GLOBAL AIDS RESPONSE

COUNTRY PROGRESS REPORT 2012

Seychelles

Reporting for the Period: January 2010 – December 2011

Submission date: 31 March 2012

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ACRONYMS AND ABBREVIATIONS

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

SBC	Seychelles Broadcasting Corporation
SDD	Social Development Department
STI	Sexually Transmitted Infections
SW	Sex worker
TOT	Training of Trainers
UA	Universal Access
UN	United Nations
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
UNIFEM	United Nations Development Fund for Women
WHO	World Health Organisation

Introduction

The National Census 2010 indicated that the mid-2010 population by single years of age for males was 44,253 and 42,272 for females or an approximate sex ratio of 1046 men for every 1000 women. The sex ratio (males per 100 females) has gradually improved for males, from 98.2 in 1998 to 103.1 in 2006 and to its present state in 2011. The demographic composition of the Seychelles is changing as indicated by some of the results of the National Census conducted in August 2010. The country is still multi-ethnic, with its population being descendents from white French settlers and their African slaves, the few Indians and Malagasy settlers, and traders from India and China. There are new immigrants from Madagascar, India, East Africa, Southern Africa, China and Russia. The main religions are Roman Catholic (76.2%), Church of England (6.1%), Hindu (2.4%) and Islam (1.6%), with the other religions, mostly Christian denominations from evangelistic or Baptist origins make up the rest of the population[1].

The Seychelles economy is driven by the tourism industry, which accounts for 25.5% of the gross domestic product (GDP)[2]. The economy also recovered after important measures were taken to address the 2008 debt crisis, weathering recent global financial and economic crises relatively well, growing by over 5% from 0.7% in 2009 to an estimated 6% in 2010. Piracy attacks and threats in the Indian Ocean continue to affect the fishing sector adversely, however. The economy is projected to grow by 4% in 2011 and 4.5% in 2012[3]. The country now has a sustainable debt position after having re-structured the debt profile.

The IMF-guided programme, started in November 2008, targets further efforts to consolidate economic stabilization gains. Monetary policies are being taken to rationalize the tax system, including preparations for the launching of a value-added tax (VAT) in mid-2012[4].

Seychelles has a concentrated epidemic and the country have developed coordination structures and strategic documents and plans and to a certain extent put in place national monitoring and evaluation systems. The Seychelles has recently developed a new policy on HIV and AIDS and STIs and a National Strategic Framework for the period 2012-2016. The current HIV/AIDS programmes aim at the primary prevention of HIV infection, and the provision of care and support to PLHIV and those persons affected by HIV. These encompass sensitization and education through IEC activities, PMTCT, HTC, surveillance, blood screening and safety, accessibility to post exposure prophylaxis, provision of ARVs, treatment of opportunistic infections, and support of PLHIV.

The Seychelles' response to the pandemic dates back to 1987 when the first HIV infection was detected. This includes a short term plan of 1987 to 1988, a medium term plan of 1989 to 1993, thereafter ongoing annual plans, and a strategic plan for HIV/AIDS/STIs in 2001. The surveillance of the epidemic is conducted at sentinel points, such as the Communicable Disease Control Unit (CDCU), antenatal clinics, Occupational Health Unit (OHU) and the blood bank in the Ministry of Health and reveals that there is an increasing trend in HIV infections. As at December 31st 2012, 502 persons (290 males and 212 females) had been tested positive for HIV infections and 94 had died of AIDS-related diseases. Though the number appears to be low, the potential for an outbreak is ever present. Several risk factors have also been associated with increased risk of HIV infection.

There are new challenges as the cases of hepatitis C continue to increase exponentially. There were 157 cumulative cases (122 males and 35 females) from 2002 to 2011. 4 cases are co-morbid ones, with both HIV and HCV, and cumulative Hepatitis C positive pregnancies stands at 3 women, all diagnosed in 2011. The figures of new cases for 2011 are even more alarming – standing at 60 (47 males and 13 females) as of December 2011.

[1] National Bureau of Statistics, Population & Housing Census 2010
[2] http://www.africaneconomicoutlook.org/en/countries/east-africa/seychelles/
[3] Ibid.
[4] http://www.imf.org/external/np/sec/pn/2010/pn10162.htm

The Respondent-Driven Sampling (RDS) Survey conducted in 2011 in two key population samples, i.e., people who inject drugs (PWID) and Men who have sex with men (MSM), have confirmed this, with recorded prevalence of at least 5 times and 14 times respectively than that found in the general population (under 1%). Furthermore, there continues to be an increasing number of new detections of People living with HIV (PLHIV). Information obtained from the sentinel site (CDCU) indicates that from January to December 2011, 42 new HIV cases have been reported. Ages range from 18 years – a male to a 78 year old female. Males account for the majority of new cases, with 59% (25) while 41% (17) were females.[5]

There is cause for concern as there are now new dynamics in the development of pandemic. There has recently been a dramatic rise in the number of persons detected with the Hepatitis C virus. "*In 2002, there were two HCV cases. No new cases were detected between 2003 and 2007. In 2008, there were eight new HCV cases, 32 cases in 2009 and 52 cases in 2010. There are eight cases of HIV and HCV co-infection. All the new HCV cases from 2008 are among IDU*"[6]. The prevalence of HIV and Hepatitis C as recorded in the RDS survey is alarming, with "*… HIV prevalence among IDU in the Seychelles was 5.8%. Only 0.7% of IDU were found to be infected with Syphilis and 0.1% infected with Hepatitis B. However, 53.5% of IDU were infected with Hepatitis C*."[7]

In the MSM sample from the RDS survey 2011, the prevalence of HIV was 13.2 and Hepatitis C was 41.9%. Moreover, amongst those who tested positive for HIV, 20.6% were co-infected with Hepatitis C. Since the first PLHIV was detected in 1987, there have been speculations amongst health and non-health professionals that the key populations must be affected in significantly different ways than the general population. However, there has never been any scientific confirmation until the recent biological and behavioural study.

The study has also changed the way health and non-health professionals, Government, civil society and all stakeholders look at the HIV and AIDS and STIs situation in the country. No longer are people comforted or basking in the illusion that the epidemic is of very low prevalence in Seychelles. Whilst this may still hold true for the general population as positive results still represent less than 1% of total annual tests done, the situation in key populations shows that the national response need to change to address the real societal, economic, psychological and behavioural drivers of the epidemic.

The HIV and AIDS and its related sectors and partners have been very active in 2010 and 2011, with various exercises, studies and other work being done. In the table below, the various national activities conducted in 2010 and 2011 are presented.

5 CDCU data, 2011

6 Ministry of Health Injection *Drug Use in Seychelles: Integrated Biological and Behavioural Surveillance Survey Round 1*. p. 10

7 Ibid. p. 60

Table 1: National activities undertaken in 2010 and 2011

Year	Activities
2010	⅄ Development of the Seychelles National Multi-Sectoral Monitoring and Evaluation Framework for HIV and AIDS and STIs ⅄ Development of the Draft National Policy on Harm Reduction Measures to address the issue of HIV and AIDS, hepatitis C and other health issues in relation to PWID, SW and MSM and vulnerable groups ⅄ Study on sex workers by the Drug and Alcohol Council ⅄ Study on sex workers by the Social Development Department ⅄ National Youth Study by the Drug and Alcohol Council ⅄ Organisation of the 9th Indian Ocean Commission Colloquium on HIV and AIDS, held in Seychelles
2011	⅄ Review of the ***National Policy on the Prevention and Control of HIV and AIDS and STIs 2001*** ⅄ Review of the ***National Strategic Plan for HIV and AIDS and STIs 2005 – 2009*** ⅄ Preparation, validation and completion of the ***National Strategic Plan for HIV and AIDS and STIs 2012-2016*** (The ***National Policy***, the ***National Strategic Framework***, the ***National Costed Operational Plan*** and the ***National Multi-Sectoral Monitoring and Evaluation Framework***) ⅄ Mode of Transmission Study ⅄ National AIDS Spending Assessment Study ⅄ Respondent-Driven Sampling Survey on PWID and MSM ⅄ Development of a Behavioural Change Communication Policy ⅄ Development of a Blood Safety Policy ⅄ Development of the National Sexual and Reproductive Health Policy ⅄ Development of the National HIV Testing and Counselling Policy ⅄ Restructuring of the national coordination body – ***National AIDS Council (NAC)***

The year 2011 culminated in the validation of the **National Strategic Plan for HIV and AIDS and STIs of the Republic of Seychelles 2012 – 2016 (NSP2012-2016)** which follows the review of the previous plan for the period 2005 – 2009 and Policy developed in 2001. The main aim is to have a national response that is coordinated, coherent and comprehensive. The new NSP is aligned to a number of international instruments, namely the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the "Three Ones" and the UNAIDS 2011 – 2015 Strategy: Getting to Zero. The national instruments include the Medium-Term National Strategic Plan 2011-2013, the Millennium Development Goals Status Report 2010 and the Seychelles Common Country Report 2010[8].

The Ministry of Health is the lead organisation in the national response to HIV and AIDS fight since the detection of the first case of HIV infection in 1987. It naturally spearheads treatment and care. However, the national response is multi-sectoral for the following programmes: prevention and behaviour change, impact mitigation and respect for human rights as well as resource mobilisation, coordination and monitoring and evaluation. Other ministries, private sector organisations and NGOs are actively involved in developing, implementing and monitoring programmatic actions at all levels – national, regional and local.

The Government is committed to providing a coordinated, comprehensive, cohesive and well-funded national response to HIV and AIDS and STIs. This commitment is expressed through the creation of the national AIDS

8 National Strategic Framework for HIV and AIDS and STIs of the Republic of Seychelles 2012 – 2016 (NSF2012-2016)

programme, adoption of the National Policy 2011 endorsed by the President, adoption of the new National Strategic Plan 2012-2016, the creation and restructuring of the National AIDS Council and the setting up of the National AIDS Trust Fund, funding of activities by government and external resources, and adherence and compliance to international conventions and principles including the UNGASS declaration.

Seychelles has made much progress in developing and implementing appropriate policies to respond to the potential national development challenge that HIV and AIDS pose. The national response has become more multi-sectoral and HIV and AIDS are no longer mainly perceived as a health issue. It is noted that NGOs, CBOs (Community-based Organisations) and FBOs (Faith-based Organisations) as well as the local private sector and the national media houses are now more engaged in implementing programmes. Moreover, they are involved in developing the policies and designing these very programmes. Most people now truly recognise the potential for a national disaster if the issue of HIV and AIDS is not addressed in an intelligent and pragmatic manner.

Therefore, the national response needs to be sustained through continuous attention from the Government, civil society, the private sector, the general public and the international community. Being a small island developing state, the Seychelles sometimes lack the necessary human, material and financial resources needed to sustain its actions. It is important, therefore, to realise that gains can be lost if actions are not sustained locally and international support wanes. This is why the new ***National Strategic Plan for HIV and AIDS and STIs 2012-2016*** pays a lot of attention to monitoring and evaluation as well as resource mobilisation to ensure that progress is continuously measured and that spending is justified.

Background and time frame for UNGASS reporting

Given the newly released instructions of the reporting of 2012, which will combine the UNGASS indicators and the Universal Access data, and taking into consideration the limited human resources of the country, UNAIDS is requested to support the country in succeeding in its reporting for UNGASS 2012, by providing financial support for a National Consultant.

Organisation of the exercise

ROLE OF THE UNGASS WRITING TEAM

The writing team was put in place to coordinate the whole process to support the country UNGASS reporting. This will greatly ease the exercise since the members of the existing Steering Committee put in place was already used to some aspects of the reporting, especially those who were forming part of the M&E Technical Working Group and the costing team. However, the steering committee work has shown some limits, especially in relation to the limited availability of the members for attending meetings and for providing technical inputs. Thus the creation of few technical UNGASS Writing team members Therefore, the meetings will be limited to a maximum of 4, and the consultant will, with the support of the NAC team, ensure one major part of the reporting with regards to the writing of the narrative reports.

Structure the UNGASS Writing Team support and coordination framework

1. Finalize the roles and responsibilities in the assignment of the national consultant
2. Identify key documents and data sources for the exercise
3. Develop methodologies and tools for the exercise
4. Develop detailed Project Work Plan, schedule of key stakeholder interviews and field visits
5. Develop the schedule of steering committee meetings (for methodology validation, Spending Matrix and for NCPI & indicators validation)

1. Recruitment of the consultant
2. Desk review + Work and consultations on the NCPI
3. Data collection for the spending information from all the stakeholders(field visit)
4. Data collection for the UNGASS indicators

5. Conduct the validation for the NCPI, the spending data and the UNGASS indicators

The methodology including the stakeholders to meet/visit

- National structures (NAC, AIDS Programme, NATF)
- Technical bodies (TAC, epidemiology and statistics units,…)
- NGOs
- International partners and Un organizations
- Faith Based Organizations
- Private Sector Organizations
- Health sector structures including health centers, the youth centre, CDCU, private practitioners, etc
- At least one district HIV&AIDS Committee
- Community based organizations and structures
- People living with HIV and Women living with HIV
- Representatives of key populations (sex workers, IDUs and MSM) and MARPs (Youth, Prisons,…)

Multi-Sectoral Steering Committee

In the framework of this exercise, the multi-sectoral Steering Committee has the following tasks and responsibilities:

- Validation of the methodology of the exercise
- Facilitation of the NAS work within respective sectors (access to informants and documents)
- Validate the NCPI report
- Validation of the spending matrix
- Validate the country UNGASS indicators before submission on line

NATIONAL OWNERSHIP OF THE PROCESS

The consultant worked directly with the NAS in Seychelles and other relevant structures of the Ministry of Health, responsible for ensuring that feedback, documentation and support were provided to the consultant for timely completion of the assignment.

To assist with the ground work and support the processes of the activities, the **Multi- sectoral Steering Committee** provided the technical assistance and monitor the progress of the exercise. In addition, the Technical Advisory Committee on HIV&AIDS and STIs (TAC) was consulted and provided their technical input during the whole process.

The final UNGASS indicators, spending data and NCPI were validated by Technical Advisory Committee for HIV/AIDs & STIs and Multi-Sectoral Steering Committee before the deadline of March 31st, 2012.

TIMEFRAME

The duration of the activity will be 25 working days to start on February 20th , 2012 and to end on March 31st, 2012.

Taking into consideration the above methodology, the following timeframe is proposed:

Activity	Timeframe	Dates	Responsible
Communication processes with the UNGASS Global AIDS Response Progress Reporting Team	31 days	1st Dec. 2010-	NAS
Online Webinar	Half a day	02nd Feb.2012	NAS
Finalisation and validation of the UNGASS development TORs Seychelles	5 days	06-10 February 2012	NAS
Establishment of the core writing team headed by the NAS	4 days	10-14th February 2012	NAS
Recruitment of the consultant	10 days	10-20 February 2012	NAS
Desk review + Work and on the NCPI including interviews	7 working days	14-21stFebrurary 2012	Core Writing team
Data collection for the spending information from all the stakeholders	15 working days	14 – 29th February 2012	Core Writing team
Data collection for the UNGASS indicators	15 working days	14- 29th February 2012	NAS
Cont - Desk review + Work and on the NCPI(Outstanding forms)	7 working days	29th Feb. – 07th March 2012	Core Writing team
Pre-validation and validation processes (NCPI, spending data and UNGASS indicators) TAC/Steering committee	**3 working days**	8th- 10th March 2012	Core Writing team/Consultant
Data processing and up loading into reporting tool	30 working days	1st – 30th March 2012	NAS
Production of **Narrative Report, NCPI, Spending matrix and CRIS Circulated for Approval** by NAC	7 working days	19th- 23rd March 2012	Core Writing team/Consultant
Final input into the reporting tool	6 working days	26th- 30th March 2012	Core Writing team/Consultant
TOTAL	**110 working days**		

Seychelles has already submitted its UNGASS Report 2009. It was then noted that the consultations undertaken were instrumental in helping to draft the report. The same consultative processes have been used in the preparation of the UNGASS Report 2011 and they have been useful in identification of areas of progress as well as those which need further attention to improve the work being done.

I. Status at a glance

Table 2: Status at a glance

INCLUSIVENESS OF STAKEHOLDERS IN REPORT WRITING PROCESS	
Extensive consultations undertaken with individual sectors and persons Data collection completed for indicators 1 – 24: Data collection for indicator 6 (NASA): Meeting with all stakeholder representatives (for NCPI): Meeting with Ministry of Health Technical Advisory Committee (TAC): Meeting with stakeholders	 February – 05th March 2012 February – 10th March 2012 01-March-2012 half-day workshop / meeting 27-March-2012 half-day workshop (morning) 27-March-2012 half-day workshop (afternoon)
STATUS OF THE EPIDEMIC	
New Cases in 2010 (January to December) PLHIV AIDS Cases Deaths HIV Positive Pregnancies New Clients on HAART	 33 (17M / 16 F)16 (9M / 7F) 8 (3M/ 5F) 6 21 (13M / 8F)
New cases in 2011 (January to December) PLHIV Cases AIDS Cases Deaths HIV Positive Pregnancies New Clients on HAART	 42 (25M / 17F) 20 (14M / 6F) 10 (10M) 6 43 (20M / 23F)
POLICY AND PROGRAMMATIC RESPONSE	
No strategic plan in 2010 & 2011; used the one for period 2005-2009 Policy dated in 2001 Both documents have been reviewed, re-drafted and adopted in 2011 Most programmes in all priority areas continued to be rolled in 2010 & 2011	
NATIONAL COMMITMENT AND ACTION Domestic and international AIDS spending by categories and financing sources: National Composite Policy Index:	 Funding matrix uploaded Separate document uploaded

I. Status at a glance (cont.)

Target 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 GARP DD	*N/A
1.2 Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15 GARP	N/A
1.3 Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months GARP	N/A
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 GARP	N/A
1.5 Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results GARP	N/A
1.6 Percentage of young people aged 15-24 who are living with HIV GARP	N/A
	Sex workers
1.7 Percentage of sex workers reached with HIV prevention programmes GARP DD	N/A
1.8 Percentage of sex workers reporting the use of a condom with their most recent client GARP DD UA	N/A
1.9 Percentage of sex workers who have received an HIV test in the past 12 months and know their results GARP DD UA	N/A
1.10 Percentage of sex workers who are living with HIV GARP DD UA	N/A
	Men who have sex with men
1.11 Percentage of men who have sex with men reached with HIV prevention programmes GARP	96%
1.12 Percentage of men reporting the use of a condom the last time they had anal sex with a male partner GARP DD UA Casual partners Commercial partners Regular male partners	 55.3% 37.3% 54.5%
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 GARP DD UA	56%
1.14 Percentage of men who have sex with men who are living with HIV GARP DD UA	13.2%
Testing and Counselling	
1.15 Health facilities that provide HIV testing and counselling services UA	100%
1.16 HIV testing in 15+ (from programme records) UA	9430
Sexually Transmitted Infections (STIs)	
1.17 Sexually Transmitted Infections (STIs) UA	100%

I. Status at a glance (cont.)

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 GARP DD UA	N/App no formal NSP
2.2 Percentage of people who inject drugs who report the use of a condom at last sexual intercourse GARP DD UA	88%
2.3 Percentage of people who inject drugs who reported using sterile injecting equipment the last time they injected GARP DD UA	No data available
2.4 Percentage of people who inject drugs that have received an HIV test in the past 12 months and know their results GARP DD UA	89%
2.5 Percentage of people who inject drugs who are living with HIV GARP DD UA	10.8%
2.6 Opiate users	345
2.7 NSP and OST sites	N/App No formal NSP or OST programs
Target 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 GARP DD UA	100%
3.2 Percentage of infants born to HIV-positive women receiving a virological test for HIV within 2 months of birth UA	100%
3.3 Mother-to-child transmission of HIV (modeled) UA	0%
3.4 Pregnant women who know their status UA	100%
3.5 Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months UA	N/A
3.6 Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing UA	100%
3.7 Infants born to HIV-infected women receiving ARV prophylaxis for prevention of Mother-to-child-transmission UA	100%
3.8 Infants born to HIV-infected women who are provided with ARVs to reduce the risk of HIV transmission during breastfeeding UA	100%
3.9 Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth UA	100%
3.10 Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit UA	100% replacement feeding
3.11 Number of pregnant women attending ANC at least once during the reporting period UA	1504 (2010) 1780 (2011)
3.12 Health Facilities UA	3 or 25%

Target 4. Have 15 million people living with HIV on antiretroviral treatment by 2015	
4.1 % of eligible adults and children currently receiving antiretroviral therapy GARP UA	100%
4.2 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy GARP UA	100%
4.2b HIV treatment 24 month retention UA	81.13%
4.2c HIV treatment 60 month retention UA	N/A
4.3 Health facilities that offer antiretroviral therapy UA	3 public 0 private
4.4 4.4 ART Stockouts UA	0
4.6. HIV Care UA	100%
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 GARP DD UA	100%
5.2 Health care facilities providing ART for PLWHIV with demonstrable infection control practices that include TB control UA	3
5.3 Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT) UA	Not relevant
5.4 Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit UA	100%
Target 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	Separate document uploaded
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) GARP	Separate document uploaded
7.1b WHO Policy questions UA	Data available
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 GARP	N/A
7.3 Current school attendance among orphans and non-orphans aged 10–14 GARP	100%
7.4 Proportion of the poorest households who received external economic support in the last 3 months GARP	**N/A

***N/A** = *Data Not Available*; **N/App** = *Not Applicable to Seychelles*

****The data is available but it is not disaggregated by category of persons assisted. Therefore, it is not possible to have the exact number of PLHIV who are receiving social welfare assistance. However, it is expected that all PLHIV requesting assistance and who have been means tested would be receiving some measure of aid from the Social Welfare Agency.*

II. Overview of the AIDS epidemic

The first set of data is from the Communicable Disease Control Unit (CDCU) and represents sentinel site data. "*Seychelles has not yet developed a specific HIV surveillance system that can be used to estimate accurately the true magnitude, or make a credible projection of the epidemic in the country. However, a new Disease and Surveillance Response Unit has been set up within the Epidemiology & Statistics Division which will be responsible to carry out the surveillance of communicable diseases and eventually non-communicable diseases in the near future*"[9]. The first recorded HIV infected person in Seychelles was diagnosed in 1987 and the first recognized full-blown AIDS case was reported in 1992.

Situation from 1987 to December 2011

Cumulatively, as of December 2011, there have been 502 PLHIV reported of whom 58% (290) males and 42% (212) females. Currently, there are 323 (182 males and 141 females) PLHIV, representing 56% males and 44% females. A cumulative 162 clients (87 males and 75 females) have been started on Highly Active Antiretroviral Therapy (HAART) to date[10].

Table 3: Cumulative data from 1987 to December 2011 (Source: CDCU, 2011)

Local Situation from 1987 to December 2011 (Cumulative data)	
PLHIV	502 (290M / 212F)
PLHIV having developed AIDS	230 (141M / 89F)
Deaths	94 (58M / 36F)
HIV Positive Pregnancies	82
Living with HIV/AIDS	323 (182 M / 141F)
Clients on HAART	162 (87M / 75F)
Left Seychelles	85 (51M / 34F)

[9] Ministry of Health, Disease Surveillance and Response Unit *HIV and AIDS, Hepatitis B, Hepatitis C and Syphilis Local Situation December 2011* p. 2

[10] Ibid. p. 3

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

Table 3b: Percentage of adults and children with advanced HIV infection receiving ART (Source: Patient Register, CDCU)

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

Situation in 2010

Table 4 below gives a summary of HIV and AIDS situation in calendar year 2010, from January to December. There were 33 new PLHIV reported, of whom 48% were females and 52% were males. The age range of the new PLHIV was from 16 years old (the youngest, a female) to 75 years old (the oldest, a male). There were also 16 new persons who had developed AIDS cases have been reported. Out of these cases, 6 were known PLHIV who had defaulted over the years and had reported in late stage of AIDS. There were 9 new reported PLHIV who had also sought treatment in late AIDS stage. One of the latter group was a known PLHIV since 2008. Their age range was from 26 to 75 years.

There were 8 AIDS-related mortalities with 2 new persons reporting in late stage of AIDS. One person died of Steven Johnson Syndrome whilst 2 other ones were known PLHIV who have defaulted over the years and hence reported in late stage of AIDS. Two clients experienced therapeutic failure due to multiple drug resistance and another had Myeloid Leukaemia. One client died as a result of post-operative complications (DIC). The clients' age ranged from 33 to 58 years.

There were 6 new HIV positive pregnancies reported in 2010, comprising of 5 new cases and 1 known case. Two women had already delivered by LSCS. Their age ranged from 18 to 32 years. All mothers have benefited from the Prevention of Mother to Child Transmission Programme (PMTCT).

Table 4: Local Situation from January to December 2010 (Source: CDCU, 2010)

Local Situation from January to December 2010 (annual data)	
PLHIV	33 (17M / 162F)
PLHIV having developed AIDS	16 (9M / 7F)
Deaths	8 (3M / 5F)
HIV Positive Pregnancies	6
New clients on HAART	21 (13M / 8F)

Situation in 2011

Table 5 below gives a summary of the situation locally for calendar year 2011, from January to December. There were 42 new clients, of whom 25 (60%) were males and 17 were females tested positive for HIV. Their age ranged from 18 (male) to 78 (40%) years old (female). There were 20 (14M/6F) new AIDS cases reported representing 70% males and 30% females. Of these, 13 were newly detected HIV cases who reported in late stage of AIDS and the remaining 7 cases had defaulted treatment and review over the years.

There were 10 deaths reported for 2011, all males, with ages ranging from 21-68 years. However it is important to note that before the introduction of HAART, AIDS related mortality was 3.1% (1 death out of 32 PLHIV) in 1993 to 15.0% (12 deaths out of 80 PLHIV) in 2001 and dropped drastically to 2.7% (7 deaths out of 206 PLHIV) in 2005 and 3.1% (10 deaths out of 323 PLHIV) in 2011. The slight increase is due to non-adherence to treatment and late stage AIDS reporting for a number of clients. Both issues are considered serious and impediments to Seychelles' achieving all the goals of "Getting to Zero". They are addressed in the new ***National Strategic Plan for HIV and AIDS and STIs 2012-2016*** and specific programmatic actions have been proposed to eliminate this problem.

Throughout 2011, 6 HIV positive pregnancies were reported. There were 5 clients (83%) who were known PLHIV. Their age ranged from 17 years to 35 years. There were 43 (20M / 23F) new clients initiated on HAART, representing 46% males and 54% females respectively.

Table 5: Local Situation from January to December 2011 (Source: CDCU, 2011)

Local Situation from January to December 2011 (annual data)	
PLHIV Cases	42 (25M / 17F)
PLHIV having developed AIDS	20 (14M / 6F)
Deaths	10 (10M)
HIV Positive Pregnancies	6
New Clients on HAART	43 (87M/75F)

Causes of AIDS-Related Mortality

Table 6 shows the number and percentages of causes of AIDS-related mortality from 1993 to 2011. The most common cause of death is respiratory failure followed by AIDS and sepsis. Other common causes include cancers of the oesophagus, cervix, rectum and liver amongst others.

Table 6: Number and percentage of causes of AIDS-related mortality (Source: MoH, 2011)

RESPIRATORY CAUSES	AIDS AND SEPSIS	CNS	CANCERS	DRUG ADVERSE REACTIONS	CARDIOVASCULAR CAUSES
30	22	18	17	4	3
32%	23%	19%	18%	4%	3%

Modes of Transmission

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

HIV Prevalence and HIV Tests

Seychelles conducts a high number of tests, well over 9000 per year. The sum is almost equivalent to 10% of the total population. Positive results remain low. Indeed, "*… Over the years there has been a general decrease in the prevalence of HIV amongst blood samples tested from VCT centers, Wards, Antenatal Clinics and Blood Transfusion Centre. This data has to be interpreted with caution since no sero-prevalence surveys has been conducted in the general population to estimate the real prevalence of HIV.*"[11]

Table 7 shows that the prevalence of HIV per 1000 tests was 3 for 2010 and 4 for 2011.

Table 7: Number of tests and prevalence per 1000 tests for 2010 and 2011 (Source: MoH, 2011)

	2010	2011
Total number of cases	33	42
Females	17	17
Males	16	25
Total No. of HIV tests	9522	9430
Prevalence per 1000 / HIV tests	3	4

The second set of data is from the RDS survey conducted in 2011 on two key populations, i.e., PWID and MSM. The results for PWID are presented first.

Table 8 shows a summary of data for prevalence for HIV, syphilis and Hepatitis B and C. HIV prevalence among PWID in the Seychelles was 5.8%. Only 0.7% of the sample was found to have contracted syphilis whilst 0.1% was Hepatitis B (HbsAg) positive. However, 53.5% of PWID had Hepatitis C (HCV). Among female PWID, 4.6% were HIV seropositive. Co-infection rate is a cause for concern as 16% of HIV positive PWID had also contracted HCV.

The median age for first sexual encounters was 15 years. PWID have multiple types of sexual partners, including occasional and commercial partners. The median number of sexual partners of the opposite sex was two and condoms use was inconsistent.

[11] Ministry of Health, Disease Surveillance and Response Unit *HIV and AIDS, Hepatitis B, Hepatitis C and Syphilis Local Situation December 2011* p. 9

Table 8: Prevalence of HIV and Syphilis among PWID, Seychelles, 2011[12]

	Seychelles (N=346)		
	N	%	95% CI
HIV			
Negative	332	94.2	89.9, 98.6
Positive	13	5.8	1.4, 10.1
Syphilis			
Negative	344	99.3	98.1, 100
Positive	1	0.7	0.1, 0.2
Hepatitis B			
Negative	1	0.1	0.02, 0.2
Positive	343	99.9	99.8, 99.9
Hepatitis C			
Negative	200	46.5	35.9, 57.0
Positive	145	53.5	42.9, 64.1

"*Three hundred and forty six (346) unique objects were distributed to IDUs one week prior to the initiation of the survey and 20.7% IDUs reported receiving one. With this information the population size estimation of IDU was calculated to be 1,671 (673, 1706) or 3.0% of the adult population of Seychelles. The mean of all multipliers is 1,283 or 2.3% of the population. Females comprise 257 of the adult IDU population in the Seychelles.*"[13]

Table 9 gives a summary of findings in relation to prevalence for HIV, syphilis, Hepatitis B and c for MSM. The results are somewhat different in terms of which disease is more prevalent in the sampled population[14]. HIV prevalence was 13.2%, compared to 41.9% for Hepatitis C. ''*No one was found to have a positive reaction to HBsAg or Syphilis. Among those who had positive test results for HIV, 20.6% ... also had positive reactions to HCV antibodies.*"[15]

[12] Ministry of Health *Injection Drug Use in Seychelles: Integrated Biological and Behavioural Surveillance Survey Round 1*. p. 60
[13] Ibid. p. 61
[14] Ministry of Health *Men Who have Sex with Men: Integrated Biological Behavioral Surveillance Survey – Round 1* pp. 60 - 62
[15] Ibid. p. 60

Table 9: Prevalence of HIV and Syphilis among MSM, Seychelles, 2011

	Seychelles (N=176)		
	N	%	95% CI
HIV			
Negative	149	86.8	80.2, 93.6
Positive	26	13.2	6.4, 19.8
Syphilis			
Negative	175	100	--
Positive	0	0	--
Hepatitis B			
Negative	175	100	--
Positive	0	0	--
Hepatitis C			
Negative	112	58.1	46.8, 68.7
Positive	63	41.9	31.3, 53.2

The prevalence rate found in the RDS survey is half of that usually found in the sentinel site, CDCU, where at least 22% of PLHIV detected are MSM. However, it is postulated that individuals with higher risk due to their behaviour may be those who seek to be tested. Therefore, the statistics collected at CDCU may be skewed. Still, it is interesting to note that there has been some change in 2011 with 86% for heterosexual and 14% for MSM transmission.

The RDS study also highlighted the fact that some MSM are also injecting drugs, with 12% reporting that they shared a needle or syringe previously used by someone else. Given that sharing needles already used by someone who is infected with HIV is an extremely efficient mode of HIV and HCV transmission, services for MSM, will need to include linkages to injecting drug use services, including evidence-based harm and risk reduction programmes such as syringe exchange and opiate substitution therapy.

HIV and Hepatitis B and C

Table 10 shows the number of people detected with antibodies of HBV. A cumulative of 20 cases have reported to CDCU since 2008 to December 2011. There were 5 (15%) females compared to 15 (75%) males of whom one person (5%) had Hepatitis B and HIV co-infection. It is important to note that 58% (11) of Hepatitis B cases were foreigners and males. The majority of the tests were carried out in the Montagne Posée Prison, the only penitentiary in Seychelles, the CDCU, the Occupational Health Clinic and the Blood Transfusion Centre.

Table 10: Number and percentage of Hepatitis B positive persons (Source: MoH, 2011)

	2010	2011
Total number of new cases	11	14
Females	5	0
Males	6	4
Total No. of HBV tests	3833	3716
Prevalence positive	0.29%	0.11%

There has been an alarming increase in the number of persons detected with hepatitis C. All cases are linked to injecting drug use since 2008. A cumulative of 157 cases of Hepatitis C has been detected from 2002 to 2011. There were 78% (122) males and 22% (35) females, with an age range from 14 years (a female) to 50 years (a male). To date, 11 persons (7 males / 4 females) have a HIV/Hepatitis C co-infection, representing 7% of the total. In 2010, there were 55 new cases detected with 13 females (24%) and 42 males (76%).

Table 11: Number and percentage of Hepatitis C positive persons (Source: MoH, 2011)

	2010	2011
Total number of new cases	55	60
Females	13	13
Males	42	47
Total No. of HCV tests	2308	2307

From January to December 2011, 60 new Hepatitis C cases have been reported, with 47 males (78%) and 13 females (22%). To date 3 persons (1 male/2 females) have died from infective endocarditis. One of these deaths (1 female) occurred in 2011. The reported Hepatitis C cases were 62 (40%) from the Psychiatric Ward , 47 (30%) from CDCU including clients referred from the two drug rehabilitation centres (Centre Mont Royal and Centre D'Accueil de la Rosière), 24 (15%)from the Prison, 23 (15%)from the private clinics, Medical Wards, Occupational Health Unit, Maternity, Casualty and Health Centers respectively.

III. National response to the AIDS epidemic

Existing policy environment

International Commitments

On the international level, the Seychelles is a signatory to eight major human rights treaties, including the ***International Covenant on Civil and Political Rights (ICCPR),*** the ***International Covenant of Economic, Social and Cultural Rights (ICESC)***, the ***Convention on the Rights of Persons with Disabilities***, the ***Convention on the Rights of the Child (CRC)*** and the ***International Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)***[16]. Specific to HIV and AIDS, the country has also committed itself to the "***Three Ones***" principles (one national HIV and AIDS coordinating authority, one national HIV and AIDS action framework, and one monitoring and evaluation framework). Further commitment is given through adherence to the **UNAIDS 2011 – 2015 Strategy: Getting to Zero. "***One of the key thrusts is to advance human rights and gender equality for the HIV response. It is considered essential to address the issue of social and legal environments that fail to protect against stigma and discrimination or to facilitate access to HIV programmes continue as they block universal access. In particular, greater efforts are needed to realize and protect HIV-related human rights of women and girls, of PLHIVs, key populations, populations at higher risk and most vulnerable communities*"[17].

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

Furthermore and closer to home, the ***WHO Country Cooperation Strategy 2008-2013*** addresses all health issues in Seychelles with some priority areas, such as non-communicable diseases linked to lifestyles (diet, exercise and work). It further notes that "*there is a need to strengthen the surveillance systems and implement an effective monitoring and evaluation system. An HIV observatory will go a long way towards strengthening information support and strategic information intelligence to inform policy, decision making and response*"[18]. Moreover, the strategy document suggests that present challenges related to HIV and AIDS prevention and treatment include the sustainability of services, as well as long-term adherence and possible resistance development to ARVs in the future. There is also concern about reported incidence of some STIs such as gonorrhoea, genital warts, genital herpes, and syphilis, although the number of cases remains low, and their link to HIV and AIDS as indicators of possible drivers of the pandemic.

The ***Republic of Seychelles: Progress Report on Declaration of Commitment on HIV and AIDS 2010***[19] provides a comprehensive assessment of the current situation, with a relatively good treatment, care and support programme in place, while still experiencing problems with being able to foster consistent behaviour change in the general key populations.

National Commitments

In 2010 and 2011, there was still no specific legislation relating to HIV and AIDS and PLHIV. However, the ***Seychelles Health Strategic Framework 2006-2016*** is based on the principles of ***Health By All*** and ***Health For All***. It focuses on the development of SMART targets to address key issues of health in Seychelles[20]. Notably, the ***National Policy on the Prevention and Control of HIV and AIDS and STIs*** was completed in 2001 and the

[16] Ministry of Foreign Affairs *Draft Report on the Implementation of the International Covenant on Civil and Political Rights* (2012)

[17] NAC *The National Policy for the Prevention and Control on HIV and AIDS and STIs of the Republic of Seychelles 2010*

18 WHO *WHO Country Cooperation Strategy 2008 – 2013 Seychelles* p. 10

19 Ministry of Health (2010) *Republic of Seychelles: Progress Report on Declaration of Commitment on HIV and AIDS 2010*

[20] UNDP *Seychelles Common Country Assessment Report 2010*

National Strategic Plan for HIV and AIDS and STIs was done for the period of 2005 to 2009. The country was operating without a strategic plan in 2010 and 2011.

However, a major review exercise of both documents was conducted in 2011. The following table is a summary of the findings of the review in relation to the policy environment for HIV and AIDS[21].

Table 12: Policy Environment - Summary of Findings of the National Review of the National Strategic Plan for HIV and AIDS 2005-2009 and the National Policy 2001

Achievements	Gaps
• The National Policy on HIV and AIDS and Other STIs 2011 is still relevant, though it needs to be reviewed • There is a functional Gender Secretariat / Unit at the Social Development Department • Human rights and gender issues are given due consideration in drafting of policies • A number of committees have been formed to work on various policies • The Workplace Policy has been drafted • The M & E Plan has been discussed and drafted • NGOs received a lot of support from the regional initiative from the IOC-AIRIS project • There are various laws and policies in place to regulate service delivery for young people.	• It is unclear which policies have been adopted or not; there is no institutional memory of these • Poor coordination and lack of continuity – no agency is sure of the progress of the dossier and of the physical whereabouts of various pieces of policy documents. Moreover, the work on policies is a series of starts and stops, with numerous changes of composition of steering committees • Too much staff turnover leads to a lack of institutional memory • The discordance in policies regarding young people in terms of age of consent and access to contraceptives leaves the group aged 15 to 17 years in limbo, with no services for them, if they choose not to seek parental consent. • It takes too long to address issues. to formulate and to adopt legislative changes and actions • Apart from the workplace policy, no other policy has been firmly adopted, enacted and applied • The NSP is not necessarily aligned to other sectoral development or strategic plans • Some NGOs are not using the capacity they have • NGOs often do not have full time staff or offices.

To address the weaknesses mentioned above, another major national exercise. Involving all partners and stakeholders, was undertaken in 2011 to draft a new policy and strategic plan. The work has been completed and has culminated in the ***National Strategic Plan on HIV and AIDS and STIs 2012-2016***. The Plan consists of four documents:

(a) The ***National Policy on the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles 2011***, which lays the foundation and principles on which are based all further actions. The core values of the National Policy are: ***Respect for, protection and fulfillment of human rights***, as stipulated in national and international instruments, ***Integration of programmes and services***, for better networking and for building effective local and international partnerships and ***Pragmatism*** with emphasis on the central role of the body of scientific evidence in programmatic actions. The **main goal** of the Policy is to "*halt new infections and reverse the trend of HIV and AIDS and sexually transmitted infections, and to care for and support those living with HIV and affected by AIDS".*

[21] NAC *Final Report on the Evaluation of the HIV/AIDS NSP 2005-2009, Updating of the National Policy on HIV/AIDS and Other STIs, and Road Map for NSP 2011-2015*

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

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

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

Whilst these international and national obligations have been factored into the national HIV and AIDS policy document, the NCPI shows, however, that there is some confusion and concern about a variety of issues. The main ones have been listed below[22].

Government Officials

(a) It is not clear for most government officials which period is covered by the national multi-sectoral strategy for HIV and AIDS. Few of them seem aware that there was no Strategic plan in place in 2010 and 2011.

(b) It is notable that there is the lack of multi-sectoral strategies with a budget for specific HIV activities.

(c) Overall, responses indicate an average of 7 out of 10 for overall strategy and national planning. However, there are limited substantial comments and examples to support that from the responses.

Civil Society

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

In summary, commitment to international and national obligations has been generally satisfactory, especially in terms on inclusiveness in national documents. However, there was no strategic plan being used in 2010 and 2011. The policy done in 2001 was still being used an official guide. Review of both documents and drafting of the new strategic plan has involved more CSO representatives. However, there is still a lack of knowledge and understanding about the policy environment of HIV and AIDS in the country as well as some dissatisfaction about the participatory processes used to develop national multi-sectoral and sectoral policies and their impact on HIV.

Prevention, knowledge and behaviour change

In 2010 and 2011, the issue of behaviour change communication and prevention strategies remains predominant in the national response to the epidemic. The continued rise in the number of new PLHIV is a sign that much needs to be done in this area. The focus of interventions is still on the general population and young people. Sessions have been conducted in schools, workplaces and districts on demand from various groups and organisations by the AIDS Control Programme, the Social Development Department, the Youth Health Centre and the Drug and Alcohol Council. These are not regularly scheduled activities.

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

[22] Ministry of Health *Analysis and Summary of Responses to the NCPI Questionnaire (2011)*

follows:

(a) The opening of a male health service by the Alliance of Solidarity for the Family (ASFF) in 2010 and proposals to provide some targeted services for MSM;

(b) Some educational and informational leaflets for MSM by FAHA (Faith and Hope Association) in 2010, as well as a survey on MSM in 2009 with financial assistance of UNAIDS;

(c) Financial and nutritional assistance to orphans and vulnerable children (OVC) and their families by HASO (HIV and AIDS Support Organisation);

(d) A number of televised public debates with phone-ins about the issue of HIV and AIDS and STIs, with some focus on Hepatitis B and C done by SBC (Seychelles Broadcasting Corporation);

(e) Some education on HIV and AIDS and safer sex, by trained interviewers, with PWID and MSM who participated in the RDS survey in 2011, once the questionnaire had been completed and biological samples taken.

(f) Youth church group members conducting ad-hoc on-site education and information sessions with street-based SWs in the capital, Victoria.

The review of the NSP 2005-2009 reveals some achievements and highlighted some weaknesses. A summary of these are presented in the table below[23].

[23] NAC *Final Report on the Evaluation of the HIV/AIDS NSP 2005-2009, Updating of the National Policy on HIV/AIDS and Other STIs, and Road Map for NSP 2011-2015*

Table 13: Prevention, Knowledge and Behaviour Change Environment - Summary of Findings of the National Review of the National Strategic Plan for HIV and AIDS 2005-2009 and the National Policy 2001

Achievements	Gaps
• Numerous prevention activities are conducted in Seychelles on a fairly regular basis and by any number of organisations, from FBOs, CBOs to registered CSOs and government agencies. • Many organisations now include HIV and AIDS in their regular sessions with young people and the general public • Organisations now conduct sessions in schools as a team, rather than officials from individual agencies going on their own. This action is most visible with the Social Development Department which includes the Drug and Alcohol Council officers, Youth Health Centre staff, social workers and probation officers. • There is thus a functional cooperation and coordination mechanism for talks in post-secondary institutions between the SDD, YHC and DAC. • Finances have been made available locally and from multilateral partners to conduct prevention activities, especially with young people. • The PSE programme is taught from primary one to secondary five, covering 11 years of formal education. It comprises of alcohol and others drugs as well as HIV and AIDS lessons. • Teachers of PSE in both primary and secondary schools are trained formally at the then Institute of Education and now at the University of Seychelles. • There are numerous national and regional activities done around World AIDS Day (1st December), for ABCD and Safer Sex. • The TAC had a sub-committee for IEC, which met a few times to discuss planning of major prevention activities	• True extent of epidemic not known • Legal framework: Discordance between age of consent for sex (15 years) and legal marriage (16 years, with the permission of parents or guardians) and the age at which contraceptives (except for condoms) are legally allowed to be dispensed (18 years and over) • Funding of education & awareness programme is not properly structured • Prevention programmes by NGO's and Youth Health Centre cannot be carried to the full and are not sustainable • It appears very difficult to measure to which extent PSE programme covers HIV related aspects and peer education programmes are run in a non coordinated manner, except for the YHC. To note also that each region was to have a youth friendly centre delivering HIV programmes, and so far this has not been achieved and the YHC has to practically cover the whole island of Mahé in terms of outreach activities • True extent of substance abuse (esp. heroin) is not known so far, though the most recent increase in Hep C clearly indicates that there is an outbreak among PWIDs • MSM population not known (homosexuality illegal): This group which according to the data of the CDCU makes up 25% of the HIV cases are marginalised and their risk of HIV infection is thus increased. Furthermore many of these individuals are bisexuals thus increasing the risk of HIV in the general population • Voluntary Counselling and Testing (VCT): Although all health centres carry out VCT the centres are not really equipped to handle confidential counselling and testing. Anonymous testing is not allowed at the clinics which further stigmatises the issues around HIV • The laboratory cannot identify which centre has the most HIV positive results. Hence intervention programmes cannot be instituted by the CDCU at these "hot spots". • Prevention programmes in the media focus on World AIDS Day mostly and tend to be less visible at other times of the year • The leaflets and posters used are now outdated and need to be redone / revised. • There are few programmes targeting specifically boys and men. • Prevention programmes do not account for cultural issues that may drive the pandemic.

Target 1. *Reduce sexual transmission of HIV by 50 per cent by 2015*

Indicator 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*
This data is not currently available as no national survey or KAP study has been conducted. The data presently available dates back to the KAP Study of 2003 and have been considered too outdated for the purpose of this report.

Indicator 1.2 *Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15*
Data is not available for this indicator for the same reasons mentioned above.

Indicator 1.3 *Percentage of adults aged 15–49 who have had sexual intercourse with more than one partner in the past 12 months*
Data is not available for this indicator for the same reasons mentioned above.

Indicator 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*
Data is not available for this indicator for the same reasons mentioned above.

Indicator 1.5 *Percentage of women and men aged 15-49 who received an HIV test in the past 12 months and know their results*
Data is not available for this indicator for the same reasons mentioned above.

Indicator 1.6 *Percentage of young people aged 15-24 who are living with HIV*
The data available comes from surveillance in sentinel sites and gives the number and percentages from the total number of tests done for the period , based on provider-initiated HTC as part of treatment process and client-initiated tests as part of voluntary HTC. As such, it does not reflect the reality of the situation and it is considered as not available for the reporting period.

Indicator 1.7 *Percentage of sex workers reached with HIV prevention programmes*
Data is not available for this indicator for the same reasons mentioned above.

Indicator 1.8 *Percentage of sex workers reporting the use of a condom with their most recent client*
Data is not available for this indicator for the same reasons mentioned above.

Indicator 1.9 *Percentage of sex workers who have received an HIV test in the past 12 months and know their results*
Data is not available for this indicator for the same reasons mentioned above.

Indicator 1.10 *Percentage of sex workers who are living with HIV*
Data is not available for this indicator for the same reasons mentioned above, as for indicator 1.6.

Indicator 1.11 *Percentage of men who have sex with men reached with HIV prevention programmes*
The data set used for this indicator comes from the RDS Survey conducted in 2011, from 20th June to 30th August. The key question was "*Do you know where to go if you wish to receive an HIV test?*" and the total number of respondents was 176. In all, 169 persons (96%) said "yes" to this question.

Indicator 1.12 *Percentage of men reporting the use of a condom the last time they had anal sex with a male partner*
The data also comes from the RDS Survey of 2011 and has been collected from the following questions - *Have you had anal sex with a male commercial sex partner in the past six months*?

Have you had anal sex with an occasional sex partner in the past six months?
Have you had anal sex with a regular male partner in the past six months?

The results have, therefore, been obtained for the three categories of partners: casual, commercial and regular. The casual partner is someone with whom the respondents have a one-off sexual encounter, whereas the commercial one is a person that they have paid or have paid them for sex. The regular partner is the person with whom the respondents have sex on a regular basis with no money or gifts exchanged between them. For casual/occasional partners, the percentage of condom use reported was 55.3% whereas for commercial partners, the reported condom use was 66.5%. The reported condom use for regular partners was 54.5%. This shows that there is still a lot of risk-taking in sexual behaviour amongst MSM.

Indicator 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*
This data comes from the RDS Survey of 2011 from two questions: "*Have you been tested for HIV in the last 12 months"* and from those who have been tested, the next question was "*Did you receive an HIV test result at testing".* The percentage of MSM who have been tested in the last 12 months and know their results was 56%; the numerator was the number of respondents (n=98) who answered "yes" to the second question and the denominator was the number of respondents (N=176) who answered "yes" to the first question.

Indicator 1.14 *Percentage of men who have sex with men who are living with HIV*
The data from the RDS Survey 2011 was calculated as follows: the numerator is the number of biological samples that tested positive for HIV (n=26) and the denominator is the total number of respondents who submitted a biological sample (N=176). The result was 13.2%.

Testing and Counselling
Indicator 1.15 *Health facilities that provide HIV testing and counselling services*
HTC is integrated in the national health system and all public health facilities in Seychelles provide HTC.

Indicator 1.16 *HIV testing in 15+ (from programme records)*
In total, 9430 tests were done for the age group 15+ in 2010 and 2011.

Sexually Transmitted Infections (STIs)
Indicator 1.17 *Sexually Transmitted Infections (STIs)*
All cases of STIs detected have received treatment during the reporting period.

Target 2. *Reduce transmission of HIV among people who inject drugs by 50 per cent by 2015*

Indicator 2.1 *Number of syringes distributed per person who injects drugs per year by needle and syringe programmes* ***Not Applicable***
Whilst there is a draft national harm reduction policy, there is no official needle and syringe programming. Some individuals and NGOs have begun an unofficial and non-sustained distribution of needles, syringes and other injecting equipment, but these are not recognised and not accounted for.

Indicator 2.2 *Percentage of people who inject drugs who report the use of a condom at last sexual intercourse*
The RDS Survey of 2011 shows that 88% of respondents indicated that they used a condom at their last sexual encounter. The numerator is the number of person (n=302) who indicated "yes" to the question ("*Did you use a condom the last time you had sex with someone?*" and the denominator is the total number of

respondents (N=345) who answered this question.

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

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

From the RDS Survey 2011, 307 (89%) respondents indicated that they did an HIV test in the last 12 months. There were 345 respondents to this question.

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

The RDS Survey indicated that 10.72% of PWID who took part were tested positive for HIV. (Numerator = 37 and denominator = 345)

Indicator 2.6 *Opiate users*

There were 345 respondents for the RDS Survey 2011 on PWID. The calculations for the estimated population size of PWID were done in the manner explained below. The number of PWI who attended one of the services in the previous year (data provided by service independently) was used as a numerator (M) and the proportion who reported attending the respective service in the year previous to the survey was used as the denominator (P). The mathematical formula to calculate the total size of the population was:

$$N = M/P$$

Where: N = Estimated Size

P = Proportion of PWID in survey corresponding to the list provided by each service the proposed one year period.

M = Number of PWID who had exposure to the service during the proposed one year period.

Confidence bounds around the population size estimates

To calculate the confidence bounds around the population size estimates two sources of variance were used: the RDSAT standard errors[24] provided for the adjusted estimates of study participants who reported that they had received services from one of the listed service providers and/or a unique object. The RDSAT standard errors are calculated based on the bootstrap procedure using the percentiles 2.5 and 97.5 of the replicate estimates for the lower and upper limit of a 95% confidence interval. In addition, the uncertainty around the number of individuals who received services from the listed service providers was calculated with a normal distribution as a good approximation of the Poisson distribution with equal mean and variance to M, where:

M = Number of individuals who received services from the listed service providers and/or a unique object and its variance. α = Type I Error. Set at a maximum 0.05; $Z1-\alpha/2$ = the normal standard transformation. When the Type I Error is 0.05, $Z1-\alpha/2$ is equal to 1.96

[24]Salganik MJ, Heckathorn DD. (2004). Sampling and estimation in hidden populations using respondent-driven sampling. Sociological Methodology, 34, 193-239.

The variances for M and P were combined by using the following formula (delta method):

$N = M / P$

$Var(N) = Var(M)/[E(P)]^2 + [E(M)]^2/[E(P)]^4 * Var(P)$

95% for $N = N \pm 1.96 \times \sqrt{(Var(N))}$

The assumptions for calculating the confidence bounds are:

- N and P are two independent variables (Covariance = 0)
- P has an approximate a normal distribution with the Standard Error equal to SE. The RDSAT output for the SE for P comes from the bootstrap percentile method and it might be asymmetric.
- P has a small Coefficient of Variation.

The population size of PWID was thus assessed using service data provided by the psychiatric unit of the Seychelles hospital and the CDCU, both located at the Seychelles hospital, in Victoria. During the RDS survey, PWID were asked whether they had received services from one of the listed service providers in the previous six months. This was used to derive an adjusted estimate of the percentage of PWID who had received the services in the previous six months. The actual number of visits to service providers by PWID in the Seychelles in the previous six months was provided by each of the services through their service data file. Population size estimations for the Seychelles using service data are provided in Table 22.

Table 13b. Population size estimates of PWID in the Seychelles, 2011

	Psychiatric unit	**CDCU**
Number of one time visits	212	49
Percent[25] who reported visiting	13.6%	7.0%
Calculation	212/.136 = 1559	49/.079=621
Standard Error	0.029	0.029
Percent of the population[26]	2.8%	1.1%
95% Confidence bounds	875, 2244	143, 1100

Three hundred and forty six (346) unique objects were distributed to IDUs one week prior to the initiation of the survey and 20.7% IDUs reported receiving one. With this information the population size estimation of IDU was calculated to be 1,671 (673, 1706) or 3.0% of the adult population of Seychelles. The mean of all multipliers is 1,283 or 2.3% of the population. Females comprise 257 of the adult IDU population in the Seychelles.

Indicator 2.7 *NSP and OST sites*
Same as for indicator 2.1

[25]Percentages are weighted using RDS Analyst
[26]Assuming that adult (15 to 64 years) population size is 55,000.

The NCPI yield the following results.

Government Officials
The NCPI indicated that all respondents agreed the country has a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population. However, most respondents (n=12) identify that the strategy lacks focus on messages promoting greater equality between men and women, and how to avoid intergenerational sex. Messages on 'Males get circumcised under medical supervision" is viewed by most as not applicable for Seychelles".

There has been a process initiated to develop a ***Social and Behaviour Change communication Framework for HIV and AIDS and STIs***. The work is in progress.

All respondents indicate there is a strategy to promote life skills based HIV education for young people which include age appropriate gender sensitive sexual and reproductive health elements. However, it is notable that there is no strategy for HIV education for out of school youth area. Most respondents (n=14) agree the country has strategy/policy in place to promote information, education and communication and other preventive health interventions for key or other vulnerable sub-populations. Most of the required elements and most of populations groups are reflected in the new strategic plan for 2012-2016.

There is good progress and access to prevention services for blood safety, PMTCT, universal precautions in healthcare settings. However, most respondents strongly disagree with progress and access to prevention services for harm reduction, including IEC on stigma and discrimination for PWID and SW.

Civil Society
All respondents (n=12) perceive that the country identified the needs for HIV prevention, but, most (n=10) also think there is need for improvement with targeted interventions. Consistent with responses in Part A, most indicate strong agreement with access to prevention services and information for blood safety, prevention of mother to child transmission, and universal precautions in healthcare settings. Once again, most responses also disagree with access to prevention services especially for harm reduction MSM, SW and PWID, among others.

It is important to note that while some respondents agree with access to prevention services for out of school youth, some disagree. Discussions with stakeholders indicate that the out-of-school youth should not be taken as a homogenous group. The members are very diverse in terms of backgrounds, needs, in-group membership, behaviour and political views. There are ad-hoc unofficial programmes being delivered to pockets of these young persons, but not all youth are being reached. The programmes are not sustained and they focus on information rather than behaviour change communication. Community groups are often not all involved in these programmes. There is a need for the various types of media available nowadays to find ways to reach these groups.

In summary, prevention programmes remain a weakness in the national response with most interventions focusing on the general population and young people in schools. Targeted interventions for key populations and vulnerable groups are few and far between. However, there are some indications of progress with two key policies/strategies being considered (harm reduction and social and behaviour change communication). More NGOs are also targeting their work towards key populations, with MSM and PWID being given the most attention so far.

Some programmes are considered to be very functional and effective, such as blood and blood products safety, PMTCT, PEP and universal precautions in healthcare settings.

Care, treatment and support

In 2010 and 2011, treatment continues the 'point fort' of the national response to HIV and AIDS and STIs. The procedures and methods are well-established and coordination is done well. Presently, all treatment is undertaken by one unit, the CDCU. ARVs are available and treatment offered

However, both the review of the national policy and the NSP2005-2009 highlighted some strong and weak points. The table below gives a summary of findings from the review.

Table 14: Treatment and Care - Summary of Findings of the National Review of the National Strategic Plan for HIV and AIDS 2005-2009 and the National Policy 2001

Achievements	Gaps
• Much progress has been made in treatment, care and support of PLHIVs, through comprehensive healthcare infrastructure. • Many health and social development issues linked to the Millennium Development Goals have been successfully resolved. • Antiretroviral therapy (ART) has been made available free to all patients who need it since August 2002. Access has been universal every year since then. • Patients are not required to be on medical schemes or private health insurance. • In terms of PMTCT, there is almost 100% access to VCT and nearly all deliveries are done in the presence of a health professional. These are followed by testing of the mothers and children • Mothers are also provided with baby milk free of charge. This is an example of good partnership between the Ministry of health and the private sector • Some NGOs provide support, especially to PLHIVs and orphans • It is possible for patients to have some options in the kinds of medicines offered to them and the number of pills taken per day by PLHIVs has significantly reduced • There is now more awareness of the needs of SWs, PWIDs and MSMs, with a number of studies funded locally done in 2010	• There is a high level of drop out (round 40%) • The patients are not always contacted to continue with the treatment regime • There are first-time patients coming with late-stage AIDS • No targeted interventions (prevention or treatment) for various MARPs (PWID, SW and MSM) • PWID who are expecting mothers are not attending ANC and they have absconded from the maternity ward, leaving their neonate in the care of the personnel • Services at present are not decentralized and all management of patients is done at CDCU • Health care professionals in the district health centres do not know the HIV status of their own patients, even when they have been the ones to refer them • No home-based care facility specifically for HIV/AIDS: This makes it difficult to care for the terminally ill patients dying of AIDS related illnesses • Stigma and secondary effects of drug regimes used remain important leading to lack of adherence and drop-out • No strong and federative network of PLHIV. Currently PLHIV fall under various NGOs (FAHA, HASO and SOLIDER) • No centre exists for PLHIVs where they can seek help, share experiences and come together as a group. This would decrease stigmatisation and discrimination • The perception of lack of confidentiality of medical professionals, perhaps due to the small size of the population, is also a major issue • PWID represent 100% of all new cases of hepatitis C recorded since 2008.

Target 3. *Eliminate mother-to-child transmission of HIV by 2015 and substantially reduce AIDS related maternal deaths*

This is, perhaps, one of the most successful parts of the national response to HIV. All pregnant women are offered HTC and treatment as per their conditions and locally-adapted WHO guidelines. Most indicators (3.1 – 3.4 and 3.6 – 3.9) are at 100% access and coverage as indicated below.

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

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

Indicator 3.4 *Pregnant women who know their status*

Indicator 3.6 *Percentage of HIV-infected pregnant women assessed for ART eligibility through either clinical staging or CD4 testing*

Indicator 3.7 *Infants born to HIV-infected women receiving ARV prophylaxis for prevention of Mother-to-child-transmission*

Indicator 3.8 *Infants born to HIV-infected women who are provided with ARVs to reduce the risk of HIV transmission during breastfeeding*

Indicator 3.9 *Percentage of infants born to HIV-infected women started on cotrimoxazole (CTX) prophylaxis within two months of birth*

100%. See introductory note above.

Indicator 3.5 *Percentage of pregnant women attending antenatal care whose male partner was tested for HIV in the last 12 months*

For this indicator, there is an issue related to prevailing social and cultural conditions of Seychelles in terms of relationships between men and women. Most children are still born out of wedlock in Seychelles[27]. This situation is not viewed as taboo, except for very young girls (<16 years). "*The proportion of nuptial births has decreased from 24.5% in 2006 to 23.4% for the first six months of 2011, while the proportion of acknowledged births (where the baby has been recognized by the father) has increased from 56.9% in 2006 to 59.4% in the first six months of 2011. The proportion of non-acknowledged births has decreased from 18.6% in 2006 to 17.2% in the first six months of 2011*."[28]

Thus, although the population is about 90% Christian of various denominations[29] (Roman Catholic, 76.2%; Anglican, 6.1%, other Christians 10%), morals in sexual matters tend to be relaxed, with men and women having numerous fairly stable monogamous relationships. This serial monogamy leads to women having a number of children from different men and their partners are not necessarily agreeable to be tested. The women are likely to have little influence in persuading the partner to be tested. Therefore, for this indicator, the requested data is not available.

Indicator 3.10 *Distribution of feeding practices for infants born to HIV-infected women at DTP3 visit*

The Seychelles has adopted a policy of providing replacement feeding for HIV-positive women who give birth. Nutritional support is also given through partnership with local supermarkets and active involvement of NGOs. For this indicator, 100% of women are thus provided with not only information, but the required material and financial assistance to provide alternative feeding practices for their babies.

[27] National Bureau of Statistics (2011) *Population and Vital Statistics: No. 2 of 2011* p. 1
[28] Ibid.
[29] National Bureau of Statistics *Population & Housing Census 2010*

Indicator 3.11 *Number of pregnant women attending ANC at least once during the reporting period*

The total number of pregnant women attending ANC at least once during the reporting period is 1504 in 2010 and 1780 in 2011, for a total of 3284.

Indicator 3.12 *Health Facilities*

Three health facilities offer services for PLHIV, including women and their children.

Target 4. *Have 15 million people living with HIV on antiretroviral treatment by 2015*

Indicator 4.1 *Percentage of eligible adults and children currently receiving antiretroviral therapy*

All persons eligible for treatment received free ART.

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

All indications are that at this point in treatment, all clients are still adhering to medications given.

Indicator 4.2b *HIV treatment 24 month retention*

Same as for indicator 4.2

Indicator 4.2c *HIV treatment 60 month retention*

It has not been possible to calculate and report on this indicator for this reporting period. However, it is known that there are defaults and non-adherence. The figure given from CDCU is 40% of the total number of clients that have been put on treatment. This issue is being addressed and more rigorous data collection and reporting are needed to ensure that progress can be successfully tracked.

Indicator 4.3 *Health facilities that offer antiretroviral therapy*

Presently, there are presently 3 (25%) health facilities that offer ART.

Indicator 4.4 *ART Stockouts*

No ART stockouts have been experienced in 2010 and 2011. There is excellent support form partners such as AIRIS-COI that ensures that stocks are always maintained.

Indicator 4.6 *HIV Care*

All eligible clients are provided with care, with the assistance of NGOs working in this area.

Target 5. *Reduce tuberculosis deaths in people living with HIV by 50 per cent by 2015*

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

All clients that are HIV-positive incident TB cases received treatment for both conditions.

Indicator 5.2 *Health care facilities providing ART for PLHIV with demonstrable infection control practices that include TB control*

Three health care facilities provide ART and treatment for PLHIV includes TB control and treatment.

Indicator 5.3 *Percentage of adults and children newly enrolled in HIV care starting isoniazid preventive therapy (IPT)*

This indicator is not applicable to the Seychelles context as such treatment is not given.

Indicator 5.4 *Percentage of adults and children enrolled in HIV care who had TB status assessed and recorded during their last visit*

All clients enrolled in HIV care are assessed and recorded for TB status in their last visit. Management remains vigorous for all clients who keep attending clinical care.

Data collected from the NCPI indicate that all respondents report that the country identified the essential elements of comprehensive package of HIV treatment, care and support services including prioritized elements like HTC, PMTCT, medication, social support, financial support. Responses to Treatment, Care and Support show impressive progress, especially as most strongly agree with the progress made in regards to free access to ART, early infant diagnosis, Post Delivery ART for women among other treatment services.

Some respondents feel that access to psychosocial support for PLHIV, HIV care and support in the workplace including referrals were not carried out as well as the others mentioned about. Some key challenges to successful treatment outcome for PLHIV included non compliance with treatment plans and loss due to lack or poor follow up services. There is general consensus that the government has a policy/strategy in place to provide social and economic support to PLHIV. However, it is important to note some respondents indicate that the social support is not framed with general welfare program for everybody eligible.

Some information remains unclear such as:

(a) whether the country has access to regional procurement and supply management mechanisms, for critical commodities, such as ARVs, condoms and substitution medication;

(b) Whether there is a specific national action plan, for orphans and vulnerable children and actual estimates of the OVC under care. One respondent indicate there is a draft plan in place but that may not be satisfactory, to indicate as an existing plan.

In summary, NCPI responses to Treatment, Care and Support, indicate very impressive progress in overall compared to other aspects of the national response. The efforts and progress in this area have been noted by WHO, as well. However, there are some key challenges, such as non-adherence to medication and defaulting on treatment with the resultant late reporting and late stage AIDS from some PLHIV. Tracking and follow-up services may need to be bolstered.

Impact alleviation

This is the priority area where NGOs are expected to be most active. There continues to be reports of stigma and discrimination against PLHIV. It is often felt that they are held up to a higher standard of behaviour than the general population. However, there has been so far no report or court relating to discrimination in the workplace or in public. Not all PLHIV experience the same forms of discrimination. The RDS survey with MSM and PWID show that the respondents report situations of stigma and discrimination.

"Sixty eight percent of IDU reported that they had received verbal insults and 2.0% reported being hit, kicked or beaten in the past 12 months because someone believed respondent has sex with other men (Table 16). Twelve percent of IDU reported being forced to have sexual intercourse when they did not want to at some point in their lives and, among those, 83.4% reported having been forced to have sexual intercourse in the past 12 months. Fifty-four percent of MSM reported being arrested in the past 12 months.[30]*"*

However, a lot of actions are being taken to ensure that the impact of HIV on PLHIV and the people affected by it is being mitigated. The Seychelles in 2010 and 2011 was reporting on a number of human rights instruments, namely the ICCPR, ICESCR, CRC and CEDAW. Indeed, the Seychelles delegation to the Human Rights Commission in its eighteenth session accepted the proposed recommendations indicating that the Constitution of Seychelles made provision for all persons to be free from discrimination on all grounds. Indeed, Article 27 of the Constitution stated that "*Every person has a right to equal protection of the law including the enjoyment of the rights and freedoms set out in this Charter without discrimination on any ground except as is necessary in a democratic society*.[31]*"*

Moreover, *"The Seychelles Government is thus considering when and to what extent the legislation could be amended to better guarantee the Constitutional precept that sexual minorities (lesbian, gay, bisexual and transsexual persons) will not to be stigmatized and discriminated against in Seychelles*.[32]*"*

The review of the national policy and the NSP2005-2009 showed that stigma and discrimination towards PLHIV and people affected by HIV were still important issues to be addressed. The summary of findings of the review is presented in the table below.

[30] Ministry of Health *Injection (sic) Drug Use in the Seychelles 2011:Integrated Biological and Behavioral Survey Round 1* p. 53

[31] Ministry of Foreign Affairs *Draft Report on the Implementation of the International Covenant on Civil and Political Rights* 2012

[32] Ibid.

Table 15: Impact Alleviation - Summary of Findings of the National Review of the National Strategic Plan for HIV and AIDS 2005-2009 and the National Policy 2001

Achievements	Gaps
• There are functional structures to assist PLHIVs, OVCs and relatives, such as the Social Welfare Agency for means-testing, Social Services and Probation Services for counseling and support. • There are at least 3 NGOs providing some kind of support, namely HASO, FAHA and SOLIDER. One NGO assists with OVCs • FBOs have informal structures for support which are used by PLHIVs and their families • The private sector is discreetly active in providing support, especially to mothers and their babies, through free provision of baby formula • There are funds available locally through the NATF and NGOs have been able to access these to provide needed support to PLHIVs and their families • NGOs have received numerous local and international training opportunities to enable them to scale up their programmes for impact mitigation	• Few or no effective targeted programmes for PLHIVs and key populations • HIV and AIDS were not always integrated in national and district level programmes • NGOs working in this field are weak, with little funds, expertise, credibility and capacity • FBOs offer little concrete support structures and mechanisms • Patients are lost through non-compliance and drop-outs • Poor coordination of social welfare needs assessment • Too much bureaucracy to obtain social welfare assistance from the government authorities • Patients have little confidence in the system in terms of confidentiality and thus do not always come back for results and treatment • Lack of community involvement: No visible programmes by the community on HIV/AIDS and especially support by community for AIDS orphans and vulnerable children. •

The responses to the NCPI on questions of human rights have varying and in some cases very inconsistent responses. However, most respondents (n=14) indicate there is existing non-discrimination law or regulation which specifies protection of people living with HIV. Law or regulation implies a policy enforceable in a court of law. This makes the shared view by respondents not so clear, since there is not yet a specific legislation for HIV and AIDS. Under Q1.1 most respondents are likely to make reference to the ***National Policy on the Prevention and Control of HIV and AIDS and STIs***.

Still, the policy has not yet been formally communicated to the National Assembly (parliament) and given legal presidential assent as a national public policy. If this were the case, the national policy would then be in place as a specific instrument, when the country still has no specific law stipulating protection for PLHIV. It is an issue that needs exploring further with stakeholders. For Q2., most respondents (n=13) agree the country still has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations including MSM, PWID, prison inmates, SW and transgendered people.

There are also a number of non responses on areas where there is some kind of regulation. This may imply limited awareness of existing policies among some stakeholders. Perceptions of national efforts to address human rights related to the key populations vary but scores just above average in overall. Notable also is the varying views about existence of programmatic actions to reduce HIV-related stigma and discrimination. Some respondents disagree they even exist. This is subject to varying interpretation but it may important to explore it further with stakeholders. It is important to find out what these programmes (if they exist) have in terms of content, delivery and design.

The meeting with stakeholders highlighted the following issue: that there are still contradictory positions

outlined in laws and policies. For example, the Public Health Act (presently under review) criminalises "wilful spreading" of HIV, the Immigration Act and policies of some financial institutions (banks) and insurance companies require HIV testing for marriage between Seychellois and foreigners and for approval of loans and life insurance, whereas the Employment Act and the national policy on HIV and AIDS prohibit these discriminatory actions against PLHIV in the workplace. Harmonisation of laws, regulations and policies is needed urgently to avoid confusion and to ensure that international obligations and national commitments are met. It is also noted that most people are not aware that they have mechanisms to redress alleged violations of rights.

In summary, the overall observation is that there are general laws on non discriminations (as in the country's Constitution, Employment Act and Public Order Bill) which may be used by anybody (through different mechanisms like Ombudsman office, the National Human Rights Commission and the courts) to seek legal redress. The real issue may be access to these existing mechanisms and their effectiveness to enable people to seek redress for alleged violation of their rights. However, considering the significant number of non responses on some of these fundamental questions, it may be assumed there is low awareness of stakeholders about existing laws that relate to discrimination in general among different population groups. This is a trend that may be explored with stakeholders to further consider its implications.

AIDS Expenditures as part of the national response

Target 6. *Reach a significant level of annual global expenditure (US$22-24 billion) in low- and middle-income countries*

Indicator 6.1 *Domestic and international AIDS spending by categories and financing sources*

The table for domestic and international AIDS spending by categories and financing sources is placed in annex, as a separate document.

The total expenditure of HIV/AIDS in 2010 and 2011 in local currency in were SR25,900,689 and SR26,882,043 respectively, out of which government have spent SR 25, 268,243 (97.6%) (in 2010) and SR26,051,550 (96.9%) (in 2011). This has shown government commitment towards the national response to HIV/AIDS.

In 2010, more AIDS Spending Categories were on *Programme Management and Administration* with SR16,534,745 (63.8%) whereas in 2011, Treatment and Care have been the leading areas of AIDS Spending Categories with SR11,714,724 (43.6%). Simultaneously, there was a decrease of spending in prevention activities from SR7,230,880 in 2010 to SR3,014,713 in 2011.

Though spending have increased in International AIDS Spending Categories, from SR 509,629 to SR 816,325 from 2010 to 2011, it was not that significant. It is to be noted that due to insufficient time for gathering this kind of information, it is believed that some categories of spending are underestimated, but at least it provides us with the spending snapshot for both 2010 and 2011.

Target 7. *Critical Enablers and Synergies with Development Sectors*

Indicator 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*

The complete report is in Annex 3

Indicator 7.1b *WHO Policy questions*

A separate document is presented.

Indicator 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*

The data available is out-dated, with the last report in 2005 for the police and the Family Tribunal. There are indications that the number of reported cases is still increasing, with a higher number of men reporting violence from their female partner.

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

School enrolment and attendance in general in Seychelles tend to be 100% for most years. Drop-outs begin in secondary school. For OVCs, it was 100% as well during the reporting period. Children who do not attend school are quickly sought out by school-based counsellors and social workers and generally re-integrated in school or for older ones in the secondary schools, into school and workplace attachment programmes.

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

All eligible households who request for assistance from the Social Welfare Agency are means tested and they receive financial help if they meet the criteria. Unfortunately, it is not possible to know which households had PLHIV. However, since coverage tends to be good, it is expected that the poorest households are receiving numerous forms of assistance (orphans, unemployment, housing).

IV. Best practices

Political leadership

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

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

(a) NAC will become a statutory body with an act of parliament to guide its works. The law has been drafted and will be presented to the National Assembly soon.

(b) NAC will be based in the Vice-President's office and will have officers taking care of the key priority areas of the national strategic plan (prevention and behaviour change, treatment and care, impact mitigation and human rights protection, resource mobilisation, and monitoring and evaluation).

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

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

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

Infrastructure development

Seychelles has invested and built modern infrastructure to house some of its key programmes. In its ***Country Cooperation Strategy 2008-2013***, the World Health Organisation notes that: "*Over the last four decades Seychelles has made remarkable progress in health development through comprehensive healthcare infrastructure*." The ***National Plan of Action on National Development 2005 - 2015*** (***NPASD)***[33] also highlights the relatively good care and support available generally. There are regional health centres and hospitals on inner-lying islands, Praslin and La Digue. Some examples of other infrastructures involved in treatment, care and support for PLHIV and people affected by HIV are as follows.

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

[33] Ministry of Health and Social Services, Social Development Division (2006) *National Plan of Action on National Development 2005 - 2015*

youth are visiting the YHC. However, the space may be too small to accommodate all the programmes run therein.

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

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

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

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

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

A supportive policy environment

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

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

Programmes

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

(a) EMTCT where coverage is 100% in most years for both antenatal and post-natal service delivery for both mother and child, with access to HTC, ART, nutritional support and good follow-up.
(b) Universal free (ARVs) treatment for all PLHIV. Recently, the Ministry of Health has acquired a PCR.
(c) Blood and blood product safety, with rigorous procedures and measures in place for testing.
(d) There is good integration of HIV/AIDS with TB management. Moreover, HTC is also integrated in the health system and it is possible to access services at all entry points in the district and main public health centres.
(e) The Ministry of Education has established a curriculum, the Personal and Social Education Programme (PSE) which has its own trained teachers for secondary schools. In this programme, HIV and STIs are addressed in an age-appropriate manner. However, the programme is still not an examinable subject. The various other weaknesses of the programme have been addressed in the new national strategic plan for 2012 to 2016.
(f) The Youth Health Centre and partners conduct outreach programmes with integrated HTC in post-secondary institutions.
(g) The Social Welfare Agency provides financial assistance to PLHIV who require such. Confidentiality is

maintained and the programme is available to all PLHIV without discrimination based on age, gender or race.

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

Monitoring and evaluation

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

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

V. Major challenges and remedial actions

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

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

(b) Challenges faced throughout the reporting period (2010-2011)

Stigma and discrimination towards key populations and some vulnerable groups
HIV and AIDS are still considered as pariah conditions, even if reactions to PLHIV and people affected by HIV are gradually improving. There were still only two persons who had publicly disclosed their positive status: one is now deceased and the other is less active for the moment. There is still no specific law for HIV and AIDS. The only strong documents are the Constitution, the Employment Act, and the Workplace Policy. It has been acknowledged that it is very difficult to prove workplace discrimination because the employer can simply use any other reasons to explain the dismissal.

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 16: Concrete remedial actions

Challenges	Concrete Remedial Actions
Implementation of targeted programmatic actions for key populations	• Harm reduction measures clearly highlighted in the new national strategic plan 2012-2016 • Civil society encouraged to apply for project grants, through the NATF and international donors, to implement clean needles, syringes and other equipment for PWID • NGOs and FBOs have begun pilot programmes targeting MSM and SW
Stigma and discrimination towards key populations and some vulnerable groups	• Proposal to have a HIV and AIDS Act • Inform the general population and key groups of their rights and how to seek redress for alleged violations of these
Need for outreach programmes	• Some CSOs have limited peer education programmes. There is a need for these to be scaled up.
Drop-outs and non-adherence to treatment	• Study proposed on causes of drop-outs, defaults and non-compliance to treatment
Patients coming in late stage of the disease	• Same as above
Client-initiated HTC still rare	• Proposal to have provide-initiated HTC in all entry points • Decentralisation of treatment services • More involvement of NGOs in HTC, e.g., ASFF
Sustainability (funding issues)	• Focus on targeted prevention for key populations to reduce incidence to ensure that the epidemic does not increase
Empowering peers	• Peer education training by NGOs (ASFF, COMPASSION) and YHC
Unprotected sex	• Targeted prevention with key populations, including peer education and outreach activities, focusing on behaviour change communication, HTC and adherence to medication
Denial and risk-taking behaviour	• Same as above
Gender inequalities	• National Gender Policy • National Gender Plan of Action • National Gender-Based Violence Plan of Action

VI. Support from the country's development partners

(a) key support received from:

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

Table 17: UNAIDS contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2010	Technical assistance and funding of the following activities: • Development of the Seychelles multi-sectoral monitoring and evaluation framework for HIV and AIDS and STIs
2011	Technical assistance and funding of the following: • Review of the ***National Policy on the Prevention and Control of HIV/ AIDS and STIs 2001*** and the ***National Strategic Plan on HIV and AIDS and STIs 2005-2009*** • Drafting of the ***National Strategic Plan for HIV and AIDS and STIs 2012-2016*** • Support to the Mode of transmission study

Table 18: ARIS –COI contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2010	
2011	• February – Overseas training / meetings - Comite de Pilotage in Comoros Islands (2 persons); Formation Outils Informatiques pour Investigation d'Epidémies in Mauritius (2 persons) • March - Infectious Subtancesship Training in Mauritius (5 persons) • March & April - Evaluation of the national HIV and AIDS programmes in early 2011. Main findings include high staff turnover leading to lack of institutional memory and constant re-training, electronic and information technology equipment being used in various key offices are old and out-dated, hampering access to rapid, reliable and effective service delivery, some of the doctors trained as 'médecin-référents' are not practising and helping with the management of patients, which is still very much centralised at the CDCU • May - Analyse de situation des systèmes de surveillance et suivi & Evaluation in Mauritius (2 persons) • September - Formation INTOEPI in Mauritius (4 persons) ; attending Collectif Urgence Toxida (CUT) Conference in Mauritius (2 persons) ; Validation & Consensus building workshop on Tele-Health in South Africa (4 persons) • November – Xme Colloque VIH Océan Indien in Madagascar (16 persons) • BCC with WHO

Table 19: WHO contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2010	• Development of M & E Framework • Supported participation in international conference on Behaviour Change Communication in Nairobi
2011	• Supported the HIV programme evaluation, policy and strategic plan development • Supported the RDS Survey on PWID and MSM with IOC • Supported national conference on Behaviour Change Communication in Seychelles • Purchased 11,000 rapid HIV testing kits for HIV Awareness Campaigns • Supported 2 participants to Harm Reuction Conference in Mombassa jointly with UNODC • Supported 3 participants for a study tour to La Reunion on harm reduction for on-the-job training • Support in updating the HTC Guidelines

Table 20: UNFPA contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2010	• February - Overseas training in Mauritius (1 person)
2011	• Funding & facilitation of the workshop on the development of a national social and behaviour change communication strategy/policy • Funding of delegates to the regional IOC Colloquium on HIV and AIDS in the Indian Ocean (November, Madagascar) • Funding of two young persons to attend the ICASA Conference in Ethiopia in December • Train new peer educators in HIV/AIDS/STIs prevention, early pregnancy, abortion, counselling and communication skills • Technical assistance for national RH action plan integrating adolescent reproductive health, KAP, research, monitoring and evaluation

Table 21: UNESCO contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2010	• Funding of the National Youth Study 2010-2011 • December - Assessment of the education response to HIV/AIDS. • Identified a number of gaps (lack of clarity on the extent to which sex education and HIV are addressed in the PSE programme in schools, need for both formal and informal education & need to and expand best practice initiatives such as peer education)

Table 22: SADC contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2010	• March - Consensus Building Workshop in Botswana (6 persons)
2011	• January - Validation & Consensus Building workshop on gender Mainstreaming guideline & Tools in Botswana (2 persons) • February - Regional TB Managers Meeting & Partnership Forum (3 persons); Southern Africa Regional Consultation in South Africa (1 person) • April - Joint SADC/EAC/COMESA/UNAIDS High level meeting on woman, girls, gender equality & HIV in Mauritius (1 person); COI/RSIE/SEGA/AM/ Invitation to the 3rd Meeting of the SEGA Technical Regional Committee in Mauritius (1 person) • June - Validation & consensus Building workshop in South Africa (2 persons) • July - HIV Testing, Counselling & Harm Reduction in Madagascar (2 persons) • September - Ninth Steering Committee on Communicable Diseases in Angola (1 person); Monitoring & Evaluation of Orphan, Vulnerable Children (OVC) in South Africa (3 persons); Validation & Consensus building workshop on Tele-Health in South Africa (1 person)

Table 23: HRI contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2010	• Full funding of 1 person to attend Harm Reduction Conference in Beirut, Lebanon
2011	• Full funding on 1 person to attend ICASA Conference in Addis Ababa, Ethiopia

Table 24: UNDP contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2010	• Training on MDGs / database / DevInfo

Table 25: AUSAID contribution to the national response to HIV and AIDS and STIs

Years	Programmes
2011	Funding of 1 person to attend a training in harm reduction conducted by the Nossal Institute of the University of Melbourne and the Burnet Institute of the Monash University (Melbourne, Australia)

It is noted that UNODC, various embassies, the Japanese International Cooperation Agency (JICA) have been helpful with a number of projects funded for NGOs, but there has been no information forthcoming from stakeholders. It is noted yet again that there are issues regarding institutional memory.

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

Most stakeholders wish for greater assistance with the development of harm reduction policy and measures so that targeted interventions could be undertaken.

VII. Monitoring and evaluation environment

(a) Overview of the current monitoring and evaluation (M&E) system

The review of the policy and the national strategic plan 2005 – 2009 indicates that there were some issues with M&E as indicated in the table below.

Table 26: Monitoring and Evaluation - Summary of Findings of the National Review of the National Strategic Plan for HIV and AIDS 2005-2009 and the National Policy 2001

Achievements	Gaps
• The NSP 2005 – 2009 discusses a framework for M & E activities • A number of studies in the operational plan has been identified as means to collect strategic information • Statistical data used to inform decisions at strategic levels • A number of mechanisms and tools were identified as means of gathering information	• There was no firmly established M & E Plan, with costed activities and responsibilities • The proposed provisions for M & E were vaguely formulated and were presented as options to be discussed and adopted in the future • The coordination mechanisms broke down and there were no risk assessment plans to mitigate for the effects of negative events and trends • Few activities done incorporated the M & E tools meant to be devised to collect information • There was no mid-term review done and as such, there were no other baseline data to conduct the NSP review • Some activities were proposed as means for collecting strategic information. However, most were not conducted as all relied on bringing in consultants. • Little or no funds allocated to M & E activities

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

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

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

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

history of the work done and what is proposed in the National Monitoring and Evaluation Framework, so as to build consensus amongst stakeholders.

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

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

(c) Remedial actions planned to overcome the challenges

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

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

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

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

(a) Epidemiology

(b) Statistics, storage and use of strategic information

(c) Health and social research methodology / tools already in use by other organisations and countries

(d) Policy planning and development

(e) Capacity-building

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

ANNEXES

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

Dates	Tasks
February – 05th March	Data Collection Completed for Indicators 1-24
February – March 10th	Collection of data for Indicator 6 (NASA)
01st March	Meeting with stakeholders/Collection of information for NCPI
	Data analysis, compilation Draft Completed Circulate 1st draft for Feedback
	All Feedback on Draft given Final Draft Completed Narrative Report, NCPI, and CRIS Circulated for Approval
27th March	Validation workshops of the entire Country Progress Report
26-30th March 2012	Entry of the Country Progress Report in the CRIS 3 (Country Response Information System)

In endorsing the national report, a meeting was organised and hosted by the AIDS Control Programme to achieve agreement and consensus on the documents. The following Technical Advisory Committee Members of HIV/AIDS and STIs, participated in the meeting and the document was amended and unanimously endorsed.

Names	Position / Organisation
1. Dr. Anne Gabriel	CMO Community - Chairperson
2. Mr Joachim Didon	Senior Statistician (Ministry of Health)
3. Dr. Daniella Malulu	CIC Mental Health
4. Ms. Josie Chetty	Senior Pharmacist
5. Mrs. Judie Brioche	Nurse Manager Youth Health centre
6. Mrs. Sabrina Mousbe	Acting AIDS Control Programme Manager
7. Mr. Propser Kinabo	Director of Clinical Laboratory
8. Mr. Leon Biscornet	(replacing) Director Public Health Laboratory (PHL)
9. Mr. Vincent Okullo	UN Volunteer UNFPA
10. Dr Shobha Hajarnis	Director-General Public Health Division
11. Dr. Jastin Bibi	Director Epidemiology & Statistics
12. Dr Cornelia Atsyor	WHO Liaison Officer
13. Mrs. Jeanine Faure	Senior Nursing Officer Disease Surveillance and Response Unit
14. Ms Rosie Bistoquet	Director of Programmes
15. Mrs. Myra Bijoux	Health Promotion Officer AIDS Control Programme
16. Mrs. Gemma Barbier	Director HRPD
17. Dr. Jude Gédéon	Public health Commissioner
18. Ms. Brenda King	Deputy CEO Social Protection Agency
19. Mrs. Peggy Azémia	Programme Manager Family Planning (FP)
20. Mrs. Penelope Simon	Pharmacist (SOP Pharmacy)

The stakeholders meeting was held on Tuesday 01st and 27th March and attended by the following persons

Names	Position / Organisation
Ms. Rosie Bistoquet	Ministry of Health Director Programmes
Mrs. Georgianna Marie	Programs- Ministry of Health
Mr. Guy Hoareau	Account- Ministry of Health
Mr. Jean Malbrook	Tripatiate/Health Econimist
Mr. Joachim Didon	Diseaseas Surveillance Unit -Ministry of Health
Ms. Tessa Siu	Gender Secretariat -Social Development Department
Ms. Lisette Malvina	Ministry of Foreign Affairs
Mr. Alex Rath	HASO NGO
Ms. Monica Servina	ASFF NGO
Ms. Marie-Annette Ernesta	Civil society
Ms. Diane Mussard	Programme Coordinator Centre Mont Royal Rehabilitation Centre
Ms. Sarah Sabadin	Seventh Day Adventist FBO
Reverend Christine Benoit	Anglican Church - FBO
Josie Chetty	Phamacist- Ministry of Health
Daniella Malulu	Psychiatrist - Ministry of Health
Georgette Furneau	CDCU - Ministry of Health
Judie Brioche	Youth Health Centre- Ministry of Health
Beryl Laboudallon	Child Protection Unit- Ministry of Social Development
Terrence Brutus	Gender Secretariat -Ministry of Social Development
Desiree Hermite	Children welfare- Ministry of Education
Francis Accouche	FBO/Seychells Scout Association
Dianna Gerry	Ministry of Home Affairs -Prison Department
Nancy Henry	Ministry of Home Affairs -Prison Department
Germaine Michaud	Seychelles Chamber of Commerce- Private sector
Robert Moumou	Rehabilitation Centre for Substance Abuse/Family Council
Sarah Sabadin	FBOs
Jeanine Faure	Focal Person(AIRIS/COI)
Sabrina Mousbe	HIV/AIDS Program- MOH
Peggy Azemia	Reproductive Health Unit- MOH

ANNEX 2: Data sources and References

1. Sentinel site data from the Communicable Disease Control Unit (CDCU)
    a. Local Situation from 1987 to December 2011
    b. Local Situation from January to December 2010
    c. Local Situation from January to December 2011
2. Policy and national programme data from the Ministry of Health AIDS Control Programme (ACP)
3. Ministry of Health (2011) *Injection (sic) Drug Use Integrated Biological and Behavioural Surveillance Survey Round 1*
4. Ministry of Health (2011) *Men Who Have Sex With Men: Integrated Biological and Behavioural Surveillance Survey Round 1*
5. Ministry of Health and Social Services, Social Development Division (2006) *National Plan of Action on National Development 2005 – 2015*
6. Ministry of Health (2001) *National Policy for the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles*
7. National AIDS Council (2012) *National Policy for the Prevention and Control of HIV and AIDS and STIs of the Republic of Seychelles*
8. National AIDS Council (2012) *National Strategic Framework for HIV and AIDS and STIs 2012 – 2016*
9. National AIDS Council (2012) *National Costed Operational Plan on HIV and AIDS and STIs*
10. National AIDS Council (2012) *National Multi-Sectoral Monitoring and Evaluation Framework for HIV and AIDS and STIs*
11. UNDP *Seychelles Common Country Assessment Report 2010*
12. Ministry of Foreign Affairs (2012) *Draft Report of the Implementation of the International Covenant on Civil and Political Rights (Seychelles)*
13. National AIDS Council (2011) *Final Report on the Evaluation of the HIV/AIDS NSP 2005-2009, Updating of the National Policy on HIV/AIDS and Other STIs, and Road Map for NSP 2011-2015*
14. Ministry of Health (2012) *Domestic and International AIDS Spending by Categories and Sources*
15. National Bureau of Statistics (2011) *Population and Housing Census 2010: Preliminary Results*
16. National Bureau of Statistics (2011) *Population and Vital Statistics: No. 2 of 2011*

Annex 3: National Commitments and Policy Instrument (NCPI)

Name of the National AIDS Committee Officer in charge of NCPI submission and who can be contacted for questions, if any: Rosie Bistoquet
Postal address: Ministry of Health, Mont Fleuri, Mahe, Seychelles
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Date of submission: 31st March 2012

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

PURPOSE OF NCPI REVIEW PROCESS

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

RESPONDENT IDENTIFICATION, RECRUITMENT AND DATA COLLECTION PROCESS

A convenient sample of 55 potential respondents was identified from different contact lists of relevant sectors and units within the government, and outside the government including Civil Society Organizations and United Nation Organizations. It is notable that most respondents make up a sample of informants from within and outside the government who could be having with some sort of familiarity with scope of issues and knowledge around national response to HIV and AIDS.
The potential respondents were contacted and standardized self administered questionnaires posted to them. The respondents were expected to complete and post back completed questionnaires to the contact person in AIDS Control Program Office. Posting back the completed questionnaire also indicated consent by the identified persons to participate in the exercise. A section of the respondents posted back completed questionnaires while others completed their questionnaires, in a stakeholders meeting organized to build consensus on the process of the NCPI data gathering and validation process. Out of the 55 invitations, only 27 participants completed and submitted their questionnaires in the review process.

SCOPE AND DATA ANALYSIS METHODS

The analysis is limited to the various questions included in the 2 questionnaires (part "A" administered to the government officials, and part "B" administered to administered to representatives from civil society organizations, bilateral agencies, and UN organizations
Part "A" covered: Strategic plan, Political support and leadership, Human Rights, Prevention, Treatment, care and support, Monitoring and evaluation, and part B covered: Civil Society involvement, Political support and leadership, Human rights, Prevention, Treatment, care and support.
The NCPI questionnaires contain both closed standard questions and open ended questions. These generated both qualitative and to some extent quantitative data. Descriptive analysis has been used to analyze the qualitative data comprising of views and comments based on the themes to identify general patterns on progress on implementation of commitment to HIV/AIDS national response. In addition, simple summary statistics (i.e. means and frequencies were calculated and interpreted to provide general impressions of the respondents.

FINDINGS

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

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

NCPI PART A (ADMINISTERED TO GOVERNMENT OFFICIALS)

I. Strategic plan

Q1: all respondents (n=15) agree there is a national multi-sectoral strategy for HIV and AIDS, however, there is somewhat confusion about the period covered. Responses indicate both 2005- 2009, and 2012-2016. Indicating the two periods in report narrative may help clarify the existing gap when there was no Strategic plan in place between 2009-2011 periods.

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

Q2. The question as to whether HIV and HIV related issues like HIV impact have been integrated in specific development plans, have mixed responses. Most respondents (n=9) think HIV have been integrated in development plans, however, evidence from document review may reveal different picture. It is not clear from the NCPI data whether HIV have been integrated effectively in different national development plans, and further discussions and validation will need to be conducted to clarify these.

Q3. The question whether the country has evaluated the impact of HIV on its socio economic development for planning purpose raises mixed views, with some respondents (n=4) disagreeing. While it may be apparent no such evaluation has been done, it will be worth to discuss this further, and or triangulate with existing findings from other documents to establish if the country has had such an evaluation. A point which is not evident has been undertaken. Responses indicate low to average scales for evaluations and use of evaluation evidence on socio economic to inform resource allocation decisions on HIV/AIDS response and it highlights the need to look into implications it may be having on the national response and what actions could be taken.

Q4. It is also not clear from the responses whether there actually exist a strategy for addressing HIV issues among national uniformed services. A small proportion of respondents don agree that a strategy actually exist (n=3).

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

Q6. In overall responses indicate an average of 7 out of 10 for overall strategy and national planning. However, there are limited substantial comments and examples to support that from the responses. Moreover, more triangulation may be needed to strengthen evidence on these issues.

II. Political support and leadership

Q1. All respondents (n=15), indicate high government officials speak publicly and favourably about HIV efforts in major forums including both ministers and officials at sub national level.

Q2. All respondents (n=15) agree the country has fully recognized national multi-sectoral HIV coordination body (i.e. National AIDS Council) with active leadership and participation, official chairperson, defined membership and including CSOs, PLWHA and the private sector. However, it is not exactly clear whether NAC has an operational function in actual coordination activities and management of national HIV/AIDS programmes. These observations may need further discussion, and highlight any perceived or actual challenges around national coordination. Also, While most respondents agree there is one national multi-sectoral coordination body (i.e. National AIDS Council), Most of the participants also agree more could be

done to increase interaction, collaboration between the government, civil society and private sector for implementing HIV/AIDS programmes and strategies
Q3. All respondents also acknowledge the country has a system in place to promote interaction between the government, civil society organizations and the private sector for implementing HIV strategies /programmes for example through NAC meetings held twice a year.
Q4. Most participants have no clue as to what proportion of the national HIV budget was spent on activities implemented by the civil society over the past year. However, this can be explored further through other existing sources of financial data.
Q5. Most respondents agree national AIDS council provide civil society support in capacity building, information, procurement and technical guidance. However, most views don't indicate 'coordination with other implementing partners' as one of the support areas
Q6. The question of whether the policies and laws have been amended to be consistent with national HIV and AIDS Control policies has mixed responses. Most response (n=13) convey the meaning of recent review of National Strategic Plan for HIV/AIDS, however, it will be important to have further discussion to clarify, that the question of review and amendment of policies and laws has wider scope, to include other related national and sectroral policies and legislations.
Q7. The scales applied are rather arbitrary and may not resonate with actual performance. It would be great to have an overall impression during the validation process.

III. Human Rights
Q1.1 Questions on human rights have varying and in some cases very inconsistent responses. However, most respondents (n=14) indicate there is existing non discrimination law or regulation which specifies protection of people living with HIV. Law or regulation implies a policy enforceable in a court of law. This makes the shared view by respondents not so clear, since we don't have specific legislation specifying people living with HIV.
While may be apparent the country has no specific non discrimination legislation or regulation which specifies protections for specific populations like MSM, sex workers etc, under Q1.1 most respondents, likely make reference to National policy on HIV and AIDS and STIs. Moreover, the issue being the fact that it is not yet even formally communicated the National Policy for HIV and AIDS and STIs have been passed by the parliament and given legal presidential assent as a national public policy. If this was the case the national policy would then be in place as a specific instrument, when the country still has no specific act of parliament stipulating protection for the PLWHAs. It is an issue that needs exploring further, with stakeholders and gather information reflecting actual situation.
Q2. Most respondents (n=13) agree the country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for key populations including MSM, people who inject drugs,, prison inmates, sex workers, and transgender people.
There are also a number of non responses on areas where there is some kind of regulation. This may imply limited awareness of existing policies among some stakeholders. Communicating policy as existing should be for those formally passed in processes upholding the rule of law/law making in the country.

IV. Prevention
Q1. All respondents agreed the country has a policy or strategy that promotes information, education and communication (IEC) on HIV to the general population. Some indicate it as integrated, since the country has no stand alone policy on IEC, however, there is a process initiated to develop social and Behaviour change communication Framework for HIV and AIDS and STIs.
Respondents also identify focus of the strategy. However, most respondents (n=12) identify strategy lack of focus on messages promoting greater equality between men and women, and how to avoid intergenerational sex. Messages on 'Males get circumcised under medical supervision, is viewed by most as not applicable for Seychelles"
Q2. All responses indicate there is a strategy to promote life skills based HIV education for young people. The strategies also include age appropriate gender sensitive sexual and reproductive health elements.
Q2.3 However, notable also is question on strategy for HIV education for out of school youth where many (n=5) respondents think there is no clear strategy in this area. It could be integrated, however the

observation may indicate, need to strengthen focus and coverage.
Q3. Most respondents (N=14) agree the country has strategy/policy in place to promote information, education and communication and other preventive health interventions for key or other vulnerable sub populations. Most respondents agree most of the elements and most of populations groups are reflected in the new Strategic plan 2012-2016
Q4. All respondents agree the country has identified specific needs for HIV prevention programmes. Also most participants strongly agree with good progress and access to prevention services for blood safety, PMTCT, Universal precautions in healthcare settings. However, most respondents strongly disagree with progress and access to prevention services for harm reduction for intraveneuous drug users, risk reduction for sex workers including IEC on stigma and discrimination. These highlight some views on trends to consider for validation, but also on the general trends in national HIV prevention efforts.

V. Treatment, care and support
Q1. All respondents report, that the country identified the essential elements of comprehensive package of HIV treatment, care and support services including prioritized elements like HTC, PMTCT, medication, social support, financial support.
Responses to Treatment, Care and Support, indicates very impressive progress especially most views strongly agree with progress of free access to Antiretroviral Therapy, early infant Diagnosis, Post Delivery ART for women among other treatment services scores very high, in the national response from the views of respondents. Some views, however disagree with access to psycho social support for people living with HIV/AIDS and HIV care and support in the workplace including referrals. The responses however, also indicate the challenges to successful treatment outcome for PLWH, including non compliance with treatment plans, loss due to follow up etc.
Q2. There is general consensus that the government has a policy/strategy in place to provide social and economic support to people infected/affected by HIV. However, it is important to note some respondents indicate that the social support is not framed with general welfare program for everybody eligible.
Q4. It is not very apparent form the responses and non responses whether the country has access to regional procurement and supply management mechanisms, for critical commodities, such as ARVs, condoms and substitution medication,
Q6. It is also not clear whether there is a specific national action plan, for orphans and vulnerable children and actual estimates of the OVC under care. One respondent indicate there is a draft plan in place but that may not be satisfactory, to indicate as an existing plan. Responses to Treatment, Care and Support, indicates very impressive progress in overall compared to other aspects of the national response.

VI. Monitoring and evaluation
Q1. Most responses indicate there is one national monitoring and Evaluation plan for HIV, however, a number of inconsistencies occur. Some respondents (n=4) indicate the M&E plan is in progress and in draft form, while to others there is an M&E framework in place. There should be further discussions, to clarify this point, and have a common statement agreed by the national stakeholders.
Q2. Most responses to the question whether national M&E plan include a data collection strategy, agrees to the entire component including 'HIV Drug surveillance, an element that is not yet conducted in the country. These views may be misleading and there is a need to have discussion in plenary to build consensus on actual scenario of M&E plan and its data collection strategy.
Q3. Some respondents indicate the budget for M&E is in progress while others don't have a clue. It will be important to have a plenary discussion before validating the true state of M&E budget.
Q4. Most respondents (n=13) identifies there is no functional national M&E Unit Some also highlight obstacles as limitation in human resources and technical capacity.
Q5. While there a couple of non responses to this question, some respondents report non existence of M&E committee or working group.
Q6. Some respondents (n=7) reports an existing national database with HIV related data. However, some few indicates this is something in progress. Comments also acknowledge some limitations of information about the content, key population and geographical coverage of HIV services, as well as their implementing organizations.

There are non responses and few responses to question, 7 and 8, which make it appropriate to have a plenary discussion with participants to gather more information, to have a clear status of the activity. Overall, there is limited comments/response to questions on M&E, possibly indicating low awareness, participation in M&E planning activities, or lack of such. It would be worth it to explore the details further with national stakeholders.

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

I. Civil Society Involvement

Generally and like some responses in Part "A" most responses in Part "B" view Civil Society participation and visible influence on decisions as limited. This may be interpreted variously, however hints on limited access to spaces of decision making, capacity, motivation and support to active participation. However, there is limited evidence to confirm any perceptions from the few comments and views on the trend. Some (n=2) respondents mention little consideration is given to the views of CSOs even when they do participate to make contributions. Specifically on:

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

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

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

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

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

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

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

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

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

CSOs and government collaboration is potentially valuable step in what should be an ongoing and fully institutionalized process of collaborative planning, implementation, monitoring, assessment and correction

of HIV responses. The momentum achieved through the process, of developing national policy and plan for STIs, 2012 – 2016 may be improved for active and meaningful engagement.

II. Political support and leadership

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

III. Human rights

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

The general observation is that general laws exist on non discriminations (i.e. as in the country's constitution) which may be used by anybody (through different mechanisms like Ombudsman office, Courts etc) to seek legal redress. May be the question could be access to and effectiveness of the existing mechanisms to enable people seek redress. However, considering significant non responses on some of these fundamental questions, it may be assumed there is low awareness about existing laws that relate to discrimination in general among different population groups. This is a trend that may be explored with stakeholders considering its implications.

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

IV. Prevention

All respondents (n=12) perceive that the country indentified the needs for HIV prevention, however, most (n=10) think there is need for improvement to have targeted interventions. In consistency with the responses in Part A, most responses here indicate strong agreement with access to prevention services and information for blood safety, prevention of mother to child transmission of HIV, Universal precautions in healthcare among others. Most responses also disagree with access to prevention services especially for harm reduction, which the government may be piloting at the initial stages, risk reduction for MSM, sex workers among others. While some respondents agree with access to prevention services for out of school youth, some disagree and it may be important to hold discussions to have a clear picture of the situation.

V. Treatment, care and support

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

Most views in part B, are generally in consistency with views in part A which includes perceptions on the existing strategy and/or policy to ensure access to treatment, care and support for key populations and other vulnerable groups. Access to treatment services are scales high except when it come to care and support for the orphans and vulnerable children. Further discussions with stakeholders may reveal more details.

CONCLUSIONS

The NCPI process has gathered important views on a number of areas useful in understanding the current country situation. There are consistent views from both part A and B questionnaires including remarkable progress in access to treatment services e.g. ARVs, but also limitation in treatment access to certain population groups. Generally, there are more shared than conflicting views on trends of national HIV/AIDS response. Not to say there is absolute agreement in all areas, but even yet the points teased out in this summary will require further corroboration with evidence from desk reviews of other documents, and validation considering not all respondents share same views on even some of the most pronounced trends. It is also important to acknowledge that, the sample of the participants in this process are relatively few, therefore, the views and general trends identified should only be interpreted carefully within reasonable scope and generalized only after triangulation with findings from desktop reviews of existing policy documents and validation with national stakeholders.

ANNEX 4 – National AIDS Spending by Categories and Financing Sources

(See separate document)