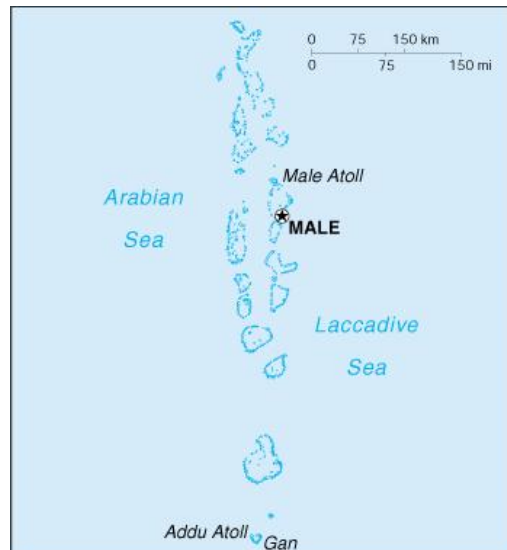


Enhancing the Response to HIV/AIDS in the Maldives

End of Program Evaluation

MDV-607-G01-H

November 2012



Contents

List of Acronyms and Abbreviations	3
Executive Summary	4
Introduction.....	11
Country Context	11
The UNDP-Global Fund Partnership	12
Enhancing the Response to HIV/AIDS in the Maldives.....	13
Program Goal and Objectives	14
Evaluation Objectives and Methodology	16
Evaluation Objectives	16
Evaluation Methodology	16
Limitations	16
Findings and Conclusions	18
Relevance	18
Coherence with National Sectoral Plans	18
Coherence with Round 6 Proposal	19
Efficiency and Effectiveness of Grant Implementation.....	20
Financial Management	20
Programmatic Results.....	22
Grant Performance as Assessed by the Global Fund.....	24
Major Achievements	25
Human Development Approach and Gender Mainstreaming	26
Relationship between Implementing Partners.....	27
Constraints to Implementation	29
Sustainability	33
Lessons Learned	35
Recommendations.....	38
Annex 1 –Documents Reviewed.....	41
Annex 2 – Key Informants	42
Annex 3 - Issues Impacting Financial Management of Round 6 Program.....	43

List of Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
BCC	Behaviour Change Communication
BBS	Biological and Behavioural Survey
CCHDC	Center for Community Health and Disease Control
CCM	Country Coordinating Mechanism
DU	Drug Users
DIC	Drop In Centre
FPM	Fund Portfolio Manager
FSW	Female Sex Workers
HIV	Human Immunodeficiency Virus
HMP	Health Master Plan 2006-2015
IDU	Injecting Drug Users
IEC	Information, Education and Communication
KAP	Key Affected Population
LFA	Local Fund Agent
MARP	Most-At-Risk Population
MoH	Ministry of Health
M&E	Monitoring and Evaluation
MSM	Men Who Have Sex with Men
NAP	National AIDS Program
NSP	National Strategic Plan
NDA	National Drug Agency
NGO	Non-governmental organization
NNCB	National Narcotics Control Board
PAF	Program Acceleration Fund
PIU	Program Implementation Unit
PMU	Programme Management Unit
PU/DR	Progress Update/Disbursement
PR	Principle Recipient
SHE	Society for Health Education
SR	Sub-recipient
SSR	Sub-subrecipient
STI	Sexually Transmitted Infection
UNAIDS	UN Joint Programme on AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing

Executive Summary

Background

The Global Fund Round 6 “Enhancing the Response to HIV/AIDS in the Maldives” Program (MDV-607-G01-H) began on 01 September 2007, with an end date of 31 August 2012. The 5-year grant award totaled USD 4 142 457 with USD 2 655 685 committed for Phase 1 and USD 1 486 772 committed for Phase 2.¹ The United Nations Development Programme (UNDP) served as Principal Recipient (PR) to the grant with the Society for Health and Education (SHE), National Drug Agency (NDA), and Centre for Community Health and Disease Control (CCHDC) as Sub-recipients (SRs). The Society for Health and Education, Journey and Open Hand served as Sub-subrecipients (SSRs).

The goal of the Round 6 Program was “To continue to maintain Maldives as a HIV low prevalence country through appropriate preventive and curative interventions.” More broadly the Program recognized the importance of creating a supportive environment, to ensure not only support for HIV/AIDS initiatives but also to reduce the stigma and discrimination often facing people living with HIV. The nine objectives of the Program were to:²

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 migrants, seafarers and resort workers;
3. Increase awareness and knowledge of STIs and HIV among young people;
4. Expand access to and coverage of quality HIV testing and counseling;
5. Strengthen the prevention and control of STIs;
6. Strengthen health service capacity to provide quality care, support and treatment for people living with HIV;
7. Strengthen health systems capacity for prevention of HIV and other blood transfusion transmittable infections through blood and blood products;
8. Strengthen the strategic information system for HIV; and
9. Strengthen the multi-sectoral response to AIDS.

This evaluation reviews the UNDP-Global Fund Round 6 HIV Program in the areas of relevance, effectiveness, efficiency, and sustainability. The evaluation was conducted by one investigator over 15 days during the period 22 Aug – 21 November 2012 (10 days on-site in the Maldives), through a combination of desk review and informant interviews. It is expected that the findings of this evaluation will be used to strengthen future implementation of the National Strategic Plan (NSP) on HIV/AIDS 2012-2016 and the Health Systems Strengthening Operational Action Plan. The findings will support planning and resource mobilization for HIV prevention initiatives in the Maldives.

¹ Program Grant Agreement for Grant Number MDV-607-G01-H

² Annex A to the Program Grant Agreement

Results and Conclusions

There is no question that this grant has achieved what it was designed to and all implementing partners view the Round 6 Program to be a success. The Round 6 Program was found to be coherent with the Health Master Plan 2006-2015, contributing specifically to the achievement of targets in the following policy goal areas:

- Ensuring people have the appropriate knowledge and practices to protect and promote their health;
- Preventing and reducing the burden of disease and disabilities and improving quality of life;
- Enhancing the response of health system in emergencies; and
- Building the culture of evidence based decision making within the health system.

Overall, grant implementation was true to the objectives and workplan of the Round 6 Proposal. No material changes were made to the grant during implementation, however some changes to indicators and targets were made to reflect new research findings and better make use of grant resources. Given that the proposal for the Global Fund grant was developed before the National Strategic Plan (NSP) 2006-2011, the indicators and targets from the grant were included in the NSP. More than half of all activities in the NSP were conducted with Global Fund grant monies.

According to the Global Fund website, as of 01 November 2012, USD 3 695 518 (89 percent of the total grant amount) had been disbursed. The flow of financial resources during the grant's life cycle is shown in Table 1 below:

Table 1: Round 6 Program Expenditure³

	2007	2008	2009	2010	2011	2012	Total
Budget	730 257	1 361 072	40 059	772 789	714 660	523 619	4 142 456
Disbursement	1 258 623	-	1 091 915	575 271	192 062	577 646	3 695 518
Expenditure	114 906	521 298	1 409 710	887 685	470 631	232 949	3 637 179

Expenditure delays in Phase 1 were primarily due to delays in recruitment of PR project personnel and delays in fulfilling Conditions Precedent included in the Grant Agreement.

Table 2 shows the programmatic results achieved through grant implementation.

³ As of Q18 (March 2012)

Table 2: Programmatic Results⁴

Objective	Indicator	Base-line	Target (Period)	Result (Period)	%	Key Achievements
Prevent HIV transmission among young people who inject drugs or are at risk of injecting drugs	# of law enforcement officers including judiciary, police and staff of correctional facility trained on IDU and HIV concerns.	0 (2007)	325 (19)	282 (18)	87	<ul style="list-style-type: none"> • 2 DICs with VCT services (Male, Fuvahmulak) targeting DUs and IDUs established • Comprehensive HIV prevention outreach programs for DUs and IDUs with peer accompanied referrals • HIV prevention for DU and IDUs conducted in prison settings • Research based advocacy sessions held for parliamentarians in advance of passing of Drug Bill
	# of peer educators trained on HIV/AIDS risks for drug users and outreach to DUs and IDUs	0 (2007)	167 (17)	195 (17)	117	
	# of DUs and IDUs reached by HIV prevention programme	0 (2007)	5 887 (19)	6 434 (18)	109	
Prevent HIV transmission among populations at risk such as migrants, seafarers and resort workers	# of peer educators trained on HIV/ AIDS risks and outreach to migrants	0 (2009)	40 (17)	29 (17)	73	<ul style="list-style-type: none"> • HIV and STI prevention outreach with IEC materials conducted in 5 languages • HIV/AIDS workplace education outreach conducted with view to development of workplace HIV policy • Migrant Fair targeting the expatriate population held on World AIDS Day 2010
	# of migrants and resort workers reached by HIV/AIDS prevention programme	0 (2007)	41 000 (16)	47 977 (16)	117	
	# of HIV education sessions held in large enterprises /companies	0 (2007)	45 (18)	22 (18)	49	
Increase awareness and knowledge of STIs and HIV among young people	% of young people 15-24 years of age who both correctly identify ways of preventing the transmission of HIV and who reject the major misconceptions about HIV transmission		50			<ul style="list-style-type: none"> • Mass media (television, radio, song and music video, printed IEC materials) campaign targeting youth, IDUs and migrants conducted
	# of teachers trained in participatory life skills based HIV/AIDS education	0 (2007)	112	119	106	
Expand access to and coverage of quality HIV testing and counseling	# of people who received testing and counseling services for HIV and received their results	4081 (2006)	1 900 (19)	2 074 (18)	109	<ul style="list-style-type: none"> • National VCT protocol established • 3 VCT centres established in NGOs to cater to MARPs and vulnerable populations • Health sector and non-health sector workers trained in VCT (collaboration with WHO)
Strengthen the prevention and control of STIs	# of Health Care Providers trained in diagnosis and clinical management of STIs	23 (2006)	341 (16)	352 (16)	103	<ul style="list-style-type: none"> • STI guidelines developed • STI training module revised • Recording and reporting tools developed • Case definition booklet developed
	# of STI cases treated at health care facilities	40 (2006)	2 502 (19)	3 953 (18)	158	
Strengthen health service capacity to provide quality care, support and treatment for people living with HIV	# of adults and children with advanced HIV infection (currently) receiving ART	1 (2006)	10 (19)	3 (18)	30	<ul style="list-style-type: none"> • 63 trained in HIV/AIDS case management and ART • Government funding of ART from Year 3

⁴ Reflects the most up to date information as available on the Global Fund website (Updated 01 Nov 2012)

Strengthen health systems capacity for prevention of HIV and other blood transfusion transmittable infections through blood and blood products	# of blood units collected through blood donation promotion offers	40 (2006)	110	550	500	<ul style="list-style-type: none"> • Year on year increase in intake of voluntary blood donors • 138 trained for voluntary blood donor recruitment • Equipment procured for the National Blood Transfusion Services
	# of clinicians trained on rational use of blood and blood products - RBC and nurses trained in blood transfusion practices	0 (2006)	432 (16)	447 (16)	103	
	# and % of donated blood units screened for HIV according to the national guidelines	100% of 8916 (2006)	8920 100% (16)	N:8920 D:8920 P:100% (16)	100	
Strengthen the strategic information system for HIV	-	-	-	-	-	<ul style="list-style-type: none"> • BBS on HIV/AIDS conducted • Qualitative research (Anything is Possible) on risk behaviours among MARPs and vulnerable populations • National size estimation and social mapping of MARPs conducted • BBS in Prisons of the Maldives conducted (UNAIDS PAF) • Implementation of MESST Assessment • National M&E Plan on HIV/AIDS for NSP 2007-2011 developed and implemented
Strengthen the multi-sectoral response to AIDS.	# of NGOs and government ministries involved in planning local responses to HIV prevention needs and care needs of people who use drugs	4 (2006)	20	32	160	<ul style="list-style-type: none"> • NSP on HIV/AIDS for 2012-2016 drafted • Joint Mid-term Review of NSP 2007-2011 conducted (support from WB, UNAIDS, WHO, UNICEF, and UNODC) • Operational Plan of NSP for 2010-2011 developed following the Joint Mid-term Review of NSP 2007-2011. • 2 prayers, 7 sessions on HIV prevention delivered in mosques, and HIV sensitization session held for Islamic scholars.

In addition to the programmatic results detailed in Table 2, the Round 6 Program has led or contributed to:

- Starting a national dialogue on topics previously regarded as taboo such as sex, condoms, sex work, and homosexuality;
- Giving a face to most-at-risk groups and a justification for why their unique needs with respect to HIV prevention must be met;
- Including members of vulnerable communities as part of the solution;
- Creating a culture of linking research to intervention;
- Advancing harm reduction as a tool in addressing HIV;
- Policy level advocacy in support of HIV prevention;
- Strengthening HIV related M&E at the national level;
- Leveraging synergies between civil society and the Government; and
- Developing the capacities of NGOs working in the field of HIV.

The Round 6 Program brought to light the needs of some of the most hidden, marginalized and stigmatized communities in the Maldives. On the other hand, gender was not an aspect that was explicitly considered or discussed during planning and implementation of grant activities. As such, an opportunity to address the gendered dimension of HIV was missed.

Constraints to Implementation

There were many constraints to effective and efficient grant implementation, with the majority persisting for the duration of the grant implementation period. Grant performance and results achieved must be viewed in the context of the following:

- Delays in recruiting implementation staff within the PR (Phase 1);
- Delays in fulfilling Conditions Precedent (Phase 1);
- Lack of capacity among implementing partners (Phase 1 and Phase 2);
- The challenging legal and social environment in the Maldives vis-a-vis marginalized groups (Phase 1 and Phase 2);
- Personnel turnover within SRs and the CCM (Phase 1 and Phase 2);
- Political instability including changes to policies, personnel and organizational structures (Phase 1 and Phase 2);
- Disbursement delays due to miscommunications and a lack of M&E capacity at the PR and SR levels (Phase 2); and
- Decentralization of the MOH, leading to data collection and reporting delays (Phase 1 and Phase 2).

Sustainability

Sustainability of grant activities was a concern expressed by all implementing partners, particularly SSRs, and at this point, it is questionable how sustainable the progress made through the Round 6 Program will be. The Maldives is now classified as a middle income country and is therefore no longer eligible for Global Fund financing. Furthermore, the Maldivian Government is experiencing a fiscal crisis, so it is not clear to what extent funding will be available for the national response to HIV.

Sustainability measures undertaken include:

- A proposed budget of just over USD 95 000 to sustain some of the VCT, STI management and blood safety activities from the Round 6 grant in 2013 has been submitted to the senior management of the MOH for review and approval;
- The Maldivian Government has publicly committed to continuing to provide ARV treatment for those who need it free of charge (Maldivian and expatriate individuals);
- UNODC has also indicated willingness to support the operation of the Journey Drop in Centre for 4 months;
- IPPF and UNFPA will fund continuation of activities implemented by SHE and targeting migrant workers. With the support of AusAID, plans include the establishment of five service delivery points (in addition

to the service delivery point supported through the Global Fund Program) that integrate sexual and reproductive health (SRH) services and HIV prevention for migrant populations;

- SHE reports that details are being finalized on an EU funded project on the contextualization of HIV within SRH; and
- The National AIDS Program (NAP) expects to submit a proposal for the longer-term funding available through the SAARC Development Fund.

Beyond financial resource constraints, there appears to be a looming leadership vacuum in the response to HIV in the Maldives. With only two staff members, it is difficult to imagine the NAP being able to effectively coordinate the national response, plan, implement, monitor and evaluate HIV, prevention, treatment and care initiatives, and develop and implement HIV research activities. The ability of CSOs will also likely be hampered as many of them are still in the early stages of organizational development, are not self-sufficient and require considerable capacity building to continue and/or improve their work. Furthermore, in many cases the salaries of staff members implementing the Global Fund program were paid through the Grant. This lack of capacity, particularly in the area of coordination, is exacerbated further by the likely event that UNAIDS will reduce its role and presence in the Maldives. Due to budgetary constraints, UNDP's role on HIV/AIDS will also be significantly reduced.

Recommendations

All Implementing Partners

- Evaluate Round 6 Program activities. Evaluations on implemented activities should be conducted and the findings should be used to inform the design and delivery of future initiatives.
- Design capacity building initiatives in a structured manner. Programs should include a dedicated budget line for capacity building and initiatives should be systematic, appropriately targeted, and subject to monitoring and evaluation.
- Institutionalize a knowledge sharing mechanism. Given the high rate of staff turnover and the finite amount of funding for capacity building initiatives, it is imperative that any new knowledge is dispersed across an organization to the extent possible.
- Design targeted interventions for youth, women, female sex workers and men who have sex with men. The BBS underscores the importance of targeting interventions to these groups.
- Document best practices for knowledge management and knowledge sharing purposes.

MoH/NAP

- Conduct a gender audit of the NSP 2012-2016 to ensure that the gendered dimensions of HIV prevention, treatment and care are considered and appropriately reflected.
- Develop a roster of facilitators to take stock of trained individuals so that their skills and knowledge can be leveraged as facilitators, consultants, Trainer of Trainers, peer educators etc. within the implementation of the NSP 2012-2016.

- Address wait lists in drug detoxification and rehabilitation services. Any constraints to accessing such services by potential clients jeopardize the integrity of outreach programs and result in missed harm reduction opportunities.
- Design a minimum package of services to be offered at DICs to set expectations for the public as well as operating standards for the DIC.
- Develop standards for peer educator trainings to ensure that the peer educator “brand” is not diluted and attrition accelerated.
- Review the current Life Skills Education curricula to determine whether the current format of life skills education can be adapted to support HIV prevention. The establishment of Youth Friendly Services could be considered as a complementary intervention.

UNDP and other UN Agencies

- Support the NAP, particularly given the magnitude of the work to be done just to maintain the current level of momentum on the national response to HIV and the paucity of resources with which to do it.
- Provide support to civil society organizations working in the area of HIV prevention, care and treatment.
- Mobilize resources to support the national response to HIV, particularly given the acute need to extend interventions beyond Male.

UNDP Headquarters

- Consider managing certain functions (eg. financial management) centrally for Global Fund Programs managed in small countries.

Introduction

Country Context

Unlike many other countries, the Maldives began to develop the infrastructure for a national AIDS response at a relatively early stage. In 1987, the Government launched a National AIDS Program (NAP) to lead, coordinate and monitor the national multi-sectoral response to AIDS. It also established the multi-sectoral National AIDS Council to serve in an advisory role to the NAP. It consists of high level policy makers and qualified technical advisors and includes representatives from government, NGOs and the private sector. The first cases of HIV in the Maldives were reported a few years later in 1991.

The Maldives has one of the lowest estimated rates of HIV prevalence (less than 1 percent) in the South and West Asia region. As of June 2012, a total of 17 cases among Maldivians and 303 cases among the expatriate migrant labour force have been reported⁵ (the Maldives has a predominantly male expatriate migrant worker population estimated at over 70 000). The exclusive mode of HIV transmission to date is heterosexual sex.⁶ The demand for antiretroviral therapy (ART) has remained low; only four people are currently receiving treatment.⁷

Although the Maldives currently has a low level HIV epidemic, there appears to be considerable risk of the escalation of HIV transmission. A situational analysis conducted in 2006 shed light on the country's vulnerability to HIV, with the following HIV risk factors identified:

- **A young, uninformed population.** An estimated 27 percent of the Maldivian population is under the age of 15 years, with low levels of knowledge on HIV transmission and limited access to accurate information on HIV and youth friendly services;
- **Increasing drug use amongst young people and increasing use of injecting drugs;**
- **Limited access to and use of condoms;**
- **Increasing HIV prevalence among expatriate workers;**
- **Increasing access to sex workers within the country;**
- **Increased travel by Maldivians to neighbouring countries with higher HIV prevalence;**
- **A high number of blood transfusions.** It was estimated that 6 500 blood transfusions were performed in 2006 primarily owing to the prevalence of Thallassaemia in the country; and
- **Political, social and cultural changes.** The impact of greater access to the outside world through satellite and internet is contributing to a less conservative environment, which in turn influences the sexual behaviour of young people.

The Biological and Behavioral Survey (BBS) on HIV/AIDS carried out in 2008 to identify, locate and gain knowledge about the most at risk populations in Male and Addu, buttressed the findings from 2006. The BBS identified HIV transmission risk factors including the high prevalence of substance abuse and increasing injecting

⁵ Monthly HIV/AIDS and STI Surveillance Report of CCHDC (April- June 2012)

⁶ Year 4 Annual Report: "Enhancing the response to HIV/AIDS in the Maldives", UNDP 2012

⁷ Monthly HIV/AIDS and STI Surveillance Report of CCHDC (April- June 2012)

drug use. For example, just under one-third of IDUs surveyed in Male and nearly one-quarter of those in Addu reported sharing an unsterilized needle at the last time of injection. Eighty-six of IDUs surveyed in Male had spent time in jail, of which two-thirds used drugs while incarcerated (one-third reported using injecting drugs).⁸

The BBS also identified the presence of syphilis and hepatitis C, overlapping risk populations, low self-risk perceptions for HIV, a knowledge-practice gap, poor health-seeking behavior and the lack of well-established HIV prevention programs. The Survey found that 90% of female sex workers (FSW) did not use condoms. Other structural and social risk factors specific to the Maldives include gender inequality, underemployment and unemployment, gender inequality, internal and external migration, political uncertainty and high levels of stigma and discrimination in relation to key and vulnerable populations.

Furthermore, the demographics and geography of the Maldives may also increase the risk of an escalating epidemic. Over one-third of the country's population of 300 000 lives in the capital, Male. This high degree of urbanization contributes to overlapping risk populations. On the other hand, the remainder of the population is scattered across 200 islands in the archipelago of about 1 190 small islands, making it difficult to reach members of most-at-risk populations (MARPs) with HIV related information and services.

Given the risk factors noted above, the Round 6 Global Fund Grant Program was a much needed and timely addition to the country's development efforts.

The UNDP-Global Fund Partnership

The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) was established in 2002 as a public-private partnership with the aim of supporting large-scale prevention, care and treatment programs addressing the three diseases. It is guided by the principle of performance-based funding and to date, has committed USD 22.9 billion to 151 countries.⁹ With its mandate of being a lean funding mechanism, the Global Fund relies on a wide range of partners to carry out key activities necessary for its functioning and success. As part of its wider engagement with the United Nations, the Global Fund has partnered with the United Nations Development Programme (UNDP) in several countries facing complex challenges. The objectives of the Partnership are:¹⁰

1. To ensure that Global Fund grants can be implemented and services delivered in countries facing exceptional development challenges, including complex humanitarian emergencies, thereby promoting an equitable distribution of Global Fund resources;
2. To promote long-term sustainability of health outcomes by developing national capacity for implementing health programmes more broadly in capacity-constrained settings; and
3. To achieve Millennium Development Goal 6 (combat HIV, AIDS, malaria and other diseases), universal access goals and other health and development goals through coordination and information sharing.

⁸ Biological and Behavioural Survey on HIV in the Maldives, Corpuz AC, Oct 2008.

⁹ <http://www.theglobalfund.org/en/about/whoweare/> Accessed Sept. 5, 2012

¹⁰ UNDP Operations Manual for Projects Financed by the Global Fund to Fight AIDS, Tuberculosis and Malaria, UNDP, July 2011.

In the Maldives, UNDP was nominated as Principle Recipient (PR) to the Round 6 “Enhancing the Response to HIV/AIDS in the Maldives” grant by the Maldives Country Coordinating Mechanism (CCM), a structure established during the Global Fund grant proposal development process. As PR, UNDP Maldives bears full responsibility for the financial and programmatic implementation of the Round 6 grant. Throughout the grant life cycle, UNDP is tasked with providing capacity development services to relevant national institutions, Sub-recipients (SRs), Sub-subrecipients (SSRs) and other implementing partners.

Enhancing the Response to HIV/AIDS in the Maldives

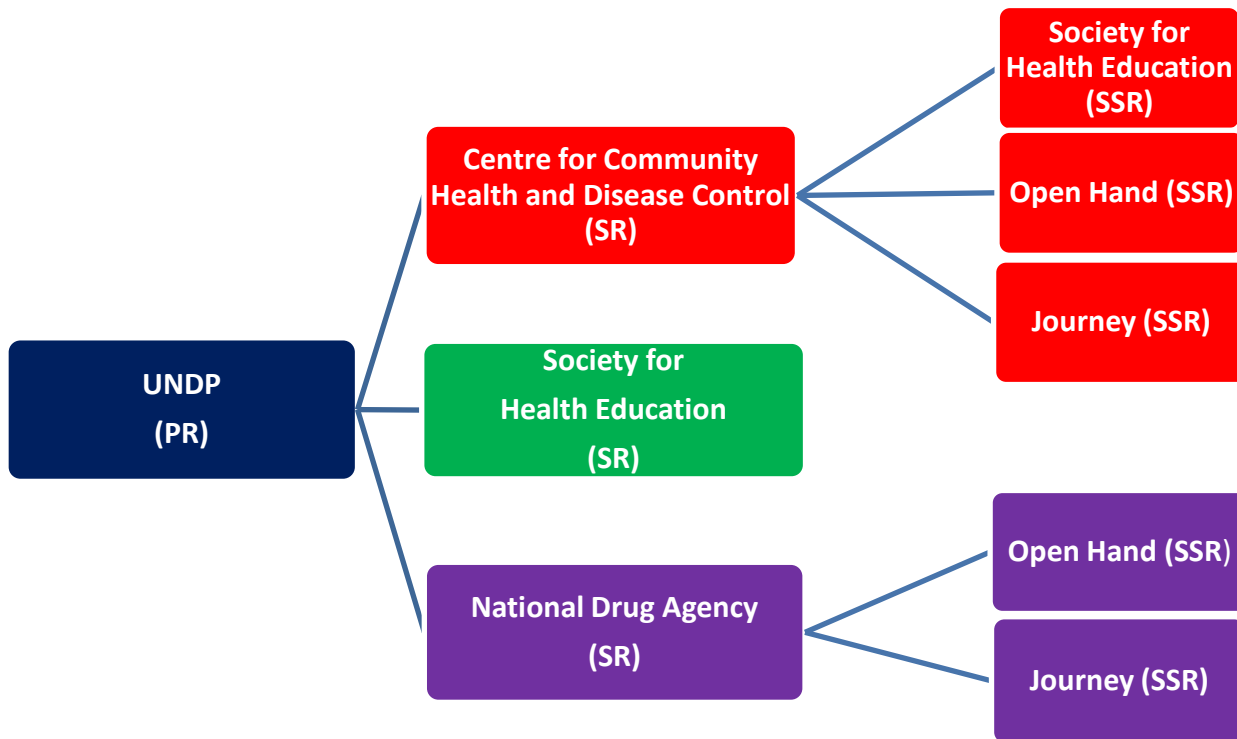
The Round 6 “Enhancing the Response to HIV/AIDS in the Maldives” Program (MDV-607-G01-H) began on 01 September 2007, with an end date of 31 August 2012. The 5-year grant award totaled USD 4 142 457 with USD 2 655 685 committed for Phase 1 and USD 1 486 772 committed for Phase 2.¹¹ The Global Fund grant represents the single largest external funding source of the NAP to date. UNDP served as PR to the grant. Consistent with the Global Fund grant architecture, the CCM was tasked with oversight of the approved grant with the Local Fund Agent (LFA) responsible for independent verification and reporting on results. Implementing partners and their inter-relationships are described below and shown in Figure 2.

- **Society for Health and Education (SHE)** – Formed in 1988, SHE is a national non-profit non-governmental organization (NGO) that addresses issues concerning women and issues of Thalassaemia, HIV/AIDS, psychosocial counseling and reproductive health.
- **National Drug Agency (NDA)** – The NDA is an independent agency formed in January 2012 and entrusted to undertake and oversee the national response to the drug problem in the Maldives. The NDA’s main functions are to regulate and monitor the implementation of all programmes within the purview of drug laws. The precursor to the NDA is the Narcotics Control Board, which was established in 1997. At the time the Round 6 grant was approved, the NDA was called the National Narcotics Control Board and was not an independent agency. By June 2010, the NNCB had been renamed the Department of Drug Prevention and Rehabilitation Service.
- **Centre for Community Health and Disease Control (CCHDC)** – The CCHDC is a department within the Ministry of Health (MoH) of the Maldives (formerly the Ministry of Health and Family), tasked with carrying out preventive health services in the archipelago. The department was previously known as the Department of Public Health. The NAP is situated within the CCHDC.
- **Journey** – Registered in 2005, Journey assists drug users to overcome their addiction and maintain their recovery through providing guidance and psychosocial support. The NGO works to prevent youth and adolescents from being exposed to drug abuse and HIV through creating awareness on drug addiction in the wider community.

¹¹ Program Grant Agreement for Grant Number MDV-607-G01-H

- **Open Hand** – Open Hand was registered as an NGO in 2009 by a group of recovering addicts who wished to help other addicts maintain their recovery. Open Hand works on primary prevention, and aims to profitably prevent youth from testing and experimenting with drugs, and supports and facilitates drug users to enter into recovery programs and reclaim a healthy, drug-free life.

Figure 2: Grant Implementation Partnerships



Program Goal and Objectives

The stated goal of the Round 6 Program is **“To continue to maintain Maldives as a HIV low prevalence country through appropriate preventive and curative interventions.”** More broadly the Program recognizes the importance of creating a supportive environment, to ensure not only support for HIV/AIDS initiatives but also to reduce the stigma and discrimination often facing people living with HIV. The nine objectives of the Program are to:¹²

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 migrants, seafarers and resort workers;
3. Increase awareness and knowledge of STIs and HIV among young people;

¹² Annex A to the Program Grant Agreement

4. Expand access to and coverage of quality HIV testing and counseling;
5. Strengthen the prevention and control of STIs;
6. Strengthen health service capacity to provide quality care, support and treatment for people living with HIV;
7. Strengthen health systems capacity for prevention of HIV and other blood transfusion transmittable infections through blood and blood products;
8. Strengthen the strategic information system for HIV; and
9. Strengthen the multi-sectoral response to AIDS.

The key target groups for the activities undertaken within the Program are:

- Injecting Drug Users and those at risk for injecting drugs;
- Migrant and mobile workers;
- Resort workers;
- Seafarers;
- Commercial sex workers; and
- Young people.

Evaluation Objectives and Methodology

Evaluation Objectives

This evaluation will review the UNDP-Global Fund Round 6 HIV Program in the areas of relevance, effectiveness, efficiency, and sustainability. Specifically, the objectives of this evaluation are to:

- 1) Assess the degree to which the Round 6 Program relates to the MOH Health Master Plan and National Strategic Plan on HIV/AIDS 2007-2011;
- 2) Assess whether the proposed activities have been implemented in line with the Round 6 Grant Proposal;
- 3) Assess major achievements (or lack thereof) during grant implementation;
- 4) Evaluate the role and performance of UNDP as PR to the Round 6 Program;
- 5) Identify major problems and constraints faced by the Round 6 Program at different levels, including National, Atoll, health facilities and SRs;
- 6) Assess the relationships among different stakeholders involved in the implementation of the Round 6 Program, including relationships between the CCM, PR, SRs, and the Global Fund itself; and
- 7) Assess the extent of UNDP commitment to the human development approach and how effectively equality and gender mainstreaming have been incorporated into the design and execution of the programme.

It is expected that the findings of this evaluation will be used to strengthen future implementation of the National Strategic Plan (NSP) on HIV/AIDS 2012-2016 and the Health Systems Strengthening Operational Action Plan. The findings will support planning and resource mobilization for HIV prevention initiatives in the Maldives.

Evaluation Methodology

The evaluation was conducted by one investigator over 15 days during the period 22 Aug – 21 November 2012 (10 days on-site in the Maldives). The evaluation uses both quantitative and qualitative data. It was undertaken through a combination of a desk review of the documents listed in Annex 1 and individual and group interviews with key informants listed in Annex 2.

Limitations

The most significant limitation to the ability of this evaluation to address the objectives given above is the lack of evaluation data. Due to implementation delays, a lack of human and financial resources within the PR, SRs and SSRs, and the timing of national surveys, it is not possible for this evaluation to draw concrete conclusions on the impact and outcomes attributable to the Round 6 Program. Funding had been requested to conduct a second BBS study in a Round 10 Global Fund proposal; however the proposal was not funded. Another key limitation to this evaluation is the high degree of turnover amongst Program implementers. An attempt was made to include

these individuals as key informants where possible; nevertheless, there were few informants that were able to give a comprehensive account of the Program's implementation. A less consequential, although still notable, limitation is the cancellation of planned site visits due to the deterioration of the security situation in the Maldives during the evaluation period. To the extent possible, this evaluation pieces together programmatic data reported to the Global Fund and insight gleaned from informant interviews to provide a holistic view of the key results achieved, challenges encountered and lessons learned during the implementation of the Round 6 Global Fund Grant Program in the Maldives.

Findings and Conclusions

Relevance

Coherence with National Sectoral Plans

The Health Master Plan 2006-2015 (HMP) details the principles and objectives of the national health policy and provides strategic guidance and direction to the public and stakeholders, to further develop programmes and plans to improve and protect the health of the Maldivian population. The HMP, developed through a consultative process led by the MOH, was developed with a view to achievement of the Millennium Development Goals, hence the 2015 end date. It is also linked to the targets of the International Conference on Population and Development. The HMP provides the basis for the health chapter of the National Strategic Action Plan, which serves as the overall plan for national development. Within the HMP, HIV prevention, treatment and care is not treated as a stand-alone intervention area. Instead, HIV-related targets are embedded within the policy goal areas. The policy goals of the HMP are to:

1. Ensure people have the appropriate knowledge and practices to protect and promote their health;
2. Ensure safe and supportive environments are in place to promote and protect health and well being of the people;
3. Prevent and reduce burden of disease and disabilities and improve quality of life;
4. Ensure all citizens have equitable access to comprehensive primary health care;
5. Establish and enforce appropriate quality assurance and regulatory framework for patient and provider safety;
6. Build public and private partnerships in health;
7. Build a competent and professional health workforce;
8. Ensure the health system is financed by a sustainable and fair mechanism;
9. Enhance the response of health system in emergencies; and
10. Build and culture of evidence based decision making within the health system.

The Round 6 Program supports the achievement of targets within policy goal areas 1, 3, 9 and 10.

Development of an NSP on HIV/AIDS with indicators and targets was one of the Conditions Precedent set by the Global Fund. As such, the NSP on HIV/AIDS 2007-2011 was developed as a follow-up to the “Strategic Plan for Prevention and Control of HIV/AIDS 2002-2006.” The NSP 2007-2011 aims to limit HIV transmission, provide care for people living with HIV, and mitigate the impact of the epidemic through the following strategic interventions:

- Providing 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;
- Reducing and preventing vulnerability to HIV infection in adolescents and young people;
- Providing HIV prevention services in the workplace for highly vulnerable workers;
- Providing treatment, care and support services to people living with HIV;

- Ensuring safe practices in the healthcare system;
- Building and strengthening capacity and commitment to lead, coordinate and provide a comprehensive response to the epidemic; and
- Strengthening the strategic information system to respond to the epidemic.

Given that the proposal for the Global Fund grant was developed before the NSP, the indicators and targets from the grant were included in the NSP. More than half of all activities in the NSP were conducted with Global Fund grant monies.

Coherence with Round 6 Proposal

A key challenge to grant implementation was limitations of the approved grant proposal itself. The grant proposal had been developed in 2006, at a time where very limited HIV related research was available to guide its content. Specifically, the grant proposal was based on:

- Knowledge of the number of Maldivians (not expatriates) living with HIV;
- A situational assessment of HIV/AIDS in the Maldives conducted in 2000; and
- A rapid situation assessment of drug abuse conducted in 2003.

As such, the indicators and targets included in the proposal were only weakly based on evidence and many baselines and targets were missing altogether. For example, at the end of Phase 1 of the grant, baselines and targets still had not been set for some outcome and impact indicators (shown in Table 1). The links between grant activities and targets were also weak in many cases. As data became available, particularly after completion of the 2008 BBS, baselines and targets were adjusted and in some cases, activities re-designed for increased relevance. Overall, grant implementation was true to the objectives and workplan of the Round 6 Proposal.

Table 1: Impact and Outcome Indicators

Phase 1

Impact/Outcome Indicator	#	Indicator Description	Baseline	Target by Yr 5
Impact Indicator	1	% of young women and men aged 15-24 who are HIV infected	0 (2008)	0%
Impact Indicator	2	% of IDUs who are HIV infected	0 (2008)	40%
Outcome Indicator	3	% of CSWs reporting condom use with every client in the last month	32% (2008)	45%
Outcome Indicator	4	% of IDUs reporting not having shared non-sterile injecting equipment	23% (2009)	-
Outcome Indicator	5	% of young people aged 15-24 reporting the use of a condom the last time they had sex with a non-regular partner	34% (2010)	-

Phase 2¹³

Impact/Outcome Indicator	#	Indicator Description	Baseline	Target by Yr 5
Impact Indicator	1	% of IDUs who are HIV infected	0 (2008)	0%
Outcome Indicator	2	Percentage of injecting drug users reporting the use of sterile injecting equipment the last time they injected	23% (2008)	40%
Outcome Indicator	3	Percentage of IDUs who reporting the use of a condom the last time they had sexual intercourse	32% (2008)	45%
Outcome Indicator	4	Percentage of young women and men aged 15-24 years who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission	34% (2010)	-

Efficiency and Effectiveness of Grant Implementation

Financial Management

As PR, UNDP is responsible for the financial management of the Global Fund Program. UNDP is tasked with ensuring that budget utilization is both timely, appropriate and in compliance with Global Fund policies and procedures and UNDP Financial Rules and Regulations. Resource flow is monitored against approved budgets and agreed work plans.

The total signed grant amount for the Round 6 Program was USD 4 142 457 with USD 2 655 685 for Phase 1 and USD 1 486 772 for Phase 2. According to the Global Fund website, as of November 2012, USD 3 695 518 (89 percent of the total grant amount) had been disbursed.

The flow of financial resources during the grant's life cycle is shown in Table 2 and Figure 2:

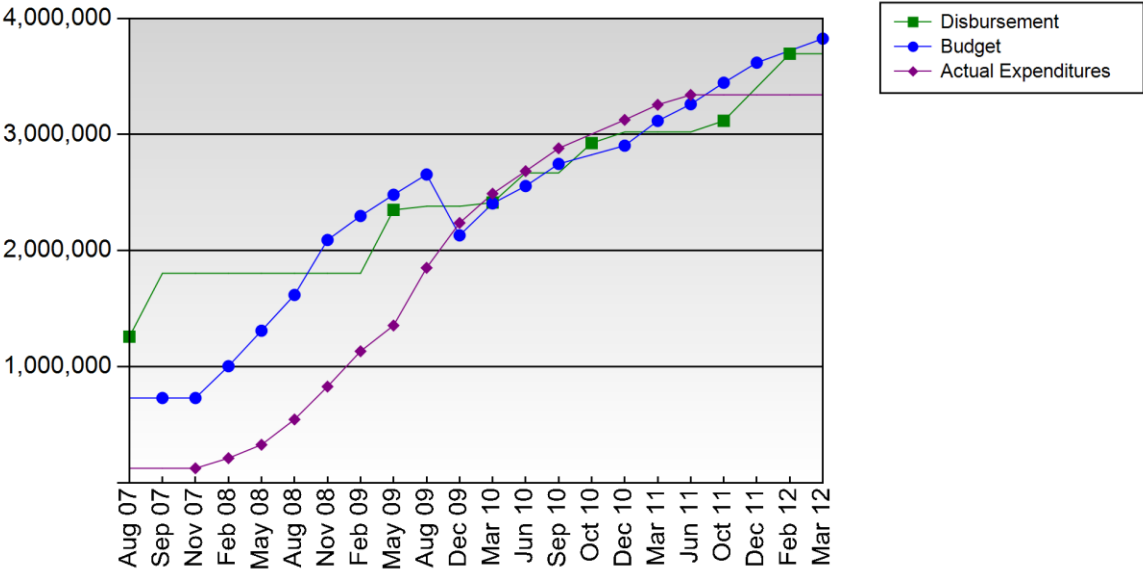
Table 2: Round 6 Program Expenditure¹⁴

	2007	2008	2009	2010	2011	2012	Total
Budget	730 257	1 361 072	40 059	772 789	714 660	523 619	4 142 456
Disbursement	1 258 623	-	1 091 915	575 271	192 062	577 646	3 695 518
Expenditure	114 906	521 298	1 409 710	887 685	470 631	232 949	3 637 179

¹³ As per Phase 2 Performance Framework

¹⁴ As of Q18 (March 2012)

Figure 2: Cumulative Program Budget, Expenditures and Disbursements to Date (as of 22 Feb 2012)



It is evident from the Table and Figure above that grant implementation, and therefore expenditure, experienced significant delays in Phase 1 (2007 and 2008) and to a lesser extent in Phase 2 (2011). Program activities only commenced in Quarter 3 of the grant implementation period and as a result, at the end of Quarter 6 (February 2009), only 61 percent (USD 1 258 623) of the USD 2 051 540 approved for disbursement until that date had actually been disbursed. The cumulative burn rate at the end of Quarter 6 was only 18%, due to delayed start up of activities. This proportion increased dramatically to 68 percent by 31 Aug 2009, owing to the efforts of the PR to speed up implementation. Despite the fact that the expenditure rate increased substantially in 2008 and 2009, a total of USD 305 147 (11 percent of the Phase 1 approved budget) was undisbursed at the end of Phase 1. The cost savings from Phase 1 were used to conduct a mapping of most-at-risk populations in the Maldives.

Programmatic Results

A summary of programmatic results is given in Table 3 below:

Table 3: Programmatic Results

Obj. #	Objective Description	Ind. #	Indicator	Base-line	Target (Period)	Result (Period)	%	Key Achievements
NDA (with Open Hand and Journey as SSRs)								
1	Prevent HIV transmission among young people who inject drugs or are at risk of injecting drugs	1.1	Number of law enforcement officers including judiciary, police and staff of correctional facility trained on IDU and HIV concerns.	0 (2007)	325 (19)	282 (19)	87	<ul style="list-style-type: none"> 2 DICs with VCT services (Male, Fuvahmulak) targeting DUs and IDUs established Comprehensive HIV prevention outreach programs for DUs and IDUs with peer accompanied referrals HIV prevention for DU and IDUs conducted in prison settings Research based advocacy sessions held for parliamentarians in advance of passing of Drug Bill
		1.2	Number of peer educators trained on HIV/AIDS risks for drug users and outreach to DUs and IDUs	0 (2007)	167 (17)	195 (17)	117	
		1.3	No of DUs and IDUs reached by HIV prevention programme	0 (2007)	5 887 (19)	6 434 (18)	109	
SHE								
2	Prevent HIV transmission among populations at risk such as migrants, seafarers and resort workers	2.1	Number of peer educators trained on HIV/ AIDS risks and outreach to migrants	0 (2009)	40 (17)	29 (17)	73	<ul style="list-style-type: none"> HIV and STI prevention outreach with IEC materials conducted in 5 languages HIV/AIDS workplace education outreach conducted with view to development of workplace HIV policy Migrant Fair targeting the expatriate population held on World AIDS Day 2010
		2.2	Number of migrants and resort workers reached by HIV/AIDS prevention programme	0 (2007)	41 000 (16)	47 977 (16)	117	
		2.3	Number of HIV education sessions held in large enterprises /companies	0 (2007)	45 (18)	22 (18)	49	
3	Increase awareness and knowledge of STIs and HIV among young people	7	% of young people 15-24 years of age who both correctly identify ways of preventing the transmission of HIV and who reject the major misconceptions about HIV transmission		50			<ul style="list-style-type: none"> Mass media (television, radio, song and music video, printed IEC materials) campaign targeting youth, IDUs and migrants conducted
		8	Number of teachers trained in participatory life skills based HIV/AIDS education	0 (2007)	112	119	106	
CCHDC (with Open Hand, Journey and SHE as SSRs)								
4	Expand access to and coverage of quality HIV testing and counseling	4.1	Number of people who received testing and counseling services for HIV and received their results	4081 (2006)	1 900 (19)	2 074 (18)	109	<ul style="list-style-type: none"> National VCT protocol established 3 VCT centres established in NGOs to cater to MARPs and vulnerable populations Health sector and non-health sector workers trained in VCT (collaboration with WHO)

5	Strengthen the prevention and control of STIs	5.1	Number of Health Care Providers trained in diagnosis and clinical management of STIs	23 (2006)	341 (16)	352 (16)	103	<ul style="list-style-type: none"> • STI guidelines developed • STI training module revised • Recording and reporting tools developed • Case definition booklet developed
		5.2	Number of STI cases treated at health care facilities	40 (2006)	2 502 (19)	3 953 (18)	158	
6	Strengthen health service capacity to provide quality care, support and treatment for people living with HIV	6.1	Number of adults and children with advanced HIV infection (currently) receiving ART	1 (2006)	10 (19)	3 (18)	30	<ul style="list-style-type: none"> • 63 trained in HIV/AIDS case management and ART • Government funding of ART from Year 3
7	Strengthen health systems capacity for prevention of HIV and other blood transfusion transmittable infections through blood and blood products	13	Number of blood units collected through blood donation promotion offers	40 (2006)	110	550	500	<ul style="list-style-type: none"> • Year on year increase in intake of voluntary blood donors • 138 trained for voluntary blood donor recruitment • Equipment procured for the National Blood Transfusion Services
		7.1	Number of clinicians trained on rational use of blood and blood products - RBC and nurses trained in blood transfusion practices	0 (2006)	432 (16)	447 (16)	103	
		7.2	Number and % of donated blood units screened for HIV according to the national guidelines	100% of 8916 (2006)	8920 100% (16)	N:8920 D:8920 P:100% (16)	100	
All								
8	Strengthen the strategic information system for HIV	-	-	-	-	-	-	<ul style="list-style-type: none"> • BBS on HIV/AIDS conducted • Qualitative research (Anything is Possible) on risk behaviours among MARPs and vulnerable populations • National size estimation and social mapping of MARPs conducted • BBS in Prisons of the Maldives conducted (UNAIDS PAF) • Implementation of MESST Assessment • National M&E Plan on HIV/AIDS for NSP 2007-2011 developed and implemented
9	Strengthen the multi-sectoral response to AIDS.	1	Number of NGOs and government ministries involved in planning local responses to HIV prevention needs and care needs of people who use drugs	4 (2006)	20	32	160	<ul style="list-style-type: none"> • NSP on HIV/AIDS for 2012-2016 drafted • Joint Mid-term Review of NSP 2007-2011 conducted (support from WB, UNAIDS, WHO, UNICEF, and UNODC) • Operational Plan of NSP for 2010-2011 developed following the Joint Mid-term Review of NSP 2007-2011. • 2 prayers, 7 sessions on HIV prevention delivered in mosques, and HIV sensitization session held for Islamic scholars.

Grant Performance as Assessed by the Global Fund

As mentioned already, UNDP is the PR and ultimately holds responsibility for the financial and programmatic performance of the grant. Grants are measured and rated by the Global Fund against country targets at each periodic disbursement of funds. The grant performance ratings received by UNDP for its management of the Round 6 grant program are shown below in Table 4.

Table 4: Grant Performance Ratings for Round 6 Program

Year	A2 Meets expectations	B1 Adequate	B2 Inadequate but potential demonstrated	N/A
2007		01 Sep - 30 Nov 2007		
2008		01 Dec 2007 - 29 Feb 2008		
2009		01 Dec 2008 - 28 Feb 2009		
2010	01 Jul - 30 Sep 2010	01 Jan - 31 Mar 2010		
2011			01 Jan - 31 Mar 2011	01 Apr - 30 Jun 2011

Grant performance ratings are based to a large extent on performance against an agreed Performance Framework of targets and indicators. The indicators for which the grant has showed underperformance across multiple reporting periods are shown in the table below:

Table 5: Indicators with repeated underperformance

SR	Indicator	Reason for Underperformance
SHE	Number of migrants and resort workers reached by HIV/AIDS prevention program	Due to the size and diversity of the migrant population in the Maldives, there was a need to conduct the program in five different languages. Difficulties were experienced in having the training modules translated to the languages. This, along with work schedules of migrants and their geographic dispersal, led to delays in recruiting peer educators. Delays in recruiting a qualified consultant to conduct the training also contributed to underperformance.
SHE	Number of peer educators trained on HIV/ AIDS risks and outreach to migrants	
SHE	% of young people 15-24 years of age who both correctly identify ways of preventing the transmission of HIV and reject the major misconceptions about HIV transmission ¹⁵	Target population could not be reached through the school system and therefore a new strategy needed to be developed.
CCHDC	Number of adults and children with advanced HIV infection (currently) receiving ART	Target was inappropriate as there are not enough people living with HIV in the Maldives that require ARV treatment.

A review of the Progress Updates/Disbursement Requests (PU/DRs) submitted during the grant implementation period and feedback from the Global Fund highlights issues and events that were noted as having impacted the programmatic and financial performance of the grant. The grant was given an overall rating of B1 (adequate) for its performance over the Phase 1 period. At that point, average performance of all indicators was at 97 percent. At the Phase 2 Review, the grant was given a 'Conditional Go', with time-bound actions predominantly focusing on improving M&E aspects of the grant. Performance on indicators improved even further during Phase 2 with

¹⁵ During Phase 2 negotiations this indicator was removed and from Phase 2 onwards it was report as an outcome indicator.

the exception of the period between 01 Jan – 31 Mar 2011, when for reasons unclear, a B2 rating was assigned. At this time, the grant is set to meet or exceed nearly all targets.

Annex 3 provides a summary of events and issues that negatively impacted programmatic and financial performance of the Round 6 Program.

Major Achievements

In assessing Table 3 (presented earlier in Programmatic Results section of this report), there is no question that this grant has achieved what it was designed to and all implementing partners view the Round 6 Program to be a success. With the exception of Indicator 6.1 (Number of adults and children with advanced HIV infection receiving ART), the PR is on pace to report meeting or exceeding most targets. Key achievements are listed in Table 3; however, many of the most significant achievements of the Program aren't immediately apparent in looking at the Table.

The Round 6 Program has led or contributed to:

- **Starting a national dialogue** on topics previously regarded as taboo such as sex, condoms, sex work, and homosexuality. For example, a mass media campaign launched as part of the Round 6 Program elicited strong reactions (both positive and negative) amongst members of the public.
- **Giving a face to most-at-risk groups** and a justification for why their unique needs with respect to HIV prevention must be met. One of the more successful activities funded by the Global Fund Program was the establishment of a DIC for DUs and IDUs. The DIC links peer outreach, access to HIV prevention information and condoms, and rehabilitation services. The demand for rehabilitation services currently outstrips supply;
- **Including members of vulnerable communities as part of the solution.** HIV prevention activities in the grant made extensive use of peer education as an information dissemination methodology.
- **Creating a culture of linking research to intervention:** The focus on M&E within the grant catalyzed the creation of a bank of national and regional data that can guide the development of HIV treatment, care and support activities. Research products include:
 - BBS (2008);
 - A Comprehensive Audience Analysis for HIV Risk in the Maldives (2009);
 - BBS in prisons (2012); and
 - Size estimation and social mapping of most-at-risk populations (2010).

It is worth noting that interventions included in the draft NSP 2012-2016 reflect research findings.

- **Advancing harm reduction as a tool** in addressing HIV in the Maldives. Harm reduction programs are a relatively new initiative in the Maldives. The Maldivian Government initiated a harm reduction program with the support of other donors; however, Journey provides the psycho-social support component to this program through the Round 6 Program. Although Journey has been active for some time, the Global Fund grant has allowed a significant scaling-up and professionalization of its work.
- **Policy level advocacy in support of HIV prevention resulting in:**
 - Passing of a more progressive Drug Bill that provides DUs and IDUs an opportunity for rehabilitation rather than requiring mandatory incarceration; and
 - Provision of free ART to members of the migrant worker community who contract HIV while in the Maldives, with no threat of deportation as a consequence of their HIV status.
- **Strengthening HIV related M&E at the national level.** Initiatives included:
 - Monitoring and Evaluation System Strengthening Tool Workshop (end 2009);
 - Technical assistance on reporting and recording formats;
 - Joint Mid-Term Review of the NSP (end 2009);
 - Development of a costed Operational Plan for the NSP (for 2010 and 2011) with technical assistance from the AIDS Strategy and Action Plan (ASAP), World Bank, WHO, UNAIDS, UNODC, and UNICEF (end 2009); and
 - Development of a National M&E plan (end 2009).
- **Leveraging synergies between civil society and the Government.** At the start of the grant, eight VCT centres were in existence in the Maldives. Voluntary, informed and confidential testing was National Policy. Provider initiated testing and client initiated testing (with informed consent) were common practices, however the voluntary self-referred clients accessing the services was rare. This Grant has supported the development of national protocols on establishment of VCT services and through this established VCT centres outside the health setting. Establishment of VCT Centres outside of the health sector has significantly increased the frequency of client initiated testing.
- **Developing the capacities of NGOs** working in the field of HIV to the extent that they are more confident in their abilities to attract and manage donor funding and successfully execute projects. One NGO SR reported that data collection and reporting practices required in the Global Fund Program were now being applied to the management of other non-Global Fund projects within the organization.

Human Development Approach and Gender Mainstreaming

Through serving as the catalyst for the collection of strategic information on HIV, the Round 6 Program did much to define target groups for HIV prevention, care and treatment initiatives. The Program brought to light the needs of some of the most hidden, marginalized and stigmatized communities in the Maldives. The PR did endeavor to target interventions to these groups but was limited in its ability to do so as the Global Fund has

strict guidelines on the extent to which a PR may deviate from the approval grant proposal. Nevertheless, the Round 6 Program attended to the needs of vulnerable and marginalized groups to an unprecedented extent.

From almost all accounts, gender was not an aspect that was explicitly considered or discussed during planning and implementation of grant activities. As such, an opportunity to address the gendered dimensions of HIV in the Maldives was missed. This was perhaps the most significant oversight in grant implementation.

Relationship between Implementing Partners

The selection of UNDP was not unanimously supported at the individual level, particularly in Phase 1. As noted in the grant proposal, the PR selection criteria included:

- Experience and capacity to manage program implementation;
- Transparent, accountable as well as robust management and financial systems;
- Ability to facilitate partnerships and build partnership capacity; and
- Knowledge of and sensitivity to HIV/AIDS issues.

Given that UNDP had handled a large amount of donor funds for crisis and recovery efforts following the 2004 tsunami and was viewed to have sufficient capacity, UNDP was selected as PR. Nevertheless, some key policy makers, SR staff members and CCM members disagreed with UNDP's PR role, while others held the expectation that the PR role would be transferred at an early stage.

In the Round 6 Program Grant Agreement, 36 percent of the approved grant budget is allocated to human resources. The issue of human resource costs remained a sensitive issue throughout the grant implementation period despite the acknowledgement in the grant proposal itself that a lack of capacity and human resources was a key constraint to grant implementation. This issue posed a barrier to the CCM staying on task and fueled the sentiment that the grant be managed by a national entity rather than UNDP.

Another issue that strained relationships among implementing partners was the delay in disbursements. It was felt by several implementing partners, particularly SRs, that such delays were not explained in an adequate, appropriate or timely fashion. This issue is discussed further in the "Constraints to Implementation" section of this report. With the exception of delays in funding and payments, it seems that the relationships between PR and SRs, and SRs and SSRs were collaborative and constructive. One SSR noted that it had received assistance from UNDP in registering for NGO status.

With respect to the PR, several implementing partners noted the PR's accessibility and willingness to provide support as positive dimensions to their relationship with the PR. Some implementing partners did express that they did not receive as much guidance on implementation and reporting as they needed or desired from the PR. This may actually be explained in part by the capacity gaps within the PR and even the LFA.

It is fair to state that the relationship between the Government of Maldives (particularly the MoH) and CSOs has been strengthened considerably through the implementation of this grant. NGOs and community based organizations are viewed as knowledgeable and useful partners in addressing HIV in the Maldives, particularly in reaching key populations and ensuring coverage of prevention, care and support activities. In some cases, the

Government is funding part of the operational costs of certain NGOs (ie. operational premises for Journey). While this is an important contribution with symbolic and practical value, this may hamper the ability of the NGO to play an advocacy role in the response to AIDS.

Relationships between UNDP and the wider UN family were likely strengthened by Global Fund grant implementation. Grant implementation provided an opportunity for increased collaboration amongst UN Agencies in the area of HIV programming. For example, UNDP and UNICEF worked together on capacity building efforts targeting Open Hand of Fuvahmulak. Collaboration was hampered by fact that Global Fund financing could not be combined with other sources of funding for joint implementation of activities. Technical assistance was provided by the World Bank (Joint Mid-term Review of the NSP, its costing and the social mapping of MARPs), the UNFPA and the UNODC. Financial contributions to HIV related work in the Maldives during the grant period came from WHO, UNICEF, UNFPA, and UNAIDS and the British Council. Nevertheless, the quality of collaboration invariably took a back seat to Global Fund timelines and some felt that UNDP seemed unwilling to maximize opportunities for collaboration for fear of jeopardizing the Global Fund funding stream and relationship.

Perhaps the more notable relationships were between implementers and their own organizations. Overall, it seems that there was limited interaction and cross-pollination between the implementing teams/units and their wider organizations. Implementation of the Global Fund grant in these cases was seen as a stand-alone initiative and there was minimal effort to integrate or identify synergies between the work being undertaken through Global Fund financing and other programmatic initiatives within the organization. In one SR's case, this division was particularly extreme during Phase 1, where some staff members actually believed that they were Global Fund employees. This confusion was exacerbated by Global Fund salary supplements, which created a significant salary differential between PIU staff and their non-PIU colleagues. Office supplies purchased with Global Fund monies created a Global Fund branding effect. Another SR complained of a lack of engagement and interest from colleagues and even supervisors due to the "exceptional nature" of the Global Fund Program. In some cases, technical staff perceived the Global Fund Program as being parallel to the NSP. Needless to say, isolation of implementers robs the wider organization of a valuable opportunity for learning and innovation at minimum, and as evidenced in the Maldives, can also undermine the organizational culture.

Several new partnerships were developed over the grant implementation period, particularly in the implementation of HIV prevention activities targeting migrant populations. These included relationships with embassies, migrant worker associations and the Maldives Association for Construction Industries (MACI). Given the cultural context within which the national response to HIV is embedded, a key partnership that should be developed further is with Islamic Scholars and the Ministry of Islamic Affairs. Collaboration to date has shown some promising results. Partnerships were also formed between NGO implementers and other NGOs providing or seeking to provide similar services. For example, Journey provided training and guidance to NGOs operating in Addu and Fuvahmulak.

Constraints to Implementation

There were many constraints to effective and efficient grant implementation, with the majority persisting for the duration of the grant implementation period. Grant performance and results achieved must be viewed in the context of the following:

- **Recruitment delays (Phase 1):** As mentioned earlier, the Maldives is a country with a relatively small population. Accordingly, the pool of qualified talent available for grant implementation at the start of Phase 1 was also limited, particularly considering that the Round 6 grant was the first Global Fund grant that the Maldives had received. At the level of the UNDP Programme Management Unit (PMU), an international programme manager was recruited in September 2008. There were delays in recruiting a finance associate with the capacity to manage the financial aspects of grant implementation. These delays required the PR to revise the Program work plan and budget for 2008.
- **Delays in fulfilling Conditions Precedent (Phase 1):** Before the start of the Global Fund grant, the response to AIDS in the Maldives was still nascent. As such, the conditions precedent to the second disbursement (2008), while appropriate, represented a considerable amount of work to be completed within a short period of time. The conditions precedent included, but were not limited to, completion of:
 - The NSP 2007-2011 to the degree that it informed the baselines and targets in the grant programme;
 - Baseline surveys to determine outcome and impact indicators;
 - An updated M&E plan; and
 - Coordination plans (UN Theme Group and Sub-recipient).

These deliverables generally require extensive consultation and in the case of the Maldives, most did not exist in any form before the start of the Round 6 grant.

- **Lack of capacity (Phase 1 and Phase 2):** A significant challenge to grant implementation, particularly at the start of the grant implementation period, was weak capacity among implementing partners. A study of capacity development needs was undertaken in April 2008 with the results published in “The Maldives HIV and AIDS Technical Needs Assessment and Technical Support Plan 2008-2009.” Based on this, a Capacity Action Plan was developed by the PR concentrating on the following two areas:
 - Strengthening the capacity of the key personnel including the CCM members to lead, coordinate and to provide comprehensive response to HIV; and
 - Providing Technical Assistance to the National AIDS Programme.

Feedback received on capacity building support provided by the PR was that the support, while appreciated, was not given as strategically as it could have been. At the same time, the degree of staff

turnover during the grant implementation period likely diluted the impact of any capacity development efforts.

- **PR:** As mentioned, a new Programme Manager in the PMU was recruited in September 2008. Weaknesses in the PR's financial management and M&E capacity were noted in the grant's Phase 2 Review and appear to have continued to some extent throughout the grant's duration. In Phase 1, the PMU included a Finance Associate and a junior Finance Associate, which in Phase 2 was reduced to one finance professional. Although, financial management appears to have improved in Phase 2, without the support of the central finance department of UNDP, it is likely that the PR would have been unable to meet the financial management demands of the grant. In terms of M&E, in the Phase 2 review, the PR was cited as having "inadequate capacity for collecting, analyzing and reporting results of programme activities, particularly in the technical areas managed by CCHDC."¹⁶ The CCHDC at that time included two of the three SRs to the grant. Data verification processes seem to have improved after this point. SRs noted that PR hosted SR meetings facilitated communication and collaboration between SRs. These meetings, which had happened regularly in Phase 1, were held infrequently in Phase 2.
- **SRs:** Capacity amongst SRs for financial and programmatic management was also very weak, compounded by an overall lack of awareness and understanding of the Global Fund grant structure and processes among key decision making bodies. The pace of certain Government procedures was incompatible with the demands of Global Fund processes and timelines. A key example of that was the processing of payments by the MoH. The process proved to be an implementation bottleneck to the extent that this responsibility had to be transferred to UNDP. UNDP made payments on behalf of all SRs during the grant implementation period. This seems to have started a trend to some degree as a more recent project with UNODC and the MoH is also following this model of 'direct execution.' Staff hired to implement activities within the grant program, while committed and motivated, were on the most part inexperienced. Several mentioned "learning by doing" and "trial and error." Several also reported receiving inadequate support and guidance on programmatic design within their respective organization and from the PR. Exposure visits were appreciated by participants as opportunities to augment their skills and knowledge; however the timing of such visits vis-a-vis the stage of programmatic implementation was often not ideal. Knowledge gained from such visits and other training activities was shared amongst colleagues only in the minority of cases.
- **NAP:** Due to the political instability and the limited staff and capacity of the NAP, it has not played as strong of a role in the implementation of the Global Fund grant. Prior to the initiation of the Global Fund Program, the HIV surveillance system was limited to HIV case reporting. Given this, it is not surprising that M&E and data quality were consistently flagged as areas of weakness during the grant implementation period.

¹⁶ Grant Scorecard Grant Number: MDV-607-G01-H

- **CCM:** The CCM includes representation from different constituencies, including the government, UN agencies, private sector organizations, faith based organizations, and NGOs. Given the small size of the country, no organization expressing an interest in being a CCM member was rejected membership and the CCM was constituted with a total of 20 members. As per the grant proposal, the role of the Maldives CCM was to:
 - Provide oversight in the development of the proposal for submission to the Global Fund;
 - Approve the final proposal for submission to the Global Fund;
 - Ensure effective implementation and monitoring of project progress and initiate midcourse correction in the Global Fund proposed work plan;
 - Ensure effective partnership coordination throughout the development, implementation and management of Global Fund proposal; and
 - Ensure transparency in the account and management of Global Fund and timely reporting to the office of Global Fund as well as to the Government of Maldives.

By all accounts, the CCM did not adequately exercise its monitoring and partnership coordination role, playing a relatively passive role with respect to implementation of the Round 6 grant. From its inception, there were challenges in ensuring that the CCM had adequate and appropriate membership. Participation from civil society proved difficult as the Maldives has a limited number of NGOs, and even fewer with experience and expertise in the area of HIV. After much effort, two NGOs (HIYAA Foundation and the Society of Women against Drugs) were admitted as CCM members by April 2009. Membership from affected populations also proved difficult, particularly given that the Maldives still has a very low number of people living with HIV. The difficulties contributed to there being weak technical capacity amongst CCM members.

It seems the CCM was most active at the start of the grant implementation period. CCM meetings were critical in ensuring that Conditions Precedent, such as development of the National Coordination Plan, were met. The meetings were also useful in identifying and addressing duplication of efforts. Since these early days, more often than not, CCM meetings have generally occurred on an ad-hoc and virtual basis.

The prevailing political environment within the country presented challenges to maintaining CCM membership, particularly in 2008. Government restructuring resulted in changes to the CCM membership and poor attendance at CCM meetings, which in turn meant that the CCM was unable to conduct regular meetings. In November 2008, a new CCM Coordinator was recruited and the CCM decided to apply for CCM funding to support its functioning.

CCM funding in the amount of USD 36 825 to be used over a one year period was granted to the Maldives CCM in Feb 2010. The bulk of the funding was used to pay for a CCM Coordinator/Secretary, an Office Assistant and administrative expenses. Some funding was also allocated for CCM meetings, site visits, and capacity building of CCM members.

Despite orientation training and capacity building initiatives by the Global Fund and supported by the PR, the CCM remained a weak structure throughout the duration of the grant. There is still confusion amongst CCM members and SRs as to what the role of the CCM was meant to be. CCM members fell short of exercising the commitment and leadership necessary to effectively guide grant implementation. The high degree of turnover and the fact that many members were appointed to their roles in the CCM may explain this in part, particularly in cases where the member was representing a body or Ministry that was otherwise uninvolved in grant implementation. SRs uniformly reported very limited interaction with CCM members, in some cases even after making efforts to engage the CCM in their work. Notwithstanding the above issues, the current membership of the CCM has expressed an interest in playing a role in the implementation of the NSP 2012-2016.

- **The legal and social environment in the Maldives vis-a-vis marginalized groups (Phase 1 and Phase 2):** The prevailing legal and social environment with respect to MARPs poses a challenge to delivering information and services to those that arguably require it the most. One of the key challenges to implementing harm reduction activities is the attitudes of policy makers and key agencies and their staff (eg. law enforcement). For this reason, it is extremely difficult to access sex workers as they fear prosecution and in the case of expatriate sex workers, deportation. There is very little government and public acknowledgement of male-male sex as a practice. In the recent past, vocal members of this community have been persecuted by members of the public. As part of the Global Fund program, trainings were held to sensitize law enforcement professionals on HIV prevention amongst DUs and IDUs. There also remain sensitivities as to the appropriate level of access to condoms in the Maldives, therefore condom distribution is difficult.
- **Staff turnover (Phase 1 and Phase 2):** As noted already, the pool of qualified human resources available to implement this grant was very limited from the outset. It is not surprising that almost no project personnel remained in their roles throughout the duration of grant implementation. Compounding this lack of stability and institutional memory was the fact that the Global Fund itself was undergoing considerable growth and restructuring of its staff complement. In all, six different Fund Portfolio Managers (FPMs) had responsibility for the Maldives Round 6 grant at different times throughout the grant life cycle. It is worth noting as well that a new NAP Manager was appointed in July 2009 (the former Manager returned in 2012) and that the LFA also changed in January of 2009. Obviously, this high degree of personnel turnover was disruptive to grant implementation, leading to miscommunications and repetitive requests for information, requiring increased investment in relationship development, and ultimately resulting in implementation delays.
- **Political instability (Phase 1 and Phase 2):** The period over which the grant was implemented also represented a period of considerable political instability in the country, with changes in key government personnel at the policy making and line Ministry levels. The first presidential election under a multi-candidate, multi-party system was held in October 2008. Leadership changed hands again earlier this year in February. A decentralization initiative using the MoH as its pilot Ministry further compounded

this issue. This instability has had a very direct impact on grant implementation, hindering the planning and implementation of activities. In several instances, the structures of SRs, or at minimum their reporting lines and the structures that they were embedded in, were changed. More than one SR staff member reported not understanding reporting lines for several months. For example the NDA assumed its role of SR as the National Narcotics Control Board, a unit within the Ministry of Gender. Its name was then changed to Drug Rehabilitation Services and the Ministry of Gender was then incorporated into the MoH. The NDA came into existence earlier this year when it was moved out from under the MoH and it now exists as an independent entity. In addition to impacting project personnel, the political changes also resulted in significant turnover among CCM members.

- **Disbursement delays (Phase 2):** Disbursement delays in Phase 2 were primarily a result of miscommunications between the Global Fund and the PR (in part related to the issue of changes in the FPM role), miscommunications between the PR and the Local Fund Agent (LFA), and a lack of M&E capacity at the PR and SR levels. As mentioned already, the Round 6 grant was managed by six FPMs during the grant implementation period. This contributed to inconsistent guidance given to the PR and delays in communication with and in provision of feedback to the PR. In turn, these issues contributed to disbursement delays. In 2011, UNDP was forced to limit implementation to essential activities and then to advance funds to finance activities from Country Office and UNDP headquarters budgets, putting its financial stability at the country level at risk. Payments to SSRs were delayed, in some cases for several months, which compromised relationships between the PR and the SR and the SR and SSRs. SSRs reported not being able to pay staff salaries and peer educator stipends, particularly to peer educators that were recovering drug users.
- **Decentralization (Phase 1 and Phase 2):** The MoH was selected as a pilot Ministry for decentralization. As the restructuring took place during the grant implementation period, and in the context of wider changes due to the changing political environment, this process posed a challenge to M&E. M&E had already been identified as an area in need of improvement by the Global Fund in its Phase 2 Review, particularly the quality of data reported from service delivery points to the CCHDC on STIs and people receiving testing and counselling services. The time taken to establish decentralized public health units within atolls disrupted existing reporting patterns and led to confusion amongst staff regarding roles and responsibilities. Consequently, implementation of actions aiming to enhance monitoring and evaluation processes were delayed.

Sustainability

In early 2011, the income classification of the Maldives was changed from least developed country to middle income. This change in classification severely limits the potential external funding sources in a country where already there are limited funding sources available for development initiatives. Most notably, the Maldives is no longer eligible for further Global Fund financing (although some key informants appear to be under the

impression that additional Global Fund funding will become available in 2014). Consequently, funding for sustaining progress made within the Round 6 grant will need to be found elsewhere.

Sustainability was a concern expressed by all implementing partners, particularly SSRs, and at this point, it is unclear how sustainable the progress made through the Round 6 Program will be. A proposed budget of just over USD 95 000 to sustain some of the activities from the Round 6 grant in 2013 has been submitted to the senior management of the MOH for review and approval. The proposal requests the following amounts:

Table 6: Proposed budget to sustain Round 6 activities

Area	Activities	Amount	Notes
VCT	(1) operation of Journey, SHE and Open Hand VCT centres (2) mobile VCT camps and promotions (3) procurement of consumables and test kits (4) stationery (5) procurement of condoms (6) VCT training (7) VCT monitoring trips	USD 56 662	USD 6323 committed in NAP 2012 budget for (6) and (7)
STI Management	(1) training on clinical management of STI (2) development, introduction and training of STI management guidelines	USD 17 359	USD 9727 committed in NAP 2012 budget for (2)
Blood Safety	(1) training on rational used of blood and blood products (2) annual planning and review meetings in regions (3) organization of blood collection sessions (4) TV and radio spots	USD 21 033	USD 7879 committed in NAP 2012 budget for (3) and (4)
Total		USD 95 054	

Given that the Maldivian Government is experiencing a fiscal crisis, it is not clear to what extent funding will be available for the national response to HIV. The Maldivian Government has publicly committed to continuing to provide ARV treatment for those who need it free of charge (Maldivian and expatriate individuals). In terms of urgent unmet funding needs in 2012, the MoH has prioritized VCT services for funding for six months from September 2013 until the 2013 budget is finalized. The funding, in the amount of USD 328 000, is not included in the NAP budget for 2012. The funding would cover basic running costs of VCT centres operated by Journey, SHE, and Open Hand. It would also cover the cost of test kits for IGMH, Fuvahmulak Hospital and SHE. As of writing, this funding request had not yet been approved.

UNODC has also indicated willingness to support the operation of the Journey Drop in Centre for 4 months, with some of the resources supporting the continued operation of the integrated VCT clinic. UNODC has indicated to the MoH that there may be further short-term funding available for activities focusing on harm reduction and HIV prevention. IPPF and UNFPA will fund continuation of activities implemented by SHE and targeting migrant workers. With the support of AusAID, plans include the establishment of five service delivery points (in addition to the service delivery point supported through the Global Fund Program) that integrate sexual and reproductive health (SRH) services and HIV prevention for migrant populations. SHE also reports that details are being finalized on an EU funded project on the contextualization of HIV within SRH. The NAP expects to submit a proposal for the longer-term funding available through the SAARC Development Fund. It is likely that UN agencies will also support selected HIV prevention, care and treatment activities.

Beyond financial resource constraints, there appears to be a looming leadership vacuum in the response to HIV in the Maldives. With only two staff members, it is difficult to imagine the NAP being able to effectively coordinate the national response, plan, implement, monitor and evaluate HIV, prevention, treatment and care initiatives, and develop and implement HIV research activities. Furthermore, the Health Information and Research Unit in the NAP has also been abolished.

This leadership deficit will most certainly be felt by CSOs as many of them are still in the early stages of organizational development, are not self-sufficient and require considerable capacity building to continue and/or improve their work. Furthermore, in many cases the salaries of staff members implementing the Global Fund program were paid through the Grant. Given that the grant is now ending, contracts of many project staff have already terminated. In such cases, the associated organizations experience an immediate reduction in their capacity to continue HIV/AIDS related work.

This lack of capacity, particularly in the area of coordination, is exacerbated further by the likely event that UNAIDS will reduce its role and presence in the Maldives. Currently, UNAIDS provides support from its office in Sri Lanka, with 3-4 missions per year to the Maldives. Going forward, any support will be provided from the UNAIDS regional office.

Due to budgetary constraints, UNDP's role on HIV/AIDS will also be significantly reduced. At this point, it is envisioned that UNDP's future contribution to the national response will come via its work in other program areas and consist of continued engagement with and capacity building of NGOs engaged in HIV work. By assuming the PR role, UNDP has de facto provided leadership support to the national response. Upon the conclusion of the Global Fund grant, and with no human resources dedicated to the programmatic area of HIV, UNDP will return to having a minimal role in the national response.

Lessons Learned

When asked to identify lessons learned through the implementation of the Round 6 Program, respondents cited the following:

Training Activities

- The effectiveness of training workshops implemented was limited due to:
 - **Language barriers.** In most workshops, information and learning materials were not presented in Dhivehi. In the future, materials and explanations for workshops held on islands must be provided in the local language to ensure maximum accessibility. This may require that local and national staff receive additional training.
 - **Inadequate targeting of training sessions.** For example, trainings targeted to doctors were in some cases attended by nurses and other medical professionals. Training sessions should be designed with a specific audience in mind and clear guidance should be given to potential participants on requirements for attendance.

- **A lack of clarity on roles and responsibilities of key actors in the MoH.** As a result of the ongoing decentralization process, there is a lack of clarity on roles amongst the National Offices, Atoll Councils, Island Councils, and Health Corporations. This poses a barrier to organization and implementation of training workshops in some regions. Written explanation of roles and mandates is essential to promote cooperation and collaboration amongst institutions at different levels of the health system.
- **Attrition of peer educators and TOTs.** During the design of a workshop involving either TOT or peer educator methodologies, attrition and/or participant availability must be given due consideration as a project risk. Selection of participants should occur with attrition in mind and the number of participants should also reflect this.

Human Resources

- In a region with limited human resources and high staff turnover, a concerted effort must be made to ensure that knowledge remains at the organizational level as well as at the individual level. The persistent lack of technical capacity amongst project staff must be addressed through continued capacity development efforts, however, a system for knowledge transfer between a staff member benefiting from a training exercise or exposure visit should be implemented.

Record Keeping

- Valuable time was lost in implementation of certain activities due to poor document storage practices. As the body of national and regional guidelines and training protocols increases, it is imperative that an effective archival system be implemented.

Communication on Funding Delays

- More than one implementing partner stated that they were unable to implement all planned activities, particularly those planned for late in the grant period, due to delays in receiving funding. Delay in payments disrupts grant implementation but also demoralizes project personnel, and compromises relationships between implementers. It is essential that delays be promptly explained and communicated through formal channels to enable implementers to better manage and communicate such delays to other partners.

M&E

- Effective M&E is the foundation of any successful national response to HIV. In the Maldives, on time data collection from hospitals is a major challenge, especially from recently privatized regional hospitals. It is important that the NAP prioritize this function and if possible dedicate a full-time staff member to this task.

Engagement of MARPs as Development Partners

- In a country with a low prevalence of HIV, targeting MARPS with HIV prevention initiatives is difficult. This task is further exacerbated in the case of the Maldives by geographical, legislative and social barriers to service delivery. For this reason, it is essential that advocacy and sensitization efforts seek to engage members of these communities as development partners. It is also essential that services consider the unique situation of such groups. For example, VCT centres tied to NGOs working on issues relevant to such groups proved to be more successful than VCT centres based in health settings.

Recommendations

General recommendations for implementing partners and specific recommendations for the NAP and UN Family are given below. Recommendations embedded in the Lessons Learned section of this report are not repeated here but should also be considered.

All Implementing Partners

- **Evaluate Round 6 Program activities.** Conduct evaluations on activities implemented and use the findings to inform the design and delivery of future initiatives;
- **Design capacity building initiatives in a structured manner.** Programs should include a dedicated budget line for capacity building and initiatives should be systematic, appropriately targeted, and subject to monitoring and evaluation.
- **Institutionalize a knowledge sharing mechanism.** Given the high rate of staff turnover and the finite amount of funding for capacity building initiatives, it is imperative that any new knowledge is dispersed across an organization to the extent possible. Organizations should develop a mechanism through which individuals benefiting from capacity building initiatives such as trainings, workshops and exposure visits are able and required to share the skills and knowledge gained with their colleagues.
- **Design targeted interventions for youth, women, FSW and MSM.** Youth and women are key populations for targeting HIV prevention initiatives, yet these groups did not benefit from Global Fund-financed HIV programming to the extent that other groups did. HIV prevention activities funded under the Round 6 program do not begin to adequately address the needs of FSW and MSM. The BBS underscores the importance of targeting interventions to these groups.
- **Document best practices.** There are several best practices that arose within the Global Fund Program that should be documented for knowledge management and knowledge sharing purposes. The Maldivian experience with peer education for migrant workers has already been documented as a best practice and is being replicated in Nepal and Bangladesh.

MoH/NAP

- **Conduct a gender audit of the NSP 2012-2016.** A gender audit of the NSP will ensure that the gendered dimensions of HIV prevention, treatment and care are considered and appropriately reflected. UNDP, with its expertise in gender, could be approached for support with this exercise.

- **Develop a roster of facilitators:** The Global Fund Program involved the training of a large number of individuals on various aspects of HIV prevention. A roster should be developed to take stock of trained individuals so that their skills and knowledge can be leveraged as facilitators, consultants, Trainer of Trainers, peer educators etc. within the implementation of the NSP 2012-2016.
- **Address wait lists in drug detoxification and rehabilitation services.** Due to the success of peer outreach initiatives, such as the program implemented by Journey, demand for such services has increased. Any constraints to accessing such services by potential clients jeopardize the integrity of outreach programs and result in missed harm reduction opportunities.
- **Design a minimum package of services to be offered at DICs.** A DIC should be tailored to the population it serves, however the services that one can expect to access at a DIC in the Maldives are highly variable. A minimum package of services would set expectations for the public and well as operating standards for the DIC.
- **Develop standards for peer educator trainings.** The training given to peer educators is variable, particularly given the increasing adoption of the peer education methodology by CSOs. Furthermore, refresher trainings seem to be uncommon. The quality of the peer educators has a direct impact on the success of the given intervention. Most peer educators take pride in their work and give their time freely or for a modest stipend. As such, it is important to ensure that the peer educator “brand” is not diluted and attrition accelerated.
- **Review the current Life Skills Education curricula.** Prior to the implementation of the Global Fund grant, life skills education was available in both primary and secondary school, however it did not include any education on sexual health. Given that youth constitute the largest proportion of the Maldivian population, it merits review as to whether the current format of life skills education can be adapted to support HIV prevention. The establishment of Youth Friendly Services could be considered as a complementary intervention.

UNDP and other UN Agencies

- **Support the NAP.** Given the magnitude of the work to be done just to maintain the current level of momentum on the national response to HIV and the paucity of resources with which to do it, it is essential that UN Agencies lend as much support as possible to the NAP.
- **Provide support to CSOs working in the area of HIV prevention, care and treatment.** Several CSOs, including SHE, Journey and Open Hand, expect to or already receive financial support from the MOH. This dependency has the potential of constraining their autonomy and ability to effectively advocate for change on HIV related policy issues at the Governmental level.
- **Mobilize resources.** The NAP will likely be facing a critical resource shortage. UN Agencies should seek to leverage relationships with the donor community and the private sector to mobilize resources to support the national response to HIV, particularly given the acute need to extend interventions beyond Male.

UNDP HQ

- **Consider managing certain functions centrally** for Global Fund Programs managed in small countries. In the case of the Maldives, with a Global Fund Program of less than USD 5 million and limited local capacity, it may have been more effective to have at least the financial management of the grant managed centrally.

Annex 1 –Documents Reviewed

1. Anything is possible: A Comprehensive Audience Analysis for HIV Risk in the Maldives with Recommendations for Communication (Aug 2009)
2. Report of the 2009 Joint Mid-Term Review of the National AIDS Response to HIV in the Maldives (Jan 2010)
3. Year 3 Report: Enhancing the Response to HIV/AIDS in the Maldives (Feb 2010)
4. Year 4 Annual Report: Enhancing the Responses to HIV/AIDS in the Maldives (Feb 2011)
5. Annual Report (March 2009-February 2010): Enhancing the response to HIV/AIDS in the Maldives (April 2010)
6. Biological and Behavioral Survey on HIV/AIDS 2008 (Nov 2008)
7. National Strategic Plan on HIV/AIDS 2007-2011 (Ministry of Health, July 2007)
8. Monitoring and Evaluation Plan of National HIV/AIDS Prevention and Control Program 2010-2011 (Dec 2009)
9. Grant Scorecard for Grant Number: MDV-607-G01-H
10. Program Grant Agreement for Grant Number: MDV-607-G01-H (Aug 2007)
11. A Report on Exercising Monitoring and Evaluation Systems Strengthening Tool (Nov 2009)
12. Affordable and Quality Health Care for All: Health Master Plan 2006-2015 Reviewed (Ministry of Health, 2010)
13. Ongoing Progress Updates and Disbursement Requests for Grant Number: MDV-607-G01-H (September 2008 – March 2011)
14. Assessment of Development Results: Maldives (UNDP 2010)
15. The Maldives HIV and AIDS Technical Needs Assessment and Technical Support Plan 2008-2009 (National AIDS Program, April 2008)
16. Draft National Strategic Plan on HIV/AIDS 2012-2016 (Ministry of Health, April 2012)
17. Enhancing the Response to HIV/AIDS in the Maldives Proposal (CCM Maldives, July 2006)

Annex 2 – Key Informants

Informant Name	Organization	Position
Ivana Lohar	UNDP (PR)	Global Fund Programme Manager
Aminath Nawal	UNDP (PR)	Programme M&E Associate
Aishath Shizleen	UNDP (PR)	Programme and Finance Associate
Azusa Kubota	UNDP (PR)	Deputy Resident Representative
Andrew Cox	UNDP (RR)	Resident Representative
Aishath Shifana	CCHDC (SR)	Program Manager (former)
Aminath Widhadh	CCHDC (SR)	Program Manager (acting) and Blood Donor Recruitment Program Officer
Abdul Hameed Hassan	CCHDC (SR)	National AIDS Program Manager
Asna Luthfee	SHE (SR)	HIV/AIDS Program Associate
Aishath Zahira	NDA (SR)	BCC Officer
Aminath Mirfath Ahmed	NDA (SR)	Programme Manager (former)
Ismail Didi	Open Hand (SSR)	Coordinator
Mohamed Faseen Rafiu	Journey (SSR)	Drop-In Center Coordinator (former)
Nasrulla Niyaz	Journey (SSR)	Coordinator
Ahmed Afaal	CCM	CCM Chair
David Bridger	UNAIDS	UNAIDS Country Coordinator (Sri Lanka and Maldives)
Paula Bulancea	UNICEF	HIV Officer (former)

Annex 3 - Issues Impacting Financial Management of Round 6 Program

Period/ Quarter	Issues
Phase 1	
1 (Sept 2007 – 30 Nov 2007)	<ul style="list-style-type: none"> Development of the NSP took longer than expected due to participatory approach Delays in recruiting PMU staff Delay in finalization of procurement plan so part of disbursement allocated to purchase of ARVs (USD 40 789) withheld
2 (Dec 2007 – Feb 2008)	<ul style="list-style-type: none"> Delays in procurement and recruitment resulting in large cash balance (1 046 564) at end of the quarter and no request for additional funds for Q3 and Q4 Low performance on target for number of teachers trained in participatory life skills based HIV education - only 6 of 16 confirmed participants attended training likely because of low level of comfort among educators in discussing STIs with students. Teachers that did attend the training agreed that the training improved their ability to discuss STI and HIV issues with students and requested that training be extended by one day.
3 (01 Mar 2008 – 31 May 2008)	<ul style="list-style-type: none"> Disbursement lags due to issues of procurement, delayed recruitment and delayed implementation of certain activities (one activity delayed due to duplication with UNODC)
4 (Jun 2008 – 31 Aug 2008)	<ul style="list-style-type: none"> Delays due to presidential elections and subsequent changes in Ministries
5 (01 Sept 2008- 30 Nov 2008)	<ul style="list-style-type: none"> Delays in certain activities (training of peer educators on HIV/AIDS prevention and reaching migrants, sea farers and resort workers with HIV prevention) due to: <ul style="list-style-type: none"> Delays in finding a consultant for the training of peer educators Identification and adoption of training materials for peer education training Difficulties in reaching migrant workers due to work schedules and geographic dispersal of migrant workers. This required identifying hot spots where migrant workers congregated. Based on WHO/UNAIDS data, number of people living with HIV requiring ARV treatment is < than target of 10. Accelerated action plan agreed between the Global Fund and PR to speed up implementation
6 (01 Dec 2008 – 28 Feb 2009)	<ul style="list-style-type: none"> Low performance on target for % of young people 15-24 years of age who both correctly identify ways of preventing the transmission of HIV and who reject the major misconceptions about transmission of HIV. Mini survey of 14 424 youth conducted but data not yet analyzed. Cumulative burn rate only 18% due to delayed start up of activities (total expenditure of USD 1 187 177 reported)
7 (01 Mar 2009 – 31 May 2009)	<ul style="list-style-type: none"> Cumulative burn rate of 68%
6, 7, 8 (01 Dec 2008 – 31 Aug 2009)	<ul style="list-style-type: none"> Delays in recruiting peer educators for HIV prevention outreach to migrant workers. Activity eventually delayed until April 2010.
Phase 2	
12	<ul style="list-style-type: none"> Failure to act on high dropout rate of peer educators Failure to reach resort workers with HIV program Inadequate analysis of results and feedback by CCHDC Deficiencies in reporting system of STI cases reported at health facilities
14 (01 Jan 2011 – 31 Mar 2011)	<ul style="list-style-type: none"> Low performance on target for number of law enforcement officers including judiciary, police and staff of correctional facilities trained both on IDU and HIV concerns (86% achieved – 176/205). SRs revised training module to attract more participants by reducing number of training days from 3 to 2 days.
16, 17	<ul style="list-style-type: none"> Partial disbursement made in Oct 2011 and no further disbursements made due to budget discrepancy within Global Fund. Discrepancy was a mismatch between Phase 2 approved budget as per the Board GSC vs the total amount for which the grant was signed.
Phase 1 and Phase 2	
All	<ul style="list-style-type: none"> Changes in FPM assigned to Maldives Capacity issues within PR and SRs in areas of data quality, financial management, M&E M&E capacity issues at national level

Maldivian Rufiyaa (MVR) and not US\$. The exchange rate is US\$ 1 = MVR 15.42