GLOBAL AIDS RESPONSE PROGRESS REPORT

REPUBLIC OF MAURITIUS

NATIONAL AIDS SECRETARIAT

MARCH 2012

PRIME MINISTER'S OFFICE

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

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

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

FOREWORD

The Republic of Mauritius is signatory to the 2011 Political Declaration on HIV/AIDS and is striving to meet the Millenium Development Goals. The 2012 Global AIDS Response Progress Report provides valuable information on the status of the country programmatic achievements towards respecting these solemn commitments.

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

This reporting round has witnessed significant improvements in the quality and quantity of data and information due to improvements in M&E systems, availability of data from serial Integrated Behavioral and Biological Surveys among Key Affected Populations and the Behavioural Surveillance Survey 2011.

The respondents included policy makers and programme managers of various national and international agencies. Following data collection, the draft findings were disseminated to stakeholders for validation and adoption.

The findings of this report highlight the fact that, although the country has made significant progress in a number of areas, namely PMTCT coverage and harm reduction among KAP, as well as data collection, analysis, and its use to monitor and evaluate programmes, we still need to make progress to reach universal access targets in certain programme areas such as HIV testing and counselling, life-skills education and condom use, among others.

A major lesson learnt during the GARPR preparation is the importance of maintaining a strong M&E system in order to track progress made in the implementation of HIV programmes. There is therefore need for further investments to strengthen the M&E systems in the country.

It is hoped that policy makers and program managers will focus on their respective indicators and targets to ensure improvements in implementation as well as in resolving existing challenges in order to close the gaps in provision of high quality services to the population of Mauritius.

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

I further wish to express my sincere thanks to the National M&E Technical Committee that provided technical guidance to the reporting team. My special thanks go to Ms Sarah Bibi Goulamally Soobhany, Mr Ramnarain Radhakeesoon and Ms Monica Deol from the National AIDS Secretariat for their assiduousness in compiling this report.

My thanks goes to Mrs Bharati Woottum and Mrs Kirpal Usha from the AIDS Unit of the Ministry of Health and Quality of Life who facilitated the data collection.

Heartfelt thanks to Mr Navin Rughoonundun and his team for the NASA Report.
I wish to point out that this report has been written solely by national officials, without any external technical assistance. It is therefore a clear indication that in-country capacity has been built through technical assistance that was kindly provided by the UNAIDS during the compilation of previous UNGASS reports for which I wish to express my gratitude.

Dr Amita Pathack,
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Mauritius

AKNOWLEDGEMENT

This 2012 Global AIDS Response Progress Report was prepared by the National AIDS Secretariat, Prime Minister's Office, with the support of the Ministry of Health and Quality of Life and the UNAIDS Country Office.

The report is based on contribution made by all key stakeholders involved in the National Response to HIV. Data on the GARPR indicators were provided by the MOH &QL departments such as the AIDS Unit, National Day Care Centre for the Immuno-suppressed, NEP, MSM and CSW programmes, TB programme, and Central Health Laboratory. Lines Ministries,such as that of Education, Youth and Sports, Social Security, Labour and Industrial Relation. Women and Child development. The Central Statistical Office has also made valuable contribution through the NCPI and during the consensus meeting to validate all the data.

As the process was a multi-sectoral one, the contribution of civil society and private sector during consultative meetings and validation workshop needs to be highlighted. As a result of their efforts, this report captures the inputs and manifold views of the civil society organisations at various levels.

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

The NASA was prepared by Mr Navin Rughoonundun, the Finance Manager of NAS in collaboration with his team.

Data was compiled, consolidated, analysed and reported by Mrs Sarah Soobhany, Programme Officer; Mr Ramnarain Radhakeesoon ,M&E Manager ,NAS and Mrs Monica Deol, M&E assistant , NAS.

I. Status at a glance

(a) The inclusiveness of the stakeholders in the report writing process

This is the fourth report from the Republic of Mauritius. In preparing the fourth Country Progress Report, the guidelines on construction of core indicators were followed as outlined in the document with minor adaptations to the national situation.

The report also details examples of best practice in mitigating the impact of HIV and AIDS, presents a brief outline of some of the challenges the country faces in meeting the goals it has set itself and the associated remedial action, it also outlines the role of the development partners in addressing the national response to the epidemic and the Monitoring and Evaluation environment. This approach seeks to build on the flow from the 2010 UNGASS report in a manner that highlights progress made.

This Country Progress Report represents the broad stakeholder consensus position on the progress made and continuing challenges to meet the Global AIDS Response on HIV and AIDS. The process of compiling the Country Progress Report was taken through various stages of consultation. The initial stage was mainly a preparatory and planning stage; the second stage involved the collection of data through interviewing key stakeholders from national, organisation-based data sources. The Lines Ministries which participated in providing access to available data were: the Ministries of Health and QL, including the AIDS Unit and the Central Health Laboratory, Social Security, Finance, Education and the Prisons Department. Other data come from donors ,development partners and non- governmental organisations.

All key stakeholders involved in the fight against HIV and AIDS were invited to a meeting on the 21st December 2011 during which they were informed about the GARPR and were also given the National Composite Policy Index questionnaire. A core Team was constituted with the following members:

- M&E Manager, M&E assistant, Programme Officer and Finance Manager –National AIDS Secretariat
- M&E focal Person- MOH &QL

- M&E focal Person- MFPWA
- M&E focal Person- PILS

The core team met on the 9th February 2012 to review the work accomplished and decided on the following:

- To meet on a weekly basis to review work accomplished; and
- To discuss roadmap for a first draft report.

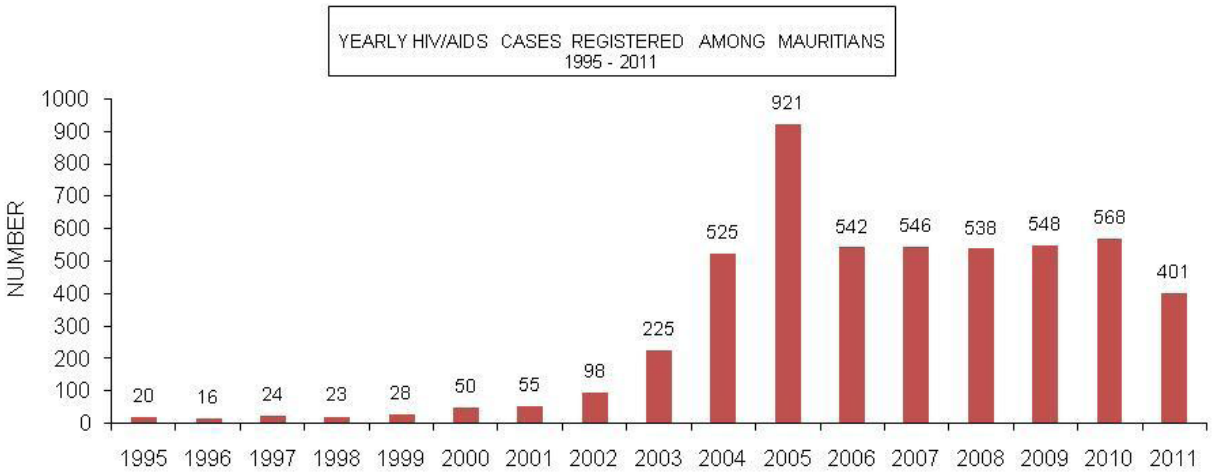
The first draft Country Progress Report was presented and discussed at the meeting held on 13th March 2012. The meeting agreed on a further consultative session arranged for the 23th March 2012, to provide a further opportunity for comment and discussion on the pen-ultimate draft report before finalisation. Data verification was also done with all organisations that provided indicator data with a view to presenting a revised report at the above- mentioned stakeholder meeting.

The final stage entailed discussion of the revised draft Country Progress Report through a constant exchange of mail between main stakeholders until consensus was reached. The pen-ultimate draft report was revised based on the comments and inputs made by stakeholders.

(b) The status of the epidemic

In the early 1990's the Republic of Mauritius was registering few positive cases. As from the year 2000, HIVand AIDS registered cases doubled each year to reach a peak of 921 in 2005.

Fig 1: Number of new HIV registered cases .

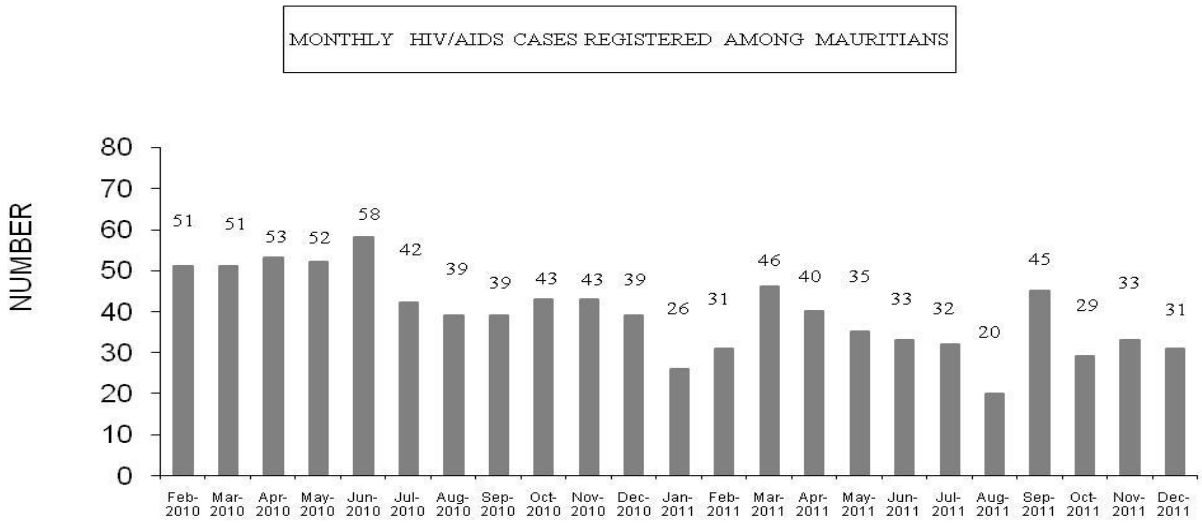


As at 2006 this rate in annual HIV incidence seemed to reach a plateau with an average of 540 cases annually till 2011 when a drop to 401 cases was observed. The monthly reported cases also dropped from an average of 50 cases in the past 5 years to 30 cases in 2011.

As at December 2011, 5,188 cases of HIV and AIDS had been detected cumulatively, out of which 1028 (19%), are females. The total number of known deaths registered among PLWHA is 533.

In 2010, 93 deaths were reported among people living with the virus compared to an annual average of 52 between 2005 and 2009. In 2011, 56 deaths were registered.

Fig 2: Monthly reported cases

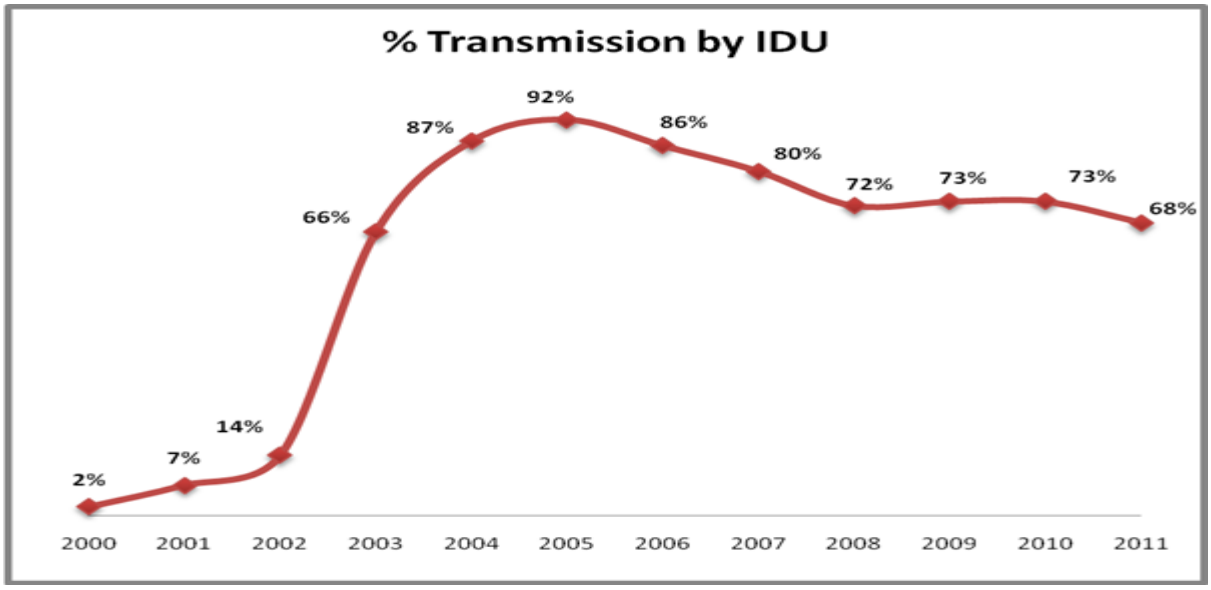


Since 1987, of all Mauritian HIV and AIDS cases, 74.5% of transmission was due to transmission through injecting drug use. In the year 2000, only 2% of the new infected cases were among PWID and gradually increased to 92% in 2005.

Following the introduction of Harm Reductions measures in 2006, transmission among the PWID steadily reduced to a 68.1% in 2011[1] as shown in figure 3.

[1] National HIV and AIDS Sentinel Surveillance, MOH &QL

Fig 3: Percentage of transmission through Injecting Drug use



(C) The policy and programmatic response

- **National HIV and AIDS policy 2010[2]**

Guiding Principles

Mauritius's response to HIV and AIDS are guided by the following principles:

- Approaches to HIV and AIDS prevention and care follow international best practice and consistent with Mauritius's religious and cultural values.

- All persons will be provided with access to the information and support they need to protect themselves against HIV infection.

- People with HIV and AIDS will have the same rights as all other citizens, and will not be discriminated against on the basis of their HIV status, gender, socio-economic status or HIV-risk factors.

[2] National AIDS Secretariat, Prime Minister's Office

- Gender norms and relations are a key factor in determining who acquires HIV in Mauritius, and in determining treatment, care and support outcomes. Mauritius's national program acknowledges this and all programs and services will devise and implement strategies that address gender norms and relations. Addressing the prevention and care needs of women and girls will be a particular focus, combined with attention to male behaviour and cultural norms that increase the likelihood of women contracting HIV.

- The connection between HIV and AIDS prevention and care will be acknowledged in programme and service design - providing treatment, care and support to individuals and families affected by HIV and AIDS will be prioritized as a core HIV prevention strategy.

- Leadership across all sectors will be fostered and valued, and the capacity of each sector to contribute to the overall response will be strengthened. This includes community leadership, which will be encouraged and supported through the mobilization and support of communities to respond to HIV.

- All parts of society, including all levels of government, the private sector and civil society will encouraged and supported to play a role in HIV and AIDS prevention and care and in reducing the impact of HIV and AIDS on individuals, families and communities.

- The challenges that HIV and AIDS presents to the development of Mauritius as a nation will be taken into account in all policies and programmes.

- Sustainability will be promoted by incorporating HIV and AIDS prevention and care initiatives into existing programmes.

- The response will be backed up by sustained political commitment and by the mobilization of resources to sustain the required effort.

HIV and AIDS is a dynamic and rapidly-changing field, about which new knowledge is constantly emerging. This policy will therefore be under regular review for its applicability and effectivess in the light of the most recent information, as well as responses.
It is expected that the National Policy will evolve over time with new scientific knowledge, information and experience gained under the leadership of the National AIDS Secretariat. Changes in our societal attitudes and behaviours will also be critical. The policies and guidelines will therefore be revised periodically to ensure that they reflect needs and changes in societal behaviour and culture. The National AIDS Secretariat will ensure that changes are made following broad consultation with the nation**.**

- **Gender and Sexuality**

It is important to understand the linkages between gender, sexuality and HIV and AIDS. Constructions of gender reflect culture, community and self-image, affecting women, men and transgendered people. Sexuality also plays a role in describing the experiences of people living with, or at risk of HIV and AIDS. The role of sexuality and sexual orientation is an important aspect of how HIV and AIDS is experienced and conceptualized.
Gender equality is one of the guiding principles of our strategic framework and it is translated by regular consultation with the Ministry of Gender equality, National Women Council, LGBTI NGOs.
In the Mid Term Review of the NSF 2006-2011, one of the priority identified for 2012-2016 is a Gender equality based approach in the area of access to medical care and patient follow-up for male and female prison inmates

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

Effective coordination and institutional management is at the centre of an effective national response to the epidemic. National AIDS Secretariat was set up under the Prime Minister's Office in 2007 to highlight the high level commitment of Government to fight the HIV and AIDS epidemic.
Civil society response play a significant role in strengthening the multi-sectoral response to HIV and AIDS.

There is the Rodriguan AIDS Secretariat to lead the response in Rodrigues Island, but due to some administrative and Human resource problems, the outcomes are quite limited.

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

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

In November 2011, The National Economic Council carried out a study on " The social integration of stigmatized Vulnerable groups". The purpose of the study is not so much to investigate into the factors which lead people to drug use, sex work, HIV infections and prison sentences, but to focus on the means to integrate the vulnerable groups into the mainstream society.

The survey contains recommendations made by the Council for the social integration of the stigmatized and vulnerable groups on whom the report focuses. These recommendations are simple and call for minor institutional or legal changes. In certain cases, proposals are group specific, as opposed to others which may apply to all marginalised groups.[3]

- **HIV Testing, Prevention and Support**

HIV Testing[4]

So far, an average of 83,000 tests are being carried out annually, half of which are among blood

[3] National Economic and social council " The Social Integration of Stigmatised Vulnerable groups" ,Nov 2011.
[4] National HIV counseling and testing Strategy in Mauritius 2011-2012

donors while 20% among are pregnant women. The rest comprises of testing low risk group such as patient undergoing cardiac surgery and renal dialysis, migrant workers, KAPs. VCT accounts for very few at the rate of 1000 per annum.
The shift towards provider-initiated HCT comes as one of the measures to reach members of the community as well as KAP.

The imperative of expanding the number of clients counseled and tested for HIV comes as a result of the constant fear of the diffusion of the epidemic from the KAP towards the general population. 5,188 people have been detected out of an estimated 8000 HIV infected people. Some 4,000 have been registered at the National Day Care Centres and the Prisons while around 3000 are being regularly followed up. Furthermore, 50% of those initiated on ARVs each year are being diagnosed at the AIDS Stage.
Under these circumstances, a vast campaign to increase testing capacities has been idendified as a top priority and a National HIV counseling and testing Strategy in Mauritius 2011-2012 has been elaborated outlining the following objectives:

1. To expand access to HCT beyond formal health-care settings into community, private sector and non-health care environments
2. To reach and diagnose a maximum of people living with HIV at an early stage of HIV infection so as to ensure appropriate referral to treatment

- **Prevention**

The most effective prevention programs are those that use a combination of strategies to achieve maximum impact. The National response[5] of the Republic of Mauritius comprises of:

- Behavioural Change Programme for different target group
- Condom promotion and distribution
- HIV testing
- Prompt diagnosis and treatment of other STIs
- Antiretroviral therapy and regular review of protocols.
- Prevention of Mother to child transmission
- Post-exposure Prophylaxis
- Harm reduction programme
- Blood supply safety

[5] National Multisectoral HIV and AIDS Strategic Framework (NSF) 2007-2011

- Infection Control In Health Care Setting
- Management of Co-infection (TB, Hepatitis B&C)

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

- **Support**

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

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

- **Stigma and Discrimination**

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

In healthcare settings people with HIV can experience stigma and discrimination such as being refused medicines or access to facilities, receiving HIV testing without consent, and a lack of confidentiality. Such responses are often fuelled by ignorance of HIV transmission routes amongst doctors, midwives, nurses and hospital staff

Lack of confidentiality has been repeatedly mentioned as a particular problem in health care settings. Many people living with HIV/AIDS do not get to choose how, when and to whom to disclose their HIV status.

Level of stigma has been measured through the IBBS among KAPs, and the KABP study 2011 in the population in general.

In the Mid Term Review 2010, one of the priority identified was to " Improve the quality of life of PLWHA, address stigma and discrimination and create an enabling environment for HIV prevention" ,taken on board in the NSF 2012-2016. To reinforce this strategy, Institutional mechanism and human rights aspects are also taken into consideration to mitigate the worst effects of stigma and discrimination. Results from an Stigma Index Survey may help in designing evidence –based strategies.

- **Human Rights :**

As an active member of the Human Rights Council, Mauritius is recognized for its strong commitment to the promotion and protection of human rights and rule of law at all levels. In a bid to support numerous thematic initiatives, Mauritius has been active in the adoption by the Human Rights Council of the resolution relating to the Mandate of the Special Rapporteur on Trafficking in Persons, especially in women and children; the resolutions on the acceleration of efforts to eliminate all forms of violence against women; the resolutions of the Rights of the Child and the resolutions on preventable maternal mortality and morbidity, to name but a few.
Our dynamic and independent judiciary plays an important role in ensuring the protection of human rights and fundamental freedoms. Strong and independent institutions also exist to guarantee the rights of the citizens such as the National Human Rights Commission, which includes the Sex Discrimination Division, the Ombudsman and the Ombudsperson for Children, *amongst others*.

The HIV and AIDS Act which was passed in December 2006, established legal provision for the observance of a rights based approach to HIV and related issues, in particular to protect PLWHA from stigma and discrimination. The Act clearly stipulates that any negative attitude towards people infected and affected with HIV is punishable by law.
This ACT also sets out unequivocal provision for the introduction of harm reduction strategies incuding Needle Exchange programme and Methadone Substitution therapy.

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

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

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

To quote the Prime Minister, Dr the Honorable Navinchandra Ramgoolam,FRCP,GOSK: "Nobody can make everybody equal but we have the duty to see that everybody gets equal chances in life".

(d) Indicator data in an overview table

Targets		**Indicators**	**YR 2009 /2010**	**Yr 2011**	**Data source**
1.Reduce sexual transmission of HIV by 50 per cent by 2015. *General population*	1.1	Percentage of young women and men aged 15–24 who correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission.	87% KABP 2008	38.8%	KABP 2011
	1.2	Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	7.3% KABP 2008	0.8 %	KABP 2011
	1.3	Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months	12.8% (15-24 only) KABP 2008	3.0% (15-24 yrs) 4.2% (15-49 yrs)	KABP 2011

	1.4	Percentage of adults aged 15–49 who had more than one sexual partner in the past 12 months and who report the use of a condom during their last intercourse	54.6% (15-24 only) KABP 2008	85.7% (15-24yrs) 55.9% (15- 49 yrs)	KABP 2011
	1.5	Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results.	4.3 % (15-24 only) KABP 2008	5.7 % (15-24yrs) 6.9 % (15-49%)	KABP 2011
	1.6	Percentage of young people aged 15-24 who are living with HIV	0.67 % (2010)	0.34 %	ANC surveillance data-Proxy
Sex workers	1.7	Percentage of sex workers reached with HIV prevention programmes		77.6%	IBBS FSW 2010
	1.8	Percentage of sex workers reporting the use of a condom with their most recent client		88.0 %	IBBS 2010
	1.9	Percentage of sex workers who have received an HIV test in the past 12 months and who know their results		69.2 %	IBBS 2010
	1.10	Percentage of sex workers who are living with HIV		28.9%	IBBS2010
Men who have sex with men	1.11	Percentage of men who have sex with men reached with HIV prevention Programmes		43.6%	IBBS2010
	1.12	Percentage of men reporting the use of a condom the last time they had anal sex with a male partner		52.9 %	IBBS2010
	1.13	Percentage of men who have sex with men that have received an HIV test		89 %	IBBS2010

		in the past 12 months and who know their results			
	1.14	Percentage of men who have sex with men who are living with HIV		8.1%	IBBS2010
2. Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015	2.1	Number of syringes distributed per person who injects drugs per year by needle and syringe programmes		30.7 %	2010/2011 NAS/MFP WA
	2.2	Percentage of people who inject drugs who report the use of a condom at last sexual intercourse	30.8 % IBBS 2009	25 %	IBBS 2011
	2.3	Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected	71.7 % IBBS 2009	89.2%	IBBS 2011
	2.4	Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results	74.8% IBBS 2009	80.1%	IBBS 2011
	2.5	Percentage of people who inject drugs who are living with HIV	47.4% IBBS 2009	51.6%	IBBS 2011
3. Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths	3.1	Percentage of HIV-positive pregnant women who receive antiretrovirals to reduce the risk of mother-to-child transmission	81% Yr 2010	95.7%	PMTCT register, MOH &QL
	3.2	Percentage of infants born to HIV-positive women receiving a virological test for HIV **within 2 months of birth.**		88% (Cohort 2009) **(Serological test after 18 months of birth)**	See narrative. Rx protocol
	3.3	Mother-to-child transmission of HIV (modelled)		16.7%	Spectrum estimates

4. Have 15 million people living with HIV on antiretroviral treatment by 2015	4.1	Percentage of eligible adults and children currently receiving antiretroviral therapy		64.3 %	ART register, MOH&QL/ spectrum
	4.2	Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy		87.4%	ART register, MOH&QL
5. Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015	5.1	Percentage of estimated HIV-positive incident TB cases that received treatment for both TB and HIV		See narrative	National TB Program MOH &QL
6. Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries	6.1	Domestic and international AIDS spending by categories and financing sources		See attached Report	NASA 2012
7.Critical Enablers and Synergies with Development Sectors	7.1	National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation)		See the narrative	
	7.2	Proportion of ever-married or partnered women aged 15-49 who experienced physical or sexual violence from a male intimate partner in the past 12 months		See narrative	Ministry of Gender Equality/ National women council
	7.3	Current school attendance among orphans and non-orphans aged 10–14		See narrative	Ministry of Education &Ministyry of SocialSec urity

	7.4	Proportion of the poorest households who received external economic support in the last 3 months		See Narrative	Ministry of Social Integration

II. Overview of the AIDS epidemic

National Prevalence

the National AIDS Secretariat convened a multi-sectoral meeting in March 2012 to estimate the prevalence among the adult population aged 15-49 yrs. Prevalence figures for HIV in Mauritius have been calculated to 0.97% (Confidence Intervals 0.6%-1.96%) amounting to an average of 8,000 PLHIV.

Monthly statistics Report reveals that Transmission of HIV infection has remained constant with an average 73% among PWIDs and 18% among heterosexual .

This situation characterizes the epidemic as a “concentrated” one, with HIV prevalence estimates above 5% among KAPs while it remains low at 0.4% in the pregnant women population.

IDUs: The IBBS PWID 2011 estimated the HIV prevalence to be at 51.6 % among a population of 10,000 IDUs with a geographical concentration around Port-Louis.

CSW: The IBBS on CSW in 2010 gave an estimated HIV prevalence of 28.9 % among a population calculated to be 1,500. The study highlighted the fact that 40% of the CSW also inject drugs.

MSM: According to the IBBS done among MSM in 2010, the HIV prevalence is 8.1%.

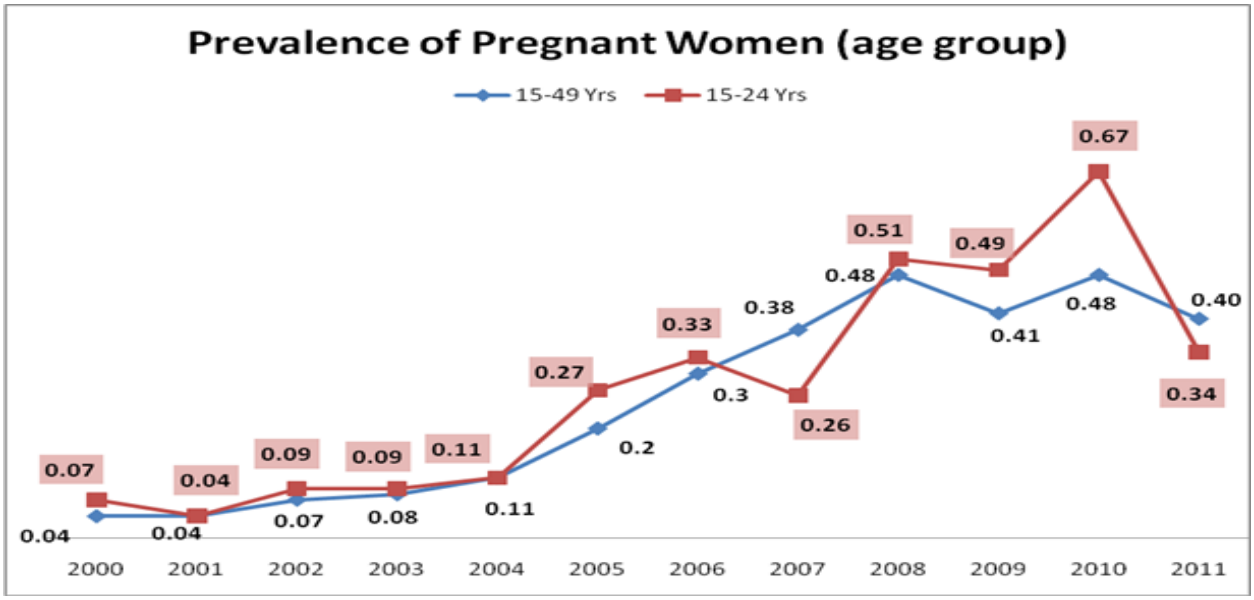
PRISON INMATES: During 2011 there was a turn- over of 4979 prison inmates, among whom the prevalence of HIV was 19.9%. this high prevalence is due to the fact that many inmates were incarcerated for drug-related offences

SEAFARERS: In 2008 the HIV prevalence among sailors was calculated to be 6.9%.

ANC Surveillance Data.

HIV prevalence among ANC attendees closely reflects the HIV prevalence in the general adult population. For this reason, ANC HIV sentinel surveillance provides important data on the status of the epidemic over time, especially in the Republic of Mauritius as 95% of pregnant women are tested for HIV.

Fig 4 : ANC Prevalence (15-49 yrs)



Source : ANC register, MOH &QL

The HIV prevalence rate among pregnant women aged 15-49% remains in the range of 0.4%-0.05% since 2009. The same data can be used as a proxy to determine the prevalence rate of HIV among youth aged 15- 24 years old and the figures shows an improvement with 0.34% in 2011 as compared to 0.67 in 2010.[6]

III. National response to the AIDS epidemic

TARGET 1 : GENERAL POPULATION

[6] ANC surveillance data, MOH &QL
Central Health Laboratory, MOH &QL.

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

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

Source: KABP 2011

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

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

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

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

Source: KABP 2011

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

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

Source: KABP 2011

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

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

Source: KABP 2011

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

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

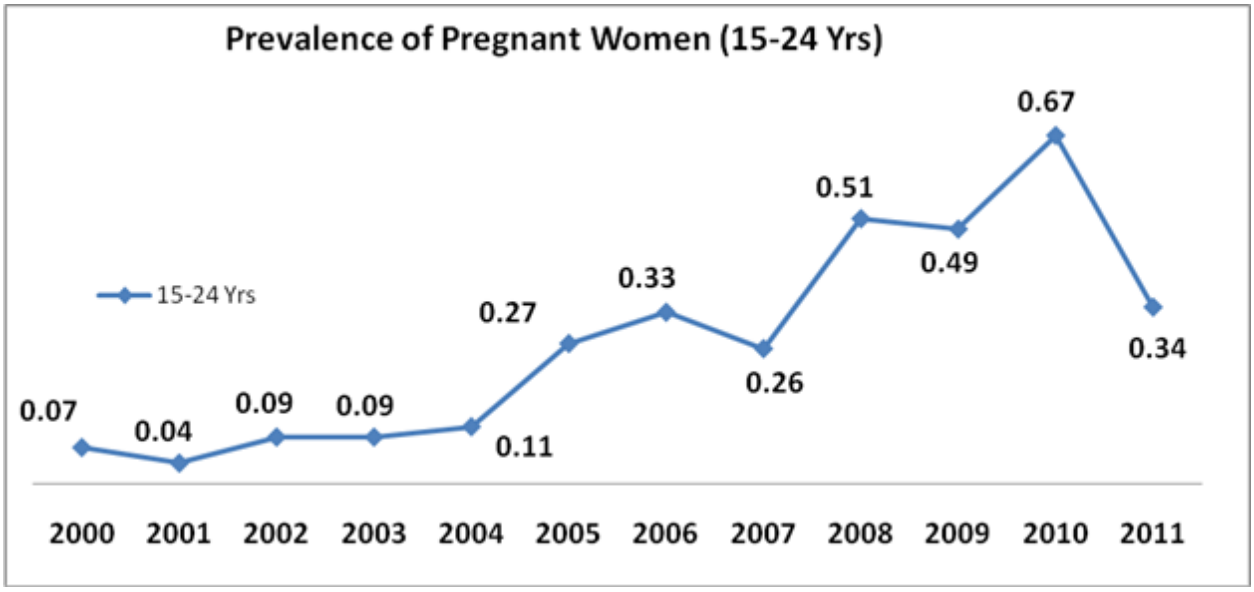
Source: KABP 2011

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

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

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

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



Actual data from ANC were used as proxy to determine the prevalence of HIV among youth aged 15- 24 which amounts to 0.34%. In comparison data from Spectrum shows a prevalence of 0.16 % among this same age group.

SEX WORKERS (IBBS 2010)

Sex work is generally tolerated in Mauritius. However, similar to many countries, FSWs are difficult to reach for research purposes due to social and legal stigma and discrimination.

To date, efforts to address the needs of FSWs have been limited. Chrysalide,one of the few organizations to address the needs of FSWs operates a center of support for women with HIV, who use drug and/or sell sex. The AIDS Unit at the MOH &QL has also a network of FSW and dispenses regular awareness sessions, HIV testing and condom distribution.
Although HIV surveillance of FSWs has been mentioned as a priority in the national HIV and AIDS strategic framework 2007 - 2011, prior to the IBBS 2010, there were no representative data neither to describe the HIV prevalence and associated risk behaviors among this population nor to determine the size of the FSW population in Mauritius.

Obtaining representative data about the prevalence of HIV and other infections and associated sexual risk behaviors is essential to planning and implementing programmatic and policy responses for these populations and for providing a baseline from which to monitor epidemic trends.

The IBBS2010 (FSW) has been focused only on Street-based CSW though there are sex workers in different settings such as massage parlour, discotheques, escort services or internet –based. Although there is anecdotal information about male sex work, no data has been captured on them.

1.7. Percentage of sex workers reached with HIV prevention programmes

Sex (FSW) Age	Numerator: Number of sex worker who replied yes to both questions	Denominator: Total number of sex workers surveyed	Percentage of sex workers reached with HIV prevention programmes
< 25	**48**	**67**	**71.6%**
25+	**184**	**232**	**79.3%**
Total	**232**	**299**	**77.6%**

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

Sex (Female Sex worker) Age	Numerator: Number of sex worker who reported that a condom was used with their last client	Denominator: Number of sex workers who reported having commercial sex in the last 12 months	Percentage of sex workers reporting the use of a condom with their most recent client
< 25	61	67	91 %
25+	202	232	8.7 %
Total	263	299	88 %

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

Sex (Female Sex worker) Age	Numerator: Number of sex worker who have been tested for HIV during the last 12 months and who know their results	Denominator: Number of sex workers responding to these questions	Percentage of sex workers who received an HIV test in the past 12 months and know their results
< 25	15	18	83.3%
25+	59	89	66.3 %
Total	74	107	69.2%

1.10 Percentage of sex workers who are living with HIV

The FSW population size: The FSW population size is based on the multiplier methodology using data provided by both the AIDS Unit of the MOH&QL and the distribution of a unique object. The FSW population estimated size is between 910 and 1320

HIV prevalence among FSW = 28.9% (IBBS 2010)

MEN WHO HAVE SEX WITH MEN (IBBS 2010)

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

Age	Numerator: Number of MSM who replied yes to both questions	Denominator: Total number of MSM surveyed	Percentage of MSM reached with HIV prevention programmes
< 25	60	156	38.5%
25+	97	204	47.5%
Total	157	360	43.6%

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

Age	Numerator: Number of MSM who reported that a condom was used the last time they had anal sex	Denominator: Total number of MSM who reported having had anal sex with a male partner in the last six months	Percentage of MSM reporting the use of a condom the last time they had anal sex with a male partner
< 25	82	153	53.6%
25+	101	193	52.3%
Total	183	346	52.9 %

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

Age	Numerator: Number of MSM who have been tested for HIV during the last 12 months and who know their results	Denominator: Number of MS responding to these questions	Percentage of MSM who received an HIV test in the past 12 months and know their results
< 25	23	25	92%

25+	**42**	**48**	**87.5%**
Total	**63**	**73**	**89%**

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

The MSM population size: There was insufficient service data to calculate an accurate population size estimate of MSM in Mauritius.

HIV prevalence among MSM was 8.1%

The Republic of Mauritius embarked on a number of HIV programmes with selected sub-populations namely PWIDs, CSWs, MSMs and prison inmates.
The low coverage of HIV programmes for PWID and MSMs is due to difficulty experienced in reaching these target groups. The key challenges were:

- Hidden population therefore it is difficult to reach
- The strategy to meet these sub-populations is not very effective
- Stigma and discrimination is rife against these sub-populations
- The environment for MSM is very hostile and socio-cultural pressure exacerbates the challenge of reaching this group
- Poor organisational structure in particular for MSM

In order to meet the UA targets proposed for the HIV programmes for PWID of 75%, CSWs – 65%, MSM 35% and sustain the level of effort with prison inmates of 98% the following strategies are proposed:

- Increased implementation of outreach programmes for the sub-populations.
- Tailoring programmes in a manner that is more easily accessible by the sub-populations
- Provide the necessary support to increase participation of NGOs in the delivery of HIV prevention programmes
- Conduct more frequent mass media campaigns for KAPs
- Distribution of condoms at workplace.

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

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

Numerator: Number of syringes distributed in the past 12 months by NSPs	**307,381**
Denominator: Number of people who inject drugs in the country	**10,000**
Number of syringes distributed per person who injects drugs per year by Needle and Syringes Programmes	**30***

Source: NEP (MOH&QL, NGOs); IBBS 2009, 2011

*If the 4,728 clients on Methadone Maintenance therapy are excluded then the number of syringes distributed per person who inject drugs per year by the NEP programme would be 61.

The IBBS 2011 also highlighted that 50% of PWID bought their syringes in private pharmacies reinforcing the assumption that more PWID are using preventive measures to decrease HIV transmission .

Challenges to meet target set in UA in 2015 are as follows:

- Due to excessive police harassment, PWIDs feel exposed when accessing the NEP sites
- There are a number of complaints reported with respect to the quality of material; the material is considered very poor in quality.
- Minors fear that they are stigmatised hence they do not participate in the programme
- Due to the lack of appropriate legislation many PWIDs are in prison with no access to syringes

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

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

- National Harm Reduction Network in place.

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

Sex	Age	Numerator: Number of PWID who reported that a condom was used the last time they had sex	Denominator: Number of PWID who reports having injected drugs and having had sexual inter course in the last month.	Percentage of PWID reporting the use of a condom the last time they had sexual intercourse
M	< 25	3	20	15%
M	25+	64	256	25%
F	<25	1	5	20%
F	25+	7	19	36.8%
Total Male	< 25/25+	67	276	24.3%
Total Female	< 25/ 25+	8	24	33.3%
Grand Total	M&F <25 /25+	75	300	25%

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

Sex	Age	Numerator: Number of PWID who report using sterile injecting equipment the last time they injected drugs	Denominator: Number of PWID who report injecting drugs in the last month	Percentage of PWID reporting the use of sterile injecting equipment the last time they injected
M	<25	30	36	83.3%
M	25+	388	433	89.6%
F	<25	4	5	80%
F	25+	23	25	92%

Total Male	**<25/ 25+**	**418**	**469**	**89.1%**
Total Female	**<25/ 25+**	**27**	**30**	**90%**
Grand Total	**M&F <25 / 25+**	**445**	**499**	**89.2%**

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

Sex	Age	Numerator: Number of PWID who have been tested for HIV during the last 12 months and who know their results	Denominator: Number of PWID responding to these questions	Percentage of PWID who received an HIV test in the past 12 months and know their results
M	**<25**	**10**	**11**	**90.9%**
M	**25+**	**109**	**138**	**79.9%**
F	**<25**	**3**	**4**	**75%**
F	**25+**	**7**	**8**	**87.5 %**
Total Male	**<25/ 25+**	**119**	**149**	**79.9%**
Total Female	**<25/ 25+**	**10**	**12**	**83.3%**
Grand Total	**M&F <25 + 25+**	**129**	**161**	**81.1%**

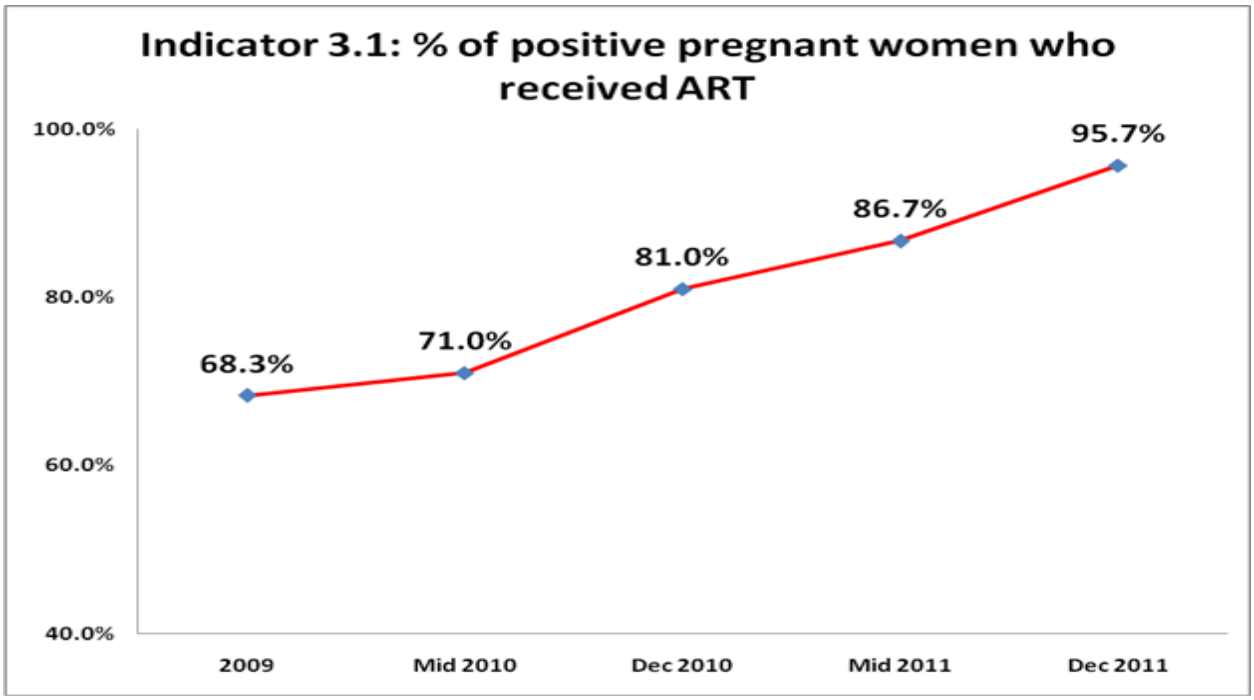
2.5 Percentage of people who inject drugs who are living with HIV

IBBS 2009	IBBS 2011
• **Size population estimates =10,000**	• **Size population estimates =10,000**
• **HIV prevalence among PWID = 47.4%**	• **HIV prevalence among PWID = 51.6%**

TARGET 3 : ELIMINATE MOTHER –TO-CHILD- TRANSMISSION OF HIV BY 2015 AND SUBSTANTIALLY REDUCE AIDS RELATED MATERNAL DEATH

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

Fig 6: Percentage of positive pregnant women receiving ART



The main challenges regarding the underperformance in 2010 (UA target was 95%) were:

- HIV positive pregnant women were not adhering to PMTCT prophylaxis,
- Majority of the women not-adhering to the PMTCT prophylaxis are pregnant women essentially among CSWs and PWIDs who are difficult to reach.
- No substantial support were given by NGOs

The target projected for UA in 2015 is 95%. The setting of this target was based on the following strategies:

- Improve on quality of ANC services with a view to attract and keep the clients on board the PMTCT protocol

- Increase contact tracing for PMTCT dropouts with dedicated support from NGOs that work with high risk groups
- Ensure dropouts receive the emergency PMTCT protocol at the time of delivery
- Empower NGOs to take a more active part in encouraging HIV positive pregnant mothers to follow PMTCT prophylaxis optimally

To have reached a 95% adherence among pregnant women within one year is a tribute to the dedication of the clinical team, cooperation of NGOs and the application of the above strategies.

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

At present all infants born to HIV positive mother were tested after 18 month of birth. As far as PCR is concerned, the setting up of testing for Newborn within 2 months of birth is in process and will be reported as per indicator in the next round.

As data for this indicator is not available, we are reporting by using data from Cohort 2009.

Cohort 2009:

Number of infants who received an HIV test (Serological) during the reporting period = 44

Number of HIV positive pregnant women giving birth in the last 12 months = 50

Percentage of infants born to HIV positive women receiving a serological test after 18 months of birth = 88%

3.3 Mother-to-child transmission of HIV (modelled)

Estimated number of children who will be newly infected with HIV due to MTCT among children born in the previous 12 months to HIV –positive women	**3**
Estimated number of HIV positive women who delivered in the previous 12 months	**54**
Estimated percentage of child HIV infections from HIV positive women delivering in the past 12 months	**5.5%**

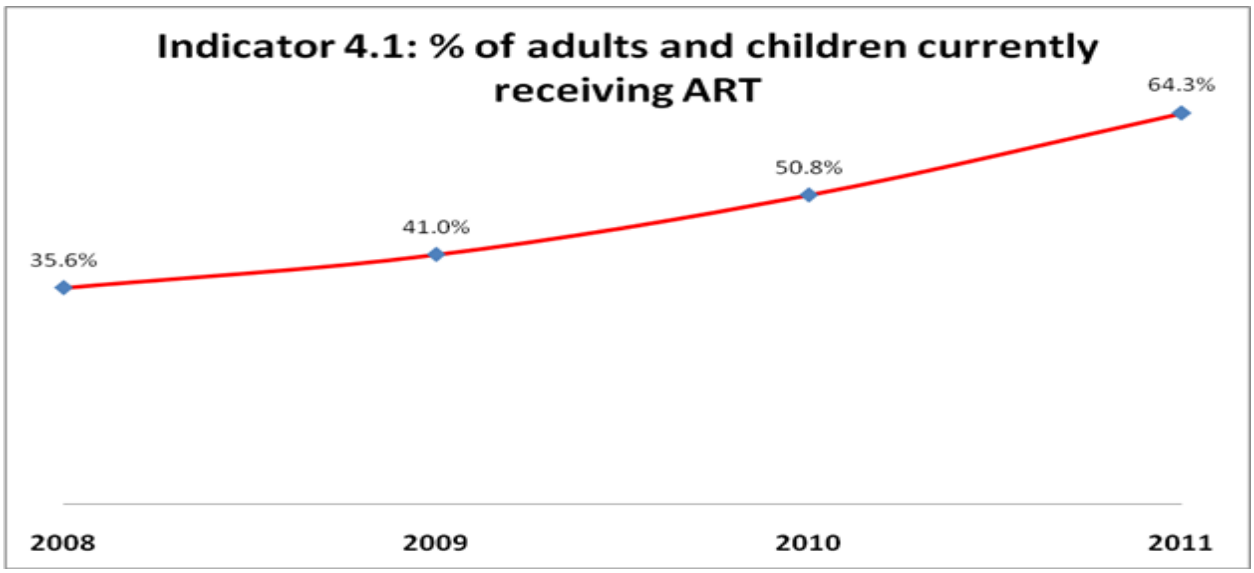
Source : PMTCT Register , MOH &QL

Numerator is based on HIV infected pregnant women receiving prophylaxis.

Denominator is based on actual number of positive women who delivered in the previous 12 months out of whom 51 received prophylaxis.

TARGET 4: HAVE 15 MILLION PEOPLE LIVING WITH HIV ON ANTIRETROVIRAL TREATMENT BY 2015

4.1 Percentage of eligible adults and children currently receiving antiretroviral therapy[7]



The public health sector has continued to ensure universal coverage for persons in need of ART, by decentralising the services. By the end of 2011, there were 4 public health facilities (National Day Care Centre for the Immuno-suppressed and Prison covering more than 80% of the island. Two additional Day care centres are in the pipeline. These facilities are linked to the Mauritius Virology Department, Central Health Laboratory located in the Regional Hospital at Candos who is responsible for conducting CD4 count tests, the viral load tests and the Polymerase Chain Reaction (PCR). Laboratory services are critical elements of this programme. Despite the progress being made, some of the main challenges that are being addressed in the scaling up of services include recruitment of adequate numbers of human resources, and strengthening of national health information systems

[7] **ART Register, NDCCI, MOH &QL**

The proportion of HIV-infected persons who need ART in a given year is linked to the evolution of the epidemic within the country and changes over time as the epidemic matures. The estimate target for 2010 was 75% and the percentage of adults and children receiving ARVs was 50.8%. There are a number of challenges for the underperformance of the in respect of the 2010 target. These are:

- Disease has matured resulting in an increase in the number of adults and children needing ARV
- The protocol with respect to earlier initiation of treatment with the CD4 count of at 350 has changed the status of the pool of adults and children needing ARVs
- There are challenges with the management of the data. The estimated need has to be established using evidence and to date the recording of the statistics is done manually.

The strategies to advance toward a target of 75% provision of ARVs to adults and children in 2015 are:

- To establish more accurately the estimated number of adults and children in need of ARVs
- To improve the management of ARV data.
- Enhanced treatment literacy
- Contact tracing of drop-outs
- Close monitoring of those on ARV.

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

Cohort	Numerator: Number of adults and children who are still alive and on antiretroviral therapy at 12 months after initiating treatment	Denominator: Total number of adults and children who initiated antiretroviral therapy who were expected to achieve 12 month outcomes within the reporting period	Precentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy
Yr 2009	**181**	**234**	**77.4%**
Yr 2010	**277**	**317**	**87.4**

Source: ART Register, NDCCI, MOH &QL

The reported target for adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy was 77.4% in 2009 .The main reason for the under-performance in this regards were:

- The Hard to reach population makes it difficult to follow up on the clients who have defaulted
- Stigma and discrimination acts as an impediment to clients continuing with treatment
- Prison inmates follow-up services are very poor. Once people are released from prison there is no mechanisms to trace them and encourage continuation of treatment

There are a number of strategies envisaged to achieve the 2015 target of 85%. These are:

- Training for NGOs to assist in following up the hard to reach populations through a peer educators programme.
- Engaging the Ministry of Social Security in respect of released prison inmates
- Contact tracing strategy has been implemented, however this needs to be increased
- Collaborative strategies with partners to increase ARV adherence

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

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

According to statistics from the National TB Programme for the year 2011,incidence rate of TB amount to 9.1% per 100 thousand inhabitants. Based on data collected at service level , 3 adults with advanced HIV infection received antiretroviral combination therapy in accordance with the nationally approved treatment protocol and who were started on TB treatment within the reporting year.

It is to be noted that:

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

TARGET 6: REACH A SIGNIFICANT LEVEL OF ANNUAL GLOBAL EXPENDITURE (USS22-24 BILLION) IN LOW AND MIDDLE-INCOME COUNTRIES

6.1 Domestic and international AIDS spending by categories and financing sources

To see NASA Report.(Annex A)

TARGET 7: CRITICAL ENABLERS AND SYNERGIES WITH DEVELOPMENT SECTORS

7.1 National Commitments and Policy Instruments (prevention, treatment, care and support, human rights, civil society involvement, gender, workplace programmes, stigma and discrimination and monitoring and evaluation). See Annex B

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

Table 1: No of cases of domestic violence registered at the Family Support Bureau 2011

	Nature of problem	January to December		
		Male	Female	Both sexes
	DOMESTIC VIOLENCE			
1	January	**14**	**147**	**161**
2	February	**15**	**146**	**161**
3	March	**19**	**157**	**176**
4	April	**14**	**119**	**133**
5	May	**17**	**148**	**165**
6	June	**19**	**113**	**132**
7	July	**12**	**107**	**119**
8	August	**20**	**140**	**160**
9	September	**15**	**122**	**137**
10	October	**17**	**107**	**124**
11	November	**17**	**122**	**139**
12	December	**15**	**130**	**145**
	Total	**194**	**1,558**	**1,752**

As such no surveys have been carried out by the Ministry of Gender Equality, but data from various Family Support Bureaux are presented in the above table. MOGE and the National Women Council have put into place a number of strategies to eliminate gender violence :

- Regular National campaign against gender violence
- Family Support Unit that provide counseling and psychological support.
- Women Shelters providing temporary shelter and protection to women experiencing physical as well as sexual violence.
- Economic empowerment through various projects encouraging women to develop skills.

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

Table 2 : School attendance for 2011- orphans and non-orphans

School attendance for 2011 - orphans and non-orphans			
	Category	**Grade**	**Quantity**
	Primary School, 10-11 yrs	V	19,310
		VI	18,282
		VI Repeaters	4,312
	Secondary School, 11 to 14 yrs	I	16,924
		II	16,373
		III	17,342
	Prevocational School, 11 to 14 yrs	I	2,544
		II	2,409
		III	2,317
	School for the disabled , 10 to 14 yrs		762
	TOTAL		100,575

In the Republic of Mauritius schooling is mandatory up to 16 years of age. Though there is no system to verify if all children are attending school, non-attendance is tackled by NGOs and CBOs on a case to case basis. School education at primary and secondary level is free. In 2010, the republic of Mauritius has a total adult literacy rate of 88% (Male youth aged 15-24 yrs = 96%; Female youth aged 15-24 yrs = 98%)

All orphans and vulnerable children irrespective of being orphans from HIV parents or suffering from any specific diseases benefitted from social and economic aid from the Ministry of Social security and Ministry of Social Integration.

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

POVERTY REDUCTION STRATEGIES

According to the Human Development Index 2011, Mauritius ranks 77 among countries of High Human Development level, which is largely due to the maintenance of universal free health care and free education .Remarkable results have been achieved towards the MDGs, with four out of eight specific goals already achieved, respectively:

- Universal primary education
- Reduction of child mortality
- Improvement of maternal health through the reduction by ¾ of maternal mortality ratio
- Gender equality through equal enrolment in primary and secondary education

The incidence of absolute poverty is relatively low, although pockets still prevail in some suburban and coastal regions in Mauritius and on the island of Rodrigues. Some 12% of the population is estimated to be poor, based on a poverty benchmark calculated at 50% of the median monthly household expenditure. The incidence of poverty is relatively higher among female-headed households (33.8%) than among male-headed households (8%). On the island of Rodrigues, the poverty rate is 30.2%. The incidence of poverty in rural areas is more than three times that of urban areas.[8]

National Empowerment Fund[9] has provided an overall coordinating framework for the Trust Fund for the social integration of Vulnerable Groups, the Eradication of Absolute Poverty (EAP) Programme, the Decentralised Cooperation Programme (DCP), the Empowerment Programme, the Programme for Rodrigues and the Corporate Social Responsibility Programme.

The Empowerment Programme provides comprehensive measures for poverty alleviation, capacity building of the vulnerable segments of the population as well as incentives for employability, entrepreneurship and establishment of SMEs. The shift has been from job creation to employment creation. Social safety nets for the eligible underprivileged have also been reinforced, such as through improved social aid, educational support, free transport for students to attend school, and increased support to specialised NGOs based on clear performance targets.

[8] Mauritius Strategy for Implementation National Assessment Report, 2010.
[9] National Empowerment fund, Annual Report 2011

The National Empowerment Foundation(NEF) has so far reached around 15 500 persons both in Mauritius and Rodrigues through its different programmes in view of creating more job opportunities, namely training, reskilling, placement programmes, circular migration, assistance to unemployed women and financial and technical assistance for micro-enterprises

As regards the special programme for unemployed women, for which an amount of Rs 10.5 m has been disbursed, some 407 women have benefitted from 2007 to October 2009, among whom 167 women have been given both financial and technical assistance for micro-enterprise projects. Furthermore, some 8, 272 persons have benefitted from the placement and training for which an amount of Rs 156.5 m has been spent from end 2006 to October 2009. Besides, around 5,445 beneficiaries have been provided assistance under the special entrepreneurship programme for a total amount of Rs 389.2 m from 2006 to October 2009.

As far as Rodrigues is concerned, from June 2008 to October 2009, some 167 people have benefitted from the various schemes for a total sum of Rs 8.8 m.

For this indicator the total number of poorest households is 6,879 (income below RS 5,000). In the last three months the Child and Family Development Programme has distributed 8,688 school materials including school uniform, shoes, school bag and pedagogical materials. 28 beneficiaries have been allocated Housing facilities.

IV. BEST PRACTICES

National PMTCT Programme

Ministry of Health and Quality of Life

Introduction:

The PMTCT programme started in December 1999 making provision to detect and provide ARVs to all HIV pregnant women in the public sector, be it in the ANC Clinics or at hospital labour wards. There are no more home deliveries actually and all pregnant women captured on these two sites represents 95% of all pregnancies, the remaining 5% being in the private sector.

Once delivered the positive mother was not put on ARV, as at that time free treatment was not yet available. As from 2000 with the free initiation of HAART for all PLWHIV needing drugs, the protocol for PMTCT also changed. The National Strategic Plan 2001-2005, 2007-2011, recognized PMTCT as a mainstay of the response against HIV and AIDS in children.

Goal:

- To reduce to zero the number of mother to child transmission of HIV.

Objectives:

- To eliminate mother to child transmission
- To determine the prevalence of HIV among pregnant women through the setting up of a proper M&E system;
- To increase the number of HIV pregnant women receiving prophylactic Antiretroviral drugs;
- To ensure that all newborns to HIV positive mothers are being provided with preventive measures.

PMTCT components

The three components of the PMTCT Surveillance System in place are as follows:

1. Testing of all pregnant women at the level of ANC clinics
2. Follow-up of all HIV positive cases regarding PMTCT services
3. Follow-up of all babies born to HIV positive women until HIV test is performed.

1. Testing of all pregnant women at the level of ANC clinics

Some 14,000 to 16,000 tests are being carried out at ANC clinics annually and approximately 50 to 70 positive cases are being diagnosed and referred to the National Day Care Centres for the Immunosuppressed for PMTCT services.

2. Follow-up of all HIV positive cases regarding PMTCT services

I. Levels at which HIV infected pregnant women are being identified:

a) Virology Department of the Central Laboratory at Victoria Hospital
b) National Day Care Centres for the Immunosuppressed (NDCCIs)
c) Hospital level point of delivery (Labour Wards)

Pregnant Women

The preventive measures of the PMTCT consist of:

- Provision of ARVs starting at 14th week of gestation;
- Determining the mode of delivery (Normal Delivery or Cesarean Section) according to results of viral load at 34th week of gestation;
- Provision of ARVs during delivery.

II. Pathway of diagnosed HIV positive women:

a. <u>Notified cases from Virology laboratory</u>

- Referred to NDCCI and regular follow-up
- Referred to NDCCI and irregular follow-up
- Referred to NDCCI and lost to follow-up: Pregnancies may be interrupted (notified / not notified abortion) or may continue and captured at hospital level at time of delivery

b. <u>Notified cases from NDCCIs</u>

- Regular / Irregular follow-up

c. <u>Hospital level at point of delivery (Labour Wards)</u>

- Diagnosed on delivery or post delivery
- New / Known cases without ANC follow-up

N.B. All cases referred to NDCCI are also referred to gyneacologist at Regional Hospitals
All deliveries are notified at the NDCCIs

3. Follow-up of all babies born to HIV positive women until HIV test is performed.

I. Levels at which babies born to HIV infected pregnant women are being registered:

a) Regular follow-up at NDCCIs
b) Babies delivered in Hospitals and referred to NDCCI

II. Pathway of babies born to HIV positive women:

a) *Regular follow-up at NDCCIs offering the following services:*
   - prophylactic treatment,
   - supply of artificial milk,
   - vaccination programmes,
   - detection of early clinical stages of AIDS and initiation of ARVs, and
   - diagnostic test for HIV

b) *Lost to follow-up*

The prevalence of pregnant women has been increasing gradually from less than 0.1% in 2000 to around 0.5% . It has then stabilized for the past three years with 60 to 75 cases annually indicating that the epidemic is not a generalized one.

Because of a 95% uptake of HIV test, it is assumed that adherence to PMTCT also is high. It is only when reporting on UNGASS Indicator "Number of HIV-infected pregnant women who received antiretroviral drugs to reduce the risk of mother-to-child transmission", that it became visible that in 2009 only 68.3% of positive pregnant women were accessing PMTCT.

Gaps identified:

1. Poor coordination between ANC staff, virology laboratory and the AIDS Units
2. Lack of a single registry for notified cases of HIV infected pregnant women
3. No proper referral and communication from ANC clinics to NDCCIs and to Gynaecologists
4. No proper follow-up of HIV infected pregnant women at hospital level
5. Cases of lost to follow-up (Pregnant women and Children) noted
6. Poor monitoring of both HIV positive pregnant women and babies born to them.
7. Poor adherence or follow-up
8. Absence of a case management protocol

Women who did not receive ARVs are those:

1. Who were diagnosed at ANC clinic (New Cases), referred to NDCCIs but did not follow treatment during pregnancy and would attend hospital for delivery;
2. Known cases not following ANC and would attend hospital for delivery
3. Diagnosed only at delivery time.

These cases can be explained by the fact that the women belong to KAP s and are as such absorbed in other activities, and would not take advantage of free services offered regarding ANC clinic and delivery; even it's for their own benefit.

Action taken:

Recognising that we are facing a major set- back in our prevention programme, the Ministry of Health and Quality of life and all stakeholders met under the coordination of the National AIDS Secretariat to develop strategies to trace all pregnant women and follow them up in the treatment, care and support process.

1. A team was constituted for contact trace women lost to follow up.
2. A strong coordinating structure was set up between the central laboratory, the contact tracing team and the Clinical team.
3. An effective communication strategy was put in place involving midwives at periphery level who is in constant contact with the central level.
4. A personalized management protocol (Case to Case basis) was adopted to accompany the positive pregnant mothers towards an adherent protocol.

The result was revealing with an 81% adherence rate to PMTCT in 2010 which progressed to 86.7% in mid -2011 and finally reached 95.7% by the end of December 2011.

Key factors that have facilitated successful implementation have been the:

- Involvement of all stakeholders
- Existence of a committed team
- Training focussing on management of pregnant mothers.
- Training on use of data for implementation and quality improvement.
- Existence of required tools/structures to support the working team.

Way Forward:

The National Strategic Plan 2012-2016 prioritizes the following strategies:

- Reduction of mother to child transmission through additional services like

a) Sexual and reproductive health with emphasis on responsible contraception

b) Involvement of male partners

c) Nutritional support

d) Dedicated paediatric clinics for a better management of babies born to HIV mother.

- Development of a Regional Health protocol to decentralize the contact tracing strategy.
- A PCR protocol to test all babies born to HIV positive mothers and also to trace out those lost to follow-up.

Association Kinouete

Association Kinouete is an NGO that provides rehabilitative interventions for detainees incarcerated in the Mauritian prison service and a reintegration programme to ex detainees prior to and upon release.
Association Kinouété began delivering services in Women's prison in 2001, delivering L'Ecoute, counselling, psychological support and group therapy to female detainees. The Association formally registered as an NGO in 2003 and further developed its services to respond to identified needs in Male Prisons.

MISSION
To provide Rehabilitation and Reintegration Services to those who are or have been in prison with a view to giving each individual the ability to ***CHOOSE, DECIDE AND PLAN*** for themselves.

OBJECTIVES (See Kinouete programme structure)

- Increasing the socio-economic situation of our clients, to minimise repeat offending.
- Assisting detainees in improving self-knowledge and better understand the concepts of responsibility whilst in prison in order to enable them make a fresh start after their release.
- Focusing on helping the ex-detainees with the challenges of re-entry into their family circle, the workplace and the society at large.

STAFFING

The Rehabilitation Team consists of 5 qualified Voluntary staff who are also board and co-opted board members. They deliver services in Women's prison, 1 rehabilitation worker delivering L'Ecoute and group therapy in Male Prison as well as liaison with Prison Welfare staff.
The reintegration service consists of 2 front line workers alongside a Programme Coordinator, with administration / financial support and a Manager.

CASE LOAD

The NGO currently have an approximate active caseload of 350 clients with a further 1000 clients who despite being dormant cases can reactivate their interaction with our service at any time. We have an average of 60 attendances at our drop in centre every month

SERVICES OFFERED

- Alongside psycho social support, the NGO now offer life skills and a preparation for employment programme in Male prisons. We currently deliver the employment programme in:

- Petit Verger Prison
- Beau Bassin Men's prison
- Richelieu Open prison pre release programme

Kinouete Employment Programme

Session
Introduction of project / Assessment Form
Life skills: Confidence and confidentiality
What is work / Why do people work / contract
Life skills: Communication
Self employment / Working for someone else / Problems detainees face when looking for work
Life skills: Needs
Talentaris / How to look for employment
Life Skills: Communication
Choices part 1
Life skills: Open group discussion
Choices part 2
Life skills: Self acceptance
Money
Life Skills: Coping with my environment inside prison
Completing a curriculum Vitae (CV)
Life skills: Coping with my environment outside prison
Completing a curriculum Vitae (CV)
Life skills: Dependence v independence
National Empowerement Foundation Placement and training
Life Skills: Dependence v independence
Money
Life Skills: My story
Talentaris / How to keep a Job
Life Skills: My Story
What concerns do you have when you are released /Kinouete reintegration team / Evaluation

This programme will be extended to Womens prison in the coming few weeks

- The NGO run a drop in centre based in Port Louis which is opened as form 9.30 am to 5.30 pm, Monday to Friday where ex detainees, or family members of detainees can engage with our services, access counselling, get assistance to visit their detained family members, access to social welfare and referral on to specialist services according to identified need.

- A peer support group, "The Encounter group" made up of ex detainees at different stages of release and progress in the reintegration process, meet once a month in a group therapy setting, to support each other in the areas that affect them.
  An elected Peer Educator is currently being empowered to raise the concerns of our client group to improve the Association Kinouete services.

- Kinouete work with clients to assess their needs, action plan in a case management framework and aim to:

- Offer routes for employment, refer clients to specialist support agencies, including drug treatment, HIV and emergency housing facilities, We are currently working with the National Empowerment Foundation to develop the current Placement and Training programme to include detainees in the pre- release phase of incarceration and thereafter upon release.

- **Advocacy** remains one of Kinouete's **key activities**. Association Kinouete works with those with experience of incarceration, relevant stakeholders and others to raise concerns, ideas and solutions for change in appropriate fora, to heighten a real second chance for detainees once they are released.

METHADONE INDUCTION PROGRAMME IN PRISON

The prison population is 2,700 with an overpopulation of 20% in Mauritius[10]. Almost 40% of the Male inmates are incarcerated because of drug-related crimes. Of the total prison population, at any one time, around 30% of inmates are HIV positive. Sharing of smuggled injecting equipment is common in prison, thus increasing the risk of HIV transmission while in state custody.

Since 2006 Inmates initiated on methadone prior to incarceration continue to receive their daily dose while in prison. In December 2011 induction to Methadone for prison inmates incarcerated more than two months was authorised by the Government of Mauritius. The programme aims to reduce the transmission of blood borne infection among prison inmates and to make the prisons environment safer for all those who work, visit and are incarcerated within Mauritius prisons[11].

In December 2011,the NGO are collaborating with the prison service in the delivery of the new methadone induction programme launched at Beau Bassin Prison. The NGO kinouete currently form part of the joint assessment panel, involving medical professionals, the prison service and NGOs. This assessment panel reviews applications of detainees wishing to join the methadone induction programme.

[10] Prison Department, 2011.
[11] Protocol for Methadone Substitution Therapy in Mauritius Prison, 2011.

The NGO also proposes improvements in relation to service delivery to appropriately promote inclusion of those suffering from substance misuse onto the MIP.

BARRIERS ENCOUNTERED

A series of barriers are impeding the reintegration process from being truly successful. These are:

1. Equal and open access to mainstream society for ex detainees.

2. Currently beneficiaries face problems of Morality certificate which ultimately bars access to stable employment. They are forced into situations of being exploited in the workplace with low wages with no job security.

3. There are also significant issues in relation to appropriate housing where there are extremely limited options to access emergency housing or short to medium housing from where they can prepare to move on to independent accommodation.

4. The housing problem are more acute for female ex detainees. Females are undoubtedly more stigmatised and face specific barriers like disassociation from their children and Mauritian Society significantly marginalises this group where by they do not get a real second chance to reintegrate into mainstream society.

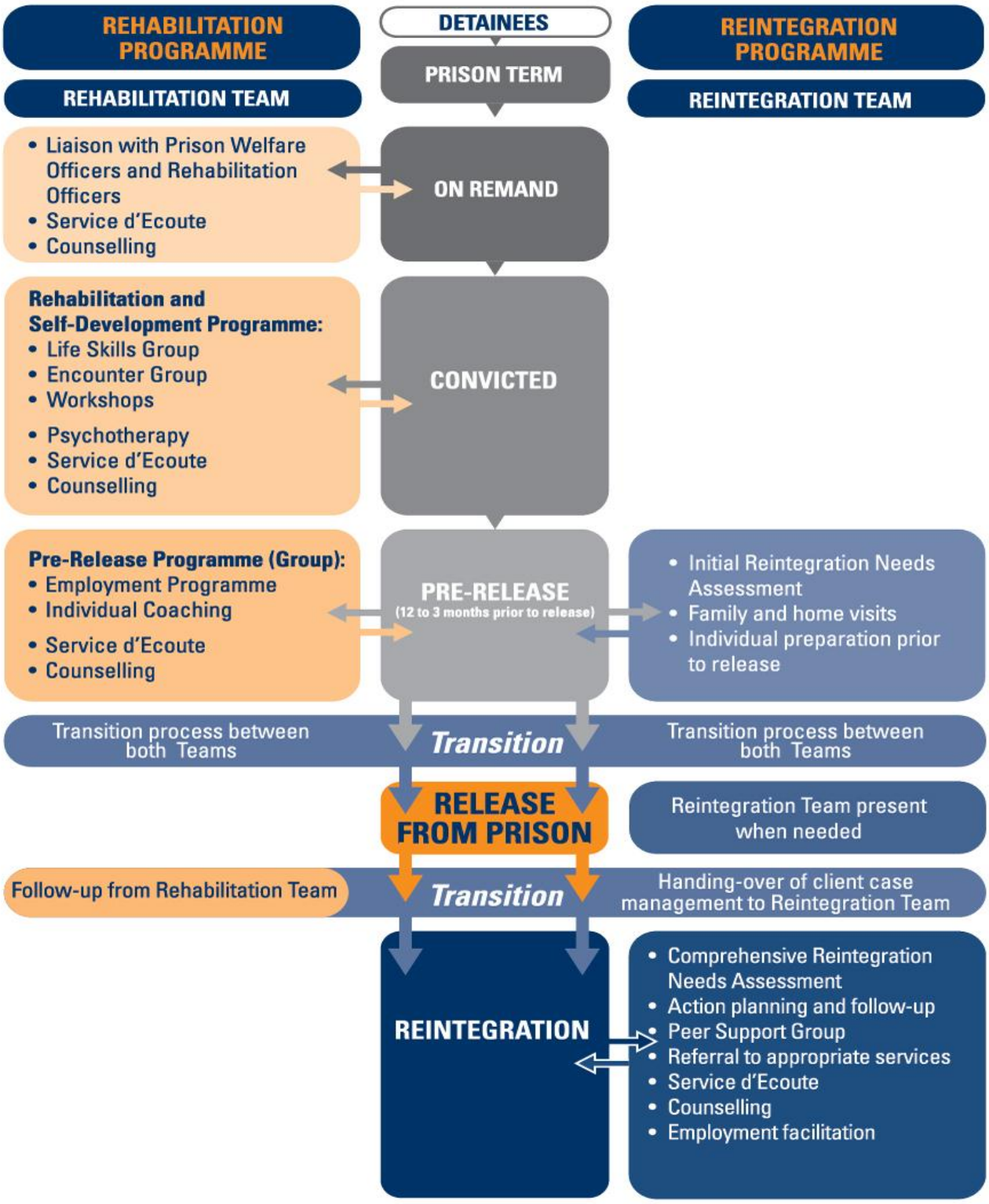
WAY FORWARD

The four main areas which form the basis for a successful reintegration are access to:

- Housing
- Employment
- Drug Treatment
- Meaningful participation in learning new skills

If an individual does not have support to house themselves and to access employment at a living wage, the reintegration process is unlikely to be successful. The question is “What will people have to do to survive if their access to society is denied?” Recidivists cannot be entirely to blame if society does not invest in structures that enable them to move forward in areas that can only be described as basic human needs.

KINOUÉTÉ PROGRAMME STRUCTURE



v. Major challenges and remedial actions

Table : Major Challenges in 2009 Remedial Actions and Progress Achieved in 2012

KEY CHALLENGES REPORTED IN 2009 UNGASS COUNTRY PROGRESS REPORT		PROPOSED REMEDIAL ACTION IN 2009	PROGRESS ACHIEVED 2009-2012
1	Baseline data on vulnerable children and a clear definition of street children in the Mauritian context so as to be able to design appropriate prevention strategies targeting children at high risk and out of school children in particular including street children	Liase with Ministries concerned and NGOs to facilitate retrieval of data, either through a survey or programmatic data on vulnerable children.	A study on Street Children in Mauritius was carried out in 2011 with the overarching objective of defining and quantifying the street children phenomenon in Mauritius and to develop appropriate strategies
2	HIV/AIDS data not centralised	An intranet system between the Central Health Laboratory, NAS, AIDS Unit and NDCCI to facilitate capture and analysis of data in a timely manner.	- M&E unit strengthened at National level - Stakeholders trained in harmonized M&E tools - Data flow established - Consolidation of data is being done at National Level, allowing analysis of data in a timely manner and facilitating decision making.
4	Low uptake of services and low adherence to ARV therapy. Still constitutes a major challenge in the management of PLWHA.	Because adherence to ART is a complex process, multifaceted interventions need to be design to improve	Multi-faceted interventions have been introduced: • Treatment literacy • Training of Staff on

		adherence e.g Patient's education, patient's – Health Care Workers relationship, psychosocial support and introduction of DOTS.	psychosocial support • A contact tracing strategy and follow-up of PLWHIV on ARV set up.
5	To reach a 100% uptake of PMTCT protocol by HIV+ pregnant mothers.	A dedicated staff for contact tracing and visit of HIV positive pregnant mother in the community	After the setting –up of a contact tracing strategy among HIV + pregnant women, a 95.7% of HIV pregnant women received PMTCT in 2011 as compared to 68.3% in 2009. Contact tracing strategy decentralized at regional level with the collaboration of midwives in ante-natal clinic.
6	Inadequate psychosocial support to PLWHA/IDU on MST and NEP	Training of trainers in psychosocial support	- Under the GFR8 funding, 2 part-time psychologist were recruited to provide psychosocial support to KAP - Peer educators among Prison inmates are regularly trained to provide psychosocial

			support
	During the validation workshop there was a lot of discussion pertaining to Home- based which is still in an embryonic stage	A protocol and a model of practice on Home-Based Care need to be set- up to guide planning, implementation through the creation of a register for all HIV/AIDS patients needing such care and to facilitate its monitoring and evaluation.	The process for the write-up of the NSF 2012-2016 has started. NGOs will be encouraged to come forward with a project on Home –based Care. Enhanced Community support through awareness.
	The setting up of a functional surveillance system remains a challenge	Provide means and dedicated human resources to implement the surveillance Plan.	-A functional surveillance system in place with regular IBBS in KAPs and BSS in general population -Sentinel surveillance sites
	Minimal participation of workplace and business sector in the fight against HIV and AIDS.	Work place and Business sector participation needs to be scaled-up and documented by regular report submitted to the National AIDS Secretariat.	With the support of the Indian Ocean Commission "AIRIS Project", an HIV Workplace Policy has been designed and validated by the Ministry of Labour.
	Need for capacity building of all partners involved in the fight against HIV have been highlighted, especially technical know-how to	Capacity building for all partners involved in the fight against HIV.	Capacity building for NGOs has been done in the following fields:

	capture funding for the NGOs.	Capacity building of service providers to scale-up HIV testing, prevention activities and treatment	• M&E • Rapid HIV testing • Psychosocial support • Project writing • Financial management • Lifeskills • Mgt of Peer education programme • NASA • RBM
	A functional national M&E System with optimal use of designed tools by both government and CSO partners	Coordination, Monitoring and evaluation of activities undertaken by NGOs, Line ministries and Civil societies involvement in the implementation of the NSF through regular reporting to the NAS including data on agreed indicators	A functional M&E system in place.
	Life skills education in school not yet well defined and catered for mostly by other Ministries and NGOs	It is becoming imperative for the Ministry of Education and Human Resource to develop a policy after a multi	This is still a challenge. Advocacy towards the Ministry of Education has been carried out regularly but it is difficult for a sole

		sectoral round table and consultancies on the design, planning of a comprehensive and standardized lifeskills-based education so as to empower the in-school youth to adopt safe behavior.	person to be responsible of all health matters in schools. This results in limited and inefficient means to bring about behavioural change through sporadic awareness in school settings in spite of the goodwill of all partners involved in the fight against HIV/AIDS..
	Post-test counseling and giving negative tests results is still a challenge in some cases	Strategies need to be developed to facilitate post test counseling and giving negative tests results among ANC attendees , Blood donors, Prison Inmates on remand.	A National HIV rapid testing strategy is in place. According to the BSS study among 15-49 yrs, 64% had an HIV test and 90% got their results
	Public and Private medical sector involvement should be reinforced specially for the PMTCT protocol.	A National HIV and AIDS policy may pave the way to a closer involvement of the private medical sector in the management of PLWHA.	Regular training of Private practitioners and midwives has been carried out. Treatment guidelines have been distributed to standardize the management of PLWHA across the service.

	Stigma and discrimination still present.	Amendments of laws that may constitute barriers to prevention and treatment.	-Efforts are being made to create an enabling environment. The Equal Opportunity Act consolidates action taken to eliminate Stigma and discrimination -Involvement of religious leaders in Mass media campaign and in the community to promote testing. - On-going training of Health care workers -Mass media campaign on prevention of stigma carried out.
	Rodrigues and outer island- Capacity building for implementation of programme and M&E still needed		Training on M&E has been carried out for Officers of Commission of Health and members of Rodriguan NGOs. Awareness and HIV rapid tests was organized for all people living in Agalega Island.
	Written policies for all HIV/AIDS issues to help remain focused	Technical Assistance for the elaboration of HIV/AIDS policies	National HIV policy in place.

KEY CHALLENGES 2012

1. In this present financial constraints environment, mobilizing fund for a robust National Response is a challenge.
2. Absence of linkage between the HIV program and other national programme
3. Absence of a partnership forum.
4. No evidence –based data to inform strategies to mitigate Stigma and discrimination
5. The development of a budgeted HIV and AIDS Research and Evaluation Strategy to guide implementation in order of priority.
6. Gender equality based approach in the area of access to medical care and patient follow-up especially in the KAP.
7. The introduction of NEP and condoms in prisons
8. A costed programme of HIV prevention and health promotion activities is prepared for 2011 in line with the government of Rodrigues budget cycle

REMEDIAL ACTIONS

- The possibility of co-funding of a project may help in mobilizing the required funding.
- Advocacy , training and human resource to facilitate the implementation of NEP in Prison
- To secure funding for the conduct of the stigma index in order to have evidence based data to establish a baseline for efforts to address stigma at the level of institutional and individual behavior.
- Advocacy to include a budget line for AIDS activities in Rodrigues in accordance with the NSF 2012-2016.

VI. Support from the country's development partners

According to the Analysis of Matrix on Financing sources by Financing Agents in NASA (2010), the government remains the major source of HIV and AIDS funding in the country, accounting for 67%, of spending in 2010.The increased proportion of spending on HIV in Mauritius by the Multilateral source can be attributed to the Global Fund Round 8 Grant in 2010.

Table: Contribution by Financing Source

Financing Source	Value (MRU)	Value in (USD)
DOMESTIC SOURCES		
Public Fund-National Funding Resource	141,944,274	4,894,630
Private Sector Contributions	7,698,567	265,468
MULTILATERAL/Bilateral		
Ambassade de France	61,224	2,111
The Global Fund to Fight AIDS, Tuberculosis and Malaria	48,586,079	1,675,382
US Government (GMS)	3,000,000	103,448
UNAIDS	4,148,949	143,067
United Nations Development Programme (UNDP)	4,296,619	148,159
World Bank (WB)	1,327,391	45,772
World Health Organization (WHO)	345,940	11,929
Fights AIDS Monaco	341,804	11,786
Indian Ocean Commission	3,857,086	133,003
INTERNATIONAL NGO'S		
Alliance	936,002	32,276
SIDACTION	1,535,584	52,951
GNP+	116,912	4,031
TOTAL	**218,196,431**	**7,524,015**

Source :NASA 2010

An appeal was also made to the private sector to contribute to the fight against HIV and AIDS through their Corporate Social Responsibility Funds[12]. The participation is still minimal but it is worth mentioning the contribution and support of the Rogers company, Barclays Bank, Mauritius

[12] Budget Speech 2007

Commercial Bank and Shell Company in terms of financial support to the NGOs, media campaign, awareness of their employees and financing surveys.

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

WHO

The core strategic areas of WHO support in 2010-2011 in line with national HIV/AIDS Strategic Plan and the pursuit of the expected results agreed upon are as follows:

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

- Provision of technical and financial support for introduction of new HIV investigations in the central Laboratory.

UNDP / UNAIDS

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

Technical support through the TSF for the Mid- Term Review of the NSF 2007-2011.

Indian Ocean Commission – AIRIS Project

The AIRIS project is a regional based project funded by the African Development Bank with the main objective of stemming the spread of HIV and start to reverse the current trend in IOC member states. To strengthen Mauritian response, the IOC/AIRIS project provide

- Technical and financial support to NGOs.

- Capacity building:

    - Referral doctors for management of PLWHA

    - Laboratory technicians

    - Key stakeholders on M&E and Surveillance.

    - Staff involved in the care and management of PLWHAS were trained on ESOPE (a software to better capture data on follow-up of PLWHA.)

- Peer review of member states system of Surveillance, Monitoring and Evaluation

UNFPA

UNFPA supports a broad spectrum of initiatives to prevent the transmission of HIV. Main achievements in 2010-2011 have been :

- The mainstreaming of HIV in the Sexual and Reproductive Health services.

- Capacity building through training of Health Care Workers.

- Strenghtened female condom utilization through the establishment of a comprehensive training programme for all Community Health Workers, Community Midwives and women Officers in women centers.

Global Fund R8

The Republic of Mauritius has achieved a successful phase 1 with an A1 rating.

For the phase 2, (2012-2014), an enveloppe of EU 2,967,754 has been approved to facilitate implementation of high impact capacity building, Scaling –up of services and the development of a robust Surveillance, Monitoring and Evaluation system.

Actions that need to be taken by development partners to ensure achievement of targets.

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

- An effective and functional Surveillance, Monitoring and Evaluation system that needs strenghtening.
- Media campaign to sustain fight against stigma and discrimination and to accelerate prevention activities.
- Surveys to gather timely data for a strategic response
-The strenghtening of the health system with the mainstreaming of HIV and AIDS and allied issues at Primary Health Community level.
-Stigma Index to have evidence-based strategies to mitigate Stigma and discrimination against PLWHIV

VII. Monitoring and evaluation environment

An overview of the current monitoring and evaluation (M&E) system

Monitoring and Evaluation is a critical component of the comprehensive HIV and AIDS plan. Since the M&E framework and "Operational Manual" developed in 2009, the Republic of Mauritius has progressed towards a developing M&E culture.

The global fund financial aid requirement for accountability and transparency has helped the M&E unit at NAS to put into place the required mechanism to improve data collection and data flow to ensure quality, valid and accurate data.

The Republic of Mauritius has **a functional Sentinel Surveillance** in place with the following sites:

- 142 ANC sites across the island including Rodrigues that provides consistent HIV and Syphilis prevalence data among pregnant women.
- Blood Donors are tested systematically for HIV, TPHA, Hepatitis B &C.
- STI clinics- All client with a case of STI are being tested for HIV.
- Counselling and Testing for all Prison Inmates
- Outreach programme with KAP (SW, MSM and PWID)

Research and Evaluation activities are key components in ensuring that the HIV response is evidence-based and responding to the appropriate aspect of the HIV epidemic in Mauritius Epidemiological research linked with ongoing surveillance is critical in assuring that the right population are being targeted by HIV interventions.
As some national level indicators can only be measured through specific research and studies, it is necessary to ensure that all evaluation and research activities capture the appropriate information needed by the M&E system

A comprehensive Research and Evaluation Strategy is in place to provide evidence-based data for Advocacy, Resource mobilization, programme planning, targeting, analysis and decision making.

- IBBS PWID 2009/2011
- Mid –Term Review of the NSF 2007-2011in May 2010
- IBBS FSW 2010
- IBBS MSM 2010
- Harm Reduction Evaluation 2011
- Joint Annual Review of the NSF 2007-2011, 2012.
- KABP (15-49 yrs)- 2012
- Street children 2012
- Rapid situational analysis on Drug Consumption in the island of Rodrigues.

Monitoring Resources spending

The tools for NASA have been developed in 2008/2009. In 2012 an intensive training in NASA was carried out with the help of UNAIDS. Following the training, the Finance Manager with a

team has carried out the NASA report for year 2010. The fact that this report has been carried out by Nationals is a proof that capacity has been built.

International Reporting

NAS with the support of national partners has consistently responded to international evaluation exercises (GARPR,AUC,SADC,UA,GFTAM and IOC) by regularly provide requested data pertaining to our National response.

Main challenges faced in the implementation of a comprehensive M&E system:

1. Timely dissemination of studies
2. Strengthened Communication among National Partners
3. Feedback mechanism to facilitate flow of information
4. Sustained capacity building at all level
5. Supervision at data collection level to ensure data quality at certain level.

Remedial actions planned to overcome the challenges.

1. To set time-frame for conduct and dissemination of surveys' findings.
2. To develop a communication strategy
3. Training on M&E to be included in the multi-sectoral operational plan.
4. Technical assistance on the use of existing software to facilitate the setting up of a National Data Base.

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