



**“KONME KAMEVVES VEDHAANE”
ANYTHING IS POSSIBLE**

A Comprehensive Audience Analysis for
HIV Risk in the Maldives
with Recommendations for Communication

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

This comprehensive audience analysis for HIV prevention in the Maldives takes a close look at seven groups considered at high risk: Injecting Drug Users (IDUs), Female Sex Workers (FSWs), Men who have Sex with Men (MSM), Migrant Construction Workers, Seafarers, Resort Workers and Youth. This audience analysis puts together, for the first time, the findings of two complementary studies, one quantitative, one qualitative: the Maldives' First Biological and Behavioral Survey (BBS) conducted in mid 2008 and an In-Depth Qualitative Study which followed in late 2008 and 2009.

The BBS documents the Maldives' low seroprevalence as of mid-2008 with 1791 blood samples taken from these seven groups deemed at high risk (only one case of HIV was found). It also gives statistical evidence of reported risk behaviors, knowledge of HIV and perceived risk among these seven groups. The Qualitative Research explores the thinking behind these statistics and offers a rare glimpse into the behaviors and life experience of members of these seven groups, in their own words. Taken together, these two studies offer the first in-depth look at the risk of HIV in the Maldives.

This comprehensive audience analysis paints a portrait of a population largely unaware of its danger; a country with a low prevalence of HIV but a high prevalence of risk behaviors and attitudes that lead to HIV. These studies found rising rates of drug injecting, much of it unsafe, especially in prisons; sex workers who inject drugs; the normality of multiple or serial sexual relationships among the young, high-risk sex (group sex, anal sex), almost non-existent condom use, and frequent mobility. In spite of these risks, the great majority of the participants in this study did not consider that they or their friends could get HIV.

Konme Kamevves Vedhaane has two English translations. The first is “**Anything Can Happen**” and this is true for HIV in the Maldives. But it also means “**Anything Is Possible**” and this, fortunately, is also true. In spite of the multiple risk behaviors, the Maldives currently still has a low prevalence of HIV, the BBS confirmed. It has what is called a “nascent epidemic.” The window of opportunity, the time for strong action is now – not later, when HIV has already begun to spread.

If there is a strong, fast, realistic and comprehensive national response to HIV, if there is clear and appropriate information targeted to the groups at risk, and if prevention commodities (such as condoms and clean injecting equipment) and prevention services (such as STI treatment and VCT) are available nationally to all those who need them, this response could stop the virus in its tracks before it gains a serious toehold in the Maldives.

If the Maldives achieves this, the country will make HIV prevention history.

Each section of this audience analysis covers one of the seven groups at risk, combining statistical information with insights and illustrative quotes from the qualitative research. The report then concludes with some general recommendations for effective HIV prevention communication in the Maldives. These recommendations are:

1: Put aside the myth that there are only 3 cases of HIV in the Maldives. Instead talk about estimated cases or HIV prevalence in the South Asia region.

While the Maldives still apparently has a low prevalence of HIV, the media focus on reported cases encourages people to believe there is no risk and their behaviors are safe. MOHF and the media should announce that the Maldives has a “nascent epidemic” and begin talking about estimated cases. This change should be announced officially to the press.

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

Islamic religious and Maldivian traditional cultural standards are worth reinforcing, but they alone will not protect the Maldives from HIV because many young Maldivians fall short of these standards. Condoms and clean injecting equipment must be easily available and accessible to everyone who needs them to protect the health of the country.

3. Begin communication now to prevent stigma and discrimination against people with HIV (PLHIV) to improve the environment for prevention and protect PLHIV’s rights.

Social support for PLHIV needs to be in place *before* many people are diagnosed with HIV. Such an enabling environment will encourage people to get tested, protect the rights of PLHIV and allow them to take an active role in prevention.

4. Promote a more compassionate understanding of those at risk of HIV, including young people who have sex outside of marriage, IDUs, MSM and FSWs. Attempts to understand and help them should be viewed as a strategic response to HIV, not as a moral issue.

Many of the risk behaviors for HIV are not acceptable within traditional Maldivian culture; nevertheless, they exist. Stigma and discrimination lead to more unsafe behaviors, while understanding these groups and the reasons for their risk can lead to good programs that help them avoid HIV and protect the country. This should be viewed as a strategic response to HIV.

5. Make use of the natural communication processes and networks within each group.

Communication based in the present communication practices and structure of a community is better than communication imposed from the outside. For example, every group has members who have developed their own strategies for safe behavior and can show others the way. These “positive deviants” are often good peer communicators for change.

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

Audience research shows that present HIV information does not meet the needs of groups at risk. The most effective materials for any group are developed with messages and ideas from the group itself and pretested among members of the group.

A companion document, *Behavior Change Communication (BCC) Strategy for HIV Prevention in the Maldives*, specifies communication strategies for each of the groups at risk.

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Acronyms & Abbreviations

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

Introduction

Konme Kamevves Vedhaane, A Comprehensive Audience Analysis for HIV Risk in the Maldives, with Recommendations for Communication combines the findings of two important studies: the Maldives' First Biological and Behavioral Survey (BBS) conducted in mid 2008 and an In-Depth Qualitative Study which followed in late 2008 and 2009. These studies take a close look at seven groups who could be at risk for HIV in the Maldives: Injecting Drug Users (IDUs), Female Sex Workers (FSWs), Men who have Sex with Men (MSM), Migrant Construction Workers, Seafarers, Resort Workers and Youth.

This audience analysis is the result of a full year's research effort on the part of the Global Fund Supported Programme in the Maldives, with the assistance of the Government, civil society groups, the United Nations Joint Team on HIV and AIDS, and the many individuals from groups at risk who contributed to the research. It is comprehensive in looking at these groups at risk through three different lenses: Statistics, Serology, and lived experience. The BBS gathered statistical information from 1769 individuals, using questionnaires. The BBS also drew blood samples from 1791 individuals, testing them for HIV, hepatitis and syphilis. The Qualitative Study followed with 41 in-depth interviews of individuals from the same groups at risk, documenting their experiences and gathering their insights, explanations and concerns. The findings of these three types of research are combined in *Konme Kamevves Vedhaane*.

Konme Kamevves Vedhaane has two translations in English. The first, *Anything Can Happen*, has a hint of danger – “happen” is a word that implies a lack of control, powerlessness in the face of outside forces. The second translation, *Anything Is Possible*, gives us back our power, suggesting our ability to make things turn out the way we would like. Both of these are true statements about HIV in the Maldives.

This audience analysis of HIV risk in the Maldives shows that there *is* reason to worry about HIV in the Maldives. There are significant present risks: behaviors, attitudes, and lack of knowledge, and the Maldives' present response, including prevention communication, is not adequate to address these risk behaviors. If these risks continue to grow unaddressed, HIV will spread in the Maldives, harming the country and particularly the young.

As this study goes to press, the Maldives still has only a very few registered HIV cases. While there are certainly other cases not yet discovered or registered, it seems that fortune still smiles on the Maldives. The Maldives is still a “nascent epidemic” with low prevalence and – more important – a chance to stay that way.

This study aims to point the way to a better understanding of the groups at risk, so that good programs can be designed to protect them and the Maldives from HIV. If the Maldives rises to the challenge, recognizes its good fortune and does not mistake it for moral superiority or the absence of risk, resists the temptations of complacency, and quickly fills this “window of opportunity” with needed interventions and good prevention communication, a serious HIV epidemic can still be avoided in the Maldives.

The Component Studies

1. The Biological and Behavioral Survey (BBS)

The Maldives carried out its first Biological and Behavioral Survey (BBS) of the risk of HIV in 2008. The study was conducted by what is now the CCHDC within the Ministry of Health and Family and supported by the GFATM. That study was first presented in November, 2008, and appears in print as *2008 Biological and Behavioral Survey (BBS) on HIV and AIDS, Republic of Maldives*.

The general objective of the BBS was to provide baseline data for a better understanding of the situation of the most-at-risk populations (MARPs), including the most-at-risk adolescents (MARA) in the Maldives. The study was designed to answer the following research questions:

- Are the MARPs in Maldives large enough to fuel an HIV epidemic in the country? If so, what is the situation of MARPs/MARA in the country?
- What is the prevalence of HIV and STI among the MARPs and MARA in the Maldives?

The BBS included three types of research: an initial mapping exercise, a statistical survey based on a questionnaire given to a sample of 1769 study participants, and a serological study based on blood drawn from 1791 participants. Three sentinel sites were involved: Male' (including Hulumale' and Vilingili), Addu, and Laamu Gan. The study, its methodology, findings and limitations are described fully in the BBS report.¹

The difference between the BBS data as presented in the BBS report and as presented here is in how it is organized. The BBS organizes its findings by category of information (e.g. demographics, risk behaviors, knowledge, etc.). This comprehensive audience analysis combines all the categories of information, organized by target group.

2. The Qualitative Research

Statistical data can quantify and even describe risk behavior, but it cannot explain it. A structured questionnaire, such as used in the BBS, gives statistical measures of key knowledge, attitudes such as perceived risk, and reported behaviors. These are essential for establishing a statistical baseline and determining priorities for intervention. However, a structured questionnaire does not easily accommodate the free-flowing ideas of the respondents. It cannot explore their thinking about those behaviors, or the underlying attitudes, traditions, norms and beliefs that make up the fabric of the culture into which risk behaviors are woven. Most important, a statistical study cannot determine what messages may move an audience to consider change, or

¹ See *2008 Biological and Behavioral Survey (BBS) on HIV and AIDS, Republic of Maldives*, Aura C. Corpuz, MD, MPH, PHSAE TSF Consultant for the UNDP/DPH-GFATM, November 2008

what channels could most effectively reach them. In other words, a statistical study cannot be used to plan good behavior change strategies or develop communication campaigns. For this, another kind of research is needed – qualitative research. Qualitative research was planned in tandem with the BBS in order to illuminate and illustrate it, and to provide information for a fully-developed Behavior Change Communication Strategy.

The Qualitative research was planned to follow the BBS in order not to interfere with it or disturb the sensitive contacts, but rather to build on them. The qualitative researchers liaised with the BBS team and benefited from their familiarity with locations and, often, their good personal contacts in the target audience. This initial understanding allowed the qualitative researchers to approach the groups comfortably and knowledgeably and ask sensitive and intelligent questions. (See Appendix A for an Overview of the Qualitative Research process.)

The Qualitative Research (QR) Team

The qualitative research was carried out by a team of well-trained researchers, chosen from the staff of the Global Fund Supported Programme in the Maldives, the SRs (NNCB, SHE and DPH) and the SSR (Journey), supplemented by other individuals chosen for their interviewing skills, good contacts and understanding of the groups at risk.

The QR Team had three intensive days of training on qualitative methods on May 27 – 29, 2008. During this training, the participants worked as a team designing the sample (specifying the segments, locations and number of interviews to be conducted), agreeing on research questions, developing the discussion guides for the seven target groups, and learning and practicing interview skills and recording techniques. The team also agreed on protocols for handling the data confidentially, including transcribing, translating and storing it – an essential aspect of all qualitative research where people are asked to share frankly their views and experiences on often highly sensitive matters.

The Qualitative Research Method

The qualitative research made use of an Audience-Centered research approach, where the respondents decided individually if they preferred to be interviewed alone (in-depth individual interviews), with a friend (dyads), with two friends (triads) or with several others (mini-groups). The respondents also decided the times and the settings of the interviews and the places where they felt most comfortable talking – often someone’s room, or a quiet corner of their favorite café. The interviewer/facilitators used simple, memorized discussion guides which allowed for a free flow of conversation but anchored the interviews in themes the facilitator could keep track of (see Appendix B, Generic Discussion Guide).

The QR team conducted 41 in-depth interviews over a period of six months from December 2008 through March 2009. In addition to the recorded interviews, some information was gathered from a focus group and internet communication, including blogs, Facebook and email.

The interviews were audio-recorded as a form of note-taking in order to capture the flow of ideas and, most important, the exact words and phrases used. The recordings were downloaded from the recorders and stored on a secure central computer. Respondents were assured that the recordings and transcriptions were only for the eyes and ears of the QR Team members, and this promise was scrupulously kept.

All 41 recorded interviews were reviewed and most, but not all, were chosen for analysis, on the basis of three subjective criteria – that they were:

- **Broad** – That they covered all or nearly all of the topics in the Discussion Guide
- **Deep** – That the interviewer probed well, so the information was not limited to easy, superficial answers.
- **Authentic** – That the interview had the ring of truth about it. This last and highly subjective criterion was used to screen out interviews where a respondent denied all awareness of risk behavior, or seemed to be giving “good” or “correct” answers he or she seemed to think the interviewer wanted to hear.

Most of the interviews were good and were used in the final analysis, but a few seemed stilted and formal, did not ring true, were inaudible, or did not yield much understanding of the group. In the end, 35 of the interviews were chosen for analysis. Most of the interviews were conducted in Divehi, but a few were conducted in English or Nepali.

The interviews were then transcribed in their original language, and those conducted in Divehi or Nepali were translated into English. As they were being transcribed, any names or other identifying marks (such as village names) were removed. The source recordings were then erased. For a record of the data and its handling, see Appendix E – Qualitative Research Final Status Report.)

Analyzing the Qualitative Data

The initial data analysis took place from May 1-4, 2009 in, a Qualitative Research Analysis Training Workshop held on Ellaidhoo Island for the QR Team participants and the Global Fund Programme Management Unit. During the Analysis Workshop, the participants worked together to prepare the transcripts for analysis, agreed on an analysis code (see Appendix D – Analysis Code) and learned and practiced a manual analysis technique. They formed Analysis Teams (see Appendix C – Qualitative Analysis Teams) and worked very long hours reading the data and sorting it manually, in two languages, into the categories of the analysis code. Finally, the teams listed the important findings and selected illustrative quotes.

The output of the Analysis Workshop was a list of Findings for each of the seven groups at risk, illustrated by quotes in the Divehi, translated into English.² This analysis was the basis for *Konme Kamevves Vedhaane*.

² Divehi and Nepali interviews were translated into English, but the interviews conducted in English were not translated into Divehi. In other words, all the Divehi quotations that appear in this report are the original statements of the respondents.

The Limitations of the Qualitative Research

Qualitative research is not intended to be statistically valid, so it should not be viewed as representative or predictive of behavior. Instead, good qualitative research is like a series of vivid snapshots, taken from an insider's perspective, showing the reality of a group at risk, their knowledge, their beliefs and attitudes, and their stories about their lives, including their risk behavior. The strength of this kind of research is not in numbers or percents, but in insight and understanding.

This qualitative study lacks the points of view of several important segments. Expatriate FSWs, for example, are not represented here because they could not be contacted. This was probably due to a series of arrests that took place during the BBS (expatriate FSWs are almost entirely absent from the BBS as well.). It is very unfortunate that their situation, point of view and communication needs are not included in this study.

Migrant workers who did not speak Divehi, English or Nepali (for example most Bangladeshis, the largest group among the migrant worker population) could not be included because the QR Team had no one who could communicate with them. Research with this key group at risk is included as an important recommendation in the BCC Strategy released concurrently with this study.³

In spite of these limitations, the qualitative findings were rich and flavorful. They illustrate the BBS statistical findings, underscoring the risks the BBS found, but beyond that they bring them to life, with flashes of humor, drama, pain and joy – the light and dark of the lived experience of HIV risk in the Maldives.

³ See *Behavior Change Communication Strategy for HIV Prevention in the Maldives* The Global Fund Supported Programme in the Maldives, Barbara Franklin, PhD, August, 2009

Injecting Drug Users (IDUs)

Unsafe injecting is the most likely flashpoint for an HIV epidemic in the Maldives and the most urgent cause for concern in HIV prevention, most experts feel. Most observers agree that injecting drug use is on the rise in the Maldives, but the number of IDUs is a subject for debate. The civil society organizations working with drug users, who know the DU community, question the estimates made by the mappers during the BBS (the BBS estimated 375 IDUs in Male' and Addu as of mid-2008).

However, these differences of opinion may partly be a matter of definition. The BBS defined an IDU as a person who had injected at least once in the past six months. Not all of those drug users inject regularly. In the BBS, 43% of the Male' IDUs and 50% of the Addu IDUs said they had injected in the past 30 days, and about a quarter said they injected weekly, daily or several times a day. Others were intermittent, occasional injectors who also used drugs in other ways and injected only under certain circumstances. However even a single shared injection puts an individual at a greatly increased risk of HIV.

“It will explode. It’s not a question of if, it’s a question of when. So definitely there will be an explosion.”

Q: You think there will be an increase in the number of injecting drug users?

“Definitely there will be an increase.”

- Male' IDU⁴

“އަދި ހިސާބުތަކާ ބެހެއްޔެވި ނޯ، ދިވެހިންނަށް ހިސާބުތަކާ ބެހެއްޔެވި ނޯ، ހިސާބުތަކާ ބެހެއްޔެވި ނޯ”
އަދި ހިސާބުތަކާ ބެހެއްޔެވި ނޯ.
ސ. ދިވެހިންނަށް ހިސާބުތަކާ ބެހެއްޔެވި ނޯ، ހިސާބުތަކާ ބެހެއްޔެވި ނޯ، ހިސާބުތަކާ ބެހެއްޔެވި ނޯ؟
“ހިސާބުތަކާ ބެހެއްޔެވި ނޯ، ހިސާބުތަކާ ބެހެއްޔެވި ނޯ.”

IDUs are the best understood risk group for HIV in the Maldives, thanks to the combined efforts of the present and past civil society groups such as Journey, SWAD, the Addu Recovery Community, Paradigm, Fashan, and the Department of Drug Prevention and Rehabilitation Services (DDPRS) of the Ministry of Health and Family, with funding and technical assistance from the UN.⁵

⁴ Wherever Divehi appears in this section, those are the original words used by the respondents in the interviews. The English language translations are provided for the convenience of non-Divehi speaking readers.
⁵ The “Wake Up” communication campaign, funded by UNICEF, combined with an eloquent qualitative report “Voices from the Shadows” have directed public attention to the problem of drug use, including the dangers of injecting drug use. A regional project supported jointly by UNODC, UNAIDS and WHO is assisting the Government with an advocacy strategy for scaling up prevention of drug use and HIV.

The NGO Journey, for example, offers DUs and IDUs outreach communication, a drop-in center in Male', and regular Narcotics Anonymous (NA) support groups. The drop-in center is housed at Greenge, where there is also a Methadone Maintenance Treatment Center, helping to protect about 35 active addicts from the risks of injecting.⁶ SWAD communicates with the families of drug-users and carries out community education to reduce co-dependence. In 2008, a number of partners (including Journey, SWAD, UNICEF, NNCB and Dhiraagu) in a nation-wide communication campaign for drug awareness, called "Wake Up."

The BBS statistical study contacted 276 IDUs (147 in Male' and 129 Addu), ranging from 17 to 49 years of age, with a median age of 25. They were almost all men (only 9 were women) and Maldivian (only 3 were expatriates.) More than half had never married (68% in Male', 61% Addu), and most were unemployed (70% in Male', 58% in Addu). The median income for those working was 5,000 MRF a month. The IDUs typically began using drugs at 16 or 17 and started injecting at 22.

The serological study drew blood from 278 IDUs, finding that 0.7% in Male and 0.8% in Addu had Hepatitis C. Although this prevalence is still low, it is evidence for sharing of injection equipment. It is significant that Hepatitis C, often viewed as a proxy indicator for the risk of HIV, is already circulating in IDU circles.

The qualitative research team conducted 8 in-depth interviews with IDUs in Male' and Addu. The active collaboration of the Male'-based NGO Journey and the Addu Recovery Community was important to the success of both quantitative and qualitative research.

Here are the major findings of both quantitative and qualitative research on IDUs – quite possibly the Maldives' group at highest risk for HIV:

⁶ The Methadone Maintenance Treatment programme is in a pilot phase. An analysis will be conducted in 2009.

Research worldwide shows that injecting also reflects market forces. For example, injecting increases when the supply is reduced by crackdowns or a disruption in the supply lines. These are difficult situations to influence through communication because they depend on policies and world events. The words of this IDU reflect that sense of powerlessness in the face of these big forces.

“The most dangerous part is that the government is tightening the [drug] source, but they do have to tighten up. To prevent [drugs coming in] they will work hard; one way or another they will run operations to limit or to control. But this leads a MRF 100 piece to cost MRF 500 and then it will be available from the underground only. There’s no way they can stop this, so when the price rises we will have no choice other than to get high by injecting.”

- Male’ IDU

"අපි ජීවිතයේදී මත් ද්‍රව්‍ය භාවිතයට යොමු වන විට, මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය 100 මිලට මත් ද්‍රව්‍ය 500 මිලට මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ."

While drug users may feel they have little choice in the matter, some turn to injecting freely out of curiosity, peer pressure, a sense of camaraderie or imitation of others they admire. Here is where communication may have a greater effect. Respondents in the qualitative research talked about various reasons for injecting including fashion, and the desire to hide a growing habit from a watchful family:

“It’s a trend among the young kids to make their girlfriends/boyfriends use heroin. I hear some say that they learned to use heroin and to inject from their boyfriends/girlfriends. ...Now so many have learned it and it’s spreading really fast.”

- Male’ IDU

"අපි මත් ද්‍රව්‍ය භාවිතයට යොමු වන විට, මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ."

“I didn’t want my brother suspecting [I was using drugs], so I injected because I didn’t want to ask for so much money.”

- Male’ IDU

"අපි මත් ද්‍රව්‍ය භාවිතයට යොමු වන විට, මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ. මත් ද්‍රව්‍ය මිලදී ගැනීමට අපට අපහසු වේ."

"ޖަލަބު ނުކުރެއްވުމަށް ބޭނުންވަނީ ބޭނުންކުރާ ވަނިގަނޑު ފަދަ ތަކެތި ބޭނުންކުރާ ފަހުން ސާފުކުރުމަށް ބޭނުންކުރާ ގޮތް ބަލާ ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ. ބޭނުންކުރާ ވަނިގަނޑު ފަދަ ތަކެތި ބޭނުންކުރާ ފަހުން ސާފުކުރުމަށް ބޭނުންކުރާ ގޮތް ބަލާ ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ. ބޭނުންކުރާ ވަނިގަނޑު ފަދަ ތަކެތި ބޭނުންކުރާ ފަހުން ސާފުކުރުމަށް ބޭނުންކުރާ ގޮތް ބަލާ ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ. ބޭނުންކުރާ ވަނިގަނޑު ފަދަ ތަކެތި ބޭނުންކުރާ ފަހުން ސާފުކުރުމަށް ބޭނުންކުރާ ގޮތް ބަލާ ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ."

ސ. " ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ?"

"ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ... ބޭނުންކުރާ ވަނިގަނޑު ފަދަ ތަކެތި ބޭނުންކުރާ ފަހުން ސާފުކުރުމަށް ބޭނުންކުރާ ގޮތް ބަލާ ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ."

IDU Finding 5

Less than half of the IDUs who share say they clean the equipment before using, and most of those do not clean well enough to prevent HIV transmission.

The BBS found that of those who shared injecting equipment less than half (41% in Male’, 50% in Addu) cleaned the equipment between users. Cleaning methods varied from boiling to washing with lemon or simply rinsing with water. Rinsing with water is not adequate to get rid of HIV because tiny blood droplets or residue may cling to the inside of a syringe or needle. What is more, those who rinsed with water generally used the same water others had used. None of these methods match the recognized acceptable cleaning techniques for HIV prevention. Clearly there is a need for communication and skills training among IDUs.

“Yea, I clean every time.”

Q: What do you use to clean it?

“We don’t clean it that well. Put some water and flush it, yea?”

- Male IDU

" ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ " ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ "

ސ. " ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ? "

" ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ " ފަދަ ގޮތެއް ހޯދުމަށް ބޭނުންވަނީ "

IDU Finding 6

Some IDUs practice and teach others safe behaviors. For example, most IDUs say they usually use their injecting equipment only once and then discard it.

The BBS found that most IDUs (68% Male’, 79% Addu) say they use a needle and syringe only once and then discard it. This is possible because needles and syringes are readily available at pharmacies, where the great majority of IDUs say they get them. Easy access to affordable injecting equipment is one of the biggest advantages for HIV prevention. The Maldives must make sure needles and syringes continue to be available to anyone who needs them.

IDUs who practice one-time use can be seen as “positive deviants” who can model safe behavior to their peers. In the box below IDUs describe, in their own words, their strategies for promoting safe injecting. These ideas from inside the IDU community can help guide the development of communication strategies and messages for IDUs and can be incorporated into targeted HIV prevention communication for IDUs.

Promoting Safe Injecting: Messages from IDUs

Buy a friend clean equipment:

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

- Addu IDU

“މަ ބަނޑު ދިނީ ވަރަށް ދަތި ވާނެ ގޮތެއް ގައި ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި. ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި. ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި.”

Tell a friend how to inject safely:

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

- Male’ IDU

“ ހަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި. ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި. ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި.”

Don’t teach anyone how to inject:

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

- Male IDU

“ ހަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި. ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި. ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި، ނަމަ ބަނޑު ލިބިދޭން ބޭނުން ނުކުރެއްވި.”

Q: Who do you think is going to get HIV?

“People with multiple sex partners and that is like 65 to 75% of Maldivians.”

- Male’ IDU

“... 75% 65% ... ”

IDU Finding 8

IDUs have significant sexual risks. They have non-regular partners, go to FSWs, sell sex, and they don’t use condoms.

Although IDUs consider their sexual behavior low risk, it is not. The great majority of IDUs do not use condoms consistently, even in the riskiest situations. More than half of IDUs have non-regular partners, many go to FSWs (38% in Male’, 52% in Addu). Some IDUs are sex workers as well – 16% of IDUs in Male and 4% in Addu say they sometimes sell sex. The BBS found that 32% of their sample of FSWs in Male’ injected drugs.

All in all, over 90% of IDUs do not use condoms consistently, even in high risk situations such as sex work, group sex, anal sex and sex with other IDUs. Only 2-3% of the IDUs said they always use condoms. In short very few IDUs really practice safe sex.

“Because from what I believe is that I won’t get the same sexual feeling while using a condom.”

Q: Did you ever use one?

“No, I never used.”

Q: Then how do you know that....?

“It’s just that I know that I will not get it. If a piece of rubber is inserted in between we will not get pleasure. That’s how I think and believe.”

- Addu IDU

“... ”

IDU Finding 9

The most common reason IDUs give for not using condoms is that they are sure their partner is healthy, although nearly all IDUs know a healthy-looking person may have HIV.

The great majority of IDUs know very well that you can't tell who has HIV by looking. The BBS found that 93% of IDUs in Male and 95% in Addu knew a healthy-looking person could have HIV. This was the highest score for this fact of any group contacted in the BBS.

Nevertheless, when asked why they don't use condoms, the IDUs came up with a number of explanations. Most of these were illogical reasons, usually "refuges," a category of explanations described in the box below:

"Refuges" – How We Fool Ourselves

"Refuges" are comforting but illogical explanations people give for their unsafe behavior, such as unsafe sex or unsafe injecting. These ideas give a person the illusion of safety without providing any real safety at all. More complex than a mere denial of risk, refuges sound logical at first. However, they are at odds with facts people know well, or internally inconsistent.

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

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

The qualitative researchers found that IDUs used a number of refuges to explain unsafe behavior. For example, this young man initially said he trusted Maldivian school girls overseas, because they studied hard – although the girls were willing to have sex with him, and presumably others. In the second example, a man prides himself on his ability to know who is likely to have an STI by studying the personality.

"Well, in Pakistan, there were some Maldivian girls who were there to study...."

Q: You didn't use condoms? Was it difficult to find there?"

"No, no, I prefer not to. And they were all very good...they had finished school and study hard and were good girls you know? I wasn't scared then, I had trust that they wouldn't have any diseases like that...but they might, right?"

- Male' IDU

The IDUs' stories of group sex are extremely disturbing to read, not only for their violence and their blatant violation of a woman's right to control her own body, but also for their risk of HIV. If IDUs are the first to be infected in a future HIV epidemic, group sex not only amplifies their own risk but also shows how the virus could jump to a wider population.

*"The way it works is that you get high and then go have group sex...one girl"
"Sometimes two girls"
"And boys"
"They all buy the girl"
"Or just give her some heroin."*

- Two Male' IDUs

"...
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"...His girlfriend betrayed him, told him that she couldn't get back together with him...so what he did was, he took her somewhere, had the lights off and got her completely naked and he slowly came down and then everybody else went in.

Q: How many guys?

"It was about 6."

- Male' IDU

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"One of the guys made a date with her. I know because they planned it all when I was there. They went to pick her up on cycle and brought her to this abandoned house...I had gone off somewhere...and when I came back it had become a problem. She was bleeding from the vagina. None of the guys had used a condom... that girl couldn't even walk...She came in under the guise that it was for lovemaking...and the 14 guys just forced themselves on her.

Q: We hear a lot about these things in terms of revenge, like say a girl cheats on someone...was this like that too?

"Nothing like that. It was just for fun."

- Male IDU

Promoting Safe Sex: Messages from IDUs

Condoms can be exciting:

"They are not just condoms, you know, it's just these different, different types of condoms to bring more pleasure."

"أنا أستخدم أنواع مختلفة من الواقيات الذكرية، لأنهم ليسوا مجرد الواقيات الذكرية، بل هي أنواع مختلفة من الواقيات الذكرية لتجلب المزيد من المتعة."

Acknowledging previous partners:

"I only have sex with the girl that I date at that time. I've had relationships with girls before, and she would have had relationships with others, too....She wouldn't have had sex with just one person. So we have used condoms."

"أنا فقط أمارس الجنس مع الفتاة التي ألتزم بها في ذلك الوقت. لقد كان لدي علاقات مع فتيات من قبل، ولها علاقات مع الآخرين، أيضًا....لأنها لن يكون لديها جنس مع شخص واحد فقط. لذلك استخدمنا الواقيات الذكرية."

Condoms are not a problem:

"I think condom is an OK thing. I don't have any problems using condom. If it was possible I would use condom always, except my wife or my steady girlfriend."

"أعتقد أن الواقيات الذكرية هي شيء جيد. ليس لدي أي مشاكل في استخدام الواقيات الذكرية. إذا كان من الممكن، سأستخدم الواقيات الذكرية دائمًا، باستثناء زوجتي أو شريكتي."

Use condoms until you're mutually exclusive:

"More than anything, when I choose a partner...I only want to be with her. I don't want any outside relationships."

Q: In case it happens, would you use condoms instead of just thinking about the pleasure?

"Yea, more than before...[until] the two of us get medically checked out and know we're both safe, and we know we're going to be mutually exclusive..."

"أكثر من أي شيء، عندما أختار شريكًا...أريد فقط أن أكون معها. لا أريد أي علاقات خارجية."
س: في حالة حدوث ذلك، هل ستستخدم الواقيات الذكرية بدلاً من التفكير فقط في المتعة؟
"نعم، أكثر من قبل...[حتى] أن الاثنين منا نذهب لفحص طبي ونعلم أننا جميعًا آمنة، ونحن نعلم أننا سنكون حصريين..."

Female Sex Workers (FSWs)

Sex work is found in every society in the world, especially where men are separated by time and distance from their regular partners. Sex work is illegal in the Maldives as in most countries, and so it is hidden, but it still exists, driven by men's demand for sexual services. Experience worldwide shows that arrests and raids do not stop sex work, because they do not stop the demand. Instead, raids and arrests simply drive sex workers into hiding, making them harder to reach with good prevention communication and, thus, making HIV transmission more likely.

The BBS mapping exercise found there are both Maldivian and expatriate FSWs. Expatriates may enter the Maldives on tourist visas and stay for a short time only, or they may enter as migrant workers but end up doing sex work, either full time or on the side. Interviews with client groups, such as the migrant construction workers, show that some have a preference for FSWs of their own nationality. For example, Nepali construction workers interviewed during the qualitative research said they preferred Nepali sex workers.

It was hard to interview sex workers during both the BBS and the Qualitative Research. Because a number of FSWs were arrested during and after the BBS, the FSWs may have suspected the researchers were drawing the police to them, either accidentally or on purpose. Since expatriate FSWs face deportation if they are discovered, their situation in the Maldives is insecure. Only one expatriate FSW was willing to take part in the BBS, and none could be reached for the qualitative research. As a result, little was learned during this research about the situation, knowledge, attitudes or HIV-related behaviors of expatriate sex workers. Nevertheless, expatriate FSWs must be part of a comprehensive response to HIV in the Maldives. The future cooperation of the police immediately before, during and after research is essential to a full understanding of HIV risk.

The BBS contacted 102 FSWs (34 in Male' and 68 in Addu), gathered as a "snowball" sample (friends of friends). All but one were Maldivians. The Male' FSWs were younger (median age 24), started doing sex work later (at median age 19), had sold sex for 5 years and had more clients (average 4 a week). A quarter of them were married. The Addu FSWs were older (median age 30), started doing sex work earlier (at median age 17, and some as young as 12), had sold sex for about 13 years and had fewer clients (average 2 a week). More than half were married. Most FSWs said they support family members – children, husband, parents or siblings.

The QR team hoped for seven interviews with FSWs in Male' and Addu, but was only able to achieve four because of the lack of trust in the wake of the arrests. All interviews were with Maldivians. Although they were limited in number, these interviews give a vivid picture of Maldivian FSWs and show why FSWs are on the front line of risk for HIV in the Maldives.

“First contact the drug user, and the drug users will link to the prostitutes.”

- Resort Worker

FSW Finding 3

Drug-addicted FSWs enter sex work through a gradual process starting with alcohol, then drugs and sex for fun.

In the qualitative research, the FSWs talked about sex in connection with drugs of all kinds, from alcohol to hash oil to heroin (*hakuru*, sugar), both chased and injected. They described the gradual process by which they began to do sex work.

In the beginning, these FSWs say they were just *gadda* (wild) girls, for whom sex and alcohol or were simply a way to have a good time. Once addicted, they might have sex with a man who came with the drugs they wanted, especially if he was a friend or a friend of a friend. As their addiction progressed, however, their need becomes more desperate and their choice of partners more limited.

The series of quotes below shows the progression from sex for fun with friends to sex for money with strangers, typical of the addicted FSW.

“I wouldn’t use ‘sugar’ and hash oil during that period. I would booze every now and then, not a lot. When I was boozing I would go with people just for fun. I would just go booze for fun and I’d have sex then.”

- Male’ FSW

“... ”

“I went for a sexual affair after I started to use hash oil. The first time I had sex I was using it.... I didn’t want [to have sex] but someone took me, since I was young [13] at that time.”

- Male’ FSW

“... ”

“I was very ‘sick’ one day...it was ‘white stuff’ then. I had used up all that I had, so my friend came...he found out I was using and he came with some stuff...so I used with him and had sex with him.”

- Male’ FSW

"Most of them aren't drug users...for example they are really close people but who wouldn't tell anyone else....I tell my partners that I can't do anything if I am not high so they have to find me something [drugs] before they do whatever they want.... They say they can't get the stuff, so they give me money for the stuff."

- Male' FSW

"...ከሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ፣ ምንም እንኳን ገንዘብ ለማግኘት ለሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ። ሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ፣ ምንም እንኳን ገንዘብ ለማግኘት ለሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ። ሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ፣ ምንም እንኳን ገንዘብ ለማግኘት ለሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ።"

FSW Finding 5

Networks of friends act as pimps, bringing paying clients lead to FSWs. The FSWs themselves may become pimps for their friends.

FSWs in the qualitative interviews talked about meeting clients through “friends”. It is not clear what interest the “friends” have in the transaction, but most likely there is some money exchanged, so these friends are acting as pimps, in fact. If a FSW cannot have sex for some reason, for example if she is pregnant, she may become a pimp for other women.

"So what happened was, well, I got pregnant...Then my friends did it...They come by to use with me...so they just hang around and ask me if they could get a deal."

Q: You mean to get them clients?

"Yeah, so I get half of what they get."

- Male' FSW

"...እኔ ግን ገንዘብ ለማግኘት ለሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ፣ ምንም እንኳን ገንዘብ ለማግኘት ለሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ። ሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ፣ ምንም እንኳን ገንዘብ ለማግኘት ለሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ። ሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ፣ ምንም እንኳን ገንዘብ ለማግኘት ለሌሎች ጋር ጥሩ ጥሩ ግንኙነት አለኝ።"

FSW Finding 6

Very few FSWs use condoms consistently with partners of any kind. They consider condoms unimportant, or for pregnancy prevention only.

All FSWs have more than one sexual partner. Many have boyfriends or a husband and non-regular partners, in addition to paying clients. Nevertheless, the BBS found that only 10% of FSWs use condoms consistently with any kind of partner. In the past seven days, the BBS found that 88% of FSWs in Male' and 98% in Addu had unprotected sex with both clients and non-

FSW Finding 10

Some FSWs report symptoms of STIs, but many of these say they just ignore them.

The BBS found that 27% of FSWs in both Addu and Male reported having had symptoms of STIs. While this is still not the majority, it is the highest rate of reported STIs found by the BBS in any group. Most of the Male' FSWs (67%) say they treat STIs by going to a health practitioner. However, half of the FSWs in Addu say when they have STI symptoms they simply do nothing about them.

Ignoring STI symptoms is dangerous for HIV prevention, because untreated STIs increase both the risk of acquiring HIV and passing it to others if condoms are not used.

FSW Finding 11

Male' FSWs have better access to information and HIV testing than Addu FSWs, but all FSWs lack interpersonal communication opportunities.

The BBS found that about 1/3 of FSWs contacted in Male' had had an HIV test. This was the highest rate of HIV testing in any group, except for the seafarers (who may be required to take the test in order to work.) However, only 4% of the Addu had been tested. There appears to be a big unmet need for voluntary counseling and testing (VCT) especially in Addu.

FSWs do not want or need to be targeted in a public way; instead, there need to be women's clinics that they could access in privacy and comfort, along with other women. VCT may be easier for FSWs to access if it is integrated with other services in a general health clinic, rather than in a specialized facility that is linked to HIV and STIs.

FSW Finding 12

There are "positive deviants" among the FSWs. About 40% of FSWs realize their risk of HIV and recommend using condoms.

Both the BBS and the qualitative research found that most Maldivian FSWs (about 60%) are casual about their risks of HIV. They view their partners as healthy and trustworthy, even though they know a healthy person can have HIV. They see pregnancy and STIs as risks with easy solutions. HIV does not appear to concern them at all, although they are closely associated with drug users, including IDUs, and are often IDUs themselves.

Fortunately there is a sizeable minority of FSWs (39% in Male', 41% in Addu) whose perceived risk of HIV is higher. These FSWs, for example, recognize that they change partners frequently, do not always use condoms, and may inject drugs, and that this puts them at risk of HIV. The table below shows why these FSWs feel they may be at risk for HIV:

Why Do Some FSWs Think They Might Get HIV?

In Male' (of 39%) In Addu (of 41%)

Often change sex partners	54%	15%
Don't always use condoms	38%	89%
Use injected drugs	38%	4%

These findings suggest that there may be two different kinds of FSWs – one well-informed and realistic about HIV, and the other poorly-informed and unrealistic. Interestingly, both of these groups were found both in Male' and in Addu.

While their behaviors are not necessarily any safer, this group of “positive deviants” can model better attitudes. The presence of this smaller group of well-informed and savvy FSWs may be important for communication with the larger group of FSWs whose knowledge and perceived risk are inadequate.

Q: Do you think any of your friends might get HIV?

“If they do it without condoms, yes. To be on the safe side, they should use them....There are some people who don't want to do it without a condom because they are scared they might get a disease or infection.”

- Male' FSW

س. "رَوَّحُوْهُ اِنَّ مَازَلُوْهُ جَرَّوْهُ اَرْجُوْهُ، اَمَّا اِيَّيْهِ فَاَعْرِضُوْهُ لِمَنْ؟"
 "مَنْ يَجْرُوْهُ يَجْرُوْهُ وَرَبُّهُ جَرُّهُ اِنَّ مَازَلُوْهُ جَرَّوْهُ، اَمَّا اِيَّيْهِ فَاَعْرِضُوْهُ لِمَنْ... اِنَّ مَازَلُوْهُ جَرَّوْهُ وَرَبُّهُ جَرُّهُ اِنَّ مَازَلُوْهُ جَرَّوْهُ، اَمَّا اِيَّيْهِ فَاَعْرِضُوْهُ لِمَنْ؟"
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Men Who Have Sex with Men (MSM)

Men who have sex with men (MSM) exist in the Maldives as they do in every society in the world. Worldwide estimates of the frequency of same-sex preference in a population vary, but some studies suggest that about 7% of any population may have same sex desires. Whether or not they can act on these desires, however, varies greatly according to the situation.

MSM in the Maldives face many dangers if they express their same-sex preferences, because this behavior is defined as illegal and is opposed by both religion and the cultural norms of some islands. Maldivian men are legally required to be heterosexual. In contradiction to these norms, young MSM in the Maldives often suffer sexual abuse by older males (whose behavior reveals them as unacknowledged MSM.) They are also mocked and teased, sometimes beaten, may lose their jobs and, if arrested for sodomy, they are publicly whipped, imprisoned and/or banished.

Naturally, in this environment most MSM hide their sexual preferences. This secrecy endangers the sexual health of MSM and their male and female partners, and it also skews the picture of HIV risk in the Maldives. Invisibility increases the risk of HIV since it is nearly impossible to work in partnership with an invisible group.

While it is even more rarely talked about or recognized, there are also Lesbians (Women who love Women) in the Maldives. Lesbian sex was reported in several of the qualitative interviews, usually as part of a group sex scenario. Fortunately for Lesbians, their sexual behaviors usually do not pose a risk of HIV. HIV prevalence has proven extremely low among this group worldwide, and as a result they are usually not included as a risk group in most HIV studies.

Q: So when you mentioned all girls having a girls night, the question that comes to me is when all you girls booze, does any sexual event take place?

“Yes, there are times it happened.... and then I am always interested to have sexual relations with a girl.”

- Male' Young Woman

The BBS contacted 126 MSM (defined as men who had had oral or anal sex with another man in the previous 12 months), 57 in Addu and 69 in Male'. A “snowball” method was used – friends contacting friends – so the sample probably does not reflect the full range of MSM in the Maldives today. The MSM ranged in age from 10 to 55, with a median age of 27 in Male' and 25 in Addu. Most were Maldivian, but 22% were expatriates: 11 in Male' and 17 in Addu.

The qualitative researchers conducted six interviews with MSM and also accessed several internet sites with Maldivian MSM content. The MSM from Male' preferred to be interviewed in English, however those from Addu preferred to speak in Divehi.

MSM Finding 1

Most MSM in the Maldives are functionally bisexual – while they may prefer sex with men, they have females partners as well.

The BBS research found that most (75%) of MSM contacted in Male' and Addu also have sex with women. This suggests that MSM in the Maldives may disguise their homosexual preferences by engaging in heterosexual behavior.

Overall, 25% of MSM are married, the BBS found, but there are important differences between Addu and Male'. In the BBS sample, 39% of the MSM in Addu are married, compared to only 15% in Male'. It appears that that MSM may hide more often in marriage in Addu, and possibly in the other atolls, than in the capital.

When MSM marry for social acceptance, it may result in confusion and pain both for the men and for their female partners. This is not a situation that lends itself to honest communication between husband and wife; instead it is a situation of duplicity and high risk for HIV. A man who has a double sex life (one with a woman and another with men) may take many risks and should practice safe sex, but he cannot easily explain to his wife why he wants to use condoms. In the face of strong taboos, he may find it difficult to purchase or carry condoms for his male-to-male sexual contacts. In addition, if he is in denial about his homosexual feelings, he may be unwilling to plan for safe sex. This puts everyone at risk for HIV – the man, his male partners, and his wife and/or girlfriends.

MSM interviewed in the qualitative research talked about the confusion MSM felt, the risks they took and the lies they told.

“Most of the others, they just don't have a clue about what they want. For example, my boyfriend... And there is this other bunch of guys who don't know what they are. They don't want to be gay...The problem is they still get the urges. Of course it's just human. It's natural. And they go back and forth, back and forth, and I don't know if they use protection or not.”

- Male' MSM¹⁰

“A very truthful husband...will swear to the woman that 'I have never slept with another woman', but the woman will never think that he'd sleep with another guy.”

- Male' MSM

¹⁰ Where a Divehi quote appears, it represents the original words of the person interviewed; the English translation accompanies it for the convenience of the non-Divehi speaking reader. Where English quotes appear alone, English was the language used in the interview

MSM Finding 2

Many MSM say they have experienced sexual abuse either as boys at home or as adults, for example in prison.

The BBS found that for 20% of the Male' MSM, forced sex (abuse) was their first experience of sex. Many of the interviewees told of abuse within the family, which they either did not dare share with their parents or which they tried to share, but no one believed them.

“I was about 7 years old...My elder brother is like 8 years older, and my other brother is like 6 years older. [My mother and elder brother were gone] so we both were all alone. The initial interest began as fun. I mean we both took off our clothes and played around, messed around, and then it got serious. And it continued like that, on and off, for the next 7 years. “

Q. Did you resist and hate it, or was it OK for you?

I really didn't know what was going on...I didn't mind so much....I kind of thought my brother was being nice to me. Basically it went on for the next 7 years, until he got a girlfriend...

Q: So your parents didn't know?

“They never knew until I finally went and told my mom....my mom didn't believe it. She denied it. She got very angry at me. She stopped talking to me. And my elder brother said he guessed what was going on....the fact that my elder brother knew something was going on and he didn't do anything about it is really hard.”

- Male' MSM

The early experience of abuse is so common among MSM that there has been speculation about the influence that it might have on later sexual preferences. One respondent speculated about this influence:

“It's not a reason for being gay, but what happens, how I perceive it, is that, when we grow up, actually heterosexuality is a social function. So basically all TV, all stories, all fairy tales, everything has heterosexuality built into it. But if you are abused when you are growing up, that constant is not there, you know. Basically it opens up a vista saying that homosexuality is there. It exists. You can have sex with the same sex....It is because the social construct is not there....Sexuality is so fluid.”

- Male' MSM

Other respondents talked about abuse in situations where others had power over them.

“When I was in jail, there was a guy in a cell...he was desperate to do it...he was a gangster leader over there...so I had to [have anal sex] with him. “

-Addu MSM

" ...
 ...
 ..."

MSM Finding 3

MSM are a hidden population only to outsiders. Among themselves, they have active interpersonal and electronic networks and meet frequently.

MSM say they meet each other at cruising sites they know, including certain streets, cafés and restaurants, the jetty, the harbour and the beach. Many also make contact electronically using cell phones, SMS or the internet. They meet in chat rooms or networking sites on internet or SMS, such as Mig 33, MIRC, Facebook or Myspace. These networks are constantly evolving.

“The Mig 33 brought a big revolution for me.”

- Male’ MSM

“[Mig 33] is not only for gay men, but there’s a particular room for gay men, and it’s almost always full...people meet there, set up a date, go for coffees, or just take them to a hotel room or just come home. And before I found Mig 33 I was on several gay websites. There are hundreds of them, actually...and now mostly people use Facebook.”

- Male’ MSM

MSM Finding 4

MSM have multiple sexual risk behaviors: partners of all types, high partner counts, and sometimes sex work.

Lacking the possibility of marriage, and the social recognition of a long term commitment, many MSM find it convenient to keep their sexual relationships casual and change partners often. As a result, there is frequent networking, including group sex. Some had very high partner counts:

“I went to coffee with a person I met through Mig 33...he was very open. He said he slept with 66 people, most of them are married with children.

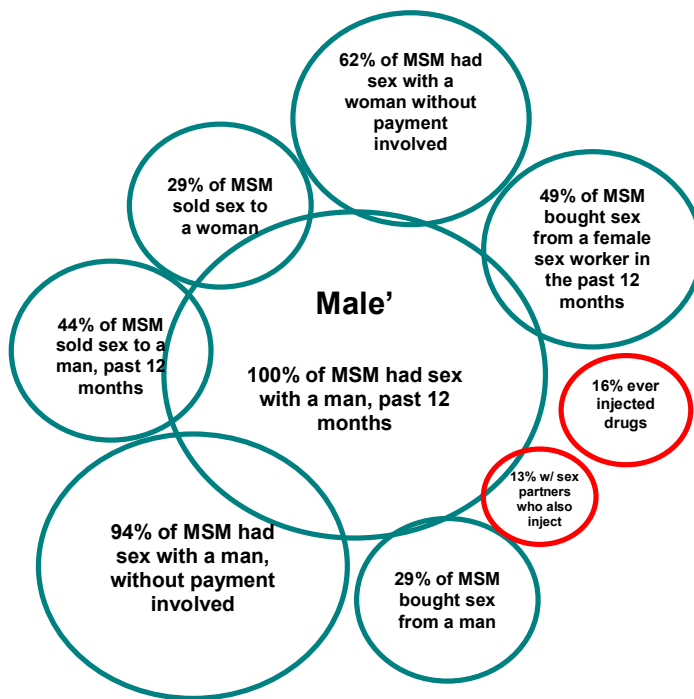
Q: Is it?

“Yes, with 66 people...His rate was every 2 or 3 night he slept with a new guy. He even set one up while I was just next to him, through Mig 33.”

- Male’ MSM

The BBS also found that MSM had more overlapping risk behaviors than any other group investigated. They had both long term steady partners (who might be wives) and casual male or female partners, who might be boyfriends, girlfriends or sex workers. Most was without payment, however 29% in Male and 18% in Addu said they had bought sex from another man, and 44% in Male' and 18% in Addu said they had sold sex to another man

This “bubble diagram” graphically illustrates the pattern of overlapping risks among Male' MSM.



These multiple risks greatly increase MSM’s chances of HIV, and also make them a potential “bridge” population who could spread HIV from one group to another in the Maldives.

MSM Finding 5

MSM almost never use condoms, whether for anal or vaginal sex.

Of the 75% of MSM who have sex with women, 98% in Addu and 82% in Male say they do not use condoms with their female partners either. Unsafe sex thus endangers the women, who may not know the men also have male partners.

Anal sex is an extremely risky behavior and must be protected with condoms to prevent the spread of HIV. Lubricant as well as a condom is needed to protect anal sex, since a condom alone may break or make sex more painful for the receptive partner.

Most MSM say they have anal sex with other men, either consensual or paying, and few use condoms for anal sex. In Addu, 100% of MSM reported having anal sex, and 86% said they did not use condoms if the sex was consensual (78% if was paid.) In Male' 94% reported having anal sex and did not use condoms 67% of the time, whether for paid or consensual sex.

"When we ask [our partners] the answer they give is that 'actually we don't prefer condoms, lack of pleasure' or it's not available at the time, something like that. They are not very concerned about it."

- Male' MSM

MSM Finding 6

MSM may use drugs in connection with individual or group sex, and some MSM inject.

Adding to their picture of multiple risks, both the BBS and the qualitative research found that MSM use drugs, often in connection with sex. Some also injected drugs, and others had IDU sex partners.

Q: Then do you ever inject?"

"Yes, inject a lot....I did it for around two years."

Q: So, when doing like that do you use same needle that has been used by another?"

"One needle which was used is also used for another. The same needle is used for three or four people as well."

Q: So, when used like that, how do you clean the needle?"

"Don't clean. We just wipe it and again use it."

Q: You don't put it in water also? Just wipe it?"

"Sometimes we don't even wipe it also."

- Addu MSM

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MSM Finding 10

Some MSM may be using HIV testing as a way to validate and continue their unsafe behaviors

While voluntary counseling and testing for HIV (VCT) is an essential part of HIV prevention on a national level, it is not a prevention tool for an individual. Instead, knowing one's HIV status will help an individual get early treatment if he is positive, and may inspire more careful future behavior if he is negative.

“Every month I do get tested.”

- Male' MSM

If an MSM is using condoms consistently and correctly and does not share needles, there is no need for regular HIV testing. In fact, regular testing can become a psychological crutch, a “refuge” in itself. A series of negative tests may even appear to excuse unsafe behaviors.

Any MSM who relies on regular HIV testing to reassure himself that he is still negative needs strong behavioral counseling so that he knows how to protect himself, rather than relying on a monthly game of chance.

MSM Finding 11

Less than half of MSM say they received information on HIV this past year, and it was mostly from the mass media.

The BBS found that only 48% of MSM in Male' and only 21% in Addu received any information on HIV this past year. Given MSM's high rates of risk behaviors and low perceived risk, the lack of information for most MSM is very worrying.

The MSM who did get information got it from the mass media primarily. It is unlikely that the mass media will discuss MSM sex adequately (particularly anal sex), since homosexuality is so taboo in the Maldives. Thus MSM are unlikely to get the HIV information they need from the mass media.

MSM need targeted media and interpersonal communication that is designed especially for them. All MSM need information specific to their risk behavior, information that is updated and reinforced constantly, so that rumors and misinformation are corrected, new MSM are informed, and older MSM are reminded of the risks.

Q: How did you get information about STI, HIV and AIDS?

“Mostly from the internet. Then I have talked to people from DPH also.”

- Male' MSM

“Actually it was only very recently that we came to know about these things, about AIDS, about using the anal area...it’s like only two years ago. Before that, we didn’t have any information.”

- Addu MSM

“*އަދު ގަވާއިދު ވަނީ ފަހުގެ ދުވަހު ގައި ހިމާރުކުނީ ރާއްޖޭގެ ބައެއް ފަރާތްތަކުން ސަލާމަތް ނުކުރާ ގޮތް ބަލައި ފެނިފައިވާ ކަމުގެ ސبب ގޮތުންނެވެ. ފަހުގެ ދުވަހު ގައި ހިމާރުކުނީ ރާއްޖޭގެ ބައެއް ފަރާތްތަކުން ސަލާމަތް ނުކުރާ ގޮތް ބަލައި ފެނިފައިވާ ކަމުގެ ސبب ގޮތުންނެވެ.*”

MSM Finding 12

Some MSM believe they might get HIV.

A minority of MSM (32% in Male’ and 21% in Addu) said they might get HIV. Their reasons were more realistic, for example injecting narcotics, not always using condoms, and often changing sex partners. Only a few seemed really aware of the risks they and other MSM were running.

“He’s still on Mig 33, I see him every night. That’s the thing, it’s so dangerous, it’s like a time bomb. It probably has already exploded. We don’t know how many people are in, you know, the window period.”

- Male’ MSM

MSM Finding 13

Some MSM understand and practice safe sex. They can be useful as peer communicators, and their ideas can help guide the development of messages.

The qualitative research found that some Maldivian MSM have given considerable thought to safety and how to protect their own health and that of their community, in the absence of any programs from the government. Here are some of the approaches and ideas for messages they recommend.

Promoting Safe Sex: Messages from MSM

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

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

"Always."

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

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

Be Prepared

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

Find a Permanent Partner

Q: [What about a permanent partnership]?

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

Make Use of Peer Networks

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

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

Migrant Construction Workers

This research looked at migrant construction workers in Male' as an example of the larger group of male migrant laborers who might be at risk of HIV. The mapping estimated a total of 7,524 migrant construction workers in Male' alone., but there are many more migrant laborers in the Maldives. The Ministry of Human Resources, Youth and Sports reported a total of 79,431 expatriates working in the Maldives as of May 31, 2009. They come from Bangladesh (50%), India (28.2%), Sri Lanka (11.3%), as well as Nepal and other countries of Asia.

Migrant workers are required to have HIV tests in order to work in the Maldives. So far, the Maldives has deported 239 migrants who were found to be HIV+ . In other words, in theory HIV prevalence among migrants is 0. However there is no accounting for the “window period” – a period of 1 to 6 months (depending on the test given) after infection with HIV but before sufficient antibodies are present to register in an HIV test. Some migrants have surely entered the Maldives during their “window period.” Others may have been infected while in the Maldives.

Male migrants live in an almost-all-male environment, separated from wives and families often for a year or more. Their lives are not easy – they may live in poor conditions, crowded into dormitories, sharing a shower and toilet. There are many stories of abuse of migrants. Some migrants say they paid labor brokers hefty fees to come to the Maldives for guaranteed jobs but once they arrived, the jobs had evaporated and they ended up in the park.

Employers routinely keep migrants' passports, so even if they are discontented, they cannot leave without the employer's permission. Research team members witnessed the difficulty a male migrant, a professional, had getting his passport back when serious illness required him to leave the country. Migrants say that if a company has economic difficulties, they may work for months without pay; some say they are never fully paid for their work.

Many migrant workers are linguistically isolated, and all are likely to be homesick at some times. In these circumstances, it is natural for some men to seek comfort in sex. Migrant workers are may have sex with sex workers, local girlfriends or each other. They may also take drugs as a way to cope with work pressures, worries and loneliness. These activities may put them at risk for HIV, a risk that is often increased by their low education, low awareness of HIV and communication isolation.

The 102 migrant construction workers contacted in the BBS were young (median age 33), and most (54%) were married. They were the poorest of the three occupational groups of men surveyed in the BBS, with a median monthly income of only MRF 2,000.

Qualitative researchers conducted five in-depth interviews with migrant construction workers of several different nationalities, in English and Nepali.¹¹ These interviews reinforce the picture of migrants' isolation and hardship portrayed in the BBS.

¹¹ The Nepali construction workers were interviewed in Nepali. Their words have been translated into English for the convenience of non-Nepali speaking reader. The Indian construction workers were interviewed in English.

Migrant Workers Finding 1

Many migrant workers know very little about HIV and how it is transmitted and prevented, and their linguistic isolation keeps them from being informed.

The BBS found that majority of migrant construction workers lack even the most basic knowledge about HIV transmission and prevention. In the BBS' assessment of knowledge of essential facts about HIV, the migrant construction workers had the lowest scores of any group. Comparing migrant construction workers' knowledge of HIVs with that of another male occupational group, the Seafarers, makes it clear that the migrant construction workers do not have the information they need to prevent HIV.

How Many Men Know the Facts of HIV?

	Having only 1 uninfected partner, who has no other partner, prevents HIV	Using condoms every time prevents HIV	A healthy looking person can have HIV	You can't get HIV from mosquito bites	You can't get HIV by sharing food w/ someone who is infected
Construction Workers	52 %	16 %	43 %	32 %	38 %
Seafarers	94 %	46 %	79 %	74 %	95 %

Construction workers' knowledge levels are much lower than that of the Seafarers, as the table above shows. For example, only 16% of migrant construction workers understood that condoms prevent HIV transmission, and only about half knew that having a faithful, uninfected partner also keeps one safe. It is puzzling what, if anything, migrant construction workers think they can do to avoid HIV, short of complete abstinence.

Less than half of the construction workers in the BBS knew a healthy-looking person could have HIV. This suggests that construction workers may be trying to choose partners that look to them as though they do not have HIV, and then practicing unsafe sex.

Note also that most construction workers believe it is possible to get HIV from mosquitoes or by sharing food with an infected person. The myths of casual transmission (e.g. mosquitoes, sharing food) tend to make people feel more fatalistic about HIV and less able to control their chances of getting it. These myths tend to reduce condom use, putting people at greater risk.

Even if HIV were talked of more in the Maldives, migrant workers would not hear of it, since they are linguistically isolated. The qualitative team came up against linguistic barriers during the research. Most migrant construction workers could not take part in interviews because the

researchers could not communicate with them. Fortunately the team included a Nepali speaker, so several Nepali migrants were included.

Migrant Worker Finding 2

The great majority of migrant workers do not think they can get HIV.

The BBS found that a mere 2% of migrant construction workers felt they might get HIV – the lowest perceived risk of any of the seven groups in this study. In explaining their low perceived risk, most (65%) migrant construction workers said they would not get HIV because they “don’t change partners frequently”, but a puzzling 22% said it was for “other reasons”. These “other reasons” were not clear, but since the migrant workers believe you may be able to tell who has HIV by looking, they be choosing “safe-looking” partners for unsafe sex.

No construction worker said he was safe from HIV because he always uses condoms.

Perceived risk is closely related to hearing about risk. Unless people hears about HIV through the media or through friends, they are unlikely to feel there is any risk of it. If migrants have heard anything about HIV in the Maldives, they have heard that the prevalence is low. Naturally they would assume that the Maldives is safe from HIV, and that they are safe in the Maldives.

“I have never heard anything about HIV in Maldives. Nobody talks about HIV in Maldives.”

- Nepali Construction Worker

Q: “Do you think HIV is a very big issue in Maldives?”

“Not right now”

Q: “Why?”

“Because 99% of people don’t have HIV.”

- Indian Construction Worker

Migrant Worker Finding 3

Migrant workers have sex with girlfriends or with Maldivian FSWs whom they may meet through drug users.

Although migrant workers feel safe from HIV, many are having sex with local girl friends or with sex workers whom they say they meet through male drug users. The BBS also found that 32% of the sample of Male’ FSWs were drug injectors themselves. (See the analysis of FSWs in the previous section.)

“While I am at the park, I hear and see my friends that they are all talking about sex... “I will be here for 5 more years, and I am sure I will meet someone...I went out today to see some women but did not meet anyone. If there are women I am sure I will go for sex.”

- Nepali Construction Worker

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

- Indian Construction Worker

Migrant Worker Finding 4

Migrant construction workers have sexual partners of many kinds, and their condom use is very low, even in situations of highest risk.

Although migrant construction workers said “not changing partners” is the way to prevent HIV and the reason they feel safe, they do have sex with various types of partners, and their reported condom use is very low with all of them. The BSS found that 54% of the migrant construction workers said they had regular sex partners and 96% of those did not use condoms. (It was not clear whether these respondents meant regular sex partners in Male’, or whether they were remembering their wives, back home.)

“Here in Male’ I have 3 girlfriends right now...But I have never used condoms. I do not know how to use condoms and never bought one either. I have been having sex with all three of them currently. I get off once a week and I have sex with one of them once in a week. I have sex every week but my girls get to have sex once in every three weeks. They do not know that I have with other women. These girls are all from Nepal”

- Nepali Construction Worker

Another 4% said they have non-regular partners, and 75% of those did not use condoms. In very risky situations the migrant construction workers reported the lowest condom use.. For example, 3% of migrant construction workers said they had sex with other men, 2% went to sex workers and 2% had sex partners who injected drugs. In these high risk situations, none of the migrants used condoms.

“I know one should use condoms while having sex with other women, but somehow I never used condoms in my life...I went for pleasure and I feel that I should get pleasure 100% as I am paying for it. I do not like using condoms... I myself have used condoms only once in my life, and that was with my wife.”

- Nepali Construction Worker

Migrant Worker Finding 5

Some migrant workers never have seen a condom and other may not know how to use one.

Migrant workers condom non-use may reflect their lack of awareness and exposure to condoms. Qualitative research also found that many had had no experience at all with condoms, had never tried them. With the lowest knowledge of any group about HIV, the lowest perceived risk of HIV, and the lowest income of any group, migrant construction workers are not likely to spend their money to buy condoms, and they have no workplace-based prevention programs to supply them with condoms.

“I know [about] migrant workers and sexual intercourse, what they are going to do, where they find [sex partners], but I don’t know what is condom.

Q: You should buy one and see what it looks like.

“I have seen one from people of public health, those guys had one condom and they told me to try also. I’m having sex with my girlfriend, but I’m not using that condom.”

- Indian Construction Worker

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

- Nepali Construction Worker

Migrant Worker Finding 6

Migrant construction workers get less HIV information than any other group, and most of it is from mass media.

The BBS found that only 18% of the migrant construction workers got HIV prevention communication in the past 12 months, less by far than any other population at high risk. Information was almost entirely from mass media such as television, radio, and newspapers.

It was not clear whether they got this information back home or since arriving in Male’, but mass media in Male’, Divehi language would be difficult for most of them to understand. For this reason, mass media is particularly inappropriate as a channel for migrants.

A few reported getting HIV information from friends. No migrant construction workers got information from NGOs, from workers’ associations, or from their employer – the easiest ways to educate migrant workers about HIV.

“I have never heard in my life how HIV is transmitted. I have been out of [my] country for almost 16 years, and who will tell us about HIV in a foreign country?”

- Nepali Construction Worker

It is clear that migrant workers have a pressing need for HIV information in a language they can understand, whether through work-place based interpersonal communication programs, or targeted media distributed to them by a civil society group or government. They are the least well-served group in the Maldives, this research found. At the present time, their HIV prevention needs are almost completely unmet.

While migrant workers are ignorant about HIV and condoms, those who are responsible for planning HIV communication and other interventions in the Maldives are equally ignorant about the migrant workers. At 80,000, migrant labor is not a population to be ignored in the Maldives, yet these groups have never been properly researched. For example, no studies have been done of the HIV risk of Bangladeshi migrants, the largest group of migrants in the Maldives. There is an urgent need for studies to be conducted in the migrants' own languages.

Stopping HIV+ migrants at the border is one thing, gives many people in the Maldives a false sense of security – false because risk behaviors do not stop there. Raising migrants' awareness of the risks of HIV through information (as in brochures, translated into their languages) is a good first step, but it is not enough. Information alone does not change behavior. It is important to work in partnership with the different national groups of migrants, to understand their risk behaviors, attitudes and knowledge re. HIV, their needs for prevention services, and what is most likely to motivate them to stay safe.

Research needs to be done in the migrants' own language, preferably by skilled researchers from their own background. Once this is done, then responsible workplace-based and other programmes be developed to support them in safe behaviors once they are in the Maldives.

Resort Workers

Resort workers in the Maldives live and work in some of the most beautiful places on earth -- pristine islands set in transparent blue water, the sites of the Maldives' world-class tourist resorts. Some of these resorts are frankly opulent, others more modest, but in either case, workers' living conditions usually contrast sharply with those of the guests on the same islands. Workers' housing ranges from very basic dormitories (hallways full of beds with no partitions), to comfortable private quarters for the senior staff. Workers' food and recreational opportunities also vary according to the management.

Regardless of the beautiful natural environment, resort workers share to a large extent the situation of migrants. Separated for long periods from their regular partners, in a largely male work environment, and with few opportunities for recreation, they face loneliness, homesickness and boredom even in their lovely settings. Moreover, about half of resort workers are migrants who may share the migrant construction workers' linguistic and cultural isolation.

The BBS mapping exercise estimated a total of 16,708 resort workers in the Maldives. Resort workers are a diverse group – Maldivians and expatriates of various nationalities, working at a wide range of jobs, from dishwashers and gardeners to highly skilled accountants and master divers, with varied backgrounds, educations and salary levels. Resort workers are separated from their families for longer or shorter times, depending on the location of the resort. Maldivian workers have easier access to their families, but cost of travel is always an issue, and only a few resorts sponsor family visits. Most resort workers are male. Many Maldivian resort workers come from Addu, although there are resort workers from every atoll.

The BBS found HIV and active syphilis among the resort workers during the serological study – this was the only group where these diseases were found. One case of HIV was found among 484 resort workers whose blood was drawn – a seroprevalence of 0.2%. In addition, the BBS found active syphilis in 1.2% of resort workers.

In the behavioral survey, the BBS contacted a total of 460 male resort workers in 46 resorts, using cluster sampling. Of these, 51% (236) were Maldivian, and 49% (224) were expatriates, with a median age of 31. Their salaries were a median of 4,500 MRF, but there was an enormous range reported – from considerably lower up to 40,000 MRF a month.

The qualitative researchers traveled to several resorts to interview workers and resort administrators. While the administrators were cooperative, the QR Team found it difficult to talk to resort workers, even privately, as long as they were on their resort island. They may have felt that revealing their sexual histories, even with guarantees of confidentiality, might reflect badly on their resort or even affect their job status. As a result, these interviews were not very productive. Instead, the QR team conducted discussions of former resort workers, including a focus group in Addu. In addition, references to work in resorts appeared in some of the interviews with MSM, IDUs, and Youth. These are included in this analysis, as well.

Resort Workers Finding 1

Resort workers have many kinds of sex partners: regular partners back home, fellow resort workers, guests at the resort, and sex workers.

There was a sharp difference between the BBS and the qualitative research regarding the sexual lives of resort workers. The BBS found a rather low level of reported sex among resort workers – most reported only regular partners or girlfriends back home.

The BBS found that 12% of the resort workers said they have non-regular partners, and only 4% said they went to FSWs. However, about 20% of the FSWs in Addu, and 10% in Male’ said that resort workers were among their most frequent clients, suggesting that the resort workers may have been under-reporting this behavior. It is possible that the resort workers’ lower estimates reflect the discomfort they felt because the BBS was conducted in the resorts.

The QR Team found that the best information on resort workers’ HIV risk came from resort workers or former resort workers contacted away from the job. When former resort workers were gather in a focus group in Addu, for example, they told a very different story. They said that resort workers go to Male’ on their days off and find FSWs by first looking for drug users in Jumhuree Maidhaan park. The drug users they take them to a guest house where a FSW (possibly an IDU herself) will be waiting, the former resort workers said:

“They first contact the drug people, and the drug people link them to the prostitutes.”

- Addu Former Resort Worker¹²

Away from the resort, resort workers described an active sex life in the resorts.

“Full blown orgy, plus watching girls having sex with girls. All kinds of sex experience.... started from the resort.”

- Male’ Former Resort Worker

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¹² Some resort workers were interviewed in Divehi and some in English, according to their preference. Wherever a Divehi quote appears, they are the original words of the resort workers interviewed and the English translation is provided for the convenience of the non-Divehi speaking reader. Wherever an English quote appears alone, the interview was conducted in English.

Resort Workers Finding 2

Job category makes a difference in resort workers’ sexual opportunities. Certain categories of employees have more chances to have sex with guests.

The qualitative researchers found that difference in job status among the resort workers makes a big difference in their access to sexual partners. The workers who have the most personal contact with guests naturally also have the greatest opportunity for sexual contact with them. These include those who work in the dive shop, the restaurant, the front desk and reception area, or the guest rooms themselves. These staff members are also likely to be better educated and to know English or another language guests can speak.

Management strictly forbids sexual contact between staff and guests, the respondents told the researchers, but it happens all the time.

“They can have sex with guests, especially the service department, the waiters, room boys – they have more freedom.. usually with German, French, mostly Europeans.”

- Addu Former Resort Worker

“I worked at a resort for 17 years, and I was a heavy alcohol drinker. So every night when I am done with my work, I go to the bar. And I entertain any single person there. And sometimes when the husband leaves the wife at the bar to drink alone, I have to entertain her....I have entertained hundreds of them in 17 years.”

- Male’ Former Resort worker

“...I have entertained hundreds of them in 17 years.”

Resort Workers Finding 3

MSM sex also occurs in resorts, but it is not clear to what extent.

Only 1% of resort workers claimed to have sex with men, the BBS found. However the QR team heard of resort workers who have sex with guests who are MSM. Male resort guests sometimes invited male resort workers to Male’ guest houses and paid them to have sex, some former resort workers told the researchers.

With hundreds of men living closely together on a resort, it would be surprising if there were not some MSM activity. Some men might have sex with a man when there are no women available. One MSM complained about this tendency of some men:

“It always happens when there are all men only....There are guys who have wives in Male' and can go on off-days to Male' once a week but still like to be engaged in MSM in the resorts, and when they are in Male' they pretend to be totally someone else, and even pretend that they have never seen me or know me at all.”

- Male' Resort Worker / MSM

Resort workers told the qualitative researchers that certain categories of workers are often said to be MSM, such as cooks, but an MSM resort worker said his partners came from all job categories.

“Staff cooks are mostly the stereotype of feminine guys who loves to be in the kitchen...they are the most noticeable [MSM] in the resorts, because they don't care what people think about them, and no one can harm them in the resort because all the staff have human rights from the company...it is one of the golden rules in the hotel industry which is still followed by all the resorts till today. So I can say that is one place we can be ourselves and not be afraid of anyone....Waiters, roomboys, front office assistants are also involved in these acts, but they are not seen or known by anyone besides those who engage in MSM.”

- Male' Resort Worker / MSM

Resort Workers Finding 4

Drugs are present in resorts but they are not allowed; if staff are discovered using them, they will be fired, resort workers say.

Drugs are not allowed among employees in any resort, and serious drug problems result in sure firing, resort workers and resort administrators said. Some of the IDUs in the qualitative research had worked at resorts before being fired for drug use. Real addicts cannot work at a resort, the respondents told the research team, because they can't attend to their jobs while sustaining a serious drug habit, but some resort workers use drugs when they come to Male' on breaks. Alcohol is reported to be commonly used, since it is freely available to guests at the resort.

Some resort workers talked about drug use involving guests. The following example of risky behavior combines drugs, group sex, and no condoms.

Q: I have heard people say that sex is very pleasurable when you are using heroin and that people engage in group sex under the influence.

“Yeah, I have had...I did in a nearby resort with an Italian girl, and then there was this guy from Philippines, I think. It was by her consent, and it was just the three of us who did it...The three of us were also using.”

Q: Did you use condoms?

“We didn't use them.”

-Male' Resort Worker

Resort Workers Finding 5

Condom use among resort workers is extremely low with partners of all kinds

The BBS found that condom use among resort workers is low, especially for the behaviors at highest risk, such as anal sex. Of the 88% who say they have regular sex partners, only 8% used condoms. Of the 12% with non-regular sex partners, less than half (44%) used condoms. Of the 4% who report sex with sex workers, 59% did not use condoms. Among those who report sex with other men, none used condoms.

When asked if they thought they could get HIV, 94% of resort workers said no, and 8% of them said it was because they used condoms consistently. While higher than some other groups, this is still a very low reported rate of condom use.

Resort Workers Finding 6

In spite of their multiple risk behaviors and the fact that HIV was discovered among them, only 94% of resort workers think they cannot get HIV.

Resort workers had the second lowest risk perception of any group studied in the BBS. Only 6% said they thought they might get HIV. Only migrant construction workers (2%) had a lower assessment of their own risk. When asked the reasons, 57% said it was because they did not change partners often, while 16% said it was because they were convinced their partners were healthy.

This is in sharp contrast to the BBS serological findings, which discovered both HIV and syphilis among resort workers only, and also to the BBS behavioral findings, which showed resort workers have numerous partners.

Resort Workers Finding 7

Resort workers' knowledge of HIV is incomplete. Most don't say consistent condom use is a way to prevent HIV but instead focus on choosing "safe" partners.

Like the migrant construction workers, resort workers' knowledge of HIV prevention was incomplete and focused inappropriately. The BBS found that only 47% of resort workers say that consistent condom can prevent HIV, while 85% say you can prevent HIV by having one faithful, uninfected partner. Among the resort workers, 75% are married. However, as with the migrant construction workers, a focus on fidelity is not a practical solution for HIV prevention for resort workers, since those who are married very seldom have the chance to be with their wives.

A few resort workers (15%) do not know that you cannot tell who has HIV by looking, the BBS found. This may be the reason why a number of resort workers say they can't get HIV because they are "convinced that their partners are healthy." This focus on the healthy partner suggests that these resort workers are judging their partners' based on appearance, or possibly on other stereotypic factors such as nationality, education, or age. These resort workers may also use

Seafarers

Seafarers were one of the first groups to contract HIV in the Maldives, so it was logical to pay special attention to them in this first comprehensive audience research. However, it appears from the findings that the Maldives has responded well to seafarers' risk of HIV. The availability of condoms on all ships, the mandatory HIV prevention education in seafarers' training and the STI treatment seafarers say they get are all excellent first steps in protecting this highly mobile group and appear to have prevented further HIV transmission among this group.

The BBS contacted 130 seafarers, using simple random sampling, as the third of the three occupational groups of men surveyed. The seafarers were older than the other two occupational groups of men (resort workers and migrant construction workers) with a median age of 43. Seafarers' median monthly income of MRF 8,500 is also higher than either resort or construction workers. All were Maldivian. Seafarers had less education overall than the other occupational groups of men – 56% had studied from grades 1 to 7 only.

The serological study found that 4% of seafarers had Hepatitis B, higher than any other group except MSM. They did not have any active syphilis, Hepatitis C or HIV, however.

The qualitative research team conducted six in-depth interviews with seafarers. All of them were older, married men, so they may not have reflected the full range of risk behavior. The interviews were also conducted in English, thus they were with seafarers who spoke English well – possibly those who were better educated than average.¹³

While they mentioned some ships that were out of the Maldives for months at a time, all of the seafarers interviewed in the qualitative research had shorter voyages, taking them out to sea for about 20 days of the month, followed by a week or ten days back home. Nevertheless, their short trips took them to many places, including countries where HIV is prevalent: Thailand, India, Singapore, Indonesia, Vietnam, Malaysia, Myanmar.

Seafarers Finding 1

Most seafarers are married, and many would prefer to work on land, close to their families, but they stay at their jobs because of the high salaries.

The BBS found that most seafarers are family men – 80% of seafarers are married. All the seafarers contacted in the qualitative research said they would rather be home with their families, but they wanted to keep their high salaries, to support their families and educate their children. Several said their wives were pressuring them to take jobs at home

¹³ Note that all the quotes but one in this section are in English, because most of the interviews with seafarers were conducted in English. Where Divehi appears, those are the original words of the respondent, and the accompanying English is a translation. Where an English quote appears alone, the interview was conducted in English.

“Everybody likes to stay with his family at home. But in Male’ there is no job to get with the same salary as we have here....”

- Seafarer

“I’ve got three children, I want to get them educated the best I can supply them so I have to go until at least another four or five years.... What you miss most in this life is the kids; smiles, what they achieved in school, things like that. You’re not always there. But this is the only way I know how to make money.”

- Seafarer

Seafarers Finding 2

Sex workers are present in all ports and even come on board the ships in some of the ports where Maldivian seafarers commonly go.

The BBS found that 6% of seafarers reported having sex with FSWs. While still low, this was higher than the 4% of resort workers and the 2% of construction workers who said they went to FSWs. This may reflect the higher income of the seafarers, as well as their highly mobile life style, and the aggressive sex work scene in ports they visit.

Seafarers say that the great majority of the FSWs they frequent (83%) are expatriates, and that they meet them at the harbour through pimps, friends and direct transactions. When seafarers travel to foreign ports, for example to Thailand, they may or may not be permitted to leave the ship, but this makes no difference, since the FSWs simply come on board the ships themselves. Seafarers say the women may come to sell tee-shirts or some other pretense, but once on board, it is clear they are there for sex.

“Even in Singapore there is sex business; Bangkok it’s 50%, in Vietnam there is also. People come on board”.

Q: And this is allowed?

“Yes, this is allowed. It’s allowed for every company, not only this company. I used to work for different company. Every ship, every company, nobody cares if those are coming on board.”

- Seafarer

One seafarer, who said he is now married and faithful to his wife, reflected on his days as a single seafarer:

“Bangkok, a lot of girls come on board. It’s like you’re married to them. They just come, when you’re alongside, the jetty, the girls come on board, take your key from you and they’re inside. It was like that.”

Q: During that time you could have women on board in your cabin?

“All the days we were there...You let somebody [stay] tonight, and the other night she will go to some other crew...Sometimes you have more girls who don’t have places to sleep. Let’s say I have one girl in my bed there, two, three girls can come and sleep here also. It was an interesting life.”

- Seafarer

Seafarers Finding 3

No seafarer admitted to having male-to-male sex, but some said they had heard of it.

Research and experience worldwide shows that men who are isolated for some time in all male populations may have sex with each other. However no seafarers admitted to this. It is not clear whether they really do not ever have male-to-male sex, or whether they were embarrassed to admit it, since there is such a strong taboo against homosexuality in the Maldives.

This seafarer’s comment suggests that it is simply something that seafarers ignore, from tact or taboo, an informal of “don’t ask, don’t tell” policy:

“Some ships [have MSM] yes, even on ships where I was working before...Generally it’s a secret, but it’s a common secret. Everybody knows about it, abut we don’t talk about it.

- Seafarer

Seafarers Finding 4

More seafarers say they use condoms than the other groups of men.

Seafarers had the highest rate of condom use of all the occupational groups of men. Seafarers reported using condoms 66% of the time with FSWs, and 75% of the times with their non-regular partners. While this is an improvement over the other occupational groups of men, seafarers still did not use condoms with FSWs a third of the time, or with their non-regular partners a quarter of the time. And seafarers almost never use condoms with their regular partners, such as girlfriends and wives, no matter what their other sexual behavior may be.

Some seafarers correctly identify the use of condoms in sex outside of marriage.

“If we go to another woman other than the wife and have sex, we use condoms, but if it’s not like that, if we don’t go to any other person other than the wife, then it’s no use. That’s how I use condoms. Sometimes there comes the time to use the condom.”

Q: Do you use it that way?

“Yeah, use it sometimes.”

- Seafarer

However 20% of seafarers are not married, and only 3% say they are safe because of using condoms. This leaves as a mystery the reason why the remaining 17% (who are probably sexually active) think they cannot get HIV.

“I don’t change partners often” was the reason given by 38% of the seafarers who said they were safe from HIV. But the largest group (44%) said they were safe from HIV for “other reasons.” These mysterious “other reasons” were not spelled out, but the researchers reported they included vague phrases such as “not taking risks” and “being careful.”

Such subjective evaluations of risk behavior offer many pitfalls. For example, it may be that seafarers are choosing partners for unsafe sex based on stereotypes of age, appearance, or nationality, or even whether they consider a woman to be a “prostitute.”

Q – Who do you think can get HIV?

“If you have sex with prostitutes.”

- Seafarer

Defining HIV risk as sex with prostitutes, for example, is too narrow a guideline to provide real safety to anyone. Many women who sell sex may not consider themselves “prostitutes” (see for example the earlier section on FSWs). In addition, many other types of partners besides sex workers may transmit HIV.

These seafarers’ “other reasons” for unprotected sex need to be explored further. Seafarers were the first group to become infected with HIV in the Maldives, and although much good work has been done with them, they continue to be actively exposed to sex work on their voyage throughout the region, and their risks need to be taken seriously.

Seafarers Finding 7

Most seafarers do not say they think that consistent condom use can prevent HIV. This may be due to a lack of knowledge or to moral judgments they may make about condoms.

Seafarers’ knowledge of HIV prevention and transmission was better than most other groups studied in the BBS, but it was still not complete. For example, the BBS found that most seafarers know that you cannot get HIV through sharing food (95%) and that a healthy looking person may have HIV (79%). Nevertheless, most seafarers still do not know that HIV transmission is decreased by using condoms every time they have sex. Only 44% of the seafarers answered that question correctly. This suggests that although seafarers have higher reported condom use than resort workers and construction workers, they still do not fully appreciate the importance of condoms in preventing HIV.

Some seafarers are reluctant to include condoms in HIV prevention believing that good behaviors are guarantee enough. This suggests that HIV prevention education give to seafarers may overstress morality and the protection offered by religion. While these principles are excellent, they do not protect many who are at risk. Practical prevention information, such as the effectiveness of condoms, also needs to be stressed.

This seafarer felt that moral messages were enough to protect him and that he had no further need for information about HIV.

“I’m already aware of that so I don’t need more information. Because I have myself guaranteed that I will not touch those prostitutes, homosexuality or any kind of these things, I will not touch.”

- Seafarer

While this self confidence is admirable, not all seafarers may be capable of this self-discipline. For those who are not, condoms need to be promoted as a valid option.

Another seafarer objected on moral grounds to the idea of telling young people about condoms.

“What I want is to give more knowledge about HIV.”

Q: And how would you like us o speak to your children...Do you think condoms are important?

“No, not the condoms. For my way, it’s about behavior. If our behavior is good, there will be no chances [of getting HIV]

- Seafarer

Seafarers Finding 8

Seafarers say they treat their STIs 100% by going to medical practitioners.

Only 3% of seafarers said they had had STI symptoms, the lowest rate of all three occupational groups of men – this correlates to their higher reported condom use. In addition, all of the seafarers who have gotten STIs say they go to medical practitioners for treatment.

Seafarers were the only group studied in the BBS to report that 100% of their STIs get proper medical treatment (other groups reported self-treating or simply ignoring their STI symptoms.) Clearly seafarers have had good prevention education in this regard.

Seafarers Finding 9

Sixty percent of seafarers got HIV information last year – the highest of any group in the BBS – but that leaves 40% still not served.

The BBS found that the majority of seafarers (60%) received HIV information in the past year. This is one of the highest rates of any group studied in the BBS, and much better than the resort workers or construction workers. This may be due to the short courses, including information on HIV, that are reportedly given to seafarers before they embark. However that still leaves a sizeable minority (40%) without HIV information. This gap needs to be filled.

Seafarers Finding 10

Seafarers like to watch movies and play cards together, providing an opportunity for HIV prevention education.

Seafarers spend a lot of time together on ship. Many seafarers say they don't get much free time, and when they do, they like to sleep, or join their mates to watch movies or play cards. It seems that seafarers' recreational options are limited. In this case, recreational activities such as movies or card games may be created for seafarers, including HIV education.

“We're watching movies sometimes, there is no other entertainment on board.”

- Seafarer

“After finish our job, we used to watch TV, movies, have too many kind of movie here, sport movies, we used to play cards, sometimes study.”

- Seafarer

“We are all men on board...we share a table for lunch and even breakfast, so that's the time we get together...if you have something to share with your colleagues, then that is the time to do it. We normally talk a lot. We gather from every other person what they have heard, what I have heard I tell them, and all that. So we have a pool of knowledge. So this is how we get information.”

-Seafarer

Films and games can be used for organized HIV prevention communication using an “edutainment” or “entereducate” model. For example, HIV prevention messages can be printed on cards, and video spots on HIV can be packaged with films, music videos or amusing short features. This is an opportunity for a creative approach to prevention education which could easily be pursued in partnership with seafarers' groups or employers.

Youth

Youth as a group is not usually considered at high risk for HIV, however Youth were included in BBS and qualitative research and are therefore included in the comprehensive audience analysis. Youth is an important target audience for HIV prevention communication in the Maldives simply they are the source for all other Maldivian groups at risk. The Maldivians who may get HIV in five years are very likely to be in the youth category today. Preparing them now to face the challenge of HIV makes sense.

Not all youth engage in risk behaviors for HIV, but many do. In addition, youth culture is shared to a large extent, so the knowledge, attitudes and perceptions of today's youth about HIV risk and behavior make a difference to the environment in which HIV prevention communication will take place in the Maldives.

The BBS contacted 460 youth in Male' using cluster sampling and 145 youth in Laamu Gan using purposive sampling. The QR Team conducted 8 interviews with youth in Male' and Laamu Gan, almost all in Divehi.¹⁴

The BBS found that the median age of youth was 18-19. In Male', 38% of the youth are working, 31% are studying and 14% are just hanging out. In Laamu Gan, 30% of the youth are working, 44% are studying, and 20% just hanging out. In education, about half in both locations had achieved their GCE O levels.

Most of the youth in both locations – 81% in Male' and 75% in Laamu Gan – had not yet married. In other words, only 19% of the BBS youth sample in Male' and 25% in Laamu Gan had been married (were either presently married, or divorced, separated or widowed).

Sex before marriage is illegal in the Maldives and can be punished severely, for example by public whipping, expulsion from school etc. However, 34% of the youth sample in Male' said they had had sex, while only 19% had been married. In Laamu Gan, 50% of the youth said they had had sex, while only 25% had been married. In other words, among the youth contacted in the BBS, 15% in Male' and 25% in Laamu Gan claimed to be sexually active but married.

Overall, nearly half of the youth in the BBS sample said they were sexually active, but only about a quarter were married. This means that for every married young person there is another unmarried young person who is sexually active. In other words, sex before marriage is very common among young people in Male' and even more common among the youth in Laamu Gan.

In addition, both the BBS and qualitative research found evidence of some very high risk sexual activity among the young, including sex work and group sex, often with drugs or alcohol.

¹⁴ Wherever Divehi quotes appear in this section, they are the original words spoken during the interview. The English translation is provided for the convenience of the non-Divehi speaking reader.

“My uncle abused me when I was six or seven years old, in kindergarten.. Now when he sees me he just points at me and says I will be better for it [sex] now than when I was young. Most of his friends know, and I think they still think of me that way. I feel cheap because I feel like I can be used by anyone, since I already was.”

- Male’ Young Woman

Youth Finding 4:

Some young people go to sex workers, and a few do sex work themselves. In most cases, condoms are not used.

The BBS found that 2% of the youth say they had sex with sex workers – nine young men and one young woman reported paying for sex. Of these, 70% say they do not use condoms.

Some young people also say they do sex work themselves. The BBS also found that 1% of the youth said they sell sex, and none of them used condoms. The qualitative researchers heard references to sex work in interviews with female youth. Sometimes money is involved, and sometimes gifts, as when a man invites a young woman to accompany him on a trip and pays for everything. In this second situation, the young woman does not think of herself as a sex worker.

“When some rich guy gets horny and calls up and says something like he will give 2000 [rufiyaa] for each, who will not go?....Now most of the girls our age, who aren’t working, and whose family are not rich, this is how they survive.”

- Male’ Young Woman

“කුමාරයා එක පැයකට 2000/- රුපියල් දෙකක් දෙනවා. ඒකට ගොස් දෙනවා. නැති නම් නිකමක් දෙනවා. නැති නම් නිකමක් දෙනවා. නැති නම් නිකමක් දෙනවා. නැති නම් නිකමක් දෙනවා.”

Q: So was there ever a time when someone paid you for sex?

“No way, nothing like that. As I said before, I work, so there is no point in going to that level.”

Q: Did you get any offer to go on a trip? ...When going to Lanka was there ever a time that someone else actually paid for the trip?

Yes, I went on two or three trips like that. For example, if a stranger offers me a trip then I would accept the offer, keeping in mind that he will want something in return...so I get everything I want in the first place.”

- Male’ Young Woman

... "Q: How many people?"
 "The whole town showed up, but my classmates found out and it was like the whole town showed up."
 "No, the girl was OK"

... "Q: How many people?"
 "At first, when we planned it was me and two more guys, but my classmates found out and it was like the whole town showed up."
 "No, the girl was OK"

Youth Finding 4:

Some young people take part in group sex, often involving drugs or alcohol.

The BBS found that a certain number of youth (8% in Laamu Gan and 1% in Male’) said they had taken part in group sex, sometimes involving drugs or alcohol. Group sex is almost always unprotected sex, especially when alcohol and drugs are involved. The practice of “buffet” is discussed above, under IDUs (where a number of young men have sex with one young woman who may or may not agree), but the qualitative researchers found that this was not only a drug users’ practice – other youth may also take part, even school boys:

“One time a classmate brought a girl and everyone was there...I was very disgusted that time.

Q: Was it rape?

“No, the girl was OK”

Q: How many people?

“At first, when we planned it was me and two more guys, but my classmates found out and it was like the whole town showed up.”

- Male’ Young Man

... "Q: How many people?"
 "The whole town showed up, but my classmates found out and it was like the whole town showed up."
 "No, the girl was OK"

Some young women also said they had group sex, sometimes with partners.

Q: How many partners were involved?

"It varies. One time the maximum number involved was 4"

Q: Was it one guy with many girls?

"Actually it would be couples. When being in one room we all booze and while drinking, each couple by couple will start getting involved sexually and in time, the partners get exchanged."

Q: Did you use condoms at that time?

"No, I didn't....We were too drunk to think about anything else. The only thing on our mind was pleasure. We were in a situation where anything as OK for us."

- Male' Young Woman

ސ. "ލަބިޔާ ފަދަ ސިޓީއެއް ހުރިހާ?"
"އަދަދު ފަދަ ސިޓީއެއް ހުރިހާ ފަދަ ސިޓީއެއް ހުރިހާ 4 ފަދަ"
ސ. "އަދަދު ފަދަ ސިޓީއެއް ހުރިހާ ފަދަ ސިޓީއެއް ހުރިހާ?"
"ފަދަ ސިޓީއެއް ހުރިހާ ފަދަ ސިޓީއެއް ހުރިހާ 4 ފަދަ ސިޓީއެއް ހުރިހާ"
ސ. "އަދަދު ފަދަ ސިޓީއެއް ހުރިހާ?"
"އަދަދު ފަދަ"

Many of the young male respondents had heard about group sex, whether or not they had taken part in it. No one, male or female, in the qualitative research expressed any concern about group sex as a risk for HIV or STIs.

"A lot of people go to her even now [for group sex], she is very famous in that way..."

-Laamu Gan Young Man

"މިހާރު ވެސް ފަދަ ސިޓީއެއް ހުރިހާ ފަދަ ސިޓީއެއް ހުރިހާ 4 ފަދަ ސިޓީއެއް ހުރިހާ"

Youth Finding 5

Although they say STIs are rare in the Maldives, youth reported higher rates of STIs than any group in the BBS except for the FSWs, and half say they don't treat them.

In Male' 19% and in Laamu 23% of the youth contacted in the BBS said they had had symptoms of STIs. This is higher than any other group studied in the BBS, except for the FSWs. When they get STIs, about half of the youth say they don't do anything about them. The other half say they go to a medical practitioner for treatment.

Youth Finding 7

Youth think of HIV as a disease of “others” who are different from themselves (e.g. drug addicts, those who go abroad or have sex with foreigners). They may believe what they consider “normal” behavior is safe from HIV, even if it is not.

Images of people with HIV as “different” prevail worldwide. In most societies, people consider HIV as a disease of “others”, although those “others” will naturally vary from group to group. In the Maldives, young people think that drug injectors, sex workers, and foreigners are at risk for People they know well, who come from their community and behave in the “normal” ways, cannot get HIV, they believe.

Q: Who is at high risk?

“In my point of view it would be people who inject...people who have sex for money. Those kinds of things. Also I hear that lots of Maldivians behave like that out of the country, so it can also be a problem.”

-Male’Young Woman

“...”
“...”
“...”

“Actually I haven’t been abroad, but what I think is people go there and do bad things; they might things like [HIV], but...there aren’t many people who have HIV in the Maldives.

- Laamu Gan Young Woman

“...”
“...”
“...”

“I do care, that’s the reason I use condoms while having sex with foreigners, because most of the times AIDS comes from foreigners. I don’t think we have it in the Maldives. If any Maldivian is infected we would all come to know who is infected easily.”

- Male’ Young Woman

“...”
“...”
“...”

Youth Finding 8

Most young people are keenly aware of drug use, even if they do not use drugs themselves.

Drug use is talked about among the young; most know who uses drugs. Many young women have male family members or friends who use drugs, and they worry about them. Unfortunately, drugs are now a part of life for young Maldivians, even for the non-users.

“Actually, the dealers are in (village). They have a farm and in that farm there is a nice house which is like a meeting point. That’s where people go and use.”

- Laamu Gan Young Man

“..... ދިވެހި ރާއްޖޭގެ ތެރޭގައި ބޭނުންކުރާ ޖާރިއާ ފަރާތްތަކުގެ ތެރޭގައި ރާއްޖޭގެ ތެރޭގައި ހުންނަ ފަރާތްތަކާއި ބޭރުގެ ފަރާތްތަކާ ދެމެހާ ގޮތެއް ނެތެވެ. ބޭނުންކުރާ ޖާރިއާ ފަރާތްތަކުގެ ތެރޭގައި ރާއްޖޭގެ ތެރޭގައި ހުންނަ ފަރާތްތަކާއި ބޭރުގެ ފަރާތްތަކާ ދެމެހާ ގޮތެއް ނެތެވެ.”

This young woman recognized that her sex partner was injecting drugs, but failed to recognize the risk that posed for her because he was not her boyfriend:

“I did see one [sexual partner] injecting, but I didn’t know what it was.”

Q: Was is a Maldivian or a foreigner?

“He was a foreigner...I had a couple of nights with him.”

Q: .You were not bothered to know about that injection?

“Yeah, actually it’s nothing that concerns me – he was not my boyfriend.”

- Male’ Young Woman

“..... ދިވެހި ރާއްޖޭގެ ތެރޭގައި ބޭނުންކުރާ ޖާރިއާ ފަރާތްތަކުގެ ތެރޭގައި ރާއްޖޭގެ ތެރޭގައި ހުންނަ ފަރާތްތަކާއި ބޭރުގެ ފަރާތްތަކާ ދެމެހާ ގޮތެއް ނެތެވެ. ބޭނުންކުރާ ޖާރިއާ ފަރާތްތަކުގެ ތެރޭގައި ރާއްޖޭގެ ތެރޭގައި ހުންނަ ފަރާތްތަކާއި ބޭރުގެ ފަރާތްތަކާ ދެމެހާ ގޮތެއް ނެތެވެ.”

"أنا فقط استخدمت الواقيين لأنني كنت في علاقة مع فتاة، والباقي من الشباب لم يهتموا بذلك. أنا فقط استخدمت الواقيين لأنني كنت في علاقة مع فتاة، والباقي من الشباب لم يهتموا بذلك."

Youth Finding 13

Only a few young people advocated or modeled safe behaviors.

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

Promoting Safe Sex: Messages from Youth

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

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

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

- Male Young Man

"أنا فقط استخدمت الواقيين لأنني كنت في علاقة مع فتاة، والباقي من الشباب لم يهتموا بذلك. أنا فقط استخدمت الواقيين لأنني كنت في علاقة مع فتاة، والباقي من الشباب لم يهتموا بذلك."

General Recommendations for HIV Prevention Communication

Six overarching, general recommendations grew out of this audience analysis. These and many other recommendations, specific to the seven target audiences, are spelled out in the BCC Strategy document: *Behavior Change Communication Strategy for HIV Prevention in the Maldives*.

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

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

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

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

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

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

one to three month invisible “window period¹⁵” during which migrants may enter with negative tests. More important, almost nothing is done to support migrants in safe behaviors in the Maldives.

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

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

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

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

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

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

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

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

¹⁵ Depending on the test given. Newer tests may shorten the window period to one month.

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

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

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

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

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

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

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

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

The highest levels of stigma in the Maldives, however, are reserved for MSM. The MSM contacted in this study shared deep and painful feelings of loneliness and alienation, and many recounted painful experiences including abuse by older males, brutality from those in authority, cruel teasing, family rejection, threat of job loss and even public whipping and banishment. In such an environment, MSM naturally hide their sexual preferences, putting their male and female partners at even greater risk for HIV. The MSM the qualitative researchers met do **not** generally want a militant public gay presence in the Maldives; they want only to be allowed to be themselves, with quiet assistance in staying safe.

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

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

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

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

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

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

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

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

Communication that is based in the present communication practices and structure of a community is better than communication imposed from the outside. For example, every group has members who have developed their own behavior change strategies and can show others the way. These “positive deviants” are those within a community who have arrived at their own solutions to problems through their own creativity and experimentation. In Diffusion terms, they are the “innovators”¹⁶ who initiate the change process, and if they also have a measure of social acceptance within their group, they are the best communicators for change.

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

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

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

This audience research clearly shows that general population information does not meet the HIV prevention communication needs of most groups at higher risk, for several reasons. One reason is that the information targeted toward the general population makes assumptions about behavior that do not match the reality of these groups at risk (for example heterosexuality). Another reason is that general population information often includes judgments or labels that alienate people at higher risk and do not produce realistic assessments of behavior. For instance, saying that avoiding sex workers is a way to avoid HIV may encourage women who trade sex for drugs to say they are not sex workers, or men to deny that their partners are sex workers, even if they pay them. A third reason is that general population HIV prevention information usually stresses behaviors such as abstinence, fidelity, sex within marriage only, and no drug use – which simply are not realistic behavioral guidelines for groups at higher risk.

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

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

¹⁶ See Everett M. Rogers, *Diffusion of Innovations* for a description of categories of those who adopt change in any population

APPENDIX A:

Overview of the Qualitative Research Process

1. Develop a Research Plan:

- Research questions
- Target audiences, sites
- Methodology
- Sample, segments, number of interviews
- Budget

2. Get permission and funding for the study.

3. Choose a Research Team.

4. Train the Research Team in qualitative methods.

5. Develop discussion guides for each target audience segment.

6. Get tape recorders and train the team in their use.

7. Gather respondents (may use key informants to contact them).

8. Conduct interviews.

9. Store a master copy of all recorded data in a central, secure place, with backup.

10. Transcribe interviews in original language (first, train transcribers).

11. Translate interviews into English (first, train translators).

12. Number the interviews (e.g. IDU 01 Addu) and the pages on electronic copies.

13. Print interviews: 2 copies in Divehi, 2 copies in English (one is 1-sided).

14. Decide on an analysis code (start with the research questions – you may add other categories as you read.)

15. Read each transcript in the original language.

16. Write the code letter, transcript number and page number in the margin, using the

1-sided copy. Mark both the Divehi and the English the same.

17. Cut up the 1-sided, coded transcripts (both Divehi and English). Tape or staple the two languages together.

18. Tape all the clipping pairs for one code category onto a big paper with a heading (e.g. all the clippings for IDUs - B – Sexual Risk on the same big paper.)

19. Taking one target audience at a time (e.g. IDUs), read all the clippings for one code category (e.g. all the clippings for IDUs - B – Sexual Risk.) Try to understand what they are saying, including the sub-text (the hidden meaning or inference.)

20. Ask yourself: What have I learned about this target audience?

21. Write each finding in a clear sentence.

- It's OK to use your intuition, and to guess & interpret! This is a creative analysis process!
- It's OK to use words and phrases such as "it seems" "may" "it is possible that..." "suggests"

22. Choose one or more quotations to illustrate each finding. Write them in both Divehi and English, noting the interview number and page number

- If you combine several quotes, use ... (same sentence) or (different sentence) and mark both page numbers

23. Mine for possible messages:

- Moving, impressive statements
- Motivating phrases

24. Write a Research Report report, including:

- Executive Summary (write this last!)
- Thanks and acknowledgements
- List of acronyms
- Table of Contents
- Introduction, background and the need for the study
- Research methodology & research plan
 - Description of method used
 - Number of interviews
 - Limitations of the study (note that its purpose was to provide insights and understanding; it is NOT statistical.)
- **Findings for each target audience**
- **Recommendations for Communication**
 - For policy changes
 - For interventions
 - For communication

25. Take a vacation.

APPENDIX B

Discussion Guide

This was the generic discussion guide. Specific variations on it were developed for the different groups. Note there were not the questions to be asked, but simply a way to remember what the researchers were trying to find out.

Sex

Since when, how many partners?
Situations – when, where?
Ever had “group sex?” If yes, describe situation. (Feelings about it.)

Drugs

Feelings about drugs
Ever tried drugs? What kind?
Ever injected? (if so, ever shared needles?)

HIV

Know the Facts? How transmitted, how prevented, curable?
HIV in the Maldives? Why or why not?
Who is likely to have HIV?

Perceived risk & reasons

Could they or friends get HIV?
Why or why not?

Condoms

Used ever? When & with whom?
Use regularly? Why or why not?
Get where?
What would it take to use condoms more/always?

Hopes and dreams

Future dreams?
Real life heroes?
Favorite leisure activities?

APPENDIX C

Qualitative Research Team Members

Interviewers:

Mariyam Naadha - Coordinator
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Helped by: Ramsha, Vijna, Shizleen, Nashwaan, Naadha

FSWs: Vijna & Naadha

Helped by Naadha, Vijna, Shizleen

MSM: Ahu & Imran

Helped by Shizleen, Naadha, Nashwaan

Construction Workers: Shizleen & Nashwaan

Seafarers: Adyb & Ramsha

Helped by Shizleen

Female Youth: Uzu & Fayaz

Helped by Naadha, Shizleen, Nashwaan

Male Youth: Nashwaan

Helped by Naadha, Shizleen

APPENDIX D

Analysis Codes

The following codes were used in the qualitative research analysis:

A – HIV: Facts, information, knowledge, image, PLHIV

B – Sexual Transmission Risk: Sexual behavior and situations of risk

C – Condoms: Use, non-use, images. (Other forms of safe sex)

D – Drug Injecting and Sharing: Injecting behavior and situations, sex with injectors

E – Safe Injecting: Cleaning (even if not effective), non-sharing, reasons.

F – Perceived Risk of HIV: Reasons for considering self at risk or not.

G – Future Hopes & Dreams:

H – Stigma and Discrimination: Discrimination against self or others, bad feelings about self (especially for MSM, IDUs).

I - Sexual Life and Networking: How to get partners (especially for MSM and FSWs.)

O – Overdose: Overdose stories (especially for IDUs.)

R – Recreation & Life on Board: Picture of life on board ship, for Seafarers (for communication planning).

APPENDIX E

Qualitative Research Final Status Report – June 30, 2009

Group / Loc /Planned /Done / Lang / Interviewer /Has Orig / Trnsc /Who Transcrd / Who's Translating? / Eng. Done

IDUs										
IDU 1	Male			Div	Naadha	Naadha	Yes	Uzu & Ibu	Naadha	
IDU 2	Male			Div	Naadha	Naadha	Yes	Uzu & Ibu	Uzu	Yes
IDU 3	Male			Div	Naadha&Ibu	Naadha	Yes	Uzu & Ibu	Ibu	Yes
IDU 4	Male			Div	Ibu & Ahu	Naadha	Yes	Uzu & Ibu	Ibu	Yes
IDU 5	Addu			Div	Ramsha	Naadha	Yes	Ibu	Ibu	Yes
IDU 6	Addu			Div	Ibu&Ram	Naadha	Yes	Ibu	Ibu	Yes
IDU 7	Addu			Div	Ahu	Naadha	Yes	Ibu	Ibu	Yes
IDU 8	Re. Prison			Eng	Barbara	Barbara	Yes	Barbara	-	Yes
IDU Total		7	8	Div			8 of 8			
FSWs										
FSW 1	Male			Div	Ram&Fathu	Naadha	Yes	Fathoo	Vijna	Yes
FSW 2	Male			Div.	Ibu & Ahu	Naadha	Yes	Ibu	Naadha	Yes
FSW 3	Addu			Div.	Naadha	Naadha	No	Stuck on rec.		
FSW mini	Male			Div	Vijna	Vijna	No	Vijna	Vijna	Yes
FSW Total		7	4				2 of 4			
MSM										
MSM 1	Male			Div	Ibu	Naadha	No	Ibu	Ibu	Yes
MSM 2	Male			Eng	Barbara	Barbara	Yes	Barbara	-	Yes
MSM 3	Male			Eng	Barbara	Barbara	No	Barbara	-	Yes
MSM 4	Addu			Div	Ahu & Ibu	Naadha	Yes	Ibu	Ramsha	Yes
MSM 5	Addu			Div	Ahu & Ibu	Naadha	Yes	Ibu	Ibu	Yes
MSM 6	Addu			Div	Ahu & Ibu	Naadha	Yes	Ibu	Ibu	Yes
MSM Total		7	6							

Migrant Construction Workers										
Constr Nep 1	Male			Nep	Ivana	Ivana	-	-	Ivana	Yes
Constr Nep 2	Male			Nep	Ivana	Ivana	-	-	Ivana	Yes
Constr Nep 3	Male			Nep	Ivana	Ivana	-	-	Ivana	Yes
Constr Nep 4	Male			Nep	Ivana	Ivana	-	-	Ivana	
Constr Eng 5	Male			Eng	Christophe	Christop	Yes	Christophe	-	Yes
Constr Total		4	5							
Resort Workers										
Resort Total	Expat	4	1	Eng	Barbara	-	-	-	-	Yes
	Maldi	3	1	Eng	Barbara	-	-	-	-	Yes
			1	Div	Ramsha	-	-	-	-	Yes
Resort Total		7	3							
Seafarers										
Seafarer 1	Male			Div	Nashwaan	Uzu		Uzu		-
Seafarer 2	Male			Eng	Christophe/Nashw	Christop	Yes	-		Yes
Seafarer 3	Male			Div	Nashwaan	Uzu		Uzu		-
Seafarer 4	Male			Eng	Christophe/Zen	Christop	Yes	-		Yes
Seafarer 5	Male			Div	Nashwaan	Uzu		Uzu		-
Seafarer 6	Male			Eng	Christophe	Christop	Yes	-		Yes
Seaf Total		4	6							

Youth

Youth male 1	Laamu			Div	Nashwaan	Naadha	Yes	Ibu	Ibu	
Youth male 2	Laamu			Div	Nashwaan	Naadha	Yes	Ibu	Ibu	
Youth male 3	Laamu			Div	Nashwaan	Naadha	Yes	-	-	
Youth female	Laamu			Div	Naadha	Naadha	Yes	Uzu	Uzu	Yes
Youth female	Laamu			Div	Naadha	Naadha	Yes	Uzu	Uzu	Yes
Youth female	Laamu			Div	Naadha	Naadha	Yes	Uzu	Uzu	Yes
Youth female	Male			Div	Ibu	Naadha	Yes	Uzu	Ibu	Yes
Youth female	Male			Div	Uzu	Naadha	Yes	Uzu	<u>Uzu</u>	yes
<i>Youth Total</i>		12	8							

The Steps of Change



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

What is Needed:

Specific messages developed by the community to counter each barrier effectively

What is Needed:

Access
Logistical support
Social support

What is Needed:

Skills
Successful experiences

What is Needed:

Social Support
Reinforcement

What is Needed:

Correct information from a source the target group finds credible

Typical Barriers:

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

Typical Barriers:

High Cost
Difficult access
Fear of negative social reaction

Typical Barriers:

Bad experience
Faulty product
Lack of skills

Typical Barriers:

Low social support
Misinformation

What is Needed:

Exposure to the innovation

Typical Barriers:

No facts
Incorrect facts

Typical Barriers:

No awareness
No exposure

Confirmation

Trial

Decision to Try

Attitude Formation

Knowledge

Awareness

INTERPERSONAL / PEER COMMUNICATION

MASS MEDIA

The Steps of Change were used in the analysis of the data. The Steps of Change were developed based on Diffusion research by Barbara A. K. Franklin, PhD Copyright All One Communication 2009

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