National AIDS Council

GLOBAL AIDS RESPONSE

PROGRESS REPORT

FULL COUNTRY REPORT

Seychelles

Reporting Period

1 January 2014 – 31 December 2014

Submission date: 20th April 2015

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ACRONYMS

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

PoA	Plan of Action
PMTCT	Prevention of Mother-To-Child Transmission
PWID	People who inject drugs
RBM	Results Based Management
RDS	Respondent-Driven Sampling
SADC	Southern Africa Development Community
SBC	Seychelles Broadcasting Corporation
SCCI	Seychelles Chamber of Commerce and Industry
SDD	Social Development Department
SIFCO	Seychelles Inter-Faith Council
STI	Sexually Transmitted Infections
SW	Sex worker
TOT	Training of Trainers
UA	Universal Access
UN	United Nations
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organisation

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ACKNOWLEDGEMENTS

This report has been prepared with the support and guidance of the National GARPR writing team of the Ministry of Health. Their contribution for the narrative version was greatly appreciated. Members contributed through direct involvement in data management and uploading of completed indicators into the UNAIDS online reporting platform 2014. The members are listed below:

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Special thanks go to all individuals and organisations who have collected, compiled and analyzed data which have been used in final reports and documents of their ministries, departments and agencies and who, generally, remain nameless, but whose work has proved indispensable to the process of completing the GARPR report 2014.

Gratitude also goes to members of both the National AIDS Council Board and Technical Advisory Committee for HIV and AIDS in the Ministry of Health leadership and commitment for timely report delivery.

Technical support was also kindly rendered by staff previously trained in use of the National AIDS Spending Assessment (NASA) Tool namely Mrs Rosie Bistoquet, Mr Jean Malbrook and Mrs Brenda King.

Further editing was conducted by Dr Jude Gedeon, Public Health Commissioner, who has overall responsibility for the AIDS Control Programme, Disease Surveillance and Response Unit and Communicable Disease Control Unit.

Finally, special thanks go to Mrs Patricia Baquero and Ms Sheila Vidot, staff of the National AIDS Council without whose help and support the report would not have been completed.

I. INTRODUCTION

BACKGROUND

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

The *Seychelles Global Response Report 2014* has brought together various national experts from government, civil society and private sector, from a wide variety of national HIV AIDS response fields with the aim of ensuring the provision of complete information, through a multi-sectoral approach. The country progress reports represent the most comprehensive data on both the status of, and response to, the Seychelles epidemic. The Seychelles is submitting the seventh Global AIDS Response Report, previously known as the UNGASS. The documents have been useful in identification of areas of progress as well as those which need further attention to improve on the work being done.

During the reporting process, the National AIDS Council of the Seychelles was undergoing a transition period based on the new enactment of the entity. The reporting was also influenced by the release of new instructions of the reporting of 2014 and new indicators. Initially affected by central problems with the GARPR reporting tool, the team finally managed to access the site in mid-March. For effective completion of the report, an additional fifteen days were granted by the GARPR team to finalise and validate the report before submission on the 15th April 2015.

In the data compiling process and report writing, it became evident that existing data on certain non-health indicators are not easily obtainable or available in the format recommended by GARPR Guidelines on the Construction of Indicators namely for the NASA proved rather difficult as persons previously trained were heavily occupied in other projects.

There is a need to continuously engage various partners to include Commitment of Declaration Indicators into existing periodic surveys and routine data collection. Indicators and data elements recommended for both the public and the private sector should take into account data requirements of the GARPR Guideline for the Construction of Indicators. Similarly, routine data collection of the Ministry of Education, Employment and Agency for Social Protection should take into account data requirements on financial support, basic life skills and HIV & AIDS in workplaces.

This year, WHO and UNICEF indicators were included in the GARPR, thus significantly simplifying the process and reducing duplication.

Availability of recent reports on the website tool greatly facilitated the reporting for 2014 as it provided easy access for reference.

ORGANISATION OF THE EXERCISE

Role of the GARPR Reporting and Writing team

THE GARPR writing team, an integral part of the reporting team, coordinated the whole process and supported the country GARPR reporting. Members also had the responsibility to present specific indicators of the report during the validation meeting held on the 10th April 2015.

Information was obtained through members of various existing structures, namely

- National AIDS Council
- Technical Advisory Committee for HIV and AIDS in the Ministry of Health
- UNFPA National Implementing Partners
- Sexual Behaviour Change Communication Committee
- Focal Persons in various organisations

Steps of the Exercise

- Structure the GARPR technical support and coordination framework
- Finalize the roles and responsibilities in the assignment of members
- Identify key documents and data sources for the exercise
- Develop detailed Project Work Plan and schedule of key stakeholder interviews
- Basic tutorial in NASA tool from persons previously trained
- Data collection for the spending information from all the stakeholders
- Data collection for the GARPR indicators

Activities implemented as per following timeframe.

Table 1. Steps of the Reporting Exercise

Activity	Timeframe	Dates	Responsible
Desk review / Soliciting information from partners	18 days	1-18 March	National AIDS Council (NAC)
Meeting with Technical Advisory Committee for HIV and AIDS in the Ministry of Health	½ day	19 March	
Meeting with National AIDS Council Board	½ day	19 March	
Meeting with reporting team on new reporting tools, guidelines and indicators	2 half days	24-25 March	
Data Verification and Entry	22 days	25 March -15 April	CDCU; DSRU; ACP; NAC
NASA Tutorial and Update	½ day	8 April	Director Programmes, Hospital Administrator & Economist
Stakeholders meeting	1 day	10 April	All
Final approval of validated reports	1 day	12-13 April	All teams
Production of final version of narrative report	5 days	14-20 April	Core writing team
Final input into the reporting tool	2 days	14-15 April	Core writing team

In the framework of this exercise, the reporting team had the following tasks and responsibilities:

- Validation of the methodology of the exercise
- Facilitation of access to informants and documents within respective sectors
- Validation of the spending matrix
- Verification of country GARPR indicators before their entry online
- Data Entry and Validation

Validation and Endorsement of the report

In endorsing the national report, a meeting was organised and hosted by the National AIDS Council to achieve validation and consensus on the documents. Members from the following committees participated actively and the document was amended and unanimously endorsed: Ministry of Health Sector Reform Committee, UNFPA Implementing Partners, Technical Advisory Committee (TAC) for HIV/AIDS and STIs, Social and Behavioural Change Committee (SBCC) and National AIDS Council (NAC).

II. STATUS AT A GLANCE

INCLUSIVENESS OF THE STAKEHOLDERS IN THE REPORT WRITING PROCESS

To support the processes of the activities, stakeholders and partners were contacted for their inputs. In addition, the National AIDS Council Board monitored the progress and Technical Advisory Committee (TAC) on HIV&AIDS and STIs was consulted and provided their technical input during the whole process.

The GARPR report 2014 was coordinated by the National AIDS Council with the keen support of the Public Health Authority (Disease Surveillance and Response Unit, Communicable Diseases Control Unit and AIDS Prevention and Control Unit). Support for NASA indicators was provided by the Health Care Agency (Directorate of Family Health and Nutrition and Health Care administration) as well as the Ministry of Health Secretariat (Directorate of Cooperation). Inputs were obtained from the Ministry of Finance (Social Protection Agency) and Ministry of Social Development, Community Development and Sports (Social Development Department).

In producing the report, existing data were sourced from the Ministries of Health, Finance and Education, including statistical reports from the National Statistics Bureau, and Health Statistical Reports.

Table 2. Status at a glance: Inclusiveness of Stakeholders

Activity	Timeframe	Date
Meeting with TAC Committee	½ day	19th March
Meeting with NAC Board	½ day	19th March
Preliminary Meeting with Reporting Team	1 day	24th March
Stakeholders' meeting	½ day	10th April

Table 3. Status at a glance: The Epidemic 2012 to 2014

New Cases January to December									
	2012			**2013**			**2014**		
	Total	Male	Female	**Total**	Male	Female	**Total**	Male	Female
New HIV Cases	**29**	15	14	**47**	1	16	**91**	55	36
New AIDS Cases	**10**	4	6	**21**	16	5	**19**	11	8
AIDS Deaths	**8**	6	4	**8**	4M	4	**19**	12	7
MTCT	**10**			**7**			**10**		
HAART	**46**	20	26	**39**	20	19	**64**	33	31
Hepatitis C	**114**	119	22	**97**	81	16	**93**	78	15
Co-Infection HC/HIV	**6**	5	1	**5**	1	5	**28**	24	4
TB	**18**	11	7	**23**	16	7	**7**	5	2

Source: CDCU, Public Health Authority

THE POLICY AND PROGRAMMATIC RESPONSE

The Seychelles has developed the following documents:

Table 4. Status at a Glance: Available Policy and Programmatic Response

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

NATIONAL COMMITMENT AND ACTION

Domestic and international AIDS spending by categories and financing sources: (NASA) Funding matrix uploaded

INDICATOR TABLE

Table 5. Status at a Glance: The indicator table

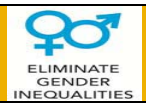
No.	Indicator	TARGET / Description	Number / %	Source
1.0		**Reduce sexual transmission of HIV by 50% by 2015**		
GENERAL POPULATION				
1.1	Young People: Knowledge about HIV prevention	% of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	88%	IBBS -2013 GARPR)
1.2	Sex before the age of 15	% of young women and men aged 15-24 who have had sexual intercourse before the age of 15	4.6%	IBBS-2013 GARPR)
1.3	Multiple sexual partners	% of women and men aged 15-49 who have had sexual intercourse with more than one partner in the past 12 months	8.5%	IBBS-2013 GARPR)
1.4	Condom use at last sex among people with multiple sexual partnerships	% of women and men aged 15-49 who had more than one partner in the past 12 months who used a condom during their last sexual intercourse	51.3%	IBSS-2013 GARPR)
1.5	HIV testing in the general population	% of women and men aged 15-49 who received an HIV test in the past 12 months and know their results	72.3%	IBBS-2013 GARPR)
1.6	HIV prevalence in young people	% of young people aged 15–24 who are living with HIV	1%	IBBS-2013 GARPR)
KEY POPULATIONS				
Sex Workers				
1.7	Sex Workers Prevention Programmes	% of sex workers reached with HIV prevention programmes	unknown	No IBBS done yet
1.8	Sex Workers condom Use	% of sex workers who received an HIV test in the past 12 months and know their results	unknown	No IBBS done yet
1.9	HIV testing in Sex Workers	% of sex workers who have received an HIV test in the past 12"months and know their results	unknown	No IBBS done yet
1.10	HV Prevalence in Sex workers	% of sex workers who are living with HIV	unknown	No IBSS done yet
Men Having Sex With Men				
1.11	Men having sex-Prevention Programmes	% of men who have sex with men reached with HIV prevention programmes	62%	GARPR IBBS/RDS 2011
1.12	Men who have sex with men:	% of men reporting the use of a condom the last time they had anal sex	N/A	GARPR IBBS/RDS 2011

No.	Indicator	TARGET / Description	Number / %	Source
	condom use	with a male partner (Question asked was *with different partner*)		
1.13	HIV testing in men who have sex with men	% Men who have sex with men that have received an HIV test in the past 12 months and know their result	27.3%	GARPR IBBS/RDS 2011
1.14	HIV prevalence of Men Having Sex with Men	% Men who have sex with men who are living with HIV	13.2%	GARPR IBBS/RDS 2011
1.16.	Testing and counselling in women and men aged 15 and older	Number of pregnant women aged 15 and older (out of the total number above) who received testing and counselling in the past 12 months and received their results	1656	Sentinel sites Surveillance
1.16.1	HTC in women and men 15 yrs and older	% of health facilities dispensing HIV rapid test kits that experienced a stock-out in the last 12 months	0%	Sentinel site Surveillance
1.17	**Sexually Transmitted Infection in Key Population**			
1.17.1	ANC –Testing for Syphilis	% of women accessing antenatal care (ANC) services who were tested for syphilis	100%	Sentinel site Surveillance
1.17.2	ANC-Positive Syphilis tests	% of antenatal care attendees who were positive for syphilis	0.12%	Sentinel site Surveillance
1.17.3	ANC – Positive test received treatment	% of antenatal care attendees positive for syphilis who received treatment	100%	Sentinel site Surveillance
1.17.4	Sex Worker – Active Syphilis	% of sex workers with active syphilis	Unknown	Outreach Programme
1.17.5	Men who have sex with men who tested positive for syphilis	% Men who have sex with men (MSM) with active syphilis	6.8	IBBS 2011
1.17.6	Adults with Syphilis	Number of adults reported with syphilis (primary/secondary and latent/unknown) in the past 12 month	47	Sentinel site Surveillance
1.17.7	Reported congenital Syphilis	Number of reported congenital syphilis cases (live births and stillbirths) in the past 12 months	0	Sentinel site Surveillance
1.17.8	Recorded gonorrhoea in men	% of men reported with gonorrhoea in the past 12 months	0.24%	Sentinel site Surveillance
1.17.9	Recorded men with urethral discharge	Number of men reported with urethral discharge in the past 12 months	0.39%	Sentinel site Surveillance
1.17.10	Recorded adults with genital	Number of adults reported with genital ulcer disease in the past 12 months	34	Sentinel site Surveillance

No.	Indicator	TARGET / Description	Number / %	Source
	discharge			
MALE CIRCUMCISION				
1.22	Male Circumcision Prevalence	% Males circumcised in last year	0.14% (including children)	GARPR, UA
1.23	Number of Men circumcised last year	Number of adult men circumcised last year	18	GARPR, UA
2.0		**Reduce transmission of HIV among people who inject drugs by 50% by 2015**		
2.1	PWID-Prevention Programmes	Number of needles and syringes distributed per PWID per year by needle and syringe programmes	0	GARPR/UA/DD Programme not yet introduced
2.2	PWID – Condom use	% of people who inject drugs reporting the use of a condom the last time they had sexual intercourse	3.8%	GARPR/UA IBBS/RDS 2011
2.3	PWID - safe injecting practices	% of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	0%	GARPR/UA IBBS/RDS 2011
2.4	PWID-HIV testing	% of people who inject drugs who received an HIV test in the past 12 months and know their results	100%	GARPR/UA/DD IBBS/RDS 2011
2.5	PWID- HIV prevalence	% of people who inject drugs who are living with HIV	5.8%	GARPR/UA/DD IBBS/RDS 2011
2.6	PWID-Estimated Opiates user	Estimated number of opiate users (non and injectors) if available)	1283 (2.3% adult population)	GARPR/UA/DD IBBS/RDS 2011
2.7	PWID-Opiates sites	Number of opioid substitution therapy (OST) sites	1	Programme
3.0		**Eliminate new HIV infections among children by 2015 and substantially reduce AIDS-related maternal deaths**		
3.1	PMTCT	% of HIV-positive pregnant women who received antiretroviral medicine to reduce the risk of mother-to-child transmission	100%	GARPR/UA
3.1a	PMTCT during breastfeeding	% of women living with HIV who are provided with antiretroviral medicines for themselves or their infants during the breastfeeding period	100%	GARPR/UA
3.2	Early Infant Diagnosis	% of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth	100% (Viral load at birth, 3 months)	GARPR/UA
3.3	MTCT modelled	% Estimated percentage of child HIV infections from HIV-positive women	10% (1 out of 10)	GARPR/UA

No.	Indicator	TARGET / Description	Number / %	Source
		delivering in the past 12 months		
3.4	Pregnant women and their HIV Status	% of pregnant women who know their HIV status (tested for HIV & received their results-during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status)	100% 10 tested 4 known + 6 new	UA
3.5	MTCT and male partner	% of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months	3.8%	UA
3.6	MTCT and ART	% of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing	All started irrespective of CD4/ clinical staging	UA
3.7	Infants initiated on ART prophylaxis	% of infants born to HIV-infected women provided with antiretroviral prophylaxis to reduce the risk of early mother-to-child transmission in the first 6 weeks	100%	UA
3.9	Infants started CTX, 2 mths	% of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth	100%	UA
3.10	Distribution of feeding practices	Distribution of mixed feeding practices for infants born to HIV-infected women at DPT3 visit	0	UA
3.11	Pregnant women attending ANC	Number of pregnant women attending ANC at least once during the reporting period	1660	UA
4.0	15 MILLION ACCESSING TREATMENT	**Reach 15 million people living with HIV with lifesaving antiretroviral treatment by 2015**		
4.1	HIV Treatment-Anti-retroviral therapy	% of adults and children currently receiving antiretroviral therapy among all adults and children living with HIV	59%	GARPR/UA/DD
4.2a	ART ; 12 months retention	% of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	59% Loss to follow up 7 Stopped ART 5 Died 6	GARPR/UA/DD
4.2b	ART-24 months retention	% of adults and children with HIV known to be on treatment 24 months after initiation of antiretroviral therapy	59% Loss to follow up 6 Stopped 8 Died 3	GARPR/UA/DD
4.2c	ART-60 months retention	% of adults and children with HIV known to be on treatment 60 months	77% Loss to follow	GARPR/UA/DD / EURO4

No.	Indicator	TARGET / Description	Number / %	Source
		after initiation of antiretroviral therapy	up 2 Stopped 1 Died 3	
4.3a	Health facilities offering ART	Number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)	8 including PEP	UA
4.3b	Health facilities offering Paediatric ART	Number of health facilities that offer paediatric antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up)	8 including Children's ward	UA
4.4	ART stock outs	% of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV drug in the last 12 months	0	UA
4.6a	HIV Care	Number of adults and children enrolled in HIV care at the end of the reporting period	441	UA
4.6b	HIV Care	Number of adults and children newly enrolled in HIV care during the reporting period	91	UA
4.7	**Viral load suppression**			
4.7a	Viral Load	% of people on ART tested for viral load who were virally suppressed in the reporting period	94%	UA
4.7b	ART tested for viral load	% of people on ART tested for viral load (VL) with undetectable viral load in the reporting period	80%	UA
5.0	AVOID TB DEATHS	**Reduce tuberculosis deaths in people living with HIV by 50% by 2015**		
5.1	Co-management of tuberculosis & HIV treatment	Number of people with HIV infection who received ART and who were started on TB treatment within the reporting year	1	GARPR/UA
5.2	Newly enrolled active TB	% of adults and children living with HIV newly enrolled in care who are detected having active TB disease	0%	UA
5.3	New enrolment on IPT	% of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)	0% Indicator N/A	UA
5.4	HIV and TB assessment	% of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit	26.1 %	UA

No.	Indicator	TARGET / Description	Number / %	Source
6.0		**Close the global aids resource gap by 2015 and reach annual global investment of USD 22–24 billion in low- and middle-income countries**		
6.1	AIDS Spending	Domestic and international AIDS spending by categories	SR 47,961,216 (USD 3.5 million)	GARPR/DD
7.0		**Eliminating Gender Inequalities**		
7.1	Prevalence of intimate partner violence	Proportion of ever married partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months	No survey conducted	
8.0		**Eliminating stigma and discrimination**		
8.1	Discriminatory attitudes towards people living with HIV	% of women and men aged 15-49 who report discriminatory attitudes towards people living with HIV	79.6%	GARPR
9.0		**Eliminate HIV-related restrictions on entry, stay and residence**		**Data collected by UNAIDS**
10.0		**Current school attendance among orphans and non-orphans (10–14 years old, primary school age, secondary school age)**		
10.1	Orphans and School attendance	**%** Current school attendance rate of orphans aged 10-14 primary school age, secondary school age	100%	GARPR
10.2	Orphans	**%** Current school attendance rate of children aged 10–14 primary school age, secondary school age both of whose parents are alive and who live with at least one parent	100%	GARPR

III. OVERVIEW OF THE EPIDEMIC

Data is from the Disease and Surveillance Response Unit of the Ministry of Health. The Unit was set up in 2012 to be responsible to carry out the surveillance of communicable diseases and eventually non-communicable diseases as well. The surveillance of the epidemic is conducted at sentinel points, such as the Communicable Disease Control Unit (CDCU), antenatal clinics,

Occupational Health Unit (OHU) and the blood bank in the Ministry of Health and reveals that there is an increasing trend in HIV infections. The Seychelles response to the pandemic dates back to 1987 when the first HIV infection was detected and the first recognized full-blown AIDS case was reported in 1992.

LOCAL SITUATION FROM 1987 TO 2014

Table 6. Cumulative HIV and AIDS data from 1987 to December 2014

Local Situation from 1987 to 2014	Total	Male	Female
Cumulative HIV Cases	**667**	387	280
Cumulative AIDS Cases	**283**	175	108
Cumulative Deaths	**136**	82	54
Cumulative HIV Positive Pregnancies	**108**		92
Living with HIV & AIDS	**441**	246	195
Cumulative Cases on HAART	**231**	125	106
Left Seychelles	**92**	59	33
Cumulative Loss to Follow- Up Cases	**40**	24	64
Cumulative Drop–outs on HAART	**28**	27	55

Source: DSRU- Ministry of Health

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

Table 7: Percentage of adults and children with advanced HIV infection receiving ART

Year	Number of adults and children with advanced HIV infection who are currently receiving ART at the end of the reporting period					Estimated number of adults and children with advanced HIV infection				
	<15 Female	<15 Male	15+ Female	15+ Male	Total	<15 Female	<15 Male	15+ Female	15+ Male	Total
2007	4	3	39	51	**97**	4	3	39	51	**97**
2008	6	3	45	59	**113**	6	3	69	83	**161**
2009	6	3	55	75	**139**	6	3	57	80	**146**
2010	5	3	60	88	**156**	5	3	60	88	**156**
2011	2	3	81	95	**181**	2	3	81	95	**181**
2012	3	4	97	111	**215**	3	4	97	111	**215**
2013	3	4	100	111	**218**	3	4	100	111	**218**
2014	4	4	104	127	**231**	4	4	104	127	**231**

Source: CDCU Patient Register Public Health Authority

HIV and Related Conditions

HIV

Since the first HIV case was diagnosed in Seychelles in 1987, a cumulative of 667 (387M/280F) HIV cases representing 58% males and 42% females have been reported to date. Currently, 441 (246M/195F) cases are living with HIV representing 56% males and 44% females. Main probable mode of transmission at diagnosis was heterosexual 57% and intravenous drug use 31% of the cases diagnosed in 2014. (In comparison, for 2011, the mode of transmission

was 86% was heterosexual; 14% was MSM).

Table 8. Most Probable Modes of HIV Transmission in 2014

Most Probable Mode of Transmission in 2014	Number of Cases	Percentage
Heterosexual	52	57
Intravenous Drug User (IDU)	28	31
Bisexual / Men having Sex with Men (MSM)	9	10
Female Sex Worker (FSW)	1	1
Mother to Child Transmission (MTCT)	1	1
Total	**91**	**100**

Source: DSRU Public Health Authority

The year 2014 has reported the highest number of new cases for HIV since 1987 with 91(55M/36F) cases, an increase of 94% compared to 2013, age ranging from 1 month old to 71 years old, both females.

Out of the 441 (246M/195F) cases living with HIV, 64 (40M/24F) cases did not access the service for over six months representing 15% of loss to follow-up (LTFU). A cumulative of 231 (125M/106F) cases was on Highly Active Antiretroviral Therapy (HAART) by the end of 2014 representing 52% of people living with HIV. Of note, 55(28M/27F) cases representing 19% of cases eligible for treatment as per WHO recommended guidelines defaulted treatment for more than three months in 2014.

The age groups most affected were the 25-29 and 30-34 years old representing 33% of the HIV cases reported from 1987 to 2014. The 50 years old and above represented 15% of the total number of cases. Males were more predominantly affected throughout the years compared to females.

With the availability of treatment, improvement in management of HIV over the years, an increasing number of cases are aging with the disease, 23% of the cases living with HIV were in the 50 years old and above age group by the end of 2014.

Probable modes of transmission at diagnosis in 2014; Heterosexual 57%, Intravenous Drug Use 31% and Men having Sex with Men 10 % respectively.

AIDS Deaths

Since the first AIDS case in 1993, a cumulative of 283 (175M/108F) AIDS cases was reported by December 2014 of which 62% males and 38% females. There were 19(11M/8F) new AIDS cases reported in 2014, a reduction of 9% compared to 21 new cases in 2013, 14 were newly diagnosed HIV cases and 5 were known HIV cases who progressed to AIDS.

A cumulative of 136 (82M/54F) AIDS related deaths has been reported since 1993 to 2014, 60% of deaths occurred in males and 40% in females.

The AIDS mortality from 1993 to 2000 has generally been on the increase, with the introduction of Highly Active Antiretroviral Therapy (HAART) in 2001, a sustained decline in the trend has been noted over the years with though an increase in mortality in 2014.

In 2002 there were 6 deaths (7%) out of 87 PLWHA, 5 deaths (3%) out of 175 PLWHA in 2006, 8 deaths (3%) out of 294 PLWHA in 2010 but an increase in AIDS mortality was noted in 2014

with 19 deaths (4%) out of 441 PLWHA. The year 2014 reported the highest number of AIDS related deaths since 1993, an increase of 137% compared to 8 cases in 2013 and age ranging from 16 to 66 years.
Of the 19 death cases, 42% were newly diagnosed with HIV in 2014, 47% were those who have defaulted treatment and follow-up and 11% died of cancers.

Possible contributing factors towards the increase in AIDS mortality were loss to follow up and late presentation of cases. In 2014, 15% of PLWHA did not access the service for over six months, 19% of cases eligible for treatment defaulted treatment for more than three months and late presentation of cases. In 2014, 42% of AIDS related deaths were newly diagnosed HIV cases who were in late stage of AIDS.

PMTCT
A cumulative of 108 HIV positive pregnancies have been reported from 1987 to 2014, 83(77%) have benefited from the PMTCT program since its introduction in 2001 from monotherapy to tri-therapy since 2003.
There were 10 new HIV positive pregnancies reported for the year 2014, an increase of 43% compared to 2013 (7), age ranging from 16 to 35 years old. Before the PMTCT era, 8 out of the 23 babies born from HIV positive mothers were infected with HIV representing a mother to child transmission of 35% compared to 3 out of the 80 babies since the introduction of PMTCT program representing a mother to child transmission of 4%. Only 4 of the 10 HIV positive pregnant mothers delivered in 2014.

HAART
By the end of 2014, there were 231(125M/106F) cases on Highly Active Antiretroviral Therapy (HAART), representing 52% of PLWHA. However, a number of treatment drop-outs are reported every year. By the end of 2014, a total of 55(28M/27F) cases representing 19% of cases eligible for treatment as per WHO recommended guidelines defaulted treatment for more than three months.
In 2014, 64 (33M/31F) new HIV cases were initiated on Highly Active Antiretroviral Therapy (HAART), representing 52% males and 48% females respectively, an increase of 5% in new cases started on treatment compared to 2013. Of the 64 new cases initiated on HAART in 2014, 19% (12) defaulted treatment for more than three months during the course of the year.

Hepatitis C
A cumulative of 486 cases of Hepatitis C reported from 2002 to 2014, 399(82%) males and 87(18%) females. Out of the 486 cases, there were 56 (43M/13F) HIV and Hepatitis C co-infection and 18 (11M/7F) Hepatitis C related deaths.
For the year 2014, 93(78M/15F) new cases of Hepatitis C were detected representing a reduction of 4% in new reported cases compared to 2013, the youngest was a 15 year old and the eldest a 52 year old, both males. The age group most affected was the 20 to 34 years representing 76% of the total cases reported for 2014. There were 28 (24M/4F) new cases of HIV and Hepatitis C co-infection, 12(8M/4F) Hepatitis C related deaths and 4 Hepatitis C pregnancies reported. Of note 3 amongst the 12 Hepatitis C related deaths in 2014 were newly Hepatitis C diagnosed cases for the year. There was a gradual increase in the incidence of Hepatitis C reported from 24 per 1000 tests in 2010 to 50 per 1000 tests in 2012 followed by a rapid decline to 26 per 1000 tests in 2013 and 23 per 1000 tests in 2014. Of the 486 cases reported to date, 483 (99%) cases were confirmed to be Intravenous Drug Users. An increase of 13% was also observed in the number of Hepatitis C tests conducted in 2014 compared to 2013.

Tuberculosis

A cumulative of 591 confirmed tuberculosis cases have been reported from 1979 to 2014, 31 tuberculosis related deaths out of 591 cases since 1976 and 31 cases of HIV & TB Co–infection reported from 2000 to 2014.

In 2014, there were 7 (5M/2F) newly confirmed tuberculosis cases reported, a reduction of 69% in new cases compared to 23 cases in 2013. Of note 14% of the new cases were expatriates. There was 1 case (male) of HIV & TB Co- Infection but no tuberculosis related deaths reported. No cases of MDR or XDR TB have been reported to date in Seychelles.

HIV Testing

Indicator 1.5: HIV testing in general population
Percentage of women and men aged 15 to 49 years received an HIV test in the past 12 months

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

Data from the DSRU indicate that the HIV incidence has remained constant at 5 per 1000 HIV tests for the year 2006 to 2008 but increased to 6 per 1000 HIV tests in 2009. From 2010 to 2012, there was a decreasing trend in the incidence. The incidence for 2013 was 5 per 1000 HIV tests.

A fluctuating trend in the number of HIV conducted between 8000 and 10000 tests. A total of 9547 HIV tests were conducted for 2013. HIV tests were conducted in all VCT centers, Wards, Antenatal Clinics and the Blood Transfusion Center.

In 2014, a total number of 10283 tests is recorded by the Clinical Laboratory in the Health Care Agency although a figure of 8211 and incidence of 9 per 1000 tests are reported by the CDCU. Also, 1261 and 240 tests respectively are reported from two private health facilities.

Other Sexually Transmitted Infections

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

Only 2 pregnant women who attended ANC services in 2014 were tested positive for syphilis, however the test was not offered during the KAPB Study in the general population.

As per last reporting period, data from the DSRU shows the trend of STIs is on the increase.

Syphilis

A reduction of 19% in new syphilis cases and a reduction of 1.34% in the number of RPR/TPHA tests performed for 2014 when compared to 2013.

A general increasing trend in the incidence of syphilis observed from 60 per 10000 RPR/TPHA tests in 2010 to 91 per 10000 RPR/TPHA tests in 2013, an increase of 52%. In 2014 there was a reported incidence of 74 per 10000 tests, representing a reduction of 19% compared to 2013.

Gonorrhoea

Increasing trend in the incidence of Gonorrhea over the years from 1 per 100 tests in 2006, 8

per 100 tests in 2008 to 22 per 100 tests in 2011 respectively. A significant decline in incidence was observed from 19 per 100 tests in 2013 to 10.29 per 100 tests in 2014, a reduction of 46% in 2014 compared to 2013.
A total of 1030 tests for Gonorrhea were conducted in 2014, a reduction of 3% compared to 2013, of which 106(84M/22F) were positive for gonorrhea representing a case detection rate of 10%. The youngest case was a 15-year-old female and eldest a 57-year-old male. The 15-24 years age group was more predominantly affected representing 46% of the total reported cases.
Antimicrobial sensitivity testing was conducted for Ciprofloxacin, Ceftriaxone and Cefixime, the three main antibiotics of choice amongst the gonorrhea cases detected in 2014. Ceftriaxone was the most sensitive at 82% followed by Cefixime at 69% and Ciprofloxacin was the least sensitive at 21%.

Chlamydia
A total of 4705 tests for Chlamydia Trachomatis were conducted from 2005 to 2014 with 762 positive cases reported representing a case detection of 16%. A fluctuating trend in the incidence over the years was observed from 9.76 per 100 tests in 2006, 14.65 per 100 tests in 2011, 27.21 per 100 tests in 2013 and 19.61 per 100 tests in 2014 respectively.
The year 2014 reported a reduction of 9% in the number of tests conducted and a reduction of 28% in positivity compared to 2013. The youngest was at 2 weeks old with *opthalmia neonatorum* and eldest a 68 year old, both males. The age group most predominantly affected was the 20-29 years, representing 48% of the cases.

IV. NATIONAL RESPONSE TO THE AIDS EPIDEMIC

Seychelles is a democratic republic consisting of 115 islands located in the Western Indian Ocean, 55.6 degrees east of Greenwich meridian and 5 degrees south of the equator. The total land area is 455km^2 and the Exclusive Economic Zone (EEZ) comprises of 1.3 million km^2 of ocean. The archipelago is largely composed of granitic and coralline islands. The geopolitical location of the Seychelles is in Eastern Africa with 100% boundaries consisting of more than 600 km of coastline and the country is relatively isolated. As a Small Island Developing State (SIDS), Seychelles has generally positive key development indicators, especially literacy rate for both sexes (94%), and a high proportion of the population with access to potable drinking water (95%) and with access to sanitation (97%) (Census 2010) and a low maternal mortality ratio of 0 per 100,000 live births and infant mortality rate 10.92 per 1.000 live births with inclusion of life expectancy at birth of 73.15 years for both sexes in 2014.

In 1990, the mid-year estimate of the population of the Seychelles was 69,507, with a birth rate of 23.1 and a death rate of 7.7 By 1995, the population had grown to 75, 304, with a birth rate of 21.0 and a death rate of 7.0. The population continued to grow until it reached 80, 410 in 1999. Since then, the Seychelles an average of 1,500 persons have been added to the population annually. The population also dropped from 2002 from 82,781 to 82,475 in 2003. For the next three years, it stayed around 82, 000 people due to fluctuations in the number of migrant workers and increase in emigration. In 2014 the mid-population estimate was 91,359 composing of males 45,278 (49.6%) and females 46,081 (50.4%) and a crude birth rate of 17.04 and a crude death rate of 7.94 per 1,000 population.

STRUCTURES IN PLACE

A. NATIONAL COORDINATION

Seychelles has a concentrated epidemic and the country has developed coordination structures and strategic documents and plans with a national monitoring and evaluation system. The HIV/AIDS Policy 2001 and the National Strategic Plan 2005-2009, were reviewed in 2011 a new policy on HIV and AIDS and STIs and a National Strategic Framework for the period 2012-2016 were hence developed to tackle the issues around coordination, prevention, treatment, care and support, impact mitigation and human rights protection. These are supported by policies and strategies for coordination and communication, resource mobilisation, human resources and monitoring and evaluation of the HIV AIDS response.

Seychelles has shown commitment to all relevant international obligations by signing treaties, conventions and / or committing itself to various requirements, such as those laid out in political declarations and UNAIDS strategic plans. The country adheres to principles and targets, such as those of the MDGs, the "Three Ones" Principle, "Getting to Zero", Universal Access, the UN General Assembly Special Session (UNGASS) Declarations of 2001 and 2011, as well as principles to access the Global Fund and other international funding sources.
The Coordinating Mechanism is further guided by international commitments.
Strong leadership is the key to success and Seychelles supports the "Three Ones" Principle which calls for one national coordinating body.

Various bodies are involved in national coordination:

National AIDS Council (NAC)
The National AIDS Council (NAC) strengthens the country's response to HIV/AIDS in Seychelles. Created in May 2002, the NAC is the highest National Authority on HIV/AIDS in Seychelles. As such, the President of the Republic is its Patron. The Minister for Health is also responsible for HIV and AIDS. In December 2013, the NAC was elevated to a legal entity through the National AIDS Council Act, as approved by the National Assembly of Seychelles.

A Chief Executive Officer and Board of members of the National AIDS Council of Seychelles were appointed by the President of the Republic of Seychelles, Mr James Michel, as from February 2014, in accordance with the NAC Act 2013, section 21. The Principal Secretary of Health chairs the NAC Board. NAC's main role is to coordinate the national response to HIV and AIDS. NAC also provides support and guidance to organisations involved in the multi-sectoral national response, namely in prevention and behaviour change, treatment and care, impact mitigation and human rights protection. It coordinates financial resources directed towards HIV and AIDS interventions.

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

The Civil Society (including NGOs, Faith-Based Organisations) and the Private Sector are represented on the National AIDS Council. The civil society was strengthened in 2014 through

the creation of the 'Citizens' Engagement Platform for Seychelles' (CEPS) which now replaces the Liaison Unit for NGOs (LUNGOS). Faith-based organisations are united through the Seychelles Inter-Faith Council (SIFCO) and the private sector is represented by the Seychelles Chamber of Commerce and Industry (SCCI). They are all involved in the national response, represented in various structures and are consulted before any major policy decisions.
The more active organisations conducting activities in 2014 include:

- HIV and AIDS Organisation (HASO) – NGO
- Alliance of Solidarity for the Family (ASFF)
- Youth Alive (FBO), and
- Everlasting Love Ministry (ELM) – FBO

Public Health Authority (PHA)

AIDS Prevention and Control Programme (APCP)

The AIDS Prevention and Control Programme (also referred to as AIDS Programme) is a unit with fulltime AIDS Programme Manager and a Health Promotion Officer under the Public Health Division in the Ministry of Health. It is responsible for coordinating the health sector response to HIV and AIDS. From 2002 to April 2014, the AIDS Programme also held the NAC Secretariat.

The AIDS Programme retains its mandate to provide technical expertise as secretariat to the Technical Advisory Committee (TAC) for HIV and AIDS.

Communicable Diseases Control Unit (CDCU)

In 2001, antiretroviral therapy was firstly introduced in the Seychelles and many HIV-infected individuals have accessed free treatment, care and support through the existing Communicable Diseases Control Unit.
The main treatment centre falls under the portfolio of the Ministry of Health, is the sole specialist referral centre in the Seychelles for the management of all sexually transmitted infections (STIs) which include HIV and AIDS, management of Tuberculosis, Leprosy, Hepatitis B and C, and Traveller's Health.

Disease Surveillance and Response Unit (DSRU)

The DSRU is a unit within the Epidemiology and Statistics section in the Public Health Authority which is responsible for disease surveillance and outbreak investigations. The unit collects health statistics on a daily and weekly basis via a web-based system, analyse and come up with recommendations for public health actions based on the WHO Integrated Disease Surveillance and Response Guidelines. There are over 40 notifiable diseases under surveillance comprising both communicable and non-communicable diseases.

The Technical Advisory Committee for HIV&AIDS (TAC)

Members are health professionals of the Ministry of Health who meet monthly to discuss issues pertaining to care and support, testing, treatment, surveillance and other guidelines. Main issues are research and surveillance; care and counselling; Blood Safety; Provision and Difficulties with antiretroviral therapy; Resource mobilisation; STI management; community activities; IEC; laboratory; and others e.g. Contact Tracing; Confidentiality.

B. EXISTING POLICY ENVIRONMENT

International Commitments

On the international level, the Seychelles is a signatory to eight major human rights treaties, including the *International Covenant on Civil and Political Rights (ICCPR),* the *International Covenant of Economic, Social and Cultural Rights (ICESC)*, the *Convention on the Rights of Persons with Disabilities*, the *Convention on the Rights of the Child (CRC)* and the *International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).*

Specific to HIV and AIDS, the country has also committed itself to the ***"Three Ones"*** principle (one national HIV and AIDS coordinating authority, one national HIV and AIDS action framework, and one monitoring and evaluation framework). Further commitment is given through adherence to the UNAIDS 2011 – 2015 Strategy: Getting to Zero.

Other international obligations are to the ***Millennium Development Goals (MDG)*** **HIV and AIDS related commitments and the** ***2011 UN General Assembly Special Session on AIDS (Political Declaration on HIV/AIDS : Intensifying our Efforts to Eliminate HIV/AIDS).***

Furthermore and closer to home, the ***WHO Country Cooperation Strategy 2008-2013*** addresses all health issues in Seychelles with some priority areas, such as non-communicable diseases linked to lifestyles (diet, exercise and work). Moreover, the strategy document suggests that present challenges related to HIV and AIDS prevention and treatment include the sustainability of services, as well as long-term adherence and possible resistance development to ARVs in the future. There is also concern about reported incidence of some STIs such as gonorrhoea, genital warts, genital herpes, and syphilis, although the number of cases remains low, and their link to HIV and AIDS as indicators of possible drivers of the pandemic.

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

National Commitments

In 2014, there was still no specific legislation relating to HIV and AIDS and PLHIV. However, the ***Seychelles Health Strategic Framework 2006-2016*** is based on the principles of ***Health*** *By* ***All*** **and** ***Health For All.***

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

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

i. The ***National Strategic Framework on HIV and AIDS and STIs 2012 – 2016*** gives the main priority areas for action. These are Prevention and Behaviour Change, Treatment and Care, Impact Mitigation and Human Rights Protection. These are supported by Coordination and Communication, Resource Mobilisation, Human Resources and Monitoring and Evaluation.

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

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

iv. The ***National Policy on the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles 2012*** lays the foundation and principles on which are based all further actions.

The core values of the National Policy are:

- ***Respect for, protection and fulfilment of human rights,*** as stipulated in national and international instruments, *Integration of programmes and services*, for better networking and for building effective local and international partnerships; and
- ***Pragmatism*** with emphasis on the central role of the body of scientific evidence in programmatic actions.

The main goal of the Policy is to ***"halt new infections and reverse the trend of HIV and AIDS and sexually transmitted infections, and to care for and support those living with HIV and affected by AIDS".***

The National HIV& AIDS and STIs Policy is aligned to and incorporates International Obligations and Alignment with Human Rights instruments: In fact one of the main considerations for the development of the National Policy was the major human rights instruments signed by the Seychelles. All of them have certain obligations that the country need to abide to once it ratifies the treaty. These include the following:

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

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

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

Other Instruments are:

- Convention on the Elimination of All Forms of Discrimination
- Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and Optional Protocol of CEDAW; and General Recommendations No. 19
- International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
- African Charter on Human and Peoples' Rights
- African Charter on the Rights and Welfare of the Child
- MDG Declaration

HIV and AIDS related commitments are:

- 2000: UN MDGs declaration to strengthen National response
- 2001: UN General Assembly Special Session on AIDS (*UNGASS Declaration of Commitment on HIV/AIDS)*
- 2001: Abuja declaration on Universal Access HIV/AIDS/TB/Malaria/STIs – 2001
- 2003: Maseru Declaration
- 2006: Brazzaville Commitment on Scaling Up Towards Universal Access to HIV and AIDS Prevention, Treatment, Care and Supporting Africa in 2010.
- 2006: UN General Assembly *Universal Access Declaration*
- 2011: Women, Girls, Gender Equality and HIV: progress towards Universal Access – Windhoek
- 2011: UN General Assembly Special Session on AIDS (Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS)

Whilst these international and national obligations have been factored into the national HIV and AIDS policy document, there is still a need to increase the awareness of government officials on strategic issues concerning HIV and AIDS.
As regards civil society, even if there has been increased involvement, participation is still viewed as low and ineffective.

In summary, commitment to international and national obligations has been generally satisfactory, especially in terms on inclusiveness in national documents.

HIV AIDS Workplace Policy

Globally, HIV and AIDS are considerable threats to the world of work. The virus strikes the most productive segment of the labour (aged 17 to 45 years), disappearing skills being often difficult to replace, slow productivity, and reduced earnings are some consequences of the spread of HIV/AIDS. They pose a threat to fundamental rights at work because of discrimination, exclusion and stigmatization of people infected or affected. Stigma, discrimination and the threat of job loss suffered by people affected by HIV or AIDS are barriers to voluntary HIV testing, which increases vulnerability and undermines the right of access to social benefits.

Despite efforts made in Seychelles to eradicate HIV&AIDS, it has been noticed that few actions were targeted to workplaces. In 2014, the HIV and AIDS policy in the Workplace of 2004 was reviewed and aligned with international workplace conventions. After its presentation to the National AIDS Council Board, the document is being finalised for cabinet approval.

C. PREVENTION, KNOWLEDGE AND BEHAVIOUR CHANGE

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

There were 76 (53 males, 23 females) respondents aged 15-49 in the KAPB and biological survey of 2013 who had more than one partner in the past 12 months. In all, 51.3% in that age group used a condom during their last sexual intercourse, 50.9% among the males and 52.2% among the females. The highest were among males aged 15-19 years which was 63.6% and the lowest were among males and females age 20-24 years, 40% "*Only 68% of respondents believe that condoms can protect you from HIV… The figures were slightly higher in 2003, with 76% of males and 77% of females believing that condoms can protect from HIV transmission*."
The perception regarding condoms may need to be changed so that they are seen as both necessary and useful for prevention of pregnancy and transmission of diseases.

In 2014, the issue of behaviour change communication and prevention strategies remained predominant in the national response to the epidemic. The continued rise in the number of new PLHIV is a sign that much needs to be done in this area. The focus of interventions is still on the general population and young people. Sessions have been conducted in schools, workplaces and districts on demand from various groups and organisations by the AIDS Control Programme, the Youth Health Centre, the Drug and Alcohol Council and non-governmental organisations. . These are not regularly scheduled activities.

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

USE OF 10 TARGETS TRACKING TOOL (based on the completed report)

Target 1: Reduce Sexual Transmission of HIV by 50% by 2015

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

General population

The HIV and AIDS pandemic in Seychelles is a concentrated on, with a prevalence of 0.87% in the general population (KAPB Study Final Report, 2013.
The HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour and Biological Survey was conducted in 2012 in the general population, aged 15 to 64 years,
The sample was composed of 1691 persons living in Seychelles at the time of the study, who are aged between 15 and 64 years. The sample was also stratified according to age, gender and district of residence. The main methods of data collection was a face-to-face interview through the administering of a pre-tested questionnaire to have information on levels of knowledge, the kinds of attitudes, and the behaviour patterns of respondents, and a biological sample (blood)

from each respondent to test for HIV and other STIs, with a rapid test in a laboratory setting.

In reference to indicators 1.1 to 1.6, the following are noted: There were

- Overall 263 (128 males, 135 females) respondents aged 15-24 in the KAPB and biological survey of 2012, 4.6% in that age group had sexual intercourse before the age of 15 years, 1.6% among the males and 7.4% among the females.

- Of 899 (407 males, 492 females) respondents aged 15-49, 8.5% in that age group had sexual intercourse with more than one partner in the past 12 months, 13.0% among the males and 4.7% among the females.
  The highest were among males aged 20-24 years which was 20.0% and the lowest were among females age 25-49 years, 3.9%.

- A total of 76 (53 males, 23 females) respondents aged 15-49, who had more than one partner in the past 12 months. In all, 51.3% in that age group used a condom during their last sexual intercourse, 50.9% among the males and 52.2% among the females.
  The highest were among males aged 15-19 years which was 63.6% and the lowest were among males and females age 20-24 years, 40%.

- Of 899 (407 males, 492 females) respondents aged 15-49 in the KAPB and biological survey of 2012, 72.3% in that age group received an HIV test in the past 12 months and know their results, 58.0% among the males and 84.1% among the females.
  The highest were among females aged 25-49 years which was 98.6% and the lowest were among males age 15-19 years, 12.8%.

In the same study, 649 women aged 15-24 were ante-natal attendees. Six (0.92%) were living with HIV, 0.86% were in the age group 15-19 years and 0.95% were in the age group 20-24 years.

In that perspective, the *National Strategic Framework for the Prevention and Control of HIV and AIDS and STIs 2012–2016* focuses on developing programmatic actions that address specifically the needs of key populations, whilst pursuing with multi-sectoral approach interventions geared towards the general population.

Major Progammes Implemented

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

Such data also helped to realign policies, the priories and programmatic actions of the strategic plan which is also scheduled for mid-term review in 2014. Moreover, the information guides national, regional and community IEC campaigns conducted by stakeholders and partners, such as the National AIDS Control Programme (ACP) and the Disease Surveillance and Response

Unit (DSRU) of the Public Health Authority, the Ministry of Education (Personal and Social Education- PSE and Students' Welfare Unit- SWU); other government agencies; NGOs, such as HIV and AIDS Support Organisation (HASO) and the Alliance of Solidarity for the Family (ASFF); and FBOS like Youth Alive (YA) and Everlasting Love Ministry (ELM).

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

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

Target 2. Reduce Transmission of HIV among People who inject Drugs by 50% by 2015

Key Populations

Integrated behavioral and biological surveillance (IBBS)

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

The Seychelles IBBS surveys were carried out by the Ministry of Health, Seychelles, in collaboration with the Projet d´Appui à l´Initiative Régionale de Prévention des IST/VIH/SIDA dans les Etats membres de la Commission de l'Océan Indien (AIRIS-COI project), National AIDS Trust Fund, and World Health Organization (WHO). Funding for technical support was provided by AIRIS-COI, United National Office of Drugs and Crime (UNODC) and WHO.
The Respondent-Driven Sampling (RDS) methodology used is a chain-referral sampling method specifically designed to obtain probability-based samples of 'hidden' and hard-to-reach populations that are socially networked. After providing informed consent, respondents completed an interview and provided blood specimens to be tested for HIV, syphilis and Hepatitis B (HbsAg) and C (HCV).

INTRAVENOUS DRUG USERS (IDU)

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

Creole or English.

KEY FINDINGS

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

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

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

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

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

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

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

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

The Seychelles have many people who inject illicit drugs: From the IBBS results, it is estimated that approximately 2.3% (or 1, 283) of the adult population in Seychelles inject drugs. Females comprise 257 of the adult IDU population in Seychelles.

Major Programmes Implemented

IDU: National Medically-Assisted Therapeutic (MAT) Strategy Providing Treatment Options for People Who Inject Drugs

The programme, conducted at the Wellness Centre in the Ministry of Health, takes a biological, psychological, social and spiritual stance using a multidisciplinary team which includes physicians, psychiatrists, nurses, psychologists, and other supporting staff.

The programme follows an integrative and holistic treatment approach, which is in line with best practice models of abstinence. It consists of a two-week residential induction phase which allows the staff of the centre to conduct HIV Testing and Counselling (HTC), to promote the use of condoms and to discuss other issues affecting the clients. However, there is no safer injecting practices and no needle exchange programme (NSP). As for the latter, it is done on an individual level by one or two individuals on an ad-hoc basis with persons that they know well.

The support of stakeholders is visible through donation and support of a gym and other equipment for rehabilitation of clients. Efficient service delivery is ensured through training of all staff working with the treatment unit in basic addictology so far conducted by the Ministry, IOC, UNODC, WHO and SADC.

So far, there has been no central and national approval for NSP with PWIDs. So far, there have been 328 for the past two years, men accounts for 84.5% (278) and women 15.2%. Out of this total 0.9% (3) were male minors below the age of 18years. The demand for such services is high as the more people are on the waiting list. The service is well established for people living with addiction. There is a need to expand the service (Introduce outpatient services)

MSM: Sex with females:

Most men self-identified as bi-sexual or heterosexual, indicating active sex with females, including partners considered being wives and girlfriends. Among those who reported having sex with a female in the past six months, 41.7% reported having ≥4 female sex partners. Less than half of MSM used a condom during intercourse with their last non-paid female sex partner.

Sex workers are the bridges in HIV/AIDS epidemic linking concentrated epidemics to the general population. Therefore sensitisation of the SW is a key aspect in HIV/AIDS prevention and control. One of UNAIDS strategy plan is to provide access and services to sex workers as a means of disease prevention and management. Devoting sensitisation campaigns and offering access to health care services to target groups has additional benefit for disease prevention and management, as with SW you can offer service to injecting drug users who are commercial sex workers.

Programmes Implemented

Sex workers

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

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

RESULTS: The majority of the CSW welcomed the idea of enrolling them to care and the outreach program. During counselling some of the constraints identified, most of them had condoms 3-4, stating that the police stopped them if they have more condoms. Although they were using condoms with clients, they were having unprotected sex with their stable partners and they were sharing needles with whomever; most of them asked if they could have a needle and a syringe. 15/16 i.e. 94% were injecting drug users (IDU). One tested HIV positive, 14/16(87.5%) were hep c (+). No one tested positive for syphilis or Hep B. In all 192 condoms were distributed. Out of the 16 only one CSW came for her results at CDCU, at the same time she was screened for other sexually transmitted infections, her results were normal.
Overall the outreach activity was well received by the CSW. Blood sample and counselling were being done on street corners; safety and privacy were at risk. The incidence of Hepatitis C is 87.5 % among the CSW and HIV incidence 6 % among CSW. Out of the 5 objectives stated above, only 4 were achieved. Enrolment to services and access to treatment failed as only one CSW came for results and she has been referred to the methadone substitution unit (WELLNESS CENTRE).

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

Survey in Sex Workers

In 2014, funds were secured with the SADC for a survey in sex workers in Seychelles in 2015.

D. CARE, TREATMENT AND SUPPORT

The Communicable Disease Control Unit (CDCU) of the Public Health Authority, is the sole specialist referral centre in the Seychelles for the management of all sexually transmitted infections (STIs) which include HIV and AIDS, management of Tuberculosis, Leprosy, Hepatitis B and C, and traveller's health. The Unit has been in operation since the first case was detected in 1987 and has well laid down guidelines and procedures. The Unit has not experienced stock out during the reporting period.

The Social Services has two clients with HIV/AIDS. They offer services such as counseling, referrals and support.
The Prison Services have their Health Services in place for taking care of HIV/AIDS clients.

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

PMTCT
In 2012, a total of 1,672, 1,630 in 2013 and 2014 1,660 of women attended antenatal clinics for their first booking and delivered. A cumulative of 108 HIV positive pregnancies have been

reported from 1987 to 2014, 83(77%) have benefited from the PMTCT program since its introduction in 2001 from monotherapy to tri-therapy today.
There were 10 new HIV positive pregnancies reported for the year 2014, an increase of 43% compared to 2013 (7), age ranging from 16 to 35 years old. Before the PMTCT era, 8 out of the 23 babies born from HIV positive mothers were infected with HIV representing a mother to child transmission of 35% compared to 3 out of the 80 babies since the introduction of PMTCT program representing a mother to child transmission of 4%. Only 4 of the 10 HIV positive pregnant mothers delivered in 2014.

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

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

Programmes Implemented

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

- **Free primary health care**, with a good distribution of regional and district health centres on the three main islands.
- **Training and deployment of midwive**s, with enhanced skills in a variety of health matters, including drugs and alcohol abuse and nutrition.
- Availability of **free family health services** (contraceptives, antenatal clinics) and nutritional support to mothers.
- **Free HIV Testing and Counselling (HTC) and Antiretroviral drug** (ARVs) for HIV positive mothers.
- **Strong Prevention of Mother-to-Child Transmission (PMTCT) programme,** which may be able to move to Elimination of Mother-to-Child Transmission EMTCT as monitoring of mothers and children tend to be comprehensive.
- **A solid antenatal, delivery and postnatal programme. School Health Programme** including Health-Promoting Schools components, which is a special programme that focuses on making the school as holistic healthy as possible, encourages schools to look at health of the school in terms of its overall environment, both physical and psychological, to promote healthy attitudes and behaviours in school personnel, parents, the community and students.
- **Availability of health professionals at childbirth**.
- **Antenatal supplemented by parenting and psychosocial support** sessions (Drug and Alcohol Council, 2013).
- **A Reproductive Health policy,** developed in 2012, focuses on aspects of women and

men's health and in particular issues pertaining to access to information and services for reproductive and sexual health. Women's health and the health of the family is a major factor that affects the country's population issues and services are put in place to target such issues.

- Following its launching in 2013, **the Campaign for Accelerated Reduction of Maternal, Neonatal and Child Mortality and Morbidity (CARMMA) 2014-2015** was further implemented by the Government of Seychelles committed to join other AU member states, in line with national priorities and AU resolution to advance health of women and children in Africa. The campaign focuses on awareness building, advocacy, mobilizing support and adopting a ROADMAP to implement agreed priority high impact interventions that will improve Maternal, Neonatal and Child health (MNCH) including adolescent health.

  A roadmap was developed as a product of a series of national stakeholder consultations and expert synthesis in line with the National Health Framework 2006-2016. It has 5 main components namely: Maternal, Men, Youth, and Neonatal and Child Health. It outlines set of strategies and interventions that form basis of commitment to further improve maternal, neonatal and child health including adolescent and men's health outcomes, accelerate progress towards achieving health related MDGs by 2015 and sustain the achievements in the long term

  The campaign will be evaluated in 2015.
- A **Sexual and reproductive health monitoring and evaluation framework** developed in line with the national reproductive health strategic plan, is used as a tool in the monitoring and evaluation of RH services in Seychelles
- **Family Planning Procedure Manuals 2007** was reviewed in 2012 and completed, printed and disseminated in 2013. Various people concerned reviewed different sections of the manual including the nurses who will be using it on a daily basis.
- **Procurement of Equipment** namely weighing scales and blood pressure apparatus for both Family Planning and Ante Natal clinics, School health nurses on Mahe and Inner Islands. These are facilitating early diagnosis and referrals of clients.
- Capacity building on **"Minimum Initial Service Package" (MISP) in emergency settings:** 30 health workers and social workers were trained on the MISP in 2013 by UNFPA.
- **A donation of reproductive health kits** to Seychelles by UNFPA (worth USD15000), complemented the existing reproductive health services being offered and included different contraceptives, drugs and disposable equipment.
- In 2013, the Youth Health Centre of the Ministry of Health in collaboration with the Sexual Reproductive Health Programme and NGO ASFF set forth the process to develop a **National Adolescent Sexual Reproductive Health Policy.** A proposal was submitted and approved in fourth quarter 2013 and desk review started in December 2013. Development of the situation analysis and the development of the policy itself were done during 2014. Validation will be done in 2015.

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

Child Health

In 2014, there were a total of 7,514 children in the age group 0-4 years, which represented 8.2% of the total population of Seychelles. Over the past 10 years, the average total number of live births has been around 1,553 births per year. In fact, the Seychelles presently has the lowest mortality in Africa and is following the WHO guidelines and protocols for Maternal and Child Health. The under-five mortality rate per 1000 live births is already low and had dropped from 16.5 in 1991 to 12.8 in 2012 and 15.7 in 2013 and 13.49 in 2014).The decline in death rate and infant mortality rate (IMR) per year had started since the 1970s. For example, the death rate dropped from 8.5 in 1971 to 7.4 in 2010 (7.94 in 2014) and IMR declined from 33.2 in 1971 to 10.8 in 2012 and 16.5 in 2013 and 10.92 in 2014.

Programmes Implemented

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

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

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

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

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

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

- **Free family planning services** and distribution of **condoms in health centres and workplaces**.

- **School health programmes** provided by the Ministry of Health have some input into life skills and empowerment programmes for in-school students and out-of-school youths is the mandate of Youth Health Centre (YHC.

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

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

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

- **The revised School Health Screening Programme (2013)** provides for the screening of secondary four students. These changes include the introduction of Human Papilloma Virus (HPV) vaccine, Breast Self-Examination (BSE) for girls, Testicular Self Examination for boys, hearing test (for implementation in the near future), and screening for Sexually Transmitted Infections and HIV testing. The implementation of the programme will be directed by the administration of written consents from parents and or guardians. **The HPV vaccine was introduced in 2014.**

- Implementation o the new **WHO guidelines on PMTCT since 2012**

TARGET 4. Reach 15 million People living with HIV with Lifesaving Antiretroviral Treatment by 2015

Treatment of HIV is still free and easily accessible to persons who meet the set WHO guideline. The PMTCT programme remains strong, even if with the advent of heroin-dependent mothers there is some risk of higher child mortality, given their non-attendance of antenatal sessions. PWIDs and MSMs have the highest prevalence of HIV and STIs, especially Hepatitis C, which pose particular challenges for behaviour change communication, treatment, follow-up and psychosocial support.
The national target for access to treatment is 100% for all who are eligible using WHO guidelines. However, adherence and clinic attendance can be an issue for some of the patients.
The efficiency of the management of treatment for people living with HIV and AIDS is demonstrated 94% people on ART tested for viral load who were virally suppressed in 2014.

By the end of 2014, there were 231 (125M/106F) cases on Highly Active Antiretroviral Therapy

(HAART), representing 52% of PLWHA. However, a number of treatment drop-outs are reported every year. By the end of 2014, a total of 55(28M/27F) cases representing 19% of cases eligible for treatment as per WHO recommended guidelines defaulted treatment for more than three months.

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

- In reference to the audit Report Assessing the efficiency of the management of treatment for people living with HIV and AIDS 2013 by the office of the Auditor General, As of March 2013, 97 (60 Males /37 Females) cases did not access the service for over six months representing 28% of loss to follow-up amongst the people living with HIV and AIDS and a cumulative of 37 (19 Males/ 18 Females) cases defaulted treatment representing 16% of the HIV and AIDS clients eligible for treatment. Similarly, six new AIDS cases and three AIDS related deaths were reported for the first quarter of 2013. It has been noted in the DSRU report[1] that 60 per cent of the new AIDS cases reported for the first quarter of 2013 were known HIV individuals who had defaulted treatment and follow-ups over the years.
  It was recommended for the unit to integrate in its calendar of activities additional programmes specific to adherence to treatment in respect to HIV and AIDS. This would ensure that the objective of treatment compliance can be targeted amongst HIV and AIDS individuals who are already on treatment and those who will eventually start treatment, as well as the general public which can also benefit through such programmes.

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

- **P/EMTCT where access is 100%** in most years for both antenatal and post-natal service delivery for both mother and child, with access to HTC, ART, nutritional support and good follow-up.
- **Regionalisation of the service** to populations of inner islands.
- **Universal free (ARVs) treatment** for all PLHIV. The Public Health Authority acquired a PCR in 2013.
- **Revision of the Sexual Assault Guidelines in 2012**

Post Exposure Prophylaxis (PEP)
The Ministry of Health developed the PEP guidelines since the year 2000, provides post-exposure prophylaxis (PEP) to all health care workers exposed to potential HIV-infected material during the course of duty. Administration of PEP requires testing of both source and exposed individuals. This service is offered to health professionals and cadres such as police and fire

officers, who are exposed to the risk of HIV infection when executing their duties and also to victims of sexual violence.

- **PEP guidelines were reviewed and upgraded in 2013**. The PEP after sexual assault guidelines was developed in 2005 and implementation is in progress. A total of 59 persons received PEP for accidental exposure in 2014, of whom 52 were health professionals, 5 were non-health professionals (needlestick injury and human bites) and 2 victims of sexual assault. Out of 59 clients, 14 were placed on expanded ARV regimen.

Target 5. Reduce Tuberculosis Deaths in People Living with HIV by 50% by 2015

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

In 2014, there were 7 (5M/2F) newly confirmed tuberculosis cases reported, a reduction of 69% in new cases compared to 23 cases in 2013. Of note, 14% of the new cases were expatriates. There was 1 case (male) of HIV & TB Co-Infection but no tuberculosis related deaths reported.

Programmes Implemented

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

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

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

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

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

- For every single case of Pulmonary TB detected, tracing and screening of close contacts is done and those with latent TB are being put of **prophylactic treatment with Isoniazid.**

- TB control program in Seychelles is **fully funded by the government** but benefitted also with technical support from SADC and WHO. In 2014, WHO funded the production of IEC materials and procurement of TB diagnostics.

E. IMPACT ALLEVIATION

Target 8: Eliminating Stigma and Discrimination

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

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

- Increasing numbers of new cases of HIV and AIDS annually. A record number of 91 new HIV cases and 19 deaths were reported in 2014.
- The change in the modes of transmission from heterosexual to PWID and MSM, with social contacts and bridges between these key populations and the general population, increasing the risk of further transmissions. In 2014, 31% of new infections were in IDUs and 57% in heterosexual persons.
- The risk of HIV Infection for individuals is relatively high especially as there is little sign of significant change in behaviour in spite of knowledge about HIV and AIDS.
- Health-seeking behaviour in men remains low, especially as services tend not to be adapted to their needs.
- The treatment for hepatitis C is difficult and costly, placing more pressure on health financing systems and programmes.
- There are still poor levels of adherence to medications in some patients (5%). This may lead to more resistant forms of the virus, and treatment will become even more difficult. Drug toxicity needs to be monitored in future.
- There are already signs of drug resistance in certain patients.
- As a result of HIV and AIDS, there is an increasing number of dependents on social services and social welfare assistance, placing severe pressure on the limited human and financial resources for these departments. Although HIV and AIDS patients (adults and children) are not handled separately, at least 80% of all applicants for social welfare are awarded benefits by the Agency for Social Protection.
- Expenditure is increasing, for both ARVs and the management of complications such as opportunistic diseases. Thus, ensuring that funds are available and sustainable on regular annual budget is now a major issue.

The National Workplace Policy is being reviewed by the Ministry of Employment in accordance with *R200 - HIV and AIDS Recommendation, 2010 (No. 200) Recommendation concerning HIV and AIDS and the World of Work Adoption: Geneva, 99th ILC session (17 Jun 2010) - Status:*

Up-to-date instrument of the General Conference of the International Labour Organization. Following findings of a previous SWOT analysis conducted in 2013, the policy instituted a core set of guidelines for all workplaces in the country to establish concrete measures to protect the human rights, health as well as the earning power of workers and productivity of the national businesses and industry in the face of the ever-changing and increasing challenges presented by the HIV and AIDS epidemic.

Specifically there are four main objectives for this policy. These are to:

1. Reduce the number of new HIV infections among workers and their families;
2. Reduce discrimination associated with HIV and AIDS in the workplace;
3. Strengthen coordination, harmonization, monitoring and evaluation of the implementation of the HIV and AIDS policy in world of work; and
4. Increase resources for development and implementation of their programmatic actions

According to the Legal Assessment report of 2013, stigmatizing and discriminatory policies and practices continue to affect people living with HIV, despite the constitutional right of every person to equal protection of the law and freedom from discrimination under Article 27 of the Constitution.

The GCHL's investigation into HIV, law and human rights reported that around the world, people living with HIV continue to feel the impact of stigma, discrimination, marginalization and abuse, both verbal and physical, in their homes, families, communities and in public institutions. In the Seychelles, CSOs working with people living with HIV and affected populations have provided anecdotal evidence of the kinds of stigma and discrimination experienced, including:

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

According to participants in these focus group discussions, stigma and discrimination lead to increased isolation, self-stigma and fear amongst affected populations and makes people unwilling or afraid of accessing HIV testing, prevention, treatment, care and support services. The National HIV Policy and NSF provide the most detailed expositions of the rights of affected populations to HIV prevention, treatment, care and support services without discrimination. Notably, HIV policies and plans provide for the specific prioritization of the rights of key populations at higher risk of HIV exposure (such as MSM, people who use drugs, sex workers,

prisoners, migrants and young people). These broad policies are furthermore supplemented by health guidelines on treatment for HIV. However, there may be a need for stronger protection for these rights in law, as well as for further training and strengthening of implementation, in order to ensure that these rights in policy translate into provision for the needs of affected populations.

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

Respondents also confirm that the country has no specific non-discrimination legislation or regulation which specifies protection for specific populations. Most respondents (n=18) agree the country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations including MSM, people who inject drugs,, prison inmates, sex workers, and transgender people.
However strong recommendations are for laws, regulations, policies and guidelines need to provide equitable access to HIV-related health care services in order to ensure effective responses to HIV and AIDS. Access to HIV prevention, treatment, and care and support services should be available to all people without discrimination and in particular should prioritise access for key populations at higher risk of HIV exposure. This requires developing appropriate HIV laws and policies as well as ensuring training for health care workers on non-discrimination and on the provision of HIV-related health care to key populations.

Programmes Implemented

- **The Legal Environment Assessment (LEA) Framework 2013** aims to improve availability of information and evidence on legal and regulatory aspects in the context of HIV and AIDS for purposes of advocacy and making recommendations for creating and strengthening an enabling environment that promotes an effective national AIDS response in accordance with the National Strategic Plan for HIV and AIDS and STIs 2012-2016.
- Funding is being sought by the UNDP for the Development of a **post LEA action plan 2014-2019** to address the recommendations based on the result of the assessment.
- National policies, **programmatic actions by civil society** and the state as well as intensive prevention and awareness campaigns for the general population have contributed to improved levels of knowledge about HIV and AIDS.
- In recent years, the national television has also **produced a few films on situations regarding the pandemic** rather than relying exclusively on foreign productions. This has increased interest in the subject and may have improved the level of knowledge and reduced stigma and discrimination. Still more needs to be done to reduce ignorance, stigma, discrimination and prejudice.

F. CLOSING THE GLOBAL AIDS RESOURCE GAP BY 2015

Target 6. Closing the Resource Gap

Since the economic crisis caused by external debt of more than 150% of GDP and the adoption

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

The government's commitment to the provision of health services together with education has always been given top priority. This is illustrated by the share of the yearly budget allocation of the national budget to the Ministry of Health in 2012 was 11.9% and 9.2% in 2013. In 2014, it was 9.8%, with an increase of 0.02% increase in absolute figures.

Table 9. Percentage Government Budget allocated to Health 2012-2014

Budget	2011	2012	2013	2014
Health Budget (SR'000)	379,635	423,950	496,186	535,401
National Budget (SR'000)	3,007,658	3,557,983	5,412,155	5,494,074
%	**12.62**	**11.9**	**9.17**	**9.75**

Source: Ministry of Health: Directorate of Cooperation

For effective calculation of expenditure incurred in HIV and AIDS during 2012-2013, the National AIDS Spending (NASA) model was applied. It is a methodology to measure and track resources of national responses to HIV, thus used to estimate HIV expenditure. It compared with Resource Needs Estimates to reflect possible financing gaps. NASA aims to measure ALL spending on HIV and AIDS from ALL sources: public, external, private and individuals in relation to health, social mitigation, education, human rights and labour. The exercise was undertaken by a team trained in Mauritius in 2011.
In 2014, however, in the absence of formal training in the use of the new tool, an attempt was made to fill in the new funding matrix to estimate HIV expenditure in the country. In many instances, the cost of some interventions, for example, those targeting most at risk populations, could not be estimated, as activities are still designed for or lumped together with those for general populations. When high risk groups are encountered, they are usually handled on an individual basis. Some interventions e.g. support and retention have not yet been costed. Revision of the National Workplace Policy was also not included.

Table 10: Total Expenditure for HIV and AIDS 2011-2014

	2011	2012	2013	2014
Total AIDS Spending (SR)	26,928,518	66,149,168	35,002,177	47,961,216
Public Sources (SR)	26,051,550	58,629,430	34,334,946	47,389,327
Public Sources as % of Total	97	89	98	99
ARV Treatment (including PMTCT & PEP)	11,714,724	8,183,955	2,184,644	1,305,132

Source: National AIDS Council 2014

The estimated AIDS Spending for given programmes was SR 47,961,216 in 2014 (USD 3.5 million).

Table 11. Percentage Expenditure as per AIDS Spending Matrix 2014

Target on AIDS Spending Matrix	Sub-Total (SR)	%
1. Prevention of sexual transmission of HIV	1,987,053.00	4.14
2. HIV prevention for people who inject drugs	3,640,565.00	7.59
3. Prevention of mother to child transmission (included in 4.)	-	-
4. Universal access to treatment	1,851,566.78	3.86
5. TB	571,529.00	1.19
6. Governance and sustainability	1,163,740.00	2.43
7. Critical enablers	108,327.00	0.23
8. Synergies with development sectors	38,588,577.00	80.5
9. Addendum items / Non-core global / Other	49,858.00	0.10
Total	**47,961,215.78**	**100**

Source: National AIDS Council 2014

As external partners reduce their financial assistance to Seychelles, the government accounted for almost 99% of expenditure in HIV and AIDS whereas other multi-lateral partners including private sectors account for the remaining 1% of the total expenditure. Social protection accounts for 81% of the funds, whilst critical enablers are lowest at 0.23%. As antiretroviral therapy becomes more universally accessible globally, the cost of ARV treatment has gradually reduced from SR 11 million in 2011 to SR 1.3 million in 2014, even if the number of patients on treatment has increased.

During the exercise, obtaining data on HIV/AIDS from other government organisations and civil society other than the National AIDS Council and Ministry of Health still remains a challenge. This will be improved through the development of an appropriate reporting mechanism by the National AIDS Council with the review of the National HIV and AIDS Strategic Plan.

Programmes Implemented

With the transformation of the National AIDS Council (NAC) into a legal entity in December 2013, the **National AIDS Trust Fund** (NATF) established in March 2002 (S.I. 6 of 2002) under the Public Finances Act (*Cap 188A*) was repealed**.** Instead, all funds are being managed by the Council in accordance to the Act.
Based on the low national HIV prevalence and being a middle income country, the Seychelles has not benefitted from the Global Fund grant or PEPFAR.

The government of Seychelles contributes annually to the NAC fund. The government contribution amounts to US$ 100,000 annually since 2008. It is specifically for prevention, treatment, care, support, enabling environment, research, monitoring and evaluation. The source of fund is derived from revenue collection levied from business, personal income tax, value added Tax (VAT) of commodities and services, Gainful Occupational Permit (GOP) from migrant employee, selling of assets, Social Security and other taxes

The purpose of the National AIDS Council Fund is to attract, manage and disburse additional resources through a multi-sectoral partnership that will make a sustainable and significant contribution to the reduction of infections, illness and death, thereby mitigating the impact caused by HIV and AIDS in Seychelles, and contributing to the achievement Millennium Development Goals (MDGs).

From 2008-2013, the NATF received 70 applications of projects for funding of which 86% were approved and minimum implementation stage ranged from one week to three years.
In 2014, 12 out of 15 applications were approved to a total amount of SR 1,108,212, which represents 85% of original funds requested.

Target 7. Eliminating Gender Inequalities

Gender inequalities

Seychelles has a good record of gender equality, with the achievement of MDG 3: the elimination of gender disparity in primary and secondary education in all levels of education by 2015. Even if there is relatively little data for this indicator, there are mechanisms in place to track Gender Based Violence (GBV), such as the monitoring that takes place at institutions which include the Police Department for self-initiated reports, Social and Probation Services for service provider initiated reports and the Family Tribunal, which also records GBV in its cases. The **Gender Secretariat** has also developed a ***Costed National Action for Gender Based Violence for the Republic of Seychelles*** and it also monitors issues such as Gender-Based Financing and Budgeting.

The data collected from various institutions do not permit to know the proportion of ever-married or partnered women aged 15-49 who have experienced physical or sexual violence from a male intimate partner in the past 12 months. Estimates may be as high as 50%, given the number of cases registered. The national strategic framework focuses on women living with HIV and AIDS, as one of the populations that need special attention. Regulatory framework is available with clear laws such as the ***Family Violence Act 2000, Employment Act 1995*** and the national action plans, but the gap is in the enforcement of the legislation and implementation of the national action plan.

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

The ***Draft National Policy on Gender*** which uses the ***SADC Protocol Gender and Development*** targets to be achieved by 2015 also provides some guidelines about what Seychelles needs to do to improve the participation and empowerment of men and women in socioeconomic development of the country. In the Draft Policy, the government makes a commitment to '*ensure that economic policies and programmes are gender responsive, address poverty and increase decent work and entrepreneurial opportunities equally for women and men.*' The main objective is to '*… ensure women and men have full and equal access to, control over and ownership of the benefits of socio-economic growth and development*

It is also important to note that HIV prevalence is higher in males than females in Seychelles, contrary to the pattern on the African continent. This issue needs to be effectively addressed, as the perception of gender issues is still focused on women and girls, even when data shows that

men are at a disadvantage in education, life expectancy and burden of NCD and in HIV and AIDS. Again the Gender Secretariat notes that "*Gender is everybody's business, not an issue that concern only women or the Ministry holding the portfolio responsibility*."

Between 2011 and 2014, Probation Services registered a total of 1902 new cases of domestic violence. Of theses, 78% were women and 22% were men.
Family Tribunal reports from the same period indicate that of the 659 persons who applied for a protection order, 90% were female and 10% male.
A survey on domestic violence is scheduled for 2015 pending funding.

Programmes Implemented

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

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

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

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

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

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

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

- Civil society is actively engaged in gender issues with a wide variety of non-governmental organizations including community-based organizations conducting nation-wide programmes: WASO for economic empowerment; Alliance of Solidarity for the Family (ASFF) for reproductive rights; Entreprendre au Feminin Océan Indien Seychelles chapter (EFOIS) for women craft workers and artisans; Seychelles Association of Women Professionals (SAWOP) assisting in personal development of their members; and Soroptimists Seychelles helping to fund charitable activities and

groups.

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

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

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

Target 10: Strengthening HIV Integration

Orphans school attendance

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

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

The trend of primary school enrollment from 1991 to 2012 averaged 99%. Enrollment ratio in some years is above 100, notably from 2010 to 2014. There seems to be no discernible inequalities for this target. Parents readily enroll their children for primary school. Indeed, they also seek to enroll their children for kindergarten or crèche which is not part of the compulsory education requirement as dictated by the Education Act (2004). The trend of primary school completion rate from 1991 to 2014 is also relatively high, averaging above 100% for both sexes.

There is real concern as a number of children placed in government or faith-based institutions could be classified as social orphans as family fabrics break down often from the scourges of drugs and alcohol.

Programmes Implemented

- There are various social programmes such as the **Dedicated Fund (government) through which parents can seek assistance**. The Fund is allocated to all state schools to ensure that no child is deprived of necessities that would affect their attendance to school. It is used for the following purposes: school meals, provide snacks mid-morning breaks,

school uniform and its accessories, pay for tailoring if necessary, stationery and assistance with bus fares. Cases are identified through self-referrals, district administrators, parents and teachers and parents have to apply for the assistance.

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

- Orphans who have lost both parents are either cared for by family members and **assisted financially by the government or are placed in foster homes.** However, a total number of 107 orphans or abandoned children are registered. In 2014, a total amount of SR 1,273,027 were paid out by the Agency for Social Protection as benefits to these children. There is a move by relevant agencies to have a separate register for biological orphans from social ones.

MAINSTREAMING OF HIV AIDS

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

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

Programmes Implemented

- A workplace policy has been reviewed and is being finalised in accordance to international norms and regulations;
- Focal persons were trained in HIV impact assessment in the workplace by UNDP officials;
- HIV and AIDS workplace focal persons have been trained in HIV & AIDS mainstreaming;
- **Outreach HTC posts** have been integrated into national community social activities including workplaces
- **Massive national sensitisation campaigns** were conducted through media
- Training of **key health professionals and non health people,** as well as civil society and private sector to help address various issues in the HIV and AIDS national response Strengthen the actions and presence of various civil society organisations in this area
- Training on Prevention and management of Reproductive health issues of non health actors.
- **Sensitisation of parliamentarians by civil society.**
- **Sensitisation of various groups,** e.g. professional groups (nurses, athletes); faith-based organisations (SIFCO, Roman Catholic clergy); the media (Media Association); NGOs (CEPS); the private sector (SCCI); community based organisations (Council for the

Elderly); and PLHIV associations (HASO).

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

V. BEST PRACTICES

POLITICAL LEADERSHIP

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

- There is also strong symbolic political leadership through the national coordinating organisation is the National AIDS Council (NAC). The President is the Patron of the NAC and supports the objectives and programmes of the national response. He has also spoken about the link between HIV and the needs of key populations and vulnerable groups. The Principal Secretary of Health is the Chairperson of the NAC Board, under the guidance of the Minister for Health.

- **NAC has become a statutory body** within the Ministry of Health, with an act of parliament to guide its works. NAC was restructured in 2014 to elicit more power, credibility and resources to coordinate, communicate, monitor and evaluate national programmes. The NAC Board is chaired by the Principal Secretary of Health and had 6 regular and 2 extraordinary meetings in 2014. The NAC also participated in validation of documents, namely, GARPR and "Getting to Zero" Consultative meetings.

- The NAC mobilised communities in "Getting to Zero" and "Test and Treat " campaigns through two large meetings with national media coverage with follow-up news items and special programmes on national radio, television and written press.

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

- Political leadership is also shown through the government allocation of funds to the National AIDS Council Fund which has replaced the repealed National AIDS Trust Fund. Both state and non-state actors are able to apply for funding for their projects and programmes. The Fund is administered by a Finance Sub-Committee of the NAC. Projects are submitted and scrutinised according to set criteria before selection.

- Other strong political leadership is indicated through **universal access to free treatment and care, including the use of overseas treatment and social welfare assistance to PLHIV.**

- On World AIDS Day 2014, the Vice-President launched the Test and Treat Campaign in Getting to Zero. He then proceeded to publicly having an HIV test. He was promptly joined by the Minister for Health and the Head of the Seychelles Inter-Faith Council (SIFCO). Stakeholders feel that this open and public gesture demonstrated both symbolic and/or real support to the national response to HIV and AIDS.

INFRASTRUCTURE DEVELOPMENT

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

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

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

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

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

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

- The faith-based **Centre d'Accueil de la Rosière (CAR)** acquired a missionary residence

in a quiet secluded area outside of the capital (Beauvoir, La Misère) to use as its rehabilitation centre. The Centre Anne-Marie Javouhey underwent renovations and accommodated its first clients in November 2014 for drug and alcohol rehabilitation services, which last 16 weeks.

- The **Wellness Centre at Les Cannelles** (opened in 2013) offers a second chance for drug addicts to embark on the first ever MAT programme. The service is providing clients with a safe drug free environment where client's are able to detox , explore and identify what personal changes they require to make in themselves and their environment to enable them maintain a drug free lifestyle.

- **"Nou La Pour Ou"** which literally translates to "We are here for you" is a non-profit, charitable NGO established in 2012. The NGO was initiated within the framework of "social rebirth" in the midst of arising social issues nationally. Its head office is based in Victoria, Mahe. Nou La Pour Ou, is fully dependent on resources and funds received by "Good Samaritans". Its main objective is to reach out and provide support and assistance to struggling single parent families, children with behavioural problems, prisoners re-entering the community, the hungry and homeless, at-risk youth especially the suicidal, and families affected by persons with substance abuse, and any other vulnerable groups; rekindling their faith and giving them hope.

A SUPPORTIVE POLICY ENVIRONMENT

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

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

PROGRAMMES IMPLEMENTED

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

- **EMTCT where coverage is almost 100%** in most years for both antenatal and post-natal service delivery for both mother and child, with **access to HTC, ART, nutritional support and good follow-up.**
- **Universal free (ARVs) treatment for all PLHIV**.

- **Blood and blood product safety**, with rigorous procedures and measures in place for testing.
- **Good integration of HIV/AIDS with TB management.** Moreover, HTC is also integrated in the health system and it is possible to **access services at all entry points** in the district and main public health centres.
- The **Ministry of Education** has established **a curriculum, the Personal and Social Education Programme (PSE)** which has its own trained teachers for secondary schools. In this programme, HIV and STIs are addressed in an age-appropriate manner. However, the programme is still not an examinable subject. The various other weaknesses of the programme have been addressed in the new national strategic plan for 2012 to 2016.
- The **Youth Health Centre** and partners conduct **outreach programmes with integrated HTC in post-secondary institutions.**
- The **Agency for Social Protection** provides **financial assistance to PLHIV** who require such. Confidentiality is maintained and the programme is available to all PLHIV without discrimination based on age, gender or race.
- The **Social Development Department** has finalised the N**ational Gender Policy** with the assistance of UNFPA and other external partners and developed a **draft** plan of action. These include taking into account the power dynamics of relationships and their role in mitigating or exacerbating the impact of HIV and AIDS and how they may also lead to greater incidence of HIV.

MONITORING AND EVALUATION

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

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

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

PROGRESS MADE ON KEY CHALLENGES REPORTED

Implementation of targeted programmatic actions for key populations: More civil society organisations are getting engaged in developing targeted programmes for key populations (men's health centre, including MSM – ASFF, peer education work - HASO). For the moment, the actions are timid, but there is momentum building for targeted programmatic actions for key populations. The major events precipitating such projects or programmes were the publication of

the results of the RDS survey on MSM and PWID, the finalisation of the national strategic plan for the period 2012-2016 and the holding, in Seychelles, of the Indian Ocean Colloquium on HIV and AIDS in the region.

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

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

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

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

Patients coming in late stage of the disease: This issue is similar to the one mentioned above and both are linked. With drop-outs and non-compliance, there are more patients that coming in with late stage of AIDS. Treatment is more difficult if not ineffective, placing further strain on the health system and affecting sustainability of programmes.
In 2014, 19 new cases of AIDS were diagnosed, of whom 13 were newly diagnosed patients.

Client-initiated HTC: Most HTC is still initiated by the service provider. To increase client-initiated HTC, perhaps there may be a need to have decentralised anonymous HTC services provided in non-health settings and by non-health professionals. In this way, the national response becomes even more multi-sectoral and addresses more adequately the needs of the public. In fact, more provider-initiated HTC should also be encouraged at various entry points into the health system, both public and private. The "Test and Treat Campaign" launched on World AIDS Day 2014 is expected to improve both provider- and client-initiated HIV testing.

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

Access to service by minors: The KAPB study showed that minors are not only engaged into early sexual relationship but taking risky sexual and illicit drug practices. The rate of teenage pregnancy is alarming. Reproductive health services including contraceptives, and HIV and hepatitis testing are not readily accessible in places most frequented by the youth.

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

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

Denial and risk-taking behaviour: Stakeholders note that there is a pervasive attitude of laissez-faire and denial around the issue of HIV and AIDS. Information is disregarded or discarded. People still engage in unsafe sexual practices and behaviours. The issue is not ignorance as KAPB studies do show quite widespread knowledge and understanding of HIV and AIDS. In spite of this, behaviour and lifestyle changes do not follow. There is thus a need to boost behaviour change communication interventions to reduce the levels and types of reckless behaviour. In the National Consultative Forum on HIV and AIDS in November 2014, participants expressed the need for more dialogue and educational sessions with the population at all levels.

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

CHALLENGES FACED THROUGHOUT THE REPORTING PERIOD

Inadequate Human resource Capacity:
Since the establishment of the AIDS Control Programme, it has had limited staffing with only a Programme Manager and a Health Promotion Officer. The secretary was posted to another section of the Ministry of Health in 2014.
The Director of Family Health and Nutrition Programme oversees five major programmes of the Ministry of Health namely: EPI, Chid Health, School Health Maternal Health, Family Planning (Reproductive Health) and Nutrition. From 2010 to 2014, the Director was the country editor and writer of the narrative reports for UNGASS and later, GARPR reporting.
In 2015, NAC took over the responsibility for country reporting.

Stigma and discrimination towards key populations and some vulnerable groups
HIV and AIDS are still considered as pariah conditions, even if reactions to PLHIV and people affected by HIV are gradually improving. There are still only two persons who have ever publicly disclosed their positive status: one is now deceased and the other is less active for the moment. There is still no specific law for HIV and AIDS. The only strong documents are the Constitution, the Employment Act, and the Workplace Policy. It has been acknowledged that it is

very difficult to prove workplace discrimination because the employer can simply use any other reasons to explain the dismissal.
Stigma and discrimination towards MSM, SW and PWID are also presently hampering access to services which have been well-integrated in the national health system. However, with the centralisation of HIV and AIDS management at the CDCU, some key population members are still reluctant to approach the site for medical and psychosocial services. It might be important to consider some decentralisation of services.

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

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

There is also a need to have early identification programmes and medical services for vulnerable women and their partners during the period of pregnancy and the early years of raising the baby, such as screening for drugs and alcohol just as is presently done for HIV, hepatitis C and other blood-borne viruses. These programmes must also include psychosocial support for parents-to-be and their children.
There is also an urgent need to provide services for heroin-dependent mothers and their babies to prevent having new generations of Seychellois falling prey to the scourge of drug dependence and its related health economic and social problems.

Access to Reproductive Health Services by 15-17 years
Evidenced based data from the IBBS 2013 shows that some minors are sexually active and the CDCU has records of minors infected with HV and Hepatitis C. The issue of contraceptives and HTC for 15 to 17 year olds remains an unresolved one, with this population being unable to access contraceptives, condoms even if the age of consent for sex is 15 years or the girl has had a baby before. Three emerging priorities are noted: reducing drug use amongst the age group of 15 to 25 years and thus reducing the number of heroin-dependent mothers, increasing targeted and well-delivered reproductive rights and health education sessions for adolescents and reducing child sexual abuse, which can account for the pregnancies of those younger than 15 years. Policy dialogue in 2014 between the Social Development Department and the Cabinet of Ministers and Attorney General have led to greater understanding of the issues at hand and easier handling of related cases.

Need for more outreach programmes
Even if at least 6 government health facilities are open 24 hours daily, government and civil society organisations still have services on site with specific opening hours. This situation makes

it harder for key populations to seek assistance. Some NGOs (ASFF, HASO), faith-based organisations (Roman Catholic and Anglican Youth Groups) and government agencies (YHC, Students' Support Services of the Ministry of Education) have started to train peers to provide targeted behaviour change communications. For now, the work is limited mostly to young people, especially those who are out-of-school. The church groups have started being present in key sites where SW gathers.
The Department of Community Development also engaged into outreach programmes for the sex workers.

Drop-outs and non-adherence to treatment
Defaults and non-compliance to treatment continue to be serious issues as depicted by the audit assessment of 2013. They are compounding the difficulties of management of clients. A number of clients are still reporting in late stage AIDS. Some have already developed resistance to the medicines, leading to treatment failure. This is an issue that needs to be addressed urgently as it also impacts on prevention and the goal of having "zero new infections". It also has an impact on sustainability of programmes as more people may contract HIV and the switch from one regimen to another.
The issue was discussed in depth at the Indian Ocean Colloquium in October 2014. On recommendation by UNAIDS, a Test and Treat Campaign was launched in favour of treating all patients as per preferred practices in a concentrated epidemic.

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

Table 12. Retention after ART Initiation

	Months after Initiating Treatment		
Retention in 2014	**12 months**	**24 months**	**60 months**
Sample Size	49	51	26
% sample	59	59	77
Lost to Follow Up	7	6	2
Stopped Treatment	5	8	1
Died	6	3	3

Source: CDCU: Public Health Authority

Patients coming in late stage of the disease
This issue is similar to the one mentioned above and both are linked. With drop-outs and non-compliance, there are more patients that coming in with late stage of AIDS. In 2014, 13 of the 91 new cases, were patients already in AIDS stage. Treatment is more difficult if not ineffective, placing further strain on the health system and affecting sustainability of programmes.

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

initiated HTC should also be encouraged at various entry points into the health system, both public and private.

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

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

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

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

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

CONCRETE REMEDIAL ACTIONS THAT ARE PLANNED TO ENSURE ACHIEVEMENT OF AGREED TARGETS

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

Table 13: Major Challenges and Concrete Remedial Actions

Challenges	Concrete Remedial Actions
Adequate Human resource in HIV Coordination	o NAC Secretariat must be equipped with a full team for effective coordination of the response
Implementation of targeted programmatic actions for key populations	o Review National Strategic Plan for HIV and AIDS o Conduct mapping exercise and gap analysis o Harm reduction measures clearly highlighted in the National HIV and AIDS strategic plan 2012-2016 o Civil society encouraged to apply for project grants, through NAC or international donors, to implement IDU needle exchange programmes o NGOs and FBOs have begun pilot programmes targeting MSM and SW o Amend the Misuse of Drugs Act (1995) o Study in the SW and prison inmates
Stigma and discrimination towards key populations and some vulnerable groups	o Proposal to have a HIV and AIDS Act o Inform the general population and key groups of their rights and how to seek redress for alleged violations of these.
Strengthen programmes for Maternal Care	o Study the population group to know the extent of the issue o Review the ANC protocol
Access to Reproductive Health Services by 15-17 years	o Undertake a youth study on sexual reproductive health o Implement the SRH minor protocols o Validate the Youth Policy
Need for outreach programmes	o Some CSOs have limited peer education programmes. There is a need for these to be scaled up.
Drop-outs and non-adherence to treatment	o Implement 2013 audit report recommendations by the auditor general o Study proposed on causes of drop-out, default and non-compliance to treatment o Trace and retain current drop-outs
Patients coming in late stage of the disease	o Conduct a "Test and Treat campaign"
Client-initiated HTC still rare	o Propose to have provider-initiated HTC in all entry points o Decentralise treatment services o Encourage involvement of NGOs in HTC, e.g., ASFF
Sustainability (funding issues)	o Focus on targeted prevention for key populations to reduce incidence to ensure that the epidemic does not increase o Advocate to Global Fund o Follow up joint regional proposals for Global Fund o Conduct training in National AIDS Spending Assessment
Empowering peers	o Strengthen peer education training by NGOs (ASFF, LAMP, ELM, Youth Alive) and YHC
Unprotected sex	o Conduct targeted prevention with key populations, including peer education and outreach activities, focusing on behaviour change communication, HTC and adherence to medication
Denial and risk-taking behaviour	o Strengthen school based programmes o Conduct targeted interventions to MARPs
Gender inequalities	o Implement National Gender Policy o Finalise National Gender Plan of Action and National Gender-Based Violence Plan of Action

VII. SUPPORT FROM COUNTRY DEVELOPMENT PARTNERS

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

Table 14. Contributions from Development Partners to the National Response to HIV and AIDS and STIs

2012	2013	2014
14.1 UNAIDS		
• A UN Volunteer Technical Advisor (UNVTA) on HIV/AIDS, Mr Jacques Sindayigaya worked in Seychelles from December 2009 to February 2012 helping to strengthen the national response to HIV/AIDS. He was based at the Ministry of Health • Technical support given in the formulation of the new national HIV/AIDS strategic framework 2012-2016, the monitoring and evaluation framework 2012 and cost operational plan 2012-2016. • Partially supported the formulation of the Modes of Transmission Study (MOT) for 2011 and since the exercise was not completed, the follow up will be undertaken in 2012 • Technical support and funding for the drafting of the national strategic plan for HIV&AIDS and STLs 2012-2016 • Participation of 5 Seychellois to the HIV/AIDS colloquium in 5 held in the Comoros 5 in	• Supported 1 participant from Social Department to attend the SECOND HIGH LEVEL MEETING OF THE Global POWER Africa Network • Training of 2 participants in HIV "Regional HIV&AIDS Estimates and Projections workshop" for countries of the Middle East and North Africa Region • Supported one participant for Regional Meeting on the Investment Approach and Investment Cases for HIV • Technical support for the Legal the development of the Legal Assessment framework	• Executive Director Mr Michel Sidibe conducted a visit to the Seychelles in April 2014 and held advocacy meetings with high government officials, UN partners and local stakeholders. He was accompanied by Drs Pierre Somse and Claire Mulanga • 2 Additional support visits to Seychelles by Dr Claire Mulanga, representative for Indian Ocean islands • Funded 3 participants to attend their meeting on UNAIDS Regional Consultation on the Retargeting Process for HIV and AIDS in Johannesburg in 19-20 May 2014 • Dr Eleanor Gouws, Regional Strategic Information Adviser conducted on 10-14 September an assessment of available data required for SPECTRUM and MOT studies for retargeting of the epidemic in Seychelles Prof Robin Williams made presentations on most cost-effective interventions in HIV and AIDS • Funded 4 participants to attend the Indian Ocean Colloquium in

2012	2013	2014
Mauritius in 2013		Reunion in October 2014
14.2 WHO		
• Financial support for Sexual reproductive health strategies including men's health programme supported • Men's study • Procurement of equipment - 50 scales, BP apparatuses and accessories • Development of costed minimum maternal and newborn service package • Capacity building of 30 participant stakeholders	• Technical support for training of HTC health professional and development of HTC tools • Promotion of Child Health programme supported • Sustenance BFHI activities • Support of 2 for review and planning of FRH Programmes	Provided both technical support and financial support to national programmes (USD 13,847) • Procurement of GenXpert Consumables • Production and printing of TB information leaflets Participation in international • Workshop on GBV, addressing gender inequalities and HIV/AIDS prevention
14.3 UNFPA (*Integration through the annual POA and extra-budgetary funding of the UNFPA/ Seychelles Country Programme Action Plan (CPAP) 2012-2015)*		
Reproductive Health • Training on management and delivery of user friendly RH/FP services • Training in integration of HIV and RH/FP services at the community level • Developing of BCC materials (including for people living with disability) • Review of family planning procedure manual • Development of Monitoring and Evaluation Framework for National RH Strategy *Population Issues* • Advocacy for mainstreaming/ integrating population issues in national and sectoral plans and policies *Gender Equality* • Trainings in GBV and care for victims for the police, health, social services, judiciary, prisons and education sectors • Validation of National	*Reproductive Health* • Training in integration of HIV and RH/FP services at the community level • Advocacy for increased and sustained resources (financial and human) for RH/FP services and essential commodities • Training in evidence based planning, monitoring and evaluation among the RH/FP service providers • Training workshop on designing male oriented RH/FP services. *Youth Adolescent Sexual & Reproductive Health and HIV* • Developing and adoption of National Minimum Standards for Youth Peer Education for RH/FP/HIV • Training of PSE teachers in management and delivery of RH/FP/HIV information in learning sessions • Technical assistance in conducting Knowledge,	*Reproductive Health* • Capacity building in management and delivery of user friendly RH/FP services, integration of HIV in these services at community level, and prevention and care for reproductive health cancers. • Development of behaviour change communication (BCC) materials for different population groups including persons living with disability. • Following a study done in 2013, training of service providers and development of BCC materials aimed to improve male health seeking behaviour / involvement • Support the CARMMA launched in 2013, which includes men's health. *Population Issues* • Review of previous plan of action and development of a second generation National Plan of Action on Population & Development *Gender Equality*

2012	2013	2014
Gender Policy and development of National Gender Plan of Action • Consultative Workshop for Costing National Gender Plan of Action • Advocacy for mainstreaming gender issues in national and sector plans and policies • Developing national media plan on GBV *Youth Adolescent Sexual & Reproductive Health and HIV* • Advocacy for decentralization or services • Training in integrated Youth friendly RH/FP/HIV services and service quality assurance • Advocacy meetings for review/harmonization of restrictive laws in access to contraceptive among young people below 18 years • Peer/life skill education and community outreach events for hard to reach youth populations including youths and adolescents in school • Developing BCC materials targeting change in risky behaviours (i.e. multiple concurrent sexual partnerships, lack of/ inconsistent condom use at high risk sex, drug use, early initiation of sex) among youths and adolescents • Skill building workshops for youths in Peer education, networking and project leadership skills *HIV Services* • Training on provider initiated HIV Testing and Counselling (HTC) for service providers especially non health service providers	Attitudes, and Practices national survey related to risks of pregnancy and transmission of HIV and STIs among youths aged 15-24 years • Developing Adolescent and Youth Sexual & Reproductive Health and Development Policy, and implementation plan *Coordination, Monitoring & Evaluation* • Funded and supported one fulltime UN Volunteer, Mr Vincent Okullo	• Sensitization for health service managers (include police, health, education, social services, judiciary, and prison sectors) on GBV and care for victims. • Advocacy for mainstreaming gender issues in national and sector plans and policies *Adolescent and youth sexual and reproductive health* • Development of Adolescent and youth sexual and reproductive health % development policy to provide an evidence based policy document, improve prominence and clarity to policy and regulatory issues, and provide a platform of actions to address related issues. • Peer/life skill education and community outreach activities to reduce risks by adopting safe and healthy behaviours in both school and hard to reach youth. • Developing BCC materials to disseminate information and improve awareness among young people on risks associated with behaviours including drug use, multiple sexual partnerships and unprotected sex, and how to reduce risks by adopting safe and healthy behaviours. *HIV and AIDS* • Training of Trainers' Course in HTC to equip nurse managers with knowledge and skills in HTC including training/facilitation skills • Joint government/ community sensitization and mobilisation meetings targeting key populations, • Participation in the Indian Ocean Colloquium to discuss mechanisms to find patients lost to follow up and put in systems

2012	2013	2014
• Validation, printing & dissemination of national HTC guideline • Review and updating HIV and STI guidelines		for better monitoring of patients *Coordination, Monitoring & Evaluation* • Support both locally and by UNFPA Madagascar for optimal coordination, monitoring and evaluation of the programme • Purchase of office equipment • Visit by UNFPA representative in August 2014 • Participation in retreat in Madagascar by local focal person
14.4 UNDP		
	• Supported Funding of the implementation of the Legal Assessment Framework	• Training (2 days) by Ms Bryony Walmsley in Mainstreaming HIV/Health and Gender-Related Issues into the Environmental Assessment Process following assessment by Mr Benjamin Ofuso-Koranteng, Policy Advisor for Mainstreaming HIV and Health into Development Planning, UNDP Regional Centre for Africa based in Addis-Ababa, Ethiopia (USD 6000)
14.5 UNODC		
	• Training of TRIP-NET for 30 participants	• Training of Stakeholders and partners in the management of intravenous drug users in November 2014 by Ministries of Internal Affairs and Department of Social Development • Professor R Douglas Bruce of Yale University in July conducted an assessment of, and made recommendations on, the national methadone programme. He also made presentations on TB, HIV and Drugs to TAC, NAC and the staff at the Wellness Centre.
14.6 SADC		
Technical Support • TB Managers meeting and partnership Forum	• SADC Regional Consensus & Validation Meeting SADC Book of Best Practices for	• Funded local participants to attend a series of meetings for capacity building in various

2012	2013	2014
• Monitoring & Evaluation meeting • Annual Review Meeting Member States HIV & AIDS Mainstreaming Focal Persons Forum • Regional Technical Meeting on HIV Related Indicators for Selected Non Health Sectors • Regional HIV& AIDS Research agenda • HIV Prevention and Research Meeting • Meeting to Review Year One of Implementation of HIV Funds Projects • Regional Consultation on Key Population meeting	Child and adolescent HIV, TB and Malaria Continuum of Care and Support" • Funding of 4 participants to a meeting in Johannesburg to develop "Minimum Standards for HIV and AIDS and Hepatitis in Prisons" • Development of joint proposals for the SADC HIV and AIDS fund Round II	thematic areas, namely HTC, PMTCT, STI management • Funded 2 participants to attend review meeting for Round II proposals in September 2014 in Johannesburg • Approved a regional project for funding in Round II entitled "Behavioral Survey in Female Sex Workers in Angola, Mauritius and Seychelles" for a total of USD 500,000
14.7 ARASA		
• Training of Trainers on HIV, TB, advocacy and Human Rights, Monitoring and Evaluation (2 participants) • Financial assistance for local advocacy projects	• Training of Trainers on HIV, TB, advocacy and Human Right, Monitoring and Evaluation (2) participants)	• Included Seychelles as potential beneficiary in their regional project concept note to Global Fund entitled: Investing Impact against HIV, TB and Malaria"
14.8 KANCO (Kenya Consortium of NGOs)		
		• Included Seychelles as potential beneficiary in their regional project to Global Fund entitled: "HIV and Harm Reduction in Africa"

VIII. MONITORING AND EVALUATION ENVIRONMENT

OVERVIEW OF THE CURRENT MONITORING AND EVALUATION SYSTEM

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

The national workplace policy is being reviewed and a new one will soon be finalised. The national strategic framework also consists of a costed action plan and monitoring and evaluation framework to ensure that progress is adequately measured.

The surveillance of the epidemic is conducted at sentinel points, such as the antenatal clinics, Communicable Disease Control Unit (CDCU), antenatal clinics, Occupational Health Unit (OHU) and the blood bank in the Ministry of Health and reveals that there is an increasing trend in HIV infections.

The ***National Strategic Plan for the Prevention and Control of HIV and AIDS and STIs 2012-2016,*** includes a National Multi-Sectoral Monitoring and Evaluation Framework (2012)

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

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

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

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

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

Moreover, NAC should also have an M&E unit operated by trained and qualified personnel to help monitor and evaluate the national response. Support is further provided by the Ministry of Health Disease Surveillance and Response Unit which collects, collates and maintains data on all diseases reported to health centres in the country, including HIV and its related morbidity and mortality. This is in line with the national development plan which places focus on the need to

collect data and to ensure that statistics are properly kept so that progress on all national targets, including health ones, are noted and used for future planning.

Apart from the mid-term review of the National HIV and AIDS strategic Plan 2012-2016, studies supported by UNAIDS, including those for Modes of Transmission, SPECTRUM, NASA, Mapping Exercise and Gap Analysis have been postponed to 2015.

CHALLENGES FACED IN IMPLEMENTING A COMPREHENSIVE M&E SYSTEM

The 2013 NCPI indicated that while all the M&E framework and structures are in place, some national stakeholders are unaware of all the work that has been done and all infrastructure established to have a robust M&E for HIV, AIDS and STIs. Therefore, there is a need for proper communication to all stakeholders about the history of the work done and what is proposed in the National Monitoring and Evaluation Framework, so as to build consensus amongst stakeholders. Other challenges noted are limitations in human resources and technical capacity, lack of information about the content, key populations and geographical coverage of HIV services, as well as their implementing organizations. It would be worth it to explore the details further with national stakeholders and conduct a mapping exercise.

However, evidence shows that most respondents to the 2013 NCPI were present for various meetings in relation to the development of the national multi-sectoral monitoring and evaluation framework both in 2010 for the preliminary work and in 2011 for the finalisation of the document. However, many seem to have forgotten their involvement which may imply that the process has not been meaningful enough for them to retain institutional memory of it.

REMEDIAL ACTIONS PLANNED TO OVERCOME THE CHALLENGES

The NAC has the responsibility to coordinate and communicate about the national response. During the GARPR exercise, national stakeholders are educated on relevant indicators in the National Multi-Sectoral Monitoring and Evaluation Framework. This is important as the projects and programmes, including those of NGO programmes and projects seeking funding, will be judged as effective and viable based on the measures taken from set targets and indicators.

Following a National Consultative Forum on HIV and AIDS on 6th November 2014, the national Test and Treat Campaign was launched on 1st December 2014. These were golden opportunities for members of the public and national stakeholders to be made aware not only of UNAIDS 10 targets and national goals and objectives, but also inform on international and national indicators used to track progress. National media covered such events extensively and the community voiced opinions on their concerns.

NEED FOR M&E TECHNICAL ASSISTANCE AND CAPACITY-BUILDING

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

- Epidemiology Statistics, storage and use of strategic information

- Health and social research methodology / tools already in use by other organisations and countries
- Policy planning and development
- Capacity-building

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

ANNEXES

ANNEX 1. CONSULTATION/PREPARATION PROCESS FOR THE COUNTRY REPORT ON MONITORING THE PROGRESS TOWARDS THE IMPLEMENTATION OF THE DECLARATION OF COMMITMENT ON HIV AND AIDS

1a. NAC Board members Advocacy meeting on 19th March 2015

Name	Title
Mrs Peggy Vidot	Principal Secretary (PS) Health; Chairperson of the Board
Dr Haresh Jivan	Private Practitioner, Vice-Chairperson
Dr Jude Gedeon	Public Health Commissioner
Bishop Denis Wiehe	Chairperson Seychelles Inter-Faith Council (SIFCO)
Mrs Marie-Nella Azemia	Member Citizens Engagement Platform of Seychelles
Ms Anna-Lisa Labiche	Member Health Professionals Council HPC/ Allied Health Professional
Mr Marco Francis	Chairperson Seychelles Chamber of Commerce and Industry (SCCI)
Mr Justin Freminot	Chairperson HIV/AIDS Support Organisation (HASO)
Ms Fatoumata Sylla	Director General, Secretariat of the Secretary General, President's Office (Youth)
Dr Jastin Bibi	Representative Seychelles Medical & Dental council (SMDC)/ Director Epidemiology & Statistics, Public Health Authority
Mrs Marie Jenny Marie	Member Seychelles Nurses & Midwives Council (SNMC)/ Senior Nursing Officer Maternity Unit
Dr Anne Gabriel	Chief Executive Officer National AIDS Council (NAC)/Secretary

1b: HIV AIDS Technical Advisory (TAC) agreement and consensus of GARPR Indicators Meeting on 19th March 2015

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

1c: Stakeholders Validation Meeting on 10th April 2015

NATIONAL AIDS COUNCIL

UNAIDS
GLOBAL AIDS RESPONSE PROGRESS REPORTING 2015
SEYCHELLES

One Half Day Validation/Workshop
10th April, 2015

Registration Form

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24				
25				
26				

ANNEX 2: DATA SOURCES AND REFERENCES

1. Public Health Authority Disease Surveillance and Response Unit (DSRU) *Annual Epidemiological Reports 2013 and 2014*
2. Public Health Authority Communicable Disease Control Unit (CDCU) *Annual Report 2014, Surveillance Data and Patient Registers*
3. Public Health Authority AIDS Control (ACP) *Programme Policy and National programme data*
4. Health Care Agency, Directorate of Family Health & Nutrition Programmes, *Reproductive Health Programme, Annual Reports*
5. Health Care Agency, Directorate of Family Health & Nutrition Programmes, *Child and School Health Programmes Annual Reports*
6. Health Care Agency, Community Health Directorate, *Youth Health Programme Annual Reports*
7. Health Care Agency, *Pharmaceutical Services Annual Report 2014*
8. Health Care Agency, *Clinical Laboratory Surveillance Data 2014*
9. Ministry of Health (2011) *Injection (sic) Drug Use Integrated Biological and Behavioural Surveillance Survey Round 1*
10. Ministry of Health (2011) *Men Who Have Sex With Men: Integrated Biological and Behavioural Surveillance Survey Round 1*
11. Ministry of Health and Social Services, Social Development Division (2006) *National Plan of Action on National Development 2005 – 2015*
12. Ministry of Health (2001) *National Policy for the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles*
13. National AIDS Council (2012) *National Policy for the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles*
14. National AIDS Council (2012) *National Strategic Framework for HIV and AIDS and STIs 2012 – 2016*
15. National AIDS Council (2012) *National Costed Operational Plan on HIV and AIDS and STIs*
16. National AIDS Council (2012) *National Multi-Sectoral Monitoring and Evaluation Framework for HIV and AIDS and STIs*
17. UNDP *Seychelles Common Country Assessment Report 2010*
18. Ministry of Foreign Affairs (2012) *Draft Report of the Implementation of the International Covenant on Civil and Political Rights (Seychelles)*
19. National AIDS Council (2011) *Final Report on the Evaluation of the HIV/AIDS NSP 2005-2009, Updating of the National Policy on HIV/AIDS and Other STIs, and Road Map for NSP 2011-2015*
20. Ministry of Health (2012) *Domestic and International AIDS Spending by Categories and Sources*
21. National Bureau of Statistics (2011) *Population and Housing Census 2010: Preliminary Results*
22. National Bureau of Statistics (2011) *Population and Vital Statistics: No. 2 of 2011*
23. Ministry of Foreign Affairs (2013) *Seychelles Millennium Development Goals Status Report 2013*
24. *Situation Analysis of Legal and Regulatory Aspects of HIV and AIDS in Seychelles final report 2013*
25. Ministry of Employment (1995) *Seychelles Employment Act 1995*
26. Ministry of Legal Affairs (2013) *Assessing the efficiency of the management of treatment for people living with HIV and AIDS Report of the Auditor General*

27. Ministry of Health (2013) *The HIV, AIDS and STIs Knowledge, Attitudes, Practice and Behaviour (KAPB) and Biological Surveillance Study Report for Seychelles*
28. Ministry of Health (2013) *Social Behaviour Change Communication Framework*
29. Ministry of Health (2012) *Introducing Medically-Assisted Therapeutic Services in Seychelles*
30. Ministry of Health and Social Development: *Report on Situational Analysis of the Institutional Response to Domestic Violence*
31. Ministry of Foreign Affairs: *Seychelles Millennium Development Goals Status Report 2013*
32. Ministry of Employment *National HIV AIDS Workplace Policy 2013*
33. *National AIDS Council ACT 2013*
34. International Labour Organization *General Conference R200 - HIV and AIDS Recommendation, 2010 (No. 200) Recommendation concerning HIV and AIDS and the World of Work Adoption: Geneva, 99th ILC session (17 Jun 2010) - Status: Up-to-date instrument*
35. Ministry of Health, *Rates of Services 2014*
36. National AIDS Council *Annual Report 2014*

ANNEX 3 – NATIONAL AIDS SPENDING BY CATEGORIES AND FINANCING SOURCES

(See separate document)+

ANNEX 4 : ENDORSEMENT OF REPORT

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