COUNTRY PROGRESS REPORT 2015

REPUBLIC OF MAURITIUS

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Table of Contents

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

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

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

I. Status at a glance

INTRODUCTION

This report is a national progress report. The 2011 Political Declaration builds on two previous Political Declarations: the 2001 Declaration of Commitments on HIV and AIDS and the 2006 Political Declaration on HIV and AIDs, reflecting global consensus on a comprehensive framework to achieve the Millenium Development Goal Six: Halting and beginning to reverse the HIV epidemic by 2015.

It recognized the need for multi-sectoral action on a range of fronts and addressed global, regional and country –level responses to prevent new infections, expand health care access and mitigate the epidemic's impact.

While these declarations have been adopted by governments, the vision encompasses private sector and labour groups, faith based organizations, non-governmental organisations and civil society, including People Living with HIV.

This report covers the period of January to December, 2014 and represents a comprehensive set of data on the status of the epidemic and progress in the response. This exercise is underpinned by the Republic of Mauritius National Monitoring and Evaluation indicators which encompass most indicators utilised in this Country AIDS Response Progress Report.

The Main objective of this document is to provide key partners involved in the National Response to HIV with essential evidence-based information on core indicators that measure the effectiveness of the National Response.

1.1 The inclusiveness of the stakeholders in the report writing process

The following methodologies were used in the compilation of this report.

1. **A technical committee** was set up to facilitate the collection of data and technical assistance at National level.

2. **Desk review**: Background documents on the HIV epidemic and response in the Republic of Mauritius and relevant National documents were reviewed. Documents included:
    a) The National Strategic Framework on HIV and AIDS 2013- 2016
    b) Programmatic Reports: Monitoring and Evaluation Reports, Annual Report.
    c) HIV Behavioural Surveillance Survey, general population, 2014.
    d) HIV sentinel surveillance data
    e) Modes of transmission Survey Report 2013
    f) Integrated Biological and Behavioural Surveillance Survey among CSW 2012 .
    g) Integrated Biological and Behavioural Surveillance Survey among MSM 2012.
    h) Integrated Biological and Behavioural Surveillance Survey among PWID 2013.
    i) Mapping Of Key Populations Survey 2014
    j) National AIDS Spending Assessment 2012
    k) Epidemic and response synthesis, programme data and other relevant data sources.

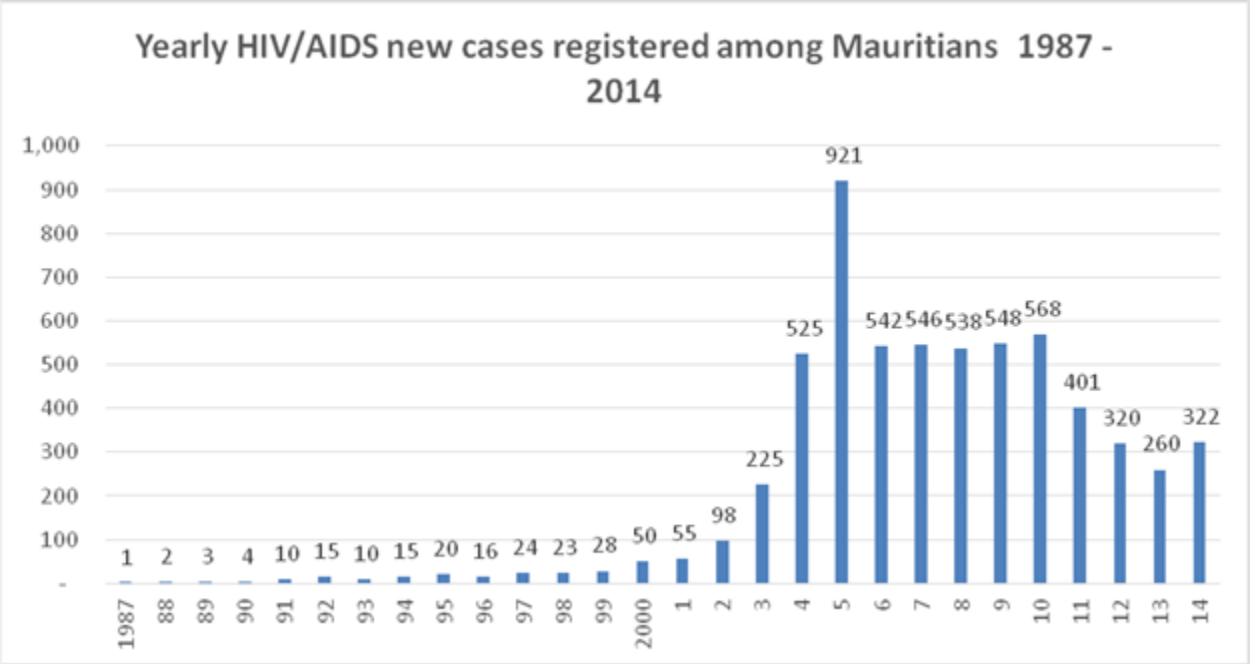
3. **Stakeholder consultations**: Key stakeholders and beneficiaries were consulted regularly since the beginning of year 2014 in the process of developing our Investment Case and the Concept Note that was submitted to the Global Fund.
4. **Data collection** was facilitated by relevant data collection tools from all partners and data consolidation done at the level of the National AIDs Secretariat.
5. **Registration on line:** Following data collection, stakeholders were invited to register on-line in order to view data entered on the system
6. **A draft** country AIDS Response Progress Report was prepared and presented at a stakeholder Validation Forum on the 26th March 2015 for **validation and consensus building** under the leadership of the NAS, Ministry of Health and Quality of Life.
7. Feedback from the consultative forum was used to **finalize the report, which was submitted on the 10th April, 2015 to the Ministry of Health prior to submission to UNAIDS.**

The validation of the Global AIDS Response Progress Report with all partners served to not only quantify the National Indicators but also served as a mechanism building and agreement on priority areas within the Republic of Mauritius HIV response in the immediate years to come.

1.2 The status of the epidemic

From the beginning of the epidemic, to date, a total number of 6090 cases of HIV have been detected. In the year 2000, only 2% of the newly detected cases were among PWID, and this percentage gradually increased to 92% in 2005 (National HIV Surveillance). Following the introduction of Harm Reduction strategies in 2006, namely the Needle Exchange Programme and the Methadone Substitution Therapy, the percentage of PWID among detected cases decreased to 68.1% in 2011, 47.2% in 2012, 38.1% in 2013. In 2014, this percentage was 31.1%.

FIG 1 : Annual cases



Source: National HIV Surveillance

The injecting behavior has largely contributed to the spread of the HIV epidemic in Mauritius. Proactive actions (HIV and AIDS Act, Needle Exchange Programme and Methadone Substitution Therapy) from the Governments and other partners have brought considerable impact on the number of detected cases among PWID. Subsequently the yearly number of cases has decreased from 401 cases in 2011, to 320 in 2012 and 260 in 2013 and increased to 322 in 2014, bringing the number of monthly detected cases from 46 in the year 2006 to 2010 to 33 in 2011, 27 in 2012 and 22 in 2013 and 27 in 2014(National HIV Surveillance). Sexual transmission within the MSM population, and from PWID, MSM and FSW to the general population remains a potential driver of further spread. Other determinants of the epidemic include multiple partners, stigma and discrimination and poverty in certain areas.

Among newly detected cases, it is noted that the number of young people aged 15 -24 years is gradually increasing, which is a combined consequence of low HIV knowledge

and early sexual debut. The HIV epidemic is dynamic and if we want to eliminate new detected cases, we have to remain vigilant on all fronts.

1.3 The policy and programmatic response

The Republic of Mauritius has a positive policy, advocacy and enabling socio political environment for implementing a comprehensive multi-sectoral programme to combat the HIV epidemic. The National response is based on the “Three-Ones Principles”. The National AIDS Secretariat under the aegis of the Ministry of Health and quality of Life coordinates the National Response with the involvement of key ministries, the private sector and civil Society through various institutional arrangements such as the Technical Working Groups, decentralised structures such as the Day Care Centres for the Immuno-suppressed, Regional AIDS Unit, civil society organisations.

The National Strategic Framework (NSF) on HIV and AIDS 2013- 2016

The National Strategic Framework (NSF) on HIV and AIDS 2013 – 2016 is the strategic guide for the national response to HIV and AIDS until end 2016. The NSF addresses the drivers of the HIV epidemic and builds on the achievements of the previous NSF. Interventions that have worked well are being scaled up and the quality of service delivery is being improved. A number of overarching principles underpin the implementation of the NSF, in keeping with gender equality, equal opportunities and the protection of human rights. The NSF is also aligned to the country’s international and regional obligations, commitments and targets related to HIV and AIDS.

The overarching results that the NSF aims to achieve by 2016 are as follows:

- Reduced HIV transmission
- Reduced morbidity and mortality of PLHIV
- Reduced stigma and discrimination related to HIV

Technical committees

With a view to ensuring greater transparency in its operations and the effective involvement and engagement of stakeholders in the preparation, design and implementation of its different programmes, the NAS, under the aegis of the Ministry Of Health and Quality of Life has set up a number of multi-sectoral technical committees made up of representatives of all sectors. The main thematic technical committees are:

- BCC
- Treatment, Care and Support with sub-groups on - Holistic care of PLHIV Palliative Care Opportunistic and co-infection.
- Policy/advocacy, Human rights and legal issues
- M&E, Research, knowledge management.
- Harm reduction

Terms of Reference for Technical Working Groups:

These technical workings groups have been institutionalized and hold regular planned meeting and provide a platform from which stakeholders from all sectors engages in providing input and disseminate information for a robust National Response. This broad stakeholder base ensured that all key areas (Government, Line Ministries, NGOs, CBOs, FBOs, civil society, service users and beneficiaries) are involved in all areas of planning and decision making

All the technical committees have their Terms of Reference and they meet every three months or on an ad-hoc basis.

Main objectives of the TGs

- Assist/ reinforce the capacity of the National leadership to coordinate, manage and monitor the expanded response to HIV/AIDS epidemic and its consequences.
- Advocate for a supportive and enabling environment for the implementation of HIV prevention, treatment, care and support in a multi-sectoral, non-discriminatory environment.
- Analyse and exchange information based on field experience.
- Identify gaps in the overall National Response to HIV in respect to the National HIV and AIDS Strategic Framework 2012-2016 and build partnership between organizations to address these gaps.
- Collaborate on common areas for capacity building, particularly in the areas of training, and development of resource materials
- Enhance communication and networking within working group and build partnership with other stakeholders including media, private sectors and other specific sectors (Tourism, Education etc…..)
- Promote the active and meaningful participation of people living with HIV and AIDS and members of MARPs.
- Optimize the timeliness, efficiency and effectiveness of HIV-related Monitoring and Evaluation activities.
- Coordinate between organizations to avoid duplication of work and ensure the achievement of best results.

The Government of Mauritius through institutions like the Ministry of Health (NAS, AIDS Unit, Harm Reduction Unit), National TB Programme, Prisons Institutions. Line

Ministries, Multi-lateral and Bi-lateral Development Partners, Private sectors, civil society, UN agencies have developped a number of Policies, Guidelines, Strategic frameworks, Acts and Related Legal instruments to create an enabling environment to respond to the HIV epidemic in Mauritius.

- HIV and AIDS ACT 2007
- National HIV Policy 2011
- Strategic documents: National HIV and AIDS Strategic Framework (NSF) 2013-2016.
- Programmatic Reports: Quarterly PUDR (Programme Update and Disbursement Request)
- Integrated Biological and Behavioural Surveys among Key populations (PWID, CSW and MSM)
- Workplace HIV Policy, Ministry of Labour. 2013
- Modes of HIV Transmission Report 2013
- Universal Access Report 2012
- Stigma Index Report 2013.
- HIV estimates 2013
- National Treatment Protocol 2014 (based on WHO treatment protocol 2013)
- HIV Rapid Testing for NGOs Guidelines, 2014.

Programmes in line with the National Response

Behavioural Change Communication

Major activities carried out to reduce sexual transmission of HIV in the general population include behavioural change communicate on interventions with different target groups taking into consideration their respective need,(General population, young people, PWID, MSM, TG, PI).

Condom promotion and distribution:

Regular condom (Male & Female) promotion and free distribution are done across the island. Correct and consistent condom use in high-risk sex is being encouraged and advocated. As from 2010 -2014, an average of 1.3 to 1.5 million condoms has been distributed.

HTC

HTC is the key entry point to HIV treatment, care and support services. Therefore the National HIV programmes encourage people to access the HTC services for early detection and access to treatment for HIV.

Key strategies were used to recruit clients for HTC:

1. The country implemented a very successful nationwide Know Your Status campaign in 2013.
2. The provider-initiated testing and counseling (PITC) at all health facilities and outreach programs
3. The provider-initiated testing and counseling (PITC) offered to the population in general through testing days organised across the country.

Stigma and Discrimination

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

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

The National Response is a multi-sectoral one where the GIPA concept is fully applied. PLWHA and service users are being regularly consulted for policy and strategy development through Focus Group Discussion and participation in the technical committees.

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

Harm Reduction Programme

Mauritius is the only country in the African region which has scaled up the provision of Needle Exchange Programs (NEP) and Methadone Substitution Therapy (MST) to a significant proportion of People Who Inject Drugs (PWID). Mauritius has been successful in the integration of Government and Non-Government Organizations' (NGO) infrastructure and workforce to address harm reduction initiatives aimed at reducing the spread of HIV. The harm reduction programme in Mauritius is in essence a vertical public health intervention which is now partially funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM).

The NEP was launched in November 2006 and is now covering the whole island with 49 distribution sites (MOH &QL =36 ; NGOs= 13) and are actually reaching 2500 – 3000 PWID per semester. While the MOH &QL services are mainly through caravan, NGOs provides needles and syringes through a back pack services, thus reaching those in the community who are reluctant to attend the caravan.

The MST was also launched in 2006 and has scaled up since its implementation and the waiting list have been significantly reduced. A particular strength of the MST program is the ability to recruit and retain a high number of clients. The Harm Reduction Unit reports 90% client retention rates over a period of one year. As at December 2014, there is a total number of 18 dispensing sites (Government only) across the islands (5 Rural /13 urban). Till date there is 5571 clients on Methadone Maintenance Therapy.

Laboratory Quality assurance in support of HIV and AIDS Programme

Laboratory support is essential to support Disease Program through screening, diagnosis and monitoring services. People Living with HIV have benefitted from laboratory tests conducted at the Central Health Laboratory:

- ELISA for HIV screening
- Confirmation by Western Blot
- CD4 levels
- HIV Viral load

Other services include routine tests, specialized tests and transfusion support and safety (100%). The NBTS is ISO Certified and Stringent Internal Quality measures are practiced on a daily basis.

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

Antiretroviral and Regular review of treatment Protocol

Mauritius has adopted the 2013 WHO Guidelines for ARV Treatment of PLHIV in view of the envisaged scaling up of the HIV programme,

Free ARV treatment was introduced free of charge in 2001 and the National Day Care Centre for the Immune-suppressed (NDCCI) being the sole point of care and treatment. In response to an increase demand, the Ministry of Health & Quality of Life is concurrently

decentralizing and scaling up HIV treatment care, including within the prison settings and Rodrigues Island.

As at end of 2014, approximately 6090 HIV positive cases had been detected, with 4085 enrolled in care and 2354 adherent ART.

PMTCT

Since 2012 , the Republic of Mauritius has been implementing the option B+ prophylaxis for HIV positive pregnant women. Since we have reached a 97% access, the government of Mauritius is now aiming at E-MTCT.

Pathway of babies born to HIV positive women:

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

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

Prompt diagnosis and treatment of other STI's

Prompt diagnosis and treatment of STIs across all population remained one of the priority of the National Programme. Health Care Providers have a unique opportunity to provide education and counseling to their patients.

Testing for HIV is recommended and should be offered to all persons who seek evaluation and treatment for STIs.

Management of Co-infection (TB, HEP C and B)

The Republic of Mauritius is a low TB burden country with an annual number of 100-120 cases of TB annually. There is a close collaboration between the two programmes and HIV testing and counselling is a routine procedure in Health care settings dealing with patients who have active TB or any chronic chest infections.

Post Exposure Prophylaxis

HIV transmission during medical procedures at hospitals has not occurred to date. 100% of donated blood units were screened in 2014. All ART centres and Regional Hospitals have the capacity to provide PEP services primarily for occupational incidents among health workers and survivors of rape. All police stations are aware of the PEP program and bring rape victims to take prophylaxis treatment prior to investigation.

Support

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

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

Health Systems Strengthening

According to the Assessment Report of the Health System Component of Clinical management of PLWHA in Mauritius carried out in July 2014,the key findings are reported in four thematic areas of Leadership & Governance, Programme Management, Service Delivery, and Strengthening Partnerships.
The findings of the review reaffirm the pivotal role that the health sector is playing within the multisectoral response to HIV and AIDS. In particular, they point to major achievements over the last few years in scaling up coverage of key services, including Harm reduction services, prevention of mother-to-child transmission of HIV, tuberculosis treatment and antiretroviral treatment. These efforts are contributing to the creation of more robust systems, capacities and partnerships for a sustained HIV/AIDS response in the health sector.

The review also identified some major constraints and challenges that threaten gains to date and impede further progress in scaling up essential HIV/AIDS services. Significant changes to programme management are required to keep pace with and maximize efficiencies in responding to the escalating burden of care. A major initiative is also required to unleash the health sector’s potential contribution to reducing the rate of new infections

Recommendations:

The recommendations to enhance the health systems for clinical management of PLHIV are guided by a public health approach that emphasizes the needs and rights of all people in Mauritius, including the poor and the marginalized, to quality health services.

1. Capitalize on current leadership to strengthen existing governance and management mechanisms at all levels
2. Addressing the human resource needs and optimising the patient: nurse and patient: doctor ratio based on the task sharing guidelines
3. Strengthening the health sector's capacity to monitor and evaluate HIV care and treatment service delivery
4. Decentralize HIV Care and Treatment
5. Facilitate service integration as a standard of care
6. Capitalize on opportunities for HIV prevention in the health sector
7. Continue to focus on quality improvement
8. Improve sustainability of services by rationalizing the cost of care
9. Maximize the potential of health sector partners
10. Strengthening operational research capacity of MOH QL

Further steps to respond to these findings should include:

- MOH QL with the leadership of NAS developing a joint work plan; and identifying the technical support required to address the findings and recommendations;
- Identifying good national and international practices that can be scaled up to strengthen service delivery especially the implementation of the new WHO recommended Consolidated strategy for responding to HIV and AIDS in Mauritius.

Community Systems Strengthening

Community system strengthening is required for NGOs working with key populations in Mauritius. A fledgling network of key population NGOs has emerged over the past decade, but substantial work is required to ensure that either the NGOs working with key populations are fully involving key population members in designing and

implementing their programs, or that new organisations developed from key populations themselves are formed and strengthened.

Specific needs include:

- The resources to advocate for key populations' access to health and other services.
- Close collaboration between, for example, NGOs focusing on PWID and FSW to ensure that the needs of "crossover" populations such as FSW who inject are met by the national HIV programme.
- Continued support from Government (Finance and Technical) to improve capacity of NGOs.

Capacity Building and Technical Support

Many of the capacity development of the human resources needed for the implementation of the programmatic response were implemented and included pre-service, in-service, on-the-job, and workshop training programs. Still Capacity building is an on-going need as programme is faced with either trained staff retreating or shifting to other services.

Policy and Programmatic questions

The questionnaire was shared with key partners and a compiled copy was inputted online.

1.4 Indicator data in an overview table.

TARGET/INDICATOR		2011	2012	2013	2014
Target 1 : Reduce sexual transmission of HIV by 50%by 2015 ***General population***					
1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	38.3% (KABP 2011)			31.8 % (BSS 2014)
1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	3.0 % KABP 2011			7.3% (BSS 2014)
1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 m onths	4.2% KABP 2011			12.6 % (BSS 2014)
1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months who report the use of a condom during their last intercourse	55.9% KABP 2011			50.7% BSS (2014)
1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	6.9% KABP 2011			20.8% BSS (2014)
1.6	Percentage of young people aged 15-24 who are living with HIV	0.3% ANC Data	0.72% ANC Data	0.78% ANC Data	1.07 % (ANC Data)

TARGET/INDICATOR		2010	2012	2013	2014
Sex workers					
1.7	Percentage of sex workers reached with HIV prevention programmes	77.6% IBBS FSW 2010	80.5% IBBS FSW 2012		
1.8	Percentage of sex workers reporting the use of a condom with their most recent client	88% IBBS FSW 2010	86% IBBS FSW 2012		
1.9	Percentage of sex workers who have received an HIV test in the past	69.2% IBBS FSW 2010	67.8% IBBS FSW 2012		
1.10	Percentage of sex workers who are living with HIV	28.9% IBBS FSW 2010	22.3% IBBS FSW 2012		
Men who have sex with men					
1.11	Percentage of men who have sex with men reached with HIV prevention programmes	43.6% IBBS MSM 2010	85.6% IBBS MSM 2012		
1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	52.9% IBBS MSM 2010	50.9% IBBS MSM 2012		
1.13	Percentage of men who have sex with men that have received an HIV test in the past 12 months and know their results	89 % IBBS MSM 2010	94.1% IBBS MSM 2012		

1.14	Percentage of men who have sex with men who are living with HIV	8.1% IBBS MSM 2010	20% IBBS MSM 2012		
TARGET/INDICATOR		**2011**	**2012**	**2013**	**2014**
Target 2: Reduce transmission of HIV among people who inject drugs by 50% by 2015					
2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes	30 Prog. data		44 Prog Data	107 Prog. Data
2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	25% IBBS PWID 2011		38.2% IBBS PWID 2013	
2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	89.2% IBBS PWID 2011		83.8% IBBS PWID 2013	
2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	80.1% IBBS PWID 2011		25.2 % IBBS PWID 2013	
2.5	Percentage of people who inject drugs who are living with HIV	51.6% IBBS PWID 2011		44.3% IBBS PWID 2013	

Target 3: Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths					
TARGET/INDICATOR		**2011**	**2012**	**2013**	**2014**
3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission		96.0% PMTCT Registers	95.8% PMTCT Registers	97.4% PMTCT Registers
3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2-3 months of birth		32% PMTCT Registers (cohort Jan-Dec 2012)	78.2% PMTCT Registers(cohort Jan-Dec 2013)	
3.3	Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months			2.9% Prog Data Cohort 2013	
Target 4: Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015					
4.1	Percentage of adults and children currently receiving antiretroviral Therapy			47.6% ART registers	
4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy			79.5% ART registers	82.1% ART Registers

Target 5: Reduce tuberculosis deaths in people living with HIV by 50% by 2015					
5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV				100% National TB Prog
Target 6 :Close the global AIDS resource gap by2015 and reach annual global investment of US$ 22–24 billion in low- and middle-income countries					
6.1	Domestic and international AIDS spending by categories and financing Sources	NASA 2011	NASA 2012		
Target 7: Eliminating gender inequalities					
7.1	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months (*All indicators with sex-disaggregated data can be used to measure progress towards target 7*			See Narrative	
Target 8 :Eliminating stigma and discrimination					
8.1	Discriminatory attitudes towards people living with HIV	36.3% KABP 2011			10.3% BSS 2014
Target 9:Eliminate travel restrictions					
9.1	*Travel restriction data is collected directly by the Human Rights and Law Division at UNAIDS HQ, no reporting needed*				

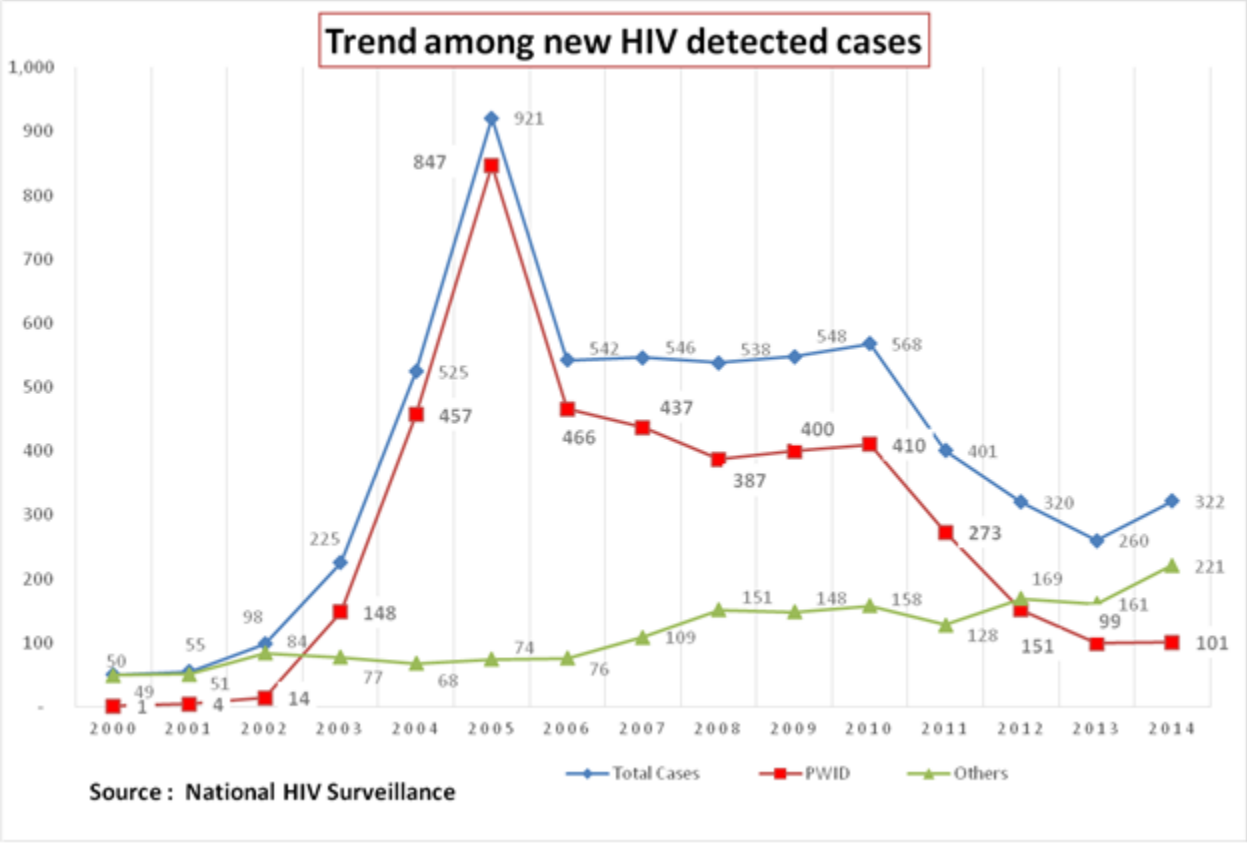
Target 10:Strengthening HIV integration					
10.1	Current school attendance among orphans and non-orphans aged 10–14			See Narrative	
10.2	Proportion of the poorest households who received external economic support in the last 3 months			See Narrative	

II. Overview of the AIDS epidemic

In 2014 the prevalence of HIV among adults of 15 years and above in Mauritius was 0.86% with an estimated number of 9191 People Living with HIV and AIDS. As of December 2014, a total of 6090 cases of HIV and AIDS had been detected cumulatively, out of which 1374 (22.6%) are females. Approximately 953 deaths due to HIV and AIDS have been reported since 1987. The HIV epidemic is concentrated in Port Louis, the capital of Mauritius.

The epidemic was IDU driven with 92% cases detected among PWID in 2005. With the introduction of Harm Reduction Programmes since then, the percentage has come to 31.1% by the end of December 2014.

Figure 2: Number of PWID among new detected cases



New Infections by Modes of transmission

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

HIV prevalence among the Key populations

People Who Inject Drugs (PWID)

Based on a mapping of key population exercise, the estimated size of the PWID population in Mauritius is 11677. Among key populations, PWID had the highest prevalence of HIV of 44.3% in 2013 (IBBS 2013). When disaggregated by sex, the prevalence reveals to be 61.8% among females and 42.5% among males. 74.9% of those surveyed reported ever sharing a needle/syringe. 76% of PWID reported ever having an HIV test; among the PWID tested in the previous twelve months, 71.0% had received the HIV test results. While 27.8% reported having between two and four sexual partners in the previous three months, 61.8% of participants indicated not using a condom during their last sexual intercourse. The interventions to reduce HIV among People Who Inject Drugs also cater for different population types including prison inmates and commercial sex workers who can also be injecting drug users.

Female Sex Workers (FSWs)

Female sex workers have the second highest prevalence of HIV currently, at 22.3% (IBBS FSW 2012). Sex workers,is estimated to be 6223 in number (Key Population Mapping 2014), operate in varied settings including massage parlours, discotheques, and escort

services and via the internet. There is not much data on male sex workers (IBBS FSW 2012). The median age of SW in 2012 was 31, and the age range was 16-63 years. The number of SWs between 15-19 years represents 8% of the population, which is two times higher than in 2010. 61.3% of the sample surveyed reported completing primary education or less. The maximum number of SWs reported living in Port -Louis (37.3%), The median age for sexual intercourse with any partner is 15 years and that for commercial sex is 19 years. 80% of those surveyed reported to have used condoms during their last sexual encounter with any sex partner (IBBS FSW 2012).

Men who have Sex with Men (MSM)

Men who have sex with men (MSM) had an HIV prevalence of 20.0% in the most recent survey (IBBS, 2012). The Mapping Exercise carried out in 2014 determined the MSM population size to be 5467, 31.5% of the MSM surveyed reported residing in Port Louis, the capital and region of highest HIV prevalence in Mauritius, and a close 30.5% reported residing in Plaines Wilhems.

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

Transgenders

The Mapping survey 2014 has facilitated the identification sites and size estimation of this particularly hidden population. The estimation size amounts to 1407. This is the first time that we have been able to separate the MSM/TG population for better programming.

Prison Inmates

The Mauritius Prisons Service comprises 6 Prisons for males, 2 female prisons and one correctional institution for the 16-18 age groups. With a turnover of more than 4500 prison inmates annually, an average of 2400 detainees are incarcerated at any point in time, out of whom approximately 500 are HIV infected. A high proportion of inmates are already HIV infected at entry. This is mainly due to the fact that many inmates were PWID or were convicted for drug-related crimes. The prisons remain the main point of detection of HIV cases especially among PWIDs until last year - (35.5% of all new HIV cases in 2008 were detected in prison, 40% in 2009 and 23.4% in 2012 and 14.9% in 2014).

People Living With HIV

There are 9191 PLHIV in Mauritius according to estimates. As at December 2014, 6090 HIV positive cases were detected, of whom around 4085 are registered with the treatment services and 2,254 are considered to be adherent to ARV. Around 70% of PLHIV are PWID. Weak adherence to treatment and loss to follow up are some of the challenges the national program faces with respect to PLHIV, very likely due to persisting myths associated with ARV, lack of faith in HIV treatment, HIV related stigma and discrimination and perceived marginalization of key populations within the health care setting. PLHIV continue to have risky behaviour putting their sexual and injecting partners at risk of infection. According to the IBBS PWID 2013, 66% of PWID ever shared a needle and among these, 50% are HIV positive. New detected cases among previously sero-discordant couples demonstrate unsafe sexual behaviour of PLHIV.

Youth and risk behaviours:

The HIV prevalence among young people aged 15-24 years is measured using the data collected at ANC clinic as proxy. Trend analysis of HIV prevalence in this age group has shown an increase from 0.34% in 2011 to 0.72 %, in 2012 and from there to 0.78 in 2013 and 1.07% in 2014 respectively. However, the youth population in Mauritius is extremely

vulnerable to HIV because of high-risk behaviours such as unsafe sexual practices and accessibility of Drugs. There is also a low personal risk perception among the youth as the epidemic is concentrated among the Key populations.

III. National response to the AIDS epidemic

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

GENERAL POPULATION

1.1 Percentage 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.

	All (15-24)	All Males (15-24)	Males (15-19)	Males (20-24)	All Females (15-24)	Females (15-19	Females (20-24)
Percentage (%) : Percentage of respondents aged 15-24 years who gave the correct answer to all five questions	31.8	30	27.9	32.5	4.4	34.6	34.2
Numerator : Number of respondents aged 15-24 years who gave the correct answer to all five questions	144	82	41	41	8	36	26
Denominator : Number of all respondents aged 15-24	453	273	147	126	180	104	76

Source : BSS 2014

Knowledge on HIV and AIDS

According to BSS 2014:

- 98 % of the population of the Republic of Mauritius have heard of HIV and AIDS and most people (66% first heard about the infection through the media)**.**

- 97% of the population are aware of at least one of the HIV-related programmes and activities available in Mauritius but only 38% of the population are aware of any service or programme that offers care and treatment to PLWHIV.

- 97% of the population are aware of at least one mode of transmission of the disease and only 57% are aware of all three major modes of transmission. Knowledge of transmission is higher in Rodrigues (73%) than in Mauritius (57%).

Preferred sources of Information on HIV and AIDS

When asked about how they would prefer to receive information on HIV and AIDS, 34% of the respondents expressed their preferences for talks on the television, 21% mentioned that they prefer to listen to talks on the radio, while 17% favour the internet over other sources, including 34% of the respondents aged between 15 and 29 years and 33% of those who have studied at tertiary level. Overall, 86% of the respondents in Rodrigues and 65% of the respondents in Mauritius would prefer to receive information on the disease through talks on the television (37% in Rodrigues versus 34% in Mauritius), on the radio (37% in Rodrigues versus 21% in Mauritius) or through talks in community centres (12% in Rodrigues versus 10% in Mauritius) rather than through other sources.

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

Almost half (47%) of the teenagers (aged between 15 and 19 years) surveyed reported that they have had a sexual intercourse, 28% have experienced oral sex, 47% had vaginal sex and 7% have experienced anal sex. The median age at the first sexual experience among the teenagers interviewed (aged between 15 and 19 years) is 15.7 years

Sex	Age	Numerator: Number of respondents(aged 15-24yrs) who report the age at which they first had sexual intercourse as under 15 years.	Denominator: Number of all Respondents Aged 15-24 years	Percentage of Respondents aged 15-24 who have had sexual intercourse before the age of 15
Male	**15 -19**	9	97	9.3%
Male	**20-24**	10	82	12.2 %
Female	**15 -19**	3	67	4.5 %
Female	**20-24**	1	67	1.5 %
Total	**15 -24**	**23**	**313**	**7.3 %**

Source : BSS 2014

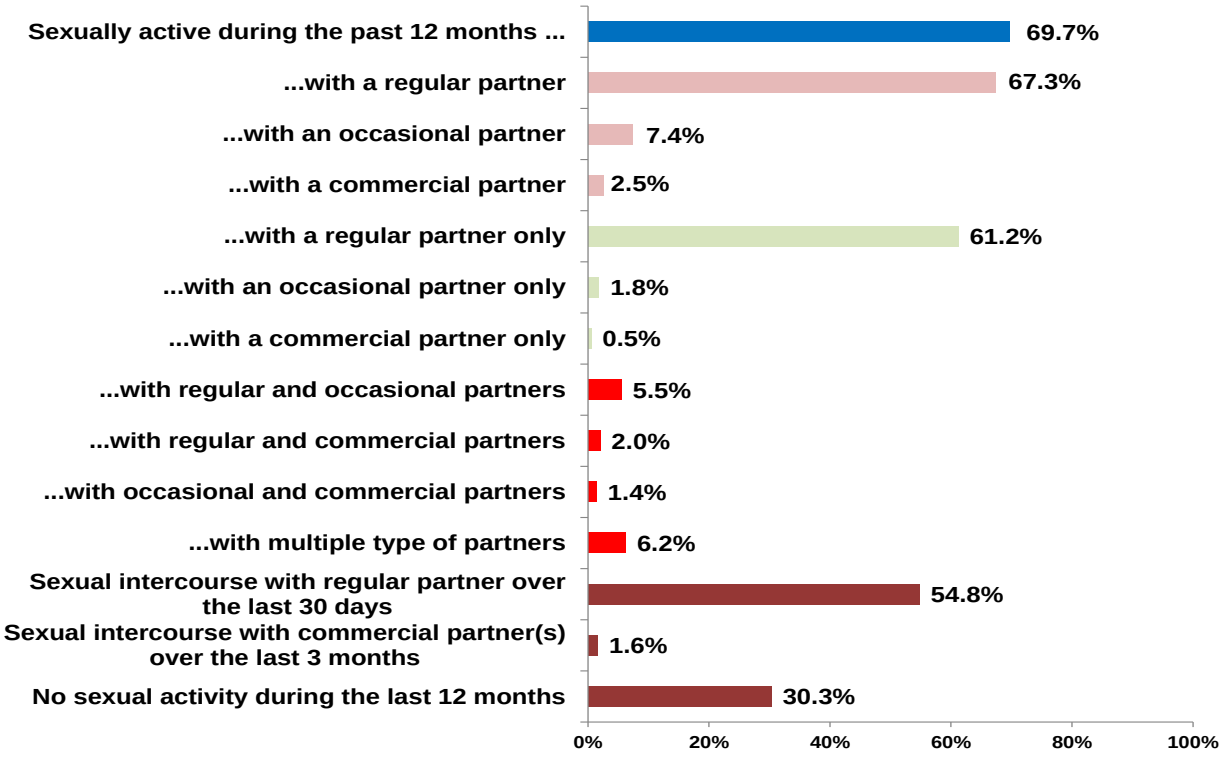
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months

Sex	Age	Numerator: Number of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months	Denominator: Number of all Respondents aged 15-49	Percentage of respondents aged 15-49 who have had sexual intercourse with more than one partner in the last 12 months
M	**15-19**	**14**	**97**	**14.4 %**
M	**20-24**	**26**	**82**	**31.7%**
M	**25 -49**	**40**	**347**	**11.5 %**
F	**15-19**	**0**	**0**	**0 %**
F	**20-24**	**2**	**67**	**3 %**
F	**25 -49**	**12**	**401**	**3%**
Total	**15 49**	**134**	**1061**	**12.6 %**

According to the BSS 2014,more than one quarter (28%) of all sexually active males had more than one sexual partner over the last 12 months. In contrast, only 3% of all sexually active females reported that they have had multiple sexual partners during the same period. Multiple sexual partners is also more frequent among younger individuals than among older individuals; 22% of the respondents who were sexually active during the last 12 months and aged between 15 and 29 years, had more than one sexual partner, compared with 14% of those aged between 30 and 49 years and 4% of those aged 50 years or more. The number of sexual partners also varies according to the level of education; only 5% of those who have studied up to primary school reported having had multiple sexual partners, while at least 16% of those who have studied at secondary (16%) level or at tertiary level (17%), had more than one sexual partner during the past 12 months. In addition, 40% of those who consume illicit drugs and 22% of those who consume alcohol had multiple sexual partners during the past 12 months.

Overall

Figure 3:Type of sexual partners during the last 12 months (BSS2014)



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

Nearly all the respondents (93%) knew of a male condom but only 59% knew about the existence of a female condom even after being shown a picture of a female condom. Knowledge of the condom is relatively higher among males (96%) than among females (91%). Moreover, more than two thirds of males (68%) knew or were able to identify a female condom as compared with only 51% of the females interviewed.

Sex	Age	Numerator: Number of respondents who reported having more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	Denominator: Number of all Respondents who reported having had more than one sexual partner in the last 12 month	Percentage of Respondents aged 15-49 who reported having more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex
M	**15-19**	10	14	71.4%
M	**20-24**	14	26	53.8%
M	**25 -49**	38	80	47.5%
F	**15-19**	0	0	0
F	**20-24**	1	2	50%
F	**25 -49**	5	12	41.7%
Total	**15 49**	**68**	**134**	**50.7%**

Source : BSS 2014

One fifth of all males (22%) admitted having sexual intercourse with an occasional or a commercial partner without using a condom. It means that 15% of all males aged 15 and above in the Republic of Mauritius have had unprotected sex with an occasional or a commercial partner during the last 12 months.

The likelihood of having an unprotected sexual intercourse with an occasional or a commercial partner is higher among those who consume alcohol (18%), those who consummed illicit drugs (30%), and those who have had an HIV test (17%).

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

A little more than 100,000 HIV tests are being carried out annually, 45% of which among blood donors while 12% among pregnant women. The rest comprises of testing patients undergoing cardiac surgery and renal dialysis, migrant workers, KAPs. VCT accounts for very few at the rate of 1500 per annum.

The vast majority of the interviewees (85%) are aware that it is possible to have a confidential test for HIV in Mauritius. Presently, 18% of the respondents reported ever having had an HIV test. 96% of those who took the test are aware of the results of their test and 70% mentioned that they took the test voluntarily. Hence, 20.8 % of all the interviewees have had an HIV test and are aware of the result of their test, but in term of coverage it is still low and need to be reinforced.

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

Sex		Age	Numerator: Number of respondents aged 15-49yrs who have been tested for HIV during the last 12 months and who know their results	Denominator: Number of all Respondents aged 15-49	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results
M		**15-19**	9	97	9.3%
M		**20-24**	18	82	22%
M		**25 -49**	98	347	28.2%
F		**15-19**	6	67	9%
F		**20-24**	18	67	26.9%
F		**25 -49**	71	401	17.7 %
Total		**15 49**	**221**	**1061**	**20.8%**

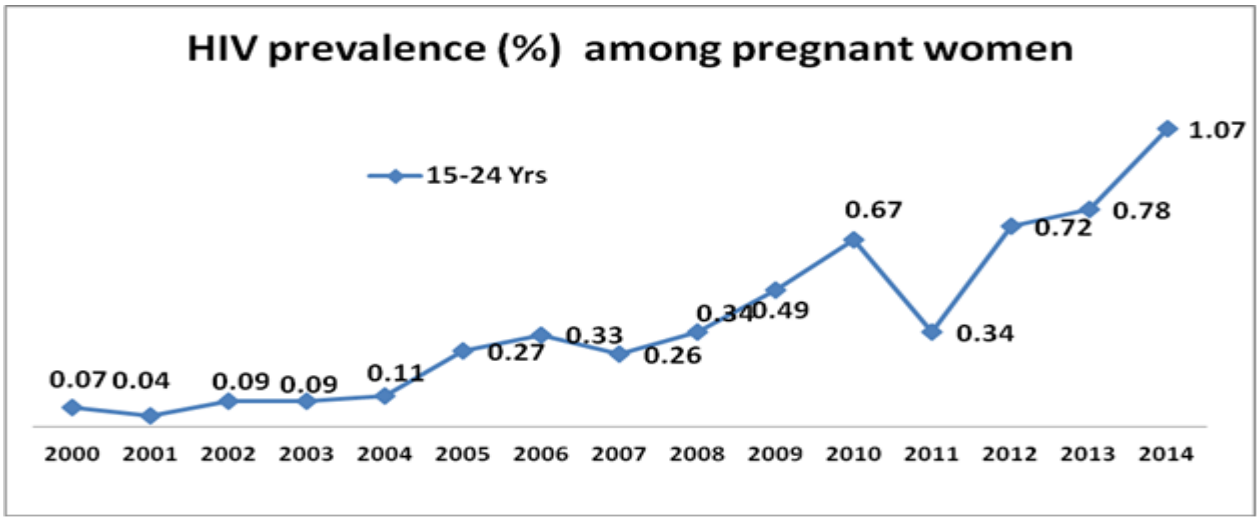
Source : BSS 2014

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

Actual data from ANC were used as proxy to determine the prevalence of HIV among youth aged 15- 24years old. In 2014, out of 12,005 pregnant women, 4200 aged between 15 -24 years were tested for their HIV status.

45 pregnant young women were diagnosed as HIV positive (15-19 yrs =14; 20-24yrs = 31). It is to be noted with great concern that the curve is moving on an upward direction reaching a prevalence of 1.07%.

Fig 4: Prevalence of Pregnant Women (15-24 yrs)



HIV surveillance Data, MOH&QL

Indicators 1.1 -1.6 :

The Republic of Mauritius's achievements in addressing its HIV epidemic among the PWID have surpassed expectations in magnitude and impact. Strong and sustained political will, inclusive and effective Partnership with civil society combined with the continuous implication of the MOH&QL as main service implementers has combined to create a successful HIV response.

However, despite meeting and in some instances exceeding the targets and commitments of the 2011 United Nations Political Declaration on HIV and AIDS, we now faces greater challenges in mitigating the epidemic among the young people aged 15-24 years.

The above results **(Indicators 1.1 -1.6 : BSS 2014)** call for an even more aggressive HIV response in the Republic of Mauritius than ever seen before. What is clear at this junction is that we need a critical reflection at national level, innovative strategies and dedicated leadership if we hoped to ensure a long term sustainability of a successful response across different identified vulnerable groups. It is clear that complacency at

this time will herald degeneration, increased costs and ultimately a reversal of investment and previous gains.

SEX WORKERS: Prevention Programmes

1.7. Percentage of sex workers reached with HIV prevention programmes

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

Source: IBBS FSW 2012

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

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

Source: IBBS FSW 2012

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

	All sex	Males	Fem	< 25	+25
Numerator: Number of sex workers who have been tested for HIV during the last 12 months and who know their results	78	0	78	24	54
Denominator: Number of sex workers included in the sample	115	0	115	32	83
Percentage: Percentage of sex workers who received an HIV test in the past12 months and know their results	**67.8**	**0**	**67.8**	**75.00**	**65.06**

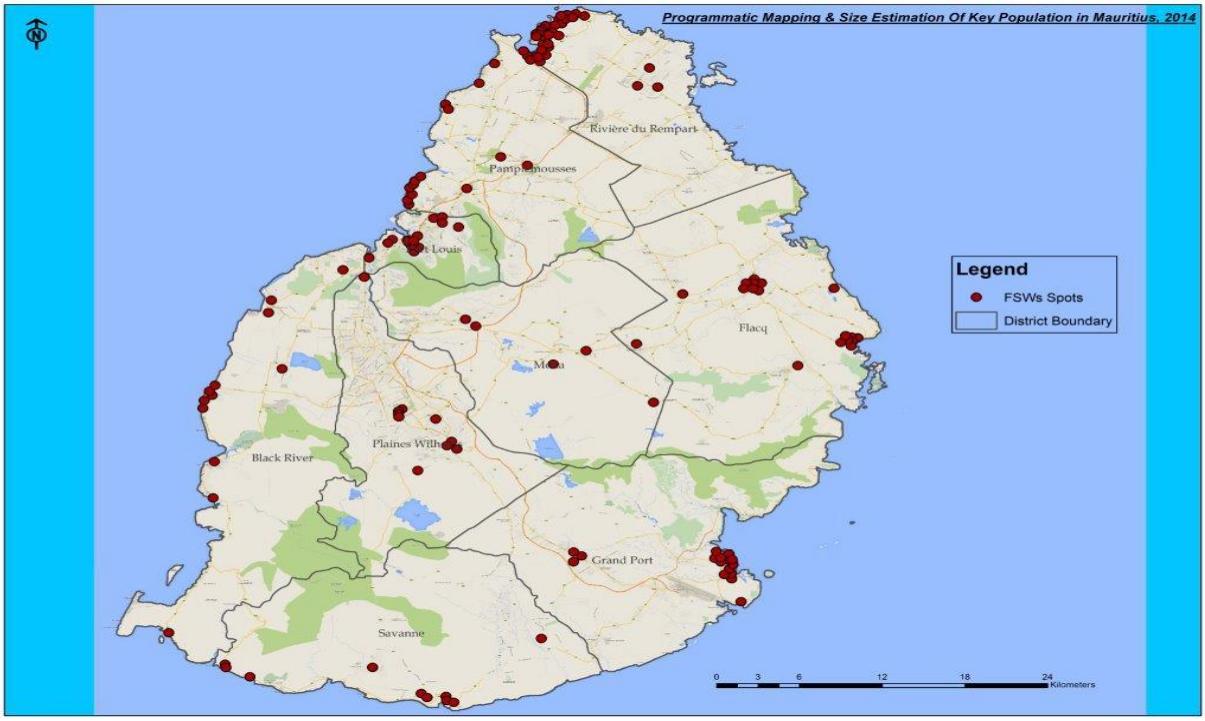
Source: IBBS FSW 2012

1.10 Percentage of sex workers who are living with HIV

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

Source: IBBS FSW 2012

Indicators 1.7- 1.10



Female sex workers (FSWs) form the second largest key population in Mauritius with an average estimated number of 6,223 (range; 5,090 to 7,356) FSWs, spread over 731 spots in Mauritius. The distribution of sex work has strong implications on prevention programs providing evidence on where prevention programs should focus

As seen in the analysis only 5% of the spots were large and more than 50% of the spots had upto 6 FSWs. Thus sex work is more spread over a large number of spots which has important programmatic implications and should be considered when services are planned for this population.

MEN WHO HAVE SEX WITH MEN: Prevention Programmes

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

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

Source: IBBS MSM 2012

1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner.

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

Source: IBBS MSM 2012

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

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

Source: IBBS MSM 2012

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

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

Source: IBBS MSM 2012

Indicators 1.11 -1.14

At present the Ministry of Health and Quality of Life (MOH&QOL) and the NGOfor LGBTI's," ARC en Ciel", are implementing outreach programs using peer educators, but the geographical as well as the coverage of these programs is limited. Information on numbers and location of key populations through the mapping exercise will serve to improve the reach of these programs.

Gender and Human Rights Issues

From the community consultations, it is clear that human rights issues continue to play a role in preventing key populations from accessing prevention materials. PWID, FSW ,MSM and transgenders all described problems with police accusing (and/or detaining) them due to their possession of syringes or condoms, or subjecting them

(and their residences) to searches due to previous arrest/ detention for drug use or sex work. There were also reports of violence towards women, including from police, especially towards female PWID and FSW. The Sodomy Law, while generally not used to prosecute MSM or transgenders, enables police and others to threaten or intimidate these communities.

TARGET 1 AND 2

SIZE ESTIMATIONS FOR KEY POPULATIONS

1. Population Size Estimate for Key Populations

Key Populations	Size Estimation Performed	If yes, when was the latest estimation performed?	If yes, what was the Size Estimation?
a) Men who have sex with men	Yes	2014	5,467
b) People who inject drugs	Yes	2014	11,677
c) Female Sex workers	Yes	2014	6,223
d) Other Key Populations (TG)	Yes	2014	1,407
Prison Inmates	Yes	2014	2400 (at any point in time)
e) Comments: To note that the Mauritian prisons (six prisons for males and two for females and a correctional Institution for the 16-18 age groups) have a turnover of more than 4,500 prison inmates annually.			

Source: Mapping Survey 2014

2. Definition used of the key population:

- **A person who injects drugs**

Within this exercise, people who inject drugs were categorized as “men or women who have injected drugs for non- therapeutic purposes, any time within the past 6 months.” Those who have self-injected medicines for medical purposes were excluded. The typologies identified in the mapping of PWID were establishment-based, pharmacies or hospital-based, home based and street based PWID.

- **Sex worker**:

In accordance with the UNAIDS Guidance Note on HIV and Sex Work,Female sex workers were defined as, “females who receive money or goods in exchange for sexual services, either regularly or occasionally ”. Female sex workers are one of the most prominent key population that exists in Mauritius and a number of typologies exist, including street-based, bar/nightclub/disco-based, massage parlor-based, guest-house based, home-based, and beach based. All of these typologies were identified and explored in the current mapping exercise.

- Note: The definition of sex worker is broad and includes those who occasionally exchange sex for gifts.

- **Men who have sex with men**

The definition utilized for men who have sex with men was from the Operational Guidelines for Monitoring and Evaluation of HIV Programs for Sex Workers, Men who Have Sex with Men and Transgender People, from December 2010 UNDP Report on the Multi-City initiative, detailing “men who have sex with men is an inclusive public health term used to define the sexual behaviors of males, regardless of gender identity, motivation for engaging in sex or identification with any or no particular ‘community’. The words ‘man’ and ‘sex’ are interpreted differently in diverse cultures and societies as well as by the individuals involved. As a result, the term MSM covers a large variety of settings and contexts in which male to male sex takes place.” MSM typologies uncovered during mapping included beach-based, establishment-based, hotel/guest house-based, residence-based, and street/open space-based MSMs.

Transgender persons:

Individuals whose gender identity and/or expression of their gender differ from social norms related to their gender of birth. The term transgender describes a wide range of identities, roles and experiences which can vary considerably from one culture to another.

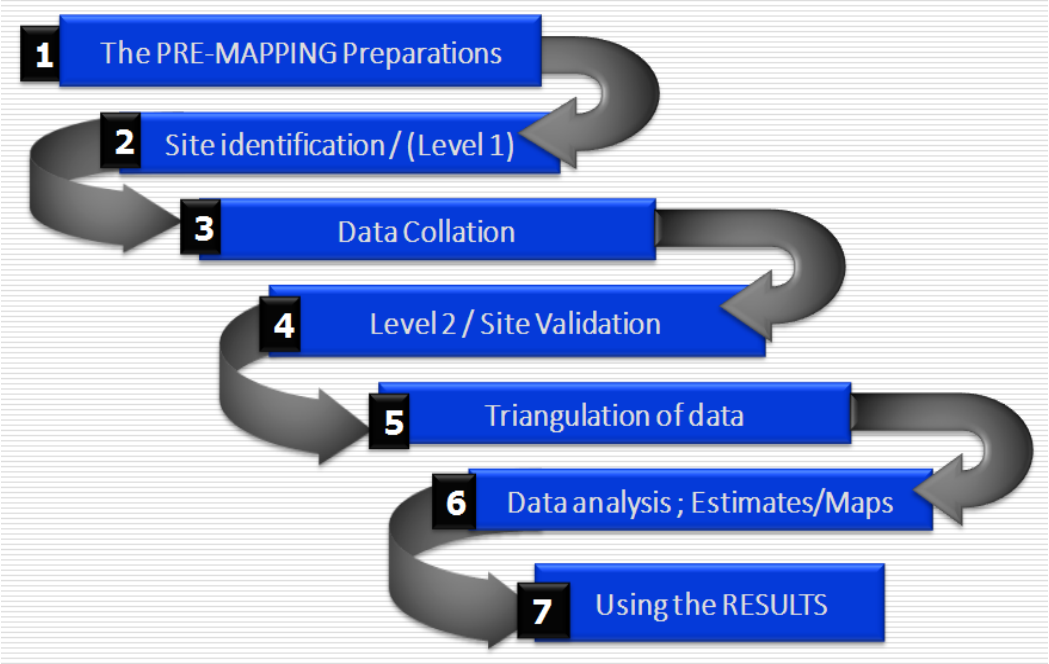
The Transgender Sex workers were defined as, “individuals whose gender identity and/or expression of their gender differs from social norms related to their gender of birth, who receive money or goods in exchange for sexual services, either regularly or occasionally.

It is important to note here that NOT all TG population in Mauritius is involved in Sex work. The overall TG population in Mauritius is definitely higher than the numbers presented in this report which only includes TGs involved in sex work.

1 Programmatic Mapping – the key approach

The overall goal of Programmatic mapping was to obtain accurate information regarding the size, location, and typologies of the key populations throughout Mauritius with the aim of developing action plans for HIV prevention interventions and programs among these specific populations. The mapping methodology utilized a geographic approach, which identified key locations where members of KAPs can be located and quantified. A detailed depiction of the mapping steps can be found below as illustrated below:

Figure 5 Graphical presentation of operational steps of Programmatic Mapping



The rationale for this approach is based on programmatic experiences of mapping key populations in diverse settings across the global, which illustrates that these populations gather in definable geographic locations. The approach therefore focuses on identifying locations, i.e. specific spots, and looks at the operational dynamics and size estimates of KPs at each spot. Broadly, the approach included two sequential steps, called level 01 and level 02. In the first level, information was collected through a systematic process from secondary key informants (KI) to determine the locations or spots ("hot spots") where KPs congregate to find sexual partners, and/or to buy or inject drugs. The KIs also provided information about the type of physical location and estimated number of KPs at each spot. The outcome from Level 1 activity was a comprehensive list of unique locations where KPs may be found, KPs typologies, and the estimated minimum and maximum of each population at all of these spots. In the second level, the spots identified where selected validated and profiled, through interviewing KPs themselves, to characterize and estimate the size of each key population.

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

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

Numerator : Number of needles and syringes distributed in past 12 months by NSPs	835656
Denominator: Number of people who inject drugs in the country	7773
Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes	107

Source: NEP (MOH&QL)

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

NEP dispensing sites:			
	Rural	**Urban**	**Total**
Govt NEP	13	23	36
NGOs NEP	6	7	13
Total	19	30	49

Challenges met during implementation of NEP programmes

- Due to police harassment, PWIDs feel exposed when accessing the NEP sites
- There are a number of complaints reported with respect to the quality of material.
- Due to the lack of appropriate legislation or policy decision many PWIDs are in prison with no access to syringes
- Clients who are on the Methadone Programme and who still inject are reluctant to come to the NEP because of fear of being discontinued on MST.
- MWID (Minors who inject Drugs) do not have access to any services.

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

- A national coordination and response of the Drug Issues.
- Further decentralisation of MSP
- Systematic communication in respect of the sites for NEP
- A revision of the Needle Exchange Protocol
- Re-inforcing the Peer Education Programme
- Conduct frequent Harm reduction awareness programme in the community so as to mitigate Stigma and discrimination.

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

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

Source IBBS PWID 2013

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

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

Source IBBS PWID 2013

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

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

Source IBBS PWID 2013

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

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

Source: IBBS PWID 2013

The HIV prevalence among PWID was 51.6% in 2011 and 44.3% 2013. Mauritius has a good initiative and program for PWID such as Needle Exchange Programme and Methadone Substitution Therapy. There is a need to increase the coverage and systems for follow up the clinical services with outreach. The partners of IDUs need to identified and targeted with HIV prevention services

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

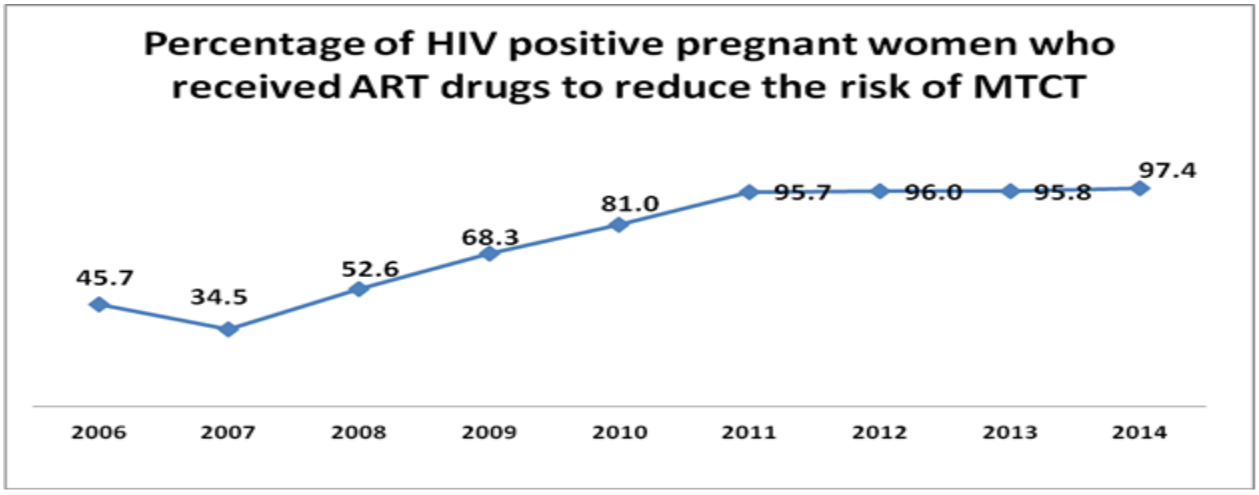
There is an immediate need to develop a protocol for Overdose Management for PWIDs and for Methadone Detoxification management.

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

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

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

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



Source: PMTCT Register, MOH &QL

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

1. Newly initiated on ART during the current pregnancy	94
2. Already on ART before the current pregnancy	19
3. Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B)	0
4. Maternal AZT (prophylaxis component during pregnancy and delivery of WHO Option A or WHO 2006 guidelines)	0
5. Single dose nevirapine (with or without tail) ONLY	0
6. Other (please comment: e.g. specify regimen, uncategorized, etc.)	0

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

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

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

Pathway of babies born to HIV positive women:

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

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

3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2- 3 months of birth.

Total number of babies born to HIV positive mother as from January to December 2013 amounts to 69. Out of these 69 babies there were 3 babies passed away. Total number of babies eligible for PCR was 72, but only 54 have undergone testing with the following results:

3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2- 3 months of birth.

	Data Value
Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	78.26%
Numerator: Number of infants who received an HIV test within two months of birth, during the reporting period. Infants tested should only be counted once	54
Test result - Positive	2
Test result - Negative	40
Test result - Indeterminate	12
Test result –Rejected by Lab(insufficient)	4
Test result – Other	0
Denominator: Number of HIV-positive pregnant women giving birth in the last 12 months	69

Source: NDCCI, MOH &QL

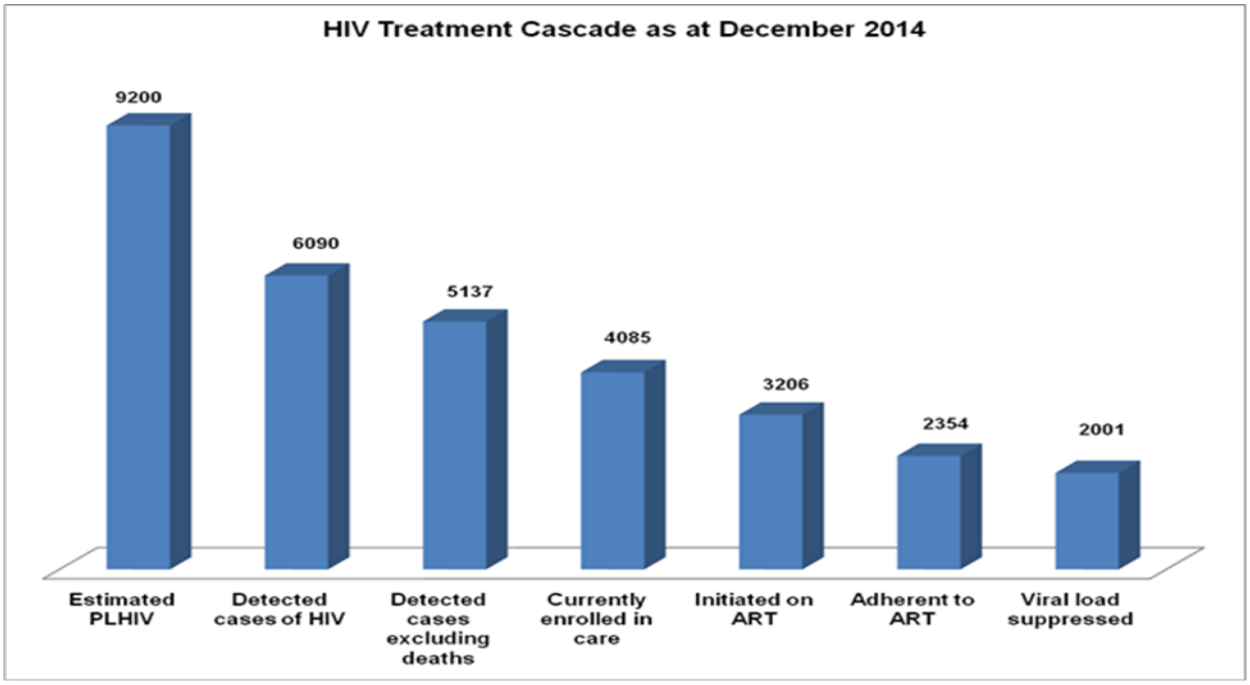
3.3 Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months

Cohort 2013	**Data Value**
Percentage: Estimated percentage of child HIV infections from HIV-positive women delivering in the past 12 months	2.9%
Numerator: Estimated number of children who will be newly infected withHIV due to mother-to-child transmission among children born in the previous 12 months to HIV-positive women	2
Denominator:Estimated number of HIV positive women who delivered in the previous 12 months	69

Source: PMTCT Programme

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

In view of the fact that the Mauritius HIV epidemic is concentrated among key populations, loss to follow up at every stage of the treatment cascade is observed. According to the treatment adherence study 2014, carried out by PILS, several contributing factors were mentioned, such as low treatment literacy, side effects of ARVs and lack of money to buy milk and food. The diagram below illustrates the actual situation:



Reduced morbidity and mortality of PLHIV

For increased longevity of PLHIV after initiation of treatment to become a reality, all PLHIV will have to be detected as early as possible, linked to care and retained. Protocols for ART are updated in line with WHO guidelines, treatment literacy provided

to patients, as well as psychosocial support, in order to ensure the optimum outcome. Toxicity monitoring and resistance tracking, as well as viral load monitoring are implemented as part of the treatment package.

4.1 Percentage of adults and children currently receiving antiretroviral therapy

	Total	Males	Females
Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	25.6%	28.5%	18.5%
Numerator: Number of adults and children currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO standards) at the end of the reporting period.	2354	1859	495
Denominator :Estimated number of adults and children living with HIV National criteria for ART eligibility varies by country. To make this indicator comparable across countries global reports will present the ART coverage for adults and children as a percent of all people living with HIV.	9191	6516	2675
Denominator :Estimated number of eligible adults and children (using national eligibility criteria)	4950	3556	1394
Percentage of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	**47.6%**	**52.3%**	**35.5%**
Number : Persons newly initiating antiretroviral therapy during the last reporting year 2014	5559	404	155

Source: ART Register, NDCCI, MOH &QL

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

	Male	Female	Total
Total number of patients initiated on ART Jan-Dec 2013 (Den)	277	102	379
Patients passed away	18	3	21
Patients loss to follow-up	31	16	47
Patients still on treatment after 12 months of treatment (Num)	228	83	311
Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	**82.3%**	**81.4%**	**82.1%**

Source: ART Register, NDCCI, MOH &QL

The WHO consultants' report on ART in Mauritius found several challenges including:

- The increased awareness to seek care has contributed to an increase of workload at outpatient Methadone dispensing sites .The five Day Care Centres are facing a situation where there are only four doctors to take care of an increasing number of patients.
- In various instances, adverse reactions of patients to ARVs were mentioned but there is no formal reporting of these effects..
- Poor living condition of some patients with limited access to food and financial income.
- Limited communication between some stakeholders. For instance at the Prisons Service, there was no regular communication between the visiting HIV/AIDS Reference Doctors and the Resident Doctors taking care of the inmates. Absence of timely communication was also noted between decision makers / care providers and beneficiaries / users or their representatives.
- At dispensation points, patients were not always receiving appropriate information on the use of their medicines or the changes that may have been made.

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

TB/HIV collaborative activities: Implementation to date

At present, all newly diagnosed cases of TB are tested for HIV, while HIV positive cases are being screened for TB only in the presence of signs and symptoms. A chest x-ray is being done for all PLHIV put on Isoniazid prophylaxis. Furthermore, all co-infected TB and HIV cases are initiated on ARV, irrespective of the clinical stage or CD4 count. Resistance to first line TB treatment is regularly monitored to ensure HIV/TB does not lead to an increased MDR-TB given, the relatively poor treatment adherence of PLHIV who inject drugs.

Challenges:

- More specific confirmatory tests such as routine sputum for AFB testing need to be carried out so as not to miss any genuine TB case, especially in the prisons.
- Insufficient capacity and low level of suspicion among care providers in health centers and operation sites for PWID to enhance TB case detection for referral to specialized treatment centers.
- Inadequate Management Information System and coordination processes.

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

	Total	Males	Females
Numerator: Number of people with HIV infection who received antiretroviral combination therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) and who were started on TB treatment (in accordance with national TB programme guidelines), within the reporting year	14		

Source: National TB Programme, MOH &QL

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

6.1 Domestic and international AIDS spending by categories and financing sources

NASA Report 2015 will be made available as soon as compiled and submitted by the finance section. The expected date is after August, 2015.

TARGET 7: ELIMINATING GENDER INEQUALITIES

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

No recent data is available to report on this indicator.

Domestic violence is not specific to any particular socio-economic group in the Mauritian society. It cuts across class, age group, ethnicity and gender. Domestic violence can be seen as a consequence of the inequality between men and women, rooted in patriarchal traditions that encourage men to believe they are entitled to power and control over their partners. The causes of domestic violence are multiple - intergenerational transmission of violence, alcohol abuse by partners, women's lack of financial autonomy

It can also be hypothesized that women who witness their father beating their mother often grow up with an increased acceptance of violence and might be more likely to condone such violence as compared to women who grow up in non -violent household.

Nevertheless we have witnessed last year four cases of women battered to death. These incidents speak volumes about gender relations in our 'paradise' island. The violence with which these acts have been undertaken highlight the fact that our Mauritian society is producing human beings who harbour anger, frustration, resentment, jealousy and hate in themselves. The reasons for this are often a complex interplay of cultural, social, economic and psychological factors.

Since 2009, the Department of gender equality has awarded to a dozen non-governmental organizations, 12.8 million rupees (320,000 euros) through local projects, to combat violence against women in Mauritius. But this is clearly not enough, what the country need is evidence based information through surveys (the last one dates back in 2012 carried out by NGO “Gender Link”) and strategies based on the findings.

TARGET 8: ELIMINATING STIGMA AND DISCRIMINATION

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

Age group	Male	%	Female	%
15-19 yrs	15	10.2	12	11.5
20-24 yrs	13	10.3	7	9.2
25-49yrs	34	9.4	34	11.3
Total 15-49 yrs	62	9.7	53	11.0
Grand total M&F	115/1117 = 10.3			

Source : BSS 2014

The Government of Mauritius meets the health care needs of its citizens through a free medical care system. HIV is regarded as a disease like any other, for which the Ministry of Health and Quality of Life provides medications, inpatient and outpatient care free of user cost. The costs of this care currently borne by the Government amounted to 2.9 Million USD in 2013, which also represents 36% of the national response to HIV.

While this system works well for most Mauritians, as noted above it is a challenge to attract key population members to these health services.

Target 9: ELIMINATE TRAVEL RESTRICTIONS

According to UNAIDS Executive Director Michel Sidibe, "Placing travel restrictions on people living with HIV has no public health justification. It is also a violation of human rights." A policy statement by UNAIDS and the International Organization for Migration confirms, adding: "blanket exclusion of people living with HIV adds to the climate of stigma and discrimination."

The Republic of Mauritius still form part of some 38 countries, territories and areas which impose some form of restriction on the entry, stay and residence of People Living with HIV based on their HIV status.

In order to move forward and to review our stand on “HIV and AIDS related travel, Stay and residence restrictions”, a committee has been set up at the level of the National AIDS Secretariat to study the financial implication of such restrictions and will make recommendations to the Government of Mauritius.

Target 10: STRENGHTENING HIV INTEGRATION

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

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

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

Key factors that have contributed to progress:

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

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

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

Source: Ministry of Education and Human Resources

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

The strategy adopted by the ***Ministry of Social Integration & Economic Empowerment*** with regard to the eradication of poverty and economic empowerment of vulnerable families in the Republic of Mauritius focusses on the following three main pillars:

(i) Child Welfare and Family Empowerment;

(ii) Social Housing and Community Development; and

(iii) Placement and Training

The National Empowerment Foundation is the implementing arm of the Ministry and targets vulnerable families having a combined household monthly income of less than Rs 6, 200 excluding social aid.

Under the three Programmes, the following support is provided:

Child Welfare and Family Empowerment

- Provision of school materials to needy children
- Setting of Day Care Centres in deprived regions
- Provision of meals, school fees, transport facilities and “accompagnement scolaire” to children attending pre-primary and primary schools up to Standard II
- Setting up of learning corners for needy children
- Provision of basic functional literacy and numeracy courses to vulnerable beneficiaries
- Provision of life skills training courses to children and their families
- Self-empowerment of vulnerable families through training and income-generating activities

Social Housing and Community Development

- Provision of social housing units under the **CIS**, **CCIS** and Social Integrated Housing Schemes

- Provision of infrastructural facilities and recreational and community development facilities in deprived regions
- Improvement of the living conditions of vulnerable families through the upgrading of their housing units and their living environment

Placement and Training

- Provision of training in various sectors to enhance their employability
- Placement opportunities to trainees after the training course
- Securing employment opportunities under the Circular Migration Project

Best practices

1. AILES: HOME BASED CARE PROJECT

AILES (Aides Infos Liberte Espoir et Solidarite) is a community-based organization working with People who Inject drugs (PWID), People living with HIV (PLHIV) and People infected with Hepatitis C. AILES was created in 2009 following the death of 34 young Injecting Drug Users aged between 24 – 45 years old (male & female) in the region of Mangalkhan and its surroundings.

Since its creation in 2009, AILES has provided services to more than 2500 PLHIV/HCV/PWID including young community members and their relatives, in the region of Mangalkhan, Curepipe, Vacoas, Quatre Bornes.

<u>These services include amongst others</u>:

- Provision of administrative papers, transport facilities, and accompaniment for admission on the Methadone Substitution Therapy
- Provision of male, female condoms, lubricants
- Provision of clean injecting materials
- Administrative procedures for social aid/Basic Invalid Pension
- Social assistance on matters of an administrative or legal nature
- Home and Hospital Visits
- Treatment literacy and Nutritional counselling
- Voluntary Counselling & Testing
- Regular attendance to National Day Care for the Immunosuppressed
- Psychological follow up & Counselling
- Intervention against stigma and discrimination through medias and concerned services
- Advocacy campaigns with NGOs working in the field of drugs and HIV.
- Support Groups for PLHIV & their relatives

HOME BASED CARE PROJECT

AILES applied for funding in 2012 under the 10th European Development Fund (Direct Support to Microprojects for poverty Alleviation).The HBC for PLHIV was validated in 2013, and the NGO's received funding on January 2014 for a period of 14 months.The project was funded by the Decentralised Coorperation Programme and by Fondation Nouveau Regard to the height of MUR 3,500,000.

The objectives of the Home Based Care are to :

1. Provide Home based care programme for PLHIVs, with full training and logistical support for family care-givers
2. Provide a variety of social support services and supplementary food/ nutrition (Social Services)
3. Promote the prevention of HIV/AIDS transmission through Treatment Literacy, psychological support and early treating and sceening of HIV
4. Alleviate stigma and prejudice through public education and advocacy

The staff recruited for the implementation of the HBC project :

1 Coordinator
3 Peer Educators (Part Time)
1 Driver (part Time)
1 Psychologist for clients
1 Psychologist for supervision of staff
1 Nurse
1 Nutritionist
1 Physiotherapist
Specialised doctors on call

Who gave support ?

AILES has obtained support from different Ministries especially from the Aids Unit Department of Candos and Volcy Pougnet(Gvt Day Care Centres). It was a great opportunity for 2 staff members of AILES to have a 15 days placement at Bellepierre Hospital with Dr. Catherine Gaud and the staff of RIVE. AILES also gained the support of PILS, specialized private doctors who helped in the clinical management of our clients .The DCP staff provided all the members with the necessary technical support and advices throughout the project.

Actions Initiated under the project

- Home Based Care Visits (Availability of professional Nurse during Home visits and admission to hospitals)
- Training of Care Givers (mother, wives, sisters, neighbours)
- Communy Sensitisation sessions on drugs, HIV, STIs
- Provisions of administrative papers and accompaniment to hospital
- Nutritional informations and Psychological follow-up
- Nursing interventions (HIV Rapid Testing, diabetes/hypertension control, dressings, pain control)
- Intervention against stigma and discrimination

Achievements

- 62 Relatives of people living with HIV were able to learn more about HIV and were able to obtain answers on the various needs and constraints of the client – Once they have understood how HIV is transmitted, they were able to accept and support them in their treatment intake, hospital appointments, nutritional needs etc.
- Reaching people where they are and seeing the different challenges they are facing (their daily living conditions, housing and other challenges) Most of them lives under the poverty line.

- Empowering clients through treatment literacy,
- Out of the 120 clients, 72 clients are adherent to their ARVs and have undetectable viral load and low CD4 count
- Putting in place different methods to facilitate intake of ARVs (Alarms, pillboxes, memos, etc) hence helping clients to develop better adherence.
- Direct Observation Therapy
- Food assistance programme to people newly initiated on ARVs
- Interventions against stigma and discrimination (Community, medias, radio, policy makers)
- Specialized care, to clients (rheumatologist, physiotherapist, psychiatrist, paediatrician, dental and eye care, psychological follow up)
- Promote utilisation of condoms (female & male)
- Screening of new HIV infections and early initiation of treatment

Why this project should be considered as a best practice?

This project should be considered as a best practice as it is a 'Projet de proximite' where you meet the client where they are. This project helps to empower PLHIV through trust and respect. PLHIV are at the heart of the project and are involved in the different phases of management. Peers were recruited and trained thus enabling them to encourage their peers to follow their treatment and eventually have a better quality of life. It is a holistic approach, and the human touch allows us to understand the challenges met by the client.

What were the parameters that made the project a success?

a) The recruitment of peer educators to whom clients can identify themselves and have trust.
b) The availability of a vehicle which allows to transport clients to hospital rapidly increasing their chances to have a better treatment. Ability to transport clients who have mobility difficulties.

c) The food assistance which is of great importance when client cannot attend work because of sides effects of ARVs. The MUR1500 social aid is not sufficient for food and other basic needs .
d) HIV rapid testing were done at our office and at the homes of clients, where cases were rapidly driven for confirmation tests to hospital and treatment was initiated rapidly (prior to consent of client)
e) The availability of 1st class supplements/ drugs to help clients boost their immune system and food replacement support when client is not able to eat properly.
f) Some of the crucial elements are : support from specialized nurse, specialised doctors and psychologist to meet the various needs of the client

Lessons learnt

HIV cannot be treated in a hostile and unfriendly environment. When treated with a holistic approach, client developed trust, feel accepted and can move forward. Accompaniment and support can help PLHIV to overcome their distress and become autonomous. Nutritional component is really capital in this project as many PLHIV lives under the poverty line. The misconceptions which people have on HIV changes completely, when the right information are given to them during home visits and peer meetings.

Early screening of cervical cancer must be done to prevent cancer in young female clients.

Following discussions with our clients, staff and partners, the HBC must be able to continue as early detection and treatment of HIV is crucial for better management. It is important to note that support from peers and supervision from parents is important in the treatment of HIV.

AILES would like to create an alimentary bank as PLHIV has nutritional needs which are not met by other organisations like Caritas and la Croix Rouge.

There is a need to have a robust Community Based Organisation who would help to provide information and support to Injecting Drug Users and People Living in other vulnerable regions.

It is also important that PLHIV who are discharged from hospital are able to have a place where they can rest and recuperate. AILES is currently looking for partners (Govt or private) to fund a Therapeutical Residence for PLHIV.

2. Prison Health Service

Turning the HIV tide in Prisons through a Peer Support Program

Introduction

*Prison*s in modern societies are complex places to manage. The phenomenon of prison overcrowding, the epidemics of serious life-threatening diseases, the continued use of prisons for housing mentally ill people and the high levels of substance abuse in many countries have all contributed to increasing the pressures on management at all levels. However our Prison Service makes no exception to the paradox that prison systems are faced to throughout the world nowadays.

People who use drugs are over-represented in prisons. Considering the high number of prison entrances and releases (turnover rate), a substantial number of people who use drugs go through prison systems annually. This fact inevitably affects security in penal institutions

The fact that a substantial proportion of prisoners are drug dependent, it is likely that a high proportion of drug dependent prisoners will continue using drugs and persist in crime – and many will be at risk of contracting HIV.

A broad range of services are being currently offered to prison inmates in an attempt to reduce their vulnerabilities during their stay in prison settings. Despite the fact that the prison make substantial effort still adherence to safe behaviour was quite low.

Therefore this Peer-led program, Prison staff-facilitated initiative was launched in 2009 following receipt of financial support from GFTAM Round 8. A cumulative number of 729 detainees have been trained since then.

Known as Peer Supporters, these volunteers are the key to this programme. All Peer Supporters must have successfully completed a 4- day training course .They are required to attend weekly group supervision with a counsellor to ensure that they maintain boundaries and offer appropriate assistance to their peers.

Client profile

- The marginalized and vulnerable groups such as injecting drug users, commercial sex worker and HIV positive inmates are all compounded within prison service. It contains the largest concentration among the most at risk population which are over-represented within the prison community. The majority of prisoners have multiple ill- health problems
- The daily average of HIV positive inmates in prison is about **450**, representing **21.6%** of the actual prison population.
- Prison has so far registered **1050** detainees on anti- retroviral treatment cumulatively, and at present there are **267** detainees on ART.

- Prison has so far housed **2704** detainees on MST cumulatively, and at present there are **433** currently on Methadone. Since December 2011, **275** detainees who are previous injecting drug users have been induced on methadone within prison settings.

Aims of Peer Support Training

- Assist in the personal development of detainees through training in basic counselling skills
- Support incoming new detainees to adjust in life in prison
- Support prison inmates in the development of their personal and social skills,
- Adopt a responsible behaviour and contribute to the provision of a caring and supportive environment.

Target group.

All detainees, but in particular;

- Detainees living with HIV
- Detainees on ART
- Detaining who inject drugs
- Detainees on MST
- HIV positive pregnant detainees

Course Contents

- Life Skills
- Listening and communication Skills
- Family life education
- Positive thinking and counselling
- HIV- AIDS
- Harm Reduction
- Treatment literacy program on ARVT
- Peer support
- Psycho social support

Resource Persons

- Prison staff
- Psychologist
- NGOs
- Peer supporters

Peer Support Activities

- Motivate detainees to attend sensitization programs
- Provide basic information on HIV -AIDS to detainees
- Support those newly initiated on ARVT for adherence
- Track and encourage HIV detainees to attend follow- up clinics
- Involve in peer support training.

Achievements

- Better support to peers requiring HIV services in prisons
- Low level of stigma
- Better retention on follow-up and treatment adherence
- High rate in attendances for VCT
- Increased knowledge about modes of HIV transmission and prevention and precautions during incarceration period.

IV. Major challenges and remedial actions

Progress on key challenges identified in the 2014 report

Although the country has made substantial efforts and progress in improving the National Response to HIV, some challenges still remain. Regular peer review and evaluation of the National Response allow the country to constantly re-engineer its responses. The challenges below were identified in the 2014 report and the country has worked towards finding solutions or mitigating their impact on the Epidemic.

Key challenges reported in 2013 -2014 Report	Proposed remedial action	Progress achieved in 2014- 2015
1. Behavior change communication and prevention interventions in the hard to reach population	• HCT coverage is still inadequate among the key population. There are still weaknesses in the assurance that referred clients actually access services to which they are referred to. This is one of the challenges that contribute to the continual loss of clients between services points. • The prevention and follow-up programmes and services for Commercial Sex Workers and Men Having Sex with Men are quite limited and in need of reinforcement.	According to the BSS 2014, people aged 15- 49 who have had an HIV test in the past 12 months and know the result amounts to 20.8 % as compared to 6.9% in 2011. However, increase of cases detected among the youth aged 15-24 yrs has been noted. Strong advocacy have been done during the process of development of the investment case and concept note for GF funding.

	• NGOs members are still waiting for accreditation by the Ministry of Health to perform HIV Rapid Tests as part of outreach among key populations.	Robust interventions package have been designed for each KP's according to needs identified during the country dialogue exercise. Formal Training has been carried out by the MOH &QL. After assessment those who succeed will be awarded their certificate and authority to conduct testing at community level. The accreditation is still awaited.
2. Treatment , Care and Support	• Treatment as prevention • PReP for sero-discordant couples • Services quality • To increase Adherence Rate	Ministry of Health is already implementing the 2013 WHO Guidelines for treatment, including recommendations for sero-discordant couples. Improvement of service quality and adherence are in process.
3. Methadone Maintenance Therapy	• To address issues of overcrowding at dispensing site and follow-up of clients.	Methadone dispensing sites have been decentralized with the objective of not exceeding 200 per dispensing site.

	• Decentralisation of Methadone service in other Prisons. • Providing ART at Methadone Dispensing site	Methadone in prisons has been decentralized fully, and is now available in all the 8 prisons in Mauritius.
4. Monitoring and Evaluation	• M&E: Quality Data and Service Delivery point analysis • An evaluation of the system	M&E Capacity building Plan has taken into consideration the need of Service providers. Evaluation of M&E system is done annually and steps to improve identified and implemented.

Challenges in the current reporting period (2014)

1. **Outreach and Peer educator programme: Coverage of key populations is still very low, and there is no uniformity in quality of services delivered.**

2. **Methadone substitution therapy: due to rapid scaling up in response to demand, quality of MST services is low in terms of psycho-social support provided to clients.**

3. **Introduction of UIC across the National HIV and Harm Reduction Programme: this is not yet fully implemented.**

4. **Early infant diagnosis of HIV: There are still babies of HIV positive mothers that are not brought for testing within three months of birth.**

5. **Programme data of detected cases show an increase in the number of newly identified cases that were infected sexually, and**

6. **An increase of newly detected cases in the age group 15-24 years.**

7. **Fertility management and reproductive health services are not integrated within HIV outpatient care, thus one prong of PMTCT, namely prevention of unwanted pregnancies among PLHIV, is not implemented by the national programme.**

8. **OVC: the programme has no data on OVCs, and thus no strategy to address their needs.**

V. Support from the country's development partners (if applicable)

The AIDS response in the Republic of Mauritius has been funded by the Government with a 75% of the total budget. Nevertheless Partner's support is essential for reaching the targets set by the NSF 2013-2016. Public funds were spent mainly on Care & Treatment, followed by programme management and prevention. Funds from international sources were spent mainly on prevention and program management

WHO

The core strategic areas of WHO support in 2014 in line with national HIV/AIDS Strategic Plan and the pursuit of the expected results agreed upon are as follows:

- **Financial support** for prevention activities For e.g
    - Young Peer educators on life skills
    - Awareness in secondary Schools (Health Club)
    - Training of Nursing staff on Management of care and support to PLWHA
    - Support peer educators programme (CSW, MSM)
- **Technical Support**
    - Assessment of the Health system component of Clinical Management of PLWHA in Mauritius
    - Assessment of the Health system of Central Health Laboratory component
    - Assessment of Procurement and Supply Management system for ARV's and other commodities required within the HIV programme.

UNDP/UNAIDS

UNAIDS is mandated to provide technical support to assist in the implementation of National AIDS programmes. Main areas of support has been technical support through the TSF. Tracking progress against the UBRAF will be a cornerstone in measuring and monitoring of the UN towards 2015 global AIDS targets.

VII. Monitoring and evaluation environment

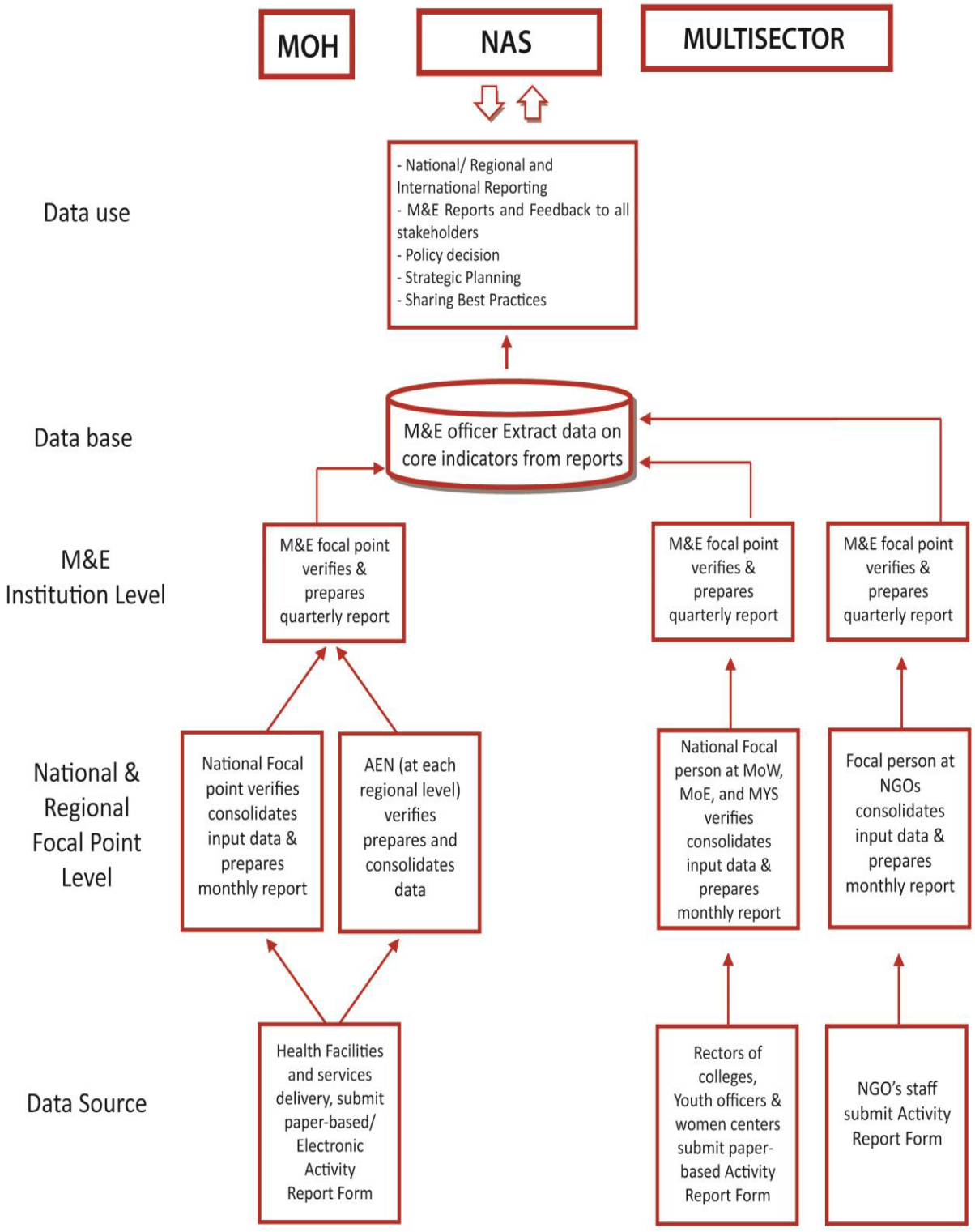
COORDINATION, PLANNING, MONITORING AND EVALUATION

Effective systems for the Monitoring and Evaluation of the NSF are essential policy and management tools. The national HIV and AIDS M&E system performs the overall coordination and systematizing of the flow of M&E data. Indicators to monitor inputs, processes, outputs, outcomes and impact are regularly used to assess collective effort towards the response. The national agreed indicators are an essential element of the national M&E system, for the monitoring of the epidemic; monitoring the proximate determinants of the epidemic (underlying behavioral risk factors); monitoring the implementation of the plan; evaluating the implementation of the plan in its effectiveness and efficiency towards the response; and the overall level of government commitment.

The NAS Monitoring and Evaluation Unit leads the monitoring and evaluation of the NSF including the research agenda in close liaison with various ministries, NGOs, international agencies and other stakeholders. The different ministries, NGOs and other stakeholders have M&E focal points whose duty is to forward all the data related to the national response towards as part of the framework to higher reporting level and ensuring that they reach the NAS for input in the Central Database.

Systematic reviews are conducted on emerging evidence on interventions to inform the response. The M&E Focal Points in ministries, NGOs and other stakeholders are responsible for M&E functions at each of service delivery point to:

- Ensure the proper functioning of the decentralized data collection and reporting structure.
- Ensure that HIV data collection is integrated into the overall management of information and proper channels are established for better reporting and information sharing between all relevant institutions.


MOH
NAS
MULTISECTOR
Data use
- National/ Regional and International Reporting
- M&E Reports and Feedback to all stakeholders
- Policy decision
- Strategic Planning
- Sharing Best Practices
Data base
M&E officer Extract data on core indicators from reports
M&E Institution Level
M&E focal point verifies & prepares quarterly report
M&E focal point verifies & prepares quarterly report
M&E focal point verifies & prepares quarterly report
National & Regional Focal Point Level
National Focal point verifies consolidates input data & prepares monthly report
AEN (at each regional level) verifies prepares and consolidates data
National Focal person at MoW, MoE, and MYS verifies consolidates input data & prepares monthly report
Focal person at NGOs consolidates input data & prepares monthly report
Data Source
Health Facilities and services delivery, submit paper-based/ Electronic Activity Report Form
Rectors of colleges, Youth officers & women centers submit paper-based Activity Report Form
NGO's staff submit Activity Report Form

- Integrate HIV interventions into the logical frameworks and strategic plans of the institutions, whereby each sector will be responsible for carrying out the HIV and AIDS actions defined in the logical frameworks and meeting the targets set.
- Track progress of the HIV and AIDS indicators and interventions within their M&E system, and report their progress towards targets as part of their annual reporting process, with a copy sent to the responsible unit and the NAS.

As per its mandate, NAS has the ultimate responsibility for HIV M&E at the national level and its main role includes the following:

• To coordinate, supervise, monitor and evaluate the national response and provide technical assistance, capacity building and training on M&E;

• To implement the national plan to monitor and evaluate the national response through defined national-level indicators;

• To identify better means of verification and setting targets; guiding and supervising systematic data collection, storage and analysis at various levels; and providing the platform for partnerships, networking and collaborating with all stakeholders in M&E; To develop national information products and disseminate them in a user-friendly and timely manner.

The main data sources are:

- Integrated Biological and Behavioral Surveys (IBBS);
- ANC surveillance data
- KAPB studies
- Monitoring and evaluation of programmes and projects;
- Special studies and research;
- Financial monitoring of the national response;
- Other sources (e.g. Patient registers, Demographic Health Survey, Statistical Bureau)

The NAS conducts data auditing and archiving in the Central Database. The gathered data is used to produce national reports which are then used by the Ministry of Health and Quality of Life and other partners for decision-making purposes. Evaluation and research activities are key components in ensuring that the HIV response is evidence-based and responding to the appropriate aspects of the HIV epidemic in Mauritius. Epidemiological research linked with ongoing surveillance is critical in ensuring that the right populations are being targeted by HIV interventions. Operational research is also necessary to assess the effectiveness of HIV interventions. Some national-level indicators can only be measured through specific research and special studies, making it necessary to ensure that all evaluation and research activities capture the appropriate information needed by the M&E system.

DATA SOURCE

1. ANC surveillance data, MOH &QL
2. ART Register, NDCCI, MOH &QL
3. Central Health Laboratory, MOH &QL
4. Global AIDS Response Progress Report, 2013, Republic Of Mauritius
5. Integrated Behavioural and Biological Survey FSW 2012
6. Integrated Behavioural and Biological Survey MSM 2012
7. Integrated Behavioural and Biological Survey PWID 2013
8. National AIDS Spending Assessment Report, NAS , 2012
9. National M&E framework, NAS 2013
10. National HIV and AIDS Sentinel Surveillance, MOH &QL
11. National HIV counseling and testing Strategy in Mauritius 2011-2012
12. National Multisectoral HIV and AIDS Strategic Framework (NSF) 2013-2016
13. Ministry of Gender Equality, Child development and Family Welfare, GBV data
14. Ministry of Social Integration and Economic Empowerment, Achievements 2013
15. Millenium Development Goals Report, Ministry of Foreign Affairs, 2013
16. Prison Department
17. Protocol for Methadone Substitution Therapy in Mauritius Prison, 2011.
18. PMTCT Registers, MOH &QL
19. Stigma Index Survey, Mauririus 2013
20. Statistics Mauritius

ANNEXES

Annex 1

2015 Global AIDS Response Progress Report Attendance at Focus Group Discussions and Consensus Workshop

NAME	ORGANISATION	POSITION
Dr A.Pathack	NAS	AIDS Coordinator
Ms Soobhany Sarah	NAS	Programme Officer
Mr R.Radhakeesoon	NAS	M&E Manager
Ms A.Saddul	NAS	Communication and Partnership Forum
Dr A.Saumtally	GF 8 (PMU)- NAS	Grant Manager
Dr R.Ponnoosamy	AIDS Unit	Officer-In-Charge
Mr N. Rughoonundun	GF 8 (PMU)- NAS	Finance Manager
Dr D.Soyjaudah	AIDS Unit, MOh&QL	Referral Doctor
Mr I.Mahadoo	Aids Unit, MOH&QL	Project Coordinator
Dr S.Appadoo	Harm Reduction Unit	Officer-In-Charge
Mrs Mala Buldawoo	AIDS Unit	M&E Focal Point
Mr J.Larhubarbe	MOH&QL	Senior statistician
Mrs Usha Kirpal	AIDS Unit	HCA/M&E assistant
Ms Anielle Jellin-Uhle	CUT	M&E
Mr S. Corceal	Harm Reduction Unit	Liason Officer
Dr S.Rhugooputh	Central Health Lab	Adviser
Dr Manraj	Central Health Lab	Director Lab services
Ms Sandrine Ah-choon	PILS	M&E Officer
Ms Emilie Trousselier	PILS	Grant Manager

NAME	ORGANISATION	POSITION
Mr Sagar Motah	Chief Health Officer	Prison Departments
Mr R.Daiboo	Ministry of Sport and Youth	Senior Youth Officer
Ms R.Nundah	Ministry of Gender and Equality	Coordinator
Ms S.Ramchurn	NAS	Communiation Officer
Dr S.Mudhoo	National TB prog. CCPL	Chest physician
Ms Brigitte Michel	AILES	Coordinator
Ms Sabrina	Parapluie Rouge	CCM representative (SW)
Ms Cindy Maistry	AILES	CCM Representative (PLWHIV)
Ms Ragini Renghen	Lacaz A	Coordinator
Ms D.Bhugun	Ministry of Social Security	OMA
Ms Georgette Talary	Chrysalide	Ass. Director
Mr Jean Daniel Wong	Arc- en- Ciel	President
Mr Jose Mendel	VISA G	President

Annex 2: National Funding Matrix

Will be available by August 2015