progress in implementing commitments.

RESPONDENT IDENTIFICATION, RECRUITMENT AND DATA COLLECTION PROCESS

A sample of 40 potential respondents was identified from different contact lists of relevant sectors and units within the government, and outside the government including Civil Society Organizations and United Nation Organizations. Out of this total 20 responded through the submission of completed questionnaire either before or after the half day workshop. It is notable that most respondents make up a sample of informants from within and outside the government who could be having with some sort of familiarity with scope of issues and knowledge around national response to HIV and AIDS.

The potential respondents were contacted and standardized self administered questionnaires posted to them. The respondents were expected to complete and post back completed questionnaires to the contact person in AIDS Control Program Office. Posting back the completed questionnaire also indicated consent by the identified persons to participate in the exercise. A section of the respondents posted back completed questionnaires while others completed their questionnaires, in a stakeholders meeting organized to build consensus on the process of the NCPI data gathering and validation process.

SCOPE AND DATA ANALYSIS METHODS

The analysis is limited to the various questions included in the 2 questionnaires (part "A" administered to the government officials, and part "B" administered to administered to representatives from civil society organizations, bilateral agencies, and UN organizations

Part "A" covered: Strategic plan, Political support and leadership, Human Rights, Prevention, Treatment, care and support, Monitoring and evaluation, and part B covered: Civil Society involvement, Political support and leadership, Human rights, Prevention, Treatment, care and support.

The NCPI questionnaires contain both closed standard questions and open ended questions. These generated both qualitative and to some extent quantitative data. Descriptive analysis has been used to analyze the qualitative data comprising of views and comments based on the themes to identify general patterns on progress on implementation of commitment to HIV&AIDS national response. In addition, simple summary statistics (i.e. means and frequencies were calculated and interpreted to provide general impressions of the respondents.

FINDINGS

The approach take consolidates the findings with an aim to highlight, the general trends, but also inconsistencies where views of respondents to part A of NCPI and part B of NCPI do not agree, rather than provide detailed report on standard practices in place or progress of HIV response over the years. Those are very apparent to and included definitely in the narrative.

The findings are outlined under major themes in the questionnaires including: "Part A" administered to government officials. These are: Strategic plan, Political support and leadership, Human Rights, Prevention, Treatment, care and support, Monitoring and evaluation, and "Part B" administered to representatives from civil society organizations, bilateral agencies, and UN organizations. These are: I. Civil Society involvement, Political support and leadership, Human rights, Prevention, Treatment, care and support

NCPI PART A (ADMINISTERED TO GOVERNMENT OFFICIALS)

I. Strategic plan

Q1: all respondents (n=20) agree there is a national multi-sectoral strategy for HIV and AIDS, however, there is somewhat confusion about the period covered. Responses indicate both 2005-2009, and 2012-2016. Indicating the two periods in report narrative may help clarify the existing gap when there was no Strategic plan in place between 2009-2011 periods.

Notable is the lack of multi sectroral strategy with specific HIV budget for the activities. Most respondents share common views on the focus of multi sectroral strategy on key populations and vulnerable populations, settings and cross cutting issues.

Q2. The question as to whether HIV and HIV related issues like HIV impact have been

integrated in specific development plans, have mixed responses. Most respondents (n=15) think HIV have been integrated in development plans, however, evidence from document review may reveal different picture. It is not clear from the NCPI data whether HIV have been integrated effectively in different national development plans, and further discussions and validation will need to be conducted to clarify these.

Q3. The question whether the country has evaluated the impact of HIV on its socio economic development for planning purpose raises mixed views, with some respondents (n=5) disagreeing. While it may be apparent no such evaluation has been done, it will be worth to discuss this further, and or triangulate with existing findings from other documents to establish if the country has had such an evaluation. A point which is not evident has been undertaken. Responses indicate low to average scales for evaluations and use of evaluation evidence on socio economic to inform resource allocation decisions on HIV/AIDS response and it highlights the need to look into implications it may be having on the national response and what actions could be taken.

Q4. It is also not clear from the responses whether there actually exist a strategy for addressing HIV issues among national uniformed services. A small proportion of respondents don agree that a strategy actually exist (n=5).

Q5. All responses indicate the country followed up on commitments made in the 2011 political declaration on HIV/AIDS

Q6. In overall responses indicate an average of 8 out of 10 for overall strategy and national planning. However, there are limited substantial comments and examples to support that from the responses. Moreover, more triangulation may be needed to strengthen evidence on these issues.

II. Political support and leadership

Q1. All respondents (n=20), indicate high government officials speak publicly and favourably about HIV efforts in major forums including both ministers and officials at sub national level.

Q2. All respondents (n=20) agree the country has fully recognized national multi-sectoral HIV coordination body (i.e. National AIDS Council) with active leadership and participation, official chairperson, defined membership and including CSOs, PLWHA and the private sector. However, it is not exactly clear whether NAC has an operational function in actual coordination activities and management of national HIV/AIDS programmes. These observations may need further discussion, and highlight any perceived or actual challenges around national coordination. Also, While most respondents agree there is one national multi-sectoral coordination body (i.e. National AIDS Council), Most of the participants also agree more could be done to increase interaction, collaboration between the government, civil society and private sector for implementing HIV/AIDS programmes and strategies

Q3. All respondents also acknowledge the country has a system in place to promote interaction between the government, civil society organizations and the private sector for implementing HIV strategies /programmes for example through NAC meetings held twice a year and the AIDS Control Programme though the multi-sectoral SBCC Committee and workplace focal persons

Q4. Most participants have no clue as to what proportion of the national HIV budget was spent on activities implemented by the civil society over the past year. This is because the annual allocation of the Ministry of Health budget does not specify the % for the NAC and the AIDS Control Programme, treatment care and support. However, this can be explored further through other existing sources of financial data.

Q5. All respondents agree national AIDS council provide civil society support in capacity building, information, procurement and technical guidance. However, most views don't indicate 'coordination with other implementing partners' as one of the support areas

Q6. The question of whether the policies and laws have been amended to be consistent with national HIV and AIDS Control policies has NO responses. All response (n=20). Based on the Legal Assessment framework report disseminated in 2013, conveyed the meaning of alignment of National HIV AIDS Policy 2012 and Strategic Plan for HIV/AIDS, 2012-2016to law reform. however, it will be important to have further discussion to clarify, that the question of review and amendment of policies and laws has wider scope, to include other related national and sectroral policies and legislations.

Q7. The scales applied is very encouraging (n=18) most respondent agree on the political support but however the appliance of programmes for key population remains undebatable.

III. Human Rights

Q1.1 Questions on human rights have varying and in some cases very inconsistent responses. However, most respondents (n=15) indicate there is existing non discrimination law or regulation which specifies protection of people living with HIV. Law or regulation implies a policy enforceable in a court of law. This makes the shared view by respondents not so clear, since we don't have specific legislation specifying people living with HIV.

While may be apparent the country has no specific non discrimination legislation or regulation which specifies protections for specific populations like MSM, sex workers etc, under Q1.1 most respondents, likely make reference to National policy on HIV and AIDS and STIs. 2012 since it has been approved by the NAC and disseminated. Additionally, the HV AIDS workplace policy was validated and communicated by the Ministry of Employment.

Q2.Most respondents (n=18) agree the country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations including MSM, people who inject drugs,, prison inmates, sex workers, and transgender people.

There are also a two of non responses on areas where there is some kind of regulation. This may imply limited awareness of existing policies among some stakeholders. Communicating policy as existing should be for those formally passed in processes upholding the rule of law/law making in the country.

IV. Prevention

Q1. All respondents (n=20) agreed the country has a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population. With the development of the SBCC Framework for HIV AIDS and STIs most agreed on the integrated,

Respondents also identify focus of the strategy. Most respondents (n=18) identify strategy is well focused on messages promoting greater equality between men and women, and how to avoid intergenerational sex. Messages on 'Males get circumcised under medical supervision, is viewed by most as not applicable for Seychelles"

Q2. All responses indicate there is a strategy to promote life skills based HIV education for young people. The strategies also include age appropriate gender sensitive sexual and reproductive health elements.

Q2.3 Most respondent (no=15) agreed on existing strategy However, notable also is question on strategy for HIV education for out of school youth where many (n=5) respondents think there is no clear strategy in this area. It could be integrated, however the observation may indicate, need to strengthen focus and coverage.

Q3. Most respondents (N=19) agree the country has strategy/policy in place to promote information, education and communication and other preventive health interventions for key or other vulnerable sub populations. Most respondents agree most of the elements and most of populations groups are reflected in the new Strategic plan 2012-2016

Q4. All respondents agree the country has identified specific needs for HIV prevention programmes. Also most participants strongly agree with good progress and access to prevention services for blood safety, PMTCT, Universal precautions in healthcare settings. However, most respondents strongly disagree with progress and access to prevention services for harm reduction for intravenous drug users, risk reduction for sex workers including IEC on stigma and discrimination. These highlight some views on trends to consider for validation, but also on the general trends in national HIV prevention efforts.

V. Treatment, care and support

Q1. All respondents report, that the country identified the essential elements of comprehensive package of HIV treatment, care and support services including prioritized elements like HTC, PMTCT, medication, social support, financial support.

Responses to Treatment, Care and Support, indicates very impressive progress especially most views strongly agree with progress of free access to Antiretroviral Therapy, early infant Diagnosis, Post Delivery ART for women among other treatment services scores very high, in the national response from the views of respondents. Some views, however disagree with access to psycho social support for people living with HIV&AIDS and HIV care and support in the workplace including referrals. The responses however, also indicate the challenges to successful treatment outcome for PLWH, including non compliance with treatment plans, loss due to follow

up etc.

Q2. There is general consensus that the government has a policy/strategy in place to provide social and economic support to people infected/affected by HIV. However, it is important to note some respondents indicate that the social support is not framed with general welfare program for everybody eligible.

Q4. All respondent agree that the country is not accessing regional procurement or supply management mechanisms, for critical commodities, such as ARVs, condoms and substitution medication. Some respondent stated the SADC vision of supporting the SADC Member states through this imitative in the future

Q6. All respondent stipulates the government commitment towards all orphans and vulnerable children whether infected with or affected by HIV, AIDS and Hepatitis. The Social Service Agency of the Ministry of Local Government ensures that all orphans are supported. Orphans are usually cared for by family members supported by financial assistance or those without family support are placed in orphanages managed by government or religious institutions. In both cases the government provides financial support. Responses to Treatment, Care and Support, indicates very impressive progress in overall compared to other aspects of the national response.

VI. Monitoring and evaluation

Q1. All responses indicate there is one national monitoring and Evaluation plan for HIV, and most agreed respondents (n=15) indicate the M&E plan is in progress and , while to others there is an M&E framework in place. Most agreed that the plan is not institutionalized for effective monitoring especially the non health indicators due to lack of human resources.

Q2. Most responses to the question whether national M&E plan include a data collection strategy, agrees to the entire component including 'HIV Drug surveillance, an element that is not yet conducted in the country.

Q3. Some respondents indicate the budget for M&E is in progress (n=16) while others don't have a clue. It will be important to have a plenary discussion before validating the true state of M&E budget.

Q4. Most respondents (n=13) identifies there is no functional national M&E Unit Some also highlight obstacles as limitation in human resources and technical capacity.

Q5. All respondents agreed that there is no functional M&E Unit specifically designed for HIV AIDS response. The current existing system is for the entire Ministry of Health. There is a couple of non responses to this question, some respondents report non existence of M&E committee or working group.

Q6. Some respondents (n=10) reports an existing national database with HIV related data. However, some few indicates this is something in progress. Comments also acknowledge some limitations of information about the content, key population and geographical coverage of HIV

services, as well as their implementing organizations.

There are non responses and few responses to question, 7 and 8, which make it appropriate to have a plenary discussion with participants to gather more information, to have a clear status of the activity.

Overall, there is limited comments/response to questions on M&E, possibly indicating low awareness, participation in M&E planning activities, or lack of such. It would be worth it to explore the details further with national stakeholders.

NCPI PART- B (ADMINISTERED TO REPRESENTATIVES FROM CIVIL SOCIETY ORGANIZATIONS, BILATERAL AGENCIES, AND UN ORGANIZATIONS)

I. Civil Society Involvement and the UN System

Generally and like some responses in Part "A" most responses in Part "B" view Civil Society participation, the UN system and visible influence on decisions as adequate compared to the 2012 results. The Civil Society are adequately represented into the planning decision making process of the national response, capacity building, motivation and support to active participation.

Q1. Most views (n=10) on CSOs influence on political commitment of high profile leaders and national policy development indicates moderate to average contribution. However, there are good examples of how CSOs and their networks have engaged high profile leaders on various issues on HIV and AIDS including stigma and discrimination, HIV prevention among IDUs among others. Generally, there is an impression of low key and not very proactive advocacy among the CSOs.

Q2. Most responses indicate CSO representatives were involved in the development of the new strategic plan and there is a trend of increasing involvement from the previous NSP even though it is still viewed as low and ineffective. However, some find limited representation when it comes to budgeting for the national strategic plan on HIV/AIDS and STI 2012-2011.

Q3. Some CSOs are involved in service delivery at the community level; however there are perceptions of few dominant groups always receiving funding for service delivery.

Q4. CSOs involvement in M&E Activities is generally considered adequate including using data for decision making.

Q5. Responses indicate somewhat good representation, especially in development of the new NSP, involving FBOs and few organizations working with Sex workers and MSM.

Q6. While access to technical support is viewed as moderate, access to funding is highlighted as a major challenge for the CSOs in Seychelles and generally access to external funding is very low.

It is also notable that despite perceived adequate influence on decision making processes, and participation, CSOs participation has been increasing in recent years and this is highlighted especially in review and developing of the last National Policy and Strategic plan for HIV/AIDS and STIs 2012-2016, where they were involved in different consultations and technical working groups.

The 2001 Declaration of Commitment on HIV/AIDS emphasize strengthening collaboration between government and civil society partners in the HIV response, and the biennial UNGASS reporting process is an opportunity for civil society to engage in a review of the implementation of commitments. The responses indicate engagement of civil society occur in a number of ways, civil society organizations also organize themselves around some networks though suffers challenge of "undemocratic" practices and weak structures. However, some respondents indicate dominant groups to always have more opportunity to participate. Some CSOs also indicate appreciation when they have the opportunity to be involved meaningfully.

Some achievements indicate the move by government to make available some funds through NATF as progressive, specific budget line for NGOs however; respondents indicate better access to funding and technical support is needed. Many Instances remain where there are fundamental differences between government and civil society perceptions of the HIV policy and program environment.

CSOs and government collaboration is potentially valuable step in what should be an ongoing and fully institutionalized process of collaborative planning, implementation, monitoring, assessment and correction of HIV responses. The momentum achieved through the process, of developing national policy and plan for STIs, 2012 – 2016 may be improved for active and meaningful engagement.

II. Political support and leadership

Generally, most respondents (n=10) also indicate the government has involved people living with HIV including key populations in policy design and programme implementation. As stated above the nature of involvement varies but most notable is in, NATF boards, development of national policy and plans for HIV and AIDS

III. Human rights

Perceptions of national efforts to address human rights related to the key populations vary but scores just above average in overall. Like the responses in Part A, most respondents have mixed views and somewhat indicate there are no specific non discrimination laws or regulations for key populations including MSM, Sex workers, people who inject drugs, and transgender among others.

The general observation is that general laws exist on non discriminations (i.e. as in the country's constitution) which may be used by anybody (through different mechanisms like Ombudsman office, Courts etc) to seek legal redress. May be the question could be access to and effectiveness of the existing mechanisms to enable people seek redress. However, considering significant non

responses on some of these fundamental questions, it may be assumed there is low awareness about existing laws that relate to discrimination in general among different population groups. This is a trend that may be explored with stakeholders considering its implications.

Notable also is the varying views about existence of programs to reduces HIV related stigma and discrimination and types. Some respondents disagree they even exist. This is subject to varying interpretation but it may important to explore it further with stakeholders, and further than that explore more on content, delivery and design of the programs as they may explain the trends in perceptions, and actual scenario.

IV. Prevention

All respondents (n=10) perceive that the country indentified the needs for HIV prevention, however, most (n=19) think there is need for improvement to have targeted interventions. In consistency with the responses in Part A, most responses here indicate strong agreement with access to prevention services and information for blood safety, prevention of mother to child transmission of HIV, Universal precautions in healthcare among others. Most responses also disagree with access to prevention services especially for harm reduction, which the government may be piloting at the initial stages, risk reduction for MSM, sex workers among others. While some respondents agree with access to prevention services for out of school youth, some disagree and it may be important to hold discussions to have a clear picture of the situation.

V. Treatment, care and support

Responses on treatment, care and support and like in part "A", indicate an impressive progress. Most respondents acknowledge the country has identified essential elements of a comprehensive package of HIV treatment, care and support including Blood safety, HTC for key populations, EMTCT etc

Most views in part B, are generally in consistency with views in part A which includes perceptions on the existing strategy and/or policy to ensure access to treatment, care and support for key populations and other vulnerable groups. Access to treatment services are scales high except when it come to care and support for the orphans and vulnerable children. Decentralisation f services for ART will be of great benefit to the client.

CONCLUSIONS

Compared to 2011, there has been an improvement on the responses from both part A and B. There has been more specific information related to each topic and involvement into the national response. The NCPI process has gathered important views on a number of areas useful in understanding the current country situation. There are consistent views from both part A and B questionnaires including remarkable progress in access to treatment services e.g. ARVs, but also limitation in treatment access to certain population groups. Generally, there are more shared than conflicting views on trends of national HIV/AIDS response. Not to say there is absolute agreement in all areas, but even yet the points teased out in this summary will require further corroboration with evidence from desk reviews of other documents, and validation considering

not all respondents share same views on even some of the most pronounced trends.

It is also important to acknowledge that, the sample of the participants in this process are relatively few, therefore, the views and general trends identified should only be interpreted carefully within reasonable scope and generalized only after triangulation with findings from desktop reviews of existing policy documents and validation with national stakeholders.

ANNEXE: STEERING/SBCC COMMITTEE (NCPI Respondents)

NO	NAME	POST TITLE	WORKPLACE/REP
2.	Jude Fred (Mr)	Chairperson –ELM	FBO
3.	Sheryn Raoul (Mrs)	AIDS Health Promotion Officer	AIDS Control Program MOH
4.	Louine Morel (Dr)	Medical Officer	CDCU MOH
5	Brigitte Gbilimou (Ms)	Provisional psychologist	Mental Health Services/wellness MOH
6	Marie-Jenny Marie (Mrs)	Member	NAC Board
7	Yvana Theresine (Ms)	Director	DAC MSACDS
8	Clarence Gill (Ms)	Nursing Officer	Les Mamelles Health Center-MOH
9	Suzanne Pierre (Ms)	Senior Social Worker	Social Services MSACDS
10	Rev. Christine Benoit	Priest	Anglican Church
11	Anael Bodwell (Ms)	YAM project officer	ASFF
12	Doreen Hotive (Mrs)	Health Promotion Officer	WHO
13	George Madeleine (Mr)	Manager Health Promotion	Health Promotion Unit MOH
14	Peter Allisop (Mr)	Chairperson	Youth Alive Roman Catholic Church
15	Brigitte Labonte (Ms)	HPO	MOE
16	Beryl Pillay (Ms)	News Reporter	SBC
17	Chantal Melanie (Ms)	Nursing Officer	Youth Health Center MOH
18	Genevieve Ali (Mrs)		NCFD
19	Justin Freminot (Ms)	Chairperson	HASO
20	Michelle Labrosse (Mrs)	secretary federation of employers	HIV & AIDS tripartite committee member (workplace)
22	Reginald Hoareau (Mrs)	Self employed	PLWHA

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ANNEX 4 – National AIDS Spending by Categories and Financing Sources

(See separate document)+

Signature:

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