REPUBLIC OF MAURITIUS

COUNTRY PROGRESS REPORT

DECLARATION OF COMMITMENT
OF THE
UNITED NATIONS GENERAL ASSEMBLY
SPECIAL SESSION (UNGASS)
ON HIV/AIDS

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LIST OF ACRONYMS

ANC	Ante-Natal Care
ART	Antiretroviral therapy
CBO	Community Based Organisation
CSW	Commercial Sex Worker
FBO	Faith based Organisation
IDU	Intravenous Drug User
IOC	Indian Ocean Commission
KABB	Knowledge, Attitudes, Beliefs and Behaviour
M&E	Monitoring and Evaluation
MFPWA	Mauritius Family Planning and Welfare Association
MOH	Ministry of Health
MSM	Men having Sex with Men
MST	Methadone Substitution Therapy
NAS	National AIDS Secretariat
NATReSA	National Agency for the Treatment and Rehabilitation of Substance Abusers
NDCCI	National Day Care Center for the Immuno-Suppressed
NEP	Needle Exchange Programme
NRL	National Reference Laboratory
NSF	National Multisectoral HIV and AIDS Strategic Framework
NSP	National Strategic Plan
PI	Prison Inmates
PILS	Prevention, Information et Lutte contre le Sida
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PRSP	Poverty Reduction Strategy Papers.
SAFAIDS	Southern African HIV and AIDS Information Dissemination Service
UNAIDS	Joint United Nations Programme on HIV and AIDS
WHO	World Health Organisation

I. INTRODUCTION

The Republic of Mauritius, a Small Island Developing State (SIDS) is situated in the south west of the Indian Ocean, some 1800 km from the east coast of Africa. It covers a surface area of 2040sq km and is divided into nine districts the semi - autonomous island of Rodrigues and the outer-island.

The mid-year 2006 population for Mauritius is 1,215,619 with an average population growth rate of 0.6% and the mid-year estimates 2006 give the 15-49 population in Rodrigues as 19,375 out of 36,907. *(Population and Vital Statistics-Central Statistics Office 2007).*

Since independence in 1968, Mauritius has developed from a low-income, agricultural- based economy to a middle- income, diversified economy with growing industrial, financial and tourist sectors. For most of the period, annual growth has been in the order of 5% to 6%. This remarkable achievement has been reflected in more equitable income distribution, increased life expectancy (male 68.92 yrs, female 76.9 yrs), lowered infant mortality rate (13.5 deaths/1000live births), lowered maternal mortality rate (0.18 death/ 1000 live births) and a much improved infrastructure[1].

The Ministry of Health and Quality of Life is responsible for the formulation of the National Health Policy. This central level is responsible for planning, resource mobilization and allocation, coordination, management, regulation and overall administration.

"The Mission Statement of the Public Health Sector is to enhance the health status of the population by improving the quality of health care and enhancing social equity through the provision of a wider range of health services and increased accessibility to every citizen."

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[1] Population and Vital Statistics- Central Statistics Office, 2007

The health profile of the Republic of Mauritius is closed to that of developed countries with the implementation of a comprehensive programme of Primary, Secondary, Tertiary and Hi-tech/quaternary health care.

In matters of HIV and AIDS in the absence of the NAS, till the early 2007, it was the AIDS Unit of the Ministry of Health that was responsible for planning, implementation and evaluation of the National AIDS Programme.

National Day Care Centre for the Immuno-suppressed (NDCCI) became functional in 1999 offering the following services:-

- Treatment of opportunistic infections
- Voluntary Counseling Testing
- Implementation of a Prevention of Mother to Child Transmission programme as from December 1999.
- Provision of Post Exposure Prophylaxis treatment to all accidental injuries and victims of sexual abuse.
- Provision of antiretroviral drugs, free of any user cost, since April 2002, to all HIV/AIDS patients in need thus contributing to the WHO "3 by 5" initiative (treat 3 million people by 2005).

Mauritius has a regionalised system of public health services through a network of accessible and free health care delivery institutions: (See annex 1)

- At the primary level through Community Health Centres and Area Health Centres
- At the secondary level through district hospitals, regional general hospitals and specialised hospitals: (Eye; ENT; Chest Diseases; Psychiatry) and an oncology department.
- Tertiary level includes cardiac surgery, neurosurgical services, renal dialysis, renal transplant, lithotripsy, laser and laparoscopic treatment, diagnostic facilities such as CT scan and MRI and Intensive Neonatology Care Units.

These health services are backed by several support services:

- Regional Laboratory services
- National Blood Bank and transfusion services
- National Pathological Services at the Central Laboratory
- National Reference Laboratory

Today non-communicable diseases (80%) and communicable diseases (20%)[2] represent the major burden of diseases.

The Government of Mauritius has placed HIV/AIDS at the core of its health agenda and has endorsed many International and Regional Resolutions and Commitments such as:

1. The Abuja Declaration on HIV and AIDS, Tuberculosis and other related infections and diseases- April 2001
2. The United Nations General Assembly Special Session Declaration of commitments- 27th June 2001
3. The Millenium Development Goal -6, drawn from the United Nations Millenium Declaration- 2000
4. The World Health assembly Resolutions on HIV and AIDS
5. The Maseru Declaration- July 2003

Mauritius has responded regularly to the biennial UNGASS and Universal Access reviews. This has included targets setting for 2008 and 2010 to ensure scaling up of prevention, treatment, care and support strategies in Mauritius. This progress report is a follow up of the 2005 report, and it focuses on the core indicators grouped into four broad categories:

1. National Commitment and action
2. National knowledge and behaviour
3. National impact
4. Global commitment and action

[2] Health Statistics, M.O.H

II .STATUS AT A GLANCE

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

In order to have an active involvement of all stakeholders, the private sector, NGOs, PLWHAs, Faith-Based Organisation, Community- Based Organisation, were incorporated in the consensus – building process for the National Composite Policy Index. Their inputs have also been sought regarding the Core National Indicators. The Government has helped to coordinate the civil society's response as there is no a coordinating body within the civil society at this present time. This process will be undertaken, but in the meantime the government has convened and facilitated the consensus meeting for the NCPI. These organizations were invited to participate in a workshop on Thursday 6th December 2007, at national level so as to review and validate the National Composite Policy Index. There has been a fruitful and active participation from all participants.

A second workshop was held on Thursday 10th of January 2008, with all the stakeholders was organised so as to review and validate the narrative part and the core indicators.

The final report submitted to UNAIDS will be widely disseminated to ensure that all stakeholders readily have access to it.

b) The status of the Epidemic:

Since 1987 when the first HIV/AIDS case was reported in Mauritius, up to end of November 2007, the total cumulative HIV/AIDS cases amount to 3258, of whom 3107 are residents. Among the residents detected as positive 2574 are male and 533 female resulting in a male to female sex ratio of 5:1[3]

Death among residents registered as HIV/AIDS cases, cumulatively as from 1987 to November 2007 amount to 217 (214 adults and 3 children) thus leaving 2890 (2410 males and 480 females) people living with the virus at present.

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[3] AIDS Unit, M.O.H & QL, Sentinel Surveillance

The number of new HIV/AIDS cases among residents has maintained an upward trend, rising from 50 in year 2000 to 921 new HIV/AIDS new cases in 2005. However, there has been a decrease in the number of cases detected (542) in 2006, and this trend seems to have been maintained for the year 2007, as 520 cases have been detected as at November 2007.

The HIV epidemic in Mauritius is classified as a "concentrated epidemic". The estimated rate of infection among the IDUs is 30% to 60%.

The UNAIDS office provided the required technical expertise and in a workshop conducted in September 2007, the data was reassessed and using the "Estimate and Projection tool", the prevalence rate of adult population in Mauritius was estimated to be 1.8% (around 12,000 people in the 15-49 population).

c) The policy and programmatic response:

National AIDS Control Programme (NACP) was established in 1987 before the first AIDS case was detected. In 2001 the first National HIV/AIDS Strategic Plan was elaborated, involving broad participation from line ministries, civil society, NGO's and the private sector.

The Government of Mauritius strongly recognizes political commitment as critical in the fight against HIV and AIDS and remains proactive to mitigate the epidemic of HIV and AIDS among the population. These responses include the following:

1. Prevention strategies in all sections of the population and outreach activities with the MARPs.
2. Concerning the drug control issues and the prevention of HIV among vulnerable population, Mauritius has ratified all three International Drug Control Conventions

   (the 1961 Single Convention on Narcotic Drugs, the 1971 Convention on Psychotropic Drugs and the 1988 Convention against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances.and the 2000 Convention on Trans-National Organized Crime. A multi-sectoral national drug control masterplan for the years 2007-2009 has been developed integrating a national HIV prevention strategy.

3. The HIV and AIDS Act 2006 ensures the full enjoyment of human rights of PLWHA, provides the legal framework to enable innovative strategies in the prevention of HIV transmission among the MARPs, namely the Needle Exchange Programme.
4. Collaboration with all partners involved in the prevention of drug use and in the drug dependency treatment, thus harmonizing interventions to have better impact.
5. HIV Testing and Counseling services have been extended to all the 5 health regions in order to encourage HIV testing among the population in general. Furthermore 3 centres are operational in the district of Port-Louis where there is a higher concentration of MARPs.
6. There has been an upgrading of the National Reference Laboratory to ensure better follow-up of PLWHA on ART.
7. A wide condom distribution network in the urban and rural areas free of user cost among the community as well as among the MARPs is ongoing.
8. Antiretroviral treatment, PMTCT regimen, Post-Exposure Prophylaxis in case of accidental exposure and to victims of rape are being provided free of user cost.
9. An Action Plan for Treatment, Care and support for PLWHA in 2006 highlights the policy of the Government to achieve targets set in Universal Access.
10. Social and financial aid for those infected and affected by HIV and AIDS is provided to mitigate the negative impact of the disease on the family and the community.

d) Overview of selected UNGASS National indicators:

	2007 Numerator/Denominator = Percentage	**Source and Year of Publication**
National commitment and Action Indicators		
1 AIDS spending, by categories and financing source	See Annex 3	
2. National Composite Policy Index	See Annex 4	NCPI, 2008
National Programme Indicators		
3. Percentage of donated blood units screened for HIV in a quality-assured manner	43,521 /43,521 = 100%	National Reference Laboratory, Candos
4. Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy	243/1200 = 20.3 % (yr 2006) 321/1200 = 26.8 % (yr 2007)	Sentinel Surveillance, AIDS Unit, M.O.H & QL
5. Percentage of HIV- positive pregnant women who received antiretrovirals to reduce the risk of mother-to child transmission	23/50 = 46% (yr 2006) 19 /60 = 31.7% (yr 2007)	Sentinel Surveillance, AIDS Unit, M.O.H & QL
6. Percentage of estimated HIV-positive incident TB and HIV	3/19 = 15.8 %	Chest Clinic- Port-Louis; NDCCI
7. Percentage of women and men aged 15 – 49 who received an HIV test in the last 12 months and who know their results	No sero-surveillance has been done up to now. 15 19 yrs = 0 20-24 yrs : 8 /307 = 2.6% 25-29 yrs = 29 /1319 = 2.2% Total = 37 /2000 = 1.8%	KABB 2004
8. Percentage of most-at –risk populations who received an HIV test in the last 12 months and who know their results	CSW:15 /50 = 30% MSM: 8/50 = 16% IDU: 5 /50 = 10%	KABB 2004
9. Percentage of most-at- risk populations reached with HIV prevention programmes	See narrative	Sentinel Surveillance, AIDS Unit, M.O.H & QL

10. Percentage of orphaned and vulnerable children aged 0 -17 whose households received free basic external support in caring for the child	100 % orphans benefit from the services available. No data available for vulnerable children	Ministry of Social Security, National Solidarity and Senior Citizens Welfare &Reform Institution
11. Percentage of schools that provided life skills-based HIV education in the last academic year	Difficult to ascertain or measure the number of hours of life skills for each grade for the last academic year).	Ministry of Education and Human Resources
Knowledge and Behaviour Indicators		
12. Current school attendance among orphans and non-orphans aged 10-14.	See narrative	Ministry of Social Security, National Solidarity and Senior Citizens Welfare &Reform Institution Ministry of Education and Human Resources
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 misconception about HIV transmission	149/681 = 21.9%	KABB Study 2004
14 Percentage of most at risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconception about HIV transmission	CSW: 1/50 = 2% MSM: 24/ 50 = 48% IDU: 31/50= 62%	KABB Study 2004
15. Percentage of young women and men aged 15-24 who have had sexual intercourse before the age of 15	14/681 = 2.1%	KABB Study 2004
16. Percentage of women and men aged 15-49 who have had sex with more than one partner in the last 12 months	104/ 2000= 5.2%	KABB 2004

17. Percentage of women and men aged 15-49 who have had more than one sexual partner in the 12 months who report the use of a condom during their last sexual intercourse	46/104 = 44.2%	KABB 2004
18. Percentage of female and male sex workers reporting the use of a condom with their most recent client	RSA= 47 % KABB: 50/50 =100%	RSA 2004 KABB 2004
19. Percentage of men reporting the use of a condom the last time they had anal sex with a male partner	24/46 =52.2%	KABB 2004
20. Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse	6/45 = 13.3%	KABB 2004
21. Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	16/50 = 32%	KABB 2004
National impact		
22. Percentage of young women and men aged 15-24 who are HIV infected	15-19 yrs:7/1,661 = 0.42% 20-24 yrs: 15/4,577= 0.33% Total: 22/6,238 = 0.35%	Sentinel Surveillance, AIDS Unit, M.O.H & QL
23. Percentage of most at risk populations who are HIV infected	See narrative	Sentinel Surveillance, AIDS Unit, M.O.H & QL
24. Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	99/117= 84.6%	Sentinel Surveillance, AIDS Unit, M.O.H & QL

III. OVERVIEW OF THE AIDS EPIDEMIC

The HIV and AIDS epidemic in Mauritius started in 1987 when the first HIV positive case was detected. As at November 2007, the total cumulative HIV/AIDS cases amount to 3258 of whom 3107 are residents. Among the residents detected positive there are 2574 males and 533 females resulting in a male to female sex ratio of 5:1.[4]

Death among residents registered as HIV/AIDS cases, cumulatively as from 1987 to November 2007 amount to 217 (214 adults and 3 children) thus leaving 2890 (2410 male and 480 female) people living with the virus at present.[5]

The progression in the number of cases has gradually increased until 2000 when the incidence reached up to 100% with 50 cases as compared to 28 in 1999. The figures more than doubled from 2002 to 2005 (**See Table 1**).This can be partly attributed to improved surveillance and testing facilities at various points (HIV testing and counseling - HTC) across the island and also regular outreach activities with the most- at- risk populations.

Table 1: Total number of new infection per year (AIDS Unit,MOH)

Year	**2000**	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**
Number of tests done	54,601	67,025	68,468	76,577	86,292	86,288	87,842	85,211 November
Number of positive cases	50	55	98	225	525	921	542	520 November

The test for HIV is done according to the three C's principles- Counseling, Consent and Confidentiality. This is clearly laid down in the HIV/AIDS Act 2006 which specified the rules and regulations concerning testing in the Republic of Mauritius.

[4] AIDS Unit, M.O.H & QL, Sentinel Surveillance
[5] AIDS Unit, M.O.H & QL, Sentinel Surveillance

The same principles are applied whether tests are being carried out in the community, outreach or in the prison. At this point in time, a sero-surveillance survey is of utmost importance to help the NAS to make estimation of real need in ART, care and Support.

This rise in the annual HIV positive cases and a significant shift in the reported mode of transmission of HIV from heterosexual to injecting drug users (IDUs) is a major cause of concern for policy makers. In the year 2000, only 2% of the new infected cases were among the IDUs but it gradually increased to 14% in 2002, 66% in 2003, 87% in 2004, 92% in 2005 and 85.9% in 2006. The HIV and AIDS epidemic is said to be "concentrated" in Mauritius with an estimated prevalence rate of 1.8% in the 15-49 population (over 12,000 with 85% IDUs).

It is well documented that once HIV infection is among the injecting drug user community, the spread is very rapid. Hence the consequences are manifold as it results in:

- A larger population of HIV positive people
- The sexual transmission to broader populations
- An increasing number of HIV positive children
- An excessive resources demand
- A widespread socioeconomic devastation

In a study[6] of IDUs, 55.8% had sex with non-regular partners and 19.2% with commercial sex workers. Only 6% used condoms with non-regular partners and 4% with commercial sex workers.

This bridging into the general population is confirmed by indicators such as the increased number of HIV infected pregnant women (prevalence has increased from 0.05% in 2000 to 0.28 % in 2006 and 0.35% in 2007) and the number among blood donors from 3 in 2000 to 18 in 2006. Furthermore the recent increase in heterosexual transmission from 5.9% in 2005 to 10.2% in 2006 is another indicator of bridging of HIV in the wider population. These major concerns need to be considered in the development of future strategies.

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[6] Study of knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius and Rodrigues-2004 (community based study-Mauritius)

Young people aged 15 to 24 years old account for 21.4% of all HIV cases in Mauritius (See Table 2). Since 2002, youth have represent 15 to 20% of all newly detected cases yearly. It should be noted that this figure represents the age at which these young people were diagnosed as HIV positive, therefore they could have been infected earlier. The factors that place young people at the centre of HIV vulnerability are the same as in other countries.[7]

Table 2: Total number of youth detected positive as from 1987 to 2006

AGE GROUP	FEMALE	MALE	TOTAL	PERCENTAGE
15 -19	50	44	94	3.6%
20 -24	122	339	461	17.8%
Total	172	383	555	21.4%

The sex ratio among cumulated HIV newly detected cases from 1987 to November 2007 is 5 males to 1 female. However women are quite vulnerable when their partners are IDUs and /or having sex with multiple partners. All three known factors that increase women's vulnerability to HIV, namely biological, economical and social prevail in Mauritius[8]. In addition, the 6,400 female sex workers, among whom there is a very high proportion (74.5%)[9] of injecting drug use, constitute a potential feminization and consequential spread of the epidemic.

[7] AIDS Unit, M.O.H & QL, Sentinel Surveillance
[8] AIDS Unit, M.O.H % QL, Sentinel Surveillance.
[9] Sida et development dans les pays iles Africain dans l'ouest de l'ocean indien (Draft)

Situation regarding the HIV epidemic in Rodrigues:[10]

The HIV situation in Rodrigues is of major concern. The first case was detected in 1998 and as at end of October 2007, 20 cases (11 males and 9 females) have been detected, in total seven of them through ante-natal care, five through IDU and 1 baby born to a mother who did not follow antiretroviral prophylaxis.[11]

But data from the HIV/AIDS Surveillance for Mauritius showed in 2003 that out of 669 cases detected, there was a gross estimate of 100 Rodriguans. Therefore the real number is most likely to be several times higher. It is difficult at this stage to know if last infections occurred during stays in Mauritius or in Rodrigues itself. History of cases reported suggests that they have been infected during their stay in Mauritius. Furthermore it was recorded that in 2006[12] about 30,079 persons residing in Mauritius plus an average of 12,535 Rodriguans from Mauritius visited Rodrigues. There is both a high increasing external mobility to and from Mauritius for study, business, tourism as well as an increased internal mobility with improved road infrastructure and transport sector.

There is definitely a set of favourable conditions for a rapid spread of HIV infection in Rodrigues:

- The proximity of Mauritius, where a soaring epidemic is taking place.
- A recent study[13] points out that 2% of the young people surveyed are currently injecting heroin and sharing injecting equipment. Although it was difficult to extrapolate to all young Rodriguans a significant pool of injectors certainly exist in Rodrigues as 5 out of the 20 cumulated cases were IDUs
- Sexual debut occur at a young age in Rodrigues (14 % before the age of 15 and concurrent sex partners are reported to be quite common)
- Condom use is particularly low and rampant poverty seems to be an important contributing factor to HIV, fuelling economic migration to Mauritius and

10 Rapid Situation Assessment, NATReSA, 2000
11 UNAIDS Assessment Mission, 27- 29th Nov 2007
12Central Statistical Office Report 2006
13Youth Health Risk Behaviour in Rodrigues- July 2006- Mauritius Institute of Health

nurturing a dangerous spiral that might lead to a generalized epidemic among the Rodriguans if no serious and urgent action is taken.

IV. NATIONAL RESPONSE TO THE HIV/AIDS EPIDEMIC

Achieving the Millennium Development Goal 6, that is, halting and reversing the HIV and AIDS epidemic by 2015 remains the overall aim of successive National Strategic Plans. The present National Strategic Framework (NSF) 2007-2011 has been conceived to respond to the findings of the Biennial UNGASS report 2005, the Universal Access consultative meeting in February 2006 and the evaluation of the previous NSF 2001-2005 in May-July 2006. Each of these was undertaken through inclusive participatory consultative process with representatives from line ministries, NGO's, faith based organization, PLWHA and vulnerable groups.

Endorsing the Three Ones Principles and in order to attain the most effective and efficient use of resources, the Government moved concurrently towards:

- One Multisectoral HIV & AIDS Action Framework that provides the basis for coordinating the work of all partners: the NSF 2007-2011
- One National AIDS Coordinating Authority (NAC) with a broad-based multisectoral mandate: the National AIDS Secretariat (NAS) at the Prime Minister's Office
- One country-level Monitoring and Evaluation (M & E) System: initiated in April 2006 with indicators validated in May 2007.

Regarding antiretroviral medication, monotherapy became available in December 1999 and was used as prophylaxis for the prevention of mother to child transmission, for accidental injuries and extended to victims of rape in 2003.Antiretroviral therapy was made available as from April 2002 and are being provided free to the user at point of consumption. At present (Cumulatively as from 2002 to November 2007), 321 patients are on such treatment, thus setting the pace to achieve the WHO "3 by 5" initiative

Several major developments took place in 2006 -2007 paving the way for the NSF 2007-2011. These include:

- The Universal Access consultative report
- The Evaluation of the implementation of NSP 2001-2005
- The development of the Action Plan for HIV Prevention among IDUs, PIs and CSWs 2003-2008.
- The Situation Analysis and Action Plan for treatment, care and support to PLWHA in July 2006 to improve the quality of care and support to People Living with HIV and AIDS
- The setting up of the Methadone Substitution Therapy Program at the National Detoxificaton Centre, Beau-Bassin in November 2006.
- The Elaboration and implementation of "The Council of Religions" project in 2006
- The enactment of the HIV and AIDS ACT in December 2006 which is an important tool in the fight against the HIV and AIDS epidemic. Besides ensuring an effective legal framework to implement the Needle Exchange Programme, it eliminates all forms of discrimination and assures the full enjoyment of Human Rights by people living with HIV and AIDS.
- The Development of a National multisectoral HIV and AIDS Communication Plan was initiated with completion of Phase 1.
- The setting-up of a National AIDS Coordinating Authority with a broad-based multisectoral mandate: the National AIDS Committee (NAC) with a National AIDS Secretariat (NAS) at the Prime Minister's Office has been set up. It ensures the implementation of the projects, programmes and activities of the strategic plan and other policies and also liaises with key actors at national, regional and international levels to ensure availability of sufficient resources to achieve the targets set.
- The finalisation of a National Monitoring & Evaluation Plan to ensure the constant monitoring and periodic evaluation of the NSF. It will also initiate relevant surveys and research work that can bring evidence-based arguments to reinforce or reorient strategies. Indicators have been identified and the costing and budgeting of the NSF have been worked out.
- The Launching of the Needle Exchange Program, November 2006.

It is to be noted that the Action Plan for HIV Prevention among IDUs, PIs and SWs 2003-2008 and the Action Plan for treatment, care and support to PLWHA in July 2006

has been integrated in the NSF 2007- 2011 so as to avoid duplication and enhance harmonization of strategic interventions.

Overall Goal of the National Multisectoral HIV and AIDS Strategic Framework (NSF) 2007-2011[14]

The overall goal of the NSF is to prevent new HIV infection and to provide a continuum of comprehensive care to all PLWHA so as to mitigate impact of the HIV epidemic on individuals, families, communities and the society at large.

Strategic objectives have been geared to address identified priorities. These are among others, the strengthening of the National Coordination, improving the quality of life of PLWHA, minimizing the transmission of HIV among MARPs and fighting stigma and discrimination.

Rodriguan performance of HIV/AIDS Strategic Plan 2004-2007

Despite a lack of resources and of systematic coordination, leaders of the response in Rodrigues have implemented a rather good part of the activities that were initially planned in the Rodrigues HIV and AIDS Strategic Plan 2004-2007.[15]

The AIDS Unit, lacking appropriate trained staff, has not been able to play its role of coordination, and instead has put most effort on field activities. Monitoring of the activities carried on by all actors has not been conducted systematically and results and lessons learnt have not been compiled to provide guidance for the collective response.

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[14] National Multisectoral HIV and AIDS Strategic Framework (NSF) 2007-2011, Ministry of Health & Quality of Life.

[15] UNAIDS Assessment Mission, 27- 29th Nov 2007

However there has been a large presence of Public and civil society players that have deployed intense efforts to reach young people and women with prevention interventions. The collective mobilization seems to be very active, if not organised. All pregnant women are tested for HIV, while a good proportion of youth are reached by proximity interventions on HIV prevention by different stakeholders.

Care and support is, on the other hand, facing the obstacle of stigmatisation of HIV infected people in a small island. Neither ART nor PMTCT can easily be carried out while maintaining the confidentiality of patients. All cases have been referred to Mauritius mainland, the public system bearing the increasing cost of transport and accommodations.

Considering the new magnitude and the type of epidemic in the neighbouring Mauritius, the response to AIDS in Rodrigues has to evolve and complementary directions to tackle the growing threat have to be considered.

V. CORE INDICATORS FOR THE IMPLEMENTATION OF THE DECLARATION OF COMMITMENT ON HIV AND AIDS – 2008 REPORTING

NATIONAL COMMITMENT AND ACTION

1. Domestic and international AIDS spending by categories and financing sources.
   (Please refer to National funding Matrix –Annex 3)

2. Government HIV and AIDS Policies.
   (Please refer to NCPI –Annex 4)

NATIONAL PROGRAMMES

<u>3. Percentage of donated blood units screened for HIV in a quality assured manner</u>
(Yr 2006)

Table: Percentage of donated blood units screened for HIV in a quality-assurance manner (Yr 2006)

	Quality assurance in HIV screening		Blood units			Percentage
Name of the blood centre or blood screening laboratory	**Standard operating procedures**	**External quality assurance scheme**	**Denominator: Donated blood**	**Screened Blood**	**Numerator: Blood screened in quality assured manner**	**Percentage of donated blood units screened for HIV in a quality-assurance manner**
A. National Reference Laboratory	Yes	Yes	43,521	43,521	43,521	
Total	1	1	43,521	43,521	43,521	**100%**
	[Number of facilities]		[Number of blood units]			[Percentage]

Source: National Reference Laboratory, Candos

In the Republic of Mauritius there is only one blood screening centre, the National Reference Laboratory. It is known as a reference laboratory in the African region and

undergoes an external quality assurance scheme regularly. Blood screening policy in the Republic of Mauritius is of international standard therefore for blood transfusion safety all donors are systematically screened through a questionnaire and tested for HIV, Hepatitis B & C and TPHA. Blood donation is done on a voluntary basis and Mega blood donations are organized regularly across the main island and Rodrigues. In May 2007 the laboratory of Rodrigues was equipped to perform ELISA test for HIV, Hepatitis B &C and TPHA.

Thus, the percentage of donated blood units screened for HIV in a quality assured manner in the previous year (2006) is 100%.

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

For the denominator, the Ante-natal Clinic Surveillance could have been used, but it will likely lead to underestimation of the population in need. The epidemic is primarily concentrated among the IDUs with more than 75% being men. Thus the percentage of HIV-positive women attending ANC will not accurately predict the prevalence in the general population.

Therefore the denominator has been calculated as follows:

The estimated prevalence is 1.8% among the 15-49 giving us a total of 12,000 people and it is generally accepted worldwide that about 10-15% will be in advanced AIDS and therefore will need ART.

As the incidence in Mauritius is very high and most of the infections are probably recent, it means that we have possibly still a low percentage of people in AIDS stage. We will therefore take 10% - 1,200 people in need of ART as the denominator.

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

Reporting period	Numerator: Number of adults and children with advanced HIV infection receiving antiretroviral therapy.	Denominator: Estimated number of adults and children with advanced HIV infection	Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy.
Jan. 2006-Dec. 2006	243	1200	**20.3%**
Jan. 2007-Dec 2007	321	1200	**26.8%**

Source: Workbook Estimates; HIV/AIDS sentinel surveillance

ART are being provided free of user cost since April 2002, and as at Nov 2007, there are 2890 PLWHA and cumulatively 321 patients on ART, out of whom 7 children and 149 in AIDS stage.

Low uptake, poor adherence and stigmatisation have been identified as major set backs towards Universal Access.

Necessary actions have been identified in the NSF 2007-2011 so as to mitigate this negative aspect of stigmatization and discrimination, namely continuous medical and nursing education on all issues pertaining to HIV and AIDS, increased accountability of Health Care Workers through their professional codes of conduct, and the enforcement of the HIV and AIDS ACT 2006.

5. Percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of mother-to-child transmission.

Since 1999, antiretroviral prophylactic protocol for the mother, implementation of safe delivery practices, prophylaxis to the infant and use of safe alternatives to breastfeeding have been introduced free of user cost.

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

Reporting period	Numerator: Number of HIV-infected	Denominator: Estimated number of	Percentage of HIV-infected pregnant

	pregnant women who received ARVs during the last 12 months to reduce MTCT	HIV-infected pregnant women in the last 12 months	women who received ARVs to reduce the risk of MTCT
Jan. 2006-Dec. 2006	23	17,751 total births (live and stillbirth) x 0.28% estimated prevalence = 50	**46%**
Jan. 2007-Dec. 2007	19	17,130 total births (live and Stillbirth) x 0.35% estimated prevalence = 60	**31.7%**

Sources: Births: Central Statistical Office; Prevalence: ANC Sentinel Surveillance

Numerator for year 2006: Out of 50 HIV -infected pregnant women detected, 38 gave birth and among those only 23 follow the full protocol.

Denominator: The multiplying method is being used.

17,751 (total number of women who gave birth in the last 12 months) x 0.28% (Yr 2006 prevalence rate of HIV in pregnant women) = 50

Therefore percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of Mother-to-child transmission in the year 2006 is 46%

Numerator for the year 2007: out of 62 HIV –Positive cases detected among the ante-natal attendees, 47 gave birth and among those only 19 follow the full protocol.

Denominator: The multiplying method is being used.

17,130 (total number of women who gave birth in the last 12 months) x 0.35 % (Yr 2007 prevalence rate of HIV in pregnant women) = 60

Therefore percentage of HIV-infected pregnant women who received antiretrovirals to reduce the risk of Mother-to-child transmission in the year 2007 is 31.7 %

This low adherence to the Prophylaxis regimen in comparison to the high degree of acceptance to do the test can be explained by the fact that the majority of our clients are found in the most-at-risk population. New strategies need to be put in place to encourage ante-natal follow-up and to reinforce adherence.

Assumptions:

1. **All births occur in the hospital.**

In fact, nearly all births do occur in the hospital. There is a small percentage (16.9%)[16] of birth occur in the private sector. There may be one or two women who give birth in the private sector who needed ARVs but were not tested and/or did not receive ARVs for PMTCT.

Provision is being made for the private sector to notify the Ministry of Health of the percentage of women tested for HIV and the number of HIV-positive women who received ARVs for PMTCT.

2. **All women attending public ANC clinics were tested for HIV**.

The opt out method is used for HIV testing of pregnant women and there is almost no refusal of the HIV test as a part of the standard care package for ANC.

3. **All women attended ANC, and thus had the opportunity to test for HIV.**

There are women who only come to the hospital to deliver and who have not attended ANC. Considering this fact, available best estimates from doctors are that 94-98% of pregnant women are tested for HIV. All Ante-Natal Clinic send their monthly statistics to the MOH and the AIDS Unit.

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

Assumption:

All TB cases are detected as Health care is highly accessible in Mauritus. Chest x-rays are being offered as a routine investigation for all those presenting with respiratory problems and care is free at point of delivery.

Denominator has been calculated as from the Year 2000, when ART was started.

Table: Percentage of estimated HIV-positive incident TB cases that received treatment for TB and HIV: January-December 2006

Sex	Numerator: Number of adults with advanced HIV infection who are currently receiving ART and who were started on TB treatment within the reporting year	Denominator: Estimated 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

[16] Health Statistics, MOH

Female	0		
Male	3 (were on ART and have started TB treatment, as well)	19 **Detected** (rather than estimated) number of incident TB cases in people living with HIV	
Total	3	19	15.8%

Source: Chest clinic – Port-Louis; National Day Care centre for the Immuno-suppressed.

The prevalence of co-infected HIV- TB cases in the population of TB patients is very low as compared to other regions (3.9% in South-east Asia, 4.7% in Europe and 33% in Africa). A total number of 24 cases were registered and all were male. 3 cases of AIDS (on ARV) were notified and 6 deaths were recorded.

The major coinfection with HIV in our concentrated epidemic is Hepatitis B & C infection especially among the IDUs. The prevalence of Hepatitis C among the injecting drug has reached more than 95%.

Population-based Surveys and Behavioural Surveys in Mauritius:

Indicators 7.-21., rely on population-based surveys and behavioural surveys. There is an urgent need to obtain baseline information and put in place the necessary plans and funding for further monitoring on a regular basis through population-based and behavioural surveys.

The primary source used for information on indicators 7.-21. are the Study of Knowledge, Attitudes, Beliefs and Behaviour Related to STIs/HIV/AIDS in Mauritius and Rodrigues, conducted in 2004. This study was conducted several years prior to the reporting period for UNGASS 2008. However, it is the only information available. The results have yet to be published, however, they are included in this report to give some indication of the knowledge, testing, and behaviour of the community and most-at-risk population. Limitations identified are the sample size.

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

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

Women and men aged 15-49	Numerator: Number of respondents aged 15-49 who have been tested	Denominator: Number of all respondents included in the sample	Percentage of Women and men aged 15-49 who received an HIV test in the last 12 months

	for HIV during the last 12 months and who know the results		and who know their results
Female		1002	
Male		998	
15- 19 yrs	0	374 (male 177; female 197	
20- 24 yrs	8	307(male 164; female 143)	**2.6%**
25 – 49 yrs	29	1319(male 657; female 662)	**2.2%**
Total	37	2000	**1.8%**

Source: Study of Knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius 2004 (community based)

This information is based on a small sample, however, it may give some indication of testing behaviour. This indicator highlights the need to carry a Population Based Survey in Mauritius

At present, the majority of tests are being carried out for blood donors, PMTCT, low risk patients (i.e. cardiac surgery etc..). For these tests, only positive cases are being called with results of the test, which means that those who are negative have not been told that they are negative. They should assume they are negative, as they have not been contacted, and thus know their results. This is a missed opportunity for counseling to influence knowledge and behaviour regarding HIV prevention.

Out of those who come to a VCT centre for testing, it is estimated that 95% receive their results. For outreach testing, where field workers bring testing facilities to at-risk populations, the percentage is lower and stands at around 60%.

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

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

MOST-AT-RISK POPULATION, sex, and age	Numerator:Number of most-at-risk population respondents who have been tested for HIV during the last 12 months and who know the results	Denominator:Number of most-at-risk population included in the sample	Percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results

COMMERCIAL SEX WORKERS			
Female (data available for female CSW only)			
<25	8	28	**28.6%**
25+	7	22	**31.8%**
Total	**15**	**50**	**30%**
MEN WHO HAVE SEX WITH MEN			
<25	1	28	**6.67%**
25+	7	22	**20%**
Total	**8**	**50**	**16%**
INJECTING DRUG USERS			
Female		9	
Male		41	
<25	0	11	
25+	5	39	**12.8%**
Total	**5**	**50**	**10%**

Source: Study of Knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius and Rodrigues-2004 (IDU, CSW,MSM-Mauritius)

The data available for this indicator dates back to 2004 and the sample chosen is quite limited. As pointed out earlier there is an urgent need to carry out surveys so as to update data.

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

For this indicator, there are specific criteria for classifying someone as having been reached by prevention programmes. This criterion was not used in the KABB, so the results are not internationally comparable. However, the KABB does provide an idea as to the reach of prevention programmes within the sample. For each most-at-risk group, the sample was 50.

Table: Percentage of most at risk populations reached with HIV prevention programmes

Most–at–risk population	Percentage reached by prevention programme
Injecting drug users	42% received information on HIV and AIDS through radio/TV, 24% participated in a seminar on HIV and AIDS
Commercial sex worker	94% got information on HIV and AIDS through radio/TV, 24% were informed by doctors and nurses
Men who have sex with men	88% had seen a poster on AIDS, 40% had participated in any AIDS programme

Source: Study of Knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius and Rodrigues-2004 (IDU, CSW,MSM-Mauritius

As no Behavioural survey has been conducted, additional data input has been obtained from the AIDS unit, M.O.H:

Most –at –risk population	Sessions in year 2006	Up to August 2007	Number of participants
Injecting drug users (outreach)	25	11	540
Detox and Rehab centre	50	52	2040
Prison Inmates	32	33	716
Commercial sex workers	6	4	160
total	**113**	**100**	**3205**

Source: AIDS Unit, M.O.H.

The priority is to reduce the spread of the infection and minimize the harm caused by the risk- taking behaviours. In the fight against HIV/AIDS associated with illicit drug use, an action plan for IDUs was elaborated and a 3-pronged strategic approach was adopted:

- Methadone Substitution therapy: It was started in November 2006 and it forms part of the demand reduction strategy.

-HIV and AIDS legislation: This paves the way to the introduction of the Needle Exchange Programme.

-Needle Exchange Programme: The provision of access to sterile injection equipment for injecting drug users and the encouragement of its use is an essential components of HIV and AIDS prevention programmes

An evaluation of these programmes will allow us to measure success, identify weaknesses and planned the way forward.

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

For data to qualify for this indicator, it needs to be from a representative survey. Till date no survey concerning vulnerable children has been carried out by the Ministry of Social Security.

There is a universal scheme for all orphans. As they are all registered, therefore 100% of orphans benefited from available services, including those who have lost their parents due to HIV/AIDS. They are not being discriminated against, thus benefiting from the same services.

The number of beneficiaries of Basic Orphan's Pension (BOP) decreased from 651 in June 2001 to 434 in June 2006. However, expenditure on BOP and Guardian's allowance rose from Rs 13 million in 2000/2001 to Rs 14 million in 2005/2006.[17]

In June 2006, 17,159 families benefited from Social Aid compared to 14,242 in June 2001, showing an increase of 20%. The amount paid increased from RS 204 million in 2000/2001 to Rs 349 million in 2005/2006.

Lately there has been an increase in the number of street children and vulnerable children, that is those with both parents being IDUs. According to Saphire – an NGO involved with street children- there are about 2,000 of these vulnerable children. The Ministry of Social Security is helping this NGO to provide care and support but it is evident that strategic interventions are of utmost importance so as to protect the future generation.

Other services available are:

- Mandatory education at primary level. Any child should be in an educational or vocational centre up to the age of 16.
- Education is free at primary and secondary level
- Transport to educational institutions is provided free to all students.
- Government is also investing in low cost housing as part of economic and social development

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

[17] Social Security Statistics 2000/2001 -2005/2006

Interview with key informant from the Ministry of Education and Human Resources highlight the fact that actually there are sessions on Family Life Education, Sexual and Reproductive Health, Non-Communicable Diseases and communicable diseases being carried out in the secondary institutions by The Ministry of Health Units, and various NGO's, but it is either at the initiative of the resource persons or from the institutions. In some private institution they do have a comprehensive life-skills based programme.

But 30 hours of life skills-based HIV education for all grade in the public sector is difficult to ascertain, thus the percentage of schools that provided life skills-based HIV Education in the last academic year cannot be measured.

The Ministry of Education and Human Resources is working on a School Health Project with an important component on sexual and reproductive health. The main barrier identified has been parental misconceptions about sexual education in school[18].

[18] Sida et Development dans les pays iles Africain dans l'ouest de L'ocean indien (Draft)

KNOWLEDGE AND BEHAVIOUR INDICATORS

12. Current school attendance among orphans and non-orphans aged 10-14

For data to qualify for this indicator, it needs to be from a population –based survey or a representative survey**.** Though none has been carried out, there are nevertheless certain policies to ensure that these children have the same opportunity as other children.

Services available are:

- Financial aid
- Education is free at primary and secondary level
- Transport to educational institutions is provided free to all students.
- Assistance with school books
- Assistance for examination fees
- Free distribution of school kit in needy area of the island.

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 misconceptions about HIV transmission

Table: Percentage of young women and men aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject misconceptions about HIV transmission

Question	Numerator: Number of respondents aged 15-24 who gave the correct answer	Denominator: Number of all respondents aged 15-24 who gave answers, including "don't know"	Percentage of young women and men aged 15-24 who gave the correct answer
1. Can people protect themselves from HIV by having one uninfected faithful sex partner	513	681	**75.3%%**
2. Can people protect themselves from HIV by using condom correctly every time they have sex?	492	681	**72.2%**
3. Do you think that a healthy-looking person can be infected with HIV, the virus that causes AIDS?	471	681	**69.2%**

4. Can people get the HIV virus from mosquito bite?	386	681	**56.7%**
5. Can people get HIV by sharing a meal with someone who is infected	467	681	**68.6%**
Final: All questions answered correctly **Age group: 15 -19yrs 20-24yrs** **Male : 31 31** **Female : 39 48**	149	681	**21.9%**

Source: Study of Knowledge,Attitudes.Beliefs and Behaviour related to STD's/ HIV/AIDS in Mauritius 2004 (community based)

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

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

MOST-AT-RISK POPULATION and question	Numerator: Number of respondents who gave the correct answer	Denominator: Number of respondents who gave answers, including "don't know"	Percentage of respondents who gave the correct answer
COMMERCIAL SEX WORKERS			
1. Can people protect themselves form HIV by having one uninfected faithful sex partner?	23	50	**46%**
2. Can people protect themselves from the HIV virus that causes AIDS by using a condom correctly every time they have sex?	42	50	**84%**
3. Do you think that a healthy looking person can be infected with HIV?	11	50	**22%**
4. Can a person get HIV from mosquito bites?	20	50	**40%**
5. Can a person get the HIV by sharing a meal with someone who is infected?	32	50	**64%**

Final: All questions answered correctly **>25 – 1** **+25 – 0** **(only female CSW)**	1	50	**2%**
MEN WHO HAVE SEX WITH MEN			
1. Can people protect themselves form HIV by having one uninfected faithful sex partner?	46	50	**92%**
2. Can people protect themselves from the HIV virus that causes AIDS by using a condom correctly every time they have sex?	46	50	**92%**
3. Do you think that a healthy looking person can be infected with HIV?	37	50	**74%**
4. Can a person get HIV from mosquito bites?	33	50	**66%**
5. Can a person get the HIV by sharing a meal with someone who is infected?	42	50	**84%**
Final: All questions answered correctly **>25 – 7** **+25 - 17**	24	50	**48%**
INJECTING DRUG USERS			
1. Can people protect themselves from HIV by having one uninfected faithful sex partner?	39	50	**78%**
2. Can people protect themselves from the HIV virus that causes AIDS by using a condom correctly every time they have sex?	45	50	**90%**
3. Do you think that a healthy looking person can be infected with HIV?	41	50	**82%**

4. Can a person get HIV from mosquito bites?	40	50	**80%**
5. Can a person get the HIV by sharing a meal with someone who is infected?	45	50	**90%**
Final: All questions answered correctly **Age group: >25 +25** **Male : 4 20** **Female : 3 4**	31	50	**62%**

Source: Study of Knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius 2004 (IDU, CSW,MSM-Mauritius)

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

Table: Percentage of young women and men aged 15-24 who report the age at which they first had sexual intercourse as under 15 years

Sex and age	Numerator: Number of respondents who report the age at which they first had sexual intercourse as under 15 years	Denominator: Number of all respondents	Percentage of respondents who report the age at which they first had sexual intercourse as under 15 years
Female		341	
Male		340	
15-19	6(male); 2 (female) = 8	374	2.1%
20-24	5 (male); 1 (female) =6	307	1.9%
Total: 15-24	11 + 3 = 14	681	2.1%

Source: Study of Knowledge,Attitudes.Beliefs and Behaviour related to STD's/ HIV/AIDS in Mauritius -2004 (community based)

It is interesting to note that in Rodrigues the situation is quite different with 14.1% young men who have had sex before the age of 15 and 12.2% young women for same[19].

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

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

Sex and age	Numerator: Number of respondents who have had sexual intercourse with more than one partner in the last 12 months	Number of all respondents	Percentage of respondents who have had sexual intercourse with more than one partner in the last 12 months
Female	13	1002	1.3%
Male	91	998	9.1%
15-19	12 (male); 2 (female) =14	374	3.7%
20-24	14 (male); 0 (female) =14	307	4.6%
25-49	65 (male); 11(female) =76	1319	5.8%
Total: 15-49	91 +13 =104	2,000	5.2%

Source: Study of knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius -2004 (community based study-Mauritius)

[19] Youth Health Risk Behaviour in Rodrigues – July 2006-Mauritius Institute of Health.

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

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

Sex and age	Numerator: Number of respondents who reported having more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex	Denominator: Number of all respondents who reported having had more than one sexual partner in the last 12 months	Percentage of respondents who reported having more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex
Female	6	13	46.2%
Male	40	91	44%
15-19	6(male) +1 (female) =7	12 (male) + 2 (female) =14	50%
20-24	6 (male) + 0 (female) =6	14 (male) + 0 (female) = 14	42.9%
25-49	28(male) + 5 (female) = 33	65 (male)+ 11(female) =76	43.4%
Total: 15-49	40 +6 = 46	91 +13 =104	44.2%

Source: Study of Knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius -2004 (community based)

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

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

Sex and age	Numerator: Number of respondents who reported that a condom was used with their last client	Denominator:Number of all respondents who reported having commercial sex in the last 12 months	Percentage of respondents who reported that a condom was used with their most recent client
Female			
<25	**28**	**28**	**100%**
25+	**22**	**22**	**100%**
Total: All ages	**50**	**50**	**100%**

Source: Study of Knowledge, Attitudes. Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius 2004 (IDU, CSW, MSM-Mauritius)

Data are available only for female sex workers. The KABB demonstrate a 100% use of condom in this most-at-risk group but in reality it is difficult for majority of sex workers to use condoms consistently with all the clients. There are several situations in which the condom is not used. Injecting drug users despite knowledge about unprotected sex, yielded to clients demanding sex without condom as they were desperate for money. At times as they were intoxicated, their condom negotiation was difficult with clients.

In contrast the Rapid Situation Assessment Study, 2004, seems to reflect more or less what really happen in reality with nearly a half (47%) of the CSW reported that they "often" or "always" used condoms with clients; about one in four (22%) reported that they "rarely" or "never" used them. CSW reported that they were particularly less likely to use condoms when clients refused it (44%) or when they would be paid more money for having unprotected sex (25%). Furthermore, three quarters of CSW who also had a regular sex partner (77%) reported that they never used condoms with this partner.[20]

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

[20] Rapid Situation Assessment 2004

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

TYPE OF SEX and age	Numerator: Number of respondents who reported that a condom was used the last time they had anal sex	Denominator:Number of all respondents who reported having had anal sex with a male partner in the last six months	Percentage of respondents who reported that a condom was used the last time they had anal sex
ANAL SEX			
<25	8	13	61.5%
25+	16	33	48.5%
Total: All ages	24	46	52.2%

Source: Study of knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius -2004 (IDU,CSW,MSM-Mauritius)

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

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

TYPE OF PARTNER, sex, and age	Numerator: Number of respondents who reported that a condom was used the last time they had sex	Denominator:Number respondents who report having had sexual intercourse in the last month	Percentage of respondents who reported that a condom was used the last time they had sex
SEX WITH REGULAR PARTNERS			
Male	6	39	15.4%
Female	0	6	
<25	0	10	
25+	6	35	17.1%
Total: All ages	6	45	13.3%

Source: Study of knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius -2004 (IDU,CSW,MSM-Mauritius)

For many drug users involved in the regular use and /or injecting of opiates, the health risk associated with sexual behaviour were often viewed as less important than the health risks associated with drug use.

Sexual activity varies in different phases of drug use

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

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

Sex and age	Numerator: Number of respondents who report using sterile injecting equipment the last time they injected drugs	Denominator:Number of all respondents who report injecting drugs in the last month	Percentage of respondents who report using sterile injecting equipment the last time they injected drugs
Female	3	9	33.3 %
Male	13	41	31.7 %
<25	2	11	18.2%
25+	14	39	35.9%
Total: All ages	16	50	32%

Source: Source: Study of knowledge,Attitudes.Beliefs and Behaviour related to STD's/HIV/AIDS in Mauritius -2004 (IDU,CSW,MSM-Mauritius)

This reflects the situation among the IDUs when taking the percentage of Hepatitis C among them (95%) though the sample size in this study is too small to carry a comprehensive analysis of the situation.

Since 2006 the Government has put into place various strategies to limit HIV transmission .among the IDUs and a new evaluation survey will help to evaluate the measures taken and show the way forward.

22. Percentage of young people aged 15 -24 who are infected

Table: Percentage of ANC attendees aged 15-24 tested whose HIV results are positive: Jan.-Dec. 2006

Age	Numerator: Number of	Denominator: Number	Percentage of ANC

	ANC attendees aged 15-24 tested whose HIV results are positive	of ANC attendees aged 15-24 tested for their HIV infection status	attendees aged 15-24 tested whose HIV results are positive
15-19	7	1,661	**0.42%**
20-24	15	4,577	**0.33%**
Total: 15-24	22	6,238	**0.35%**

Source: **National Reference Laboratory**

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

Table: Percentage of Most-at-risk population who are HIV infected

MARP	Numerator:Number of members of the MARP who test positive for HIV	Denominator:Number of MARP tested for HIV	Percentage of MARP who are HIV infected
IDUs & CSWs	165	830	19.9%
PIs	254	3412	7.4%
Total	**419**	**4242**	**9.9%**

Source: HIV Sentinel Surveillance

A seroprevalence sentinel surveillance system within these categories is important to keep tract of the epidemic and also to evaluate the prevention strategies

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

Table: Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy (yr 2006)

Sex and age	Numerator:Number of adults and children who are still alive and on ART at 12 months after initiating treatment	Denominator:Total number of adults and children who initiated ART during the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up	Percentage of adults and children who are still alive and on ART at 12 months after initiating treatment
<15	0		
Female 15+	18	20	**90%**
Male 15+	81	97	**83.5%**
Total: All ages	99	117	**84.6%**

Source: National Day Care Centre for the Immuno-suppressed, Cassis

VI. BEST PRACTICE

In Mauritius the project identified by SADC as a best practice is the **Methadone Substitution Therapy Programme**. Although the programme has recently begun a few conclusive results are available and in September 2007 SAFAIDS has been commissioned to conduct the documentation.

The aim of the Methadone Substitution Therapy in Mauritius is to primarily treat drug abusers through an oral form of opiate (methadone) and prevent the transmission of HIV infection. Mauritius launched its MST (Methadone Substitution Programme) in an "emergency" response fashion thus adopting a programme that suits its specific environmental context.

An overview of the founding steps towards the programme included the following events:

- In 2001 the first glimmerings of the MST concept began to take form. A handful of clinicians working with IDUs and mindful of the looming hazard IDU had on the HIV epidemic on the country, together with PLWHA, embarked on a mass media activities targeting the general population and lobbying efforts targeting country's political leaders. This advocacy stance was based on extensive research and experiences gained by experts in the country.
- In 2004 outcomes from a Rapid Assessment Report of Substance Abuse in Mauritius further reinforced the need to urgently tackle the IDU problem in the country, using an effective intervention, such as methadone or buprenorphine therapy.
- In 2005 the UNODC held deliberations with the government of Mauritius to prompt the operationalisation of the MST programme.
- Findings and recommendations from the above assessment, coupled with the advocacy efforts, secured the necessary political backing to establish and embark on the MST programme in Mauritius, through Cabinet approval in February 2006.
- The Ministry of Health and Quality of Life then proceeded to consult a series of international experts, and received extensive technical guidance, as a prelude to the MST programme establishment.

- In 2006 an external assessment of the organizations and centres working in the field of drug abuse treatment, as well as general health facilities was conducted to ascertain capacity gaps and strengths upon which the programme would be based.

- Consultative meeting were held and induction session with personnel from the National Agency for Treatment and Rehabilitation of Substance Abusers (NATReSA), the pharmaceutical services, the AIDS Unit and other relevant departments in the MOH&QL.

- Experts training were hosted in 2006 for over 80 medical and para-medical personnel, including physicians, nurses, psychologist, pharmacists and dispensers, staff of the AIDS Unit as well as rehabilitation officers.

- A sound procurement and dispensing system was established.

- The establishment of policy framework and guidelines for the introduction of an efficient and cost-effective MST programme for opiate abusers in the country was guided by various regional and international documents and standards

- The National Detoxification Centre, Barkly, was identified as the centre for client induction into the programme.

A first draft of the best practice report has just been submitted for Peer Review. Following inputs and comments from the Peer Review Team, the consultants will finalise the report and transmit it to SADC for validation as one of the best practices for the region.

To date there are 400 male clients on Methadone with 24 drop-outs. It is costly and difficult to target the entire IDU population and the need to scale up is of utmost importance because with the actual rate of enrolling clients, it might take too long to achieve any improvement, thus defeating the purpose of detoxification.

The Ministry has announced the extension of the Barkly Centre and the inclusion of female clients in the programme and also the necessity of scaling-up the programme as the waiting list is long. An evaluation of the actual programme has been scheduled.

VII. MAJOR CHALLENGES 2005 AND REMEDIAL ACTIONS

KEY CHALLENGES REPORTED IN 2005 UNGASS COUNTRY PROGRESS REPORT	PROPOSED REMEDIAL ACTION IN 2005	PROGRESS ACHIEVED 2006 - 2007
1. The need for strong leadership and political will	Advocacy for a national multisectoral response. To put HIV and AIDS high on the government agenda	The "Three Ones" principle guided the Ministry of Health and the stakeholders in the development of the 2007-2011 National Multisectoral HIV and AIDS Strategic Framework. The National AIDS Committee met on the 27th April 2006 under the chairmanship of the Prime Minister and decisions taken lead to an expanded National response
2. Inadequate multisectoral and coordinated response	To establish a cohesive national response	Systematic participatory process with all the stakeholders in matters concerning HIV and AIDS. The setting-up of National AIDS Secretariat Role and responsibility of stakeholders are clearly defined in the NSF 2007-2011.
3. Stigma and Discrimination	Reinforce strategies to mitigate the impact of stigma and discrimination	Continuous information and education of the community, health professionals, teachers. training of peer educators, workplace awareness HIV and AIDS ACT 2006, the promulgation of which ensures full enjoyment of Human Rights but its enforcement remain a continuous challenge
4. Inadequate participation and commitment of some stakeholders in the National AIDS Programme	Advocate for increased commitment and action of some stakeholders including media and religious leaders	Elaboration and implementation of the Council of Religions HIV and AIDS project in 2006. Development of a National HIV and AIDS Media Communication Plan has been initiated with completion of phase 1.
5. Inadequate sexual and	Mainstream sexual and reproductive health	The AIDS Unit, M.O.H & QL and NGO's such as Action Familiale,

reproductive health education in schools. Life skills based education need to address the HIV and AIDS issue more directly	education in school curriculum. Life skills based education should be harmonized and inserted in the school curriculum.	EVA(Education a la vie et a l'Amour), MFPWA do carry session of Family Life Education regularly but still having difficulty to put into place a comprehensive life skills-based project The Ministry of Education and Human Resources is working on a School Health Project with an important component on sexual and reproductive health.
6. Lack of clear and coordinated process for monitoring and evaluation	Setting up of an M&E unit	A monitoring and evaluation unit has been set up at the National AIDS Secretariat in line with the "Three Ones" principles as recommended by UNAIDS.
7. Recognition and appreciation of the need for more effective strategies among high risk groups that meet the special circumstances prevailing in the groups	Design effective strategies for high risk groups Providing for treatment and rehabilitation of drug users.	National Multisectoral HIV and AIDS Strategic Plan 2007-2011 Methadone Substitution Therapy was started in Nov, 2006. HIV/AIDS legislation paving the way to the introduction of NEP Launching of the NEP in November 2006

Source: UNGASS Report 2005

a) Challenges faced during the 2006-2007 reporting

Knowing our epidemic is very important in terms of strategic planning, advocacy and resource mobilization regarding priority needs in view of harmonizing national response. The following challenges have been identified:

1. The UNGASS report preparation has been a major eye-opener in highlighting data needs for an efficient monitoring and evaluation system.
2. Baseline data from Sero-prevalence survey and updated Behavioural Surveillance Survey are not available.
3. The nascent M&E unit has limited Human and logistic resources. The Monitoring and Evaluation (M&E) exercise is still difficult as data on HIV and AIDS is still not centralized
4. Although numbers of tests are significant yet only positive results are conveyed.

5. Low uptake of People living with the virus including pregnant women for testing, counseling and consequently for ARV treatment
6. Poor compliance for PMTCT essentially among MARPs
7. Outreach activities including the needle exchange programmes towards MARPs not yet optimal.
8. Although much is being done regarding sensitization on HIV and related issues by various stakeholders at the level of schools, yet life skills-based education remains piecemeal and is not yet standardized
9. No baseline data is available for vulnerable children which needs further precise definition in the Mauritian context
10. Transferring knowledge towards safer behaviour among youth and MARPs
11. High cost and lack of sufficient human resource for the scaling up of the Methadone Substitution Therapy programme for IDUs
12. Persistent stigmatization and discrimination towards PLWHA leading, among others, to low representativeness in decision-making bodies
13. Low private sector involvement including the medical sector in the fight against HIV and AIDS
14. Non-optimal follow-up of PLWHA on ARV due to lack of viral load monitoring
15. Poor coordination and monitoring of the epidemic in Rodrigues

b) Remedial actions

- In Mauritius, poverty baseline has not yet been established, therefore assistance is needed to carry a PRSP so as to determined area of intervention and the mainstreaming of HIV/AIDS into poverty alleviation strategies and social development program.

- International and national technical assistance for capacity building of the M&E unit leading to reinforcement of national research and development capacity.
- The setting up of an intranet system between the M&E Unit of the NAS, the AIDS Unit, the NDCCI, the Prison AIDS Unit and the Virology Laboratory
- The reviewing of the practicalities of blood testing and result announcement at all health points to ensure that counseling is provided to HIV negative persons also.

- The re-engineering of the outreach strategies for an holistic approach through formal training of dedicated outreach workers to reach out to more PLWHA including HIV positive pregnant women
- Multisectoral round table and consultancies on the design, planning of a comprehensive and standardized life skills-based education to be implemented by dedicated fully trained teachers covering all school grades in order to empower our young people towards adoption of safer behaviours .
- The extension of a life skills-based education to out of school youth through an effective networking
- Liaison with line Ministries to facilitate retrieval of baseline data for vulnerable children
- Support for strengthening strategies for substance abuse prevention and reduction and scaling up of Methadone Substitution Therapy and Needle Exchange Programmes.
- Ongoing sensitisation at all levels including the general public to decrease stigma and discrimination
- Advocacy towards the private sector for greater involvement
- Provision of logistic support for the follow-up of patients on ARV
- Improvement of the set-up of the present NDCCI for an effective Day Care and the setting up of an additional Day Care in another region for easier access to treatment, care, support
- The setting up of a Rodrigues AIDS Unit for a comprehensive response to the HIV and AIDS epidemic

VIII. SUPPORT FROM THE COUNTRY'S DEVELOPMENT PARTNERS

Considering the new magnitude of the HIV epidemic in Mauritius as well as the evolving situation in Rodrigues, technical and financial assistance from the UN agencies (WHO, UNAIDS, UNDP, UNFPA, UNODC, WB), from other international and regional bodies such as the French Cooperation, the African Development Bank, the SADC have been sought with regards to technical oversight in the planning of surveys and funding of prevention, treatment, care and support strategies.

To achieve MDG 6 such assistance remains vital to reverse this upward evolving trend in the Republic of Mauritius. Getting a more precise picture of our epidemic through prescribed surveys and setting up of appropriate surveillance systems is a major stepping-stone towards a comprehensive national response. A fully operational NAS is essential to ensure this goal.

Following funding from World Bank, The Government of Mauritius has invited expressions of interest for consultancy services to clarify the role of National AIDS Secretariat in the following areas:

- Institutional coordination
- Monitoring and evaluation
- Policy environment
- Resource mobilization and
- Capacity building.

As from 2008, Mauritius, through the signature of a Memorandum of Understanding with the Clinton Foundation, will be benefiting from lower prices of ARVs and drugs for opportunistic infections.

Global Fund Round 8: Mauritius being an upper middle income country has not been eligible (except for the first call) for funding under the Global Fund so far. With its concentrated epidemic in a small island developing state, Mauritius will be sending its proposal for the 8th call. Technical assistance will be required to ensure that it does not miss this funding opportunity.

IX. MONITORING AND EVALUATION ENVIRONMENT

To effectively fulfill its mandate to coordinate the National responses, the National AIDS Secretariat needs to understand the scope and effect of HIV and AIDS interventions. In order to do this a functional and effective M&E system needs to be in place.

In May 2006 a National Monitoring and Evaluation Plan was developed. The terms of reference for this M&E Unit is clearly laid down in the NSF 2007-2011.

This process was supported through international consultancy from UNAIDS. Following stakeholder consultations a draft plan was shared and a review workshop was held to identify core country indicators. This plan constitutes the core element of the National M&E System and the M&E unit is centralized within the new institutional arrangement of the National AIDS Secretariat under the Prime Minister's office.

Reinforcement regarding human resource, infrastructure and logistic support together with capacity building for the M&E Unit is essential. Capacity building at the level of stakeholders in M&E is also very important to ensure quality data input.

Annex 2

Consultation/preparation process for the Country Progress Report on monitoring the follow-up to the Declaration of Commitment on HIV/AIDS

1) Which institutions/entities were responsible for filling out the indicator forms?

		Yes	No
a)	NAS	Yes ✓	No

2) With inputs from

		Yes	No
Ministries:	Education	Yes ✓	No
	Health	Yes ✓	No
	Labour	Yes ✓	No
	Foreign Affairs	Yes	No ✓
	Social Security	Yes ✓	No
	Youth and Sports	Yes ✓	No
	Women & Child Development	Yes ✓	No
	Human Rights	Yes ✓	No
Civil society organisations		Yes ✓	No
People living with HIV		Yes ✓	No
Private Sector		Yes ✓	No
United Nations Organisations		Yes ✓	No
Bilaterals		Yes	No ✓
International NGOs		Yes	No ✓
Others (please specify)		Yes ✓	No
	Council of Religions	Yes ✓	No

		Yes	No
3)	Was the report discussed in a large forum?	Yes ✓	No
4)	Are the survey results stored centrally?	Yes	No ✓
5)	Are data available for public consultation?	Yes ✓	No

6) Who is the person responsible for submission of the report and for the follow-up if there are questions on the Country Progress Report?

Name / Title: Dr (Mrs) Amita PATHACK, National AIDS Coordinator
Date: 14 January 2008
Please provide full contact information:
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Annex 3

National Funding Matrix – 2007

Cover Sheet

Country: Republic of Mauritius
Contact Person at the National AIDS Secretariat:
Name: Dr (Mrs) Amita Pathack **Title**: National AIDS Coordinator

Contact Information for the National AIDS Secretariat:
Address: 4th Floor, Cerné House, Chaussée Street, Port Louis, Mauritius
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Telephone: 213 5328
Fax: 213 5332

Reporting Cycle: 2006 calendar year ……. or fiscal year ✓
For a fiscal year reporting cycle, please provide the start and end month/year:
July 2006 to June 2007

Local Currency: Mauritian Rupees

Average exchange rate with US dollars during the reporting cycle: Rs 31

Methodology:

1) From Budget
Ministry of Health and Quality of Life – Senior Finance Officer, Finance Section
2) Central Statistics Office Report on Ministry of Social Security, National Solidarity and Senior Citizens Welfare & Reform Institutions
3) World Health Officer – Programme Officer
4) UNFPA Country Activities from Desk Officers:
    a. Mr J. Sungkur, Ministry of Health and Quality of Life
    b. Mr P. Apavoo, Ministry of Youth and Sports
    c. Mr. Valymamode, Rodrigues Regional Assembly
    d. Mr Appadoo, Ministry of Women's Rights, Child Development, FW & CP

Budget Support: Is budget support from an international source (e.g a bilateral donor) included under the Central/National and/or Subnational sub-categories under Public Sources of financing?
Yes --
No -✓

	2006 / 2007		2007 / 2008	
	USD	**RS.**	**USD**	**RS.**
Primary Health Care and Health Promotion	**$18,400,451**	**570413970**	**$22,663,924**	**702581650**
Hospital Services	**$98,058,098**	**3039801030**	**$120,967,431**	**3749990350**
Total Health Budget	**$116,458,548**	**3,610,215,000**	**$143,631,355**	**4,452,572,000**

	AIDS Spending Categories		TOTAL	Government	UN Agencies
1	**Prevention**	**$505,818**	**15,680,343**	8689463	6990880
2	**Care and Treatment**	**$303,990**	**9,423,686**	4096367	5327319
3	**Orphans & Vulnerable Children**	**$456,452**	**14,150,000**	14150000	
4	**Program Management and Administration Strengthening**	**$197,945**	**6,136,280**	5379305	756975
5	**Incentives for Human Resources**	**$26,546**	**822,917**	301807	521110
6	**Social Protection and Social Services excluding Orphans and Vulnerable Children**				
7	**Enabling Environment & Community Development**	**$9,790**	**303,480**	270000	33480
8	**Research excluding operations research**	**$806**	**25,000**		25000
	TOTAL	**$1,501,345**	**46,541,706**	**32,886,942**	**13,654,764**

National Funding Matrix
AIDS Spending Categories by Financing Sources

Period : July 2006 / June 2007
Average Exchange Rate for the Year: 1 USD = Rs 31

	AIDS Spending Categories	Financing Sources		
		TOTAL	Government	UN Agencies
	TOTAL (Local Currency - *Mauritian Rupees***)**	**46,541,706**	32886942	13654764
1	**Prevention (*sub-total*)**	**15680343**	**8689463**	**6990880**
1.1	Mass media	**255742**		255742
1.2	Community mobilization	**840815**	382108	458707
1.3	Voluntary counselling & testing	**1409303**	1293060	116243
1.4	Programs for vulnerable and special populations	**118255**	66275	51980
1.5	Youth in school	**358435**	4500	353935
1.6	Youth out of school	**1385152**	1200000	185152
1.8	Programs for sex workers & their clients	**1874641**	1782850	91791
1.9	Programs for MSM	**785126**	700000	85126
1.10	Harm reduction programs for IDUs	**2497792**	2444100	53692
1.11	Workplace activities	**413645**	116570	297075
1.12	Condom social marketing			
1.17	Prevention of mother to child transmission	**700000**	700000	
1.22	Universal precautions	**625549**		625549
1.99	Unaids and UNDP	**4415888**		4415888
2	**Care and Treatment (*sub-total*)**	**9423686**	**4096367**	**5327319**
2.4	Antiretroviral therapy	**9423686**	4096367	5327319
3	**Orphans & Vulnerable Children (*sub-total*)**	**14150000**	**14150000**	
3.9	Beneficiaries of basic orphan's pension	**14150000**	14150000	
4	**Program Management and Administration Strengthening (*sub-total*)**	**6136280**	**5379305**	**756975**
4.1	Program Management	**5700691**	5379305	321386
4.3	Monitoring & evaluation	**392646**		392646
4.8	Information technology	**42943**		42943
5	**Incentives for Human Resources (*sub-total*)**	**822917**	**301807**	**521110**
5.5	Training	**822917**	301807	521110
6	**Social Protection and Social Services excluding Orphans and Vulnerable Children (sub-total)**			
7	**Enabling Environment & Community Development (*sub-total*)**	**303480**	**270000**	**33480**
7.4	AIDS-specific programs involving women	**303480**	270000	33480
8	**Research excluding operations research which is included under (sub-total)**	**25000**		25000
8.5	Behavioural research	**25000**		25000

UN Agencies - ***WHO*** (Rs 7,751,147) ***UNFPA*** (Rs 1,487,729) ***UNAIDS & UNDP*** (Rs 4, 415,888)