UNGASS COUNTRY PROGRESS REPORT

Maldives

January 2008 – December 2009

NATIONAL AIDS PROGRAMME
Centre for Commnity Health and Disease Control
Ministry of Health and Family

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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
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. UNGASS report writing process

The Maldives commenced UNGASS report preparation at a very late stage. Since Maldives has very little or no experience in UNGASS reporting, request for technical assistance was sent to UNAIDS, and UNAIDS supported by providing two external consultants to facilitate data collection and drafting of the narrative report. A working group was formed with representative of government (health and other sectors), civil society including NGOs / CBOs and UN agencies to prepare the report.

NCPI part A was completed by NAP, at the briefing session focal points for completing part A (NAP) and B (UN & civil society) of NCPI was identified. The drafts were shared with the working group and the consultants and updated with the comments received. A stakeholder meeting was held to present the report for consensus prior to submission.

The time constraint was a major challenge for preparation of Maldives UNGASS Report. Furthermore, there was some miscommunication at the start of the process which was clarified after attending the Writer's Workshop in Nepal Kathmandu.

Due to the limited capacity within the country to prepare such a report, with assistance from UNAIDS, one data review consultant visited during March 2010, to facilitate data collection. Support for writing the report was obtained through a consultant who provided support via online communications. However, this approach presented with lots of limitations as the best approach would have been for the consultant to visit the country and lead the discussions that led the formulation of the report. This was a good learning experience and it is anticipated that for the next UNGASS report the country would have been more prepared and have a more organized roadmap planned with adequate time frame.

B. Status of the epidemic

The total estimated number of people living with HIV in the Maldives has remained at less than 100 since 2001, when HIV screening was initiated. As of 2007, 14 cases had been reported to be living with HIV to date and 10 have died. Probable mode of transmission is through unsafe sexual intercourse. So far, there was neither case through blood and blood products nor maternal to child transmission (MTCT). Neither is there through IVDU.

Cumulative 257 HIV infected expatriates were detected up to December 2009 who had to leave Maldives as they were not granted work permits.

The first Biological and Behavioral Survey on HIV and AIDS (BBS), carried out in 2008 among vulnerable populations surveyed (FSWs, MSM, IDUs, sea farers, resort workers,

construction workers and youth) found HIV among male resort workers, at 0.2%.[1] Estimated HIV prevalence has remained below 0.1% in adults aged 14-49 as well as in young women and men aged 15-24.[2]

However, vulnerability factors to HIV are present namely: existence of high drug use and intravenous drug use becoming common, high sexual activity with partners and low condom use in these relations, young marriages and high divorce rate, large migrant expatriate population and internal migration and a young population. Currently, HIV prevention interventions are directed to drug and injecting drug users, migrants, and youth among the general population. There are no interventions for sex workers (SW) and men who have sex with men (MSM)[3] although the HIV situation analysis in 2006 and the BBS highlighted their existence and high behavioral risks.

C. Policy and programmatic response

The Maldives National AIDS Programme (NAP) is government-led and is strongly supported by United Nations agencies. The National Strategic Plan on HIV in the Maldives 2007-2011 (NSP) provides programme direction and aims to limit HIV transmission, provide care for infected people, and mitigate the impact of the epidemic through seven strategic directions:[4]

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 National AIDS Committee (NAC), formed in 1987 provides oversight to the NAP. It has successfully advocated for HIV related issues.

The GFATM is the only financing mechanism in the country, and the main funder of the NAP. UNDP has a support role as principal recipient of the Round 6 grant. UNDP is the Principal Recipient (PR) and the NAP is one of three sub-recipients (SR). The funding corresponds to five of the seven strategic priorities of the NSP.

[1] Maldives Country Profile. www.aidsdatahub.org
[2] Ibid
[3] GFATM progress reports
[4] MOH 2006, National Strategic Plan on HIV/AIDS, Republic of Maldives, 2007-2011

D. UNGASS indicator data in an overview table (Indicators reported)

Indicator	Numerator/ 2010 2008 2009	Denominator	Remarks
3 Percentage of donated blood units screened for HIV in a quality assured manner	Blood units QA 9181 11709 SOP 0 NA Global blood review report	N units screened 9181 11709	All under QA No SOP for 2009 Data could not be disaggregated by sites (Number of blood units screened by sites.) Thus some sites that have SOP could not be included. SOP data is not available for 2009. The 2008 UA indicator was reported as 100% not taking in to consideration of SOP
4 Percentage of adults and children with advanced HIV infection receiving antiretroviral therapy*	No. on ART by 31st of December 2008 /2009 Total No <15 15+ <15 15+ 0 2 0 1 Male -3 Female -0	Estimated no of adults with advance HIV infection Estimates –spectrum **2008 – 36** **2009 - 35**	2008 data extracted from WHO health sector response report The government provides free ART to all those in need. Only 3 PLWHA Were on ART , no new cases commenced in 2009, no one defaulted or died
8 Percentage of most-at-risk populations that have received an HIV test in the last 12 months and who know the results	SW N had a test all <25 25+ 14 9 5	Number surveyed all <25 25+ 102 42 60 41 61	Extracted from the BSS report No missing data given in the BSS report
	MSM N had a test all <25 25+ 12 5 7	Number surveyed all <25 25+ 126 51 75	As above
	IDU N had a test all M F <25 25+ 47 41 6 16 31	Number surveyed all M F <25 25+ 276 267 9 108 168	As above

Indicator	Numerator/ 2010 2008 2009	Denominator	Remarks
21 Percentage of injecting drug users who reported using sterile injecting equipment the last time they injected	Number reporting the use to sterile needle and syringe: all M F <25 25+ 93 91 2 16 18	Number of injecting drug users who report injecting drugs in the last month all M F <25 25+ 130 123 7 62 68	
23 Percentage of most-at-risk populations who are HIV infected	Number infected FSW 0 MSM 0 IDU 0	Number tested 102 126 276	Among 484 Resort workers HIV prevalence o.2%
24 Percentage of adults and children with HIV known to be on treatment 12 months after initiation of antiretroviral therapy	2008 cohort still alive and on ART at 12months >15 alive & on ART - 0 <15 alive and on art- 2 Male 2 Female 0 (0 deaths) 2009 cohort after 12 months >15 - 0 <15 – 1 Male - 1 Female 0 0 death	Number adults children initiated ART 12 months prior to the beginning of the reporting period (including those who have died , stopped ART and lost to follow up 2 1	Interpret with caution as Numbers are low

II. Overview of the AIDS epidemic

The result of BBS 2008 confirms that there is a potential route for HIV transmission in the country. A sizeable number of risk groups (FSW, Male clients of FSW, MSM, IDU and youth) were found in Male', Addu and Laamu. HIV infection was found among the male clients (who are resort workers) of FSW. Although HIV prevalence is still below 1%, sexually transmitted infections (STIs), particularly, syphilis, an ulcerative STI was detected among the resort workers with a prevalence of 1.2%. Likewise, Hepatitis B was also detected among the resort workers, MSM, sea farers, construction workers and IDU. One of the ominous signs of the spread of HIV in Asia is the existence of injecting drug use coupled with commercial sex. This first BBS detected Hepatitis C circulating among the IDU in Male' and Addu, and that, commercial sex among this group is prevalent. It must be noted that Hepatits C implies a widespread needle and syringe sharing and this is the most efficient way of transmitting the virus.[5]

[5] Corpuz AC, October 2008, Biological and Behavioral Survey (BBS) and HIV/AIDS, Republic of Maldives

The survey found high rates of STI and Hepatitis, as summarized in Table 1.

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

An alarming set of risk behaviours and interface among the most at risk populations were also uncovered by the BBS. This scenario is seen among the MSM, IDU, clients of FSW and the youth and these potential channels for HIV transmission are accelerated by the non-condom use in multiple sexual partnerships and widespread sharing of unsterile needles and syringes.

Maldives is also showing other warning signals which need to be closely monitored by the national program: injecting drug use in prisons and rehabilitation centers and the risk behaviors found among the 18-24 year age group (selling of sex, buying of sex, MSM partnership, injecting drug use, multiple partnerships through group sex, sex with non-regular partners).

Other information gathered by the BBS pointing to the HIV vulnerability of the country are: low self-perception of risk; pervasive belief that the practice of Muslim religion and the non-existence of HIV in the country will protect one from HIV; poor health-seeking behavior with a number self-medicating or doing nothing for STI signs and symptoms despite availability of health facilities that can address the problem.

Likewise, VCT (Voluntary Counseling and Testing) is also unpopular. Although awareness on HIV transmission is quite high, it is clearly seen that condom use is low and sharing of injecting needles and syringes are also prevalent.[6]

The 2009 Joint Mid-Term Review of the National Response to HIV in the Maldives (JTMR) concludes that data gathered to date show an epidemic characterized by low overall prevalence but with high vulnerability and risk, i.e. high epidemic potential. The most likely trigger for an HIV epidemic in the Maldives is injecting drug use, because of:

- The 'efficiency' of sharing contaminated needles as an HIV transmission route compared to sexual transmission
- The relatively large number of Maldivians using drugs
- The apparently increasing share of drug users shifting towards injecting rather than smoking (according to key informants)
- The high prevalence of needle sharing (according to the BBS and key informants)

[6] Ibid

- The history of HIV epidemics in other Asian countries which confirms that often these epidemics started with injecting drug use as the main driver.

III. National response to the AIDS epidemic

The National AIDS Programme, under the Center for Community Health and Disease Control – Ministry of Health and Family (CCHDC/MoHF), is in charge of the overall coordination of the national response to HIV. It is governed by the NAC, which was formed in 1987 and chaired by the Minister of Health and Family. It has established good relationships with other parts of the MOHF, with other government partners like the Ministry of Education (MOE), Ministry of Islamic Affairs (MOIA), Maldives Police Services, Maldives National Defense Force (MNDF) and with civil society organizations (CSO). Maldives has recently costed work plan for 2010-2011 of the National Strategic Plan 2007-2011 that harnesses the power of a multi-sectoral participatory approach, although it was learned that there is very limited non-government organizations (NGOs) existing in the country.
The Maldives Global Fund Proposal for Round 6 was successful. UNDP is the Principal Recipient (PR) and the NAP is one of three sub-recipients (SR). 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 migrant, 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.

A. Prevention

<u>Blood safety</u>
Blood safety is a priority given the high incidence of Thallasmia which requires frequent blood transfusions (number of patients transfused during year 2008 had been 5,755 and majority was thallasemic). 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 participate in external quality assurance scheme. However standard operating procedures or local written instructions for transfusion of blood to patients are not adhered to by many labs.

HIV testing

Majority of the HIV tests were mandatory testing for pre-surgery, medical, work permit and screening blood donors. Of the total 29,936 HIV tests carried out in year 2008, only 21 were through VCT 21/29,936 (0.07%). While 27,753 tests were done and 374 (1.35%) came through VCTs in 2009. However this should be interpreted with caution as to whether there is increased VCT uptake or error in recording the categories. Pre employment HIV screening 49% (14704/29936) in 2008 and 34% (9562/27753) were the largest category for HIV tests. Provider initiated testing is carried out for the purpose of diagnosis of symptomatic HIV infection. A Large category of testing was reported as other (1,368 in 2008 and and 2,024 in the 2009)

Mothers under ante-natal care (ANC) are screened for HIV with informed consent, signing a declaration form and could opt out. For 2008, 4313 samples were tested and 3911 in 2009. Blood screened for PMTCT accounts for 14% (4313/29936 in 2008) and (3911/27753 in 2009) in both years.

Prevention Intervention for MARPs

A thorough review of the National Response was very timely for the preparation of this 2010 UNGASS Country Progress Report. Below are excerpts from the JMTR report which describe the interventions happening or not happening in the Maldives.

Injecting Drug Users

Since 2007 the Maldives have managed to provide a number of interventions to prevent HIV for IDUs including aftercare services and outreach (IEC) via NGOs (Journey, SWAD, SHE), a pilot project for oral substitution therapy (OST) with methadone and a new detoxification center. UNICEF has, for the past three years, supported the NGO Journey to run an aftercare service for ex-drug addicts. There are also two centers for rehabilitation run by the Government in Male' and Addu that provide residential care using the 'therapeutic community model'. Several activities related to injecting drug users are currently funded via the GFATM mechanism, which annually aims to reach 1,200 injecting drug users (including injecting drug users) with peer education; 77 peer educators had been trained as of March 2009, with 1,841 drug users (including IDU) being reached with IEC as of the end of February 2009.[7] Most of the focus of work on injecting drug use is on male drug users; no specific approaches for female drug users or for the female partners of male drug users have yet been developed.

Men who have sex with Men

The JMTR team found little evidence of HIV prevention interventions among men having sex with men (one NGO has done some informal work in Male, without having funding for this). In the Maldives, homosexuality is illegal and a strong social taboo and stigma is associated with it. Despite this, 126 MSM were enrolled in the recent BBS; low condom use and a high prevalence of Hepatitis were found among them. No civil society organization exists which deals directly with the issue of HIV prevention among MSM, nor is there any organization that can (or aims to) represent MSM due to widespread stigma.[8] The Maldivian

[7] 2009 Joint Mid-Term Review of the National Response to HIV in the Maldives
[8] Ibid

situation calls for a socio-culturally appropriate approach where male to male sex is seen as a risk behavior to be addressed in the wider context of male sexual health.
The JMTR recommends that an intervention for MSM be integrated into a wider approach focusing on improving the sexual health for vulnerable men in the strategic action plan for 2010-11.[9] Similar to sex work and injecting drug use, agreement should be reached among stakeholders about a comprehensive and standardized package of interventions for high-risk men. These efforts would be greatly helped if an understanding with relevant authorities about the provision of condoms (and lubricants) to men (including unmarried men) can be reached.[10]

Prison inmates

In prisons all individuals vulnerable to HIV/STI/Hepatitis come together in an environment with often very risky practices, where the potential for spread of disease to uninfected inmates is very real. Approximately 80% of inmates at any given time are drug users and many of these are injecting drug users. Except for limited provision of information materials and 'lectures', until today no comprehensive interventions to reduce the risk of infection with HIV/STI/Hepatitis (or other diseases) have been implemented in prisons; condoms (and lubricants) are not available.[11]

Youth, migrants and other groups

The JMTR team found that most of the HIV prevention activities currently implemented in the Maldives aim at awareness rising within the general population, including Maldivian workers in the tourism industry and, to some extent, migrant workers. The financing from the GFATM/R6 has enabled NAP to conduct some activities with you, carry out awareness campaigns at targeted workplaces such as resorts, and start a safe practice project for health care workers. Tens of thousands of resort and other workers are starting to be reached with outreach via the GFATM grant. The JMTR team could not establish the exact content of these awareness raising programs, however often these programs do not mention those sexual behaviors that are most likely to expose people to HIV. According to key informants, drug use and drug injection are mentioned, but not in a comprehensive manner.

The Youth Health Café (YHC) is a programme run by Ministry of Human Resources, Youth and Sport (MOHRYS) and is supported technically by UNFPA. YHC's aim is to create awareness and provide services for adolescents and youth on sexual and reproductive health. Life skills education, thematic sessions, peer education and other activities are conducted to deliver information to its target group through various social fairs and open days. YHC refers young people to counseling and health services when there is a need. It reaches several hundred young people per year; many are repeaters. As part of the thematic sessions, 9 half day seminars are organized specifically on HIV per year, with 20-50 persons attending – mostly out-of-school and unemployed youth. The Café does not hand out condoms directly. Its hotline gets several phone calls per day; for a while there was a radio phone-in show about the hotline, after which the number of calls would spike. Referrals to maternity clinics take place for (un)married pregnant youth; according to key informants, young males with questions about homosexuality have been referred to religious counselors, with unknown results. YHC is exploring to set up medical services for youth, including STI testing. There

[9] Ibid
[10] Ibid
[11] Ibid

are an additional 12 Youth Centers in different locations in the Maldives (which are not supported by UNFPA); its managers were recently formally trained for 1 year in youth work. Activities and programs of the Youth Centers have little specific focus on HIV and STI prevention. Not all centers are equally active and there is no common focus.

Meanwhile the Ministry of Education is preparing to integrate life-skills and HIV education in its curriculum for upper primary and for secondary school students (starting from Grade 6). Currently HIV is integrated in the subject on Islam; it is now planned to be integrated in Health Education. This is expected to happen in the middle of 2010. A life-skills based HIV prevention training program with teachers is ongoing under the GFATM grant, with 119 teachers trained as of the end of May 2009 via in-service training); however the MOE has yet to integrate life-skills and HIV education into the core curriculum of the recently established teacher training college.

In Male' 3 out of 6 high schools have instituted a peer education program, which is collaboration between the MOE and NGOs. The inclusion of HIV in the program, specifically whether it includes information on high risk behaviors, was not clear.

Migrants were identified as a highly vulnerable population. Migrants include particularly fishermen, resort workers and construction workers. These groups would be helped by (i) the introduction of work place prevention programmes particularly in the construction industry; as well as (ii) outreach and support to itinerant fishermen who are compelled to fish further away from their home island, by focusing on particular 'hotspots' where they stop en route to their next fishing destination

B. STI care / management

The true STI burden cannot be assessed as there is no proper STI surveillance system and poor reporting by the private practitioners, limited facility for etiological diagnosis and poor ST care seeking behaviour of patients. Etiologic management is carried out in only one hospital- the Indira Gandhi Memorial Hospital (IGMH) while regional and Atolls (group of islands under one administration) carry out syndromic management. The reporting of syndromes is much desired as some islands /areas report high prevalence of STIs, could be influenced by the quality and skills of the staff. Though the Health care staffs are trained in syndromic management they are not authorized to prescribe or dispense STI drugs. Program data shows that most commonly reported STI is vaginal discharge. There are no special clinics for STI services for MARPs. According to the BBS 2008 STI care seeking behaviour among the high risk groups has been poor and majority have taken treatment from pharmacy or do not take treatment at all.

The detection of syphilis among resort workers with a prevalence of 1.2% during the recently conducted BBS is a concern as a cofactor for increasing risk of HIV transmission. Hepatitis B prevalence among MSM 6%, seafarers (4%), 3% among resort workers and 0.8% among IDU also highlight sexual risks and risky injecting practices among these populations. which is confirmed by the findings of 0.7-0.8% Hep C infection among IDUs.

C. Knowledge and Behaviour Change

The BBS highlight 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.

Nearly all (98%) FSW in Addu and 88% in Male' reported unsafe sex with a client in the past 7 days; 100% and 80% reported unsafe sex with a regular partner in the past 7 days, indicating a clear potential pathway for HIV into sexual networks in which monetary exchange plays a role. MSM in Addu and Male' used condoms consistently in 21% and 36% of their encounters with men and in only 2% and 17% of their sexual encounters with women, respectively. Regarding sexual networking, IDU, similar to MSM, have a wide-ranging sexual network. In Addu and Male, 97% and 90% of IDU had sex in the past 12 months. 65% and 74% had a regular sex partner (of whom only 1% and 2% were also injecting); 54% and 55% had a non-regular partner, 52% and 38% bought sex; 4% and 16% sold sex; 2% of male IDU sold sex to another man in both locations and 1% and 2% of IDU reported consensual sex with another man. Importantly, 59% of IDU reported unsafe sex in the past 12 months.

The mean age of debut of drug use of current injecting drug users was 16 in Male' and 17 in Addu. In both locations, the median age at which current IDU had shifted to injecting drugs was 22. A third (31%) of IDU in Male' and 23% in Addu reported sharing an unsterilized needle at the last time of injection. Cleaning of needles occurred but often using inappropriate and unsafe techniques.

D. Treatment, care and support

Care and support for PLWHA

Government hospitals provide care and support to three (3) PLWHAs, with two on first line and one on second line ART regimen. All three are still alive 12 months hence since commencing ART giving a 100% treatment outcome. The number of persons estimated to be in need of ART in 2008 is 7 and 7 in 2009.

Only one ART center in Male, offers ART free of charge according to national guidelines. CD4 is available for ART monitoring however, viral load testing is not available. Currently the patients are on first line regime. Second line regime will be made available as per requirement according to the national guideline. Scaling up of ARV is not planned yet due to small numbers. Since there are no NGOs currently providing home based care and support, community based psychosocial care is limited.

HIV and AIDS Financing

In 2006, the Ministry of Health allocated US$120,000 to the HIV/AIDS Program and an additional US$131,000 was provided by external sources.[12] At that point in time, there was an estimated US$1,769,766 in unmet Finances. The Ministry of Health was forecast to allocate US$329,000 to the National HIV/AIDS Program and related activities between 2006

[12] Wijangarrden J. W. D. The HIV & AIDS situation in the Republic of Maldives in 2006. UNICEF, National HIV & AIDS Council (NAC), Ministry of Health of the Maldives and the UN Theme Group on HIV & AIDS. August 3, 2006

and the end of 2010.[13] External funders include WHO, British Council, UNFPA and UNICEF. The annual amount provided by these external sources will decline to approximately US$82,000 by 2010[14]

The Maldives' GFATM Round 6 which had initially been approved for close to 5 million US$ for five years had been reduced to US$ 2.289 million for use from 2009-2012 due to slow implementation and other reasons. The GFTAM funding is the main source of support for the NAP. The 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 (the building of capacity and commitment of the NAP to lead and coordinate the national response). 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.

IV. Major Challenges and Remedial Actions

The first BBS has clearly shown that the risk environment of Maldives is evolving rapidly and entails close monitoring, thus, surveillance rounds need to be implemented periodically.

A constraint until recently has been frequent turnover of staff, and a long period of vacancy of the national program manager position, which has undermined the steering and key coordination role of the NAP for the national response.

The JMTR posed the following recommendations to improve the National Response to HIV and AIDS:

1. The National AIDS Program should lead the development of a 2010-2011 action plan, focusing on the gaps identified and costed during this JMTR.
2. As a major priority, the NAP should refocus efforts on prevention for those most at risk. A Technical Working Group for Targeted Interventions should be established, starting its work focusing on IDU. It should include all relevant stakeholders, including drug users, program implementers, religious leaders, and judiciary and police representatives.
3. All donor-related positions in the NAP structure should be renamed and amalgamated within one single organizational structure, with clear lines of responsibility, avoiding the current parallel systems of GFATM & NAP.
4. Capacity development of the CCM on issues of sexual diversity, male sexual health and prevention prior to the next round proposal.

Furthermore, the BBS 2008 also gave the following action points:

1. Cost out the establishment and maintenance of an active surveillance system (biological and behavioral) and request for a regular annual funding from the Ministry of Health and Family

[13] Ibid
[14] Ibid

2. Solicit technical assistance to use findings of the BBS, mapping and other reports from the peripheral clinics in estimating the size of the most-at-risk population and people living with HIV for better program planning
3. Forge partnership with the national reference laboratory in the establishment of an active HIV surveillance system
4. Review targets set in the National Strategic Plan utilizing the findings in the BBS
5. Spearhead development of a behavior change communication plan that emphasize condom use for STI prevention, correct misconceptions about religion as protective blanket against HIV, increase awareness on the existence of HIV in the country, address interactions between high risk populations recognizing that they are not isolated population
6. Consider uniqueness of behavior dynamics across sites and design interventions that address specific, localized risks
7. Popularize VCT and intensify promotion of the importance of knowing one's HIV status
8. Re invent health clinics that will attract clients not only from the general population but also from the marginalized population as well as the male population for their STI concerns
9. Design a full package of HIV prevention outreach services which include IEC, condom distribution and unsterile needle and syringe distribution and encourage participation of NGOs
10. Discuss with NNCB, Home Ministry, Journey and other NGOs catered to drug users the BBS findings of high prevalence of unsterile needle and syringe sharing and existence of drug use and injecting drug use inside the prisons and rehabilitation centers
11. Conduct advocacy activities and encourage participation of the FSW, MSM, IDU
12. Solicit assistance of the Tourism Ministry to involve resort owners in designing HIV/STI prevention program specific for resort worker
13. Coordinate with the sea farers and construction workers association and discuss behavioral issues encountered by these groups and encourage their participation in developing HIV/STI prevention program
14. Coordinate with Education Ministry and discuss risk behavior among the youth and solicit their assistance in designing HIV/STI prevention program geared towards the in-school youth
15. Review guidelines regarding discrimination and ethical considerations during surveillance and research
16. Consider reaching out to religious people and discussing with them findings of the BBS

Challenges identified in NCPI A and B

Political commitment and focus from Ministry of Health and Family, and other Ministries 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.

Lack of established rules and regulation allowing the government to conduct prevention programmes especially for MARPs.

Limited number of NGOs and their lack of capacity to design and implement HIV prevention interventions targeting MARPs and vulnerable populations including its monitoring and evaluation.

Absence of a comprehensive harm reduction programme for DUs leading to inefficiency in providing quality services. Intervention such as condoms distribution, needle and syringes exchange programme, are not available for the target populations. In addition , intervention specially designed for females (drug users, wives/partners of drug users, mothers of drug users) and youth affected by drugs.

Limited political commitment hinders creation of enabling environments for addressing most at risk populations. As BBS has shown, there is large number of MARP, hidden and with extremely high risk behaviours for HIV.

Lack of coordination among UN agencies, and the government leads to duplication of HIV prevention interventions.

Weak recording and reporting systems of STIs impedes early warning signs of HIV epidemic.

The majority HIV testing takes place as a mandatory one, and without counselling (pre or post or both are lacking). Of those tested, the most at risk populations are almost negligible.

Cultural and religious barriers for MARP interventions especially Harm reduction for IDU, hinders to align policies and laws /regulations for enabling environment to effective implementation.

Condom promotion among risk groups as well as unmarried youth

Gender issues and overcoming cultural/religious barriers for promoting condoms, addressing women issues, also there are no specific programmes for women IDUs

ANC and blood donor screening or pre-surgical screening and PIT without proper counselling

Non availability of a standardized recording and reporting formats for PLWHA under care.
Stigma and discrimination of PLWHA within health care settings

V. Support from the Country's Development Partners

External funders include GFATM, WHO, British Council, UNFPA and UNICEF. UNFPA and WHO have been providing technical and financial support for HIV & AIDS awareness and prevention programmes. The Government of Italy, through UNDP, is funding a drug abuse prevention programme. The annual amount provided by these external sources will decline to approximately $82,000 by 2010[15]

a. Key support received

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.

UNDP is a key partner to the GFATM and is the UN agency assuming the role of Principal Recipient of GFATM grant in the Maldives. In its role as Principal Recipient, UNDP is responsible for the financial and programmatic management of the GFATM grant as well as for the procurement of health and non-health products. In all areas of implementation, UNDP provides capacity development services to sub-recipients (SR) and implementing partners.

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. Programme support staffs from the government and the civil society were trained in the following areas of:

- Programme Management
- Behaviour Change Communication.
- Procurement supply management
- Financial management
- Monitoring and evaluation

UNDP mobilized Technical Assistance for the sub-recipients in the areas of Financial Management, Monitoring and Evaluation and Blood Safety. National Monitoring & Evaluation Plan on HIV/AIDS developed.
Key stakeholders in the mapping of high risk groups UNDP has linked Technical Assistance from the World Bank to conduct the first of its kind in-depth mapping exercise of the Most-at-Risk Populations in the Maldives.

UNDP facilitated the participation of policy makers, stakeholders in the International Conference on AIDS in Asia-Pacific (ICAAP), exposure visits and supported the enhancement of knowledge in programming and implementation of HIV related services for youth through stakeholder consultations. As a result of the joint action plan formulated after the ICAAP meeting, the issue of HIV was addressed in the sermons (nation-wide) of the 2 Friday prayers and 7 sessions on the HIV and the preventative behaviours within the Islamic

[15] Ibid

context was delivered in 7 mosques. With support from UNDP, Ministry of Health and Family organized a sensitization programme on HIV for the Islamic scholars in partnership with Ministry of Islamic Affairs.

A research-based advocacy meeting was held for the parliament members on Drug abuse and HIV scenario in the Maldives, highlighting the current issues that needs need to be considered when passing the recently drafted Drug Bill

Training and sensitization sessions were also conducted for the law enforcement officers on Most-at-Risk Populations' vulnerability to HIV/AIDS and to enhance their knowledge on HIV/AIDS.

Health care personnel were trained in Voluntary Counselling and testing, safe blood transfusions; consolidated blood transfusion services and on HIV care needs and ARV. Peer group education trainings were conducted on HIV AIDS risks for drug users, Injecting drug users and migrants. HIV prevention intervention DUs and IDUs held for prisons inmates covering 100% female and 84% of male inmates population in Maafushi Prison (as of March 2009). Interventions for migrants on HIV prevention conducted in 5 languages (Bengali, Tamil, Nepalese, Singhalese and English) and Multilingual Outreach programmes have been initiated and on-going. Additionally, Mass Media campaign on HIV Prevention "HIV ah huras alhamaa" was launched targeting high risk groups.

Internal funding of the national HIV and AIDS response has been very limited and hence, The Global Fund grant is the single largest external funding of the NAP to date. The Global Fund proposal was developed prior to the current HIV & AIDS National Strategic Plan. All the nine objectives of the Global Fund grant are consistent with the NSP, although the NSP has a somewhat broader scope. The Global Fund grant should be seen as a funding modality to support implementation of the NSP.

In support of the NSP and the UNDAF development outcomes, the UN agencies have identified projects and activities for implementation during the programme cycle 2008-2010. The following briefly describes the general areas of support by the UN agencies in the Maldives:

The WHO provides comprehensive support to national authorities on HIV/AIDS. WHO is extending technical support in the following areas: Surveillance, estimations and STI related trainings; PMTCT (prevention of mother to child transmission); VCT (voluntary counselling and testing); ART (anti retroviral therapy) and blood safety. The WHO Resident Representative chairs the UN Theme Group on HIV and AIDS and UN Joint AIDS Team.

Throughout 2008-09 UNICEF implemented a HIV and drug prevention project aimed at reducing the risks and vulnerability to HIV among the most-at-risk adolescents, particularly identified drug users. In line with this aim, the project seeked to increase the knowledge, skills and access to outreach services for most-at-risk and especially vulnerable adolescents and youth so that they can protect themselves against HIV/AIDS, sexually transmitted diseases and addiction to harmful substances. A basic pillar of this project will be seeking positive behavioural development in most-at-risk adolescents. Building on the interventions of the previous country programme, this project will continue to strengthen the capacity of those partners involved in HIV and drug prevention and will advocate for the development of a comprehensive age- and gender-sensitive package of services for most at risk adolescents

and youth, including the replication to selected islands of referral systems and initiatives that focus on the rehabilitation and reintegration of drug users. In addition, during 2009 UNICEF supported one NGO to develop and implement a peer drama project that was an innovative intervention in Maldives. The students were selected from one of the high schools and a national actor trained them in peer drama. Through this intervention UNICEF empowered young people and offered them the opportunity to participate in activities that affect them and to access the information and services they need to protect their health.

UNICEF also worked with the Ministry of Health and Family in the PMTCT area providing trainings and technical support.

The focus of UNFPA's work is the link between reproductive health and HIV, with a strong focus on adolescents and youth. The interventions supported by the UNFPA life skills education program for in- and out-of-school adolescent/ youth, represent one of the critical areas for coordinated programming. It has attempted to reach out to the sex workers and other vulnerable groups through peer educators. UNFPA provides substantial technical support to the Ministries of Education, Youth and Health, Gender and NGOs.

UNODC has been providing technical support on HIV and drugs from its Regional Office for South Asia, in Delhi. Throughout 2008-09 UNODC implemented two regional projects which have ongoing operations in the Maldives. They are titled RAS/H13: Prevention of transmission of HIV among drug users in SAARC countries and RAS/H71: Prevention of spread of HIV amongst vulnerable groups in South Asia.

The goal of Project RAS/H13 is to reduce the spread of HIV among drug using populations in SAARC countries and its purpose is to assist governments and communities to scale-up comprehensive prevention and care programs for drug users, especially Injecting Drug Users, and their regular sex partners.

The overall objective of the RAS/H71 is to enhance institutional and technical capacities of relevant ministries and civil society partners to mount effective intervention programmes to reduce the risk of substance-related transmission of HIV in prison settings (including opioid substitution treatment for drug dependents).

b. actions that need to be taken by development partners to ensure achievement of the UNGASS targets

- Prevention - scaling up of quality prevention programmes for most-at-risk populations (SW, MSM, DU, prisoners and beach boys)

- Management - strengthening of coordination and management capacity of the national response through the National AIDS Programme within the Ministry of Health and Family.

- Policy - strengthening of the legal and policy framework

- Strategic information – continued strengthening of the monitoring and evaluation capacity of the NAP, with a particular focus on a behavioural and sentinel surveillance and coverage of interventions with most-at-risk.

At the request of the NAP, UNAIDS supported a consultant to develop a Technical Needs Assessment and Technical Support Plan 2008-2009[16]. The key thematic priority area for technical support was prevention, particularly how to design and run programs for most at risk populations. Better coordination between technical support providers was also identified as a need with NAP playing the role of coordinator.

VI. Monitoring and Evaluation Environment

A vital component of program support is the availability of accurate, timely and accessible data to inform program planning. A key strategic direction of the current NSP is to strengthen the strategic information system to respond to the epidemic, and steps have been made towards this aim. To date, the BBS 2008 is the most comprehensive and recent data available on HIV in the Maldives.[17] As such, findings from this Survey are widely relied upon in the preparation of the UNGASS Country Progress Report. The Report of the 2009 Joint Mid-Term Review of the National Reponse to HIV in the Maldives December 7-13, 2009 did a thorough assessment of the M & E component of the country's HIV programme. To quote directly from the report:

"The existing national M&E plan that exists to support the NSP – 'is very weak and does not address all important elements of an M&E plan'.[18] 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 DHS), 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. Key weaknesses in the data management of the NAP include the overall lack of capacity in strategic information and data-systems management. There is also no system in place for providing and receiving feedback between the Management Unit of the NAP and the SR/implementing partners. There is a lack of clear ToR with sub-entities in the NAP with regard to reporting requirements and deadlines

2. Not all necessary elements are included in the current M&E plan (eg. no yearly targets are specified in the NSP in terms of outputs and outcomes);

3. Lack of denominators for most of the coverage-based indicators.

4. The M&E plan is not costed: there is no budget and there are no details for some of the planned M&E activities

[16] The Maldives HIV and AIDS Technical Needs Assessment and Technical Support Plan 2008-2009, National AIDS Program, April 2008 (UNAIDS/TSF)
[17] Maldives Country Profile. www.aidsdatahub.org
[18] A report on exercising monitoring and evaluation systems strengthening tool,By Phanindra Babu Nukella, The Republic of Maldives, November 2009.

5. Health managers at the island, atoll and national level do not have easy access to M&E data collected;

6. Utilization of studies that can inform planning and programming is not optimized

An important way to disseminate HIV related information is via the National AIDS Council, which consists of representatives from all relevant sectors. However, the NAC does not meet regularly, and some of its tasks seem to have been largely taken over by the Country Coordinating Mechanism (CCM) in connection with the dominant funding mechanism in the country (GFATM).

WHO and UNAIDS are planning to provide training on M&E and information management to all relevant staff in the NAP and its implementing partners before June 2010. UNDP has committed to support the development of an operational manual for M&E data management systems.

UNDP has indicated it will support the process of strengthening the national M&E plan by March 2010. It has been recommended in the MESTT (2009) that a national M&E Unit needs to be created and an M&E coordinator recruited, a budget for M&E would be agreed on, denominators would be established, a timeframe and targets for indicators would be set and a system for M&E data dissemination would be designed[19].

Recommended M & E activities

1. Conduct size estimations/risk behavior mapping focusing on the three key risk behaviors.
2. Conduct an independent evaluation of interventions conducted for injecting drug users so far (for example, OST, detoxification, rehabilitation and outreach).
3. Conduct feasibility research for responses addressing risk behaviors (drug use, male sexual health, highly vulnerable women) as well as targeted interventions for prisoners in the Maldivian context.
4. Include these evaluation activities (1-3) in the strategic action plan and budget for 2010-11.

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ANNEXES

ANNEX 1: National Composite Policy Index questionnaire (Part A)
ANNEX 2: National Composite Policy Index questionnaire (Part B)

ANNEX - 1

National Composite Policy Index (NCPI) questionnaire

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] 2007-2011*

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 2007 (2007 – 2011)
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	No
Labour	Yes **X**	No	Yes	No **X**
Transportation	Yes **X**	No	Yes	No
Military /police	Yes **X**	No	Yes	No **X**
Women	Yes	No **X**	Yes	No **X**
Young people	Yes	No **X**	Yes	No **X**
Other Tourism Fisheries	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

UNDP, through GFATM- blood safety,
HIV prevention for DU/IDU, seafarers, resort workers and migrants
Care and treatment PLWHA

UNODC,	Drug users
UNICEF,	young 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 **X**	No
g. Other specific vulnerable subpopulations* seafarers, resort workers, migrants	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 **X**	No
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*

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 commercial sex workers, clients of sex workers, MSM and male sex workers , youth, prisoners, migrant 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	Yes **X**	No

implementation?		
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:
During the last year of implementation of NSP 2002-2006 number of opinion leaders , NGOs , HIV professionals raised concern on increase in risk behaviours and commissioned a situation analysis to guide development of new NSP .The report was approved by NAC , members including civil society. Following this a participatory process led by the ministry of health and family ,conducted series of stakeholder meetings involving government , (health and non health ministries) and civil society organizations to develop national strategic plan in 2007 , defining strategic priorities, objectives , and major activities.. Civil society included were mainly NGOs working with DU, youth and UN agencies.

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 **X**	No	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 **X**	No
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 **X**	No
Reduction of stigma and discrimination	Yes **X**	No
Women's economic empowerment (e.g. access to credit, access to land, training)	Yes **X**	No
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 and scholarships abroad. Also, voluntary testing available.

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

Yes **X**	No

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

a. Women	Yes **X**	No

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

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 **X**	No
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:

Drug use – possession and trafficking is illegal, Drug control legislation and legal framework. The principal legislative act of Maldives dealing with narcotic drugs and psychotropic substances is law number 17/77 as amended in 1995 and 2001. The 2001 amendments facilitated confidential interviewing with drug users for the purpose of research. Alcohol is not included in the law on drugs. It is controlled under the law of Islamic Shari'ah.

The amended law of 1995 (Section 2 of the law) awards life imprisonment for offences of trafficking of prohibited drugs by either, cultivation, manufacture, exportation, importation, selling, buying, giving or possession for sale of one gram or more of a banned substance. Under section 4 of the law, using or possessing for personal use of less than one gram of a banned substance attracts a penalty of imprisonment, banishment or house arrest for a period between 5 and 12 years, or referral to rehabilitation with the possibility of a suspended legal sentence.

For first-time drug offenders, the sentence may be suspended for three years while they undergo rehabilitation under the supervision of NNCB. If an offender undergoes satisfactory rehabilitation and remains within the law for the 3-year period, the suspended sentence is deemed to be fully served and he/she is set free. If on the other hand, the offender is unable to complete this period of rehabilitation successfully, he/she is handed over to the Department of Penitentiary for enforcing the sentence.

The Law also allows a drug addict to make a self-submission to the rehabilitation assessment committee of Narcotic Control Board and request for treatment. This opportunity is available for those with no other offences or cases pending against them.
Note: Drug Bill has been redrafted and submitted to the Parliament for endorsement.

MSM - Male to male sex is illegal in Maldives. According to the Section 15, clause 173 (8a) "Sexual activity with a member of the same sex", under the "Rules of adjudication", the punishment is to be lashed *(tha'zeer)* between 19 to 39 times and banished or imprisoned for a period between 1 to 3 years, taking into account, the severity of the offence.

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 checkup 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, 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 among public health authorities and law enforcement agencies regarding allowing interventions on prohibited behaviours to occur without police intervention, but without formally legalizing these behaviours. The dialogue between civil society and government is taking place

Drug use should be recognised as a health issue, not a criminal act, effective prevention activities for drug users /IDU could be hampered unless a legislative measure is available

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
Migrant workers,
ANC,
PLWHA
Youth
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 2009?

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

Since 2007, what have been key achievements in this area:
Development of NSP, 2007-2011 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 MARP 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 MARP interventions , and lack technical capacity , none for MSM/Sex workers
As the NAC is a hierarchy 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]*

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	No **X**

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

Yes	No

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

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 2009?

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

Since 2007, what have been key achievements in this area:

What are remaining challenges in this area:
To have regulations to create an enabling environment for NAP and other partners to implement interventions for MARP with trust and security.

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:

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

.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	-

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 2007, 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 MARP 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 MARP
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 2007-2011

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 2007, what have been key achievements in this area:
-In 2008, the first Bio-Behavioural Survey -- (BBS) was conducted in the Maldives20. 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 2007-2012 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
-Pilot project for oral substitution therapy-with methadone commenced in Male the commercial hub in 2009 –
- A new detoxification centre opened in Villangi in 2009
- UN agencies supported aftercare services including psychosocial care and parental counselling services for ex - drug addicts through "Journey past 3 yrs
- Government run 2 rehabilitation centers in Male and ADDU –providing residential care using " therapeutic education community model
- Current GFATM funded project aims at reaching 1200 IDU with peer education 2007-2011, already 77 peer educators were trained, and 1841 IDU reached with IEC as end Feb 2009
- A mapping exercise is planned – to be conducted in ..... 2010 including DU,MSM and sex workers which will facilitate planning implementation of TI aimed at MARP and budgeting –
- 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 MARP (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 MARP to be strengthened as there are no special STI clinics for MARP
- Condom promotion among risk groups as well as unmarried youth
- Increase VCT uptake by MARP as accessibility is an issue with the distribution of MARP 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

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 2007, 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.
-In the region majority of married women (monogamous) are infected through their husbands ,thus gender sensitive issues such as partner disclosure, inheritance of property rights may be a concern.
- For PMTCT programmes to address the first and second prongs of preventing HIV infection among young girls, contraception services , should be given more attention as screening of pregnant women is not cost effective in low prevalence situation.
-NGOs or PLWHA organisations to support community and home based care for PLWHA is a challenge due to small numbers for fear of breach of confidentiality .
-Capacity building of clinicians to diagnose HIV infection early and provision of quality care and ART
-Reduce stigma and discrimination of PLWHA in health care settings

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 2007, 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] 2007-2011

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 2007-2011 developed more focus on MARP
- BBS in 2008 and Joint review of national response in 2009 , helped the donors and NAP to focus on gaps –Interventions for MARP 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 2010-2011

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 MARP 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 MARP/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 2007, what have been key achievements in this area: Review of National M&E system in …… Development of National M&E plan in 200…

ANNEX - 2

National Composite Policy Index (NCPI) questionnaire

Part B

I. HUMAN RIGHTS

1. **Does the country have laws and regulations that protect people living with HIV against discrimination? (including both general non-discrimination provisions or provisions that that specifically mention HIV, focus on schooling, housing, employment, healthcare etc.)?**

Yes	**No X**

1.1. IF YES specify if HIV is specifically mentioned and how or if this is a general non-discrimination provision.

2. **Does the country have non-discrimination laws or regulations which specify protections for most at risk populations and other vulnerable sub populations?**

Yes	**No X**

2.1 IF YES for which sub populations?

Women	Yes	No X
Young people (adolescents and youth)	Yes	No X
IDU	Yes	No X
MSM	Yes	No X
Sex workers	Yes	No X
Prison inmates	Yes	No X
Migrant /mobile populations	Yes	No X
Other		

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

Briefly describe the content of these laws:
Briefly comment on the degree to which they are currently implemented:

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

Yes X	**No**

a. If yes, for which sub populations?

Women	Yes	No

Young people (adolescents and youth)	Yes	No
IDU	Yes X	No
MSM	Yes X	No
Sex workers	Yes X	No
Prison inmates	Yes	No
Migrant /mobile populations	Yes	No
Other		

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

Drug use – possession and trafficking is illegal, Drug control legislation and legal framework.The principal legislative act of Maldives dealing with narcotic drugs and psychotropic substances is law number 17/77 as amended in 1995 and 2001. The 2001 amendments facilitated confidential interviewing with drug users for the purpose of research. Alcohol is not included in the law on drugs. It is controlled under the law of Islamic Shari'ah.

The amended law of 1995 (Section 2 of the law) awards life imprisonment for offences of trafficking of prohibited drugs by either, cultivation, manufacture, exportation, importation, selling, buying, giving or possession for sale of one gram or more of a banned substance. Under section 4 of the law, using or possessing for personal use of less than one gram of a banned substance attracts a penalty of imprisonment, banishment or house arrest for a period between 5 and 12 years, or referral to rehabilitation with the possibility of a suspended legal sentence.

For first-time drug offenders, the sentence may be suspended for three years while they undergo rehabilitation under the supervision of NNCB. If an offender undergoes satisfactory rehabilitation and remains within the law for the 3-year period, the suspended sentence is deemed to be fully served and he/she is set free. If on the other hand, the offender is unable to complete this period of rehabilitation successfully, he/she is handed over to the Department of Penitentiary for enforcing the sentence.

The Law also allows a drug addict to make a self-submission to the rehabilitation assessment committee of Narcotic Control Board and request for treatment. This opportunity is available for those with no other offences or cases pending against them.
Note: Drug Bill has been redrafted and submitted to the Parliament for endorsement.

MSM - Male to male sex is illegal in Maldives. According to the Section 15, clause 173 (8a) "Sexual activity with a member of the same sex", under the "Rules of adjudication", the punishment is to be lashed *(tha'zeer)* between 19 to 39 times and banished or imprisoned for a period between 1 to 3 years, taking into account, the severity of the offence.

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 checkup which includes a HIV screening test. However, tourists entering on tourist visa, medical checkup is not required..

Briefly comment on how they pose barriers
There are no explicit laws, regulations or policies that become obstacles to effective HIV prevention, treatment, care & support for most at risk populations and other vulnerable subpopulations. However, since Maldives is a Muslim country there are barriers that stem from the religious beliefs, making it t difficult to talk about existence of sexual activity that take place in the

country.

As any sexual activities outside marriage as well as same sex relations are illegal, reaching this population is extremely difficult. In the Maldives is 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 among public health authorities and law enforcement agencies regarding allowing interventions on forbidden behaviours to occur without police harassment but without formally legalizing these behaviours. The dialogue about improving the environment (policy, laws, and regulations) and making welcome for HIV preventions among MARPs between civil society and government is taking place.

Drug prevention programmes include aftercare activities as well as OST services. However OST are not widely promoted.

Premarital and extramarital sex is illegal and only married couples have access to condoms through family planning services. For unmarried youth couples this choice is not available due to the low in the country and this affects the prevention interventions designed for young. However, the condoms are available for everyone from pharmacies.

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

Yes X	**No**

IF YES, briefly describe how human rights explicitly mentioned in any HIV policy or strategy?

The strategy addresses the human rights issue in a very broader context. The strategy is in line with the policy plan statement.

5. **Is there a mechanism to record, document and address cases of discrimination experienced by people living with HIV, most at risk population and/or other vulnerable subpopulations.**

Yes	**No X**

If YES, briefly describes the mechanism.

6. **Has the government, through political and financial support, involved PLWHA, most at risk populations and/or other vulnerable subpopulations in governmental HIV-policy design and programme implementation?**

Yes X	**No**

If YES, describe some examples:

The National Strategic Plan (NSP) for National AIDS Programme (NAP) was developed with involvement from the NGOs working with/members of drug user's organisation.

The proposal for Global Fund Round 6 was prepared by the CCM, which has 22 members (41%

government, 39% NGOs and UN agencies). "Journey" a NGO formed mostly by ex drug users along with two other NGOs – Society for Women Against Drugs (SWAD) and Society for Health Education (SHE) are involved in implementation of prevention interventions targeted at DU, IDU and families since 2007 providing aftercare services, out reach (IEC) and counselling. They are Sub recipient of GF grant. The governmental institutions are leading the treatment and rehabilitation services (one Methadone Clinic, two detoxification and one rehabilitation centre).

UN agencies (UNICEF, UNDP, WHO, UNODC) and American Embassy collaborates with the government in programme implementation.

7. **Does the country have a policy of free services for the following**

a. HIV prevention services	Yes X	No
b. ARV	Yes X	No
c. HIV related care & support interventions	Yes X	No

If YES, given resource constraints, briefly describe what steps are in place to implement these policies and include information on any restrictions or barriers to access for different populations:

There is no policy in place regarding free access for different category to public services. For each and every HIV positive Maldivian the treatment (ARV) is free of charge provide by the Ministry of Health and Family (MoHF), via NAP. The treatment is provide by the Government from own resources and is not donor dependent. As the numbers of PLWHA are very few currently, sustainability of provision of ART programme is not an issue.

The three sub recipients, of the Global Fund financed project are implementing to address 5 strategic areas of NSP including:

- prevention interventions for MARP and other vulnerable populations,
- strengthening prevention and control of STIs, blood safety
- prevention of HIV in health care settings,
- strengthen health system capacity for quality care, support and treatment for PLWHA and strategic information system.
- strengthening multisectoral response through capacity building of NGOs will support implementation of the programmes.

However care and support interventions are limited due to the few HIV positive cases.

The number of prevention services are limited due to constrains:

- **Resources constrains within Government and NGOs**

- *human resources* (limited number of human resources; limited knowledge/skills about HIV prevention intervention especially for MARYPs; frequent change of experienced and skilled staff)
- *accessibility* (the inhabited islands are spread and there is limited access)
- *funds* (the Government as well as the NGOs don't have the necessary capacity to absorb the available funds)

Additionally, in terms of constrains, cultural and religious barriers play a major role in designing effective interventions for MARP. The Sahria law and the cultural barriers need to be addressed in the future, which impede effective interventions for MARP with better advocacy.

8 **Does your country have a policy to ensure equal access for women and men to HIV prevention, treatment, care and support?**

Yes X	**No**

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

Yes	**No X**

9. **Does the country have a policy to ensure equal access, for most at risk populations and/or vulnerable subpopulations to HIV prevention, treatment, care and support?**

Yes X	**No**

If YES briefly describe the content of the policy:

The country has a NSP which identifies the need for adequate services for MARPS. As a part of enhancing the access, for testing and prevention in MARPs, there has been recommendations in the VCT guidelines to undertake provider initiated testing for the people who belong to vulnerable groups , as well as the facilities have been extended to the IDU population through the NGO catering to the needs of active as well as recovering addicts.

9.1. If YES, does this policy include different types of approaches to ensure equal access for different most at risk population and/or vulnerable subpopulations?

Yes X	**No**

10. **Does your country have a policy prohibiting HIV screening for general employment purposes (recruitment, assignment/relocation, appointment, promotion, termination)?**

Yes	**No X**

11. **Does your country have a policy to ensure that HIV/AIDS research protocols involving human subjects are reviewed and approved by a national /local ethical review committee?**

Yes X	**No**

If YES does the ethical review committee include representatives of civil society including PLWHA

Yes	**No X**

If YES, describe the approach and effectiveness of this review committee:

There is a national research committee (National Health Research Committee - NHRC).

The Civil Society is aware of this committee and has been submitting proposal to this committee.

The committee is in a phase of strengthening itself by inviting and increasing the representation from Civil Society.

12. **Does your country have the following human right monitoring and enforcement mechanisms?**

Existence of independent national institutions for the promotion and protection of human rights, including human rights commissions, law reform commissions, watch dogs and ombudspersons which consider HIV and AIDS related issues within their work.	**Yes**	**No X**
Focal points within governmental health and other departments to monitor HIV related human rights abuses and HIV related discrimination in areas such as housing &employment	**Yes**	**No X**
Performance indicators or benchmarks for compliance with human rights standards in the context of HIV and AIDS efforts	**Yes**	**No X**

13. **In the last 2 years, have members of the judiciary (including labour courts/employment tribunals) been trained/sensitized to HIV/AIDS and human rights issues that may come up in the context of their work?**

Yes	**No X**

14. **Are these following legal support services available in your country?**

Legal aid systems for HIV and AIDS case work	**Yes**	**No X**
Private sector laws firms or university based centres to provide free or reduced-cost legal services to PLWHA	**Yes**	**No X**
Programme to educate, raise awareness among PLWHA concerning their rights	**Yes**	**No X**

15. **Are there programmes designed to change societal attitude of discrimination and stigmatization associated with HIV/AIDS to understanding and acceptance?**

Yes X	**No**

If YES, what type of programmes?

Media	**Yes**	**No X**
School education	**Yes**	**No X**
Personalities regularly speaking out	**Yes**	**No X**
Other	**Yes X**	**No**

Society for Health Education (SHE) being one of the Sub-Recipient (SR) of the GF project, has implemented programs for HIV educational sessions for large enterprises. In order to ease

development of strategies targeting employees, documentation regarding ILO workplace policies were collected and researched to find applicable policies befitting the Maldivian context.

These HIV Educational sessions included fundamental information on STIs and HIV/AIDS, an assessment of needs of companies/enterprises, open discussions and importance of HIV/AIDS programs in the Maldives. After the sessions, documentation derived from information on the needs assessment was to provide companies with documented information and a formative guideline to adopting HIV/AIDS policies in the workplace within a Maldivian context.

Overall, how would you rate the policies, laws and regulation in place to promote and protect human right s in relation to HIV/AIDS in 2009?

2009	**Very poor**									**Excellent**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

- New drug bill drafted and submitted to the Parliament for endorsement.
- Sensitising law enforcement officers on HIV issues on training programmes by UNDP
- Civil society and parliamentarians have begun to have a dialogue on drug and HIV/AIDS issue
- NSP and action plan to address advocacy
- BBS conducted in 2008 generated very reach information on MARP especially youth. This information helped the civil society to design and implement more effective interventions.
- BCC strategy developed

What are the remaining challenges in this area:

- Political commitment and focus from health and other ministries 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
- Establishing rules and regulation who will allow the GOV to conduct prevention programmes especially for MARP.

Overall, how would you rate the efforts to enforce the existing policies, laws and regulations?

2009	**Very poor**									**Excellent**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

What are the remaining challenges in this area:

II. CIVIL SOCIETY PARTICIPATION

1. **To what extent civil society contributed to strengthen the political commitment of top leaders and national strategy/policy formulations?**

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

Comments and examples:

In 2009, civil society was involved in the advocacy activities among policy makers. In addition, Department of Drug Prevention and Rehabilitation Services (DDPRS) through UNDP (PR for GF in Maldives) conducted some sensitization sessions among parliamentarians about the HIV/AIDS situation and Drug Bill. This bill does not cover the HIV/AIDS topic.

2. To what extent civil society representatives have 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:

The representatives of the NGOs, civil society and UN agencies were involved in the planning and budgeting process. Due to the lack of knowledge among civil society, most of the time the technical assistance comes from the specialists from the UN system.

3. To what extent are the services provided by civil society in areas of HIV prevention, treatment, care and support included in

a) the National AIDS strategy?

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

b) the National AIDS budget?

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

c) National AIDS reports?

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

Comments and examples:

There are only few NGOs (Journey, Society for Health Education-SHE, and Society for Women Against AIDS-SWAD, Open Hand) active in drug prevention intervention, which is linked with HIV prevention information.

4. To what extent is civil society included in the monitoring and evaluation (M&E) of the HIV response?

a)developing national M&E plan

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

b) participating in M&E committee/working group responsible for coordination of M&E activities

Low High

0	1	**2**	3	4	5

c)M&E efforts at local level

Low High

0	1	**2**	3	4	5

Comments and examples:

The M&E system is still the weakest components in the NAP. UNDP, through Global Fund financing, is expected to strengthen M&E system by having a National M&E plan in place and system strengthen. In additional there will capacity strengthening of the M&E personnel at the national and provincial level in the next 2 years.

UN agencies have contributed towards enhancing capacity of the NAP staff and NGOs in programme delivery, reporting and recoding data.

The Civil Society is still weak in M&E, they don't have the capacity to collect data in a standardized manner and analyze the information for dissemination.

5. To what extent is the CS representation in HIV efforts inclusive of diverse organizations (e.g. network of PLWHA, organizations of sex workers, faith based organizations)?

Low High

0	**1**	2	3	4	5

Comments and examples:

There are only few NGOs made by beneficiaries (drug users/ex drug users or families affected by drugs)
No PLWHA NGOs or female sex workers and MSM NGOs

6 To what extent 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 HIV activities?

Low High

0	1	2	**3**	4	5

Comments and examples:

There are three major donors in the country: GF, UNICEF, UNODC
Technical assistance is provided by UNICEF and WHO.
UNDP was the PR for GF funds.

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

Prevention for youth	<25%	<25-50	50-75%	>75%
Prevention for vulnerable population IDU MSM Sex Workers	<25% 25% <25%	25-50% 25-50 25-50%	50-75% 50-75%	>75% >75%
Counselling & testing	<25%	*25-50%	50-75%	>75%
Clinical services (OI/ ART	25%	25-50%	50-75%	75%
Home based care	** <25%	25-50%	50-75%	75%
Programs for OVC	** <25%	25-50%	50-75%	75%

* HIV Counselling and testing on site is provided by Journey (NGO) as well as the governmental institutions

** Actually, home based care and programmes for OVC are not applicable

Overall, how would you rate the efforts to increase civil society participation in 2009?

2009	**Very poor**									**Excellent**
	0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

- Strategic information collected through BBS with civil society participation 2008
- Interventions scaled up for DU with committed NGOs
- Number of NGOs involved in planning and implementation has increased
- Number of NGOs submitting proposals for funding increased as capacity built

What are the remaining challenges in this area:

- Lack of NGOs only working on HIV prevention targeting, DU/IDU and their families
- Lack of NGOs working with MSM, CSW as yet
- Lack of capacity among NGOs in designing interventions and implementation , monitoring and evaluation
- Harm reduction programmes are not covering the all spectrum of interventions (condoms, needle and syringes exchange programme)

III. PREVENTION

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

Yes X	No

If YES, how were these specific needs determined?

A rapid need assessment 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 (JMTR) of the NAP/ National Strategic Plan (NSP) was conducted in 2009 which identified gaps and gave directions for strengthening and scaling up of the implementation of NSP 2007-2011.In addition it has been strongly suggested by the JMTR to do a size estimation and social mapping for the MARP. This has been taken into consideration and the process is already in progress.

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**		
Blood safety	Agree **X**	Don't agree	N/A
Universal precautions in health care settings	Agree	Don't agree **X**	N/A
Prevention of mother-to-child transmission of HIV	Agree	Don't agree **X**	N/A
IEC* on risk reduction	Agree **X**	Don't agree	N/A
IEC** on stigma and discrimination reduction	Agree	Don't agree **X**	N/A
Condom promotion	Agree	Don't agree **X**	N/A
HIV testing & counselling	Agree	Don't agree **X**	N/A
Harm reduction for injecting drug users	Agree	Don't agree **X**	N/A
Risk reduction for men who have sex with men	Agree	Don't agree **X**	N/A
Risk reduction for sex workers	Agree	Don't agree **X**	N/A
Programmes for other vulnerable sub-populations	Agree	Don't agree **X**	N/A
Reproductive health services including STI prevention & treatment	Agree **X**	Don't agree	N/A
School-based AIDS education for young people	Agree	Don't agree **X**	N/A
Programs for out of school young	Agree	Don't agree **X**	N/A
HIV prevention in work place	Agree	Don't agree **X**	N/A
Other [write in]	Agree	Don't agree	N/A

***There are few programmes run by NGOs or governmental institutions but they do not cover the majority of the population.*

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

2009 Very poor Excellent

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

Since 2007, what have been key achievements in this area:

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

In 2008, the first Bio-Behavioural Survey (BBS) was conducted in the Maldives[21]. 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.

Followed by the BBS, a qualitative research was conducted to get in-depth analysis of the trends and behaviours of the high risk groups. The outcome of these studies has formulated the BCC strategy which defines targeted intervention for these groups.

The key intervention for the last two years were as follows:

- Peer outreach for the DU and IDU in Male, Fuahmulak and Addu
- HIV and STI awareness for migrant worker
- Training and sensitizing of Law enforcement officers on MARPs vulnerability and HIV
- Training of Health care providers on ST I ,VCT, HIV and Blood safety
- HIV awareness among youth

The BBS highlight 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.

Nearly all (98%) FSW in Addu and 88% in Male' reported unsafe sex with a client in the past 7 days; 100% and 80% reported unsafe sex with a regular partner in the past 7 days, indicating a clear potential pathway for HIV into sexual networks in which monetary exchange plays a role. MSM in Addu and Male' used condoms consistently in 21% and 36% of their encounters with men and in only 2% and 17% of their sexual encounters with women, respectively. Regarding sexual networking, IDU, similar to MSM, have a wide-ranging sexual network. In Addu and Male, 97% and 90% of IDU had sex in the past 12 months. 65% and 74% had a regular sex partner (of whom only 1% and 2% were also injecting); 54% and 55% had a non-regular partner, 52% and 38% bought sex; 4% and 16% sold sex; 2% of male IDU sold sex to another man in both locations and 1% and 2% of IDU reported consensual sex with another man. Importantly, 59% of IDU reported unsafe sex in the past 12 months.

The mean age of debut of drug use of current injecting drug users was 16 in Male' and 17 in Addu. In both locations, the median age at which current IDU had shifted to injecting drugs was 22. A third (31%) of IDU in Male' and 23% in Addu reported sharing an unsterilized needle at the last time of injection. Cleaning of needles occurred but often using inappropriate and unsafe techniques.

IDU

In the last few years (2008-2009) prevention focusing drug users scaled up however focus mainly in Male' focusing on males. There is still a lack of services for female as well as for youth. Most of the detoxification services are exclusively for men, they don't address female, and youth clients needs.

At the moment there are four centres (**Drug Rehabilitation Centre** in Himafushi-established in 1997; **Regional Drug Rehabilitation Centre –** established in 2005 which was closed in July 2009; two detoxification centres established in 2009) lead by the Government who provide

[21] Corpuz AC, October 2008, Biological and Behavioral Survey (BBS) and HIV/AIDS, Republic of Maldives

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

services (treatment, physiological support, residential care, and religious support) for drug users or ex drug users. In 2009, the new Government launched their strategic action plan for the next 4 years that covers major issues related to drug use and HIV prevention in Maldives.

Methadone Maintenance Treatment (MMT) centre opened in Male' by UNODC and the former National Narcotic Control Bureu (NNCB) was established in August 2008. Now, Department for Drug Prevention and Rehabilitation Services (DDPRS) - former National Narcotics Control Bureau is responsible for the monitoring and evaluating this activity, as Governmental institution.

The MMT in Maldives was started as pilot programme, which has a maximum capacity of 60 clients and is supported by a psycho social programme. Journey works very closely with the MMT clinic in providing assistance to select clients for the programme as well as supporting the psychosocial programme. Past experience shows that the psycho social programme is lacking many required services and therefore is rather ineffective. Also, past experience shows MMT programme lacks leadership therefore is rather ineffective. As a result many clients on methadone are still abusing drugs frequently and aren't able to become more productive and self supportive. This area needs to be improved for the sustainability of the programme.

In 2009, two new detoxification centres were opened in Vilinghilli and Hulhu-Meedho Even if they don't have any rules and regulations in place the number of clients is increasing.

In the last 3 years, Journey (NGO) has been providing after care services for drug users as well as for their family with support from UNICEF. Last year, Rajjee Foundation Maldives had came up with a partnership project between NGOs and the Government and extended the after care services. The project is coordinate by Journey as one of the most experience Maldivian NGO in drug prevention and rehabilitation area. Another 3 NGOs are involved in this project – Hand in Hand, SHE and SWAD. This project is a pilot project funded by American Embassy.

Last year with the support from UNDP/GF, Journey opened a VCT Centre. They provide VCT service on site free of charge for all the clients interested in this service. As part of the aftercare project develop in partnership with the Government, all the NGOs involve in this project refer and promote Journey's VCTC for all their clients.

Journey as well as SWAD is very actively engage also in advocacy for high level political leaders for promoting prevention programmes, care/support and treatment for drug users or recovery drug users.

In prisons

HIV/AIDS information disseminated to the prisons inmates through peers trained under the outreach programme for DUs and IDUs. 100% female inmates' population in Maafushi Prison (as of March 2009) and 84% of male inmates population in Maafushi Prison (as of March 2009) reached with HIV information.

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

Blood safety
No TT HIV reported in Maldives. All blood units are screened prior to transfusion and participate in external quality assurance system.

PMTCT
Sero prevalence of HIV among pregnant women and no reported cases of MTCT yet. 100% screening of pregnant women attending ANC services.

What are the remaining challenges in this area:
The 2 priority strategic areas of NSP, which are not addressed through GFATM round 6 and need attention are:

- interventions for key populations
- building capacity NAP .

Taking into consideration the findings from 2008 BBS and mid term evaluation of the NAP recommendations, NAP will address these two strategic areas more in the second phase of the project funded by GFATM.

Political commitment is needed to create an enabling environment for addressing most at risk populations. As BBS has shown, there is large number of MARP, very hidden and with high HIV risk behaviours.

Comprehensive intervention for MARP is necessary, including condom promotions especially among young population. Increase VCT uptake among MARP as accessibility is an issue with the distribution MARP in several atolls./regions

Comprehensive harm reduction programme for DUs are required based on the BBS findings. It is also very important to design and implement prevention and rehabilitation programmes for female affected by drugs (drug users, wives/partners of drug users, mothers of drug users). Another group who need to be address is youth. As mentioned in the MTR report youth is one of the groups who didn't benefited of effective intervention in the past.

At present, the efforts of harm reduction are not harmonised and well-coordinated therefore a lot of duplication is there. Establish strong coordination among the implementers – government, NGOS and donors to prevent duplication of strategies, policies and services. Therefore there is an attempt to adhere to "3" one principle by having a common National M&E framework.

Reporting systems of STIs (Syndromic management, need strengthening to capture early warning of an impending HIV epidemic). Syndromic management of STIS especially among MARP to be strengthened as there are no special STI clinics for MARP and a Policy decision on giving authorization to the community health workers for prescribing or dispensing drugs.

A research among inmates is needed because there is a lack of information about the HIV situation in prisons. Based on the research's findings NAP can design and implement appropriate intervention for this population.

IV. TREATMENT, CARE AND SUPPORT

1. **Has the country identified the specific needs for HIV treatment, care and support services**

Yes	No **X**

If YES, how were these specific needs determined?

If NO, how are HIV treatment, care and support services scaled up?
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 centre, and no specific care and support systems planned. Scaling up is not planned at this stage, to make available at regional and Atoll level s and training of health care providers on ART provision .

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

HIV and AIDS treatment, care and support services	**The majority of people in need have access**		
a. Antiretroviral therapy	Agree **X**	Don't agree	**NA**
b. Nutritional care	Agree	Don't agree **X**	**NA**
c. Paediatric AIDS treatment	Agree	Don't agree	**NA X**
d. Sexually transmitted infection management	Agree	Don't agree **X**	**NA**
e. Psychosocial support for people living with HIV and their families	Agree	Don't agree **X**	**NA**
f. Home-based care	Agree	Don't agree **X**	**NA**
g. Palliative care and treatment of common HIV-related infections	Agree **X**	Don't agree	**NA**
h. HIV testing and counselling for TB patients	Agree	Don't agree **X**	**NA**
i. TB screening for HIV-infected people	Agree **X**	Don't agree	**NA**
j. TB preventive therapy for HIV-infected people	Agree	Don't agree **X**	**NA**
k. TB infection control in HIV treatment and care facilities	Agree	Don't agree **X**	**NA**
l. Cotrimoxazole prophylaxis in HIV-infected people	Agree **X**	Don't agree	**NA**
m. PEP for occupational exposure	Agree	Don't agree **X**	**NA**
n. HIV treatment in workplace	Agree	Don't agree	**NA X**
• HIV care & support in work place • Including alternative working arrangement	Agree	Don't agree	**NA X**

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

2009	**Very poor**									**Excellent**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Since 2007, what have been key achievements in this area:

What are the remaining challenges in this area:

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

TO optimize utilisation of the VCT centres in public (8 at present) and 2 stand alone VCT centres (Majority of HIV tests were for PIT and for pre-employment screening, blood donor screening or pre-surgical screening). The majority HIV testing takes place as a mandatory one, and without counselling (pre or post or both are lacking). Of those tested, the most at risk populations are almost negligible.

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

Yes	**No X**	**NA**

2.1. If YES, is there an operational definition for orphans and vulnerable children in the country?

Yes	No

2.2. If YES, does the country have a national action plan specifically for orphans and vulnerable children?

Yes	No

2.3. 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?

Not applicable as no OVC reported to date

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

2009	**Very poor**									**Excellent**
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Since 2007, what have been key achievements in this area: *What are the remaining challenges in this area:*										