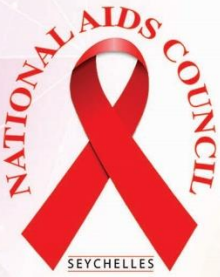

HIV & AIDS

2019 – 2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis

SEYCHELLES

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2019-2023

National Strategic Plan for HIV, AIDS and Viral Hepatitis

SEYCHELLES

FOREWORD BY THE PRESIDENT

The 2019-2023 National Strategic Plan for HIV, AIDS and Hepatitis is the culmination of many months of preparation by the National AIDS Council working in close collaboration with UNAIDS, other Ministry of Health departments, and local stakeholders from many different sectors. This collaborative approach emphasises the growing awareness among all partners that the challenges of HIV and AIDS can only be successfully addressed by working together. This dedication and commitment were amply demonstrated during the workshop to finalise the Plan and forum to develop the operational plan. Participation by communities and individuals from all sectors and representing a wide range of organisations will help to ensure a truly national action.

The 2019-2023 National Strategic Plan for HIV, AIDS and Hepatitis addresses the realities of Seychelles and the evolving epidemic of HIV, AIDS, other sexually transmitted infections, hepatitis and tuberculosis. The epidemic itself, and its evolving nature, reflect the pattern of behaviour in our society. The complexities of our sexuality, our relationships, our culture, beliefs and attitudes influence the transmission of the HIV and other infections. They also affect our reactions to infection and illness and whether and how we support each other, or stigmatise and discriminate members of our own communities and families. The Strategic Plan is therefore about us, and for us, as a community, as a people and as a nation. In taking into account our realities and specificities and addressing our vulnerable and key populations, our men and women, and our boys and girls, we can better devise the right approaches to tackling the epidemic and its impact.

The Strategic Plan and its Monitoring and Evaluation Framework, which will guide our interventions over the next five years, are expressions of our pledge as a nation and determination to face HIV, AIDS and Viral Hepatitis, not only as medical and health problems, but also to address them as cultural, social and economic issues, affecting all communities of our society and every Seychellois family. Let us now, and in the years ahead, join our efforts and let us ensure that the Plan is translated into concrete, focussed and sustained action to protect our people and care for those infected with or affected by HIV, AIDS and Viral Hepatitis.

Danny Faure
President of the Republic of Seychelles
April 2019

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The National AIDS Council wishes to thank everyone who has been instrumental in bringing to completion the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis, together with its related Monitoring and Evaluation Framework. Your contribution has been most appreciated and has been essential to the success of the project.

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Ministry of Health (MOH)
- Office of the Minister
- Principal Secretary's Secretariat; including Local Consultant Dr Agnes Chetty and Health Promotion Unit
- National AIDS Council Board and Secretariat
- Health Care Agency, especially Directorates of Community Health Services, Family Health and Nutrition, and Hospital Services; Pharmacy Section; Clinical Laboratory; Mental Health Unit; and Youth Health Centre
- Public Health Authority, in particular: AIDS Control Programme; Communicable Disease Control Unit; Disease Surveillance and Response Unit; Public Health Laboratory; Occupational Health Unit and Public Health Section
- Social and Behaviour Change Communication Committee
- Technical Advisory Committee for HIV, AIDS and STIs
- HIV and AIDS Prevention Task Force

Other Government Ministries, Departments and Agencies
- President's Office: Legal Affairs Department, Office of the Attorney General
- Vice-President's Office: Foreign Affairs Department; Seychelles Broadcasting Corporation
- Designated Minister's Office, Departments of Local Government and Home Affairs (Prison Division, Police Division); Youth, Sports and Culture; Risk and Disaster Management
- Ministry of Education and Human Resource Development: Education Department
- Ministry of Employment, Immigration and Civil Status: Employment Department
- Ministry of Family Affairs, including National Council for the Disabled
- Ministry of Finance, Trade, Investment and Economic Planning
- Office of the Ombudsman
- Agency for the Prevention of Drug Abuse and Rehabilitation

Civil Society Organisations
- Alliance of the Solidarity For the Family and its Youth Action Movement
- Citizens' Engagement Platform
- Drug Utilisation Response Network Seychelles
- Everlasting Love Ministry
- Health Professional Associations
- HIV and AIDS Support Organisation
- Lesbian, Gay, Bisexual, Transgender, Intersex, and Allies, Seychelles
- Seychelles Inter-Faith Council
- Seychelles Media Association
- Seychelles Paster Lannwit
- Youth Alive

Private Sector
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We are thankful to all persons, from their respective organisations, or in their own capacity, who provided sound advice and counsel in the process of finding the best strategy for the 2019-2023 national response to HIV, AIDS and Viral Hepatitis in Seychelles.

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
APDAR	Agency for the Prevention of Drug Abuse and Rehabilitation
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral (drugs)
BCC	Behaviour Change Communication
BSS	Behavioural Surveillance Survey
CD4	Cluster Differentiation 4
CSO	Civil Society Organisation
DALYs	Disability Adjusted Life Years
DURNS	Drug Users' Rehabilitation Network (Seychelles)
EMTCT	Elimination Mother-to-child Transmission of HIV
FBO	Faith-Based Organisation
FP	Family Planning
FSW	Female Sex Workers
GAM	Global AIDS Monitoring
GARPR	Global AIDS Response Progress Report
GBV	Gender-Based Violence
HAART	Highly Active Antiretroviral Therapy
HASO	HIV and AIDS Support Organisation
HBV	Hepatitis B Virus
HCA	Health Care Agency
HCV	Hepatitis C Virus
HF	Health Facility
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HTC	HIV Testing and Counselling
IBBS	Integrated Biological Behavioural Survey
ICTC	Integrated Counselling and Testing Centre
IDU	Injecting Drug Users/Intravenous Drug Users
IEC	Information, Education, Communication
KP	Key Population
LEA	Legal Environment Assessment
MC	Male Circumcision
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MoH	Ministry of Health
MSM	Men who have Sex with Men

MSW	Male Sex Workers
NAC	National AIDS Council
NGO	Non-Government Organization
NSEP	Needle and Syringe Exchange Programme
NSP	National Strategic Plan
OI	Opportunistic Infection
OST	Opiate Substitution Therapy
PCR	Polymerase Chain Reaction test
PEP	Post-Exposure Prophylaxis
PHA	Public Health Authority
PICT	Provider-Initiated Counselling and Testing
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PrEP	Pre-Exposure Prophylaxis
PWID	People Who Inject Drugs
QI	Quality Improvement
SBCC	Social and Behaviour Change Communication
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
STI	Sexual Transmitted Infection
TWG	Technical Working Group
TB	Tuberculosis
UNAIDS	Joint United Nations Program on AIDS
UNGASS	United Nations General Assembly Special Session on HIV and AIDS
UN	United Nations
WHO	World Health Organization

SECTION ONE: INTRODUCTION AND BACKGROUND

1.1. Introduction

The Seychelles is a small island state with a population of 95,000 inhabitants. Life expectancy at birth is 74.8 years (80.8 years for women and 69.5 years for men)[1]. The right to health is enshrined in the constitution and all health services are available free of charge at the point of delivery in government facilities. Geographic access to health services is good and the population to doctor ratio was 591:1 in 2016[2]. The Seychelles' response to the Acquired Immune Deficiency Syndrome (AIDS) began 30 years ago. The first Human Immunodeficiency Virus (HIV) infection was detected in 1987 while the first case of AIDS was reported in 1993. The government has put in place and incrementally strengthened the national response to HIV through the implementation of the short and medium-term plans and subsequently the 2005 national strategic plan (NSP) was developed. A second strategic plan for the period 2012-2016 was developed which focused on scaling up the HIV response. The 2012-2016 NSP was characterised by implementing programs for HIV prevention amongst Key Populations (KPs), providing access to low-cost high quality antiretroviral (ARV) generic medicines, a phased scale-up of interventions over time, and engagement of diverse stakeholders including civil society and people living or affected with HIV.

The HIV epidemic remains one of the major public health and development challenges in Seychelles. By December 2017, it was reported that 676 people were living with HIV or AIDS in the Seychelles.[3] The country has a concentrated HIV epidemic with high levels of HIV amongst certain key populations at higher risk of HIV exposure including youth aged between 15 and 24 years, people who inject drugs (PWID), men who have sex with men (MSM) and sex workers (SW).

In a study conducted in 2011 among men who have sex with men (MSM), the prevalence was found to be 13.2% in that group and, while data on HIV incidence and prevalence amongst MSM is limited, there is a recent recognition of MSM as a key population with growing HIV incidence. Injecting drug use is recognized as a matter of increasing concern, with more recent information available on HIV amongst people who use drugs. The HIV prevalence among people who inject drugs and SWs is estimated to be about 5.8% and 4.6% respectively. From 2012-2016, 30% (103/343) of newly diagnosed HIV cases were among PWID. Additionally, as the drug problem escalates, the number of cases of Hepatitis C (HCV) diagnosed increased, from less than 20 cases in 2008 to 186 cases in 2017. There are now also more cases of HIV/HCV co-infection. While sex work is suspected to have increased significantly over the recent years, no systematic study has been conducted, before the one of 2015 to estimate HIV

[1] Seychelles in Figures, 2017 edition. National Bureau of Statistics, Seychelles

[2] Seychelles in Figures, 2017 edition. National Bureau of Statistics, Seychelles

[3] Mid-year Epidemiological Report, September 2017

prevalence among this population group.[4] The IBBS done among MSM (2011) and FSW (2015) reported heavy drug use among all Key Populations groups; 51% of MSM and 31% of FSW reported injecting drug use. A large proportion of MSM (67%) reported buying or selling sex[5] whereas, 27% of PWID reported having sex with a commercial sex partner in the month preceding the study.

The National Strategic Plan for HIV and AIDS 2012-2016 drew upon experiences of earlier strategies, built on the Millennium Development Goals (MDGs) and the United Nations General Assembly 2006 and 2011 Political Declarations on AIDS. It set its targets to achieve the following by 2016:

- reduce new HIV infections by 50%;
- reduce AIDS-related deaths by 25%; and
- reduce new infections in children by 90%.

By the end of the NSP period the achievements were:

- new reported cases of HIV were nearly multiplied by 2;
- AIDS incidence were divided by approximately 4.4;
- AIDS Mortality were nearly divided by 3;

In summary the end of term review concluded in September 2017, recommended the following for consideration in the new National Strategic Plan for HIV and AIDS:

- Put in place targeted intervention strategies to match changing dynamics of bridge and key populations;
- Improve yield of detection through strong linkages with other components, roll out newer strategies including community based testing and a targeted approach to HIV counselling and testing (HCT) amongst key populations;
- Strengthen HCT programme management through increased involvement of community health facilities, civil society organisations (CSOs) and ensure timely and adequate supply of rapid test kits;
- Pursue continued efforts towards elimination of mother to child transmission of HIV;
- Effectively implement the commitment to 'Test and Treat' for key populations and PLHIV through expansion of the treatment program to community based health facilities;
- Strengthen the integration of services for programme management and ensure linkages across all programme components for effective individual-level case tracking and retention;
- Focus on institutional strengthening – capacity building and strengthening supervision to reinvigorate the program;
- Focus on expansion of the program through the utilisation of CSO and NGO capacity to provide HIV services into the community;

[4] GovernmentofSeychelles(2012)*GlobalAIDSResponseCountryProgressReport* Available at http://www.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2012countries/ce_SC_Narrative_Report[1].pdf[Accessed23rd March 2018 see also country situation analysis Available at http://www.unaids.org/ctrysa/AFRSYC_en.pdf[Accessed23rd March 2018]

[5] Integrated biological and behavioural surveillance survey among Men who have sex with Men in Seychelles, 2011.

- Revitalise IEC strategies by shifting to interactive formats, harnessing channels for specific audience segments such as key populations and PLHIVs, upgrading the IEC material and making it relevant to the changing context and new programme guidelines; and
- Update all HIV related policies, guidelines and clinical protocols to ensure effective delivery of HIV services across the country.

In addition to the above recommendations, the end of term review also recommended addressing structural drivers of the epidemic that increase the risk or act as barriers for access to services, since much of the attrition along both the prevention and treatment cascade is attributable to structural factors that are amenable to enabling interventions including effective biomedical, behavioural and structural interventions. This is in alignment with the international best practices. "*The fundamental shift that needs to happen in the 2019-2023 NSP is to better contextualise it to people's needs and contexts, optimally use innovation and address the structural drivers of this epidemic (sic.)*".[6]

The overarching health sector vision is 'the attainment, by all people in Seychelles, of the highest level of physical, social, mental **and spiritual health and living in harmony with nature'.** In line with this vision, the health sector has defined its mission as "*to relentlessly promote, protect and restore health and quality of life and dignity of all people in Seychelles with the active participation of all stakeholders, through the creation of an enabling environment for citizens to make informed decisions about their health'*.[7]

The National Health Strategy contains indicators and targets to be achieved by 2020, including the 90-90-90 targets for HIV and AIDS. Other sector ministries indicate their commitment to address HIV in their strategies and programmes. The National AIDS Council has a mandate and commits to coordinating the multi-sector HIV and AIDS response. The commitment by Seychelles to the global Joint United Nations Programme on HIV and AIDS (UNAIDS) Strategy 2016-2021 and the Sustainable Development Goals (SDGs) adopted by the United Nations General Assembly includes a commitment to Fast-Tracking the HIV response towards ending the AIDS epidemic as a public health threat by 2030.

While extensive efforts have been made to create an enabling environment, work still needs to continue in addressing stigma and discrimination; continuing and expanding the implementation of human rights for key populations and PLHIV; decreasing gender inequality and violence against women, young boys and adolescent boys and girls as well as harmful norms of 'masculinity' and 'femininity'; and to change social attitudes and the criminalisation of sex work (SW), men who have sex with men (MSM) and people who use drugs (PWUD).

[6]UNAIDS–Lancet Commission: *Defeating AIDS—Advancing Global Health, 2015, p 197*
[7] Seychelles, National Health Strategic Plan 2016-2020

1.2. Global and Regional Commitments

1.2.1 Global Commitments

1) Lancet Commission

In June 2015, a diverse group of experts in HIV, health, and development from around the globe came together to investigate how the AIDS response could evolve in a new era of sustainable development, summarized in the Lancet Article "*Defeating AIDS—advancing global health"*. The following recommendations were presented:

1. Urgently escalate AIDS efforts, get serious about HIV prevention, and continue expanding access to treatment;
2. Mobilize more resources, spend efficiently, and emphasize sustainability;
3. Demand robust accountability, transparency, and better data;
4. Forge new paths to uphold human rights and address criminalization, stigma and discrimination;
5. Reinforce and renew leadership and engagement of people living with HIV;
6. Invest in research and innovation in all facets of the AIDS response; and
7. Promote more inclusive, coherent, and accountable governance for AIDS and health

2) Sustainable Development Goals

In September 2015, the United Nations General Assembly adopted the Resolution 70/1 *Transforming our World: the 2030 Agenda for Sustainable Development*. Building upon the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs) commit governments across the globe to an Agenda for 2030 to end poverty, to combat inequalities, to protect human rights and gender equality, and to ensure lasting protection of the planet. The SDGs lay the groundwork for a significant increase in the level of ambition for HIV, moving from the MDG targets on halting and reversing the epidemic to ending the epidemic by 2030.

3) UNAIDS: On the Fast-Track to End AIDS

In October 2015, the Joint United Nations Programme on HIV and AIDS (UNAIDS) released its Strategy for 2016–2021 *On the Fast-Track to End AIDS* with an aim to end the AIDS epidemic by 2030 with "**Zero** new infections, **Zero** discrimination and **Zero** AIDS-related deaths".

The UNAIDS Fast-Track Strategy calls upon the AIDS movement, led by people living with and affected by HIV, to offer a model for a people-centred, rights-based approach to global health and social transformation. The strategy issues a call to front-load investments to close the testing gap and reach the 90–90–90 treatment targets to protect health for all. Seychelles is committed to the 90-90-90 targets:

- 90% of people living with HIV know their status;
- 90% of people living with HIV who know their status receive treatment; and
- 90% of people living with HIV on treatment have suppressed viral loads.

Furthermore, Seychelles has committed to:

- 90% of priority populations including sex workers, men who have sex with men, people who inject drugs and prisoners have access to HIV combination prevention services; and
- 90% of people living with HIV, at risk of and affected by HIV report no discrimination, especially in health, education and workplace settings

UNAIDS, in its effort to turn the tide of HIV, identified 10 targets as requirements to achieve globally, by 2020, the Strategic Milestones of fewer than 500,000 new HIV infections; fewer than 500,000 AIDS-related deaths; and the elimination of HIV-related discrimination.

4) WHO Guidelines on when to start ART and PrEP for HIV

In September 2015, WHO early release treatment guidelines made two key recommendations:

- ART should be initiated in **everyone living with HIV at any CD4 cell count**
- The use of daily oral pre-exposure prophylaxis (PrEP) is recommended as a prevention choice for **people at substantial risk of HIV infection** as part of combination prevention approaches; informed by evidence from clinical trials and observational studies released since 2013, showing that earlier use of ART results in better clinical outcomes for people living with HIV compared with delayed treatment.

The 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis was developed in the context of these latest global strategies, aiming to end HIV as public health threat by 2030. While ambitious, countries around the globe are aiming to achieve the same vision. There is no doubt that front loading investments as early as possible will help to reduce the total cost of achieving the goals of this strategy. While the government of Seychelles has largely funded the response to the HIV epidemic, financial assistance and contribution from international development partners are needed to ensure that Seychelles can invest in expanding cost efficient and effective prevention and treatment coverage required for achieving the 90-90-90 targets.

1.2.2 Regional Commitments

Despite the progress in and the global, continental and regional commitments to addressing HIV, the HIV response in Southern Africa still faces significant challenges that limit progress. One of the key challenges to meeting the international and regional targets is the continued high levels of HIV prevalence and vulnerability to HIV among specific populations, namely sex workers, men who have sex with men (MSM), people who use drugs (PWUD), people who inject drugs (PWID), transgender persons and people in prisons.

Given the vulnerability of key populations, SADC together with its member states has provided Member States with a framework to develop specific programming aimed at key populations. The SADC Regional Strategy for HIV and AIDS Prevention, Treatment and Care and Sexual

and Reproductive Health and Rights among Key Populations 2017-2020 has requested the countries in the region to commit to the following:

1) Addressing legal and policy barriers

Legal and policy barriers influence HIV risk. Ensuring these factors contribute positively to an enabling environment to assist the delivery and impact of interventions is essential. If the legal and policy barriers are not addressed, the impact of health sector interventions will be limited. Essential activities for successful interventions to address legal and policy barriers have included, among others: training and sensitizing key populations about relevant laws, their human rights and how to access justice; advocating for reviewing and reforming laws and policies; providing access to justice and bringing cases to account for violations against key populations; and organizing legal aid programmes and legal empowerment of key populations to increase access to justice.

2) Ensuring financial commitments

Allocating appropriate financial resources to programming for key populations is necessary to address barriers. Essential activities include, among others, ensuring resource mobilization and sustainability.

3) Community empowerment

The empowerment of key populations has been critical in the development of successful programming. Essential activities to ensure that key populations can meaningfully participate in programmatic interventions have included, among others: developing and strengthening key population–led organizations and networks; supporting capacity building and mentoring of key populations to enable them to participate in all levels of a programme; strengthening the management and capacity of key population organizations; and supporting community mobilization and sustaining social movements.

4) Addressing stigma, discrimination and vulnerability to violence

Addressing stigma, discrimination and vulnerability to violence facing key populations has resulted in reducing the barriers they face in accessing critical services. Essential activities for these successful interventions have included, among others: training among law enforcement (police), health care workers and judiciary and building institutional accountability with police to uphold the rights of key populations.

5) Ensuring the availability of and access to comprehensive health services

A number of interventions have been found to produce the most benefit in ensuring the availability of and access to comprehensive health services. Essential activities have included, among others: providing health, psychosocial, legal and other support services to key populations who experience violence; ensuring the availability of voluntary HIV testing and counselling, pre-exposure prophylaxis, viral hepatitis, TB and SRH services, harm reduction, and male and female condom and lubricant supplies; recruiting and training community

outreach workers on how to implement outreach and linking to services; and establishing safe spaces to provide community members with a comfortable place to relax, rest, get information and interact with each other and with the programme.

Furthermore, the Joint Meeting of SADC Ministers for Health and Ministers responsible for HIV in November 2017 recommended the following:

I. Member states should systematically implement the regional Framework for Health and HIV financing. This is especially important give that countries are expected to increase domestic resources to support focused HIV prevention interventions.
II. In order to achieve the 90-90-90 targets, Member States should focus on the pillars of HIV prevention, that is, condom programming, adolescent girls and young women, voluntary medical male circumcision, key populations and PrEP where applicable. Furthermore, Member States must identify high risk groups, define the intervention packages for each of the five pillars and set targets to allow systematic monitoring of progress.
III. There is need to expand the HIV Testing and Counselling (HTC) services and treatment programs in order to realise the 90-90-90 targets.

1.3. Rationale for the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis

The 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis has been developed, building on the successes and the lessons learnt in the implementation of the 2012-2016 NSP, to address the gaps and challenges identified in the end-of-term review in September 2017 and in the following consultation process. The 2019-2023 NSP continues to adhere to the principles established in the previous strategy, adjusts to the scientific findings and advances in HIV prevention and treatment, and adopts the most recent global strategic and programmatic recommendations, adjusted to the country context.

The 2019-2023 NSP has been developed for implementation in the rapidly changing international political environment. The Millennium Development Goals (MDGs), the international and regional framework for the previous NSP, is being replaced by the Sustainable Development Goals (SDGs), which extend from 2016 to 2030. SDGs, adopted by the UN General Assembly in 2015, include a target for “Ending AIDS” embedded in an integrated health goal. Adjusted to the SDG framework, the UNAIDS strategy for 2016-2021, “Fast-tracking to Zero”, presented to UNAIDS Programme Coordinating Board for approval in October 2015, will provide the programmatic guidance for reaching the target.

UNAIDS has introduced the ambitious treatment target 90-90-90, adopted in the Seychelles country context: 90% of key populations tested and know their results, 90% of those detected HIV positive placed on ART, and 90% of those adhering to ART having suppressed viral load.

The aim is to achieve the targets by 2020 through Fast Tracking, which also includes reaching 80% of key populations with effective prevention programmes. The aim is eventually to “End AIDS” by 2030 by raising the treatment targets to 95-95-95% and the prevention target to 90%. The development of the 2019-2023 NSP was, therefore required not only to help in translation of these policies and guidelines into action, but also to take advantage of the enabling and conducive policy and planning environment in the response.

A second critical factor was the need to decentralise services, engage all community health services sites and expand the prevention treatment and care to meet the achievement of the 90-90-90 targets. The community is an under-utilized resource in this fight to eliminate HIV, and the need to more closely coordinate facility and community activities and interactions has never been more apparent. Communities have a key role to play in identifying, promoting and facilitating service uptake among members of key and vulnerable populations but, increasingly, also in shifting specific tasks (such as HIV screening and adherence support) away from overburdened healthcare service providers to community-and home-based service delivery models which have been demonstrated effective in other settings. Communities and civil society organizations play an additional role in working to ensure key enablers are in place so that service delivery achieves maximum impact. Therefore, strengthening social networks and community organizations will have a positive impact on the ability of populations including the Key Populations to engage in health care and effectively contribute to the achievement of the NSP 90-90-90 goals by 2023.

The third critical factor in the timing of the development of the 2019-2023 NSP was the increasing emphasis on fiscal efficiency and responsibility. The fourth generation NSP must first foster a national planning paradigm shift in response to the new environment for investment in HIV and AIDS and also, ensure country ownership and leadership is a primary consideration, requiring broad based consultation in all phases. The development of the 2019-2023 NSP, therefore, offered an opportunity for all stakeholders to engage in a process designed to think differently about the national strategic response to HIV and AIDS.

Finally, important new evidence on HIV treatment and prevention indicate for the first time the opportunity to end AIDS. These interventions are of high impact and cost effective—therefore appropriate for all countries, particularly those with concentrated epidemics, such as Seychelles. These developments require a complete change in the approach and delivery of HIV prevention, treatment and care services to ensure Seychelles fully operationalizes these evidence-based, high impact interventions. The 2019-2023 NSP process provided a critical opportunity to assess, strengthen, and correct the response.

1.4. Process to develop the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis

The development of Seychelles' 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis was initiated in 2016 and followed in 2017 by the End-of-Term Review of the progress made under the NSP 2012-2016. The process included review of the reports and other information, and extensive consultations with key government and non-governmental experts and civil society representatives. Extensive consultations took place from 2016 onwards through workshops, technical working groups, forums etc. to identify challenges, gaps and needs for capacity building and financial inputs; and to discuss and make recommendations on improving the HIV response across the country.

Technical working groups (TWGs) comprising government officials from the Ministry of Health and other line ministries, civil society and non-governmental organisations, networks for key populations and implementers of the HIV response. Two stakeholder workshops and a number of mini consultative workshops were held. The first broad-based stakeholder workshops focused on identifying the strategic imperatives for the 2019-2023 NSP. As indicated, many mini consultative workshops were held to review and inform the development of the results and the strategic interventions. The final workshop was held to validate the contributions made from the first workshops and the consultations conducted in the intervening period.

Consultations were held in 2017 and 2018 with key partners, Ministry of Health (MOH), National AIDS Council (NAC), line ministries (Employment Bureau, the Agency for Prevention of Drug Abuse and Rehabilitation), civil society organisations, non-governmental organisations and networks for key populations to discuss the HIV strategic issues and challenges and identify the key priorities for the 2019-2023 response. [8]

[8]List of participants is in annex: 1

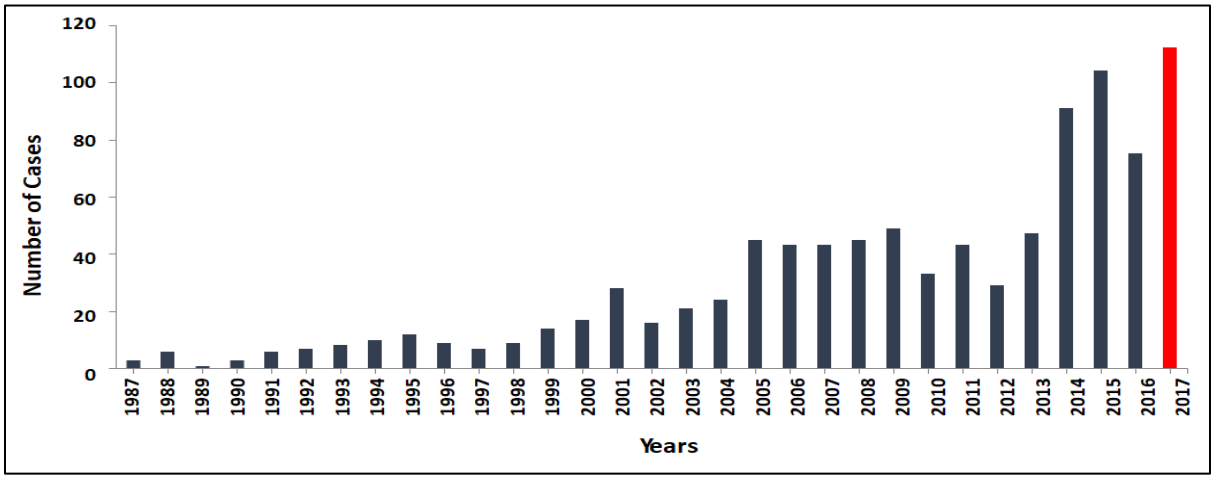
SECTION TWO: HIV, AIDS AND VIRAL HEPATITIS SITUATION IN SEYCHELLES

2.1 Epidemiological Situation

The Global AIDS Response Progress Report (GARPR) of 2016 and Global AIDS Monitoring (GAM) Report 2017 provide a comprehensive overview of the epidemic situation and response up to 2017. This report has been updated by other information, including the key Integrated Biological and Behavioural Study (IBBS) conducted on heroin users, which indicate that the number of people who inject drug (PWID) continues to increase while the HIV prevalence in the PWID groups seems to remain the same as the results from the 2011 IBBS study. Key population groups seem to be increasing.

Seychelles has a concentrated HIV epidemic and the prevalence rates remain elevated among key populations, which include PWID, PWUD, sex workers (SW), and men having sex with men (MSM). The number of people living with HIV (PLHIV) in the Seychelles by December 2017 was estimated at 676 persons, representing 62% males and 38% females.[9]

Figure 1. New reported cases of HIV from 1987 to December 2017 in Seychelles[10]



From January to December 2017, 112 (86M/26F) new HIV cases were diagnosed representing 77% males and 23% females. Of note, 26% (29) of the newly diagnosed HIV cases were co-infected with Hepatitis C; all those co-infected were PWIDs.

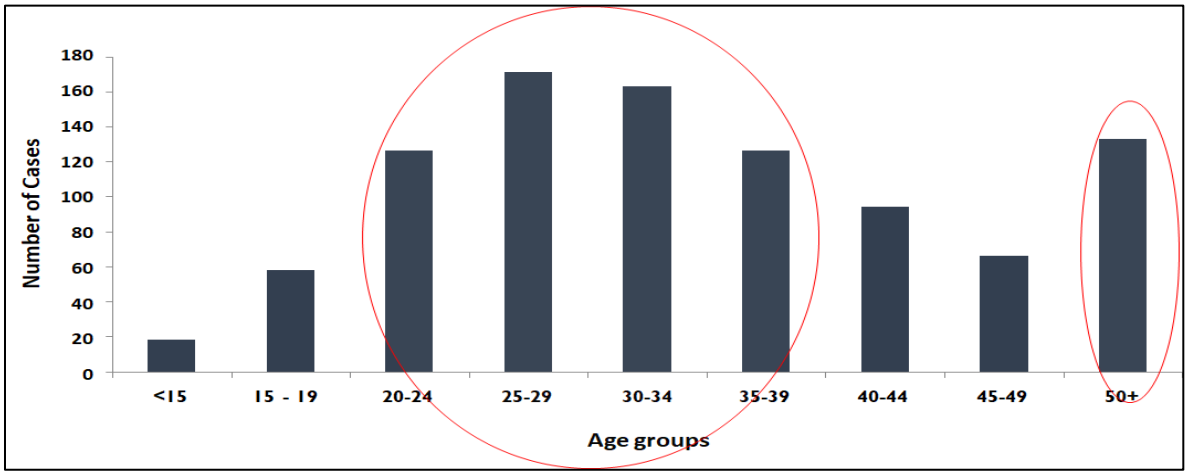
The age group most affected were those aged 25 to 29 years, followed by the age group 30-34 years old representing, 35% of the HIV cases reported from 1987 to December 2017.

The age group 50+ years represented 14% of the total number of cases. The new HIV cases in those less than 15 years old were mainly children infected through Mother to Child Transmission (MTCT).

[9] 2017, Epidemiological Report

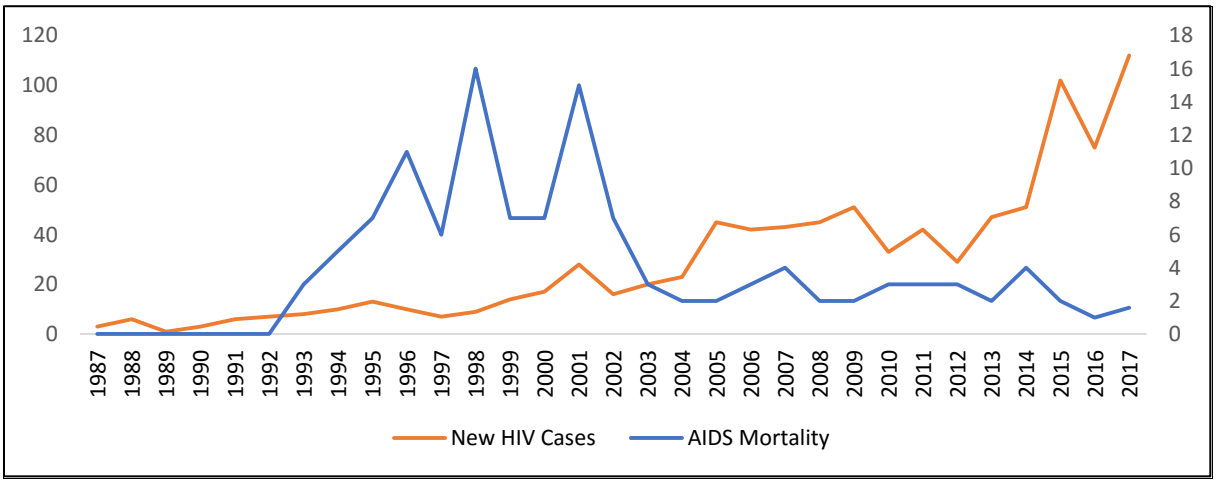
[10] 2017, Epidemiological Report

Figure 2: New HIV cases by age group at diagnosis from 1987 to December 2017 in Seychelles[11]



A cumulative of 332 (206M/126F) AIDS cases were reported from 1987 to December 2017 of which 62% were males and 38% females. There were 20 (13M/7F) new AIDS cases reported from January to December 2017, an increase of 100% compared to the same reporting period in 2016 (9), age ranging from 24 to 56 years old. It is important to note that the number of AIDS cases reported for the first 6 months of 2017 is equal to that of the total number of AIDS cases reported for the year 2016.

Figure 3. AIDS Mortality from 1987 to December 2017 in Seychelles[12]



A cumulative of 177 (109M/68F) AIDS related deaths was reported for the period 1993 to December 2017, 61.5 % of deaths occurred in males and 37.5% in females. From January to December 2017, 18 (11M/7F) AIDS related deaths were reported, an increase of 157 % compared to the same reporting period in 2016 (7), age ranging from 32 to 76 years old.

Of note is that the number of AIDS related deaths represents any death in a person who was HIV positive at the time of death, irrespective of cause of death.

The availability of Highly Active Antiretroviral Therapy (HAART) since its introduction in 2001 has clearly shown a positive impact in AIDS mortality with a sustained decline in the incidence

[11] 2017, Epidemiological Report

[12] 2017, Epidemiological Report

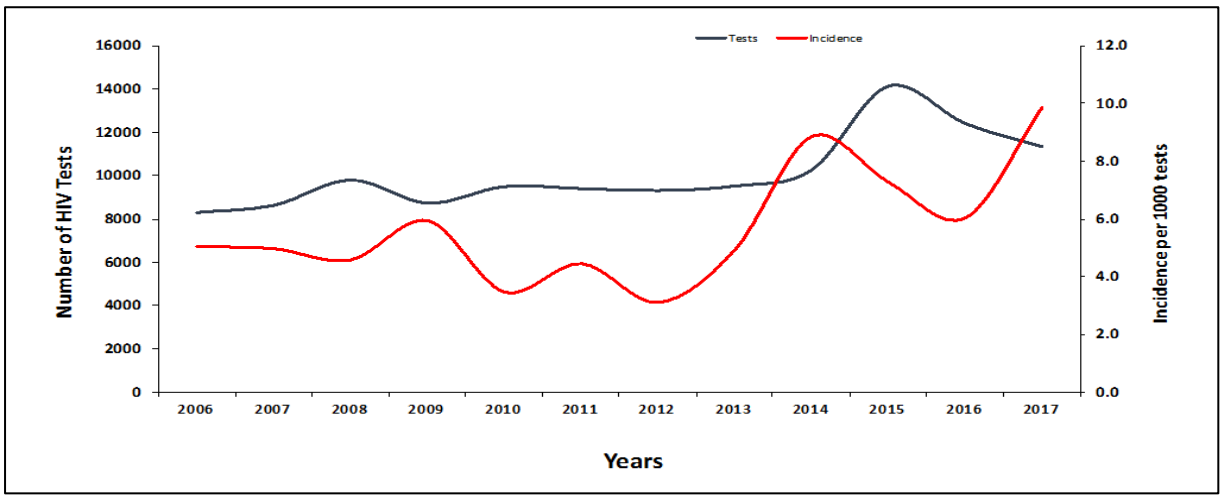
over the years compared to the non-treatment era; 3 per 100 PLWHA in 1993, 7 per 100 PLWHA in 2000, 3 per 100 PLWHA in 2006, 2012 and 2017.

2.2 HIV Testing, Surveillance and Surveys

HIV testing in Seychelles started as early as 1987, provided for free by government. Currently, HIV testing is provided to all pregnant mothers, and is accessible from any health facility, public or private for the rest of the population. In addition, rapid tests can be accessed from CDCU and some public and private health facilities. The Ministry of Health is promoting both voluntary and confidential HIV testing (VCT) and Provider Initiated Testing and Counselling (PITC). IBBS surveys have been carried out for all key populations (PWID, FSW and MSM), with a Knowledge, Attitudes and Practices study conducted in 2013 and a second survey for Heroin Users (2017).

The testing and screening programmes include routine HIV screening of all donated blood and blood products, and opt-out antenatal screening. HIV testing is offered to patients with TB, STIs and Hepatitis, clients of harm reduction programmes, contacts of HIV infected persons, and clients attending health facilities. Premarital HIV testing is encouraged and accessible to anybody irrespective of faith.

Figure 4. Incidence of HIV amongst Total Number of HIV Tests conducted from 2006 to 2017 by Health Care Agency, Seychelles[13]

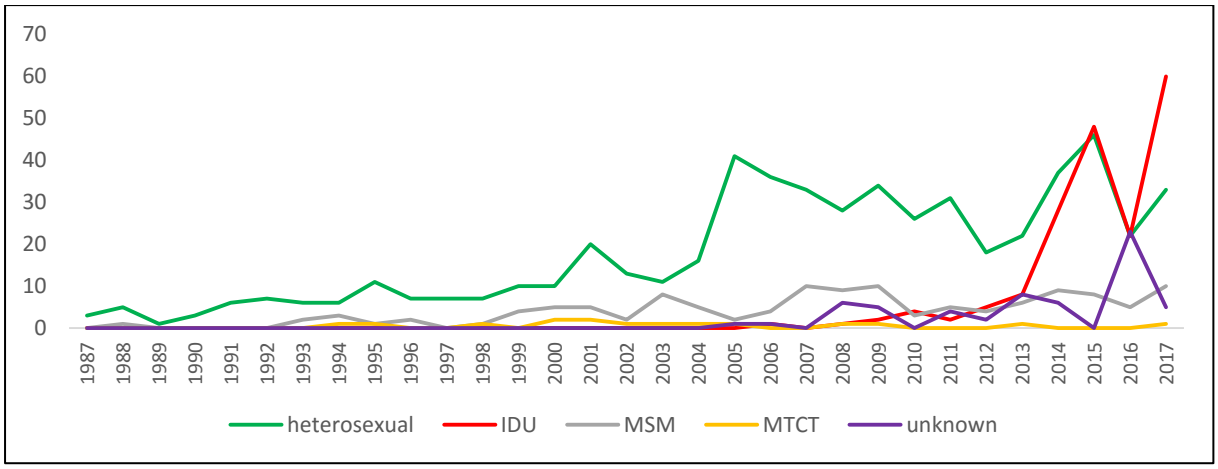


The number of tests conducted over the years remained more or less constant until 2015, when there was an increase of 40% from the previous year. A total of 11,359 HIV tests were conducted in 2017. HIV tests were conducted in all HCT centres, wards, Antenatal Clinics and the Blood Transfusion Centre. In 2017, out of these, 9.9 % was HIV positive. Despite strengthening the surveillance programme and intensified testing the detection rate of HIV appeared to be decreasing. The surveillance data and routine screening activities demonstrate

[13] 2017, Epidemiological Report

that HIV is still confined within the key populations and that the prevalence among general population is still low, less than 1% (KAP 2012).

Figure 5: Most Probable Modes of Transmission of HIV as per Patient History in Seychelles[14]



2.3 Prevention of Mother to Child Transmission of HIV and Syphilis

PMTCT services were introduced in 2001 and guidelines have evolved over the years in line with global recommendations. As mentioned above, all pregnant women attending antenatal clinics are offered HIV testing using a routine opt-out approach, and the majority of women, almost 100%, accept to be tested. All pregnant women infected with HIV are managed at the CDCU and currently all HIV infected pregnant women are eligible for ART (Option B+) and HIV-exposed infants receive appropriate ARV prophylaxis. For early infant diagnosis (EID) of HIV, blood samples are sent overseas.

From 2012-2016, 47 pregnant women infected with HIV were reported by the CDCU, some of the women were newly diagnosed, whereas a few pregnancies occurred in women known to be living with HIV. Three MTCT transmissions were reported during the last five years with one infant death from AIDS: there was a suspected case of HIV transmission during breastfeeding. Partner testing is offered for partners of pregnant women, however, uptake of testing by partners is very low.

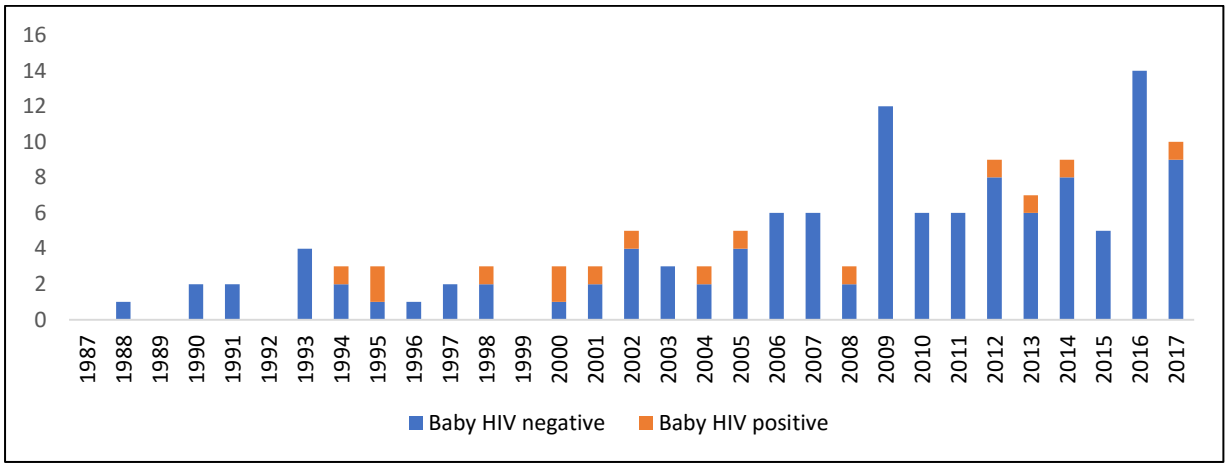
All pregnant women attending antenatal clinics are offered HIV testing using a routine opt-out approach, and the majority of women, almost 100%, accept to be tested. All women living with HIV (WLHIV) have access to sexual reproductive health services including family planning.

A total of 134 HIV positive pregnancies were reported from 1988 to December 2017, of which 88 (68%) benefited from the PMTCT program since its introduction in 2001 from mono-therapy to tri-therapy to date. Prior to the introduction of PMTCT, 8 out of the 23 babies born from HIV

[14] 2017, Epidemiological Report

positive mothers were infected with HIV, representing a mother to child transmission rate of 35% compared to 4 out of the 106 babies since the introduction of PMTCT program representing a mother to child transmission rate of 3.7%. To note, 2 babies were diagnosed HIV positive at 9 months old after birth though their mothers tested HIV negative throughout their pregnancies.

Figure 6. HIV negative and HIV positive babies born of HIV positive mothers from 1988 to 2017 in Seychelles[15]



2.4 Key Populations

A number of developments for key populations have been legislated to improve the enabling environment. The National Assembly voted to decriminalize sodomy in 2016, and following this an association of lesbian, gay, bisexual, transgender, intersex and allies, the LGBTI Sey was launched, advocating that *"all people are accepted and affirmed, regardless of sexual orientation or gender identity"*.

The Misuse of Drugs Act 2016 makes provision for alternative or non-custodial sentencing of drug users. Article 39.(1) notes that *"in dealing with a drug dependent person, whether before or after conviction, the primary objective of the Court shall be to ensure that the person has access to all available treatment, education, rehabilitation, recovery and social reintegration services necessary to effectively address the person's dependency and prevent further drug-related harm."* A Secretariat, the Agency for the Prevention of Drug Abuse and Rehabilitation (APDAR) was established in the President's Office in 2016, to lead a comprehensive and coherent national response; and a first national network of drug users (DURNS) is established.

2.4.1 People who use Drugs (PWUD), especially People who inject Drugs (PWID)

It is estimated that there are about 2,560 (2017) PWID in the country[16] which is increased from 1,671 (2011). Furthermore, this represents an increase from 3.0% and 3.3% of the total

[15] 2017, Epidemiological Report
[16] IBBS of Heroin Users, 2017

population of Seychelles, aged 15 years and above.[17] The HIV prevalence among PWID was 5.8% in 2011 and 22% in 2017.

The *National Harm Reduction Strategies 2009–2014* and the *Introduction of medically assisted therapeutic services for Key Population in Seychelles – strategy 2012* spearheaded the implementation of harm reduction services for PWID. The needle and syringe programme (NSP) was officially started by MOH in 2016, and currently this service is available at three fixed sites (Mahé, Praslin and La Digue). Opioid substitution therapy (OST) using methadone is now available at 4 sites (Wellness Centre, Pointe Larue Community programme, Mont Royale Centre and Dove Centre, Praslin). The demand for both Methadone Substitution Therapy (MST) and NSP has increased substantially with approximately 800 IDUs on the waiting list of MST. The number of syringes dispensed by the Communicable Disease Control Unit increased from 4000 Omnican syringes in 2016, to 21550 for 2017.[18] Very few (<50) PWID were on methadone maintenance therapy in 2017 but there was a plan to scale up services.

The country had the highest per capita incarceration rate in the world[19] in 2016; many people are incarcerated for drug-related crimes. In 2017, there were no formal HIV prevention services for prison inmates. Currently, inmates who present to the prison doctor for any ailment are offered HIV and HCV testing. A total of 246 HIV tests were done in 2016 and 4% of inmates tested HIV positive. ART is available for all inmates living with HIV however; uptake was around 50% in 2016 and 2017.

2.4.2 Men who have Sex with Men (MSM)

In the 2011 IBBS, HIV prevalence among MSM was 13.2% and prevalence of Hepatitis C (HCV) was 41.9%. Among MSM who tested positive for HIV, 20.6% were co-infected with HCV. No one was found to have a positive reaction for Hepatitis B (HBsAg) or Syphilis[20].

More than 65% of MSM reported having commercial male sex partners and almost 40% reported having occasional male sex partners in the past six months. Condom use with these sex partners was inconsistent indicating numerous opportunities for the further spread of HIV in this population.

Fifty four percent of MSM ever injected drugs, among which 51% did so in the last six months, among which 12% reported sharing in the last six months. Majority of the MSMs who reported injecting drugs reported doing so daily or almost daily.

[17] IBBS of Heroin Users, 2017
[18] Source: APDAR
[19] Countries with the largest number of prisoners per 100,000 of the national population, as of April 2016. Statista2017.https://www.statista.com/statistics/262962/countries-with-the-most-prisoners-per-100-000-inhabitants/
[20] IBBS, MSM, 2011

2.4.3 Sex Workers (SW)

The HIV prevalence among FSWs was 4.6%. Hepatitis C prevalence was 34.6%.[21] The IBBS (2015) report on behavioural data indicated that FSWs were engaged in sexual behaviours that placed them at risk of contracting HIV and other STIs, with multiple partners including one-time partners (60.9%) and non-paying casual partners (20.5%). Male condom use was low (27.5%) with regular partner due to mutual trust. Female condom use was also very low.

Most of the FSWs were relatively young (around 24 years), with one or two children and having left school during the secondary education years (47.4%). Most (81.4%) were also single or were in co-habitation with a partner. Earnings pre- and post- sex work were very different, with only 0.6% earning about US$720 monthly doing other previous work and 21.2% with earnings of more than US$800 monthly with sex work. Use of illegal drugs was very high (94.2%) and current use was also high (86.5%). Injecting drug use was reported by 39.7% and 30.8% were currently injecting, especially heroin.[22]

2.4.4 People in Prisons

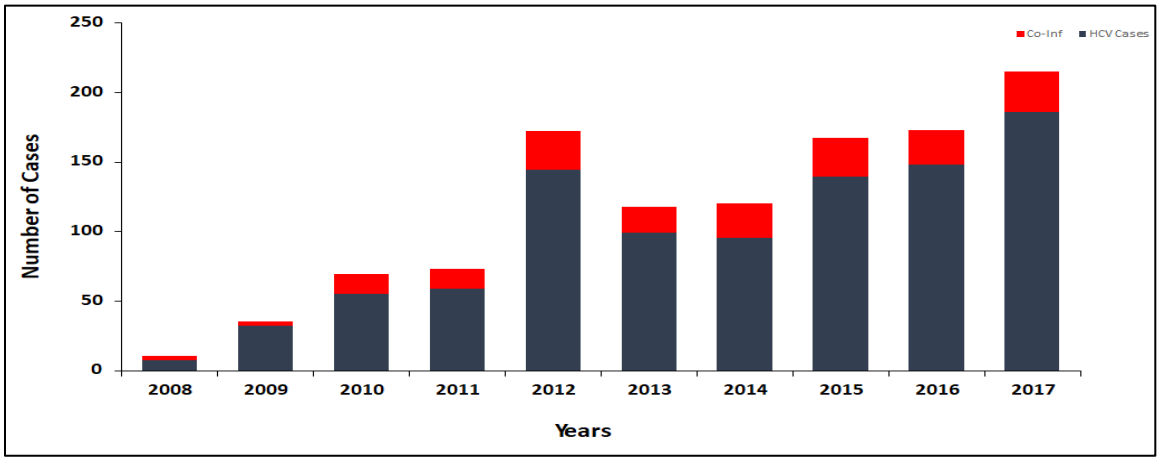
In 2015, the HIV prevalence in a sample of prisoners tested by prison health services was 9.4%[23] and in 2016, the prevalence was 4.1%[24]. Like all persons, prisoners are entitled to enjoy the highest attainable standard of health. This right is guaranteed under international law in Article 25 of the united National Universal Declaration of Human Rights and Article 12 of the International Covenant on Economic, Social and Cultural Rights. As a key or vulnerable population, marginalised in terms of interventions and because of their illegal activities, prisoners do not readily access needed health services such as detoxification, due to unavailability. Sexually transmitted infections (STI) management and HIV infection may often go untreated. As at December 2017, there has been no formal IBBS conducted in prison.

2.5 Co-infections - Hepatitis C

A total of 966 cases of Hepatitis C were reported from 2002 to 2017 of which, the majority 83.6% were males and 158 (16.4%) were females. For the same period, 190 (20%) were HIV/HCV co-infected of which 167 (88%) were males and 23 (12%) were females; the youngest person was a 15-year-old and the eldest a 52-year-old and both were males.

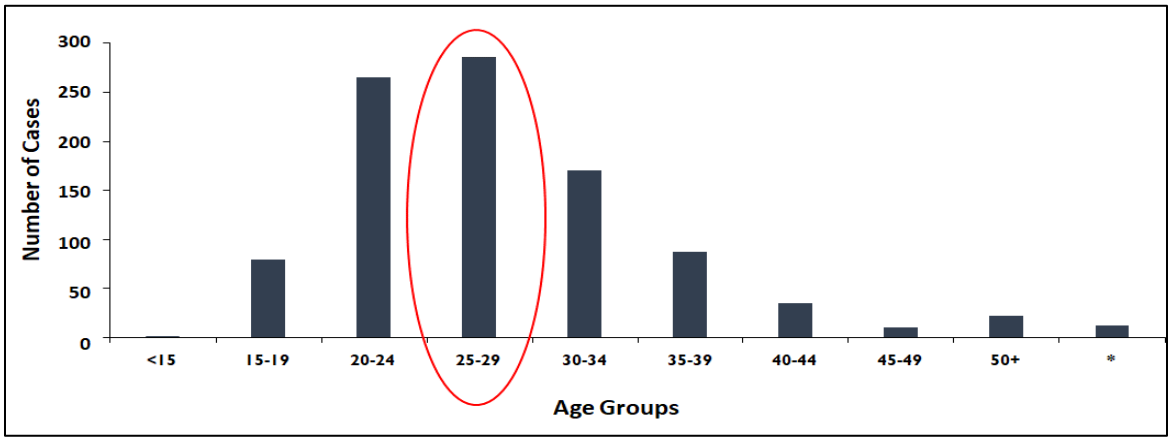
[21] IBBS, Female Sex Workers, 2015
[22] IBBS, Female Sex Workers, 2015
[23] GARPR 2016
[24] GAM 2017

Figure 7: Hepatitis C and HIV Co-infection from 2008 to 2017 in Seychelles[25]



There has been a gradual increase in the incidence of Hepatitis C reported from 24 per 1000 tests in 2010 to 50 per 1000 tests in 2012 followed by a decline to 26 per 1000 tests in 2013 and 23 per 1000 tests in 2014.

Figure 8: Hepatitis C cases per age group at diagnosis from 2008 to 2017 in Seychelles[26]



Of the 966 cases of Hepatitis C reported as at December 2017, the majority (99%) of cases were confirmed to be People Who Inject Drugs (PWID).

The highest number of Hepatitis C cases was reported in the age groups 20-24 years and 25 – 29 years of age representing 76% of the total cases reported. There were 31 Hepatitis C related deaths of which 20 (64.5%) were males and 11 (35.5%) were females.
New cases were also reported in the 15-19 and 50+ age categories.

[25] 2017, Epidemiological Report
[26] 2017, Epidemiological Report

SECTION THREE: NATIONAL STRATEGIC PLAN FOR HIV, AIDS AND VIRAL HEPATITIS TO MEET THE 90-90-90 TARGETS

3.1 The 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis at a Glance

An estimated 676 people were living with HIV in Seychelles by December 2017. In the same year, 112 people were newly infected with HIV and cumulatively for the period 1987 to 2017 there were 177 AIDS-related deaths[27]. In the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis, Seychelles has accepted the challenges of being effective in ending the AIDS epidemic as a public health threat by 2030, through achieving the 90-90-90 treatment targets by 2020.

This is the third multi-sectoral National Strategic Plan for HIV, AIDS and Viral Hepatitis (NSP) for Seychelles. The National Health Strategy (2016-2020) and the HIV Policy for the Prevention and Control of HIV, AIDS and STIs guarantee basic health services free of cost to Seychellois citizens. As HIV control is one of the priority national development programmes, the NSP 2019-2023 carries the ethos of this constitutional provision to guarantee access to basic health services as a fundamental right of every citizen.

The NSP 2019-2023 is a set of evidence-informed strategies focused on building one consolidated, unified, rights-based and decentralized HIV programme with services that are integrated in the general health services of the country. It builds on lessons learned from implementation of the National Strategic Plan for HIV 2012-2016, its end-term review, the National Health Strategic Plan 2016–2020, the IBBS for Heroin Users, consultation on the key strategic priorities and other strategic information from studies, surveys and assessments.

The National Strategic Plan for HIV, AIDS and Viral Hepatitis 2019-2023 was prepared through a wide range of consultations, including the Seychelles Government, civil society networks, international partners and service providers and the National AIDS Council. The NSP includes recommendations from these consultations as strategic priorities.

The strategic priorities are to:

- identify and reach key populations with a combination of initiatives to prevent HIV;
- focus on reaching key populations through outreach and, by communities of key populations, through in-reach;
- recommend and offer HIV ‘Test and Treat’ services, regardless of CD4 count;

[27] 2017, Epidemiological Report

- retain people living with HIV in treatment, resulting in undetectable viral load;
- enhance critical programme and critical social enablers;
- establish functional public-civil society-private partnerships to bridge the prevention-treatment continuum through task-sharing; and
- focus on innovative, well-coordinated and integrated services towards primary HIV prevention for and with key populations.

Key populations remain the main focus of the 2019-2023 NSP. In Seychelles, these populations include male and female sex workers, clients of sex workers, men who have sex with men, people who inject drugs and people in prisons. In addition, all pregnant women are the focus of the National Strategic Plan for HIV, AIDS and Viral Hepatitis for elimination of vertical transmission of HIV and syphilis.

Innovative service delivery approaches include intensified testing to reach key populations through facility-based outreach and community-led in-reach; linking testing to treatment and retention with smart and innovative referral systems, and introducing test for triage, initiated through community-led HIV screening. Task-sharing to identify, reach, recommend, test, treat and retain is essential, central and fundamental in the 2019-2023 NSP. In order for this forward-looking prevention-treatment continuum to be successful within a case-finding/case management approach, the capacity and competence of health service providers and trained community laypeople will be updated and made fit for purpose. By investing in this 2019-2023 NSP in a combination of focused and innovative services, activities and strategies to prevent new HIV infections, Seychelles will close the prevention gap.

With HIV Vision 2030, the prospect of zero new HIV infections has never been so real. Time-proven approaches, combined with new tools and discoveries, will provide people with a real chance of protecting themselves and preventing HIV transmission, leaving no one behind.

3.2 Guiding Principles for the National HIV and AIDS Response

3.2.1 Focus on evidence-based interventions for maximum impact

The development of the 2019-2023 NSP, in alignment with global guidance and shrinking international funding, has been drastically refocused around impact. The interventions which have the highest impact are those which take highest priority in this NSP. In order to virtually eliminate HIV in Seychelles, it is imperative that all funding, interventions and activities rally around the 90-90-90 targets.

3.2.2 Improved targeting of critical interventions to Key Populations

Although Seychelles has substantially invested in the implementation of prevention programmes with key populations, greater efforts are required to achieve zero transmission of

HIV by 2030. The 2019-2023 NSP needs to be more effective with the targeting of HIV prevention, treatment and care interventions for key populations; these efforts must additionally be carefully targeted at those populations most at risk of either becoming infected with HIV or of infecting others, while, at the same time, focussing on vulnerable groups such as youth, women, migrants and the population in general. This means that HIV testing will be focused around the settings and populations where the most HIV-positive individuals can be identified and linked to treatment. In health facilities, routine testing for HIV will be massively scaled up, and in community settings, the key populations (men who have sex with men, persons who use drugs especially Injecting Drug Users, sex workers and prison inmates) as well as other vulnerable populations such as male and female adolescents and youth, people with STIs, and other highly mobile groups will become the focus.

3.2.3 Quality Improvement

Creating and ensuring both continued high demand for HIV services as well as effective services necessitates an increased emphasis on quality improvement. The rationale for Quality Improvement (QI) and programme monitoring and evaluation (M&E) methods is used to determine whether prevention services for key populations and persons with HIV are acceptable, and implemented as intended and are yielding the expected improvement in outcomes. The focus of the QI efforts will be on improving adherence to clinical practice guidelines; on increasing efficiency, lowering costs, and utilizing staff and health information more efficiently; and on improving care coordination or patient flow.

3.2.4 Service Integration

Sexual Reproductive Health (SRH) and HIV Family Planning (FP) are the second prong of PMTCT; widely accessible and consistently available FP services through multiple points of contact with patients/clients are a critical component to controlling the HIV epidemic. Stronger integration between SRH and HIV & AIDS interventions will lead to a number of health outcomes and benefits which would include among others: (1) improved access to, and uptake of key services; (2) better access of PLHIV to services tailored to their needs; (3) reduced AIDS-related stigma and discrimination; (4) improved coverage of underserved and key populations such as sex workers or men who have sex with men; (5) greater support for triple protection against unintended pregnancy, HIV, and STIs especially for young people; (6) improved quality of care; and (7) enhanced effectiveness and efficiency of the response.

3.2.5 Multi-Sectoral Inclusion

The national response to HIV and AIDS covers other health sector programmes such as TB, nutrition, and reproductive and child health services, as well as social and economic sector responses, including a multi-sectoral approach to achieving the 2020 and 2030 targets of ending the AIDS epidemic.

3.2.6 Community Engagement

Active participation of community leadership, cultural and religious leadership, formal and informal segments of the private sector, community based organisations, PLHIV leadership and community groups are needed to complement the efforts of the public sector. Community engagement will rally around the efforts to realize the 90-90-90 targets and keeping those who are negative, HIV-free. Activities will target in particular adolescent girls and young women, young men who want to protect themselves through use of condoms, safer sex practices, and those who are tested negative from prioritised testing efforts. The intervention will include demand creation for services, knowledge sharing on services, mobilizing communities to access prevention services, conducting referrals of HIV positive individuals to health facilities, conducting follow-ups for ART clients to ensure treatment adherence, and providing psychosocial support to PLHIVs.

3.2.7 Human Rights

Strategies to address the HIV epidemic are hampered in an environment where human rights are not respected. For example, discrimination against and stigmatization of key populations such as SWs, PWUDs and MSM drive these populations underground which then impedes efforts to reach these populations with prevention and treatment initiatives, thereby increasing their vulnerability to HIV. Similarly, failure to provide access to appropriate information about HIV, or treatment, and care and support services further fuels the AIDS epidemic.[28] An effective response to HIV and AIDS is hampered if these rights are not respected. Human rights will therefore be safe-guarded through promoting gender equity and equality in HIV services along with ensuring a stigma-free environment and protection of patient-rights in facilities. The strategy of protection and promotion of human rights will be essential in preventing the spread of HIV and mitigating the social and economic impact of the pandemic. Efforts should be made to engage police and other law enforcement apparatus to ensure human rights are observed hence reducing vulnerabilities of risk groups to HIV.

3.2.8 Gender

According to UNAIDS (2013),[29,] HIV continues to be driven by gender inequalities and harmful norms that promote unsafe sex and reduce access to HIV and sexual reproductive health services for men, women and transgender persons. The pervasive social, legal and economic disadvantages faced by women reduce their ability to protect themselves from HIV infection.

There are several factors which predispose women and girls to HIV: women and girls have greater physiological vulnerability to HIV and gender inequalities include vulnerability to rape,

[28] OHCHR, (2014). HIV AND AIDS and Human Rights
[29]UNAIDS (2013). UNAIDS Report on Global AIDS epidemic

sex with older men, unequal access to education and economic opportunities. These make HIV-related risks especially acute for girls and young women. In comparison to men, women are more likely to acquire HIV at an early age, resulting in a global HIV prevalence among girls and young women that is double or greater than among males of the same age (UNAIDS 2013).

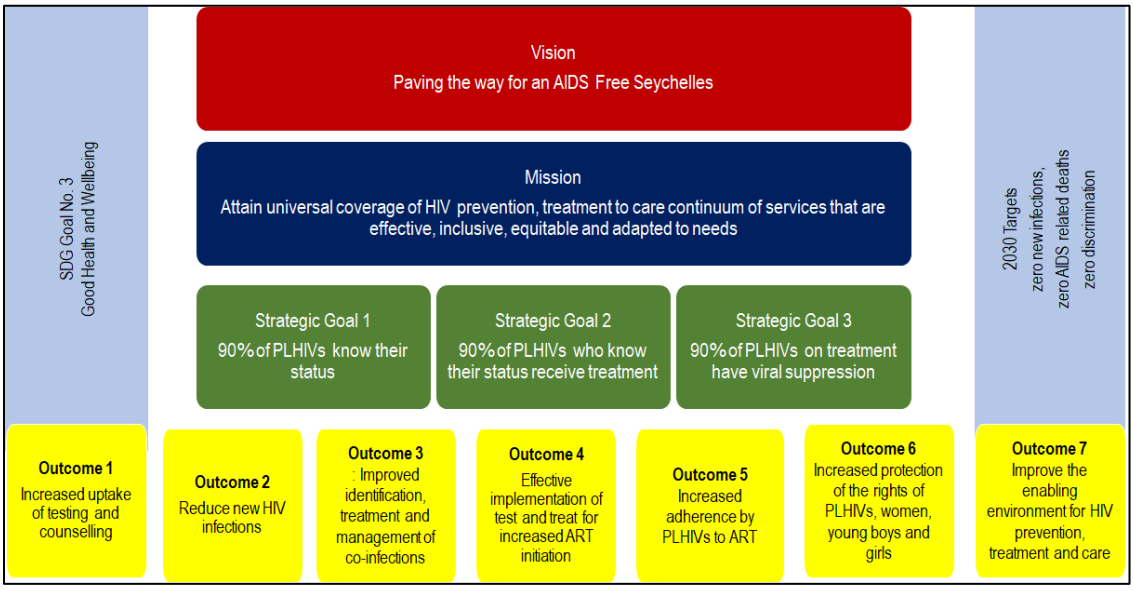
The 2019-2023 NSP promotes a comprehensive sexuality and gender transformative interventions to prevent new HIV infections through risky sex, support service utilisation, retention in care and adherence. The 2019-2023 NSP will build on positive efforts made to promote couple's communication, and stigma reduction through effective community mobilisation efforts in collaboration with religious and community leaders. Community efforts will be further aligned to support the prevention, treatment and care continuum.

3.3 Vision, Mission, Goals and Outcomes

3.3.1 The Results-Based Framework 2019-2023

The 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis is designed around a results-based framework that reflects the commitments and 90-90-90 targets by 2023. The framework is based on a causal relationship between the vision, mission, goal and the strategic outcomes. The overview of the results framework is detailed in Figure 9.

Figure 9. Seychelles 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis Results Matrix



To maximize the impact of the response, the country will invest adequately and strategically, prioritising where, for which people and what to invest in to generate best returns. The priorities are based on what has been identified to work in local context. Furthermore, these strategic outcomes will be articulated in terms of inputs, outputs and costs in the implementation plan.

While there are several external and internal risks that may positively or adversely affect results, the combination of strategies adopted will be calibrated according to the epidemiological, health priorities and available resources.

3.3.2 Summary of Strategic Priorities

A summary of strategic priorities based on NSP goals and outcomes is shown in below.

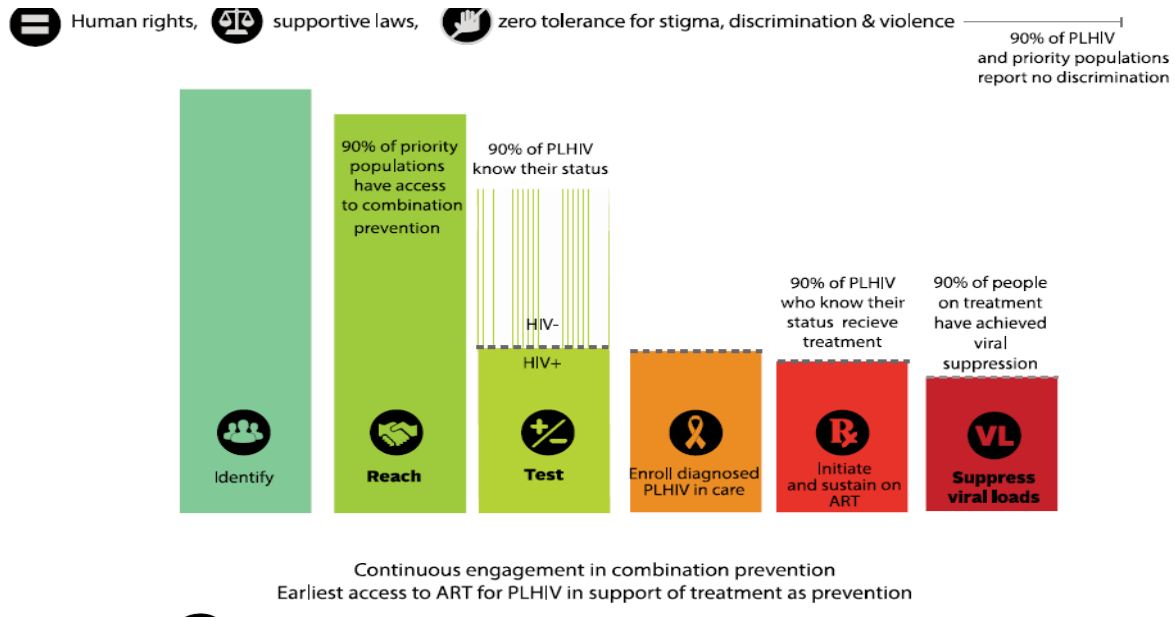
Figure 10. Strategic Priorities based on NSP Goals and Outcomes

NSP Goal	NSP Outcome	Strategic Priority	
1	1	1.1	Scaling up of HIV testing and counselling for all with a specific focus on key populations and at-risk populations (youth and adolescents)
	2	2.1	Reduced new HIV infections amongst key populations through sexual transmission
		2.2	Implementation of advocacy, communication and social mobilisation programs for the uptake of counselling, testing and treatment
		2.3	Reduced new HIV infections amongst key populations through injecting drug use
		2.4	Reduced new HIV infections amongst people in closed (prison) settings
		2.5	Reduced new HIV infections amongst youth and adolescents
		2.6	Elimination of mother-to-child transmission of HIV and syphilis
2	3	3.1	Increased uptake of ART by PLHIVs
		3.2	Strengthened linkages to care and support services
	4	4.1	Diagnosis, treatment and management of PLHIVs with STIs
		4.2	Diagnosis, treatment and management of PLHIVs with Hepatitis B and C
		4.3	Screening for Cancers
3	5	5.1	Increased retention on ART
4	6	6.1	Responsiveness of the social and legal environment to the rights of PLHIVs
		6.2	Implementation of gender responsive HIV programming
5	7	7.a	Improved enabling environment for HIV prevention, treatment and care – Policies and Guidelines
		7.b	Improved enabling environment for HIV prevention, treatment and care – Health Systems
		7.c	Improved enabling environment for HIV prevention, treatment and care – Community Systems
		7.d	Improved enabling environment for HIV prevention, treatment and care – Coordination and Management of the National HIV response
		7.e	Improved enabling environment for HIV prevention, treatment and care – Monitoring and Evaluation
		7.f	Improved enabling environment for HIV prevention, treatment and care – Costing and Financing the HIV Response

3.4 NSP Goal 1: 90% of all PLHIV know their status

Figures 11 and 12 illustrate case-finding and case management in the continuum of identifying, reaching, recommending, testing, treating and retaining people on anti-retroviral therapy through task-sharing, founded on public – CSO/NGO – private partnerships. These principles and practices lie at the centre of, and will be applied to each of the strategic priorities of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis.

Figure 11: Seychelles 2019-2023: HIV Prevention, Care and Treatment Continuum



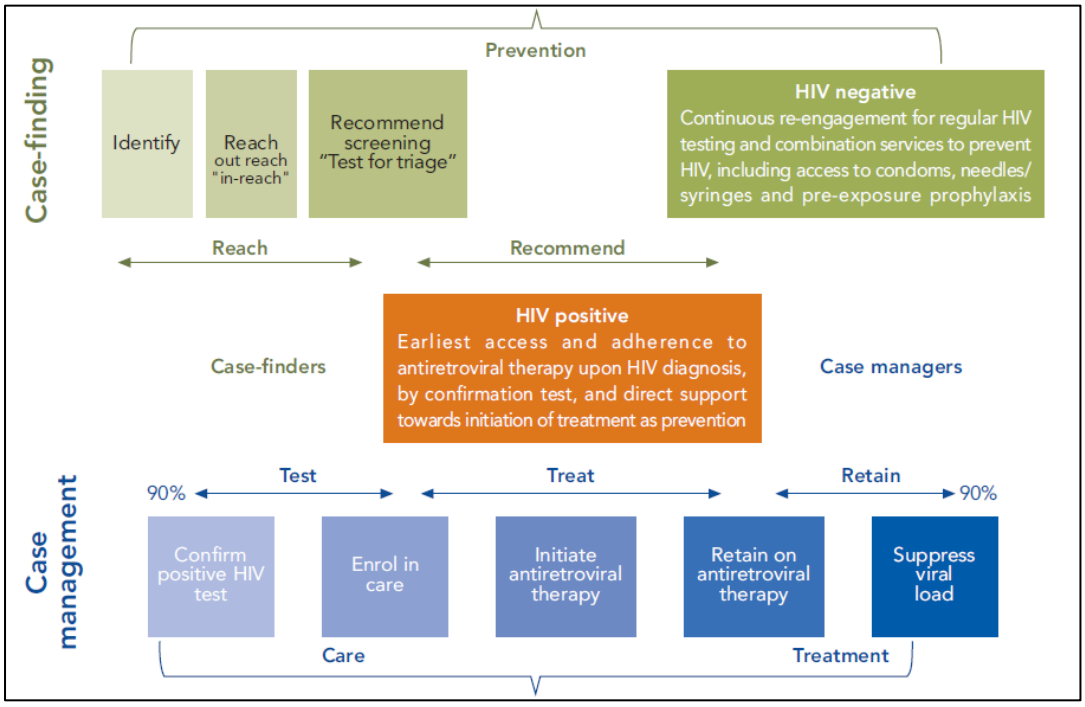
HIV prevention programmes are most effective when they address social, gender and age groups with the highest HIV incidence rates and the largest numbers of new HIV infections while also being tailored to their socio-cultural context. In all settings, programmes will define priority populations based on regular epidemiologic and socio-demographic analyses of data to determine which population groups are most affected and their size. This means that the most intensive community outreach and demand generation is needed for key population groups, priority populations (youth and adolescents) and people living with HIV.

3.4.1 NSP Outcome 1: Increased uptake of counselling and testing services

There is overwhelming evidence that early antiretroviral treatment keeps people living with HIV healthy and reduces the social and economic costs of advanced HIV-related illness, care of orphaned children and lost productivity. Effective treatment averts death and also prevents transmission of HIV[30].

[30] WHO, PROGRESS REPORT 2016 PREVENT HIV, TEST AND TREAT ALL, WHO SUPPORT FOR COUNTRY IMPACT

Figure 12: Identify, reach, recommend, test, treat and retain-continuum of prevention, care and treatment



The Seychelles has committed to achieving the 90-90-90 targets by the end of 2020, with 90% of all PLHIVs knowing their status by 2020; 90% of all those that are HIV positive on treatment by 2020; and 90% of all PLHIV on treatment being virally suppressed by 2020. The achievement for these three targets will be 95% by the end of 2023.

Strategic Priority 1.1: Scaling up of HIV Testing and Counselling for all with a specific focus on key populations and at-risk populations (youth and adolescents)

As indicated above, a key drive for the Seychelles in the 2019-2023 NSP is to achieve the 90-90-90 targets across the country and population groups by 2023 to reach the 90-90-90 targets, it is necessary to achieve the first target i.e. 90% of PLHIV know their status. This cannot be achieved unless the programme significantly scales up HIV testing and counselling services in key populations with highest yield, using a blend of strategies including expansion of VCT to all health facilities, training of health care workers to provide testing at community health facilities, use of outreach and community based testing to increase the testing coverage. A continuum of supplies to all HIV counselling and testing facilities for effective programme performance and satisfactory service to clients must be ensured.

To increase the scale up of HIV testing and counselling the following will be implemented:

1) *Establish Population estimates*:

One of the key challenges in achieving the First 90 is lack of data to determine the population estimates for PLHIVs. A total of 12,353 tests were done in 2016 indicating approximately 10% coverage. The testing gap amongst key population groups is not known. The 2017 IBBS study for IDUs indicated that there were approximately 2500 IDUs (3.3%) an increase from 1500 (3%) in 2011. The estimated number of sex workers is 586 (2015) and MSM is 1,084 (2011). Analysis of programme data has indicated that there is 90% gap in testing of bridge population, approximately 12% in pregnant women and 95% in partners of PLHIV.

2) Address gaps in HIV case detection:

Out of the estimated 94 600 inhabitants, cumulatively there were 960 HIV cases detected (1%), 676 PLHIV in the Seychelles and only 434 were on ART by the end of 2017. In other words, the gap between the number of PLHIV and those on treatment was 36%. A critical gap exists with respect to retention. Linked to the gaps in case detection is the ***Late detection of PLHIV:*** With'90-90-90' being the cornerstone of the 2019-2023 NSP, the emphasis would need to be on early detection through strategies of decentralising HIV testing and counselling services to community health facilities, expand the HIV testing and counselling services through the utilisation of a variety of testing modalities including, community based testing using rapid test kits, targeted testing of key populations (KPs) in ghettos, places where KPs socialise or where sex workers solicit their clientele etc.

3) Targeted outreach testing for key affected and vulnerable populations

Seychelles, having a concentrated epidemic, has not done well enough in the last decade to raise overall awareness and acceptability of HIV testing and counselling services. Key populations face barriers to HIV testing and service utilisation due to age, gender, marginalisation, and stigma. Community settings provide an important entry point for case finding of HIV+ at risk individuals within high prevalence areas or groups. Moving forward, community mobilization and community testing is imperative to reach key population groups that are a higher risk of becoming HIV positive.

The aim will be to identify people who are positive and to increase access for HIV positive people to treatment and retain these people in services to ensure there is viral load suppression. Increased emphasis will be made through community mobilization, and communication designed for PLHIV support, facilitate partner testing, early infant diagnosis and paediatric treatment for family members. Leveraging impact mitigation and community care activities, targeted mobilization of key populations and PLHIV families will provide accessible HIV Testing and Counselling (HTC) services within the community setting or household.

Key populations will also be reached through hotspot testing. Community wide mobilization to reach key populations will integrate demand for HTC services with formalized referrals to

facility-based HTC, and close the loop on retention, care and support services through engaging civil society organisations. Increased collaboration between health facilities civil society organisations is important for the HTC programme to be successful. Routine meetings will highlight issues related to reaching key populations and support case finding through facility-based and civil society organisations.

Expansion of a closed referral system between civil society organisations and clinical sites will increase uptake and measurement of service uptake. Frontline health workers, community based structures, and civil society organisations will manage trained lay referral agents and volunteers. Community wide-referrals will work in partnership with facilities to ensure that bi-directional referrals are supported for community case management.

4) Service Delivery Approach

The 2015 World Health Organization (WHO) Consolidated Guidelines on HIV Testing Services[31] recommend that trained lay providers can independently conduct safe and effective HIV testing services using rapid diagnostic tests. Task-sharing, the rational redistribution of tasks between cadres of health-care providers with longer training and other cadres with shorter training, including trained lay providers, is a pragmatic response to increasing the effectiveness and efficiency of all available personnel and to enable the existing workforce to serve more people.

Expanding HIV testing services to trained lay providers working in the community will increase access to these services and their acceptability to people from key populations and other high-priority groups. These groups may be reluctant or unable to use HIV testing services in health facilities. Services delivered by trained lay providers can be both welcome and important, providing information and teaching skills that facilitate safer behaviours. Trained lay providers based in the community or a facility can provide HIV testing services, link people to treatment and prevention services, and provide ongoing care and support. Their role can help to reduce prejudice, expand the coverage of HIV testing services, and improve the uptake of services.

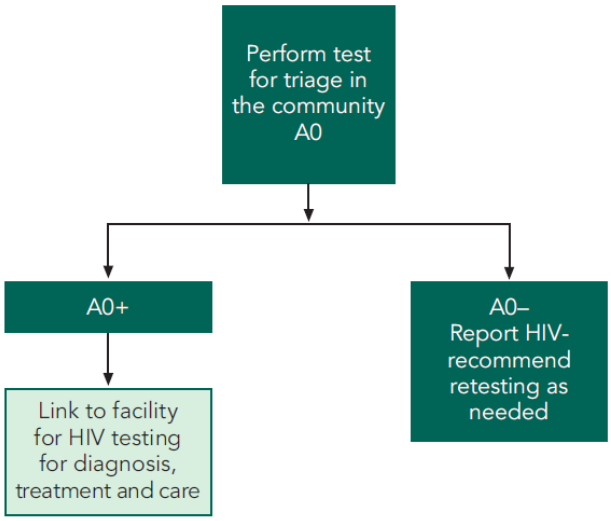
To this end the following will be considered:

- ***Service Delivery Approach*** - A critical aspect of the decentralised model of testing is the linkage to treatment and retention in care of people testing positive for HIV. This necessitates the need for strong referral systems and case management services that needs to be introduced systematically. The role of a case manager who supports the person living with HIV is pivotal to the success of the “identify, reach, recommend, test, treat and retain” approach from a medical and psychosocial perspective over a long period: the person may, for example, be symptom-free and not understand the importance of adherence, be living with alcohol or substance dependence.

[31]Human development report 2014. New York: United Nations Development Programme; 2014

- **Service delivery modalities to promote HIV testing -** The following service delivery approaches will be considered for expanding the HIV testing services:
  - ***Facility-based***: in existing clinical settings such as community health centres, antenatal care, opioid substitution therapy sites;
  - ***Community-based***: in-reach among key populations using mobile units, entertainment sites, and hotspots for sex work and injecting drug use, and also discordant couples. This will include community led testing using "test for triage".

Figure 13: "Test for Triage"



Test for triage. is a community-led HIV testing approach involving:

- Trained and supported lay providers conducting a single HIV rapid diagnostic test, referred to as A0 in Figure 11.
- Lay providers promptly link people with reactive test results to a facility for further HIV testing and, if necessary, assessment for treatment.
- People with non-reactive test results are informed of their results, referred and linked for appropriate services to prevent HIV, and for retesting according to HIV risk and national guidelines.

5) Strengthening the human resource capacity to deliver testing

- ***Strengthening capacity of health workers*** - In order to reach these ambitious Provider-Initiated Testing and Counselling (PITC) targets, additional staff will be needed to provide the services. To this end, new staff will be trained and existing staff will be retrained in health facilities (static and mobile). A cohort of trainers will need to be trained and annually recertified to take charge of these services across the country. This strategy is borne out of the challenges experienced with the HTC programme, in particular reaching key populations.
- ***Engaging CSOs/NGOs*** – Community-level services, in particular those to prevent new HIV infections, needs to be developed and implemented by and for civil society organizations. To achieve the first 90, the better integration of community and health facility services is essential, and new ways of working and task-sharing will be adopted.

To achieve the 2023 targets the following will be implemented:

- **Normalize HIV testing in health care settings:** More effective collaborations between health care professionals and other partners to ensure that no opportunity for HIV testing is overlooked. Professional training and education, enhanced supervision and integration of HIV testing in diverse service settings are needed.
- **Link recipients of HIV testing services with follow-up HIV services:** Appropriate referral mechanisms should be in place in all settings where HIV testing is delivered to ensure that service recipients being tested have ready access to needed HIV prevention and treatment services. Where feasible, co-locating HIV testing and clinical services in the same setting helps facilitate immediate linkage and may reduce loss to follow-up at early stages of the HIV treatment continuum.
- **Build and support community demand for HIV testing** through implementing proven models to increase knowledge of HIV sero-status, including multi-disease health screening campaigns and integration of voluntary HIV testing and counselling into wider health screening.
- **Undertake information and mobilization campaigns** in, and in partnership with, highly affected communities, emphasizing the therapeutic and secondary prevention benefits of HIV treatment and addressing misperceptions about HIV testing and available HIV treatment and care options.
- **Undertake communication initiatives** to educate communities about their right to be free of coercion with respect to HIV testing
- **Leverage community-led efforts to promote HIV testing**: Communities, especially people living with HIV, are best positioned to address misconceptions about HIV testing and treatment. Community-led initiatives would educate communities about the importance of early diagnosis and the availability of simple, well-tolerated treatment regimens.
- **Scale up couple counselling and testing services:** Scale-up should draw from the lessons learned in implementing couples' services in various settings.
- **Integrate HIV testing and counselling**, including couples counselling, into community based multi-disease prevention efforts: HIV screening would be promoted and provided alongside other health interventions.
- **Support community leadership to partner in delivery of HIV testing services**. Community systems are often better equipped to reach individuals who need HIV testing services and to deliver services in an effective, rights-based, culturally competent manner.

Table 1: Estimates of tests required among different population groups to achieve first 90%

PRIORITY	Pregnant Women	General Population	Youth and Adolescents[32]	KPs - IDU	KPs - SW	KPs - MSM
Total Population	1645	98,477[33]	27,349	2,560	586[34]	1084[35]
Number of HIV tests required for 95% coverage	100%	90,820	25,981	2,432	556	1,029
Number of HIV tests required for scale up of 90% coverage	100%	86,040	24,614	2,303	527	975

Table 2: Targets for HIV Testing 2019 – 2023 in Seychelles

PRIORITY	Baseline	2021	2023
Estimated number of PLHIVs	676 (2017)[36]	TBD	TBD
% of pregnant women attending antenatal clinics (ANC) and/or had a facility-based delivery and were tested for HIV during pregnancy and know their results	100% / 1645 (2017)[37]	100%	100%
Number and % of people 15–49 years tested and know their status	12,535 (2016)[38] (number of tests in 2016)	80,000 (90%)	90,000 (95%)
Number and % of youth and adolescents tested and know their status	649 or 10.8% (antenatal attendees 15-24 MOH 2013)	24,614 (90%)	25,981 (95%)
Number and % of PWIDs tested and know their status	29.4%[39] (2017)	1920 (75%)	2250 (90%)
Number and % of Sex Workers tested and know their status	53.8%[40] (2015)	527 (90%)	556 (95%)
Number and % of MSM tested and know their status	59.1%[41] (2011)	975 (90%)	1,029 (95%)
Number and % of PWIDs living with HIV	8% (IBBS Heroin users, 2017)	5.5%	3.3%
Number and % of Sex Workers living with HIV	4.6% (IBBS FSW, 2015)	3%	2%
Number and % of MSM living with HIV	13.2% (IBBS MSM, 2011)	10%	7%
Number and % of transgender persons living with HIV	N/A	TBD	TBD
Number and % of prisoners living with HIV	28 (end 2017) or 6.35 %	5%	3%

[32]The Seychelles National Youth Council defines youth as persons between 15 to 30 years of age, June 2014
[33]Population figures are estimates by Countrymeters (countrymeters.info) based on the latest United Nations data, 30 April 2018
[34]IBBS, FSW, 2015
[35] IBBS, MSM 2011
[36] Local Situation Report, December 2017
[37] GARPR, 2017
[38] MOH Health Strategy, 2016
[39] IBBS, PWID 2017
[40] IBBS, FSW 2015
[41] IBBS, MSM 2011

3.4.2 NSP Outcome 2: Reduced new HIV Infections

HIV prevention in the 2019-2023 NSP will focus on addressing the primary drivers of HIV transmission in Seychelles, injecting drug use and sexual transmission through: intensifying the Harm Reduction programme, including needle syringe programmes and opioid substitution therapy for people injecting drugs; preventing sexual transmission amongst sex workers and MSMs; intensifying advocacy amongst young people; preventing transmission in prison settings; and achieving early elimination of mother to child transmission of HIV and syphilis. It is recognized that effective ART will also constitute prevention by drastically reducing sexual transmission to intimate partners of PLHIV whose viral load is suppressed. The implementation of the strategic priorities for 2019-2023 will provide the basis for achieving the 90-90-90 targets by end 2023.

Strategic Priority 2.1: Reduced new HIV infections amongst key population through sexual transmission

Strengthening of prevention of sexual transmission will include advocacy and support activities which apply for all key populations, female and male SWs, MSM and IDUs, as well as interventions specific for each of these populations. In view of the increasing trend of sexual transmission, a technical working group needs to be established for prevention of sexual transmission, to develop innovative strategies for prevention of HIV transmission and to strengthen existing programmes for prevention of sexual transmission, to improve coverage and quality of interventions. A case management approach needs to be introduced to ensure adherence to treatment and continuum of services linking health and community level services, including accompanied referrals and peer groups.

For the 2019-2023 NSP for HIV, AIDS and Viral Hepatitis, the following will be implemented:

a) Review existing strategies including awareness programmes and activities to encourage and facilitate behavioural change among key populations;
b) Build an enabling environment for behavioural change through community mobilisation and the support of community and religious leaders;
c) Raise awareness and build knowledge and awareness on HIV and other diseases (Hepatitis and STIs), among key populations and youth, their spouses and sexual partners;
d) Support and promote the use of condoms and lubricants among key populations and their partners or clients;
e) Improve and strengthen client-friendly HCT, STI and SRH services to all key populations, including psychosocial counselling;
f) Develop and scale up services on sexual and reproductive health, counselling and treatment related to STIs, HIV and AIDS to ensure universal access to services;
g) Expand and scale up HIV prevention programming incorporating a comprehensive package of services for men who have sex with men (MSM), sex workers and PWIDs; and
h) More effectively introduce PrEP and PEP for prevention of sexual transmission.

Table 3: Targets for Management of Condoms and Sexual Reproductive Health 2019–2023 in Seychelles

INDICATORS	BASELINE	2021	2023
MANAGEMENT AND DISTRIBUTION OF CONDOMS			
% of female sex workers reporting condom use with most recent client	81.3%[42]	90%	95%
% men who have sex with men reporting condom use at last anal sex with a male partner	54.5%[43]	70%	80%
% of people who inject drugs, reporting condom use at last sex	44.1%[44]	60%	80%
Development of a comprehensive condom strategy through broad based consultation by target date	0%	31 Dec 2020	N/A
HIV PREVENTION AND SEXUAL REPRODUCTIVE HEALTH PROGRAMS			
% of youth and adolescents (15-24) reached with HIV prevention programmes (define package of services)	88% (IBBS 2013)	90%	95%
% of PWID reached with HIV prevention programmes (HTC and condoms as defined package of services)	64% (IBBS, 2017)	70%	80%
% of SWs reached with HIV prevention programmes (HTC and condoms as defined package of services)	51% (IBBS, 2015)	60%	80%
% of MSMs reached with HIV prevention programmes (HTC and condoms as defined package of services)	96% (IBBS, 2011)	96%	96%
Update school curriculum on Personal and Social Education to include Prevention & Early Intervention, HIV prevention and SRH by target date	N/A	2020	N/A
Number and % of schools implementing the updated school curriculum on life skills education, HIV prevention and SRH in last academic year	N/A	100%	100%

Strategic Priority 2.2: Implementation of Advocacy, Communication and Social Mobilisation Programs for the uptake of counselling, testing and treatment

A significant scaling up of Advocacy, Communication and Social Mobilisation will be needed to achieve the programmatic goals set for AIDS control as per different milestones. The Advocacy, Communication and Social Mobilisation needs to focus on those areas which has the most to offer and where the strategies can be most effectively concentrated to help address the key challenges of AIDS control at country level:

- Reaching out to 'At risk', youth and other unattended population groups to promote safe behaviours and HIV testing
- Promoting 'gendered' messages for HIV prevention, against intimate partner violence, and couple testing.
- Ensuring early diagnosis/detection and treatment adherence
- Addressing stigma and discrimination
- Information on social protection and other supportive measures

[42] IBBS, FSW 2015
[43] IBBS, MSM 2011
[44] IBBS, PWID 2017

- Empowering people affected by AIDS
- Mobilising political commitment and resources

The vision is for all communities to reach a level of empowerment to protect themselves against HIV and also, access HIV-health services. By implementing the Advocacy, Communication and Social Mobilisation interventions from health-care settings to house-holds, PLHIVs will be supported and treated with dignity and respect. Furthermore, steps will be taken for people living with HIV and communities to increasingly be involved in shaping the AIDS response.

For the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis the following is proposed:

a) Provide communication support for meeting different programmatic targets such as prevention messages for pregnant women and their partners for early testing;
b) Develop a communication strategy to meet 90-90-90 HIV treatment targets and provides a way for elimination of HIV transmission by 2030;
c) Foster participatory planning, management and evaluation capacity involving people living with HIV and communities;
d) Support and develop strategies to achieve key behavioural and social changes, and leveraging the health messaging component of the Social and Behaviour Change Communication (SBCC) Plan, with a focus on local context;
e) Enhance comprehensive knowledge and create an environment that fosters early testing and treatment through motivating key populations, bridge population and other groups, including women, using innovative communication approaches;
f) Target age-specific messaging for promoting the SBCC approach among general population and vulnerable groups including youth;
g) Generate a demand for quality services, strengthen linkages and avail social protection schemes by PLHIVs;
h) Provide an enabling environment to reinforce positive attitudes, beliefs and practices to address stigma and discrimination;
i) Reinforce messages on sexual, reproductive health and rights for women; and
j) Mobilise political commitment and resources for AIDS control.

Table 4: Targets for Advocacy, Communication and Social Mobilisation

INDICATORS	BASELINE	2021	2023
Social and Behaviour Change Communication (SBCC)			
Number and % of PWIDs reached with SBCC	75.4%	80%	90%
Number and % of MSM reached with SBCC	N/A	60%	80%
Number and % of SWs reached with SBCC	N/A	60%	80%
Number and % of prisoners reached with SBCC	N/A	60%	80%
Number and % of transgender persons reached with SBCC	N/A	60%	80%
Number and % of youth and adolescents reached with SBCC	N/A	60%	80%

Strategic Priority 2.3: Reduced new HIV infections amongst key population through injecting drug use

One of the primary modes of transmission in Seychelles continues to be through injecting drug use. Sustaining and scaling up of the existing comprehensive prevention interventions which consist of the harm reduction programme, needle and syringe exchange and methadone maintenance therapy, remain a priority and will need to be further intensified. The needle-syringe distribution and opioid substitution therapy programmes need to be much improved, as the numbers of people who inject drugs receiving new needles and syringes and opioid substitution therapy are unacceptably low. This important harm-reduction programme towards preventing HIV and other infections, such as hepatitis B and C, needs to be scaled up to provide increased access to PWIDs

The potential of opioid substitution therapy (OST) in Seychelles to substantially reduce HIV infections further by reducing the injecting pool and supporting adherence to antiretroviral therapy and hepatitis C virus treatment has remained largely unlocked. Key challenges in the current programme have been limited coverage of services; services being unlinked to other HIV and hepatitis C virus prevention, treatment and care services; and limited quality impacting on both demand and retention.

The expansion OST will address supply and demand issues and must be client-centred in order to improve demand. A key barrier to client retention in opioid substitution therapy is the need for daily visits to the opioid substitution therapy site. The current service delivery model for harm reduction, including opioid substitution therapy, needs to be reviewed in consultation with clients, and services need to be designed to take a differentiated approach towards unstable and stable clients. A competent and good quality approach followed in some countries to improve the user-friendliness of treatment is to set up dispensing sites where clients who have been started on treatment and are stable after two months can access.

For a successful harm-reduction programme, intensified collaboration among various ministries is essential, particularly between the Ministry of Health and the Agency for Prevention of Drug Abuse and Rehabilitation (APDAR). Collaboration must address issues of client-centred care and diversified treatment modalities, and ensure that drug dispensing and storage follow international good practice.

Males and females at higher risk for HIV, such as sex workers and their clients, female partners of males who inject drugs, and men who have sex with men, are another priority in the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis. Through both outreach and in-reach, these key populations, including young key populations, need to access services through programmes that address HIV prevention, sexual exploitation, violence in sex work and elimination of vertical transmission of HIV and syphilis, and in their contacts with other health

services, including sexual and reproductive health and rights services. A gradual introduction of pre-exposure prophylaxis could be achieved for selected key populations in settings with good-quality clinical, laboratory and retention monitoring and counselling support.

For the 2019-2023 NSP for HIV and AIDS the following will be implemented:

a) Build an enabling environment for HIV prevention amongst people injecting drugs and their partners by mobilizing key stakeholders, including health officers at community level, the care providers, community networks (e.g. DURNS) and peer support groups, NGOs, local authorities and law enforcement, through local coordination councils;
b) Develop innovative strategies to address challenges in the delivery of HIV treatment for people who inject drugs, map the high-risk locations, provide access to friendly services, including during extended service hours, improve linkages between community and health services by locating CSOs/NGOs in health facilities and support community services;
c) Establish treatment adherence peer support system to ensure adherence to treatment, train and accredit the CBOs and outreach workers in case management and continuum of care to ensure adherence;
d) Intensify and scale up HIV prevention for PWID and their partners and spouses, including referrals to needle and syringe exchange programmes and opioid substitution therapy;
e) Intensify targeted behaviour change initiatives for male and female PWID, emphasize risk reduction and promote safer sexual behaviours;
f) Develop innovative approaches to attract women who use drugs or are partners of people who use drugs to address sexual transmission and sexual health;
g) Review and revise as appropriate the package of services offered to programme beneficiaries, to include sexual and reproductive health services, opioid substitution therapy, community-based support and hepatitis screening;
h) Strengthen management of HIV prevention among drug users in prisons, other detention facilities and drug rehabilitation centres; and provide access to MST and HIV services; and
i) Establish training and advocacy for police and other uniformed services, and develop training curricula.

Table 5: Targets for reducing HIV transmission through injecting drug use 2019–2023 in Seychelles

PRIORITY	Baseline	2021	2023
% of youth and adolescents who inject drugs of those surveyed[45]	43.8%	Reduce by 50%	Reduce by 75%
% of people who inject drugs receiving opioid substitution therapy (OST)	6.2% (GARPR 2017)	75 % (National Drug Control Master Plan, 2012)	75%
Number of facilities providing OST	8	TBD with APDAR	TBD with APDAR
Number of facilities providing comprehensive NSP package	3	TBD	TBD

[45] IBBS, PWIDs 2017

PRIORITY	Baseline	2021	2023
Number of sterile needles–syringes distributed in past 12 months by needle–syringe programmes.	21,550	TBD	TBD
% of people who inject drugs reporting the use of sterile injecting equipment the last time they injected	74.8% (IBBS Heroin Users,2017)	80%	90%
Number of needles and syringes distributed per person who injects drugs per year by needle and syringe programmes	5.7 (GARPR, 2016)	TBD	TBD

Strategic Priority 2.4: Reduced new HIV infections amongst people in closed (prison) settings

Providing prisoners with the knowledge and means to protect themselves against HIV infection, and providing effective care treatment and support to prisoners living with HIV and AIDS, is a strategic intervention of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis. The effective control of HIV and AIDS in prisons has important public health consequences beyond prisons.

Investments in programmes for people in closed (prison) settings are important. Although the legislation has looked at diversion programs for drug users, the arrests of drug users continue. Many of these people end up in prisons and custodial institutions, where they are exposed or expose others to HIV and may be cut off from the HIV services on which they rely.

Incarcerated populations have the same right to health as any other segment of the population. Health services are provided by the prison and detention centre authorities, in coordination with the national health authorities, following the nationally agreed protocols. Standard operating procedures need to be developed to ensure the services are delivered during detention and will remain uninterrupted after detention.

To ensure HIV prevention, treatment and care services are provided to prisoners the following need to be considered for the 2019–2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis:

- **Education and Awareness**
- **HIV Testing and Counselling**
- **Care, Treatment and Support**

a) **Education and awareness** - Provide on a continuing basis access to accurate, non-judgemental, and accessible information on HIV and AIDS in various formats. This should include clear and unambiguous information on routes of transmission, the types of behaviours (i.e. unsafe sexual activity, syringe sharing) that pose a risk of HIV transmission, the proper and effective use of comprehensive HIV and AIDS prevention, care and support measures, and correct myths and misinformation about routes of transmission. Information should be accessible in a confidential and non-discriminatory fashion.

b) **HIV Testing and Counselling** – Provide access to confidential HIV testing with counselling for prisoners where such testing is available in the outside community. This should include access to anonymous HIV testing in jurisdictions where such testing is available outside of prisons. Furthermore, the following should be provided:
   - Ensure prisoners are provided with sufficient information to enable them to make an informed choice about whether to undertake a test or to refuse testing if they so choose.
   - Ensure well-informed pre- and post-test counselling as a mandatory component of HIV testing protocols and practice, and ensure effective support is available to prisoners when receiving test results and in the period following.
   - Ensure the confidentiality of HIV test results of prisoners.
   - Ensure that informed consent and pre- and post-test counselling are mandatory for all HIV testing practices in prisons – including diagnostic testing, the use of rapid test kits, and testing as part of post-exposure prophylaxis protocols.

c) **Care, treatment and support** – provide access to appropriate and professional HIV and AIDS care, treatment and support equivalent to that available in the outside community, including access to diagnostics, antiretroviral treatment, and health promotion options. Furthermore, ensure that prevention and treatment of STIs, TB, and hepatitis and other opportunistic infections are provided as key components of comprehensive HIV and AIDS care.

Table 6: Targets for reducing HIV transmission amongst Prisoners

PRIORITY	Baseline	2021	2023
Number and % of prisoners tested and who know their results	246 (GARPR 2016)	90%	90%
% of prisoners who tested HIV positive	6.35% (Prison Record 2017)	5%	3%
% of prisoners who are HIV positive receiving ART	69.4% (GARPR 2016)	80%	90%

Strategic Priority 2.5: Reduced new HIV infections amongst youth and adolescents

Young people aged 10 - 24 years from key populations are at increased risk for HIV, due partly to multiple biological and psychological transitions and developmental stages, such as establishing an identity during this period. Among these key populations are young men who have sex with men, transgender young people, young people questioning their sexual identity and sexual orientation, young people who inject drugs, young sex workers, and young people who belong in multiple groups.

It is therefore critical to stop new HIV infections and untimely HIV-related deaths through both primary and secondary prevention and better management approaches. Using an interwoven prevention and treatment cascade approach, the starting point for all interventions must be HIV counselling and testing. Subsequent interventions for both HIV-negative and HIV-positive youth must be “adolescent-centred,” occur within the socio-ecological context of young people and take advantage of the innovations and technologies that youth have easily incorporated into

their daily lives. In order to achieve the global goals of zero new HIV infections, zero AIDS-related deaths and zero discrimination, a sustained focus on HIV research, policy and advocacy for Young Key populations (YKPs) must occur.

Encouraging young people to access and remain engaged with sexual and reproductive health and other adolescent health services is key. Engagement with health services needs to be at the local level, integrated, quick, confidential, non-prejudicial and hassle-free. Capacity-building of health service providers must include youth-specific needs and issues. Legal protection of young people will be ensured so their specific human rights are respected.

For the 2019-2023 NSP for HIV and AIDS the following will be implemented:

a) Enhance delivery of curriculum and co-curriculum related to HIV education and awareness in school and higher learning institutions;
b) Strengthen awareness programme using interactive and multimedia to reach out adolescent and young people;
c) Facilitate and support existing programme for young people with drug use behaviour in school and higher learning institutions;
d) Increase uptake of HIV testing among young-key-populations; and
e) Improve treatment adherence among adolescents living with HIV (ALHIV) and Young PLHIVs with support group.

Table 7: Targets for reducing HIV transmission amongst youth and adolescents

PRIORITY	Baseline	2021	2023
Number and % of youth in schools reached with HIV prevention messages	N/A	90%	100%
Number and % of youth reached with HIV prevention messages	88% (IBBS 2012)	90%	95%
Number of peer support groups for young people with drug use behaviour established	0	TBD	TBD
Number and % of youth and adolescents tested for HIV and who know their results	N/A	90%	95%

Strategic Priority 2.6: Elimination of mother to child transmission (EMTCT) of HIV and Syphilis

Seychelles in 2015 achieved the elimination of mother-to-child transmission (EMTCT) of HIV and is currently on track for eliminating the mother to child transmission of HIV. Building on the successful Prevention of Mother to Child Transmission (PMTCT) programme, Option B+ was started in 2012 in government health facilities. A key area of consideration during the 2019-2023 period is the engagement of partners/spouses in the programme and more effective linkage of EMTCT to existing SRH programmes.

Package of services currently offered:

- The HIV testing and counselling (pre-test and post-test) services are offered as part of the Antenatal Care (ANC) package at the ANC clinics and Integrated Counselling and Testing centres (ICTC).
- The prevention and treatment services to all pregnant women attending the health care facility are availed.
- All HIV positive pregnant women, including those presenting in labour and breastfeeding, are initiated on lifelong triple ART for preventing mother-to-child transmission risk.
- For infants of HIV positive pregnant women, prophylaxis with Zidovudine is started at birth for a recommended duration of four weeks, followed by a minimum of four weeks of cotrimoxazole, prior to early infant diagnosis at two months.
- HIV infected babies are started on a second line triple therapy regimen of Zidovudine/Lamivudine/Kaletra.
- HIV infected mothers are discouraged from breastfeeding and are offered exclusive replacement feeding for a duration of the first six months after delivery.
- All pregnant women are tested for syphilis and offered treatment if she is found to be infected. Partner contact tracing and offer of treatment are done for both HIV and syphilis.

For the 2019-2023 NSP for HIV and AIDS the following will be implemented:

a) Maintain the provision of quality, comprehensive national PMTCT services, in line with the WHO recommended four pronged strategies, to reach pregnant women, their partners and their infants, including key populations;
b) Strengthen community awareness of HIV to increase enrolment in the PMTCT programme and other related antenatal, family planning, sexual and reproductive health, voluntary confidential counselling and testing services, particularly among key populations; and
c) Ensure the availability of PMTCT in all ANC facilities, so that all HIV-infected pregnant women and their HIV-exposed infants receive ARV treatment, prophylaxis and breastfeeding education and supplies.

Table 8: Targets for eliminating mother to child transmission of HIV and Syphilis

INDICATORS	BASELINE	2021	2023
PROVISION AND UPTAKE OF PMTCT			
% of pregnant women who have been tested for HIV and know their results	100%	100%	100%
Number and % of pregnant women living with HIV giving birth in the past 12 months (as a % as all pregnant women in that year)	10 (0.6%)	10 (0.6%)	10 (0.6%)
Estimated % of children newly infected with HIV from mother-to-child transmission among women living with HIV delivering in the past 12 months	1% (MoH, 2017)	0%	0%
% of HIV-positive pregnant women who receive antiretroviral medicine to reduce the risk of Mother-To-Child-Transmission	100%	100%	100%
Final MTCT transmission rate	10 %	0%	0%

INDICATORS	BASELINE	2021	2023
TESTING AND COUNSELLING			
% of infants born to women living with HIV receiving a virological test for HIV within two months of birth	91.7% (GARPR, 2016)	100%	100%
Coverage of syphilis testing in women attending antenatal care services at any visit	100%	100%	100%
% of pregnant women attending ANC whose male partners were tested for HIV during pregnancy	3.8% (GARPR, 2014)	90%	95%

3.5 NSP Goal 2: 90% of all PLHIVs receive antiretroviral therapy

3.5.1 NSP Outcome 3: Effective implementation of 'Test and Treat' for increased ART initiation

Strategic Priority 3.1: Increased uptake of ART by PLHIVs

For the 2019-2023 NSP for HIV, AIDS and Viral Hepatitis, the following will be implemented:

- **Accelerate uptake of ART**
- **Ensure enabling environment for achieving universal access to ART**

a) ***Accelerate uptake of ART***:

Increasing the pace of expansion of ART coverage and improving ART adherence are the primary objectives of this 2019-2023 NSP to reaching the second and third 90. The expansion of the testing program will require an associated expansion of the treatment program.

To enhance coverage for ART and improve retention, a multi-pronged strategy needs to be planned through:

- Plugging the loss of clients from HCT to ART: Use of, PLHIV networks, CBOs/NGOs, community and religious leaders;
- Improving access to ART: ART services will need to be scaled up, in a phased manner, based on variations, epidemiology and need;
- Differentiated care to improve efficiency at ART centres, clientele counselling etc. will be need to be considered;
- Comprehensive clinical management with global standards of HIV care;
- Addressing cross cutting issues of paucity of human resources and monitoring and evaluation; and
- Treatment literacy and awareness on the importance of the uptake of ART and adherence to the treatment regimen.

b) ***Ensure enabling environment for achieving universal access to ART:***

To maintain good quality of care support and treatment services, which are provided in a non-discriminatory sensitised manner, at all service delivery sites, a comprehensive approach for ensuring high quality implementation of services for PLHIV needs to be planned and implemented. It will include:

- Onsite and distant mentoring of service delivery sites, supportive supervision, cadre wise induction and refresher trainings of the health workers using updated training curricula, continued medical education programme for clinical staff, and focused quality improvement initiatives at each site.
- Clinical and programme mentoring will enable health workers to practice new skills at service delivery sites with the support and guidance of more specialised and experienced professionals. Effective mentoring will promote application of classroom learning in clinical and programmatic settings by enhancing skills, knowledge, and confidence of health workers in service delivery; improving the quality of care and patient outcomes; and strengthens systems, policies, and procedures that support delivery of high quality care. Furthermore, the key areas under this would be:
  - Mentoring and supervision support
  - Focussed quality improvement
  - Developing revised and updated training curricula
  - Regular review meetings for continuous improvement in quality
  - Strengthened M&E system
  - Convergence with general health system for effective utilisation of infrastructure and facilities

The 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis will focus on the following:

- Anti-stigma programmes
- Community literacy with respect to HIV treatment and rights.
- Programme management and innovation
- HIV treatment programmes for key populations services
- Training, supervision and policy enforcement

a) **Anti-stigma programmes**, including school-based initiatives, should be implemented and/or strengthened; and key stakeholders, such as religious leaders and organizations or networks of people living with HIV and key populations, should be engaged in broader efforts to fight stigma and discrimination. Seychelles needs to actively work to create programmes to reduce discrimination in health care settings, implement mechanisms for civil society monitoring and reporting on discrimination and coercion and establish accessible and effective systems for support and redress in cases of health care–related discrimination.

b) **Community literacy** should be increased with respect to HIV treatment and rights. Treatment literacy programmes empower people living with HIV to understand the

importance of early HIV diagnosis and the availability of simplified, safer and highly effective regimens that dramatically improve health and the quality of life. Treatment and rights literacy enables people to make informed decisions about their health and helps generate broad-based demand for HIV testing and treatment services. Empowered individuals understand their rights, including the right to a fair and public hearing by an independent and impartial tribunal if rights are violated.

c) **Programme management and innovation** will be given priority to close gaps in the HIV treatment cascade. Individual clinical and service settings would immediately implement and strengthen quality improvement mechanisms, identifying and monitoring specific process and outcome indicators and using findings to enhance service quality and impact. The ministry and other partners would intensify quality monitoring through such means as quarterly site visits by quality assurance teams. Service sites would be given incentives to use innovation to enhance linkage, retention and adherence.

d) **HIV treatment programmes for key populations** would be integrated into other routine outreach services that are managed by community based service organizations and key populations themselves. In light of new data underscoring the prevention benefits of antiretroviral treatment for people who inject drugs, efforts are urgently needed to enhance outreach and treatment delivery for this heavily affected population. Integrating HIV programmes in ongoing outreach services for key populations not only facilitates access for key populations into health services but also mitigates the deterrent effect of stigma and discrimination.

e) **Training, supervision and policy enforcement** are required to increase the responsiveness and sensitivity of mainstream health systems to mitigate stigma and discrimination.

Table 9: Targets for scale up and uptake of ART

INDICATORS	BASELINE	2021	2023
UPTAKE OF ART SERVICES			
Estimated number and % of people living with HIV who are on ART	434 (CDCU 2017) 62%	805 (90%)	850 (95%)
Number and % of people living with HIV who initiate ART	907 (MoH, 2017) 80%	85%	90%
% of PWIDs living with HIV who are receiving ART	42% (IBBS, 2017)	80%	90%
% of SWs living with HIV who are receiving ART	57% (IBBS, 2015)	80%	90%
% of MSMs living with HIV who are receiving ART	N/A	80%	90%
% of prison inmates living with HIV who are receiving ART	69.4%	80%	90%
Number of facilities providing ART	3	5	7
% of facilities with stock-outs of antiretroviral drugs	0	0	0

Strategic Priority 3.2: Strengthened Linkages to care and support services

Evidence shows that Social and Behaviour Change Communication (SBCC) plays an important role in supporting HIV prevention and care outcomes.[46] A number of activities have been undertaken to educate the public on the availability of HIV treatment, how it works, its effectiveness and where to get further advice. With the scale up of ARVs, continued and expanded effort is required to make the public aware of the new ART coverage goals and the anticipated impact on the HIV epidemic in Seychelles. In addition, information on the availability of facility and community-based care and support services will need to be widely disseminated involving community led initiatives. Coupled with this is the development and production of targeted messages and communication materials for the different segments of the population that include PWIDs, MSMs, SWs, and prison inmates. Additionally, community efforts are needed to not only increase awareness of ART, but to establish community norms that are accepting and supportive of ART adherence. Community and civil-society groups will play a major role in this effort to disseminate targeted information, facilitate and support treatment uptake and retention, and encourage supportive community norms around ART adherence.

Patients may be lost at various stages in the care continuum. To reduce morbidity and mortality, early identification of HIV positive persons and immediate start of ART will work towards achieving the 90-90-90 UNAIDS goal to maximize the effectiveness of existing program strategies to virtually eliminate progression to AIDS, premature death and HIV transmission. Earlier initiation on ART may have implications on retention and adherence, and examples of sub-populations include adolescent girls on Option B+, key populations and youth. There is also loss to follow up of HIV-exposed infants. Retention in care to ensure optimal monitoring on ART and the attainment of viral suppression, which has been well established as a strategy to prevent HIV transmission, must be strengthened.

Table 10: Targets for linkages to care and support for PLHIVs on ART

INDICATORS	BASELINE	2021	2023
Linkages to care and support for ARVs			
Number and % of PLHIVs not on treatment identified	242 (MoH, 2017) 63%	80%	90%
Number and % of newly diagnosed people linked to HIV care	98 (GAM, 2017) 88%	90%	95%
% of HIV positive adults receiving HIV care whose partner's status is known	TBD	TBD	TBD
Psychosocial support			
Number and % of PLHIVs receiving psychosocial support	TBD	30%	60%

[46]Journal of AIDS 2014 http://www.healthcommcapacity.org/jaids-health-communication-plays-hiv-prevention-care

3.5.2 NSP Outcome 4: Improved identification, treatment and management of co-infections

Strategic Priority 4.1: Diagnosis, treatment and management of PLHIVs with sexually-transmitted infections (STIs)

There is an established epidemiological synergy between HIV and STI. To impact HIV transmission and improved sexual and reproductive health, there is a need to strengthen STI diagnosis and treatment. The STI control and prevention programme needs to provide standardised STI services as part of Sexual and Reproductive Health (SRH) services at all levels of health system; especially focusing on key population, women, adolescent and youth. The programme will build capacity of health care to provide regular supportive supervision to enhance the quality of services.

The specific strategies include:

- **Syndromic case management** with appropriate laboratory test, inclusive of screening for HIV as well as Syphilis, will remain the corner stone of STI management for 'key populations as well as general population at all levels of care. The service package would include condoms, partner management and counselling services.
- **Destigmatisation** as well as standardisation of STI services.
- **Standardised service packages** for 'key populations, women, adolescent and youth through flexible service delivery approach. Regular clinical contact with key populations is important to reinforce preventive communication, counselling, addressing the SRH need and providing STI management. STI services need to be decentralised and provided at majority of the community health centres as part of the enhanced response. This will include symptomatic and presumptive treatment, a regular medical check-up, and biannual periodic Syphilis screening.

Strategic Priority 4.2: Diagnosis, treatment and management of PLHIVs with Hepatitis B and C

According to the 2017 IBBS report, of the estimated population of 2,500 PWID, 8%[47] are HIV positive, 35.6% are infected with Hepatitis C. Priority for vaccination against Hepatitis B needs to be expanded to all PLHIV in the treatment and care centres, then to PWIDs at the operating sites level for PWIDs, and in the prison to alleviate the burden of co-infection. As far as treatment is concerned, it would be pertinent to know the morbidity outcome of these infections through a survey and to undertake an exercise on the cost-benefit of treatment. Health care workers and persons at risk of potential exposure should be vaccinated against Hepatitis B.

[47] IBBS for Heroin Users, 2017

Strategic Priority 4.3: Screening for Cancers

Cervical Cancer is the second most common cancer in women worldwide. Human papillomavirus (HPV) is considered to be the causing agent and contamination is associated with a variety of conditions including, early start of sexual activity and multiple sexual partners. It is of note that such risk factors are also often common with HIV infections.

Key activities that will be implemented during the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis period include:

a) **Communication and Education:** Women as well as health care workers need to be educated on the link between HIV and AIDS and cervical cancer. Women are also not aware of the current cervical cancer screening policy and as such fail to access their rights in this regard.

b) **Policy development:** The existing cervical cancer screening policy is outdated and needs to be revisited. The current cervical screening policy should be expanded to include women who should be offered screening upon HIV positive diagnosis and then at regular intervals. Women and girls who have reported a history of sexual assault need to similarly be provided with screening at an appropriate time.

c) **Education and awareness of the public** about cervical cancer and the link with HIV and AIDS needs to take place.

d) **The provision of HPV vaccine** to girls only can be less efficient when unprotected sex occur between a vaccinated girl and unvaccinated boy. HPV vaccination for boys should also be considered.

e) **SRHR policies** should be integrated with HIV and AIDS. The integration of these two services is needed as there is a strong relationship between these services. This needs to be matched to resources to provide integrated services.

f) **Partnerships with all stakeholders** including the Ministry of Health need to be forged to address redressing, monitoring and evaluation, policy and service provision

Table 11: Targets for identification, treatment and management of co-infections

PRIORITY	Baseline	2021	2023
STIs Assessment and treatment			
% of men reporting an STI in the past 12 months	1% (CDCU 2017)	TBD	TBD
% of PWIDs screened for STIs	15.7% (IBBS 2017)	60%	80%
% of SWs screened for STIs	26% (IBBS 2015)	60%	80%
% of individuals seropositive for syphilis	0.02	TBD	TBD
Hepatitis C Screening and treatment			
% of people starting anti-retro viral therapy who were tested for hepatitis C virus (HCV)	47.6%	70%	90%

PRIORITY	Baseline	2021	2023
% of PWIDs starting anti retro viral therapy who were tested for hepatitis C virus (HCV)	44.4%	70%	90%
% of people co-infected with HIV and HCV starting HCV treatment	8.6%	70%	90%
% of PWIDs co-infected with HIV and HCV starting HCV treatment	8.1%	70%	90%
Hepatitis B Screening and treatment			
% of people co-infected with HIV and HBV receiving combined treatment	66.7%	70%	90%
% of PWIDs co-infected with HIV and HBV receiving combined treatment	36.4%	70%	90%
TB Screening and treatment			
% of people in HIV care (including PMTCT) who were screened for TB in HIV care and treatment settings	60%	80%	90%
% of people living with HIV and newly enrolled in HIV care who have active TB disease	0% (MOH 2017)	0%	0%
Screening and treatment of Cancers			
% of women living with HIV 30-49 years old who report being screened for cervical cancer using any of the following methods: visual inspection with acetic acid (VIA), Pap smear or human papilloma virus (HPV) test	84.6% (MOH 2017)	90%	95%
VMMC			
Number of male circumcisions performed	70 (MOH 2017)	500	1000

3.6 NSP Goal 3: 90% of all people on ART will be virally suppressed

3.6.1 NSP Outcome 5: Increased adherence by PLHIVs to ART

Strategic Priority 5.1: Increased retention on ART

1) Education and awareness

To improve adherence and ensure good treatment outcomes, explicit support systems for users and community mobilisation and advocacy processes that promote the rights of people living with HIV and AIDS will be established. The responsibility for adherence is given to the clients themselves, but occurs within a clear framework of support, a period of treatment preparedness and the building of trusting relationships with providers. This is very different to the traditional paternalistic and passive relationship between health care workers and patients - changing this represents the key innovation challenge of the ARV programme. Central to this relationship are the front-line providers, expert clients and community mobilisers who have to champion the purpose and process of adherence to ART. However, for sustained realisation of good

treatment outcomes, community systems strengthening for support, advocacy and kinship remains crucial.

2) Facility Based Support

Sustaining a programme of universal ARV access also requires facilitating patient adherence to ART; ensuring that people take their medication every day for the rest of their lives. Poor adherence rapidly leads to the emergence of drug resistance and treatment failure at the individual level. If resistance develops on a wide scale, this will have broader public health implications, including the cost of maintaining a large number of people on second and third line regimens. Obligations on the part of individuals to adhere have to be matched by obligations on the part of the health system to ensure continuous access to uninterrupted supplies of drugs, skilled providers and laboratory support able to maximise the safety and efficacy of drugs, a supportive environment and community norms for adherence.

3) Community Based Support

Community based care and support is an integral part of comprehensive treatment and care for PLHIV, and should be standardised and integrated into the wider care and support system. This NSP will scale up the provision of community-based care and support services in support of the ART programmes, ensuring increased emphasis in catchment areas of high-burden facilities, where the absolute number of patients requiring community support is highest.

The growing bi-directional referral system between facilities and communities will continue to be strengthened, improved and consolidated. In addition, the quality of community support services will be improved by establishing and strengthening technical and institutional capacities of PLHIV and CSOs/NGOs, particularly in adherence support and monitoring. The training of CSOs/NGOs, including peer educators, community leaders and volunteers, will complement services by health workers. Over the 2019-2023 period PLHIVs will be followed-up in the community thereby reaching the 90% target of viral load suppression by 2023.

Table 12: Targets for PLHIVs on ART who are virally suppressed

INDICATORS	BASELINE	2021	2023
ART Retention			
Number and % of people living with HIV and on ART	434 or 62%	80%	90%
Number and % of people living with HIV and on ART who are retained on ART 12 months after initiation	98 or 95% (GAM 2016)	95%	98%
Establish standard operation procedures for referral and feedback by target date	0	2020	N/A
Number of NGOs and CSOs trained in advocacy and adherence support	0	5	10
Viral load testing			
% of all PLHIVs on ART will be virally suppressed.	62% (Annual Health Report, 2017)	80%	90%

INDICATORS	BASELINE	2021	2023
% of people living with HIV and on ART who have virological suppression (<1000 copies/ml) at 12 months after initiating treatment	83% MoH, 2017	90%	95%
% of people (children and adults) on ART with viral load test results at 12 months	100%	100%	100%
% of people living with HIV with the initial CD4 cell count <200cells/mm3 during the reporting period	16.1%	TBD	TBD
AIDS Mortality			
Rate: Total number of people who have died from AIDS-related causes per 100 000 population	19 %	15%	10%
Rate: Total number of people(aged 15+ years) who have died from AIDS-related causes per 100 000 population	0 %	0 %	0 %

3.7 NSP Goal 4: Zero Stigma and Discrimination

More than three decades into the HIV epidemic, stigma and discrimination continue to hamper efforts to prevent new infections and engage people in HIV treatment, care and support programmes. Numerous studies have linked HIV related stigma with refusal of HIV testing, non-disclosure to partners and low uptake of biomedical prevention services and commodities, including condoms, pre- and post-exposure prophylaxis and ART.[48],[49] Similarly, internalized stigma, which refers to the negative consequences that result when people believe that stigmatizing public attitudes apply to them,[50] is a well-established barrier to medication adherence.[51]

The recent shift in the global AIDS response to biomedical prevention will require acceptance and uptake of prevention approaches, such as, pre-exposure prophylaxis and universal testing and treatment, at the population level.[52] Effective interventions to reduce stigma and discrimination are crucial to the success of biomedical prevention.[53] Such interventions need to be integrated into national responses and address the stigmatization process.[54] Stigma and discrimination interferes with HIV prevention, diagnosis and treatment, and can become internalised by people living with HIV and AIDS.[55] Importantly, stigma and discrimination are often enacted through discrimination (defined as the rejection or prejudicial treatment of different categories of people or things, especially on the grounds of race, age, health status or

[48]Abdool Karim Q, Meyer-Weitz A, Mboyi L, Carrara H, Mahlase G, Frohlich JA, et al. The influence of AIDS stigma and discrimination and social cohesion on HIV testing and willingness to disclose HIV in rural KwaZulu-Natal, South Africa. Glob Public Health. 2008;3(4):351_65.
[49]Turan JM, Bukusi EA, Onono M, Holzemer WL, Miller S, Cohen CR. HIV AND AIDS stigma and refusal of HIV testing among pregnant women in rural Kenya: results from the MAMAS study. AIDS Behav. 2011;15(6):1111_20.
7. Corrigan PW, Penn DL. Lessons from social psychology on discrediting psychiatric stigma. Am Psychol. 1999;54(9):765.
[50]Corrigan PW,Watson AC. The paradox of self-stigma and mental illness. Clin Psychol: Sci Pract. 2002;9(1):35_53.
[51]Rintamaki LS, Davis TC, Skripkauskas S, Bennett CL, Wolf MS. Social stigma concerns and HIV medication adherence. AIDS Patient Care STDs. 2006;20: 359_68.
[52]Dai JY, Gilbert PB, Hughes JP, Brown ER. Estimating the efficacy of pre-exposure prophylaxis for HIV prevention among participants with a threshold level of drug concentration. Am J Epidemiol. 2013;177(3):256_63.
[53]Earnshaw VA, Bogart LM, Dovidio JF, Williams DR. Stigma and racial/ethnic HIV disparities: moving toward resilience. Am Psychol. 2013;68(4):225_36.
[54]Stangl A, Go V, Zelaya C, Brady L, Nyblade L, Stackpool-Moore L, et al. Enabling the scale-up of efforts to reduce HIV stigma and discrimination: a new framework to inform program implementation and measurement. XVIII International AIDS Conference, July 18_23. Vienna; 2010.
[55]Alonzo AA, Reynolds NR: Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory. Soc Sci Med 1995, 41(3):303–315.

gender), hostility and prejudice against PLHIV (as well as their partners and families), denying them equal access to essential services in many cases.[56]

Stigmatisation associated with HIV and AIDS is underpinned by many factors, such as lack of understanding of the disease (including misconceptions about modes of transmission), lack of access to treatment, irresponsible media reporting, and the incurability of AIDS. Stigmatization is additionally conflated with widespread, prejudice and fears relating to socially sensitive issues (including sexuality, sex work) which themselves contribute to HIV risks and vulnerability among members of key populations.[57] Not only is HIV and AIDS-related discrimination a human rights violation, but it is also necessary to address such discrimination and stigma in order for public health goals related to HIV and AIDS prevention and management to be achieved.[58]

HIV-related stigma and discrimination drive the risk of, and vulnerability to, HIV infection by keeping people from accessing prevention, treatment, care and support services thereby depriving them of their human rights. Consistent with the UNAIDS vision to Getting to Zero discrimination, this result focuses on actions that ensures that persons infected and/or affected by HIV and AIDS have their fundamental rights respected, that they have the same access to services as the rest of the community, and that being infected and/or affected by HIV and AIDS does not constitute a barrier or obstacle to accessing health, social, economic and psychosocial services. Where rights are found to have been violated, access to justice programme for affected people and communities are also going to be important.

The following will be implemented to support the NSP Goal on zero stigma and discrimination:

It is well known that HIV has negative effects on the health of individuals and families, but also on their economic and social wellbeing. It is evident that increased access to ARV helps PLHIV to remain healthier and contributes towards zero HIV related death - therefore remaining economically active for longer so that income generating activities and vocational training are becoming an increasingly important part of the care and prevention package for PLHIV and their families.

- **The social environment** of PLHIV has to be supportive, free from stigma and discrimination,
- **The legal framework** must be clear regarding the rights of PLHIV and those at perceived risk of HIV.
- **Interventions to support achievement** of this result will be directed towards Policy Makers, People infected and affected by HIV, Key Populations, Women and the General Population.

[56]Link BG, Phelan JC: Stigma and its public health implications. Lancet 2006, 367(9509):528–529.
[57]Herek M: Thinking about AIDS and stigma: a psychologist's perspective. J Law Med Ethics 2002, 30(4):594.
[58]Aggleton P, Wood K, Malcolm A: HIV-related stigma, discrimination and human rights violation: case studies on successful programmes. Geneva: UNAIDS best practice collection; 2005. http://data.unaids.org/publications/ irc-pub06/jc999-humrightsviol_en.pdf.

3.7.1 NSP Outcome 6: Increased protection of the rights of PLHIVs, women, young boys and girls

Strategic Priority 6.1: Responsiveness of the social and legal environment to the rights of PLHIVs

Human rights, gender, justice, equity and inclusion are centrepieces for an effective HIV response. The key populations and people living with HIV continue to experience prejudice and discrimination, including in the health services. Many of them require extensive social protection and support. Special attention will be given to human rights and gender issues and zero tolerance monitored, so that nobody is left behind in **achieving the 90-90-90 targets and** the HIV response towards ending the AIDS epidemic. Law enforcement and other uniformed services have an important role to play in protecting disadvantaged key populations and need to be well-trained in their functions. The Agency has an important part in this, including in the scale-up of opioid substitution therapy and harm-reduction programmes and participation in condom promotion and distribution.

Strategic Priority 6.2: Implementation of gender responsive HIV programming

Advancing human rights, as enunciated in the Universal Declaration of Human Rights, and gender equality for the HIV response means ending the HIV-related stigma, discrimination, gender inequality against women and girls that drive the risk of, and vulnerability to, HIV infection by keeping the said people from accessing prevention, treatment, care and support services. It means putting laws, policies and programmes in place to create legal environments that protect people from infection and support access to justice. At the core of these efforts is protecting fundamental human rights in the context of HIV— including the rights of women, young boys and girls and men who have sex with men.

1) Increased protection of women, young girls and boys

Implementing interventions to address gender inequalities and gender-based violence as drivers of HIV in girls, women and young boys are particularly vulnerable to HIV infection because of their biological vulnerability and due to gender norms, roles and practices which increase risks while reducing their capacity to protect themselves. Acknowledging the fact that gender inequality hinders social and economic development, the achievement of gender equality remains one of the critical components of the HIV agenda. Within targeted geographic settings, CSOs, CBOs, and communities are critical players in the delivery of comprehensive community packages which address gender barriers across continuum.

Additionally, a package of clinical and social services will be promoted and provided to survivors to mitigate the harm associated with GBV. This will include timely and appropriate provision of healthcare screening and medical documentation for individuals wishing to pursue legal redress (as well as assistance and referral in seeking police and legal services), trauma counselling, access to sexual and reproductive health services including emergency contraception, and

timely provision of post-exposure prophylaxis as appropriate. Patient intake at appropriate healthcare services (including STI and HTS providers) will include screening questions to identify GBV survivors, and training and sensitization for healthcare providers will include content on appropriate management of GBV survivors. SBCC activities and promotional materials will increase awareness and acceptability of these services among target audiences.

2) Increased uptake of health services with respect to SRH

Consultations with FSW highlight vulnerability such as discrimination in access to services (especially health); stigma in the community; violence (amongst themselves, law-enforcers and by clients); and high numbers of sexual partners. The implementation of the SW operational/action plan is considered in the context of this NSP.

In light of this, the 2019-2023 NSP will strive to undertake the following:

- Conduct advocacy for FSW to carry out participatory assessments with their peers in order to assess what puts them at risk for HIV infection and the obstacles they face when trying to protect themselves from HIV.
- Develop a range of communication, education, skills building, and condom distribution.
- Undertake sensitization of health provider attitudes with all the other HIV prevention communication interventions targeting sex workers.
- Use the peer-to-peer approach to help women educate each other on these rights and impress upon risk reduction behaviours.
- Recognizing that the vulnerability of this population group is closely linked to behaviours and attitudes of their sex partners and community norms, make a deliberate effort to:
    - Engage community leaders,
    - Increase male involvement campaigns;
    - Conduct gender-based violence reduction programmes, and psycho-social support.
    - Integrate messaging in areas of family planning and include all other HIV prevention interventions and barriers to uptake.

Table 13: Targets for Zero Stigma and Discrimination

INDICATORS	BASELINE	2021	2023
Social and legal protection			
% of people aged 15–49 with discriminatory attitudes towards people living with HIV	82% (GARPR, 2013)	0%	0%
Stigma index score	N/A	TBD	TBD
% of sex workers who avoided seeking HIV testing because of fear of stigma	N/A	0%	0%
% of men who have sex with men who avoided seeking HIV testing because of fear of stigma	14% (IBBS, 2011)	5%	0%
% of people who inject drugs who avoided seeking HIV testing because of fear of stigma	6% (IBBS, 2011)	0%	0%
% of people from key populations who have experienced discrimination by health workers	N/A	0%	0%

INDICATORS	BASELINE	2021	2023
% of health facility staff observations of stigmatizing or discriminatory behaviour against people living with HIV	N/A	0%	0%
Gender responsive programming			
Number of interventions implemented to address gender inequalities and gender-based violence (including young and adolescent boys)	N/A	TBD	TBD
Number of facilities providing clinical and social services to survivors to mitigate the harms associated with GBV	N/A	TBD	TBD
Number of people who received PrEP at least once during the reporting period	2	TBD	TBD
Number and % of health facilities where PrEP is available	1	3	TBD
Number and % of health facilities where PEP is available	100%	100%	100%

3.8 NSP Goal 5: Facilitate a sustainable national response to HIV and AIDS

In order to reach the goal of ending AIDS by 2030 and of fast tracking by 2022, the critical enablers include: Strengthening health and community services to ensure service capacity for expanded case load from fast tracking, intensifying support to NGOs/CBOs to build up capacity for community level services, and promoting integrated health service-community continuum of care and services. Sustainable domestic financing will be secured for fast tracking and ending aids, including establishment of adequate accountability and auditing mechanisms. Quality information will be provided, including synchronizing information from multiple information sources.

3.8.1 NSP Outcome 7.a: Improve the enabling environment for HIV prevention, treatment and care – Policies and Guidelines

The HIV and AIDS response was predicated on the HIV and AIDS Policy. The regional and global commitments signed by Seychelles have rendered this policy as out-dated. A new National Policy on HIV and AIDS needs to be developed that is premised on an enabling social and legal environment that is characterised by being free of stigma and discrimination.

The new HIV and AIDS Policy needs to focus on strengthening the legal framework for implementing HIV and AIDS interventions, needs review its practices to address the criminalization of activities engaged in by key populations, and the policy should be informed by the findings of the Legal Environment Assessment (LEA) conducted in 2013 and action plan prepared in 2017.

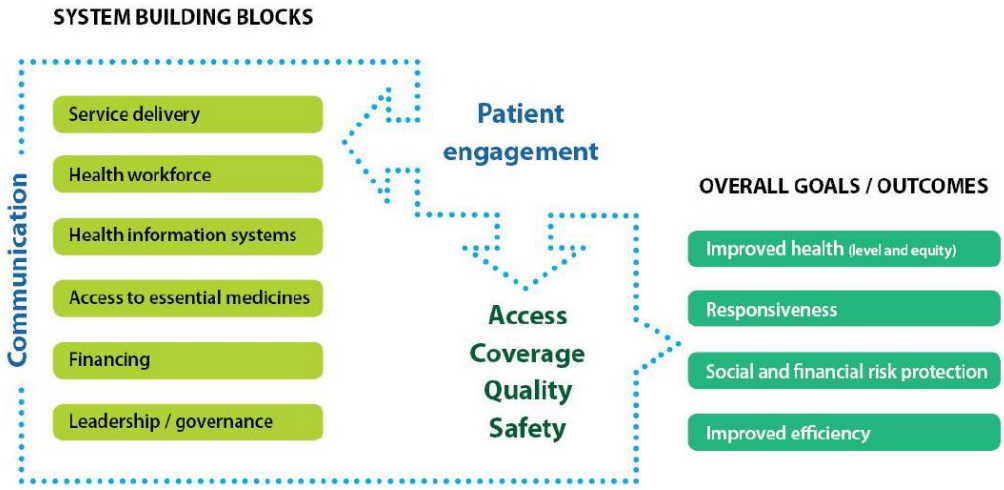
At global and regional levels, Seychelles is also a signatory of a number of conventions and declarations including the commitment to 'Test and Treat' and the SADC agreement, which

form a further important guiding framework for national laws, policies and regulations relating to HIV.

3.8.2 NSP Outcome 7.b: Improve the enabling environment for HIV prevention, treatment and care – Health Systems

Successful implementation of the national HIV response relies upon strong and functional health systems to achieve more equitable and sustained improvements across health services and health outcomes[59]. The six building blocks described by World Health Organization (WHO) describing health systems in terms of six core components or "building blocks": (i) service delivery; (ii) health workforce; (iii) health information systems; (iv) access to essential medicines; (v) financing; and (vi) leadership/governance (Figure 13). The subsequent WHO monitoring framework recognized that "sound and reliable information is the foundation of decision-making across all health system building blocks."

Figure 14: WHO Health Systems Framework



Investing now to strengthen health systems is a strategic imperative. A strong health system is the best insurance against a disease burden that is shifting rapidly and in unpredictable ways.[60] Evidence of this is apparent in West Africa where the worst Ebola outbreak in history led the United States to mount one of the largest ever and most complex responses to any global health crisis. This is more than a tragic story of the unyielding spread of a deadly virus; it tells of the breakdown of health systems – inadequate facilities, staff, and investments – in already fragile environments. Health systems' limitations like these are binding constraints to further progress in global health.

[59]WHO. Everybody's Business: Strengthening Health Systems to improve Health Outcomes; WHO's Framework for Action: Geneva: WHO 2007

[60]

To strengthen the health systems the following strategic interventions will be considered in the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis:

- **Health Workforce**
- **Leadership and Governance for the HIV response**

3.8.2.1 Health Workforce

A well performing health workforce for the HIV program requires sufficient numbers and skills mix for service delivery and program management. Evidence-based planning for HRH remains elusive due in part to weak capacity by MoH to generate real time data to forecast future HRH needs and costs. These gaps need to be closed. The National ART Program relies almost entirely on CDCU for treatment initiation and follow-up prescribing. Continued ART scale-up will require at least a moderate increase of HR allocation to ART services while clinical protocols will need to remain simple and streamlined. Increasing pre-service training outputs, in-service training through clinical mentoring, task shifting through training and placement of lay counsellors, expert patients and other volunteers to increase the health workforce will improve linkage, retention and adherence to treatment.

The system for the HIV program is centralised and has **not achieved** success in decentralizing ART initiation to primary care level through task shifting, the use of fixed dose combination therapy and simplified empirical clinical guidelines, with minimal reliance on laboratory services to determine clinical eligibility. Similarly, testing has not expanded and remains the purview of the medical laboratory technicians, at best an inappropriate fit, as the necessary skills for pre- and post-test counselling are not within the skills set of this cadre of health workers.

Continued ART scale-up will require increased numbers of frontline health workers to retain patients along the care continuum and provide quality services. The National Health Strategy (2016-2020) identifies increasing production of the health workforce by focusing on health cadres; fostering stakeholder coordination to achieve synergy in effective HR planning, management, and training/development; and strengthening HR information system and research as key priorities.

HRH policy review and a supportive regulatory environment is essential to formalize task sharing for HIV service delivery through endorsement of revised scopes of practice and pre-service syllabus for frontline service providers[61]. To further support task sharing and assure quality standards of treatment and care, the national HIV program needs to develop the supervision protocol includes a systematic review and verification of primary records (patient cards and registers) at all sites, serving as a quarterly data quality audit to ensure accuracy and completeness of HIV program data and conduct quarterly supportive supervision to every ART site. Systematic chart reviews need to be conducted to assure compliance with clinical guidelines and facilitates on-the-job training and targeted clinical mentoring.

[61] Global Recommendations and Guidelines for task Shifting for HIV AND AIDS, WHO, 2007

3.8.2.2 Leadership and Governance for the HIV response

The leadership and governance of health systems, is arguably the most complex but critical building block of any health system. In Seychelles, the Health System Strengthening (HSS) cannot be achieved without effective leadership and governance at human capacity and regulatory levels.

Key considerations in the implementation of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis are:

a) **Include those directly involved in making decisions** (strategic political leaders such as the Minister, health parliamentary committees, policy makers, hospital directors and managers at national and district levels).

b) **Develop a leadership assessment tools for leadership capacity for the HIV response in the health sector:** Since the regulatory authorities often take on critical functions in supporting the environment for achieving the health targets, NAC through its board will develop a leadership assessment tools for leadership capacity for the HIV response in the health sector. In particular, it will assess the capacity for leadership for results and use of evidence for decisions making. The findings of the assessment will inform scope and content of leadership development in the health sector and the provision of technical support for senior managers in implementing the HIV and AIDS response.

c) **Amend the current HRH strategy and align to the areas of investment** in the 2019-2023 National Strategic Plan for HIV, AIDS and Hepatitis. The establishment of a skilled health workforce is a prerequisite for achieving the 90-90-90 targets and challenges health systems is not sufficient alone. Other challenges include the appropriate distribution of tasks, the retention of trained personnel, working conditions and occupational safety. Finally, although a well-trained workforce is an essential prerequisite to high-quality health care, quality is also determined by the organization of the health care system in which the workforce is operating. The strategic interventions will require an amendment to the current HRH strategy for a more sustainable approach to developing human resources for achieving the 90-90-90 targets, such that that pre-and in-service training is embedded in a flexible national process of developing human resources – ensuring the match between the workforce needs and the supply for HIV interventions while making sure that other parts of the health sector are not harmed.

The key activities will include:

- national training and human resource assessments and planning;
- provide guidance to human resource planning;
- advocacy and monitoring to resolve barriers to the development of human resources.

3.8.3 NSP Outcome 7.c: Improve the enabling environment for HIV prevention, treatment and care – Community Systems

The interface between primary health care systems and community systems in the advent of changes in the AIDS landscape is catalytic to the delivery of effective package of integrated primary health services. In this respect, Seychelles recognises the need for developing tools and products for strengthening community based organisations capacity to advocate for the inclusion of community priorities, and participation in monitoring and reporting the performance of the HIV response.

Strengthening community based strategies across the HIV prevention care and treatment cascade is vital to engage civil society and will prove more essential to reach the ambitious targets set for 2023. Strengthening the leadership and governance of civil society organisations and local community infrastructure is an entry point to an effective integrated HIV response. In addition, sustaining the important functions of CSOs in community mobilization and holding those in authority accountable requires that these CSOs are sustainable and accountable themselves. The 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis aims to prioritize strengthening leadership and governance for CSOs as well support CSOs working in the HIV response to build effective sustainability strategies over the next five years.

The 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis calls for the active participation of civil society (community, cultural and religious leaders, private sector, CBOs, PLHIV, key populations and community groups) in moving towards the ambitious 90-90-90 targets. To relieve the burden on healthcare providers, a number of the non-clinical tasks relating to patient follow-up and adherence support need to be shifted to community based, lay health workers and volunteers and will rely on civil society organisations and networks working with key populations and PLHIVs.

CSOs/NGOs however require both funding and technical assistance to strengthen their activities. To strengthen these organisations the following needs to be considered during the implementation of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis:

- Provision of technical assistance and tools to strengthen community based HIV organizations and groups in HIV technical areas such as HTC, PMTCT and ART.
- Organizational systems strengthening.
- Provision of grants.
- Supporting coordination of partnerships, networking and collective advocacy on priority issues such as uptake of HTC, ART adherence, harm reduction programs and condoms.
- Conducting action research and promoting knowledge management that includes dissemination of lessons learned and evidence-based programming.
- Improving monitoring and impact measurement.

3.8.4 NSP Outcome 7.d: Improve the enabling environment for HIV prevention, treatment and care – Coordination and Management of the National HIV Response

3.8.4.1 Guiding Principles

The adoption of the multi-sectoral and decentralised approaches in the coordination and management of the national response is required in Seychelles. The process demands innovation, clarity of roles and responsibilities linked to institutional mandates and comparative advantages. The national response coordination and management is premised on the Three Ones' principle:

I. One agreed HIV and AIDS Action Framework that provides the basis for coordinating the work of all partners.
II. One National AIDS Coordinating Authority, with a broad based multi-sector mandate.
III. One agreed country level Monitoring and Evaluation System.

The initial guiding principles to formulating the revised structures are summarised below:

- *Access to Relevant Information:* Information and its use in effective M&E is key to the NAC being able to fulfil its coordination and monitoring mandate. Accurately recorded information must be made available 'bottom-up' from all stakeholders involved with the implementation and must adhere to standard formats. Furthermore, it must be made available and shared regularly through NAC structures to be fully reviewed and used in implementing M&E.
- *'Bottom-up' Approach:* Governance and reporting arrangements will start at the lowest level through program implementers and finally to NAC. There will be a clear guiding framework to support implementation and set out expected roles and responsibilities.
- *Accountability and Responsibility:* Accountability and responsibility for implementation and coordination activities will be strengthened at all levels with a step-up process for feedback and reporting at the next level of governance. Appropriate ownership for reporting and implementation outcomes will be established.
- *Reporting:* A standard framework of reporting will guide the regular monitoring and tracking of 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis implementation. Reporting will be completed by each implementer (MOH, CSOs, NGOs, other line ministries), and verified and passed upwards through formal reporting channels to NAC. Governance arrangements will require direct ownership of all reports, their content and outcomes.
- *Transparency:* The entire 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis implementation and coordination process will be based on clear and open communication that leads to a common understanding and discussion of relevant facts. There will be no ambiguity in decision-making and there will be a common understanding of expectations and requirements among everyone involved.

- *Meaningful Involvement of People Living with HIV and Key Populations:* Governance structures will recognise the important role to be played by PLHIVs and key populations and will involve them in governance structures.

3.8.4.2 Governance and Coordination of the National HIV Response

The National AIDS Council (NAC) established by the Seychelles Government provides leadership and coordinates the national response to HIV and AIDS. It is governed by a Board of Commissioners led by the Chairperson who is appointed by the President. The other members are selected from all constituencies namely: private, public, faith, civil society, and PLHIV. Major roles include reviewing and approving NAC policies and procedures, annual work programme and hiring of secretariat executive staff.

Specific roles of the Council are to: (i) guide development and implementation of the national strategy; (ii) facilitate policy and strategic planning in sectors, including local government; (iii) advocate and conduct social mobilization in all sectors at all levels; (iv) mobilise, allocate and track resources; (v) build partnerships among all stakeholders in country, regionally and internationally; (vi) knowledge management through documentation, dissemination and promotion of best practices; (vii) map interventions to indicate coverage and scope; (viii) facilitate and support capacity building; (ix) conduct overall monitoring and evaluation of the national response; and (x) facilitate HIV and AIDS research.

3.8.4.3 Implementing Partners

Within these governance and institutional frameworks, actual implementation of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis is the responsibility of a wide range of implementing partners from the public and private sectors, and civil society.
These include:

- **Ministry of Health** plays a key role in the multi-sectoral response, for technical direction and service delivery in biomedical areas of prevention, treatment and care. The specific roles of the MoH include: (a) developing policies and guidelines on biomedical HIV and AIDS interventions; (b) planning and implementing biomedical HIV and AIDS interventions; (c) coordinating health sector thematic areas; (d) providing technical support for HIV and AIDS policy development; (e) providing technical support in implementation of health-related HIV and AIDS interventions; and (f) surveillance for HIV, AIDS and STIs.
- **Other line Ministries** directly or indirectly support the national response. Line Ministries provide services up to the community level. Ministries need to establish focal points for HIV and AIDS and are expected to mainstream HIV and AIDS into their sectoral work, provide technical support to the response, and organise workplace interventions for staff.
- **NGOs, FBOs and CBOs** form the core of the implementing agencies and among others things carry out advocacy, assist communities to mobilise resources locally, document best community practices and support capacity building programmes in collaboration with NAC.
- **Private Sector** organisations under the responsibility to mainstream HIV and AIDS through workplace policies and programmes.

Coordination and management remain essential, during the period of 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis. The focus will be on establishing coordinating structures to ensure the efficient and effective national HIV response, governance and leadership, social and resources accountability, and more importantly ensuring that duty bearers and other service providers adhere to human rights such as the right to health, privacy and protection while providing essential services. Emphasis will also be laid on ensuring that rights holders (service beneficiaries) are able to access health services without fear of being stigmatised or discriminated against. An environment that supports efficiency in service delivery is characterised by well-articulated mandates, roles and responsibilities, a functional joint programme review mechanism, planning and development process, and a strong monitoring and evaluation system.

NAC as the overall coordinating body will ensure that the strategic roles of communities, civil society, PLHIV and key populations are clearly defined and communicated. It will also ensure that decisions in such an environment are evidence-based and focus on specific results; they are gender sensitive and anchored in a human rights framework.

3.8.5 NSP Outcome 7.e: Improve the enabling environment for HIV prevention, treatment and care – Monitoring and Evaluation

In line with the Three Ones' Principle, a comprehensive national HIV and AIDS Monitoring, Evaluation and Research Framework (M&E Framework) has been developed to coordinate stakeholders towards one agreed country-level monitoring and evaluation system. The development of the National M&E Framework was participatory involving wider stakeholders at public, private and community levels and in harmony with the global (GARPR & GAM Report) and country specific indicators.

Information gathered from M&E of HIV and AIDS programmes will be used for tracking the epidemic trends and the national response to HIV. The goal of National M&E Framework is to provide timely and accurate strategic information to guide the planning of the national response to HIV and AIDS in order to achieve the object of national response. Information sources include among others: a) Mapping of Key Populations; b) Monitoring of overall programme coverage; b) Monitoring of prevention services; e) Monitoring of treatment services; f) Monitoring of impact mitigation; g) Operational research conducted to increase the effectiveness of prevention, treatment, care and support programmes.

Line ministries, CSOs and NGOs involved in the implementation of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis will continue to operate their own systems for programme monitoring and evaluation using standard common indicators. The National M&E Framework will consolidate information which is generated by the government and other key stakeholders. Achievement of expected results and targets will be monitored and evaluated periodically.

3.8.5.1 Indicators and Targets

To monitor the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis, the indicators for measuring programme coverage targets have been selected to get consistent and accurate information on programme performance and outcomes, which ensure that key populations will have access to high quality prevention, treatment, care and support services. These indicators are in line with the UNAIDS global target on the achievement of the 90-90-90 targets and ending AIDS by 2030 in Seychelles.

3.8.5.2 Monitoring and Evaluation Process

Monitoring and evaluation programme will capture and evaluate programme implementation from input, activities and output to impact level. All stakeholders involved in the response to HIV are contributors to achieving the targets, measured using the standard common indicators, and are equally responsible to ensure that their activities are regularly monitored, reported and utilised to measure progress.

The National AIDS Council Secretariat within the Ministry of Health is given the responsibility to monitor and evaluate the overall HIV and AIDS framework. The NAC Secretariat is also empowered to ensure that all relevant stakeholders report to the Secretariat on specific indicators as necessary. NAC Secretariat will work with Ministries and civil society organisations to lead the national programme monitoring and evaluation. Utilising strategic information gained from the M&E, the NAC Secretariat will evaluate the existing response as well as suggest areas needing improvement or adjustment.

3.8.5.3 Surveillance

Seychelles began conducting integrated bio-behavioural surveillance survey (IBBS) among key populations for the first time in 2011 and the following year conducted a knowledge, attitude and perception study under the auspices of Ministry of Health. Biological component (HIV test) was integrated into the surveys. Strategic information collected and analysed by surveillance system includes estimations of key populations and their locations. The information will be designed, collected and analysed with technical support to have meaningful data collection programme planning and for future projections.

3.8.5.4 Guidance and Reporting

Horizontal working relationships between government and non-government agencies are critical to ensure that there is appropriate programme monitoring at both operational and national levels. National HIV and AIDS Monitoring, Evaluation and Reporting Guidelines need to be developed, and used to guide monitoring and evaluation of the 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis implementation. These guidelines will be kept as simple and practical as possible to allow monitoring, evaluation and reporting to be properly carried out. The guidelines will be disseminated, and training of all service providers conducted so that monitoring, evaluation and reporting will be optimized.

3.8.5.5 Progress Monitoring

Progress monitoring and evaluation needs to be conducted through joint government and civil society periodic performance reviews. The intention of the performance reviews is to evaluate progress based on coverage, effectiveness, relevance and sustainability of programmes. The frequency of the HIV programme review will be every 6 months with the MoH taking the lead. The review will be conducted with government and civil society organisations responding to 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis.

The NAC Secretariat chaired by the Monitoring and Evaluation Specialist/CEO will lead the HIV programme performance reviews conducted. This includes strengthening of Secretariat's own technical capacity and the capacity of the involved Ministries and civil society organisations

3.8.5.6 Annual Progress Report

The NAC Secretariat will coordinate and facilitate the preparation of annual progress reports and development of annual work plans through the national HIV programme performance review, which will be discussed and finalised as part of the annual joint stakeholder meeting held towards the end of each year. The input to the annual progress report will also be based on HIV programme performance review undertaken.

The annual progress report will provide information on the progress made in implementing the operational plans. Based on programme monitoring data which is routinely collected by the NAC Secretariat, an assessment is made whether planned activities have been implemented and whether planned outputs and expected results have been achieved, and whether corrective adjustments need to be made.

The annual progress report will be based on the indicators and targets agreed in the M&E framework, which include core indicators detailed in the body of this 2019-2023 National Strategic Plan for HIV, AIDS and Viral Hepatitis. Based on data collected by the NAC Secretariat and stored in a centralised database, an analysis will be made concerning the progress made in achieving the agreed targets for these core indicators. The annual progress report will include an analysis of most recent surveillance data as well as data from other recent surveys in order to assess changing and emerging epidemiological trends. Based on the results and findings of the assessments presented in the annual progress report, the NAC Secretariat, in close consultation with its partners, will prepare or revise the work plan for each coming year.

3.8.5.7 Mid Term Review

A mid-term review of the implementation of the 2019-2023 National Strategic Plan is planned to take place in 2021. The review on the progress made in the implementation of the national response will be discussed in joint stakeholder meetings and will suggest adjustments and direction and scope of future implementation of the response.

3.8.5.8 *Impact Evaluation*

An interim evaluation will take place in 2021, to evaluate the implementation of achieving the 90% PLHIVs knowing their status and 90% PLHIVs are on ART. It will recommend corrective action and adjustments to the 2019-2023 National Strategic Plan if necessary. The final evaluation of the 2019-2023 National Strategic Plan will take place in the second half of 2023. These evaluations will assess the results in the achievement of targets, analysing the available data to verify outcome and impact in comparison with baseline values for core indicators. These evaluations will not only assess effectiveness of individual programmes and of the overall national response, but will take into consideration the quality and efficiency of programmes and interventions.

3.8.5.9 *HIV and AIDS Research*

Monitoring and evaluation of the 2019-2023 National Strategic Plan will also require data collected through research, including regular surveys. Research compliments monitoring and evaluation by building a knowledge base which will guide the national response. Thematic research will be conducted to better understand underlying causes, dynamics and impacts of the epidemic, such as epidemiological trends, new and emerging areas of concern and a better understanding of vulnerability and long-term consequences of the epidemic.

3.8.6 NSP Outcome 7.f: Improve the enabling environment for HIV prevention, treatment and care – Costing and Financing the HIV Response

Costing and financing are crucial in the mounting of a response to HIV and AIDS. These elements will be addressed and completed during the costing phase of the NSP and M&E Framework.

Table 14: Targets for improving the enabling environment for HIV prevention, treatment and care

PRIORITY	BASELINE	2021	2023
Strengthen the delivery of HIV prevention, treatment and care services			
Development of the HIV Policy to support the new international and regional obligations	2012	2020	N/A
Testing and counselling guideline developed by target date	2015	2020	N/A
Treatment management guideline developed by target date	2015	2020	N/A
Comprehensive Condom Distribution and Management strategy developed by target date	0	2020	N/A
Clinical protocols for the management of the HIV response developed by target date	2015	2020	N/A
Level of functionality of the M&E system	0%	100%	100%
% of M&E operational plan activities implemented.	0%	100%	100%

SECTION FOUR: ANNEX

List of Persons who officially participated in the development of the 2019-2023 National Strategic Planning for HIV, AIDS and Viral Hepatitis

We are also thankful to many other individuals, from their respective organisations, or in their own capacity, who are not mentioned here, who provided sound advice and counsel in the process of charting the best strategy for the 2019-2023 national response to HIV, AIDS and Viral Hepatitis in Seychelles.

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