

# **Behavior Change Communication Strategy for HIV Prevention in the Maldives**

**The Global Fund Supported Programme  
in the Maldives**

Submitted by  
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## **HIV in the Maldives - A Portrait of Risk**

### **Quotations from Respondents in the Qualitative Research, 2008-9**

*“I was told there are two people out of some twelve [who had HIV]. I’ve heard there were twelve before, so now it’s two; the rest must have gone or passed away, so it’s not bad.”*

- Male Seafarer

*“I have seen lots of people sharing the same needle...around 5 to 10 groups of people sharing the same needle.”*

- Male Drug User (returning from Jail)

*“I know I will get “sick” the very next day, so I need that money. I don’t have a choice so I just close my eyes and say yes.”*

- Drug Addicted FSW

*“I think yes, 89% of migrant workers have sex with some other ladies...They are the wives of drug users. First they will look for drug users, and they’ll give money to them, and through that money they will get you to the sex worker.”*

*“I do not know how to use condoms and never bought one as well. In the last 5 years I had sex with 50 women and I never used condoms. “*

-Migrant Construction Workers

*“ We all booze and while drinking, each couple by couple will start getting involved sexually and in time, the partners get exchanged.”*

*Q: Did you use condoms at that time?*

*“No, I didn’t....We were too drunk to think about anything else.”*

- Young Woman (General Population)

*“He couldn’t even remove the syringe when he died. After some time we found him dead and we were in panic. You know I still want to live in this world abstaining from drugs.”*

- Injecting Drug User

*“To say that letting young people have condoms encourages them to have sex is the same as saying that giving someone a toothbrush encourages him to eat more sweets.*

- Research Team Member

**“Today, in the Maldives, with HIV anything is possible.”**

- Research Team Member

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# INTRODUCTION TO THE BCC STRATEGY FOR HIV AND AIDS IN THE MALDIVES

This BCC strategy has been developed based on comprehensive audience research, and it follows on and is linked to two companion documents: *The 2008 Biological and Behavioral Survey on HIV and AIDS in the Republic of Maldives*, and *Konme Kamevves Vedhaane - a Comprehensive Audience Analysis for HIV Risk in the Maldives*, August, 2009.

These two studies were conducted by the Global Fund Supported Team in the Maldives, in collaboration with its partners, the CCHDC (then DPH), DDPRS (then NNCB), SHE and NGO Journey. Together, these two documents document the findings of quantitative and qualitative research done on seven groups at higher risk for HIV in the Maldives: Injecting Drug Users, Female Sex Workers, Men who have Sex with Men, Migrant Construction Workers, Seafarers, Resort Workers and Youth.

The BBS gathered statistical and serological data on over 1,700 respondents, both Maldivians and migrants in the Maldives. The qualitative research followed with 41 in-depth interviews on members of these same risk groups. Together, these two documents paint a picture of a country with a low prevalence of HIV but a high prevalence of the attitudes and risk behaviors that could lead to an HIV epidemic – attitudes and behaviors that have led to HIV in neighboring countries – such as rising rates of reported unsafe drug injecting both in Male' and in prison, IDUs who sell sex, unprotected sex with multiple partners, and frequent inter-island and international travel.

Although they are surrounded by high risk behaviors, nearly all of the participants in these two studies (like most Maldivians) did not believe that they or their friends were at risk for HIV.

The BCC Strategy incorporates the general recommendations for communication from *Konme Kamevves Vedhanne*. These general recommendations include shifting discussion of HIV from reported cases to estimated cases; widening prevention options from a sole focus on good behavior to options of condoms and clean injecting equipment for those who need them; developing targeted media using an audience-centered communication approach; recruiting and training peer communicators; and starting now to prepare for stigma and discrimination.

In addition, this BCC Strategy provides specific strategic communication recommendations for each of the seven groups at high risk, based on both the statistical and the in-depth qualitative research with them. Their knowledge and gaps in knowledge, attitudes, reported behavior and communication preferences are the bases for the communication recommendations made here.

*Konme Kamevves Vedhaane* concluded that the present moment is a unique window of opportunity, when a strong, fast, realistic, comprehensive response to HIV could stop the virus in its tracks before it has a chance to gain a toehold in the Maldives. This BCC strategy describes such a response to the threat of HIV in the Maldives.

It is the hope of the development team that this BCC Strategy will help the Maldives reorient its communication response to HIV, making it more appropriate to the real needs of those at risk, and thus preventing an epidemic in this beautiful island nation.

# Acknowledgements

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  - Ministry of Youth
  - Paradigm
  - Society for Health Education
  - Society of Women Against Drugs
  - UNDP
  - UNFPA
  - UNICEF
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# Acronyms & Abbreviations

BBS	Biological and Behavioral Survey
BCC	Behavior Change Communication
CCM	Country Coordinating Mechanism
CCHDC	Center for Community Health and Disease Control
DDPRS	Department of Drug Prevention and Rehabilitation Services
DPH	Department of Public Health (now CCHDC)
FSW	Female Sex Worker
GFATM	Global Fund on AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
HIV Test	A test for the presence of antibodies to HIV in the blood
IDU	Injecting Drug User
MARA	Most-at-risk Adolescents
MARP	Most-at-risk Population
MOHF	Ministry of Health and Family
MSM	Men Who Have Sex with Men
NAC	National AIDS Council
NAP	National AIDS/STI Program
NNCB	National Narcotics Control Bureau (now DDPRS)
NGO	Non-Government Organization
PLHIV	Person/people Living with HIV
QR	Qualitative Research
SHE	Society for Health Education
SR	Sub-recipient of Global Fund grant
SSR	Sub-sub-recipient of Global Fund grant
STI	Sexually Transmitted Infection
SWAD	Society of Women Against Drugs
UNAIDS	The United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing (for HIV antibodies)
WHO	World Health Organization

# Introduction to HIV and AIDS in the Maldives

A double necklace of coral atolls, a thousand plus small islands amidst the brilliant blue waters of the Indian Ocean, the Republic of the Maldives is a unique nation – unique in loveliness, unique in its combination of language, culture and religion, and geography. A population under 400,000, distributed over a country 820 km long and 130 km wide, would seem to make the Maldives one of the world's less densely populated nation. However nearly half of the people live crowded onto the capital island of Male', where the population density of 58,000 per square kilometer is double that of New York City. The rest of the population is spread out over hundreds of islands, separated by vast stretches of water, making the Maldives unique also in terms of the challenge of responding to the threat of HIV.

## The Early Response to HIV

The Maldives took important early steps to prevent HIV. In 1987, the government launched a national response to HIV, forming a multisectoral body, the National AIDS Council (NAC) to direct the National AIDS Program (NAP). The NAP in the newly restructured Ministry of Health and Family is responsible for leading, coordinating and monitoring the national multi-sectoral response to HIV and AIDS.

The Maldives has signed the Millennium Development Goals, which aim to halt and begin to reverse the spread of HIV and AIDS by 2015. The progress report pledges to collect evidence on sexual behavior of high risk groups and plan and implement targeted interventions for them, improve access to condoms, and promote VCT. The National Strategic Plan on HIV and AIDS aims to maintain the low prevalence of HIV in the Maldives, improve the quality of life and health of PLWHA and their families, and create an enabling environment to mitigate the impact of HIV.

In support of the National Strategic Plan, the Maldives succeeded in obtaining Global Fund Round 6 funding of US \$4.87 million over five years, with (among others) the objectives of preventing HIV transmission among young people who inject drugs or are at risk of injecting drugs and preventing HIV transmission among populations at risk such as migrants, seafarers and resort workers. This BCC Strategy was developed with these objectives in mind.

Everyone in the Maldives, whether Maldivian or expatriate, needs good HIV prevention communication and skills, as well as access to prevention commodities and services. However, this strategy focuses on seven groups of people at higher risk: injecting drug users (IDUs), female sex workers (FSWs), men who have sex with men (MSM), migrant construction workers, seafarers, resort workers and youth. The first six are the groups among which HIV epidemics have first taken hold in other countries in the Asia region.

The seventh group addressed in this BCC strategy is youth. While not all youth are at high risk for HIV, youth is the source of the future members of all the groups at higher risk. Youth is also the best group to approach to make the society-wide changes that could spare the Maldives a major HIV epidemic in the future.

If Maldives fails to meet the needs of these seven groups, the chances of facing a fully blown HIV epidemic increase. If, on the other hand, the Maldives offers these seven groups effective communication about HIV, gives them access to crucial commodities and services and enlists them as true partners in prevention, much can be done to protect the Maldives from HIV.

### Low Risk Perception vs. High Risk Behavior

The Maldives is often referred to as a “low prevalence country” for HIV. More properly it has a “nascent epidemic,” as the BSS puts it. Since the first case in 1991, reported cases of HIV in the Republic of the Maldives have been few – a total of 253 cases, with the vast majority (239) among migrant workers who were not permitted to remain in the country after being diagnosed. This has made it easy for most Maldivians to believe that the problem of HIV was successfully stopped at the border. However, HIV is famous for ignoring national borders, as worldwide experience shows.

Two important studies of HIV risk were conducted in 2008, showing that the risk behaviors that can lead to HIV are well-established in the Maldives. *The 2008 Biological and Behavioral Survey on HIV and AIDS in the Republic of Maldives* and *Konme Kamevves Vedhaane - a Comprehensive Audience Analysis for HIV Risk in the Maldives* document unsafe injecting, unprotected sex with multiple partners, serial monogamy, group sex, gang rape, commercial sex, and unprotected male-to-male sex. A huge mobile population of male migrant workers, frequent travel by Maldivians to other countries in the region, and gender inequalities add to the HIV risk. This research shows that in spite of the present low prevalence of HIV, the potential for an epidemic is significant.

Put simply, the Maldives appears to owe its present low HIV prevalence primarily to good luck. Past good luck, while something to be profoundly grateful for, is not an effective HIV prevention strategy in the present, nor is it any guarantee of low prevalence for the years to come. As an advisor recently put it, “the history of HIV in the Maldives is still in the future.”<sup>1</sup>

It is hoped that the communication interventions outlined in this BCC Strategy will help the Maldives hold onto its present good luck and make use of the window of opportunity to enable this unique and beautiful country to avoid the spread of HIV.

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<sup>1</sup> Franck Geneus, Advisor to the Global Fund Supported Programme in the Maldives, verbal communication, 2008.

# The BCC Strategy Development Process

## Statistical Research: The BBS

The BCC strategy development began with the Maldives' First Biological and Behavioral Survey (BBS). The BBS included three types of research: an initial mapping exercise, a statistical survey based on a questionnaire given to a sample of 1769 study participants, and a serological study based on blood drawn from 1791 participants. Three sentinel sites were involved: Male' (including Hulumale' and Vilingili), Addu, and Laamu Gan. The study, its methodology, findings and limitations are described fully in the BBS report.<sup>2</sup> The BBS was first disseminated in November, 2008.

## The BCC Strategy Development Consultation Workshop:

A BCC Strategy Development Consultation Workshop was held on Dec. 3, 2008, soon after the BBS dissemination, with 26 participants from government, the UN, civil society, and the private sector. (see *Appendix A: List of Participants in the BCC Strategy Development Consultation Workshop and Appendix B: Recommendations of BCC Strategy Development Consultation Workshop*).

During the consultation workshop, the participants first heard a summary of the most important findings of the BBS for the seven groups at risk: IDUs, FSWs, MSM, Migrant Construction Workers, Resort Workers, Seafarers and Youth, and had a quick review of the audience-centered communication planning process. Then the participants formed teams corresponding to their interest or familiarity with the different the seven groups contacted during the BBS. In these teams, they analyzed each group's needs for HIV prevention and developed key recommendations for communication. At the end of the day, these ideas were then presented to the Strategy Consultation Workshop as a whole. After discussion, the workshop participants approved the recommendations.

Based on the BBS and the work of the BCC Strategy Consultation Workshop, the first draft of this BCC Strategy was developed and shared with partners, including participants in the Consultation, government, civil society, and the UNJT in April, 2009.

## Qualitative Research and Analysis

The BBS was followed by qualitative research, with the same seven groups at risk, building on the contacts and insights of the BBS researchers. A Qualitative Research (QR) team was trained in the techniques of in-depth interviewing using an audience-centered approach, where the interviewees control the conditions of the interview, including time, place and number of participants. The interviews resembled natural conversations among friends, with the interviewer providing a minimum of structure by introducing topics and asking clarifying questions. All the interviews were audio recorded with full permission of the participants.

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<sup>2</sup> *2008 Biological and Behavioral Survey (BBS) on HIV and AIDS, Republic of Maldives*, Aura C. Corpuz, MD, MPH, PHSAE TSF, Consultant for the UNDP/DPH-GFATM, November 2008

The QR team conducted 41 in-depth interviews over a period of six months from December 2008 through March 2009. In addition to the recorded interviews, some information was gathered from focus groups and internet communication, blogs, Facebook and email. The interviews were recorded with the permission of the participants, and 35 were transcribed and (if not in English) translated.

The 35 transcripts were analyzed during a Qualitative Research Analysis Training Workshop in Ellaidhoo Island, May 1-4, 2009. The workshop participants were all QR Team members: interviewers or others who had taken part in the transcription or translation of the data. The workshop participants formed teams to sort the interview data for each audience group into categories in both Divehi and English. The teams then agreed on the most important findings and selected illustrative quotes in two languages.

This analysis was the basis for a comprehensive audience analysis of the seven groups, combining both quantitative and qualitative findings. This report, entitled *Konme Kamevves Vedhaane – Anything is Possible*, is scheduled to be printed and distributed in September, 2009.<sup>3</sup>

### Review of the BCC Strategy

As a final step in assuring this strategy was sensitive to the needs of the target audiences and adequate to meet them, representatives of a number of the target groups reviewed the sections and commented or suggested changes. These suggestions were taken into account and modifications made accordingly.

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<sup>3</sup> *“Konme Kamevves Vedhaane”- Anything Is Possible, A Comprehensive Audience Analysis for HIV Risk in the Maldives, with Recommendations for Communication.* Barbara A.K. Franklin, Ph.D. Male’, The Global Fund Supported Programme in the Maldives, August 2009.

# General Communication Recommendations

Six overarching, general recommendations for communication were included in the comprehensive audience analysis, *Konme Kamevves Vedhaane – Anything is Possible*. These link the findings of the audience analysis to this BCC strategy and form the basis for a more realistic and solid HIV communication approach. These general recommendations apply to all the target groups and should inform all communication for HIV in the Maldives.

These general communication recommendations are repeated here, verbatim:

**1: Put aside the myth that there are only 3 cases of HIV in the Maldives. MOHF and the media should change immediately from talking about reported cases to estimated national HIV prevalence, or about HIV prevalence in the South Asia region.**

It is certainly not true that there are only two or three cases of HIV in the Maldives. Reported cases never reflect actual cases, even in settings where surveillance is complete. Yet audience research shows that this belief is one of the main reasons most Maldivians (and most migrants in the Maldives) do not seriously believe they are at risk for HIV. All public discussions of HIV in the Maldives revolve around the low number of reported cases. This belief lulls the country into complacency, gives a false impression of safety and of isolation from the region, and excuses many unsafe behaviors by encouraging the dangerous idea that Maldivians' present sexual and drug use attitudes and behaviors can continue indefinitely without danger of HIV.

Responsible discussion of HIV requires citing estimated cases (the current UNAIDS estimate for the Maldives is ) and, in the case of the highly mobile Maldivians, it would be wiser still to talk about the neighborhood. There are major HIV epidemics in the Maldives' immediate region. India and Nepal now have significant epidemics, and those of Bangladesh and Pakistan are growing, driven by unsafe injecting, followed by unsafe sex. Indonesia, another Muslim majority country, once secure in its low prevalence, has seen cases multiply and now faces the looming threat of a major epidemic.

Besides conforming to international best practice, there are at least three good reasons why the Maldives should not take their reported 3 or 4 HIV cases literally.

First, Maldivians travel. As inhabitants of an island country at an international crossroads, Maldivians have always been travelers. Now, more than ever, Maldivian young people travel to nearby countries for study, work and holidays, engage in risky behaviors there and return to the Maldives.

Second, the Maldives lives by its migrant workers. The nearly 80,000 migrants hosted by the Maldives, mostly male, are only permitted into the Maldives after mandatory HIV tests. This seems to provide a great deal of psychological security to Maldivians, but HIV hides well in a one to three

month invisible “window period<sup>4</sup>” during which migrants may enter with negative tests. More important, almost nothing is done to support migrants in safe behaviors in the Maldives.

Third, it is common practice for Maldivians who can afford it to travel to India or Sri Lanka for medical care (particularly potentially embarrassing care, such as birth control, STI treatment or abortions.) It is quite possible that there are Maldivians with HIV who have not chosen to be tested and treated in the Maldives, where they would become reported cases numbers four, five, etc., but would make an effort to go outside the country for HIV testing and treatment.

The NAP should begin immediately to describe the Maldivian HIV situation as a “nascent epidemic” (as the BBS calls it) and replace the reported cases with a more realistic estimation, or a range of estimations, based on international best practice in case estimating. Whenever reported cases are cited, this information should always be added. This change in communication policy should be distributed to the media and announced at a press conference in the near future.

**2: Continue to promote abstinence, sex in marriage only, and fidelity, but do not rely on “good behavior” alone to prevent HIV among youth in the Maldives. Condoms and clean injecting equipment must be also available to everyone who needs them.**

“Good behavior” (no sex before or outside of marriage, no alcohol, no drugs) is the best prevention against HIV. These solid principles of Islam (as well as those of other major religions) will protect a society as long as everybody follows them.

But while Maldivians love and deeply value their national religion, many also engage in many risk behaviors. In addition, HIV moves without prejudice through sexual networks that include both “good” and “bad” behavior. The most frequent new cases of HIV in many countries in this region now are faithful, monogamous, married women, with no risk behavior except legally and morally sanctioned sex with their husbands.

The Maldives should continue to stress the precepts of Islam and offer the solid guidelines of “good behaviors” through the voice of religious leaders and to the young in schools, but there must also be options for safe sex and safe injecting to protect those who do not follow those principles. To capture everyone in a safety net, the Maldives urgently needs to widen the range of HIV prevention options, without regard to moral judgments.

Condoms must be promoted for sexually active, non-monogamous Maldivians of all ages, and safe injecting with clean equipment for IDUs – the entire country’s health depends on these options being available to all who need them.

Fears are often expressed that allowing the young to have condoms will encourage them to have sex. This is equivalent to saying that urging people to brush their teeth encourages them to eat more sweets. In fact, evidence gathered worldwide shows that in countries that allow the young to have condoms and educate them early on reproductive health, the young do *not* start to have sex sooner.

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<sup>4</sup> Depending on the test given. Newer tests may shorten the window period to one month.

On the contrary, in countries where there is open discussion of sex, disease and condoms, young people usually start to have sex later than in countries where those subjects are taboo.

*To say that letting young people have condoms encourages them to have sex is the same as saying that giving someone a toothbrush encourages him to eat more sweets.*

Similarly, Oral Substitution Treatment (OST) such as Methadone Maintenance Treatment (MMT) do not encourage drug use; they merely help ensure that already addicted individuals do not take drugs in dangerous ways, where they might get HIV or hepatitis and infect others.

### **3. Promote a more compassionate understanding of those at risk of HIV (young people who have sex outside of marriage, IDUs, MSM and FSWs) as a strategic response to HIV.**

While heterosexual relations within marriage can also carry a risk of HIV (and do, more and more frequently worldwide and in the South Asia region) many of the risk behaviors for HIV are not acceptable within traditional Maldivian culture. Young people who have sex outside of marriage, IDUs, MSM, FSWs are present in the society. Understanding the behaviors of these groups and the reasons for their risk can help them stay safe.

Stigma and discrimination leads to unsafe behavior. In the qualitative research with IDUs, for example, virtually all told the same story. Hopelessness in jail leads drug users to seek drugs, often to start injecting. On release, the barriers they face trying to reintegrate into society often contributes to their relapse.

Sexually active youth in the Maldives also suffer from stigma, discrimination and legal consequences of what is to them a normal act. Sex outside of marriage is extremely common in the Maldives (as mentioned above, the BBS found that 30% of youth 18 to 24 said they were both sexually active and unmarried), but it is also illegal and can be punished by public whipping, and expulsion from school, among others. Since an unwed pregnancy is usually the proof of sex outside of marriage, it is really not the sex but the pregnancy that is punished, and then only in the case of the young woman. This leads to an increase in illegal and dangerous abortions. A girl expelled from school for pregnancy is permanently disgraced and will not be readmitted, even if she does not carry the pregnancy to term. A young life should not be ruined by the selective punishment of such a widespread behavior as sex among the young.

This research found that FSWs are often ordinary young women who have become drug addicted, or find themselves without any other way to live. Some young women are occasional sex workers, as are some young men. They need support to change those behaviors or, at least, stay healthy to have better lives in the future. The present punitive approach does not facilitate behavior change.

The highest levels of stigma in the Maldives, however, are reserved for MSM. The MSM contacted in this study shared deep and painful feelings of loneliness and alienation, and many recounted painful experiences including abuse by older males, brutality from those in authority, cruel teasing,

family rejection, threat of job loss and even public whipping and banishment. In such an environment, MSM naturally hide their sexual preferences, putting their male and female partners at even greater risk for HIV. The MSM the qualitative researchers met do **not** generally want a militant public gay presence in the Maldives; they want only to be allowed to be themselves, with quiet assistance in staying safe.

Anticipating and solving the problems of stigma and discrimination against these groups is an essential part of HIV prevention in the Maldives, and it should start now, in anticipation of the future. A three-step communication approach is called for:

First, advocacy is needed at high levels to change laws and policy. Second, training is needed for all those who administer policy or influence others, including the mass media. Third, offering a discrete helping hand to the groups at risk can help them change their attitudes and behavior, to stop being part of the problem and start being part of the solution for HIV in the Maldives.

The National Strategic Plan mandates working with highly stigmatized groups including MSM and FSWs as a top priority. There is no time like the present to act on this good idea.

#### **4. Begin communication now to prevent stigma and discrimination against people with HIV (PLHIV), to improve prevention and protect the rights of PLHIV.**

The moving story told by an IDU respondent, in the box on the next page, reveals the level of stigma and discrimination the Maldives can expect towards HIV, and it illustrates the crucial role played by support, even when it comes from the least unexpected quarters.

There is a close connection between reduced stigma and HIV prevention in any society. People are much less willing to practice safe behaviors in a climate of blame, disgust, fear and rejection. Instead, such a climate leads to denial of risk, turning eyes away from both danger and prevention. People who feel they might be at risk but fear they might be rejected socially if they have HIV do not get tested, or if they do get tested, they hide their diagnosis and may not get the treatment and support they need. They may also continue to behave unsafely, putting others at risk. PLHIV who feel hopeless, stigmatized and rejected do not contribute to an enabling environment for HIV prevention.

#### ***“We’d Sit in a Circle” - A Positive Response to an HIV Positive***

*“He didn’t inject before, but what happened to him was, when his family found out he had HIV, they sort of kicked him out...the way they saw him changed. When all this stuff happened, he became very depressed and alone and he started injecting heroin.*

*And because I’m an addict and we were both from the same island so we were pretty close...Even in front of us his family, his own sibling and cousins would say upsetting things to him, that he’s bringing shame to the family name...They’d say a lot of mean things to him when he needed their help and support the most, the people who needed to give him the most support. He got really upset when people said that to him. Probably that’s why he passed away so quickly.*

*So when we used with him, say we’d have the heroin on a piece of paper, we’d all sit together basically in a circle, not one person here and there, but all*



On the other hand, as the previous quote shows, when PLHIV are brought out of the dark into a friendly light, the whole society benefits. As PLHIV increase in number in the Maldives, PLHIV self-help organizations should be formed to meet the needs of those with HIV.

**5. Make use of the natural communication processes and networks within each group, e.g. use “positive deviants” as peer communicators to model and encourage behaviour change.**

Communication that is based in the present communication practices and structure of a community is better than communication imposed from the outside. For example, every group has members who have developed their own behavior change strategies and can show others the way. These “positive deviants” are those within a community who have arrived at their own solutions to problems through their own creativity and experimentation. In Diffusion terms, they are the “innovators”<sup>5</sup> who initiate the change process, and if they also have a measure of social acceptance within their group, they are the best communicators for change.

Much research shows that people most change their behavior due to the influence of their close peers. The most enduring change comes from within a community; it is not imposed from the outside.

A diffusion approach to communication for behavior change should be adopted within different the different groups at risk in the Maldives. This is equivalent to sailing with the current, instead of against it.

**6. Develop targeted communication materials to meet the specific needs of the different groups at risk.**

This audience research clearly shows that general population information does not meet the HIV prevention communication needs of most groups at higher risk, for several reasons. One reason is that the information targeted toward the general population makes assumptions about behavior that do not match the reality of these groups at risk (for example heterosexuality).

Another reason is that general population information often includes judgments or labels that alienate people at higher risk and do not produce realistic assessments of behavior. For instance, saying that avoiding sex workers is a way to avoid HIV may encourage women who trade sex for drugs to say they are not sex workers, or men to deny that their partners are sex workers, even if they pay them.

A third reason is that general population HIV prevention information usually stresses behaviors such as abstinence, fidelity, sex within marriage only, and no drug use – which simply are not realistic behavioral guidelines for groups at higher risk.

The predominance of general population account for many skewed perceptions found in this study – for example, when IDUs say they will be safe from HIV because of their sexual behavior, or when migrants, resort workers, or seafarers view fidelity, rather than condoms, as their best prevention method, although they are separated from their wives for months or years at a time and have other partners in the Maldives. People need prevention options that match the reality of their lives.

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<sup>5</sup> See Everett M. Rogers, *Diffusion of Innovations* for a description of categories of those who adopt change in any population

The most effective materials for any group are targeted to the specific needs of the group concerned. This can be done if materials developed based on insights from the group (for example using the messages and strategies from the positive deviants revealed in this qualitative research). Best of all is when communication is developed in partnership with the group at risk – developed, pre-tested and conducted with their active participation. Experience worldwide shows that these are the campaigns that really work to prevent HIV.

# Injecting Drug Users (IDUs)

IDUs are a likely flashpoint for a potential explosion of HIV in the Maldives. Once HIV enters the IDU population, it can spread very quickly among them through unsafe injecting. Unsafe sex spreads it further, and the risk to the community as a whole greatly increases. The BBS showed that Hepatitis C (often used as proxy indicator for HIV risk, since it is spread through sharing of injecting equipment) is already circulating among IDUs in both Addu and Male.

A punitive drug law exacerbates the situation for drug users and may make injecting more likely when drug users are sent to prison, when supply of drugs is limited, or when they want to use quickly and efficiently to avoid detection. However, the drug law is now undergoing revision so, hopefully, some of these problems to safe behavior may decrease in the future.

The Comprehensive Audience Analysis *Konme Kamevves Vedhaane, Anything is Possible*, examined the quantitative and qualitative data from the BBS and the qualitative study and came up with the following findings on IDUs:

## Findings on IDUs:

1. Most IDUs have spent time in prison, and many say they learned to inject there.
2. IDUs see as an increase in injecting in the Maldives and explain it by market forces, or as a trend among drug users.
3. Nearly 1/3 of IDUs say they have shared injecting equipment. This may be because most inject in social situations where there is peer pressure to lend or borrow equipment.
4. Some IDUs share equipment without knowing by using a common cotton filter, common water, or a common supply of liquid drug.
5. Less than half of the IDUs who share equipment say they clean it before using, and most of those do not clean well enough to prevent HIV transmission.
6. Some IDUs practice and teach others safe behaviors. For example, most IDUs say they usually use their injecting equipment only once and then discard it.
7. Most IDUs think they will not get HIV because they believe their sexual behavior is safe – they are less concerned about their injecting risk than their sexual risk.
8. IDUs have non-regular partners, go to FSWs, sell sex, and they don't use condoms.
9. The most common reason IDUs give for not using condoms is that they are “sure their partner is healthy,” although nearly all IDUs know a healthy-looking person may have HIV – a “refuge” (*see box below*).

10. Many IDUs have been involved in group sex, where condoms are never used.
11. Most IDUs have seen hard times, including arrest and violence, and have witnessed suffering and even the death of friends from overdose.
12. IDUs feel the effects of social rejection, stigma and discrimination and find social reintegration very difficult, even after rehabilitation.

### ***“Refuges” – How We Fool Ourselves***

“Refuges” are comforting but illogical explanations people give for unsafe behavior, such as unsafe sex or unsafe injecting. These ideas give the illusion of safety without providing any real safety at all. Refuges sound logical, but they are at odds with facts people know well, or internally inconsistent.

For example, *“I only inject with friends I trust”* is a refuge when someone knows that you cannot tell who has HIV by looking. Similarly *“I think my partner would tell me if she had any diseases”* is a refuge, when someone knows that most people with HIV don’t know they have it.

People need to be reminded of the facts they know and then helped to look logically at the illogical explanations they may be using for their unsafe behavior.

Refuges need to be deconstructed systematically through skillful communication and carefully crafted messages that are pre-tested with the target audience to verify their effect in countering the refuge.

13. IDUs’ HIV knowledge is generally good, but there are gaps, especially in Addu.
14. When IDUs have symptoms of STIs, most of them simply ignore them.
15. Some IDUs already understand and practice safe sex. These IDUs can be useful peer communicators, and their ideas can help guide message development.



## Promoting Safe Injecting: Messages from IDUs

### Buy a friend clean equipment:

*“I used to say that sharing is a weird thing and I don’t like it, but you know the problem is he couldn’t afford it [his own injecting equipment]...I was earning money, so what I did was I offered him RF 100 and got one for each of us. And we used them separately.”*

- Addu IDU

Qm5 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

### Tell a friend how to inject safely:

*“I can go and tell them the consequences [of unsafe injecting]. Though I know it’s bad to use drugs, I have to say that it’s okay to use and then give them advice on safe methods to use. No one will recover right away. It never happens. Even I did it step by step.”*

- Male’ IDU

Qm5 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

### Don’t teach anyone how to inject:

*“I decided that I won’t teach anyone how to inject, because I already had made the mistake of injecting. So I tried really hard not to teach anyone how to inject. Especially Maldivians.”*

- Male IDU

Qm5 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

# BCC Strategy for IDUs

Based on the audience analysis and the work of the BCC Strategy Consultation and other partners, here are the recommendations for communication with IDUs:

## **1. Expand oral substitution treatment (OST) services to new sites, based on successful operation of present methadone maintenance clinic.**

A harm reduction approach (including easy access to clean needles and syringes, condoms, appropriate information and referrals) is imperative to prevent an IDU-based epidemic in the Maldives. The following communication strategy for IDUs, is based on the recognition that harm reduction is urgently needed.

### *A Harm Reduction Approach*

Harm reduction is an approach that puts protection of the public health first, above legal or moral objections to behaviors such as drug use or sex work. It recognizes that these behaviors exist and supports behavior change while also trying to minimize harm to the community. Harm reduction has been pioneered internationally for decades and is endorsed by UNAIDS. There is much evidence that harm reduction reduces HIV transmission and helps protect the public health, while repressive measures (such as arresting drug users or sex workers) do not change their risk behavior and make it more difficult to prevent HIV.

Harm reduction for IDUs means making sure they have clean injecting equipment and condoms to protect their and the community's health, while also offering them more permanent solutions, including stopping injecting, and drug rehabilitation. An example of harm reduction is a needle exchange program (NEP) for drug injectors. In a NEP, current injectors trade their used needles and syringes for a package that contains clean needles and syringes, condoms, and information and referral for HIV testing, STI treatment, counseling and drug rehabilitation.

A NEP not only helps prevent an HIV epidemic from starting or spreading among IDUs but also gives organizations trying to help drug users the regular opportunity to meet IDUs, interact with them, and support them in longer term goals.

The Maldives presently has one Methadone Maintenance Treatment Center, based in Male'. This programme which has been going on since 2008, is presently in its pilot phase and its effects will be analyzed in 2009.

The participants in the BCC Strategy Consultation Workshop recommended the expansion of methadone maintenance therapy for the Maldives. Methadone maintenance began in 2008 and is presently limited to a single site in Male'. Methadone and other forms of OST are an important part of a harm reduction policy, reducing unsafe injecting and crimes involving IDUs.

## **2. Provide comprehensive package of services at Drop-In Centers, including services for female drug users.**

At present 15% of IDUs have access to programs that supply clean needles and syringes, the BBS found. It was unclear where these IDUs were accessing these supplies, since there are currently no such programmes registered in the Maldives. Perhaps they were unofficial efforts on the part of local organizations who recognized the need and acted accordingly to protect the public health.

To protect the Maldives from HIV, all IDUs urgently need access to needle exchange programs (NEPs). NGOs and CBOs need to be supported and trained to run these programs in a unobtrusive, low-key way within the IDU communities, with the active participation of IDUs themselves. An NEP may be located in NGO-run Drop-In Center (DIC), or the NEP can be taken directly to the community on foot, by motorcycle, van or boat (mobile DICs).<sup>6</sup>

If services for drug users are delegated to island or atoll-based health facilities as proposed in a recent advocacy strategy developed by UNODC and discussed in the Future Search conference, needle exchange could also be island or atoll-based.

## **3. Conduct limited, targeted advocacy for harm reduction with IDUs and their NGOs, families and key authorities.**

For a NEP to function, it needs the agreement of police and local authorities not to interfere. Advocacy needs to be done with three important audiences: IDU organizations, IDUs' families, and local authorities including the police. A first step would be to interview key members of these target audiences to hear their concerns. Messages backed up by evidence should then be developed tailored to the Maldivian context, pre-tested and delivered as targeted communication to those groups.

Harm reduction experts such as the Asian Harm Reduction Network (AHRN)<sup>7</sup> and the International Harm Reduction Association (IHRA)<sup>8</sup> may help provide evidence for the success of the harm reduction approach. Channels could include individual meetings, presentations with visual media such as powerpoint and print materials for backup. Respected opinion leaders and ex-IDUs should be involved in this advocacy effort.

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<sup>6</sup> A needle **exchange** program is different from a needle **distribution** program in requiring a recognized, current injector to bring and exchange his/her used equipment. In this way, new injectors are never recruited, but habitual injectors are kept from acquiring or spreading infection. This language may help to reassure public fears that the program may recruit new people into drug use.

<sup>7</sup> See <http://www.ahrn.net>

<sup>8</sup> See <http://www.ihra.net>

## 5. Train “positive deviants” as peer communicators to discourage injecting among drug users, and promote safe injecting and safe sex among active injectors.

Research shows that all people are most easily persuaded to change their behavior by their peers – the people they see as most similar to themselves. Although people can learn facts and get information from many sources, research shows that they change their attitudes and behavior through the influence of their peers. This is especially true for a group such as IDUs who have a special lifestyle and culture that sets them apart.

The suggestions for communication for both safe injecting and safe sex, made by IDUs during the qualitative research (*see boxes above*) provide a solid, audience-centered starting point for the development of the work of peer communicators.

### ***Opinion Leaders, Positive Deviants & Ideal Change Agents***

Diffusion of Innovations research shows that change comes naturally in a community through a chain of peer-to-peer communication within the group, based on the trust and familiarity people feel for others they see as similar to them and sharing their situation. This flow of change is a natural and on-going process, like the current in the sea. If those who plan campaigns for change understand this natural process, they can develop campaigns that go with the flow, rather than trying to sail upstream.

To make use of this natural, ongoing change process, when promoting a behavior change, we should look for members of the target community whose behavior is copied by others. These “**Opinion Leaders**” are often not the formal leaders but popular individuals others admire and tend to emulate. But while these opinion leaders may lead the change process in their community, they may not lead it in the direction we would like it to go.

A second important type of individual in any community is “**Positive Deviant**” who has found an original way solve a problem that others in the community also face. Positive Deviants deviate from group norms in a good way. For example, a FSW who has found a way to get her clients to use condoms is a “Positive Deviant” for that community.

One of the best strategies for interpersonal communication is to identify “Positive Deviants” and help them become “Opinion Leaders” who can show other group members how to change their behavior. This person then becomes an “**Ideal Change Agent.**” Diffusion research describes the Ideal Change Agent as someone from any group, who is just like the other group members except for having changed a behavior. In other words, the IDU who injects safely, the FSW who uses condoms every time, is the Ideal Change Agent for that

## **6. Develop targeted materials for IDUs to address their gaps in knowledge, attitude and practice, and offer referral for services.**

The comprehensive audience analysis showed that IDUs need accurate information about HIV transmission and prevention. They had gaps in knowledge (such as the belief that mosquitos may cause HIV). They had an unrealistic perceived risk, focused on unsafe sex when unsafe injecting may be an even bigger risk for them. Their attitudes included “refuges” such as the idea that their partners were healthy (although over 90% knew that a healthy looking person can have HIV.)

IDUs in the Maldives need a more realistic perceived risk, focused on real behaviors, such as injecting and condom use habits, rather than on mistaken beliefs such as their ability to choose safe partners for unsafe sex or injecting. They also need skills, such as effective cleaning, condom use, and communication skills such as saying no to a friend who wants to borrow needles, or persuading a sex partner to use a condom.

Members of the IDU community, especially “positive deviants” can help develop strategies and messages for behavior change, and these can be modeled by fictional characters who are similar to real IDUs – an effective communication strategy for developing self-efficacy – a belief that change is possible.

Targeted materials should be developed by organizations working in the community, with inputs from members of the target audience and guidance from communication specialists. All materials should be based on the information, questions and concerns, words and phrases from the target audience and always pretested with the m..

## **7. Train pharmacists to sell injecting equipment and condoms without prejudice to anyone who asks for them.**

Research in the Maldives did not turn up so many objections to pharmacists as in many places. It appears that purchasing injecting equipment is not so often a barrier as it is elsewhere. Nevertheless, pharmacists can be effective partners in harm reduction if they are trained well in this approach and convinced of its value.

This should begin with simple research – perhaps key informant interviews or focus groups – to identify the pharmacists’ information needs, questions and concerns. Trainings can then be developed to address any concerns or needs of pharmacists re. harm reduction.

## **8. Centralize services for IDUs in drop-in centers (DICs) or mobile units that serve a full range of IDU’ needs.**

As a marginalized and criminalized population, IDUs may feel uncomfortable about coming for services to centers designed to serve the general population. Evidence for this is the BBS finding that less than 20% of IDUs have ever had an HIV test, and that the majority of IDUs ignore symptoms of STIs, rather than going to medical practitioners to treat them. IDUs are much more likely to feel comfortable if they can get STI diagnosis and treatment, HIV testing, counseling and referral at a

“one-stop shop” designed specifically to serve them. If there is no permanent DIC in a given IDU community, mobile services can be organized to serve IDUs on a regular basis.

**9. Develop advocacy communication to change laws and policies, train media and sensitize the public to the harm reduction approach.**

Advocacy for policy makers should be developed and gradually introduced in an attempt to change laws and policies that make safe injecting and safe sex difficult in the Maldives. These include laws and policies that: limit public discussion of safe sex and injecting, prevent distribution of condoms and injecting equipment, and put drug users at risk of arrest if they volunteer for rehabilitation. Advocacy may include meetings, conferences, print materials, and study tours to places where harm reduction is in place.

Media professionals should be trained in harm reduction and encouraged to portray risk groups more realistically and compassionately so they can influence the public. NGOs can help with interpersonal communication, meetings and discussions.

**10. Develop materials and interpersonal communication for spouses of IDUs to increase understanding of their risk and promote condom use among them.**

An IDU-based HIV epidemic could quickly spread to a wider population through the regular sex partners of IDUs (wives, girlfriends, husbands, boyfriends) unless there is consistent condom use.

Some preliminary research could be done among IDUs’ wives and girl friends, to find out if they are aware of the HIV risk and can negotiate condom use with their IDU partners. This research could be used to generate arguments partners could use to persuade IDUs to use condoms.

Targeted print materials could then be developed and distributed along with condoms by interpersonal communicators who could lead discussions to help IDUs’ partners develop skills in negotiating condom use. Groups such as SWAD in Male’ could carry out this work.

# Female Sex Workers (FSWs)

Sex work is found in every society in the world, especially where men are separated by time and distance from their regular partners. Sex work is illegal in the Maldives (as in most places) so it is hidden. Arrests and raids do not stop sex work but only drive it underground, making it harder to establish good HIV prevention programs, and therefore more dangerous.

Two special concerns about female sex workers (FSWs) in the Maldives stand out from the research. The first is that 1/3 (32%) of the Maldivian FSWs contacted in Male' say they inject drugs. Injecting sex workers are a red flag for HIV, because they form a bridge between two populations at high risk, IDUs and clients of FSWs, who in turn are linked to a general population of women. Protecting IDU FSWs from HIV is a matter of urgent concern to the Maldives.

The second concern is that it is nearly impossible to reach expatriate FSWs, who may be as many as half the FSW population. Both BBS and qualitative researchers found expatriate FSWs unreachable, because of arrests that followed soon after the BBS research had begun. Very careful and very targeted communication is needed to reach these women, and a higher degree of trust that now exists.

FSWs in the Maldives have very limited access to communication and services designed especially for them. Their illegal status has prevented them from being the target of good programmes, although they are listed as one of the most important groups for HIV prevention in the National Strategy. Many other countries have successfully resolved this issue and developed FSW programs without legalizing sex work; hopefully the Maldives will also be able to arrive at such an accommodation, in the interests of public health.

A few, small low-key projects have provided advice and support to FSWs on a personal basis, and FSWs are welcome, like other women, to make use of STI clinic services. However, there is as yet no targeted FSW program. A small, pilot FSW programme was proposed as part of the Maldives' submission for Global Fund Round 9, but at the last minute the submission was withdrawn.

In spite of these problems, the Maldives has, little by little, increased its understanding of FSWs. The BBS and the qualitative research have added considerably to what is known about them. The comprehensive audience analysis *Konme Kamevves Vedhaane, Anything is Possible*, examined the quantitative and qualitative data from the BBS and the qualitative study and came up with the following findings on FSWs:

1. Many FSWs are also drug users: nearly a third in Male' say they inject drugs, and many have IDU sex partners.
2. Clients recognize that they can access FSWs through male drug users.
3. Drug-addicted FSWs enter sex work through a gradual process starting with alcohol, then drugs and sex for fun.

4. Drug-addicted FSWs may not think of themselves as sex workers but rather as addicts desperate for drugs.
5. Networks of friends act as pimps, bringing paying clients lead to FSWs. The FSWs themselves may become pimps for their friends.
6. Very few FSWs use condoms consistently with partners of any kind. They consider condoms unimportant, or for pregnancy prevention only.
7. About 60% of FSWs do not believe they can get HIV, but their reasons are illogical.
8. Most FSWs know where to get condoms, but very few carry them.
9. Most FSWs' focused on fidelity, not condom use, as a way to prevent HIV – this suggests that past HIV communication was not appropriate for them.
10. Some FSWs report symptoms of STIs, but many of these say they just ignore them.
11. Male' FSWs have better access to information and HIV testing than Addu FSWs, but all FSWs lack interpersonal communication opportunities.
12. There are “positive deviants” among the FSWs. About 40% of FSWs realize their risk of HIV and recommend using condoms.

## **BCC Strategy for FSWs**

Based on the audience analysis and the work of the BCC Strategy Consultation and other partners, here are the recommendations for communication with FSWs in the Maldives:

### **1. Find FSWs who are willing to advise and collaborate on HIV prevention programs to meet the needs of FSWs.**

Some community and civil society groups in the Maldives already have informal links with FSWs. Because sex work is illegal and strongly stigmatized, these contacts are confidential, and they should remain so. FSWs know their own community best, so groups wanting to work with FSWs should invite selected FSWs to collaborate in planning the program, developing targeted materials, and selecting good outreach workers, eventually becoming peer communicators themselves.

The first contacts with FSWs should be made on the FSWs terms, asking their help and offering any needed assistance in return. FSWs will need to learn to trust these programs not to increase their vulnerability to arrest.

### **2. Develop a mentoring relationship with successful FSW program elsewhere in the region.**

Organizations for FSWs elsewhere in the world have learned how to overcome many practical problems in carrying out projects with FSWs, ranging from interface with police and other authorities to good communication approaches to the FSWs themselves, to techniques FSWs can use to persuade clients to use condoms. Technical assistance from these organizations could help to start HIV prevention programs for FSWs in the Maldives. There are successful programs in India, for example, and in Bangladesh. An international group such as the International Network of Sex Work Projects can be contacted through their website and may provide a referral. *Web address barb.* Early contacts with a successful program elsewhere may help a newborn FSW project in the Maldives navigate the rough waters of setting up a project and may also help with the content of communication for FSWs, once the program is well-established. For example, FSW programs elsewhere in the world have developed skills in condom negotiation, practical use of condoms, and ways to make condom use more erotic and attractive for clients.

**3. Train a cadre of empathetic Outreach Workers to reach out to FSWs. A mentor relationship with a successful FSW project from the region may be useful here.**

In the beginning, outreach workers will be the most important communicators with FSWs. Good outreach workers are people FSWs like and trust, who understand and can communicate well with them. Outreach workers can bring FSWs health information, access to condoms, referral for HIV testing and STI treatment and can help them with problem solving.

There are many existing protocols for effective outreach to FSWs, including training and reporting protocols, and successful models from other countries in the region, including India and Bangladesh. An initial study visit by a small team may be useful to establish supportive links and a mentoring relationship with a group undertaking a successful project in a neighboring country.

**4. Develop targeted materials to fill FSWs' specific communication needs, including more accurate perceived risk, correct knowledge and realistic HIV prevention strategies.**

Research shows that FSWs have received general population information about HIV, and, as a result, they have ideas about HIV risk and prevention that are not appropriate for their situations. For example, FSWs in the BBS said that not changing partners often was the way to prevent HIV. This is an unlikely prevention strategy for a sex worker, whose economic well-being involves maximizing the number of partners she can serve.

FSWs need prevention strategies of consistent condom use, as well as the negotiation skills to persuade their clients to use condoms (or the practical skills of putting them on the clients without the clients knowing.) General population HIV communication is not suitable for FSWs. Instead, targeted materials should be developed using audience-centered methods, with inputs from the FSWs themselves, and pre-tested with members of the target audience.

The BBS and qualitative research suggest that FSWs need the following communication content:

- Injecting drugs and sex work is a deadly combination – safe injecting and safe sex are essential for your safety

- Only consistent condom use (not “having healthy partners”) prevents HIV.
- HIV cannot be transmitted by mosquitos or sharing food.
- It is impossible to tell by looking who has HIV – so you cannot “choose healthy partners.”
- Most people who have HIV don’t know it
- Untreated STIs increase the risk of HIV.
- You have the power to prevent HIV (a self-efficacy message.)

The way messages are expressed, the words and images, need to reflect the point of view of the women; they should be developed in collaboration with the FSWs themselves.

#### **4. Carry out limited, targeted advocacy with police to allow communication with FSWs without the threat of arrest.**

Successful communication with FSWs requires non-interference from the police. If the police follow the communicators in order to identify and arrest the FSWs, the Maldives will surely fail in its attempts to prevent HIV in this key population. The experience of the BBS, where expatriate FSWs’ arrests stopped completely their participation in the study should be regarded as a lesson in what can happen when authorities are not convinced the importance of their remaining neutral at crucial moments in HIV prevention communication.

Beyond good research, FSWs need ongoing communication, a good supply of condoms, and access to clean needles if they are IDUs. These needs will not be met unless outreach workers and peer communicators have permission to operate. While they do not need to be given official approval, they need at least the tacit agreement of the police and local authorities to operate without interference, and freedom from surveillance and the threat of arrest while they do.

Solid, evidence-based persuasive arguments need to be developed and communicated to police and local authorities, using a Harm Reduction approach (See box on **page ???**).

A logical first step would be to conduct initial interviews with police and key local officials to hear their concerns. Authorities then need to be educated about the harm reduction approach, with evidence-based communication, including statistics showing how easy access to condoms lowers the rates of HIV and STI among FSWs and clients. Presentations, individual meetings and discussions with authorities would be useful, backed up by print materials with evidence of harm reduction’s success in other settings. Finally an agreement needs to be negotiated with police concerning outreach workers’ and peer communicators’ ability to move freely and communicate with anyone without observation or interference. This communication should be undertaken jointly by the government, NGOs and international partners.

#### **6. Identify and train interested FSWs as peer communicators to help other FSWs with condom use and negotiation skills.**

Using peer communicators in programs for special groups such as FSWs is a good strategy because it makes use of existing on-going processes of change in a community. If selected FSWs have

already been involved in helping develop materials and in pre-testing them, and have begun to distribute condoms through an informal or formal arrangement, it should not be a big step to engaging them as peer communicators. Peer Communicators should be chosen for their active interest in the welfare of their community, their contacts and comfort communicating and the level of trust they enjoy from other FSWs. It is essential that peer communicators be condom users themselves..

There are many good models for developing and running a Peer Communication program. Sometimes peer educators are paid a small stipend, but often they are volunteers who are compensated for their expenses, given small gifts or rewarded with recognition. Experience shows that FSW peer educators are often motivated more by contributing to the welfare of their community than by money or gifts.

### **7. Involve FSWs and trusted others in the distribution of condoms, lubricants and HIV information to other FSWs and clients.**

The BBS found that FSWs did not carry condoms. Only one of the FSWs contacted could show a condom. The others were not carrying them. Ways to help FSWs carry condoms discretely and comfortably also need to be developed. Advocacy with the police should also insist on condoms never being used as a reason to arrest a woman on suspicion of sex work.

Anecdotal evidence suggests that men may be the ones who are assumed to be responsible for condoms, both deciding when to use them and providing them, even in a sex work situation. It is essential for FSWs to take control of condom use with all their partners.

Lubricant is also important for FSWs because without it, condoms may cause painful friction, making the women less likely to want to use them, or they may even break. For FSWs to protect themselves and their clients, they need a good supply of lubricant, as well as condoms, and to be in charge of their use. To empower FSWs in this way, it is useful to involve them in the distribution. Condoms can be distributed free by an NGO through FSW peer communicators, they can be marketed through nontraditional outlets in the sex work areas, or they can be sold by FSWs themselves to their clients, or to each other, as peer communicators, adding an economic incentive to their use.

### **8. Provide community based - access to STI screening and treatment as well as health information for women in general.**

FSWs are part of a larger population of women needing sexual health services, and some FSW needs could most easily be met through an approach to women in general. For example, a mobile van may bring STI services at low cost to a neighborhood to provide checkups, STI screening and STI treatment to all women in that area, free or at discounted prices. This may allow FSWs to access the services without prejudice or exposure.

# Men Who Have Sex with Men (MSM)

The qualitative research found that the highest levels of stigma in the Maldives are reserved for MSM. Naturally, in this environment, most MSM hide their sexual preferences. This secrecy endangers the health of MSM and their male and female partners, making it harder for MSM to plan for and practice safe sex.

The illegality of sodomy according to shariya law hangs over the MSM population as a continuous threat. If they are arrested for sodomy, MSM are subject to public beating, imprisonment and/or banishment. Many As a result, many MSM who can afford it leave the country, while others want only to live quietly, out of the public eye.

In spite of these problems, MSM in the Maldives have gradually become more comfortable expressing their point of view. The MSM contacted in this BBS and qualitative research may be considered a hidden population to most Maldivians, but they are not hidden to each other. Instead MSM in the Maldives have a strong sense of community with active social and sexual networks. These networks offer the possibility for good communication for HIV prevention. MSM are one of the groups identified as high priority for HIV prevention in the Maldives' National Strategic Plan. It should be a relatively easy matter to organize communication for HIV prevention using MSM's existing channels of communication

The BBS and the qualitative research have added considerably to what is known about MSM. The comprehensive audience analysis *Konme Kamevves Vedhaane, Anything is Possible*, examined the quantitative and qualitative data from the BBS and the qualitative study and came up with the following findings on FSWs:

1. Most (75%) of MSM in the Maldives also have sex with women, as well as men, and 25% are married.
2. Many MSM have experienced sexual abuse, either as boys or as adults, for example in prison.
3. MSM are a hidden population only to outsiders. Among themselves, they have active interpersonal and electronic networks and meet frequently.
4. MSM have multiple sexual risk behaviors: partners of all types, high partner counts, and sometimes sex work.
5. MSM almost never use condoms, whether for anal or vaginal sex.
6. MSM may use drugs in connection with individual or group sex, and some MSM inject.

7. Most MSM do not think they can get HIV because they are convinced their partners are healthy.
8. More than half of MSM cannot accurately identify the ways HIV can be prevented.
9. When MSM have symptoms of STIs, most say they do nothing about it.
10. Some MSM may be using HIV testing as a way to validate and continue their unsafe behaviors
11. Less than half of MSM say they received information on HIV this past year, and it was mostly from the mass media.
12. About 1/5 of MSM believe they might get HIV.
13. Some MSM understand and practice safe sex. They can be useful as peer communicators, and their ideas can help guide the development of messages.

## **BCC Strategy for MSM:**

Based on the audience analysis and the work of the BCC Strategy Consultation and other partners, here are the recommendations for communication with FSWs in the Maldives:

### **1. Develop a discrete MSM project within an existing community organization.**

In countries where homosexuality is illegal, it is difficult to establish an organization to serve MSM. In those settings, one way to begin is for an organization with a strong community-based program, already working in HIV prevention, to develop an MSM project within its ongoing program. This could be an NGO, a CBO or a government organization with a strong community presence, such as the Youth Health Café. Initially, the project could be headed by a woman who knows and understands the MSM community, who respects and is respected by them, and who can speak on their behalf.

MSM should be involved in all aspects of the project, including planning; recommending communication channels, approaches, sites and times for outreach; and collecting information and on-going feedback from the MSM community. However confidentiality is extremely important to MSM, who feel – with some reason – that their social standing, their job security and even physical safety depend on their remaining anonymous. For this reason, all initial contacts with MSM should be discrete. Reports and records should not use real names, to avoid exposing anyone. As time goes

by, certain members of the MSM community may be willing to take a more public leadership role in the work.

**2. Use MSM-friendly media such as internet or Mig 33 to provide HIV prevention information tailored to the needs of MSM.**

MSM already have active communication networks among themselves. Mig 33 and other mobile phone based networks and websites such as facebook offer the possibility of networking for MSM and could also be used as sources of information, discussion, advice and referrals for MSM. An MSM communication project should keep an eye open for other MSM-friendly and confidential channels.

In all Muslim countries, HIV prevention programs face difficulty in communicating openly with MSM because of legal and religious barriers. Fortunately communication does not need to be open to be effective. There are some very good models for MSM communication within the Muslim world. In the Muslim majority country of Kosovo for example, an anonymous MSM organization maintains a website for the MSM community addressing a wide variety of MSM concerns and a men's VCT and drop-in center where MSM feel comfortable. This website offers a way for readers to ask questions and answers requests for information. Many MSM in the Maldives have access to the internet and could access such a site.

**3. Develop print materials, such as pamphlets or pocket books, targeted to MSM to fill knowledge gaps, develop appropriate attitudes, and model safe sex and negotiation skills.**

Research findings and conversations with MSM can provide the basis for messages specific to the questions and concerns of MSM. Targeted materials could include pamphlets or pocket-sized booklets with information about HIV risk, transmission and prevention, the importance of condoms and lubricants, safe injecting and referral for services. Materials can also use fictional characters to model safe sex decisions and condom negotiation.

These materials should be developed with the active collaboration of MSM community members and should be pre-tested among them. MSM programs in some countries where MSM face stigma and discrimination have chosen to keep materials inclusive, referring to all of men's risks, both heterosexual and homosexual. This would certainly make sense in the Maldives where 75% of MSM also have sex with women.

**4. Make condoms and lubricant available in places convenient for MSM, using vending machines or small shops.**

Condoms and lubricant need to be readily available to MSM at places where they are likely to be needed. Condom vending machines have often proven to be a good solution for making condoms more available. Vending machines can be placed in youth hangouts, in men's toilets near cruising sites, and in cafés and restaurants where MSM meet. Normal corner shops could also sell condoms and lubricant.

**5. Select and train peer communicators to circulate discretely in MSM cruising sites with information, condoms and lubricant.**

As soon as they are willing, individual MSM should be integrated into the program as peer communicators. This can be done without public attention. MSM who accept that role can simply circulate in their normal cruising and socializing sites and chat with their friends. Peer communicators can give out materials, answer questions, and distribute condoms and lubricant. Peer communicators should always be Positive Deviants who already practice safe behaviors. *(See box on p. 25)*

**6. Be prepared to provide “damage control” and manage the response to public discussion of MSM.**

Any public campaign on MSM, no matter how carefully it is conducted, will need to be accompanied by damage control – a communication response to adverse public reactions. The response to the releasing of the BBS at the end of 2008 gave a preview of the negative reaction that any public discussion of MSM can engender. Even among institutions actively working to prevent HIV, there were reports of harassment, including increased teasing and labeling. This embarrassed and intimidated some men and was entirely counterproductive to the cause of HIV prevention.

National AIDS bodies, international organizations and NGOs, especially those working with MSM, need to anticipate negative reaction to the public discussion of MSM research or projects and be ready with a damage control plan, including activities at different levels. Within public and international institutions, the highest level of leadership should take a stand against such teasing and labeling, identifying it correctly as a form of sexual harassment and following up, if necessary, with disciplinary action. NGOs should be ready to back up this stand, insisting on the same standards of respect within their own ranks and among the public.

**7. Partner with mass media to portray same sex orientation as part of the range of human sexuality, while advocating for changes in policies and laws that now put MSM in danger.**

The Maldives general population needs to understand that same sex preference is part of the range of human sexuality in all societies, whether or not the society accepts it. Since there are laws against sodomy in the Maldives, this idea runs counter to the Muslim religion and the traditional culture of some islands, and it may be difficult to communicate at first.

However homosexuality has been against the law in many other countries who now regard homosexual behavior by two consenting adults as a matter of individual preference, not subject to law. International experience shows clearly that repressive programs and policies are counterproductive with MSM (as with FSW and IDUs), because they simply drive those behaviors into hiding and make it more difficult to protect the public health. A harm reduction approach applies to MSM, as well as to FSWs and IDUs.

Advocacy could involve sending key officials on exposure visits to places where HIV programs for MSM work without interference, training of media professionals and interviews with MSM activists from other Muslim countries where MSM groups are active. The National AIDS Council should work to decriminalize private sexual behavior involving two consenting adults, while at the same time, systems need to be put in place to protect boys from sexual abuse by men.

**8. Base messages from MSM on ideas expressed by “positive deviants” from within the MSM community.**

Some MSM are already active advocates of safe sex, the qualitative research revealed. These positive deviants offer ideas for messages and approaches that could form the basis of effective communication with MSM. The box on the following page includes some quotes from MSM that promote safe sex.

## ***Promoting Safe Sex: Messages from MSM***

### **If It's Not On, It's Not On!**

*Q: When you sleep with somebody you practice safe sex?*

*"Always."*

*Q: How do you get them to do that, what do you say?*

*"I don't say anything...I just do it. So if they don't want, just get out....You don't want it, but I want it, that's all. I don't do much talking....Sorry, you're not my cup of tea, please leave, there's the door."*

### **Be Prepared**

*"I have always everything with me...whenever wherever I go I carry in my pocket."*

### **Find a Permanent Partner**

*Q: [What about a permanent partnership]?*

*"I think it's one of the best things to do. That they can avoid all possibilities of disease carrying from one to the other. Because when you are settled with one person you know what you're doing, where you have been....If I get a relationship that is dedicated only to me without having relations with others, I can have oral and anal sex without using condoms. So now I'm searching for that, but I don't know how I can get it."*

### **Make Use of Peer Networks**

*Q: So what can we do to support gay guys in this community to be safe?*

*"Find a couple of gay guys and get them to speak together. Find some key people. Peer education, that is the only way we can reach them."*

# Migrant Construction Workers

The Maldives lives on the labor of its migrant workers, about 80,000 of them. Those who work as laborers have particularly difficult lives. The BBS mapping estimated a total of 7,524 migrant construction workers in Male alone, most from Bangladesh. They live in a nearly all-male environment, separated from their regular female partners for a year or more at a time, linguistically isolated and often homesick, with a limited income, much of which is sent home.

Language difficulties are the biggest handicap in communicating with migrant workers. An analysis of the HIV communication needs of migrant construction workers reveals enormous information gaps. Mass media is one-way communication that cannot answer their questions or clarify misunderstandings and is likely to be hard for workers to understand because of the language. Friends are a famously inaccurate source of information on HIV, given to rumors and misinformation. As a result, migrant construction workers know less about HIV than any other group surveyed, and they do not take their risk seriously.

The BBS painted a picture of migrant construction workers as a group at great potential risk of HIV, and qualitative research reinforced that picture. Those who speak neither English nor Divehi are truly isolated in terms of information, including HIV prevention information, and this is reflected in the research findings about them. They simply do not have the information they need to protect themselves from HIV.

Here are the findings on migrant construction workers as described in *Konme Kamevves Vedhaane*.

1. Many migrant workers know very little about HIV and how it is transmitted and prevented, and their linguistic isolation keeps them from being informed.
2. The great majority of migrant workers do not think they can get HIV.
3. Migrant workers have sex with girlfriends or with Maldivian FSWs whom they may meet through drug users.
4. Migrant construction workers have sexual partners of many kinds, and their condom use is very low, even in situations of highest risk.
5. Some migrant workers never have seen a condom; other may not know how to use them.
6. Migrant construction workers get less HIV information than any other group, and most of it is from mass media.
7. Construction workers see being faithful to one partner, not condom use, as the way they can prevent HIV.

# **BCC Strategy for Migrant Construction Workers**

Based on the audience analysis and the work of the BCC Strategy Consultation and other partners, here are the recommendations for communication with FSWs in the Maldives:

## **1. Develop comprehensive workplace HIV prevention programs for migrant construction workers.**

The most logical and efficient way to reach migrant construction workers with information on HIV would be through their workplaces. NGOs can be contracted to develop workplace programs for workers and construction companies can be required to implement them. There are many good models for workplace HIV prevention programs. Ideally employers should sponsor the development of these programs and support the materials and supplies (condoms) needed, but as a minimum they should provide work time and space for HIV prevention communication sessions for their employees. Workplace prevention programs should be held in each of the major languages spoken by the migrants and should be interactive, combining presentation with opportunities for discussion. Support materials, condoms, individual counseling if requested, and referral for STI screening and treatment and HIV testing should be part of the program. Government should consider requiring workplace HIV prevention programs as a condition for giving companies work permits.

## **2. Conduct research with migrants in Bengali and other languages.**

Both the BBS and the qualitative research with migrant construction workers was done in English or Divehi because of the research teams' limitations. Some qualitative research was also done in Nepali. However, research also needs to be done in Bengali, the language of most of the migrant construction workers, and other languages migrant construction workers speak. For example, a Bengali-speaking research team should be engaged to conduct interviews about sexual habits (including MSM), investigate deep attitudes and generate questions and concerns. During this research, words and phrases can be gathered and then used in the development of Bengali language materials.

### **3. Develop targeted print materials for migrant construction workers in all of their native languages.**

Low level literacy printed materials for migrant workers should be developed in all of the migrant workers' languages, using an audience-centered method. This would begin with research with those workers to gather their questions and concerns, as mentioned above. Since many migrants have little education, materials should be designed for low-literacy and should include many illustrations. Materials should cover basic information about HIV transmission and prevention, should make it clear that mosquitoes and sharing food do not transmit HIV, that HIV has no visible symptoms, and that most people with HIV do not know it.

### **4. Encourage migrant workers to develop national associations to meet their needs.**

Qualitative researchers learned that there is a Nepali association that meets regularly and concerns itself with many needs and interests of Nepali migrants. Such associations could be crucial to the wellbeing of migrants who are linguistically and socially isolated.

Migrants from Bangladesh, for example, could benefit from such a national institution, which could also provide a natural platform for HIV prevention and other health-related information and services for migrant workers. Other language and national groups of migrants should be encouraged to form their own associations.

### **5. Organize distribution of condoms and access to health-related services in migrants' gathering spots.**

All migrant workers need easy access to condoms and lubricant. These could be provided through vending machines, at their worksites or living places, or through their embassies or national support groups (once these are formed). They could also be distributed to migrants on the seafront, or near Jumhooree Maidaan where they gather in evenings and on the weekends. Jumhooree Maidaan and the seafront are natural sites for other services to migrants, including distribution of HIV prevention information, HIV testing, and STI screening and treatment. A mobile clinic could be set up periodically to check and treat migrants, provide counseling and HIV prevention information.

### **6. Form an NGO or CBO to serve migrant labor health and welfare needs, including HIV prevention.**

Migrant laborers are a sizeable group with many needs. There is a niche for a civil society organization to serve migrants' HIV prevention and other health and welfare needs. An interested group of individuals should undertake this and receive approval for a migrant workers' NGO, perhaps with support from the UN or government.

# Resort Workers

Resort workers live and work islands of unbelievable beauty, holiday destinations for foreigners who may save for years for a Maldivian holiday. In spite of their lovely workplaces, however, many resort workers are isolated and lonely. There is considerable diversity among resort workers – diversity in terms of income, job status, nationality, working conditions, and opportunity for contacts with guests. In general, the English speaking resort workers enjoy better working conditions than the resort laborers who do not speak English. About half of the resort workers are migrants, who share the pains and difficulties of their brothers, the migrant construction workers. The other half are Maldivians, who enjoy better status, more contact with foreign guests, and greater access to home.

Resort workers who speak English or Divehi are better served with communication on HIV than migrant construction workers, and their knowledge of HIV is correspondingly higher. However resort workers share with construction workers a dangerously low risk perception, very low condom use, and faith in abstinence and fidelity for HIV prevention. Like migrant workers, resort workers live far from their regular partners and may be socially and culturally isolated. Resort workers urgently need appropriate, workplace-based HIV programs, access to condoms and to STI and HIV services.

Resort workers have many risks of HIV relating both to their isolation and to their proximity to resort guests. While the Maldives tests all migrant workers for HIV, it does not test all traveling Maldivians, nor all tourists. The only HIV discovered by the BBS was among resort workers.

Resort workers, as group who live and work together would seem to be easy and obvious audiences for solid HIV prevention education programs. Nevertheless, very few resorts currently have any HIV prevention education or support programs, although a number said they were interested in establishing them, if they had support from the government or NGOs. This is an area urgently calling for a scaling up of HIV prevention activities.

Here are the findings of the BBS and qualitative research on resorts, as described in the comprehensive audience analysis *Konme Kamevves Vedhaane*.

1. Resort workers have many kinds of sex partners: regular partners back home, fellow resort workers, guests at the resort, and sex workers.
2. Job category makes a difference in resort workers' sexual opportunities. Certain categories of employees have more chances to have sex with guests.
3. MSM sex also occurs in resorts, but it is not clear to what extent.
4. Drugs are present in resorts but they are not allowed; if staff are discovered using them, they will be fired, resort workers say.

5. Condom use among resort workers is extremely low with partners of all kinds
6. In spite of their multiple risk behaviors and the fact that HIV was discovered among them, only 94% of resort workers think they cannot get HIV.
7. Resort workers' knowledge of HIV is incomplete. Most don't say consistent condom use is a way to prevent HIV but instead focus on choosing "safe" partners.
8. Resort workers' HIV information needs are not met through the workplace, but through the mass media. Condoms are not always sold in resorts.
9. Some guests encourage resort workers to use condoms, or even give condoms to them.

## **BCC Strategy for Resort Workers:**

Based on the audience analysis and the work of the BCC Strategy Consultation and other partners, here are the recommendations for communication with FSWs in the Maldives:

### **1. Develop and mandate HIV communication programs for resort workers in their workplaces.**

Very few of the resorts visited during the BBS currently offer HIV prevention programs for their staff, however most managements were interested in establishing or improving them. Resorts may have HIV programs at annual events, such as World AIDS Day. However, resort workers need ongoing HIV prevention communication, not only single day events.

Participants in the BCC Strategy Consultation recommended approaching the faculty of HRS to develop a good workplace-based curriculum. Many good models for workplace prevention exist and could be used as a basis. A good curriculum should be interactive and ongoing. It would include live or video presentations, backed up by materials such as brochures and posters, discussion, skills-building, peer communication and counseling.

NGOs may be contracted to conduct trainings for resorts or, in the bigger resorts, a staff health office could take responsibility for implementing it. The costs of resort workers' HIV prevention programmes should be born by the resorts themselves. Government should consider requiring resorts to implement HIV prevention programs for their workers as a condition for operating in the Maldives.

Peer communication is an important aspect of workplace prevention programs, providing skills building sessions, as well as social support and behavior change modeling. Peers need to be trained with a good curriculum with an emphasis on confidentiality. Peer communicators need skills (for

example condom use and negotiation skills, and listening and counseling skills) as well as thorough knowledge of HIV transmission and prevention. Resort management should reward peer communicators with release time from work and recognition for their service to the resort community.

**2. Develop targeted print materials for migrant construction workers in all of their native languages.**

Resorts need a permanent supply of targeted materials on HIV, such as brochures or videos for resort workers in all of their native languages. The content of brochures should be specific to the situation and risks of the resort workers, both Maldivian and expatriate. Materials should be developed by an audience-centered method, starting with qualitative research to gather resort workers' concerns and questions, in their own words. The materials should then be designed and pre-tested with an audience of resort workers.

**3. Provide resort workers with anonymous access to a reliable supply of condoms and lubricant.**

Resort workers need a permanent supply of condoms and lubricant, affordable or free, and available anonymously and at all hours. Workers should not have to go to anyone, such as the health officer, to ask for condoms; this would be very likely to discourage them. Instead, workers should simply be able to pick condoms up discretely whenever they need them.

Ideally, hotel management would provide a supply of condoms free of charge, as an investment in the health of their workforce. If not, condom vending machines could be placed in convenient locations around the workers' living quarters.

**4. Organize regular health camps by mobile teams offering STI screening and voluntary counseling and testing (VCT) for HIV.**

As part of a regular workplace HIV prevention program, resort workers should have periodic access to STI services, including confidential STI screening and treatment if needed, and voluntary, confidential HIV counseling and testing (VCT). Screening and STI treatment and VCT can be performed by mobile teams, with all results given only to the employee. Hotel management should support this service logistically and (ideally) financially, as part of their commitment to a healthy workforce.

**5. Link migrant resort workers to migrant workers' national associations, once these are established.**

As recommended in the section on migrant construction workers above, national groups of migrants should be encouraged to form associations for mutual support, as Nepali migrants have already done. Bangladeshi, Indian, Sri Lankan, Filipino and other national groups of migrants who work at resorts

should be encouraged to take part in these migrants' associations once they are formed. These associations can support migrants in many ways, benefiting the resorts as well as their migrant members.

## **6. Advocate with resort management for policies that will help protect resort workers from HIV and STIs.**

Government can help resorts deal with the potential threat of HIV among their employees by developing best practice models and offering guidelines for policies that will help protect resort workers.

Some of the policies proposed by the BCC Strategy Consultation Workshop participants include:

- Frequent visits to family for resort workers
- Sponsored family visits to the resort
- Information and free services to spouses of resort workers, such as annual medical checkups, including counseling.

# Seafarers

Seafarers were among the first Maldivians to be infected with HIV, and seafarers were included in the research as one of three occupational cohorts of men who were considered as source groups for clients of FSWs. However, the 2008 BBS found no HIV among seafarers. In addition, seafarers had better health-seeking behavior and better condom use than other groups of men. These facts suggest that shipping companies and seafarers training institutions have responded to the early threat of HIV by supporting their seafarers in HIV prevention.

Seafarers are also better informed about HIV than any other group except FSWs. Their knowledge levels are higher in most ways and their condom use with FSWs is much better than any other group studied in the BBS. However, there are still gaps in seafarers' communication re. HIV. Some are not very well-informed. The information they are getting on HIV needs to be reviewed to see if it is accurate and complete.

In addition, in spite of their high condom use, the BBS found that many seafarers do not claim condom use or sticking to one partner as reasons for their low perceived risk, but instead say they are safe from HIV for "other reasons". These "other reasons" were not clearly expressed but it may be that seafarers believe they can choose "safe" partners for unsafe sex. There are many unanswered questions about the HIV knowledge, attitudes and behavior of seafarers that still need to be explored.

In fact seafarers are frequently faced with risk situations, as their voyages take them to places where aggressive sex work is commonplace and HIV is prevalent: Thailand, India, Singapore, Indonesia, Vietnam, Malaysia, Myanmar. As men who live and work together, seafarers offer numerous opportunities for HIV prevention communication.

The comprehensive audience analysis lists the following as findings about seafarers:

1. Most seafarers are married, and many would prefer to work on land, close to their families, but they stay at their jobs because of the high salaries.
2. Sex workers are present in all ports and even come on board the ships in some of the ports where Maldivian seafarers commonly go.
3. No seafarer admitted to having male-to-male sex, but some said they had heard of it.
4. More seafarers say they use condoms than the other groups of men.
5. There are condoms on board all ships, but some seafarers may find it embarrassing to ask for them.
6. The majority of seafarers think they cannot get HIV, but their reasons were not always clear or convincing.

7. Most seafarers do not say they think that consistent condom use can prevent HIV. This may be due to a lack of knowledge or to moral judgments they may make about condoms.
8. Seafarers say they treat their STIs 100% by going to medical practitioners.
9. Sixty percent of seafarers got HIV information last year – the highest of any group in the BBS – but that leaves 40% still not served.
10. Seafarers like to watch movies and play cards together, providing an opportunity for HIV prevention education.

## BCC Strategy for Seafarers

**1. Review the communication materials on HIV for seafarers to see if the information is accurate, complete and correctly focused. Based on that assessment, revise materials or develop new materials.**

Seafarers get more HIV-related information than almost any other group in this strategy, but there still seem to be some gaps in their knowledge, and 40% of seafarers still get no HIV information. It would be best to start by reviewing the HIV-related information most seafarers are currently receiving to see if it is accurate, complete and correctly focused, as well as available widely. If not, materials need to be revised, or new ones developed.

The BBS research findings suggest some gaps in seafarers' present knowledge and attitudes about HIV. For example, seafarers may believe that “not changing partners often” offers enough protection against HIV so condoms are not important. They may have ideas of how to “be careful” or “not take risks” re. HIV that are not accurate. The lack of clear statements about condoms suggests that they may need more specific information about prevention.

Seafarers' communication needs to be clear and focused, including the following messages:

- *If you have more than one sexual partner, you must use condoms every time you have sex, no matter who that partner may be. There is no other way to protect against HIV.*
- *It is impossible to choose a safe partner for unsafe sex by looking, asking or guessing*
- *You can't see who has HIV, and most people who have it don't know it.*
- *There are only 3 reasons to think you can't get HIV: 1. no sex, 2. sex with only one faithful uninfected partner, or 3. using condoms every time.*
- *Some men have sex with other men, anal sex is very risky and condoms and water-based lubricant must be used every time.*
- *There is no possibility of casual transmission of HIV (mosquitos, sharing food.)*

**2. Review, and if necessary, strengthen the HIV curriculum in the maritime education programs.**

NAP should also review existing the existing HIV curriculum in the maritime education and training programs and recommend revisions as needed. All trainings on HIV should include information on drug injecting, STIs and VCT, as well as male-to-male sex. They should avoid vague formulas such as “stick to one partner” and should instead provide specific guidance re. safe sex, including condoms, and safe injecting. NAP should offer oversight and provide technical support for the training of seafarers.

**3. Advocate with ship’s captains and officers to accept HIV communication programs and condom promotion on board ship.**

Seafarers reportedly get HIV prevention information in short courses before embarking. However, seafarers spend most of their working lives either on board ship or at ports away from the Maldives, so shipboard HIV programs may also be needed. Captains and ship’s officers must be convinced of this – this may require some advocacy. It may be helpful to begin with some key informant interviews to find out their concerns; advocacy communication can then be developed. Testimonials from other captains and examples of shipboard programs may be useful. Once they agree, ship’s captains and officers, as well as some seafarers should be involved in developing ship-board HIV programs.

**4. Develop HIV communication programs for use on board ships, including targeted communication materials and condom distribution.**

There are a number of models of HIV prevention programs on board ships, including educational sessions supported by brochures, pamphlets and posters, peer communication and counseling. Audio or video programs can also be developed, where HIV prevention information or persuasive messages promoting condom use are interspersed with music or comedy. TVM, VTV, VHITV or radio channels can help develop these CDs or DVDs to distribute to shipboard programs. Models for effective shipboard education can be adapted based on programs in other seafaring nations, or they can be developed specifically for the Maldives by government or NGOs.

## **5. Ensure a good supply of condoms on board ship.**

Shipboard HIV prevention communication must be supported with condom distribution. Condoms should be distributed anonymously on ships, either made freely available or sold through condom vending machines placed on ship. The BCC Strategy Consultation Workshop participants suggested condoms be made available in the mess room.

## **6. Develop interactive HIV trainings for shipping companies and their seafarers when in port.**

In addition to shipboard education, seafarers need a strong, basic orientation to HIV prevention before they embark. The NAP, an NGO or CBO could develop an entertaining, interactive workshop curriculum for seafarers and conduct trainings for seafarers on behalf of shipping companies or other seafarers' organization.

These trainings should not be limited to lectures or presentations but should be based on interpersonal communication to teach condom use and negotiation skills, refocus seafarers' perceived risk on condom use, and build social support for condom use with all non-regular partners.

In some port cities,<sup>9</sup> the government requires shipping companies to train all workers in HIV at least once yearly as a condition for their license to use the port. A local NGO is contracted to do the trainings. This benefits the shipping company, the seafarers and the NGO.

## **7. Conduct outreach to seafarers' partners.**

Participants in the BCC Strategy Consultation Workshop proposed that HIV prevention communication for seafarers be extended to their families, especially their wives. A curriculum for a short training for seafarers' wives could include basic HIV transmission and prevention information, opportunities for discussion and problem solving, and condom use and negotiation skills. The training should be offered to seafarers' wives on a voluntary basis.

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<sup>9</sup> For example in General Santos City in the Philippines.

# Youth

Youth were included as a group at risk in the BBS and the qualitative research, not because all young people have risky behavior (although some definitely do) but because youth is the source community for all the other Maldivian groups at risk. Preparing all young people to face the challenge of HIV now makes sense.

The BBS and the qualitative research found evidence of some very high risk behavior among youth, ranging from injecting drug use to group sex and even sex work, combined with very low condom use and an extremely low perceived risk of HIV. Youth as a whole need to be better oriented to HIV prevention. Moreover, youth culture is shared to a large extent, so the shared knowledge, attitudes and perceptions of today's youth about HIV risk and behavior will make a difference to the Maldives' future health. All of this makes youth in general an important target audience for a BCC strategy for HIV.

Here are the chief findings of the comprehensive audience research about youth:

1. Sexually active youth may have many partners – a median of 5 a year – but they use condoms only occasionally, and only to avoid pregnancy, not disease.
2. Youth don't use condoms for disease prevention because they “trust their partners” - They don't understand the concept of sexual networking over time, and they don't realize that most people with HIV don't know they have it.
3. Sexual abuse is common, young women say. Many report they were abused sexually when they were very young.
4. Some young people go to sex workers, and a few do sex work themselves. In most cases, condoms are not used.
5. Some young people take part in group sex, often involving drugs or alcohol.
6. Although they say STIs are rare in the Maldives, youth reported higher rates of STIs than any group in the BBS except for the FSWs, and half say they don't treat them.
7. Most young people believe they won't get HIV because it is so rare in the Maldives.
8. Youth think of HIV as a disease of “others” who are different from themselves (e.g. drug addicts, those who go abroad or have sex with foreigners). They may believe what they consider “normal” behavior is safe from HIV, even if it is not.
9. Most young people are keenly aware of drug use, even if they do not use drugs themselves.

10. Young people had the lowest and least specific knowledge of HIV prevention and transmission of any Maldivians in these studies.
11. Youth who believe they are at risk may reassure themselves by having an HIV test rather than changing their behavior.
12. Only half the youth are getting HIV information, and most of it is from television, school or friends.
13. Young people want HIV information from a variety of media, including television, the internet and specialized doctors.
14. Only a few young people advocated or modeled safe behaviors.

## **BCC Strategy for Youth**

The following recommendations for communication for youth were developed:

### **1. End the ban on discussion of condoms in mass media and interpersonal communication with unmarried youth.**

The single most important action that could be taken to protect Maldivian youth from HIV (as well as STIs and unwanted pregnancies) is to end the present ban on discussing or showing condoms in mass media and public venues where unmarried youth may be present. All HIV prevention work in the Maldives is seriously hampered by the restrictions on mention and availability of condoms. This policy is based on a mistaken concept of youth as sexually inactive and sexually naïve, and also on the false assumption that frank discussion of sex and availability of condoms promote sexual activity. In fact both research and worldwide experience prove that in societies where sex is discussed openly and condoms are available, young people tend to delay the start of sexual activity.

### **2. Create more opportunities for youth to discuss sexuality both in and out of school.**

Youth need more than information about sexuality; they need to develop their own ideas and values about their sexuality. They need to opportunities to talk with friends about standards and norms of sexual behavior, determine their own sexual values and develop the skills and confidence to uphold them.

One response to this need has been Life Skills. Life Skills programs, available in many schools, offer youth a chance to clarify their values, including values about sexuality. However many teachers are reported to be so uncomfortable with the units that deal explicitly with sex and HIV that they skim over them or even omit them. So that these crucial units are well conducted, interested teachers need

better training. Where teachers are not comfortable, trained facilitators need to be invited into schools to lead those sessions.

Life Skills programs could also be organized for youth out of school. A greater variety of communication opportunities exist outside of school. Channels suggested by the BCC Strategy Consultation team on youth include street plays by youth volunteers (for example from the Youth Health Café), and discussions with trained peer communicators as facilitators.

### **3. Give youth information on reproductive health using innovative and entertaining channels.**

Youth in the Maldives don't know enough about reproductive health in general, including HIV and other STIs. The BCC Strategy Consultation team on youth recommended a number of ideas for innovative and entertaining channels through which young people could learn about reproductive health. For radio and television, these included short dramas (specific to the culture), forums, panel discussions, spots, animations, documentaries and songs. In magazines and newspapers, the participants recommended articles, columns, jokes, puzzles cartoons, comics, ads, messages. Live music shows and street plays, posters, placemats, coasters and calendars were also recommended.

The team recommended that the CCHDC, NGOs, the Youth Health Café, NCA, CBOs and Atoll Level Youth Centers develop and deliver communication on reproductive health to youth. Role modeling is an important aspect of communication for youth, so those who carry out the campaign should be comfortable talking about sex and prepared for frank discussion of reproductive health issues.

### **4. Make mass media communication on HIV more specific about risk, including serial monogamy, casual transmission and male-to-male sex.**

The BBS research shows that all groups at risk, including youth, get their information on HIV primarily from the mass media, especially television. HIV communication in the mass media frequently deals with generalities and euphemisms, such as “stick to one partner” –**get wording from prev. Maldivian campaigns** this may be why so many groups explain their low perceived risk of HIV by “not changing partners frequently,” when research shows that many have several types of partners. Such generalizations do not clearly explain what must be done to avoid HIV, especially in a country where serial monogamy is the norm. One partner *at a time* does not prevent HIV. Unless condoms are used, only those with one mutually faithful, uninfected partner is safe.

Another common misunderstanding was about casual transmission. Many Maldivians, including youth, were not aware that you cannot get HIV from mosquito bites or sharing food. Finally, the risks of anal sex with either a man or a woman need to be covered in all communication about HIV for information to be complete. Since so many rely on it, mass media communication on HIV needs to be much more specific and accurate.

This could be accomplished through two strategic approaches: 1) by training journalists and other media professionals in complete and accurate HIV information, and 2) by NAC developing guidelines and then overseeing mass media communication on HIV.

**5. Advocate for policy changes that will protect the sexual health of the youth, including STI checkups for unmarried women.**

The BCC Strategy Consultation Team on Youth recommended advocating for changing laws and policies in ways that protect young people’s sexual health. At present, unmarried women cannot legally be given gynaecological checkups for STIs although many are sexually active and they cannot legally obtain contraceptives. As a result, unmarried women who develop STIs or fall pregnant must either leave the Maldives for STI treatment or abortions, or, if they cannot afford to travel, must resort to self treatment for STIs and desperate and dangerous illegal abortions at home. In addition, pregnant school girls lose their right to attend school, whether or not they give birth.

The BCC Strategy Consultation Team on Youth recommended a complete turnaround of this policy, with free gynaecological checkups, and access to treatment and contraception to all women.

The BCC Strategy Consultation team on youth also recommended a change in the present policy restricting young people’s access to condoms. The team recommended easier access to condoms of all kinds, including flavored, colored and ribbed, to make them more attractive to youth. Condoms should be placed where they can be accessed easily: in cafés, halfway houses, youth centers, the Youth Health Café, as well as in health centers, pharmacies, and vending machines.

**6. Train a cadre of youth peer communicators to promote safe behaviors, building on the ideas of those few young people who already show positive attitudes towards prevention or promoted safe behaviors.**

The research found that very few young people were at all sensitized to the HIV and the need to practice safe behaviors. “Positive deviants” who modeled or advocated safe sex behaviors (except for abstinence) were rare among the youth. This research revealed very few examples of sexually active youth who used or encouraged others to use condoms, for example. This means that to make use of peer communication, a group of youth will have to be trained in HIV prevention basics. A single example follows of a sexually active young man who advocates condom use:

***Promoting Safe Sex: Messages from Youth***

Sexual abstinence and no use of drugs is the best prevention for HIV. A good number of youth in the BBS sample were not sexually active yet, and therefore were safe – but for how long?

Among the sexually active youth, there were very few examples of young people advocating safe behaviors to prevent HIV’

*“I use condoms because of two main reasons: first obviously if it’s a girl, it’s pregnancy. I am scared because of that. And then there are so many addicts and stuff, we don’t know what the hell they are carrying inside of them.”*

- Male Young Man

# Final Words

*"People say there is no use trying to change the world. But if we don't try, will it change?"*  
- Jonathan Mann

Dr. Jonathan Mann, the inspirational first Director of the World Health Organization's Special Program on AIDS (the grandparent of today's UNAIDS) often talked about the fundamental changes required in a society to meet the challenge of HIV. True to Mann's vision, this communication strategy urges some fundamental changes in the way the Maldives has approached the risk of HIV and those most at risk for HIV.

This BCC strategy asks the Maldives to acknowledge the presence of a previously ignored population – men who have sex with men – and find a way to meet their urgent need for protection against HIV. It asks the Maldives to admit that the country has some responsibility for populations previously viewed as other countries' problems – the various national groups of migrants who work in the Maldives and face HIV risk here. It also encourages the Maldives to look critically at young people and the information on HIV and the forms of protection now available to them. Finally, it urges the Maldives to take a hard, fast look at the effects of the punitive strategies now used to deal with the groups most at risk – arrested drug users and sex workers who hide to avoid arrest or deportation. Do these punitive approaches ultimately protect the public from HIV, or do they endanger the public further?

In short, this BCC Strategy challenges the Maldives to look carefully at its current HIV prevention program in the light of the recent audience research and ask two crucial questions: "Is it appropriate?" "Is it enough?"

A communication strategy is only as strong as the will that goes into carrying it out. It is possible to put a BCC strategy document such as this on the shelf and go back to the business of HIV prevention as usual. It is also possible to use a document such as this as a catalyst for needed change.

The Maldives' good fortune in avoiding HIV up to now has been remarkable. But it is not carved in stone that the Maldives will remain a low prevalence country. Neighboring countries have seen their HIV status change, often dramatically and in a very short time, due to the same risk behaviors revealed in the Maldives by recent research. The last question is the most important this BCC Strategy asks:

Will the Maldives take action in time?

## Appendix A

### List of Participants in the BCC Strategy Consultation Workshop Dec. 3, 2008

	Name	Position	Organization
1.	Mohamed Iruisham	Lance Corporal	Maldives Police Service
2.	Fathimath M???,	Lance Corporal	Maldives Police Service
3.	Mirfath Faiz	Sub Inspector	Maldives Police Service
4.	Animath Leena Ali	Sergeant	Maldives Police Service
5.	Aly Adyb	Advocacy Officer	Journey
6.	Ahmed Najeeb	Chair Person	Paradigm
7.	Ibrahim Mahir	Member	Journey
8.	Ahlan? Rauf		Maldivers Diving Centre
9.	Aishath Ibrahim	Director	Ministry of Health & Family
10.	Mohamed Rashid	Program Coordinator	Drug Rehabilitation Services MOH
11.	Ahmed Adam	Vice Chair	Journey
12.	Ismail Fayaz	Peer Worker	Journey
13.	Mohamed Basu	Peer Worker	SWAD
14.	Ibrahim Shaz		Paradigm
15.	Mohamed Nashwaan Ismail	Program Manager	Society for Health Education GF
16.	Mariyam Naadha	BCC Officer	National Narcotics Control Bureau GF
17.	Aminath Sheron	BCC Officer	MOH CCHDC GF
18.	Abdulla Adam	CCM Secretary	MOH CCHDC GF
19.	Rifua Rasheed	Finance Officer	MOH CCHDC GF
20.	Fathimath Niha	Program Assistant	MOH CCHDC GF
21.	Aminath Mirfath Ahmed	Program Manager	MOH CCHDC GF
22.	Ramsha A. Sattar	BCC Officer	Society for Health Education GF
23.	Aminath Nawal	Finance Associate	UNDP GF
24.	Uzma Abubakur	Team member	Qualitative Research Team GF
25.	Ahmed Gaveem		UNFPA
26.	Paula Bulancea		UNICEF
27.	Aishath Zahira	Commonwealth Youth Ambassador	Ministry of Youth



## APPENDIX B: Recommendations of BCC Strategy Development Consultation Workshop, Dec. 3, 2008

<b>IDUS: What do they need?</b>	<b>How can it be achieved?</b>	<b>FSWs: What do they need?</b>	<b>How can it be achieved?</b>
Information	<ul style="list-style-type: none"> <li>• Peer outreach organized by NGOs</li> <li>• TV and radio by government</li> <li>• Advocate for policy change</li> </ul>	IEC for awareness	Mass media (advocate for condom use)
Access and availability of clean needles (Needle Exchange Program)	<ul style="list-style-type: none"> <li>• Drop-in centers</li> <li>• Outreach through Mobile NEP</li> <li>• Training for pharmacists</li> <li>• Drop-in centers</li> </ul>	<ul style="list-style-type: none"> <li>• Skills building : Condom demonstration and lubricant use</li> <li>• Skills building: Communication skills</li> </ul>	Through peer communicators
Access to condoms and lubricant	<ul style="list-style-type: none"> <li>• Vending machines in public bathrooms</li> <li>• Shopping centers</li> <li>• Peer outreach</li> <li>• Commercially available</li> <li>• Drop-in centers</li> </ul>	Sensitization on safe practices	Conducted through outreach programmes to the general women's population
VCT/STI services	<ul style="list-style-type: none"> <li>• Strengthen existing services</li> <li>• Coordinate w/ implementers, referral</li> <li>• Mobile STI/VCT services</li> </ul>	Condom access	Outreach programmes (NGOs & civil society to guest house, cafes, massage parlours, etc.
Oral substitution treatment (Methadone)	<ul style="list-style-type: none"> <li>• Expand existing Methadone Treatment Center / services</li> </ul>	Legal rights	Vending machines or free distribution
Attitude change for IDUs	<ul style="list-style-type: none"> <li>• Outreach to IDUs</li> <li>• Self-help programs</li> <li>• Support groups</li> <li>• Treatment programmes</li> </ul>	<ul style="list-style-type: none"> <li>• Legalize SW or</li> <li>• Tolerance (decriminalization)</li> </ul>	Policy advocacy
Awareness of services for IDUs	<ul style="list-style-type: none"> <li>• Proper coordination, referral</li> <li>• Mass media</li> <li>• Outreach</li> <li>• Youth program</li> <li>• Advocacy</li> </ul>	Empowerment and opportunities for women	<ul style="list-style-type: none"> <li>• Vocational skills</li> <li>• Training</li> <li>• Soft loans</li> </ul>
Public awareness and attitude change re. harm reduction	<ul style="list-style-type: none"> <li>• Mass media information about harm reduction</li> </ul>	Counseling and rehabilitation services	By the MMT clinic and Rehab
Supportive environment for comprehensive service delivery	<ul style="list-style-type: none"> <li>• Publicize survey findings</li> <li>• Advocacy /awareness</li> </ul>	STI Screening services, including proper checkups for unmarried women.	<ul style="list-style-type: none"> <li>• Free, discounted prices for checkups</li> <li>• for the general population</li> <li>• Screening for STIs if confined</li> <li>• Mobile vans equipped for STI checkups</li> </ul>
		VCT	<ul style="list-style-type: none"> <li>• More outlets or at health centers</li> <li>• Outreach to promote VCT</li> </ul>
		SW association to gather group support	Can operate as an NGO to fight against stigma, discrimination and call for the protection of women at risk.

## MSM:

### What do they need?

Advocate for more open information on HIV/AIDS and STI, universal access to condom distribution

#### Media campaign

- BBS findings
- Maldives situation
- Condom usage / lube pros & cons

Condom availability/ access/ usage

### How can it be achieved?

National AIDS Council, advocacy with government (civil society and the Global Fund), meetings and workshops.

#### Media by NAP, GF and civil society:

- TV – infotainment
- Radio – ads
- Internet – youth based sexual and reproductive health sites
- MIG 33 – MSM specific group
- Posters – IEC

A fear-based campaign on all media (ads, teledramas, PSAs) NAP, GF, civil society

#### Advocacy by NAP, GF, civil society:

- Advocacy for normal corner shops to sell condoms
- Condom machines at youth hangouts
- Health centers, clinics have focal points on sexual and reproductive health,
- Sex shops????

## Migrant Construction Workers

### What do they need?

Information

Medical

Construction worker NGOs or groups with representation from the construction workers

Access to condoms

Policies and protocols

### How can it be achieved?

Initial stage, multilingual, through recruiting agency and government

- Check ups/ VCT by Government
- Counseling /followup by NGOs
- Mandatory classes – Recruiting agency
- Fliers in their languages
- Survival kits (toothbrush, soap, condoms, messages) – Construction companies

Provide information, IEC, with illustrations  
Hot lines  
Support groups by nationality

Through embassies, vending machines, guest houses.  
Someone to distribute near Jumhooree Madaan  
Through construction companies

Policy level sensitizing  
Health system strengthening  
Advocacy

## Resort Workers:

### What do they need?

Knowledge / information

- HIV transmission, prevention
- Drugs

Skills

Testing

Condoms

Policies

Services

### How can it be achieved?

- Pamphlets, posters in living quarters and in Male office
- Clips / documentaries
- Trainers, peer educators among resort workers
- Expats provided with materials in own language
- Approach faculty of HRS to develop a module on HIV prevention for trainees
- Work with companies for continuous training in the workplace

- Counseling on HIV/ST provided by peer counselors or specialized professionals
- Skill building sessions

Mobile teams (resorts to cover logistics and payment)

Free placed in living quarters (dispenser) also in Male (pay toilets, etc.)

Arrange frequent visits to family or family visits to resorts  
Develop best practice models (pilots)  
Provide information and free services to spouses (annual medical check-ups, including counseling)

Family planning services and counseling and information on PMTCT

## Seafarers:

### What do they need?

Leaflets and other informational materials in several languages

Condoms

Job security (?) [more access to regular partners]

Workshops on local ships

Medical check ups

Strengthening the existing HIV/AIDS in educational programs in maritime trainings

Media/ advocacy programs targeted to Seafarers

Educate family members (wife, kids)

VCT awareness programs

### How can it be achieved?

Distributed through the shipping company, in port and/or on board.

On board ships, easy accessibility (e.g. in the mess room), with an awareness program

Advocate for more home leave.

Provided through NAP or NGOs

Awareness / policy of mandatory regular checkups.

Constant supervision [oversight?], support by NAP. These programs [should] include drugs, STIs, VCT

TVM, VTV, VHITV, Radio, etc.

Focusing on outreach to family members

NAP

## Youth:

### What do they need?

### How can it be achieved?

Skills

- Life skills education in and out of school
- Use peer educators for special target groups
- Street plays by youth volunteers (Youth Health Club)
- Pamphlets, posters, placemats in restaurants
- Role modeling

Information on reproductive health

- CCHDC, NGOs, Youth Health Café, NCA, CBOs and Atoll Level Youth Centers
- Short dramas on radio and TV, culture specific
  - Programs (forums, panel discussions, spots, animations, songs, documentaries)
  - Magazines, newspapers – articles, columns, jokes, puzzles cartoons, comics, ads, messages
  - Street plays
  - Posters, placemats, coasters, calendars
  - Role modeling
  - Music shows

Access to condoms, assorted, ribbed, etc.

- CCHDC
- Cafes, restaurants, public toilets
- NGOs, halfway houses, youth centers, Youth Health Café
- Health centers
- Pharmacies
- Vending machines

Peer support groups

Use peer educators as facilitators

Reduction of stigma

Awareness, information

Access to reproductive health services

- Regular gynaecological checkups (Youth Health Café)
- Free testing and medication

# The Steps of Change



Who is your Target Audience?  
 What barriers are they facing?  
 What do they need now?

**What is Needed:**

Specific messages developed by the community to counter each barrier effectively

**Typical Barriers:**

Low perceived risk  
 Gender expectations  
 Negative Images  
 Low self-efficacy  
 Stereotypes  
 Religious beliefs  
 Denial, Refuges  
 ...and many more

**What is Needed:**

Correct information from a source the target group finds credible

**Typical Barriers:**

No facts  
 Incorrect facts

**What is Needed:**

Exposure to the innovation

**Typical Barriers:**

No awareness  
 No exposure

**What is Needed:**

Access  
 Logistical support  
 Social support

**Typical Barriers:**

High Cost  
 Difficult access  
 Fear of negative social reaction

**What is Needed:**

Skills  
 Successful experiences

**Typical Barriers:**

Bad experience  
 Faulty product  
 Lack of skills

**What is Needed:**

Social Support  
 Reinforcement

**Typical Barriers:**

Low social support  
 Misinformation

**Confirmation**

**Trial**

**Decision to Try**

**Attitude Formation**

**INTERPERSONAL / PEER COMMUNICATION**

**Knowledge**

**MASS MEDIA**

**Awareness**

Steps of Change developed by Barbara A. K. Franklin, PhD  
 All One Communication,  
 based on Diffusion of Innovations  
 research findings. 2009



