



REPRODUCTIVE HEALTH POLICY FOR SEYCHELLES



MINISTRY OF HEALTH

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FOREWORD

The formulation and design of the National Reproductive Health Policy is an indication of governments' commitment towards the paradigm shift of reorienting the Maternal and Child Health/Family Planning services to Sexual and Reproductive Health approach. This policy takes cognizance of the existing Government policies, in particular the National Population Policy which forms the basis for all population related programmes.

The development of the policy involved extensive consultations with stakeholders and opinion leaders at both the national and district level. The team that worked on development of the policy consisted of representatives from: various technical units of the Ministry of Health, the UNFPA and WHO country offices, the Ministry of Social Development Department (Policy & Research and Gender sections), Department of Legal Affairs, Ministry of Education and Employment, Ministry of Local Government & Youth , Non-Governmental organizations, Private Sectors, Faith Based Originations, and other . This was done to ensure that the policy addresses the gaps, needs and concerns of the nation as identified by programme managers, implementers and communities at grassroots level.

The formulation and design of the National Reproductive Health policy is a result of the recognition that improving the quality of life calls for providing comprehensive and quality health care services and making services accessible to the clientele. The challenge is to provide these services, that are gender sensitive, in an environment that is welcoming to the adolescents/youth, men and the elderly through trained and competent health personnel.

The National Reproductive Health Policy gives a description of national sexual and reproductive health issues, outlines the objectives of the policy and provides what could be done to alleviate the problems and address identified needs. The document is expected to guide programme managers, donors and implementers on priority issues and interventions. The Policy document also outlines guidelines on how to offer and deliver services. Improving quality of care is critical to improving clients' health status as well as increasing access to, and utilization of Sexual and Reproductive Health services.

The Ministry of Health presents the above as guiding tools in the reorientation of health services to sexual and reproductive health. We urge all programme managers, supervisors and service providers to read these and use them as reference materials in their day-to-day work. It is vital that all recognize that the benefits of having these important documents can only be realised if they are used appropriately.

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The Ministry of Health gratefully acknowledges the contributions of the core team working on this document. (See Annex 6) We would like to express our appreciation and gratitude to the Ministry of Education and Employment, Ministry of Social Development Department, Ministry of Local Government, Youth and Culture, Department of Legal Affairs, the Civil Societies namely the Alliance Solidarity For a Solid Family, Fathers Associations, the Anglican, Catholic Churches, for the support and for releasing their staff to be part of the team working guiding the two international consultants and also took time to provide their inputs, in the process of finalisation of the policy.

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LIST OF ACRONYMS

ANC	Ante- Natal Care
GDP	Gross Domestic Product
MCH	Maternal & Child Health
FP	Family Planning
ICPD	International Conference on Population & Development
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
RHCS	Reproductive Health Commodity Security
UK	United Kingdom
NGOs	Non Government Organisations
RH	Reproductive Health
IUCD	Intra Uterine Contraceptive Device
TOP	Termination of Pregnancy
UNFPA	United Nations Funds for Population Activities
Hb	Haemoglobin
STI	Sexually Transmitted Infection
MoH	Ministry of Health
HPV	Human Papilloma Virus
CDCU	Communicable Disease Control Unit
CT	Computerized Technology
MRI	Magnetic Resonance Imaging
IEC	Information Education Communication
NIHSS	National Institute of Health & Social Studies
MSM	Men having Sex with Men
UN	United Nations
TB	Tuberculosis
GOP	Gainful Occupational Permit
IV	Intra Venous
WHO	World Health Organisation
NGO	Non Governmental Organisation
SRH	Sexual Reproductive Health
NCDCU	Non-Communicable Diseases Control Unit
FH&DP	Family Health & Disease Prevention
STIs	Sexually Transmitted Infections
AG	Attorney General
ICCS	International Conference Centre of Seychelles
VCT	Voluntary Testing and Counselling

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1.0 INTRODUCTION

The Republic of Seychelles has experienced a significant improvement in life expectancy and decrease in infant mortality over the past 30 years. However a number of indicators of sexual and reproductive health remain relatively poor in the country, including high rates of sexually transmitted infections and teenage pregnancy and the incidence of abortion. In recent years the uptake of modern methods of contraception and cervical cancer screening has fluctuated, and services are increasingly seeing the impact of drug and alcohol abuse on reproductive health.

Reproductive Health has been described as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Implicit in this definition is that people are able to have satisfying and safe sexual relationships, have the ability to reproduce and freedom to decide if, when and how often to do so’. Reproductive health affects all Seychellois across their lifespan.

Improving the quality of life of our citizens depends on the contributions of different services, agencies, and voluntary and community groups. A range of programmes and initiatives have been developed in Seychelles that have had an impact on the reproductive health of the population. Appendix 1 sets out the documents reviewed in the development of this policy.

The development of this policy was led by the Ministry of Health, draws together the key strategies through which the reproductive health of the population will improve, based where possible on evidence of the reproductive health needs of the population and the evidence base on how these needs can be addressed effectively, efficiently and equitably. It should be viewed as a development tool, providing guidance to all stakeholders involved in the development and implementation of reproductive health programmes and services. for further details see Appendix 2.

2.0 SITUATION ANALYSIS

The Republic of Seychelles has experienced a significant improvement in life expectancy and decrease in infant mortality over the past 30 years. However a number of indicators of sexual and reproductive health remain relatively poor in the country, including high rates of sexually transmitted infections and teenage pregnancy and the incidence of abortion. In recent years the uptake of modern methods of contraception and cervical cancer screening has fluctuated, and services are increasingly seeing the impact of drug and alcohol abuse on reproductive health. Domestic violence is also prevalent in Seychelles. These issues are discussed in the sections that follow.

Seychelles consists of a group of islands off the East coast of Africa in the Indian Ocean. The three principal Islands are Mahe, Praslin and La Digue. With an economy based on tourism and fisheries, Seychelles is ranked 57th in the world in the Human Development Report (2009) , and has already met most of the eight Millennium Development Goals. Given its small size and economy, Seychelles is vulnerable to both the impact of wider economic and political change, and population change due to inwards or outwards migration.

Table 1: Key development indicators we have updated figures from 2010 census

	Year	Value
GDP Per capita (US \$)	2009	9047
Adult literacy rate	2010	96%
Adult female literacy rate	2010	96%
Population/Doctor ratio	2009	779
Pupil/teacher ratio	2010	12:1
Access to free education for boys and girls	2010	3-16 years
Households with flush toilet	2007	94%
Households with treated water supply (%)	2007	87

The population in 2010 was estimated to be 86,525, and is characteristically young with 22.7% aged less than 15 years and 53.4% of women reproductive age (15-49 years). The proportion of the population aged 65 years and over is increasing, and the total population is expected to grow by over 10,000 residents over the next ten years.

Given small total population size and the vulnerability of the country to wider economic and political influences, it is difficult to develop stable predictions of population growth or change.

Table 2: Population size and characteristics

	2004	2010	2017
Total population	82,474	86,525	95,700
Male	40,6510	44,253	47,500
Female	41,823	42,272	48,200
Under 15 years (%)	25.2	22.8	23.7
15-44 years (%)	50.8	49.0	45.3
45-64 years (%)	16.1	20.3	23.7
65 years and over (%)	7.9	7.9	7.2
Median age	29	31	N/A

Dependency ratio (no. aged < 15 years + >65 years per 1000 population aged 15 to 64)	494	441	N/A
% living on La Digue and outer islands	3.2	2.6	N/A
Population growth rate	-0.4%	-0.9%	NA

In 2010, life expectancy at birth was 69.09 years for men and 77.5 years for women. The infant mortality rate varies considerably year on year due to the small numbers involved, but had increased to 14.0 in 2010 compared to 10.8 per thousand live births in 2009.

Table 3: Key health outcomes

	2009	2010
Life expectancy (total)	72.8	73.2
Life expectancy men	68.4	69.0
Life expectancy women	78.0	77.5
Crude death rate	7.8	7.7
Total registered live births	1,580	1,504
Total number of infant deaths	17	21
Infant mortality rate	10.8	14.0
Early neonatal deaths	4	13
Late neonatal deaths	7	5
Neonatal Mortality Rate	7.0	12.0
Peri-natal mortality rate	10.7	14.5

The Total Fertility Rate has declined steadily from 5.2 in 1975 to 2.3 in 2010 and the country has experienced a relatively low population growth rate.

Table 4: Summary of key reproductive health indicators

	2009	2010
No of women of reproductive age 15-49	23,701	23,123
% of all women aged 15-49	56.7%	55.1%
Total fertility rate	2.38	2.34
Total number of births	1,580	1,504
Birth rate (per thousand population)	18.1	17.4
Total number of abortions	471	562
Abortion rate (per total reported pregnancies)	22.8%	27.1%
Contraception prevalence rate	36.3%	46.2%
Mean age at first pregnancy	22.9 years	23.8 years

Health care services that impact on reproductive health include family planning, maternity, infant and child health, contraception and infertility, miscarriage and abortion, prevention and control of sexually transmitted diseases, cancer services, and interventions focused on harmful practices such as gender based violence. A range of other agencies also have an influence on reproductive health, including health education and promotion in schools, social care and support services, voluntary and community based programmes.

In Seychelles, healthcare is free at the point of use for all citizens. The health system includes the main Hospital in Victoria, 3 cottage hospitals, 1 rehabilitation unit, the psychiatric hospital, the youth health centre and 16 district health centres. Primary health care services include primary medical services, family planning, childhood immunisation and developmental assessment, antenatal and post natal care, school health and health promotion. Population uptake and coverage of these programmes is generally good, for example immunisation coverage against the most common childhood diseases is almost 100%.

As a component of primary health care, the national maternal & child health (MCH) and family planning (FP) programmes have led to great improvements in health outcomes for children and families, preventing deaths and ill health and enabling people to control the size and spacing of their families.

3.0 POLICY GOAL

To ensure that all Seychellois have the best possible chance of enjoying safe and satisfying sexual relationship/s, can determine whether and how often they have children, and give their children the best possible start in life.

4.0 POLICY OBJECTIVES (According to areas in Sexual Reproductive Health)

Developing reproductive health programmes in Seychelles

4.1 Safe motherhood

To enable women to prepare for and have a safe pregnancy , delivery and post partum;
To promote healthy child development;
To ensure families adopt safe parenting practices that support the health of the child and mother, including infant feeding.

4.2 Family planning and contraception

Increase access to and uptake of modern contraceptive methods, including long active reversible methods and emergency contraception;

Improve access to family planning services for vulnerable groups, including young people.

4.3 Pregnancy testing

To improve access to pregnancy testing and enable women to make informed choices about their pregnancy or future fertility

4.4 Infertility

To reduce the prevalence of infertility;

To improve access to information and services for infertile couples.

4.5 Termination of pregnancy and abortion

To reduce the incidence of abortion;

To prevent unsafe abortion;

To provide information on the different options available for a woman with an unintended pregnancy so as to help her make an informed choice.

4.6 Sexually transmitted infections (STIs)

These statements focus on reproductive health, and should be read in conjunction with the National Policy for Prevention and Control of HIV/AIDS/STIs;

The ministry is committed to build the capacity of the whole population but particularly youth and other vulnerable groups to prevent the spread of HIV/AIDS/STIs;

There will be sustained commitment to improve co ordination at all levels for STIs, HIV/AIDS and other blood borne viruses in its prevention and control;

The ministry will ensure that HIV, STIs and other blood borne virus counselling and testing are used to maximize prevention efforts and improve access to effective treatment and care services;

4.7 Cancers of the reproductive system

To raise awareness amongst service providers and the public about the importance of prevention, screening and early detection for Cancer services and survival;

To develop quality assurance mechanisms which ensure that effective cancer prevention, screening and treatment services are delivered.

4.8 Other gynaecological dysfunction and menopause

To improve access to information and services relating to other gynaecological dysfunction and menopause.

4.9 Sexual dysfunction

To ensure access to information and services relating to sexual dysfunction.

4.10 Gender and violence

To address the population's reproductive health issues arising from emotional, physical and sexual abuse;

To reinforce detection and support individuals vulnerable to abuse;

To develop a zero tolerance approach towards violence amongst service providers and clients;

To provide appropriate care and support to victims of abuse.

4.11 Vulnerable Groups

To ensure access to reproductive health care to all vulnerable groups;

To initiate and develop programmes to meet their specific needs.

4.12 Youth and Adolescent Reproductive health

Strengthen access to adolescents-friendly sexual and reproductive health information, counselling and medical care services for various groups of adolescents;

Reduce the incidence of unplanned pregnancy, unsafe abortion, HIV and other sexually transmitted infections amongst adolescents by sensitising adolescents and parents on their rights and responsibilities towards access to Sexual and Reproductive Health Services;

Reduce social and cultural barriers which affect reproductive and other health and rights of young Seychellois through provision of accurate information and skills to both parents and adolescents;

Strengthen adolescent- friendly services in all health Centres and through schools;
Strengthen adolescents' negotiation skills for safe sex, specifically female minors through revision of existing life skills programmes;

Review existing SRH services in health Centres and schools to meet the needs of adolescents.

5.0 POLITICAL COMMITMENT

Health is essential for our citizens to enjoy a high quality of life, and for the sustained economic and social development of our country. The Government is committed to

intensive action to attain the goal of health for all and by all; that is the level of health that will permit the people to lead socially and economically productive lives (National Health Policy 2005). In 1994, Seychelles adopted the ICPD Programme of Action which placed the human person at the centre of concerns for sustainable development and called for universal access to reproductive health by 2015.

The policy makes reference to the National Health Policy (2005) and the National Population Policy for Sustainable Development (2007). It is closely linked with the National Strategic Plan for HIV/AIDS (2007-2010) and the National Strategic Plan for RHCS (2006). This policy is also closely linked to the Millennium Development Goals, specifically improvement of maternal health, reduction of child mortality and control of HIV/AIDS.

6.0 LEGAL FRAMEWORK

6.1 Consent to sexual relationships

In Seychelles, the same laws apply to heterosexual and homosexual activity and offences can be committed by anyone over age of criminal responsibility.

It is an offence to intentionally engage in sexual touching with a young person age 13, 14 or 15.

A person aged over 18 is liable to up to 14 years imprisonment for this offence, or if aged under 18 is liable for up to 5 years imprisonment. Persons may claim they believed the person to be over 16 in their defence. Intentional sexual touching of a person under 13 is an absolute offence- i.e. the defence that they believed they were over 16 is not permissible. Imprisonment of up to life is liable for touching involving penetration and up to 14 years for non-penetration.

6.2 Consent to medical treatment

Adults (over 18) are usually regarded as competent to decide their own treatment. If a person under 18 refuses to consent to treatment, it may be possible in some cases for their parents to overrule their decision. However, this can only be exercised on the basis that the welfare of the child is paramount.

Young people (under 18) have the same right to confidentiality as other patients.

In the UK, young people under 16 years can consent to medical treatment if they have sufficient maturity and judgement to enable them to fully understand what is proposed. Although it is unlawful for a man to have sex with a girl under 16, it is lawful for doctors to provide contraceptive advice without parental consent providing certain criteria are met. These criteria, known as the Fraser guidelines, require that the health professional be satisfied that:

The young person understands the professional's advice;
They cannot be persuaded to inform their parents

They are likely to begin, or continue having, sexual intercourse with or without contraceptive treatment Unless the young person receives contraceptive treatment their physical or mental health, or both, are likely to suffer
The young person's best interests require them to receive contraceptive advice or treatment with or without parental consent

Although these criteria specifically refer to contraception, the principles are deemed to apply to other treatments, including abortion. In the UK these guidelines referred specifically to doctors, but are considered to apply to other professionals e.g. nurses, youth workers, health promotion workers although this has not been tested in court.

Similar Guidelines have been reviewed by different groups locally and adapted to our Seychelles context (see appendix 4). The RH services covered by the guidelines do not involve only contraception but extend to HIV testing, screening and treating of sexually transmitted infections, providing information, counselling and education etc.

6.3 Confidentiality

Common law recognises the concept of confidentiality and legal action can be taken if confidential information is disclosed or misused. Professional codes of conduct place a duty on doctors, nurses and health professionals not to disclose information about an individual without their consent, except in exceptional circumstances. For example, if the professional believes that the health, safety or welfare of the patient or others is at grave risk.

6.4 Emergency contraception

Emergency contraceptives are mostly prescribed by medical officers after consulting the client and they are also dispensed by Family Planning nurses to their regular clients if and when the need arises. Emergency contraceptives are also prescribed and dispensed in Accident & Emergency units; outside regular Family Planning service hours, if emergency contraceptives are not available in the dispensary, the nurses in charge on that particular shift can obtain them from the Family Planning room.

The Intra-uterine contraceptive device (IUCD) can also be inserted as a form of emergency contraceptive though this is less popular in Seychelles; such is mostly done by gynaecologists but can also be done by trained Family Planning nurses.

6.5 Abortion

In Seychelles, Abortion is presently defined as the termination of a pregnancy before the foetus is capable of extra-uterine life. The gestational age of viability is 26 completed weeks or birth weight of 800 grams. In Seychelles there is provision for the termination of pregnancy under the TOP Act 1994. The procedure is performed at Victoria Hospital. The woman receives counselling prior to and after the procedure and is followed up at a family planning clinic. For persons less than 18 years old, decision regarding termination of pregnancy has to be approved by the parents.

The Ministry of Health's guidelines for provision of contraception/reproductive health services to clients under 18 contained in the family planning manual does not provide most young people access to contraception without parental consent. Very few girls under 18 years old would seek their parent's permission to start on contraception, as most often they do not want their parents to know that they are sexually active. In other cases, doctors are often unsure about their legal rights and responsibilities in relation to providing reproductive health services to patients less than 18 years.

The above situation results in poor management of reproductive health risks amongst sexually active young people.

6.6 Medical records

In Seychelles, anyone can apply to see their own medical records. Parents can ask to see their children's records but permission can be refused if the information within them was given in the expectation that it would not be disclosed to them. The record holder must be satisfied that the young person gave permission for their parents to see their records.

7.0 POLICY OVERSIGHT AND PARTNERSHIP

The Ministry of Health will provide leadership and coordination in the implementation of this reproductive health policy. It will be responsible for the provision of reproductive health services and will coordinate activities being conducted by other ministries, NGO's and the private sector. It will provide guidance, monitor and evaluate performance and quality of services being provided. The Ministry will review the policy taking into account changes in the needs of the population. A National Reproductive Health Committee is already established, with membership from a range of stakeholders and chaired by the Principal Secretary Ministry of Health. This Committee will be responsible for the monitoring and evaluation of implementation.

8.0 GUIDING PRINCIPLES

In developing this policy, the following principles were adopted:

8.1 Respect for human rights

The Government recognizes the right to the enjoyment of the highest attainable standards of physical and mental health for every citizen. All providers of health care will ensure that citizens can exercise freedom to make decisions in all matters relating to their sexuality, family planning and reproductive health.

8.2 Equity of service provision

The Government will strive to ensure services are provided in an equitable way that is ensuring that services are provided to those that need them and will benefit from receiving them regardless of their individual characteristics.

8.2 Ensuring access to high quality services

The Government is committed to providing access to primary healthcare services that are free at the point of use, and will ensure that all programmes continuously strive to improve the quality of information, counselling and services they offer to clients.

8.3 Integration of services

The Government will strive to ensure that services impacting on reproductive health are offered in an integrated, joined up manner to ensure maximum effectiveness and optimal use of available resources.

8.4 Gender equity and equality

The Government will encourage all programmes to consider gender differences and encourage positive attitudes regarding sexuality and gender roles.

8.5 Multisectoral approach

Reproductive health addresses health issues that go beyond the health sector. The determinants of reproductive ill-health are multiple and include gender and social inequity, social injustice, marginalization and poverty. A multisectoral approach involving government, civil society, the private sector and bilateral and multilateral partners will be crucial for addressing reproductive health issues.

8.6 Evidence based and sustainable services

All health services are based on scientific evidence, are within affordable limits and sustainable for the future.

9.0 POLICY STATEMENTS

9.1 Developing reproductive health programs in Seychelles

The Ministry of Health recognises that reproductive health issues may present in many settings, and that this policy should be read in light of other relevant policy statements.

The Ministry recognises that health care and other staff will require training and development to implement this policy and clinical guidelines arising from it. It will therefore provide induction to all new staff including expatriate doctors and nurses, returning graduates, and locum staff on local reproductive health services and clinical guidelines.

Seychelles is a partner in the regional UNFPA reproductive health commodities security strategy. The ministry will work to ensure that there is a consistent supply of contraceptives and other commodities to support reproductive health.

The population of Seychelles is small which makes it difficult to identify statistically significant trends in reproductive health in a timely way. In addition, with the increasing use of private health care providers and pharmacies the ministry will need to establish mechanisms to gather intelligence from these services in order to identify unmet health needs. This will build on current arrangements to report cases of notifiable disease to the ministry.

As a priority, methods to collect data on uptake of modern methods of contraception will be established.

9.2 Safe motherhood

Maternity services are well established in Seychelles. The maternal and child health programme was established to ensure that appropriate ante and post natal care is available to all women. Nearly all women deliver in a hospital setting, with trained health personnel attending 100% of pregnancies and deliveries. In recent years, the country has achieved good maternal and infant health indicators; the infant mortality rate averaged 11.6/1000 from 2006 to 2010, and the maternal mortality rate averaged 39.5/100,000 live births during the same 5 years.

However, maternity service providers face a number of emerging challenges. Many women book late for ante natal care, reducing opportunities for disease prevention and health promotion. Teenage pregnancy rates remain significantly high, whilst an increasing number of women are pregnant in their later years. Both groups may experience higher rates of complications, the latter also having a higher risk of foetal abnormalities. Preconception advice is available but is not part of a regular programme. Nutrient supplementation is targeted to reduce iron deficiency anaemia in pregnancy.

There has also been an increase in the prevalence of obesity and substance misuse in the population with associated obstetric complications and requiring the active identification and management of blood borne viruses such as HIV and hepatitis B&C. Although exclusive breastfeeding is normally advocated only less than 60% are actually practising it. Formula feeding is increasingly common on the ward following delivery.

9.2.1 Policy Objectives

To enable women to prepare for and have a safe pregnancy , delivery and post partum;

To promote healthy child development;

To ensure families adopt safe parenting practices that support the health of the child and mother, including infant feeding.

9.2.2 Policy statements

The Ministry of Health will deliver a universal Maternal and Child Health programme through the primary health care system. This will be delivered by staff trained to deliver obstetric care.

Preconception advice and care will be provided as part of the reproductive health programme in primary care services (currently provided through family planning clinics). This will also include promotion of nutritional status focusing on attaining healthy body weight and good micronutrient status such as iron and folic acid. The Ministry shall review the immunization guidelines to consider offering Tetanus toxoid to all female at 25 years of age.

Early booking for antenatal care will be encouraged, aiming for over 95% of women booked within the first 10 weeks of their pregnancy.

Ante-natal care services will be provided through regional centres, and women will be encouraged to book within their region. All high risk pregnancies will be referred to the ante natal specialized referral point at Victoria or Praslin Hospitals.

9.3 Ante natal care will include:

Ante-natal screening as set out in ANC guidelines. Women may choose to opt out of this programme, but the reasons for them declining the offer should be recorded. Relevant data will be recorded for surveillance purposes e.g. unlinked antenatal HIV prevalence;

Advice on healthy diet and physical activity to all women within the first three months of pregnancy. Folic acid supplements (recommendation is 400ug) will be provided for all women up to the 12th week of pregnancy either as a single dose supplement or combined with iron. Iron supplementation will not be provided unless clinically indicated (Hb < 11g/dl);

Risk assessment process to identify specific needs, including medical problems, genetic fetal abnormalities, smoking, body mass index, substance misuse, mental health problems, and domestic violence;

Antiretroviral therapy for all pregnant women who are HIV positive to prevent progression to AIDS and transmission to their child;

Advice and support in preparation for delivery, including pain management and relief.

All women will be encouraged to deliver their baby in specialised points and no planned deliveries will take place at home. Women living on the outer islands will be encouraged to

move to Mahe/Praslin/La Digue by 7 month gestation (earlier if higher risk). All babies requiring neonatal intensive care will be looked after by the unit at specialised point. The Ministry will establish an inquiry committee for all maternal deaths. It will also develop a mechanism for investigating near-misses in obstetric care.

All cases of neonatal death will be reviewed within the perinatal mortality meetings. Following a miscarriage, still birth or neonatal death all women will be reviewed and referred to appropriate services:

After delivery and before discharge, all women will be offered family planning advice and methods.

All women will receive a post-natal home visit within 2 weeks of delivery by a midwife at community level.

All births will be notified within 28 days of delivery.

All pregnant women will be given information about the optimal methods to feed their infants.

9.3.1 Family planning and contraception

Family planning programmes represent a cost effective means of preventing unwanted pregnancy, poverty and social exclusion and have made a major contribution to women's empowerment. Decentralised family planning services were established in Seychelles in the early 1980s and are currently provided in each health centre (13 on Mahe including Youth Health centre, 2 on Praslin, 1 on La Digue and 1 on Silhouette). These services have had a significant impact on family size and the rate of unwanted pregnancy. Family planning clinics provide hormonal pills and injectables, the IUCD, condoms and other barrier methods. Currently hormonal IUCDs and implants are not available. Clients requesting sterilisation are referred to the Gynaecology service at Victoria Hospital. Oral contraceptive pills are the most popular method (64%), followed by injectable (20%), IUCD (5%), condoms and sterilisation.

Family planning services are available from private doctors, and condoms and oral contraception are sold through pharmacies. Data on contraception prevalence is currently gathered from Ministry of Health services only, making it difficult to gauge the level of unmet need. Historically, clinical supplies have been provided through donor agencies including the UNFPA. Interruptions to supply reduce both the effectiveness of contraception methods, and women's confidence in the programme. Family planning programme clinical guidelines need updating.

The reported contraceptive prevalence rate for modern methods has declined from 60% in 1996 to 46.2% in 2010. More recently the total number of attendances at family planning clinics has fallen from 38,867 in 2004 to 35,656 in 2010. In part this reflects the availability of alternative private providers, but lack of staff continuity and lack of confidentiality/privacy in clinic settings have also been cited as contributory factors. Inadequate follow up of women who drop out of the programme, limited male involvement, and inequities in women's access to the IUCD as a method of emergency contraception have been identified as priorities. These will be addressed through an update of the FP

Procedures Manual, and improvements to service data collection and reporting. Update figures if possible

9.3.2 Policy objectives

Increase access to and uptake of modern contraceptive methods, including long active reversible methods and emergency contraception;

Improve access to family planning services for vulnerable groups, including young people.

9.3.3 Policy statements

Family planning services will be available for individuals or couples, but women do not require the consent of their partner to access family planning services;

Individuals will be able to access any reproductive health service, regardless of where they live or work;

There are no age thresholds for clients accessing family planning services. Issues relating to parental consent for young people are discussed in section 9.13 of this policy;

Each service will make provision for women who require emergency appointments or repeat prescriptions and ensure that appointments are made available as early as possible;

Suitable alternatives to routine family planning clinic times will be provided for vulnerable clients and women at high risk of experiencing an unwanted pregnancy;

Family planning services will advise clients on the full range of family planning methods available in an unbiased manner;

Local stocks of the full range of methods will be maintained to minimise the risks of interrupted supplies;

Emergency contraception (hormonal and IUCDs) will be available to all women who request it, and women will be supported to ensure they are aware of the services and how to access it;

The Ministry of Health respects the fact that family planning service providers may have a contentious objection to some interventions. However this must be balanced against the duty of care that service providers have for their client's health and well-being, and the need to provide services in an equitable and fair way.

All service providers must declare if they have a contentious objection to any of the interventions set out in the Family Planning procedures manual, and agree a referral process

with the family planning programme manager to ensure that any women wanting to access these interventions is able to do so in a timely and appropriate way;

The Ministry of Health will seek to develop a clinical governance framework for family planning services provided by private pharmacies, and include uptake of these services in national family planning programme monitoring and evaluation arrangements;

Family planning services will promote the use of both female and male condoms in addition to other methods of contraception amongst those with sexual behaviour that puts them at high risk of contracting an STI. Condoms will be made available through a range of other community settings, including health centres, bars and discotheques;

Patient education is a key component of effective family planning programmes. Resources and guidance for practitioners will be developed to support this, including media campaigns where appropriate;

The Ministry of Health will consider the following service developments:

Review the current family planning programme with the aim of extending its remit to include pre-conception care, infertility and sexual health and improve access for men and older women.

Review the range of contraceptives available locally with the aim of promoting the most cost effective, safe and acceptable methods. The Family Planning procedures manual will be updated accordingly

9.4 Pregnancy testing

Pregnancy tests are available at all health centres on request through family planning clinics and doctors. Tests requested are normally paid for by clients (currently SR50), although if requested by the doctor it is provided free as any other routine investigation. All tests offered are of immediate response (HCG Sensitivity). Tests are also available through private doctors and licensed pharmacies. Currently clients can also buy pregnancy test kits over the counter from private pharmacies and private doctors.

One key problem is linking up the testing service with antenatal booking and provision of psychological support or other services such as HIV testing or the need for folic acid supplementation. This is not done systematically, something which needs to be addressed.

9.4.1 Policy objective

To improve access to pregnancy testing and enable women to make informed choices about their pregnancy or future fertility

9.4.2 Policy statements

Women will be supported to find out if they are pregnant without delay. This will enable them to make and act on informed decisions about their pregnancy;

Free and confidential pregnancy testing services will be available at each health centre, through family planning clinics and at Accident and Emergency Units;

All pregnancy results will be given by a health care provider who needs to provide accurate information and support about pregnancy decisions, including emergency contraception and contraception if appropriate;

Prompt referral to specialist services should be undertaken, aiming to ensure that women book for ante natal care as soon as possible before 12 (weeks gestation);

The ministry will develop guidelines for private pharmacies which sell pregnancy test kits on advice for women buying the test;

Positive test results should be used as an opportunity to emphasise the importance of early antenatal booking and to introduce folic acid supplements;

Women with an unwanted pregnancy should be counselled on their options and referred appropriately;

Negative test results should be used as an opportunity to discuss contraception, STIs and safer sex.

9.5 Infertility

The true prevalence of infertility in the country is not known although anecdotal reports suggest more women/couples are being seen at the health centres because of their inability to conceive. Prevention of infertility includes STI prevention and management, and healthy weight strategies.

A weekly infertility clinic currently takes referrals from medical officers and family planning nurses, but there are no clinical guidelines on the management of infertility at present. Investigations available locally include sperm count, blood tests, hormonal assays, ultrasound, hysterosalpingogram, and diagnostic laparoscopy. Service data collection and management need to be strengthened in the near future.

9.5.1 Policy objectives

To reduce the prevalence of infertility;

To improve access to information and services for infertile couples.

9.5.2 Policy statements

Health services will ensure that interventions to prevent infertility are promoted e.g. encouraging early presentation for signs/symptoms of sexually transmitted infections and ectopic pregnancy.

Clinical guidelines will be developed to support the prevention and management of infertility, including counselling, referral pathways and links with fostering and adoption agencies. Staff will be trained in their use.

The Ministry of Health will consider the following service developments:

Development of sperm donation services

A national chlamydia screening programme nationally

9.6 Termination of pregnancy and abortion

Abortion is presently defined as the termination of pregnancy before the foetus is capable of extra-uterine life. The gestational age of viability is 26 completed weeks or birth weight of 800g. In Seychelles there is provision for the termination of pregnancy under the “Termination of Pregnancy Act” (1994). The procedure is performed at Victoria Hospital and all women would normally receive counselling prior to and after the procedure and follow-up is normally done at the family planning clinic. For persons less than 18 years, parental consent is required.

The total number of abortions (terminations and miscarriages) is on the increase between 2006 and 2010 (range 443-562 per year), with 58.8% of all abortions in the women aged 20-34 years.

Table 5: The total number of reported abortions by age 2006-2010

Age Groups	2006	2007	2008	2009	2010
10– 14	3	5	6	6	9
15 – 19	71	69	81	90	122
20 – 24	98	92	79	83	105
25 – 29	99	108	77	102	100
30 – 34	90	86	93	73	112
35 – 39	56	54	68	74	88
40 & above	26	32	49	43	26
TOTAL	443	446	453	471	562

Source: Epidemiology and Statistics Section

Illegal and unsafe termination practices have been documented in Seychelles and cases still present. It is also reported that some woman travel overseas to terminate a pregnancy, in some cases to countries where they are obtained illegally through a potentially unsafe procedure (e.g. Mauritius). These women may present late with symptoms where a termination has led to complications, and may not provide a complete medical history for fear of prosecution. Prompt diagnosis and treatment is essential in these cases to prevent infertility and further complications.

9.6.1 Policy Objectives

To reduce the incidence of abortion;
To prevent unsafe abortion;

To provide information on the different options available for a woman with an unintended pregnancy so as to help her make an informed choice.

9.6.2 Policy Statements

Women who consider requesting an abortion will receive comprehensive, accurate and unbiased information about their options and the process;

Practitioners who are ethically opposed to abortion will follow relevant professional guidance and refer to another practitioner without delay.

A system where health professionals can opt out of filling the forms for terminations of pregnancy will be put in place, but they have a duty to refer within the health centre.

Women will be referred for an abortion assessment in a timely way. The Ministry of Health will review these referral pathways, and consider the scope for self referral where appropriate.

Women will be offered a choice of abortion methods (12wks gestation), clinically appropriate for their gestation and individual circumstances. When late abortion is needed, provision is available up to the maximum legal/medical time limit.

Women will be offered screening for STIs and treatment where appropriate.

Women will have access to counselling and support if needed during or after the abortion process.

The Ministry of Health will sensitise communities about prevention of unwanted pregnancy, the risks associated with unsafe abortion, and the conditions and procedures for obtaining abortion under the TOP Act of 1994.

Services should improve access to emergency and post abortion contraception.

All women will be given contraception immediately post abortion.

Guidelines on abortion services will be developed for staff, and training provided to support implementation.

The Ministry will aim to build the capacity of health and health related personnel on counselling, prevention and management of complications of unsafe abortions.

9.7 Sexually transmitted infections (STIs)

Untreated sexually transmitted infections cause a range of signs and symptoms, infertility, and in some cases death. The burden of STIs falls mainly on young people and those least able to practise safer sex, including sex workers, migrant workers, and those with low educational attainment.

A national policy on the prevention and control of HIV/AIDS/STI was adopted in Seychelles in 2001, and the current National HIV/AIDS strategic plan 2005-2009 is coming to an end. Syndromic management of STIs was introduced in 1996. HIV remains one of the

most significant developmental challenges in Seychelles today, and it is evident that the HIV epidemic is continuing despite continued education and prevention efforts.

The three main modes of transmission of HIV/AIDS in Seychelles are heterosexual (76%), mother to child transmission (7%) and men having sex with men (17%). However the blood borne virus (HIV and Hepatitis C) transmission risk of the relatively new practice of injecting drug use on the islands has now been documented. Transmission of HIV from mother to child during pregnancy or delivery can be prevented if the woman's HIV status is known early in pregnancy.

The national programme faces a number of challenges including: continued discrimination and stigmatization of individuals with HIV, limited understanding of high risk group needs, barriers to targeting some at risk groups (including men that have sex with men and commercial sex workers), and low coverage of target group populations in testing (including injecting drug users and partners of people with HIV). The legal response has not provided clarity regarding access to testing and treatment in < 18 year olds, or in cases of wilful spread.

9.7.1 Policy Objectives

These statements focus on reproductive health, and should be read in conjunction with the National Policy for Prevention and Control of HIV/AIDS/STIs;

The Ministry is committed to build the capacity of the whole population but particularly youth and other vulnerable groups to prevent the spread of HIV/AIDS/STIs;
There will be sustained commitment to improve co ordination at all levels for STIs, HIV/AIDS and other blood borne viruses in its prevention and control;
The Ministry will ensure that HIV, STIs and other blood borne virus counselling and testing are used to maximize prevention efforts and improve access to effective treatment and care services;

9.7.2 Policy Statements

The Ministry of Health will take the lead in engaging relevant partners in prevention efforts to reduce the levels of HIV and STIs and other blood borne viruses;

All health services will ensure the promotion of safer sexual practices within relevant clinical guidelines, and actively promote the uptake of HIV and STI testing, including post abortion clients;

HIV/STI and other blood borne virus prevention strategies will be developed for priority target groups including injecting drug users and men that have sex with men;

Reproductive Health services will follow appropriate guidelines for partner notification in cases of HIV and STIs;

Implementation of guidelines on the notification of STIs will be strengthened, including induction for new medical officers;

Pre-conception support will be provided for women/couples with HIV or other STIs;

An opt out HIV screening and counselling programme will be provided in ante natal and maternity services, to improve maternal health outcomes and prevent mother to child transmission;

Services will not be provided in a way that stigmatises or discriminates against people with HIV or STIs;

The Ministry of Health will consider the following service developments:

Provision of hepatitis B vaccination for high risk groups that were not immunised through the childhood immunisation programme

Introduction of hepatitis B & C surveillance systems

Introduction of Chlamydia screening (see infertility section)

9.8 Cancers of the reproductive system

Cancer is the second most common cause of death in Seychelles after cardiovascular disease, with an incidence of approximately 100 new cases annually. Cancers of the breast and reproductive system accounted for 35%-43% of all cancers annually between 2002 and 2008 update

There are a number of challenges in assessing cancer trends in a small population. Historically cancer cases were recorded through the laboratory service, but a cancer registry was established in 2007. This does not capture those accessing private/overseas treatment currently.

There is good evidence on prevention of cancer risk factors such as tobacco, diet (alcohol, processed meat), obesity and physical inactivity and exposure to human papilloma virus (HPV) and sunlight.

Breast cancer remains the predominant cancer in women in Seychelles, followed by cervical cancer as is seen in most populations. The number of cervical cancer cases has increased in recent years, while uptake of cervical cancer pap smears has declined. Similarly there has been an increase in the number of women diagnosed with breast cancer over the past five years. However given the small size and mobility of the population it is hard to establish

whether this reflects expected variation or an upward trend. Prostate cancer is the most common reproductive cancer in men in Seychelles.

Pap smears to identify cervical cancer are currently available through family planning clinics, private clinics, Youth Health Centre and the Communicable Disease Control Unit (CDCU), Antenatal Clinic, female surgical ward, gynaecology outpatient clinics. There is no comprehensive screening programme with routine call and recall across the whole population of eligible women. Colostomy is provided at Victoria Hospital.

An alarmingly, the number of women having a pap smear annually appears to be falling. Local mammography to detect breast cancer is available for women with symptoms or a family history, but there is no comprehensive breast screening programme currently. Breast cancer detection relies on promotion of breast self examination by family planning services, and case finding by healthcare staff. Referred cases are seen at a dedicated breast clinic at Victoria hospital, with access to mammography and other diagnostics.

Diagnostic services available locally include ultrasound, radiology (CT/MRI), laboratory (histo/cytopathology), surgery, and chemotherapy. Patients may be assessed for overseas treatment and specialized care, such as radiotherapy.

9.8.1 Policy objectives

To raise awareness amongst service providers and the public about the importance of prevention, screening and early detection for Cancer services and survival;
To develop quality assurance mechanisms which ensure that effective cancer prevention, screening and treatment services are delivered.

9.8.2 Policy Statements

Pap smears to identify cervical cancers, will be offered to all women from 2 years after they are sexually active up until 70 years. A systematic way of inviting all women of eligible age to come for their pap smears and promote uptake of the test will be developed;

As a matter of urgency, the Ministry of Health will review reasons for the declining uptake of cervical cancer smear tests and put measures in place to increase the coverage of this programme;

Pap smears will be available through all RH services and specialist clinics, and regular training and supervision will be available for smear takers to reduce the number of inadequate samples taken;

The cervical screening programme will establish a fail-safe system to ensure that women with positive results are followed up appropriately;

Reproductive Health services will offer to examine women's breasts once a year and support women to conduct self examinations

Women with a family history of breast cancer will be referred to the breast clinic for follow-up;

All health services will promote awareness of self-examination for testicular cancers;
The Ministry of Health will develop clinical guidelines to support health service providers in the early detection of breast, cervical, prostate and testicular cancer;
The National Cancer Control Plan will ensure the inclusion of cancers of the reproductive health systems;
Data on cancers of the reproductive systems will be collected through the National Cancer Registry;
The Ministry of Health will work with key partners to raise awareness on prevention, early presentation and screening for cancer;
The Ministry of Health will consider the following service developments:
Introduction of Human Papilloma Vaccination into the National Expanded Program for Immunisation.
Introduction of liquid based cytology for cervical smear tests to improve detection rates;
Review the case for introduction of comprehensive, population level cervical cancer and breast cancer screening programmes

9.9 Other gynaecological dysfunction and menopause

Other gynaecological dysfunction can have a negative impact on women's quality of life. Women may present to a range of health professionals in health centres with this problem, including their family planning nurse or doctor. Women with other gynaecological dysfunction require support in managing its impact on their quality of life, and may require further investigations as to the cause. Optimal care is offered for these women and specific cases are referred for management by the gynaecological team. Urgent referrals can also be made.

Menopause is a physiological process that marks the end of reproductive capacity for women. The transition to menopause may vary from woman to woman. Combined with the reduction in hormone levels, these changes can result in emotional distress. A weekly specialist menopause outpatient clinic at Victoria Hospital provides services to these women. There is more public awareness of menopause in recent years, following media and community interventions.

9.9.1 Policy Objectives

To improve access to information and services relating to other gynaecological dysfunction and menopause.

9.9.2 Policy Statements

The Ministry of Health will develop clinical guidelines and care pathways for women with other gynaecological dysfunction and going through the menopause, and training offered for providers of reproductive health services. These will include prevention of osteoporosis and cardio vascular disease, contraception, and promotion of cervical screening and breast examination;

Clinical guidelines on other gynaecological dysfunction and menopause will be promoted amongst other health care providers to support appropriate referral;

The Ministry of Health will review the need for menopause IEC materials for women to support self-management of signs and symptoms and facilitate appropriate access to services, including psychological support. This will include the importance of a balanced diet to reduce cardio vascular risk and maintain bone health;

A clinical lead and for advocate for other gynaecological dysfunction and menopause will be identified to lead on service development and evaluation;

The Ministry of Health will ensure that drugs, resources and appropriate services needed to manage other gynaecological dysfunction and the menopause are available;

9.10 Sexual Dysfunction

Sexual dysfunction affects an individual's ability to have satisfying sexual relationships, and can occur in both women and men. Although individuals may be reluctant to seek advice or support, sexual dysfunction can have a major impact on quality of life. Both men and women may experience a loss of sexual interest/ libido. Common physical problems seen in women include pain on penetration or prolonged vaginal contraction. Men may experience early/premature ejaculation or difficulties achieving or maintaining an erection (erectile dysfunction).

Reduced sexual libido may be associated with aging, during menopause (women) and andropause (men). The physical causes may also be associated with alcohol and drug misuse, or be a side effect of drug therapy for other clinical conditions. Individuals may be reluctant to disclose these problems due to perceived stigma, and a lack of knowledge about its management.

9.10.1 Policy Objectives

To ensure access to information and services relating to sexual dysfunction.

9.10.2 Policy Statements

The Ministry of Health will develop clinical guidelines and care pathways for sexual dysfunction, including access to appropriate management and psychological support; A clinical lead for sexual dysfunction services will be identified to lead on service development and evaluation, and staff development;

The clinical lead for sexual dysfunction services will ensure they develop in a way that does not stigmatise the individuals that use them;

The Ministry of Health will review the need for IEC materials for patients and the public to improve understanding of sexual dysfunction and its management, with the aim of improving access to services and reducing stigma;

9.11 Gender based violence

Domestic or ‘intimate partner’ violence is a growing problem in Seychelles, Police case doubled between 2000 and 2005, while Family Tribunal cases increased by 42% between 2006 and 2008. The vast majority of victims consistently remain female, however recently a small but significant growing number of men have begun coming forward for help. While most victims remain silent and never report their abuse to the authorities, a population based study conducted by the Gender Secretariat in 2006 uncovered that as many as 1/4 women and 2/9 men have experienced moderate physical violence, and 11% of women had been raped by an intimate partner at some point in their life.

Female victims were found to be more vulnerable to physical and psychological injury, while pregnant women and mothers are at greatest risk of victimisation.

Gender based violence contributes to many health problems including physical injury, depression, alcohol and substance misuse, sexually transmitted infections, unwanted or unplanned pregnancies, pregnancy complications, maternal injury/death, miscarriage, still birth/death and often limits the ability of the woman to manage other chronic illnesses such as diabetes or hypertension. Impacts are wide ranging, endangering personal and family safety, the ability to earn a living, and child well-being in general.

Recent international clinical studies have demonstrated that a brief screening process can effectively identify abuse in pregnant women, and a ten minute intervention has been developed that can effectively increase the safety of pregnant abused women.

A local study (Adonis, 2008) of the response of health services to domestic violence suggests that although health services in Seychelles are often the first point of contact for victims there are no standard procedures set out as guidelines for professionals to govern how they respond. The scope of this response spans beyond the immediate emergency medical response to in depth needs assessment, counselling and advice, and referral to other agencies.

9.11.1 Policy Objectives

To address the population's reproductive health issues arising from emotional, physical and sexual abuse;

To reinforce detection and support individuals vulnerable to abuse;

To develop a zero tolerance approach towards violence amongst service providers and clients;

To provide appropriate care and support to victims of abuse.

9.11.2 Policy Statements

The Ministry of Health in collaboration with other relevant departments will adopt a Risk Indicator Framework for Domestic Violence, facilitating service providers to identify individuals at risk of abuse and their perpetrators;

The Ministry of Health will work to develop Domestic Violence, Rape and Assault Operational Guidelines for healthcare service providers with appropriate referral pathways and multi-agency case management;

A mechanism for integration of all gender based violence guidelines from different service providers will be established;

The Ministry of Health will encourage and support victims to report abuse as early as possible to protect the individual and their family from further abuse and offer protection to the wider public;

The Ministry of Health will support the adoption of best practices through staff training and development;

Reproductive health services will need to ensure that individuals have confidence in how their cases would be managed after their cases have been disclosed;

The ministry will identify a lead for domestic violence and sexual assault against adults, to develop guidelines, provide staff training and monitor and evaluate implementation;

Staff concerns will need to be addressed over fear of retaliation from abuser. Victims of abuse will be assessed for their mental well being and referred appropriately;

The Ministry will establish a communication strategy to raise public awareness;

The issue of gender based violence will be institutionalised into NIHSS curriculum.

9.12 Vulnerable Groups

The burden of poor sexual and reproductive health is not evenly distributed within the population. Some groups have specific needs, whilst others experience significantly worse outcomes than the rest of the population. In principle the Ministry of Health will work towards ensuring that these needs are accurately assessed, and appropriate resources are allocated in an equitable way to meet them.

The groups identified to date include:

9.12.1. Men

The majority of services currently report a low level of male involvement in sexual and reproductive health services. A number of reasons have been posed, including cultural norms, access barriers, fear of stigma, and failure to address men's needs (e.g. sexual dysfunction). The Ministry of Health is keen to address this in order to encourage men to be more able and responsible in managing their own health and their sexual behaviour (eg condom use).

9.12.2. Sex workers

The type and extent of sex work is not well defined in Seychelles, and remains illegal. In general, sex workers have multiple partners yet may be less able to negotiate using a condom putting them at increased risk of unwanted pregnancy and STIs. This is particularly true of sex workers with substance misuse problems, or in abusive relationships. Health needs include reliable contraception, regular screening for STIs/HIV, and rapid access to counselling, testing and treatment. Services may be required outside of routine opening hours, and more effort may be required to ensure follow up.

9.12.3. Men that have sex with men (MSM)

A 2008 UNAIDS rapid assessment of the most at risk populations suggests that one in ten men in Seychelles have had sex with a man. The majority are bisexual, many married or living with a woman due to social expectations. There are no gay venues in Seychelles, and although there are some known cruising areas and social networks there are no obvious settings in which to provide services. The UNAIDS study suggests that condoms use is not systematic, HIV prevalence is significant, and that some young MSM are involved in sex work. Stigma remains an obstacle to prevention, and anecdotally individuals may seek private treatment to protect confidentiality.

Further consultation is required to agree future policy direction. Possible interventions include peer education and leadership, sensitisation of staff (discos etc), dedicated phone line for advice, and mobile HIV testing and counselling.

9.11.4. People in prison

Seychelles has one prison which currently accommodates individuals with convictions and those on remand, men and women, and juveniles. Health services for inmates include routine periodic visits by a nurse and doctor for minor health problems. Inmates are taken to specialist services as required on referral. There have been anecdotal reports of sexual relationships, drug abuse (including injecting), rape and sexual assault amongst prison inmates and this has been evidenced in prison populations around the world.

Although inmates have restricted rights, they may have a range of reproductive health needs which need to be addressed to reduce the harm caused to that individual or their community on their release. Female inmates may be pregnant, deliver, or be nursing when convicted. They may be sexually active or become pregnant in prison. They may require contraception, STI testing and treatment, Pap smear, breast examination, and menopause

advice. Male inmates may also be sexually active in prison with other inmates (male or female) and need to access condoms.

9.11.5. Mobile populations (Migrant workers, sailors, and travellers)

The population of Seychelles is very mobile. With a high level of population turn over it is important to maintain a high level of awareness of reproductive health and how to access services, both in Seychelles and overseas.

Many Seychellois have immigrated to other countries over the years, with some returning periodically or to resettle. Resident Seychellois travel for business, education and leisure. In 2007 there were 52,500 resident departures to international destinations, of which 29,000 were holiday related.

A number of expatriate workers are employed across a range of occupations including construction, tourism, fisheries and some public sector jobs. Some of these workers have access to Ministry of Health services through their contract of employment, while for others their employer is responsible for their healthcare. The majority of migrant workers do not come with their spouse. All migrant workers requiring GOP are screened for HIV infection and TB on arrival in Seychelles, providing an opportunity for health promotion.

Seychelles has a large port, accommodating fishing and cargo vessels, cruise ships, and navy vessels from Seychelles and other defence forces. Seychelles also attracts a large number of tourist visitors each year. In 2009 there were 157,500 visitor arrivals in Seychelles, 90.1% of which were holiday related. Of these, 77.4% of visitors originated in Europe, 11.8% from Africa, and 7.4% from Asia. This amounted to 1.607 million tourist nights, with an average length of stay of 10.2 days.

9.12.6. Drugs users and alcohol abusers

Substance misuse may have a negative impact on sexual health in many ways. Individuals with an altered psychological state are more likely to practice unsafe sex, and may be less likely to present for screening or diagnosis. Those with chaotic lifestyles are less likely to adhere to treatment regimes. The relatively new practice of injecting drug use increases the risk of blood borne virus transmission, and the level of dependence associated with heroin use makes it more likely that that individuals may resort to criminal activity and/or sex work to supply their addiction.

The Ministry of Health and Social development recognises that we need to understand the emerging needs of those abusing drugs and/or alcohol better, and how services can respond to meet them more effectively.

9.12.7. Person with disability

An estimated 2% of the population lives with a disability. Persons with disabilities have the same sexual and reproductive health needs as other people, yet they often face barriers to information and services. Existing services can be adapted to accommodate persons with disabilities. Increasing awareness to both staff and the public is the first and biggest step towards successful planning and designing of programmes to suit persons with disabilities. Family planning needs maternal health and need for protection in violence for this vulnerable group of people deserves attention since those needs are often neglected and overlooked.

Historically, persons with disabilities have been denied information about sexual and reproductive health, furthermore they are often deprived the right to establish relationships and to decide whether, when and with whom to have a family. Many are subjected to force termination of pregnancy and sterilizations. They are more likely to experience physical, emotional and sexual abuse. They are likely to become infected with HIV and other STIs or subject to other form of gender based violence.

9.12.8. Policy Objectives

To ensure access to reproductive health care to all vulnerable groups;
To initiate and develop programs to meet their specific needs.

9.12.9 Policy Statements

Harm reduction and rehabilitation strategies should be adopted in providing services for the most at-risk groups. The Ministry will need to consider the following options:

Improve ways to reach the most-at risk groups;

Scale up current programs to include harm reduction strategies such as needle exchange programs for IV drug users.

The development of guidelines for health workers in reaching and managing IV drug users.

Health care providers will aim to find innovative ways in reaching the most at-risk groups either through formal or informal networks to improve access to reproductive health services (which includes peer education and leadership, sensitisation of staff);

Health care providers will consider whether an individual is involved in sex work when taking a sexual history, and tailor their advice appropriately. This should also include referral of child protection issues. Clinical guidelines and intervention plan should be developed and implemented by all service providers;

All prison inmates should have a comprehensive health assessment by a medical officer on admission to prison, including an assessment of their reproductive health needs and risks and drug/alcohol history. The Health and Prison Services will work together to support and protect inmates who report that they are victims of sexual abuse or rape;

Female inmates should access services throughout their pregnancy, delivery and post partum and should be supported to breastfeed their baby up to 6 months;

Inmates convicted of sex offences should be offered rehabilitation before release into the community;

The Ministry of Health will consider the following service developments:

Peer education and condom provision to reduce harm relating to sexual health and drugs in prison;

Development of standards operating procedures on relevant issues eg management of pregnant inmates, access to condoms and contraception, management of cases of rape and assault;

New migrant health assessment/screening will include provision of advice on reproductive health and services in Seychelles for the migrant workers and their spouse if appropriate, including where to access contraception, condoms and STI/HIV testing and treatment;

The Ministry of Health will work with companies employing migrant workers to ensure appropriate reproductive health advice and services are provided, with translation and/or interpreters available as required. Employers will be encouraged to provide free condoms to their workers;

The Ministry of Health will ensure that condoms are available for sailors and sea farers transiting in Seychelles. Travel health guidelines, including reproductive health, will be developed to support health and education services providing travel health advice to Seychellois travelling overseas;

Tourists will be able to access local reproductive health services directly or through the tourist doctor. Payment will be required in line with the national policy;

Hotels and other tourism accommodation will be encouraged to provide access to condoms within their establishment.

The Ministry of Health will ensure that all SRH programmes also reaches and serves persons with disabilities.

Persons with disability who is sexually active should be provided with protection that suites their individual needs to prevent unwanted pregnancies and transmission of infections including HIV.

Capacity of service providers should be strengthened to meet the needs of persons with disabilities.

Access to information and access to existing health facilities should be improved to suite persons with disabilities. [Special considerations to be applied to all groups, e.g. Braille or big prints for sight impaired clients]

9.13 Youth and Adolescent Reproductive health

Adolescence (age 10 to 19) is a time of social, physical and psychological transition, a "preparation period" during which the child develops into an adult (WHO). It is a time where young people are faced with a number of challenges unique to their age groups. These include changes in the body brought on by puberty.

Apart from the unique challenges they face, adolescents like in many nearby countries, faced a number of sexual reproductive health problems. These include early sexual debut, unplanned teenage pregnancies, sexually transmitted infections, HIV and AIDS, unsafe abortion, sexual abuse and violence.

A number of indicators confirm that adolescents reproductive health in Seychelles is at high risk, and that efforts to address these issues is still of paramount importance.

Results from the Child Well Being study, 2009 depicted a notable proportion of adolescents reported having had unprotected sex before the ages of 18 years. Similar study also showed that 26% of girls' age 14 to 17 years of age reported having sex with someone older than them.

Table 6: Key indicators of teenage reproductive behaviour in Seychelles 2005-2010

Indicator	2005	2006	2007	2008	2009	2010
% of 15- 45 year old were teenagers	15.0	15.1	14.2	14.4	14.6	14.5
% of all births to teenage mothers	14.8	14.5	15.4	15.1	15.7	13.8
% of all first births to teenage mothers	31.1	28.5	29.8	27.8	32.2	24.1
% of all second births to teenage mothers	5.8	4.2	4.8	4.6	3.2	4.6
% of all abortions (spontaneous/induced) to teenagers	17.4	16.7	16.6	19.2	20.4	23.3
% of all known pregnancies to teenagers	15.4	15.1	15.6	16.0	16.8	16.4

% of all contraceptive users who were teenagers	2.8	9.2	4.2	4.1	4.6	4.6
% of adolescents who tested HIV positive out of the total population tested positive	6.7	11.9	4.6	11.4	7.7	3.0

Source: Epidemiology and Statistics Section

The above table indicates that the incidence of teenage pregnancy remains fluctuated throughout the years. Despite the fluctuation in the total number of births, and reported abortions, there is substantial evidence that the above does not reflect the true picture of the current situation.

The recorded positive pregnancy test being recorded at the health centres level does not relate to with the number of births and abortions being reported in this particular age group. This indicates that many of these unplanned pregnancies are resulting in unsafe abortions. Many of the pregnancies amongst adolescents are unplanned, and are unwanted, resulting in rising unsafe abortion rates and premature deliveries, school drop outs and a multitude of social, medical and psychological problems which has an impact on the individual, the family and the economy of country in general.

Despite the above concerns, it consultation suggests that the reproductive health needs of adolescents have not been adequately addressed within existing services. This is because of the various barriers that hinder access to meet the needs of this particular age group, including the attitudes of service providers towards provision of RH services to minors, the law pertaining to minors, and poor communication between parents and minors.

Cost-benefit analysis reveals that non-action towards addressing the reproductive health needs of minors does have serious socio-economic impacts at various levels.

The Ministry of Health in collaboration with other ministries, NGO's and parents can play a vital role in improving access to reproductive health services to adolescents. This can be achieving by improving the quality and ranges of services provided to adolescents through a friendly and non judgemental attitude.

9.13.1 Policy Objectives

Strengthen access to adolescents-friendly sexual and reproductive health information, counselling and medical care services for various groups of adolescents;

Reduce the incidence of unplanned pregnancy, unsafe abortion, HIV and other sexually transmitted infections amongst adolescents by sensitising adolescents and parents on their rights and responsibilities towards access to Sexual and Reproductive Health Services;

Reduce social and cultural barriers which affect reproductive and other health and rights of young Seychellois through provision of accurate information and skills to both parents and adolescents;

Strengthen adolescent- friendly services in all health Centres and through schools;

Strengthen adolescents' negotiation skills for safe sex, specifically female minors through revision of existing life skills programmes;

Review existing SRH services in health Centres and schools to meet the needs of adolescents;

9.13.2 Policy Statements

The Ministry of Health will advocate for the best legal, social and cultural environment for the promotion of the adolescent and young people Reproductive health.

The Ministry of Health will provide integrated adolescent reproductive health services as part of its national reproductive health service;

The Ministry of Health will review and amend the procedures of access to reproductive health services for 15-17 years for health professionals working with adolescents to better take in account the right and the health interest of the young people.

Access to reproductive health services for 15-17 years will be guided by a the “Fraser Guidelines” for health professionals working with adolescents;

The ministry will review and amend the existing procedures for the management of minors < 15 years old with history of sexual abuse or other Sexual and reproductive health problems;

The Ministry will integrate the diagnosis and management of sexually transmitted infections in the adolescent reproductive health services;

All further training educational institutions should guide adolescents in how to access sexual and reproductive health services and provide condoms in an appropriate way;

Health professionals working within reproductive health will be trained in sexual reproductive health (SRH) adolescents and youth;

Local standards will be developed to ensure reproductive health services are ‘adolescent friendly’ based on the WHO model;

The Ministry of Health will ensure that reproductive health services are available outside of school hours;

All adolescents requesting termination of pregnancy or hospitalised with abortion complications will receive pre and post abortion counselling as well as information about contraceptives use and the dangers of unsafe abortion. All patients will be referred to their respective the Health Centre or the Youth Health Centre to be seen by psychologist, counsellor or nurses.

Girls of school age who have a baby will be supported to complete their education after delivery;

The Ministry of Education will ensure that all children and young people should compulsory follow the Personal, Social and Education programme and create a mechanism to monitor the effectiveness of the programme;

The Ministry of Education with the technical support of the Ministry of Health will establish a mechanism to provide refresher training on sexual reproductive health to teachers , counsellors and other professionals working with adolescents;

The Ministry of Education in partnership with the Ministry of Health will strengthen its sexual reproductive health component in the Personal, Social and Education programme to meet the current needs of adolescents;

The Ministry of Health will review its School Health Programme to determine ways to identify young people who are at risk of poor sexual and reproductive health and develop clear pathways for referrals to appropriate services.

10.0 INSTITUTIONAL FRAMEWORK FOR REPRODUCTIVE HEALTH

10.1 Ministry of Health - (MOH)

In the health reform system, the Ministry of Health serves as the overall body for policy formulation, coordination, resource mobilization and forward planning for the whole health sector. The Ministry therefore, shall coordinate, evaluate and monitor the implementation of the policy.

10.2 Public Health Department

As the national executing agency for the Ministry of Health in the overall technical management of the health sector, the Directorate of Family health and Nutrition of the Public Health Department is responsible for overall delivery of quality reproductive health services. It supervises all other Health departments i.e. Hospital management maternity wards, District Health Services of the Community Health Services.

10.3 Reproductive Health Unit

Reproductive Health Unit of the Public Health Department in the Ministry of Health, shall carry out the functions of co-ordination monitoring and evaluation on behalf of the Ministry. The unit shall be the secretariat of the reproductive health and multi-sectoral sub-committees of the Inter Agency Technical Committee on Population and Development.

10.4 District Health Centres

The policy implementation shall be co-ordinated in the District Health Centres through District Health Team, namely the Nurse Managers and technical nurses and midwives. They shall be charged with the responsibility of ensuring the implementation of the policy at the district level.

10.5 The Reproductive Health sub-committee of the inter-agency technical committee on population and development

The Inter-Agency Technical Committee on Population and Development (ITCP) shall reinforce the technical base required for the implementation of the policy through the reproductive Health Subcommittee. The ITCP through the Reproductive Health Subcommittee shall reinforce the institutional capacities for programme design, development, coordination, monitoring and evaluation of the implementation of the policy. Its membership comprise of senior technical officials from appropriate institutions. It shall also assist the Ministry in revision of the policy by providing the required technical inputs.

10.6 Private and Non-Governmental Organizations

Private, non-governmental organization and religious organizations shall continue to participate in Reproductive health activities. Due recognition and support shall be given to their work, expertise, experience and resource capabilities.

10.7 Co-operating Partners

Donor agencies and international non-governmental organizations such as the UNFPA, WHO, will continue to play a vital role in providing support to the implementation of this policy. To achieve this, there will be need for improved co-ordination and collaboration among the donors with Government and Non-Governmental Organization.

11.0 MONITORING AND EVALUATION

The implementation of reproductive health policy will be monitored and evaluated on a regular basis in order to improve the quality of service provision. The monitoring and evaluation plan shall be continuous to measure outcomes, impacts and overall success and ultimately ensure strengthening of the reproductive health programme through field visits and reporting.

11.1 Monitoring

The monitoring of the implementation of the Reproductive Health Policy will be done in following ways:

Provision of supportive supervision by technically trained nurses to re-inforce morale and adherence to accurate record keeping e.g. partograms and registers at all levels. Regular supervisory safe motherhood committee meeting at facility and community

Levels

Quarterly and annual progress reports.

Mid-term programme reviews.

Institute routine surveillance of all maternal deaths occurring in the community health facilities.

Conducting maternal death audits at facility level to improve quality of maternal health services.

Reviewing and streamlining the standard technical guidelines, record keeping and Ensure referral systems provide feed back information on outcomes to enable referring medical staff assess the effectiveness of their screening and referral programmes.

Reviewing and streamlining the standard technical guidelines, record keeping and health information system including provision of training in use of data.

The Reproductive Health Program shall provide a basis for monitoring and valuating interventions as well as facilitate information sharing between collaborating agencies.

Use the Reproductive Health Subcommittee of the ITCP (Inter-Agency technical committee) as a forum for collaboration and co-ordination with other sectors.

11.2 Evaluation

Evaluation will be done through:

Conducting routine surveys.

Tracking inter-mediate and long term indicators based on programme objectives and national Inter-Reproductive Health Programme.

12.0 GLOSSARY

Total Fertility Rate: The average number of children that would be born alive to a woman during her lifetime if she were to pass through her child bearing years conforming to the age-specific fertility rates of a given year.

Life Expectancy at Birth: The average number of years a newly born infant is expected to live if current mortality trends were to continue.

Maternal Mortality Rate: The number of women who die due to pregnancy and child birth complications per 100,000 live births in a given year.

Infant Mortality Rate: The number of deaths of children under one year of age in a given year per 1,000 live births in that year.

Parity: The number of children born live to a woman.

Adolescent: Person aged between 10 - 19 years.

Abortion: Is termination of pregnancy cexpulsion or extraction of embryo/fetus. before 22 weeks of gestation or below 500gm weight of fetus.

Infertility: Absolute inability of a couple to achieve pregnancy after 12 months of active sexual intercourse.

Sub-fertility: relative inability / difficulty at conceiving.

Fertility: The actual output of births, as opposed to the potential output.

Cervical cancer: Cancer (Malignancy) arising from the neck of the womb (cervix).

Menopause: The normal cessation of menstruation at the end of reproductive age which normally happens at 50^h year and 51" year of life.

Breast cancer: Malignant tumour arising from the breast.

Menarche: The beginning of menstruation.

Menstruation: The periodic flow blood from the cavity of the womb.

Cardiovascular Disease: The disease of the heart muscle and blood vessel.

Osteoporosis: The increased ponousness of bone due to lack of calcium salts.

Blood Lipid Profiles: One of a group of fatty substances that are insoluble in water but soluble in alcohol.

Lipo-protein cholesterol: One of a group of fatty proteins that are present in blood plasma.

Destrogen: One of several steroid hormones which have similar functions. It controls female sexual development.

Hormone: Substance which on absorption into the blood influence the action of tissues and organs other than those in which they are produced.

Obstetric Trauma: Injury suffered by the genital (Birth) tract during labour.

Genital Prolapse: Downward placement from normal position of female genital organs i.e. uterus bladder, rectum to weakening, ligaments that support these organs. This can be mild to complete protrusion through the vagina.

Ante Natal Care: Ante Natal Care is the care provided to pregnant women from conception through to onset of labour.

Postnatal Care: This is the care provided to the woman and her baby at the follow up postnatal visit from the time of discharge from hospital to the end of the puerperium.

Prenatal Loss: Loss of pregnancy/ baby before delivery, this includes abortion and stillbirths.

Menopausal transition: (Climacteric) this is a period 5 to 10 years before actual menopause and after.

13.0 APPENDIXES

13.1 Documents Reviewed in the Policy

The Core Working Group carried out a desk review of a number of policy documents and plans of the Ministry of Health. The documents include the following:

- National Health Policy, 2005
- National Health Strategic Framework (2005-2009)
- National Policy for the Prevention and Control of HIV/AIDS and Sexually Transmitted Diseases, 2001
- Reproductive Health Commodity Security Strategic Plan (2007-2009)
- National HIV/AIDS Strategic Plan (2005-2009)
- National Population Policy for Sustainable Development, 2007
- Health Statistics, 2009
- Seychelles in Figures, 2010 Edition

13.2 Appendix 2: Development process for the National Policy on Reproductive Health

A participatory process was used throughout. The process included the following steps:

13.2.1 Setting up of a Core working Group responsible for preparing the policy.

The team was made up of the following persons:

Mrs Gylian Mein MCH Programme Manager,
 Ms Peggy Azemia FP Programme Manager,
 Mrs Judie Brioche, Youth Health Coordinator,
 Dr Anne Gabriel DG Disease Prevention and Control 2008
 Dr Eileen Louange Programme Manager Cancer/Mental Health 2008
 Mrs Jeanine Faure HIV/AIDS Programme Manager 2008
 Mrs Rosalie Isnard Health Statistics Unit
 Mrs Josiane Confait Health Coordinator
 Dr K. Luchmaya UNFPA Consultant
 Mrs. Sarah Romain Ag Director General FH&DP
 Mrs. Vicky Hobart, Public Health Consultant, NHS City and Hackney, UK
 Ms. Tessa Siu Senior Research officer
 Ms. Tania Labiche (Population unit)
 Mrs. Rosie Bistoquet Control HIV/AIDS Programme
 Mr. Danny Poiret Director Policy and Planning
 Mrs. Sylvette Evenor Child Protection unit
 Ms. Farzana Jumaye AG's office
 Dr. Zia Rizvi Consultant In Charge Obstetrics & Gynaecology unit
 Ms Georgette Furneau Nurse Manager CDCU
 Mrs Gina Michel Programme Manager M.H & Cancer

13.2.2 A RH Situation Analysis workshop

A RH Situation Analysis workshop was held 5th and 6th December 2006 at the English River Health Centre. There were presentations on family planning, maternal and child health, and HIV/AIDS situation in Seychelles. The main stakeholders discussed the

achievements in all these areas and also identified the areas where action was necessary. Priority components and issues were identified.

13.2.3 Field Visits

Field visits were held to the Youth Health Centre, Baie Lazare and Takamaka Health Centres. Consultations were held with the Health Coordinator and staff.

13.2.4 Working sessions with key stakeholders

Working sessions were also held with Ms A. Cafrine Director of Community Health Services, Dr Fernando da Silveira the WHO Liaison Officer and Dr Z. Rizvi Consultant Obstetrician and Gynaecologist at Victoria Hospital.

13.2.4 Preparation of the Policy Draft

The Consultant assisted the Core Working Group to use the RH Situation Analysis to formulate a draft of the RH policy. Writing the policy document was carried out during five days from 28 January to 1 February 2008.

13.2.5 Preparation of Implementation Plans

Based on the draft policy document, a two day workshop was held to develop implementation Plans on 4 and 5 February. Fourteen persons participated in the development of the implementation plans.

13.2.6 National Consensus Workshop at the International Conference Centre

The draft Reproductive Health policy was presented for discussion at a consensus Workshop held on Thursday 7 February 2007. More than one hundred stakeholders attended the workshop. Copies of the policy were distributed and in small groups, participants examined the policy and made comments and suggestions.

13.2.7 Validation workshop in April 2009

With the arrival of an UK consultant, working sessions was also held with stakeholders, followed by a validation workshop which was carried out in April 2009 at ICCS whereby input from various other stakeholders was sought.

13.3 Appendix 3: Objectives from the 1998 National Strategy for implementation of the recommendations of the ICPD:

- To ensure that comprehensive and factual information and a full range of reproductive health care services, including family planning , are accessible, affordable, and acceptable to all those who need them.
- To promote responsible sexual and reproductive behaviour, especially among adolescents.
- To improve the quality of family planning advice, IEC, counselling and services

- To increase the participation and sharing of responsibility of men in the actual practice of family planning
- To increase awareness of the consequences of the HIV infection and AIDS at individual, community and national levels

13.4 Appendix 3: Guidelines for providing Reproductive Health Services for young people (15-17years)

Young men and women can consent for sex once they reach the age of 15. Generally, parental consent is required for a young person aged under 18 to receive treatment including prescribed drugs and contraceptives.

If a young person aged 15-17 years presents to a health care provider and is sexually active, it is appropriate to consider their need for sexual and reproductive health care including health education and counselling, contraception, HIV testing and Sexually Transmitted Infections (STIs) treatment. In normal circumstances, the young person should be encouraged to discuss these issues with their parents and obtain their parents' consent for them to receive appropriate services and treatment. Parental Consent for their child to receive treatment can be given in the following ways:

The parent attends the service with the child

The parent is provided with adequate information about the treatment being offered to the child and provides a signed and written consent with contact details for follow up.

However, in exceptional circumstances, young people may not feel able to seek parental consent to obtain treatment, for example, (a) if they are being sexually abused and the parent/guardian is responsible for/encouraging or neglecting that abuse or (b) if the young person is sexually active and cannot be persuaded to disclose this to their parents/guardian.

Under such circumstances, designated health care professionals (doctors/nurses) can provide reproductive health advice and treatment (contraception, HIV Testing, Pregnancy Testing, and STI treatment) without parental consent providing the following criteria are met. The health care professional must be satisfied that:

The young person understands the health care professional's advice; They cannot be persuaded to inform their parents/guardian;

They are likely to begin, or continue having, sexual intercourse with or without contraceptive treatment;

Unless the young person receives reproductive health advice or treatment, their physical or mental health, or both, are likely to suffer;

The young person's best interests require them to receive reproductive health advice or treatment with or without parental consent

The health care professional will ensure that this process is appropriately documented. Parents can ask to see their children's records but permission can be refused if the information within them was given in the expectation that it would not be disclosed to them. The record holder must be satisfied that the young person gave permission for their parents to see their records.(Proposed revised guidelines – April 2009)

14.0 References

1. The Constitution of the Republic Of Seychelles 1994, Ministry of Foreign Affairs
2. The Seychelles Millennium Development Goals Status Report 2010.
3. The International Conference on Population and Development (ICPD) report- Cairo in1994,
4. The National Health Policy reviewed in 2005
5. The National HIV & AIDS and STIs Policy 2001-ubder review 2011
6. The National Health Strategic Framework 2006 – 2016
7. The National Population Policy 2007
8. The Evaluation report for Health of the Young People and Underserved Groups 2011
9. The Seychelles National Youth Policy 2007
10. Rogo, Khama, Valentino Lemaand George Rae.. Chapel Hill, NC., Ipas Postabortion Care: Policies And Standards For Delivering Services In Sub-Saharan Africa1999.
11. Rogo, Khama, 1999, Paper presented at the JHPIEGO Conference on PAC Baltimore. Md., May 20- 211999, Decentralising Postabortion Care Services: Insights From A Decade In Africa.
12. Rogo, Khama, Lisa Bohmer and Christine Ombaka, 1999. Pre-intervention research report East African
13. Medical Journal 76 (Suppl.): II, Developing Community-Based Strategies To Decrease Maternal Mortality And Morbidity Due To Unsafe Abortion.
14. WHO, Contraceptive Eligibility Criteria.
15. WHO Geneva, WHO Service Guideline on Abortion.
16. WHO guide for Service Delivery, Emergency Contraception.
17. WHO, Intrauterine Devices: Technical and Managerial Guidelines for Services, 1997, WHO, Geneva.
18. WHO, Safe Motherhood.