

UNGASS COUNTRY PROGRESS REPORT
Maldives

Reporting period: January 2008 – December 2009

Submission date: 31 march 2010

Table of Contents

Acronyms

I. Status at a Glance

- A. UNGASS report writing process*
- B. Status of the epidemic*
- C. Policy and programmatic response*

II. Overview of the AIDS Epidemic

III. National Response to the AIDS Epidemic

- A. Prevention*
- B. STI Care/Management*
- C. Knowledge and behavior change*
- D. Treatment, care and support*

IV. Major Challenges and Remedial Actions

V. Support for Development Partners

VI. Monitoring and Evaluation Environment

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

ANNEX 2: National Composite Policy Index questionnaire

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

Indicator	Numerator/ 2010 2008 2009	Denominator	Problem	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 who 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 31 st 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 to be extracted from WHO health sector response report	The government provide 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	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	
	N had a test all <25 25+ 13 6 7	Number surveyed all <25 25+ 126 51 75	As above	
	N had a test all M F <25 25+ 21 18 3 6 15	Number surveyed all M F <25 25+ 129 124 5 52 77	As above	

22 Percentage of young women and men aged 15–24 who are HIV infected*	Copy from UA Number infected 0	Number tested 609		
23 Percentage of most-at-risk populations who are HIV infected	Number infected FSW 0 MSM 0 IDU 0	Number tested 94 124 278		Among 484 Resort workers HIV prevalence 0.2%
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 Hepatitis C implies a widespread needle and syringe sharing and this is the most efficient way of transmitting the virus.⁵

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)

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

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

⁶ Ibid

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

Blood safety

Blood safety is a priority given the high incidence of Thalassemia which requires frequent blood transfusions (number of patients transfused during year 2008 had been 5,755 and majority was thallemic). 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

⁷ 2009 Joint Mid-Term Review of the National Response to HIV in the Maldives

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 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

⁸ Ibid

⁹ Ibid

¹⁰ Ibid

¹¹ Ibid

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 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^{Error! Bookmark not defined.} 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 2010¹⁴

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 2010¹⁵

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 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.

¹⁵ Ibid

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 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 sought 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 2008-2009¹⁶. 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 Response 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 designed¹⁹.

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.

19

ANNEXES

ANNEX 1: Consultation/preparation process for the country report on monitoring the progress towards the implementation of the Declaration of Commitment on HIV/AIDS

ANNEX 2: National Composite Policy Index questionnaire