COUNTRY PROGRESS REPORT

Maldives

2010 - 2011

NATIONAL AIDS PROGRAMME

Centre for Commnity Health and Disease Control

Ministry of Health and Family

Table of Contents

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal care
BCC	Behavior Change Communication
BBS	Biological and Behavioral Survey on HIV/AIDS
CCHDC	Center for Community Health and Disease Control
CCM	Country Coordinating Mechanism (for GFATM grants)
CSO	Civil Society Organisation
CST	Care, Support and Treatment
DDPRS	Department of Drug Prevention and Rehabilitation Services
DOTS	Directly-Observed Treatment (for Tuberculosis)
DU	Drug use
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IEC	Information, Education, Communication
IGMH	Indira Gandhi Memorial Hospital
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use(r)
JMTR	Joint Mid-Term Review
MARP	Most At Risk Population(s)
MOE	Ministry of Education
MOHF	Ministry of Health and Family
MOHRYS	Ministry of Human Resources, Youth and Sport

MOIA	Ministry of Islamic Affairs
MSM	Male to male sex/Men who have Sex with Men
NAC	National AIDS Committee
NAP	National AIDS Programme
NGO	Non-Governmental Organization
NSP	National Strategic Plan on HIV in the Maldives 2007-2011
NDA	National Drug Agency
OST	Oral Substitution Treatment
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
STI	Sexually Transmitted Infections
SW	Sex worker
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNODC	United Nations Office for Drugs and Crime
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

I. Status at a glance

A. Report writing and data collection process

Based on the experience from the previous reporting round in 2010, National AIDS programme, lead the data compilation and report writing process. A working group was formed to prepare the report.

NCPI part A was completed by NAP, a consultative meeting was organized to get feedback and consensus on the completed NCPI A and an independent consultant was identified and delegated to facilitate completion of part B (UN & civil society). Stakeholder meeting was held to present the report for consensus building prior to submission.

B. Status of the epidemic

The Republic of the Maldives is situated in the Indian Ocean, close to India and Sri Lanka. It consists of nearly 1,200 islands and atolls, of which around 200 are inhabited. In addition, there are around 90 inhabited islands that have been developed as tourist resorts.

According to the Department of National Planning Maldives has a population of 325,135 in 2011[i]. In 2009, it was estimated that 120,000 Maldivians live in the capital Male'[ii], which is only 1.8 square kilometers, making it one of the most densely populated places in the world (i.e. 66,700 persons per km^2 excluding migrants). Only 3 other islands have a population of more than 5,000 people; an additional 12 islands have between 2,000 and 4,999 inhabitants.

According to the Department of Planning, there were 70,259 non-Maldivian migrant workers in the Maldives in 2009[iii] of whom only 8% were women. Most migrants work in lower-paid jobs in the construction and tourism industries, but there were also 2,446 expatriate teachers working in the education system, or 31% of the total number of teachers[iv]. The large majority of migrants come from other South-Asian countries. Despite the high number of migrants, un-/underemployment among the Maldivian population is high. The population of youth is growing by 4.26% a year, much more than the increases in the overall population, and each year a larger percentage of youth complete higher education, yet remains un- or under-employed. The lack of employment opportunities contributes to a long-term dependence on parents and extended family[v]. The 2006 Census reported youth unemployment of 16.2% in Male and nearly 19% in the atolls. Most Maldivian people work in Government positions (24,085)[vi], fishery (13,504) and tourism (15,298)[vii].

Data on the HIV epidemic in the Maldives is available in the form of case reports, among Maldivians, 15 cases of HIV had been identified via this method between 1991 and end of 2011. 11 of these people have died. Three out of the four people living with HIV in the Maldives are receiving antiretroviral treatment (ART), provided by the government**Error! Bookmark not defined.**. Among expatriate migrants, 257 cases had been identified as end of2009 (as a result of which they could not obtain a work permit / permit to stay and had to leave).

In 2008, the first BBS was conducted in the Maldives[viii]. Data was collected on sexual behavior and drug injecting behaviors, showing wide range and closely interconnected sexual networks across survey groups.

In 2010, a Risk Behavior Mapping was conducted at selected islands and atolls. The researchers, using both geographical mapping and network analysis, developed size estimations for those at highest risk[ix].

1. Female sex work

The Risk Behavior Mapping estimated the number of female sex workers at the 12 islands that were selected for inclusion to be between 545 and 625, i.e. around 585 persons. About a third of them were in Kaafu/Male. The largest proportion (37%) was aged 25-34; 8% were under 18 years old. Based on the mapping results it was estimated that there are a total of 1,139 female sex workers [range: 1030-1247] in the whole country.

2. Male to male sex

The risk behavior mapping report[ix] estimated that there were 685 MSM in the 12 selected islands [range: 577 to 792]. The MSM definition used included men who had sex with men 'as matter of preference or practice, regardless of their sexual identity or sexual orientation, and irrespective of whether they also have sex with women or not.' Hence, the term does not refer to those men who might have had sex with other men as part of sexual experimentation or very occasionally, depending on special circumstances. 3.5% of the mapped MSM were under 18 years old, and almost 40% were aged 18-24. Based on these findings, it was extrapolated that there are a total of 1,199 MSM [range: 975 to 1,408] in the Maldives.

3. Injecting Drug Use

The risk behavior mapping report[ix] estimated that there were 410 injecting drug users in the mapped islands; most (by far) were in Male (233-267 persons) and Fuvamulah (69-79 persons). Two thirds were in the 25-34 age group; only 0.6% was under 18 years of age. Based on the estimates, taken from islands representing 40% of the Maldivian population, it was estimated that there are 793 injecting drug users [range: 690-896] in the Maldives.

A School Health survey was held in 2009[x], in which 3,421 grade 8-10 students participated from 39 schools across the country (14 in Male, the rest in the atolls); the response rate was 80%. 5.4% of students (7.5% of males, 3.2% of females) in grade 8-10 across the country reported to have used drugs in their lifetime, with much higher reports of drug use in the atolls (6.1%) than in Male (3.7%). Among students who had ever tried drugs, a bit over two thirds (67.7%) were 13 years old or younger when they first tried it. 6.7% of Maldivian students reported current alcohol use (males reported more than twice the rate of females) and 11.6% currently smoked (males reported triple the rate of females).

The European Union is supporting the implementation of a large-scale Drug Users Survey in the Maldives, supported technically by UNODC. This research was being prepared at the time this document was written (June-July 2011)[xi].

4. Sexual behaviour of youth

In a sub-sample of youth in a reproductive health survey conducted in 2004[xii], 14% of males and 5% of females under the age of 18 admitted being sexually active. Of those who were sexually active 45% never used condoms. It should be noted that the response rate for under18 year olds was only 42%, varying from 100% in some islands to only 12% in Male.

Considering the taboo on young people's sexuality in Maldivian culture, young people with sexual experience may be more likely to refuse participation in a survey about reproductive health or sexual behavior than young people without sexual experience, especially if the methodology applied in the research requires face-to-face communication about sex. This may be a reason why the 2008 BBS survey provided much higher estimates of youth sexual activity: about a third (32%) of youth in Male' and half (50%) of youth in Laamu reported to have had sex in their lifetime; 25% and 37% had permanent partners; 2% and 9% reported non-regular partners; 2% and 0% had sex with FSW; 2% and 3% had partners who inject drugs; 0% and 1% sold sex and 0.4% and 0% reported consensual male to male sex. For those who were sexually active, the median number of partners in the past 12 months was five. Condom use during premarital sex across different age groups ranged from 8% to 54%.

5. Population awareness of HIV/AIDS

The 2009 Demographic Health Survey supported by UNFPA, WHO and UNICEF, focused on women[xiii]. More than 7,000 women were interviewed across the Maldives, of whom only 1.7% was in the 15-19 age range; 39.4% were in their twenties. At least 94% of all sub-samples had heard of HIV/AIDS. 79% of the total sample knew that condoms could prevent HIV; 91.8% knew that limiting oneself to one uninfected partner could prevent HIV and 80% mentioned abstinence as a prevention method. 67.2% of the women in the sample knew that a healthy-

looking person can still have HIV, but 26.3% thought HIV could be transmitted by mosquitoes and 11.6% thought it could be transmitted via 'supernatural means'. Overall only 41.5% of the women had 'comprehensive knowledge' about HIV, meaning that they knew consistent use of a condom during sexual intercourse and/or having just one uninfected faithful partner can reduce the chance of getting HIV, as well as rejecting the two most common misconceptions about HIV.

Majorities of the women knew that HIV could be transmitted from a mother to her child during pregnancy (85.4%), delivery (70.0%) or breastfeeding (63.6%). There were no significant differences in HIV knowledge between the age groups.

The above-mentioned School Health Survey (2009)[x] found that nationwide, 67.2% of boys and 74.3% of girls in grade 8-10 had heard of 'HIV infections or the disease called AIDS (Acquired Immunodeficiency Syndrome)'. In Male, the numbers were 75.9% and 84%, and in the atolls 63.4% and 70.0%, respectively.

6. Sexually transmitted infections (STI)

The 2008 BSS survey found high rates of STI and Hepatitis, as summarized below:

Survey group	**Pathogen**	**Prevalence in %; (N)**
Resort workers	Syphilis	1.2 (484)
Resort workers	Hepatitis B	2 (484)
Construction workers (Male')	Hepatitis B	3 (102)
Seafarers	Hepatitis B	4 (100)
IDUs (Addu)	Hepatitis B	0.8 (128)
IDUs (Addu, Male')	Hepatitis C	0.8 (128), 0.7 (150)
MSM (Addu, Male')	Hepatitis B	6 (55), 1.4 (69)

Table: Overview of serologic findings of the 2008 BBS

No HIV, Syphilis or Hepatitis was found among female sex workers (N=94) or youth (N=609) in the BSS survey locations. However over a quarter (27%) of women engaged in sex work in both locations self-reported signs of an STI; so did almost a fifth (19%) of sexually active youth in Male' and almost a quarter (23%) in the atoll of Laamu, and 17% of MSM in Male' and 12% in Addu; for IDUs self-reported STI symptoms occurred in 16% of those interviewed in Male' and 11% in Addu. Self-reported STI symptoms were reported by 3% of seafarers, 4% of construction workers and 7% of resort workers.

Health seeking behavior varied widely, ranging from 100% of seafarers going to a health practitioner to 0% of MSM in Addu. A bit over two-thirds of FSW in Male' and one third in Addu sought treatment for STI; youth ranged between 33% to 48% across two sites. The lowest treatment uptake was reported by MSM (0% in Addu and 17% in Male' sought treatment).

C. Policy and programmatic response;

National AIDS Program and National AIDS Council

National AIDS Control Program was launched in 1987 with the aim of limiting the spread of HIV in the country. National AIDS council, NAC, a multi-sectoral representative body was formed to provide direction to National AIDS Control Program (NAP). The Center for Community Health and Disease Control is responsible for implementing the National Strategic Plans, under guidance of the National AIDS Council, which consists of Government, NGO and private sector stakeholders.

The National AIDS Program has successfully advocated for HIV related issues, including the drafting of a new Drugs Bill. It was successful in acquiring funding from the Global Fund under Round 6, which provides funding for the implementation of (part of) the current (2007-2011) NSP (see below).

National Strategic Plan on HIV/AIDS 2007-2011

The current National Strategic Plan was developed in 2007[xiv] with support from the UN joint team on AIDS. The NSP 2007-11 aims to limit HIV transmission, provide care for infected people, and mitigate the impact of the epidemic through seven strategic directions:

1. Provide age and gender appropriate prevention and support services to key populations at higher risk: drug users, sex workers and men who have sex with men.
2. Reduce and prevent vulnerability to HIV infection in adolescents and young people.
3. Provide HIV prevention services in the workplace for highly vulnerable workers.
4. Provide treatment, care and support services to people living with HIV.
5. Ensure safe practices in the healthcare system.
6. Build and strengthen capacity and commitment to lead, coordinate and provide a comprehensive response to the epidemic.
7. Strengthen the strategic information system to respond to the epidemic.

The NSP 2007-11 will be followed by the NSP 2012-2017, which will be based on this situational assessment document and the findings of the JMTR report.

Global Fund grant (2006)

The Maldives Global Fund Proposal for Round 6 was successful. It had initially been approved for close to 5 million US$ for five years, but due to slow implementation and other reasons, only US$ 2.289 million is now available for 2009-12 (September/August)[xv]. UNDP is the Principal

Recipient and the NAP is one of three sub-recipients. The funding supports nine objectives, corresponding to five of the seven strategic priorities of the National Strategic Plan 2007 – 2011 (i.e. 2, 3, 4, 5 and 7 - see above) as follows:

1. Prevent HIV transmission among young people who inject drugs or are at risk of injecting drugs.
2. Prevent HIV transmission among populations at risk such as migrants, seafarers, and resort workers.
3. Increase awareness and knowledge about STIs and HIV among young people.
4. Expand access and coverage of quality HIV testing and counseling.
5. Strengthen the prevention and control of STIs.
6. Strengthen health service capacity to provide quality care, support and treatment for people living with HIV.
7. Strengthen health systems capacity for prevention of HIV and other transfusion transmittable infections through blood and blood products.
8. Strengthen the strategic information system for HIV.
9. Strengthen the multisectoral response to HIV/AIDS.

The recent Mid-Term Review noted that NSP priorities that are not adequately covered by the current financial support from the Global Fund Grant Round 6 are priority 1 (the provision of prevention services to key population groups: drug users, sex workers and men who have sex with men), and priority 6 (building of capacity and commitment of the NAP to lead and coordinate the national response). The JMTR team concluded that these are two critical gaps that will need to be supported for the second phase of the national strategic plan 2010-2011 in order to strengthen and sustain the national response. The Operational Plan (see below) addresses some of these concerns. A GFATM proposal for Round 9 had been partly developed but was not taken forward by the Country Coordinating Mechanism. A proposal was submitted for Round 10, but was not approved.

Operational plan on HIV 2010-11

The Operational Plan[xvi] was developed based on the budgets/proposals of the GFATM grant (see above) as well as the findings and recommendations from the JMTR (December 2009). It includes the result of costing workshops focusing on assessing funding needs for 'Most At Risk Population (MARP) activities'. The operational plan follows the NSP's 7 strategies (see above), but, apparently in response to the JMTR recommendations, places a much stronger focus on the need to respond to those most at risk. It notes that the ongoing GFATM grant does not provide support for the top priority strategy in the NSP 2007-11 (which is to focus on people

engaging in risk behaviors), with the exception of some interventions focusing on drug users. The draft plan therefore focuses on additional interventions for people engaged in sex work and male to male sex, as well as one pilot needle exchange project in prisons, to be implemented in 2011. Costing workshops were held and NGO representatives were involved in estimating the sizes of 'target populations', in expectation of more solid size estimation data that was planned to come out in 2010 (but will come out in July 2011). Based on these initial estimated population sizes and a targeted coverage of 80%, a minimum of USD 163,673 was needed for 2010 and USD 239,142 for 2011. The resource gap was USD 57,789 in 2010 and USD 130,443 in 2011.

National Drug Bill

The new National Drugs Bill will formalize the current public health view which considers drug addicts first and foremost as patients in need of treatment rather than as criminals that need to be punished under the judicial system. Drug dealing will continue to be a crime. This is a very important improvement of the enabling environment for HIV prevention interventions. While developed and 'ready to pass' in 2009, the bill had, as of June 2011, still not passed parliament.

National Education and National Health Master Plans

The Ministry of Health has, in 2010, updated its 10-year Master plan; the Ministry of Education (MOE) is in the process of doing so. Both plans provide a 'policy umbrella' for more specific policy and programmatic actions that can reduce the vulnerability of young people and reduce risk behaviors among particular groups in Maldivian society.

School Health Policy (2011)

The MOE has issued a new National Policy on School Health, published in January 2011. The overarching goal of the School Health Policy 2011 is 'to mainstream health and wellbeing into the education system of the country by 2015.' One of the seven objectives of the policy is 'to empower students with skills and competencies that enable them to make healthy choices to prevent health problems, maintain and improve their health, and adopt healthy behaviours.' A total of twelve outcome indicators were identified in the 2011 School Health Policy monitoring and evaluation tool, to evaluate policy implementation. According to a recent UNFPA study, none of these are connected to any reproductive health outcomes. The only indicator remotely connected to reproductive health is one on sexual abuse, which is the "percentage of students who were physically forced to have sexual intercourse when they did not want to", according to the UNFPA study. The study concludes that 'It is evident from the 2011 School Health Policy that the provision of reproductive health information and services is not a policy priority in the school education sector at the moment, despite the noted policy objective to empower students with the necessary skills to make the right decisions to preserve and protect their health.'**Error! Bookmark not defined.**

D. Indicator data in an overview table

Indicator	Numerator	Denominator	Remarks
1.6. Reduction in HIV Prevalence	Number of antenatal clinic attendees (aged 15-24) tested whose HIV test results are positive 0	Number of antenatal clinic attendees (aged 15-24) tested for their HIV infection status 2108	Percentage of young women aged 15-24 who are HIV-infected 0.00
1.15 Health facilities that provide HIV testing and counselling services	Number of health facilities that provide HIV testing and counselling services All 11 public 9 Private 0	Total number of health facilities All 196 Public 194 Private 2	Percentage of health facilities that provide HIV testing and counselling services All 5.61 Public 4.64 Private 0.00

1.16 HIV Testing in 15+ (from programme records)	Number of women and men aged 15 and older who received HIV testing and counselling in the past 12 months and know their results 618 Number of women and children aged 15 and older received testing and counselling in VCT sites in the past 12 months and know their results 618 Number of pregnant women aged 15 and older who received testing and counselling in the past 12 months and received their results		National STI survaillance report Data Collection Period : Sat, 2011-01-01 - Sat, 2011-12-31
1.17 Sexually Transmitted Infections (STIs)	Number of women attending first visit ANC services who were tested for syphilis 1744	Number of women attending first visit ANC services 2108	Percentage of women accessing antenatal care (ANC) services who were tested for syphilis at first ANC visit 82.73
Percentage (%) Percentage of antenatal care attendees who were positive for syphilis	Number of antenatal care attendees who tested positive for syphilis 2	Number of antenatal care attendees who were tested for syphilis 1744	Percentage of antenatal care attendees who were positive for syphilis 0.11
2.6. Opiate users	Number of people on OST in all OST sites 78	-	One site
2.7. NSP and OST sites	Number of NSP sites (including pharmacy sites providing no cost needles and syringes) 0		

3.4 Pregnant women who know their HIV status Number of pregnant women who were tested for HIV in the last 12 months and received their results - during pregnancy, during labour and delivery, and during the post-partum period (<72 hours), including those with previously known HIV status	Total number tested (including previously known positives) 3176 Total number tested and received results (including previously known positives) 3176 Total number testing positive (including previously known positives) 0		
3.4 Pregnant women who know their HIV status (a) Total number of pregnant women attending ANC who were tested during ANC and received results or knew their positive status.	Number tested (including previously known positives) 0 Number tested and received results (including previously known positives) 3176 HIV+ out of number tested (including previously known positives) 0		

3.4 Pregnant women who know their HIV status (a.i) Number of pregnant women with unknown HIV status attending ANC who were tested during ANC and received results	Number tested 3176 Number tested and received results 0 HIV+ out of number tested 0		
4.4 ART Stockouts	Number of health facilities dispensing ARVs that experienced a stock-out of at least one required ARV in the last 12 months : 1	Number of health facilities dispensing ARVs: 1	Percentage of health facilities dispensing antiretrovirals (ARVs) for antiretroviral therapy that have experienced a stock-out of at least one required ARV in the last 12 months : 100
4.3 Health facilities that offer antiretroviral therapy	Number of health facilities that offer antiretroviral therapy (ART) (i.e. prescribe and/or provide clinical follow-up) Total 1 Disaggregation by public/private Public 1 Private 0 Unknown/unspecified 0		

3.12 Health Facilities

	Number of health facilities providing ANC services	Number	196
	Number of health facilities providing ANC services that also provide CD4 testing on site, or have a system for collecting and transporting blood samples for CD4 testing for HIV-infected pregnant women	Number	1
	Disaggregation by availability of CD4 testing	On site	1
			0
		Uncategorized/other (please specify in Comments field)	0
	Number of health facilities that offer paediatric ART	Number	1
	Percentage of health facilities that provide virological testing services (e.g. polymerase chain reaction) for diagnosis of HIV in infants on site or from dried blood spots	Percentage (%)	0
Numerator	Number of health facilities that provide virological testing services (e.g. PCR) for diagnosis of HIV in infants on site or from dried blood spots (DBS)	Total	0
	Disaggregation by availability of virological testing	On site	0
		Through dried blood spots (DBS)	0
		Uncategorized/other (please specify in Comments field)	0
Denominator	Number of health facilities that provide follow-up for HIV-exposed infants	Total	0
	Targeted number of health facilities based on national programme plans	Total targeted	0

4.1. HIV Treatment: Antiretroviral Therapy

	All Adults and Children	Males	Females	Sex Unknown	<15	<1	1 - 4	5 - 14	15+	Age Unknown
Percentage (%) Percentage of eligible adults and children currently receiving antiretroviral therapy	100.00	100.00	Missing	Missing	Missing	Missing	Missing	Missing	100.00	Missing
Numerator Number of adults and children with advanced HIV infection who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	3	3	Missing	Missing	Missing	Missing	Missing	Missing	3	Missing
Denominator Estimated number of adults and children with advanced HIV infection	3	3	Missing	Missing	Missing	Missing	Missing	Missing	3	Missing

4.2. HIV Treatment: 12 Months retention

	All	Males	Females	<15	15+
Percentage (%) Percentage of adults and children with HIV known to be on treatment 12 months after initiating antiretroviral therapy If data on 12-month retention are not available for patients that initiated antiretroviral therapy in 2010 specifically, but available for patients that initiated antiretroviral therapy during an earlier time period (e.g. 2009 or 2008), please specify the period in the comment field above: Started antiretroviral therapy between [month]/[year] and [month]/[year]	66.67	66.67			66.67
Numerator Number of adults and children who are still alive and on ART at 12 months after initiating treatment	2	2			2
Denominator Total number of adults and children who initiated ART during the twelve months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up	3	3			3

	Lost to follow-up	Stopped Therapy	Died
Additional info: In addition to 'alive and on ART', please report other outcomes at 12 months after initiating treatment	0	0	1

4.2b HIV Treatment: 24 month retention

Percentage (%)	Percentage of adults and children with HIV still alive and known to be on treatment 24 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2009) If data on 24-month retention are not available for patients that initiated antiretroviral therapy in 2009 specifically, but available for patients that initiated antiretroviral therapy during an earlier time period (e.g. 2008 or 2007), please specify the period in the comment field above: Started antiretroviral therapy between [month]/[year] and [month]/[year]	Total	
Numerator	Number of adults and children who were still alive and known to be on treatment 24 months after initiation of antiretroviral therapy	Total	2
Denominator	Number of adults and children who initiated antiretroviral therapy during 2009 or the specified period (including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow-up at month 24)	Total	1
Additional info		Lost to follow-up	0
		Stopped therapy	0
		Died	1

4.2c HIV Treatment: 60 month retention

Percentage (%)	Percentage of adults and children with HIV still alive and known to be on treatment 60 months after initiation of antiretroviral therapy (among those who initiated antiretroviral therapy in 2006) If data on 60-month retention are not available for patients that initiated antiretroviral therapy in 2006 specifically, but available for patients that initiated antiretroviral therapy during an earlier time period (e.g. 2005 or 2004), please specify the period in the comment field above: Started antiretroviral therapy between [month]/[year] and [month]/[year]	Total	
Numerator	Number of adults and children who were still alive and on antiretroviral therapy 60 months after initiating treatment	Total	1
Denominator	Number of adults and children who initiated antiretroviral therapy during 2006 or the specified period (including those who have died since starting therapy, those who have stopped therapy, and those recorded as lost to follow-up at month 60)	Total	2
Additional info		Lost to follow-up	0
		Stopped therapy	0
		Died	1

III. National response to the AIDS epidemic

Maldives being a low prevalence country, major efforts have been put on prevention and maintaining the low level of HIV infection in the Maldives. Through established national surveillance mechanisms and required screening performed under medical care, a total of 15 cases of HIV had been identified among Maldivians between 1991 and 2011. Out of which 11 have passed away. Under the health screening carried out on expatriate migrant workforce to enable their work visa, a total of 257 HIV infected persons had been identified *(as a result of which they could not obtain a work permit / permit to stay and had to leave).*

Health sector responses

Testing and counselling

There were 8 VCT centers in the Maldives (Indira Gandhi Memorial Hospital, Villingilli health center and six regional hospitals). Besides that, two VCT centers are established in the NGOs , one working with drug users and another working with youth and migrant workers.

- Antenatal attendees: According to national testing guidelines, pregnant women should be offered an HIV test, allowing them to opt out; also, pre-test and post-test counseling should be provided and written informed consent should be obtained prior to testing. However, contrary to these guidelines, all pregnant women are still screened for HIV along with Venereal Disease Research Laboratory test and hepatitis B, but pre-test and post-test counseling is not available. 1,368 women were tested in 2008 and 2,024 in 2009, accounting for around 14% of all HIV tests conducted in those years[Error! Bookmark not defined.].
- Self-referred clients seeking VCT: eight VCT centers have been established in Maldives[Error! Bookmark not defined.]. According to key informants, there is very low demand for VCT, likely due to the stigma attached to HIV as well as very low levels of perceived risk. In 2008 only 21 test results were reported through VCT (0.07% of the total) and in 2009 there were 374 (1.35%); the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) report**Error! Bookmark not defined.** notes that it is not certain if misreporting of categories might be behind this rise, or a genuine increase in the uptake of testing. The GFATM supported project reports that 697 people received testing and counseling and received their results from the start of the project in 2007 until 30 June 2010.
- Closed settings/institutions: No HIV testing is offered in prisons or juvenile detention centers. HIV testing is provided to clients entering drug treatment centers, as a routine test – informed consent is usually, but not always, obtained, according to key informants in 2006. Although a medical examination is carried out in the intake process for the Correctional and Training Center for Children HIV testing is not part of it.

- Pre-employment HIV testing: Several international employers require HIV testing as part of pre-employment medical examination. The national labor regulations require the testing of sailors and other expatriate workers. Any foreign person is seeking employment in Maldives is being tested for HIV as part of pre-employment medical examination. If they are found positive, their employment application is denied. Pre-employment screening was the most important source of HIV test results (49% of the total of nearly 30,000 tests in 2008 and 34% of the total in 2009).

Treatment and care for people living with HIV

Ever since the introduction of ARV Treatment in the country in the year 2003, the government is committed to fully support the provision of ARV treatment services, including regular CD4 testing, in accordance with the most recent National and WHO guidelines. National antiretroviral therapy (ART) guidelines were developed in 2005, and updated in 2011, to reflect recent changes in treatment regimen. Four people (3 locals and 1 foreigner) are currently receiving antiretroviral treatment at the only ART center in the country, which is in Male. There is one CD4 counting machine in Male', but viral load testing is not available in the country. However, blood samples are sent abroad to regional refferal laboratoraities for viral load testing, when required.

Sexually transmitted infections

In the Maldives, surveillance of STIs consists of universal syndromic STI case reporting, sentinel etiological STI case reporting and a cross-sectional community based STI survey repeated every 3-5 years (recent data could not be found for review in this report). The annual syndromic reporting of sexually transmitted infections has been strengthened in 2004, but the National AIDS Programme acknowledged in a 2010 document that reporting is still weak[Error! Bookmark not defined.]. The GFATM supported programme reported that 2,587 STI cases had been treated at health care facilities as of 30 June 2010, and that 316 health care providers had been trained in diagnosis and clinical management of STIs, both are much higher than the targets set at the beginning of the program in 2007[Error! Bookmark not defined.]. Unfortunately there is no breakdown of specific STIs available.

Sexual and Reproductive health care

Antenatal care for pregnant women is widely available across health centers in the islands and in Male'. Screening for HIV and other diseases is standard procedure. Sexual health uptake for other groups in Government health centers is limited, with few STI cases found or treated by the health sector. The NGO Society for Health Education runs a free reproductive health clinic in Male' and makes regular visits to the islands for ad-hoc free health care. Most doctors and nurses are volunteers. Contraceptives are available but only for married couples.

Promotion of a safe blood supply

Blood safety is a priority given the high incidence of Thalassemia which requires frequent blood transfusions (number of patients transfused during year 2008 had been 5,755 and majority was thalasemic). The National blood policy was formed with external consultants' assistance in 2007 guidelines on rational use of blood, encouraging voluntary non remunerative donations and donor deferral. Another strategy was the development of a Donor Declaration Form. All donated Blood units are screened for HIV, and other TTIs (Hep B, Hep C, Malaria and Syphilis) in government hospitals and laboratories. However, standard operating procedures or local written instructions for transfusion of blood to patients are not adhered to by many labs[Error! Bookmark not defined.].

There are two central blood banks in the capital city; one is at the National Thalassemia Center (approx 30 transfusions per day) and the other one at the Indira Gandhi Memorial Hospital. In 2006, it was reported to the review team that the blood bank facilities are not well utilized. For example, in Indira Gandhi Memorial Hospital only 7 units were stored at that time. The six regional hospitals have been equipped with storage facilities (capacity for 40 units each). However, the frequency of transfusion approximates only one to two per year. A separator for blood components is available. Specialists in transfusion medicine or haematologist are not available in the Maldives. Thalassemia seems to be the only major haematological disease. All of these factors result in lack of blood component requirement and preparation.

Prevention activities

Drug use prevention and rehabilitation

The Department of Drug Prevention and Rehabilitation Services (DDPRS) sits in the Ministry of Health and Family. It is responsible for planning, delivering and monitoring drug treatment and rehabilitation, and drug prevention services. Already established National Drug Prevention Program had been an enabling avenue for implementation of prevention measures among injecting drug users (IDUs). Prevention is extended to reach prisons for incarcerated populations. Drop – in Centers are established with comprehensive programmes including Voluntary Counseling and Testing Services.

Opiod Substitution Therapy (OST), a Methadone programme was initiated in 2008, with a strong psychosocial component attached to it, which is mainly managed by trained counselors. The CSOs run by and for drug users provide additional support services. The programme has been independently reviewed both by the World Bank and UNODC. Both the reviews have proved to be an excellent measuring scale for the success of the MMT Program in the country. Based on data from the mapping the Government has decided to extend and scale up the OST programme, with fewer conditions for inclusion.

Focus on migrant workers

The AIDS prevention program also focuses on addressing the needs of the migrant workers, specially the expatriate migrant workers. Peer education and outreach services have been extended, to reach the expatriate migrant workers. BCC materials are developed in their native languages, and peer educators from the representing nationalities are trained, and regular health camps are organized. A VCT services has been setup primarily for migrants.

Gaps in the response to HIV/AIDS in the Maldives

Prevention: Insufficient focus on highest-risk behaviours

The Operational Plan for HIV in the Maldives 2010-11 acknowledges that the biggest gap in the current response to HIV in the country is the lack of strategic focus on the behaviors most likely to kick-start a potential epidemic: injecting drug use, male to male sex and transactional sex/sex work. Part of the reason for the absence of interventions for those most at risk is the current legal framework, which outlaws these behaviors and drives people who are involved in them underground. This contradicts with the public health need to reach out to people engaging in these behaviors (including those in prisons).

The Maldives outlaws male to male sex, following the British colonial penal code as well as interpretations under Sharia law. The Maldives also outlaws premarital and extramarital sex (including sex work). Although married people have access to condoms via birth control services, the provision of condoms to unmarried people is not allowed, despite the fact that unmarried people, from an HIV prevention perspective, need condoms most. Sex work is outlawed in all other Asian countries too, and male to male sex is outlawed in several other Muslim countries (Malaysia, Pakistan, Bangladesh and Iran, for example). However, in many of these countries a pragmatic balance has been struck between law enforcement agencies and agencies promoting public health (MOHF/NAP and NGOs) making interventions focusing on 'forbidden' behaviors possible without police harassment, but at the same time without formally allowing or 'legalizing' these behaviors. In such countries, successful HIV prevention interventions have been established and are operating.

Research and data gaps

STI surveillance

Universal syndromic STI case reporting is established. For surveillance purposes, the most useful STI syndromes are male urethral discharge, male genital ulcers and female genital ulcers. Vaginal discharge has a low specificity for STIs.

Qualitative data on the socio-cultural context of high-risk behaviours

Especially in the Maldives, where there is limited or no experience in programming for those engaging in high-risk behaviors, solid anthropological research is needed to assess how these behaviors 'work', in which contexts, and who are 'gatekeepers' and 'significant others' when these behaviors occur. This information is pivotal in order to design programs; questions include: where to start? Which messages to include or to exclude? How to overcome barriers to accessing services and other issues related to acceptability? Whereas there is some good information about injecting drug users, regarding sex work and male-to-male sexual activity, only anecdotal evidence is available at present.

Operations research

No information is available about the effectiveness and appropriateness of existing interventions. For example, it is not known exactly whether the content of peer education outreach sessions for migrants and resort workers is comprehensive; for instance the extent to which it includes harm reduction messages or any information about the behaviors most likely to transmit HIV is not known. There is no data about the effectiveness of the 'community therapeutic model' employed in the Government's detox centers for drug users, nor on the community reintegration program currently run by Journey and SWAD. It is unclear to what extent the planned life skills education program in schools will include any reference to HIV risk behaviors and, if it does, whether the teachers are sufficiently able to teach these topics.

IV. Best practices

Recently, Maldives is going through lot of changes, politocally and socially. However much is sensitive, the issues around HIV. The Government has put effort to bring about possible Policy and legislation change which is necessary. A new drug law has been enacted in 2011 which provides provisions for drug treatment, where people who use drugs are sentenced to treatment, not incarceration. Hence the drug law which was recently enacted is in a position to command the type of treatment that is indicative for each drug user. OST will now be a legally prescribed treatment which will benefit key populations immensely.

The MMT program which began as a pilot program has now terminated its pilot status and has been streamlined into mainstream programs for drug users. This was done, mainly keeping in mind the harm reduction philosophy.

Considering human rights as key principles of service delivery; access and universal coverage is vital. A scale–up measure for reaching universal access to treatment, the government of

Maldives has made an important policy decision that all expatriate migrant workers who gets HIV positive while working in Maldives are provided access to free HIV treatment and care.

Also, access to health care is ensured through a universal health insurance scheme, where every Maldivian is automatically joined, with a common premium, which is paid by the Government. Therefore, PLHIV will be able to access medical services as any other individual.

Efforts on sensitization of law enforcement officers has proven to be effective; currently syringes or condoms are not used as evidence of crime, and there are no reports of people who carry a condom or a syringe are subjected to harassment and intimidation.

Key Affected Populations are recognized as an important stakeholder. Representatives from the informal networks and groups of KAPS have actively engaged in the development of national policies and plans to ensure that their voice and opinions are reflected, captured in the development and planning process.

V. Major challenges and remedial actions

- To align policies and laws /regulations for enabling environment to effective implementation
- Cultural and religious barriers for KAPS interventions especially Harm reduction for IDU
- Few NGOs to address KAPs interventions , and lack technical capacity , none for MSM/Sex workers
- Even though the Government supports and encourage setting up prevention services for KAPs', lack of capacity among NGOs hinders effective service delivery for KAPs.
- Establishing systems to allow the GOVT to conduct prevention programmes especially for KAPS
- Denial by some of the key stakeholders that the KAPS does not exist and no civil society organisations or members of high risk populations to implement TI
- Introducing comprehensive harm reduction programme for IDUs including needle exchange programs
- Reporting systems of STIs (Syndromic management) , need strengthening to capture early warning of an impending HIV epidemic
- Syndromic management of STIs especially among KAPS to be strengthened as there are no special STI clinics for KAPS
- Condom promotion among risk groups as well as unmarried youth
- Increase VCT uptake by KAPS as accessibility is an issue with the distribution of KAPS in several Atolls./regions –

- Gender issues and overcoming cultural /religious barriers for promoting condoms, addressing womens issues no specific programmes for women IDUs
- creating enabling environment for government and NGOs to carry out research /surveys and interventions in prisons
- To develop a standardized recording and reporting formats for PLWHA under care. At present socio demographic data , are recorded at NAP upon entry but limited clinical details to monitor adherence , drug resistance and quality of care are recorded.
- The M&E plan is not costed, and no details for some of the planned activities .hence donor support for funds is difficult to ensure.
- Data analysis and sharing at peripheral level is not functional and Inconsistency of data
- Logistics /Terrain hamper timely data flow and monitoring and supervising of the data collection and quality assurance
- Lack of interest in reporting due to lack of skills of staff at periphery
- Convince policy makers and political and community /religious leaders of evidence /strategic implications and overcoming denial , and lack of interest

VI. Support from the country's development partners

AIDS programme of the Maldives is mainly funded by external donors and mechanisms; such as GFATM, WHO, UNFPA and UNICEF. WHO provides technical support for HIV & AIDS activities.

UN system support to the HIV response in the Maldives is coordinated through the UN Joint Team on AIDS. Individual UN agencies brought strategic support throughout this period in terms of awareness and programmatic support largely in the form of technical assistance. The UN Joint Team on AIDS in the Maldives is active and the principle coordination body of this support.

In order to strengthen the national response to HIV in the Maldives, UNDP has provided consistent support to the government and the civil society organizations to be involved in planning and implementing key activities that impacts HIV response.

VII. Monitoring and evaluation environment

Monitoring and evaluation is weak, and strategic information systems to measure progress are not in place. The common distinction the BBS makes between occupational cohort males (resort workers, construction workers, seafarers) and categories based on risk behaviors (IDUs, MSM, SWs) is misleading, as these are not mutually exclusive. An example of this confusion is that the BBS report concludes that one HIV case was found in a male resort worker – without explaining via which behavior this person had acquired his infection – as if the risk behaviors occurred only in the separate categories of MSM, SWs and IDUs, and not in the occupational cohort males.

The existing national monitoring & evaluation (M&E) plan that exists to support the NSP, 'is very weak and does not address all important elements of an M&E plan' according to a recent report[xvii]. Strengths of the M&E system included:

1. The current M&E Plan is clearly linked to the NSP;
2. There are indicators measuring disease and behavioral trends;
3. The NAP worked together with those responsible for coordinating large-scale household surveys (i.e. the Demographic Health Survey), avoiding duplication;
4. There are protocols for ensuring the confidentiality of sensitive data and for how long source data need to be retained.

Weaknesses identified included:

1. Not all necessary elements are included in the current M&E plan;
2. The M&E plan is not costed: there is no budget and there are no details for some of the planned M&E activities (this may have been addressed since the report came out);
3. Goals and objectives of the plan are not time-bound;
4. Health managers at the island, atoll and national level do not have easy access to M&E data collected;
5. No yearly targets are specified in the NSP in terms of outputs and outcomes;
6. Lack of denominators for most of the coverage-based indicators (but this has improved since the Risk Behavior Mapping report has established these denominators[ix].

ANNEXES

ANNEX 1: National Commitments and Policy Instrument (NCPI)

References/footnotes

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National Commitments and Policy Instrument (NCPI)

Part A

I. STRATEGIC PLAN

1. Has the country developed a national multisectoral strategy to respond to HIV?
(Multisectoral strategies should include, but are not limited to, those developed by Ministries such as the ones listed under 1.2)

Yes **X**	No	Not applicable

Period covered: *[write in] 2009-2011*

IF NO or NOT APPLICABLE, briefly explain why.

***IF YES*, complete questions 1.1 through 1.10; *IF NO*, go to question 2.**

1.1 How long has the country had a multisectoral strategy?
Number of Years: *[write in] since 1987(NAP started in 1987) coordinated by NAC a mulisectoral body. Situation analysis in 2006 and current NSP in 2009 (2009 – 2011, reviewed in 2009)*
1.2 Which sectors are included in the multisectoral strategy with a specific HIV budget for their activities?

Sectors	Included in strategy		Earmarked budget	
Health	Yes **X**	No	Yes **X**	No
Education	Yes **X**	No	Yes X	No
Labour	Yes **X**	No	Yes	No X
Transportation	Yes **X**	No	Yes	No X
Military /police	Yes **X**	No	Yes	No X
Women	Yes X	No	Yes X	No
Young people	Yes X	No	Yes X	No
Youth	Yes X	No	Yes X	No
Other: Fisheries	Yes X	No	Yes	No X
Other: Tourism	Yes X	No	Yes	No X

Note: In Maldives, Women and young people does not fall into separate sectors, they are under health sector.

IF NO earmarked budget for some or all of the above sectors, explain what funding is used to ensure implementation of their HIV-specific activities?
Donor funds

GFATM-	Blood safety, HIV prevention for DU/IDU, migrants
UNODC,	Harm reduction for Drug users (ex. OST)
UNICEF,	young people and adolescents (in and out of school youth)
UNFPA	women and youth
WHO –	Technical support

1.3 Does the multisectoral strategy address the following target populations, settings and cross-cutting issues?

Target populations		
a. Women and girls	Yes **X**	No
b. Young women/young men	Yes **X**	No
c. Injecting drug users (including those in closed settings)	Yes **X**	No
d. Men who have sex with men	Yes **X**	No
e. Sex workers	Yes **X**	No
f. Orphans and other vulnerable children	Yes	No X
g. Other specific vulnerable subpopulations* seafarers, resort workers, migrant workers	Yes **X**	No
Settings		
h. Workplace	Yes **X**	No
i. Schools	Yes **X**	No
j. Prisons	Yes **X**	No
Cross-cutting issues		
k. HIV and poverty	Yes	No X
l. Human rights protection	Yes **X**	No
m. Involvement of people living with HIV	Yes X	No
n. Addressing stigma and discrimination	Yes **X**	No
o. Gender empowerment and/or gender equality	Yes **X**	No

1.4 Were target populations identified through a needs assessment?

Yes **X**	No

IF YES, when was this needs assessment conducted?
Year: *[write in] 2006, and followed up in 2011, a social mapping exercise was carried out*

IF NO, explain how were target populations identified?

1.5 What are the identified target populations for HIV programmes in the country?
[write in] injecting DU, female/male sex workers, MSM, youth, prisoners, migrant workers, Industrial workers (Resort workers)

1.6 Does the multisectoral strategy include an operational plan?

Yes **X**	No

1.7 Does the multisectoral strategy or operational plan include:

a. Formal programme goals?	Yes **X**	No
b. Clear targets or milestones?	Yes **X**	No
c. Detailed costs for each programmatic area?	Yes **X**	No
d. An indication of funding sources to support programme implementation?	Yes **X**	No
e. A monitoring and evaluation framework?	Yes **X**	No

1.8 Has the country ensured "full involvement and participation" of civil society* in the development of the multisectoral strategy?

Active involvement **X**	Moderate involvement	No involvement

IF active involvement, briefly explain how this was organised: A participatory process led by the ministry of health and family, conducted series of stakeholder meetings involving government and civil society organizations to develop national strategic plan in 2009 , defining strategic priorities, objectives , and major activities.. Civil society included were mainly NGOs working with DU, youth and UN agencies. And recently the development of the NSP 2012 – 2016 was initiated, and a similar process took place, with greater involvement of KAPs, as stakeholders.

IF NO or MODERATE involvement, briefly explain why this was the case:

1.9 Has the multisectoral strategy been endorsed by most external development partners (bi-laterals, multi-laterals)?

Yes **X**	No

1.10 Have external development partners aligned and harmonized their HIV-related programmes to the national multisectoral strategy?

Yes, all partners **X**	Yes, some partners	No

IF SOME or NO, briefly explain for which areas there is no alignment / harmonization and why

2. Has the country integrated HIV into its general development plans such as in: (a) National Development Plan; (b) Common Country Assessment /UN Development Assistance Framework; (c) Poverty Reduction Strategy; and (d) sector-wide approach?

Yes **X**	No	Not applicable

2.1 ***IF YES***, in which specific development plan(s) is support for HIV integrated?

a. National Development Plan (National Strategic Action Plan)	Yes **X**	No	NA
b. Common Country Assessment / UN Development Assistance Framework	Yes **X**	No	NA
c. Poverty Reduction Strategy	Yes	No X	NA
d. Sector-wide approach	Yes **X**	No	NA
e. Other: *National blood policy, reproductive health strategy*	Yes **X**	No	NA

2.2 IF YES, which specific HIV-related areas are included in one or more of the development plans?

HIV-related area included in development plan(s)		
HIV prevention	Yes **X**	No
Treatment for opportunistic infections	Yes **X**	No
Antiretroviral treatment	Yes **X**	No
Care and support (including social security or other schemes)	Yes **X**	No
HIV impact alleviation	Yes	No X
Reduction of gender inequalities as they relate to HIV prevention/treatment, care and/or support	Yes **X**	No
Reduction of income inequalities as they relate to HIV prevention/treatment, care and /or support	Yes	No X
Reduction of stigma and discrimination	Yes **X**	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes	No X
Other: [write in]	Yes	No **X**

3. Has the country evaluated the impact of HIV on its socioeconomic development for planning purposes?

Yes	No **X**	NA

3.1 IF YES, to what extent has it informed resource allocation decisions?

Low	0	1	2	3	4	5	High

4. Does the country have a strategy for addressing HIV issues among its national uniformed services (such as military, police, peacekeepers, prison staff, etc)?

Yes **X**	No

4.1 IF YES, which of the following programmes have been implemented beyond the pilot stage to reach a significant proportion of the uniformed services?

Behavioural change communication	Yes	No **X**
Condom provision	Yes	No **X**
HIV testing and counselling	Yes **X**	No
Sexually transmitted infection services	Yes **X**	No
Antiretroviral treatment	Yes	No **X**
Care and support	Yes	No **X**
Others: [write in]	Yes	No X

If HIV testing and counseling *is provided* to uniformed services, briefly describe the approach taken to HIV testing and counseling (e.g. indicate if HIV testing is voluntary or mandatory etc):

Mandatory testing on recruitment and training

5. Does the country have non-discrimination laws or regulations which specify protections for most-at-risk populations or other vulnerable subpopulations?

Yes	No X *

*In the 2009 report, it was reported as having a law. Based on the understanding that existing laws does not discriminate based on background.

5.1 ***IF YES,*** for which subpopulations?

a. Women	Yes	No
b. Young people	Yes	No
c. Injecting drug users	Yes	No
d. Men who have sex with men	Yes	No
e. Sex Workers	Yes	No
f. Prison inmates	Yes	No
g. Migrants/mobile populations	Yes	No
h. Other: *[write in]*	Yes	No

IF YES, briefly explain what mechanisms are in place to ensure these laws are implemented:

Briefly comment on the degree to which these laws are currently implemented:

Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for most-at-risk populations or other vulnerable subpopulations?

Yes **X**	No

6.1 ***IF YES,*** for which subpopulations?

a. Women	Yes	No **X**
b. Young people	Yes	No **X**
c. Injecting drug users	Yes	No X
d. Men who have sex with men	Yes **X**	No
e. Sex Workers	Yes **X**	No
f. Prison inmates	Yes **X**	No
g. Migrants/mobile populations	Yes	No **X**
h. Other: *[write in]*	Yes	No **X**

IF YES, briefly describes the content of these laws, regulations or policies:

A new drug law has been enacted in 2011 which provides provisions for drug treatment, where people who use drugs are sentenced to treatment, not incarceration. Hence the drug law which was recently enacted is in a position to command the type of treatment that is indicative for each drug user. OST will now be a legally prescribed

MSM - Male to male sex is illegal in Maldives under Maldivian penal code as well as interpretation under Sharia law.

Migrants- Under (Maldivian Immigration Act), “persons afflicted with a dangerous contagious disease that may be of risk to public health, or considered to have any other dangerous disease” may not have permit to entry. Therefore, anybody applying for a work visa is required to undergo a medical check-up which includes a HIV screening test. However, tourists entering on tourist visa, medical checkups are not required.

Briefly comment on how they pose barriers:
As any sexual activities outside marriage as well as same sex relations is illegal under Maldivian penal code as well as interpretation under Sharia law. Therefore, reaching this population is extremely difficult. In the Maldives its hard to speak about sex industry since sex in return for money or services happens in a non-formal, hidden and inexplicit way. Because of stigma and strong social taboo homosexuality is not a very popular subject among general population. There is lack of pragmatic understanding on how to deliver services to the key populations without having to legalize some of the behaviours. The dialogue between civil society and government is taking place

7. Has the country followed up on commitments towards universal access made during the High-Level AIDS Review in June 2006?

Yes **X**	No

7.1 Have the national strategy and national HIV budget been revised accordingly?

Yes **X**	No

7.2 Have the estimates of the size of the main target populations been updated?

Yes **X**	No

7.3 Are there reliable estimates of current needs and of future needs of the number of adults and children requiring antiretroviral therapy?

Estimates of current and future needs **X**	Estimates of current needs only	No

7.4 Is HIV programme coverage being monitored?

Yes **X**	No

(a) ***IF YES***, is coverage monitored by sex (male, female)?

Yes **X**	No

(b) ***IF YES***, is coverage monitored by population groups?

Yes **X**	No

IF YES, for which population groups?
Drug users/IVDU
Sex workers
MSM
Migrant workers,

ANC,
PLWHA

Briefly explain how this information is used:
For planning TI/training NGOs and Ministry of health staff, resource allocation

(c) Is coverage monitored by geographical area?

Yes **X**	No

IF YES, at which geographical levels (provincial, district, other)?
Central
Atoll.
Briefly explain how this information is used:

7.5 Has the country developed a plan to strengthen health systems, including infrastructure, human resources and capacities, and logistical systems to deliver drugs?

Yes **X**	No

Overall, how would you rate *strategy planning efforts* in the HIV programmes in 2011?

Very poor	0	1	2	3	4	5	X 6	7	8	9	10	Excellent

Since 2009, what have been key achievements in this area:
Development of NSP, 2010-2011 with participation of all stakeholders which was costed , and followed by a national action plan and M&E plan

What are remaining challenges in this area:
To align policies and laws /regulations for enabling environment to effective implementation
Cultural and religious barriers for KAPS interventions especially Harm reduction for IDU,

II. POLITICAL SUPPORT

Strong political support includes: government and political leaders who speak out often about AIDS and regularly chair important AIDS meetings; allocation of national budgets to support HIV programmes; and, effective use of government and civil society organizations to support HIV programmes.

1. Do high officials speak publicly and favourably about HIV efforts in major domestic forums at least twice a year?

President/Head of government	Yes **X**	No
Other high officials	Yes **X**	No
Other officials in regions and/or districts	Yes **X**	No

2. Does the country have an officially recognized national multisectoral AIDS coordination body (i.e., a National AIDS Council or equivalent)?

Yes **X**	No

IF NO, briefly explain why not and how AIDS programmes are being managed:

2.1 ***IF YES***, when was it created?

Year: 1987 *[write in]*

2.2 ***IF YES***, who is the Chair? Minister of Health

Name: Dr. Aminath Jameel Position/title : Minister of Health and Family

2.3 ***IF YES***, does the national multispectral AIDS coordination body:

have terms of reference?	Yes **X**	No
have active government leadership and participation?	Yes **X**	No
have a defined membership? ***IF YES***, how many members? *[write in]*	Yes **X**	No
include civil society representatives? ***IF YES***, how many? *[write in]*	Yes **X**	No
include people living with HIV? ***IF YES***, how many? *[write in]*	Yes	No **X**
include the private sector?	**Yes X**	No
have an action plan?	Yes	No **X**
have a functional Secretariat?	Yes **X**	No
meet at least quarterly?	Yes	No **X**
review actions on policy decisions regularly?	Yes **X**	No
actively promote policy decisions?	Yes **X**	No
provide opportunity for civil society to influence decision-making?	Yes **X**	No
strengthen donor coordination to avoid parallel funding and duplication of effort in programming and reporting?	Yes	No **X**

3. Does the country have a mechanism to promote interaction between government, civil society organizations, and the private sector for implementing HIV strategies/programmes?

Yes **X**	No	NA

IF YES, briefly describe the main achievements:
NAC and the CCM have members representing government ,civil society and the private sector which promotes interaction between the implementing partners, Government, NGOs and UN agencies.
The National strategic plan and policy statement clearly mentions involvement of civil society and private sector in planning strategies and implementing the programmes
The round 6 GFATM HIV proposal is implemented through a project with the, partnership of government (NAP) NGOs and the UNDP to address blood safety , interventions for IVDU and programs for seafarers, resort workers and migrants.
Also, NAP organizes regular coordination meetings, attended by representatives from government, UN and civil society

Briefly describe the main challenges:
Few NGOs to address KAPs interventions , and lack technical capacity , none for MSM/Sex workers
As the NAC is a highest level body, regular meetings to coordinate activities is not practical. There are no subcommittee of NAC to coordinate the specific key strategic areas IE. Surveillance, legal and ethical prevention including IEC , for care and support for PLWHA, monitoring & evaluation including research etc.
To have a skilled person/S as Program focal points with specific TORs in the ministry/NAP for each area for better coordination and accountability
Frequent change /transfer of skilled staff hampering continuity of work

4. What percentage of the national HIV budget was spent on activities implemented by civil society in the past year?
Percentage: *[write in] Nil*

5. What kind of support does the National AIDS Commission (or equivalent) provide to civil society organizations for the implementation of HIV-related activities?

Information on priority needs	Yes **X**	No
Technical guidance	Yes **X**	No
Procurement and distribution of drugs or other supplies	Yes **X**	No
Coordination with other implementing partners	Yes **X**	No
Capacity-building	Yes **X**	No
Other: *[write in]*	Yes **X**	No

6. Has the country reviewed national policies and laws to determine which, if any, are inconsistent with the National AIDS Control policies?

Yes X (drug law)	No

6.1 ***IF YES***, were policies and laws amended to be consistent with the National AIDS Control policies?

Yes X	No

IF YES, name and describe how the policies / laws were amended:

Drug a law which allows and encourages treatment, also under the law MMT can be prescribed as one of the treatment options for drug users specially IDUs'.

Name and describe any inconsistencies that remain between any policies/laws and the National AIDS Control policies:

Overall, how would you rate the *political support* for the HIV programme in 2011?

Very poor	0	1	2	3	4	5 X	6	7	8	9	10	Excellent

Since 2009, what have been key achievements in this area:

What are remaining challenges in this area:

Even though the Government supports and encourage setting up prevention services for KAPs', lack of capacity among NGOs hinders effective service delivery for KAPs.

III. PREVENTION

1. Does the country have a policy or strategy that promotes information, education and communication (IEC) on HIV to the *general population*?

Yes **X**	No	NA

1.1 ***IF YES***, what key messages are explicitly promoted?

 Check for key message explicitly promoted

a. Be sexually abstinent	**X**
b. Delay sexual debut	**X**
c. Be faithful	**X**
d. Reduce the number of sexual partners	**X**

e. Use condoms consistently	**X**
f. Engage in safe(r) sex	**X**
g. Avoid commercial sex	**X**
h. Abstain from injecting drugs	**X**
i. Use clean needles and syringes	-
j. Fight against violence against women	**X**
k. Greater acceptance and involvement of people living with HIV	**X**
l. Greater involvement of men in reproductive health programmes	**X**
m. Males to get circumcised under medical supervision	-
n. Know your HIV status	**X**
o. Prevent mother-to-child transmission of HIV	**X**
Other: *[write in]* -	

1.2 In the last year, did the country implement an activity or programme to promote accurate reporting on HIV by the media?

Yes **X**	No

2. Does the country have a policy or strategy promoting HIV-related reproductive and sexual health education for young people?

Yes **X**	No	NA

2.1 Is HIV education part of the curriculum in:

primary schools?	* Yes upper primary	No **X**
secondary schools?	Yes **X**	No
teacher training?	Yes **X**	No

2.2 Does the strategy/curriculum provide the same reproductive and sexual health education for young men and young women?

Yes **X**	No

2.3 Does the country have an HIV education strategy for out-of-school young people?

Yes **X**	No

3. Does the country have a policy or strategy to promote information, education and communication and other preventive health interventions *for most-at-risk or other vulnerable sub-populations?*

Yes **X**	No

IF NO, briefly explain: .1 ***IF YES***, *which populations* and *what elements of HIV prevention* do the policy/strategy address?

 Check which specific populations and elements are included in the policy/strategy

	IDU*	MSM**	Sex workers	Clients of sex workers	Prison inmates	Other populations *(write in)
Targeted information on risk reduction and HIV education	**X**	**X**	**X**	**X**	**X**	migrant workers police, resort workers , seafarers
Stigma and discrimination reduction	**X**	**X**	**X**	**X**	**X**	X
Condom promotion	**X**	**X**	**X**	**X**		X
HIV testing and counselling	**X**	**X**	**X**	**X**	**X**	X
Reproductive health, including sexually transmitted infections prevention and treatment	**X**	**X**	**X**	**X**	**X**	X,,
Vulnerability reduction (e.g. income generation)	NA	NA	-	NA	NA	-
Drug substitution therapy	X	NA	NA	NA	NA	-
Needle & syringe exchange	-	NA	NA	NA	NA	-

IDU*=injecting drug users MSM**=men who have sex with men

Overall, how would you rate *policy* efforts in support of HIV prevention in 2009?

Very poor	0	1	2	3	4	5	6	7	8	9 **X**	10	Excellent

.

Since 2009, what have been key achievements in this area:
Sensitising law enforcement officers on HIV on training programmes by UNDP
Civil society and parliamentarians have begun to have a on drug and HIV/AIDS issue
NSP and action plan to address advocacy.
BBS conducted in 2008 generated very reach information on KAPS especially youth. This information helped the civil society to design and implement more effective interventions

What are remaining challenges in this area:
Establishing rules and regulation who will allow the GOV to conduct prevention programmes especially for KAPS
Political commitment **and focus from health and other minis tries in** the formulation of a National AIDS policy to address above issues in the context of very few numbers of PLWHA and hidden nature of the HIV situation

4. Has the country identified specific needs for HIV prevention programmes?

Yes **X**	No

IF YES, how were these specific needs determined? Situation analysis of HIV/AIDS in Maldives in 2006 A rapid need assessments was done in the 2006, and this was followed by a BBS in 2008 to check the risk behaviours of the most of risk population and youth. A joint mid term review in 2009 has reviewed the implementation of the National Strategic plan which identified gaps and gave directions for Strengthening and scaling up of the implementation of NSP 2009-2011

IF NO, how are HIV prevention programmes being scaled-up?

4.1 To what extent has HIV prevention been implemented?

HIV prevention component	**The majority of people in need have access**		
Blood safety	*Agree* **X**	*Don't Agree*	*NA*
Universal precautions in health care settings	Agree **X**	Don't Agree	NA
Prevention of mother-to-child transmission of HIV	Agree **X**	Don't Agree	NA
IEC* on risk reduction	Agree **X**	Don't Agree	NA
IEC* on stigma and discrimination reduction	Agree	Don't Agree **X**	NA

Condom promotion	Agree	Don't Agree **X**	NA
HIV testing and counselling	Agree **X**	Don't Agree	NA
Harm reduction for injecting drug users	Agree	Don't Agree	NA **X**
Risk reduction for men who have sex with men	Agree	Don't Agree **X**	NA
Risk reduction for sex workers	Agree	Don't Agree **X**	NA
Reproductive health services including sexually transmitted infections prevention and treatment	Agree **X**	Don't Agree	NA
School-based HIV education for young people	Agree	Don't Agree **X**	NA
HIV prevention for out-of-school young people	Agree	Don't Agree **X**	NA
HIV prevention in the workplace	Agree	Don't Agree **X**	NA
Other: *[write in]*	Agree	Don't Agree	NA

Overall, how would you rate the efforts in the *implementation* of HIV prevention programmes in 2009?

Very poor	0	1	2	**X** 3	4	5	6	7	8	9	10	Excellent

.

Since 2009, what have been key achievements in this area:

-In 2008, the first Bio-Behavioural Survey -- (BBS) was conducted in the Maldives1. A total of 1,791 serologic samples were taken across five groups: female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU), occupational cohorts of men (OCM – including seafarers, construction workers and resort workers) and youth, across Male', Addu and Laamu atolls. The BBS highlighted alarming HIV and STI risky behaviour (sexual intercourses without protection as well as drug injecting by sharing needles and syringes) among population calling for action for prioritisation of the national response based on new evidence[1] Corpuz AC, October 2008, Biological and Behavioral Survey (BBS) and HIV/AIDS, Republic of Maldives

-Based on the BBS's findings, NSP identified the strategies for HIV prevention for some of the vulnerable population (migrant workers).

-During 2008-2009, the interventions for migrant workers consisted in distribution of IEC materials, peer education sessions, condom promotion and distribution, STI prevention, counselling and testing.

-The GFATM round 6 grant for 2009-2012 address prevention interventions for IDU, youth and other vulnerable populations (seafarers, migrants),blood safety and preventionof of HIV in health care setting (PEP, universal precautions) .Already phase one is completed

-IDUs

even before detecting the first case of IDU related HIV infection , prevention efforts started , and with a broad level of support for intervention by (GOV,NGO, Donors & UN agencies, prevention focusing IVDU scaled up however focus mainly on male IDU as women IDU are low.

-Provision of number of new interventions , including after care services and outreach (IEC) addressing safe injecting via NGOs –Journey, SWAD,SHE

political commitment

- A statement on HIV is included in the political manifesto in 2009

-education on cleaning needle/syringe for reuse

-promoting VCT for HIV through the VCT centers While Journey offers HIV testing on site , SHE /SWAD promotes IDUs to attend Journey and public VCT centers

-Second phase of Oral substitution therapy-with methadone initiated in 2011
- UN agencies supported aftercare services including psychosocial care and parental counselling services for ex - drug addicts through "Journey past 3 yrs
- Government run 1 rehabilitation center providing residential care using " therapeutic community model
- Current GFATM funded project aims at reaching 1200 IDU with peer education 2009-2011, already 77 peer educators were trained, and 1841 IDU reached with IEC as end Feb 2009
- A mapping exercise conducted in 2010 including IDU,MSM and sex workers which will facilitate planning implementation of TI for KAPS
- In prisons limited IEC activity is conducted limited, discussion ongoing to introduce a comprehensive harm reduction package with the support of police and Ministry of home affairs official
-National drug bill – to address DU/IDU as a health issue than a criminal act will pave the way for creating - enabling environment for DU interventions In 2009 , and 105 law enforcement officers and police were - trained in HIV and IDU issues
-100% screening of donated blood to ensure blood safety
- Screening of pregnant mothers with informed consent-for PMTCT

What are remaining challenges in this area:
- The 2 priority strategic areas of NSP which is not addressed through GFATM round 6 Need attention. Interventions for key populations , and building capacity NAP
- plan delivery of comprehensive prevention interventions and implement programmes for MSM , sex workers and Identify budget
- Political commitment and create and enabling environment to address MSM and sex workers
- as BBS has shown existence of large number of KAPS (very hidden and) with high HIV risk behaviours denial that it does not exist and no civil society organisations or members of high risk populations to implement TI
- Introducing comprehensive harm reduction programme for IDUs including needle exchange programs as and when needed
-Capacity build NGOs on implementation
- build NAP staff in programme management skills and technical skills for implementation
-Reporting systems of STIs (Syndromic management) , need strengthening to capture early warning of an impending HIV epidemic
-Syndromic management of STIs especially among KAPS to be strengthened as there are no special STI clinics for KAPS
- Condom promotion among risk groups as well as unmarried youth
- Increase VCT uptake by KAPS as accessibility is an issue with the distribution of KAPS in several Atolls./regions –
Gender issues and overcoming cultural /religious barriers for promoting condoms, addressing womens issues no specific programmes for women IDUs
-creating enabling environment for government and NGOs to carry out research /surveys and interventions in prisons

IV. TREATMENT, CARE AND SUPPORT

1. Does the country have a policy or strategy to promote comprehensive HIV treatment, care and support? (Comprehensive care includes, but is not limited to, treatment, HIV testing and counselling, psychosocial care, and home and community-based care).

Yes **X**	No

1.1 IF YES, does it address barriers for women?

Yes **X**	No

1.2 IF YES, does it address barriers for most-at-risk populations?

Yes **X**	No

2. Has the country identified the specific needs for HIV treatment, care and support services?

Yes	No **X**

IF YES, how were these determined?

IF NO, how are HIV treatment, care and support services being scaled-up?

.

The projections of PLWHA are below 35 next 5 years .

As Maldives is in very early stage of the HIV with low prevalence, very few are being detected . Very few need ART, since ART program was commenced in 2004, 3 have benefited. ART is provided in a single center, and no specific care and support systems planned. Scaling up is not planned at this stage, to make available at regional and Atoll levels and training of health care providers on ART provision. Government has strated poroviding free ART to froeign maigrant workers, if they are found to be HIV positive and requiring ART, while working in the Maldives.

Currently services are planned based on program records on number of PLWHA detected on screening , socio demographic data including gender, number on ART, and deaths

If the needs are the estimation of burden of PLWHA and how many adult and children need ART and for PMTCT, Co-trim prophylaxis data is available with NAP from estimations and projections

2.1 To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access		
Antiretroviral therapy	Agree **X**	Don't Agree	N/A
Nutritional care	Agree	Don't Agree **X**	N/A
Paediatric AIDS treatment	Agree	Don't Agree	N/A **X**

Sexually transmitted infection management	Agree **X**	Don't Agree	N/A
Psychosocial support for people living with HIV and their families	Agree **X**	Don't Agree	N/A
Home-based care	Agree	Don't Agree **X**	N/A
Palliative care and treatment of common HIV-related infections	Agree	Don't Agree **X**	N/A
HIV testing and counselling for TB patients	Agree	Don't Agree **X**	N/A
TB screening for HIV-infected people	Agree **X**	Don't Agree	N/A
TB preventive therapy for HIV-infected people	Agree **X**	Don't Agree	N/A
TB infection control in HIV treatment and care facilities	Agree **X**	Don't Agree	N/A
Cotrimoxazole prophylaxis in HIV-infected people	Agree **X**	Don't Agree	N/A
Post-exposure prophylaxis (e.g. occupational exposures to HIV, rape)	Agree **X**	Don't Agree	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	Agree	Don't Agree	N/A **X**
HIV care and support in the workplace (including alternative working arrangements)	Agree	Don't Agree **X**	N/A
Other: [write in]	Agree	Don't Agree	N/A

3. Does the country have a policy for developing/using generic drugs or parallel importing of drugs for HIV?

Yes **X**	No

4. Does the country have access to regional procurement and supply management mechanisms for critical commodities, such as antiretroviral therapy drugs, condoms, and substitution drugs?

Yes **X**	No

IF YES, for which commodities?: [write in]

ARV, Condoms, substitution drugs

Overall, how would you rate the efforts in the implementation of HIV treatment, care and support programmes in 2009?

Very poor	0	1	2	3	4 **X**	5	6	7	8	9	10	Excellent

Since 2009, what have been key achievements in this area:
-
What are remaining challenges in this area:

- TO optimize utilisation of the VCT centers in public (8 at present) and 2 stand alone VCT centers. (Majority of HIV tests are mandatory for pre-employment screening, ANC and blood donor screening or pre-surgical screening and PIT without proper counselling)
-To develop a standardized recording and reporting formats for PLWHA under care. At present socio demographic data , are recorded at NAP upon entry but limited clinical details to monitor adherence , drug resistance and quality of care are recorded.

- As the number of PLWHA are few , increasing ART centres to increase accessibility is not justified, at Atoll or provincial level However follow up of patients for monitoring ART drug resistance, adherence and compliance to treatment , partner screening and positive prevention of discordant couples is of concern in the future due to the wide geographical distribution of PLWHA.

5. Does the country have a policy or strategy to address the additional HIV-related needs of orphans and other vulnerable children?

Yes	No **X**	NA

5.1 IF YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

5.2 IF YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No **X**

5.3 IF YES, does the country have an estimate of orphans and vulnerable children being reached by existing interventions?

Yes	No

IF YES, what percentage of orphans and vulnerable children is being reached? % [write in]

Overall, how would you rate the efforts to meet the HIV-related needs of orphans and other vulnerable children in 2009?

Very poor	0 **X**	1	2	3	4	5	6	7	8	9	10	Excellent

Since 2009, what have been key achievements in this area: What are remaining challenges in this area:

V. MONITORING AND EVALUATION

1. Does the country have one national Monitoring and Evaluation (M&E) plan?

Yes **X**	In progress	No

IF NO, briefly describe the challenges:

1.1 IF YES, years covered: [write in] 2009-2011

1.2 IF YES, was the M&E plan endorsed by key partners in M&E?

Yes **X**	No

1.3 IF YES, was the M&E plan developed in consultation with civil society, including people living with HIV?

Yes	No **X**

1.4 IF YES, have key partners aligned and harmonized their M&E requirements (including indicators) with the national M&E plan?

Yes, all partners	Yes, most partners **X**	Yes, but only some partners	No

IF YES, but only some partners or IF NO, briefly describe what the issues are:

2. Does the national Monitoring and Evaluation plan include?

a data collection strategy		
IF YES, does it address:	Yes **X**	No
routine programme monitoring	Yes **X**	No
behavioural surveys	Yes **X**	No
HIV surveillance	Yes **X**	No
Evaluation / research studies	Yes **X**	No
a well-defined standardised set of indicators	Yes **X**	No
guidelines on tools for data collection	Yes **X**	No
a strategy for assessing data quality (i.e., validity, reliability)	Yes **X**	No
a data analysis strategy	Yes **X**	No
a data dissemination and use strategy	Yes **X**	No

3. Is there a budget for implementation of the M&E plan?

Yes	In progress	No **X**

3.1 IF YES, what percentage of the total HIV programme funding is budgeted for M& E activities? % [write in]

3.2 IF YES, has full funding been secured?

Yes	No

IF NO, briefly describe the challenges: The M&E plan is not costed, and no details for some of the planned activities .hence donor support for funds is difficult to ensure. A budget for M&E activities identified only for GFATM funded project. evaluation of national M&E plan in 2009 identified this as a weakness .

3.3 IF YES, are M&E expenditures being monitored?

Yes	No

4. Are M&E priorities determined through a national M&E system assessment?

Yes **X**	No

IF YES, briefly describe how often a national M&E assessment is conducted and what the assessment involves: An assessment of M&E system using MEST was conducted in 2009 and may be reviewed in the external review of national response prior to development of next NSP.

GF continues to monitor the M&E activities.

IF NO, briefly describe how priorities for M&E are determined:

5. Is there a functional national M&E Unit?

Yes	In progress	No X

IF NO, what are the main obstacles to establishing a functional M&E Unit? Human resources, lack of skilled staff in M&E Funds

5.1 IF YES, is the national M&E Unit based

in the National AIDS Commission (or equivalent)?	Yes	No **X**
in the Ministry of Health? (National AIDS Programme)	Yes **X**	No
Elsewhere? [write in]	Yes	No **X**

.2 IF YES, how many and what type of professional staff are working in the national M&E Unit?

Number of permanent staff:		
Position: [write in]	Full time/part time?	Since when ?
Position: [write in]	Full time/part time?	Since when ?
[Add as many as needed]		
Number of temporary staff:		
Position: [write in]	Full time/part time?	Since when ?
Position: [write in]	Full time/part time?	Since when ?
[Add as many as needed]		

5.3 IF YES, are there mechanisms in place to ensure that all major implementing partners submit their M&E data/reports to the M&E Unit for inclusion in the national M&E system?

Yes **X**	No

IF YES, briefly describe the data-sharing mechanisms:
NAP receive data from programme activities , UN theme group, and from PR UNDP .This is sent to Health information unit (CCHDC) which is the central unit which forward to the NAC .

What are the major challenges?

- Data analysis and sharing at peripheral level
- Inconsistency of data by NAP surveillance (collected monthly) and GF quarterly from same source
- Logistics /Terrain hamper timely data flow and monitoring and supervising of the data collection and quality assurance
- Lack of interest in reporting due to lack of skills of staff at periphery

6. Is there a national M&E Committee or Working Group that meets regularly to coordinate M&E activities?

No **X**	Yes, but meets irregularly	Yes, meets regularly

6.1 Does it include representation from civil society?

Yes	No

IF YES, briefly describe who the representatives from civil society are and what their role is:

7. Is there a central national database with HIV- related data?

Yes **X**	No

7.1 IF YES, briefly describe the national database and who manages it [write in]
NAP is responsible for ensuring collection,compilation, analysis and dissemination of HI/STI data regular basis ensuring quality , relevant and accurate.This will be fed in to the computerised national Health information system in the MOHF(CCHDC) .

7.2 IF YES, does it include information about the content, target populations and geographical coverage of HIV services, as well as their implementing organizations?

a. Yes, all of the above X
b. Yes, but only some of the above: [write in] c. No, none of the above

7.3 Is there a functional* Health Information System?

At national level	Yes **X**	No
At subnational level IF yes , at what level(s) Atoll All health units	Yes **X**	No

(*regularly reporting data from health facilities which are aggregated at district level and sent to national level; and data are analysed and used at different levels)

8. Does the country publish at least once a year an M&E report on HIV and on, including HIV surveillance data?

Yes	No **X**

9. To what extent are M&E data used
9.1 in developing / revising the national AIDS strategy?

Low	0	1 **X**	2	3	4	5	High

Provide a specific example: • The 2006 situation analysis data was used to revise the 2002-2006 strategy and a new NSP 2009-2011 developed more focus on KAPS

- BBS in 2008 and Joint review of national response in 2009 , helped the donors and NAP to focus on gaps –Interventions for KAPS SW/MSM, capacity building of NGOs for implementation & NAP skills to plan and administer the National response including M&E m need for revising the NSP 2009-2011

What are the main challenges, if any?
Convince policy makers and political and community /religious leaders of evidence /strategic implications and overcoming denial , and lack of interest

9.2 for resource allocation?:

Low	0	1	2	3 **X**	4	5	High

Provide a specific example:
The size of the population and the risks of HIV transmission was taken into prioritisation and allocating resources esp. for KAPS interventions such as human resource needs , capacity building, procurement of commodities (condoms, ART, OST)and tests etc

What are the main challenges, if any?

9.3 For programme improvement?:

Low	0	1	2	3 **X**	4	5	High

Provide a specific example:
The evidence from BBS - increasing risk behaviours (reusing needles & sharing among IV drug users) and low reach with HIV prevention programmes for IDU, led to re-plan increase coverage with BCC and opening more service delivery points.

What are the main challenges, if any?
Lack of human resource/NGOs working with KAPS/enabling environment

10. Is there a plan for increasing human capacity in M&E at national, sub national and service-delivery levels?:
a. Yes, at all levels
b. Yes, but only addressing some levels: [write in]
c. No **X**

10.1 In the last year, was training in M&E conducted

At national level?	Yes	No
IF YES, Number trained: [write in]		
At subnational level?	Yes	No
IF YES, Number trained: [write in]		
At service delivery level including civil society?	Yes	No
IF YES, Number trained: [write in]		

10.2 Were other M&E capacity-building activities conducted other than training?

Yes	No **X**

IF YES, describe what types of activities: [write in]
Overall, how would you rate the M&E efforts of the HIV programme in 2009?

Very poor	0	1 **X**	2	3	4	5	6	7	8	9	10	Excellent

Since 2009, what have been key achievements in this area:
Review of National M&E system in ……
Development of National M&E plan in 200…

National Commitments and Policy Instrument (NCPI)

Part B

I. CIVIL SOCIETY[41] INVOLVEMENT

1. To what extent (on a scale of 0 to 5 where 0 is " Low" and 5 is " High") has civil society contributed to strengthening the political commitment of top leaders and national strategy/policy formulations?

LOW					HIGH
0	1	2	**3**	4	5

Comments and examples:

Representatives from NGOs and UN agencies participated and were involved in the formulation of the National Strategic Plan and Drug Bill. This was done through consultations .

2. To what extent (on a scale of 0 to 5 where 0 is " Low" and 5 is " High") have civil society representatives been involved in the planning and budgeting process for the National Strategic Plan on HIV or for the most current activity plan (e.g. attending planning meetings and reviewing drafts)?

LOW					HIGH
0	1	2	3	**4**	5

Comments and examples:

Representatives from all NGOs who were doing work in the areas of AIDS or drugs were involved in the planning and developing of the National Strategic Plan. These consutations involved youth groups, migrants and other vulnerable groups and were held in 4 regions of the country. Civil society representatives were also involved in the research process prior to the planning of the NSP. They were also completely involved in the social mapping process.
As the NSP is still in the preliminary stages of planning they have not been involved in the budgeting process. However, they will be consulted on the budget for HIV programmes, as most of the NGOs involved in AIDS are GF implementing bodies.

41 Civil society includes among others: networks and organisations of people living with HIV, women, young people, key affected groups (including men who have sex with men, transgendered people, sex workers, people who inject drugs, migrants, refugees/displaced populations, prisoners); faith-based organizations; AIDS service organizations; community-based organizations; ; workers organizations, human rights organizations; etc. Note: The private sector is considered separately.

3. To what extent (on a scale of 0 to 5 where 0 is " Low" and 5 is " High") are the services provided by civil society in areas of HIV prevention, treatment, care and support included in:

a. The national HIV strategy?

LOW					HIGH
0	1	2	3	**4**	5

b. The national HIV budget?

LOW					HIGH
0	1	2	3	**4**	5

c. The national HIV reports?

LOW					HIGH
0	1	2	3	**4**	5

Comments and examples:
Currently the civil society is highly involved in the process of finalising components of the National Strategic Plan.

4. To what extent (on a scale of 0 to 5 where 0 is " Low" and 5 is " High") is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a. Developing the national M&E plan?

LOW					HIGH
0	1	2	3	**4**	5

b. Participating in the national M&E committee / working group responsible for coordination of M&E activities?

LOW					HIGH
0	1	2	3	**4**	5

c. Participate in using data for decision-making?

LOW					HIGH
0	1	2	**3**	4	5

Comments and examples:
UNDP throught GF financing has been helping to strengthen the M&E system. As UN agencies have contributed heavily towards enhancing the capacity of civil society members, especially those NGOs working with AIDS, these NGOs have been involved highly in the monitoring process. There has been wide consultations with NGOs in setting the directions for the National Strategic Plan.

5. To what extent (on a scale of 0 to 5 where 0 is " Low" and 5 is " High") is the civil society sector representation in HIV efforts inclusive of diverse organizations (e.g. organisations and networks of people living with HIV, of sex workers, and faith-based organizations)?

LOW					HIGH
0	1	**2**	3	4	5

Comments and examples:
Cultural and religious issues around HIV and Key populations prevent NGOs from working with vulnerable populations such as MSM and sex workers. Hence, there are no PLWA, female sex worker or MSM NGOs.

6. To what extent (on a scale of 0 to 5 where 0 is " Low" and 5 is " High") is civil society able to access:

a. Adequate financial support to implement its HIV activities?

LOW					HIGH
0	**1**	2	3	4	5

b. Adequate technical support to implement its HIV activities?

LOW					HIGH
0	1	**2**	3	4	5

Comments and examples:
There are no funds provided by the Govt to support civil society programs in this area. They are mostly reluctant to associate with such NGOs even when the Govt has no capacity to implement some of the programs that civil society could. There is no system of support and the little support that is available comes from personal contacts. Most support comes from other donor agencies rather than the govt.

7. What percentage of the following HIV programmes/services is estimated to be provided by civil society?

Prevention for key-populations				
People living with HIV	**<25%**	25-50%	51-75%	
Men who have sex with men	**<25%**	25-50%	51-75%	
People who inject drugs	<25%	25-50%	**51-75%**	
Sex workers	**<25%**	25-50%	51-75%	
Transgendered people	**<25%**	25-50%	51-75%	
Testing and Counselling	<25%	25-50%	**51-75%**	
Reduction of Stigma and Discrimination	**<25%**	25-50%	51-75%	
Clinical services (ART/OI)*	**<25%**	25-50%	51-75%	
Home-based care	# <25%	25-50%	51-75%	
Programmes for OVC**	# <25%	25-50%	51-75%	

*ART = Antiretroviral Therapy; OI=Opportunistic infections
**OVC = Orphans and other vulnerable children

home based care and OVC are not applicable

8. Overall, on a scale of 0 to 10 (where 0 is " Very Poor" and 10 is " Excellent"), how would you rate the efforts to increase civil society participation in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	**8**	9	10

Since 2009, what have been key achievements in this area:
• A more comprehensive program run by NGOs for drug users, working closely with the Department for Drug Prevention and Rehabilitation Services in the treatment of drug users. • referalls done by the NGOs •NGOs contribution to reporting is major and it is more formalized and standardized •consultations on NSP
What challenges remain in this area:
• Lack of NGOs working with MSM and sex workers, due to stigma attached to these • Lack of laws and rules to stop discrimination against vulnerable populations

II. POLITICAL SUPPORT AND LEADERSHIP

1. Has the Government, through political and financial support, involved people living with HIV, key populations and/or other vulnerable sub-populations in governmental HIV-policy design and programme implementation?

Yes	No

IF YES, describe some examples of when and how this has happened:
Members from these groups have been involved in the consultation and mapping processes. They were also involved in the community group consultations.

III. HUMAN RIGHTS

1.1 Does the country have non-discrimination laws or regulations which specify protections for specific key populations and other vulnerable subpopulations? Circle yes if the policy specifies any of the following key populations:

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	Yes	**No**
Men who have sex with men	Yes	**No**
Migrants/mobile populations	Yes	**No**
Orphans and other vulnerable children ***Not applicable***	Yes	No
People with disabilities	**Yes**	No
People who inject drugs	Yes	**No**
Prison inmates	Yes	**No**
Sex workers	Yes	**No**
Transgendered people	Yes	**No**
Women and girls	**Yes**	No
Young women/young men	Yes	**No**
Other specific vulnerable subpopulations [write in]:	Yes	**No**

1.2. Does the country have a general (i.e., not specific to HIV-related discrimination) law on non-discrimination?

Yes	**No**

IF YES to Question 1.1 or 1.2, briefly describe the contents of these laws:
Briefly explain what mechanisms are in place to ensure that these laws are implemented:
Briefly comment on the degree to which they are currently implemented:

2. Does the country have laws, regulations or policies that present obstacles[42] to effective HIV prevention, treatment, care and support for key populations and other vulnerable subpopulations?

Yes	No

42 These are not necessarily HIV-specific policies or laws. They include policies, laws, or regulations which may deter people from or make it difficult for them to access prevention, treatment, care and support services. Examples cited in country reports in the past have include: " laws that criminalize same sex relationships" , " laws that criminalize possession of condoms or drug paraphernalia" ; " loitering laws" ; " laws that preclude importation of generic medicines" ; " policies that preclude distribution or possession of condoms in prisons" ; " policies that preclude non-citizens from accessing ART" ; " criminalization of HIV transmission and exposure" , " inheritance laws/rights for women" , " laws that prohibit provision of sexual and reproductive health information and services to young people" , etc

2.1. IF YES, for which sub-populations?

KEY POPULATIONS and VULNERABLE SUBPOPULATIONS		
People living with HIV	**Yes**	No
Men who have sex with men	**Yes**	No
Migrants/mobile populations	**Yes**	No
Orphans and other vulnerable children *Not applicable*	Yes	No
People with disabilities	Yes	**No**
People who inject drugs	**Yes**	No
Prison inmates	Yes	No
Sex workers	**Yes**	No
Transgendered people	**Yes**	No
Women and girls	Yes	**No**
Young women/young men	Yes	**No**
Other specific vulnerable populations[43][write in]:	Yes	No

Briefly describe the content of these laws, regulations or policies:
The Maldivian constitution is based on the Islamic Shariah and hence all prohibitions pertaining to Islam are applicable.The constitution also states that all Maldivians should be Muslims. Possession and trafficking of drugs is illegal. MSM is illegal in the Maldives. "Sexual activity with a member of the same sex is punishable by law: 19-39 lashes and banishment or imprisonment for 1-3 years. Migrants – persons afflicted with a dangerous contagious disease may not have permit to enter the Maldives. Although there are no laws preventing effective HIV
prevetion and treatment the fact that it is a 100% Muslim country creates barriers. Briefly comment on how they pose barriers: Because of the religion and prohibitions associated with it, it is extremely difficult to work in the open with groups like sex workers and MSMs. Mostly these groups are unacknowledged and those who provide support for these are stigmatised.

3. Does the country have a policy, law or regulation to reduce violence against women, including for example, victims of sexual assault or women living with HIV?·

Yes	**No**

43 Other specific vulnerable populations other than above, may be defined as having been locally identified as being at higher risk of HIV infection (e.g. (in alphabetical order) bisexual people, clients of sex workers, indigenous people , internally displaced people, prisoners, and refugees)

Briefly describe the content of the policy, law or regulation and the populations included.

4. Is the promotion and protection of human rights explicitly mentioned in any HIV policy or strategy?

Yes	No

IF YES, briefly describe how human rights are mentioned in this HIV policy or strategy:
Policy on AIDS does talk about not publicizing those testing positive and also outlines guidelines on how medical personnel should not discriminate against HIV?AIDS patients.

5. Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, key populations and other vulnerable populations?

Yes	**No**

IF YES, briefly describe this mechanism:

6. Does the country have a policy or strategy of free services for the following? Indicate if these services are provided free-of-charge to all people, to some people or not at all (circle " yes" or " no" as applicable).

	Provided free-of-charge to all people in the country		Provided free-of-charge to some people in the country		Provided, but only at a cost	
Antiretroviral treatment	**Yes**	No	Yes	No	Yes	No
HIV prevention services[44]	**Yes**	No	Yes	No	Yes	No
HIV-related care and support interventions	**Yes**	No	Yes	No	Yes	No

If applicable, which populations have been identified as priority, and for which services?

7. Does the country have a policy or strategy to ensure equal access for women and men to HIV prevention, treatment, care and support?

Yes	**No**

7.1. In particular, does the country have a policy or strategy to ensure access to HIV prevention, treatment, care and support for women outside the context of pregnancy and childbirth?

Yes	**No**

8. Does the country have a policy or strategy to ensure equal access for key populations and/or other vulnerable sub-populations to HIV prevention, treatment, care and support?

Yes	No

IF YES, Briefly describe the content of this policy/strategy and the populations included:
The National Strategic Plan identifies the need for services related to HIV/AIDS and vulnerable populations. VCT services are provided. These services are made available to IDUs through an NGO catering to the needs of active as well as recovering addicts.

44 Such as blood safety, condom promotion, harm reduction for people who inject drugs, HIV prevention for out-of-school young people, HIV prevention in the workplace, HIV testing and counseling, IEC on risk reduction, IEC on stigma and discrimination reduction, prevention of motherto-child transmission of HIV, prevention for people living with HIV, reproductive health services including sexually transmitted infections prevention and treatment, risk reduction for intimate partners of key populations, risk reduction for men who have sex with men, risk reduction for sex workers, school-based HIV education for

young people, universal precautions in health care settings.

APPENDIX

8.1. IF YES, does this policy/strategy include different types of approaches to ensure equal access for different key populations and/or other vulnerable sub-populations?

Yes	No

IF YES, briefly explain the different types of approaches to ensure equal access for different populations:
No inputs

9. Does the country have a policy or law prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?

Yes	No

IF YE,S briefly describe the content of the policy or law:

10. Does the country have the following human rights monitoring and enforcement mechanisms?

a. Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watchdogs, and ombudspersons which consider HIV-related issues within their work

Yes	No

b. Performance indicators or benchmarks for compliance with human rights standards in the context of HIV efforts

Yes	No

IF YES on any of the above questions, describe some examples:

11. In the last 2 years, have there been the following training and/or capacity-building activities:

a. Programmes to educate, raise awareness among people living with HIV and key populations concerning their rights (in the context of HIV)[45]?

Yes	No

b. Programmes for members of the judiciary and law enforcement[46] on HIV and human rights issues that may come up in the context of their work?

Yes	No

12. Are the following legal support services available in the country?

a. Legal aid systems for HIV casework

Yes	No

b. Private sector law firms or university-based centres to provide free or reduced-cost legal services to people living with HIV

Yes	No

13. Are there programmes in place to reduce HIV-related stigma and discrimination?

Yes	No

IF YES, what types of programmes?		
Programmes for health care workers	Yes	No
Programmes for the media	Yes	No
Programmes in the work place	Yes	No
Other [write in]:	Yes	No

14. Overall, on a scale of 0 to 10 (where 0 is " Very Poor" and 10 is " Excellent"), how would you rate the policies, laws and regulations in place to promote and protect human rights in relation to HIV in 2011?

Very Poor										Excellent
0	1	2	3	4	5	6	7	8	9	10

45 Including, for example, Know-your-rights campaigns - campaigns that empower those affected by HIV to know their rights and the laws in context of the epidemic (see UNAIDS Guidance Note: Addressing HIV-related law at National Level, Working Paper, 30 April 2008)

46 Including, for example, judges, magistrates, prosecutors, police, human rights commissioners and employment tribunal/ labour court judges or commissioners

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

15. Overall, on a scale of 0 to 10 (where 0 is " Very Poor" and 10 is " Excellent"), how would you rate the effort to implement human rights related policies, laws and regulations in 2011?

Very Poor										Excellent
0	1	2	**3**	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

IV. PREVENTION

1. Has the country identified the specific needs for HIV prevention programmes?

Yes	No

IF YES, how were these specific needs determined?
A recent social mapping was done which showed high risk behaviours in key populations. Although the prevalence of the disease is quite low in the nation, the populations at risk are quite high. After the initial BBS was done in 2008 which identified the risk behaviours of youth and MARPs, the NSP has been formulated to address these gaps. The formulation of the NSP was done with wide consultations with the civil society, especially those working with drug users and youth.
IF NO, how are HIV prevention programmes being scaled-up?

1.1 To what extent has HIV prevention been implemented?

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Blood safety	1	2	3	**4**	N/A
Condom promotion	**1**	2	3	4	N/A
Harm reduction for people who inject drugs	1	2	**3**	4	N/A
HIV prevention for out-of-school young people	**1**	2	3	4	N/A
HIV prevention in the workplace	1	2	**3**	4	N/A
HIV testing and counseling	1	2	**3**	4	N/A
IEC[47] on risk reduction	1	2	**3**	4	N/A
IEC on stigma and discrimination reduction	**1**	2	3	4	N/A
Prevention of mother-to-child transmission of HIV	1	2	3	4	**N/A**

47 IEC = information, education, communication

HIV prevention component	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Prevention for people living with HIV	1	2	3	**4**	N/A
Reproductive health services including sexually transmitted infections prevention and treatment	1	**2**	3	4	N/A
Risk reduction for intimate partners of key populations	**1**	2	3	4	N/A
Risk reduction for men who have sex with men	**1**	2	3	4	N/A
Risk reduction for sex workers	**1**	2	3	4	N/A
School-based HIV education for young people	1	**2**	3	4	N/A
Universal precautions in health care settings	1	2	**3**	4	N/A
Other[write in]:	1	2	3	4	N/A

2. Overall, on a scale of 0 to 10 (where 0 is " Very Poor" and 10 is " Excellent"), how would you rate the efforts in the implementation of HIV prevention programmes in 2011?

Very Poor										Excellent
0	1	**2**	3	4	5	6	7	8	9	10

Since 2009, what have been key achievements in this area:
What challenges remain in this area:

V. TREATMENT, CARE AND SUPPORT

1. Has the country identified the essential elements of a comprehensive package of HIV treatment, care and support services?

Yes	No

IF YES, Briefly identify the elements and what has been prioritized:
Briefly identify how HIV treatment, care and support services are being scaled-up?

1.1. To what extent have the following HIV treatment, care and support services been implemented?

HIV treatment, care and support service	The majority of people in need have access to…				
	Strongly disagree	Disagree	Agree	Strongly agree	N/A
Antiretroviral therapy	1	2	3	**4**	N/A
ART for TB patients	1	2	3	4	N/A
Cotrimoxazole prophylaxis in people living with HIV	1	2	3	4	N/A
Early infant diagnosis	1	2	3	4	**N/A**
HIV care and support in the workplace (including alternative working arrangements)	**1**	2	3	4	N/A
HIV testing and counselling for people with TB	**1**	2	3	4	N/A
HIV treatment services in the workplace or treatment referral systems through the workplace	**1**	2	3	4	N/A
Nutritional care	**1**	2	3	4	N/A
Paediatric AIDS treatment	1	2	3	4	**N/A**
Post-delivery ART provision to women	1	2	3	4	**N/A**