Operational Plan on HIV 2010-11

Maldives

April 2010

National AIDS Programme
Centre for Community Health and Disease Control

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal care
ART	Anti-Retroviral Treatment
ARV	Anti-Retroviral (drugs)
BCC	Behaviour Change Communication
BBS	Biological and Behavioural Survey on HIV/AIDS
CBO	Community Based Organisation
CCHDC	Center for Community Health and Disease Control
CCM	Country Coordinating Mechanism (for GFATM grants)
DDPRS	Department of Drug Prevention and Rehabilitation Services
DIC	Drop-in Centre
DU	Drug use(r)
FP	Family Planning (services)
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 (December 2009)
MARP	Most At Risk Population(s)
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOHF	Ministry of Health and Family
MSM	Male to male sex/Men who have Sex with Men
NAC	National AIDS Committee
NAP	National AIDS Program
NGO	Non-Government Organization
NSP	National Strategic Plan on HIV in the Maldives 2007-2011
OI	Opportunistic Infection
OP	Operational Plan
OST	Oral Substitution Treatment
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PR	Public Relation
QA	Quality Assurance
SD	Strategic Direction
SE	Supportive Environment
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SW	Sex work(er)
TA	Technical Assistance
TB	Tuberculosis
TWG	Technical Working Group
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
USD	United States Dollar
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
WB	World Bank

Notes on text and content

The OP 2010-11 is built on the seven strategic directions as lined out in NSP 2007-11. The GFATM proposal and budget does not follow the same outline 100%, but operates with nine objectives instead of seven and has a bias for IDU/DU of the MARP populations.

The GFATM budget has its own timeline for yearly budget running from 1st September to 31st August the following year. It has not been possible to make exact budget estimates covering 1st January to 31st December since it is unknown which activities in the GFATM budget that has been carried out before and after 1st January. As a consequence the September 2009- August 2010 GFATM budget has been used ~ budget year 2010, and September 2010- August 2011 has been used ~ budget year 2011. Since September 2011-August 2012 GFATM budget for HIV has a smaller grant than previous year, the sum of money available from GFATM grant for 2011 might have been underestimated.

The JMTR 2009 focuses on all MARP populations and emphasises the lack of strategic information to lead and coordinate the fight against HIV and AIDS at the Maldives. The OP 2010-11 takes this into account although there are still outstanding issues in the DRAFT version.

The OP 2010-11 is a DRAFT version and has not included the findings of the BSS 2010 survey. If this is made available during the coming month – the mapping of vulnerable groups will be included into the HIV Operational Plan for the coming years.

10th April 2010

Executive Summary

To be inserted in final version!

1. Overview of the Operational Plan 2010-11

The Operational Plan, OP, has been developed on the basis of the budget of GFATM grant for September 2009-August 2010 and September 2010-Augsut 2011 and findings, recommendations from the JMTR carried out in December 2009 including a costing workshop focusing on budgeting for MARP activities.

1.1 Structure of Operational Plan

1.1.1 Seven strategies

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

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

Appendix 1 presents an overview of the seven strategies, objectives and strategic outcomes of the seven strategies. The costed OP 2010-11 in Appendix 2 does only show activities active in the planning period. Outputs linked to activities have mainly been included for activities that are not part of the GFATM budget. Since the GFATM proposal and budget do not include outputs, links to the GFATM budget has been provided for.

1.1.2 Key objectives

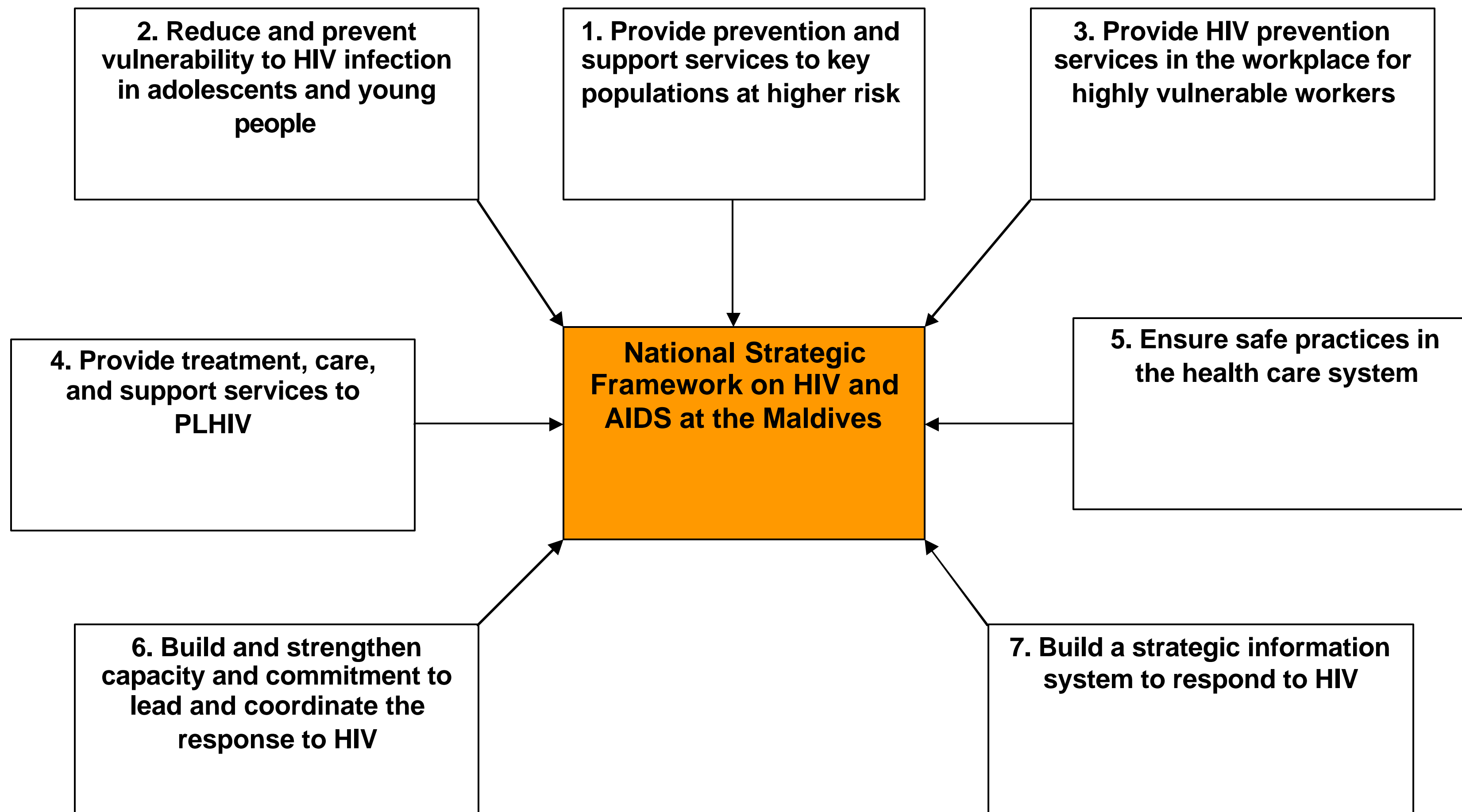
For each strategy, the key objective has been included. The key objectives are broad statements of what each strategy seeks to achieve. Key objectives are specific and often include percentage of certain population/target groups that should be reached in the planning period. For example 80% of people at higher risks have skills and knowledge to protect themselves; 80% of eligible PLHIV receive ART.

1.1.3 Activities and expected results

The Operational Plan sets outs activities which will be undertaken to achieve each objective. The expected results of these activities have been defined as strategic outcomes representing end results of achievements. The Operational Plan covers two years 2010 –2011.

This document is accompanied by costed Operational Plan 2010-11, which is organised around the seven strategic directions – Appendix 2 .

Figure 1: The National Strategic Plan on HIV and AIDS 2007-2011: Seven Strategies



2. Background for OP 2010-11

2.1 Emphasis on MARPs

The NSP 2007-11 aims to limit HIV transmission, provide care for infected people, and mitigate the impact of the epidemic through seven strategic directions – see figure 1.

The financing from the GFATM/R6 have enabled NAP to initiate and strengthen youth programmes, carry out awareness campaigns at targeted workplaces such as resorts, implementing provision of ARV treatment, starting safe practice project in the health care system, strengthen capacity and commitment among stakeholders, and strengthen coordination.

In December 2009 a JMTR identified two major gaps to be addressed during the last two years of the current HIV Strategic Plan. These are:

- Effective best practice interventions for most-at-risk populations: people having unprotected sex with multiple partners and people with unsafe practices injecting drugs. These groups are often identified as MSM, SWs (both men and women), and IDUs including IDUs in prison settings.
- Weak monitoring and strategic information systems to measure progress.

The Maldives are fortunate at this stage to have very few HIV cases. However, the basis for developing a concentrated HIV epidemic is prevalent. The country has high rates of hepatitis B (and C), STI rates are average for the region but much higher than for Sri Lanka. Further, taboos and lack of awareness of public health implications of driving underground sex work (whether opportunistic, regular street-based or escort based) and MSM make the Maldives society at risk of spread of STIs, HIV and hepatitis. The Maldives society is characterised by high level of divorce and re-marriages – in effect the Maldives have several sexual partners over a lifetime. This makes some divorced women left with few economic means and child responsibility vulnerable to engage in multiple sexual relationships to provide for themselves and their family. The JMTR identified single mothers as a group in need of targeted SRH interventions to cater for their health and welfare.

2.2 Resources from GFATM/R6

In 2007 the Maldives received GFATM grant of USD 4,142,457.00 for five years 2007-12 (August/ September). At present Maldives are into the first year of phase 2 covering September 2009- end of August 2012. The grant from GFATM is the dominating financial source for the HIV programme and the budget is consequently determining activities for the OP 2010-11. However, the GFATM budget for 2010-11 is not completely at par with the strategic directions and objectives in the NSP 2007-11. This has implications for the OP 2010-11 since a number of financial gaps can be identified at present point of time. Firstly, no interventions for high risk groups except for IDUs are included although capacity building and BCC have been financed in previous years. The interventions for prisons only include training of staff but no interventions (VCT, STI treatment, IDU harm reduction interventions, condom distribution, counselling/BCC) targeting prison populations are budgeted for. Secondly, the budget for building a strategic system to respond to the epidemic is under-funded. This is dealt with in more details for the individual strategic directions.

3. Strategic directions and OP 2010-11

The OP is build around NSP 2007-11 strategies, objectives, and projected activities. Some of the areas of activities in the individual strategic directions have already been fulfilled; some are still active in OP 2010-11 continuing their activities from previous years, and some are new activities such as targeted interventions for SWs and MSM.

3.1 Strategic Direction 1: Prevention and support services to populations at higher risk

During 2007-09 the Maldives have managed to provide a number of interventions to prevent HIV for IDUs including a pilot project for methadone and a detox clinic. However, much more needs to be done in this field including stock taking of what has been learnt and how to organise comprehensive IDU service packages based on best practices in the coming years. NAP in cooperation with NGOs working in this

field needs to strengthen coordination, scale up what works and widen the services being provided in the coming years based on lessons learnt. Further, more work is needed on advocacy for harm reduction interventions (OST as well as clean needle exchange programme). Present legislation does not allow for clean needle exchange programme – the Joint MTR recommended that advocacy move forward on this since its importance for public health is not well understood among decision-makers and the public. Finally, the JMTR recommended that established detox clinics be organised within a comprehensive package of services to yield appropriate return of investment.

Until today no comprehensive package for women (and men) engaging in commercial sex has been launched at the Maldives. At the end of 2009 NGOs have been able do identify 3-4 hotspots for street work but not much has been done to serve this vulnerable population with appropriate skills and services (condoms and treatment of STIs). One NGO has been training women involved in sex work and escort work at resorts and hotels. However, the main core of interventions for this highly vulnerable group has been awareness-raising. The mapping of this important most-at-risk group at the start of 2010 will assist the Maldives to target SW interventions based on need and the lessons learnt so far. Scale-up of SW interventions are assessed to be key to fighting HIV at the Maldives. Women leaving prisons has been identified as vulnerable group that needs targeted SRH and HIV interventions. This should be further explored by NAP and budgeted for in OP 2010-11.

The JMTR carried out in December 2009 recommended that an intervention for MSM be integrated into a wider approach focusing on improving the sexual health for vulnerable men in OP 2010-11, and that funding be secured for interventions targeting male to male transmission of HIV. This will require more informed advocacy and capacity building among decision makers, including key CCM members, to ensure a solid understanding of how public health interventions can and should be implemented also in contexts where risk behaviours are illegal. Agreement should be reached among stakeholders about a comprehensive and standardized package of interventions for high-risk men. The JMTR 2009 recommended that a phased program focusing on improving male sexual health be designed based on the findings of the BSS, the upcoming size estimation and risk behaviour mapping study, taking into account what is feasible within the socio-cultural context.

Approximately 80% of inmates at any given time are drug users and many injecting drug users. Until today no interventions to reduce the risk of getting infected by infectious diseases have been implemented and condoms are not available at correctional facilities. The police and Ministry of Home Affairs are positive to implementation of HIV program and prefer needle exchange program to be piloted in 2011. Such programs should include a BCC component aimed at both prison population and the guards.

3.1.1 Resources for SD1:

GFATM Round 6 grant money is presently financing a component to prevent HIV transmission among young people who inject drugs or are at risk of injecting drugs. The component includes an advocacy sub-component targeting policy makers and key stakeholders with focus on IDU/DU among young people. Until the end of 2009 one drop-in center, DIC, in Male providing oral substitution treatment, has been allocated resources provided by GFATM financing mechanism. The finances from GFATM also cover some training of law enforcement officers and staff at correctional facilities. The total sum at disposal for 2010 and 2011 is approx. USD 105,884 and USD 108,699, respectively.

The DRAFT OP 2010-11 includes interventions for SWs, MSM and one pilot prison intervention including needle exchange for 2011. Since the number of high-risk persons to be covered is unknown (April 2010) but awaiting the finalisation of the BSS the figures of coverage for target populations are those identified at the costing workshop carried out in December 2009 including NAP, MoH, MoHA officials, and a range of NGOs active in the field of HIV. The figures are based on what was assessed as possible to reach in 2010-2011 irrespective of NSP 2007-11 key objectives: 80% of groups at higher risk. The OP 2010-11 DRAFT requires minimum USD 163,673 and USD 239,142, respectively. These figures will probably increase during the review of OP 2010-11 and when more exact figures become available from the mapping study. The resource gap for this strategic direction 1 is minimum USD 57,789 and USD 130,443 for 2010 and 2011, respectively.

3.2 Strategic Direction 2: Prevention and reduction of vulnerability of young people

Substantial resources went into this strategic direction via the phase 1 of the GFATM grant funding a range of BCC, education model, capacity building activities, and to ensure a supportive environment. In fact supportive environment activities including BCC/PR activities consumed 69% of total GFATM grant and 21% of total budget in the two years of phase 1, respectively (JMTR 2009).

3.2.1 Resources for SD 2

For OP 2010-11 the budget is minimal at USD 34,124 and USD 23,624, respectively. The resources are for BCC community outreach mentoring, monitoring, and a mini survey of HIV knowledge of young people.

3.3 Strategic Direction 3: HIV Prevention services in the workplace for vulnerable workers

The activities budgeted for in the GFATM grant for 2010-11 include a comprehensive prevention package developed and implemented for police and defence force including peer education, condom distribution, BCC, VCT, and STI activities; a comprehensive prevention package for people who are away from home in long periods; and HIV education at the workplace developed for government offices and private sector.

3.3.1 Resources for SD 3

For OP 2010-11 the GFATM budget is USD 54,430 for both years. In December 2009 the JMTR learnt that the police force was developing a HIV strategy – only preliminary cost for this strategy is available at present time (April 2010).

3.4 Strategic Direction 4: Treatment, care and support to PLHIV

The strategic direction of treatment, care and support include blood safety-, STI-, ART delivery-, VCT-, and PMTCT activities. In OP 2010-11 the most resource demanding activity is related to integrating VCT into ANC, FP, and TB services including capacity building of health staff at atolls and strengthening of STI diagnosis and treatment. The budget for ART is modest since capacity building has been funded in previous periods and only 5 and 7 people are expected to undergo ART in 2010 and 2011, respectively. (These figures are from the costing seminar in December 2009 and are higher than those included in the GFATM budget.)

3.4.1 Resources for SD 4

MoHF is providing resources for a significant number of HIV test/year – approx. 35,000 in 2009. This number could be reduced and the OP 2010-11 proposes a reduction to 30,000 in 2010 and a further reduction to 20,000 in 2011. For a relatively small population at the Maldives it is a high number of HIV test level. The number represents a high cost that is assessed to have a further potential for down-scale. The present cost is estimated at USD 239,004 and USD 159,336 for 2010 and 2011, respectively (after downscale). The integration of VCT into STI-, FP-, ANC-, and TB services also constitute a substantial cost in OP 2010-11: USD 99,123 for both years. The provision of ART and drugs for prophylaxis of opportunistic infections is modest at USD 11,728 for both years. The GFATM budget estimates that only 1 person will need ART during 2010-11. It is however uncertain if this amount could cover more PLHIV on ART.

3.5 Strategic Direction 5: Safe practices in the health care system

This strategic direction includes provision of safe blood and access to PEP for health care workers. The blood component has been substantial funded over the first part of the planning period of NSP 2007-11 and has constituted 14% and 35% of total GFATM grant in the first two years (phase 1) of the GFATM 5-year grant period. This share has now been reduced substantial for 2010-11 and is planned to constitute approx. 7% of total resources of OP 2010-11. The activities include recruiting and retaining voluntary blood donors, development and implementation of a QA system, and promotion of rational use of blood products. A budget for these activities is available through the GFATM financing mechanism for OP 2010-11. However, no budget is available for PEP in the GFATM budget for the planning period.

3.5.1 Resources for SD 5

The GFATM budget for 2010 and 2011 for ensuring a safe blood supply has decreased to approx. USD 49,000 for both years.

3.6 Strategic Direction 6: Capacity strengthening to lead and coordinate HIV response

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 recommended that the coordination role of NAP 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. It is uncertain if the GFATM budget provide for such activities since emphasis is on civil society?
Supporting environment, strengthening of civil society, institutional capacity building has been a relatively high proportion of the HIV budget during NSP 2007-11. For 2008 this strategic direction constituted 69% of total HIV budget with a substantial PR cost. In 2009 this component had decreased to constitute 21% of total GFATM budget. However, in 2010 and 2011 this part constitutes more than 1/3 or total GFATM resources including overhead for UNDP, who administer the GFATM grant.

3.6.1 Resources for SD 6

For 2010 and 2011 the GFATM budget for building skills and expertise to lead, coordinate and implement effective HIV programmes is USD 327,055 and USD 314,343, respectively.

3.7 Strategic Direction 7: Build strategic information system to respond to HIV epidemic

Having objective information about the HIV infection and spread of drug use among different population groups is important to track the epidemic as well as to monitor the program implementation and its impact. It is critical to undertake study and estimate size of most at risk population in the Maldives for IDUs, SWs and MSM. Regular Integrated Bio-Behavioural Survey (BBS) among prisoners, IDUs, SWs, and MSM will be necessary. These studies will help monitor the infection spread among groups at risk as well as link the infection rates with behaviour factors. This information will be important to plan/adjust interventions among groups-at-risk as well as it will generate information about HIV prevalence that will inform National Monitoring and Evaluation System. Supplementary independent evaluations/studies in the form of operational research on behaviour pattern of highly vulnerable groups should be carried out as appropriate to guide the National response.
At the start of 2010 the Maldives is still without an effective strategic information system. The OP 2010-11 will have to address this appropriately and the activities need to be operationalised by NAP for planning and budgeting purposes. The GFATM has insufficient resources allocated to provide for this critical component for an effective response including one mapping study in 2010 and M&E strengthening including cost of CCHDC.

3.7.1 Resources for SD 7

The GFATM budget for 2010 provides a budget of USD 100,000 for mapping exercise in 2010 and has no budget for 2011 for this purpose. For M&E systems strengthening, USD 34,308 is set aside in 2010 GFATM budget and USD 17,308 in 2011. During the costing exercise in December 2009 in connection with JMTR the issue on strategic information was discussed briefly and the following need for resources was estimated. This has to be operationalised and consolidated by NAP before the OP 2010-11 is finalised since it obviously include a resource gap.

Strategic information	**2010 (USD)**	**2011 (USD)**	**2010-2011 (USD)**
MIS for HIV and AIDS	50,000	15,000	65,000
MER incl. Operational Research	50,000	50,000	100,000
BBS	100,000	0	100,000
Sub-total, strategic information	***200,000***	***65,000***	***265,000***
Multisectoral & decentralisation	***268,596***	***268,596***	***537,192***
Policy and Legislation	***50,000***	***50,000***	***100,000***

4. Resource gap of OP 2010-11

In the coming years the GFATM grant is the most important external financial source for investing in the fight against HIV at the Maldives. However, as explained earlier, the financial year of the GFATM grant is running from September to August creating some uncertainties to exactly how much money will be available in the period January to end of year 2010 and 2011.

Table 1 shows the approximate resource requirement and resource commitment in the planning period.

Table 1. Estimated resource requirement and resource gap. OP 2010-2011

	Resources required USD		Resources budgeted USD		Identified resource gap USD	Partners/Resource source	Budget Comments
Strategies	2010	2011	2010	2011			
SD1 MARP	149,050	195,273	108,699	108,699	126,924	DDPRS, GFATM, MOHA, UNODC, national NGOs...	GFATM grant only covers IDU interventions. UNODC contribution unknown
SD2 Young people	34,124	23,624	34,124	23,624	0	GFATM, national NGOs	GFATM grant only
SD3 Workplace	54,430	54,430	54,430	54,430	0	GFATM, national NGOs, Ministries, police, MOHA	GFATM grant. Expense for police strategy no known!
SD4 ART&care	380,923	301,255	380,923	301,255	0	MOHF, GFATM, national NGOs...	GFATM grant for strengthening STI and VCT services. MOHF includes HIV testing
SD5 Blood&PEP	48,917	49,217	48,917	49,217	0	MOHF, GFATM	GFATM, MOHF resources not known. Blood only.
SD6 Coordination	327,055	314,343	327,055	314,343	0	MOHF, CCHDC, NAP, GFATM	GFATM grant only. Might need more elaboration!
SD7 Strategic info.	134,308	17,308	134,308	17,308	0	MOHF, CCHDC, NAP, GFATM	GFATM grant only. Will need more elaboration!
TOTAL	**1,128,807**	**955,450**	**1,088,456**	**868,876**	**126,924**		

Note: GFATM budget is September 2009-August 2010 for 2010 and September 2010-August 2011 for 2011

The financing of MARP interventions (SD1) might change when the result of the mapping exercise is known. However, there are limits to what scale that can be reached within the planning period.

SD2, 3 and 5 is solely funded by GFATM grant plus the national resources from mainly the health sector system (including staff costs and costs for general HIV testing).

SD4 includes USD 239.000 and USD 159.336 for HIV testing in 2010 and 2011, respectively financed by MOHF budget estimated at 30.000 and 20.000 HIV tests in 2010 and 2011, respectively.

SD 6 is in table 1 only including GFATM grant money. Critical review of resource gap for advocacy and other coordination activities should be reviewed before finalisation of the OP 2010.2011.

Strategic information (SD7) is presently under-funded to reach an acceptable level for NAP to appropriately monitor the HIV epidemic. NAP will have to provide more information on what is needed to reach an acceptable level of strategic information to fight HIV and AIDS at the Maldives.

Appendix 1: National Strategic Plan on HIV and AIDS 2007-11: Overview of Strategies, Key Objectives and Strategic Outcomes

STRATEGIES	**1: Provide age-and gender-appropriate prevention and support services to key populations at higher risk: drug users, persons in penitentiaries, female sex workers (FSW) and men who have sex with men (MSM)**	**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 (expatriate workers, seafarers, resort workers, police, & MNDF)**	**4: Provide treatment, care and support services to people living with HIV**	**5: Ensure safe practices in the health care system**	**6: Build and strengthen capacity and commitment to lead, coordinate and provide a comprehensive response to the epidemic**	**7: Build a strategic information system to respond to the epidemic**
KEY OBJECTIVES	*80% of people at higher risks have achieved knowledge, skills and attitudes to protect themselves against HIV by provision of a scaled-up and effective packages of HIV prevention services*	*1) 80% of young people have correct knowledge on HIV and AIDS 2) 90% of schools provide life-skills based HIV education 3) 50% vulnerable adolescents are reached with prevention services*	*1) 50% of the targeted workforce are reached by HIV prevention services 2) 80% of targeted workforce groups have correct knowledge on HIV and AIDS*	*1) All STI, FP, ANC, and TB services provide VCT 2) 80% of eligible PLHIV receive ART 3) 100% of identified HIV positive pregnant women receive PMTCT services 4) 100% of HIV-exposed infants receive cotrimoxazole prophylaxis*	*1) 100% of donated blood units appropriately screened for HIV 2) 100% of health care workers have access to PEP 3) All health care facilities properly dispose of infectious waste*	*1) Enhanced leadership and management for effective multi-sectoral response to HIV 2) All responsible staff in Ministries, NGOs and CBOs have undergone capacity building and training of HIV management and implementation*	*Strategic information to guide an effective response improved and used for planning and implementation*
STRATEGIC OUTCOMES	Improved knowledge and safe behaviour practices of all target groups (safer sex practices and safer injecting practices)	Increased knowledge and attitude on HIV prevention amongst adolescents and young people	Increased access to and coverage of quality HIV prevention workplace programmes for target groups	Increased capacity of health services to provide, deliver and manage VCT services	Transmission of infection among health care providers- and seekers limited or negligible	Strengthen capacity of NAC and the national HIV programme to guide multi-sectoral implementation of NSP 2007-11	Trends and changes in HIV prevalence and HIV and STI related risk behaviours and knowledge among different risk and vulnerable groups tracked over time
	Reduced risk and vulnerability to HIV infection of all target groups	Increased skills of vulnerable adolescents to reduce risk and vulnerability of HIV	Improved knowledge and safe behavioural practices of all target groups	Increased capacity of health services to provide quality HIV diagnostic, treatment and care services	Ensured screening of all donated blood and organs	Enhanced programme mgt. and technical capacities of key institutions and NGOs to lead and implement	Effectiveness of HIV prevention and care interventions and activities monitored and evaluated

	Increased availability and access to appropriate and differential prevention services	Increased access to age-and gender appropriate HIV prevention and preventive servicesfor vulnerable young people	Reduced risk and vulnerability to HIV infections of all target populations	Increased availability of appropriate care and support services to PLHIV and their families	Increased knowledge on HIV transmission modes and prevention methods and 100% use of universal precautions	Establish national M&E system to effectively monitor and evaluate the national response and implementation of 3 Ones	All aspects of key programme service delivery areas effectively monitored and evaluated
	Enhanced supportive environment and policy framework to protect the rights of IDUs, sex workers, and MSM to effective HIV prevention services	Enhanced supportive environment for adolescent health and development and risk reduction programming	Enhanced supportive environment and workplace policy framework on HIV prevention, care and support	Assured availability of drugs, supplies and commodities related to delivery of ART	Implemented and regularly monitored blood safety policy in all health care settings	Implemented multi-year National Action Plans based on NSF 2007-11	Resources, inputs and outputs contributing to the programme monitored
				Increased involvement of civil society and community support for treatment, care and support to PLHIV and their families	Improved access of necessary quality supplies		
				Established and monitored continuum of prevention to treatment, care and support	Increased access and awareness of PEP services		

Source: NSP 2007-11, Maldives

Appendix 2: Costed OP 2010-2011 (2010 prices)

SD	Strategy/Activity set	Outputs	Unit	National Estimates (N)	Baseline achieved 2009	Unit cost USD	Targets 2010	Cost 2010 USD	Targets 2011	Cost 2011 USD
Objective 1: 80% of people at higher risks have achieved knowledge, skills and attitudes to protect themselves against HIV by provision of a scaled-up and effective packages of HIV prevention services										
SD1	**Prevention of HIV for higher risk persons**									
1	***Comprehensive prevention package for IDUs***		***No. of persons***				***150***	***62,847***	***225***	***94,271***
	Needles distribution	1) Access to needle and syringe is ensured from DIC and outreach programme(s). 2) Drug dependency, drug substitution treatment improved and expanded. BC education through peers and DIC provided incl. condom promotion, tailored health service, and IDU/DU friendly VCT services.			0	***343***	100	34,312	150	51,468
	Methadone Maintenance Therapy				45	***571***	50	28,536	75	42,803
	Behavioural change									
	Condom distribution									
	Primary health care									
	Support cost									
	VCT services									
	Investments									
2	***Comprehensive prevention and care package for institutionalised persons***		***No. of persons***		***0***	***42***	***0***	***10,500***	***250***	***10,581***
	Needles distribution	One pilot prison to provide a comprehensive package of prevention services for inmates in 2011. Package to include VCT, STI, BCC, training of prisoners and as a pilot for IDUs a needle exchange component. In 2010 a feasibility study will be carried out.								
	Behavioural change									
	Condom distribution									
	Primary health care									
	Support cost									
	VCT services									
	Enabling environment									
	Feasibility study							10,500		
3	***Comprehensive prevention package for sex workers***		***No. of persons***		***0***	***292***	***50***	***14,623***	***150***	***43,869***
	Condom distribution	Targeted condom promotion expanded, peer education and								
	Behavioural change									

	STI services Support cost Other support services VCT services Investments	outreach education (BCC) for direct and indirect sex workers are provided in prioritised areas. DIC are established as needed. STI and VCT services friendly to target group provided and used.									
4	***Comprehensive prevention package for MSM***		***No. of persons***		***0***	***292***	***100***	***29,155***	***150***	***43,732***	
	Condom, lubricants distribution Behavioural change STI services Support cost Other support services VCT services Investments	Targeted condom promotion expanded, peer education and outreach education (BCC) for visible MSM is provided in prioritised areas. DIC are established as needed. STI and VCT services friendly to target group provided and used.									
5	***Supportive environment, coordination and partnership developed DU and IDU only (national, community, public-private)***							***46,548***		***46,689***	
	SAPP staff	Activity 1.1.1 in GF budget 10-11						21,412		21,412	
	Advocacy meeting, policy makers	Activity 1.1.2 in GF budget 10-11						2,674		2,674	
	National meetings	Activity 1.1.3 in GF budget 10-11						5,882		5,882	
	Peer Training DU and IDU	Activity 1.2.3 in GF budget 10-11						5,765		6,121	
	Training and mentoring (I)DU	Activity 1.2.4 in GF budget 10-11						9,956		9,600	
	IEC material (I)DU	Activity 1.2.5 in GF budget 10-11						859		1,000	
Objective 2: 1) 80% of young people have correct knowledge on HIV and AIDS; 2) 90% of schools provide life-skills based HIV education; 3) 50% vulnerable adolescents are reached with prevention services											
SD2	**Reduction and prevention of vulnerability to HIV infection in adolescents and young people**										
1	***Comprehensive and age- and gender- appropriate HIV prevention information to target group***		***% reach***					***34,124***		***23,624***	

	General awareness and knowledge of STI and HIV among young people	BCC community outreach mentoring, monitoring and mini survey of HIV knowledge of young people. Activity 3.1 in GF budget 10-11						34,124		23,624
Objective 3: 1) 50% of the targeted workforce are reached by HIV prevention services; 2) 80% of targeted workforce groups have correct knowledge on HIV and AIDS										
SD3	**Prevention of HIV for highly vulnerable workplace populations**									
1	***Comprehensive prevention package for highly vulnerable workplace populations***							***54,430***		***54,430***
	Comprehensive prevention package developed and implemented for police and defence force	Peer education; condom distribution; BCC; VCT; and STI. Activity 1.1.5 and 1.1.6 in GF budget 10-11						10,560		10,560
	Comprehensive prevention package developed and implemented for people who are away from home for long periods	Peer education; condom distribution; BCC; VCT; STI; and supportive environment. Activity 2.1-2.2 in GF budget 10-11						38,332		38,332
	HIV education at the workplace programme developed for government offices and private sector	Activities 2.3. and 2.3. in GF budget 10-11						5,538		5,538
Objective 4: Provide treatment, care and support services to people living with HIV										
1	***Integrate VCT into STI services, FP, ANC, and TB services***		***No of VCT***					***239,004***		***159,336***
	Carry out HIV testing for clinical settings and VCT points		No of HV tests		35,000		30,000	239,004	20,000	159,336
2	***Provide comprehensive treatment and care for PLHIV***		***No of PLHIV***					***141,919***		***141,919***
	Strengthened provider initiated testing and counselling through maintaining standards of consent, counselling and confidentiality	VCT friendly services established and running. Training of 20 health workers at atolls. Activity 4.1.1, 4.1.2, 4.1.4 in GF budget 10-11	VCT sessions provided					84,366		84,366

	Training of health staff from atolls in VCT	Training of 20 health staff from atolls. Activity 4.1.3 in GF budget 10-11	No trained					14,757		14,757
	Strengthening of STI diagnosis and treatment	Training of 40 health workers and provision of extra services. Activity 5.1 in GF budget 10-11	No trained					31,068		31,068
	Ensuring consistent and affordable supply of quality assured ART, drugs for prophylaxis and treatment of opportunistic infections	Procurement of ARV. Activity 6.1.1 in GF budget 10-11	PLHIV on ART				5	11,728	7	11,728
Objective 5: Ensure safe practices in the health care system										
SD5	**1) 100% of donated blood units appropriately screened for HIV 2) 100% of health care workers have access to PEP 3) All health care facilities properly dispose of infectious waste**									
1	***Ensuring safe blood supply***							***48,917***		***49,217***
	Recruiting and retaining voluntary non-remunerated blood donors	Blood donor recruitment officers active. Mobile blood selection sessions on Activity no 7.1.1 and 7.1.3 in GF budget 10-11	No of officers					18,386		18,386
	Developed and implemented national strategy for screening of all donated blood for transfusion transmissible infections	Annual planning and review meeting for all responsible BTS staff. Activity 7.1.2 in GF budget 10-11	No of par-ticipants					8,451		8,451
	Developed, implemented and sustained QA systems, GLP and GMP in all aspects of BTS	Training of 40 clinicians and nurses on rational use of blood products - atolls. Activity 7.1.6 in GF budget 10-11						11,080		11,380
	Promoting rational use of blood and blood products	TV and radio spots. Activity 7.1.4, 7.1.5 in GF budget 10-11	No of spots					11,000		11,000
2	***Practise universal precautions in all health care settings including health care waste management***							***0***		***0***
Objective 6: Build and strengthen capacity and commitment to lead, coordinate and provide a comprehensive response to the epidemic										

SD6	**1) Enhanced leadership and management for effective multi-sectoral response to HIV 2) All responsible staff in Ministries, NGOs and CBOs have undergone capacity building and training of HIV management and implementation**									
1	***Strengthen leadership and multi-sectoral coordination mechanisms***							***0***		***0***
2	***Build skills and expertise to lead, coordinate and implement effective HIV programmes in the government and NGOs***							***327,055***		***314,343***
	Supportive environment, strengthening of civil society, and institutional capacity building	PR events. Activity 9.1.1-9.1.5 in GF budget 10-11	Events people trained					268,596		268,596
	Overhead UNDP	GF office - operational costs. Activity 9.1.8 in GF budget 10-11						58,459		45,747
Objective 7: Build a strategic information system to respond to the epidemic										
SD7	**Strategic information to guide an effective response improved and used for planning and implementation**									
1								***134,308***		***17,308***
	Conducted mapping and estimation of population size among high risk groups, annually	Mapping exercise MARPs. Activity 8.1.2 in GF budget 10-11						100,000		0
	Other M&E systems strengthening including cost of CCHDC	Capacity building (unspecified) Activity 8.1.1, 8.1.3 in GF budget 10-11						34,308		17,308
TOTAL								1,143,430		999,319