World Health Organization

SEYCHELLES COUNTRY OFFICE

COUNTRY COOPERATION STRATEGY 2016-2021

Seychelles Country Cooperation Strategy, 2016-2021

ISBN: 978-929023356-5

Suggested citation. Seychelles Country Cooperation Strategy, 2016-2021. Brazzaville: WHO Regional Office for Africa; 2019. Licence: CC?BY-NC-SA?3.0?IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Designed and printed in the WHO Regional Office for Africa, Brazzaville, Congo

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ABBREVIATIONS

AfDB	African Development Bank
AIDS	Acquired Immunodeficiency Virus
AIDS	HIV/AIDS Program
AMS	Activity Management System
AU	Africa Union
BADEA	Arab Bank for Economic Development in Africa
BCG	Bacille-Calmette-Guerin
BPOA	Biennial Program of Work
CCS	Country Cooperation Strategy
CDP	Chronic Diseases Program
CMT	Communication and Management Technologies Program
COMESA	Common Market for Eastern and Southern Africa
CPC	Communicable Disease Prevention and Control Program
CRD	Communicable Disease Research Program
CSR	Epidemic Alert and Response Program
CVD	Cardiovascular Diseases
DAH	Development Assistance for Health
DaO	Delivering as One
DPT	Diphtheria-Pertussis-Tetanus
EDM	Essential Medicines Program
EPI	Expanded Program for Immunization
FCTC	Framework Convention on Tobacco Control
GDP	Gross Domestic Product
GNI	Gross National Income
GPW	General Program of Work
HCA	Health Care Agency
HDR	Human Development Report
HFS	Health Financing and Social Protection Program
HIV	Human Immunodeficiency Virus
HOON	Health of our Nation
HPR	Health Promotion Program
HRH	Human Resources for Health Program
HSD	Policy Making for Health in Development Program
HSP	Health Systems Policies and Services Delivery Program
IDSR	Integrated Disease Surveillance and Response
IHR	International Health Regulations
IMR	Infant Mortality rate
INJ	Violence, Injuries and Disabilities Program
IRS	Health Information and Research for Health Systems Program
IVD	Immunization and Vaccine Development Program
KAP	Knowledge Attitudes and Practices
MERP	Macro-Economic Reform Program
MDG	Millennium Development Goals
MNH	Mental Health and Substance Abuse Program
MOH	Ministry of Health
MMR	Maternal Mortality Rate
NAC	National AIDS Council
NBS	National Bureau of Statistics
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHP	National Health Policy
NHSP	National Health Strategic Plan
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
PCC	Person centred care
PHA	Public Health Authority
PHC	Primary Health Care
PHE	Health and Environment Program
PLWHA	People living with HIV or AIDS
PPE	Program Planning and Evaluation
PRM	Partnership and Resource Mobilization
PSS	Procurement and Supply Services
RDO	Regional Director's Office/WR's Office
SAMOA	SIDS Accelerated Modalities for Action
SARS	Severe Acute Respiratory Syndrome
SDGs	Sustainable development goals
SIDS	Small Islands Developing States
SOs	WHO Strategic Objectives
SSDS	Seychelles Sustainable Development Strategy
SSDSC	SSDS Steering Committee
TB	Tuberculosis
TFR	Total Fertility Rate
TOB	Tobacco program
UN	United Nations
UNAIDS	United Nations Program for AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WHA	World Health Assembly
WHO	World Health Organization
WCO	WHO Country Office
WP	WHO Work plan

1 PREFACE

The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthen WHO capacity and make its deliverables more responsive to country needs. It reflects the WHO Twelfth General Programme of Work at country level, and aims at achieving greater relevance of WHO's technical cooperation with Member States by focusing on identification of priorities and efficiency measures in the implementation of the WHO Programme Budget. It takes into consideration the role of partners including non-state actors that support Governments and communities. The CCS is being formulated within the WHO Regional Office for Africa's Transformation Agenda that is based on a smart technical focus, pro-results values, accountability and effective communication with internal and external partners.

This Third Generation CCS draws on lessons from the implementation of the first and second generation CCS, the country focus strategy and the United Nations Sustainable Development Goals Partnership Framework. The CCS is also in line with the global health context and the move towards Universal Health Coverage, integrating the principles of country ownership, a focus on results, inclusive partnerships and transparency and mutual accountability, as formulated in the Global Partnership for Effective Development Cooperation and the principles underlying the “Harmonization for Health in Africa” (HHA), UHC 2030 alliance and the “International Health Partnership Plus” (IHP+) initiatives, reflecting the policy of decentralization and enhancing the capacity of Governments to improve outcomes of public health programmes.

The document has been developed in a consultative manner with key health stakeholders in the country and highlights the expectations of the work of the WHO Secretariat. In line with the renewed country focus strategy, the CCS is to be used to communicate involvement of WHO in Seychelles; formulate the WHO Seychelles workplan; advocate, mobilize resources and coordinate with partners; and shape the health dimension of the United Nations Strategic Partnership Agreement and other health partnerships in the country.

I commend the efficient and effective leadership role played by the Government in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff under the stewardship of the WHO Representative to facilitate cost-effective implementation of the programmatic orientations of this document for improved health outcomes, which contribute to better health and development in Seychelles.

Dr Matshidiso Moeti
WHO Regional Director for Africa

EXECUTIVE SUMMARY

Over the past four decades, Seychelles has made remarkable social and economic progress. Its population enjoys free primary health care, which is guaranteed under the country's Constitution and there is universal access to health care including antiretroviral therapy, universal access to safe drinking water, good sanitation and housing provision. The country is in the high human development category and is classified as a high-income country. Gender parity in terms of educational levels and women's participation in decision-making is high. The country has made remarkable progress in health-care development through a comprehensive health-care infrastructure. The average life expectancy at birth reached 73.2 years in 2015 and infant and maternal mortality is low.

Despite its success in addressing some key health issues, Seychelles faces a number of challenges. In terms of impact and health outcomes, the life expectancy falls short of what is expected of a high-income country and the 10-year gap in life expectancy between men and women needs attention. Mortality is primarily driven by noncommunicable conditions, particularly cardiovascular and respiratory diseases and cancer that account for 60-70% of all deaths.

In the area of health services, a broad range of interventions are available to respond to health needs. A comprehensive national health policy and national health strategy have been elaborated, which are mainstreamed into the Sustainable Development Strategy for Seychelles. These are informed by the need to consolidate the achievements made in the MDGs, and build towards attaining the Sustainable Development Agenda imperatives. A strong emphasis is being placed on interventions that address risk factors contributing to HIV, Hepatitis C, and noncommunicable conditions.

The health system is being re-engineered to align it with this SDG focus. Efforts at improving health workforce sustainability and productivity are prioritized, to improve on availability of specialized health workers and reduce dependence on imported workers. In addition, innovative, IT-driven methods for health information system management are being introduced, to accelerate availability and use of information in decision-making. Service delivery systems are being redesigned to focus more on person-centred services, and strengthening community/household capacities and involvement in health actions. Better and more efficient health financing modalities are being explored, to improve on the efficiency of use of available resources.

This third generation CCS therefore defines how WHO will support Seychelles in attaining its health agenda, in the context of the SDGs. It was developed through extensive consultation with health and health-related stakeholders in government and non-government entities active in Seychelles. It is informed by the National Health Strategic Plan, and the UN Strategic Partnership Agreement which defines the Government's, and the UN's focus respectively during this period.

The CCS is built around the following five strategic priorities that were identified for WHO cooperation with the Government of Seychelles: communicable and noncommunicable diseases, service quality, organization and management, human resources for health and health for all at all ages. The Strategic Agenda for WHO cooperation for the period 20162021 is as follows:

The Strategic Agenda for WHO cooperation for the period 20162021 is as follows:

WHO Seychelles Strategic Agenda, 2016 - 2021

Strategic Priority 1	**Halt, and reversal of the rising burden of NCDs through a multi-sectoral approach to address the 4 diseases and 4 risk factors most responsible for current & future NCDs in Seychelles**
Focus area 1.1	Strengthen the capacity of the health system to implement the NCD strategic plan with specific focus on alcohol and tobacco control, plus promoting healthy nutrition and lifestyles
Focus area 1.2	Improve access to interventions addressing substance use and abuse and rehabilitative services to address drug use and mental health challenges
Focus area 1.3	Improved capacity for evidence generation on the magnitude, root causes and consequences of violence and injuries and the development of prevention strategies.
Strategic Priority 2	**Introduction of new and ensuring sustained delivery of existing interventions targeting emerging or re-emerging conditions to eradicate, control and/or eliminate targeted communicable diseases**
Focus area 2.1	Strengthen the national capacity to prevent, detect and respond to health security threats in line with the International Health Regulations (IHR)
Focus area 2.2	Consolidate immunization activities, with a focus on vaccination quality assurance, initiation of new immunization products & technologies, and accelerating polio end-game initiatives.
Focus area 2.3	Support equitable access to innovative approaches and evidence based interventions for prevention, treatment and care of HIV/AIDS, STIs and Hepatitis.
Strategic Priority 3	**Putting in place innovations in quality, effectiveness & responsiveness in provision of essential services focusing on person centeredness, client management &service organization**
Focus area 3.1	Establish innovations in client management that improve person centredness,targeting improvements in quality assurance, standards setting, accreditation, and technologyadoption
Focus area 3.2	Improve health information systems design and effectiveness, targeting systems for research and knowledge management, patient management and vital statistics
Focus area 3.3	Modernized health service delivery system, with prioritization of norms, standards and protocols for effective service delivery, innovative financing approaches, and reoriented organization of services
Strategic Priority 4	**Attaining a fit for purpose and motivated health workforce through improvements in regulation, production and management of the health workforce**
Focus area 4.1	Establish a system and a comprehensive long term plan for the production and management of human resources for health based on the national health policy and strategic plan.
Focus area 4.2	Increase skills supply through pre-service medical education, continuous professional development, increased career development opportunities and targeted recruitment.
Focus area 4.3	Increase productivity of the health workforce through process reengineering, performance management, strategies for staff retention and motivation and optimal use of public and private sector skills.
Strategic Priority 5	**Achieving health for all at all ages through the promotion of health through the life course**
Focus area 5.1	Improve health services for women, children, adolescents and any underserved age cohorts
Focus area 5.2	Enhance the capacity for provision of health services for the elderly including palliation.
Focus area 5.3	Increase scope of services for vulnerable target groups with special needs across the life course

The work of WHO in Seychelles shall be focused on support to addressing these priorities. The three Biannual Programs of Work during the period of this CCS 3 shall highlight the planning and budgeting priorities that will be made to facilitate movement towards these priorities.

1 INTRODUCTION

CHAPTER 1: INTRODUCTION

1.1 Overview of the Country Cooperation Strategy

The Country Cooperation Strategy (CCS) is WHO's medium-term strategic vision to guide its work in and with Seychelles in support of the country's health agenda as defined in the National Health Policy (NHP) and the National Health Strategic Plan 2016-2020 (NHSP).

The CCS reflects WHO's global and regional policy framework and seeks to:

(a) Elaborate the support WHO will provide to support the country address its health aspirations and priorities as defined in the National Health Policy and Strategic Plan;

(b) Function as an interface between the country's health priorities as well as the global health agenda as defined in the Sustainable Development Goals (SDGs) and the 12th WHO General Programme of Work (GPW) 2014-2020;

(c) Strengthen emphasis on how WHO will respond to emerging issues;

(d) Provide a framework to facilitate the WHO Programme Budget's (PB) bottom-up planning process;

(e) Ensure that the national health priorities including health and health-related national sustainable development targets inform the WHO biennial workplan;

(f) Inform and reinforce the health dimension of the *United Nations Seychelles Strategic Partnership Agreement 2016-2020* (SPA) and act as a basis for aligning WHO's collaboration with other UN bodies and development partners;

(g) Provide a significant opportunity to mobilize and partner with all sectors that generate health and promote a culture of multisectoral work to address priorities of the NHSP and integrate the health and health-related SDG targets into the NHSP.

The development of the third generation CCS comes at a time when Seychelles has just elaborated its NHSP that emphasizes the central place of health in national development and seeks to mobilize resources and efforts from all sectors of society for the pursuit of the health of the nation. In addition to this, the country has defined the *Seychelles Sustainable Development Strategy 2012-2020 (SSDS)* that notes the central position of health in social and human development and recognizes the importance of healthy homes in addressing the risks of infectious diseases and the promotion of better nutrition and physical activity in the prevention of noncommunicable diseases. The NHSP builds on these considerations to elaborate the medium-term focus for health development.

The CCS is based on a thorough and systematic assessment of the health needs and challenges faced by Seychelles. It is guided by the key policy aspirations outlined in the NHP for Seychelles, the sector priorities elaborated in the NHSP and the reforms from the modernization drive in the Seychelles health sector which started in 2013.
The third generation CSS spans the period 2016-2021 and is harmonized with the UN SPA, the SDGs,

bilateral cooperation and regional cooperation initiatives of the Indian Ocean Commission, the African Union and SADC. It builds on the first and second generation CCS documents, which covered the periods 2002-2007, and 2008-2013 respectively.

This document builds on the comprehensive consultations with key health stakeholders in Seychelles undertaken during the process of the development of the NHP and the NHSP, and additional consultations with some key stakeholders. Its formulation was guided by a core team including the local WHO staff, officials from the Ministry of Health (MoH), the Public Health Authority (PHA) and the Health Care Agency (HCA), National AIDS Council, Ministry of Foreign Affairs and representatives of civil society organizations.

1.1 WHO Corporate Policy Framework: Global and Regional Directions

The work of WHO in country is guided by its core functions, the global health agenda, the regional Transformation Agenda and the Country Corporation Strategy at the country level. At the operations level, the work is guided by the biennial programme of work (BPOA).

The work of the WHO is guided by its core functions, which are:

(a) Providing leadership in matters critical to health and engaging in partnership where joint action is needed;

(b) Shaping the research agenda and stimulating the generation, dissemination and application of valuable knowledge;

(c) Setting norms and standards, and promoting and monitoring their implementation;

(d) Articulating ethical and evidence-based policy;

(e) Providing technical support, catalysing change, and building sustainable institutional capacity;

(f) Monitoring the health situation and assessing health trends.

WHO's global vision for health is defined in the *12th General Programme of Work 2014-2020* (GPW) endorsed at the Sixty-sixth WHA in 2013. It identifies six leadership priorities that provide programmatic direction for the coming period:

(a) Advancing universal health coverage

(b) Accelerating the achievement of the health-related Millennium Development Goals up to and beyond 2015

(c) Addressing the challenge of noncommunicable diseases

(d) Implementing the provisions of the International Health Regulations (2005)

(e) Increasing access to medical products and other health technologies and

(f) Addressing the social, economic and environmental determinants of health.

Two priorities that reflect the governance and managerial aspects of reform are WHO's governance role and reforming management.

The *Africa Health Transformation Programme 2015-2020: a Vision for Universal Health Coverage* is the strategic framework guiding WHO's contribution to the emerging sustainable development platform in Africa over this CCS period. Launched in 2015, it seeks to strengthen capacity and reorient WHO's work in the African Region, based on a more effective, efficient and results-driven approach. Likewise, the *Transformation Agenda of the WHO Secretariat in the African Region* focuses on "*a WHO that the staff and stakeholders want*" and is built around four focus areas:

(a) ***Pro-results values:*** fostering the emergence of an organizational culture that is defined by the values of excellence, team work, accountability, integrity, equity, innovation and openness

(b) ***Smart technical focus:*** prioritizing WHO's technical work in Africa to ensure it is in line with regional priorities, with interventions that are evidence-based and take into account lessons learnt

(c) ***Responsive strategic operations:*** ensuring that the WHO in Africa evolves into an organization with enabling functions that efficiently support delivery of programmes, and

(d) ***Effective communications and partnerships:*** fostering a more responsive and interactive organization, internally among staff members and externally with stakeholders.

The ultimate goal of the Transformation Agenda is to guarantee access to a package of essential health and related services in all Member States, and thus achieve universal health coverage with minimal geographical, financial and social obstacles. It is built around facilitating attainment of the Sustainable Development Goals and their targets as they relate to health.

Figure 1: Interrelations among SDG 3 targets, means of implementation and other SDGs

SDG 3 GOAL: ENSURE HEALTHY LIVES AND PROMOTE WELL BEING FOR ALL AT ALL AGES		
TARGET 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all		
MDG unfinished and expanded agenda	*New SDG 3 targets*	*SDG3 means of Implementation targets*
TARGET 3.1: Reduce maternal mortality TARGET 3.2: End preventable newborn and child deaths TARGET 3.3: End the epidemics of HIV, TB, malaria and NTDand combat hepatitis, waterborne and other communicable diseases TARGET 3.7: Ensure universal access to sexual and reproductive health-care services	TARGET 3.4: Reduce mortality from NCD and promote mental health TARGET 3.5: Strengthen prevention and treatment of substance abuse TARGET 3.6: Halve global deaths and injuries from road traffic accidents TARGET 3.9: Reduce deaths from hazardous chemicals and air, water and soil pollution and contamination	3.a: Strengthen implementation of framework convention on tobacco control 3.b: Provide access to medicines and vaccines for all, support R&D of vaccines and medicines for all 3.c: Increase health financing and health workforce in developing countries 3.d: Strengthen capacity for early warning, risk reduction and management of health risks
Interactions with economic, other social and environmental SDGs and SDG 17 on means of implementation		

To this end, WHO's focus in the African Region is built around the following five strategic priority areas:

(I) Improving health security by tackling epidemic-prone diseases, emergencies and new health threats

(Ii) Driving progress towards equity and universal health coverage through health systems strengthening

(Iii) Pursuing the post-2015 development agenda while ensuring that the MDGs are completed,

(Iv) Tackling the social and economic determinants of health, and

(V) Building a responsive and results-driven Secretariat

2 HEALTH AND DEVELOPMENT SITUATION

CHAPTER 2: HEALTH AND DEVELOPMENT SITUATION

2.1 Political, social and macroeconomic context

The Republic of Seychelles is a small, service-based, island State, with a land area of 445 km^2, made up of 115 islands situated in the South-Western Indian Ocean, more than 1,500 km from the East Coast of Africa with an exclusive economic zone (EEZ) of 1.3 million km^2. The main habitable islands, Mahé, Praslin and La Digue, share the bulk of all economic activities. Victoria, the capital of Seychelles, is located on Mahé, the largest of the three main islands.

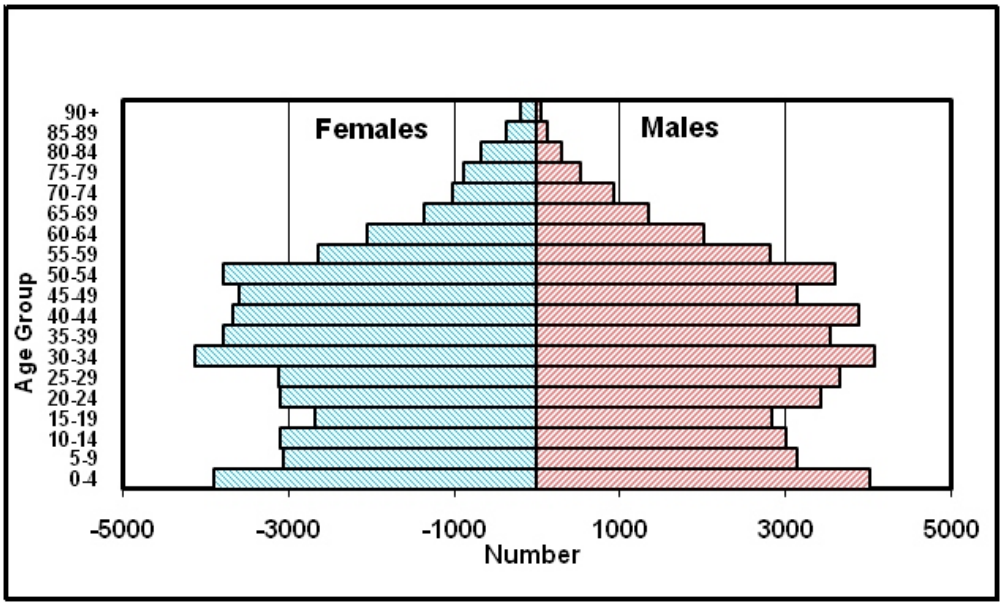
Figure 2: Map of Seychelles

It is a multi-ethnic, multilingual society, with Creole as the main language, and English as the administrative language (together with French). While the main religion is Christianity, other major religions are represented.

The estimated mid-year population in 2015 was 93 419 comprising 46 322 males and 47 097 females or a ratio of 0.984 man to 1 woman. The population is ageing and there has been a clear shift in the age structure of the population as evidenced in the population censuses of 1994, 2002 and 2010.

The National census put the number of households at 24 770 in 2010 (National Statistics Bureau, *Seychelles in Figures* 2015 Edition) of which 51% were female-headed. The average household size is decreasing from 4.3 in 1999 to 3.7 in 2010 and 3.4 in 2013 (Household Budget Survey, NBS 2013). The crude birth rate has continued to fall over the past 20 years from 21 in 1995 to 17.3 in 2006 to 17 in 2014. The average life expectancy at birth has also increased and reached 74.2 in 2015 with a ten-year gap in life expectancy between males and females.

Figure 3: Population Pyramid, mid 2015 population estimates



Source: National Bureau of Statistics, 2016

Seychelles has made remarkable economic and social progress since independence in 1976. The Constitution of Seychelles ensures the progressive realization of economic and social rights such as education, health, housing, employment, food security, social security, safety and a safe environment. These efforts and continued investments have paid off: school enrolment at the level of secondary education is at 100% and the literacy rate is estimated at 94% with no disparity between the sexes; free primary health care and universal access to health care, including antiretroviral therapy; universal access to safe drinking water, good sanitation and housing provision. While in 2013, up to 82% of households owned their home, social housing is provided for the needy. Seychelles has also established an advanced social safety net to support the most vulnerable.

The country ranked 64th in the *2015 Human Development Index,* placing it in the 'high human development' category. With a GDP of US$ 14 599 (2015), Seychelles is also classified as a high-income country based on the World Bank classification. Tourism and fishing/fish processing are the major pillars of the economy, contributing 30% and 8% of gross domestic product, respectively. The national unemployment rate is recorded at 4.1% for 2014 (4.0% for males and 4.2% for females). Youth unemployment is considered serious at a rate 2.7 times higher than overall unemployment and it is higher for females than for males.

Despite its high income status, pockets of poverty still exist in Seychelles. A study by the National Bureau of Statistics (NBS) in 2013 estimated the poverty line at SCR 3945 (equivalent to US$ 315.6) per adult equivalent per month and the proportion of the population below the poverty line was estimated at 39.3% and the food poverty line was at SCR 3193 (US$ 255.4), translating to a head-count food poverty of 24.3%.

Table 1: Selected economic statistics, 2010-2015

Indicators	2012	2013	2014	2015
1. GDP US$ million (market price)	1135	1426	1560	1364
2. GDP Per Capita US$ (market price)	12,792	15,850	17,072	14,599
3. Inflation rate (%)	7.1	4.3	1.4	4.0

Source: National Bureau of Statistics; Central Bank of Seychelles

2.2 Health status (burden of disease)

The overall life expectancy at birth has continued to increase and reached 74.2 years in 2015 (78.7 for women and 70.1 for men), but it still falls short of what is expected of a high-income country as shown in the World Health Statistics 2015. The causes of the women-men age difference, which has widened in recent years moving from 6.8 years in 2006 to 9.9 years in 2014 and 8.6 in 2015, needs further research. Indicators of health impact include infant mortality at 10.6 per 1000 live births in 2015 and maternal deaths of zero per 1500-1600 births in the most recent years (with the exception of one maternal death in 2013 and 3 in 2015). Neonatal deaths constitute the majority of the overall infant mortality. In 2015, the neonatal mortality rate was reported at 6.3 per 1000 live births, in part attributable to preventable intra-partum causes such as aspiration pneumonias mostly in the first week of life that lead to respiratory distress of the newborn. The major causes of death during the period 2010-2015 are shown below.

Table 2: Main causes of death, 2010-2015

	2010		2011		2012		2013		2014		2015	
	No	%	No	%	No	%	No	%	No	%	No	%
Deaths, of which	664		691		651		717		725		703	
Circulatory system	220	33	250	36	246	38	224	31	202	28	216	31
Neoplasm	89	16	122	18	111	17	119	17	95	13	151	21
Respiratory system	109	13	115	17	99	15	123	17	125	17	88	13
External causes of mortality	39	6	58	8	29	4	47	7	46	6	52	7
Infectious and parasitic	51	8	29	4	50	8	58	8	81	11	47	7

Source: Seychelles in figures 2015 edition, NBS

In 2015, diseases of the circulatory system contributed 30.7% to mortality and within that category, hypertensive diseases accounted for 29% of deaths and 23% were due to other heart diseases. Neoplasms accounted for 21.5% of total deaths and within this category, 19% was due to malignancy of the colon/rectum and 12% to malignancy of the prostate. The third highest contributor to mortality are diseases of the respiratory system, which contributed 12.5% to total deaths. These are consistent with trends in the five years preceding 2014, during which cardiovascular and respiratory diseases and cancer accounted for 6075% of deaths and amenable cancers constituted one third of all cancer deaths, which implies the role early detection and primary prevention could play in reducing cancer mortality. Accidents, infectious and parasitic diseases and diseases of the digestive system (in about equal order of importance depending on the year) together account for 20% of all deaths.

The major risk factors are behavioural and metabolic, contributing 43% and 39% respectively to different causes of death and injury.

2.2.1 Noncommunicable diseases

Noncommunicable diseases are the main causes of morbidity and mortality in recent years, reflecting changes in lifestyles and diet with the major risk factors being obesity, tobacco use, alcohol abuse and lack of physical activity.

Although adult cancer risk factors have reduced over time in response to prevention campaigns, the prevalence is still high; the current smoking rate is 31% among men and 8% among women; adult men consume an equivalent of 9 litres of pure alcohol per capita per year, while among women the rate is 2 litres per capita per year but steadily rising; the level of physical inactivity among men and women is 18% and 23% respectively.

Table 3: Comparison of non-communicable disease risk factors prevalence in 1989 and 2013

Risk factor	Males		Females	
	1989	2013	1989	2013
Diabetes	6.2	11.9	6.2	10.8
Impaired fasting blood glucose "pre-diabetes"	17.8	32	16.1	17.4
Hypertension BP>140/90	44	37	33	22
Obesity				
Overweight (BMI 25-29)	24	35	28	33
Obese (BMI >30)	2	22	23	39
Smoking	50.3	28.3	9.8	5.1
Alcohol consumption				
Moderate drinking	19	34	20	35
Marked drinking	22	28	5	6
Heavy drinking	34	11	3	1

Source: Seychelles Heart Study 1989 & 2013

Road traffic accidents showed an increase of 32.3% in 2014 compared to the rate in 2010 (table 4 in the appendix). 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 drink-driving, seatbelts, speeding, helmets, and road design and infrastructure.

Box 1: Trends in non-communicable diseases risk factors

The results of the two Seychelles Heart Studies conducted in 1989 and 2013 show increasing prevalence of non-communicable disease risk factors during that interval. The number of persons with diabetes and pre-diabetes has increased markedly over time and it is estimated that there are approximately 6000 persons with diabetes in the population aged 25-64 years of which 40% have not been identified and treated. Although the prevalence of hypertension did not increase between 1989 and 2013, the number of persons treated or not treated has increased markedly because of the increasing aging population. It is estimated that there were approximately 18,000 persons with hypertension in 2013 in the age group 25-64 years. The 2013 study report asserts that the marked improvement in the health care for hypertension over the period could explain the significant increase in the proportion of individuals with hypertension who are aware of their condition, are receiving treatment for it and who have controlled blood pressure. However, the percentage of hypertensives with controlled blood pressure is still low.

Comparing 1989 to 2013, the prevalence of combined overweight (i.e. moderate excess of weight, BMI: 25-29 kg/m2) and obesity (marked excess of weight, BMI =30 kg/m2) has doubled in men (from 28% to 57%) and also has markedly increased in women (from 51% to 72%). The increasing and aging population between 1989 and 2013 and the increasing prevalence of overweight and obesity over time have resulted in largely increasing numbers of overweight and obese persons in the population. In 2013 there were 48'830 overweight or obese persons aged 25-64.

The age-adjusted prevalence of smoking has decreased over time and the number of cigarettes smoked per day in male smokers has also decreased. These improvements are partly responsible for the significant decrease in the age-adjusted mortality rates of cardiovascular diseases and lung cancer between 1989 and 2013. The Seychelles Heart Study claims that decreasing prevalence of smoking in men might be due to the tobacco control program in Seychelles since the late 1980s. The study report asserts that continued awareness programs, fairly high tax on tobacco products (>65% of total cost of cigarette packet in 2014), and impact of comprehensive legislation on tobacco control in 2009 might all have contributed.

The prevalence of heavy drinking (=5 drinks per day on average), which was very high in men in 1989 and 1994, has decreased over time, but is still substantial in 2013 (nearly 11% of men in 2013). However, the prevalence of both moderate drinking (1-2 drinks per day) and marked drinking (3-5 drinks per day) has increased over time in both men and women.

Source: National Health Strategic Plan 2016-2021, MOH

2.2.2 Communicable diseases

In the area of communicable diseases, HIV/AIDS, Hepatitis C, leptospirosis, sexually transmitted infections (STIs) and mosquito-borne diseases such as dengue, are the main concerns. HIV prevalence among the general population is less than 1% and is characterized as a concentrated epidemic among the high risk groups (see box 2).

A Respondent Driven Sample (RDS) Survey carried out among MSM and IDU showed high HIV and Hepatitis C prevalence within this group. Other high risk groups include prison inmates and migrant workers.

Table 4: Selected communicable diseases in Seychelles, 2010-2015

	2010	2011	2012	2013	2014	2015
Diarrhoea	2,673	1,739	6,362	6,324	6,446	7,402
Conjunctivitis	6,426	2,760	1,325	1,300	1,490	13,096
Hepatitis C	55	55	141	97	83	143
Dengue	0	7	0	17	0	12
Influenza like syndrome	1,941	2,974	1,969	3,564	1,726	291
HIV new& old cases	33	41	29	47	91	103
Leptospirosis	42	15	17	28	35	167
Tuberculosis	13	17	18	23	12	10
Meningitis	8	10	7	0	4	1
Imported cases of malaria	3	4	15	14	0	9

Source: Epidemiology & Health Statistics Section, Public Health Authority

Vector-borne diseases such as dengue, chikungunya and leptospirosis have assumed public health importance. Leptospirosis is the major cause of death among communicable diseases. Of the 672 suspected cases of leptospirosis in 2014, 50 (49M/1F) were confirmed cases representing an increase of 78% in confirmed cases compared to 2013 (28 cases). Out of the 50 confirmed cases, there were 11 deaths, all males, representing a fatality rate of 22% compared to 5 deaths in 2013. Rodent control with case management is the main focus of Leptospirosis management in the country.

In 2004 the country faced a dengue epidemic, while a chikungunya epidemic ravaged the Indian Ocean islands in 2006 including Seychelles. While malaria is not endemic, a total of 45 imported cases were reported between 2010 and 2015. 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 is ever re-introduced. There is a need therefore to develop an effective integrated entomological surveillance and early warning system for vector-borne diseases in the country.

Re-emerging diseases (such as dengue, chikungunya, Zika) and other new diseases, such as avian influenza, Ebola and SARS, spread by international travel, are also potential threats and point to the need for stronger epidemiological surveillance and laboratory capacities in the context of the International Health Regulations and collaboration with the Indian Ocean Epidemiological Surveillance Network.

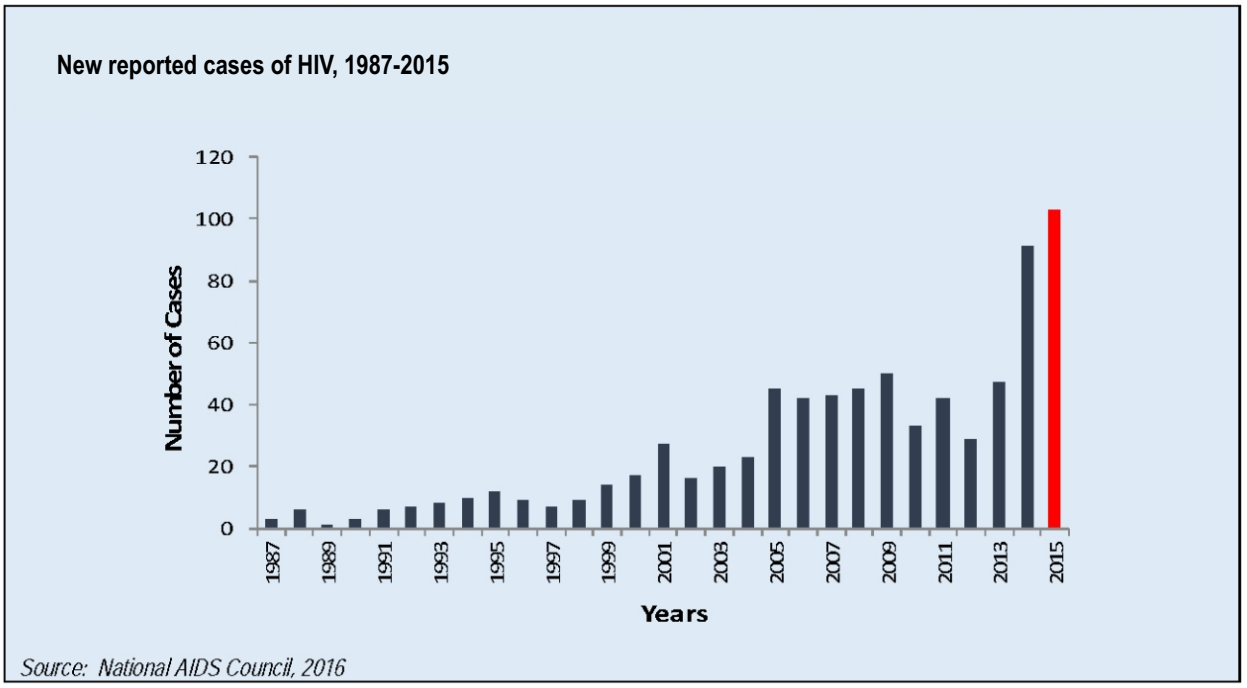
Box 2: Trends in HIV/AIDS , Hepatitis C and Sexually Transmitted Diseases

The first HIV case was diagnosed in 1987 and since then a cumulative total of 768 (462M/306F) HIV cases of which 60% males and 40% females have been reported. In 2015, 526 (312M/214F) persons were living with HIV of which 59% males and 41% females. The highest number of new cases was reported in 2015 with 103 (76M/36F) cases an increase of 13% compared to 2014.

From 1993, when the first known AIDS case was detected to December 2015, a total of 298 (186M/112F) AIDS cases have been reported. A substantial decline in mortality has been noted since the introduction of HAART in 2001 although a sharp increase in mortality was noted in 2014 when there were 19 deaths in one year. The possible contributing factors to the increased mortality were loss to follow-up and late presentation of cases.

There has been a gradual increase in the incidence of Hepatitis C reported from 2008 to 2015. By the end of 2015, 628 (523M/105F) cases of which 83% males and 17% females, have been reported, out of which 96 (81M/15F) had HIV positive and Hepatitis C co-infection and 24 (15M/7F) had Hepatitis related deaths. Ninety nine (99) percent of all cases to date are confirmed IDU.

There has been a general increase in the incidence of STIs over the period 2010 to 2015 but in each case there has been a sharp decline recorded in 2014. The cumulative number of confirmed tuberculosis (TB) cases from 1979 to 2015 is 597 out of which 31 TB related deaths and 30 cases of HIV and TB co-infection have been reported.



2.2.3 Reproductive health

Noticeable progress has been made in reducing the maternal mortality ratio through effective antenatal care and delivery handled by trained personnel. The maternal death rate is considered to be one of the lowest in the WHO African Region. While the fertility rate has declined and is presently just above replacement level, teenage pregnancy remains a challenge in Seychelles with 32% of all first pregnancies occurring in the 15-19 age group and two thirds of all first pregnancies occurring in 15-24 year olds. Concern has also been expressed over the estimated number of illegal abortions. With a significant number of pregnancies and abortions occurring among teenagers, there is a real need to improve adolescent health outcomes.

The contraceptive prevalence rate for modern contraceptive methods use among women is reported to be low but there are no reliable statistics on contraceptive prevalence. Existing information relates to government service users only and contraceptive users in private sector services are not captured. Condoms are supplied free of charge by the Ministry of Health as a means of preventing the spread of STIs and HIV/AIDS and are also sold at private pharmacies and a few other shops. The number of users is not really known. Pap smear coverage is reported to be low and declining, but there are no reliable statistics. There is a need to improve awareness and health-seeking behaviour among women.

2.2.4 Vulnerability and Disaster Management

Seychelles as a Small Island Developing State is classified as high-risk because of its size and its vulnerability to natural and environmental disasters. Floods, tropical storms, mudslides and tsunamis are some of the disasters that the island is prone to. Chikungunya and dengue as well as potential pandemic diseases such as the Influenza A (H1N1) pandemic are also a high priority for Seychelles.

Major climate change effects have been experienced, but it is believed that the impacts of climate change are likely to become more evident in the next 10 years. The *Seychelles National Climate Change and Health Adaptation Acton Plan 2014-2018* has been developed to facilitate joint collaboration between health, environment and other stakeholders to address the possible health impact of climate change.

2.2.5 Food security

Food Security is one of the vulnerabilities of the country. Seychelles is a net importer of food with about US$ 87.79 million worth of food imported into the country in 2011 compared to the US$ 40 88 million food export, mainly as fish and fish products. Local food production continues to decline: from 1995 to 2012 vegetable and fruit production fell from 65% to 50% of consumption, while local poultry production fell from 80% to 10% in 2012 due to trade liberalization as part of the overall economic reform from 1998. The Government has undertaken several measures to improve food safety and security in the country through development and implementation of sectoral policies.

2.3 Health System response

The *National Health Policy* drafted in 2015 builds on and replaces the current *National Health Strategic Framework 2006-2016*. It reaffirms the right to health for all citizens as provided for in the Constitution, underpinned by a person-centred approach to health care. The health policy framework positions health at the centre of development both as a beneficiary of and a contributor to socioeconomic development. It defines the health sector vision as '**the attainment, by all people in Seychelles, of the highest level of physical, social, mental and spiritual health and living in harmony with nature'.**

In line with this vision, the health sector mission 'to facilitate attainment of this vision is to relentlessly promote protect and restore health & quality of life and dignity of all people in Seychelles with the active participation of all stakeholders, though creation of an enabling environment for citizens to make informed decisions about their health'. This mission is a direct reflection of the importance the Government of Seychelles places in the right to health and the unyielding respect for human dignity. Article 29 of the Constitution of Seychelles reiterates the commitment of the State (the duty bearer) to health care provision and reaffirms the responsibility of the citizen (the rights holder) therein. As such, the health sector mission is translated into the three principles of *Health for all, by all and in all*.

The *National Health Strategic Plan 2016-2020*, the first medium-term plan of the NHP, defines the medium-term goal of the health sector as being to '**consolidate attainment of Universal Health Coverage with critical health and related services important for the health and harmony of life**'. This goal recognizes the progress Seychelles has made in ensuring universal access to health, but places emphasis on addressing the remaining elements that will ensure this translates into sustained universal health coverage (UHC) to enable attainment of health for all, in all and by all in Seychelles. The health status that Seychelles seeks to have, by 2020, shall be commensurate with the level of investment in health that it has made as a high income country. The country has defined five impact targets to be attained by that date:

1. Improve life expectancy at birth by 7⁄4 years (M/F)
2. Reduce by at least 10% the overall burden of morbidity/mortality due to the top 30 conditions with elimination of leptospirosis, measles, filariasis, intestinal parasites, and Hepatitis B
3. Stop the increase, and begin to reverse the burden due to the top 30 conditions responsible for the rising burden of morbidity/mortality
4. Contain the identified behavioural, metabolic and environmental risk factors to morbidity/mortality
5. Eradicate the conditions for which feasible strategies exist, such as poliomyelitis.

A clear strategic focus has been defined to facilitate attainment of this Strategic Agenda. In addition, a number of actions have been taken, in each of the health system building blocks to coordinate the sector response.

2.3.1 Governance and management of the public health sector

Since 2014, following the recommendations of the *Health Taskforce Report (2013*) and the overarching goal of modernizing and strengthening the health system, the public health sector has adopted a new structure. The new structure introduces delineation and separation of functions of entities within the public health sector.

Box 3: Modernisation of the organization of the public health sector

The new organization structure proposed formalizes the following:

i) **Ministry of Health (MOH):** headed by a Principal Secretary and responsible to formulate health sector policy development, planning, monitoring and evaluation, and oversees the implementation of health strategies by the three public bodies for health care provision and training in health care.

Three public bodies for health care provision and training in health care:

ii) **Health Care Agency (HCA):** An autonomous agency to manage the provision of primary, secondary and tertiary care. It will oversee the development of integrated health care services, strengthening community-based care, (including recruiting family health specialists in regional health centers), and improving the efficient use of Seychelles Hospital services (including improved admissions and referral mechanisms, deployment of selected specialists consultations in regional centers and reorganization of centralized specialist clinics).

iii) **Public Health Authority (PHA)**: An independent entity to regulate the health sector and provide for the protection of the population's health. It regulates health services, health premises, health practitioners as well as the environmental and commercial activities that impact on health.

iv) **National Institute of Health and Social Services (NIHSS)**: An autonomous entity to be the academic arm of the teaching hospital, provide pre-service education and for continuous in-service education of health workers and the institutionalization of high level health research.

The three public bodies will account for their performance to the Minister through regular reports and other mechanisms. The roles and functions of the PHA and the HCA are detailed in the Acts that were passed in 2013.

Source: Health Task Force Report, MOH 2013

Other ministries, agencies, professional councils, NGOs and the private sector contribute to the health of the nation. The Ministry of Health facilitates the work of professional councils that regulate health professionals. The activities of NGOs are recognized as important in the health sector in areas of prevention and awareness-creation, although civil society's participation in health care is minimal. Participation of civil society is mostly in support of specific causes such as the National Council for Children to promote the welfare and rights of children, the Cancer Concern Association for assisting cancer patients and their families; the Diabetes Society of Seychelles for prevention and awareness-creation; etc. Faith-based organizations are largely involved in pastoral care and many have established programmes targeted at behaviour and lifestyle changes. However, civil society largely lacks adequate resources, both financial and human, and programme management skills.

2.3.2 Service delivery systems

Seychelles has developed a robust network of health facilities that focus on primary care and have achieved universal coverage of services. In the public health sector, there are 17 health centres (13 on Mahé, 2 on Praslin, 1 on La Digue and 1 on Silhouette Island); 3 cottage hospitals (one each on Mahé, Praslin, and La Digue); and a tertiary hospital (1), a rehabilitative hospital (1), and a psychiatric hospital (1) all located on Mahé. In addition, there are services provided in specific settings such as prisons, schools, etc. Facility-based services are complemented with a number of programmes such as the school health programmes, workplace interventions, community interventions and home visits. A growing number of private health facilities complement the government health services and in 2014 there were 22 private general practitioner

offering family health care, diagnostic facilities and some specialized care, four dental clinics and nine pharmacies. Seychelles Hospital is the main referral hospital, which offers some tertiary care, while two referral hospitals offer psychiatric and rehabilitative care. The bulk of highly specialized treatment takes place overseas, and the cost of overseas treatment was US$ 1.4 million in 2015.

Table 5: Health facilities statistics, 2010-2015

	2010	2011	2012	2013	2014	2015
Government establishments						
Hospitals	6	6	6	6	6	6
Hospital beds	330	315	307	302	302	302
Health centres	18	18	18	18	18	18
Private clinics						
General practitioners	9	14	14	14	22	22
Dentists	5	5	5	3	4	4
Pharmacists	3	2	3	7	9	9
Inpatient admissions – Seychelles Hospital						
Number of admissions	11,314	10,756	11,010	11,890	11,566	13,315
Average length of stay (nights)	4	4	4	4	4	5
Bed occupancy rate (%)	62	67	68	66	65	66
Admissions per bed	51	62	57	52	51	59
Number of beds	223	200	192	227	227	227
Outpatient and clinic attendance – Government establishments only						
Doctors consultation	324,895	310,839	304,103	301,364	320,108	348,318
Family planning	26,182	26,445	28,989	28,232	31,172	30,585
School health	8,952	10,119	10,373	9,464	11,990	13,393
Home visits	11,505	10,932	10,746	10,003	11,951	12,975

Source: Seychelles in Figures: 2015 Edition, NBS

Health promotion activities are being undertaken by the Ministry but lack coordination, coherence and leadership. There is a need therefore to develop a coherent and inclusive health promotion policy and strategic plan to coordinate and streamline activities not only in the health sector but in other sectors and with other partners. Positive outcomes over the years include the enactment of the *National Tobacco Control Act in 2009*, *Food Act in 2014*, *National Drug Control Master Plan 2013-2017, National School Nutrition Policy, and the Seychelles Strategy for the Prevention and Control of Non Communicable Diseases*. Increasingly, a number of civil society partners such as the Cancer Concern, Soroptimist, Rotary, Diabetic Association, etc., are participating to enhance health literacy and advocate for improved quality of health services offered. There is need to develop a formal mechanism of coordination among civil society as well as aligning their activities to target sector priorities.

A gap analysis study conducted in 2010 revealed that the MoH does not have an established quality improvement and patient safety programme. Equally, staff have not been trained in quality improvement. Feedback information to clients from the providers is not based on a standardized system and there is need for wide dissemination of public information to clients on their entitlements and on the services provided in the health facilities. An infection control policy was developed in 2014 and is being implemented and monitored by the Infection Control Unit.

2.3.3 Human Resources for Health

According to a health workforce survey conducted in 2013, Seychelles has a robust staffing situation despite challenges in recruitment and retention. The number of doctors, nurses, and midwives in relation to the population far exceeds the benchmark associated with good basic maternal and child health outcomes. In spite of the high per capita ratio of health professionals, the country is heavily dependent on expatriate

professionals. Seychelles has no medical school or postgraduate opportunities, so physicians or specialists either train or are recruited from abroad. Attrition in the public health sector is low (5% per year) but may be on the rise.

Table 6: Human resources for health 2010-2015

Health Personnel	2010	2011	2012	2013	2014	2015
Medical Practitioners (GP)	100	107	93	120	140	135
Consultants	16	18	15	14	13	14
Dentists	18	17	13	20	18	18
Pharmacists	4	5	4	4	7	6
Allied Health Professionals	543	510	397	483	609	648
Nurses	412	490	419	416	432	
Students Nurses	44	87	97	75	114	51
Other Health Ancillaries	285	227	558	263	216	214
Total	***1,422***	***1,461***	***1,596***	***1,395***	***1,549***	

Source: Seychelles in figures, 2015

Health workers are sufficient in terms of numbers when compared to other African countries, but there are skill gaps, and the workforce is not well aligned to respond to the current needs of the population. Performance of health workers could be further optimized based on workload, and additional research is required to achieve even better health outcomes with the human resources already available.

2.3.4 Health information system, and Monitoring and Evaluation

There are a number of information systems in the health sector, none of which is integrated, some are not up to global standards, while some require updating. Seychelles lacks a legal framework to govern confidentiality and access and use of data maintained by such systems. Existing information is not fully analysed and utilized to inform evidence-based planning, programme management, monitoring and evaluation of sector performance. The MoH, with financial support from the Indian Government, is developing an integrated digital health information system as part of a modernization drive.

2.3.5 Health Products and Technologies

Medical products and medicines in particular are expensive as Seychelles lacks economies of scale. Sourcing of good quality products at competitive prices remains a priority for the country. The current expenditure will continue with the provision of vaccines and management of chronic conditions such as hypertension, heart disease, diabetes and HIV that require life-long treatment. Seychelles became a member of WTO in April 2014, and must be proactive in order to take advantage of arrangements such as TRIPS and the TRIPS flexibilities to ensure sustainable access to essential pharmaceuticals. Following the enactment of the *Public Health Act*, a unit in charge of Medicines regulation has been created. Strategies of pooled procurement of medicines and technology are being discussed to ensure that Seychelles benefits from the economies of scale afforded by its membership of the regional body, SADC.

The main diagnostic facilities are SK Diagnostic Centre and the Clinical Laboratory run by the Health Care Agency, and the Seychelles Public Health laboratory (SPHL) operated by the Public Health Authority. These facilities are used by other sectors and the private sector health services for their specific needs. The absence of an equipment management policy and plan which define standard equipment needs by health facility and procurement procedures, repair and maintenance and disposal of unserviceable equipment needs to be addressed.

2.1.1 Health financing

The Government is the major provider of health services, which are tax-financed and free at all points of service and organized as closely as possible to the population. Political commitment towards health remains high with the Ministry of Health obtaining an allocation of 11% of the national budget in 2015. Demand for health has been increasing due to demographic, social, environmental and technological factors, the re-emergence of diseases such as chikungunya and dengue and the potential threats of global pandemics of newly emerging diseases and as well as rising public expectations. The financial sustainability of the health system and the efficient utilization of resources are the two main challenges.

Table 7: Selected health financing indicators, 2010-2015

Indicator	2012	2013	2014	2015
1.Total health expenditure as a % of Total Public Expenditure	26.3	21.3	15.1	
2. Total Health expenditure US$ million		46.1	45.4	46.1
3. Total Gov. expenditure in Health as a % of National Budget	11.92	9.17	9.75	10.35
4. Per Capita Health Spending (US$)		496	499	496
5. Overseas treatment US$ million	1.55	1.78	1.73	1.39

Source: Ministry of Health

Sustainability calls for addressing the issues of health financing using the two-pronged approach of: cost-containment and efficiency-enhancing measures and broadening health-care financing by reducing public provision and financing of health. Moreover, as a small island State, Seychelles has low economies of scale particularly for capital investment, and unit cost of service provision will remain high. Advances in technology further increase costs, and rising public expectations for high-quality care demand continuing and expanding investment. It is crucial that the introduced measures do not radically depart from the broad principles which have guided health-care provision in the country and that the Government continue to play the leading role.

Box 4: Health Financing: analysis of the National Health Accounts 2009 &2013

Government is the major financer of health accounting for 87 percent (in 2009) and 93 percent (in 2013) of the total health expenditure. The two rounds of National Health Accounts have further documented that total health expenditure has increased substantially between 2009 (per capita US$297) and 2013 (per capita US$500), Health as a share of GDP has also increased from 3.5 percent in 2009 to 4.5 percent in 2013. Total health expenditure as a percentage of GDP is lower compared to some other island economies and small OECDcountries. However, the rate of increase in recent years has been steep and calls for strategies for cost containment, efficiency and alternative financing in the medium term. The two main cost drivers in the health sector are salaries and wages, and medicines and medical supplies. The main factors influencing the current and projected increase in health investment include the increase in the burden of non-communicable diseases requiring expensive tertiary care treatment, including overseas treatment and the ageing of the population.

Source: 2013 National Health Account Report

2.4 Cross cutting issues gender and rights

Women play a very significant role in the social, economic and political fabric of Seychelles. Gender parity is very strong in Seychelles in terms of educational levels. Equal opportunities are offered for enrolment of boys and girls in school up to tertiary level and Government makes the effort to create a fair and level education playing field such as free education, monthly allowances for students, bus passes, ensuring no gender stereotyping in the selection of students. However, disparity exists in enrolment, achievement and job-seeking behaviours. There has been an increase in drug dependence, with more men treated for drug dependence than women. Existing data is suggestive of an increasing trend in gender-based violence, with formally reported police cases increasing in the last two decades. The majority of reported victims are females and it is believed that many more victims remain silent. Women's participation in decision-making is remarkable. In 2014, women occupied 36% of Chief Executive positions in Government, 29% in Cabinet and 44% in the National Assembly.

2.5 Development partners environment

2.5.1 Partnership and development cooperation

The official development assistance (ODA) received by Seychelles has declined substantially since the 1990s because the country's per capita income level rose and Seychelles was officially declared a high-income country in 2015. Seychelles is not eligible for direct funding from the Global Fund

Table 8: Total official development assistance (ODA) received by Seychelles from donors, 2012-2014

	2012	2013	2014
Gross ODA (all donors) (USD million)	37.7	30.0	15.1
Bilateral share (% gross ODA) (%)	48.5	49.9	51.4

Source: OECD database (OECD statistics, 2016: www.oecd.org)

The table above indicates that the share of aid from bilateral agencies is almost equal to that from multilateral agencies. However, aid for the health sector has been declining since 2000 in line with the shift in focus from social support to cooperation programmes on environment, education and trade. On average, only 2% of the bilateral ODA over the 2013-2014 period was destined for health and population.

Table 9: Major active development agencies in the health sector, 2012-2014

Agency	Mechanism	Areas of cooperation	Funds allocated 2010-2014 (US$ million)
UN Agencies			
World Health Organization	WHO Country Cooperation Strategy 2008-2013	Capacity building, Technical assistance, Advocacy, equipment & supplies	4.6
UNDP	7th Country Program	HIV/AIDS	No data
UNFPA	Country Program Action Plan	Population issues, adolescent reproductive health, prevention of HIV/STIs, improving involvement of non-state actors	0.225
UNODC		Drug and alcohol control	no data
Other international Organizations			
Indian Ocean Commission	Technical Cooperation Agreement	Capacity building for HIV/AIDS awareness & prevention	2.0[1]
Bilateral partners			
France	Technical Cooperation Agreement	Specialist visits, scholarships, HIV/AIDS prevention	No data
Chinese government	Memorandum of Understanding	Anse Royale Hospital; provision of medical staff	11.0
Cuban government	Memorandum of Understanding	Technical assistance – specialist doctors; medical education	No data
Indian Government	Memorandum of Understanding	Telemedicine, equipment & supplies; health information system	2.41
Morocco	Memorandum of Understanding	Specialist doctors	No data
Knights of Malta	Technical Cooperation Agreement	Equipment & supplies	0.15
Others:	Memorandum of Understanding	Various areas	0.02
Local NGOs			
Round Table, Soroptimists, Cancer Concern, etc…	Non-formal	Equipment & supplies; awareness and advocacy; patient support;	0.3

Source: Ministry of Health, Ministry of Foreign Affairs

[1] *Relates to the period 2009-2015*

2.5.2 Collaboration with the UN System

Key partners in the health sector include United Nations agencies, bilateral partners, financial institutions and nongovernmental organizations, contributing through diverse mechanisms and supporting a vast array of services, some focused on specific diseases (polio, TB, HIV/AIDS), some on strengthening health systems and some on particular services (reproductive and child health services).
WHO remains the Government's major multilateral partner in health care and the only resident UN organization in the country. In addition to WHO, other UN agencies active in Seychelles include IFAD, FAO/IOTC, UNESCO, OCHA, UNEP, UNAIDS, UNIDO, UNFPA, UNODC, ILO, IAEA, UN Women, UN-HABITAT, OHCHR and UNDP, most of which operate from their Mauritius and Madagascar offices.
Seychelles became a Delivering as One (DaO) country in 2013 and a coordinator was appointed in 2014. This has brought greater harmonization and alignment of cooperation programmes between the various UN agencies. UN agencies with no physical presence in Seychelles work through the WHO Country Office. The work of UN agencies locally is coordinated through the *Strategic Partnership Agreement 2016-2020 (SPA)*, which is the overarching agreement between the UN System and the Government of Seychelles. The SPA is built around three results groups: Blue and Green economy; Health, HIV/AIDS and substance abuse and Rule of Law.
There is a need to extend coordination to include other international organizations and bilateral donors in order to further improve the efficiency and impact of the assistance given, maintain a focused approach towards the areas of need and achieve greater coherence for the development of Seychelles.

Seychelles considers its adhesion to, and participation in the various multilateral organizations/agencies as invaluable towards improving the performance of the health sector in Seychelles, but its participation in those regional and international bodies is in many instances inhibited by a very 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. Other equally important developments include the ongoing efforts by UN agencies and intergovernmental bodies to develop indicators and an eventual Vulnerability Index for Small Island Developing States (SIDS) and innovative alternative financing mechanisms such as the "Blue Bonds" which allow for debt swapping in return for support with marine conservation and climate change.

2.5.3 Contributions to the global health agenda and SDGs

Seychelles has had a history of contributing to the global health agenda through its participation in the WHO governance bodies and through longstanding bilateral relations with France through Reunion, with India, Cuba, South Africa, and China and through the Indian Ocean Commission. Seychelles has been part of the drive to integrate the Southern African subregion in terms of health through the SADC Protocol on Health.

Seychelles has been in the forefront of the sustainable development agenda for SIDS. It spearheaded the promotion of "*healthy islands*" through the WHO SIDS initiative, extending it to the Caribbean and Indian Ocean regions and to non-state islands. Presently, Seychelles leads the *SIDS Renewable Energy and Energy Efficiency Initiative* and was elected Vice-President of SIDS DOCK 2016-2017. In 2016, Seychelles was selected to sit on the Programme Subcommittee of the WHO Regional Committee for Africa for a period of three years. As an active member of the community of Small Island Developing States and an advocate for sustainable development in the face of vulnerability posed by climate change, Seychelles has firmly endorsed the SIDS Accelerated Modalities of Action (SAMOA) Pathway adopted by the United Nations in 2014. The Pathway provides a common framework for sustainable, inclusive and equitable economic growth, while addressing the challenges posed by climate change and other environmental threats. It also addresses many issues of human development and its calls for action on health echo many other resolutions and declarations that Seychelles has also endorsed.

In future, Seychelles should gear its institutions, with the support of the UNCT, to share its skills and expertise with other countries in some of the following areas: implementing a person-centred care (PCC) initiative; preparation of National Health Accounts (NHA), addressing the social determinants of health, attaining universal access to all health services and immunization and polio eradication.

In relation to the SDGs, the country has, as a whole, placed the attainment of the SDGs at the centre of its overall economic development. The country is championing the "Blue Economy" as its future sustainable development model. This entails looking for the best nature-inspired technologies to shift society from scarcity to abundance by tackling environmental and other problems in innovative ways. The country's development agenda - the Seychelles Sustainable Development Strategy (SSDS) - is designed with this focus, and a Blue Economy Strategic Roadmap has been defined. All sectors are expected to have a focus on sustainability and nature-driven strategic approaches. An SSDS Secretariat is to be established to coordinate and monitor movement towards attainment of the SSDS. This shall be guided and monitored by the Seychelles Sustainable Development Intersectoral Steering Committee (SSDSC) which shall meet not less than four times a year to review the work and progress of the Secretariat. This forum shall encompass all stakeholders involved or interested in the implementation of the SSDS.

WHO in Seychelles is working closely with the MoH to mainstream the health focus and actions into this national sustainable development strategy. The health policy and health strategy have been elaborated on the basis of this orientation and are well focused on defining how health will contribute to the overall sustainable development of the country.
There is a fairly good alignment therefore, of the WHO, Government and health sector-specific documents and frameworks in terms of their focus, strategic approaches and timelines as shown below.

Table 10: Alignment of key policy and strategic documents of Seychelles

Seychelles	2014	2015	2016	2017	2018	2019	2020	2021
CCS third generation								
National Health Policy								2030 →
National Health Strategic Plan								
Seychelles Sustainable Development Strategy								
The UN Seychelles Strategic Partnership agreement								
National Climate Change and Health Adaptation Action Plan								
12th GPW (WHO)								
WHO AFRO Transformation Agenda								

2.6 Review of WHO's cooperation over the past CCS cycle

The Seychelles office operated as a WHO Liaison Office during the past CCS cycle. WHO is one among four UN agencies based in the country and is recognized as an important partner in health. Cooperation between WHO and Seychelles was formalized 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) and since then, the office has initiated a wide range of collaborative programmes with the Government of Seychelles and plays an important role in national health development.

2.6.1 Current work Programme

WHO has been giving technical support to local partners and committees involved 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.

The work Programme for the 2008-2013 CCS focused on the six focus areas of communicable diseases, HIV/AIDS, family and child health, noncommunicable diseases, institutional capacity of the Ministry of Health and response to and mitigation of emergencies and natural hazards. The major focus has been on WHO's core functions of setting norms and standards and monitoring their implementation and articulating policy options. Table 3.1 indicates the programme of action expenditure for the period 2014/2015. Going forward, a focus on monitoring the health situation and assessing health trends is warranted along with resource mobilization to support the implementation of the NHSP.

Table 11: Most recent Programme of action expenditure 2014/2015 by category

Category	Description	Expenditure (US$)
1	Communicable diseases	68,795
2	Non communicable diseases	66,846
3	Promoting health through the life course	49,484
4	Health systems	59,170
5	Preparedness, surveillance and response	12,857

Source: WCO Seychelles, 2016

2.6.2 Human Resources

The current staff component stands at six: a Head of WHO Country Office, together with support staff. The team is expected to provide the required technical, diplomatic and administrative support as defined in the technical cooperation agreement. Specifically, the team is expected to:

(a) Play a convening, partnership, representation and advocacy role for WHO, and the wider UN in Seychelles.

(b) Provide and coordinate technical cooperation, policy advice and dialogue for health in areas defined as priority by the country.

(c) Avail required administration and management support to facilitate efficient, transparent and relevant provision of support to the Seychelles health agenda.

2.6.3 Support from WHO Regional Office and Headquarters

As part of the WHO reform process, the Organization has been working towards ensuring that it operates as one from the country office, regional and global levels. As such, support to the country from the regional and global levels is well harmonized within the country focus and priorities. Any support from these levels is demand-driven and guided by the technical expertise required by the health sector at specific points. This assistance is in various forms, from provision of guidance/orientation, physical missions to the country, and/or provision of financial support. Significant support from the Regional Office and Headquarters has been provided in the areas of HIV/AIDS control, integrated vector control, NCDs, reproductive health, immunization and vaccines, health systems, and health security and emergencies.

2.6.4 Strengths, Weaknesses, Challenges and Opportunities for WHO Country Cooperation

As the Government of Seychelles works towards strengthening the health care system in collaboration with WHO, several factors have helped to optimize WHO's support to the country. A SWOT analysis conducted at the end of the last CCS highlighted several factors affecting the operationalization of WHO cooperation in Seychelles.

Table 12: Summary of SWOT analysis

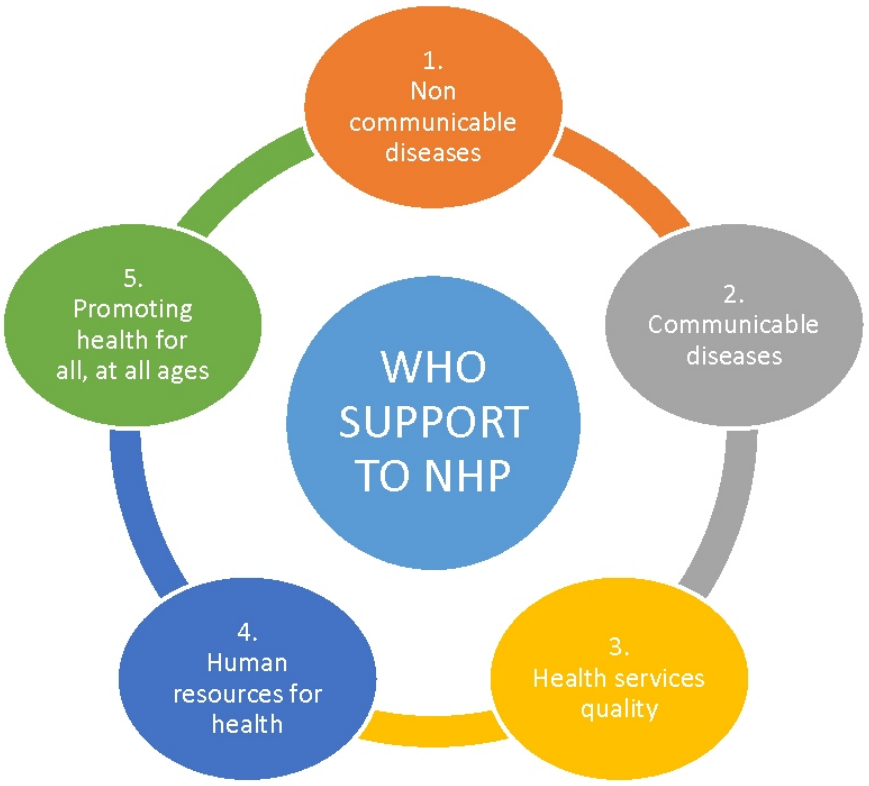
STRENGTHS	WEAKNESSES
✓ The WHO Office is physically located within the grounds of the Ministry of Health, which means the office and the staff are readily accessible which makes liaison and communication quick. ✓ The staff of the WHO office are well integrated in the health structure through their participation on various committees. This ensures that they have first-hand knowledge of the needs of the health sector and they are able to respond quickly in emergency situations. ✓ The make-up of the WHO country team ensures continuity and capacity development of Seychellois staff. ✓ Rated "*most important partner in health development*" and a quick gateway to obtain much needed technical resources outside of Seychelles.	✓ The WHO Office locally has played a limited role in monitoring health situations and in assessing health trends and in resource mobilization which are areas considered critical for continued health development in Seychelles. ✓ Program managers perceive WHO funding administration procedures as bureaucratic and onerous which discourage them to access the funds available under the BPOA ✓ The WHO is not seen as advocating for health issues outside of Ministry of Health organized activities ✓ Difficulty in discerning impact of WHO assistance ✓ High expectations of WHO as a funding agency-WHO's focus is on technical assistance whereas policy makers require increased funding to support Program implementation
OPPORTUNITIES	**THREATS**
✓ WHO's participation in several country high level steering and technical committees and good partnership with the government sector facilitates early identification of emerging issues and establishment of linkages with non-health sectors ✓ National Health Policy and National Health Strategic Plan elaborated which means both short term and long term health priorities identified ✓ Strategic Partnership Agreement –UN in Seychelles ✓ Political stability ✓ Government's commitment towards health- high budget allocation to health ✓ Potential as a channel for Seychelles contribution to the global health agenda ✓ Major government investment in health infrastructure and services – including implementation of a digital health information system ✓ High level of Gender parity ✓ Vaccine Preventable diseases eliminated and most infectious diseases are under control ✓ The country provides free health care at the point of use and the majority of the population have easy access to health facilities ✓ Increase in number of private medical practitioners ✓ Good physical infrastructure networks in the country ✓ High level of human development ✓ Health related MDGs achieved	✓ Impact of being a high income country and increased difficulty in accessing development funding ✓ Vulnerability as a SIDS, to natural disasters as a result of climate change and to food insecurity because of the high dependency on imports for most commodities including food ✓ Sustainability of Health Financing; ✓ Increase of HIV/AIDS epidemic ✓ Pandemic diseases requiring emergency response plans ✓ High operational cost for secondary and tertiary medical care and 'medicalization' of PHC which add to health care costs; ✓ Dependence on expatriate health specialists because of lack of specialist skills in-country and the absence of local medical tertiary education establishments ✓ Absence of sister UN agencies operating in health based in country which limits the numbers of partners and funding opportunities for health ✓ Absence of a national mechanism to assessProgram implementation

3 Setting the Strategic Agenda for WHO cooperation

CHAPTER 3: SETTING THE STRATEGIC AGENDA FOR WHO COOPERATION

The Strategic Agenda consists of a set of priorities and CCS focus areas for WHO's cooperation with the Government of Seychelles as reflected in the Biennial Plans of Action (BPOA). The Strategic Agenda has been jointly agreed between WHO and the Health Department and its partners to support the NHSP 2016-2020 and action to take forward the health and health-related SDGs.
The overarching goal of the NHP is to ensure the right to health of all Seychellois through the principle of health for all, health by all and health in all. In this context, the five strategic priorities identified for WHO cooperation for the period 2016-2021, are shown in the figure below:

Figure 4: Areas for strategic focus by WHO, 2016-2021



The strategic priorities constitute the medium-term priorities for WHO's cooperation with the Government of Seychelles, on which WHO will concentrate the majority of its resources over the CCS cycle. Each strategic priority contributes towards achieving at least one NHSP priority as well as the health and health-related SDGs. The achievement of each strategic priority is the joint responsibility of the Seychelles Government and WHO.

The CCS focus areas reflect the expected achievements required for realizing the CCS strategic priorities and each one links directly with an NHSP priority, GPW outcome and directly or indirectly with health and health-related SDG targets and SPA outcomes as mapped out in the subsequent table.

Each of the strategic priorities and focus areas are of equal importance to the other strategic priorities and focus areas. The order in which they appear in the CCS does not indicate their relative significance or order in which they should be addressed.

Table 13: Strategic agenda for WHO cooperation, 2016-2021

Strategic Priority 1	**Halt, and reversal of the rising burden of NCDs through a multi-sectoral approach to address the 4 diseases and 4 risk factors most responsible for current &future NCDs in Seychelles**
Focus area 1.1	Strengthen the capacity of the health system to implement the NCD strategic plan with specific focus on alcohol and tobacco control, plus promoting healthy nutrition and lifestyles
Focus area 1.2	Improve access to interventions addressing substance use and abuse and rehabilitative services to address drug use and mental health challenges
Focus area 1.3	Improved capacity for evidence generation on the magnitude, root causes and consequences of violence and injuries and the development of prevention strategies.
Strategic Priority 2	**Introduction of new and ensuring sustained delivery of existing interventions targeting emerging or re-emerging conditions to eradicate, control and/or eliminate targeted communicable diseases**
Focus area 2.1	Strengthen the national capacity to prevent, detect and respond to health security threats in line with the International Health Regulations (IHR)
Focus area 2.2	Consolidate immunization activities, with a focus on vaccination quality assurance, initiation of new immunization products & technologies, and accelerating polio end-game initiatives.
Focus area 2.3	Support equitable access to innovative approaches and evidence based interventions for prevention, treatment and care of HIV/AIDS, STIs and Hepatitis.
Strategic Priority 3	**Putting in place innovations in quality, effectiveness & responsiveness in provision of essential services focusing on person centeredness, client management &service organization**
Focus area 3.1	Establish innovations in client management that improve person centredness,targeting improvements in quality assurance, standards setting, accreditation, and technologyadoption
Focus area 3.2	Improve health information systems design and effectiveness, targeting systems for research and knowledge management, patient management and vital statistics
Focus area 3.3	Modernized health service delivery system, with prioritization of norms, standards and protocols for effective service delivery, innovative financing approaches, and reoriented organization of services
Strategic Priority 4	**Attaining a fit for purpose and motivated health workforce through improvements in regulation, production and management of the health workforce**
Focus area 4.1	Establish a system and a comprehensive long term plan for the production and management of human resources for health based on the national health policy and strategic plan.
Focus area 4.2	Increase skills supply through pre-service medical education, continuous professional development, increased career development opportunities and targeted recruitment.
Focus area 4.3	Increase productivity of the health workforce through process reengineering, performance management, strategies for staff retention and motivation and optimal use of public and private sector skills.
Strategic Priority 5	**Achieving health for all at all ages through the promotion of health through the life course**
Focus area 5.1	Improve health services for women, children, adolescents and any underserved age cohorts
Focus area 5.2	Enhance the capacity for provision of health services for the elderly including palliation.
Focus area 5.3	Increase scope of services for vulnerable target groups with special needs across the life course

This Strategic Agenda is informed not only by the need to respond to the Seychelles health agenda as defined in its National Health Strategic Plan, but also by the expectations of the global, regional and national stakeholders of WHO in Seychelles. As such, it is well aligned with the expectations of the United Nations as defined in the Strategic Partnership Agreement (Seychelles DaO instrument), WHO's Global Programme of Work, and the overall Sustainable Development Agenda as shown below.

Table 14: Linking CCS focus areas to NHSP priorities, GPW Outcomes, SDG Targets and UN outcomes

CCS STRATEGIC PRORITIES	CCS FOCUS AREAS	NHSP PRIORITIES	GPW OUTCOMES	SDG TARGETS	UN SPA OUTCOMES
Strategic priority 1: Non communicable diseases	Focus area 1.1: NCD implementation	Screening for major NCD risk factors	Increased access to interventions to prevent and manage non-communicable diseases and their risk factors	3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention, treatment and promote mental health well being	Health, HIV/AIDS and substance abuse
	Focus area 1.2: Mental health and substance abuse		Increased access to services for mental health and substance use disorders	3.5: Strengthen the prevention and treatment of substance abuse	Health, HIV/AIDS and substance abuse
	Focus area 1.3: violence and injury prevention	Determinants of health for advocacy?	Reduced risk factors for violence and injuries with focus on road safety, child injuries and violence against women, children and youth	3.6: Have the number of global deaths and injuries from road traffic accidents	Health, HIV/AIDS and substance abuse
Strategic priority 2: Communicable diseases	Focus area 2.1: Emergency preparedness, response and recovery	Disease surveillance and response systems in line with International Health Regulations	All countries have minimum core capacities required by the International Health Regulations (2005) for all hazard alert and response Increased capacity of countries to build resilience and adequate preparedness to mount rapid, predictable and effective response to major epidemics and pandemics	3.d: strengthen capacity of all countries in particular developing countries, for early warning, risk reduction and management of national and global health risks	Health, HIV/AIDS and substance abuse
	Focus area 2.2: Expanded Program on Immunization (including polio)	Immunisation	Increased vaccination coverage for heard to reach populations and communities	**3.2**: End preventable deaths of newborn and children under 5 years of age End preventable deaths of newborn and children under **3.3**: End epidemics of AIDs, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	Health, HIV/AIDS and substance abuse
	Focus area 2.3: HIV, STIs and Hepatitis	HIV, STI & hepatitis C	Increased access to key interventions for people living with HIV	**3.3**: End epidemics of AIDs, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases	Health, HIV/AIDS and substance abuse
Strategic priority 3: Health services quality	Focus area 3.1: Person centred care	Organization of health service delivery	Policies, financing and human resources are in place to increase access to people centred, integrated health services	**3.8**: Achieve universal health coverage	Health, HIV/AIDS and substance abuse
	Focus area 3.2: Research and information	Health information management Health research and evidence generation	All countries have properly functioning civil registration and vital statistics system	**17.18**: By 2020, enhance capacity building and support to developing countries to increase significantly the	Health, HIV/AIDS and substance abuse

CCS STRATEGIC PRORITIES	CCS FOCUS AREAS	NHSP PRIORITIES	GPW OUTCOMES	SDG TARGETS	UN SPA OUTCOMES
				available of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, etc.	
	Focus area 3.3: sector reform and financing	Sector accountability Health services quality of care	Policies, financing and human resources are in place to increase access to people centred, integrated health services	**3.8**: Achieve universal health coverage	Health, HIV/AIDS and substance abuse
Strategic priority 4: Human resources for health	Focus area 4.1: HRH planning	Health workforce production	Policies, financing and human resources are in place to increase access to people centred, integrated health services	**3.c**: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries	Health, HIV/AIDS and substance abuse
	Focus area 4.2: Training and recruitment	Health workforce recruitment and deployment	Policies, financing and human resources are in place to increase access to people centred, integrated health services	**3.c**: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries	Health, HIV/AIDS and substance abuse
	Focus area 4.3: HRH productivity, retention and motivation	Health workforce management	Policies, financing and human resources are in place to increase access to people centred, integrated health services	**3.c**: Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries	Health, HIV/AIDS and substance abuse
Strategic priority 5: Promoting health for all, at all ages	Focus area 5.1: reproductive, sexual, child and adolescent health.	Mother and child health Appropriate health seeking behaviour	Increased access to interventions for improving the health of women, new-borns, children and adolescents	**3.8**: Achieve universal health coverage **5.6**: Ensure universal access to sexual and reproductive rights	Health, HIV/AIDS and substance abuse
	Focus area 5.2: Elderly and palliative care	Health services quality of care	Increased proportion of older people who can maintain an independent life.	**3.8**: Achieve universal health coverage	Health, HIV/AIDS and substance abuse
	Focus area 5.3: vulnerable target groups	Identifying and strengthening household awareness of required healthy behaviour	Policies, financing and human resources are in place to increase access to people centred, integrated health services	3.8: Achieve universal health coverage	Health, HIV/AIDS and substance abuse

4 Implementing the Strategic Agenda

CHAPTER 4: IMPLEMENTING THE STRATEGIC AGENDA

To facilitate the implementation of the proposed strategic response in Seychelles with measurable and sustainable impact would require a coordination and implementation framework involving the main actors in the health sector, taking into account the Delivering as One (DaO) initiative. Emphasis should also be laid on the need to incorporate activities planned by other UN agencies, bilateral cooperation agencies and civil society and NGOs.

4.1 WHO Country Office

The WHO Country Office's (WCO) role is to coordinate and lead the provision of WHO support as outlined in this CCS, to ensure adequate facilitation of the country health agenda. This calls for a range of capacities to exist/be at the disposal of the WCO for this purpose, ranging from:

(a) Technical capacities to lead support and dialogue across the Strategic Agenda.
(b) Convening, partnership, representation and advocacy to rally stakeholders around the key results relating to the Strategic Agenda.
(c) Administrative, operational and managerial capacity to efficiently execute expected functions related to the Strategic Agenda.

Regular functional review of the WCO is needed, to ensure that its capacity is well aligned to the expectations of the country, UN partners, civil society, and other stakeholders in the health development of Seychelles.

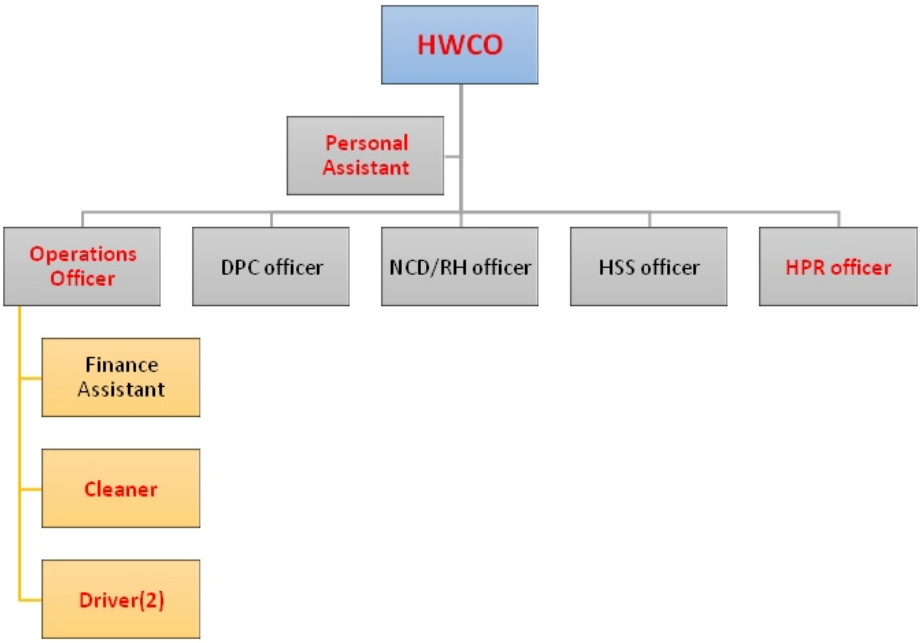
An independent functional review conducted at the beginning of the CCS period by the WHO Regional Office, as part of the Transformational Agenda to ensure fitness for purpose has led to the identification of the following as key competencies needed in the WCO:

(a) Technical areas
  (i) Disease prevention and control to coordinate work relating to strategic priority 2
  (ii) NCDs and reproductive health to coordinate work relating to strategic priority 1
  (iii) Health systems and services to coordinate work relating to strategic priorities 3 and 4
  (iv) Health promotion to coordinate work relating to strategic priority 5 and social determinants.

(b) Administrative areas
  (i) Operations assistant to coordinate and supervise office administration and operations
  (ii) Finance assistant to coordinate finance functions and ensure separation of duties in line with WHO administrative SOPs
  (iii) Support functions relating to drivers and office maintenance.

The related organogram in line with these requirements is shown in the figure below.

Figure 5: Functional organogram for WCO Seychelles



*NB: **Bold** Staff in position at beginning of the CCS 3*

4.1 WHO Regional Office and the Intercountry team

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

(a) Advocacy support to include Seychelles in potential areas of financial support, notwithstanding its levels of health indicators, low HIV prevalence and high GDP;

(b) Support in ensuring funding through the regular budget and other sources for implementation of the planned interventions;

(c) Facilitation of sharing of best practices and exchange of experiences among countries.

5 Evaluation of the CCS

CHAPTER 5: EVALUATION OF THE CCS

The development of the CCS document built on extensive consultations and reviews undertaken in the health sector during the development of the NHP and the NHSP 2016-2020. The current CCS is aligned with the current biennial plans of action for 2016-2021 and will be subject to review and evaluation in order to accommodate changes in the health development situation in the country.

The level of implementation of the components and subcomponents of the CCS Strategic Agenda will be implemented through three consecutive biennial programme workplans and budgets. The results-based monitoring and evaluation framework will follow on the key indicators agreed in the biennial workplan.

5.1 Purpose of monitoring and evaluation

The purpose of monitoring and evaluation of the CCS will be to assess WHO's contribution to the implementation of the Seychelles NHP and NHSP 2016-2020 through the implementation of the CCS Strategic Agenda. As the Strategic Agenda laid out in the CCS is implemented through workplans, the monitoring will assess the degree of implementation of the CCS Strategic Agenda and consistency between the strategic priorities, main focus areas and strategic approaches with the workplans for 2016-2017, 2018-2019 and 2020-2021. The findings and lessons learnt from the reviews will be used as input in the development of the next CCS.

5.2 Timing

The WHO Country Office in collaboration with the MoH and other stakeholders will undertake mid-term and final evaluations of the CCS Strategic Agenda in 2018 and 2021 respectively. The review cycle should follow closely or coincide if possible with the mid-term and final reviews of the implementation of the NHSP 2016-2020.

5.3 Type of monitoring and evaluation

The WHO Country Office will conduct regular internal monitoring exercises with the MoH technical focal points and an annual assessment of programme implementation against identified targets, indicators and timeframes.

The results-based monitoring and evaluation framework will be used to monitor key indicators in the biennial workplans. WHO and MoH will conduct jointly the biennial evaluation to summarize experiences and lessons learnt, identify difficulties, problems and chart the way forward.

The mid-term review of the CCS implementation will be integrated into the biennial evaluation of 2018-2019 in the third quarter of 2018. The evaluation is to assess progress towards the achievement of the strategic priorities and strategic focus areas and correct the implementation process of the CCS. Outcomes of the evaluation will be used for the development of the WHO biennial programme budgets for 2020-2021.

The final evaluation in the third quarter of 2021 will focus on determining whether the purposes of the CCS have been realized and the strategic priorities achieved. The findings will inform the formulation of the next CCS.

5.1 Evaluation methodology

The evaluation process is led by the HWO, who shall designate a CCS evaluation working group drawn from country staff and which may include an external element hiring of an external consultant and the involvement of stakeholders especially for the final evaluation.

5.4.1 Regular, ongoing monitoring

The main focus of the regular ongoing monitoring is to continuously review whether:

(a) the CCS priorities and strategic focus areas are reflected in the country's WHO biennial workplan;

(b) the core staff of the country office has the appropriate core competencies needed in country for delivering the WHO technical cooperation required by the CCS priorities and strategic focus areas.

The regular, ongoing monitoring functions as an early warning system to alert the CCS Core team to the need for refocusing the biennial workplans and adjusting as feasible country office staffing patterns or seeking additional technical support through contracting mechanisms or from Regional Office or Headquarters to meet the technical support requirements.

The specific framework for the regular ongoing monitoring shall be determined by the Region.

5.4.2 Mid-term evaluation

The main focus of the mid-term evaluation is:

(a) to determine progress in the strategic focus areas (whether the expected achievement(s) required for reaching the strategic priority are being realized);

(b) to identify impediments and potential risks that might demand attention and which might warrant changes in the strategic priorities or focus areas; and

(c) to identify actions required to improve progress during the second half of the CCS cycle.

As such, the mid-term evaluation is essentially a risk assessment and a management tool to alert the country office to those CCS focus areas which might require special attention, corrective action including revised guidance for country-level programme budget and resource allocation, or revision of the strategic priorities to which they specifically contribute if they are to be realized. The specific framework for the mid-term evaluation and to guide the CCS evaluation working group in their review of relevant documents and discussions with country staff, national stakeholders, and partners shall be determined by the Region.

5.4.3 Final evaluation

The main focus of the final evaluation, a more comprehensive assessment than is required in the mid-term, is:

(a) to measure the achievement of the selected national Sustainable Development Goals targets linked to the CCS Strategic Agenda;

(b) to identify the main achievements and gaps in implementing the CCS Strategic Agenda in terms of its content and in relation to the Multilateral Organisation Performance Assessment Network (MOPAN) performance areas;

(c) to identify the critical success factors and impediments; and

(d) to identify the principal lessons to be applied in the next CCS cycle.

The specific framework for the final evaluation shall be determined by the Region.

The final evaluation or a document based on the final evaluation should be prepared, describing the main achievements, gaps and challenges, and noting the lessons learnt and the appropriate recommendations. The document should be shared for comments with the Regional Office and Headquarters. Lessons learnt from the evaluation of CCSs should be shared with other countries, particularly within similar country groupings, within the Secretariat and with Government and partners.

APPENDICES

APPENDIX I: Country Cooperation Strategy development Core Team

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Appendix II: Basic Country Indicators

WHO region	Africa
World Bank income group	High Income
CURRENT HEALTH INDICATORS	
Total population in thousands (2015) *	93,419 (2015)
% Population under 15 (2015)	23.4
% Population over 60 (2015)	10.9
Life expectancy at birth (2015) * Total, Male, Female	Total: 74.2 Male: 70.1 Female: 78.7
Neonatal mortality rate per 1000 live births (2015)	8.6 [6.3 – 11.5]
Under-five mortality rate per 1000 live births (2015)	13.6 [10.6 – 17.2]
Maternal mortality ratio per 100 000 live births (2015)	NA
% DTP3 Immunization coverage among 1-year-olds (2015)	97
% Births attended by skilled health workers (2015)	99.0
Density of physicians per 1000 population (2014) *	2.17 *Doctors: 1.92* *Dentists: 0.26*
Density of nurses and midwives per 1000 population (2014) *	4.6 (2014)
Total expenditure on health as % of GDP (2014)	3.37
General government expenditure on health as % of total government expenditure (2014)	92.21
Private expenditure on health as % of total expenditure on health (2014)	7.79
Adult (15+) literacy rate total (2015)	92
Population using improved drinking-water sources (%) (2015)	95.7
Population using improved sanitation facilities (%) (2015)	98.4
Poverty headcount ratio at $1.25 a day (PPP) (% of population) (2015)	0.3
Gender-related Development Index rank out of 148 countries (2015))	--
Human Development Index rank out of 186 countries (2015)	64

Sources of data:
* **-** Seychelles in figures, 2015
All other data from the Global Health Observatory: March 2016, http://apps.who.int/gho/data/node.cco.ki-SYC?lang=en
NB: Maternal mortality events are too few to calculate a meaningful ratio

World Health Organization