

THE HIV/AIDS SITUATION IN THE REPUBLIC OF THE MALDIVES IN 2006

**National HIV/AIDS Council (NAC),
Ministry of Health of the Maldives
and the UN Theme Group on HIV/AIDS**

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
CCM	Country Coordinating Mechanism (for GFATM proposal)
DPH	Department of Public Health
GFATM	Global Fund on HIV/AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
MATI	Maldives Association of Tourism Industries
MOE	Ministry of Education
MOGFA	Ministry of Gender and Family Affairs
MOH	Ministry of Health
MOT	Ministry of Tourism
MOTCA	Ministry of Transportation and Civil Aviation
MSM	Men who have sex with men
NAC	National HIV/AIDS Council
NNCB	National Narcotics Control Bureau
NSP	National Strategic Plan on HIV/AIDS
PLWHA	Person living with HIV/AIDS
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNTG	United Nations Theme Group (on HIV/AIDS)
WHO	World Health Organization

Foreword

So far, the Republic of the Maldives has seen a very low level of HIV infection, especially when compared to neighboring India and some other Asian countries. While the Maldives must be pleased with this situation, there is no time for complacency.

This situational analysis report, conducted by DPH/MOH with support from UNICEF and WHO, shows high levels of HIV vulnerability in the country. Especially in the capital but also in the outer islands, injecting drug use – through which many HIV epidemics have started in the region – is on the rise. An economy and society characterized by mobility and gender imbalances further fuels the potential for HIV to spread.

In order to address HIV thoroughly and to make sure the Maldives is spared from an epidemic that has engulfed parts of India, Southeast Asia and China, it is imperative that we take a thoughtful and humane approach. It is important that the existence of risk behaviors in our country – including the increasing incidence of injecting drug use, premarital sex among the young, sex between men and commercial sex – is acknowledged. Following the current assessment, the new national strategic plan on HIV/AIDS in the Maldives should outline ways to better address the needs of people engaging in risk behaviors, so that we will guarantee that our current status as a low-prevalence country is continued.

I further hope the National Strategic Plan will help the health system prepare for better care and support facilities for people living with HIV/AIDS.

I hope that the process of formulation of a new, multi-sectoral strategic plan to prevent HIV/AIDS in the Maldives, which will follow the approval of this situational analysis document by the National AIDS Council, will be truly inclusive – incorporating the voices and needs of a wide group of Maldivians who are at risk of HIV/AIDS, as well as public health, tourism, education, gender, law enforcement officials and religious leaders.

Dr Abdul Azeez Yoosuf
Deputy Minister of Health

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Background

This situational assessment was commissioned by the UN Theme Group on HIV/AIDS, funded by UNICEF and WHO, to support the Ministry of Health's Department of Public Health (DPH), as part of the National HIV/AIDS Council, in the development of a new multi-sectoral National Strategic Plan on HIV/AIDS for 2007-2011, as a follow-up to the current National Strategic Plan (NSP) that was developed in 2000.

The objectives of this document are first, to update the situational analysis conducted in 2000, taking into account the changes that the Maldives have undergone since then; second, to review ongoing responses to HIV/AIDS in the country; and third, to provide basic recommendations for initializing new, expand or strengthen existing interventions, as a first step in the forthcoming strategic planning process.

This review was conducted in the context of the globally agreed UNAIDS Policy Position Paper on Intensifying HIV/AIDS Prevention, which is particularly relevant to the Maldives' situation – characterized by high risk and vulnerability and low prevalence. It also links to the recently completed and approved Seventh National Development Plan 2006-2010 and the 2006-2015 Health Sector Master Plan.

It should be stressed that apart from the efforts of DPH in the development of this document, it has drawn information and inputs from a wide range of sectors and actors, including the Ministry of Education, the Ministry of Gender and Family Affairs, the Ministry of Tourism, the Ministry of Transportation and Civil Aviation, the Ministry of Youth and religious, business and civil society organizations.

In Part One, the report reviews the HIV/STI situation in the Maldives. It will give an overview of the HIV/STI epidemiological situation, followed by a discussion of risk behaviors in the Maldives and an overview of factors enhancing vulnerability to HIV/AIDS. This part includes a discussion of possible scenarios for the further development of the HIV epidemic in the country.

In Part Two, the policy context is discussed, including the structure of the National HIV/AIDS Council and policy documents that provide guidance to the forthcoming National Strategic Plan.

This is followed in Part Three by a review of responses to HIV/AIDS by Government, UN, NGOs and other actors.

In Part Four, an analysis of gaps in the response to HIV/AIDS is presented, based on a comparison of the situation outlines in Part One and responses described in Part Two and Part Three.

In Part Five, 29 recommendations are presented, meant as feedback for the development of a National Strategic Plan later in the year.

The following methods were used for the compilation of this report:

- 1 Review of documents, reports, epidemiological data and research findings
- 2 Key informant interviews with Government and NGO staff
- 3 Focus group discussions with persons vulnerable to HIV¹
- 4 In-depth interviews with persons with risk behaviors
- 5 Exploration of hidden population networks through the internet, and internet chats with members of hidden populations
- 6 Field visits and observations

In Annex 1, an overview of people met is provided. In Annex 2, a list of documents reviewed and referred to is given. In Annex 3, there is an overview of the Maldivian health system. In Annex 4, there are two case studies of hidden populations interviewed for this assessment. In Annex 5, three 'case study scenarios' for the future of HIV/AIDS in the Maldives are presented, and two scenarios are sketched for the possible evolution of the epidemic in the country.

¹ In this report, a distinction is made between 'people at high risk of HIV/AIDS' and 'persons vulnerable to HIV/AIDS'. A person at high risk of HIV/AIDS is a person who has sex with multiple partners without using condoms (including MSM and sex workers), or sharing needles when injecting drugs (Injecting Drug Users, or IDU). A person vulnerable to HIV/AIDS is somebody who is more likely to be exposed to HIV/AIDS (for instance, by being sexually involved, knowingly or unknowingly, with persons at high risk) or engage in risk behaviour(s) than a person who is not vulnerable to HIV/AIDS.

Part I: The HIV situation in the Maldives

The Republic of the Maldives is an Islamic country situated in the Indian Ocean, close to India and Sri Lanka. It consists of nearly 1,200 islands and atolls, of which around 200 are inhabited. In addition, there are around 50 officially inhabited islands that have been developed as tourist resorts.

According to preliminary 2006 census data, it has a population of nearly 300,000. 104,403 Maldivians live in the capital Male', which is built on an island sized only 1.8 square kilometers, making it one of the most densely populated places in the world (i.e. 58,000 persons per km² excluding migrants). The annual population growth rate is 1.7%; in Male', however, it was 5.7% between 2000 and 2006, meaning the population of the capital grew by almost 50% since 2000 (Population Census report, 2006). Only 3 other islands have a population of more than 5000 people; an additional 12 islands have between 2000 and 4999 inhabitants.

According to the Ministry of Planning, there were 38,413 migrant workers in the Maldives in 2004; most of them work in lower-paid jobs in the construction and tourism industries, but there were also 2,316 expatriate teachers working in the education system. More recent data indicate the number of foreign migrant workers is now closer to 50,000. Despite this, un(der)employment among the Maldivian population is high. Most people work in Government positions, fishery and tourism; around 1200 are employed as seamen for local and international companies (MOT, personal communication).

There are primary schools in all inhabited islands; lower secondary schools are only in the larger islands, with only 3 higher secondary schools outside Male'. Literacy rates and primary school enrollment rates are high (MOE, personal communication).

1.1. Epidemiological overview

Prevalence of HIV/AIDS

The first HIV-positive case in the Maldives was reported in 1991. Until mid-2006 a cumulative total of 13 HIV -positive cases have been reported among Maldivians and 168 cases among expatriates; in 2005 and the first half of 2006, no new cases have been reported. Of the 13 HIV-positive cases reported among Maldivians, 10 were seamen, two were the spouses of these sailors, and one was a resort worker who traveled abroad with a foreign tourist. Eleven of the 13 cases were male.

All infections were reportedly acquired through heterosexual route of transmission; despite the high level of drug use and the increasing popularity of injecting drug use, no needle or syringe related transmission has been reported so far.

It was noted by the Ministry of Transport that the reason most HIV positives were seamen was because of the thorough screening policy that is in place for this group; all seamen are medically tested before getting a permit to work.

Of the 13 HIV-infected, 11 developed AIDS; of these, ten have died and one is currently on antiretroviral treatment. As of 31 December 2005, 168 HIV cases were found among expatriate workers aged 15-55; between 1 January and 30 June 2006, 15 HIV cases were detected among foreign expatriate workers. Their visa / work permit applications were denied.

Awareness of HIV/AIDS

In a 2004 reproductive health survey supported by UNFPA, 99% of the sample had heard of HIV/AIDS, and 91% knew at least one way of HIV transmission. However, this included 69% of those who responded who said that 'respecting religious tradition' was a way of preventing HIV; this probably means monogamy and / or abstinence, but the survey did not make this clear. Only 50% agreed that condoms can protect against HIV and 34% did not know that a healthy looking person can have HIV.

Sexual behavior

No behavioral surveillance has been conducted in the Maldives to monitor sexual risk behaviors and condom use; however some data on sexual behavior has been collected as part of other research.

In a sub-sample of youth in the above-mentioned reproductive health survey, 14% of males and 5% of females under the age of 18 admitted to having been sexually active. Of those who were sexually active 45% never use condoms. It should be noted that the response rate for under-18 year olds was only 42%, varying from 100% in some islands to only 12% in Male.

Most likely, considering the taboo on young people's sexuality in Maldivian culture, young people with sexual experience are much more likely to refuse participation in a survey about reproductive health than young people without sexual experience. The above mentioned percentages are therefore likely an underestimate. This conclusion is shared by key informants, who report that most young people in the age of 14-20 are sexually active, with very high estimated percentages of sexual activity for both men and women.

Thalassemia

The prevalence of Thalassemia is high in the Maldives. Nearly one out of five Maldivians carries the genetically determined Thalassemia trait. Thalassemic patients undergo frequent blood transfusions, which is the most efficient way of HIV transmission. However, thus far no transfusion-associated HIV infection has been notified in Maldives, and recently steps have been undertaken to prevent this from happening.

Tuberculosis

Tuberculosis is not a major health problem in the Maldives. According to the National TB Program, 123 TB cases were reported in 2005; the trend of TB cases is stable. Part of the reason for this low number could be the stigma which is commonly attached to this disease, which could lead to underreporting of TB. Application of DOTS is widespread in the country. According to WHO, the Maldives have achieved the objectives of the Global TB targets since 1997. 1 of the 13 known HIV cases was diagnosed and treated for TB in 2004.

Sexually transmitted infections (STI)

Syndromic STI reporting indicates that the prevalence of STIs is low. In 2005, a total of 141 ulcerative STI were reported and 169 men reported with discharge, in all public health facilities. There is lack of information on the completeness of reporting, in particular with respect to private clinics and practice. In addition, more people may have asymptomatic STIs. A laboratory-based survey conducted at IGMH and regional hospitals in 2002 found the prevalence of gonorrhoea or Chlamydia infection among pregnant women to be 10%². However, the sample size of this study was small and the results can not be generalized to the entire population.

The above mentioned reproductive health survey, conducted with support from UNFPA in 2004 as a follow-up to a previous survey in 1999, found that 68% of health care workers said that STIs were 'very rare' in the Maldives. The proportion of the sample who could mention at least one sign of STI rose from 35% in 1999 to 48% in 2004. Knowledge about STI transmission also rose: 90% could mention a method to prevent STI. The proportion of people who said they would access a health facility if they had an STI symptom rose from 86% in 1999 to 96% in 2004. Despite this finding, as experienced in other South Asian countries, it is possible that due to stigma and a perceived lack of confidentiality, STIs may often not be reported to the health authorities, number of STI treated in private clinics and practice and people may self-treat STIs through buying drugs from pharmacies and / or seeking treatment in clinics abroad.

1.2. People engaging in risk behaviors

Injecting and other drug use

Several key informants reported that the prevalence of drug use (cannabis, hashish, glue, 'cologne' and heroin) is on the rise, and that injecting drugs is becoming more common. The National Narcotics Control Bureau (NNCB) reports that the estimated population size of drug addicts is 3000. Research conducted in 2004 indicated injecting was practiced by 8% of drug users. Research currently in progress is indicating the figure today may be as high as 20%. Key informants in Male' estimate that nearly a quarter of drug users there are estimated to be injecting drug users (NNCB, personal communication). These data have been extrapolated from the number of drug users caught by the police multiplied by a factor based on the estimated percentage of drug users that is caught by the police. The majority (90%) is male. About 20% are less than 20 years of age. Injecting sometimes starts early;

² Ministry of Health, Republic of Maldives. A study on reproductive tract and sexually transmitted infections, 2002.

cases are known of children starting as early as 9-12 years old (NNCB, personal communication). The NGO Journey estimates that the percentage of drug users caught by the police is much lower than the NNCB thinks, that their extrapolation is therefore an underestimate, and that the true number of drug users is closer to 8000 (Journey, personal communication).

In Addu, the Southernmost atoll, where different key informants reported that between 30 and 70% of young men and few women are using drugs. Injecting drug use was growing there too, but not rapidly; it was estimated 10% of drug users (i.e. 37% of the male population of the islands) inject drugs in Addu, which is less than in Male'.

Most drug users appear to be concentrated in Male' and in Addu, but drug users can be found in all islands. The most common drug used is brown sugar (smoked heroin or inhaling with a pipe – i.e. 'chasing the dragon'). Heroin is easily available in Male'; several key informants mentioned heroin can be bought "everywhere". Prices fluctuate; 1 gram of heroin currently costs nearly 1000 Rufiyaa (80 USD). The approximate daily need for an addict is half a gram, sometimes more. Recently it appears the Government has cracked down on drug dealers, with the number of incarcerated drug dealers on the rise. As a result, the price of heroin has risen and drug users are more tempted to inject drugs than to inhale.

Some drug users are from higher income families and can afford the drugs; other drug users have to resort to crime, including drug dealing, in order to finance their addiction. Some drug dealers reportedly have started involving children as drug dealers, since children can not be sentenced to jail sentences. Female drug users – of whom there are fewer than males – are apparently sometimes involved in sex work. Key informants who are former drug users report that many male addicts also have sex with female addicts, and 'pay' them with drugs. Sex also occurs between male drug users themselves, whether or not in return for drugs; 3% of sexually active drug users reported same-sex experiences in the UNDP assessment of drug use conducted in 2002.

The number of recreational or 'part-time' drug users is not known. Recreational drugs are cannabis and hashish, but also heroin and alcohol. Drug use among resort workers is considerable; in contrast to the rest of the country, alcohol is also easily available in the resorts, and some resort workers are reported to use alcohol frequently. Despite the fact that needles and syringes are widely and cheaply available in pharmacies (the price of a syringe and needle is only 6 Rufiyaa or 0.52 USD), key informants report that needle sharing occurs frequently.

Pharmacists sometimes refuse to sell syringes to people who do not have a prescription for medicines, for unclear reasons.

It appears that rising prevalence of injecting drug use, combined with the practice of needle / syringe sharing, is the most likely entry point for the HIV epidemic in the Maldives at present (see Scenario 1 in [Annex 5](#)). The fact that some migrant workers are also addicts, and that some seamen inject drugs as well – let alone the possibility of foreign visitors

sharing needles with local drug users – all provide possible avenues for HIV to enter the circuit of Maldivian drug users. In many countries (Thailand, Vietnam, China, India), prevalence levels of more than 40% have been reported in less than 6 months after the introduction of HIV in IDU circuits that were previously unaffected; this is a definite possibility in the Maldives as well, though its relative isolation also provides unique opportunities for prevention. See [Annex 4](#) for a case study of a female drug user who was also involved in sex work.

Sex work

Not without reason, sex work is often jokingly referred to as ‘the oldest profession in the world’. Supplying sex for money, food or favors has been part of human survival strategies for centuries; so has the demand for sex, mainly among men. Despite sex work existing in all countries in the world (without exception), in almost all countries it is also considered illegal.

In the Maldives, especially in Male’ and in resorts with all-male labor populations, with overwhelmingly male populations who are either unmarried or away from their wives or girlfriends, latent demand for sex services – both among Maldivians and migrants – must be considered large. Based on key informant interviews and observations, it can be derived that there are several forms of sex work found in the Maldives, similar to the situation in other countries:

- Individual sex workers: In Male’ there is a small number of women who offer sexual services – either because they are poor, or because they simply want to live a better life with a higher level of consumption. They charge around 250 Rf per customer, and sex takes place in cheap guesthouses. They serve mainly immigrant workers, but also local Maldivian men. According to key informants, in all islands with a population of more than 500, there are one or two women working as sex workers. The entire population of the island is aware of this; and likely, many men living on the island have at one or more occasions slept with these women, either to gain sexual experience while teenagers, or in instances of extramarital sex. Often the women have several children conceived by different men. They are heavily stigmatized, and often live slightly out of sight; men make sure they are not seen near their house during daytime. Seamen often know these women on each island and visit them, as was reported by key informants on Addu Atoll.
- Second, there are networks of ‘middle men/women’ who have telephone numbers of several women and whom customers call to arrange for sex. These networks include foreign prostitutes, who come to the Maldives on visa runs from their usual location of work in Sri Lanka and India; they stay for 30 days to make money here, and then return to their usual work place. There are women from Sri Lanka, India, but also from Southeast Asian countries and even some from Russia and Eastern Europe. Many return on a regular basis. They base themselves in guesthouses, and their arrival is often pre-announced to a network of customers. Maldivian women charge 250 Rf up; foreign women charge 500 Rf or more per customer; as a result, their clients are mainly middle and upper class Maldivian men. They do not go outside to look for customers but rely on middle men/women for this. According to a

female former drug user, some drug using sex workers are provided drugs – not money – in exchange for sex with men by female pimps, of whom there are about 3 in Male’.

- Third, there are a few venue-based sex work establishments. All-out brothels or go-go bars do not exist in the Maldives. However, over the past years, several massage parlors have opened in Male’; some focus on massage only, but most of them also offer sex services. Usually the price for a massage is 200 Rf; if sexual services are required, the price rises to 500 Rf or more. Some of the parlors employ women from the Philippines, Thailand and other countries, but most employ Maldivian women. In recognition of the fact that many massage parlors are used as ‘fronts’ to cover sex services, politicians have passed a law banning all 38 massage parlors from August 1st onwards. There continue to be certain restaurants and teahouses in Vilingili and near the harbor-front where women can be found for sex work. Furthermore, a few women who are part of dance troupes that entertain tourists in resorts must be considered vulnerable to engage in sex work, key informants reported.
- Male sex work seems rare. However, one 13-year old and one 14-year old boy were found who reportedly have sex with men in exchange for money, for as little as 30 Rf. The boys estimated there are about 10 more boys in a similar position in their quarter. Sex takes place in cheap guesthouses around the cities, and customers are mainly port laborers.

Despite moral or other concerns, the lesson learned in many countries is that it is almost impossible to suppress demand for and supply of sex work; the challenge is to find societal support to separate the moral question about the desirability of having sex work in society from the public health question of how to make sure these behaviors do not lead to a major HIV epidemic. Religious leaders can provide moral teachings to try to reduce the demand for sex or drugs; meanwhile, for those who ‘stray’, the public health sector should work with representatives of this hidden population to prevent HIV transmission, by increasing levels of knowledge and skills, provision of condoms and improved access to health services.

When closing them down, if experience in other countries is anything to go by, these establishments will reopen in another form, be it restaurants, tea houses, foot massage, karaoke or hair dressing saloons. The importance of telephone networks will likely grow too, especially since the number of Maldivians who own mobile phones is growing rapidly.

Male to male sex

Sex between men occurs in all societies and cultures. All informants asked about homosexuality during this review answered that the phenomenon exists in the Maldives. There is no hard data on the prevalence of male-to-male sex in Maldivian society; the only figure is the UNDP survey among drug users, in which 3% of drug users admitted to same-sex experiences. Based on information obtained from key informants, it is likely that the following five forms of homosexuality occur in the Maldives, similar to other countries:

- Male to male sex between teenagers: as part of growing up, boys may explore their emerging sexuality by playing ‘games’ with each other, for example while having a shower (see case study below). These games usually involve mutual masturbation,

but sometimes also oral and anal sex. Key informants estimate at a large proportion of Maldivian men experience this form of same-sex behavior when they are young.

- Similar to the above, male to male sex between men in all-male environments can occur for similar reasons: when men are away from their wife for a long time, some turn to each other for 'sexual relief'. Migrant workers in resorts, immigrant workers working in construction or other jobs in Male and seamen living in all-male accommodations are possible examples. They see this behavior as a form of 'play' or of 'sexual relief' rather than as 'homosexuality'.
- Male to male sex in which exchange plays a role: sometimes, especially poor and young men (sometimes men in acute need of drugs) have sex with other men in exchange for money, drugs or certain favors. Little evidence of this form of homosexuality was found in the Maldives, except for the two boys who sold sex (see section above).
- According to scientific literature, between 3 and 5% of men have exclusive or overwhelming homosexual orientation / desire, meaning that they are 'structurally' sexually attracted to other men. This category of men may prefer to remain unmarried, although in Islamic countries, family expectations and societal pressures may lead them to get married and start their own family. According to key informants, in the Maldives 90-95% of men with homosexual orientation do get married. Being married does not prevent them from continuing their sexual activity with men. Many of these men find partners through social networks, and increasingly by using the internet.
- A very small number of men are born with the natural inclination to be a female; often they are called 'transgenders'. The difference with the group above is that these men have a desire not only to have sex with other men, but also to be (accepted as) women, and perform female functions in society. 3 to 5 transgenders were observed in Male'; the situation in other islands is not known.

In the Maldives, all these forms of homosexuality exist. Since homosexuality is illegal, it happens underground and largely unmarked and unnoted. Despite this, small social networks of MSM were found, and 185 entries of Maldivian men were found on one well-known gay dating website. One key informant, who was 21 years old, had met about 27 people using the internet; he had had sex with one of them. Another key informant who was 23 years old had met 5 male sex partners through the internet, including one man who would become his partner for six months. He had also met several 'friends' who were not sex partners. Many MSM were married. Maldivian MSM are constantly afraid of disclosure; they keep two strictly separate lives. Often they move away from their villages on the islands to Male', or from Male' abroad to study or work, to escape societal and family scrutiny.

Levels of condom use are reportedly low; one young MSM engaged in an internet chat did not know that anal sex could transmit HIV. The four other MSM interviewed for this assessment did not use condoms consistently; the two young male sex workers mentioned in the section on sex work had never heard about HIV/AIDS and had never used condoms with their customers. One other MSM, who had been involved with western gay men and

had traveled abroad, seemed to have better knowledge of how HIV is transmitted. See [Annex 4](#) for a case study of one of the MSM interviewed.

1.3. Factors enhancing vulnerability

The vulnerability-enhancing factors discussed in this section apply disproportionately to adolescents and young people in the Maldives. According to the Ministry of Planning and UNFPA, the proportion of the population younger than 15 has begun to decline from the level of 45% it reached in 2000, while the number of adolescents in the 10-19 year age group is currently at its peak (MOP/UNFPA 2005). Many of the factors discussed below amplify each other, and make that a larger percentage of adolescents are at risk of HIV/AIDS in the Maldives than adolescents in other countries in the region.

Globalization and the growing influence of money and consumption

The Maldives is developing fast, and outside influences, especially on young people, through media, internet and commercial outlets are more persuasive than ever before. With rising incomes (GDP per capita rose from 1407 USD in 1994 to 2261 USD in 2003³), mobile phones, motorbikes and electronic equipment are becoming more important – especially for urban youth; as a result, making, having and spending money become more important. Given urban poverty, boredom, peer pressure and lack of employment opportunities, the lure of ‘escaping’ into heroin use is very real; connected to this, many people start dealing drugs or engaging in crime in order to make money. According to key informants, the ‘sugar daddy syndrome’ seen in Africa is also starting in Male’ – rich(er) older men engage in sexual relations with teenage girls, in exchange for expensive gifts or money (Youth Café staff, personal communication).

The frustration and even despair arising from the gap between the ambitions, materialistic desires and aspirations of young people on the one hand and the lack of formal employment, healthy entertainment opportunities and education opportunities on the other hand must be seen as important vulnerability-enhancing factors for young people, increasing their likelihood to engage in risk behaviors, including crime, drug abuse, sex work and premarital sexual relations.

Related to this, it appears that the gap between standards of living in Male’ and in the other islands is widening. This leads to more people migrating to Male’, which in turn further increases the gap. Some key informants in this assessment mentioned that prices are rising in Male’ and that problems of crowding and poverty are on the rise.

Gender inequality

Although inequality of the sexes in the Maldives is less severe than in some other South Asian countries, Maldivian women are still not treated equally when it comes to reproductive rights. For example control of married women over contraceptives is often limited. Domestic violence and sexual violence against women is prevalent in the Maldives. Child sexual abuse occurs too, in 80% of the cases involving girls. With many social changes occurring in the Maldives recently, apparently leading to more vulnerability,

³ Source: Statistical Year Book of Maldives 2004, in: MOP/UNFPA 2005

especially of young men and women, a small but growing group of youth turns to more conservative forms of Islam, in some cases aiming to turn back some of the progress in women's empowerment made over the past decades (Ministry of Gender and Family Affairs, personal communication).

High levels of premarital sex

Apart from the UNFPA-supported reproductive health survey, which likely underestimated the level of premarital sexual activity due to methodological pitfalls (i.e. no self-reported questionnaire and possibly as a result a very high refusal rate), no data on levels of premarital sex were found. Without exception, however, key informants interviewed in all groups and in all professions reported that most young people are sexually active before they get married. This was the equally the case for men as for women. Despite moral taboos, there seem to be few constraints on young people's sexuality in everyday life.

Low levels of condom use, especially among single people

There is high awareness in the population about HIV/AIDS, but due to perceived linkages of HIV to immoral behaviors or 'bad people', perceived 'self-risk' is low. As a result, condom use is low, too. Condoms are available at pharmacies at a price of 10 Rufiyaa (USD 0.80) for 3 pieces; however, only 12% of young people who admitted to be sexually active reported to 'always' use condoms in the 2004 reproductive health survey. Condom use among men having sex with men is low, too; some were not aware that HIV could be anally transmitted. The Government allows free distribution of condoms, but only for family planning to married couples.

According to key informants, some young people use withdrawal as a technique to prevent pregnancy. Abortions occur when things go wrong; there are illegal places where abortions are conducted, informants report; for better and safer abortions the wealthier would travel abroad.

Mobility and migration

The Maldives is a country characterized by high levels of internal and external movement of the population. About 1,200 Maldivian men work as officially registered seamen for transportation companies; several thousand more work as fishermen (fishermen are not registered). Thousands of Maldivians leave the country each year to further their education abroad, or travel as businessmen or tourists. It is well known that when people leave their family or their community, decreased social control, loneliness and new opportunities and desires may lead them to engage in risk behaviors which they would not engage in at home. In the case of tourists, some may actively search destinations where they can engage in activities that are forbidden or frowned upon at home, without social consequences.

The Maldives has a big (around 50,000), mainly male, population of labor immigrants, especially in Male', employed in low-paid jobs that Maldivian people find unattractive; most of them are from Sri Lanka, Bangladesh, India and Nepal. Their living quarters are often even more crowded than those of local Maldivians; they literally have to sleep in shifts, and

they have few rights. Some of them work 7 days per week and many complain that wages are paid late or not at all.

There are significant communities of Maldivians living abroad: the biggest group of them in Trivandrum, India numbers around 5,000 and similar numbers live in Sri Lanka. There is frequent travel back and forth to the Maldives. Newspaper reports mention that some Maldivians are involved in behaviors that may put them at risk of HIV there.

Furthermore, there are hundreds of traders that come into the Maldives for short periods of time, on an almost daily basis, to sell vegetables, foods and other goods at the market. Some of them, after making a good profit on their sales, may look out to engage a sex worker before returning home abroad. Since these are not residents of the Maldives, this group is not tested for HIV.

Unequal sex ratios

Partly due to internal migration and mobility, there are huge differences in sex ratio (i.e. the number of males per 100 females) within the Maldives. In the resort islands the situation is most extreme: 8,869 Maldivian males are employed there, versus 215 females, giving a sex ratio of 4,115 men per 100 females (Preliminary Population Census data, 2006). Considering the fact that all resorts except one are on otherwise uninhabited islands, and most migrant workers have time off only once per year, most of them quite literally live in a 'world without women'. In Male' the sex ratio is 103 males per 100 females, but this excludes a number of an estimated 25,000 migrants in Male' alone, most of whom are male; if we assume 95% of migrants are men, the sex ratio in Male becomes around 150. In the administrative islands, on the other hand, the sex ratio is 85 and population growth is negative. This may facilitate sexual contacts between men.

The main reason for the unequal sex ratio across the Maldives is male labor migration to other islands on the one hand, and mostly male immigrant workers seeking lower-paid jobs in construction and services on the other hand.

Tourism

In the past, the Government has attempted to separate tourists from locals, probably in order to avoid some of the negative consequences of tourism found in places like Sri Lanka, the Philippines and Thailand. However, this system of 'tourism apartheid', where resorts on uninhabited islands were encouraged, and 99% of tourists not even staying in Male' or any other Maldivian settlement, has contributed to major work-related migration of (mainly male) Maldivians to the resorts, creating unequal sex ratios and a range of social problems within families and communities. Recognizing this, the Government is now planning to build more resorts in islands where Maldivians live, so that families can stay together and live around the resorts (7th National Development Plan 2006-2010). This will bring along new vulnerabilities for the communities surrounding resorts.

Despite reports to the contrary by the Ministry of Tourism, five former resort workers were asked whether sexual relations occur between resort workers and tourists; all said this happened "if we have a chance". One key informant added that some men working in the

resorts had sex with each other in the staff quarters; alcohol (which is easily available in the resorts, in contrast to the Maldivian-inhabited areas) was widely used and drugs are available as well.

Multiple partnering pattern: (re)marriage and divorce

Divorce rates and remarriage rates are high in the Maldives. In 2005, 3400 marriages were recorded, and 1161 divorces (Statistical Pocketbook 2005:16) Part of the reason, according to key informants, is that sexual relations are only 'legal' when in the context of marriage; as a result, people get married quickly, and divorce often, whereas in other countries these relationships may occur without marriage. High rates of sexual partner change increase the vulnerability to HIV in the context of marriage. Divorce and divorced women are not stigmatized in Maldivian society. 21% of both men and women gave 'infidelity' as the reason for divorce in a survey (RLP/MOY survey 1995, quoted in Jenkins 2000). Only 8% of marriages end due to the death of a spouse. The age of first marriage seems to be increasing for both men and women. However, according to key informants, by far most couples are sexually active before, or without, getting married. The cultural pattern of early marriage with rapid remarriage predates the Maldives' conversion to Islam. A proportion of divorced couples apparently remarry again, so that women end up having 3-4 marriages to 2-3 men over their lifetime. Similar marriage patterns are found among island societies in the Pacific, and may be related to the constrictions of atoll life and matrilineal social structures, which predated patrilineal social structures currently in place in the Maldives (Jenkins 2000:9). In 2001, a new Family Law was introduced, and divorce rates started dropping gradually. However, in 2005 a steep rise in divorces was recorded, for unclear reasons – possibly related to social turmoil following the tsunami (Ministry of Gender and Family Affairs, personal communication).

Crowding

In Male', over 130,000 people (including foreign migrants) are crammed in 1.8 square kilometers of space. There are few high-rise buildings – and those that are there have a maximum height of 9 floors. Rents for a one-room apartment are at least 350 USD per month; as a result many young people report sharing a one room apartment with four or more other people; stories of seven family members in one room are not uncommon. Families from outer atolls sometimes send their children to Male' as a group and share the costs of a one-room apartment between them. Key informants report that psychosocial problems and stress occur as a result; risky behaviors could also result from this, especially if supervision of young people is limited.

Stigma and discrimination

High levels of fear and stigma in a society are major obstacles to encourage HIV testing and counseling in the population. If VCT uptake is to be improved, it is important to gain insight in this. Although drug use was seen as a bad thing by everybody interviewed, levels of stigma against drug users appear to be decreasing with the increase of the number of families with a drug user in their midst. While on the one hand drug users report that 'family members do not accept us'; on the other hand, most drug users are staying with their families and taken care of, and are not kicked out of the house. Levels of disapproval of sex work are high, but everybody seems to know one or more people involved in it, and sex

workers appear able to do their work without harassment. Officially premarital sex is still frowned upon, but virtually all informants in this assessment estimate that a large majority of the young are already sexually experienced when they marry. The highest stigma was found towards MSM.

Silence and taboos about sexuality

As in many other Islamic and other societies, issues surrounding sexuality, especially sex work, premarital / youth sexuality and homosexuality are not openly discussed. Levels of knowledge about reproductive health and about sexuality are low (UNFPA, personal communication). Many young people are in the dark about developments going on in their bodies, and can get panicky about sexual feelings emerging during adolescents. The telephone counselors at the Youth Health Clinic reported young people calling to them with very basic questions about reproductive health and sexuality, and the 2004 Reproductive Health survey also reported gaps in knowledge about these areas.

Piercing habits

Apparently there is a growing habit among some people to pierce body parts in beauty parlors around Male' and possibly elsewhere as well. It is not known to what extent piercing instruments are sterilized properly.

Part II: Policy, leadership and management

2.1 Policy structure

National AIDS Control Program and National AIDS Council

A comprehensive AIDS Control Program was launched in 1987 with the aim of limiting the spread of HIV in the country. The President's Office formed a multi-sectoral representative body, the National AIDS Council (NAC), to provide direction to National AIDS Control Program (NAP). The Department of Public Health was given responsibility to implement the 2002-2006 National Strategic Plan, under guidance of the National HIV/AIDS Council, which consists of the following stakeholders:

Government:

Ministry of Health, Department of Public Health, Ministry of Defense and National Security, Maldives Education Development Center, Ministry of Transport and Civil Aviation, Ministry of Construction and Public Works, Ministry of Foreign Affairs, Ministry of Tourism, Ministry of Atolls Administration, Male' Municipality, Supreme Council for Islamic Affairs, Television Maldives, People's Majilis

NGOs:

Society for Health Education, Foundation for Advancement of Self Help in Attaining Needs and Kunduhulhudhoo Island Development Society

Private sector:

Maldives Association of Tourism Industries (MATI)
Maldives National Chamber of Commerce (MNCC)

The NAC last met in 2005, and it met in July 2006 to discuss this assessment report. It is important that it conducts more regular meetings, and that its membership is expanded to include the UN Theme Group Chair.

2.2 The broader policy environment

National Strategic Plan 2002-2006

The current National Strategic Plan was developed in 2001. Its goals were to prevent HIV transmission in the country and to build the country's capacity to respond effectively to the possible spread of HIV/AIDS.

Apart from the above mentioned goals, the objectives of the plan included:

1. Sustain high level political commitment and an integrated response at various levels, including the community
2. Provide adequate care and support for PLWA
3. Promote safe practices and behavior among target groups
4. Decrease the prevalence of STI
5. Decrease social and economic impact

The NSP's strategies include better surveillance, improve the evidence base for policy making and programming, developing tools for behavior change programs and empowering young people in and out of schools with knowledge and life skills.

Despite aiming to be multi-sectoral in nature, the Department of Public Health developed it largely in isolation from other NAC members. About 35-40% of the activities and strategies in the work plan, especially those that were to be implemented by the health sector, have been implemented, according to key informants. Apart from lack of non-health sector involvement, lack of funds was reported as a reason for the low implementation rate.

National Reproductive Health Strategy 2005-2007

The Government of Maldives recently developed the National Reproductive Health strategy. It states that reproductive health is a crucial component of general health. There are seven thematic areas, with one being on sexually transmitted infections and HIV/AIDS. The goal of this thematic area is to maintain the current low prevalence of STIs and HIV/AIDS in the Maldives. The three objectives are to (1) strengthen the diagnosis and treatment facilities at the central, regional and atoll levels for STIs including HIV/AIDS, (2) increase awareness among men, women and adolescents on STIs and HIV/AIDS from current levels and (3) increase use of condoms for STI/HIV/AIDS prevention. The interventions include the use of condoms for dual protection (family planning and STI/HIV prevention) to be specifically targeted to young men.

Seventh National Development Plan 2006-2010

The 7th National Development Plan was recently developed. The Social Development section of this document aims to increase enrolment in secondary and tertiary education, and improve services for the most disadvantaged and vulnerable children. Importantly, it also outlines strategies to decrease youth unemployment and improve entertainment and recreation facilities for young people, and outlines ways to promote healthy lifestyles (NDP 2006:115-123). The document provides ample opportunity to improve HIV/AIDS and sexual health related knowledge and skills needed among vulnerable youth, and should be used as a guiding document in the development of the next NSP on HIV/AIDS.

National Education and National Health Master Plans 2006-2010

The Ministry of Health has recently completed its new five-year Master plan; the Ministry of Education is in the process of doing so. Both plans provide a 'policy umbrella' for more specific policy and programmatic actions that can reduce the vulnerability of young people and reduce risk behaviors among particular groups in Maldivian society. The MOE has also approved a National Policy on School Health in 2004, which refers to HIV awareness activities as well as life skills.

Millennium Development Goals

The Maldives has signed up to the Millennium Development Goals, agreeing to have halted by 2015, and begun to reverse the spread of HIV/AIDS. The Maldivian Government's progress report mentions as a main challenge 'to ensure sustained low prevalence of HIV/AIDS in the country', and commits to collect evidence on sexual behavior of high risk groups and plan and implement targeted interventions for these groups. It also commits to

strengthen the active surveillance system following international standards, improve access to condoms and promote VCT (MDG Maldives Country Report 2005).

Part III: Actors and responses to HIV/AIDS in the Maldives

3.1 Health sector responses

For an overview of the structure of the Maldivian health sector, see [Annex 3](#).

Testing and counseling

In line with the NSP of 2002-2006, HIV testing facilities have been made available at all 54 blood transfusion services outside of Male in 6 regional hospitals, 10 Atoll hospitals and 38 health centers. In Male there are four HIV testing facilities in the IGM Hospital, National Thalassemia centre and two private hospitals.

HIV tests in use are three different rapid tests most commonly used, ELISA and radio-immunoblot. HIV diagnosis in symptomatic and asymptomatic suspects is made based on three positive test results using rapid test as the first test and ELISA and rapid test as confirmatory tests.

In Maldives, voluntary, informed and confidential HIV testing with written consent is recommended. Any positive HIV is notified to the Department of Public Health (DPH). The National AIDS Programme in the DPH will ensure strict confidentiality of this data and will use it only for the purpose of program planning.

- ANC attendees: at the current low level of the epidemic, sentinel surveillance among women attending ANC is not recommended by WHO, at least not as a surveillance strategy. Nevertheless, all pregnant women are screened for HIV along with VDRL and hepatitis B. Contrary to WHO and UNAIDS guidelines, there is often no pre-test and post-test counseling. According to Government guidelines, written informed consent is obtained prior to testing of all antenatal women.
- Self-referred clients seeking Voluntary Counseling & Testing (VCT): five VCT centers have been established in Maldives. According to key informants, there is very low demand for VCT.
- Drug users: No HIV testing is offered to drug users.
- Closed settings/institutions: No HIV testing is offered in prisons. HIV testing is provided to clients entering drug treatment centers, as a routine test – informed consent is usually, but not always, obtained.
- Pre-employment HIV testing: Several international employers require HIV testing as part of pre-employment medical examination. The national labor regulations require the testing of sailors and other expatriate workers. The Ministry of Transportation reported that all 1200 seamen working internationally are registered and will obtain a permit to work if they can show a health certificate less than 90 days old and proof of passing four health related 'exams', of which HIV is part. Any foreign person is seeking employment in Maldives is being tested for HIV as part of pre-employment medical examination. If they are found positive, their employment application is denied.

In contrast to the national policy stipulating written consent for all HIV testing, according to key informants this is not always followed. In IGM Hospital, around 30 to 50 tests are performed per day for pre-operative screening and screening during ANC (along with Hepatitis B and VDRL). Staff reported that these tests are sometimes performed without informing the patient. The patient does have to pay 50 Rf (100 Rf for foreigners) for screening test. Other tests are done for work permits for expatriate workers who cannot produce a complete medical including HIV test result. Only around two HIV tests per month are sent from VCT. The practice of testing Maldivians who return after having lived abroad for more than 1 year has recently been abolished. VCT is free.

In the Addu Regional Hospital written consent is always obtained. The majority of clients do consent about the HIV test. Only one to two per year decline in antenatal clinic and none of those tested for pre-operative screening refused to be tested during the past year.

There are no CD4 counting machines in any central or regional hospital. One PCR machine has been placed in IGM hospital.

Sexually transmitted infections

STIs constitute a major public health problem worldwide. The impact of these diseases is magnified by their potential to facilitate the spread of HIV. An STI surveillance system acts as an early warning system of HIV infection rates in low-level HIV epidemics, allowing for HIV interventions to be put in place early. In the Maldives, surveillance of STIs consists of universal syndromic STI case reporting, sentinel etiological STI case reporting and a cross-sectional community-based STI survey repeated every 3-5 years. The annual syndromic reporting of sexually transmitted infections has been strengthened in 2004. Treatment for STIs is prescribed in health centers and hospitals, but cases are rarely reported.

Promotion of a safe blood supply

An estimated 6500 blood units are transfused per year, mostly for chronic anaemia in Thalassaemia patients. There is currently no national blood transfusion policy. The development of a national blood transfusion policy has been initiated by the Government with the support of WHO in 2006. Transfusion Transmitted Infections (TTI) screening for HIV, hepatitis B, hepatitis C and syphilis are mandated in all health care services under the Ministry of Health. TTI screening for donor blood in all blood transfusion centres in the Maldives is performed by rapid tests which are not recommended. This is due to the small numbers of donors to be tested at a time and the need for screening all blood quickly case by case.

There are two central blood banks in the capital city; one is at the National Thalassaemia Center (approx 30 transfusions per day) and the other one at the Indira Ghandi Memorial (IGM) Hospital. It was reported to the review team that the blood bank facilities are not well utilized. For example, in IGM Hospital only 7 units are currently stored. The six regional hospitals have been equipped with storage facilities (capacity for 40 units each). However, the frequency of transfusion approximates only one to two per year. Four Atoll hospitals will receive storage facilities by the end of 2006. A separator for blood components is available. Specialists in transfusion medicine or haematologist are not available in the Maldives.

Thalassemia seems to be the only major haematological disease. All of these factors result in lack of blood component requirement and preparation.

Providing adequate quantities of safe and quality blood is a major concern for all levels of blood banks in the Maldives. At present almost all the blood supply is from direct donations using replacement donors. Most of the Thalassemia patients recruit their own donors, often from their own pool of blood donors. However, a stock of blood supply should be maintained to cope with emergency needs for blood transfusion in certain conditions such as GI bleeding, postpartum hemorrhage, complicated surgery and DIC.

The donors are screened through a risk assessment questionnaire. However, these procedures are not standardized. It has been reported that family replacement donors may feel under pressure to donate and may therefore hide aspects of their health and lifestyle, which could mean that their blood is more likely to contain infection. Therefore WHO does not recommend the use of replacement donors.

After cross matching of donor blood with the recipient blood the donor is screened for HIV, VDRL, Hepatitis B and C.

A major constraint is timely blood donation and transportation of units.

Reproductive health care

Antenatal care for pregnant women is widely available across health centers in the islands and in Male'. Screening for HIV and other diseases is standard procedure. Sexual health uptake for other groups in Government health centers is limited, with few STI cases found or treated by the health sector. The NGO Society for Health Education runs a free reproductive health clinic in Male and makes regular visits to the islands for ad-hoc free health care. Most doctors and nurses are volunteers. Contraceptives are available for married couples.

Care and support for people living with HIV/AIDS

Currently there are 3 people with HIV alive in the Maldives; one of them is on antiretroviral treatment, which is provided for free at the Indira Gandhi Memorial Hospital. The other two are still healthy and are working as seamen.

3.2 Prevention activities

Drug use prevention and rehabilitation

From the Government side, currently there are two drug rehabilitation sites, one in Himmafushi island, serving mainly Male', consisting of three parts: a drug rehabilitation centre with 58 inmates; a detention centre with 78 inmates a special center for children without any clients (personal observation and communication 26 July 2006). Another centre with 30 places is located in Addu Atoll. There are plans to increase the capacity to 50 places by the end of 2006 to deal with growing demand.

Drug detoxification is both voluntary and involuntary. In the rehab center, there are three phases for the drug users. First is the detoxification phase, in which drug users are

deprived of drugs; they are not given substitute drugs to relieve the pain of detoxification, but are given painkillers. After the detoxification phase, which lasts 3 to 4 weeks, the clients enter the rehabilitation phase in the facility, which lasts 6 to 9 months, depending on progress. This program is based on the concept of the 'therapeutic community' and the ex-addicts are subjected to a full daily program, with 5-times-a-day prayers and moral teachings. While there is attention for other than moral issues, there is little or no attention for issues related to the mechanisms and workings of addiction, for safe needle use (this could be considered, considering the high rate of relapse), or for the often negative peer pressure ex-addicts face upon return from rehab, which may lead to relapse. Some ex-addicts have reported to benefit from religious teachings, which helped them to stop. Others are less religiously inclined, and need other approaches. After this phase, they enter the 'pre-entry' phase, during which they are working in the rehab center or following some of the activities, but they do not have to follow the full rehab programme. This phase lasts anywhere between 1 and 6 months. Then they re-enter the community, and are forced once a day but with gradually diminishing frequency, to come to sign and random urine tests at the 'halfway house' in Male' or Addu. The clients are followed up to 12 months in this way. Nevertheless, the relapse rate is more than 65%. Out of those who drop out, 15% are during early phase and 50 % during early detention and the remaining 35% during the later follow-up phase. Initial findings of a UNICEF supported survey indicate that relapsed addicts are not monitored carefully when they provide urine, and that they sometimes submit somebody else's urine or even any fluid that looks a bit yellow rather than their own urine.

Harm reduction principles, such as promoting inhaling drugs over injecting or promoting needle replacement, are not supported in the Government program. However, some education about HIV is sometimes provided. Ex-addicts reported that counselors do not know much about the psychological and social workings of addiction and peer pressure, and that they do not understand them. Parents also need to learn more about addiction and how to deal with it (Yakita/UNICEF research, preliminary findings, p.15).

The provision of free clean injecting equipment to addicts is not allowed in the Maldives; however syringes and needles are widely available in pharmacies, with no questions asked. There are ongoing discussions on the introduction of oral substitution treatment.

An NGO, called Journey, has been established by ex-drug addicts about six months ago. The NGO is running a drop-in center and conducts outreach to drug addicts; it is also involved in prevention of drug abuse for young people in and out of schools. It also provides limited recreation facilities; there is a TV and a pool table where ex-addicts can hang out. An important part of their strategy is to reduce the relapse rate among ex-addicts released from the Government's rehab centers by providing social support and after-care. They also raise awareness among addicts and non-addicts about the workings and dangers of drug addiction in general, and of needle sharing in particular. They receive financial and technical support from UNICEF, have been allocated office space on Government premises by the NNCB and receive technical support from an Indonesian NGO.

Education sector: Life skills Education

UNFPA has been working with the Ministry of Education and the Ministry of Youth in implementing a pilot life skills education program in secondary schools in three atolls, including Male'; recently also 6th grade students in primary schools have been targeted.

Limitations of the program are that the words 'sex' or 'sexuality' or 'condoms' are not included in the curriculum or life skills manual for primary and secondary schools, only for the third package for out-of-school adolescents.

UNICEF has also conducted some activities in the area of life skills education.

Teacher training institutions do not yet provide any information or methodologies for new teachers to deal with these issues in their classes, and teachers reportedly feel uncomfortable discussing issues related to sexuality in their classrooms. 40% of teachers are untrained (MOE, personal communication). With ongoing education reform efforts going on, there is an important opportunity to improve this situation: it is important that the general curriculum in schools include more explicit and useful information and skills related to reproductive health, sexuality and HIV/AIDS for students.

Education sector: School health program

There is limited integration of HIV/AIDS and a more limited integration of issues related to gender and sexuality in the school health program. The WHO concept of Health promoting schools is followed; 25 pilot schools are involved; the target is to cover 25% of schools by the end of 2007. UNICEF is promoting child friendly schools; 80 schools received support under this program.

Prevention for out-of-school youth

Apart from the life skills activities for out of school youth mentioned above, UNFPA also supports a 'Youth Health Café' located in the Youth Center in Male. The facility is severely underutilized, with only around 5 people coming in each day. A key informant reported that the center is too strictly managed and not youth-friendly, and that condoms are not provided there, so for young people with sexual health questions or needs there is no point in going there except to get information.

It was reported that the center does get a number of telephone calls each day with questions related to reproductive health and sexuality, including questions about HIV/AIDS, sexual relations, homosexuality and masturbation.

Out of school youth with drug problems can drop-in at the center of Journey.

Behavioral Change Communication responses for people with high-risk behavior

No behavior change communication programs are in place for people engaging in high-risk behaviors, except for the work conducted by Journey for drug users.

Spiritual and psychosocial support activities

The NGO Society for Health Education, which is chaired by the First Lady, runs a counseling service on family planning. Counselors also see unmarried people with sexual health problems, but no condoms are provided to them in line with Government policies. The main focus of the NGO has been on screening and public awareness of Thalassemia.

Apart from the work by Journey and the Government 'halfway houses' for recovering drug addicts, no such support activities were reported. Drug users in Government facilities complain about the fact that counselors are often considered too young and do not have experience with addiction problems of any kind; support activities in the rehab centers are not tailored to the expressed needs of addicts, but are based on a program copied from the USA (called Therapeutic Community). Ex-addicts report it is easier for them to communicate with counselors who are ex-addicts; this partly explains the success of the Journey after-care program.

Research

The Ministry of Gender and Family Affairs is working on a broad survey on gender violence, including sexual violence against women and children. A qualitative study has been completed and the survey will be conducted later this year.

UNICEF and the Indonesian NGO Yakita are working on a rapid assessment survey on drug addiction, implemented by the NGO Journey. Initial findings are expected soon.

Part IV: Analysis: Gaps in the response to HIV/AIDS in the Maldives

3.1 Lack of involvement of the non-health sector & civil society

The most striking gap in this assessment has been the lack of involvement in the response to HIV/AIDS by the non-health sector. This may partly be because of unclarity in the assignment of tasks of NAC members from non-health sectors.

Programs improving knowledge, attitudes and skills for vulnerable youth in secondary schools and youth out of schools should be strengthened, in which the Youth Ministry, the Ministry of Gender and Family Affairs, the Ministry of Health and the Ministry of Education should take a joint lead.

Despite their influence over every-day life, the role of religious leaders in reducing fear, stigma and discrimination, as well as in promoting healthy lifestyles, is still limited. Here lies a major opportunity for a strengthened response reaching out to young people and adolescents.

It will be difficult for Government officials to work with MSM, sex workers or drug users on HIV prevention, or to refer them to health services, if they live in fear of being arrested or reported to the police. There is an important role for civil society organizations to reach out to hidden populations. Civil society is underdeveloped in the Maldives; there are few functioning NGOs working on HIV related issues for vulnerable young people (Journey, for drug users, is the main one); none are working for sex workers, MSM, migrants, resort workers or young people out of schools. Civil society organizations should be supported and strengthened to expand self-help groups and sexual health interventions for vulnerable groups and for people engaging in high-risk behaviors, including sex workers, men having sex with men, migrants and resort workers.

3.2 Policy gaps

Multi-sectoral policy to reduce HIV vulnerability among youth

A multi-sectoral policy on reducing HIV vulnerability among young people in the Maldives is lacking. Such a document should be developed in the context of the NAC and the forthcoming NSP, outlining clear roles and objectives for different Ministries.

Policy towards drugs

The Maldives has a clear policy on drug use. Drug use is illegal and results in imprisonment. The possession of more than 1 gm results in life long imprisonment. The carrying of needles and/ or syringes cannot be used as evidence for drug use. Only witness of active drug use or drug dealing is used as evidence for containment. A recent Presidential Decree states that anybody who is a "menace to society" can be contained in a detention centre for 3 months; a positive urine test is sufficient evidence for this sentence. This containment can be extended once. As a result of the current drugs policies, 80% of the 300 inmates in prison are drug related convicts and out of those, 30% are sentenced for life.

It is important that pharmacists are aware that selling syringes is not unlawful in the Maldives if efforts to reduce needle sharing by encouraging drug users to use their own needles are to be successful.

Policy towards sex work

Sex work is illegal in the Maldives, as it is in most other countries. As a result, there is no policy on sex work and HIV/AIDS in place, and sex work is punishable by law.

Policy on male to male sex

WHO has declassified homosexuality as a disorder or a disease since 1993. Nevertheless, the Maldives remains one of a few countries criminalizing male to male sex. There is no separate policy on reducing HIV transmission in this group.

3.3 Research and data gaps

HIV/AIDS surveillance

WHO recommends that HIV biological surveillance should include:

- HIV infection case reporting in addition to AIDS case reporting;
- Mapping to estimate the population size of groups at high risk such as injecting drug users, sex workers, and men having sex with men in order to plan for biological sentinel surveillance;
- Sentinel sero-surveillance among injecting drug users where population numbers seem to be sufficient; and
- Cross-sectional surveys among vulnerable populations such as out-of –school youth and migrants could complement the information.

Routine HIV testing of antenatal women or other general population groups in low HIV prevalence settings is not considered as useful (see [Annex 6](#)).

Behavioral surveillance

Behavioral surveillance is of vital importance in a low level epidemic, as it provides information about the trends in high risk behavior which serve as an early warning of the extent of impending HIV infection. In the Maldives, despite indications of high risk behaviors in the population, data on sexual behavior or condom use among high risk and vulnerable groups is not collected at the moment

STI surveillance

Universal syndromic STI case reporting is established. For surveillance purposes, the most useful STI syndromes are male urethral discharge, male genital ulcers and female genital ulcers. Vaginal discharge has a low specificity for STIs.

Qualitative data on the socio-cultural context of high-risk behaviors

Regarding sex work and male-to-male sexual activity, only anecdotal evidence is available at present. The same can be said for sexual activity among young people. Qualitative research on levels of stigma and discrimination in the population is also lacking.

3.4 Awareness and prevention program gaps

People engaging in high risk behaviors

Currently limited HIV awareness and prevention programs are in place for drug users (i.e. only one project in Male' was identified); no HIV awareness or programs are in place for men having sex with men or for sex workers.

There are very few civil society organizations and basically no networks and self-help groups of affected communities such as (ex-) injecting drug users, sex workers and MSM. Experience in China, North-Eastern India, Malaysia, Viet Nam and more recently Indonesia has demonstrated that once HIV enters the injecting drug user population, countries can expect large and sustained HIV epidemics (see Annex 5). A study in Indonesia shows that 110,000 infections among the general population and 60,000 infections among IDUs could have been delayed or averted if successful HIV prevention programs and policies had been in place before the virus entered this population. Introducing harm reduction interventions at an early stage to prevent the introduction of HIV into this community is therefore of critical importance. There are yet no harm reduction programs although injecting behavior is increasing. Targeted condom programs for STI and HIV prevention are not in place.

Vulnerable adolescents

Most efforts in awareness raising and prevention have been knowledge-based, and less focused on attitudes and skills; moreover, they have mostly been directed at young people in schools, who must be considered less vulnerable to HIV/AIDS than their peers outside schools or people engaged in high risk behaviors. Younger religious leaders have not yet been involved in these efforts.

Families and health care workers

Families and health care workers have no knowledge on how to deal with drug users and ex-drug users. They do not know how to support them to get away from drugs or remain clean after drug treatment.

3.5 Care and support program gaps

The one person who is alive and has AIDS is receiving appropriate health care at the Indira Gandhi Memorial Hospital. The integrated management of adult and adolescent as well as childhood infections for acute and chronic care including social support programs should be strengthened and should cover the care and support needs for people living with HIV.

In terms of support programs for people vulnerable or at risk to HIV/AIDS, the NGO Journey is implementing support groups for addicts and ex-addicts.

3.6 Human and financial resource gaps

Human resource capacity to deal with any of the gaps above is limited.

National costings indicate that for the past four years, approximately US\$2,020,766 annually has been required to be expended to effectively implement a National HIV/AIDS Program. In 2006, the Ministry of Health allocated \$120,000 to the HIV/AIDS Program, an additional \$131,000 has been provided by external sources. In this current period, there is an unmet financial need of \$1,769,766.

The Ministry of Health expenditure is forecast to almost double in the next four years. By the end of 2010, the Ministry of Health plans to allocate US\$329,000 to the National HIV/AIDS Program and related activities.

External sources of funding include WHO, British Council, UNFPA and UNICEF. By the end of 2006, the Maldives will have received during the year a total of US\$131,000 in external funding. Over the next three years, it is anticipated that amount received from external sources will decline to approximately \$82,000 in 2010.

Part V: Recommendations

This section is divided in immediate and in medium-term recommendations, all of which should be further elaborated on in the forthcoming strategic plan. The immediate recommendations should be implemented as soon as possible, possibly overlapping with the forthcoming strategic planning process.

5.1 Five Immediate recommendations

1. It is important to strengthen a more multi-sectoral approach in the Maldives, meaning full involvement of the non-health sector in HIV prevention responses. This can be done, among others, by having more frequent meetings of the National HIV/AIDS Council, inviting non-health sectors to inter-atoll health meetings and vice versa . The forthcoming development of the new NSP should include non-health sector and NGO/UN involvement. The National AIDS Council should establish working groups for preparing key areas in the strategic plan (these proposed Working groups are highlighted below).
2. It is imperative to foster a deeper understanding of sex work, premarital sex and male to male sex in the context of Maldivian culture and society, so as to design appropriate and effective behavior change strategies for people engaging in these behaviors by doing targeted social research on the context of high-risk behaviors; this is also important to convince key policy makers that these behaviors exist and are significant in the Maldivian context.
3. Given the importance of monitoring the spread of HIV/AIDS & STI in high risk groups, the National AIDS Program should assess the feasibility of mapping and estimating the size of high risk groups. Based on the information that becomes available about the type and size of high risk groups such as injecting drug users, sex workers and men having sex with men, behavioral surveys in these groups should be designed, to be conducted in the second half of 2007. Biennial behavior surveillance among in-school and out-of school youth, uniformed personnel and other vulnerable population groups should be added at a later stage.
4. Key policy makers and opinion influencers need to be better informed and more exposed to the HIV/AIDS situation in the region, in order to mobilize their leadership for a more comprehensive national response to HIV/AIDS. Therefore, training, awareness raising and advocacy activities for key policy makers are urgently needed in the Maldives, to overcome some of the barriers to the implementation of necessary prevention programs. This could be done by organizing technical seminars in the Maldives or organizing a study tour to other Asian – especially Islamic – countries.
5. A High Risk Reduction Task Force should be formed, consisting of law enforcement officials, public health officials, opinion influencers and other stakeholders ‘on the ground’, starting first in Male’ and expanding to other areas if successful. The main

aim of the task force would be to forge a broad coalition and consensus about HIV prevention goals among groups at high risk in the capital. A pragmatic agreement should be worked towards to reach hidden populations. If possible, representatives of hidden populations should be included in this task force.

5.2. 24 Medium-term recommendations

Policy and leadership

1. The Ministry of Education, Ministry of Youth and Ministry of Gender and Family Affairs should work together with youth representatives and young religious leaders in developing a multi-sectoral policy aimed at reducing HIV vulnerability among youth, including life skills and drug demand reduction strategies. This document should be linked to the Seventh National Development Plan which is currently being finalized, and the forthcoming NSP on HIV/AIDS. (Working group 1: HIV and vulnerable youth)
2. Special efforts should be directed at facilitating collaboration between the nodal ministries responsible for narcotics control and HIV to garner multi-sectoral commitment to strengthening drug demand reduction, drug treatment, rehabilitation and HIV prevention for IDUs. It is important that the recently approved new policy towards drug abuse is further developed, following internationally accepted principles of harm reduction. Key to this change is an agreement that drug addiction should be viewed as a health and a social problem, rather than as a crime. (Working group 2: HIV and drug abuse)
3. A National Policy on written informed consent for HIV testing has been released. At the same time the health care providers and laboratory technicians should be trained in the principles of WHO/UNAIDS strategy of provider-initiated testing ensuring that HIV testing is truly voluntary and confidential.
4. STI and HIV prevention activities with sex workers and their clients are to be implemented. It is important that a modus operandi on sex work and HIV is discussed between public health and law enforcement officials, as well as religious leaders and other opinion influencers, as has happened in many other countries in the region. As recommended in the national reproductive health strategy, condom distribution should not be restricted for family planning purposes but include the dual protection approach for both, STI prevention and family planning. (Working group 3: STI/HIV and Sex Work)
5. While male to male sex is often discouraged from a moral or religious point of view, from the public health perspective it is desirable to engage men having sex with men in an attempt to help them reduce HIV transmission; not only between men, but also between men who have sex with men and their wives or girlfriends. Civil society, law enforcement officials and the public health sector should discuss a Memorandum of

Understanding, aimed at an agreement not to actively prosecute MSM based on their sexual behavior, in exchange for the commitment of MSM to practice safer sex with their male and female partners (Working group 4: HIV and male-to-male sex).

6. It is important that UN agencies collaborate better in coordinating technical and financial assistance on HIV/AIDS related policy and program development to the Maldivian Government. The UN Theme Group on HIV/AIDS should meet more frequently and a joint UN work plan on HIV/AIDS should be developed, based on the forthcoming National Strategic Plan. The UN Theme Group Chair should be a member of the National HIV/AIDS Council.

Strengthening the evidence base: Surveillance, monitoring and evaluation and research

7. Overall national capacity in STI and HIV/AIDS program monitoring, surveillance and research should be strengthened. In conjunction with stakeholders, develop a national monitoring and evaluation plan describing key information needs, indicators, sources of data collection, frequency of data collection, and a plan for data analysis, dissemination and use (see Annex 6) (Working Group 5: HIV/STI Surveillance and research)
8. In a low level epidemic, it is recommended that HIV biological sentinel surveillance should be set up among high risk groups. The vulnerability assessment indicates that adequate sample could be reached to set up sentinel surveillance among (I)DUs.
9. While biological sentinel surveillance helps in case finding and notification, it does not serve the purpose of monitoring trends over time in a sentinel population with very low prevalence of HIV. As HIV testing services expand, and as the uptake for HIV testing increases, data from voluntary and confidential HIV testing and counseling services may provide more representative information about the HIV problem in the country. HIV infection case reporting should include minimal demographic data such as age, sex, occupation, education, risk factor, date and clinical stage at diagnosis, CD4 if available, opportunistic infections and whether treated with antiretrovirals or not.
10. The existing universal syndromic reporting of sexually transmitted infections should cover reporting from private clinics. Due to little sensitivity the reporting of vaginal discharge should be omitted. In order to assess the true prevalence of STIS the prevalence of syphilis, gonorrhoea, Chlamydia trachomatis, HSV-2 and other STIs, a community-based STI survey should be conducted.
11. It is important that sociological and anthropological studies are conducted on young people's increased HIV risk and vulnerability caused by the increasing role of consumption and money, the increased use of the internet for dating, a growing generation gap, high mobility, disillusion and boredom, a lack of employment, education and recreation opportunities, and how these factors can be addressed.

Blood safety

12. It is important that the blood bank system is strengthened and that non-remunerated voluntary donors are recruited. As recruitment of voluntary non-remunerated blood donors becomes more common, it will be possible to screen donated blood for HIV based on unlinked anonymous testing.

Prevention targeting vulnerable youth

13. The Ministries of Education, Youth, Gender and Family Affairs and Health should work together to integrate and improve HIV prevention programs and condom promotion programs for vulnerable young people in the country, including life skills programs for young people in and out of schools. It is imperative that young people themselves, as well as young religious leaders, are actively part of such efforts.
14. A strategy of mainstreaming HIV and sexual health into other health programs should be considered, including in pre-employment programs for migrants, hotel schools and other tourism-related training activities, and training programs for social and health workers.
15. The formation or strengthening of young people's civil society groups, possibly in the context of religious activities, should be considered to promote healthy lifestyles.
16. Behavior change programs, condom promotion and IEC materials should be developed for migrants, including seamen and those working in tourist resorts, with involvement of the Ministry of Tourism, Ministry of Transportation and Civil Aviation, MATI and the Department of Public Health.

Prevention targeting groups at high risk

17. The implementation of two carefully monitored pilot programs for drug users should be considered: One to provide clean needles and syringes, and a program to use methadone for the most heavily addicted drug users.
18. The Journey program on after-care for ex-addicts should be carefully evaluated and if found successful, its successes should be replicated in Addu Atoll and other islands.
19. An emergency HIV prevention pilot program is needed for sex workers, both male and female, based on a needs assessment.
20. An emergency HIV prevention pilot program is needed for men having sex with men, especially focusing on the HIV risk of anal sex, based on a needs assessment

HIV testing and counseling

21. VCT services in Male' and all atolls should be improved, following concepts of voluntary confidential client-initiated VCT as well as provider-initiated HIV testing which should give an option opt out, pre-test and post-test counseling, not only for positives but also for negatives.

Address stigma and discrimination

22. In order to promote VCT and STI treatment seeking behavior, especially among vulnerable young people and groups engaging in high risk behaviors, as well as to help reduce the high relapse rate of ex-addicts it is important that stigma and discrimination of these groups is addressed.

Prepare for being able to provide care and support

23. With improved surveillance and better uptake of VCT, it is likely that more HIV cases will be found in future years. It is therefore necessary to enhance the capacity of hospitals and health centers to provide care and support for persons living with HIV/AIDS. Tools developed by WHO and UNICEF on management of HIV as part of integrated management of adult-, adolescent- as well as childhood infections (IMAI and IMCI) for acute and chronic care, including social support programs, should be adapted for use in the Maldives. A program to reduce fear of HIV transmission among health care workers is needed and capacity building for strengthening HIV counseling, syndromic management of STIs, the management of ART and HIV opportunistic infections.
24. Standards of confidentiality need to be further strengthened across the health systems.

Annex 1: People consulted

Government

Health sector

HE Dr Abdul Azeez Yoosuf, Deputy Minister of Health

Ms Aminath Rasheeda, Assistant Executive Director of Department of Public Health and CCM

Ibrahim Shaheem, Deputy Director General, DPH, MOH

Mohamad Rameez, Deputy Director, National HIV/AIDS Programme, Department of Public Health

Abdul Hameed, Programme Manager, Health Promotion, Department of Public Health

Shareefa Manike, Director, Laboratory Services, Dept. of Medical Services

Ahmed Khaleel, MOH

Ms Shameema Hussain, National TB Program Manager, MOH

Indira Gandhi Memorial Hospital, Male

Dr Ali Nazeem, senior registrar in medicine, dept. of internal medicine

Dr Pravin Nair, Senior Registrar in Microbiology

Dr Ali Latheef, Senior Registrar in Medicine

Ms Ashiya Saeed, Laboratory Technologist

Fathimath Abdul Qayyoom, Staff Nurse

Shiyama Ali, Staff, Auxilliary Nurse

Addu Rehab Center

Naadira Aoam, Counsellor

Aiminath Xeenaa, Counsellor

Himmafushi Rehab Center

Fathmath Adhla, assistant counselor, in charge of DRC

Aishath Lizian, assistant counselor, in charge of children's rehab center

Mohamed Shaneez, counselor trainee

Transportation sector

Mohamed Latheef, Director, Ministry of Transport and Communication (also member of the NAC)

Abdul Nasir Mohamed, Director, Ministry of Transport and Communication

Tourism sector

Aishath Ali, Director, Human Resource Development, Ministry of Tourism and Civil Aviation

Sim I Mohamed, Secretary General, Maldives Association of Tourism Industry

Former guesthouse owner, Male'

Current guesthouse owner, Addu Atoll

Two immigrant staff at a hotel in Male'

Four former Maldivian resort workers

One current Maldivian resort worker

Education sector

Mr Husain Rasheed, Senior coordinator for school health programs, MOE

Ms Aminath Mahamed, Teacher educator for school health programs and former secondary school teacher, MOE

Ministry of Youth

Youth Health Café director and staff

Ministry of Gender and Family Affairs

Maana Rafiu, Director General

Athifa Ibrahim and Emma Fulu, officers involved in research on gender violence

United Nations

Johan Faegerskioeld, Programme Coordinator, UNICEF Maldives

Piyali Mustaphi, Project officer, Health and Nutrition section, UNICEF Maldives

Mohamed Saeed, Assistant Project officer, UNICEF Maldives

Farah , programme officer, UNFPA Maldives

Ying-Ru Lo, Regional advisor HIV/AIDS, WHO Regional Office, New Delhi

Ian Macleod, Regional advisor HIV/AIDS, UNICEF Regional Office, Kathmandu

Aldo Spina, consultant for WHO

Dr.Ohn Kyaw, WHO

Civil society

Mohamed Rashid, Director, Journey

Adeel Mohamed, member and consultant to Journey

Nathalie Panabokke, consultant to Journey

Dr Mausooma Kamaldeen, Society for Health Education, FP clinic

Aminath Naskida, Nurse (FP clinic and youth kiosk)

Key informants

Four MSM interviewed in Male' and one MSM interviewed through internet in Male'

Two former sex workers and drug addicts in Male'

Two underage male sex workers in Male'

3 former drug users in Addu

Several former drug addicts in Male'

Two drug addicts in rehab in Himmafushi

Two transgendered persons

Seven teenage boys in group discussion, Addu Atoll

Eleven young women in group discussion, Addu Atoll

Annex 2: References

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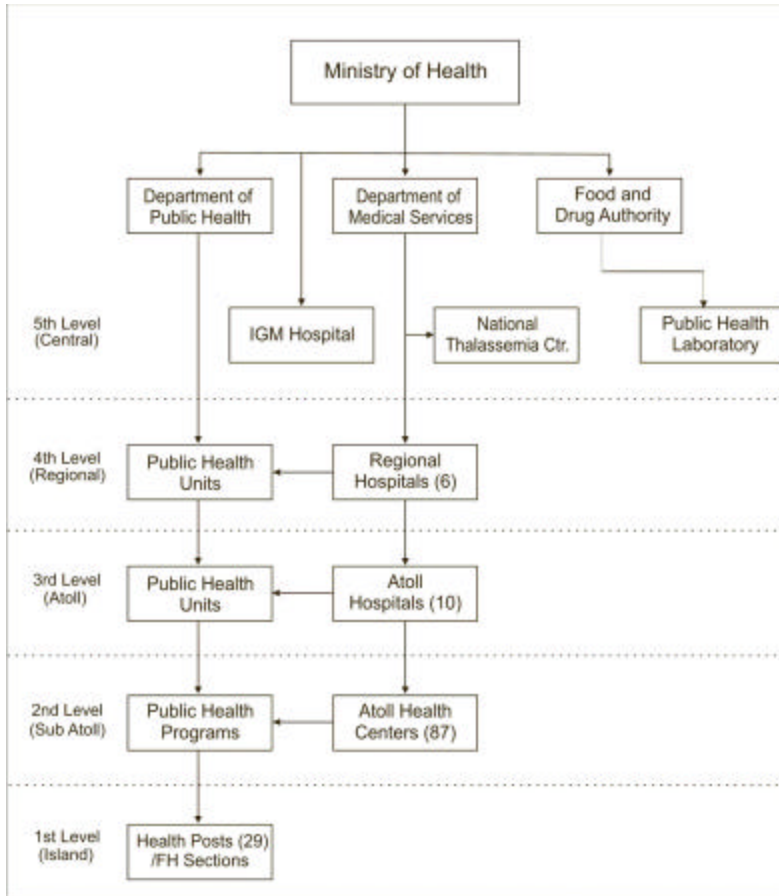
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YAKITA/UNICEF. Together we can. Facilitation of addict driven rapid assessment in Maldives. July 2006

Annex 3: Organization of the Health System



Annex 4: Case studies

Key informant interview: MSM, Male

O. is currently in his thirties and works in a resort. He was born in Male and lived with many brothers, sisters, cousins and extended family members in a relatively small house. When he was 6 years old, someone in his household taught him how to masturbate while in the shower; a bit later, he started oral sex and when he was 9, he was forced into anal sex by a member of the household. He was sexually involved with school mates and several other men during his teenage years. He had a more serious relationship with a man for about six months, after which he broke up. For one period of time, he felt very lonely and rejected, and he attempted suicide. While working at the resort, he has been sexually involved with several Western tourists, and with one of them he has traveled to a European country for one month. He tried to find a job there but did not succeed.

Now, he says he really would like to settle down with a single partner. He is fed up with playing around. He finds friends and sometimes sex partners using the Internet. He finds fulfillment and friendships mainly during work; he only comes back to Male to visit his family, once in a while.

He says 9 out of 10 MSM in Male' get married, in the end. But they will not give up sex with other men. He is pessimistic about the future for MSM in the Maldives. He always uses condoms, but thinks condom use among MSM is not the norm. Most of his Maldivian male partners had to be convinced strongly to use them, he said.

He says limited male-to-male sex work exists in the Maldives. Some male drug users sell sex to Maldivian and other men, or have sex in exchange for drugs, but apart from that sex work is largely ad-hoc. A Western male couple lived in the Maldives for a while, and O. worked with them. They had no shortage of local teenage boys who were willing to engage in sexual activities with them in exchange for money or gifts, O said.

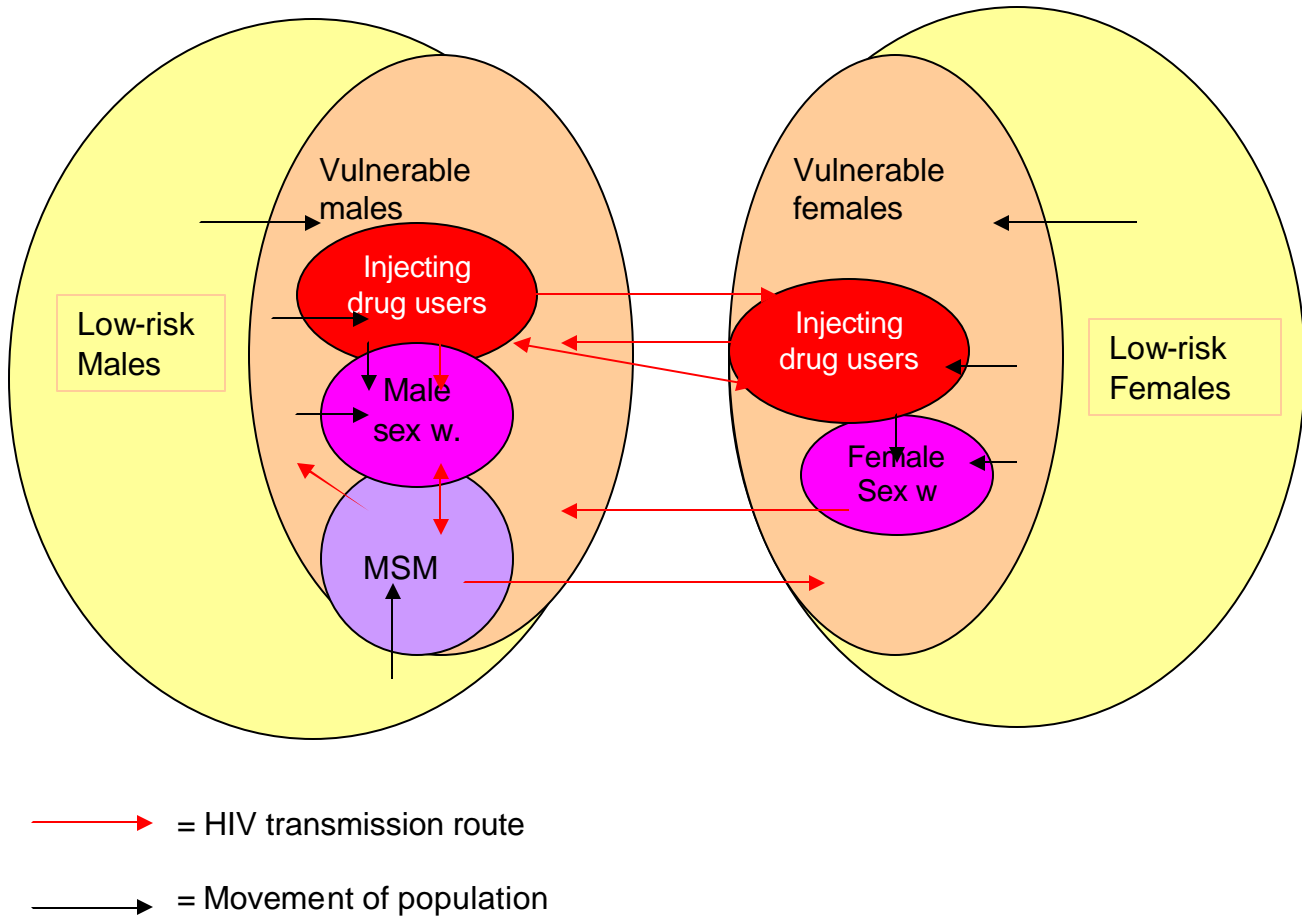
Case study: M, female drug user and sex worker

M (not her real name) started using drugs when she arrived for study abroad when she was around 20 years old, and met friends from the Maldives and from other countries who were using drugs. She felt lonely and wanted to be part of a group of friends, and soon started smoking heroin. She never injected, as she has a fear of needles. Since heroin was so cheap in the place she lived, she could finance her addiction using the money her parents sent to finance her studies. But after she came back to Male', she could no longer afford it. She was involved in sex work for a while, and then found a drug dealer as her boyfriend, and he provided in her needs.

After some months, she was caught by the police and sent to a rehab center, where she stayed for 3 months. Within a month after coming out, she got hooked on heroin again. After 3 months, she was caught again and sentenced to 6 years in jail. However she and her family managed to persuade authorities to allow her to go to rehab once again. This time she stayed for 8 months. After her release she relapsed once again, meeting with her friends and her boyfriend who were still addicted. Then she went to rehab voluntarily. Since two weeks she got out, after four months; she is determined to stay clean and pick up her studies.

Annex 5: Scenarios for future growth of HIV in the Maldives: three case studies and a macro-level scenario with and without interventions

Figure 1: Population movements and HIV transmission across groups



In figure 1, the links between increased vulnerability, risk behaviors and possible HIV transmission routes are shown. The 'Low risk males' circle feeds the 'vulnerable males' circle (through migration, mobility, peer pressure, disillusionment / boredom, increasing societal pressure to earn money, etc) as well as a circle of men who have sex with men. Some men in the 'Vulnerable males' circle use drugs; part of them move into the red circle of Injecting drug users. Some men who use drugs need money desperately and may move into the male sex work group; other poor vulnerable men may move into this group too. Low-risk females, through similar processes as those mentioned for men, with the additional factor of gender imbalance, move into the 'Vulnerable females' circle; from there, some of them become drug users or sex workers or both.

If this system works in isolation, nothing will happen – i.e. even if needle sharing is common and condom use is low, there will be no HIV epidemic. So – how can HIV be introduced into this system? This can happen in the following ways:

1. A Maldivian can get infected while abroad, either by sharing needles, receiving an unsafe blood transfusion or by having unprotected sex.
2. A foreigner – either a tourist, or a migrant who is HIV infected but who during his time of recruitment was still in the window period, during which HIV is undetectable.

The three scenarios below are derived from information that was collected from key informant interviews. It is information about unsafe behaviors that could have led to HIV infection, and to entry of HIV in the system above.

Case 1

Ali is a seventeen-year-old Maldivian boy of a middle class family, who goes to study in India. He finds a circle of Indian and Maldivian friends, some of whom use drugs. He is introduced to heroin, and injects regularly. Due to the difficulty of obtaining clean injecting equipment on the campus where he is staying, Ali and his friends share injecting equipment regularly. During one of these sessions, a friend of a friend is part of the group; this person is HIV positive. As a result, Ali and all of his injecting friends become infected.

After returning to Male' Ali gets a girlfriend and tries to quit. However, some of his Maldivian friends also return from studying abroad, and soon he resumes injecting drugs. Normally he uses his own needles, but one night the pharmacy is closed, and he is in severe need. He shares the needle of a friend; unknowingly, Ali transmits HIV to his friend.

Ali breaks up with his girlfriend, but not without infecting her first. Both Ali and his newly infected friend soon have new girlfriends; within six months time, both of them have infected their girlfriends. One of these girls is also a drug user, and shares needles with some of her friends. Because they are in acute need of money, they start going with men in exchange for drugs and money...

Case 2

Ahmad is a young man with a secret. He is attracted to other men. When he was a teenager, he found out that while most of his friends would have fun with him, despite the fact that most of them were really attracted to women. Ahmad is lonely and decides to work in a resort, to be away from his family and to try to forget about his 'problem'. While at the resort, he meets an older man from the UK. Ahmad meets up with him after work, and they have sex. They do not use condoms. Without knowing it, Ahmad gets infected with HIV. After a while, Ahmad is transferred to another resort. Many of the male staff are lonely, like himself, and they do not mind having sex with Ahmad. Without being aware of it, Ahmad infects up to three fellow workers over the following months. These fellow

workers will go back to their wives over the coming holidays.... Some of them inject drugs now and then...

Case 3

Mohamed is a successful businessman. He travels abroad often, and while in Bangkok he enjoys going to massage parlours. He meets many beautiful Thai women, some of them do not insist in using condoms. Mohamed gets infected, and so does his wife and another lover...

Fortunately, so far in the Maldives, HIV has entered only the category of 'Vulnerable males' (11 cases) and 'Vulnerable females' (i.e. the spouses of vulnerable males). If the virus enters in the 'risk behavior' groups – sex workers, injecting drug users or men who have sex with men – it is likely that the virus will spread to many people before it may be detected, since none of these groups are currently part of surveillance or screening efforts.

What is the 'worst case' scenario in the Maldives?

If we assume there are 4,000 drug users in the Maldives, of whom 25% inject and all share needles; if we assume there are 100 part-time and full-time female and male sex workers, none of whom use condoms; if we assume there are 5,000 MSM in the Maldives (i.e. 5% of an estimated 100,000 sexually active men), none of whom use condoms and 95% of whom are married, and if we assume 25,000 young people and 30,000 Maldivian migrants are vulnerable to HIV due to unsafe sex with either of the groups mentioned above, and we compare these numbers with observed HIV prevalence rates in other Asian countries, the following table appears:

Table 2: HIV/AIDS cases in the Maldives in 2015 – **without** interventions

Group	Est. Pop. Size	Possible HIV infection rate	# of possible HIV cases
IDU	1,000	40%	400
Sex workers	100	30%	30
MSM	5,000	25%	1250
Vulnerable youth	40,000	8%	3200
Migrants	30,000	3%	900
Total			5,780

We assume here that vulnerable youth and migrants are at risk of infection partly due to their involvement with MSM, sex workers and IDU. Hence, in terms of interventions, reducing the transmission in these three groups is key.

We see that without interventions, assuming no condom use and widespread needle sharing, 5,780 Maldivians could be infected with HIV/AIDS in the medium term, equivalent to a prevalence rate of more than 2%.

Now, we assume that due to interventions, HIV rates can be kept at a lower level. This is shown in Table 3 below.

Table 3: HIV/AIDS cases in the Maldives in 2015 **with** interventions

Group	Est. Pop. Size	Reduced HIV infection rate	# of possible HIV cases
IDU	1,000	5%	50
Sex workers	100	2%	2
MSM	5,000	2%	100
Vulnerable youth	40,000	0.2%	80
Migrants	30,000	0.2%	60
Total			292

As can be derived from the table above, the number of infections that could potentially be prevented if comprehensive prevention measures will be put in place could be as high as $(5,780-292) = 5,488$.

Annex 6: HIV surveillance

The recommended framework for HIV surveillance in a low level epidemic is given below:

Main Question	Core surveillance	Additional surveillance
Are there groups with risk behavior?	-Formative research and mapping of groups with potential risk behavior -Analysis of available STI surveillance data	-Mapping to cover a larger geographical area, and to be conducted more frequently -Estimate size of groups with potential risk behavior
What are the main risk behaviors?	Risk behavior surveys in groups considered at high risk for HIV infection	-Increased geographical coverage of risk behavior surveys -STI incidence and prevalence studies in groups with risk behavior
How much HIV infection is there?	-HIV sero-surveillance in identified groups with risk behavior -Analysis of available blood donor HIV screening data	-Larger coverage and increased frequency of HIV sero-surveillance in identified groups with risk behavior -HIV sentinel sero-surveillance in pregnant women in urban areas
Who else might be affected and to what extent?	-AIDS case reporting -HIV case reporting	-Risk behavior surveys focused on potential bridging populations

Key surveillance questions for a low level epidemic are:

- Is there any risk behavior that might lead to an HIV epidemic?
- In which sub-population is that behavior concentrated?
- What is the size of these sub-populations?
- How much HIV is there in those subpopulations?
- Which behaviors expose people to HIV in those sub-populations and how common are they?
- What are the links between the sub-populations and the general population?