

Final

**National Strategic Plan for the
Prevention and Control
of HIV/AIDS**

Republic of Maldives
2014-2018

Ministry of Health
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Executive summary



Acronyms

AIDS – Acquired Immuno Deficiency Syndrome
ANC – Ante Natal Care
ART – Anti Retroviral Therapy
BBS – Biological and Behavioral Survey
BCC – Behavior Change Communication
CBOs – Community Based Organizations
CITC – Client Initiated Testing and Counseling
DDPRS – Department of Drug Prevention and Rehabilitation Services
DOTS – Directly Observed Treatment Short course
DPRS – Department of Penitentiary and Rehabilitation Services
FSW – Female Sex worker
GFATM – Global Fund to fight AIDS, Tuberculosis and Malaria
HIV – Human Immuno deficiency Virus
MARP – Most At Risk Population
MNDF – Maldives National Defence Force
MoE – Ministry of Education
MoHF – Ministry of Health
MoHE – Ministry of Higher Education and Employment
MoY – Ministry of Youth
MPS – Maldivian Police Service
MSM – Men having Sex with Men
NAC – National AIDS Council
NAP – National AIDS Programme
NGO – Non Governmental Organization
NNCB – National Narcotics Control Bureau
PEP – Post exposure prophylaxis
PITC – Provider Initiated Testing and Counseling
SAARC – South Asian Association for Regional Cooperation
SEARO – South East Asia Regional Office
STIs – Sexually transmitted illnesses
TB - Tuberculosis
UN – United Nations
UNDP – United Nations Development Programme
UNFPA – United Nations Population Fund
UNICEF – United Nations Children’s and Education Fund
VCT – Voluntary Counseling and Testing
WHO – World Health Organization

Policy Statement on HIV/AIDS

The government continues to take HIV/AIDS as a serious public health concern in the country and directs efforts to reduce risk behaviors and prevention of HIV spread in the country, as evidenced by the review of the National strategic plan 2007-2011.

Guided by the National AIDS Council, the HIV program will adopt a multi sector approach with UN agencies, NGOs and government bodies as skate holders. And the National AIDS Control Program, Centre for Community Health and Disease Control, will be the main coordinating body responsible for all related nation-wide activities.

To sustain Maldives as a low HIV prevalent country priority will be given for prevention mechanisms. This targets prevention methods directed towards different segments of population, the general population, vulnerable groups and Key affected populations and three different target populations requiring different levels and types of intervention.

The government recognizes the right to prevention and treatment where everyone in the Maldives is able to access the service of testing, counseling and free ARV treatment once diagnosed with HIV/AIDS including expatriate migrant workers with a valid work permit

To increase the uptake of HIV testing services, the policy of HIV testing will be moved from solely voluntary counseling and testing (VCT) to provider-initiated and client-initiated counseling and testing (PICT and CICT), therefore, will focus on test and counsel.

Build and strengthen capacity and commitment to lead, coordinate and provide a comprehensive response to the epidemic.

Strengthen the strategic information system for HIV.

Integration of HIV into existing health services, and making it part of other information channels (i.e. via the workplace, education system, religious sermons, media, et cetera) should continue

Promote convergence of HIV and sexual/ reproductive health services, as well as integration of HIV into the wider health system.

A 'Memorandum of Understanding' between public health agencies and law enforcement agencies, allowing for HIV prevention interventions focusing on 'vulnerable women' (sex work) and 'vulnerable men' (including men who have sex with men) to occur without fear for police intervention

Focus on taboo, denial and stigma of risk behaviors and people living with HIV in the next wave of advocacy, information and education activities. Continue media communications activities, including message development to create awareness about HIV risk behaviors and to strengthen support in the population for targeted interventions and reduce stigma and discrimination of those most at risk.

It is recommended that a phased program focusing on improving male sexual health is designed based on the findings of the BBS, the upcoming size estimation and risk behavior mapping study, taking into account what is feasible within the socio-cultural context.

Ensure regular supply and utilization of HIV, Hep B, Syphilis, Hep C test kits in regional hospitals and health centers by instituting a logistic supply chain and monitoring system.

Most-at-risk populations, youth and vulnerable groups have access to harm reduction interventions and rehabilitation services

Situational Analysis

The Republic of the Maldives is an Islamic country situated in the Indian Ocean, close to both India and Sri Lanka. It consists of nearly 1,200 islands and atolls, of which around 200 are inhabited, with a total projected population of 325,135 people in 2011. There were 70,259 non-Maldivian migrant workers in the Maldives in 2009 of whom only 8% were women. Male' the capital city on an island sized 1.8 Sq kilometers has 66,700 persons per Sq Kilometer excluding migrants. Only 3 other island have a population of more than 5000 people. Net enrollment rates in primary and lower secondary schools are high at 95.7% and 77.4% respectively; enrollment in higher secondary level was only 14.1% as of 2009. Enrollment for girls was slightly higher than that of boys at all levels. The 2006 Census reported youth unemployment of 16.2% in Male' and nearly 19% in the Atolls.

Before 2008, the only data on HIV in the Maldives was available in the form of case reporting. Since then a number of surveys and research projects have been conducted. In 2008, the first Bio-Behavioural Survey (BSS) was conducted in the Maldives. A total of 1791 serological samples were taken across five groups: female sex workers (FSW), men who have sex with men (MSM), injecting drug users (IDU), occupational cohorts of men (OCM- including seafarers, construction workers and resort workers) and youth, across Male', Addu and Laamu atolls. One HIV infection was identified, in a male resort worker. In 2010, a Risk Behavior Mapping was conducted at selected islands and atolls.

A compilation -"The HIV and AIDS situation and related policy and programmatic responses of Maldives"-of findings from such and other sources has been jointly published by MoHF, UN joint Team on AIDS and TSF in 2011. All data in this document, unless otherwise stated has been sourced from this compilation.

Among Maldivian's, 14 cases of HIV had been reported between 1991 and 2009. In addition a further 257 cases had been identified amongst expatriate migrants, again up until 2009. Two out of three people living with HIV (PLHIV) are receiving antiretroviral treatment provided by the Govt. To date HIV prevalence is considered low, although recent research indicates that behavior that places people at-risk to HIV transmission is occurring.

Potential for a concentrated epidemic: most-at-risk populations

In many countries throughout Asia and the Pacific, HIV epidemics start with the virus spreading rapidly among people who inject drugs (IDU) and use non-sterile injecting equipment. Many may also buy and sell sex, allowing HIV to spread to larger networks of sex workers and their clients. Men who have sex with men (MSM) are another category that is most at risk for HIV. Such populations exist in Maldives too. The Risk Behavior Mapping Survey (2010) estimated the number of female sex workers at the 12 islands that were selected for inclusion to be between 545 and 625. It estimated that there were between 577 to 792 MSM, and 410 IDU in the 12 selected islands. It was extrapolated that there are a total of 1199 MSM (range 975 – 1408) in the Maldives.

In a sub-sample of youth in a reproductive health survey conducted in 2004, 14% of males and 5% of females under the age of 18 admitted to having been sexually active. Of those who were sexually active 45% never used condoms.

The 2009 Demographic Health Survey supported by UNFPA, WHO and UNICEF, focused on women and more than 7000 women were interviewed across the Maldives. Overall only 41.5% of the women had “comprehensive knowledge” about HIV. The School Health Survey (2009) found that nationwide, 67.2% of boys and 74.3% of girls in grade 8-10 had heard of “HIV infections or the disease called AIDS”.

HIV prevalence¹ in the Republic of the Maldives continues to be low, even amongst most-at-risk populations. However, recent behavioral research indicates that high risk behaviors for STI and HIV transmission are occurring. Female sex workers and injecting drug users both report very low consistent condom use², while a substantial percentage of men who had sex with men reported they had also had sex with women within the past 12 months³. IDU and MSM have a wide ranging sexual network. Nearly a third (31%) of IDU in Male’ and nearly a quarter in Addu reported sharing an unsterilized needle at the last time of injection 86% of IDU in Male’ had been in jail. Two thirds (64%) of them used drugs while in prison and a third (32%) reported injecting drugs while in jail. More details of such and related behaviors and research findings are given in the relevant sections below.

These findings highlight the potential for HIV transmission through specific behaviors, namely; people having multiple concurrent sex partners and/or injecting drugs.

A further challenge concerns, the legal environment in the Maldives which currently criminalizes these risk behaviors; male-to-male sex, drug use and sex work, making prevention activities far more difficult to implement.

Factors enhancing vulnerability

Structural and social factors can increase a person’s vulnerability to HIV. In the Maldives such factors include; under employment and unemployment, gender inequality, mobility, sexual violence against children, premarital sex, multiple partnering pattern, crowding, tourism, silence and taboo about sexuality, low condom use and high levels stigma and discrimination for people living with HIV and those most-at-risk to HIV.

¹ Note: The percentage or number of people living with HIV at a given time.

² BBS (2008)

³ BBS (2008)

Young people in the Maldives face a number of these vulnerabilities and are especially at risk when engaged in high risk behaviors such as having multiple concurrent sex partners and/or inject drugs.

Focusing the response to HIV

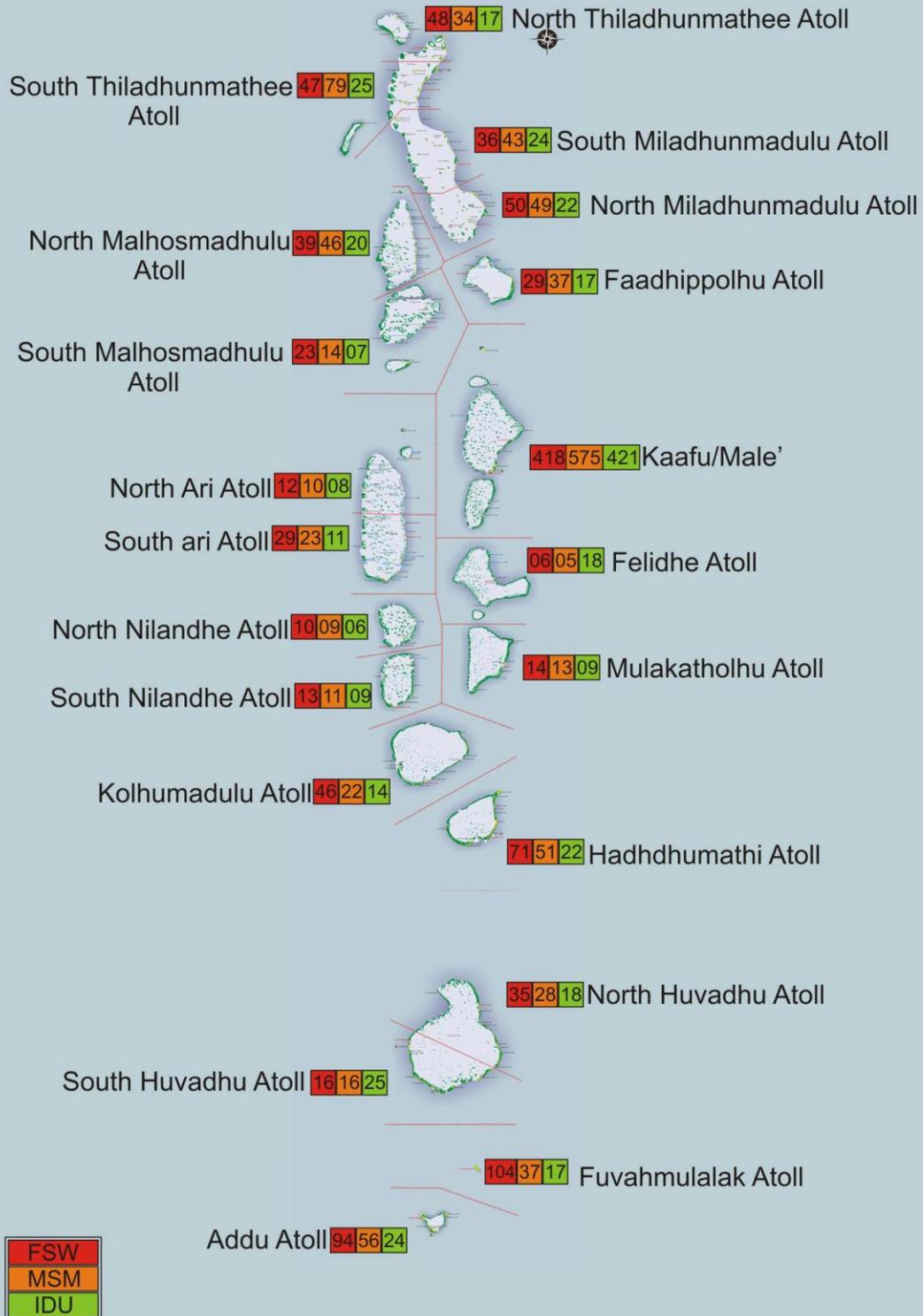
The general population is at low risk of HIV infection, hence the need to focus what limited resources are available more strategically. Prevention preparedness for the Key Affected Populations (KAP) like IDU, sex workers and MSM and those most vulnerable (including youth), as recommended by the last review of the National Programme on HIV, is clearly a priority. Concentrated epidemics are more effectively spread through injecting drug use and it is here that the Maldives must focus its efforts along with HIV prevention for sex workers and men who have sex with men.

Population size estimates for those most-at-risk are a critical first step to effective planning for service delivery and have now been undertaken in the Maldives for the first time. The results show that with a small but focused effort, in a few key geographic areas up to 80% of most-at-risk populations could be reached with prevention efforts. Such coverage would ensure the continued maintenance of low HIV prevalence throughout the country.

Most-at-risk populations size estimates and potential prevention coverage		
Risk behaviour	National estimate	80% prevention coverage achieved through quality outreach covering
People injecting drugs	793	Kaatu/Male, Gnaviyani
Female sex workers	1139	Kaatu/Male, Gnaviyani, Addu, Thaa, Haa, Dhaal and Haa Atoll
Male-to-male sex	1199	Kaatu/Male, Gnaviyani, Addu and Thaa Atoll

There has been insufficient focus on highest risk behaviours that facilitate spread of HIV (IDU, Sex work, MSM). In addition a better understanding between the law enforcement and public health agencies in the form of policies or MoU allowing for HIV prevention activities focusing on “vulnerable women” and “vulnerable men” has still not occurred. The best HIV response scenario for the Republic of the Maldives will be to invest in an effective early warning system through more effective HIV surveillance, in particular behavioral surveillance. At the same time it will be critical to build prevention preparedness, with a focus on effective targeting of prevention efforts for those most-at-risk. This includes addressing critical issues affecting the enabling environment and wider policy environment including policies of the non health sector stakeholders (education) that currently act as barriers to prevention, such as the criminalization of high-risk behaviors.

Estimated Number Of MARPS in Maldives by Atoll



Developmental Process of the Maldives National Strategic Plan for the Prevention and Control of HIV/AIDS -2012-2016

The National Strategic Plan on HIV/AIDS 2012-2016, aims at reducing HIV transmission and HIV-related morbidity, mortality, and disability in the Maldives. The preparatory steps for National Strategic Plan development were initiated by the National AIDS programme in January 2011 based on the World Health Organization – Regional Office of South East Asia (WHO SEARO) steps on National Strategy plan development. An HIV/AIDS situational analysis was done in May 2011 with support from UNAIDS and in consultation with a broader range of stakeholders. A road map for NSP development was developed in consultation with the Joint UN Team on AIDS in the Maldives. An in-country core team consisting of National AIDS programme staff, UN colleagues was formed to steer the process of National Strategic Plan development.

The regional stakeholders consultation workshops were organized in Male', Addu, Laamu and in Khuludhufushi in Sep 2011. The regional stakeholders' consultation workshops provided possible strategic directions, outcomes, and activities for the next 5 years based on the thematic areas and according to the decentralized system with clearer targets, comprehensive strategies for KAP and vulnerable population based on issues identified while implementing the previous NSP

The in country core team with support from members of Civil society Organizations, reviewed the inputs from the regional stakeholders' consultation workshops and compiled a draft NSP document for the peer review. The peer reviewed document was presented in the National stakeholders' consultation for pre endorsement consensus, which was held in last week of November 2011. The monitoring and evaluation part of the NSP was developed in the first week of December, with technical support from UNAIDS. An NAP meeting was held in December 2011 and draft was reviewed and comments provided. It was decided to seek further assistance from WHO and UNAIDS to incorporate the comments from these two meetings and to simplify the document and contextualize it to specific needs of Maldivian population. Review of the NSP draft was carried out by WHO in February- March 2012 and the document was circulated to stakeholders for comments.

The final draft of National Strategy Plan for the Prevention and Control of HIV/AIDS 2012-2016, including the monitoring and evaluation plan will be presented by the Ministry of Health to the National AIDS council for approval in April 2012.

Key Principles of National Strategic Plan

An effective HIV/AIDS response can build on the strengths of, as well challenge, the prevailing traditional values and societal norms. National and community leadership is essential to ensure the goal of the National Strategic Plan is achieved and key leaders will need to be engaged and involved in promoting the strategy and its activities. The National Strategic Plan for the Prevention and Control of HIV/AIDS identifies the following key principles as essential to ensure a more effective national response to the HIV epidemic. These principles were built on previous experiences about what works best in the specific context of the Maldives:

- Programming is from *human rights perspective*, is equitable and the response to HIV/AIDS will be gender and rights based with a specific focus on the rights of people infected and affected by HIV/AIDS as well as vulnerable people. In this regard all aspects of human rights (such as confidentiality, right to health including sexual and reproductive rights of women and men, non discrimination, non-stigmatization etc) are adhered to while providing services to PLHIV and their families.
- Equal and equitable access to prevention services is guaranteed for Key Affected Populations (KAPs), vulnerable people including adolescents, young people, migrants, workers in tourism industry addressing stigma and discrimination.
- Greater Involvement of People Living with HIV (GIPA) and participation of Key Affected Populations, in programme design, development and implementation.
- Universal Access to prevention, treatment, care and support services for all people on equitable basis; integration of HIV into general health programme particularly for SRH, MCH (PPTCT).
- Evidence-informed planning and programming and focusing resource allocation at defined priorities based on vulnerability and risk factors associated with various groups and communities after thorough analysis of issues including gender analysis.
- Decentralized, multi-sectoral and interdisciplinary engagement - this calls for a proactive response from all the related sectors with mutual accountability.
- ONE principle – one coordinating authority, one national programme, and one national monitoring system is key to all national response to HIV/AIDS.

The strategy relies on collaboration between government and other public, private and nongovernment entities. The National AIDS Council will be responsible for coordination of efforts. The Government has a responsibility for creating an enabling environment for growing local nongovernmental organizations to conduct activities with risk groups in an atmosphere of trust and security.

Goal

To maintain the low prevalence of HIV in the Maldives and prevent further transmission.

Objectives

Objectives of the National Strategic Plan for the Prevention and Control of HIV/AIDS:

- a) To scale up prevention programmes in the Key Affected Populations
- b) To improve prevention efforts for general population and special groups including youth and migrants
- c) To reduce stigma and discrimination

Strategic Direction 1 – Strengthen HIV prevention, care, treatment and support services

The health sector is responsible for configuring and supporting comprehensive programmes and service delivery models that address the needs⁴ of populations and for ensuring that these services are accessible, acceptable and equitable. Where there are barriers to implementation of priority interventions, supportive policy, legal and social environment that facilitates equitable access to prevention, treatment and care should be created.

A) Focus on specific needs of Key Affected Populations (KAP):

There is at present insufficient focus on preventing the risk behaviors that have maximum potential for HIV infection. The Operational plan for HIV in the Maldives 2010-11 acknowledges that the biggest gap in the current response to HIV in the country is the lack of strategic focus on the behaviors most likely to kick-start a potential epidemic: injecting drug use, male to male sex and transactional sex/sex work. As all these behaviours come in conflict with the law, a pragmatic balance needs to be struck between the legal framework and law enforcement agencies on one hand, and agencies promoting public

There is at present insufficient focus on preventing the risk behaviors that have maximum potential for HIV infection.

health (MoHF/NAP and NGOs) on the other. This will make possible to implement interventions focusing on key behaviors without police harassment but at the same time without formally allowing or “legalizing” these behaviors. Such an understanding

between public health authorities and law enforcement authorities needs to be reached at the earliest. Data also points out the congregation of risk factors and thus the futility of seeing vulnerable populations under strait jacketed labels. This poses significant challenges for programming. In addition, well devised multi-sectoral strategies to reduce the impact of vulnerability enhancing factors (lack of formal employment, healthy entertainment opportunities and education opportunities, sexual violence, premarital sex, silence and taboos about sexuality) for young people as they may increase the probability of risk behaviours including drug use, sex work and premarital sex , need to be put into place.

i) Injecting Drug users: The Mid -Term Review team in December 2009 emphasized that the most likely trigger for an HIV epidemic in Maldives is injecting drug use because of

⁴ All figures in this document are taken from the document “The HIV and AIDS situation” 2011 (MoHF, UNJTA, tsf) Cross references are provided where ever appropriate.

the relatively large number of Maldivians using drugs, increasing shift towards injecting drug use rather than smoking, high prevalence of needle sharing in some areas, and the “efficiency” of shared contaminated needles as an HIV transmission route. More needs to be done to prepare for a potential HIV epidemic among IDU in Maldives and thus provision of HIV prevention services amongst the IDU population should remain a major focus in the coming years.

Expected outcomes by 2016: based on 2010-11 mapping data

- 60% of estimated numbers of IDU in key sites are reached through harm reduction interventions
- 55% of IDU report safe use of injecting equipment
- 55% of IDU report consistent condom use with their sexual partners
- National standards for targeted interventions developed by 2015

Key Issues and challenges: Since 2007, a number of interventions to prevent HIV for IDUs have been implemented including aftercare services and outreach (IEC) via NGOs, a pilot project for oral substitution therapy (OST) and a new detoxification centre. This – considering that no case of injecting drug- use related HIV infection has been yet reported in Maldives - is remarkable in itself. However numerous challenges persist.

- ⁵90% of injecting drug users operate as a part of closely knit and hidden networks.
- Most of them are based in Kaafu/Male’ and in Gnaviyani.
- One in three IDU, especially those who are in closed settings like prisons, share the equipment (needles, syringes, cotton filters, common water and common supply of liquid drugs) with others due to the lack of harm reduction services.
- ⁶Sex work and IDU also overlap: over a third of sex workers were injecting drugs.
- Sexual risk for HIV due to overlaps with sex work and multi-partner sex was high though the self perception about risk is seen as “very low”.
- Coverage of a comprehensive package of HIV interventions for people who inject drugs is limited to Male’.
- There was a strong demand for detoxification among drug users pointing out the unmet need for such services. The detoxification clinics lacked some basic equipment.
- Harm reduction programs need further advocacy for their acceptance by policy makers at various levels. Presently OST is available from one center in Male’.
- The required separation between criminal justice and therapeutic interventions is yet to be defined.
- Except for limited provision of information materials, no comprehensive interventions to reduce the risk of infection with HIV/STI/Hepatitis have been implemented in prisons.

⁵ The 2010 Risk Behavior Mapping study

⁶ BBS 2008

- There are no interventions on harm reduction for close settings.

Strategic approaches:

- Provide preferential focus to the key geographical areas: Primary focus should be kept on those geographical areas (Kaafu/Male' and Gnaviyani) that amongst them have the majority of IDU and where relatively high coverage could be achieved easily for other risk factors too. The prioritized geographical areas could be reviewed keeping in view the information from surveys in the future. The networks of IDU in the prioritized areas should be involved in providing prevention services while maintaining the confidentiality of the individuals
- Provide a package of comprehensive and simultaneous interventions: Drug users who inject drugs and their sexual partners will receive prevention services. Comprehensive prevention and support services both in the community and in the closed or custodial settings such as the prisons and closed drug rehabilitation centers should be provided to them. Specific approaches to reach out to female IDUs and female partners of male IDUs for the comprehensive set of interventions will be developed. The following comprehensive set of interventions –to be simultaneously implemented - for HIV prevention for people who inject drugs (PWID) is recommended.
 - a. targeted information, education and communication for IDUs including Behaviour Change Communication programs that focus on assessment of risk along with the messages on prevention of HIV and Harm reduction
 - b. needle and syringe programs (NSPs)
 - c. improved access to drug dependence treatment-in particular opioid substitution therapy (OST), and detoxification services: increase the number of centres providing such services, equipping fully the existing and new centres with the required equipment, to be manned by trained personnel and provided with supportive supervision. The functioning of the centres should be periodically reviewed for effectiveness and retention rates.
 - d. improved access to voluntary counseling and testing services so as to enable people to know their HIV status.
 - e. promoting and supporting condom use
 - f. prompt detection and management of sexually transmitted infections
 - g. prompt management of HIV and OI – in case an IDU is discovered to be HIV positive
- Build capacities for delivery of services: capacities for comprehensive harm reduction interventions (outreach, oral substitution therapy as well as clean needle exchange programmes) are to be scaled up.

- Intensify dialogue with police and Ministry of Home Affairs for implementing evidence-based programmes to prevent HIV in prisons. It is important to put in place HIV/STI prevention programmes for spouses of prison inmates. Law enforcement officers should be trained on HIV and IDU concerns.
- Strengthen Community-based outreach for delivering HIV prevention (and treatment and care if required) to IDUs.
- Monitor and document the changing patterns of drug use and HIV related risk behavior so as to inform programming.
- Intense advocacy, citing public health evidence, should be initiated and maintained in the coming years to support and sustain harm reduction programmes
- NAP to take lead in all kinds of efforts that acknowledge drug addiction as a medical issue so as to facilitate public health and social support interventions with drug users.

ii) Sex workers: Sex workers, female and male are one of the most vulnerable groups to be affected by HIV as specific behaviors and contextual factors exacerbate their vulnerability. This also puts their clients and regular partners at risk. It found that female sex work in the Maldives has many patterns. It is largely network based, operated by a

A comprehensive HIV prevention and support programme for women (and men) engaging in transactional sex is yet to be launched.

range of mediators. Most of the sex workers are home based and utilize modern technology to procure clients, some (“escort girls”, or “safari girls”) accompany clients to tourist locations, some solicit clients in the street and the smallest group works from massage parlours. Some are expatriates. In addition, some divorced and other wise

vulnerable women are known to engage in multiple concurrent or serial sexual relationships to provide for themselves and their family. There is a need to design and deliver interventions for these highly “vulnerable women”. Clustering of risk behaviors is also seen in sex workers. Some are drug users including injecting drug users. 102 female sex workers were recruited into the behavioral part of the BSS of which 94 also provided

Expected outcomes by 2016

- 80% of estimated numbers of sex workers in key sites are reached through targeted interventions
- 80% of sex workers report consistent condom use with clients
- STI prevalence amongst sex workers is under 15% (baseline -27% -BBS 2008)

samples for HIV testing of which none tested positive.

Key Issues and challenges:

- The Risk Behavior Mapping estimated that there were a total of 1139 (range 1030-1247) female sex workers in the country and they are more scattered than the IDU and MSM.
- Nearly all, (98%) in Addu and 88% in Male', reported unsafe sex with a client in the past 7 days.
- In Addu 7 out of 68 sex workers recruited for BBS were younger than 18 years of age – clearly outlining the challenges.
- A median of 4 clients per week were reported in Male'.
- 9 -12% of female sex workers reported expatriate clients in the past 12 months.
- 83% of seafarers, 3% of resort workers and 2% of construction worker clients reported sex with an expatriate female sex worker.
- A very low condom use (12% in Male' and 2% in Addu) was reported. Male construction workers who visited sex workers reported 0% condom use.
- For BBS 2008, 27% of the Female sex workers self reported STI symptoms
- A comprehensive HIV prevention and support programme for women (and men) engaging in transactional sex is yet to be launched.
- There is paucity of anthropological research contextualizing these behaviors and how they work and who are the gatekeepers.
- Balancing the legal and moral aspects -as extramarital sex (including sex work) is outlawed - and the public health issues is a challenge.
- Single mothers and divorced women are in need of targeted SRH interventions to cater to their health and welfare.

Strategic approaches:

- Focus on “vulnerable women”: programmes to reach out to the “vulnerable women” - including divorced women, single mothers and those released from prisons amongst others -should also provide the umbrella for interventions for sex workers. Such programmes need to address the identified vulnerabilities and risk practices of Maldivian women.
- Provide a geographical coverage to key areas: as the FSW are more scattered, in order to cover 80% of them in the biggest clusters interventions would need to cover atleast 6 islands (Kaafu/Male', Gnaviyani, Addu, Thaa, Haa, Dhaal and Haa Alif)
- Provide priority interventions for sex workers and their clients : promote condom (male and female condom) use; detect and manage STIs; strengthen peer outreach for IEC; enabling people to know their HIV status; and provide improved social support including income generation and legal services.
- Carry out assessments to determine underlying vulnerabilities of sex workers and their clients.
- Improve access to health especially Reproductive Health services: the RH services / Women well being clinics need to include STI diagnosis and management and be private and confidential and stigma free. Required legal and social frameworks that are right based should be developed

iii) **Men having sex with men (MSM):** The phenomenon exists in Maldives like in other societies and cultures though largely remains underground, unmarked and unnoticed. The

A fifth of the MSM enrolled in the BBS reported that their first sexual contact with another male was forced, often in the context of family and often when they were very young.

Risk Behavior Mapping Report estimated that there were 685 (range 577 to 792) MSM in the 12 selected islands. 3.5% of the mapped MSM were under 18 years old, and almost 40% were aged 18-24. It was extrapolated that there were 1199 (range 975 – 1408) MSM in the Maldives. The BBS

study had recruited 126 MSM for the behavioural part of the study⁷. The “Anything is Possible” study described highly active and vivid online networks of Maldivian MSM and the constant fear of disclosure and the need to keep two strictly separate lives. No information pertaining to transgender (TG) is available. As MSM draws stigma and to make it easier for them to access programs, the interventions for MSM need to be packaged as broader male sexual health programs focusing on “vulnerable men”.

Expected outcomes by 2016

- 80% of estimated numbers of MSM at key sites are reached through targeted interventions
- 80% of MSM report consistent condom use.
- 80% of MSM report having received an HIV test and know the results in last 12 months.

Key Issues and Challenges:

- The mean reported age of sexual debut (through the BBS research) was 16 and 17 in Male’ and Addu respectively.
- A fifth of the MSM enrolled in the BBS reported that their first sexual contact with another male was forced, often in the context of family and often when they were very young.
- Nearly all (93-94%) reported consensual sex with a male in the past 12 months.
- Nearly two third of them also had had sex with women in the past year.
- MSM in Addu and Male’ used condoms consistently only in 21% and 36% of their sexual encounters with men, and only in 2% and 17% of their sexual encounters with women.
- It also high lighted that 16% of the MSM in the study reported to have injected drugs⁸.

⁷ BBS 2008

⁸ BBS 2008

- The female partners of MSM may also be at enhanced risk for HIV that needs to be quantified and addressed.
- Highest level of social stigma is faced by this group.
- Presently, interventions for HIV prevention among men having sex with men are subsumed under general preventive interventions that may not be suitable and effective for the group with special needs.
- As there is no organization representing MSM, it becomes difficult to involve them in obtaining their inputs for program implementation.

Strategic approaches:

- Develop programmes for improving “male sexual health”: programmes to reach out to this segment of most at risk group need to be developed under the umbrella of programmes for improving male sexual health. They should include provision of IEC and counseling on aspects of male sexual health, nutrition, tobacco, and mental health; condom promotion and availability; and STI services. Strong linkages with and referrals to HIV programmes should be developed and peer outreach services provided.
- Carry out systematic collection of data and strategic information on STIs and HIV and needs and vulnerabilities of this segment of population.
- Involve prison authorities to provide access to imprisoned population to interventions to improve male sexual health.
- Devise broad multisectoral programs: for this an MoU between Public Health Agencies and law enforcement agencies allowing for HIV interventions focusing on MSM to occur without fear of any police reprisal.

B) Strengthen key services for improved prevention efforts:

Strong efforts to strengthen HIV prevention, care and treatment through the broader context of preventing, and managing sexually transmitted infections, promotion of safe blood supply, and comprehensive condom programming are required. Efforts must be made to scale up and improve the utilization of these crucial services not only for the KAP but also for vulnerable groups like the youth, migrant workers and the general population.

1) Strengthen provision of STI services:

Expected outcome by 2016

- Increase the number of fully functional STI centers in the country by 50% (baseline – number of such centers in 2011)

Key Issues and Challenges: Surveillance of STIs in the Maldives consists of universal syndromic STI case reporting. 2587 STI cases had been treated at health care facilities till 30 June, 2010. There is no breakdown of specific STIs available. Pregnant women are routinely screened for Syphilis. However this is not done so for Key affected populations. Though no HIV, Syphilis or Hepatitis was found among female sex workers or youth in the BBS 2008, the table below provides the overall STI status.

Cohort / Group	Female Sex workers	Sexually active youth (Male')	Sexually active youth (Lammu)	MSM Male'	MSM Addu	IDU Male'	IDU Addu	Resort workers
% self reporting of STI	27%	19%	23%	17%	12%	16%	12%	7%

Health care seeking behavior varied widely, ranging from 100% of seafarers to 0% of MSM in Addu going to health practitioners. This reflects the situation across risk behaviours and challenges for developing and implementing interventions. Surveillance of STI consists of universal syndromic STI case reporting, sentinel etiological STI case reporting and cross sectional community based STI surveys repeated every 3-5 years. Though the annual syndromic reporting has been strengthened in 2004, it needs to be strengthened further. 316 health care providers had been trained in diagnosis and clinical management of STI till 30 June 2010.

Strategic approaches:

- Strengthen provision of STI services for the key affected populations - awareness raising, promotion of health care seeking behaviour, clinical services, contact tracing, Hepatitis B vaccination, PICT services, referral and laboratory support - to be strengthened by utilizing innovative methodologies to cater to the specific contexts of the groups.
- Strengthen STI services for youth and other vulnerable groups - STI clinical services including regular check-ups, correct diagnosis by syndrome or laboratory test, counselling support for reduction in further risk taking, notification and treatment of STIs including in sexual partners, promotion and provision of condoms, with clear guidance on correct and consistent use, HIV testing and counselling, and outreach services; and peer education,
- Provide PICT for all STI clients including adolescents
- Design and make available IEC communication materials, BCC materials for outreach and peer education activities for KAP.
- Disseminate widely the available guidelines on STI and update them periodically
- Provide periodic training to all prescribers who have not received any STI training in the past two years, on syndromic management for STIs.
- Support participation of doctors in Master's level courses in sexual health medicine.

2) Safe blood supply services:**Expected outcome by 2016**

- Availability of Safe blood supply in all the Atolls
- 100% of donated blood units being screened for HIV , according to national guidelines
- Number of clinicians and nurses trained on rational use of blood and blood products and safe blood transfusion by December 2016 : - 472

Key Issues and Challenges: The National Blood Policy (2007) provides guidelines on rational use of blood, encouraging voluntary non remunerative donations and donor referral. All donated blood units are screened for HIV and other TTIs (Hep B, Hep C, Malaria and Syphilis) in Govt hospital and laboratories, however the standard operating procedures or local written instructions for transfusions may not be adhered to by many other labs. The facilities of the blood banking units in the two central blood banks in Male' and the six regional hospitals are underutilized. Timely blood donation and transportation of units are major constraints at times.

Strategic approaches:

- Carry out capacity building of selected health workers in blood safety, rational use of blood,
- Promote involvement of voluntary, non-remunerated, screened blood donors selected from low risk populations.
- Strengthen and enforce use of the self-screening questionnaire (risk assessment) by donors before donation and counselling/testing for important blood borne transmitted disease (HIV, HBV, HCV and syphilis); and train health workers involved in these procedures, to ensure screening is systematic and effective.
- Procure adequate supply of safety gear and infection control equipment, and enhance blood storage facilities at the existing centres
- Ensure quality in all steps from blood collection to blood transfusion (vein –to – vein)
- Make all efforts including utilization of mass media to increase the base of voluntary blood donors.

3) Comprehensive Condom Programming:

Expected outcome by 2016

- Increase in the outlets providing Condoms and lubricants by 50% (Baseline – number of outlets in 2011)

Key Issues and Challenges: There is high awareness in the population about HIV/AIDS including condoms, but due to perceived linkages of HIV to immoral behaviors and low self perceived risk, condom use is low. Condom use during the risky sex is an important behavioural indicator for prevention of HIV and STI. Through BSS, a very low condom use (12% in Male’ and 2% in Addu) was reported by sex workers.

Nearly all sex workers, (98%) in Addu and 88% in Male’, reported unsafe sex with a client in the past 7 days, indicating a clear potential pathway for HIV and the existing challenges for programming in this area.

Nearly all sex workers, (98%) in Addu and 88% in Male’, reported unsafe sex with a client in the past 7 days, indicating a clear potential pathway for HIV and the existing challenges for programming in this area. Male construction workers who visited sex workers reported 0% condom use pointing out another challenge related to

raising awareness on HIV prevention in this group. In the Reproductive Health Survey (2004), only 12% of young people who admitted to be sexually active reported to ‘always’ use condoms. Condom use among MSM is low too. Condoms are available over the

counter from pharmacies and from NGOs. Female condoms are not widely available. Water-based lubricant is generally not available.

Strategic approaches:

- Continue the current free distribution system from selected sites while strengthening distribution and monitoring of other outlets – drop-in centers, targeted intervention sites, pharmacies, health facilities, resorts, hotels and lodges.
- Condom promotion and distribution: Explore, pilot and implement innovative ways to promote condom usage and distribute condoms in high-risk settings including prisons and to vulnerable populations including youth and migrant labour.
- Regularly estimate condom, including female condom, and lubricant supply (logistics: projection, procurement, stock and distribution) and demand (promotion and motivation for use) taking into account different needs dependent upon population size and behavioural patterns of various groups including populations most at risk.
- Procure and promote the use of water-based lubricant to be supplied with condoms.
- Conduct research on the social marketing of condoms and lubricants.

4) Prevention of Mother To Child Transmission (PMTCT)

Expected outcome by 2016:

- 90% of pregnant women visiting ANC clinics have comprehensive knowledge on HIV infection and prevention and access to PPTCT program
- 100% of women attending ANC clinics are tested for HIV as per the national guidelines that allow an “opt-out”. (Baseline – % tested in 2011)

Key Issues and challenges: According to the national testing guidelines, pregnant women should be offered an HIV test with an option to “opt-out”, pre and post-test counseling should be provided and written informed consent should be obtained prior to testing. However these guidelines are not always followed and pre and post-test counseling is not available at some facilities. 1368 women were tested in 2008 and 2024 in 2009, accounting for around 14% of all HIV tests conducted in those years

PMTCT; which largely depends upon primary prevention of HIV among women, prevention of HIV transmission from an infected mother to her child, and Care and support for HIV infected women and infants; is yet to be fully integrated into reproductive health services being delivered through the existing health care infrastructure.

Strategic approaches:

- PMTCT / PPTCT - Continue early ANC registration and universal HIV screening of all pregnant women as per the national guidelines,
- Provide prophylactic treatment to all infants born to sero positive women – in case any mother is detected to be HIV positive.
- Disseminate guidelines on PMTCT/PPTCT so as to keep the providers informed of all dimensions related to testing.
- Guidelines for management of HIV positive mother, and her infant to be developed and disseminated

C) Preventing HIV in general population and special groups including youth, migrants and people in prisons.

1) Strengthening prevention efforts for general population and special groups:

The National Strategy Plan on HIV/AIDS 2007-11 focused on the provision of HIV prevention services to the key affected populations. Since the drivers of HIV epidemic in

However most of the HIV prevention activities currently implemented in the Maldives aim at awareness raising within the general population especially youth and to some extent migrant workers and often these programs do not mention those sexual behaviors that are most likely to expose people to HIV.

Maldives continue to persist and increase, the emphasis should remain on providing prevention services to these populations. However steps should be taken to provide HIV prevention information, skills and

services for the special populations in order to reduce their vulnerability to HIV infection. These populations include adolescents, young people, migrants, expatriate workers, seafarers, workers in tourism industry, uniformed forces, health care providers and prisoners and wage workers.,

Expected outcome by 2016:

- 90% of general population have comprehensive knowledge on HIV infection and prevention
- 95% of youth have comprehensive knowledge on HIV infection and prevention
- 80% of SRH service providers (governmental, non-governmental organizations, private facilities) integrate good quality STI services targeted to general male and female population.

Key Issues and Challenges:

- The DHS 2009 focused on women and pointed out that though 94% of all sub-samples had heard of HIV/AIDS, overall only 41.5% of the women had “comprehensive knowledge” about HIV/AIDS.
- 14% of males and 5% of females under the age of 18 admitted to having been sexually active (Reproductive Health Survey 2004). Of those sexually active 45% never used condoms.
- In the BBS survey (2008) 32% of youth in Male’ and 50% of youth in Laamu reported to ever have sex in their lifetime. Condom use ranged from 8-54%.
- Among the youth the myths about drug use or users are not discussed adequately.
- Levels of knowledge about reproductive health and sexuality are low. The Life

- Skills education (LSE) program is only available in some schools and is yet to be incorporated into the national curriculum. In addition the socio- cultural barriers to providing LSE (specifically reproductive health related information), capacity constraints, poor collaboration, and lack of strategic direction are the existing challenges.
- Only the students who study subjects of Biology and Islam are imparted some reproductive health related information through the school education curriculum after its revision in 2009.
- The Youth Health Café (YHC) reaches several hundred young people a year and its hotline gets several calls a day. However it is yet to set up medical services including STI testing for youth.
- However most of the HIV prevention activities currently implemented in the Maldives aim at awareness raising within the general population especially youth and to some extent migrant workers and often these programs do not mention those sexual behaviors that are most likely to expose people to HIV.
- No specific services for general population/women have been instituted.
- Other than training 18 peer educators for migrants, (include fishermen, resort workers and construction workers) there are no other specific interventions to meet the needs of the Maldivian and non-Maldivian migrants.
- Except for provision of information material no comprehensive interventions to reduce the risk of infection with HIV/STI/Hepatitis have been implemented in prisons or juvenile detention centres.
- The programs for spouses of prison inmates are not in place.
- Majority of HIV testing is related to pre-employment testing, pre-surgical screening and blood screening.

Strategic approaches:

A low(er) cost strategy to improve awareness of HIV among the general population, further integration of HIV into existing health services, and making it a part of other information channels (workplace, education system, religious sermons, media) is recommended. Providing free condoms to those most in need and ensuring that condoms are available to all sexually active people shall remain essential HIV prevention interventions

- Health sector to actively provide guidance and collaborate with other sectors on provision of mass media information and communications on HIV, sexuality education (including abstinence), school-based HIV education to improve awareness on HIV among the general population, youth and other special groups; and equitable provision of quality health services in innovative ways.
- Strengthen STI services so that most-at-risk and vulnerable populations have better access to these services.
- Carry out assessment of the situation of the migrant workers. Ensure equitable access to health services for migrant workers. IEC material and counseling services should be available in the own language of the migrant workers where ever required.
- Design and implement behavior change interventions to promote safe sex, increase demand, and improve use of condoms by young people and risk groups.
- Establishment of Youth friendly clinics/spaces with access to information and services on HIV: In order for young people to benefit from HIV prevention, health services must take their unique concerns and needs into consideration and provide them with HIV related services. Prevention services for adults can be modified so that they are youth friendly. There should also be youth-specific prevention services in settings where young people are more likely to access them including schools, universities, youth clubs, popular youth hang-outs, workplaces and pharmacies. Community outreach and linkages between services in the health sector and other sectors should be provided. Policy issues related to age constraints should be addressed.
- Link / integrate HIV services with MNCH, RH and other relevant services: family planning, reproductive health, and sexually transmitted infection (STI) services to ensure the delivery of a package of essential HIV interventions efficiently.
- Collaborate with and build skills of religious leaders to deliver messages on safe behavior and responsible practices to prevent HIV in vulnerable groups and sensitize religious leaders to promote positive attitude towards youth and vulnerable populations

- Workplace HIV prevention activities will be undertaken for prioritized groups like seafarers, resort workers, construction laborers, and other workers whose job keeps them away from home for long periods of time, such as police, MNDF, customs, teachers etc.
- Collaborate with relevant authorities to provide the needed range of services for people in prisons and similar settings, including condom and water-based lubricant distribution, clean needle and syringe provision, opioid substitution therapy, HIV testing and counseling, provision of antiretroviral therapy and treatment for sexually transmitted infections.
- Collaborate with relevant ministries and organization, to map young people who are vulnerable and at risk of getting in to sex work; and ensure that efforts are in place to reach the population with support services and alternative options, to prevent them from getting in to sex work.
- Collaborate with relevant authorities to sensitize and build capacity of the law makers/judiciary/legal sector to develop related laws and establish system to make families accountable for preventing children getting in to high risk behaviors for HIV.

2) Increasing access to Voluntary Counseling and Testing (VCT)

Expected outcome by 2016:

- Quality assured PICT services available in all six regions
- 80% of those who report having taken an HIV test in the last six months know the results of the test

Key Issues and challenges:

- Apart from facilities in hospitals and health centers for pre pre-operative testing, there were 8 VCT centers. Two VCT centers work outside the public health system.
- Pre-employment screening was the most important source of HIV test results (49% of the total of nearly 30,000 tests in 2008 and 34% of the total in 2009).
- There is a low demand for VCT – 21 tests in 2008 and 374 in 2009. This is likely due to the stigma attached and the low levels of perceived risk.
- No HIV testing is offered in prisons or juvenile detention centers.
- HIV testing is provided to clients entering drug treatment centers but informed consent is not always obtained. Thus the “Three Cs” – informed Consent, Counselling and Confidentiality—are not always being maintained.
- Guidelines for testing as well as operationalising the VCT service were developed and endorsed in 2009. However many a times, especially for ANC attendees, these guidelines are not followed and pre and post test counseling is not provided.
- The guidelines do not mention MSM and young people under 18 years old.

Strategic approaches:

The UNAIDS/WHO policy on HIV testing and counseling defines two main categories:

- i. client-initiated HIV testing and counseling (CITC);
- ii. provider-initiated HIV testing and counseling (PITC).

In Maldives while Voluntary testing and counseling (VCT) as the basic policy for testing should continue, however PITC is recommended for the general population and special groups.

- Increased uptake of VCT services: -make existing VCT centers more client friendly accessible and stigma free to those most at risk; train Health care providers in pre and post – test counseling, strengthen the involvement of NGOs for provision of VCT;
- Develop protocols and Standard Operating Procedures (SOPs) for provision of VCT services through Public Health System, NGOs and private practitioners (who will do what)
- Link VCT services to ongoing youth-centered activities and to STI and reproductive health services.
- Ensure regular supply of required kits and reagents by instituting a logistic supply chain and monitoring system.
- Develop algorithms and guidelines for HIV testing

3) Improved Infection control in Health settings:**Expected outcome by 2016:** (BBS 2008 data as baseline)

- 100% of facilities providing care and treatment to PLHIV follow the guidelines and have access to PEP by 2016

Key Issues and challenges:

Though no case of HIV infection in Health Care Providers (HCP) has been reported, it is important that all health facilities and HCP follow the guidelines for prevention of such infections and have access to post- exposure prophylaxis (PEP). There is also the need to revise the guidelines on Post exposure prophylaxis (PEP)

Strategic approaches:

- All health facilities should have: (a) a zero tolerance policy for HIV transmission; (b) an infection control plan; (c) a person or team responsible for infection control, and

(d) available supplies to ensure the implementation of preventive measures including standard precautions.

- Prevent transmission of HIV in health care settings through primary prevention measures such as standard precautions, injection safety and safe waste disposal, as well as secondary prevention measures such as post-exposure prophylaxis for occupational exposure.
- Develop strategies, tools and guidelines for infection control, standard precautions, the rational and safe use of injections and infectious waste management.
- Provide a full course of Hep B immunization to all health care providers –especially those who are at risk of being exposed to blood and blood products.
- Develop a permanent HIV prevention and control structure, specific equipment and trained and motivated staff for implementing infection control guidelines
- Ensure provision of PEP starter kits in Regional Hospitals.
- Revise guidelines and systems for reporting of occupational accidents of health workers, and provide ART for PEP to reduce the risk to health care workers of HIV infection.
- Update PEP guidelines and system for counselling, testing and monitoring, and also the referral system for health units that do not / cannot stock ART.
- Regular monitoring and evaluation of blood services (testing of HIV among blood donors), and review of HIV testing coverage among ANC mothers.
- Orientation programmes for medical professionals, who are newly recruited (special focus on expatriate workforce) on two important aspects PMTCT and Infection control.

D) Improved care, treatment and management of People Living with HIV:

HIV treatment and care programmes should, along with provision of anti retro viral therapy (ART), include prophylaxis, diagnosis and treatment for common opportunistic infections (OI) and co-morbidities. Particularly important is diagnosis and treatment for pneumonia, diarrhea, TB, viral hepatitis, malnutrition and other clinical conditions that are more serious for people living with HIV (PLHIV). Focus should also be provided to safety of the health workers including for PEP.

Expected outcome by 2016:

- Number of facilities providing ART services and management of OIs increased to three. (baseline -1 facility in 2011)
- 100% of PLHIV receive ART and care and management for OIs from Public Health facilities or other designated facility (Baseline – 100 % received such care in 2011)
- Guidelines on management of OIs developed and disseminated by 2015.

Key Issues and challenges:

- National ART guidelines were updated in 2010.
 - There is only one center providing ART services. Currently two persons are receiving ART.
 - Package of services for targeted interventions (TI) has not yet been developed.
 - There is one CD4 counting machine but viral load testing facility is not available and, if required, blood samples are sent abroad.
- There is one CD4 counting machine but viral load testing facility is not available and, if required, blood samples are sent abroad.
- There is also the need to revise the guidelines on the management of OIs.
 - Standardized recording and reporting formats for the PLHIV under care have not been developed.
 - Stock out was reported to happen in the facility providing ART services.
 - Provision of specific equipment and trained and motivated staff to implement comprehensive infection control strategies and procedures needs to be strengthened.
 - The scaling up of ART, given the low prevalence of HIV, should only be carried out if there is a need in future.
 - At present a focus is required on areas of convergence of services.

Strategic approaches:

- Develop a nationally agreed package of services for TI
- Ensure adequate and continuous drug supply and quality assurance/control for ARV drugs, by developing and adhering to a logistic supply chain and monitoring system.
- Strengthen involvement of NGOs working with vulnerable and KAP individuals for provision of care, treatment and management services.
- In case of need for ART scale up, focused efforts on improving treatment access and adherence by involving the community in planning and managing the treatment programme be carried out.
- Establishing mechanisms to collaborate between HIV and TB programmes; TB infection control in health care and congregate settings; HIV testing of TB patients; antiretroviral therapy and cotrimoxazole preventive therapy (CPT) for TB patients infected with HIV; and intensified TB case finding among PLHIV followed by isoniazid preventive therapy (IPT) for those without active TB.

Strategic Direction -2: Strengthening strategic information systems for HIV programme and research

Strategic information guides health policy, planning, resource allocation, programme management, service delivery and accountability. It is essential for action at all levels of the health system. There is pressing need to invest in strategic information to guide programme planning and sustain national and international commitment and accountability.

Expected outcome by 2016

- Integrated behavioural and biological surveillance (IBBS) of KAP are undertaken on a regular basis and reported to measure outcomes and the impact of the response
- Reporting on biomedical HIV services (including ART, PMTCT, condom programming, blood safety) is integrated into the MoH HMIS and reported regularly
- HIV related operational research is coordinated and prioritised by 2015
- STI surveillance system strengthened and etiologic surveys on syndromes carried out regularly

Key Issues and Challenges:

- HIV in Maldives is mostly concentrated among populations at high risk of infection and is different from other countries that may reflect predominantly generalized heterosexual epidemic.
- Most of the data is derived from “rapid assessment” exercises.
- Though there is some good information available about IDU, largely anecdotal evidence is available regarding sex work and MSM.
- Little ethnographic or socio-cultural background insights are available regarding contexts in which high risk behavior takes place.
- There is limited anthropological research in assessing how high risk behaviors work, in which contexts, who are the gatekeepers and significant others when these behaviors occur. Thus the programming –including communication strategy - remains uninformed.
- No information from operational research is available about the effectiveness and appropriateness of existing interventions – including “community therapeutic model” employed in the detox centers.

No information from operational research is available about the effectiveness and appropriateness of existing interventions.

- There is still weak monitoring and evaluation of responses to the epidemic and strategic information systems to measure progress are yet to be in place.
- Protocols for efficient flow of information from periphery to centre and then back to periphery are yet not in place.
- Statistical modeling to better understand trends in HIV prevalence in most at risk population is yet to be carried out.
- It is essential that more data is available to conduct modelling and this underscores the importance of strengthening surveillance systems as well as the collection of routine data.
- The inputs from the regional consultation workshops and the recommendations from Situational Analysis clearly indicate the need for BBS at least once in 3 years.

Strategic approaches:

- Map and develop reliable estimates of the size of the population at high risk for HIV to inform assessment of needs and development of appropriate policies and programmes.
- Conduct anthropological studies and collect in depth information on the contexts in which high-risk behaviors occur, moving beyond ‘rapid assessments’ to inform policy formulation and programming.
- Conduct operations research for responses addressing risk behaviors (drug use, men having sex with men, sex workers) in the Maldivian context, focusing on feasibility, acceptability and preferred modes of delivery.
- Develop a national M&E Guideline including M&E plan, national indicators and their definition, data flow mechanism, and quality control mechanism of collected data.
- Conduct independent evaluation of the national HIV response focusing on interventions in the key groups.
- Carry out periodic research (every three years) to understand the STI prevalence in the high risk group and general population.
- Revise HIV section of Demographic Health Survey to collect and analyze responses to major behavioral questions related to HIV infection in general population in the next round of the DHS survey
- Conduct integrated BBS at least every 3 years among the MARPs (i.e in the next 5 years – in 2012, 2015)
- Standardization of recording and reporting formats for the services provided.
- Conduct Mapping and size estimation studies focusing on MARPs at regular intervals.

Strategic Direction -3: Create an Enabling Environment

The health sector plays an essential role in fostering supportive environment including reducing HIV-related stigmatization and discrimination, and remove structural barriers⁹ to accessing HIV services. Linking between HIV and other key health areas is crucial for leveraging broader health outcomes. Such links are also important to ensure that HIV responses benefits from investments in other related health areas.

Expected outcome by 2016

- HIV and related health and social issues integrated into school curriculum
- National level HIV coordination mechanism developed to create a legal environment to address rights violations and discrimination of people living with HIV, KAP and special groups in need.
- 60% of populations in special groups including adolescents, young people, migrants, people in closed settings participate in stigma reduction campaigns through public media, community meetings and special stigma reduction activities
- 50% of religious leaders sensitized to promote positive attitude towards KAP

Key Issues and Challenges:

Stigma, discrimination and protection of Rights High levels of fear and stigma in the society are major obstacles for HIV testing and counselling and in turn can facilitate transmission of HIV. Various types of stigma related to risk behaviours exist in Maldives, though levels of stigma against drug users appears to be decreasing with the increase of the numbers of families with a drug user in their midst. Levels of disapproval for sex work are high but sex workers appear able to do their without harassment. Officially premarital sex is still frowned upon. The highest stigma was found towards men who have sex with men.

Gender Inequities: The Maldives has a Gender Empowerment Measure (GEM) of 0.429 and ranks 90th out of 109 countries for which calculations have been made. Maldivian women are still especially not treated equally when it comes to

⁹ Structural barriers are systematic barriers (social, cultural and legal) faced by key populations that deter them from accessing HIV services and reduce the effectiveness of services.

reproductive rights. Control of married women over contraceptives is often limited. Gender inequality –negotiating safer sex, attitudes to women’s reproductive rights – persists and can be linked to HIV in many complex ways.

Social health, mental health and stress: Globalization the growing influence of money and consumption and media is being increasingly seen in Maldives. The

The 2009 School Health survey found that an astonishing 19.9% of school based youth had seriously considered suicide.

frustration and even despair arising from the gap between the ambitions, aspirations and materialistic desires of young people on one hand and the formal employment, healthy entertainment opportunities and education opportunities on the other

hand can be important vulnerability enhancing factors for young people because they may increase the chance that they engage in risk behaviors, including crime, sex work and premarital sexual relations. The 2009 School Health survey found that an astonishing 19.9% of school based youth had seriously considered suicide. Inter-atoll disparity and inequality have increased, as well as disparity and inequality between Male’ and the atolls.

Domestic Violence and sexual abuse: Domestic violence and sexual violence is known to occur as does child sexual abuse -80% of the cases involve girls. 12% of women aged 15-49 have been sexually abused before the age of 15. Effective prevention strategies and support services for the victims of sexual abuse and child abuse are still lacking. High divorce rates and remarriage rates are also seen. Issues surrounding sexuality, sex work, youth sexuality are not openly discussed. Reproductive health needs especially of the young people are thus not provided adequate focus.

Mobility and Migration There is significant internal and external movement of the population. Tourism has further contributed to major work related migration of the Maldivians to the resorts. Decreased social control, loneliness and new opportunities may lead such people to engage in risk behaviour.

Strategic approaches: Removing gender-based health inequities and protecting the rights of people living with HIV and key populations are crucial steps to achieving universal access goals and health-related MDG targets. The health sector also has an important role to play in providing evidence on the links between gender equity, human rights, the social determinants of health, and HIV. Specific interventions should be implemented in the health sector with policies and programmes revised to reduce gender-based inequities and ensure human rights protections for key populations.

- Develop and implement National HIV Advocacy and Communication strategy focusing on addressing taboo, denial and stigma towards KAPs.

- Sensitise key service providers to address stigma and discrimination towards populations most at risk including youth, and people living with HIV.
- Develop a program to engage with religious leaders to enlist their support on the various issues including drug use and sexual risk taking, and. to promote positive attitude towards vulnerable population including adolescents, young people, migrants, expatriate workers, seafarers, workers in tourism industry, uniformed forces people in closed settings and wage workers
- Develop national level HIV coordination mechanism to create a legal environment to address rights violations and discrimination for people living with HIV, MARP and other vulnerable populations
- Support NGOs, FBOs, CSO working in health and related areas to address the needs of KAPS, community sensitization to overcome stigma and discrimination against HIV through trainings and workshops
- Develop a media and communications strategy for improving knowledge, assessing risk perception, stigma reduction of risk behaviors, and in support of safe behaviors related to HIV prevention.
- Campaigns will utilize radio, television, and other outlets through which mutually reinforcing messages are offered via interpersonal, community, and national channels. These should be reinforced with community interventions. Special localized media campaigns that are focussed at selected geographical areas / local areas will also be carried out.
- Provide communities with appropriate information on drugs, addiction, risk and vulnerability increasing factors and on the importance of reintegration of recovering drug users into society and making available appropriate job opportunities to them. The families of drug users are to be provided with counseling and support to cope with the day to day challenges that they face.
- Develop and implement a BCC strategy for prevention in targeted interventions with populations most at risk including youth, and populations with increased vulnerability. The BCC strategy will include:
 - Development of a BCC training manual and training of key service delivery staff to give them the skills to work with the different vulnerable populations.
 - Utilize data from BBS and other surveys for development of a communications strategy including behaviour change communications for STI HIV prevention and management, including risk reduction, maintenance of safe behaviors, consistent condom use, and early diagnosis of STI and HIV infection; to support (a) the work of key service delivery staff, and (b) mass media messages on STI and HIV prevention for high risk and vulnerable populations.
 - Improved participation of targeted audiences, in particular most at risk populations and improved collaboration between implementing organizations working with targeted audiences using the common BCC strategy.

- Establish a BCC Advisory Group based at NAP with participation from mass media, implementing organizations, populations most at risk including youth, and populations at increased risk and increased vulnerability.
 - Collect, analyse and disseminate gender based health information in order to identify transmission factors, health service inequities and programme impact.
 - Promote gender based provision of services and gender auditing of services and programs by allocating financial resources to programmes aimed at overcoming gender related barriers.
 - Support and collaborate with all initiatives and interventions that promote gender equity and rights of the population
 - Support involvement of populations most at risk including youth, and populations at increased risk and increased vulnerability, including people living with HIV in programme design and implementation to reduce stigma and discrimination.
 - Carry out Media sensitization for supporting populations most at risk including youth, promoting their rights to enable them to access services like anybody else in society.
 - Promote provision of Life Skills education for in-school and out of school adolescents through schools and in the community; and integration of HIV and related health& social issues into school curriculum.
 - Advocate for and support review of the appropriate laws and regulations to decrease HIV vulnerability and improve access to health services and protect human rights.
 - Develop and coordinate long-term resource mobilization plans to mobilize and sustain both external and domestic funding.
 - Stock taking and periodic review of the legal environment (legal mapping) to identify existing laws and regulations which act as bridges and barriers in delivering services (Example: condom programming).
-

Coordination/Implementation mechanisms

Coordination/Implementation mechanisms

For the multisectoral engagement and effective implementation of this strategy, following roles and responsibilities are designed. It is however recognized that given the complex nature of HIV epidemic, strong collaboration and mutual ownership and accountability is required for effective response.

NATIONAL AIDS COUNCIL

National AIDS Council is the highest policy body, consisting of multi-sectoral representatives chaired by the minister of Health and Family. It will provide directions to the National HIV/AIDS response and guide the implementation of the National Strategic Plan on HIV/AIDS 2012-2016.

MINISTRY OF HEALTH

HEALTH PROTECTION AGENCY

Under the Ministry of Health, in order for providing HIV and AIDS services, Health Protection Agency will develop work plan, implement and monitor HIV and AIDS related services. The Centre will implement the activities through central and regional level health structures, island public health units, health centres, health posts. **National HIV/AIDS program**, placed within the Health Protection Agency, has the responsibility to lead, plan and coordinate national response to HIV/AIDS, mobilise international and external resource , monitoring and evaluation of national response and implementation of the National Strategic Plan, provide technical guidance and support to other ministries, departments and NGOs, and implement specific activities such as surveillance and collection of national information on HIV as defined in the action plan.

Also, HPA will support the civil society organizations, groups and networks; to enhance their capacity to implement HIV/STI related services.

CIVIL SOCIETY ORGANIZATIONS (including networks, local NGOs, CBO)

Civil society will be major implementing partners of the NSP. They will do direct implementation of prevention services, such as outreach activities for the general population and delivery of comprehensive package of preventive interventions for identified key population groups. They will provide service in collaboration and or in support of government health system. It is recognized that some Key population groups may not access government run services for various practical reasons (opening hours, stigma and discrimination, confidentiality), therefore be approaching NGO run facilities. However, they will also, play the key role in bridging the key population to mainstream health services; another important role of civil society is provision of care and support

services of people infected and affected by HIV and AIDS. Most importantly, civil society will contribute in National M&E activities.

Role of Sectoral Ministries in National Response to HIV

The NSP calls for systematic and coordinated action from line ministries beyond the Ministry of Health. Selected line ministries have a role to play in prevention by reducing vulnerability to and risk of HIV transmission among the population it serve, contribute to care and support for people living with HIV, to help reduce stigma and discrimination and to create enabling environment. Also, a national coordination mechanism will be established to ensure budget allocations for HIV and AIDS are coordinated at National level.

Table 1: Proposed Role of sectoral ministries

Ministry/Sector	Proposed Role and Mainstreaming approach
Ministry of Health	<p>SD 1 - Policy making, developing of guidelines for monitoring and regulation, technical assistance for prevention in general population.</p> <p>SD 1– Policy making, monitoring & regulation, implementation, strategic program development & coordination for prevention in vulnerable populations.</p> <p>SD 3 - Super vision, policy level support and quality assurance of programmes, formation of TWG in relation to KAPs and coordinate.</p> <p>SD 3 – Policy making and guidelines formulation (composition of physician, OBG, Dermatology, psychosocial support (psychiatrist), paediatrics – Male’ based – ToR)</p> <p>SD 1 – Planning, organising, leading and controlling. Establishing guidelines and standards, implementing, regulation monitoring and evaluation</p> <p>SD –1,2 and 3 Lead the national response on HIV</p> <p>SD -2 –Strengthen Strategic Information collection and dissemination system</p>
Ministry of Finance	<ul style="list-style-type: none"> ○ As with other P1 programme, advice, advocate and allocate appropriate resources as per the plan of line ministries for HIV related function.
Ministry of Education	<p>SD 1 – Facilitating Policy making, developing of guidelines for monitoring and regulation, technical assistance for prevention in general population.</p> <p>SD 1 – Facilitating Policy making, monitoring & regulation, implementation, strategic program development &</p>

Ministry/Sector	Proposed Role and Mainstreaming approach
	<p>coordination for prevention in vulnerable populations.</p> <p>SD 1 – Incorporating life skills programmes into school curriculum</p> <ul style="list-style-type: none"> ○ (Incorporate HIV topics in curriculum at different level including in adult and continuing education curriculum. Emphasise on reducing stigma and discrimination in all related activities.) ○ Strengthen capacity of the teachers on how to provide adolescent friendly information on Sexual and reproductive health and HIV related queries. <p>SD 3 – Facilitate and make policies that require school health assistants and counselors to have training in HIV/AIDS and prevention, conducting awareness sessions for parents regarding HIV/AIDS and prevention</p> <p>SD 3 – Lead the national response on HIV - omit</p> <ul style="list-style-type: none"> ○
Faculty of Health Sciences	<ul style="list-style-type: none"> ○ SD 1 – Include training in HIV/AIDS and prevention and treatment and care in relevant courses. ○ SD 1 – Offering Life Skills Education (LSE) as a core subject to all teaching related courses ○ SD 1 Youth Friendly Health Services (YFHS) module to be added in the curriculum of all Health related courses
Faculty of Maritime studies	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops, training of students and staff in HIV/AIDS and prevention
Ministry of Tourism	<ul style="list-style-type: none"> ○ SD 1 - Incorporate HIV in its internal and external training programme including tourism training institutions. Emphasise on reducing stigma and discrimination in all related activities. ○ SD 1 - Conduct awareness programmes for employees in the tourism industry (hotels, guest houses, resorts, safaris, tour operators) about HIV and AIDS and preventive ways. ○ Prepare workplace policies. ○
Ministry of Home Affairs	<p>SD 1 – Facilitate in the Policy making, developing of guidelines for monitoring and regulation, technical assistance for prevention in general population.</p> <ul style="list-style-type: none"> ○ SD -3 Emphasise on reducing stigma and discrimination in all related activities. ○ SD 1– Work in collaboration with other stakeholders to ensure services for incarcerated populations.

Ministry/Sector	Proposed Role and Mainstreaming approach
Department or Penitentiary and Rehabilitation	<ul style="list-style-type: none"> ○ Sensitization workshops and capacity building workshops for staff working in prison settings and other closed settings (rehabilitation center, detention centers) ○ SD 3 – Facilitating in making an appropriate laws and policies to promote the accessibility of MARPS for prevention and care services. ○ SD 1– Work in collaboration with other stakeholders to ensure services for incarcerated populations. ○ SD 3 Emphasise on reducing stigma and discrimination in all related activities.
Juvenile Justice Unit	<ul style="list-style-type: none"> ○ SD 1 Sensitization workshops and capacity building workshops for staff working in prison settings and other closed settings (rehabilitation center, detention centers)
Ministry of Islamic Affairs	<ul style="list-style-type: none"> ○ SD 1 – Creating awareness of HIV/AIDS within a religious perspective ○ SD 3 Creating behaviour change attitude in the general public towards increasing health seeking behaviour. ○ SD 3 – Curriculum development on sensitization of religious scholars for stigma reduction. ○ SD 1 -Educating the MARPS on religious principles. ○ SD 1– Creating awareness material on HIV/AIDS and prevention in relation to religion. ○ SD 3 - Emphasise on reducing stigma and discrimination in all related activities. ○
Ministry of Transport and Communication	<p>SD 1 – Facilitate in Policy making, developing of guidelines for monitoring and regulation, technical assistance for prevention in general population.</p> <ul style="list-style-type: none"> ○ SD 3 Sensitization workshops and support of implementation of activities, creating a supportive environment for staff. ○ SD 3 Emphasise on reducing stigma and discrimination in all related activities.
Ministry of Human Resources Youth and Sports	<p>SD 1 – Facilitate in Policy making, developing of guidelines for monitoring and regulation, technical assistance for prevention in general population.</p> <ul style="list-style-type: none"> ○ SD 3 Sensitization workshops and support of implementation of activities, creating a supportive

Ministry/Sector	Proposed Role and Mainstreaming approach
	<p>environment for staff.</p> <p>SD 1 – Policy making, monitoring & regulation, implementation, strategic program development & coordination for prevention in vulnerable populations.</p> <p>SD 1– Work in collaboration with other stakeholders to provide services for MARPS and other Vulnerable youth.</p> <ul style="list-style-type: none"> ○ SD 3 -Emphasise on reducing stigma and discrimination in all related activities. <p>SD 1-</p> <ul style="list-style-type: none"> ○ Adolescents policy and strategy is now in place ○ Include prevention message and S&D activities in its regular programme for adolescents ○ Incorporate HIV in its internal and external training programme including labour training institutions. ○ Monitoring and evaluation by incorporating define indicator in routine progress reporting forms. <p>SD 2 - Research and capacity building in adolescents related activities and organisations</p>
Ministry of Defense and National Security/ Maldives National Defense Force	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops and support of implementation of activities, creating a supportive environment for staff. ○ SD 3- Emphasise on reducing stigma and discrimination in all related activities.
Maldives Police Service	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops and support of implementation of activities, creating a supportive environment for staff. ○ SD 3 -Emphasise on reducing stigma and discrimination in all related activities. ○ SD 3 – Facilitations of making appropriate law and policies to promote the accessibility of MARPS for prevention and care services. <p>SD 3– Work in collaboration with the other stake holders to create an enabling and supportive environment.</p> <ul style="list-style-type: none"> ○
Maldives Customs Service	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops and support of implementation of activities, creating a supportive environment for staff. ○ SD 3- Emphasise on reducing stigma and discrimination

Ministry/Sector	Proposed Role and Mainstreaming approach
	<ul style="list-style-type: none"> ○ in all related activities.
Ports Authority	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops and support of implementation of activities, creating a supportive environment for staff. ○ SD 3- Emphasise on reducing stigma and discrimination in all related activities.
Department of Immigration and Emmigration	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops and support of implementation of activities, creating a supportive environment for staff. ○ SD 3-Emphasise on reducing stigma and discrimination in all related activities. ○
Department of National Planning	<ul style="list-style-type: none"> ○ SD 1,2 and 3 - Advise, advocate appropriate resources as per the plan of line ministries for HIV related function. ○ Seek technical inputs from ministry of health (NCASC), HSCB as appropriate. ○
National Drug Agency	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops and support of implementation of activities, creating a supportive environment for staff. ○ SD 3- Emphasise on reducing stigma and discrimination in all related activities. ○ SD 1 – Increase information in rehabilitations center on free delivery of condoms, injections and other activities. ○ SD 1 and 2 - Policy level support in advocacy, monitoring, regulating and funding.
Attorney General’s Office	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops and support of implementation of activities, creating a supportive environment for staff and Clients. ○ SD 3- Emphasise on reducing stigma and discrimination in all related activities. ○ SD 3 – Making an appropriate law and policies to promote the accessibility of MARPS for prevention and care services. ○ SD 1 – Revise currently existing laws, in a way that enhances/enables prevention, treatment and care services related to HIV/AIDS ○ Work in collaboration with other Stake holders
Prosecutor General’s Office	<ul style="list-style-type: none"> ○ SD 1 – Sensitization workshops and support of

Ministry/Sector	Proposed Role and Mainstreaming approach
	<p>implementation of activities, creating a supportive environment for staff and Clients.</p> <ul style="list-style-type: none"> ○ SD 3- Emphasise on reducing stigma and discrimination in all related activities. ○ SD 1 – Facilitating the making of an appropriate law and policies to promote the accessibility of MARPS for prevention and care services ○ SD 1,2 and 3- Work in collaboration with other stakeholders.

Local Councils (Including the Atoll councils)

The mandate of the local councils is to provide primary health care and public health services to the public. As per the SOPs provided by the Ministry of Health the Local councils will carry out their responsibilities in relation to the response of HIV/AIDS in the country. The mandate of the Atoll Councils is to monitor the performance of the local councils.

Health Services Corporation

A number of Health Services Corporations have been formed by the previous Government in 2010 through its policy of corporatization of all health care service centers and hospitals in the country under the Government. The health corporations were formed to cater to the health care needs of not only the capitals of the atolls but also the community at large. The Health Services Corporations would be supporting the HIV response by providing basic HIV prevention – testing. User friendly, quality and confidential testing services. The Health Services Corporations will also provide provision of care, support and treatment.

Private Sector

Private sectors has crucial role in national and international advocacy both for resource mobilisation and for effective implementation of national policy and programmes. Continuous dialogue with private sector need to be maintained to expand their role and engagement in HIV prevention, treatment care and impact mitigation.

Media

1. Capacity building of media – it must be continuing process
2. Encourage journalist to identify issue in HIV
3. Encourage media involvement in HIV/AIDS prevention and stigma reduction
4. HIV communication strategy (what are the communication issues, what are the role of media, how they can participate in such process, how to set up regular discussion and dissemination process)

M&E Plan
