World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2013

SEYCHELLES

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ABBREVIATIONS

ADB	:	African Development Bank
AIDS	:	Acquired immune deficiency syndrome
AIDS	:	HIV/AIDS Programme
AMS	:	Activity Management System
AU	:	African Union
BCG	:	Bacille-Calmette-Guérin
BADEA	:	Arab Bank for Economic Development in Africa
CCS	:	Country Cooperation Strategy
CDP	:	Chronic Diseases Programme
CMT	:	Communication and Management Technologies programme
COMESA	:	Common Market for Eastern and Southern Africa
CPC	:	Communicable Disease Prevention and Control programme
CRD	:	Communicable Disease Research programme
CSR	:	Epidemic Alert and Response programme
CVD	:	cardiovascular diseases
DAH	:	Development Assistance for Health
DPT	:	Diphtheria-Pertussis-Tetanus
EDM	:	Essential Medicines programme
EFTCA	:	Egyptian Technology Cooperation Fund
EPI	:	Expanded Programme for Immunization
GDP	:	Gross Domestic Product
HDR	:	Human Development Report
HFS	:	Health Financing and Social Protection programme
HIV	:	human immunodeficiency virus
HPR	:	Health Promotion programme
HRH	:	Human Resources for Health programme
HSD	:	Policy Making for Health in Development programme
HSP	:	Health Systems Policies and Services Delivery programme
IDSR	:	Integrated Disease Surveillance and Response
IHR	:	International Health Regulations
IMR	:	infant mortality rate
VINJ	:	Violence, Injuries and Disabilities programme
IRS	:	Health Information and Research for Health Systems programme
IVD	:	Immunization and Vaccine Development programme
KAP	:	Knowledge Attitudes and Practices

MERP	:	Macro-Economic Reform Programme
MDG	:	Millennium Development Goals
MNH	:	Mental Health and Substance Abuse programme
MOHSD	:	Ministry of Health and Social Development
MMR	:	Maternal Mortality Rate
NBS	:	National Bureau of Statistics
NCD	:	Noncommunicable diseases
NGO	:	Nongovernmental organisation
NIHSS	:	National Institute of Health and Social Studies
ODA	:	Official Development Assistance
OECD	:	Organization for Economic Cooperation and Development
OPV	:	Oral Polio Vaccine
OSERs	:	Office Specific Expected Results
PHC	:	Primary Health Care
PHE	:	Health and Environment programme
PLWHA	:	People living with HIV and AIDS
PPE	:	Programme Planning and Evaluation
PRM	:	Partnership and Resource Mobilization
PSS	:	Procurement and Supply Services
RDO	:	Regional Director's Office/WR's Office
SARS	:	Severe Acute Respiratory Syndrome
SIDS	:	Small Islands Developing State
SOs	:	WHO Strategic Objectives
STI	:	sexually transmitted infections
TB	:	Tuberculosis
TFR	:	total fertility rate
TOB	:	Tobacco programme
UN	:	United Nations
UNAIDS	:	Joint United Nations Programme on HIV/AIDS
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
VCT	:	voluntary counselling and testing
WHO	:	World Health Organization
WLO	:	WHO Liaison Office
WP	:	Work Plan

EXECUTIVE SUMMARY

In recognizing the ever-increasing diversity of challenges facing countries' efforts to improve the health of their populations, WHO is stepping up its responsiveness to individual countries' health needs, and becoming more strategic in its approaches to supporting countries achieve their national health goals.

This 2nd Country Cooperation Strategy (CCS) for Seychelles describes the ways in which the WHO Country Office (WCO) intends to support the country in advancing human health. It outlines strategic priorities for the WHO Country Office (WCO) for 2008–2013, and also focuses on broadening health partnerships with key developmental partners at country level for efficient use of international health resources for Seychelles.

To this end, the CCS provides a clear framework for WHO's technical cooperation with Seychelles, highlighting the relevant strategies to be utilized in addressing priority health issues.

This CCS is based on extensive consultations with various key partners of health in Seychelles, as well as the contributions of WHO staff at the country and regional levels. The results of the broad consultative process in alignment with the elements of the National Health Strategic Framework for Seychelles, 2006-2016, guided the development of this CCS.

Over these past four decades, Seychelles has made remarkable progress in health development through a comprehensive healthcare infrastructure. Located throughout the country and based on the principles of equity and access, healthcare reaches people in all 16 health administrative districts. One of the key strengths of the Seychelles health system has been the commitment of the government to raise the human development standards of its people to the highest levels through the Primary Health Care Strategies.

Although Seychelles has been successful in addressing key health issues, the health system still faces a number of challenges. These include improving the quality and delivery of its health care services, setting up an effective monitoring and evaluation system, addressing the high turnover of health professionals, and tackling rising levels of noncommunicable diseases, HIV/AIDS and other emerging diseases.

A review of the first-generation CCS indicated that whilst much was achieved, there were still issues that need be addressed, particularly in the areas of health services organization and delivery, human resource development, surveillance, research and health information and health promotion.

The Seychelles WCO's close working relationship with key developmental health partners is crucial to helping to achieve the strategic objectives of the CCS. The WCO will take into account the need for a stronger harmonisation with non-resident UN Agencies to avoid duplication of efforts and to ensure efficient utilization of available resources.

The WCO will utilize this CCS as a fundamental tool for planning and coordinating its support to the government over the next 5 years. The implementation of the CCS's Strategic Agenda will span three consecutive biennial workplans.

PREFACE

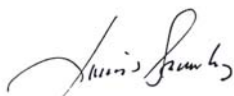
The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.



Dr Luis G. Sambo
WHO Regional Director for Africa

SECTION 1

INTRODUCTION

The Country Cooperation Strategy (CCS) is an integral part of WHO's Country Focus Policy (CFP), which aims at optimizing WHO's involvement and contribution towards Seychelles' health sector development, aimed at achieving national and international health goals. The CCS reflects WHO's mandate, roles and functions globally, and seeks to:

(a) Improve the implementation of its key strategies in line with the country's health needs;

(b) Empower the country to exercise more influence in the global and regional public health agendas;

(c) Synchronize the WHO Country Strategy with the Medium-Term Strategic Plan for 2008–2013 and the Eleventh General Programme of Work for 2006–2015;

(d) Strengthen WHO's partnerships with other development partners at the country level; and

(e) Harmonize health inputs and maximize the use of resources in a more collaborative environment.

The development of the CCS at this time is opportune, as Seychelles is in the process of reviewing its health policies, systems and infrastructure, which, in the face of mounting costs, need to become more strategic and responsive to the needs of the population. Other supporting factors include:

(a) The government's desire to sustain a high level of stewardship by providing overall direction and leadership to bring value to the health system;

(b) Ongoing changes in donor interests;

(c) The need to generate more internal capital and implement cost-containment and efficiency-enhancing measures;

(d) The strengthening of collaborative efforts between the Ministry of Health, private health care providers and the civil society;

(e) Efforts to develop and sustain human resources in heath; and

(f) The need to for greater collaboration between the health ministry and other ministries.

The CCS is based on a thorough and systematic assessment of the country's health needs and challenges. It has taken into consideration the key elements of the National Health Strategic Framework for Seychelles for the period 2006–2016, the current reforms in the Seychelles health sector, and the UN Common Country Assessment (CCA), 2006.

This second-generation CSS spans the period 2008–2013 and is harmonised with the UN CCS Framework, the UN Millennium Development Goals (MDGs), and bilateral and regional cooperation initiatives of the Indian Ocean Commission (IOC) and the African Union (AU).

This document is the outcome of comprehensive consultations between key health stakeholders in Seychelles. Its formulation process was guided by a core team that included local WHO Country Office staff, the UNDP Resident Representative, and officials from the Health and Foreign Affairs ministries and the National Statistics Bureau. A list of key stakeholders consulted is found in Annex 1.

WHO is the government's major multilateral partner in health, the only resident UN agency in the country and a recognized important partner in health to Seychelles since 1980. WHO works closely with non-resident UN Agencies to ensure optimal utilization and maximum benefits of available resources. WHO will continue to play brokerage and facilitating roles to support the Ministry of Health and Social Development (MoHSD) to successfully implement sector-wide approaches (SWAps) to health care in the Seychelles.

The WHO Liaison Office will continue dialogue with the MoHSD and other partners to ensure the smooth implementation and monitoring of the interventions in the workplan. The implementation of the CCS Strategic Agenda will be carried out in three consecutive biennial workplans and budgets. A results-based monitoring and evaluation framework will be used to monitor key indicators in the biennial workplans.

Mid-term and final evaluations of the CCS Strategic Agenda will be conducted in 2010 and 2013 respectively.

SECTION 2

COUNTRY SITUATION ANALYSIS: HEALTH AND DEVELOPMENT CHALLENGES

2.1 COUNTRY PROFILE

2.1.1 Geography and Population

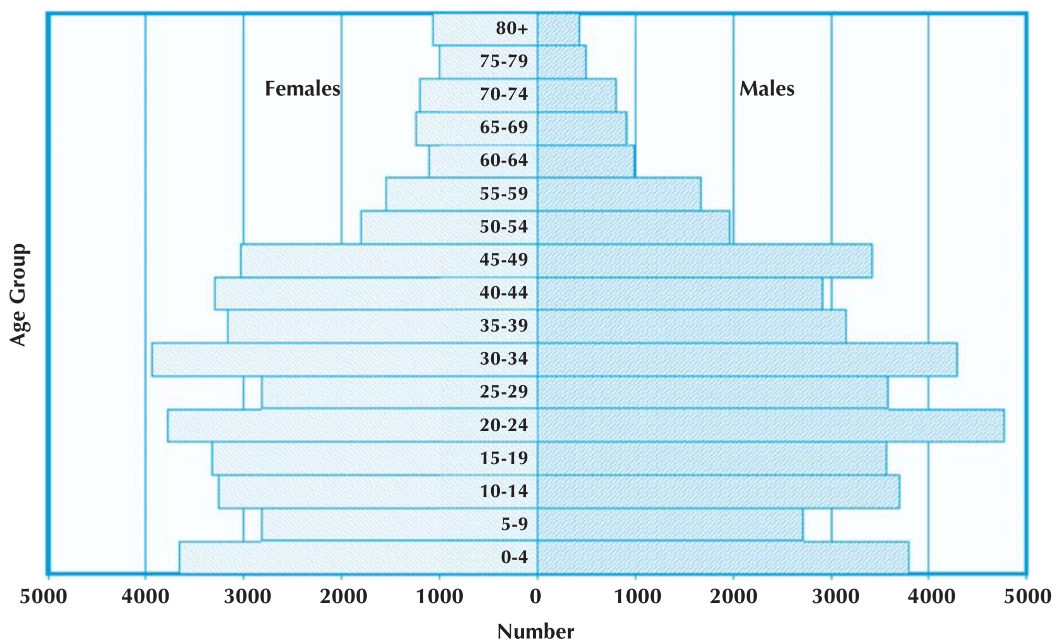
Seychelles is a multi-ethnic trilingual society, with Creole as the population's mother tongue and English and French as the main the administrative languages. Whilst the main religion is Christianity, other major religions are represented.

With a land area of 445 square kilometres, the country is an archipelago of about 116 islands situated in the South-Western Indian Ocean, more than 1,500 km off the East Coast of Africa, and with an exclusive economic zone of 1.3 million sq. km. The main habitable islands—Mahé, Praslin and La Digue—share the bulk of the country's economic activities. Victoria, the capital of Seychelles, is located on Mahé, which is the largest of the three main islands (Fig 2.1).

The estimated mid-year population in 2007 was 85,032, comprising 20,933 households (National Statistics Bureau, August 2007). The population structure shows a trend from a younger towards an older population (Annex 2, Fig 2.2), with males forming 51% of the population.

Fig. 2.1 Map of Seychelles

Fig. 2.2 Seychelles population pyramid, 2007. Source: National Statistics Bureau, 2008



Average household size decreased from 4.3 to 3.7 persons between 1999 and 2007 (National Statistics Office, Household Expenditure Survey, 2007). Crude birth rate has continued to fall over the past 20 years, from 21 to 17.3 per 1000 population between 1995 and 2006. Average life expectancy at birth has increased from 63 in 1960 to 73.1 in 2007, with an eight-year gap in life expectancy between males and females (National Statistics Bureau, March 2008).

2.1.2 Socioeconomic Overview

Seychelles' economic and social progress since independence has been remarkable. The country was ranked 50th in the 2007 Human Development Report, and is now considered a middle-income developing state. However, whilst the country has been able to achieve relatively high levels of GNP per capita, US$ 10,733 in 2007, this significant social and economic progress has not yet led to the total elimination of poverty; a 1996 study indicated that there may be "pockets of poverty" in the Seychelles. The economy, which is service-oriented, is supported by the manufacturing, construction, tourism, fishing, trade and transport sectors, which together contributed to about 70% of the GDP in 2006 (National Statistics Bureau, February 2008) (Table 2.1).

Table 2.1 Selected economic statistics

	2004	2005	2006
1. GDP US$ million (market price)	836.0	883.8	967.7
2. GDP per capita US$ (market price)	10,136	10,667	11,439
3. Total health expenditure (as a percentage of total public expenditure)	19.5	22.6	20.4
4. Total HRH expenditure (as a percentage of national health budget)	59.5	63.7	57.8
5. Total Health expenditure (US$ million)	28.7	33.3	35.4
6. Total Government expenditure in health (as a percentage of national budget)	10.4	9.3	10.5
7. Per capita health spending (US$)	349.4	350.9	345.1
8. HRH training (US$)	181,818	72,727	79,725
9. Overseas treatment (US$ million)	1.14	0.95	1.6
10. Inflation rate	3.9	0.9	-0.4

Source: National Statistical Bureau; Central Bank of Seychelles; MoHSD

Seychelles has a high literacy rate of 96% (in 2007), with no disparity in rates between the sexes. Girls and boys are equally entitled to the 15 years of compulsory education up to the secondary level.

2.1.3 Governance

The country achieved its independence from Britain in 1976. Between 1977 and 1993 it was governed under a single-party socialist system. In 1993 Seychelles became a multi-party democratic republic, adopting the current constitution, which guarantees fundamental rights and equal opportunity and protection for both men and women.

Women's participation in decision making is remarkable. Women occupy 24% of the Chief Executive positions in the government, 20% in the cabinet and 20% in the National Assembly. Seychelles has ratified most international conventions and treaties related to health, including the Framework Convention on Tobacco Control (FCTC).

2.2 HEALTH SYSTEMS DEVELOPMENT

2.2.1 Health Policies

The Health Strategic Framework (2006–2016) is based on the principles on the "Right to Health Care: Health for All and Health by All," inscribed in the Seychelles Constitution and the Health Policy Declarations of the Government of Seychelles. The development of health over the past two decades has followed the Primary Health Care (PHC) approach. Within 30 years Seychelles has developed its physical health infrastructure and enhanced its human resource capacity in a very efficient way using the PHC principles. Equity is the fundamental principle in the financing and organization of the healthcare system in Seychelles.

The government is the major provider of health services, which are tax-financed, free at all points of service and organized as close as possible to the population. Political commitment

towards health remains high; the Ministry of Health and Social Development obtained an allocation of 14.5% of the national budget in 2008.

As a result of effective PHC and the high priority accorded by the government to healthcare, Seychelles has achieved impressive scores in health indicators. For example, in 2006 neonatal mortality rate was 6.13 per 1000 live births; infant mortality rate was 9.5 per 1000 live births; and under-5 mortality ratio was 10.9 per 1000 live births. Immunization coverage in the same year for BCG, DPT3, OPV3 and measles was 100%. Life expectancy in 2007 stood at 73.1 years; 77.7 for females and 68.9 for males (National Statistics Bureau, Statistical Abstract, 2007).

2.2.2 Organization of Health Services

The Ministry of Health and Social Development (MoHSD), the principal provider of health services in Seychelles, has the overall responsibility for planning, directing and developing the health system for the benefit of the entire population.

Seychelles has a three-tier system, consisting of one central referral hospital, 3 cottage hospitals, one rehabilitative hospital, one mental hospital, one youth health centre and 16 district health centres located throughout the country. The government-funded services are complemented by a private service system. In 2006, there were 7 private medical clinics, 5 dental clinics and 2 pharmacies. Most private practitioners provide primary treatment, referring patients to government-run secondary and tertiary care services when required.

Victoria Hospital is the main referral hospital, which offers some tertiary care, whilst two referral hospitals offer psychiatric and rehabilitative care. Primary and secondary care is provided by health centres which are equitably distributed on the major islands. The distribution of these health facilities in 2006 is given in Annex 3. The bulk of highly specialized treatment takes place overseas; such treatment cost US$1.6 million in 2006 (Table 2.1).

2.2.3 Sectoral Collaboration

Several ministries actively contribute to the development and maintenance of the health sector in Seychelles. These include the Ministry of Education for health education efforts; and the Ministry of Community Development, Youth, Sports and Culture for health education among the young people and other specific population groups. These ministries have gained valuable experience in health-promotion efforts, and have established networks through which they can easily intervene. Better coordination and harmonisation in the health-related activities between all these ministries, in particular in the area of health education and promotion, is, however, necessary.

2.2.4 Civil Society

Civil society's participation in health care is minimal. This may be as a result of the government's role as the sole health care provider in Seychelles over the last 30 years. The participation of the civil society is mainly in the support specific causes. For instance, the National Council for Children in promoting the welfare and rights of children; the Cancer Concern Association in assisting cancer patients and their families; the Diabetes Society of Seychelles in prevention and awareness-creation; the Drug and Alcohol Council in spearheading policy development for national drug control; the Red Cross in supporting emergency and humanitarian actions; and HIV/AIDS support organisations in offering STI and HIV/AIDS awareness and support for people living with HIV and AIDS. Faith-based

organisations are largely involved in pastoral care and many have established programmes targeted at behaviour and lifestyle changes.

However, civil society organizations in Seychelles often lack adequate financial and human resources and programme management skills.

2.2.5 Human Resources Development

More than half of the total health budget expenditure is consumed by human resources. Paramedical and auxiliary health staff constitute the largest proportion more than 40% of the health workforce. Medical officers, nurses, and other primary health care staff are in short supply. The per capita ratios of doctors, midwives, and nurses per 10,000 inhabitants are 9.8. 24 and 48.9 respectively, considered to be among the highest in the WHO African Region.

The country is heavily dependent on expatriates in the top professional cadres—61.8% of all medical doctors in Seychelles in 2007 were from 18 different nationalities (Annex 4) There is a need, therefore, to develop standard protocols and to strengthen the expatriate orientations and induction programs during recruitment and engagement.

Retention of the health work force remains a challenge. In 2005, no less than 18 senior nurses left the country, for various reasons including demotivation and lack of clear career development paths.

Most undergraduate and post-graduate training in health is done overseas, and WHO has supported and continues to support human resource development. In addition, the government has special arrangements with a number of overseas universities for students wishing to pursue studies in specific fields.

2.2.6 The National Institute of Health and Social Studies

Pre-service training of nurses started in 1947. Currently the training school (the National Institute of Health and Social Studies) has evolved into a multi-disciplinary national training institution for nurses, paramedical and social workers. It has an expanded mandate of providing quality education and training in health and social studies at the tertiary level, through national and international collaborations and partnerships.

2.2.7 Health Financing

The government has a strong commitment to the provision of health services, as evidenced by the provision of the highest government sectoral allocation to the health sector. This allocation amounted to 10.3% and 10.5% of the GDP in 2004 and 2006 respectively (Table 2.1), and 12% and 14.5% in 2007 and 2008 respectively.

Demand for health services has been increasing due to various demographic, social, environmental and technological factors. These include the re-emergence of diseases like chikungunya and dengue; the potential threats of global pandemics of emerging diseases; and rising expectations of the population. The two main challenges to the health system are financial sustainability and the efficient utilization of resources.

Sustainability calls for the issue of health financing to be addressed using a two-pronged approach: cost-containment through efficiency-enhancing measures, and broadening health care financing by reducing the public provision and financing for health. However, it is

crucial that any introduced measures do not radically depart from the broad principles that have guided health care provision the country, and that the government continues to play the leading role.

2.3 HEALTH PROFILE

2.3.1 Noncommunicable Diseases, Injuries, Substance Misuse and Mental Health

The burden of disease in Seychelles has gradually shifted to noncommunicable diseases (NCDs), injuries and mental health. NCDs currently form the main burden of disease, with an upward trend seen over the last 10 years. The main causes of disease-related morbidity and mortality in 2007 were mainly cardiovascular diseases (30%), neoplasm (19%), respiratory system disease (12%), infectious and parasitic diseases (8%) and external causes (7%) (Table 2.2). This shift can be attributed to epidemiologic transition as well as affluence and changes in lifestyles and habits of the population.

Table 2.2 Main causes of death, 2003–2007

	2003	2004	2005	2006	2007
Deaths by number	**668**	**611**	**673**	**664**	**630**
Circulatory system	248	221	251	236	190
Neoplasm	100	108	107	103	117
Respiratory system	54	61	91	76	78
Infectious and parasitic	28	49	50	52	52
External causes	53	38	34	47	42
Deaths by percentage					
Circulatory system	37%	36%	37%	36%	30%
Neoplasm	15%	18%	16%	16%	19%
Respiratory system	8%	10%	14%	11%	12%
Infectious and parasitic	4%	8%	7%	8%	8%
External causes	8%	6%	5%	7%	7%

Source: **Seychelles in Figures, 2008 Edition**

The major risk factors contributing to NCDs are obesity, tobacco use and alcohol abuse, as well as lack of physical activity.

Road traffic accidents increased by 11.7% between 2003 and 2006. Road traffic injuries can be prevented by promoting action and strengthening legislation around the factors with the greatest impact on road traffic injuries, such as curbing drunk-driving, enforcing the use of seatbelts and helmets, enforcing speed limits, and improving road design and infrastructure.

Mental and neurological disorders (including disorders arising from the use of alcohol and other psychoactive substance) and mood disorders (excluding schizophrenia) were the most frequent causes of admission at the psychiatric ward of Victoria Hospital in the age

group 15–54 years in 2006. However, epidemiological data on mental health diseases and disorders among the general population is not available to support a comprehensive public mental health programme.

The level of alcohol consumption and drug abuse, particularly among the youth, is of national concern. From 2000 to 2005 the number of patients admitted with substance misuse at the psychiatric ward at Victoria Hospital increased by 22.6%. In 2005 70.3% of all admissions were attributed to substance abuse compared to 59.3% in 2000.

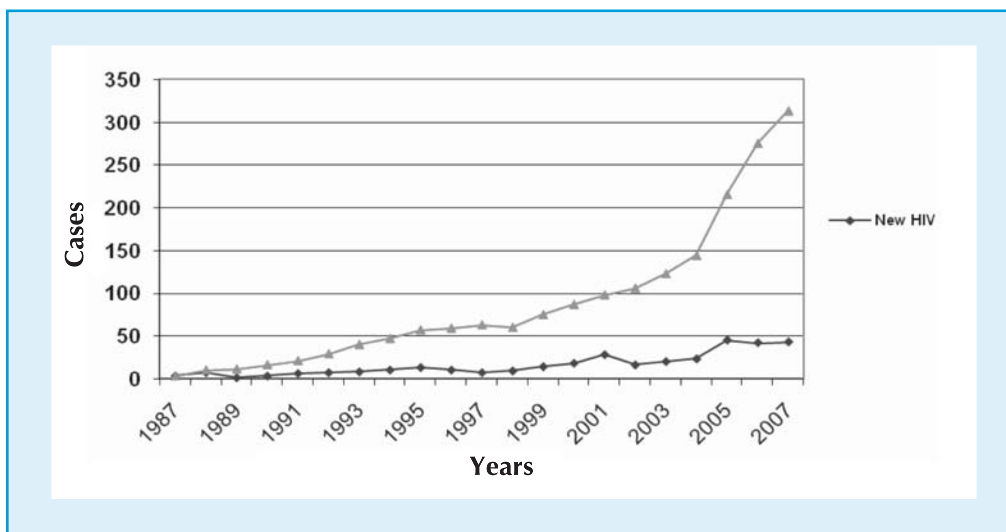
Seychelles ratified the Framework Convention on Tobacco Control (FCTC) in 2003, a treaty that aims at stimulating and harmonizing national legislation for tobacco control. The Seychelles Bill for Tobacco Control has been drafted. The Bill constitutes a comprehensive legislation that follows sound public health principles and addresses most of the obligations under the Framework Convention.

2.3.2 Communicable Diseases

Vaccine-preventable diseases (VPDs) have almost disappeared from the islands due to high vaccination coverage and the effective implementation of preventive programmes. The last neonatal tetanus, poliomyelitis and whooping cough cases were recorded in 1960, 1968 and 1990 respectively. However, high immunization coverage must be sustained to prevent the risk of importation of VPDs, particularly in view of the numerous tourists and migrant workers that visit the country.

HIV in Seychelles has a low prevalence of less than 1% in the general population, but occurs as a concentrated epidemic in high-risk groups. By the end of December 2007, the Ministry of Health and Social Development had reported a cumulative total of 217 persons living with HIV and AIDS (PLWHA), of whom 98 had progressed to AIDS. There was a sharp increase in the number of PLWHA, particularly from 2004 (Figure 2.3).

Figure 2.3: HIV/AIDS trends in Seychelles, 1987-2007



HIV/AIDS data for populations at high risk, such as men who have sex with men (MSM), commercial sex workers (CSW), intravenous drug users (IDUs), mobile workers, prison inmates

and sailors, is not available. WHO, in collaboration with other partners, plans to support specific sero-prevalence and knowledge, attitudes and practices (KAP) surveys to generate these data.

There is a need to strengthen the surveillance systems and implement an effective monitoring and evaluation system. An HIV observatory will go a long way towards strengthening information support and strategic information intelligence to inform policy, decision making and response. Currently, the Indian Ocean Commission is planning to set up a regional HIV observatory. The National Policy on HIV and AIDS and the National Strategy call for coordinated action on the part of government, nongovernmental organisations, the private sector, community groups and the general population in the implementation of the "Three Ones" principle which advocates for:

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

Voluntary counselling and testing was introduced in 1995 and uptake of VCT in pregnant women is over 80%. However, several misconceptions still exist concerning HIV modes of transmission (National KAP Study, 2003) and the epidemic has been growing in the youth. Discrimination of PLWHA is still prevalent.

Since 2001, antiretroviral (ARV) drugs have been freely available for all eligible HIV-positive pregnant women and their newborns. This was followed by universal access of antiretroviral therapy to all eligible patients in 2003, though services are still centralized at the tertiary care unit. Care and support services are provided free of charge to all PLWHA by the Ministry of Health and Social Development, and at least 102 (53.1 %) PLWHA were receiving ARVs by the end of June 2007; the WHO target is 80% by the end of 2010.

Present challenges related to HIV/AIDS prevention and treatment include the sustainability of services, as well as long-term adherence and possible resistance development to ARVs in the future. In this area WHO will work jointly and closely with UN agencies to develop a jointly funded comprehensive and integrated plan.There is reported incidence of some STIs such as gonorrhoea, genital warts, genital herpes, and syphilis, although the number of cases remains low.

Some vector-borne diseases have assumed public health importance in the country. In 2004 the country faced a dengue epidemic, and in 2006 a chikungunya epidemic ravaged the Indian Ocean islands, including Seychelles (Table 2.3). Malaria is not endemic; since 2002 a total of 46 imported cases have been reported mainly among the 15–44 years age group. Although the malaria vector was last seen on an outlying island in 1930, in the absence of an effective entomological surveillance and early warning system, the number of imported malaria cases is enough to establish transmission if the mosquito vector were to ever be re-introduced. There is a need, therefore, to develop an effective integrated entomological surveillance and early warning system for vector-borne disease in the country.

Rodent-borne leptospirosis occurs in isolated or time-limited outbreaks. Rodent control with case management is the main focus of leptospirosis management in the country. An isolated case of meningococcal meningitis in early 2007 was rapidly contained. Emerging diseases (e.g. dengue, chikungunya) and other new diseases posed by globalization such as

avian influenza and SARS are also potential threats, and point to the need for stronger epidemiological surveillance and strengthened laboratory capacities in the context of the International Health Regulations (IHR), and close collaboration with the Indian Ocean Epidemiological Surveillance Network. There is a need to develop contingency plans for pandemic influenza.

Table 2.3 Selected Communicable Diseases in Seychelles, 2002-2007

	2002	2003	2004	2005	2006	2007
Diarrhoea	4435	4585	4584	4984	6089	4631
Conjuntivitis	1951	1857	1525	1367	2022	14736
Chikungunya	0	0	0	258	8984	1008
Dengue	0	5	405	0	1	0
Influenza like syndrome	0	0	0	736	1172	424
HIV new&old cases	160	180	203	248	290	333
Leptospirosis	52	35	35	26	46	58
Tuberculosis	29	10	13	11	22	10
Meningitis	9	14	5	8	5	6
Malaria (imported)	3	10	15	3	4	11

Source: Health Information and Statistics Section of the Department of Health

2.3.3 Reproductive Health

Noticeable progress has been made in reducing the maternal mortality ratio through effective antenatal care and delivery handled by trained personnel. Maternal mortality rates in Seychelles are among the lowest in the WHO African Region, and the country is on track for achieving MDG 6: Improve maternal health.

In 40 years (1966–2006) the total fertility rate (TFR) declined sharply, from 7 to 2.11 children per woman. Teenage pregnancy, however, has become a big problem in Seychelles, with 32% of all first pregnancies occurring in 15 to 19 year olds. Two-thirds of all first pregnancies occur in 15 to 24 year olds. In the recent past the Health Department has expressed concern over the estimated number of illegal abortions. With a significant number of pregnancies and abortions occurring among teenagers, there is a real need for the adolescent health policies and legislation in the country to be harmonised, in order to improve adolescent health outcomes.

The prevalence of modern contraceptives use among women aged 15–49 stood at over 60% in 2000 and 36% in 2007. Condoms are supplied free by the Ministry of Health and Social Development as a means of preventing the spread of STIs and HIV/AIDS. They are also sold at the three private pharmacies and a few retail shops. The number of users is not accurately known, making it difficult to estimate overall contraceptive prevalence. The percentage of women aged 15 years and above having a pap smear done dropped from 23.5% in 2000 to 19.0% in 2007. There is therefore a need to improve awareness and health-seeking behaviour amongst women.

2.3.4 Vulnerability and Disaster Management

As a Small Island Developing State, Seychelles is classified as being at high risk, owing to its small land mass and vulnerability to natural and environmental disasters. Floods, tropical

storms, mudslide and tsunamis are some of the disasters that the islands are prone to. Chikungunya and dengue, as well as potential pandemic diseases like Influenza A are also high priority for Seychelles.

In view of the above, the government of Seychelles has created a Department of Risk and Disaster Management in the President's Office, mandated to mitigate the effects of natural disasters and minimize their social and economic impact. Assisted by high level committees and in collaboration with development partners, the Department has been working towards establishing an early warning system, designing hazards models, mapping risks and vulnerability, etc. A number of Intervention Plans have been devised, but capacity in this area remains a challenge. A Health Sector Response Plan has not yet been developed, and WHO will be providing technical assistance for the development of such a plan.

SECTION 3

DEVELOPMENT ASSISTANCE; AID FLOWS, INSTRUMENTS AND COORDINATION

The official Development Assistance for Health (DAH) received by Seychelles over the years has greatly contributed in assisting the country achieve more rapidly the improved health outcomes it seeks. A variety of health programmes in Seychelles, inspired and supported by donors, have worked at scale and contributed to more than three decades of steady improvements in health. Though this progress results largely from the general effects of steady economic growth, and government investment in health and improvements in education, there are many compelling examples of the success and impact of DAH-backed initiatives. In general, however, the official development assistance received by Seychelles has declined substantially since the 1990s, because as the country's per capita income has risen steadily, and Seychelles is now classified as a Small Island Developing State, ineligible for certain types of DA.

3.1 OVERALL TREND IN DEVELOPMENT AID

Donor agencies/partners and Seychelles are continuously testing and implementing innovative approaches to the use of Official Development Assistance (ODA), by simultaneously seeking ways to raise the effectiveness of existing aid streams and more traditional financing mechanisms. As shown in Table 3.1, there has been a gradual increase in the total amounts of ODA to Seychelles from 2002–2006. The sharp increase recorded in 2005 (from USD 10.33 million in 2004 to USD 14.99 million in 2005) was the result of aid related to the Tsunami that devastated the Indian Ocean region in December 2004.

Table 3.1 Total ODA received by Seychelles from donors, 2002-2006

Year	2002	2003	2004	2005	2006
All donors, (US$m)	7.85	9.21	10.33	14.99	13.95
Multilateral only, (U$m)	4.22	3.18	2.91	6.89	7.48

Source: OECD database (OECD. Stat, 2008; www.oecd.org)

There was a sharp increase the amount of aid received by Seychelles from multilateral agencies between 2004 and 2005.

Aid destined for the health sector has declined since 2000, as most agencies now focus their cooperation programmes on sectors like the environment, education and trade, perhaps due to the accomplishments already made in the health sector.

3.2 MAJOR ACTIVE DEVELOPMENT AGENCIES IN THE HEALTH SECTOR

The Government of Seychelles has a number of key partners in the health sector, including the United Nations, bilateral partners, financial institutions and nongovernmental organizations, all contributing through diverse mechanisms to the overall development agenda of Seychelles, as set out in the Seychelles Strategy 2017. Moreover, development assistance for the health sector supports a vast array of activities and services, some focused on specific diseases (polio, TB, HIV/AIDS), others on strengthening health systems and others still on particular services (e.g. reproductive and child health services).

3.2.1 Multilateral Partners

UN Agencies

WHO remains the government's major multilateral partner in healthcare, and the only UN organization resident in the country. Most other UN organizations supporting the country operate from offices in Mauritius and Madagascar. WHO has supported Seychelles in the areas of capacity building, technical assistance, advocacy and provision of equipment and supplies. WHO allocate an average of US$ 1.6 million to Seychelles each biennium.

UNDP in Mauritius coordinates the UN. The UN Common Country Assessment (CCA, 2007) has been developed and provides valuable sectoral diagnosis of the prevailing development situation in Seychelles. It serves as a vital tool for UN inter-agency dialogue and identification of potential synergies. The CCA's priorities for health are in the areas of national health systems; health legislation through harmonization of existing health-related laws; health promotion and awareness; disease prevention and control; and universal access for all health interventions. UNDP is contributing to the HIV/AIDS response through its 7th Country Programme (2007–2010) for Seychelles.

UNFPA supports population-related issues and adolescent reproductive health by improving reproductive health commodity availability, prevention of HIV and sexually transmitted infections, and improving the involvement of non-state actors. Seychelles recently signed its Country Programme Action Plan (CPA) with UNFPA for 2008–2011. The goal of this CPA is to contribute towards addressing population issues that the country is faced with and which are continually arising, and also ensuring that the quality of life of the population continues to progress. According to the CPA 2008–2011, U$ 50,000 will be disbursed annually by UNFPA through the Government of Seychelles in order to implement various projects.

The support given to Seychelles by UNAIDS has been limited, but the latter has shown its willingness to assist Seychelles in monitoring HIV/AIDS prevalence in the country.

Other International Organizations

In the past, Seychelles benefited from African Development Bank (ADB) assistance for the Victoria Referral Hospital (the Yellow Roof Building); construction of health centres; procurement of equipment; upgrading of the School Health Studies and Emergency Department; and training. However, in the last couple of years, Seychelles has not directly benefited from ADB assistance to the health sector. This is partly because Seychelles, with its high GDP, is no longer eligible for assistance under certain programmes financed by ADB. However, ADB, in collaboration with the Indian Ocean Commission (IOC), is currently financing a project called AIRIS-COI, which aims at building capacity for HIV/AIDS awareness and prevention at the country and regional levels, improving the access of PLWHA to better

medical care; and monitoring the evolution of the epidemic in the Region. Through this regional project, Seychelles has received assistance in the form of training and capacity building.

The Arab Bank for Economic Development in Africa (BADEA) was an active partner in the past, when it provided concessionary loans to build health centres. However, the Bank has not provided any grant or aid for the health sector in recent years.

Seychelles considers its adhesion and participation in the various multilateral organizations/agencies as invaluable towards improving the performance of its health sector, but unfortunately the country's participation in these regional and international bodies is in many instances inhibited by the required high level of per capita contribution. The increasing acceptance and adoption by the international community of the "Capacity to Pay" principle in calculating countries' scale of assessment is therefore a welcome development.

3.2.2 Bilateral Partners

France remains one of the largest bilateral donors, accounting for a major proportion of all assistance for the health sector in 2007. The cooperation with the French government is mainly done through the Island of Réunion. In 2007, approximately € 275 000 was allocated for the visits of specialists alone, and € 200 000 for scholarships, short-term trainings and exchanges. France is also financing the regional project URSIDA-COI, which was set up in 2005. This regional project has two essential components: paramedical training and the fight against HIV/AIDS. In 2007, 13 local nurses and 1 local doctor received their diplomas in emergency care from the University Victor Segalen, Bordeaux 2.

The Chinese government is another major bilateral donor to Seychelles, with a focus on economic support. There are a number of capital projects in the pipeline, including the construction of a building for the National Assembly, a school and a hospital. Cooperation is based on the needs of the Seychelles Government as communicated to the Chinese government. Over 200 Seychellois participated in workshops in China in 2007. There are currently 13 Chinese medical officers serving at the Victoria Hospital in varied specialities. There are 12 Chinese volunteers working in the Ministry of Health and Social Development, including medical doctors and nurses.

The Cuban government continues to be an active partner in the health sector and provides a wide range of technical assistance in various specialized fields. For the years 2006 and 2007, this assistance was valued at about € 400 000 and € 600 000 respectively, with the provision of nearly 50 experts each year recruited to work at the Ministry of Health and Social Development. The Cuban government also provides about 1 scholarship each year for the medical field, valued at about € 15 000.

The Indian Government has had a long-standing collaboration with the Seychelles government in various sectors, including health. In health-related areas there has been collaboration in terms of short-term training for Seychellois students and consultancies from India. One of the projects currently being supported by the Indian Government through the Pan African Network System is the establishment of a satellite terminal station in Seychelles, which will facilitate the implementation of telemedicine. While opportunities for the provision of specialists on a need basis are also available, the Ministry of Health and Social Development refers Seychellois patients to private hospitals in India for specialist treatment.

The Combined Joint Task Force for the Horn of Africa (a branch of the US Department of Defence) has also assisted the Ministry of Health and Social Development in the renovation of the Anse la Blague Clinic and the construction of a new morgue facility at the Baie Ste Anne Hospital. The cost of these projects has been valued at US$ 210 000. Assistance has also been provided for the renovation and extension of the Grand Anse Praslin Clinic, valued at US$ 273 000.

Other equally important health partners are Spain (€ 23 000 for training in 2007), the Russian Federation, Ireland, and the United Kingdom. The Knights of Malta granted SCR 1 000 000 in 1995 for the construction of the Haemodialysis Unit at the Victoria Hospital. Two ambulances were donated to the Ministry of Health, in August 2001. There were also two donations of medical supplies amounting to € 124 632 in 2003. In 2007, € 35 000 was allocated by the Knights of Malta for the provision of medical equipment. So far, assistance from the Knights of Malta has been focused on equipment, but possibilities are being explored in the training of health staff.

In October 2007, Seychelles received a donation of specialized medical and laboratory equipment and hospital beds from the Abu Dhabi government.

It is expected that technical assistance between Seychelles and Egypt, as enshrined in the Egyptian Technical Co-operation Fund for Africa (EFTCA), will resume in the coming years, since Egypt has showed its willingness to provide medical practitioners to the Ministry of Health and Social Development, and Seychelles has made several requests for assistance for different fields, which include internal medicine, psychiatry, and ophthalmology.

Local NGOs are also active partners of the Ministry of Health and Social Development. Over the years, the Round Table Organization, the Rotary Club, the Masonic Lodge of Seychelles, the Amusement Centre, Soroptimists, SAWOP, and many other individuals and organizations have made important donations of equipment, supplies and materials. The ministry has acknowledged these as being both valuable and significant.

3.3 MECHANISMS AND TOOLS OF COORDINATION

The responsibility for coordinating grants and technical assistance is vested with the Ministry of Foreign Affairs. However, in practice, the technical ministries concerned have the authority to coordinate grants and technical assistance, and ensure monitoring and evaluation. Whereas no formal coordination mechanisms exist, the Ministry of Foreign Affairs is committed to promoting sector-wide approaches in the coordination of grants and technical assistance in order to ensure performance.

There is the need for consistent and predictable funding support from donors for the health sector, even after the desired outcomes have been achieved, as this allows the maintenance and strengthening of the accomplishments. In other words, good performance should be rewarded rather than penalised. In this context, the salient economic, social and environmental characteristics of Seychelles as a Small Island Developing State (SIDS) should be taken into consideration when determining and coordinating the assistance given for the health, as well as other sectors.

Moreover, it is also strongly recommended that greater harmonisation and alignment of cooperation programmes exist between the various UN agencies, namely UNDP, UNAIDS and UNFPA, as well as with other regional organizations like the Indian Ocean Commission. Such alignment will improve the efficiency and impact of the assistance given, to maintain a

focused approach towards the areas of need, and achieve greater policy coherence for the development of Seychelles, all while respecting the need for local ownership. In fact, during the 46th Conference of Health Ministers of the East, Central and Southern African (ECSA) Health Community held in Seychelles from 25 to 29 February 2008, it was emphasized that health challenges need, more than ever, to be looked at in a holistic way and addressed in an multi- and inter-sectoral manner.

In this context, it is worth noting the multisectoral coordinating mechanisms which exist in the fight against HIV/AIDS, comprising of many ministries and NGOs. The National AIDS Committee is the apex inter-ministerial body for HIVAIDS responsible for policy issues. Moreover, a Public Finance act was set up in 2002 for the National Aids Trust Fund, with the following objectives:

(i) To promote national interest and commitment to the present and future control of HIV/AIDS and those infected and affected,

(ii) To mobilise resource for the HIV/AIDS programme, and

(iii) To promote and support national programmes.

There is compelling evidence to support the fact that a sector-wide approach (SWAp) (as opposed to traditional project-based approaches) increases health sector coordination, strengthen national leadership and ownership, and strengthens countrywide management and delivery systems. Such approaches are also thought to reduce duplication, lower transaction costs, increase equity and sustainability, and improve aid effectiveness and health sector efficiency. As such, WHO will work closely with UN Agencies not present in the country to promote the introduction of SWAps through the creation of a mechanism for coordination of health partners involving the civil society and NGOs.

SECTION 4

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO has been –and still is –undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges, and ultimately achieve the health-related MDGs. The WHO Corporate Strategy forms the broad framework for this organizational change process.

4.1 COUNTRY OFFICE

The mission of WHO remains "The attainment by all peoples, of the highest possible level of health" (Article 1 of the WHO Constitution). The WHO Corporate Strategy, the 11th General Programme of Work 2006–2015 and the Strategic Orientations for WHO Action in the African Region 2005–2009, outline key features through which WHO intends to make the greatest possible contribution to health. The Organization aims at strengthening its technical, and policy leadership in health matters, as well as its management capacity to address the needs of Member States in their efforts to meet the health-related MDGs.

4.2 CORE FUNCTIONS

The work of the WHO is guided by its core functions, which are based on the Organization's comparative advantage, namely:

- Providing leadership in matters critical to health and engaging in partnership where joint action is needed;
- Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;
- Setting norms and standards, and promoting and monitoring their implementation;
- Articulating ethical and evidence-based policy;
- Providing technical support, catalyzing change, and building sustainable institutional capacity;
- Monitoring the health situation and assessing health trends.

4.3 GLOBAL HEALTH AGENDA

In order to address health-related policy gaps in social justice, responsibility, implementation and knowledge, the Global Health Agenda identifies seven priority areas, which include:

1. Investing in health to reduce poverty;
2. Building individual and global health security;

3. Promoting universal coverage, gender equality, and health-related human rights;
4. Tackling the determinants of health;
5. Strengthening health systems and equitable access;
6. Harnessing knowledge, science and technology; and
7. Strengthening governance, leadership and accountability.

In addition, the WHO Director–General has proposed a six-point agenda as follows:

1. Health Development;
2. Health Security;
3. Health Systems;
4. Evidence for Strategies;
5. Partnership; and
6. Improving the performance of WHO.

The Director-General has, in addition, indicated that the success of the Organization should be measured in terms of results on the health of women and the African population.

4.4 GLOBAL PRIORITY AREAS

WHO's Global Priority Areas are outlined in the 11th General Programme of Work. They include:

- Providing support to countries in moving to universal coverage with effective public health interventions;
- Strengthening global health security;
- Generating and sustaining action across sectors to modify the behavioural, social, economic, and environmental determinants of health;
- Increasing institutional capacities to deliver core public health functions under the strengthened governance of ministries of health; and
- Strengthening WHO's leadership at global and regional levels and supporting the work of governance at country level.

4.5 REGIONAL PRIORITY AREAS

Regional priorities take into account various overarching documents, including global documents and the resolutions of the WHO governing bodies; the health-related MDGs, the NEPAD Health Strategy, resolutions on health adopted by Heads of State of the African Union; and the organizational strategic objectives outlined in the Medium-Term Strategic Plan (MTSP), 2008–2013.

These regional priorities have been expressed in the Strategic Orientation for WHO Action in the African Region, 2005–2009. They include prevention and control of communicable and non-communicable diseases; child survival and maternal health; emergency and humanitarian action; health promotion; and policy making for health in development and other determinants of health. Other objectives cover health and environment; food safety and nutrition; health systems (policy, service delivery, financing, technologies and laboratories); governance and partnerships; and management and infrastructure.

In addition to the priorities mentioned above, WHO is committed to supporting countries attain the health-related MDGs, and assisting them in tackling their human resource challenges. In collaboration with other agencies, the problem of how to assist countries source financing for individual country goals will be addressed under the leadership of the countries themselves. To meet these added challenges, one of the important priorities of the WHO Regional Office for Africa is that of decentralization and the installation of Inter-country Support Teams to further support countries in their own decentralization process, so that communities may be benefit maximally from the technical support availed to them.

To effectively address the priorities, the Regional Office is guided by the following strategic orientations:

- Strengthening the WHO Country Offices;
- Improving and expanding partnership for health;
- Supporting the planning and management of district health systems;
- Promoting the scaling up of essential health interventions related to priority health problems; and
- Enhancing awareness and responses to key determinants of health.

4.6 MAKING WHO MORE EFFECTIVE AT COUNTRY LEVEL

The outcome of the expression of WHO's cooperate strategy at country level will vary from country to country, depending on the country-specific context and particular health challenges. But building on WHO's mandate and its comparative advantage, the six critical core functions of the Organization, as outlined in section 4.2, may be adjusted to suit individual country needs.

SECTION 5

CURRENT WHO COOPERATION

5.1 COUNTRY OFFICE

The WHO Country Office in Seychelles is currently operating as a WHO Liaison Office. WHO is one among two UN agencies based in the country, and is recognized as an important partner in health. Cooperation between WHO and Seychelles began on 7 October 1980 with the signing of the Agreement for the Establishment of Technical Advisory Cooperation Relations. However, it was not until December 1986 that WHO formally established its office in Seychelles, with the appointment of a resident WHO Liaison Officer (WLO). Prior to that, WHO/Kenya and later, WHO/Tanzania had overseen Organization's activities in Seychelles. From 1986 to date, the office has initiated a wide range of collaborative programmes with the government of Seychelles, and played an important role in national health development.

5.2 INTERSECTORAL COLLABORATION

WHO provided technical support to local partners and committees in the health sector, such as the Drug and Alcohol Council, the Millennium Development Goals Advisory Committee, the National AIDS Council, the UN Theme Group on AIDS, the National Research Committee on Health, the Road Safety Advisory Committee, and other bodies.

As there are no other UN agencies providing technical support at country level, the tendency has been to address all priorities, whilst giving higher importance to addressing unfinished objectives in First-Generation CSS (Annex 5).

Strategic Objectives 1, 2, 3, 6, 10, 12 and 13 were identified in consultations as high-priority, and Objectives 4, 5 and 11 as medium priority (Table 5.1). The current workplan for biennium 2008–2009 covers 9 Strategic Objectives selected as priority by the government, with a focus on programmes such as IVD, CSR, CPC, HIV/AIDS, CDP, MNH, INJ, HPR, TOB, PHE, HSP, HFS, HRH, IRS, EDM, PRM, RDO, CMT, PSS and PPE. However, it is expected that following the 2008 review and its subsequent work plan, all 13 strategic objectives will be covered—with the addition of Strategic Objectives 4, 5 and 9, the following additional programmes will be included: CAH, SRH, EHA, FOS, and NUT.

Table 5.1. **Current Work plan 2008-2009 by budgetary allocations**

Strategic Objectives		Priority	Programme	Budget (US$)
SO1:	To reduce the health, social and economic burden of communicable diseases.	High	IVD, CPC, CSR	211 000
SO2:	To combat HIV/AIDS, tuberculosis and malaria (emerging diseases).	High	AIDS	43 000
SO3:	To prevent and reduce disease, disability and premature death from chronic non-communicable diseases, mental disorders, violence and injuries.	High	CDP, MNH, INJ	116 000
SO4:	To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, the neonatal period, childhood and adolescence; improve sexual and reproductive health; and promote active and healthy ageing for all individuals.	Medium	CAH, SRH	
SO5:	Reduce the health consequence of emergent disasters, crises and conflicts and minimise their social and economic impact.	Medium	EHA	
SO6:	To promote health and development, and prevent or reduce risk factors for health conditions associated with the use of tobacco, alcohol, drugs and other psychoactive substances.	High	HPR, TOB	104 000
SO7:	To address the underlying social and economic determinants of health through policies and programmes that enhances health equity and gender responsive.		HSD	
SO8:	To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health.		PHE	20 000
SO9:	To improve nutrition, food safety and food security throughout the life course and in support of public health and sustainable development.		FOS, NUT	
SO10:	To improve health services through better governance, financing, staffing and management, informed by reliable and accessible evidence and research.	High	HSP, HFS, HRH, IRS	235 300
SO1:	To ensure improved access, quality and use of medical products and technologies.	Medium	EDM	24 000
SO12:	To provide leadership, strengthen governance and foster partnership in collaboration with countries in order to fulfil the mandate of WHO in advancing the global agenda.	High	PRM, RDO	552 000
SO13:	To develop and sustain WHO as a flexible, learning organization, enabling it to carry out its mandate more efficiency and effectively.	High	CMT,PSS, PPE	384 000
	Total			**1 689 000**

5.3 HUMAN RESOURCES

The current staff component at the WCO stands at six: a WHO Liaison Officer (a Medical Officer), a Health Information and Promotion Officer; an Administrative Officer; and 3 support staff. From the outset, the post of WLO has been combined with that of a specific technical position requested by the MoH. This trend has continued, with the current WLO providing technical support to the Epidemiology and Statistics Department of the MoH, as part of his Terms of Reference.

5.4 SUPPORT FROM WHO REGIONAL OFFICE AND HEADQUARTERS

The support received by Seychelles from WHO Regional Office for Africa and Headquarters has been in the areas of policy and technical advice, equipment and supplies, information sharing and national capacity building. From 2004 to 2007 WHO/AFRO undertook 27 technical missions to the country to assist in areas of HIV/AIDS; vaccine procurement management; vaccine stock management; IMAI adaptation and training in HIV care; non-laboratory staff training in HIV rapid testing; ambient air quality control; ICT assessment; monitoring and evaluation of work plans; setting up of cancer register; review of nursing curriculum; Health Promotion Policy; chikungunya outbreak; Human Resource for Health Policy and Plan; EPI Comprehensive Multi-Year Plan (CMYP), 2008–2012; Verification Mission on Certification Documentation of Polio Eradication; and Mission on Global 2020 Vision workshop.

In view of the expectations for technical support in the area of Health Sector Reform, human resource development and health financing, the WHO Liaison Office will mobilise technical assistance to support the MoH in these areas.

5.5 WHO COLLABORATION WITH UN SISTER AGENCIES AND BILATERAL COOPERATION

WHO will work closely with UN Agencies not present in the country to ensure maximum utilisation and benefits of available resources, with a focus on harmonisation and alignment. WHO will play the brokering role to support the MoHSD to successfully implement SWAps. Further, WHO will provide technical support on integrated disease surveillance and response (IDSR) to implement cooperation in the context of the Indian Ocean project for EPI surveillance.

5.6 STRENGTHS, WEAKNESSES, CHALLENGES AND OPPORTUNITIES FOR WHO COUNTRY COOPERATION

As the government of Seychelles works towards strengthening its health care system in collaboration with WHO, several factors have helped to optimize WHO's support to the country. A SWOT analysis highlighted the factors affecting the operationalization of the WHO cooperation in Seychelles in order to maximize its strengths, correct its weaknesses, capitalize on opportunities, and deter potentially devastating threats.

Table 5.2 Summary of SWOT Analysis

STRENGTHS

- The actual presence of WHO in the country;
- Committed WLO staff;
- Ongoing and open dialogue between WLO, MOH and other partners;
- Improved communication with AFRO;
- Result-based management;
- WHO country budget mostly secured;

WEAKNESSES

- AMSWEB installed but not fully functional;
- WHO country GPN link not operational;
- Weak follow-up mechanism within MoHSD to deal with WHO Country cooperation;
- Increasing number of unplanned activities;
- Insufficient awareness of WHO work plan by programme managers;
- Limited human resource in the WHO Liaison office;
- Delay in acquiring equipment and supplies;
- High expectation of WHO as funded agency;

OPPORTUNITIES

- Political stability;
- The political commitment of the Government towards health;
- WHO presence in several country level steering and technical committees;
- Major government investment in health infrastructure and services;
- Good government sector partnership;
- Inter Country Support team for Eastern and Southern countries resourced and functional;
- Most infectious diseases under control or eliminated;
- High level of Gender balance;
- Vaccine Preventable diseases eliminated and most infectious diseases under control;
- Accessibility to health facilities by the population;
- Increase in number of private medical practitioners;
- Major investment by Government in health infrastructure and services;
- Good network of communication within the country;
- High level of human development;
- Health related MDGs achieved;
- High budget allocated by Government to health;
- Free health care;

THREATS

- Small Island Developing State (SIDS) status
- Sustainability of Health Financing;
- Shortage of foreign currency;
- Realignment of the Seychelles Rupee resulting in very high cost of living;
- Increase of HIV/AIDS epidemic;
- Natural disasters and pandemic diseases;
- Dependency on imports for most commodities;
- High operational cost for secondary and tertiary medical care;
- Medicalisation of PHC;
- Dependence on expatriate health specialists;
- Absence of sisters UN agencies operating in health based in country;
- Sisters UN agencies under different UN Coordinator based in different countries;
- Absence of Monitoring and Evaluation mechanism to assess programme implementation;
- Limited number of partners and funding; opportunities for health;
- High turnover of MoHSD programme; managers and attrition of qualified staff;

SECTION 6

STRATEGIC AGENDA: AGREED PRIORITIES FOR WHO COUNTRY COOPERATION

6.1 RESPONDING TO CURRENT NEEDS

The Country Cooperation Strategy (CSS) forms the basis for technical cooperation between WHO and the Government of Seychelles as reflected in the Biennial Plans of Action. The Ministry of Health Strategic Framework 2006–2016 provided the structure for alignment of the CSS, as well as the UN Common Country Assessment priorities (Table 6.1). WHO in Seychelles continues in its efforts to strengthen its advisory and advocacy functions, as well as its role as a neutral broker supporting the government's efforts to sustain and improve health sector performance. The CCS focused on priority areas where WHO has a comparative advantage, and also on the health development analysis in the previous chapters. Five strategic directions for the CSS have been identified (Table 6.1)

The WHO reiterates its position that the MoHSD and other national stakeholders are the owners, leaders and main implementers of the health plan. WHO will only be minimally involved in routine implementation on short-term, time-specific cases with evident critical gaps. However, in light of the evolutionary nature of the health and social environment, these are flexible interventions to accommodate changes in priorities and activities over the period of the CCS.

Table 6.1: Linking the Ministry of Health and Social Development Strategic Framework 2006-2016 and the UN common Country Assessment (CCA) 2007 with the CCS

Ministry Priorities	United Nation CCA Priorities	CCS Priorities
Goal 2: Provide mental health services to the individual, family, and community throughout the lifespan; **Goal 3:** Improve the management of priority noncommunicable diseases;	• Improve disease prevention and control strategies;	1. Support the development of integrated inter-sectoral approaches in order to prevent and reduce disease, disabilities and premature deaths from non-communicable diseases, mental health, violence and injuries;
Goal 4: Improve the detection, prevention and treatment of priority communicable diseases and outbreaks of new diseases; **Goal 6:** Improve the prevention and the control of HIV/AIDS and STIs;	• Improve disease prevention and control strategies;	2. Reduce the health, social and economic burden of communicable diseases;
Goal 5: Improve the prevention and management of life threatening accidents emergencies and mass casualties;		3. Reduce health consequences of emerging disasters, crises and conflicts and their socioeconomic impact;

Goal 1: Improve the health status of all individuals, families and communities in Seychelles; **Goal 7:** Improve the efficacy of the Ministry of Health transport services; **Goal 8:** Improve the performance of the ministry's strategic equipment; **Goal 9:** Improve the management practices of health services delivery; **Goal 11:** Ensure that the public health sector is staffed to provide health services;	• Strengthen national health systems development (including the development of health services, human resources, surveillance system, research and health information systems and promotion of cooperative strategies and partnerships for health development; • Harmonise existing health-related laws;	4. Enhance health systems, performance of health research and health security;
Goal 10: Achieve a health-promoting society;	• Strengthen health promotion and awareness activities; • Support to promote Universal Access to health care;	5. Promote healthy lifestyles, healthy environment, and multi-sectoral public policies, and address the socioeconomic determinants of health;

6.2 COMPONENTS OF THE CCS STRATEGIC AGENDA

1. Support the development and implementation of integrated intersectoral approaches in order to prevent and reduce disease, disability and premature death from noncommunicable conditions, mental disorders, violence and injuries.

Recognising the high and increasing burden of noncommunicable diseases, mental disorders, violence and injuries, WHO will improve the country's capacity for applying preventive measures, improving clinical management and increasing community awareness on lifestyle issues, through the following activities:

(a) Improve capacity to increase access to interventions pertaining to noncommunicable diseases, mental disorders, violence and injuries.

(b) Strengthen capacity for the development and implementation of policies, strategies and regulations for chronic noncommunicable conditions, mental disorders, violence and injuries, including a Monitoring and Evaluation (M&E) framework;

(c) Improve capacity for evidence generation on the magnitude, root causes, risk factors, and consequences of chronic noncommunicable conditions, such as tobacco use, physical inactivity, overweight, diabetes and hypertension;

(d) Strengthen the management of rehabilitative services;

(e) Strengthen capacity building for continuing professional development of staff dealing with chronic noncommunicable conditions, mental disorders, violence and injuries;

(f) Improve national capacity for implementation of the provisions of the WHO Framework Convention on Tobacco Control and the proposed Tobacco Bill;

(g) Strengthen capacity to develop an M&E framework, including evaluating the impact of health promotion;

(h) Provide technical support in capacity building on health systems research, mainly in the development of research proposals, and report writing.

2. Reduce the Health, Social and Economic Burden of Communicable Diseases

WHO will focus on addressing the HIV/STIs disease burden amongst high-risk groups, continue to intensify disease surveillance, and maintenance of the country's polio-free status, and develop core capacities for International Health Regulations (IHR). The following activities have been suggested:

(a) Support access to vaccines of assured quality, including the introduction and initiation of new immunization products and technologies;

(b) Strengthen the district-based immunisation programme and other child survival interventions to maximise access to vaccines;

(c) Support certification of poliomyelitis eradication, and appropriate containment of polioviruses, leading to a simultaneous cessation of oral polio vaccination in the country;

(d) Strengthen district-level capacity in order to increase access by at-risk populations to essential interventions for prevention and eradication neglected diseases, including zoonotic diseases;

(e) Strengthen national capacity in disease surveillance and response to major epidemic and pandemic-prone diseases in line with integrated disease surveillance (IDS) strategy and IHR;

(f) Support the systematic monitoring and assessment of HIV/AIDS as it relates to the Millennium Development Goals (MDGs);

(g) Strengthen capacity to increase access to equitable and innovative approaches and evidence-based interventions for the prevention, treatment and care for HIV/AIDS and STIs;

(h) Support the implementation of the National Strategic Plan for STIs and HIV/AIDS;

(i) Advocate for and ensure availability of drugs for STI, HIV/AIDS, TB and leprosy treatment;

(j) Support the development and implementation of a surveillance and M&E system to provide strategic information on the progress towards targets and resource allocation for HIV/AIDS, STIs and tuberculosis control.

3. Reduce the health consequences of emergent disasters, crises and conflicts, and minimize their social and economic impact

WHO will support the Ministry of Health to develop the health component of the national disaster preparedness plan, which includes an update on preparedness for pandemic influenza, and vector-borne diseases such as chikungunya and dengue. Activities proposed are:

(a) Provide technical support in capacity building for national emergency preparedness and disasters response;

(b) Provide technical support in capacity building for a timely response to disasters associated with natural hazards;

(c) Provide technical support in coordinating communicable disease control following natural disasters.

4. Enhance health system performance and health research

WHO will support the MoH in developing a Human Resource Plan and policies on health financing, food safety, blood safety, and pharmaceutical supply management, as well as in conducting research on the socioeconomic determinants of health. Specific activities include:

(a) Improve managerial capacity for policy development, strategic planning and programme implementation;

(b) Strengthen HRH capacity of MoH for improved implementation of health interventions;

(c) Support pre-service curriculum development (particularly in the field of community health nursing) and link up the National Institute of Health and Social Studies (NIHSS) with other regional training institutions;

(d) Support the development of a comprehensive health financing policy and plan;

(e) Assist MoH to assess, develop and implement plans for improving the health management information systems;

(f) Build capacity to implement and monitor food safety and nutrition policies at national level;

(g) Develop country capacity for generating evidence, through research, on the Socioeconomic Determinants of Health (SDH), and gender equity in health programming;

(h) Provide support to a develop national drug policy and plan;

(i) Strengthen national capacity for effective regulations to ensure access to quality and safe medical products and technologies, including blood transfusion and parenteral therapy;

(j) Provide technical support in strengthening the management structure for the maintenance of medical and hospital equipment.

5. Promote healthy lifestyles, healthy environments and multisectoral public health policies, and address the socioeconomic determinants of health. Specific activities include the following:

(a) Improve country capacity for occupational and environmental health prevention, service delivery and surveillance;

(b) Continue providing technical support to ensure safety and compliance to public and environmental health regulations;

(c) Provide technical assistance to strengthen community development initiatives to address health determinants, meet local needs and promote community participation;

(d) Strengthen health promotion capacity nationally and integrated across all relevant programmes; and

(e) Strengthen multi-sectoral collaboration in health-related activities and advocate for health to be addressed as a key element of the country's development.

SECTION 7

IMPLEMENTING THE STRATEGY

To achieve measurable and sustainable impact, the implementation of the proposed strategic agenda in Seychelles will require a coordination and implementation framework that involves the main actors in the health sector. Such a framework will take into account the delivering as "One UN" initiative and the recently launched International Health Partnership. The need to integrate with activities planned by other UN agencies, bilateral cooperation agencies, the civil society and NGOs, will be emphasized.

7.1 WHO LIAISON OFFICE

The most important task for the WHO Liaison Office (WLO) is to support the country in improving some health indicators, and sustaining the current health status, in partnership with the government, partners and the community. The WLO will act mainly as a facilitator, and the office is expected to remain small. Led by an epidemiologist, the six person core team within the WLO is expected to facilitate a staff development plan to strengthen the administrative and technical competences of WLO staff, and their capacity to effectively support the WLO's shift to a more strategic role.

The WLO shall continue dialogue with the Ministry of Health and Social Development and other partners to ensure the smooth implementation of the planned interventions in the work plans and continuous assessment of the implementation of the CCS. However, it is envisaged that there will be various managerial and administrative implications for the WLO in implementing the CCS. An agreement on a monitoring and evaluation framework and a periodic and consultative review of the implementation process is required, for instance. It is expected that the WLO will continue to support human resources development in health as a priority.

To better meet the HR needs in technical areas, a mapping of competencies for the implementation of the CCS ought to be undertaken. This might involve an analysis of options: from the specific categories of staff with appropriate skills, to the units and sections with specific capabilities.

It is suggested that the WLO's role become more strategic, particularly as follows:

- Work closely with UN agencies for a comprehensive and joint programme of support to the country. It has been suggested that WLO, with the support of the other UN agencies, considers the recruitment of a national professional officer (NPO) to support a coordinated response and to move the joint programme agenda;
- Mobilize the necessary technical assistance for the country health agenda (health Sector reform, HR, health financing, disease surveillance, etc.);
- Contribute through IDSR and IHR to strengthening global health security;
- Contribute to resource mobilization for new health challenges; and
- Support government capacities to deliver core public health functions.

7.2 WHO REGIONAL OFFICE AND THE INTER-COUNTRY TEAM

Continuous support from the WHO Regional Office for Africa and headquarters will also be crucial to ensuring the successful implementation of the CCS. The WHO Intercountry Support Team based in Harare is expected to play a supportive role in providing technical support, which will require:

- Advocacy support to include Seychelles in potential areas of financial support, despite its high performance in global health indicators, low HIV prevalence and high GDP;
- Support in ensuring funding through the regular budget and other sources for implementation of the planned interventions;
- Facilitation of sharing the best practices and exchanging experiences among countries.

SECTION 8

MONITORING AND EVALUATION

The development of this 2nd Generation CCS (2008–2013) was based on extensive consultations and reviews to reflect the health and development situation, as well as remaining health challenges in Seychelles. The CCS is aligned with the current Biennial Plans of Action for 2008–2013 and will be subjected to periodic review and evaluation to accommodate changes in the health and development situation in the country.

The components and sub-components of the CCS Strategic Agenda will be implemented through three consecutive biannual programme work plans and budget. A results-based monitoring and evaluation framework will follow on the key indicators agreed in the biennial work plan.

Within the framework of the results-based management systems, implementation will be monitored every year, based on a written report by the CCS monitoring team. This team will be made up of members of the CCS Core Team and 5 members of the stakeholder groups consulted during the CCS's formulation, i.e. partners, other ministries, the private sector, and the civil society. In-depth evaluations of selected programmes will be undertaken to determine their outcome and impact on national health development.

An evaluation of the effectiveness of the implementation of the CCS Strategic Agenda, and its impacts on the health and development challenges identified in the CCS document, will be carried out at the mid-term in 2010. At the end of the CCS period (2013) a final evaluation will be undertaken by WHO. It is suggested that this is carried out by a team made up of representatives from Seychelles, and WHO Regional Office for Africa and WHO Headquarters.

The CCS document will be reviewed shortly after the evaluation, in accordance with prevailing situation in the country and outcomes of the evaluation.

ANNEX 1. List of Contributors to the CCS

Name	Title/Organization
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1. Mr. Michel Vielle	Director General
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2. Dr Benoit Kalasa	UNFPA Representative Madagascar, Country Director for Comoros, Mauritius, Seychelles
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Ministry of Foreign Affairs

1. Minister Patrick Pillay	Minister
2. Ambassador Mr. Callixte d' Offay	Principal Secretary
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Ministry of Education

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3. Ms Antoinette Hoarau	President, Nurses Association (NARS)
4. Mrs Rosemary Elizabeth	Chairperson, Seychelles HIV/AIDS Links Association
5. Mr Steve Lalanne	CEO, LUNGOS
6. Mr Patrick Andre	Chairman, Road Safety Advisory Committee

CCS Country Core Team

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13. Mr Jude Padayachy	Chief Executive Officer, National Statistics Bureau
14. Mr Henry Bastienne	NPO/HIP/WLO, WHO Liaison Office

ANNEX 2. Seychelles Vital and Health Personnel Statistics

	YEAR					
	2002	2003	2004	2005	2006	2007
Mid-year population	83 723	82 781	82 474	82 852	84 600	85 032
No. of registered births	1481	1498	1436	1536	1467	1499
Crude birth rate (per 1 000 pop)	17.69	18.10	17.41	18.54	17.34	17.81
No. of registered deaths	647	668	611	673	664	653
Crude death rate (per 1 000 pop)	7.73	8.07	7.41	8.12	7.85	7.84
No. of registered infant deaths	26	25	17	16	14	16
Infant mortality rate (per 1 000 live births)	17.56	16.69	11.84	10.42	9.54	10.67
No. of early neonatal deaths	9	14	10	7	6	8
No. of late neonatal deaths	13	6	2	7	3	4
No. of post neonatal deaths	4	4	5	2	5	4
No. of neonatal deaths	22	20	12	14	9	12
Neonatal Mortality Rate (per 1,000 live births)	14.85	13.35	8.36	9.11	6.13	8.01
No. of stillbirths	15	18	7	13	16	11
No. of perinatal deaths	24	32	17	20	22	19
Perinatal mortality rate (per 1 000 live births and stillbirths)	16.04	21.11	11.78	12.91	14.83	12.58
No. of registered child deaths	1	4	4	1	2	3
Under five mortality rate (per 1 000 population under five years)	4.14	4.38	3.10	2.48	2.28	2.55
Under five mortality ratio (per 1,000 live births)	18.23	19.36	14.62	11.07	10.91	12.68
No. of registered maternal deaths	1	0	1	`1	0	0
Maternal mortality ratio (per 100,000 livebirths)	67.52	0.00	69.64	65.10	0.00	0.00

Life expectancy at birth (years)

	2002	2003	2004	2005	2006	2007
Male	67.44	66.17	69.01	67.39	68.87	68.87
Female	76.00	76.10	76.44	77.13	75.66	77.70
Average	71.50	70.92	72.64	71.93	72.20	73.14

Health personnel (both private and public sector)

	2002	2003	2004	2005	2006	2007
Number of doctors	110	115	100	113	83	101
Population per doctor	820	720	825	733	1019	842
Number of nurses	379	422	422	390	414	411
Population per nurse	221	196	195	212	204	207
Number of dentists	27	23	22	17	20	21
Population per dentist	3101	3599	3749	4874	4230	4049

Source: **Health Information and Statistics Unit of Ministry of Health and Social Development**

ANNEX 3. Distribution of Health Facilities

Distribution of Health Facilities, 2006

Level of care	Name	No. of beds
Specialized services	Psychiatric Hospital	50
	Geriatric hospital	68
	Rehabilitative hospital	43
Tertiary	Victoria Hospital	239
Secondary	Anse Royale Hospital	21
	Baie Ste Anne Hospital	37
	La Digue Hospital	15
Primary	Silhouette	12
Total		485
Estimated Mid Year Population		84 600
In-patient beds per 10,000 population		57
Number of Health regions		6
Number of Health districts		17
Number of health facilities	Government	17
	Private	8
Total		**25**

Source: **Health Information and Statistics Unit of Ministry of Health and Social Development**

ANNEX 4. Human Resources for Health

4.1. Health Personnel (Government Establishments) 2002 to 2006

Health Personnel	2002	2003	2004	2005	2006
Medical practitioners (GP)	94	107	91	72	75
Consultants	7	13	16	15	16
Dentists	13	16	16	10	15
Pharmacists	6	8	6	7	4
Other professionals	110	145	154	185	187
Paramedics	510	399	417	429	493
Nurses	379	422	422	390	414
Students nurses	90	99	78	86	73
Other health ancillaries	586	517	622	607	372
Total	**1795**	**1726**	**1822**	**1801**	**1649**

Sources: **Health Statistics Unit Ministry of Health and Social Development**

4.2. Medical and Dental Personnel by Sex and Origin, 2007

		DENTIST			PHYSICIAN			Grand Total
		Female	Male	Total	Female	Male	Total	
Expatriate	Generalists	1	6	7	7	24	31	38
	Specialists	1	2	3	17	28	45	48
Total Expatriate		2	8	10	24	52	76	86
Seychellois	Generalists	1	3	4	7	13	20	24
	Specialists		2	2	8	19	27	29
Total Local		1	5	6	15	32	47	53
Grand Total		**3**	**13**	**16**	**39**	**84**	**123**	**139**

Source: Ministry of Health Nominal Roll as at October 2007

4.3 Number of Expatriates Recruited 1995–2006

HRH Category	Number of Expatriates Recruited					
	1995–1996	1997–1998	1999–2000	2001–2002	2003–2004	2005–2006
Medical Consultant		2	20	14	9	7
Senior Medical Officer	5	4	14	2	20	5
Medical Registrar		4	19	29	1	2
Medical Officer	1	7	9	18	2	6
Specialist Medical Officer					11	1
Senior Medical Registrar		7	14		18	12
Senior Dental Officer	2	4		1	13	
Physiotherapist			1	1	2	
Staff Nurse		1				4
Principal Pharmacist			1			
TOTAL	8	28	78	65	76	37

Note: Information obtained from Quarterly Reports and Staff Movements.

4.4 Top-five diagnoses at psychiatric ward discharges, including deaths, 2002–2006

	2002		2003		2004		2005		2006	
	Discharges	%	Discharges	%	Discharges	%	Discharges	%	Discharges	%
Schizophrenia, schizotypal, and somatoform disorders	156	35.6	138	37	168	33.9	157	30.5	100	38.3
Mental and behavioural disorders due to use of alcohol	106	24.2	88	24	92	18.6	98	19	56	21.5
Mood (affective) disorders	90	20.6	73	20	85	17.2	84	16.3	30	11.5
Neurotic, stress-related, and somaroform disorders	30	6.9	19	5.1	14	2.8	17	3.3	4	1.5
Other reasons	56	12.7	57	15	136	27.5	159	11.9	71	27.2
Total	**438**	**100**	**375**	**100**	**495**	**100**	**515**	**100**	**261**	**100**

Source: Health Information and Statistics Unit of Ministry of Health and Social Development

Annex 5: Review of First Generation CCS

Strengthening National Health Systems Development

1. Organization of Health Services and Sustainable Development

(a) Supporting the Ministry of Health in its stewardship function in the analysis, review, finalization or formulation of National Health Policy and Sectional Policies and Plans, mainly in the areas of Non-Communicable Diseases, Health Promotion, Food & Nutrition, Mental Health and Human Resources for Health and Research.

- **Support provided – ongoing process – still relevant.**
- **however more needs to be done, i.e. support capacity building to develop internal policies and plan.**

(b) Providing technical support to strengthen the capability of health systems to deal with chronic conditions, to enhance adherence to therapies and behaviors and to reinforce long-term care.

- **Support provided mainly in the area of ARVs; diabetes– ongoing process –still relevant.**

(c) Providing technical advise on models of best practices of cost-sharing of healthcare;

- **No support provided; still relevant.**

(d) Strengthening the Ministry of Health capacities to develop technical guidelines in specific areas.

- **Support provided – ongoing process – still relevant.**

(e) Providing technical support in strengthening the management structure for maintenance of medical and hospital equipments.

- **No support provided; Needs review given the restructuring of the Ministry of Health – focus should not be on hospital equipment.**

(f) Supporting the MOH in the development of mechanisms to ensure an effective drug supply management system, including rational use of pharmaceuticals including ARV.

- **MoH to agree on this issue internally and report at next meeting.**

(g) Provide expertise and promote local capacities to ensure monitoring and evaluation mechanisms of impact of public health interventions programmes.

- **No support provided – still relevant.**

(h) Promoting systematic monitoring and assessment of impact and health outcomes of progress towards Millennium Development Goals (MDGs).

- **Support provided – still relevant and requires support.**

2. Human Resources Development

(a) Assist the Ministry of Health in the updating of the human resources policies and plans to ensure appropriate skills among nationals based on human resources needs.

- **Support provided – Needs support to develop action plan, M&E and implementation.**

(b) Support selective capacity building in collaboration with MoH, involving private practitioners as a strategy to promote public-private partnership in healthcare delivery.

- **Support partially provided – still relevant; need to further improve collaboration.**

(c) Facilitate the networking with other health training and research institutions based on the major needs and specificities of the country.

- **No support provided – still relevant.**

(d) Continue to support fellowship awards in the main areas identified in the human resources development plan, preferably in the African Region.

- **Support provided – still relevant and of high importance to government; need further support.**

(e) Facilitate discussions about upgrading managerial skills of health professionals, addressing the issues of motivation and staff retention.

- **No support provided – still relevant; Need for retention policy**

(f) Strengthen the development of the National Institute of Health and Social Services (NIHSS) with experts, curriculum development, documentation and networking with

other similar regional training institutions to effectively perform its role as the main national training institution.

- **Support provided – Two missions to develop curriculum; still relevant.**

3. Strengthening Surveillance, Research and Health Information Systems

(a) Advocate for strengthening the health information and research units within the Directorate of Planning Research and information.

- **Support provided – equipment provided; mission undertaken; still very relevant; needs further support.**

(b) Facilitate the formulation of the Technical Guidelines for Integrated Disease Prevention and Response and capacity building for early detection for emerging and re-emerging diseases.

- **Support provided – still relevant; needs support for implementation.**

(c) Support in the review of the Health Research Policy and priorities.

- **Support provided – still relevant; need to maintain support.**

(d) Provide technical support in capacity building on health systems research, mainly in development of research proposals, data analysis and report writing.

- **No support provided – still relevant; need support.**

(e) Promote adequate technical and financial support in development of research in key identified priority areas.

- **No support provided – still relevant.**

(f) Support the maintenance of a feedback system of epidemiological data to facilitate decision-making process based on evidence-based information.

- **No support provided – still relevant; need support.**

4. Promoting Cooperation and Strategic Partnership for Health Development

(a) Advise partners in health-related activities and continue to advocate for health to be addressed as a key element for country's development.

- **Support provided – still relevant; need more involvement of WHO.**

(b) Provide technical support to the MoH to enhance its capacity for partners coordination, including the organized private sector, NGO's and CBO's and other national stakeholders.

- **No support provided – still relevant; need support.**

(c) Act as a broker for appropriate allocation of partners' resources based on the main identified priorities and gaps.

- **No support provided – still relevant.**

(d) Provide technical support to MoH to develop guidelines for promoting partnerships and project proposals for local resource mobilization.

- **Partial support provided – still relevant.**

5. Health Promotion

(a) Provide technical support to develop or adjust policies, establish institutional framework and mechanisms and mobilize and allocate resources for health promotion components in programmes on a horizontal integrated basis.

- **Partial support provided – still relevant; need assistance to develop strategic plan, M&E framework and implementation.**

(b) Support the MoH to undertake advocacy to increase the awareness and support for the use of health promotion in health and non-health sectors and players.

- **Support provided – still relevant; need approval from government to adjust policies before implementation.**

(c) Support in the establishment of appropriate mechanisms for linking health promotion interventions in non-health sectors with the national health systems.

- **Partial support provided – still relevant; part of policy issue.**

(d) Provide technical guidelines for health promotion interventions and for evaluation of the effectiveness and impact of health promotion interventions among target population.

- **Partial support provided – still relevant; needs assistance to develop strategic plan, M&E framework and implementation.**

(e) Support the country's implementation of the Framework Convention on Tobacco Control.

- **Support provided – still relevant; await tobacco bill; needs assistance to develop strategic plan and implementation.**

6. Adolescent and School Health Programmes

(a) Advocacy for adolescent-friendly health services.

- **No support provided – still relevant.**

(b) Provide technical support to improve understanding of adolescent behaviour through focused operational research.

- **No support provided – still relevant; need support for focused operational research; evaluation of programme.**

(c) Support the implementation of active adolescent and school health programmes to promote positive behavioural changes to reverse the trend of risk behaviours and unhealthy lifestyles.

- **Support provided – still relevant.**

(d) Provide technical guidelines for health promotion interventions and for evaluation of the effectiveness and impact of health promotion interventions among target population.

- **No support provided – still relevant.**

7. Disease Prevention and Control Vaccine-preventable Diseases

(a) Advocate with MoH and partners including the private sector to ensure sustainability of the levels of vaccination coverage achieved so far with the addition of other necessary vaccines.

- **Support provided – still relevant; need to sustain effort.**

(b) Provide support in disease surveillance for the early diagnosis of new cases.

- **Support provided – still relevant.**

(c) Ensure technical support for polio-free certification process in the country.

- **Support provided – still relevant; WHO gave technical support and the country got polio-free certification.**

(d) Strengthen the information system, sharing documentation and promoting participation of nationals in regional and international meetings on vaccine preventable diseases.

- **Support provided – Done.**

Other diseases

(a) Promote the implementation of the National Strategic Plan for STI/HIV and AIDS, with a multi-sectoral involvement.

- **Support provided – still relevant; need to sustain; need assistance to develop operational plan, M&E framework and implementation.**

(b) Ensure technical support for the prevention and control of HIV transmission through effective management of STI, prevention of mother-to-child transmission and voluntary counseling and testing.

- **Support provided - still relevant; needs assistance to develop guidelines, strategic plan and implementation.**

(c) Advocate for support on drugs availability particularly for STI, ARV, anti-tuberculosis for DOTS and leprosy.

- **Support provided - still relevant; needs assistance to sustain programme.**

Noncommunicable Diseases Prevention

(a) Assist in the development of national policy and strategic plan for NCDs.

- **No support provided - still relevant; await development of global framework**

(b) Provide technical support in the implementation of the NCD operational plans, monitoring and evaluation of the impact of the interventions.

- **No support provided - still relevant.**

(c) Promote technical support to ensure cost-effective interventions in the mental health and substance abuse area.

- **Support provided - still relevant; need for review.**

(d) Facilitate the integration of noncommunicable disease within the IDSR.

- **Support provided - Done.**

(e) Provide technical support in the assessment of risk factors associated with NCD, mainly in cardiovascular diseases, neoplasm, obesity and diabetes.

- **Support provided - still relevant; requires support for the Cancer Registry.**

(f) Promote technical support to ensure cost-effective interventions in mental health and substance abuse.

- **No support provided - still relevant.**