

MONITORING AND EVALUATION PLAN OF
NATIONAL HIV/AIDS PREVENTION AND
CONTROL PROGRAM

2010-2011

National AIDS Programme

Centre for Community Health and Disease Control

Republic of Maldives

ACKNOWLEDGEMENTS

Following the results of exercising Monitoring and Evaluation Systems Strengthening Tool and as a result of 2009 year Joint Mid-term Review of National Strategic Plan (2007-2011), the country felt the strong need of developing a national M&E plan for the remaining period of NSP, i.e., for two years (2010-2011). It is in this context, the key partner of the National AIDS Program, UNDP, has requested Mr. Phanindra Babu Nukella (M&E Consultant in the area of HIV/AIDS and Reproductive Health) to lead the process and develop national M&E plan for the republic of Maldives. The NAP and UNDP Maldives express sincere appreciation and is grateful to his efforts in understanding the country context in no time, in leading the process and developing the plan. His directions to take it forward are particularly praiseworthy.

The NAP and UNDP Maldives is equally thankful to all the key stakeholders such as MoH&F, SHE, Journey, SWAD, CCHDC, DDPRS, UNDP Maldives, Ministry of Education, Ministry of Islamic Affairs, Maldives Police Service and DPRS etc. in offering the valuable inputs on draft plan and to have agreed to be owners of this plan.

The NAP and UNDP/Maldives is grateful to Joint Mid-term Review team consisting of Mohamad Hameed (National AIDS Program/MOH), David Bridger (UNAIDS), Mariam Claeson (World Bank), Caitlin Wiesen (UNDP), Kunal Kushore (UNODC), Vimlesh Purohit (WHO), Camelia Olaru-Raita (UNICEF), Ivana Lohar (UNDP), Aminath Nawal (UNDP), Anita Alban (World Bank consultant), and Jan de Lind van Wijngaarden (UNAIDS consultant) for their invaluable and timely comments in finalizing this M&E plan.

LIST OF ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal care
BCC	Behavior Change Communication
BBS	Biological and Behavioral Survey on HIV/AIDS - 2008
CCHDC	Center for Community Health and Disease Control
CCM	Country Coordinating Mechanism
DDPRS	Department of Drug Prevention and Rehabilitation Service
DPH	Department of Public Health
DPRS	Department of Penitentiary and Rehabilitation Service
DOTS	Directly-Observed Treatment (for Tuberculosis)
DU	Drug use(r)
FSW	Female Sex Work(er)
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
IEC	Information, Education, Communication
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use(r)
JMTR	Joint Mid-term Review of NSP
MESST	Monitoring and Evaluation Systems Strengthening Tool
MOE	Ministry of Education
MOH&F	Ministry of Health and Family
MOIA	Ministry of Islamic Affairs
MSM	Male to male sex / Men who have Sex with Men
NAP	National AIDS Program
NNCB	National Narcotics Control Bureau
NSP	National Strategic Plan on HIV in the Maldives 2007-2011
OCM	Occupational Cohort Males
RDQA	Routine Data Quality Assurance
SHE	Society for Health Education
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex work(er)
SWAD	Society for Women against Drugs
TB	Tuberculosis
VCTC	Voluntary counseling and testing centres

CONTENTS

- 1. BACKGROUND**
- 2. DEVELOPMENT OF NATIONAL M&E PLAN**
- 3. FRAMEWORK FOR MONITORING AND EVALUATION**
 - 3.1 Goal of the National Program
 - 3.2 Target Group
 - 3.3 Purpose of National M&E Plan
- 4. PROGRAM ACTIVITY AND DISEASE MONITORING**
 - 4.1 Current Situation of Prevention Activities
 - 4.2 Size Estimations/Risk Behaviour Mapping
- 5. TRACKING THE EPIDEMIC AND BEHAVIOURAL MONITORING**
 - 5.1 Tracking epidemic
 - 5.2 Behavioural Monitoring
 - 5.3 Indicators Measuring the Progress
 - 5.4 Mass Media Campaign
- 6. Data Sources**
 - 6.1 Biological and Behavioural Surveys
 - 6.2 Management Information System
- 7. Information Flow**
- 8. Data Quality Assurance and Monitoring Service Quality**
- 9. Operations Research/Special Studies**
- 10. Capacity Building – National Management Unit and Sub-Reporting Entities**
- 11. Program Evaluation**
- 12. Dissemination of M&E data (Information Products)**
- 13. M&E Budget**
- 14. Budgeted Action Plan to implement M&E Plan for the Period 2010-2011**

Annexes

1. List of indicators and its definitions
2. List of documents referred

1. BACKGROUND

The Republic of Maldives has a population of over 309,575 (male-156,714 and females-152,861), 36% of which comprises the youth population, and an expatriate migrant labour force 50,000. Before 2008, the only data on the HIV epidemic in the Maldives was available in the form of case reports: among Maldivians, 13 cases of HIV had been identified via this method between 1991 and 2009. 10 of these cases have since died. No new case reports were recorded since then. Among expatriate migrants, 168 cases had been identified (and deported) up until 2006¹. Compared to many countries in the region, Maldives has a low prevalence of HIV. The Maldives has signed the Millennium Development Goals, which aim to halt and begin reverse the spread of HIV by year 2015. The challenge for the Maldives is to ensure that it remains a low HIV prevalence country in spite of increasing high risk behavior among some population groups.

The National Strategic Plan (2007-2011) on HIV/AIDS aims to maintain the low prevalence of HIV in the Maldives, improve the quality of life and health of PLHIV and their families, and create an enabling environment to mitigate the impact of HIV through its seven strategic directions:

The NSP 2007-11² aims to limit HIV transmission, provide care for infected people, and mitigate the impact of the epidemic through seven strategic directions:

- 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.
- Reduce and prevent vulnerability to HIV infection in adolescents and young people.
- Provide HIV prevention services in the workplace for highly vulnerable workers.
- Provide treatment, care and support services to people living with HIV.
- Ensure safe practices in the healthcare system.
- Build and strengthen capacity and commitment to lead, coordinate and provide a comprehensive response to the epidemic.
- Strengthen the strategic information system to respond to the epidemic.

The National AIDS Program, in December 2009, had set up a joint review team comprising of National AIDS Program/MOH, UNAIDS, World Bank, UNDP, UNODC, WHO,

¹ MOH/NAP 2006, The HIV/AIDS situation in the Republic of the Maldives in 2006.

² MOH 2007, National Strategic Plan on HIV/AIDS, Republic of Maldives, 2007-2011

UNICEF, and UNDP to conduct mid-term review of NSP (2007-2011) that offers clear strategic directions and recommendations to improve the performance of the HIV/AIDS prevention and control program in the country. According to the report³ on exercising monitoring and evaluation systems strengthening tool (MESST), the M&E plan that exists to support the NSP ‘is very weak and does not address all important elements of an M&E plan’.

Therefore, incorporating the recommendations from mid-term review of NSP and gaps identified in MESST, the national M&E plan has been developed for the remaining period of NSP i.e., from 2010 to 2011.

Through this M&E plan, the program results at all levels (impact, outcome, output, etc.) can be measured to provide the basis for accountability and informed decision making at both program and policy level. This document provides the framework for the monitoring of HIV/AIDS programs in the country. It serves as guidelines for HIV/AIDS monitoring and evaluation for decision makers, key stakeholders in the national HIV/AIDS response and program officers on essential data to be collected, utilized and reported to local and national level authorities. This plan also addresses other M&E elements like information products, data quality, information flow, evaluation & research, capacity building and dissemination of M&E data. It draws extensively on concepts and methodologies from the *Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria*, developed in collaboration between the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNAIDS, WHO, USAID and other stakeholders.

2. DEVELOPMENT OF NATIONAL M&E PLAN

The report of 2009 year joint mid-term review of National Strategic Plan formed the basis for developing the national M&E plan. As the country is yet to define and launch the comprehensive package of services for many of the sub-population groups/people most at risk as well as youth, the M&E plan is made little broader allowing the possible changes in scope and scale in the National AIDS Program for next couple of years.

A four-stage approach has been followed in developing the national M&E plan:

1. The report of 2009 year joint mid-term review of National Strategic Plan formed the basis for developing the national M&E plan. As the country is yet to define and launch the comprehensive package of services for many of the sub-population groups/people most at risk as well as youth, the M&E plan is made little broader

³ A report on exercising monitoring and evaluation systems strengthening tool. The republic of Maldives, November 2009. By Phanindra Babu Nukella.

allowing the possible changes in scope and scale in the National AIDS Program for next couple of years.

2. The draft plan (developed following the observations and recommendations of 2009 year joint mid-term review) has been shared with UNDP and National AIDS Program for the initial comments and accordingly the comments addressed.
3. The National AIDS Program has conducted a day workshop with key stakeholders (such as MoH&F, SHE, Journey, SWAD, CCHDC, DDPRS, UNDP, Ministry of Education, Ministry of Islamic Affairs, Maldives Police Service and DPRS etc.) in the country where in the M&E plan has been disseminated with an aim to receive further comments, inputs and to make sure that they own the plan.
4. The draft plan has also been shared with the Joint Mid-term review team of NSP constituted with the representation from World Bank, UNAIDS, WHO, UNODC, National AIDS Program/MoH, UNDP and UNICEF and received further feedback. The feedback and inputs have appropriately been incorporated.

The M&E plan has undergone all these four stages successfully and accordingly finalized.

3. FRAMEWORK FOR MONITORING AND EVALUATION

3.1 Goal of the National Program

To maintain the low prevalence of HIV in the Maldives, improve the quality of life and health of PLHIV and their families, and create an enabling environment to mitigate the impact of HIV

3.2 Target Group

Injecting Drug Users, Resort and Construction workers, Seafarers, Youth, Prison inmates, Female Sex Workers and their clients, and Men who have Sex with Men.

3.3 Purpose of National M&E Plan

The overall purpose of this M&E plan is to help National AIDS Program to track the spread of epidemic and understand the changing behavior of population groups so that well informed and timely decisions are taken at program and policy level in mitigating the impact of HIV/AIDS.

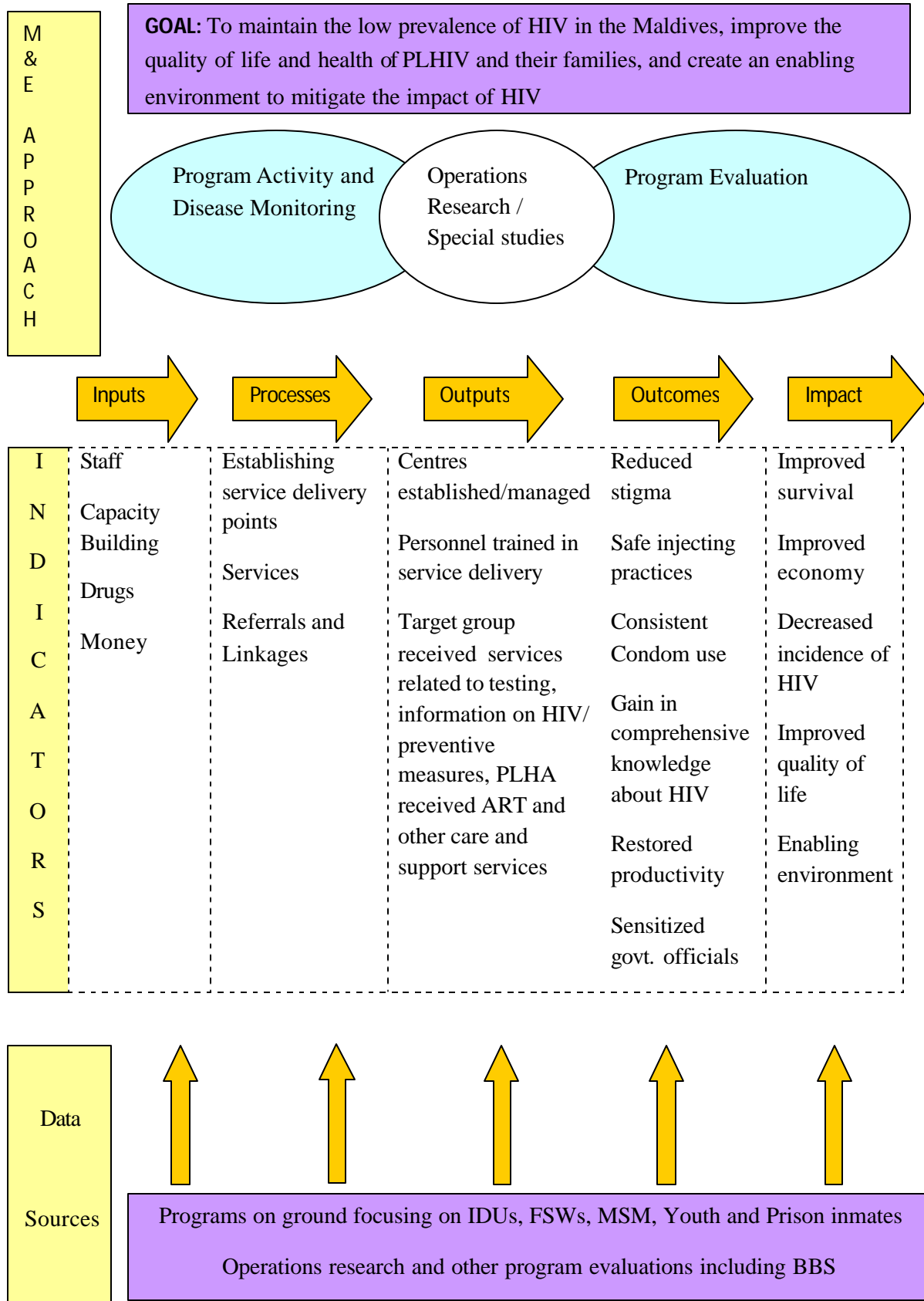
The present monitoring and evaluation system is developed with an aim to:

- Collect evidence of activities and results
- Assess the quantity and quality of achievements of targets,
- Identify operational gaps in the program and accordingly address them to improve program efficiency
- Help develop clear M&E data management processes that will enable systematic collection, collation, processing, analysis, and interpretation and use of data
- Help define a list of core indicators that enables tracking of progress among different sub-population groups
- Help identify issues for operations research that offer valuable solutions and thereby improve efficiency of the program
- Describe the key data sources to be used to gather necessary M&E data.
- Establish clear information flow channels between the different stakeholders in the country
- Develop a plan for strengthening the capacity of all partners involved in the monitoring and evaluation of HIV/AIDS programs including National M&E unit.
- Describe the dissemination mechanisms of all critical information amongst all stakeholders, implementing agencies and among the general public.

The expected outputs on the implementation of the M&E Plan:

- Strengthening the Monitoring and Evaluation System
- Quality and timely reporting by all program implementers
- Establishment of a data depository and database
- Structured coordinated flow of routinely collected information among stakeholders at various levels of the M&E system
- Establishment of monitoring and evaluation dissemination strategy
- Development of Capacity Building Plan
- Identify Research and Evaluation Agenda

Fig.1 - The monitoring and evaluation framework: an Operational Plan



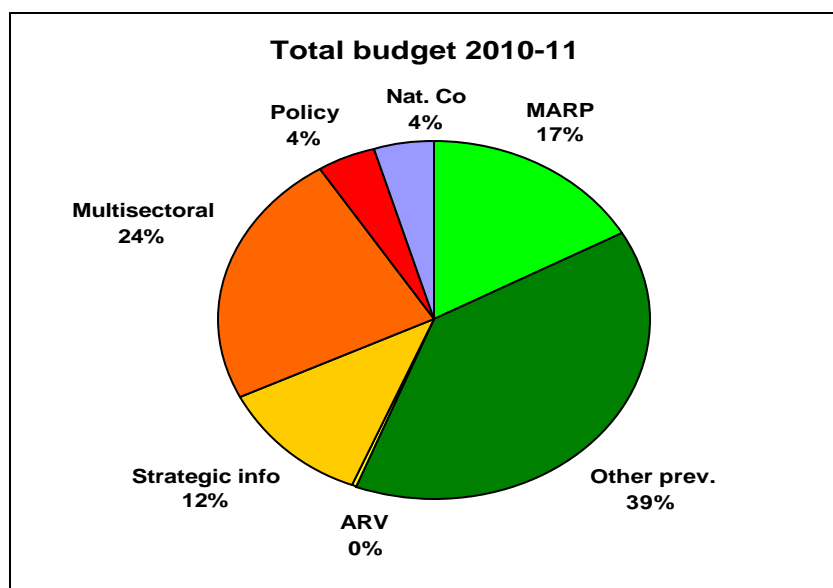
The guiding principles of the M&E plan include:

- The M&E plan would include minimal number of indicators that are easy to capture and analyze
- Most of the indicators are drawn from international guidelines and thereby allowing more scope for comparison across regions
- Use of uniform reporting tools consistently across the country
- Conducting Operations research/special studies as appropriate
- The program activity monitoring data will be promptly analyzed, linked to routine supervisory system and fed back for program improvement

4. PROGRAM ACTIVITY AND DISEASE MONITORING

As the country has a low prevalence of HIV, the national response should essentially focus its efforts on prevention. The Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) grant is the only key financing mechanism in the country, and the main funder of the NAP. The total budget for 2010-2011 (from all sources, including GFATM) includes activities for Sex Work and MSM and a prison program for the first time, as well as harm reduction interventions. In total, targeted interventions focusing on high risk behaviours consume 17% of total HIV spending in 2010-2011 (see Fig. 2 below). This is odd; for a low-level epidemic like Maldives, one would expect targeted interventions to consume a much higher percentage of resources⁴.

Fig. 2: Total HIV Spending in 2010-2011



⁴ Report of the 2009 Joint Mid-term review of the National Response to HIV in the Maldives

With the existing financial resources, at present, the country has been implementing activities focusing on harm reduction among injecting drug users, awareness-raising among sex workers and awareness campaigns at targeted workplaces such as resorts.

Before the program activity monitoring of these activities is discussed, it is worthwhile to look into the current situation of these activities, as stated in the *report of 2009 Joint Mid-term review of National Response to HIV in Maldives*.

4.1 Current Situation of Prevention Activities

Prevention focusing on injecting drug use

Since 2007 the Maldives has managed to provide a number of interventions to prevent HIV for IDUs including outreach (IEC) with the support from NGOs (Journey, SWAD and SHE), a pilot project for methadone provision and a new detoxification center. Several activities related to injecting drug users are currently funded via the GFATM mechanism, which annually aims to reach 1200 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 2009⁵. There exists an OST (methadone) clinic in Male' and an additional detox clinic in Villingili during 2009. Indeed, reported relapse rates of more than 65% have been confirmed for the existing Maldivian detox services, with some key informants estimating it may be closer to 95%. The OST clinic was found to have been without urine testing equipment for more than 4 months; hence methadone was provided to clients without testing their urine for evidence of recent heroin use. The methadone was provided to both drug user- and injecting drug user addicts, without proper psycho-social counseling. As a result of this, according to key informants, many clients started to combine methadone and heroin, with the resulting aggression and fights. Perhaps most seriously, it has led to decreased support for OST as an essential harm reduction intervention, even among drug users themselves.

Prevention focusing on sex work

In the Maldives, it is hard to speak of a sex industry, since sex in return for money or services happens in a non-formal, hidden and sometimes inexplicit way. There are no brothels or other formalized establishments for sex work. Until today, no comprehensive package for women (and men) engaging in transactional sex has been agreed upon or launched in the Maldives. The joint mid-term review team learnt that NGOs have been able to identify 3-4 hotspots for

⁵The Grant proposal and progress reports can be downloaded from the GFATM website at www.theglobalfund.org/programs/grant/?compid=1369&grantid=574&lang=en&CountryId=MDV

street-based sex work but not much has been done to provide appropriate skills and services (condoms and treatment of STIs) to people engaging in this behavior. One NGO has been training women involved in sex work and escort work at resorts and hotels. However, the mainstay of these interventions has been awareness-raising; little attention has been given to other components of a more comprehensive response focusing on reducing HIV transmission in the context of sex work, like welcoming VCT centers, welcoming STI services and the provision of condoms and lubricants.

Prevention focusing on men who have sex with men

The Joint mid-term review team currently found little evidence of HIV prevention interventions among men having sex with men. In the Maldives, homosexuality is illegal and a strong social taboo. Despite this, 126 MSM were enrolled in the recent BBS; low condom use and a high prevalence of Hepatitis was found among them. No Maldivian 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.

It is recommended that a program focusing on improving male sexual health is designed based on the findings of the BBS, the upcoming size estimation and risk behavior mapping study, taking into account what is feasible within the socio-cultural context. Such a broad program can address several vulnerabilities and risk practices of Maldivian men. After such a program has been established, the possibility of a more specific program for MSM under its umbrella could be considered.

Prevention focusing on prison inmates

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. The Joint mid-term review team advises to introduce public health (including harm reduction) services for prison inmates. Such programs should include a BCC component aimed at both the prison population and the guards. Specifically, the review team proposes a prison-based comprehensive harm reduction program, including OST, along with other essential STI and HIV prevention services be piloted.

Prevention for youth and other groups

Most of the HIV prevention activities currently implemented in the Maldives aim at awareness raising 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 SHE and NAP to initiate and strengthen youth programs, 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. However, often these programs do not mention sexual

behaviors that are most likely to expose people to HIV (i.e. unsafe sex in exchange for money or goods and unsafe anal sex (including between men). Drug use and drug injection are likely mentioned, but not in a comprehensive manner; the message is often only on how ‘bad’ drugs are (and implicitly how immoral drug users are). The reasons why people use drugs are not discussed, local myths about drug use and drug users are not dispelled, and the mechanism of addiction is rarely mentioned, a lack of understanding of which further contributes to the stigmatization of drug users⁶.

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 2009⁵ via in-service training); however the Ministry of Education (MOE) has yet to integrate life-skills and HIV education into the core curriculum of the recently established teacher training college.

4.2 Size Estimations/Risk Behaviour Mapping

The current situation analyses of prevention activities, as described above, offers following implications for M&E:

1. With regard to interventions conducted for injecting drug users so far, (for example, OST, detoxification, rehabilitation and outreach), the NAP will conduct an independent evaluation to help understand quantitative and qualitative insights in the implementation of such programs, thereby, develop comprehensive package of services focusing I/DUs and improve the quality of service delivery. UNODC would provide technical support to the NAP of Maldives in planning, developing and implementing this activity.
2. It is believed that I/DU population is increasing in the country. Therefore, to identify potential areas where I/DUs are concentrated, to obtain the denominators disaggregated for age, sex, catchment area and socio-economic status, and to plan for effective outreach, the size estimations /risk behavior mapping will be carried out across all inhabited atolls.
3. With regard to designing and expanding interventions related to Sex Work and MSM, the potential geographic areas and size of the population is not known. To develop interventions and implement them (including effective outreach plan), the strategic information on their size and risk behavior mapping is indispensable. The NAP plans to conduct size estimations/risk behavior mapping of these population and use it for developing comprehensive package of services.
4. With regard to intervention focusing on prison inmates, according to the recommendation of JMTR, a feasibility study will be conducted at a small prison on

⁶ Maldives Police Service, Paper on national HIV strategy and the Police, December 2009

prison-based methadone project to reduce harm, and a needle exchange program and document the lessons learnt that help in scaling up the intervention.

5. TRACKING THE EPIDEMIC AND BEHAVIOURAL MONITORING

5.1 Tracking epidemic

There are 8 Voluntary counseling and testing (VCTC) existing in the Maldives (IGMH, Villingilli health center and six regional hospitals). Recently, two new VCTC have been inaugurated outside the public health system. Guidelines for testing as well as operationalising the VCT service were developed and endorsed by the Center for Community Health and Disease Control (CCHDC) in April 2009. The review of data for HIV testing in the past year suggests, however, almost negligible use of these services: only 21 people came for voluntary tests, according to a key informant, though the centers have been used for thousands of provider-initiated tests. The majority of testing in the Maldives is related to pre-employment screening, pre-surgical operation screening and blood screening⁴. In order to increase (voluntary) uptake of the services, the VCT centers will be made friendly and accessible to those most at risk, and outreach and IEC interventions should help promote them. The NSP aims to have VCT services at all ANC, TB and STI managing units. Therefore, the epidemic, atleast until 2011 year, will continue to be monitored with the help of VCTCs on an ongoing basis. Since the risky behaviors are increasing particularly among sub-population groups, introducing sentinel surveillance system in the country at least at selected areas (like STD and IDU sites) will help in effective tracking of epidemic on a yearly basis.

5.2 Behavioural Monitoring

Having objective information about HIV and STI infection and associated risk behaviors is important to track the epidemic as well as to monitor program implementation and its impact. Regular (two-yearly) BBS focusing on HIV and STI transmission via these behaviors remains necessary. This information will be important to plan/adjust interventions (and assess their effectiveness) as well as generate information that will inform a National Monitoring and Evaluation System⁴. The first BBS was conducted in year 2008 covering sub-population groups like FSW, MSM, IDU, Occupational Cohort Males (Seafarers, Construction Workers and Resort Workers) and Youth (15-24 years) through which the country could gather useful strategic information and obtained baseline values.

The sample size per risk group, BBS, The Republic of Maldives, 2008 is presented below ⁷:

⁷ 2008 Biological and Behavioural Survey on HIV/AIDS, UNDP/Maldives

Target Group	Sampling technique	Sample Size	
		Behavioural	Serologic
FSW	Snowball	34 in Male'	32 in Male'
		68 in Addu	62 in Addu
MSM	Snowball	69 in Male'	69 in Male'
		57 in Addu	55 in Addu
IDU	Snowball	147 in Male'	150 in Male'
		129 in Addu	128 in Addu
OCM			
Seafarers	Simple random sampling	99	100
Construction Workers	Simple random sampling	101	102
Resort Workers	Cluster sampling	460	484
Youth	Cluster sampling	460 in Male'	469 in Male'
	Purposive sampling	145 in Laamu (Gan)	140 in Laamu
Total		1769	1791

The BBS will be conducted at the end of NSP that allows measuring improvements in key behaviours among the population shown above.

5.3 Indicators Measuring the Progress

As programs related to I/DUs, resort workers, construction workers and youth are currently in place and as noted earlier, the GFATM/R6 grant is the only key financing mechanism in the country addressing these populations, and the main funder of the NAP; the impact, outcome indicators for NSP have been taken from the performance framework for phase 2 of GFATM program. Further, the output indicators are also accordingly taken from the performance framework of GFATM for these populations. Together with UNDP, only three NGOs (Journey, SHE, SWAD) are working in the country. Other than these, the NSP on its own does not currently operate any program in the country.

At present, under current NSP, there are no focused interventions covering FSWs and MSM, therefore, no indicator for FSWs and MSM has been listed here.

Impact / outcome Indicator	Indicator	Baseline			Targets		
		Value	Year	Source	Year 2010	Year 2011	Year 2012
Impact	% of IDUs who are HIV infected	0%	Oct-08	BBS	0%		0%
Outcome	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	23%	Oct-08	BBS	29%		40%
Outcome	Percentage of IDUs who reporting the use of a condom the last time they had sexual intercourse	32%	Oct-08	BBS	38%		45%
Outcome	Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	One mini survey has been planned in October 2009. The results of which will inform the baseline values and then the targets for the remaining period. Another mini survey will be conducted in year 2012 among youth that help measure the progress against the targets.					

Source: The Performance Framework for phase 2, GFATM (Round 6 program), 2010-2012

Some of the output indicators that represent the national AIDS program are:

Indicator	Baseline (if applicable)			Targets (cumulative)	
	Value	Year	Source/ Responsible partner	Year 2011	Year 2012
Number of law enforcement officers including judiciary, police and staff of correctional facility trained on IDU and HIV concerns	0	2007	NNCB	265	345
Number of peer educators trained on HIV AIDS risks for drug users and outreach to DUs and IDUs	0	2007	NNCB	137	167
No of DUs and IDUs reached by HIV prevention program	0	2007	NNCB	4,987	6,187
Number of peer educators trained on HIV/ AIDS risks and outreach to migrants	0	2009	SHE	25	40
Number of migrants and resort workers reached by HIV/AIDS prevention program	0	2007	SHE	41,000	47,500
Number of HIV education sessions held in large enterprises / companies	0	2007	SHE	42	48
Number of people who received testing and counselling services for HIV and received their results	4081	2006	DPH- MoH	1,200	1,600
Number of Health Care Providers trained in diagnosis and clinical management of STIs	23	2006	DPH- MoH	341	381
Number of STI cases treated at health care facilities	40	2006	DPH- MoH	2,202	2,602
Number of adults and children with advanced HIV infection (currently) receiving antiretroviral therapy	1	2006	DPH- MoH	10	10

Number of clinicians trained on rational use of blood and blood products - RBC and nurses trained in blood transfusion practices	0	2006	DPH- MoH	432	472
Number and % of donated blood units screened for HIV according to the national guidelines	100% of 8916	2006	DPH- MoH	8920* (100%)	8920* (100%)

*Targets are annual basis and not cumulative
Source: The Performance Framework for phase 2, GFATM (Round 6 program), 2010-2012

NOTE Baseline Source: Post November 2008, after the presidential elections, new government has been established and the ministries have changed. The changes are as follows: DPH has changed to Centre for Community Health and Disease Control (CCHDC) and NNCB to Department of Drug Prevention and Rehabilitation Services.

5.4 Mass Media Campaign

The research conducted in Maldives found out that risk behaviors for HIV in the Maldives are very common. For example, injecting drug use and needle-sharing are increasing rapidly, young people change partners frequently, men may visit sex workers, and very few people use condoms. These are the same behaviors which have caused HIV epidemics in neighboring countries⁸.

Therefore, with the support from GFATM (Round 6), UNDP in coordination with the National AIDS Program, DDPRS and SHE a mass media campaign (television and radio spots) has been developed, pre-tested and launched to make sure the public is aware of the risks and motivate them to protect themselves against HIV.

The Target Audience: The target audience for the campaign is young people who may be at risk through unsafe sex or injecting. However, since this campaign will be broadcast, it may be seen by any member of the community, including children.

The spots are released in four phases. Each phase will run about a quarter period and therefore, the entire media campaign in four phases will spread across the year.

Goal of Phase 1:
Increase awareness of HIV as a potential threat to the Maldives.

⁸Proposal for a Mass Media Campaign on HIV, The Global Fund in the Maldives, August 12, 2009

Goal of Phase 2
Enhance perceived risk of HIV among sexually active young people and drug injectors.
Goal of Phase 3
Make condoms more acceptable by associating them with humor, and with cool ways to protect oneself.
Goal of Phase 4
Model social support by older Maldivians for condom use by the young.

Since this is important and major activity to be carried out from January 2010 in the country by airing several TV and Radio spots, as a part of the M&E plan, efforts will be made to understand the effectiveness of this mass media campaign for each phase.

Overall, the effectiveness will be studied through the following objectives:

1. Assess the awareness levels of HIV among target audience
2. Retention and comprehension of the messages
3. Viewership and listenership
4. Assess the perceived risk of HIV among sexually active young people and drug injectors
5. Acceptance of Condoms by youth and its social support by older population

This effectiveness study will help understand the efficacy of such a media campaign and thereby take a programmatic decision whether to continue such campaigns in future too and what alternations need to take place in the messaging. Also, the study would offer cues to choose appropriate TV and Radio channels and timings to increase the viewership and listenership.

6. Data Sources

Two major data sources can be identified: (a) data sources for indicators that will be measured by surveys such as Biological and Behavioural Surveys focusing on key sub-population groups such as FSWs, MSM, IDU, Prison inmates, Seafarers, Construction and Resort Workers, mini survey among youth population that will provide outcome and impact indicators; and (b) data sources for indicators that will be measured using regular management information system that offer process and output indicators. In addition, the population based surveys such as Demographic Health Survey and Multi-Indicator Cluster Survey, if carried out by external agencies, will also provide useful strategic information.

6.1 Biological and Behavioural Surveys

Please refer to “behavioural monitoring” in section 5.

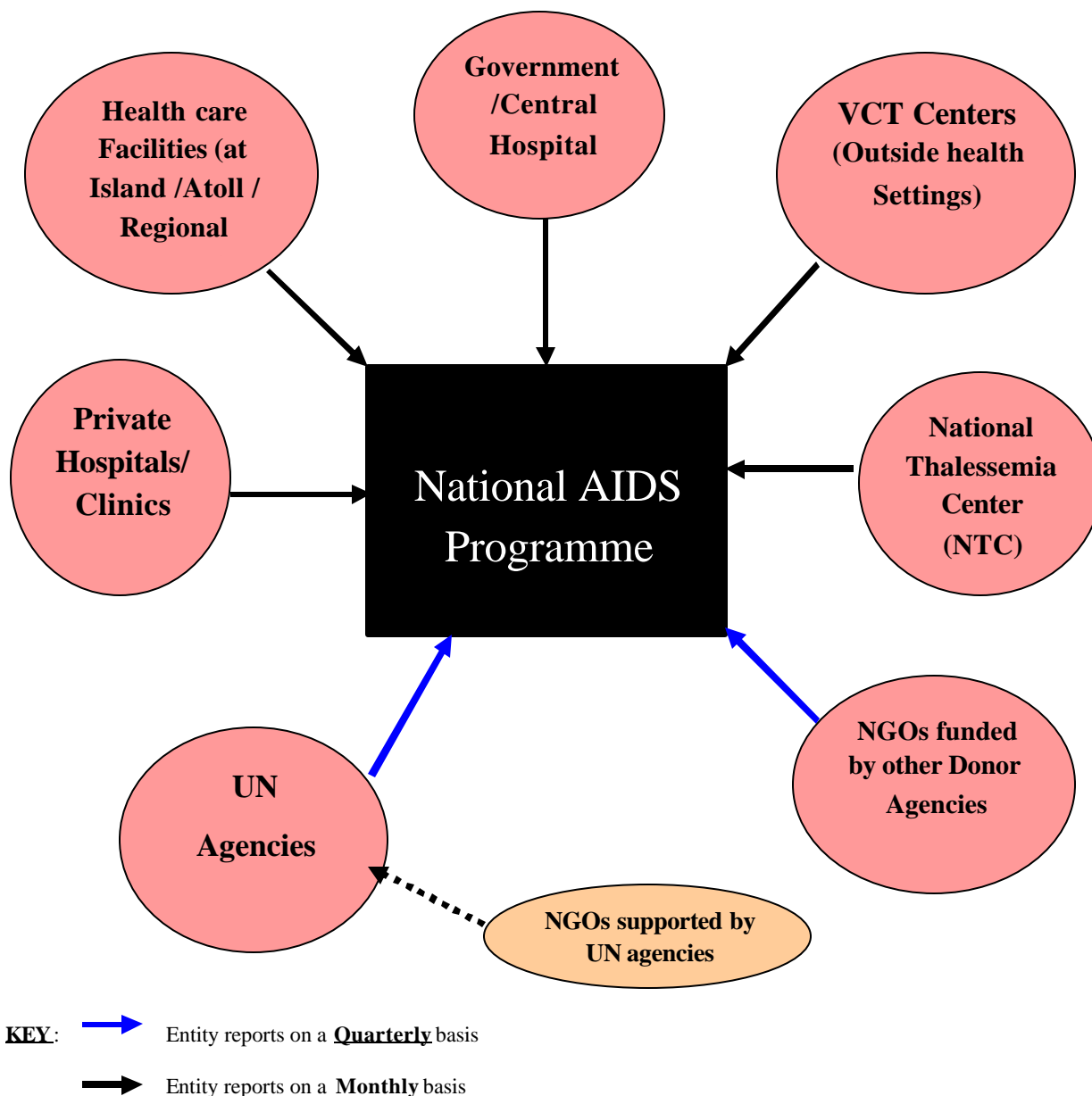
6.2 Management Information System

There exist a management information system (MIS) covering the interventions among youth (15-24 years), injecting drug users, seafarers, construction and resort workers. As there are no formal interventions for FSWs, MSM and Prison inmates, there is no management information system in place.

Mostly, the MIS for the target groups such as youth (15-24 years), injecting drug users, seafarers, construction and resort workers come from the GFATM (Round 6) funded program implemented by UNDP Maldives. According to the report on exercising monitoring and evaluation systems strengthening tool³, the frequency of data collection set out in MIS is not feasible at certain times given the fact that there is staff turnover and incomplete information is maintained at service delivery points. The national program has circulated standardized data collection forms that capture people reached for various services, however, data quality is an issue as the national program has not yet provided clear instructions on how to fill-up those forms and there are no operational definitions for community outreach activities under the national program. Furthermore, till now, there have been no standard recording and reporting formats for the PLHIV under care (pre-treatment as well as on ART)⁴.

Therefore, an M&E Working Group consisting implementing partners and National AIDS Program will be set up to review all existing reporting (monthly and quarterly reporting forms) and recording tools (registers, client registration forms, referral slips etc.) that are currently implemented by various partners in the country. The working group will help standardize the tools with appropriate timelines that are feasible to follow. The working group will meet as and when necessary, and will update the tools as per the modifications in the program strategies.

7. Information Flow



The data flow that is currently being followed in the country is presented in the figure shown above. The same will be followed for next two years of NSP. The VCTC and Private Clinics are currently reporting HIV and STI cases respectively as and when they find them. Thus, steps will be taken to inform the concerned institutions to report it on a regular basis although no case is detected. These measures will help strengthen the reporting system.

8. Data Quality Assurance and Monitoring Service Quality

The M&E plan proposes to establish the following mechanism that ensures data quality at all levels and for all types of service delivery points such as VCTC, STI clinics, ART Centres etc.

- Regular site visits – The implementing partners and National AIDS program will make periodic visits to the service delivery points using supervisory check list to assess program delivery and reliability of MIS data. These visits ensure availability and completeness of all indicator source documents for the selected reporting period.
- Trace and Verification: Trace and verify reported numbers: (1) Recount the reported numbers from available source documents; (2) Compare the verified numbers to the site reported number; (3) Identify reasons for any differences. The Routine Data Quality Assessment (RDQA) tool developed by GFATM will be followed, in this regard. RDQA will be implemented at frequent intervals at randomly selected sites and for selected indicators. As a part of RDQA, cross-checks will be performed- “cross-checks” of the verified report totals with other data-sources (eg. Inventory records, laboratory reports, etc.).
- Spot checks (if feasible): Perform ‘spot checks’ to verify the actual delivery of services or commodities to the target populations.

9. Operations Research/Special Studies

Supplementary operations research on behavior pattern of highly vulnerable groups will be carried out as appropriate to guide the National response.

For example, there are 8 VCTC existing in the Maldives. The review of data for HIV testing in the past year suggests, however, almost negligible use of these services: only 21 people came for voluntary tests, according to a key informant, though the centers have been used for thousands of provider-initiated tests. This is true in spite of receiving the reports on high STI case detection rates in the country. In this regard, a special study may be planned to understand the factors affecting the utilization of VCTC services on a voluntary basis and identify ways to make VCT services more user friendly so that VCTC are optimally utilized.

Another operations research study could be whether training of service providers including proper psycho-social counseling and arranging equipment at the methadone clinic in Male’ and an additional detox clinic in Villingili would reduce relapse rates? (reported relapse rates of more than 65% have been confirmed for the existing Maldivian detox services, with some key informants estimating it may be closer to 95%) or are there any other factors contributing to such a high relapse rate?

10. Capacity Building – National Management Unit and Sub-Reporting Entities

At present, there are three officers working for the National AIDS Program, out of which one officer is responsible for M&E. This officer in the Management Unit (MU) is responsible for data management and ensuring strategic use of M&E data. The MU does not have capacity

in strategic information and data-systems management as they did not receive any formal training. Currently, it reviews the quality of data submitted by Sub-reporting entities and is also able to identify inconsistencies but not in a position to resolve them. There exists no mechanism to address missing data and sub-reporting entities are not provided feedback on quality of reporting, except in few donor funded projects such as GFATM (R6) of UNDP. Thus, building the capacity of the management unit on M&E would enable the aggregation and analysis of data from programs implemented across the country, regardless of source of funding, and will become an effective decision-making unit at the national level. It is envisaged that once the national M&E unit will become fully functional, it will assume responsibility for the implementation and maintenance of these initiatives at the national level.

The capacity building needs of the management unit with regard to M&E are:

1. To be able to manage strategic information and data-systems including data verification, feedback to partners, identification of missing data and quality of data, resolving data inconsistency etc.
2. Help build the systems to avoid double counting for people reached and trained both at health facility and community settings
3. Enhance the capacity on analyses of routine data and of periodic surveys
4. Enhance the capacity on supervising the sub-reporting entities and offer timely support

Development of an operational manual for M&E data management systems addressing issues across – data quality, inconsistency, mistakes, missing data, late reporting, incomplete, inaccurate etc. would offer an immense help to the management unit. WHO and UNAIDS would provide technical support for this activity

11. Program Evaluation

The M&E plan proposes a comprehensive evaluation of National AIDS Program (2007-2011) at the end of NSP period. This would include both qualitative and quantitative evaluation. Also, it would look at the secondary information available from various sources such as VCTC, STI clinics, ART Centres and data from other NGOs.

Quantitative evaluation will focus on outcome and impact parameters. Some of the key parameters are listed below:

- % of IDUs who are HIV infected
- Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected
- Percentage of IDUs reporting the use of a condom the last time they had sexual intercourse

- Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission

While these outcomes and impact indicators are to come from BBS, a comprehensive analysis framework will be made with the help of process and output indicators from regular MIS. These analyses would link process and output indicators to the outcome and impact indicators. More indicators to be covered in the final evaluation are presented in *Annex 1-List of indicators*.

Qualitative evaluation will focus on:

- Coordination role of NAP for the overall success of the program
- Internal partnerships with various bodies like MOE, MOIA, police, civil society/NGOs etc.
- External partnerships with donor agencies like GFATM, UNODC etc. and international survey agencies that conduct DHS and MICS etc.
- Bringing technical support to the country with the help of UNAIDS, UNODC, WHO, UNFPA etc.
- Enabling environment. Arriving at a consensus between relevant authorities and intervention implementers, advocacy with key ministries and opinion leaders to enable targeted interventions to take place, media communications activities, issues like taboo, denial and stigma of risk behaviors and people living with HIV
- Case studies and testimonials of beneficiaries

The final program evaluation will bring in international expertise in designing the evaluation, its implementation and supervision. The evaluation will cover all interventions that are in place across the country and consider their collective impact.

12. Dissemination of M&E data (Information Products)

Presently, the program does not provide easy access of M&E data to health managers at different levels such as island, atoll and at national. As part of the Program's commitment to support the development and dissemination of strategic information, all M&E data conducted under the Program will be disseminated to governmental and non-governmental partners.

The key modes of dissemination, but not limited to, are:

- All monthly/quarterly reports received from sub-reporting entities (after being verified for its quality) will be posted on the MoH web page.
- Quarterly newsletters (with some analyses of M&E data by means of graphs, maps etc.) will be prepared and send them to all relevant stakeholders in the country
- As and when new information or updated information is available (either on treatment protocols or M&E data), it will be disseminated in seminars that will be organized only to disseminate information
- Where appropriate, media will be used for wider and faster dissemination

- The essence of field visits emerging from trip reports will also be shared with respective partner organizations.

13. M&E Budget

The budget to implement the strategies/activities laid out in this M&E plan is presented in the below **“Action Plan to implement M&E Plan for the Period 2010-2011”**

14. Budgeted Action Plan to implement M&E Plan for the Period 2010-2011

Activity	Verifiable Indicators of progress for next two years	Year 2010				Year 2011				Funding available (USD)	Source of Funding
		Jan-Mar.10	April-June.10	July-Sept.10	Oct-Dec10	Jan-Mar.11	April-June.11	July-Sept.11	Oct-Dec.11		
Conduct an independent evaluation of interventions conducted for injecting drug users so far	? Availability of evaluation report of interventions among IDUs by June 2010									15,000.00	Funding source not identified
Size estimations/risk behavior mapping among IDU, FSW and MSM	? Availability of report on size estimations/risk behavior mapping by June 2010									150,000.00	GFATM World Bank UNAIDS and UNDP
Launch feasibility study at a small prison on prison-based methadone project to reduce harm, and a needle exchange program	? Availability of a concept note and detailed implementation protocol on prison based methadone project by July 2010 ? Availability of feasibility study report by Dec.2011									20,000.00	Funding source not identified
Biological and Behavioural Survey among all target groups	? Availability of study design and survey tools by Aug.2011 ? Launch data collection by Dec.2011									150,000.00	Funding source not identified
Effectiveness of mass media campaign	? Number of TV and Radio spots aired – achieved vs planned ? Report on evaluation of mass media campaign available for each phase of the campaign									10,000.00	GFATM

Mini survey among youth	? Availability of study design and survey tools by Jan 2010 ? Availability of report of mini-survey among youth by June 2010									24,000.00	GFATM
Review of existing MIS and update it as per changes in the program strategy and develop MIS for new interventions for FSW and MSM	? Setting up of M&E working group with representation from all relevant stakeholders ? Availability of standardized tools by May 2010									10,000.00	Funding source not identified
Introduce standard recording and reporting formats for the PLHIV under care	? Standardized tools and formats available by April 2010									500.00	NAP
Data quality assurance	? Availability of at least 10 reports of field visits for data quality assurance, per year, by national management unit covering different atolls									20,000.00	Funding source not identified
Special Study 1 on uptake of VCT services	? Availability of concept note, study design and tools by April 2010 ? Availability of report by July 2010									12,000.00	Partially funded by WHO. Gap of US\$10000 exists
Special Study 2 on reducing relapse rate	? Availability of concept note, study design and tools by July 2010 ? Availability of report by Oct. 2010									5,000.00	Funding source not identified
Capacity building of national management unit and other entities	? National MU and other sub-reporting entities receive formal training on data management systems									15,000.00	GFATM

Program Evaluation	<p>? Availability of M&E operational manual</p> <p>? At least 80% of service delivery points reporting to the national AIDS Program</p> <p>? At least 80% of reports received are on time and with quality</p> <p>? Final detail program evaluation report being available</p>									10,000.00	Funding source not identified
Dissemination of M&E data	<p>? No. of dissemination workshops organized.</p> <p>? At least, 3 quarterly news letters (with M&E data analysis) are printed and shared with key stakeholders, per year</p>									5,000.00	GFATM
TOTAL										446,500.00	

Annex 1 – List of Indicators and its definitions

Indicator 1

Percentage of IDUs who are HIV infected

Rationale

Most-at-risk population groups typically have the highest HIV prevalence in countries with either concentrated or generalized epidemics. In many cases, the prevalence among these population groups can be more than twice the prevalence among the general population. Reducing prevalence among most-at-risk population groups is a critical measure of a national-level response to HIV. This indicator is calculated here for injecting drug users.

Definition of the indicator

Numerator: Number of members of the IDUs who test positive for HIV

Denominator: Number of members of the IDUs tested for HIV

Disaggregation: Age groups: <25 years, 25+ years, Sex: female, male

Measurement

This indicator is calculated using data from HIV tests conducted among members of IDUs.

Tools: Biological and Behavioral Surveillance Survey (BBS)

Frequency: Once, at the end of NSP

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS, 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Indicator 2

Percentage of young women and men aged 15–24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission

Rationale

HIV epidemics are perpetuated through primarily sexual transmission of infection to successive generations of young people. Sound knowledge about HIV is an essential prerequisite - albeit, often an insufficient condition - for adoption of behavior that reduces the risk of HIV transmission.

Definition of the indicator

Numerator: Number of respondents aged 15–24 years who answered all five questions correctly

Denominator: Number of all respondents aged 15–24 years

Disaggregation: Age groups: 15–19 years; 20–24 years

Sex: female, male

Measurement

This indicator is constructed from responses to the following set of prompted questions.

1. Can the risk of HIV transmission be reduced by having sex with only one uninfected partner who has no other partners?
2. Can a person reduce the risk of getting HIV by using a condom every time he or she has sex?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing food with someone who is infected?

The first three questions should not be altered. Questions 4 and 5 ask about local misconceptions and may be replaced by the most common misconceptions in your country. Examples include: “Can a person get HIV by hugging or shaking hands with a person who is infected?” and “Can a person get HIV through supernatural means?”.

Those who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator. An answer of “I don’t know” should be recorded as an incorrect answer.

Scores for each of the individual questions (based on the same denominator) are required as well as the score for the composite indicator.

Tool: Mini survey among youth

Frequency: First survey in Jan-March 2010 year in the form a mini survey

Second survey, at the end of NSP

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS, 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Indicator 3

Percentage of injecting drug users reporting the use of a condom the last time they had sexual intercourse

Rationale

Safer injecting and sexual practices among injecting drug users are essential, even in countries where other modes of HIV transmission predominate, because: (1) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (2) injecting drug users can spread HIV (such as through sexual transmission) to the wider population.

Applicability: countries where injecting drug use is an established mode of HIV transmission

Definition of the indicator

Numerator: Number of respondents who reported that a condom was used the last time they had sex

Denominator: Number of respondents who report having had sexual intercourse in the last month

Disaggregation: Age groups: <25 years; 25+ years, Sex: female, male

Measurement

Respondents are asked the following sequence of questions:

1. Have you injected drugs at any time in the last six months? 2. If yes: have you had sexual intercourse in the last six months?

3. If answering yes to both 1 and 2: did you use a condom when you last had sexual intercourse?

Whenever possible, data for injecting drug users should be collected through civil society organizations that have worked closely with this population in the field.

Access to survey respondents as well as the data collected from them must remain confidential.

Tool: Behavioral Surveillance Survey questionnaire for injecting drug users

Frequency: Once, at the end of NSP

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS, 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Indicator 4

Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected

Rationale

Safer injecting and sexual practices among injecting drug users are essential, even in countries where other modes of HIV transmission predominate, because: (1) the risk of HIV transmission from contaminated injecting equipment is extremely high; and (2) injecting drug users can spread HIV (such as through sexual transmission) to the wider population.

Applicability: countries where injecting drug use is an established mode of HIV transmission

Definition of the indicator

Numerator: Number of respondents who report using sterile injecting equipment the last time they injected drugs

Denominator: Number of respondents who report injecting drugs in the last month

Disaggregation: Age groups: <25 years; 25+ years, Sex: female, male

Measurement

Respondents are asked the following sequence of questions:

1. Have you injected drugs at any time in the last six months?
2. If yes: the last time you injected drugs, did you use a sterile needle and syringe?

Whenever possible, data for injecting drug users should be collected through civil society organizations that have worked closely with this population in the field.

Access to survey respondents as well as the data collected from them must remain confidential.

Tool: Biological and Behavioral Surveillance Survey questionnaire for injecting drug users

Frequency: Once, at the end of NSP

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS, 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Indicator 5

Percentage of most-at-risk populations who both correctly identify ways of preventing the sexual transmission of HIV and who reject the major misconceptions about HIV transmission

Rationale

Concentrated epidemics are generally driven by sexual transmission or use of contaminated injecting equipment. Sound knowledge about HIV is an essential prerequisite if people are going to adopt behavior that reduces the risk of infection. This indicator should be calculated separately for each population group that is considered most at risk in a given country: sex workers, injecting drug users and men who have sex with men.

Definition of the indicator

Numerator: Number of most-at-risk population respondents who correctly answered all five questions

Denominator: Number of most-at-risk population respondents who gave answers, including “I don’t know”, to all five questions

Disaggregation: Age groups: <25 years; 25+ years, Sex: female, male

Measurement

Respondents are asked the following five questions:

1. Can having sex with only one faithful, uninfected partner reduce the risk of HIV transmission?
2. Can using condoms reduce the risk of HIV transmission?
3. Can a healthy-looking person have HIV?
4. Can a person get HIV from mosquito bites?
5. Can a person get HIV by sharing a meal with someone who is infected?

The first three questions should not be altered. Questions 4 and 5 may be replaced by the most common misconceptions in the country.

Respondents who have never heard of HIV and AIDS should be excluded from the numerator but included in the denominator.

Scores for each of the individual questions – based on the same denominator – are required in addition to the score for the composite indicator.

Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents as well as the data collected from them must remain confidential.

Tool: Biological and Behavioral Surveillance Survey for most-at-risk populations

Frequency: Once at the end of NSP

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS, 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Indicator 6

Number of individuals from the targeted audience reached through community outreach with at least one HIV information, education, communication or behavior change communication

Rationale

This indicator measures the number of individuals who attended community outreach activities focused on creating awareness on how to prevent HIV. Community outreach is defined as any effort to affect change that might include peer education, classroom, small group and/or one-on-one information, education, communication or behavior change communication. Some programs have clear messages designed to reach a specific audience. For the purposes of this indicator count, community outreach does not include large-scale public gatherings.

Definition of the indicator

Numerator: Number of individuals reached with HIV information, education, communication or behavior change communication

Denominator: Not applicable

Disaggregation: By target group

Measurement

The data on this indicator will be collected through program monitoring reports of implementing partners. These records are compiled and aggregated to obtain an overall measure of the reach of prevention programs. Implementers at the community level need to devise reliable tracking mechanisms that capture accurate data to avoid double counting. The designated national body for data aggregation is responsible, to the extent possible, for adjusting for overlap between multiple programs serving the same individuals in a target area. An individual may be counted in separate program areas, such as youth out of school, who may be served (and therefore counted) separately by a youth program, program targeting married men, antiretroviral therapy program, etc.

Tool: routine program monitoring reports

Frequency: quarterly

Indicator 7

Number of most-at-risk populations reached with HIV prevention programs

Rationale

Most-at-risk population groups are often difficult to reach with HIV prevention programmes. However, preventing the spread of HIV among these populations and among the general population requires that they access these services. This indicator should be calculated separately for each population group that is considered most at risk in a given country: sex workers, injecting drug users, men who have sex with men and youth out of school.

Definition of the indicator

Numerator: Number of most-at-risk populations who have received a basic package of services

Disaggregation: Age groups: <25 years versus 25+ years

Sex: female, male

Most-at-risk population groups: injecting drug users, men who have sex with men, sex workers, young people out of school

Measurement

The data should be collected through program monitoring reports of implementing partners on a more routine basis. These records are compiled and aggregated to obtain an overall measure of the number of people reached by a prevention program, including young people out of school. Implementers at the community level need to devise reliable tracking mechanisms that capture accurate data to avoid double counting. Whenever possible, data for most-at-risk population groups will be collected at the community level through organizations that have worked closely with these people. There is a need to ensure that clients served (as opposed to client visits) for the same service or across services are counted. Data for this indicator will also be tracked through behavioral surveillance surveys (see UNGASS #9 indicator). There is a need for clear information flow mechanisms and tools (devised by national-level partners and bodies) that capture this kind of community data into national-level databases. Different types of services will all count the same in estimating overall service coverage. It is suggested that the essential minimum package of services for most-at-risk population groups should include:

- material on behavior change communication (promoting safer behavior);
- consumables (condoms; syringes if client is also an injecting drug user);
- counseling from a social worker or other relevant specialist; and
- referral to another specialist or service, as appropriate and based on individual client needs.
- This list defines the minimum number of services that an individual should receive to be counted as
- “reached” and by no means diminishes the importance of other relevant services provided at service delivery points.

Tool: programme reports

Frequency: continuous, with monthly or quarterly aggregation

Indicator 8

Percentage of most-at-risk-populations who received an HIV test in the last 12 months and who know their results

Rationale

To protect themselves and to prevent infecting others, it is important for most-at-risk populations to know their HIV status. Knowledge of one's status is also a critical factor in the decision to seek treatment. This indicator should be calculated separately for each population that is considered most at risk in a given country: sex workers, injecting drug users and men who have sex with men. Countries with generalized epidemics may also have a concentrated subepidemic among one or more most-at-risk population groups. If so, they should calculate and report this indicator for these population groups.

Definition of the indicator

Numerator: Number of most-at-risk population group respondents who have been tested for HIV during the last 12 months and who know the results

Denominator: Number of most-at-risk population group included in the sample

Disaggregation: Age groups: <25 years, 25+ years, Sex: female, male

Whenever possible, data for most-at-risk populations should be collected through civil society organizations that have worked closely with this population in the field. Access to survey respondents and the data collected from them must remain confidential.

Measurement

Respondents are asked the following questions.

1. Have you been tested for HIV in the last 12 months?
2. If yes: I don't want to know the results, but did you receive the results of that test?

Tool: Biological and Behavioral Surveillance Survey among most-at-risk populations

Frequency: Once, at the end of NSP

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS, 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Indicator 9

Percentage of sexually active young women and men aged 15–24 years who received an HIV test in the last 12 months and know their results

Rationale

To protect themselves against HIV and to avoid infecting others, sexually active young people should know their HIV status. This indicator provides a measure of the effectiveness of interventions that promote HIV counseling and testing among young people. This is important to know, because young people may feel that there are barriers to accessing services related to sensitive issues, such as sexual health.

Definition of the indicator

Numerator: The number of respondents aged 15–24 years who had an HIV test in the last 12 months and who know their results

Denominator: The number of respondents aged 15–24 years who have had sexual intercourse in the last 12 months

Disaggregation: Age groups: 15–19 years, 20–24 years, Sex: female, male

Measurement

In a population-based survey, respondents are first asked whether they have had sexual intercourse in the last 12 months. Those replying affirmatively are then asked whether they were tested in the last 12 months and, if yes, whether they know the results of their HIV test. Those replying affirmatively to these three questions are counted in the numerator.

The validity of the data may be affected by reporting bias because some respondents may not want to admit to knowing their HIV status for fear of being pressed to disclose it. Conditions under which respondents are interviewed are likely to affect reporting bias. For example, respondents are more likely to be reticent if data are collected in the presence of other people than if they are collected in strict privacy.

Tool: Mini survey among youth

Frequency: First survey in Jan-March 2010 year in the form a mini survey

Second survey, at the end of NSP

Source

Core indicators for national AIDS programs: guidance and specifications for additional recommended indicators. Geneva, UNAIDS, 2008.

Indicator 10

Number of cases of sexually transmitted infections treated

Rationale

Similar types of behavior put people at risk for both sexually transmitted infections and HIV. People with sexually transmitted infections may be at higher risk of acquiring or transmitting HIV infection due to the co-factor effect of an existing sexually transmitted infection. Services for sexually transmitted infections provide opportunities for comprehensive care that includes early treatment; counseling and communication about behavior change and information for sexual partners; access to testing for HIV infection; and an entry point into care programs for people living with HIV. Treating sexually transmitted infections quickly and effectively reduces the possibility of further transmission of infection.

Definition of the indicator

Numerator: Number of cases of sexually transmitted infections (determined syndromically or etiologically) identified at selected facilities that were treated.

The following sexually transmitted infections have been shown to be important co-factors for HIV transmission or acquisition and should therefore be considered for the assessment: curable genital ulcers, notably chancroid and syphilis; other curable sexually transmitted infections including *Neisseria gonorrhoeae* and *Chlamydia trachomatis*, which may present as urethral discharge. Where treatment of herpes viral infection is included as a part of national guidelines, assessment for appropriate genital ulcer disease therapy should include anti-herpes treatment.

Measurement

Tools: program records

Frequency: quarterly

Disaggregation : By sex (male, female) and age

Indicator 11

Percentage of donated blood units screened for HIV in a quality-assured manner

Rationale

Blood safety programs aim to ensure that all blood units are screened for transfusion-transmissible infections, including HIV, and that only the units that do not react on screening tests are released for clinical use. In many countries, blood units are not screened for all the major transfusion-transmissible infections. Even when screening does occur, inaccurate test results often compromise the safety of blood due to the poor quality or incorrect storage of test kits. Further, inadequate staff training or a lack of standard operating procedures may result in laboratory errors. This could lead to blood units being classified as safe even when they are infectious, posing a serious risk of transmission of HIV through unsafe blood. Universal (100 percent) screening of donated blood for HIV and other transfusion-transmissible infections cannot be achieved without mechanisms to ensure quality and continuity in screening. Sometimes, interruptions to supplies of test kits and reagents, or emergency situations, can result in the use of blood for transfusion without screening for transfusion-transmissible infections. The development of systems that provide reliable and regular supplies of low-cost, high-quality test kits and reagents and effective stock management is therefore essential to ensure universal quality screening of blood units. Thus, screening all donated blood units for HIV in a quality-assured manner is crucial. Two key components of quality assurance in screening are:

- the use of documented and standardized procedures (standard operating procedures) for the screening of every blood unit; and
- participation of the laboratories in an external quality assessment scheme for HIV screening in which external assessment of the laboratory's performance is conducted using samples of known, but undisclosed, content to assess its quality system and assist in improving standards of performance.

Definition of the indicator

Numerator: Number of donated blood units screened for HIV in blood centers or blood screening laboratories that have both: (1) followed documented standard operating procedures and (2) participated in an external quality assurance scheme

Denominator: Total number of blood units donated. In this context, donation refers to any blood collected for the purposes of medical use. This includes all possible types of providers of blood, regardless of whether they receive remuneration or not. Examples of different categories of blood donors include:

- *voluntary non-remunerated blood donor: an altruistic donor who gives blood freely and voluntarily without receiving money or any other form of payment;*
- *family or replacement blood donor: a donor who gives blood when it is required by a member of the patient's family or community, which may involve a hidden paid donation system in which the patient's family pays the donor;*
- *paid donor: a donor who gives blood for money or other form of payment; and*
- *autologous donor: a patient who donates his or her blood to be stored and reinfused, if needed, during surgery.*

Measurement

The information relates to data from the previous 12 months (January–December). This information should be available from the national blood transfusion service or the national blood program manager in the health ministry. The following information is required to measure this indicator.

1. How many total blood units were donated in the country?

For each blood center and blood screening laboratory that screens donated blood for HIV:

2. How many units of blood were donated in each blood center or blood-screening laboratory?

3. How many donated units were screened in the blood center or blood-screening laboratory?

4. Does the blood center or blood-screening laboratory follow documented standard operating procedures for HIV screening?

5. Does the blood center or blood-screening laboratory participate in an external quality assessment scheme for HIV screening?

From this information, the indicator will be calculated.

Tools: FRAME Tool (Framework for Assessment, Monitoring and Evaluation of blood transfusion services): a rapid assessment tool used by the WHO Global Database on Blood Safety

Frequency: annually

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS, 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Indicator 12

Percentage of never married young women and men aged 15–24 years who have never had sex

Rationale

This indicator measures the percentage of never married young people surveyed who report they have never had sex (that is, the self-reported prevalence of virginity among young people). Abstinence and delayed sexual initiation can help young people protect themselves against sexually transmitted infections, including HIV. Looking at this prevalence within narrow age ranges (15–16, 17–18, 19–20, 21–22 and 23–24 years or by age in years) over time allows program managers to assess whether the age at sexual debut is changing.

Definition of the indicator

Numerator: Number of never married young women and men who have never had sexual intercourse

Denominator: Number of never married young women and men aged 15–24 years surveyed

Disaggregation: Age group: 15–19 years; 20–24 years (see above for narrow age ranges)

Sex: female, male

Measurement

The numerator is measured by asking never married male and female survey respondents aged 15–24 years whether they have ever had sexual intercourse. If they answer no to this question, then they are counted in the numerator.

The denominator includes all male and female survey respondents aged 15–24 years who were never married, including those that are cohabiting.

Tool: Mini survey among youth

Frequency: First survey in Jan-March 2010 year in the form a mini survey

Second survey, at the end of NSP

Source

Core indicators for national AIDS programs: guidance and specifications for additional recommended indicators. Geneva, UNAIDS, 2008.

Indicator 13

Percentage of women and men aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months

Rationale

The spread of HIV largely depends on unprotected sex among people with a high number of partnerships. Individuals who have multiple partners (concurrently or sequentially) have a higher risk of HIV transmission than individuals that do not link into a wider sexual network.

Definition of the indicator

Numerator: Number of respondents aged 15–49 years who have had sexual intercourse with more than one partner in the last 12 months

Denominator: Number of all respondents aged 15–49 years

Disaggregation: Age groups: 15–19, 20–24 and 25–49 years

Sex: female, male

Measurement

Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked: in the last 12 months, with how many different people have you had sexual intercourse?

Tool: Population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative surveys)

Frequency: As and when such international survey takes place

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Indicator 14

Percentage of women and men aged 15–49 years who have had more than one sexual partner in the past 12 months reporting the use of a condom during their last sexual intercourse

Rationale

Condom use is an important measure of protection against HIV, especially among people with multiple sexual partners.

Definition of the indicator

Numerator: Number of respondents aged 15–49 years who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex

Denominator: Number of respondents aged 15–49 years who reported having had more than one sexual partner in the last 12 months

Disaggregation: Age groups: 15–19, 20–24 and 25–49 years, Sex: female, male

Measurement

Respondents are asked whether or not they have ever had sexual intercourse and, if yes, they are asked:

1. In the last 12 months, with how many different people have you had sexual intercourse?

If more than one, the respondent is asked:

2. Did you or your partner use a condom the last time you had sexual intercourse?

Tool: population-based surveys (Demographic and Health Survey, AIDS Indicator Survey, Multiple Indicator Cluster Survey or other representative surveys)

Frequency: As and when such international survey takes place

Source

Monitoring the Declaration of Commitment on HIV/AIDS: guidelines on the construction of core indicators. 2008 reporting. Geneva, UNAIDS, 2007 (http://data.unaids.org/pub/Manual/2007/20070411_ungass_core_indicators_manual_en.pdf).

Annex 2 - List of documents referred

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2. MOH 2007, National Strategic Plan on HIV/AIDS, Republic of Maldives, 2007-2011
3. A report on exercising monitoring and evaluation systems strengthening tool. The republic of Maldives, November 2009. By Phanindra Babu Nukella.
4. Report of the 2009 Joint Mid-term review of the National Response to HIV in the Maldives
5. The Grant proposal and progress reports can be downloaded from the GFATM website
6. Maldives Police Service, Paper on national HIV strategy and the Police, December 2009
7. 2008 Biological and Behavioural Survey on HIV/AIDS, UNDP/Maldives
8. The Performance Framework for phase 2, GFATM (Round 6 program), 2010-2012
9. Proposal for a Mass Media Campaign on HIV, The Global Fund in the Maldives, August 12, 2009
10. Monitoring and Evaluation Toolkit: HIV/AIDS, Tuberculosis and Malaria , February 2009, The Global Fund