



UNGASS COUNTRY PROGRESS REPORT

SEYCHELLES

Reporting for the Period: January 2006 – December 2007

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INTRODUCTION

In Seychelles, the HIV and AIDS epidemic is concentrated, yet it poses a big challenge and threatens to reverse the gains the country has made in its socio-economic development and stability since its independence. When estimating HIV incidence for countries one is often met with technical and operational difficulties. HIV prevalence among the age group 15 to 19 is commonly taken as a proxy of incidence, given that it is considered as recent infections. In Seychelles, among first time ANC attendees aged 15 to 19 for the year 2007, HIV prevalence stood at 2.5%. This statistics may be indicative of the not only the future HIV trend in Seychelles but also an indication of the socio-economic challenge the pandemic may produce.

However, given the potential challenges posed by the epidemic, the country has not developed capacity to estimate the prevalence.

The UNGASS Declaration of Commitment on HIV/AIDS 2008 report was compiled by the Department of Health, Republic of Seychelles. The process was conducted by a work team coordinated by the Programme Manager in the 'AIDS Unit'. The team comprised members from CDCU, Health Statistics Unit and the National Statistical Bureau. The team coordinated the assembling of data and report writing.

This report has been compiled with participation and involvement of the Public Sectors, Ministries and Departments. In producing the report, we also relied mainly on existing data from the Department of Health. These included data sourced from the Health Statistics Unit, CDCU, and Health Statistics Reports.

Key informants included members of the President's Office, the Ministry of Finance, the Ministry of Education, WHO Liaison Office, HASO, Barclays Bank and others who completed the National Composite Policy Index Questionnaire. Officials of the Ministries of Employment, Education and Health provided data as well as additional documentation on HIV/AIDS workplace policies and practices. The Ministry of Education conducted a rapid desk survey on life skills education in schools.

In the data compiling process and report writing, it became evident that existing data on certain indicators are not easily obtainable or available in the format recommended by UNGASS Guidelines on the Construction of Indicators. During the course of the exercise, the urgent need for a monitoring and evaluation framework became evidently clear. Had an efficient and effective monitoring and evaluation framework been in place it would have rendered the exercise easier.

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

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

for the Construction of Indicators. Similarly, routine data collection of the Education Department should take into account data requirements on HIV/AIDS life skills education.

It was evident in the various consultation forums, including the validation meetings, that there is a zeal within the various services to contain the epidemic before the situation escalates. In this light a monitoring and evaluation framework is an urgent necessity. The process of compiling this report was instrumental in renewing this engagement. During the process it was also noted that though the country compiled and prepare the two previous UNGASS reports, 2003 and 2005, there are no evidence that they were ever received by UNAIDS.

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II. STATUS AT A GLANCE

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<p>NATIONAL PROGRAMME AND BEHAVIOUR</p> <p>Prevention</p> <ol style="list-style-type: none"> 3. Percentage of donated blood units screened for HIV in a quality assured manner: 100% 4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy: 100% 5. Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission: 100% 6. Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV: 100% 7. Percentage of women and men aged 15-49 who received an HIV test in the last 12 months and who know their results: 100% 8. Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results: Not Available 9. Percentage of most-at-risk populations reached with HIV prevention programmes: Not Available 10. Percentage of orphaned and vulnerable children aged 0–17 whose households received free basic external support in caring for the child: Not Available 11. Percentage of schools that provided life skills-based HIV education in the last academic year: 100%
<p>KNOWLEDGE AND BEHAVIOUR</p> <ol style="list-style-type: none"> 12. Current school attendance among orphans and among non-orphans aged 10–14: Not Available 13. Percentage of young women and men aged 15–24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: Not Available 14. Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission: Not Available 15. Percentage of young women and men aged 15–24 who have had sexual intercourse before the age of 15: Not Available 16. Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months: Not Available 17. Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse: 16.6% 18. Percentage of female and male sex workers reporting the use of a condom with their most recent client: Not Available 19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner: Not Available 20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse: Not Available 21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected: Not Available
<p>IMPACT</p> <ol style="list-style-type: none"> 22. Percentage of young women and men aged 15–24 who are HIV infected: 1.13% 23. Percentage of most-at-risk populations who are HIV infected: Not Available 24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy: 55.0%

III OVERVIEW OF THE HIV AND AIDS EPIDEMIC IN SEYCHELLES

HIV and AIDS in Seychelles represent a concentrated epidemic. The burden of disease related to AIDS was relatively low at the end of 2007. Prevention, treatment, care and support programmes are national concerns. The National Policy on HIV and AIDS as well as the National Strategy call for coordinated action on the part of government, non-governmental organisations, the private sector, community groups and the general population. In this regard, the implementation of the National Strategic Plan for 2005 to 2009 is progressing forward steadily. Inevitably, there are a number of challenges including the implementation of the “Three Ones”.

To provide common, policies, directions and a road map, a country is required to have a National HIV and AIDS Strategic Plan, which mirrors the aspiration and contributions of all sectors of the society. A complete Strategic Plan with quantitative and qualitative aspects will be particularly helpful in pooling resources for sustained, coordinated action. This facilitates effective means of intervention, hence meeting the needs of the country in the field of HIV and AIDS.

The Ministry of Health leads the HIV/AIDS fight since the detection of the first case of HIV infection in 1987. Government commitment has been expressed through the creation of the national AIDS programme, adoption of a National Policy endorsed by the President, creation of the National AIDS Council and National AIDS Trust Fund, funding of activities by government and external resources, and adherences to international convention and principles including the UNGASS declaration. However, currently the fight is still mainly perceived as a health issue and the need for a significant move to a multi-sectoral approach cannot be overemphasized. (National AIDS Council, 2005)

Though HIV and AIDS pandemic has not as yet a problem on the scale of some other countries, Seychelles has made significant strides in developing and implementing appropriate policies to respond to the potential challenge of HIV and AIDS. It is in the process of moving away from a health sector driven response to a multi-sectoral response involving various sectors of our society.

HIV/AIDS presents a real and surmountable challenge for Seychelles. Despite its status as middle-income country, and small island state, the HIV/AIDS situation in Seychelles requires continued attention from both its government and the international community. The pandemic will not only have a social impact but also an economic impact at the individual and national levels as the country will most feel the brunt of providing medical care for those infected, and losing human resources, especially those who are economically active. (National AIDS Council, 2005)

The National Strategic Plan 2005 to 2009 was crafted by the Ministry of Health and major local partners, in collaboration with UNDP, UNAIDS and WHO. The national strategic plan is intended to guide the country's response to the epidemic. It is not a plan for the health sector specifically as no single sector, will by itself overcome the HIV/AIDS epidemic. All government departments, organisations and stakeholders will use this framework as a basis to develop their own plans thus ensuring a well coordinated effective and efficient response. It was the product of a workshop with the aim of achieving consensus on the HIV and AIDS

national Strategies and involved over hundred participants who consequently reviewed the draft plan and make recommendations.

In countries that have had significant successes in slowing down or reversing the trends in HIV infection, the key elements contributing to the successes have been consistent interest and commitment at the highest levels of leadership and persistent action by all groups in society, including people living with HIV and AIDS. These imply massive mobilisation of resources dedicated to prevention through education, information and communication, control through well established public health measures and caring through clinical services and support for those infected and affected.

There is strong political will and commitment over the years with regards to HIV and AIDS. In Seychelles, we will recall the various interventions made by the President of the Republic and his Minister of Finance. Below are few pertinent statements made by the President and the Designate Minister, who is also the Minister of Finance in addressing the whole population on HIV and AIDS related issues:

"A preparedness culture also means that we should constantly be on our guard and take preventative measures to deal with increasingly global diseases that may threaten our public health. The prevalence of HIV and AIDS is on the increase in our society and we must all make more prevention efforts. My government has made a long-term commitment to providing ante-retrovirals to those in need." (President J. A. Michel, 2006, State of the Nation Address 2006)

"We cannot afford and allow the HIV and AIDS epidemic to destroy our precious human resources. My presence is not only a stark reminder of my government's commitment to fight HIV and AIDS but also my personal conviction that we can only win over this scourge if we fight it hard and fight it together"(President J. A. Michel, 2007, National Aids Council Meeting 2007)

"My government invests enormously in the health services to give each and everyone the best service and care. According to the World Health organization, statistics have shown that we have the best health services within the region. The government spends a lot for health and 19% of its budget is dedicated to the health sector."(President J.A. Michel, 2007, State of the Nation Address 2007)

"We are working hard to have better health facilities for all our citizens. We need to continue to intensify our efforts to tackle HIV and AIDS, drug and alcohol. We will be giving more support to non-governmental organizations and encourage the setting-up of district support groups around the country to better sensitize our communities on these problems."(President J. A. Michel, 2007, National Day Address 2007)

"The government of Seychelles is living up to its commitments. For many years, we are steadfastly providing Universal Access to treatment, care, support and prevention services."(President J.A. Michel, 2007, World Aids Day 2007)

"With this budget, we will continue to make progress in health care as one of our priorities. Modern societies increasingly place quality of health at the top of the national agenda. There is political commitment on the

part of the Government and the National Assembly to make a difference where HIV and Aids is concerned and to help spread the message on the real dangers of this epidemic and to encourage people to do their HIV test early. As has been the case this year, the government will continue to contribute SR 1 million (Seychelles Rupees) to the National Aids Trust Fund.”(Mr. Danny Faure, Minister of Finance, 2007 Budget Address 2008)

The National AIDS Council (NAC) is a multi-sectoral and multidisciplinary committee in the National Policy on the Prevention and Control of HIV/AIDS in Seychelles. The National AIDS Committee was established in recognition of the need for participation of all other sectors of society in the co-ordination and monitoring of the response. Members of the NAC are experts in their field and their participation is a tremendous contribution in addressing the HIV and AIDS issues in Seychelles. The terms of reference of the council are:

- Creating and strengthening partnerships for an expanded national response to the AIDS epidemic among all sectors;
- Advising on the National Strategic Plan on HIV/AIDS in Seychelles;
- Determining activities for the Strategic Plan;
- Advising the Cabinet on issues pertaining to HIV/AIDS policy;
- Planning, co-ordination, monitoring and evaluation of the national response to HIV/AIDS/STIs;
- Recommending appropriate research;
- Advocating for the effective involvement of sectors and organisations in implementing programmes and strategies;
- Mobilising resources for programme implementation;
- Initiating and/or undertaking policy formulation and review;
- Encouraging greater involvement of persons living with HIV or AIDS;

The membership of the NAC is as follows:

- Principal Secretaries;
- Representatives of selected national organisations and associations. These include Business; People living with HIV/AIDS; Non-government organisations; Faith-based organisations; Trade Union; Women; Children; Youth; District administrators; Legal and Human Rights; Sport; Media; and Men’s Association;
- Individuals selected in their own private capacity; and the
- AIDS prevention and control programme manager

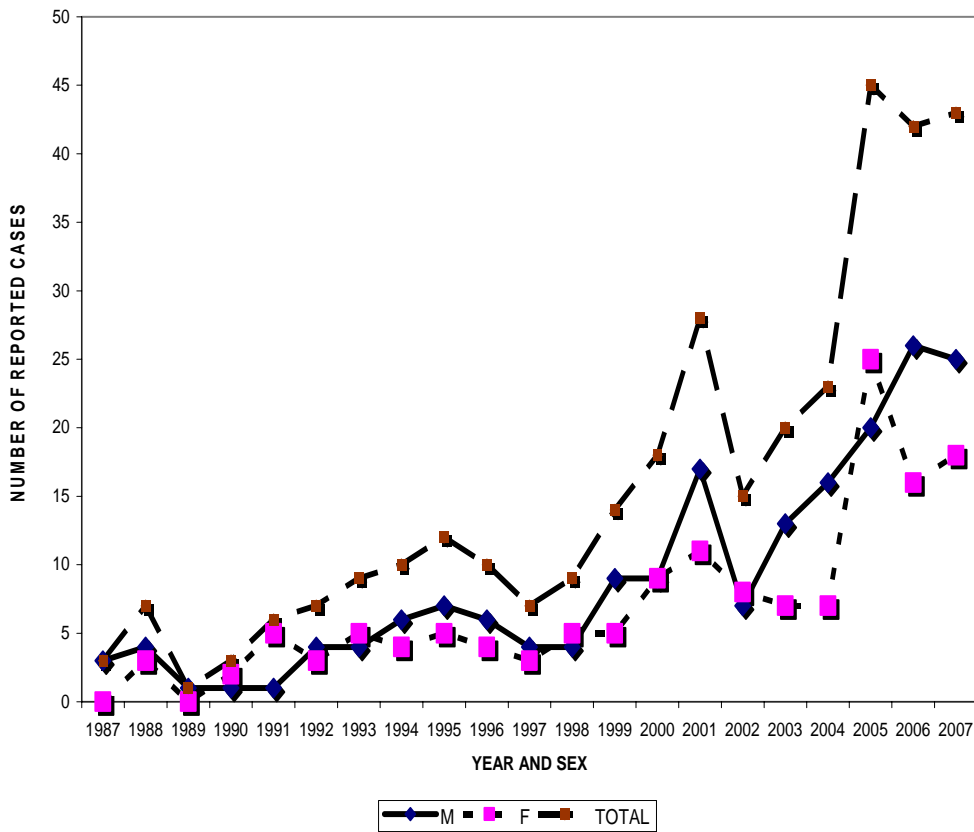
Over the last few years we have seen a growth of the partnership and mobilisation of various sectors across the country. Funds for HIV and AIDS programmes can be mobilised from many sources, both national and international. To reflect the national character of the epidemic and action against HIV and AIDS, a National AIDS Trust Fund has been established. The fund is similar to the Environment Trust Fund, created by an Order made by the Minister of Finance under the Public Finances (Control and Management) Act, 1974.

Government's commitment to address HIV and AIDS in Seychelles has been demonstrated by consistent increases in the allocation towards HIV and AIDS over the last few years. This is illustrated by budgetary trends of the health budget as well as by the specific HIV and AIDS budget.

Currently there are no methods used in Seychelles to estimate the prevalence and incidence of HIV and AIDS. Statistics on the epidemic is obtained from patient records kept at the CDCU, Maternity wards and health centres.

The first recorded HIV infected person in Seychelles was diagnosed in 1987 and the first recognized full-blown AIDS case was reported in 1992⁽¹⁾. Figure 1 shows the cumulative number of HIV infections, AIDS cases and related deaths since the beginning of the epidemic in Seychelles. As at December 2007, 115 persons had been diagnosed with AIDS, while 332 persons were recorded as having been tested positive for HIV infection. Antiretroviral therapy has been made available free of charge to all patients in need since August 2002.

FIGURE 1. REPORTED CASES OF HIV BY SEX IN SEYCHELLES 1987 TO 2007



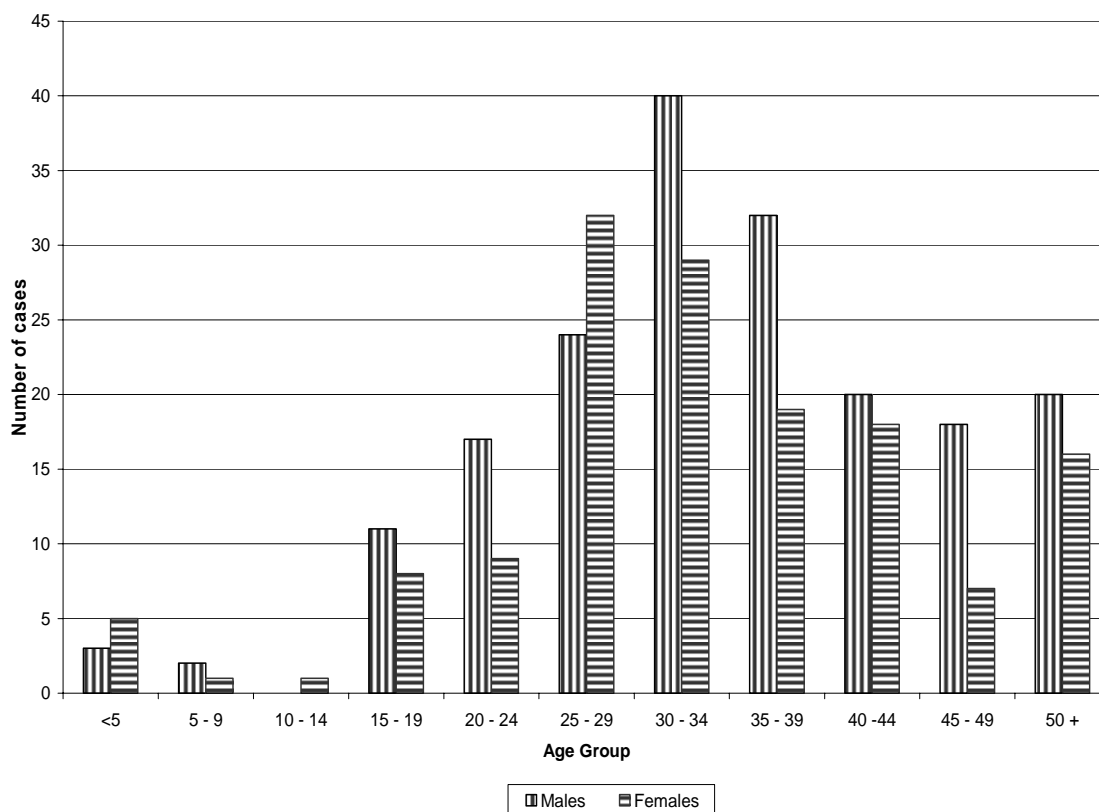
Source: Communicable Disease Control Unit, Department of Health

Figure 1 shows the number of HIV reported cases by age and sex from 1987 to 2007. From the statistics, in

2007, there were 25 males and 17 females reporting with HIV infection or a ration of 1.4 males to 1 female.

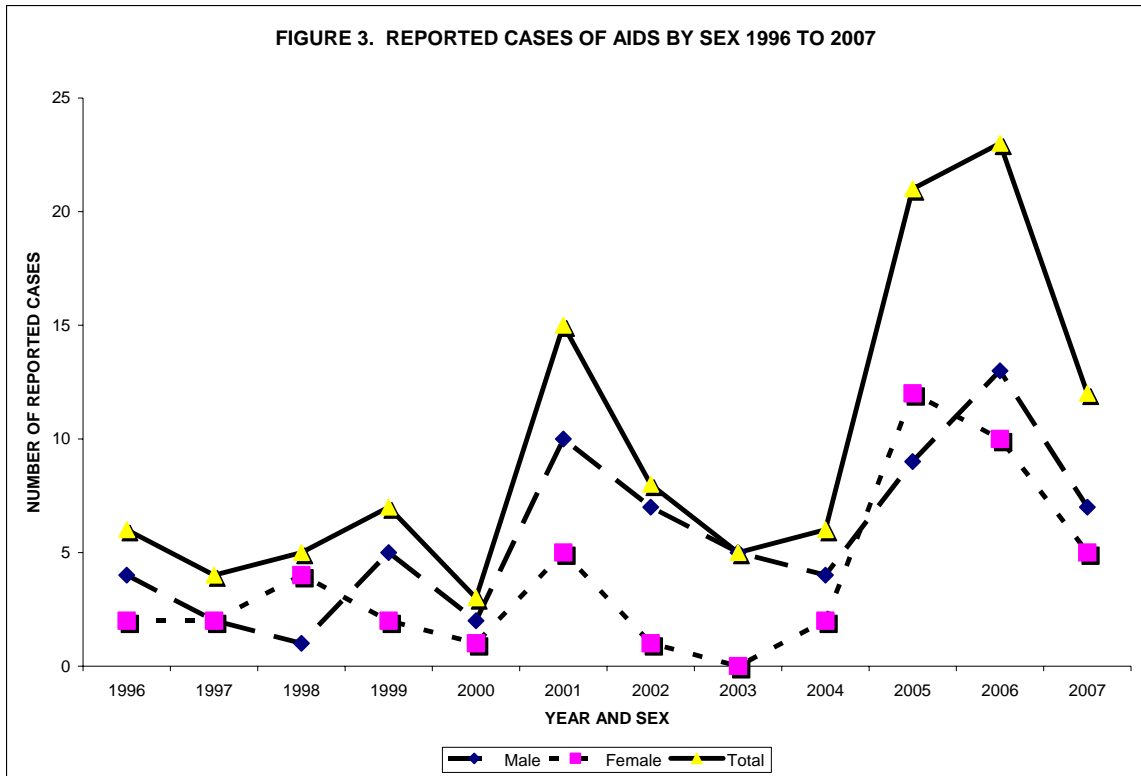
Figure 2 shows the reported HIV positive cases by gender and age group for the years 1987 to 2007. Most of the reported HIV positive cases were in the 25 to 39 age group. Except for the age group 25 to 29, males were the most infected in all age categories.

FIGURE 2. HIV Positive Cases by Gender and Age Group 1987 to 2007 in Seychelles



Source: Communicable Disease Control Unit, Department of Health

Figure 3 shows the number reported AIDS cases by gender and age group for the years 1987 to 2007. Most of the reported HIV positive cases were in the 25 to 39 age group. Except for the age group 25 to 29, males were the most infected in all age categories.



Source: Communicable Disease Control Unit, Department of Health

IV. NATIONAL RESPONSE TO AIDS EPIDEMIC

Seychelles is a multi-ethnic society, which has its origin on the three continents: Africa, Asia and Europe. The main religion is Christianity and other major religions are represented. Religious belief is respected and seems to have strong influence to the people's values and daily practices.

The estimated mid-year population for Seychelles in 2007 was 85,032. The 15 to 64 adult population was estimated at 58,134. There were 43,160 males and 41,872 females or an approximate sex ratio of 1031 men for every 1000 women. The Total Fertility Rate in 2006 was 2.1. The mean age of childbearing was 26.5 years and the mean age at first marriage was 32 years for male and 30 years for female. Life expectancy at birth was 70.3 years (65 for males and 75.9 years for females) and infant mortality rate was 9.6 per 1,000 births in 2006.

Seychelles' economic and social progress since independence has been very remarkable. According to the Human Development Report (2007), Seychelles is currently ranked 50th in the world. However, the economy is very vulnerable due to its dependence on two main sectors, tourism (directly contributes 10% to 15% of GDP and two-thirds of foreign exchange receipts) and fisheries, which provide the bulk of national income as well as foreign exchange. Tourism especially is very sensitive to changes in the international economic and political environment. Furthermore, the economy of Seychelles is, to a very large extent, dependent on imports.

Seychelles is a multiparty democracy politically divided into 25 districts, with central government led by a President. Elected Members of the National Assembly bring forward debates for policy discussion and decision-making by the National Assembly. The Ministry of Finance allocates funds across ministries and sectors according to priority needs.

Seychelles has a comprehensive health structure, which comprises of 1 central referral hospital, 3 cottage hospitals, 1 rehabilitative hospital, 1 mental hospital, 1 youth health centre and 16 district health centres located throughout the country with a decentralised system of providing basic health services in the community. Equity is a fundamental principle behind the financing and organization of health care system in Seychelles. Government-funded services are free of charge to every citizen and are complemented by a private service system. The whole population has access to basic health care, and yearly immunization coverage against the most common childhood diseases is almost 100%.

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 of Communicable Disease Control Unit, antenatal clinics, Occupational Health Unit and the blood bank in the Ministry of Health and reveals that there is an increasing trend in HIV infections. As at June 2007, 332 persons have been tested positive for HIV infections and though the number appears to be low, the potential for an outbreak is present. Several risk factors have been associated with increased risk of HIV infection.

Following an extensive consultation process, the five-year Strategic Plan for HIV and AIDS for 2005 to 2009 was launched. During the formulation process, five key points were considered.

- **Focus** – ensuring that interventions are targeted to individuals and groups that have the most significant effect on the epidemic dynamics. The age group 15 to 34 has been selected with special attention of the CSWs and MSM.
- **Coverage** – ensuring that as many key people and groups as possible are reached. In the development of the plan, a broad based multi-sectoral and multidisciplinary approach was used to develop effective and collective responses.
- **Quality** – in using a wide based approach contextual situations and group norms have been considered.
- **Sustainability** – this issue has been seen as crucial in ensuring successful political, financial and technical support by all sectors of society in the implementation of short-medium and long term interventions
- **Impact** – due attention has been given so that there is a balance of focus, coverage, quality and sustainability, thus maximizing the potential impact.

The National Strategic Plan provides the framework within which interventions geared towards initiating and executing a comprehensive response to the epidemic are undertaken. The current HIV/AIDS programmes aim at the primary prevention of HIV infection, and the provision of care and support to those already infected or affected. These encompass sensitization and education through IEC activities, PMTCT, VCT, surveillance, blood screening and safety, accessibility to post exposure prophylaxis, provision of ARVs, treatment of opportunistic infections, and support of PLWHAs.

As mentioned earlier, Seychelles effort to combat HIV/AIDS began in 1987 on discovery of the first HIV case. The Ministry of Health, in particular, has developed some strategies to prevent and control HIV/AIDS and other sexually transmitted infections since the late eighties. These have been

- A Short-Term Plan (1987-1988);
- A Medium-Term Plan (1989-1993);
- A Long-Term Plan (1993 and beyond);
- A Strategic Plan for HIV/AIDS/STIs in 2001.

An AIDS-IEC Committee was formed in 1988 within the Ministry of Health and supported by the Technical Advisory Committee for HIV/AIDS/STIs a year later. Following a workshop on AIDS counselling in 1991, the first non-governmental organization to deal with HIV/AIDS, the HIV/AIDS Support Organisation (HASO) was born and later registered in 1995. An expanded UN Theme Group for HIV/AIDS was created in 1996 by the resident WHO Liaison Officer.

All previous HIV/AIDS plans were driven solely by the health sector. As it became clear worldwide that HIV/AIDS is not only a health problem but also a development crisis, the need for a multi-sectoral approach became more evident.

The development of the National Strategic Plan was initiated by the Government of Seychelles in early 2001 with a view to involve all sectors of society in the fight against HIV/AIDS. However, it was mostly health-driven. With the formation of the NAC in May 2002, the strategic process was facilitated and the draft has been reviewed and amended by a multi-sectoral team. The process was designed in respect to the UNAIDS guidelines on strategic planning and lessons learned. The process benefited from appropriate technical and financial support from UNAIDS, WHO, UNDP, Government of Mauritius and the Indian Ocean Initiative against HIV/AIDS.

Guidance was obtained through a steering committee comprising of representatives of different ministries and organisations. The situation and response analyses were further facilitated by information based on interviews of relevant stakeholders and review of existing documents. These analyses enabled to identify vulnerability and risk factors, and priority areas for interventions.

The formulation process started during a multi-sectoral workshop from 12th –15th August 2003. For each priority area, strategic objectives, with target activities, opportunities for implementation and key implementing bodies were identified. Strategies were prioritized in relation to acceptability, feasibility, technical soundness and impact. It was also stressed on the importance of the flexibility of the plan. The workshop was facilitated by the UNAIDS Regional Programme Adviser, WHO Liaison Officer, UNDP/UNAIDS Programme Manager and the National HIV/AIDS Coordinator in Mauritius, who also guided the team to draft the document.

The National Strategic Plan was validated by all stakeholders during a workshop.

Due attention was paid to the following key principles of strategic planning:

- Participatory approach which ensures full involvement and ownership by all relevant stakeholders;
- Determinants-driven planning;
- Prioritisation of problems and strategies based on analysis of trends and current status of the epidemic and the response;
- Relevance to the Millennium Declaration Goals and particularly to the UNGASS Declaration.

The process can be summarised in the following major steps:

- Formulation and implementation of the National Policy framework which triggers multi-sectoral mobilisation;
- Resource mobilisation including technical resources;
- Information gathering including sectoral reviews and surveys;
- Preliminary draft of the national strategic plan by the MOH;
- Prioritisation and planning workshops at national, sectoral and community levels;
- Costing and Budgeting;
- Consultation at political and national levels;

- Approval by the cabinet;
- Dissemination to all stakeholders.

The National Strategic Plan 2005 to 2009 calls for the following structures for its implementation (National AIDS Council, 2005):

The National AIDS Council (NAC) was launched on 24th May 2002 and has met on several occasions since. It has been appointed the Country Coordinating Mechanism (CCM) for the Global Fund Proposal. Other important items on the agenda have been: Legislation and regulations; Working Groups by the different sectors; Counselling needs; National AIDS Trust Fund; Antiretroviral therapy; Specific individual needs of PLWHAs; Stigma and Discrimination. The NAC reports to the Cabinet through the Minister for Health.

The National AIDS Trust Fund was created for massive mobilisation of resources for prevention through education, information and communication, control through well established public health measures and caring through clinical services and support for those infected and affected. Since its launching on 11th October 2002, the Fund has raised over SR 200 000. Its terms of reference are:

- To create national interest and commitment for the prevention and control of HIV and AIDS and the care of those infected and affected;
- To mobilise resources for HIV/AIDS programmes;
- To promote and support national programmes on HIV/AIDS

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

The AIDS-IEC is a multi-sectoral sub-committee of the TAC, launched in 1988 with a mandate to develop a national strategy for dissemination of HIV/AIDS information and an integrated approach to IEC within the Ministry of Health and other sectors.

The AIDS Prevention and Control Programme (also referred to as AIDS Programme) is a unit with full-time AIDS Programme Manager and secretary under the Division of Health Education and Promotion in the Ministry of Health. It is heavily reliant on the Health Promotion Section, with a full-time AIDS-IEC Coordinator. It is responsible for advocacy and prevention aspects of HIV/AIDS, reaching a wider community. However, it is much involved in planning, facilitation, coordination, implementation, monitoring and evaluation of activities. The section has received assistance from WHO, UNAIDS and UNDP officials. The AIDS Programme also holds the NAC Secretariat.

The Expanded UN Theme Group was launched in 1996 and meets every two months. The UN Theme

Group has managed to survive a few setbacks. Together with the TAC, the UN Theme Group has been the task force in planning national activities e.g. Global Fund Proposal and World AIDS Day activities. It is chaired by WHO and co-chaired by the Ministry of Health. The main objectives of the UN Theme Group are advocacy and resource mobilisation. The UN Theme group does not have a budget. Activities are implemented by MOH and other agencies.

The Faith-Based Organisations (FBOs) meet at least quarterly with the AIDS Programme to discuss activities and share experiences. All FBOs are invited to attend.

The Social Services Committee comprises of representatives from Ministry of Social Affairs and Employment, Social Security Scheme, CDCU, AIDS Programme, Medical Social Worker, Representatives of Medical Ward and North East Point Hospital, HASO and FAHA. It discusses and sorts out problems related to social services, for example, financial benefits, home care and employment issues.

Focal persons are in contact for dialogue between organizations and the AIDS Programme and can be co-opted on any committee as necessary.

The Seychelles HIV/AIDS Links Association, launched in February 2004, is a network of eleven NGOs involved in the HIV/AIDS response. It is affiliated to the East African National Network of AIDS Service Organisations.

Though a strategic plan is in place, sectoral operational plans are still to be developed. This would be the next important stage. The development of the operational plan will be a chance to incorporate and develop some important features of the national health system and should be guided by a number of important principles. These could include, amongst others;

- Strengthening the National Health System;
- Creating and maintaining high quality care;
- Universal care and equitable implementation;
- Reinforcing the key Government strategy of prevention;
- Providing a comprehensive continuum of care and treatment;
- Developing a sustainable health programme;
- Promotion of healthy lifestyles.

Seychelles has a policy of all persons to have equal access to prevention, treatment and care. The Constitution makes provision for any law, programme or activity, which has as its object the amelioration of the conditions of all persons, including disadvantaged persons or groups. All research protocols involving human subjects are reviewed and approved by an Ethics Committee. Except for Article 27 of the Constitution, there are no specific laws or regulations that provide against discrimination on any grounds as is otherwise necessary in a democratic society. Homosexuality, commercial sex work and drug abuse are illegal in Seychelles. However, as it was indicated in the consultative meetings, except for drug abuse, the law enforcing institutions does not go out of its way to enforce these laws. Social offences, for example, failure to honour payment ordered by Family Tribunal, are punishable by imprisonment.

New Policy on HIV - Workplace HIV and AIDS policies, programmes and practices in Seychelles are formulated and implemented within the legislative and policy framework. Existing laws and policies ensure that those infected with HIV or those living with HIV are not subjected to discrimination, they receive necessary support and care, and that risk to HIV infection is reduced in the workplace. Monitoring and evaluation systems of workplace HIV and AIDS policies and programmes are being further developed.

Seychelles has created a legislative and policy framework for protection of employees infected with HIV against discriminatory and unfair labour practices in the workplace. The laws and policies are applicable in both private and public sector. Specific public service regulations prescribing minimum standard for HIV and AIDS workplace programmes are also available.

High political commitment exists in Seychelles for HIV/AIDS. For example, the President contributed to the Foreword of the National AIDS Policy, which was endorsed by the Cabinet in December 2000. The National AIDS Council created in 2000, has representatives from key ministries namely Finance, Education, Health, Employment and Social Affairs, and Foreign Affairs and regularly reports to the Cabinet, advising the Government on HIV/AIDS national strategies and interventions, in accordance to the national policy. The National AIDS Trust Fund was gazetted by the Vice President and Minister of Finance and is chaired by the Principal Secretaries of Health and Finance. (National AIDS Council, 2005).

A NATIONAL COMMITMENT AND ACTION INDICATORS

Domestic and international AIDS spending by categories and financing sources

National funds spent by governments on HIV/AIDS are a measure of national government commitment to fight HIV/AIDS. UNGASS indicator guidelines require information on national funds to comprise expenditure on the following four categories of programmes and totals for each to be specified separately.

- STI control activities
- HIV prevention
- HIV/AIDS clinical care and treatment
- HIV/AIDS impact mitigation

The guidelines further require that costs of any multilateral or bilateral international donor-funded government programmes to be included. All local NGO programmes should be excluded, except programmes that are funded by national government.

Public Sources

	2003	2004	2005	2006	2007
	Public Sources	Public Sources	Public Sources	Public Sources	Public Sources
Prevention and Control of AIDS	14,531				
World AIDS Campaign	38,500	1,819		62,390	13,780
Government of Seychelles contribution to HIV Committee (National AIDS Trust Fund)					1,000
TOTAL					

Source: Ministry of Finance, WHO Country Office, UNDP Country Office

International Sources

	2003	2004	2005	2006	2007
	International Sources	International Sources	International Sources	International Sources	International Sources
UNDP/Strengthening evidence-based multi-sectoral responses to HIV/AIDS	204,470	127,670	4,030		
HIV Sub-type study					4,784
TOTAL					

Source: Ministry of Finance, WHO Country Office, UNDP Country Office

Total

	2003	2004	2005	2006	2007
Prevention and Control of AIDS	14,531	0	0	0	0
UNDP/Strengthening evidence-based multi-sectoral responses to HIV/AIDS	204,470	127,670	4,030	0	0
World AIDS Campaign	38,500	1,819	62,390	62,390	13,780
HIV Sub-type study	0	0	0	0	4,784
Government of Seychelles contribution to HIV Committee (National AIDS Trust Fund)	0	0	0	0	1,000
TOTAL	257,501	129,489	4,030	62,390	1,018,564

Source: Ministry of Finance, WHO Country Office, UNDP Country Office

National Composite Policy Index

The National Composite Policy Index (NCPI) consists of two parts – Part A and Part B.

Part A is administered to government officials and includes the following:

- Strategic plan
- Political support
- Prevention
- Treatment, care and support
- Monitoring and evaluation.

Part B is administered to representatives from nongovernmental organizations, bilateral agencies, and UN organizations and includes the following:

- Human rights
- Civil society involvement
- Prevention
- Treatment, care and support

For part A, response were received from the Office of the President, the Ministry of Finance and the Ministry of Health. WHO, the Barclays Bank (Seychelles) Ltd, the HIV/AIDS support group and the Seychelles Federal Workers Union responded for part B.

Response from the survey, indicate that a national multisectoral strategic plan to combat AIDS has been developed, for two years now, covering the period 2005 to 2009. Sectors are included in the strategic plan and with a specific HIV budget for their activities, include Health, Education, Labour, Military and the Police, Women and Young People.

The plan addresses issues pertaining to the following target populations, settings and cross-cutting issues: women and girls; young men and women; HIV, AIDS and poverty; Prisons; Gender empowerment and gender equality; Schools; Workplace; and .Addressing stigma and discrimination; Human rights protection; Prisons; Involvement of people living with HIV.

The target populations were not identified by needs assessments or needs analysis, but by a research conducted in 1997 using biological and behavioural data was in 1997. Samples from the STI clinic and ANC were collected and analysed in conjunction with data from interviews conducted on sexual behavior. These included information on age at first intercourse; sex of partner(s), number of partners, type of sexual intercourse, and use of condom in the last month. The information gathered were used as guidelines to introduce algorithms for the management of STIs and presented in the document entitled 'Management Guidelines for Patents with Sexually Transmitted Diseases 1998'). The guideline provides for special attention to be given to women, young men and women. However, the importance of tailoring interventions to reach men was often not considered. There is a willingness to address this gap and ensure that plans have a special focus on behaviour change for men. This exercise identifies the target populations as

women, young women, young men, commercial sex workers, men who have sex with men, and injecting drug users.

The multi-sectoral strategy includes an operational plan. The operational plan include: indications of funding source; a Monitoring and Evaluation framework; Detailed budget of costs per programmatic area; Formal programme goals; Clear targets and milestones. The strategy was developed with the “full involvement and participation” of civil society. Civil society includes among others: Networks of people living with HIV; women’s organizations; young people’s organizations; faith-based organizations; AIDS service organizations; Community-based organizations; organizations of key affected groups; workers organizations, human rights organizations.

The current challenge though, is the implementation of the Plan of Action. Once this fully aligned, all Development Partners should provide support in line with this Plan of Action.

The challenges in the implementation of the Plan of Action are as follows: the National AIDS Secretariat (NAS) consists of only one person; the Technical AIDS Council, which used to conduct regular meetings at least monthly, is not currently functional on a regular basis; Greater commitments to action in HIV and AIDS control efforts is needed; Mechanisms for Monitoring & Evaluation need to be put in place.

Representatives from nongovernmental organizations, bilateral agencies, and UN organizations indicated that laws and regulations are in place to protect people living with HIV against discrimination, including the vulnerable sub-populations. Further, the President chairs the National AIDS Council (NAC) where all stakeholders are represented. People living with HIV/AIDS (PLWHA) have been involved in national and international conferences and trainings and drafting the national policy for HIV prevention and control and the 2005-2009 National Strategic Plan (NSP). PLWHA and youth have participated in HIV/AIDS prevention activities. However, to date, there are still few leaders openly from most-at-risk populations who are involved in programme implementation. The new strategic plan was introduced in 2005. With the introduction of the new Workplace Policy in 2007, further advances have been made in non-discrimination regarding the HIV/AIDS.

Since the last report 2005, there has been some progress made in the implementation of HIV prevention programmes. The programmes are now more specific in their interventions, giving greater attention to most-at-risk populations. There have also increased the number of services for youth at the district levels. Churches have begun programmes for youth. In addition, secondary prevention has improved. There was more organised coordination of prevention efforts in 2005. The level of coordination has dropped in the past two years, though activities have increased. Decentralisation has occurred and more organisations outside the Ministry of Health have become active. As the efforts in implementation increases, there is a need to retain the important element of coordination to make our efforts more effective.

B. NATIONAL PROGRAMMES

Percentage of donated blood units screened for HIV in a quality assured manner

Blood products are living human tissue used in the treatment of patients and, as other biological products, are not without risk. Blood safety is concerned with the overall process of delivering blood products to the patient. A quality assurance system is in place to ensure that the process is safe. This can be ascribed to the efforts in Haemo vigilance to ensure the safety and quality of the blood supply.

Haemo vigilance incorporates the surveillance of procedures carried out at the time of blood collection, the entire blood component processing chain, the transfusion episode, the outcome of the transfusion, as well as an appropriate look-back process. Haemo vigilance thus identifies factors throughout the process that may be related to risk. Haemo vigilance plays a critical role in ensuring that laboratory and clinical blood transfusion practice is optimal.

Seychelles is self-sufficient for blood products and all blood products are procured from voluntary, non-remunerated blood donors. All products are processed, and screened for the presence of transmissible diseases and red cell antibodies before being released for eventual administration to patients. In this chain of events there are numerous activities, which may contribute to transfusion reactions. In the last three decades enormous resources - financially, intellectual, technological and governmental - have been invested in improving the purity, potency and safety of the blood that is collected, tested, packaged, and labeled as suitable for transfusion

Blood transfusion is only done at one location by the Ministry of Health and at the Blood Transfusion Centre at the Victoria Hospital – the national reference laboratory, using standard operating procedures and with a quality assurance scheme in place. The following is the reported units of blood screened in a quality assured manner from the Blood Transfusion Centre, Ministry of Health, for the twelve-month period, starting 1 November 2006 to 1 November 2007.

Number of units of blood units transfused:	1708
Number of blood units screened for HIV:	1708
Number of units screened up to WHO and national standards:	1708

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

Table 1: Percentage of adults and children with advanced HIV infection receiving ART

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
2004	<15 Female: 1 <15 Male: 2 15+ Female: 16 15+ Male: 30 Total: 49	<15 Female: 1 <15 Male: 2 15+ Female: 16 15+ Male: 30 Total: 49
2005	<15 Female: 3 <15 Male: 2 15+ Female: 23 15+ Male: 34 Total: 62	<15 Female: 3 <15 Male: 2 15+ Female: 23 15+ Male: 34 Total: 62
2006	<15 Female: 4 <15 Male: 3 15+ Female: 30 15+ Male: 45 Total: 82	<15 Female: 4 <15 Male: 3 15+ Female: 30 15+ Male: 45 Total: 82
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

Source: Patient Register, CDCU

There are no estimates of the current prevalence of neither HIV nor have estimates of the number in need of ARVs been conducted in Seychelles. Seychelles has a concentrated epidemic and the workbook method of estimates is supposedly a better method for estimation than EPP and SPECTRUM, however the Workbook method does not appear to yield a good measure. In the absence of better estimates, the number of cases detected at Health Centres, meeting WHO Clinical Stage criteria for initiation on ART was used as a proxy for people in need of ARVs.

Reliable information on the percentage of people with advanced HIV infection receiving antiretroviral combination therapy is obtained from the register of patients kept at the CDCU. This is because there is an extensive network of health centres covering all districts in Seychelles and most people requiring health and medical attention have access to government health service. These services are offered free at the point of service. There are few private medical clinics but over 95% of the population are served by the government run health centres. The data currently available have been compiled from the records of the Communicable Disease Control Unit to which suspected cases from all health facilities are referred for confirmation and case management. These facilities include antenatal clinics, the blood bank, the

Occupational Health Unit, hospital services, district health centres and private clinics. All HIV and AIDS patients are attended to by the Communicable Disease Control Unit.

There are 97 people currently on antiretroviral therapy and being attended to by the Communicable Disease Control Unit. These translate into 43 females and 54 males currently on antiretroviral therapy. In 2006 there were 82 people, 34 females and 48 males on antiretroviral therapy. All people identified as requiring antiretroviral therapy are on treatment. The antiretroviral therapy is free and patients are not required to be on medical schemes or private health insurance. Further, the Ministry of Health has issued a series of clinical guidelines for the management of patients infected with HIV and AIDS.

It is noted that there are more women are diagnosed and treated for STIs than men. However, for HIV and AIDS, many more men than women are presenting with symptoms and diagnosed. It has been hypothesized that this is because the epidemic is currently concentrated among MSM.

Percentage of HIV-positive pregnant women who received antiretroviral to reduce the risk of mother-to-child transmission

Table 2: Percentage of HIV-infected pregnant women who received ARVs to reduce the risk of MTCT

Reporting period	Numerator: Number of HIV-infected pregnant women who received ARVs during the last 12 months to reduce MTCT	Denominator: Estimated number of HIV-infected pregnant women in the last 12 months	Percentage of HIV-infected pregnant women who received ARVs to reduce the risk of MTCT
Jan. 2004-Dec. 2004	7	7	100
Jan. 2005-Dec. 2005	6	6	100
Jan. 2006-Dec. 2006	5	6	83
Jan. 2007-Dec. 2007	3	3	100

Sources: CDCU, ANC and ART Patient Records

All the births in Seychelles take place in Maternity Wards of the Ministry of Health in four hospitals. Most of the pregnant women attend ANC. Nearly all pregnant women who attend ANC are tested for HIV (99.9%). The test is supposed to be offered twice throughout pregnancy, but not all health centres offer the test twice, and some women refuse the second test. Those who have never attended ANC are tested before or after giving birth, if possible. However, the exact number of pregnant women in need of ARVs for PMTCT cannot be obtained due to the fact that not all pregnant women may be tested for HIV, and thus some may not be detected as needing ARVs for PMTCT. Moreover, the private sector is not included in these figures and testing for HIV among pregnant women is conducted less frequently at private facilities.

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

Table 3: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV: 2004 to 2007

Year	Number of adults with advanced HIV infection who are currently receiving ART and who were started on TB treatment within the reporting year	Detected number of incident TB cases in people living with HIV	Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV
2004	Male: 2 Female: 0 Total: 2	Male: 2 Female: 0 Total: 2	Male: 100% Female: 100% Total: 100%
2005	Male: 1 Female: 1 Total: 2	Male: 1 Female: 1 Total: 2	Male: 100% Female: 100% Total: 100%
2006	<i>Male: 3</i> <i>Female: 3</i> <i>Total: 6</i>	<i>Male: 3</i> <i>Female: 3</i> <i>Total: 6</i>	<i>Male: 100%</i> <i>Female: 100%</i> <i>Total: 100%</i>
2007	Male: 1 Female: 0 Total: 1	Male: 1 Female: 0 Total: 1	Male: 100% Female: 100% Total: 100%

Source:

All patients diagnosed with TB are automatically screened for HIV. All patients who have been identified as HIV-positive are screened for TB if they have a cough or any symptoms related to TB. Suspected cases of TB are referred to the Communicable Disease Control Unit (CDCU) for diagnosis and management. Private doctors also refer patients to the CDCU. Once the diagnosis is confirmed for TB, the patient is admitted to the Medical ward at the Victoria Hospital. These patients are attended to by Doctors from CDCU. Three to four weeks after initiation of treatment, sputum tests are conducted. When all the smears are negative, the patient is discharged from hospital.

DOTS is carried out and arrangements are made with their respective health centres with monthly follow-up at the CDCU. Approximately 95% compliance has been found through the DOTS. If a patient does not come for an appointment that day or the following day, they are usually traced to determine what has happened.

Lately, a number of smear negative cases have been identified that are positive on culture. Sensitivity tests cannot be carried out in Seychelles, specimens must be sent to England at the cost of GBP60 per specimen, plus packing costs. These costs are usually borne by government. Formal training in sputum smear was not carried out in the lab. Only one person in the Ministry of Health has received formal training. Formal training and refresher courses are required. A reference lab for such training ought to be identified.

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

Data for this indicator is not available, as no population-based surveys have been conducted recently to include this information. Information available from health centres indicate activities and may be the same person performing, thus, we cannot determine the percentage of the population that has received an HIV test in the last 12 months and knows their results.

However, the last population-based survey that was conducted was the KAP study in 2003. It was reported that 1705 participated in the study; 538 (31.6%) respondents reported having had a HIV test; of these 436 (81.0%) reported ever finding out the result.

Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know their results

Data for this indicator is not available, as no population-based surveys have been conducted to include this information. Thus, we cannot determine the percentage of most at risk population that has received an HIV test in the last 12 months and knows their results.

Percentage of most-at-risk populations reached with HIV prevention programmes

Data for this indicator is not available, as the focus has been concentrating on other aspects of the programme. No survey has been conducted recently.

Percentage of orphaned and vulnerable children aged 0-17 whose households received free basic external support in caring for the child

The social security system in Seychelles is organised such that all vulnerable individuals including orphans and vulnerable children are supported. Further, all orphaned and vulnerable children are cared for by either their family or the few orphanages in the country. However, there are no statistics as to the number or percentage of orphaned and vulnerable children whose households received basic external support in caring for the child.

Percentage of schools that provided life skills-based HIV education in the last academic year

For the last thirty years, the government of Seychelles has laid particular emphasis on the development of two key social institutions; the Ministry of Health and the Ministry of Education. This is in line with policies to promote a healthy and educated nation. The Ministry of Education is addressing the issue of HIV and AIDS in the education and training system. The main areas of focus have been implementation of life skills and HIV and AIDS programmes in all primary and secondary schools. This programme also includes the training of teachers, counsellors and peer educators.

Education is free from pre-primary to secondary, and subsidized for tertiary schooling. In general, Seychelles enjoys an estimated 91,5% of adult literacy rate. In 2003, there were 26 primary schools, 3 of which were privately-owned and of the 13 secondary schools, 3 were privately-owned. Post-secondary academic, technical or vocational education is offered in 9 institutions. All children between the ages of 6 and 14 years are enrolled in school.

As part of Life Skills development, education on HIV and AIDS is taught at primary and secondary schools throughout Seychelles as part of the Personal and Social Education component. Except for three private schools, all schools in Seychelles are government run. All teachers have to undergo training at the National Institute of Education before practicing. All schools follow the same syllabus.

C. KNOWLEDGE AND BEHAVIOUR

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

No population-based or representative surveys have been carried out in Seychelles, therefore there is no qualified data. It is the law in Seychelles that all children have to attend school through the age of 15. The law is very strictly enforced and it is likely that there is only a very low percentage of children not attending school.

However, we do have information from the Department of Health and Social Development, which reports that in 2006, there were 135 children on social assistance. Statistics are not collected on whether a child's parents are alive or not. In Seychelles, Orphans are taken in by the President's Village, religious institutions, or family. Statistics are not collected on orphans, per se, but on vulnerable children. However, children are identified as needing social assistance through MEANS testing—this is a battery of indicators that gives a rating of whether support to the child is adequate to sustain them, mostly financial and social indicators regarding household income and (give examples of social indicators).

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

The KAPS was conducted in 2003 whereby 2,000 people were randomly selected from the National Housing and Population Census database (1997). The study focused on individuals aged 15–65 years old and was conducted in 25 health districts. Of all the respondents, 63.4%; 59.1% males and 66.9% females, were able to answer questions that would identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV.

Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

Data not available is available for this indicator as no surveys has been carried out.

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

The latest survey where this information was requested was the National Youth Survey of 1998.

However, a study on knowledge, attitudes and practices (KAP) conducted in January-February 2003 was

designed to evaluate the current level of knowledge, attitudes and practices among the Seychellois population from 15-65 years old. A questionnaire pre-tested, anonymous unlinked was administered.

Out of 2,000 persons randomly and proportionally selected based on the population distribution from Mahé, Praslin, La Digue and Silhouette from 26 health districts, 1,706 voluntarily participated.

Males and females were comparable in most of the socio-demographic indicators. The mean age of the respondents was 35.6. Ninety nine percent of the respondents had heard about HIV/AIDS. However, several misconceptions still exist concerning the HIV modes of transmission. Strong association was found between correct attitudes and the level of knowledge of the respondents.

Negative attitudes related to discrimination of people infected or affected with HIV and AIDS are still prevalent. Apart from respondents who were married or living with a regular partner, 81% had experienced sexual intercourse. The median age at first sexual intercourse was 17 years for males and 18 years for females. Males reported more frequently commercial sexual intercourse compared with females ($p=0.0000$). Genital discharge was reported in 2% of the cases and genital ulcers in 1%. Among those who reported having had sex with commercial sexual partners in the past month, 32% (18/56) did not use condoms, mainly due to the fact that they did not like it (45%). Only 2% (39/1692) of respondents did not know a place where condoms could be obtained. The most reported source of information related to male and female condoms was television (54%), radio (18%) and health centres (8%).

The results demonstrate that although the level of information on STI, HIV and AIDS is high, misconceptions still persist. Wrong attitudes and behaviours relating to the disease need to be analysed in a multi-sectoral context, to improve the health education strategies, particularly among youth.

Percentage of women and men aged 15–49 who have had sexual intercourse with more than one partner in the last 12 months

Since an important way to reduce the transmission of the AIDS virus is to remain faithful to one partner, the 2003 survey asked questions about the number of partners respondents had in the 12 months preceding the survey. Eleven percent of women respondents reported having more than one sexual partner in the previous year, compared with 23 percent of men. The percentage for both sexes was 16.6%.

Men and women in their 20s are most likely to have multiple partners. Among men, the proportion reporting more than one partner increases with education level; among women, there is no consistent relationship.

Percentage of women and men aged 15–49 who had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse*

The 2003 survey included a series of questions related to HIV and AIDS and sexually transmitted infections in both the Women's and Men's questionnaires. Since condom use is an important method of preventing the spread of HIV, women were asked about condom use. The data indicate that almost 40 percent of women who had sexual intercourse in the 12 months prior to the survey, said they had ever used a condom. One-third of women said they had used a condom the last time they had sex, though the proportion varies by type of partner. Only 15 percent of women say they use condoms with their husbands or live-in partners, while 47 percent say they used a condom the last time they had sex with a non-cohabiting partner.

Percentage of female and male sex workers reporting the use of a condom with their most recent client

Data not available is available for this indicator as no surveys has been carried out. No study or surveys has taken place amongst Most at Risk Population, including among sex workers.

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

Data not available is available for this indicator as no study or surveys has taken place amongst Most at Risk Population.

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Data not available is available for this indicator as no study or surveys has taken place amongst Most at Risk Population.

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

Data not available is available for this indicator as no study or surveys has taken place amongst Most at Risk Population.

D. IMPACT INDICATORS

Percentage of young women and men aged 15 –24 years who are HIV infected

Up to 30th November 2007, 617 women aged 15 – 24 had given birth in that year in Seychelles. Of these, 162 were aged 15 to 19 and 449 were aged 20 to 24. In the age group 15 to 24 years 7 tested positive or 1.13%. Amongst the 15-19 years old, 4 or 2.47 percent tested positive, and among the 20 to 24, 3 or 0.66 percent tested positive.

The relatively high percentage of 15 to 19 that tested positive, and could also be an indication of recent infection and a proxy for incidents, is alarming.

Percentage of most-at-risk populations who are HIV infected

Data not available is available for this indicator as no study or surveys has taken place amongst Most at Risk Population.

Reduction in mother-to-child transmission Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy

Record from the patient records in 2006 indicate that the percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy was 55.0% - 61.54% males and 42.86% females. Of the 20 patients, 13 males and 7 females, that started treatment in that year, 11 patients were still on treatment 12 months later - 8 males and 3 females,

V. BEST PRACTICE

Health policies and systems

The National Health Policy in Seychelles is based on the principle of Health for all and by all¹⁸. In implementing this policy, the Government's strategy is to ensure that health care services are accessible to all Seychellois and that access is based on need and not ability to pay. That Primary Health Care should be free at the point of delivery is a principle that is engrained in the Constitution. Health services are, therefore, free at the point of use and organized as close as possible to all those who require such services, by spacing health centres such that access time is not more than thirty minutes travel time. In this regard, Government's top priorities are sustained development of Primary Health Care; the development of human resources; quality-assurance and ensuring that the services respond appropriately to changing health needs and situations. Health promotion and protection are emphasized, since most of the health problems are related to changing life styles. Furthermore, with increasing cases of cancer, cardiovascular and chronic degenerative diseases, attention will focus on strengthening the role of secondary and tertiary care for provision of specialized services in support of primary health care.

These stem from the government believes in people centred development and that the health of the people not only contributes to better quality of life but also is essential for the sustained economic and social development of the country as a whole.

Gender Equality

One of the factors that drive the epidemic has been identified as gender inequality. In Seychelles, women and men enjoy full economic, political and civil rights. Seychelles is among the top countries in the Southern Africa Development Community region to have met targets for female representation at all decision-making levels. There is 35 per cent female representation in parliament, 15 per cent at the ministerial level and 45 per cent at chief executive and middle-management levels. However, the low capacity of institutions with responsibility for gender mainstreaming continues to hamper efforts to achieve gender parity. The National Plan of Action for Social Development, 2005-2015, calls for the elaboration of a national gender policy and a national gender action plan to address specific gender issues in line with the Beijing Platform for Action. These include sex-disaggregated data, more reliable national statistics, gender difference, economic areas and sharing parental responsibilities. A main concern is the increased incidence of gender-based violence. Special attention is being paid to the incorporation of gender awareness into policies and programmes through gender-sensitive indicators for monitoring and evaluation.

Health financing and Organisation of Health Services

Since 1977, health has been one of the priority areas in the country's budgetary allocation. It has featured as the most important sector for the years 2006 and 2007, in terms of annual budgetary allocations.

The Ministry of Health is the principal provider of health services in Seychelles. It has the overall responsibility for planning, directing and developing the health system for the benefit of the entire population of Seychelles. The Ministry is headed by the Minister of Health and supported by a Principal Secretary who is the Chief Executive Officer, and by a Special Advisor appointed by the President.

The health care system in Seychelles is organized according to three distinct levels, namely primary, secondary and tertiary care. The distribution of health facilities and beds by level of health care also reflects the geographic characteristics of Seychelles, which comprises several islands. Emphasis has been and continues to be on primary health care where most of the disease prevention, health promotion, curative care and rehabilitation take place. To assist in the delivery of primary health care services, the country is divided into sixteen health districts. Each health district has a health centre staffed by a district health team, headed by a Health Coordinator, who is a senior member of the health team. The main function of the health coordinator is to ensure the smooth running of the district health programmes.

VI. MAJOR CHALLENGES AND REMEDIAL ACTIONS

The development and launch of the National Strategic Plan 2005 to 2009 is a significant step towards ensuring that the country has a common strategic approach. This Strategic Plan has been disseminated widely, and specific support has been provided to other government departments and civil society sectors to ensure participation in the implementation of the strategies within the Plan. This provided the impetus for major interventions. However, an operational plan and a monitoring and evaluation framework need to be developed and implemented. This would allow government and its partners, especially the NGS sector, to address key strategies within the Strategic Plan, and closer collaboration in the implementation of these activities.

A, major capacity constraints has been identified in Seychelles. There is limited capacity at the systemic, institutional and individual levels as the primary barriers to effective management of health and other commitments. Furthermore, national capacity outside the public sector is not properly harnessed to bridge this gap. The decreasing investment in human capital has forced the country to rely heavily on expatriate labour in several key sectors of the economy. Lack of competent local manpower to match socio-economic development needs poses a serious challenge to the sustainable development of Seychelles.

The country is still heavily dependent on expatriate personnel at the top professional cadres of medical officers and dental officers and consultants. About 60% of all medical doctors being expatriates, human resources development has been and still is one of the major concerns for the country. This is mainly due to the continuous shortage of nationals trained in the health professions. Currently there are 12.5 medical doctors per 10,000 inhabitants, 24 midwives per 10,000 inhabitants and 46.9 nurses per 10,000 inhabitants. There is no local University in the country and most undergraduate and post-graduate training are done overseas. Special arrangements exist with a number of reputable Universities such as University of Manchester (UK) and Edith Cowan (Australia) where students wishing to pursue studies in certain specific fields do part of their degree courses locally.

Now that the strategic plan has lived half of its life, there is need to launch a midterm review of the Strategic Plan to further strengthen the Plan and guide implementation plans. Further, a mid term review will provide important input for the new plan beyond 2009.

When comparing the Strategic Plan and the activities of Health and Government as it relates to HIV and AIDS, it is clear that the strategies and policies of the country are on track. However, the operation plan for effective intervention and a monitoring and evaluation framework is missing.

One of the main challenges of implementation of the National Strategic Plan relates to capacity to implement. At the government level a particular challenge is the skills building of health workers to ensure they have the clinical skills to manage patients with TB, STIs and opportunistic infections, according to the standard treatment guidelines.

Seychelles is a small country with a limited number of human resources. To evaluate the availability of

human resources, the National Strategic Plan 2005 -2009 indicated that it will be necessary to audit the existing human resources at national, regional and district levels. The audit should assist in establishing standards of personnel at district, regional and national levels of management. However, such an audit is yet to be completed

A relatively weak area is a clear and coordinated process for monitoring and evaluation. Most efforts currently are vertical and ad hoc, and do not feed into the national health information system that can provide critical information for planning and monitoring of interventions at district, provincial and national level. The next step is for the Department of Health to develop a monitoring and evaluation framework that is based on the Strategic Plan, rather than on vertical programmes.

VII. SUPPORT REQUIRED FROM COUNTRY'S DEVELOPMENT PARTNERS

The effective implementation of the activities as outlined in the National Strategic Plan 2005 – 2009 will largely depend on the availability of human, financial and institutional resources. To make a significant difference in the epidemic over the next five years on a national level an estimated US \$ 20 million is required. These include the:

- Integration of HIV/AIDS in district social committees and sectoral working groups;
- Commitment to distribute funds according to the HIV/AIDS Strategic Plan;
- Commitment to spend over 80% of the funds in one financial year;
- Commitment to roll funds over into the new financial year without risk of penalty;
- Commitment to prioritise the process of HIV/AIDS spending within the districts and sectors;
- Commitment to ongoing national, regional and inter-district communication;
- Regular review of the implementation of HIV/AIDS Plans;
- Establishment of realistic goals and objectives that can be implemented within regions and districts or sectors. (National AIDS Council, 2005).

The sustainability of the response will depend on an efficient monitoring process in the area of policy development, institutional strengthening and service delivery (National AIDS Council, 2005).

Unfortunately Seychelles does not benefit much support from the Development Partners. Seychelles as a middle income island country does not qualify for support from development partners and receives very little support. Most of the indicators use by development partners for support is based on income per capita. Small island population also spend a lot per capita because of the economy of scale. However, even within the 'Small Island Developing States' within the south west Indian ocean shows disparate per capita expenditure on health. For example, the per-capita expenditure for health per habitant per year ranges from 25 USD in Comoros to 599 in Seychelles (RD Speech). There is however an interesting development to reconsider the case of "Small Island Developing States".

For example, the 'Mauritius Declaration' of January 2005 issued by the United Nations at the occasion of the "International Meeting to Review the implementation of the Programme of Action for Sustainable development of Small Island Developing States", expressed concern about increasing incidence of health issues, and commitment to address them comprehensively, at regional and global level.

Not only It is felt that the issue of vulnerability of island state is not being properly addressed in international forums, but the case of small islands state present a particular problem in terms of health, the MDGs and socio economic development. Though on average Small Islands Developing States are closer to the health Millennium Development Goals and some attained already some of these goals, the vulnerability of these states to HIV and AIDS may present a potential problem to Small Island states. Seychelles and In October 23, 2006, the Seychelles Government and the World Health Organisation co-sponsoring the first "Meeting of African Ministers of Health of Small Island Developing States". In his opening address, the Regional Director for WHO AFRO recognised that the "the health situation in the 46 Member-States of WHO African

region presents common features but also specificities that are dominant in Island States, for which WHO should dedicate a particular attention”.

The initiatives offer for Small Islands Developing States and multi-lateral partners the opportunity to identify and discuss the critical health problems and the way the local infrastructures, especially the health systems are responding to them. It allows the opportunity to exchange experiences and views about the future developments towards the highest possible level of health in your countries.

However, few development bilateral partners do support the country and government has instituted a sound framework for the coordination of support activities through the Ministry of Foreign Affairs and International Cooperation. Further, due to the number of partnership activities associated with health, the Department of Health has established unit for International Cooperation to ensure that activities of development partners are geared to the Strategic Plan.

There are several areas where development partners can play a significant role, especially in strengthening the programmatic capacities – working with both formal government and with the NGOs, which are well structures and have organised between themselves, a high level of coordination by the Liaison Unit of Non Governmental Organisation of Seychelles.

Civil society becoming more organised, has helped with partnership at between national and regional organisations, such as WHO, UNDP, UNAIDS, PILS from Mauritius, “RIVE Ocean Indien” and ARPS from La Reunion, AIRIS-Commission Ocean Indien. However, support is at a minimum. Churches and community-based organisations are contributing to HIV and AIDS efforts on a local level.

Support from development partners would go a long way to enhance the ‘Three Ones’ principles. At the International Conference on AIDS and STIs in Africa (ICASA) held in Nairobi, Kenya, in September 2003, officials from national coordinating bodies and relevant ministries of African nations, major funding mechanisms, multilateral and bilateral agencies, NGOs and the private sector gathered for a consultation to review principles for national-level coordination of the HIV/AIDS response.

The principles were identified through a preparatory process at global and country levels, initiated by UNAIDS in cooperation with the World Bank and the Global Fund to Fight AIDS, Tuberculosis and Malaria and have been further refined in dialogue with other key donor partners.

Various opportunities and challenges presented by the growing diversity of funding mechanisms and partnerships for HIV/AIDS action were noted. Participants underlined the need to further clarify roles and relationships in this diversity, the urgency of local action and the imperatives of an enabling policy environment.

There was strong consensus on three principles applicable to all stakeholders in the country-level HIV/AIDS response:

- One agreed HIV/AIDS Action Framework that provides the basis for coordinating the work of all partners.

- One National AIDS Coordinating Authority, with a broad based multi-sector mandate.
- One agreed country level Monitoring and Evaluation System.

Using these three pillars as the overall focus, a variety of ways can be used to bring together self-coordinating entities, partnerships and funding mechanisms for concerted action.

In Seychelles, the National AIDS Council is the national AIDS coordinating authority. Its main role is to advise government on HIV and AIDS policy; and advocate for the effective involvement of sectors and organisations in implementing programmes and strategies.

Support is required in providing capacity ad to assist the National AIDS Council to discharge its function of advocating effective involvement of sectors and organisation.

The 'National HIV and AIDS Strategic Plan 2005 -2009' is a broad based national strategic plan designed to guide the country's response to the epidemic.

Support would be required in preparation of the new strategic plan, when the current one comes to an end in 2009. This will entail supporting the Department of Health in defining the National Strategic Plan review process for designing and developing a new costed National Strategic Plan.

Support would be required to facilitate coordination, monitoring of progress of the national response and alignment to government priorities, WHO and UNAIDS could provide such a support.

There is a need to develop a 'Monitoring and Evaluation Framework for the Comprehensive HIV and AIDS Care, Management and Treatment programme in Seychelles' with the aim of monitoring the resources invested, the activities implemented, services delivered as well as evaluate outcomes achieved and long-term impact made by the 'National HIV and AIDS Strategic Plan'.

UNAIDS and WHO could work with the National AIDS Council to develop a tool for regular monitoring of National Strategic Plan. This support can even go further as to to strengthen the Department of Health, Monitoring and Evaluation capacity through support to development of the various components National Health Information Systems.

Another area that requires definite assistance is in the development of capacity and ensuring that programmes are implemented in effective and efficient manner. A criticism that emerged very strongly in the UNGASS consultative meetings was that consultants from the development partners perennially comes to the country makes the same assessments and recommendations. It is clear from their missions' reports and recommendations that the country does not have the requisite capacity to implement certain programmes, yet there is no attempt to support the country to correct these anomalies.

Amongst challenges that support can benefit the country in addressing not only issues to do with HIV and AIDS but in strengthening the Health Sector when addressing these are: support in strategic and operational planning, including assistance to develop a costed implementation plan and a monitoring and evaluation framework. Particular attention needs to be given to result-based management methodologies. As mentioned earlier, support in estimates and projections of HIV and AIDS is also required.

The experience of Seychelles in developing and implementing its health policies, framework and infrastructure in addressing health problems is not by capturing best practices – the experience is that programmes are not well documented, and this makes sharing lessons more difficult. Documenting best practices also plays an important role in being able to communicate efforts.

The joint efforts of government, civil society and development partners towards common goals, as expressed in the Strategic Plan, are crucial to a coordinated response to HIV, AIDS and STIs and support from development partners would go a long way in addressing not only the HIV and AIDS situation, by the strengthening of the Health System in general.

The international consultant suggested that a Plan of Action/Operational Plan is urgently needed. For recommendations to be translated into action, a timeframe for the completion of necessary tasks and the entity responsible needs to be designated. Moreover, regular meetings of both a high-level policy-oriented working group (NAC) and a technical implementation-focused working group (TAC) need to be occurring and functional systems of accountability put in place to ensure that tasks are completed. The appropriate human and financial resources must be put in place to accomplish designated tasks.

The most urgent need is to translate recommendations and strategic plans into operations and action for the sake of curbing the epidemic in Seychelles. It is strongly felt and as suggested by the international UNGASS consultant in her report, Seychelles has the opportunity to save countless lives and avoid a massive disaster by immediately investing heavily and wisely to prevent the epidemic from having a much greater effect on the most-at-risk populations and exploding in the general population. At present, the epidemic is concentrated in most-at-risk populations about which Seychelles has almost no information and for whom there can be few evidence-based prevention, care, treatment, and support programmes without accurate information about the epidemic and the most-at-risk populations. With increasing bridging to the general population, evidence-based programmes and tailored interventions for a wide range of demographic groups are needed immediately. A functional M&E system needs to be put in place quickly to provide the necessary data to guide effective interventions.

A substantive permanent UNAIDS presence to assist the country in developing and implementing strategies would go a long way in avoiding the aforementioned possible massive disaster posed by the epidemic and in potentially saving countless lives.

VI. MONITORING AND EVALUATION ENVIRONMENT

In Seychelles, there is no integral monitoring and evaluation efforts. There is a need to elaborate and implement a monitoring and evaluation framework for HIV and AIDS. The National Strategic HIV and AIDS Plan 2005-2009 spells out that the HIV/AIDS Strategic Plan must be reviewed periodically at national, sectoral and district levels. Monitoring was to be done quarterly, yearly and after five years will ensure that activities are being implemented according to the plan and that all partners contribute to the accomplishment of policy objectives. All stakeholders, including the MOH, will submit quarterly reports to NAC on their HIV/AIDS activities. (National AIDS Council, 2005; 64).

The National AIDS Council Secretariat has overall responsibility for the implementation of the Strategic Plan. It was expected that a mechanism of constant and consistent reporting by districts and sectors to national structures and vice versa will be developed. Information from the regular review of successes or failures was to be used to serve as a communication tool among stakeholders to provide guidelines on appropriate activities in which to be involved. (National AIDS Council, 2005; 64).

Specific measurable targets and indicators needs to be developed for each objective. A national behavioural survey that was to be undertaken in 2007 to measure changes in HIV related risk behaviours was not done. There is currently insufficient capacity to establish and maintain a system to produce baseline data and M&E indicators.

No Monitoring and Evaluation framework for the National Strategic HIV and AIDS Plan was developed. However, there are many parallel efforts to monitoring and evaluation which can be brought into together into the national response in an integral component of the HIV and AIDS strategic plan and the generic monitoring, epidemiological and public surveillance role of the Department of Health. These will in line with the "Three Ones" principles. Current specific HIV and AIDS monitoring, surveillance and research activities include:-

- The National Health Information System infrastructure;
- Programme evaluation studies that have been conducted in past. These include studies on evaluation the HIV and AIDS epidemic; and behavioural studies;
- Programme monitoring indicators are also collected through programme monitoring including reporting of new HIV and AIDS cases, the PMTCT programme monitoring, Patients statistics from the Communicable Disease Control Unit in the Ministry of Health, HIV testing at the ANC clinics, etc;
- National indicators on HIV and AIDS form part of the Department of Health's set of Health Goals, objectives and Indicators.

As we have indicated before, there is a need to establish the prevalence of HIV and AIDS. It is recommended that biological surveys need to be conducted to assist in determining prevalence and estimate the needs, as cases detected may not be a good proxy for need and may greatly underestimates need.

ANNEX1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

In endorsing the NCPI, two meetings were organised and hosted by the AIDS Control Programme to achieve agreement and consensus on the documents. The following participated in the meeting and the document was unanimously endorsed.

1. Dr. Jude Gedeon – PS Health
2. Dr. Fernando da Silveira –WHO Liaison Officer
3. Miss Rebecca Lalande – UNDP
4. Dr. Anne Gabriel – Director Non-Communicable Diseases
5. Miss Linette Mussard – Clinical Laboratory
6. Dr. Fred Arrisol – DGPH
7. Dr. Jastin Bibi- Medecin referent HIV/AIDS
8. Mrs. Jeanine Faure – ACPM
9. Miss Georgette Furneau – CDCU
10. Mr. Justin Freminot – HIV and AIDS Support Organization (National AIDS Council)
11. Miss Maggy Ernesta – Barclays Bank
12. Mrs Barbara Carolus Andre– Ministry of Education
13. Miss Elizabeth Charles – Ministry of Finance
14. Mr. Michael Charlette–President’s Office
15. Mrs. Judy Brioche- Health Coordinator, Youth Health Centre
16. Miss Flavie Sinon – Statistics Officer, Department of Health;
17. Miss Gaynor Mangroo – Statistics Officer, Department of Health;
18. Mr. Jude Padayachy – Local consultant
19. Mrs. Monique Boivin – External consultant
20. Mr. Antoine Lautee -Seychelles Police Force
21. Mr. Marcel Rosalie – representative of HIV and AIDS Support Organization
22. Miss Jasmine Dupres- representative of HIV and AIDS Support Organization
23. Miss Josepha Jeannevol- Representative of HIV and AIDS Support Organization

ANNEX 2: DATA SOURCES AND REFERENCES

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ANNEX 3: CORE TEAM

This document was compiled with the assistance of a multidisciplinary and multi-sectoral core team, which included the following:

1. Dr Fernando da Silveira – WHO Liaison Officer;
2. Dr Fred Arrisol – Director General, Public Health, Department of Health;
3. Dr Jastin Bibi – Medecin referant HIV/AIDS, Department of Health;
4. Miss Georgette Furneau – Nurse Coordinator, Communicable Disease Control Unit, Department of Health;
5. Miss Flavie Sinon – Statistics Officer, Department of Health;
6. Miss Gaynor Mangroo – Statistics Officer, Department of Health;
7. Mr Jude Padayachy – Chief Executive Officer, National Statistics Bureau;
8. Mrs Jeanine Faure – AIDS Control Programme Manager