Report of the 2009 Joint Mid-Term Review of the National Response to HIV in the Maldives
December 7 – 13, 2009

National AIDS Programme - UN joint team on AIDS - World Bank

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Abbreviations

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)
CST	Care, Support and Treatment
DDPRS	Department of Drug Prevention and Rehabilitation Services
DOTS	Directly-Observed Treatment (for Tuberculosis)
DU	Drug use(r)
FSW	Female Sex Work(er(s))
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
MOIA	Ministry of Islamic Affairs
MOHRYS	Ministry of Human Resources, Youth and Sports
MSM	Male to male sex/Men who have Sex with Men
NAC	National AIDS Committee
NAP	National AIDS Program
NGO	Non-Governmental Organization
NSP	National Strategic Plan on HIV in the Maldives 2007-2011
OCM	Occupational Cohort Male
OST	Oral Substitution Treatment
PLHIV	People living with HIV
PR	Principal Recipient
SE	Supportive Environment
SR	Subrecipient
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex work(er)
SWAD	Society of Women Against Drugs
TB	Tuberculosis
ToR	Terms of Reference
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
YHC	Youth Health Café
WHO	World Health Organization

Introduction & objectives of the joint mid-term review

In 2006, the National AIDS Commission (NAC) adopted the Situation Analysis on HIV in the Maldives[1], based on which a National Strategic Plan on HIV and AIDS (NSP)[2] was developed and adopted by the NAC in 2007. Also in 2007, the National AIDS Program (NAP) obtained resources from the Global Fund on AIDS, Tuberculosis and Malaria (GFATM) to support it in the implementation of the NSP.

Half-way through the NSP period (2007-2011), this Joint Mid-Term Review (JMTR) aimed to assist the National AIDS Program in taking stock of achievements and challenges in implementation so far. Specifically, the JMTR had the following objectives:

1. To assess the status and dynamics of the HIV epidemic in the Maldives
2. To assess whether national responses adequately address the dynamics of the epidemic
3. To assess the implementation of the NSP to date, with a focus on priorities and analysis of gaps
4. To recommend strategic actions for 2010-2011 to fill the gaps, and estimate the cost of doing so.

The JMTR took place between 7-13 December 2009. A multi-agency team took part in the JMTR, consisting of Abdul Hameed (National AIDS Program/CCHDC/MoHF), David Bridger (UNAIDS), Mariam Claeson (AIDS Strategic Action Plan & World Bank), Caitlin Wiesen (UNDP Regional Center Colombo), 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 documentation and reporting).

The methodology of the JMTR was three-fold:

1. Review of documents (See footnotes in the text and Annex 1 for a list of reviewed documents)
2. Key informant interviews (See Annex 2 for a list of persons/organizations consulted)
3. Field visits (See Annex 2 for a list of the field visits)

The full JMTR team was in the Maldives during the period of 7 – 10 December. The costing workshop led by Anita Alban took place directly after the JMTR, 15 – 17 December, building on the JMTR review of priorities and financial gaps.

[1] MOH/NAP 2006, The HIV/AIDS situation in the Republic of the Maldives in 2006
[2] MOH 2006, National Strategic Plan on HIV/AIDS, Republic of Maldives, 2007-2011

Epidemiology of HIV, STI and associated risk behaviors in the Maldives

Before 2008, the only data on the HIV epidemic in the Maldives was available in the form of case reports: among Maldivians, 14 cases of HIV had been identified via this method between 1991 and 31 October 2009. 10 of these cases have since died. No new case reports were recorded through case reporting since. Among expatriate migrants, 243 cases had been identified up until 2009[1] (as a result of which they could not obtain a work permit / permit to stay and had to leave).

In 2008, the first Bio-Behavioral Survey (BBS) was conducted in the Maldives[3]. A total of 1,791 serologic samples were taken across five groups: female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU), occupational cohorts of men (OCM – including seafarers, construction workers and resort workers) and youth, across Male', Addu and Laamu atolls. One HIV infection was identified in a male resort worker. It is not clear via which risk behavior he became infected.

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

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

Table 1. Overview of serologic findings of the 2008 BBS

No HIV, Syphilis or Hepatitis was found among female sex workers (N=94) or youth (N=609) in the survey locations. 27% of FSW in both locations self-reported signs of an STI; so did 19% of sexually active youth in Male' and 23% in Laamu and 17% of MSM in Male' and 12% in Addu; for IDU self-reported STI symptoms occurred in 16% of those interviewed in Male' and 11% in Addu. Self-reported STI symptoms were reported by 3% of seafarers, 4% of construction workers and 7% of resort workers. Health seeking behavior varied widely, ranging from 100% of seafarers going to a health practitioner to 0% of MSM in Addu. A bit over two-thirds of FSW in Male' and 1 third in Addu sought treatment for STI; youth ranged between 33-48% across two sites. The lowest treatment uptake was reported by MSM (0% in Addu and 17% in Male' sought treatment).

Data was collected on sexual behavior and drug injecting behaviors, showing wide ranging and closely interconnected sexual networks across survey groups.

Female Sex Workers and their clients

FSW [N=94] reported a median of 4 clients per week in Male' and 2 clients per week in Addu. Just 2-6% of the occupational cohort males – who were apparently selected to partake in the

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

research as proxy for clients of sex workers - reported sex with a FSW in the past 12 months, with a median frequency of 1-3 encounters per month among those who reported this behavior. FSW reported very low consistent condom use (12% in Male' and 2% in Addu); male construction workers reported 0% condom use. This contrasted with the reported condom use of the occupational cohort males: 67% of seafarers and 41% of resort workers reported to consistently use condoms. 9-12% of FSW reported expatriate clients in the past 12 months; one FSW in Male' had worked as a sex worker in Malaysia. 83% of seafarers, 3% of resort workers and 2% of construction worker clients reported sex with an expatriate FSW.

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.

Men who have Sex with Men

The mean age of sexual debut of MSM [N=126] was 16 and 17 in Male' and Addu, respectively. One out of five MSM in Male' reported their first sexual experience with another male was forced upon them. MSM were found to have a wide range of sex partners. 93-94% reported consensual sex with a male in the past 12 months and about two thirds in both Addu and Male' also had had sex with women in the past year. Selling sex to a man was reported by 18 and 44% in Addu and Male, respectively; buying sex from a man (18% and 29%), selling sex to a woman (5% and 29%) and buying sex from a woman (16 and 49%) were also significant risk behaviors. 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.

Injecting Drug Users

The mean age of debut of drug use of current injecting drug users [N=276] 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. Most IDU in both locations did not carry syringes with them for fear of being arrested. A fifth (20%) of IDU in Male' and a smaller number (6%) in Addu had travelled to other places to inject, mainly in the Maldives but also Bangladesh and India were mentioned. A bit less than a third (30-26%) of these 'mobile' IDU reported unsterilized needle sharing, indicating an important potential entry route for HIV into networks of Maldivian drug injectors.

A large majority (86%) of IDU in Male' had been in jail. Two thirds (64%) of them used drugs while in prison and a third (32%) reported injecting drugs while in jail. For Addu the figures were 56% ever in jail, 66% using drugs and 14% injecting while in prison. Nearly a fifth (18%) of Male-based IDU who had been through rehab reported using drugs while in the drug rehabilitation center, versus 28% in Addu. A third of drug-using rehab clients in Male' reported injecting while in rehab; no such cases were found in Addu.

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.

In conclusion, data 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.

Youth

About a third (32%) of youth in Male' and half (50%) of youth in Laamu reported to ever have sex in their lifetime; 25% and 37% had permanent partners; 2% and 9% reported non-regular partners; 2% and 0% had sex with an FSW; 2% and 3% had partners who inject drugs; 0% and 1% sold sex and 0.4% and 0% reported consensual male to male sex. For those who were sexually active, the median number of partners in the past 12 months was five.

National response: Structures, management, policies and strategies

National AIDS Programme

The National AIDS Programme, under the CCHDC/MoHF, is in charge of the overall coordination of the national response to HIV. It is governed by the National AIDS Council, which was formed in 1987. It has successfully advocated for HIV related issues, including the drafting of a new Drugs Bill (see below) and was successful in acquiring funding from the Global Fund under Round 6, which complements the current NSP (see below). It has established good relationships with other parts of the MOHF, with other Government partners (Ministry of Education - MOE, Ministry of Islamic Affairs - MOIA, police, etc) and with civil society/NGOs. 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.

National Strategic Plan 2007-2011

The NSP 2007-11[2] aims to limit HIV transmission, provide care for infected people, and mitigate the impact of the epidemic through seven strategic directions:

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

Global Fund grants

The Maldives Global Fund Proposal for Round 6 was successful. It had initially been approved for close to 5 million US$ for five years, but due to slow implementation and other reasons US$ 2.289 million is now available for 2009-12 (September/ August)[4]. 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.

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

6. Strengthen health service capacity to provide quality care, support and treatment for people living with HIV.
7. Strengthen health systems capacity for prevention of HIV and other transfusion transmittable infections through blood and blood products.
8. Strengthen the strategic information system for HIV.
9. Strengthen the multisectoral response to HIV/AIDS.

The 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.

The Global Fund grant was prepared by the Country Coordinating Mechanism (CCM), which has 22 members (41% government, 39% NGOs and UN agencies – WHO, UNFPA, UNICEF, UNDP). 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 grant. The tendency among all the stakeholders with whom the JMTR team met was to refer to the national AIDS response, as the "GFATM project", with the 'branding' of staff positions, interventions and activities as 'GFATM project staff', 'GFATM activities' et cetera. It will be important to change these perceptions, and be clear about the appropriate roles and responsibilities to the MOHF/NAP and its development partners and donors. Staff working in the National AIDS program, are NAP staff (irrespective of where the funding of their positions come from) and not GFATM staff. This is also a trend that should be resisted for the sake of sustainability and to enhance MOHF/NAP ownership over the program. The JMTR team therefore calls for a renaming and amalgamation of GFATM and other donor-related positions and programs within the structure of the NAP, with the Government clearly in charge. The forthcoming development of a National Action Plan 2010-2011 under the leadership of the NAP program manager is an appropriate first step towards this.

A GFATM proposal for Round 9 had been partly developed but was not taken forward by the CCM. The next round offers a new opportunity to submit an application that takes into account the main recommendations and findings of this JMTR and the subsequent costing of the identified gaps. The implementation of the national AIDS plan funded by the GFATM grant is further discussed later in this document.

Technical Support Plan 2008-2009

At the request of the NAP, UNAIDS supported a consultant to develop a Technical Needs Assessment and Technical Support Plan 2008-2009[5]. Key findings included the need to develop the HIV knowledge and program skills in newly recruited staff, and an enhancement of the NAP's program management skills in the light of the successful GFATM grant. 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; the NAP should play the role of coordinator.

Paper on National HIV/AIDS Strategy and the Police

The Maldivian Police shared a recent paper that was developed in preparation for the development of a comprehensive HIV prevention strategy for the police force. Though not an official document, it identifies several areas in which the police need technical assistance, including:

1. The development of an AIDS strategy;
2. Training of police academy trainers for AIDS awareness programs;
3. Development of an effective AIDS curriculum for the police academy;
4. Improvement of data collection systems related to drug rehabilitation;
5. Improving police crime prevention program related to sex work and drug use;
6. A study on drug use and needle sharing[6].

Recommendations

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.

[5] The Maldives HIV and AIDS Technical Needs Assessment and Technical Support Plan 2008-2009, National AIDS Program, April 2008 (UNAIDS/TSF)

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

National Response: Prevention

Across Asia, HIV epidemics are driven by three key risk behaviors: unsafe injecting drug use, unsafe sex in the context of the sex industry and unsafe sex between men[7]. The JMTR team reviewed prevention responses focusing on these three behaviors, as well as prevention-related activities focusing on the general population and youth. A section on prisoners was also added, since most prisoners report using or having used drugs and in many countries prisoners also have a higher likelihood to engage in commercial sex or in male to male sex. It should be noted, however, that it is these *behaviors* that lead to HIV acquisition and transmission, not the membership of a particular group.

Prevention focusing on injecting drug use

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[4]. In line with the larger share of males versus females using drugs, 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.

The facts that prevention efforts for drug users have already started in the Maldives before the first (known) case of injecting drug-use related HIV infection has been recorded, and that there is a broad level of support for such interventions, are remarkable achievements.

The JMTR team appreciates the attempt to introduce oral substitution treatment (OST), with the recent establishment of the OST (methadone) clinic in Male' and an additional detox clinic in Villingili during 2009. However, international experience shows that unless such clinics are well prepared, staff well trained and supervised, and unless such services are appropriately linked to other services (i.e. delivered within the context of a comprehensive package of harm reduction services), the return on investment will be limited. 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, considered to be key to success for this harm reduction intervention. 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. As a serious negative side-effect of the OST approach taken in the pilot phase, the prison authorities now appear to have opted out of introducing OST in prisons (even though they may reconsider after a proper evaluation of the

[7] Report of the Commission on AIDS in Asia, 2008

OST experience so far). Prison authorities are still interested in implementing a safe needle pilot project.

The OST pilot project (supported and managed by UNODC) provides important implementation lessons. It will be important to evaluate these lessons, build consensus among all stakeholders on how to move OST forward as an integral part of comprehensive harm reduction services, in an appropriate and well controlled manner.

The JMTR team could not establish whether outreach to drug users with information, education and communication occurs in a systematic and comprehensive manner, whether messages are gender/age specific, whether messages about the harm of drugs are balanced with information about their attraction and the resulting pitfalls of addiction[8].

More needs to be done to prepare for a potential HIV epidemic among IDU in the Maldives. This should start with stock taking of what has been learnt, followed by multi-stakeholder agreement on a standardized package of services for the prevention of HIV among IDUs, based on global, regional and national evidence of what works and what doesn't. Improved communication between all stakeholders is a key first step towards achieving this.

Capacity building in the proper delivery of comprehensive harm reduction interventions (outreach, oral substitution therapy as well as clean needle exchange programmes) is needed, based on the standard comprehensive package mentioned above. The JMTR team recommends an immediate independent evaluation of past and current activities, before a re-start of the OST program in the context of a wider package of services. The re/introduction of OST, possibly exploring different treatment options and delivery strategies could be done as operations research, to assess the feasibility, cost and effectiveness of alternative options.

In support of the planning of HIV prevention, treatment and care among IDUs, the forthcoming mapping and size estimation (scoping mission, January 2010) will be important, also to know the magnitude of the problem.

Prevention focusing on sex work

If injecting drug use often ignites HIV epidemics, multiple concurrent sexual networking practices between drug-users and others often fuel it further – and in Asian countries, often these conditions are met in the context of a more or less formal sex industry[7]. In the Maldives, however, 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. In general, Maldivian society is characterised by a high level of divorce and re-marriages – in effect several partners over a lifetime (for example, the recent BBS found a median number of 5 sex partners in the past 12 months among sexually active youth). The divorce rate may be influenced by the particular geography and economy of the Maldives, leading to long periods of separation between husbands and wives – something the new Development Plan wants to address by ending the decades-old policy of separating tourism and related employment from Maldivian living areas.

Focus group discussions with stakeholders indicated that divorced women are often left with few economic means, but they often bear the responsibility for children; this may lead them to engage

[8] Journey/UNICEF, 2007, Voices from the Shadow, Based on a study of drug use behavior in the Maldives

in multiple concurrent or serial sexual relationships to provide for themselves and their family. The mission team learnt from the NGO SWAD that single mothers therefore are in need of targeted SRH interventions to cater for their health and welfare. Indeed, the linkages between economic dependency, gender imbalances and exchange as aspects of sexual relationships are not always distinguishable from the definition of 'sex work' as employed in HIV prevention jargon (or in the BBS, for that matter). It is important to realize that while the BBS reports on 'sex workers' as a separate group from the implicit 'general population', there are probably very few (if any) women or men who agree or self-identify with the sex worker-label and/or who make sex work their fulltime, only, life-long 'career'. It is important to focus on the behavior of providing sex in exchange for money, goods or favors and the vulnerability that this brings. Therefore in the context of the Maldives, 'highly vulnerable women' may be a more appropriate label under which to design and deliver interventions focusing on women with multiple sexual relationships.

One NGO mentioned that women leaving prisons are highly vulnerable and in need of targeted SRH and HIV interventions. This should be further explored by NAP.
Until today no comprehensive package for women (and men) engaging in transactional sex has been agreed upon or launched at the Maldives. The mission team learnt that UNFPA, in 2006-2007, has been able to identify 3-4 hotspots for street-based sex work. UNFPA 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, i.e, facilitating access to VCT centers, STI services and the provision of condoms for vulnerable women at high risk.

The forthcoming mapping of high-risk behaviors will include sex work, which will assist the Maldives in designing and expanding interventions based on the needs of people engaging in sex work, incorporating the few lessons learnt so far. These efforts would be greatly helped if an understanding with relevant authorities about the provision of condoms and other essential STI and HIV prevention services to unmarried men and women, most at risk, can be reached.

Prevention focusing on men who have sex with men

In Asian countries, HIV transmission via male to male sex contributes between 5-20% of all HIV infections nationally, and in some countries more[7]. The JMTR team found little evidence of HIV prevention interventions among men having sex with men (one NGO has done some informal work in Male, without having funding for this). In the Maldives, homosexuality is illegal and a strong social taboo and stigma is associated with it. Despite this, 126 MSM were enrolled in the recent BBS; low condom use and a high prevalence of Hepatitis were found among them. No civil society organization exists which deals directly with the issue of HIV prevention among MSM, nor is there any organization that can (or aims to) represent MSM due to widespread stigma. Therefore, rather than promoting strengthening of 'communities' of MSM, which has occurred in India, Nepal, Thailand and other countries, 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, and that GFATM funding be secured for interventions targeting male to male transmission of HIV, either through a new application to GFATM or by amendment of current grant. This will require more informed advocacy and capacity building among decision makers, including key CCM members, to ensure a solid understanding about how public health interventions can and

should be implemented also in contexts where risk behaviors are illegal, drawing on successful experiences from neighboring countries with similar socio-cultural and religious contexts.

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.

It is recommended that a phased program focusing on improving male sexual health is designed based on the findings of the BSS, 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. The information and communications efforts of the program should already now focus more specifically on reducing stigma towards vulnerable groups at high risk, including MSM, to increase their access and use of services considering the levels of stigma surrounding homosexuality.

Prevention focusing on 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. The JMTR team recommends the introduction of public health (including harm reduction) services for prison inmates as a high priority; as such interventions have proven to have good results and are highly cost-effective. Such programmes should include a BCC component aimed at both the prison population and the guards. Specifically, the mission team proposes that a prison-based comprehensive harm reduction program, including OST, along with other essential STI and HIV prevention services be piloted.

The JMTR team was encouraged by the dialogue with police and Ministry of Home Affairs officials on the prospect of implementing such evidence-based programmes to prevent HIV in prisons.

Prevention for 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 message is often only on how 'bad' drugs are (and implicitly how immoral drug users are). The reasons why people use drugs are not sufficiently 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 users[8].

The Youth Health Café (YHC) is a programme run by Ministry of Human Resources, Youth and Sport (MOHRYS) and is supported technically by UNFPA. YHC's aim is to create awareness and provide services for adolescents and youth on sexual and reproductive health. Life skills education, thematic sessions, peer education and other activities are conducted to deliver information to its target group through various social fairs and open days. YHC refers young people to counseling and health services when there is a need. It reaches several hundred young people per year; many are repeaters. As part of the thematic sessions, 9 half day seminars are organized specifically on HIV per year, with 20-50 persons attending – mostly out-of-school and unemployed youth. The Café does not hand out condoms directly. Its hotline gets several phone calls per day; for a while there was a radio phone-in show about the hotline, after which the number of calls would spike. Referrals to maternity clinics take place for (un)married pregnant youth; according to key informants, young males with questions about homosexuality have been referred to religious counselors, with unknown results. YHC is exploring to set up medical services for youth, including STI testing. There 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[4] 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. Another important development is the plan of the new Government to replace expatriate teachers in secondary schools (currently 80% of the total of around 600) by Maldivian teachers by 2015. Furthermore, recently School Boards have been established besides the Parent-Teacher Associations that already existed; the implications for HIV prevention in schools need to be clarified.

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.

Rather than supporting 'parallel' programs to inform the general population about HIV and STI, there remains continued scope for integration of HIV and STI prevention in existing health, education and social services. From an epidemiological viewpoint this is preferable than investing scarce HIV prevention resources in general awareness programs that prevent few, if any, HIV infections (See also the section on Convergence under Treatment, Care and Support).

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.

Recommendations

1. Define and agree on (costed) targeted intervention standards for injecting drug use, male sexual health/male to male sex and vulnerable women/female sex work, as well as for prison-based interventions focusing on all three behaviors.
2. Seek agreement within the working groups on protocols, guidelines, M&E indicators, roles and responsibilities and ensure un-interrupted supplies before establishing or scaling up prevention interventions.
3. Identify and pilot the most feasible and appropriate delivery strategies to implement and scale up the interventions defined under (1), starting with an evaluation of the OST program for the design of the IDU prevention strategy.
4. Based on the mapping and size estimation, to be done in early 2010, start micro planning for the delivery of targeted interventions.
5. Include (1) – (4) in the strategic action plan and budget for 2010-11, and secure funding for these gaps in the current national response.

National response: Enabling environment

Interventions for HIV prevention among vulnerable groups are difficult to implement without a strong enabling environment The NSP is an important element of the enabling environment, and so are the national protocol for HIV (outlining what to do if someone is found to be HIV positive), the National Health Act (which includes HIV) and especially the new National Drug Bill which is about to be brought to the Parliament. This Bill will formalize the current public health view which considers drug addicts first and foremost as patients in need of treatment rather than as criminals that need to be punished under the judicial system. Drug dealing will continue to be a crime. This is a very important improvement of the enabling environment for HIV prevention interventions which the Government should be commended on.

Under the GFATM grant, 105 law enforcement officers, including police, had been trained on HIV and IDU concerns up to the end of February 2009; 29 workshops had been held on HIV in the workplace in large enterprises[4]. Also, on two occasions HIV was part of the Friday prayers; transcripts of the sermons show a humane perspective, with a call for compassion for those affected by HIV and drugs. The JMTR team was impressed by the willingness of officials and religious leaders to discuss the issue of HIV.

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

In the Maldives such an understanding between public health authorities and law enforcement authorities has not yet been reached, but a beginning of a dialogue has started, as witnessed by the JMTR team during an HIV advocacy (theater and discussion) session with parliamentarians and civil society. In order to reach high risk groups, strategic engagement with religious leaders is essential and can be highly effective at reducing stigma.

The JMTR team recommends, in line with recommendations in the Situational Analysis of 2006, that a high-level Working Group dealing with high risk behaviors is established, led by the NAP. This Working Group is tasked with preparing for and overseeing HIV prevention interventions aimed primarily at those injecting drugs and other vulnerable groups, and with exploring whether some of the funds for prevention in the current GFATM program can be reprogrammed from general workplace and youth-oriented interventions towards better targeted interventions, for greater program impact. Most importantly, this Working Group should be a platform for dialogue between public health and law enforcement officials; representatives of people engaging in high risk behaviors should also be part of this group, if possible.

Recommendations

1. The Working Group for Targeted Interventions (see recommendations of previous section) must come to an understanding between relevant authorities and intervention implementers, reaching a consensus on how to enable them to effectively reachvulnerable and most at risk Maldivians with necessary interventions.
2. Continue, strengthen and monitor ongoing advocacy with key ministries and opinion leaders (including religious leaders) to enable targeted interventions to take place.
3. Continue media communications activities, including message development to create awareness about HIV risk behaviors and to strengthen support in the population for targeted interventions and reduce stigma of those most at risk.
4. Focus on taboo, denial and stigma of risk behaviors and people living with HIV in the next wave of advocacy, information and education activities.
5. Review the legal framework to facilitate access and use of HIV prevention and treatment services by vulnerable groups at highest risk.

National response: Treatment, Care and Support

Blood Safety

The Maldives has a well established blood bank system, since Thalassemia is widespread. Still, relatively high priority (defined as the percentage of GFATM resources allocated) has been given to secure safe blood during the first half of the strategic plan. There have been no cases of HIV transmission following blood transfusion or infusion of blood products in the Maldives. However there have been donors who were positive for Hepatitis B and C. There is a need for increasing the base of voluntary blood donors. Further improvement in a systematic blood transfusion system (including storage facilities) and further training on the rational use of blood should be considered within the context of integrated services (see discussion on convergence).

STI Management

There are two mechanisms for reporting STI – the atolls and regional hospitals follow syndromic reporting while the Indira Gandhi Memorial Hospital (IGMH) has etiological management. It has been noted by the NAP that some areas/islands were having higher detection of STI. However, there is a need for in depth analysis of these reports, looking at their quality and the skills of the reporting unit before the higher prevalence reported can be confirmed. An exercise for data verification, authentication and the skill of the reporting units in identifying and reporting STI syndromes correctly should be considered. There have been issues with the reporting of STI; for example, there may be significant non-reporting of STI by clinicians within the facility. It is recommended to have a meeting with the hospital administrators, identify the issues in documentation and reporting and resolve these.

It was also noted that people most at risk of HIV infection are usually not availing the services at the public health system. A standardized package of services for the high risk population (discussed in a previous section) should include a component on STI management. Much training for STI management has been conducted in atolls/regional hospitals. However, the majority of the trainees have been community health workers, who are not authorized to prescribe or dispense drugs. MOHF should take a clear policy decision on who is selected for these trainings as if trainees do not usually provide drugs, training them in syndromic management is a waste of resources. In case they may be allowed to prescribe or dispense STI drugs in future, there is need to define the recording and reporting tools for them to use (standardized across the country).

Clinical Management including antiretroviral treatment (ART)

The ART program was included as a part of the national response in 2004. Three people have since benefited from the program. National guidelines for the use of antiretroviral therapy in the Maldives were agreed on in 2005. Since then, there have been significant revisions of the global guidelines in light of the new evidence emerging about treatment types and regiments; the national guidelines have not yet been changed accordingly. The country also needs to revise and elaborate on its guidelines for post-exposure prophylaxis of HIV and the management of OIs. The program needs to continue to provide ARV to PLHIV, as it has been doing till date. Given the low prevalence of HIV, and the very few people in need of ART, it is recommended that the scaling up of ART provision and availability to the regional or atoll levels (including planned trainings for health care providers in ART provision) should be reconsidered, and instead focus on areas of convergence of services.

Till now, there have been no standardized recording and reporting formats for the PLHIV under care (pre-treatment as well as on ART). Therefore, it is hard to assess the adherence of the PLHIV to ART, as well as the quality of care that has been imparted. At present, the program relies on the memory of the treating physician and the summary sheet at NAP (this contains socio-demographic details taken upon intake, and no clinical details). In preparation for a bigger future caseload, there is a need to develop a system for documentation of individual care.

Voluntary counseling and testing

There are 8 VCT centers existing in the Maldives (IGMH, Villingilli health center and six regional hospitals). Recently, two new VCT centers have been inaugurated outside the public health system. Guidelines for testing as well as operationalising the VCT service were developed and endorsed by the 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 screening. Increased (voluntary) uptake of the services should be an objective of further focused interventions; the VCT centers should be made client-friendly and accessible to those most at risk, and outreach and IEC interventions should help promote them. Though the NSP aims to have VCT services at all ANC, TB and STI managing units, it is recommended that before expanding into new areas there should be an attempt to promote existing centers first. Linkage of existing VCT services to ongoing youth centered activities and future targeted interventions for high risk populations as well as to existing STI and reproductive health services should be considered rather than establishing parallel structures (see below).

Prevention of Mother to Child Transmission (PMTCT)

PMTCT services are an integral part of a complete package of quality health care services that should be offered to pregnant women. In the Maldives, it is recommendable to add a PMTCT component to the existing services (SRH, MNCH) and to integrate this issue into a comprehensive training package that covers all the aspects of care provision, infant feeding practices, and neonatal care.
In the near future it will be critical that more effective ways be identified to link an integrated PMTCT and pediatric CST with programmes for people engaging in high risk behaviors.

The case for convergence with other programs

As the prevalence of the HIV remains very low even in those with high risk behaviors it is recommended to promote convergence of many HIV prevention, treatment and care interventions with other programs, such as reproductive health and TB (see Figure 1) below, while keeping in mind the need to specifically target interventions to those engaging in high risk behaviors, who might not access routine health services in a highly stigmatized environment where also confidentiality might be difficult to enforce.

Examples of this could be to make HIV testing available at sites that offer treatment of STI, linkages to targeted interventions, to existing ANC sites, and to family planning. This principle goes beyond VCT: for example, condom distribution at health centers or other public health services could be considered, and the provision of ART via DOTS outlets could be considered. At the island/most peripheral level, HIV-SRH convergence could entail mutual referrals and joint public information, education and communication activities. At the atoll hospital level, converging HIV and SRH services means paying attention to dual-purpose interventions such as the diagnosis and treatment of reproductive tract infections and STIs, provision of counseling and distribution of condoms, and in the future perhaps preventing parent-to-child transmission.

At the central level and at Regional hospitals, this integration should be more comprehensive, and HIV-SRH service convergence could mean provision of partially integrated services such as adding voluntary counseling and testing to family planning services, introducing family planning services in HIV clinics, and providing SRH counseling, HIV counseling and life-skills, and sexuality education in both.

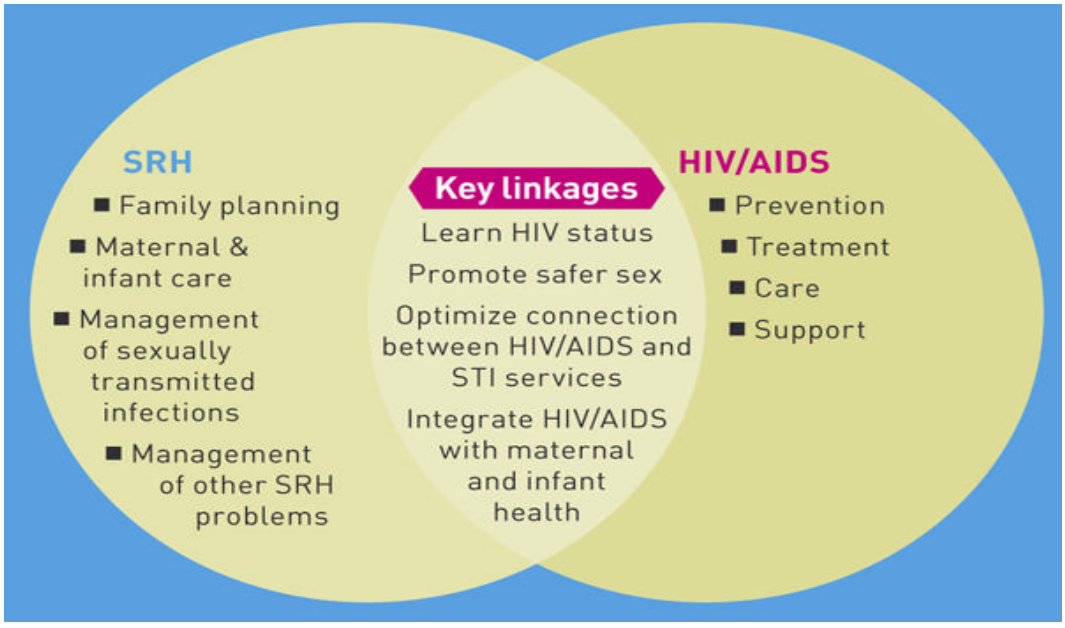


Figure 1. Key linkages between sexual & reproductive health (SRH) and HIV/AIDS services.

Recommendations

1. Promote access and use of voluntary counseling and testing services for those most at risk for HIV (making it part of the comprehensive package of services defined by the proposed Working Groups).
2. Promote convergence of some of the HIV and sexual/reproductive health services where the greatest synergy can be achieved, as well as integration of HIV into the wider health system, aiming at the general population of the Maldives, as appropriate, while keeping in mind the need for vulnerable groups at highest risk to access and use services.

National response: Strategic Information

Second generation surveillance

In line with the NSP, the first BBS that was conducted in 2008 filled an important gap in strategic information to inform the national response, and also provided an important set of data to be used as a baseline. While the prevalence of HIV was low, levels of self-reported STI and associated risky behaviors (including high turnover of sexual partners and low condom use) were very high and targets for the national response now focus on reducing these risk behaviors.

According to the NAP, there are plans to repeat the BBS in 2011. Funding for this should be identified since funds for a repeat survey have not yet been secured.

Size estimations

The absence of information about the estimated number of people engaging in each of the three key risk behaviors (injecting drugs, male to male sex, sex work) who are in need of services is an important data gap at the time of the JMTR, and also a key need for establishing targets for coverage and M&E (see below). However, the first steps towards obtaining this information have now been planned, with a scoping mission January 2010, and it seems plausible that size estimates studies will be conducted during 2010.

Monitoring and evaluation

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' according to a recent report[9]. 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.

[9] A report on exercising monitoring and evaluation systems strengthening tool,By Phanindra Babu Nukella, The Republic of Maldives, November 2009.

Weaknesses identified included:

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

Denominators are available for occupation-based target populations, such as resort workers and migrant construction workers.

UNDP has indicated it will support the process of strengthening the national M&E plan by March 2010. It has been recommended in the MESTT (2009) that a national M&E Unit needs to be created and an M&E coordinator recruited, a budget for M&E would be agreed on, denominators would be established, a timeframe and targets for indicators would be set and a system for M&E data dissemination would be designed[9].

Information management and dissemination

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. A positive finding was that there is a person in the Management Unit responsible for data management and ensuring strategic use of M&E data, but this person needs additional training[9].

The Management Unit is planning to develop clear ToRs on M&E and information management for the NAP and its implementing partners. In line with the capacity assessment and training plan, 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.

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).

Needs assessment/qualitative data

An 'audience assessment' was conducted during 2009, focusing on HIV risk and perceptions among different groups of Maldivians[10]. It confirmed low risk awareness among the population and shed some light on common misconceptions regarding HIV. It is important that the findings

[10] "Konme Kamevves Vedhaane" – Anything Is Possible, A comprehensive audience analysis for HIV risk in the Maldives with recommendations for communication, GFATM supported program in the Maldives, August 2009.

of this important work find their way into actual program and intervention design for Maldivians. The same goes for an ethnographic study on injecting drug use that was conducted in 2007[8]. In terms of qualitative research, the social-cultural dynamics related to sex work and male to male sex remain little understood in the Maldivian context; this information is important to design culturally appropriate and feasible interventions focusing on these behaviors.

Recommendations

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.

National Response: Resource allocation

In this section, the utilization (Year 1) and planned allocation (Year 2 and Year 3-5) of GFATM resources for the National Response are analyzed, demonstrating the development in priorities in HIV, which have shifted radically since the start of the NSP. It is important to mention that despite the dominance of GFATM in terms of the quantity of funding provided, other donors also contributed significantly to the national response to HIV in the Maldives. It covered some of the gaps/interventions that couldn't be funded through GFATM, specifically focusing on Priority 1 of the NSP (e.g. UNODC – methadone programme; UNICEF and UNODC – outreach programme for DU/IDUs; UNFPA – Youth Café interventions for SW and revision of LSBE curriculum) and other unfunded priorities (i.e. WHO/UNICEF/UNODC – capacity building for various service providers such as HIV counselors, lab technicians etc).

In the below the expenditure of the GFATM grant is studied in more detail. Supportive environment (SE) and safe blood systems have been the dominating activities in terms of GFATM expenditure, taking a whopping combined 83% in Year 1 and 60% in Year 2 (Figure 2 and Figure 3).

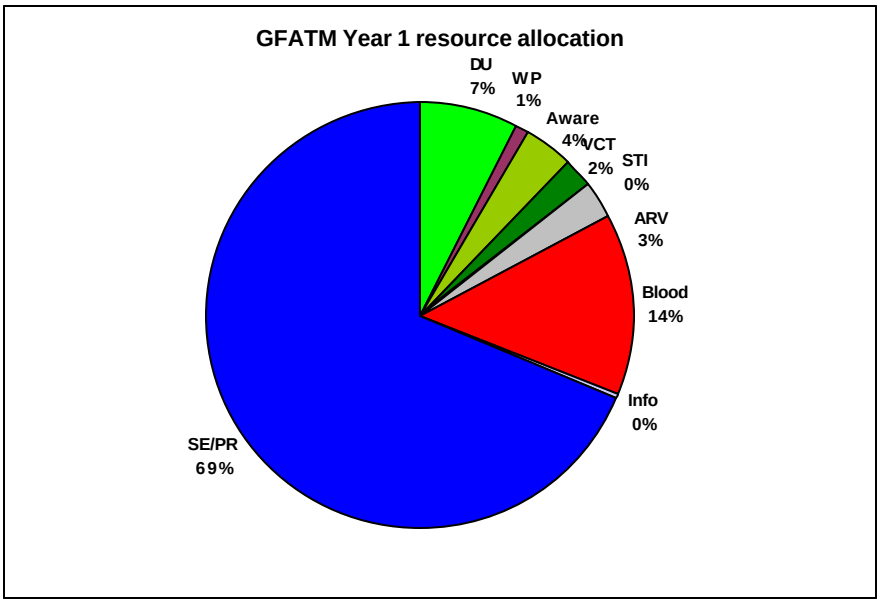


Figure 2. Allocation of resources for the first year of the GFATM grant (DU = drug user interventions; WP = Workplace interventions, SE/PR = Supportive Environment and Public Relations)

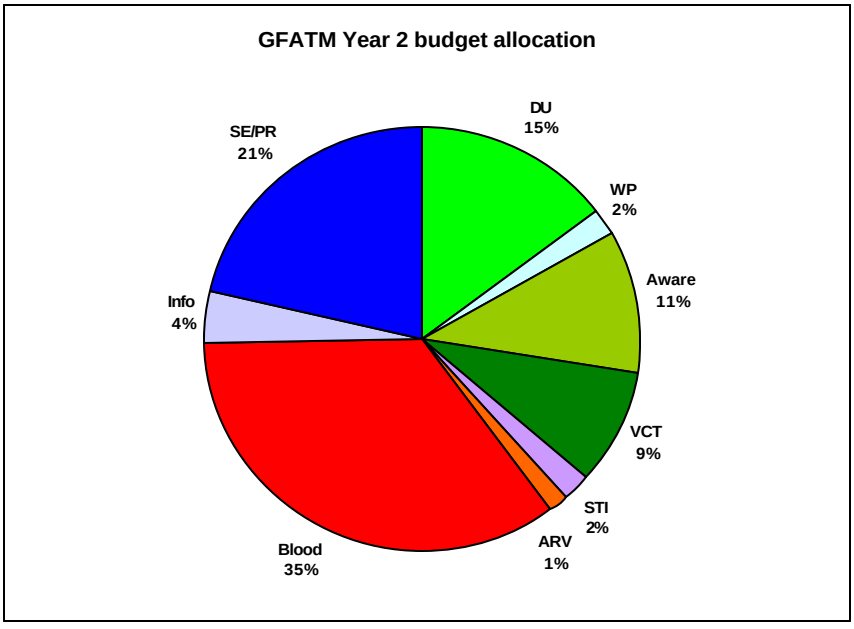
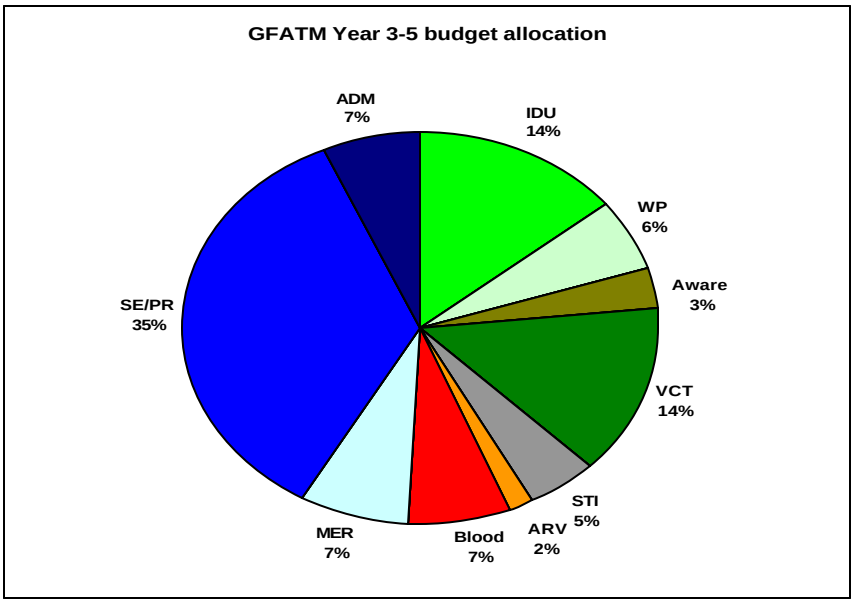


Figure 3. Planned allocation of resources for the second year of the GFATM grant
In the 3-year budget covering 2009-12 of the GFATM financing the share for safe blood will decrease to 7% and SE to 35% of the total (Figure 4).

Figure 4. Planned allocation of resources for year 3-5 of the GFATM grant



Note the previously mentioned relatively low share of resources allocated for prevention with high-risk groups (i.e. only IDU, with no funding earmarked for sex work or male sexual health). However, the total budget for 2010-2011 (from all sources, including GFATM) includes activities for SW and MSM and a prison programme for the first time, as well as harm reduction interventions. In total, targeted interventions focusing on high risk behaviors will consume 17% of total HIV spending in 2010-2011 (Figure 5). This is not optimal. For a low-level epidemic like the Maldives, targeted interventions are a program priority and should therefore consume a much higher percentage of resources and "other" prevention initiatives to consume relatively less resources.

Explanations given for the low allocation of resources focusing on those most at risk include that such interventions are not deemed feasible and/or that they can not be scaled-up faster than is currently planned. Another explanation might be lack of hard data on the prevalence of/contexts of risk behaviors in the Maldives on a sufficient scale to warrant major investment in interventions. This is one of the reasons why the forthcoming mapping study focusing on these high risk behaviors and the size estimation is of utmost importance.

Another barrier for scaling up of interventions targeting high-risk behaviors lays in the lack of agreement on a comprehensive package of HIV prevention interventions focusing on these behaviors, based on best-practice evidence. Not having such a package makes it difficult to assess what needs to be scaled up, where, to whom and at what cost. Work is planned on reaching this agreement and should be completed before the outcome of the mapping study is available.

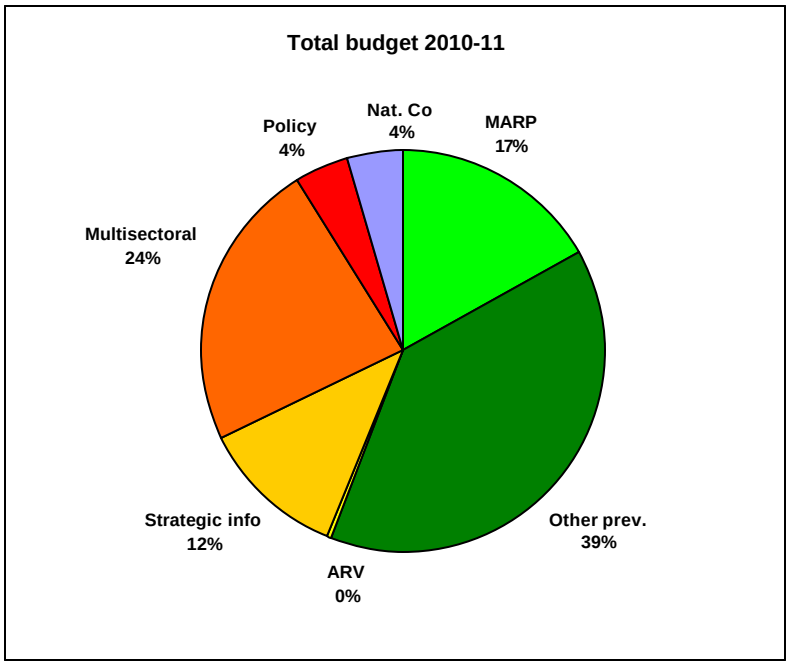


Figure 5. Estimated spending on HIV in 2010-2011 (all GFATM resources for two years and assuming 100% utilization; this includes the outcome from the costing workshop on resource needs for interventions covering people with high-risk behaviors, at rather low estimates of # of people in need of such interventions).

It is anticipated that during the coming five years the prevention component and especially the priority one covering high-risk groups will consume much more of the total resources allocated for HIV. The outcome of the mapping exercise will assist the Maldives in knowing existing and setting targets for necessary coverage.

Recommendations

1. More funds are needed for prevention focusing on people engaging in high risk behaviors. If a second proposal for GFATM/R10 focusing on prevention for high risk males and females is not feasible, some of the GFATM/R6 program funds should be reprogrammed towards such high impact interventions. At this stage this seems most feasible for interventions focusing on IDU/DU.

Conclusions

The Maldives are fortunate at this stage to have very few people living with HIV. However, the risk factors for a concentrated HIV epidemic are there. The country has high rates of hepatitis B (and C), STI rates are average for the region but much higher than for Sri Lanka, condom use is low across the board, there is a high rate of sexual partner change among parts of the population, and needle sharing is reported by a significant share of injecting drug users. Further, taboos and stigma have driven underground the behaviors most likely to fuel a future HIV epidemic: injecting drug use, male to male sex and sex work. The National Response is now better funded than ever before: it is key that those elements of the NSP focusing on addressing the drivers of the epidemic are now prioritized.

Half-way through the implementation of the National Strategic Plan, the key conclusion the JMTR team reaches is that despite high levels of risk and an increased availability of funds for HIV prevention, the Maldives have yet to start effective best practice interventions for most-at-risk populations (i.e. injecting drug users, those involved in transactional sex and males who have sex with males). Significant resources for HIV prevention have already been expended, but apart from peer education for injecting drug users, they are not well targeted, reaching mainly Maldivians who are very unlikely to be at risk for HIV. The time for massive investments in awareness campaigns is over. The Maldives will have to enter into provision of comprehensive services to populations most at risk to avoid a concentrated epidemic among people with high-risk behaviors.

In order to do so, and in line with recommendations already made in 2006, the JMTR team advises the NAP to form a high-level working group dealing with the issue of high risk behaviors in the legal, social and cultural context of the Maldives, identifying ways to provide services to people engaging in behaviors that are in conflict with the existing legal framework and religious context, seeking common ground between good public health and the law.

There are important lessons from past work with injecting drug users, a few lessons on sex work, but none for MSM. For injecting drug use interventions, an independent evaluation of past and existing efforts is called for. The JMTR team suggests to pool the information from the past BBS, the upcoming size estimation and social mapping studies, recent costing exercises and the lessons learnt so far in reaching those most of risk.

Using this information, a multi-stakeholder agreement on a comprehensive standard-package of interventions for people engaging in high risk behaviors must be agreed on, including an understanding between law enforcement authorities and public health actors about the provision of condoms and other services to those most in need. These actions will be essential to design, implement and scale-up interventions targeting Maldivians at high risk for HIV, and to monitor the coverage of different elements of the comprehensive standard package.

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. It is critical to undertake mapping studies and estimate the number of people engaging in risk behaviors in the Maldives, focusing on injecting drug use, transactional sex and male to male sex. Regular (two-yearly) BSS 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 System.

Supplementary independent evaluations/studies in the form of operational research on behavior patterns and the social context of people engaging in high risk behaviors should be carried out as appropriate to guide the National response.

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

Overall, there is a need to strengthen NGOs working with individuals most vulnerable and most at risk for HIV by building their capacity in the field of targeted interventions. Based on evaluations of what was done in the past in the Maldives and in other countries (i.e. Malaysia, Indonesia, Iran), as well as agreement on a comprehensive standard package for targeted interventions discussed above, training for civil society organizations on what can work in the Maldives is needed. This will also help create more demand for VCT and STI services, which are currently underutilized.

Effective implementation of the National response to the epidemic requires close collaboration and effective coordination among different ministries, among governmental and non-governmental sectors, among different vertical programs and health care services, collaboration among different projects supported by international donors and other multilateral agencies like UNAIDS, UNDP, UNICEF, UNODC, World Bank and the financing mechanism GFATM. The JMTR team found that the GFATM supported program and the NAP appear to be operating relatively separate, as parallel systems. This is not a desirable or sustainable solution. The coordination role of NAP should be strengthened and NAP provided the necessary command in the Government and managerial/planning skills to lead the multi-sectoral National response in the fight against HIV at the Maldives.

A low(er)-cost strategy to keep awareness of HIV among the general population is recommended: further integration of HIV into existing health services, and making it part of other information channels (i.e. via the workplace, education system, religious sermons, media, et cetera) should continue – however, no significant HIV prevention resources should be used for this purpose, as the number HIV infections prevented via such activities is negligible.

Summary of recommendations

Structures, Management, Policies and Strategies

1. The National AIDS Program should lead the development of a 2010-2011 strategic action plan, focusing on the gaps identified during this JMTR, and costed
2. As a major priority, the NAP should refocus efforts on prevention for those most at risk. A Technical Working Groups for Targeted Interventions should be established, starting with IDU. It should include all relevant stakeholders, including drug user, implementer, religious 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.

Prevention

4. Define and agree on (costed) targeted intervention standards for injecting drug use, male to male sex/male sexual health and sex work/vulnerable women.
5. Seek agreement within the working groups on protocols, guidelines, M&E indicators, roles and responsibilities and ensure un-interrupted supplies before establishing or scaling up interventions.
6. Identify and pilot the most feasible and appropriate delivery strategies to implement and scale up these standard interventions.

Enabling environment

7. Come to an understanding between relevant authorities and intervention implementers, reaching a consensus on how to enable them to effectively reach vulnerable and most at risk Maldivians with necessary interventions.
8. Continue, strengthen and monitor ongoing advocacy with key ministries and opinion leaders (including religious leaders) to enable targeted interventions to take place.
9. Focus on taboo, denial and stigma of risk behaviors and people living with HIV in the next wave of advocacy, information and education activities. Continue media communications activities, including message development to create awareness about HIV risk behaviors and to strengthen support in the population for targeted interventions and reduce stigma of those most at risk.

Treatment, care and support

10. Promote access and use of voluntary counseling and testing services for those most at risk for HIV.
11. Promote convergence of HIV and sexual/reproductive health services, as well as integration of HIV into the wider health system.

Strategic information

12. Conduct size estimations/risk behavior mapping on the three risk behaviors.
13. Conduct an independent evaluation of interventions conducted for injecting drug users so far (for example, OST, detoxification, rehabilitation, outreach).
14. Conduct feasibility research for responses addressing risk behaviors (drug use, male sexual health, highly vulnerable women) in the Maldivian context.

Allocation of resources

15. If a proposal for GFATM/R10 focusing on prevention for high risk males and females is not feasible, some of the GFATM/R6 program funds should be reprogrammed towards such high impact interventions, based on the costing exercize (See Annex 3 for the costing).

Annex 1 – Documents reviewed

The HIV/AIDS Situation in the Republic of the Maldives in 2006, Jan W de Lind van Wijngaarden, National HIV/AIDS Council (NAC), Ministry of Health of the Maldives , UN Theme Group on HIV/AIDS, Maldives 2006

National Strategic Plan on HIV/AIDS, Republic of Maldives 2007-2011, Ministry of Health, Maldives 2007

GFATM/R6 Project document and progress reports from the Maldives, 2007-2009, from GFATM website.

Maldives UNGASS country progress report, Maldives 2007

2008 Biological and Behavioral Survey (BBS) on HIV/AIDS, Aura C. Corpuz, Republic of Maldives 2008

Voices from the Shadow. Based on a study of drug use behaviour in the Maldives, Journey/UNICEF, Maldives 2007.

A report on exercising monitoring and evaluation systems strengthening tool, Phanindra Babu Nukella, The Republic of Maldives, November 2009

The Maldives HIV and AIDS Technical Needs Assessment and Technical Support Plan 2008-2009, David Lowe, National AIDS Program, Maldives, April 2008

"Konme Kamevves Vedhaane" – Anything Is Possible. A comprehensive audience analysis for HIV risk in the Maldives with recommendations for communication, GFATM supported program in the Maldives, Barbara A.K. Franklin, Maldives, August 2009

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

Report of the Commission on AIDS in Asia, 2008

Annex 2 – people visited and institutions consulted

Ministry of Health
Dr. Aiminath Jameel, Minister of Health
Mr. Abdul Bari Abdulla, Deputy Minister of Health
Dr. Ibrahim Yasir Ahmed, Director General of Health Services

NAP, Centre for Community Health and Disease Control
Dr. Ahmed Jamsheed Mohamed, Director General
Mr. Abdul Hameed, Senior Public Health Programme Officer

DDPRS
Ms. Aminath Zeeniya, Director General
Mr. Mohamed Rashid
Mr. Ali Shareef
Mr. Mohamed Azim Abdul Hadhee

Ministry of Home Affairs
Maimoona Ahmed

Ministry of Islamic Affairs
Dr. Abdul Bari
Ah Shaikh Mohamed Faarooq
Thulsooma
Ahmadulla Jameel
Athifa Jaleel
Mohomed Faiz
Izzudin Adnan
Shameem

Ministry of Education
Mr. Hussain Rasheed Moosa

Maldives Police Service
Insp. Hussain Reshyf Thoha
(and three other people)

Youth Health Café
Ms.Aishath Rasheed, Director, Ministry of Human Resources, Youth & Sports
Ms. Aishath Nazhath, Director, Ministry of Human Resources, Youth & Sports
Ms Afaf Ibrahim Didi, Coordinator, Youth Health Café, Ministry of Human Resources, Youth & Sports
Ms. Shadiya Ibrahim, Assistant Representative, UNFPA Maldives
Mr. Ahmed Gaveem, National Programme Associate, UNFPA Maldives

SHE
Dr. Aishath Shiham
Mr. Asim
Ms Leena

SWAD
Ms Fathimath Afiya, Chairperson
Ms Aishath Rishtha, Program Manager
Ms Bashara Bagir, Program Coordinator
Ms Aishath Fareedh, Councelor
Mr Mohamed Basil, Program coordinator

Journey
Mr Adam Achmed, Board Member and Project Coordinator
Ms. Mayan Mohamed, Aftercare Project Coordinator

GFATM support team
Aishath Shifana
Ivana Lohar (UNDP)
Aminath Nawal (UNDP)

Annex 3 – Gap analysis and preliminary costing of interventions

See separate PDF file compiled by Anita Alban

Annex 3 – Results of costing

The JMTR was followed by a two-day workshop (15-16 December) on costing the targeted interventions to prevent HIV identified by the JMTR. The participants were government institutions, partners in AIDS, and a wide range of NGOs working in the field. The emphasis was on targeted interventions for high-risk groups and included two comprehensive best practice models for IDU harm reduction intervention and one model for prisons included a safe needle component. The Ministry of Home Affairs representative at the WS suggested a safe needle project to be piloted in a smaller prison – OST was not a priority since the Maldives at present time did not have an effective model. Outreach models including drop-in-center was costed to cover FSW and MSM interventions. These interventions include counseling, condoms, and access to user-friendly STI and VCT services (referral). Finally, costs of police HIV strategy was imputed in a draft format awaiting further data from the police.

The cost of activities for strategic information, coordination, and policy & legislation was discussed with NAP. Finally, the budget for HIV activities funded by the GFATM, Round 6 including the period 2009-12 was added to accomplish one costed action plan for the Maldives. However, some uncertainty is attached to when the funding from GFATM actually will take place in 2010-11 since the GFATM budget covers September 2009-August 2012. The reader needs to take this into account.

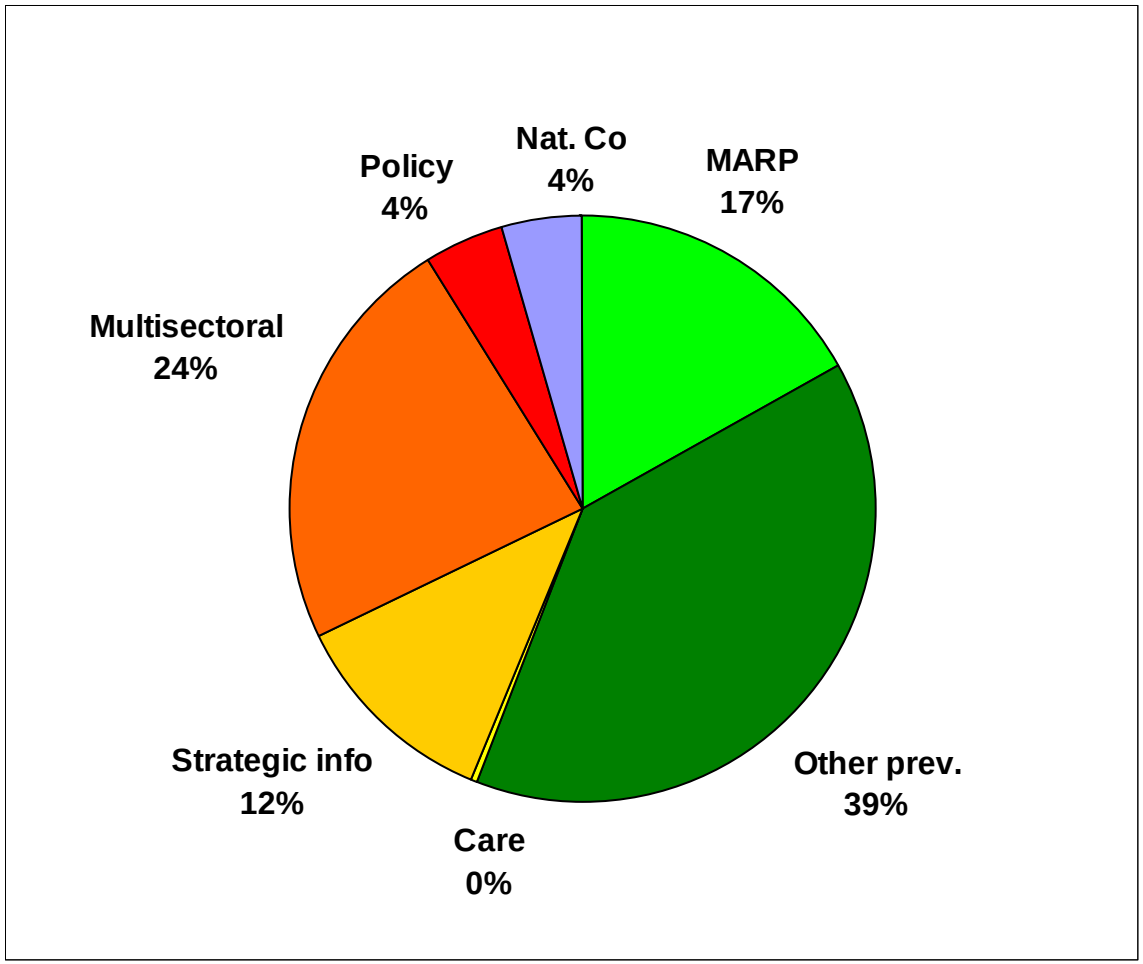
The spreadsheets are referred to as Mal-INPUT since the INPUT model (UNAIDS, ADB Costing Guidelines for Asia and the Pacific) has been used to estimate costs of targeted interventions. For information a number of spreadsheets are included as cases. For those interested the Master copy of Mal-INPUT, please refer to NAP for further information/material.

The following pages are copies of spreadsheets showing total resource need 2010-2011, resource allocation, and examples of costing sheets of targeted interventions as they were discussed during the workshop. Mal-INPUT examples are from the demo version that will be revised at regular basis by NAP.

Resource Need for HIV activities Maldives 2010-2011 (2009 prices) excl. Overhead for GFATM UNDP unit

HIV intervention	USD 2010	USD 2011	USD 2010-11	MVR 2010-11	Comments
Prevention					GFATM 2010-11 years not accurate
High-risk groups interventions	166,899	216,842	**383,741**	**4,892,692**	but approximations
IDU outreach	34,312	51,468	**85,779**		WS estimate 10-15% higher figures for GFATM
IDU OST	28,536	42,803	**71,339**		WS estimate (UNODC funding??)
FSW	21,934	32,902	**54,836**		WS estimate
MSM	43,732	32,799	**76,532**		WS estimate
Prison interventions	28,435	56,870	**85,305**		WS estimate
Police	9,950	0	**9,950**		WS estimate - will increase
Other prevention interventions			**892,743**	**11,382,479**	
Safe blood	49,517	49,517	**99,035**		GFATM 2010-11
HIV testing	239,004	159,336	**398,340**		(MoH financing) @ USD 7.97 (Sri Lanka default)
Ext. Migrant workers	43,870	43,870	**87,739**		GFATM 2010-11
Workplace					GFATM 2010-11
STI strengthening	31,068	31,068	**62,136**		GFATM 2010-11
VCT	99,123	99,123	**198,246**		GFATM 2010-11
Awareness campaigns	23,624	23,624	**47,247**		GFATM 2010-11
Sub-total, prevention	***653,105***	***623,379***	***1,276,484***		
Care and support					
HAART	1,967	2,225	**4,192**		GFATM has other figures (USD 23,456)?
OI	12	18	**30**		Not identified
Sub-total, care and support	***1,979***	***2,242***	***4,221***	**53,822**	
Strategic information					
MIS for HIV and AIDS	50,000	15,000	65,000		NAP proposal (GFATM total 168,924, 3 years)
MER incl Operational Research	50,000	50,000	**100,000**		GFATM= only staff and training?
BBS	100,000	0	**100,000**		GFATM= USD 100,000; ME plan = USD 185,600?
Sub-total, strategic information	***200,000***	***65,000***	***265,000***	**3,378,750**	
Multisectoral & decentralisation	***268,596***	***268,596***	***537,192***	**6,849,198**	GFATM - mainly staff for PR??
Policy and Legislation	***50,000***	***50,000***	***100,000***	**1,275,000**	GFATM has some money for this - not clear?
Coordination, national					
Capacity building, HR	50,000	50,000	**100,000**		NGOs and health?
Sub-total National coordination	***50,000***	***50,000***	***100,000***	**1,275,000**	
TOTAL	**1,223,680**	**1,059,218**	**2,282,897**	**29,106,940**	
GFATM	**893,000**	**699,281**	**1,592,281**	some HIV tests	**Some uncertainties (includes Overhead for UNDP)**

Resource allocation – total budget excl. overhead for UNDP/GF unit



Injecting drug users - oral substitution

target clients of a center	100	?

behaviour change		USD
staff	**units**	**salary/year**
Psychiatrist	0.25	4,500
doctor	0.25	4,500
nurse	0.3	3,960
PE	0.5	1,200
Other?		
TOTAL		**14,160**

Retraining	1000

running costs	**USD**	
rent	4,000	
overhead	2,500	
bookkeeper	1,440	15%
project manager	2,340	15%
other expenses	1,600	Guard?
total	***11,880***	

IEC	100	
enabling environment	800	??

commodities&services		**USD**	
	amount/pt/year	unit price	cost/ 250 pts/year
methadon	365	0.53	19,418
test	150	0.4	6,000
Cups	365	0.01	365
condoms	100	0.07	700
total			**26,483**
Methadone price	**EUR 0.38**	4.85	Nycomed/dose

UNIT COST

Cost component	**MVR**	**USD**	**%**
Behaviour change			
Staff	180,540	14,160	24.81%
Training	12,750	1,000	1.75%
Running cost	151,470	11,880	20.82%
IEC	1,275	100	0.18%
Commodities&services			
Drugs	247,580	19,418	34.02%
Usables	76,500	6,000	10.51%
Condoms	8,925	700	1.23%
Overdose kits			0.00%
Enabling environment	10,200	800	1.40%
Investments	12,750	1,000	1.75%
M+E	25,668	2,013	3.53%
TOTAL	**727,657**	**57,071**	**100.00%**
UNIT	**7,277**	**571**	

Currency conversion: USD 1 = MVR 12.75 *0.07843*

investments	5000	depriciation	5 years	1000

monitoring and evaluation	2013.15

Salaries (USD)	**per month**	**per year**	**per hour**
doctor	1500	18000	9.38
nurse	1100	13200	6.88
Counsellor	1250	15000	7.81
Manager	395	4740	2.47
Project ass.	800	9600	5.00
Project manager	1300	15600	8.13
PE	200	2400	1.25

1920

Sex worker interventions

Target	150
Reached	75

The interventions include DIC/resource center and outreach services

target clients	150

Programme management	**USD**	with	w/o house!
Running costs			
rent	4,500	Male	
overhead	3,000		
book keeper	2,343		
project manager	1,564		
cleaner	600		
other expenses	1,000		
TOTAL	**13,007**		

training (5 days a year)	
10% of staff cost	916

STAFF	**Salaries per year**	**Staff**	**Cost USD**
doctor	18,000		0
PE	2,400	0.50	1,200
Field worker	1,000	1.00	1,000
Manager	4,740	0.25	1,185
Proj. ass	7,100	0.25	1,775
Project manager	16,000	0.25	4,000
TOTAL			**9,160**

UNIT COST PER YEAR

	MVR	**USD**	%	
Behaviour change				
PE identification & mapping	63,750	5,000	15.20%	Relevant??
Staff	116,790	9,160	27.84%	
Training	11,679	916	2.78%	
Running cost	165,842	13,007	39.53%	Necessary?
IEC	287	23	0.07%	
Commodities & services				
STI treatment	5,355	420	1.28%	
Condom distribution	13,474	1,057	3.21%	
Enabling environment	10,200	800	2.43%	Guesstimate
Investments	12,750	1,000	3.04%	
MER	19,369	1,519	4.62%	
TOTAL, 75 SWs	**419,496**	**32,902**	**100.00%**	
TOTAL, 150 SW				
UNIT	**5,593**	**439**		
UNIT, full capacity, 150	**2,797**	**219**		

Currency conversion 1: *12.75*

USD

Rapid tests	1		Check
condoms	0.07		
inf.material	0.3		
STI treatment	28	Default	

Prisoners interventions

Prisoners	250	turn over	300	IDUs in prison	800 ?
HIV infected persons	***0*** ?				

Activities/interventions	MVR	USD	%	Comments
VCT - once per year (95%)	45,422	3,563	12.65%	Hep, STI, HIV in 2010
Condoms/year	11,156	875	3.11%	Planing stage MOH!
Desinfectans	7	256	0.00%	41% of prisoners
STI treatment, 50/year	26,775	2,100	7.46%	Numbers NA! A
Needle and syringes	14,310	1,122	3.98%	Pilot may be possible
IDU/OS	0	0		Not using methadone
Feasibility study on NE	133,875	10,500	37.28%	In 2010
Psycho-social services			0.00%	Consultant
IEC	2,100	165	0.58%	
PEP kits	0	0	0.00%	Price to be determined
Training of prison staff	76,500	6,000	21.30%	
Training of prisoners	31,875	2,500	8.88%	NGO training, 95% coverage
S, M&E (5%)	17,101	1,354	4.76%	
TOTAL costs	**359,121**	**28,435**	100.00%	
UNIT COST	**1,197**	**114**		
USD	12.75	0.07843		

				15	USD 54600	BSS	
				42			
				in 2011			
				2745	5000	0.549	
					56,983		

Main assumptions:

* Same number of IDUs per year, same coverage of services
* 41% of prisoners are IDUs - 48% DUs
* first year no needle exchange but awareness and condoms

Capacity is a problem!

	piece/client	USD price	
Condoms	50	0.07	
Desinfectants	250	0.01	Latvia default
Syringes/needles	365	0.03	Latvia default
Inf.materials	1	0.549	
Medicine	2.00	1	

Prisoners interventions, continued
Resource allocation example