World Health Organization

Country Cooperation Strategy *at a glance*

Mauritius

This map is an approximation of actual country borders.

Total Population (2006)	**1,215,619**
% under 15 (2006)	**23.7%**
Population Urbanised (%) (2006)	**43.4**
Life expectancy at birth(2006)	**68.9 (M)** **75.7 (F)**
Gross National Income (GNI) per capita US$ (2006)	**5,450**
Adult (+15) literacy rate(2006)	**84.3%**
Human Development Index Rank (out of 177 countries) (2006)	**65**
Human Poverty Index Rank (out of 108 countries) (2006)	**27**
% population with sustainable access to improved sanitation (2004)	**100 %**

Sources:
Annual Health Statistics 2006, Ministry of Health & Quality of Life, Human Development Report 2006. Central Statistics Office 2006, Ministry of Education & Human Resources

The Republic of Mauritius consists of two Islands, the main Island and the self governing island of Rodriguez. Mauritius became independent in 1968 and Republic with a Westminster type of democracy in 1992. Since independence it has gradually moved from the status of under-developed to middle level economy with stability. It covers and area of 2000 square kilometers and a population of 1.2 million inhabitants. The country has made much progress with its health indicators as life expectancy is 75 years, under 5 mortality is 17.1/1000 live births, maternal mortality ratio is 0.36/1000 live births.
live births. The age distribution is typically the tree type found in developed economies. Sound macro-economic planning has gradually moved Mauritius from an agrarian to a manufacturing and service oriented economy. The past decade saw Mauritius sustaining its position among the first 20 "Medium Human Development" countries, ranking 65th in 2007. Concurrently, the Human Development Index (HDI) for Mauritius rose from 0.772 to 0.804. With a Human Poverty Index of 11.4 Mauritius ranked 27th out of 108 developing countries.

HEALTH & DEVELOPMENT

Mauritius has reached an advanced stage in its epidemiological transition. Communicable diseases, problems of maternal and child health (MCH) has markedly decline and are controlled effectively. On the other hand noncommunicable and chronic diseases are on the rise. Coverage rates for immunization, ante and postnatal care, and attended births have reached relatively high levels overall throughout Mauritius and the Island of Rodrigues as a result of implementation of a comprehensive national and maternal child health programmes within the framework of the National PHC Programme.

Noncommunicable diseases (NCDs) in Mauritius represent 74 per cent of the total burden of disease in men and 76 per cent in women and include diabetes, hypertension, cerebrovascular diseases, cancer, mental illness and substance related diseases linked to tobacco use and alcohol abuse.

The prevalence of diabetes mellitus has stabilized over the past decade.In 2004, the national NCD survey confirmed for the first time a slight decrease in the prevalence of diabetes to 19.3%. Overall, within the age group 20 - 59, diabetes is more prevalent among males than females. This pattern is reversed for age group over 60, with higher prevalence rates among females. Prevalence of high blood pressure estimated at 29.8% of adults aged 35 to 64 years in 2004 has been stable since 1992. The crude prevalence of hypertension in 2004 by age-group shows that only 4.5% of adults aged 20-29 years is hypertensive. Control among diabetes and hypertensive patients receiving treatment is generally poor.

The rapid industrialization along with the openness of the island to the external world has brought in its wake changes in life styles in turn impacting on the health and nutritional welfare of the communities. Negative effects that arise from a more sedentary life style are associated with lowered physical activity; issues related to time allocation; tendency to consume more convenient foods; and preference to settle for less strenuous recreational activities.

Age-standardised prevalence of obesity and overweight dropped for the first time since 1987 but is still remains relatively high at 35.7%.The declining trend is largely attributable to increasing physical activity as high as 100% among males aged 30 or more and of about 500% among females of the same age over the period 1987 -2004. Prevalence of abusive alcohol consumption among males rose to 19.1% in 2004, representing an increase of 20% between 1998 and 2004. Tobacco consumption continues to decrease steadily with current smoking among males dropping from 57.9% in 1987 to 35.9% in 2004.

Cancer is the third most common cause of death in men. This pathology is likely to increase with the aging population and the increase of risk factors related to changes in lifestyles. According to the National Cancer Registry (NCR) the incidence of all cancers combined for the period 2001-2004 was 95.5 per 100 000 for males and 126.2 per 100,000 for females. Mortality/ incidence ratio was 0.8 for males and 0.6 for females.

The HIV epidemic in Mauritius is classified as 'Concentrated' with prevalence of around 30 – 60% among vulnerable groups such as prison inmates, intravenous drug users and commercial sex workers (CSWs).At the beginning of the epidemic, the mode of transmission of the virus was predominantly heterosexual. A shift in mode of transmission from heterosexual to injecting drug use occurred in 2003 when 66 % of the new cases were detected among Injecting Drug Users (IDUs) as compared to 14% in 2002. This shift reached its peak in 2005 (92%) and leveled off to around 80% in 2007.

OPPORTUNITIES	CHALLENGES
• National Health Sector Strategy will be developed • Public /Private partnership within the health sector	• Control of noncommunicable diseases and risk factor • Continued surveillance of communicable diseases • Continued development of human resources for health • Aging population

PARTNERS

The first and only United Nations Development Assistance Framework (UNDAF) developed for Mauritius covered the period 2001-2003. With the transfer of the UNICEF and UNFPA in December 2003 to Madagascar, Mauritius is since classified by UNDG as 'Category C / non-harmonized cycle' countries, implying that a CCA/UNDAF process is not a requirement. Instead its relevance is left to the appreciation of the UN Country Team. On the basis of availability of reasonable national strategic documents providing sectoral analyses and identifying country priorities the UNCT (Mauritius) decided not to proceed with the CCA/UNDAF process in Mauritius.

The Ministry of Finance & Economic Empowerment is the authority to coordinate grants and technical assistance and ensure its monitoring and evaluation. There is no formal sector-wide approach (SWAp) mechanism in place to align and harmonize technical and financial support between the government and all the potential partner organizations in the health sector. However, the Ministry of Finance & Economic Empowerment is well aware of its role to harmonize donor support and ensure its alignment with national plans and strategies. Commitment to promote sector-wide approaches in the future is palpable.

Three platforms where the health partners share best practices, experience, information and discuss challenges are the UNTG on HIV and AIDS and the Country Coordinating Mechanism (CCM) for The Global Fund to Fight AIDS, Tuberculosis and Malaria. The UNTG meetings are convened monthly with the chair almost every year. The Country Coordination Mechanism (CCM), which is chaired currently by the NAS, was revamped in February 2008 with Mauritius being eligible for the 8th Round of the Global Fund.

OPPORTUNITIES	CHALLENGES
• Strong economy and economic forecasts. • Introduction of a Programme-Based Budget (PBB) as from 2008 embedded in a 3-year Medium Term Expenditure Framework (MTEF). This is a paradigm shift in budgetary process from an input-based annual activity to a performance-based approach linking funds to outcomes and outputs. • Mauritius is now eligible for The Global Fund for Round 8 after not being eligible under the previous rounds	• Not a donor favourable country in view that Mauritius is classified as an upper middle income country

WHO STRATEGIC AGENDA (2008-2013)

A. Building individual and global health security

A.1 : To strengthen the control and prevention of new HIV infection and to provide a continuum of comprehensive care to all PLWHIV in order to mitigate the impact of the HIV epidemic on the population at large

A.2 : To support and sustain national capacity building of competencies required by the International Health Regulations for alert and response systems in epidemics and other public health emergencies

A.3 : To build national capacity to undertake better detection, assessment and response to major epidemic and pandemic-prone diseases

B. Tackling the determinants of health (behavioural, social and environmental) through sustainable multi sectoral action

B.1: To promote healthy lifestyles and cost-effective primary and secondary care interventions for prevention and control of major NCDs and injuries, and for mental health promotion

C. Strengthening health systems and equitable access

C.1: To strengthen health system capability so as to adopt a results-based approach for effective policy-making in line with the spirit of the Programme Based Budgeting and Medium Term Expenditure Framework

C.2: To enhance the planning, provision (with focus on equitable access) to essential medical products, services and technologies of assured quality and responsiveness to users

ADDITIONAL INFORMATION

WHO country page **http://www.who.int/countries/mus/en/**