COUNTRY PROGRESS REPORT
Maldives

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Health Protection Agency
Ministry of Health
Maldives

Contents

Acronyms

AIDS	Acquired Immunodeficiency Syndrome
ANC	Ante-natal care
BBS	Biological and Behavioral Survey on HIV/AIDS
FSW	Female Sex Worker
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
IEC	Information, Education, Communication
IGMH	Indira Gandhi Memorial Hospital
IOM	International Organization for Migration
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug Use(r)
JMTR	Joint Mid-Term Review
KAP	Key Affected Population(s)
MOE	Ministry of Education
MOH	Ministry of Health
MDG	Millennium Development Goals
MSM	Male to male sex/Men who have Sex with Men
NAC	National AIDS Council
NAP	National AIDS Programme
NGO	Non-Governmental Organization
NSP	National Strategic Plan on HIV in the Maldives 2014-2018
PLHIV	People living with HIV
PMTCT	Prevention of Mother to Child Transmission
SDG	Sustainable Development Goals
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

I. Status at a glance

Epidemiological data continues to show the HIV/AIDS epidemic in the Maldives may be characterized as low prevalence but high vulnerability, risk and epidemic potential.[1] As of 2015, 23 HIV positive cases had been reported among Maldivians, among which 12 have died. In contrast, by 2015, 356 HIV positive cases were found among expatriates during pre-employment screening, and thus were not granted work permits.[2] 9 Maldivians (and 1 expatriate until his contract concluded in 2014) continue to receive antiretroviral treatment provided by the Maldivian government.[1]

Majority of these were identified through case reporting, and most infections were reportedly acquired though heterosexual transmission,[1] and one case of transmission via blood transfusion in 2013.[2] Thus far there have not been any reported transmission through intravenous drug use, nor through mother-to-child transmission. However, HIV infection was found among men who have sex with men (MSM) in 2011, and among injecting drug users in 2012. The year 2012 also saw the first reported case of pediatric HIV/AIDS.[3]

The first Biological and Behavioral Survey (BBS) of 2008 remains the only large-scale study to date, collecting 1791 serological samples from select vulnerable populations including Female Sex Workers (FSWs), Men who have Sex with Men (MSM), Injecting Drug Users (IDUs), Occupational Cohorts of Men (OCM including sea farers, resort workers, construction workers), and youth across Male', Addu Atoll, and Laamu Atoll.[4] Although it identified one HIV positive case, the BBS 2008 revealed extensive unsafe sexual behavior, injecting drug use, and interconnected sexual networks between the high-risk groups surveyed.[1] The 2010 Risk Behavior Mapping and the 2011 Situation Analysis corroborates these findings and identified the following factors as contributing to high vulnerability: globalization and growing influence of money and consumption; gender inequality; sexual violence against children; high levels of premarital sex; low levels of condom use; unequal sex ratios; mobility and migration; tourism; crowding; multiple partnering pattern; crowding; stigma and discrimination; and silence and taboos about sexuality.[1]

[1] The HIV and AIDS Situation: Related Policy and Programmatic Responses of the Maldives (Ministry of Health, 2011)
[2] National AIDS Programme (NAP) records (retrieved 2015)
[3] National HIV Registry (retrieved 2016)
[4] 2008 Biological and Behavioral Survey on HIV/AIDS (UNDP, 2008)

A. Policy and programmatic response

The Government of Maldives continues to prioritize the national response to the AIDS epidemic as a major public health concern, guided by the National AIDS Council (NAC) that convenes cross-sectoral stakeholders including government bodies, UN agencies and non-governmental organizations (NGOs). The National AIDS Program (NAP), situated under the Health Protection Agency (HPA) of the Ministry of Health, coordinates the efforts to ensure Maldives remains a low prevalent country. The newly revised National Strategic Plan for the Prevention and Control of HIV/AIDS 2014-2018 (NSP) aims to maintain the low prevalence of HIV in the Maldives and prevent further transmission, providing three broad strategic directions (details for which are discussed in Section III):[1]

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

- Focus on specific needs of Key Affected Populations (KAP)
- Strengthen key services for improved prevention efforts
- Preventing HIV in general population and special groups including youth, migrants and people in prisons
- Improved care, treatment and management of People Living with HIV

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

Strategic Direction 3: Create an enabling environment

[1] National Strategic Plan for the Prevention and Control of HIV/AIDS 2014-2018 (Health Protection Agency, 2013)

B. Indicator data

People living with HIV who know their status – (Percentage of people living with HIV who know their status (including data from case-based reporting)

	All	Males (all ages)	Males (0-14)	Males (15-49)	Males (50+)	Females (all ages)	Females (0-14)	Females (15-49)	Females (50+)
Cumulative number of people living with HIV diagnosed	23	19	1	17	1	4	0	4	0
Cumulative number of AIDS-related deaths	13	10	0	10	0	3	0	3	0
Numerator (A-B)Number of people who are alive and know their status	10	9	1	7	1	1	0	1	0
Denominator Estimated number of people living with HIV (e.g. from Spectrum)	10	9	1	7	1	1	0	1	0

*Estimates based on Spectrum not available, Spectrum not applicable to Maldives because of the low numbers

HIV prevalence from antenatal clinics by age group - Maldives – 2015 (HIV prevalence among women attending antenatal care clinics in the general population)

	All (15-49)	15-25	25 and above
Numerator Number of pregnant women who tested HIV positive (including those who already know their HIV positive status) who attended antenatal clinics	0	0	0
Denominator Number of women tested for HIV at antenatal clinics (including those who already know their HIV positive status).	4700	1606	3094

This indicator has been under reported, therefore, not included in the online reporting system. Government will carry out an assessment to identify bottle necks and provide recommendations to strengthen reporting.

STIs by syndrome

Male Urethral Discharge 15-24	Male Urethral Discharge 25+	Total Male Urethral Discharge	Vaginal Discharge 15-24	Vaginal Discharge 25+	Total Vaginal Discharge	Male Genital Ulcer 15-24	Male Genital Ulcer 25+	Total Male Genital Ulcer	Female Genital Ulcer 15-24	Female Genital Ulcer 25+	Total Female Genital Ulcer	Total No .of STI syndromes
7	31	38	233	823	1056	0	1	1	4	11	15	1110

HIV testing from a VCT center

HIV tested through VCT										**Total**	
<15 yrs		15-24		25-49		>49		E. tested	Pos+	**Tested**	**Positive**
Male	Female	Male	Female	Male	Female	Male	Female				
1	1	41	35	91	39	14	19	125		366	0
0	0	0	0	126	14	11	0	0		151	0
0	0	54	8	33	7	0	0	0		102	0
1	1	95	43	250	60	25	19	125		619	**0**

II. Overview of the AIDS epidemic

With the second Bio-Behavioral Survey still in the preparatory stage, the BBS 2008 remains the most recent large-scale prevalence study on the AIDS epidemic in the Maldives. As such, the figures presented in previous country progress reports remain in effect, and the more notable points are provided below:

The results of BBS 2008 revealed potential routes for HIV transmission in the country. Sizeable numbers of risk groups (FSW, Male clients of FSW, MSM, IDU and youth) were found in Male', Addu and Laamu.[1] The Risk Behavior Mapping Survey (2010) done in 12 islands across Maldives extrapolated the data to calculate the national estimates of 1139 FSWs, 1199 MSMs and 793 IDUs with high percentages of the key populations concentrated in Male' alone (FSW 37%, MSM 48% and IDU 53%).[2]

Although HIV prevalence is still below 1%, sexually transmitted infections (STIs), particularly, syphilis, an ulcerative STI, was detected among the resort workers with a prevalence of 1.2%. Likewise, Hepatitis B was also detected among the resort workers, MSM, seafarers, construction workers and IDU.[1]

BBS 2008 also detected Hepatitis C circulating among the IDU in Male' and Addu, and that, commercial sex among this group is prevalent. This practice of injecting drug use combined with commercial sex is one of the ominous signs of the spread of HIV in Asia. It must be noted that Hepatitis C implies a widespread needle and syringe sharing and this is the most efficient way of transmitting the virus.

OBJ

The BBS 2008 found high rates of STI and Hepatitis, as summarized below.

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Survey group	Pathogen	Prevalence (N)
Resort workers	Syphilis	1.2 (484)
Resort workers	Hepatitis B	2 (484)
Constr workers (Male')	Hepatitis B	3 (102)
Seafarers	Hepatitis B	4 (100)
IDU (Addu)	Hepatitis B	0.8 (128)
IDU (Addu, Male')	Hepatitis C	0.8 (128), 0.7 (150)
MSM (Addu, Male')	Hepatitis B	6 (55), 1.4 (69)

[1] 2008 Biological and Behavioral Survey on HIV/AIDS (UNDP, 2008)

[2] The HIV and AIDS Situation: Related Policy and Programmatic Responses of the Maldives (Ministry of Health, 2011)

An alarming set of risk behaviors and interface among the most at risk populations were also uncovered by the BBS 2008. This scenario is seen among the MSM, IDU, clients of FSW and the youth and these potential channels for HIV transmission are accelerated by the non-condom-use in multiple sexual partnerships and widespread sharing of unsterile needles and syringes.

Maldives is also showing other warning signals which need to be closely monitored by the national program: injecting drug use in prisons and rehabilitation centers and the risk behaviors found among the 18-24 year age group (selling of sex, buying of sex, MSM partnership, injecting drug use, multiple partnerships through group sex, sex with non-regular partners).[1]

Other information gathered by the BBS pointing to the HIV vulnerability of the country are: low self-perception of risk; pervasive belief that the practice of Muslim religion and the non- existence of HIV in the country will protect one from HIV; poor health-seeking behavior with a number self-medicating or doing nothing for STI signs and symptoms despite availability of health facilities that can address the problem. Likewise, VCT (Voluntary Counseling and Testing) is also unpopular. Although awareness on HIV transmission is quite high, it is clearly seen that condom use is low and sharing of injecting needles and syringes are also prevalent.

The 2009 Joint Mid-Term Review of the National Response to HIV in the Maldives (JTMR) concludes that data gathered to date show an epidemic characterized by low overall prevalence but with high vulnerability and risk, i.e. high epidemic potential. The most likely trigger for an HIV epidemic in the Maldives is injecting drug use, because of:

- The 'efficiency' of sharing contaminated needles as an HIV transmission route compared to sexual transmission
- The relatively large number of Maldivians using drugs
- The apparently increasing share of drug users shifting towards injecting rather than smoking (according to key informants)
- The high prevalence of needle sharing (according to the BBS and key informants)
- The history of HIV epidemics in other Asian countries that confirms that often these epidemics started with injecting drug use as the main driver.

[1] 2008 Biological and Behavioral Survey on HIV/AIDS (UNDP, 2008)

III. National response to the AIDS epidemic

The National Strategic Plan for the Prevention and Control of HIV/AIDS 2014-2018 (NSP) provides the framework and priorities for the national response to the AIDS epidemic in the Maldives. With the goal to maintain the low prevalence of HIV in the Maldives and prevent further transmission, the NSP identifies 3 objectives:

1) To scale up prevention programmes in the Key Affected Populations
2) To improve prevention efforts for general population and special groups including youth and migrants
3) To reduce stigma and discrimination

The national response to HIV/AIDS prevention, care, treatment and support as well as knowledge and behavior change efforts are guided by the 3 overarching Strategic Directions of the NSP:

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

- Focus on specific needs of Key Affected Populations (KAP)
- Strengthen key services for improved prevention efforts
- Preventing HIV in general population and special groups including youth, migrants and people in prisons
- Improved care, treatment and management of People Living with HIV

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

Strategic Direction 3: Create an enabling environment

A. Prevention

Under the Strategic Direction 1, the NSP aims to strengthen key services for improved prevention efforts. These include the following:

Strengthen provision of STI services: 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 (the most recent being the BBS 2008, with the second one scheduled for 2015 but delayed to 2016).1 As of this reporting cycle in 2016, STI surveillance has revealed 1147 positive syndromic STI cases, and 35 positive for syphilis.[2] The targeted outcome for 2016 is to increase the number of fully functional STI centers by 50% and as such, preparations for establishing such a center in Male' (Dhamanaveshi) is underway.

[1] National Strategic Plan for the Prevention and Control of HIV/AIDS 2014-2018 (Health Protection Agency, 2013)

[2] NAP records (retrieved March 2016)

Safe blood supply services: 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 (Hepatitis B, Hepatitis C, Malaria and Syphilis) in Government hospital and laboratories, however the standard operating procedures or local written instructions for transfusions may not be adhered to by many other labs. The targeted outcome by 2016 includes ensuring 100% of donated blood units being screened for HIV as per national guidelines.[1] As of this reporting cycle in 2016, 16,389 blood donors were screened for HIV among which 3 tested positive. Under the Thalassemia programme, 46 were tested and 1 tested positive.[2]

Comprehensive Condom Programming: Although high levels of knowledge about HIV/AIDS and using condoms was noted in the DHS 2009, but due to perceived linkages of HIV to immoral behaviors and low self perceived risk, condom use is low across all most-at-risk populations.[1] The targeted outcome by 2016 is to increase in the outlets providing condoms and lubricants by 50%[1]

Prevention of Mother To Child Transmission (PMTCT): The national testing guidelines stipulates that, pregnant women should be offered an HIV test, allowing them to opt out; also, pre- and post-test counseling should be provided and written informed consent should be obtained prior to testing. However, contrary to these guidelines, all pregnant women are still screened for HIV along with VDRL and hepatitis B, and pre- and post-test counseling is not available.[1] The NSP targets for 2016 include 100% of women attending ANC clinics are tested for HIV as per the national guidelines that allow 'opt-out'. Efforts to achieve this are underway with the establishment of the new Guidelines for PMTCT of HIV as part of reproductive and maternal health services.[2] Under this guidelines, 3704 women were tested in 2014, and as of this reporting cycle in 2016, 6828 women were screened at ANC visits and none tested positive.[3]

Focus on specific needs of Key Affected Populations: Under the Strategic Direction 1, the NSP aims to implement targeted interventions for the Key Affected Populations. However, as reported in the 2015 Country Progress Report, most interventions have tended to be located in Male' only, supported by only 2 active NGOs, and have mainly focused on IDUs, with no notable interventions for FSWs, MSMs or migrant populations. There are 2 drop-in centers for IDUs in Male', and have HIV counseling and blood collection services available within their facilities. Opioid Substitution Therapy (OST) is being piloted as a special program though the National Drug Authority (NDA), but are

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[1] The HIV and AIDS Situation: Related Policy and Programmatic Responses of the Maldives (Ministry of Health, 2011)

[2] Guidelines for the Prevention of Mother to Child Transmission (PMTCT) of HIV (Health Protection Agency, 2013)

[3] NAP records (retrieved March 2016)

awaiting review and scale-up. Despite the need and intent to focus on KAPs, as of this reporting cycle in 2016, only 21 IDUs, 11 Sex Workers, and 5 MSMs were tested for HIV and none tested positive.[3]

The NSP identifies a key challenge in implementing such interventions for KAPs- "As all these behaviors 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 health 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." (p.14)[1]

HIV testing and counseling: The Maldivian 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.[1] As reported in 2015, this service is available from all hospitals and health centers; anyone can access to these services free of charge. In addition, there are 8 centers designated to promote and offer free testing and counseling. Two VCT centers have been established outside the public health system, within NGOs that offer targeted services for key populations, youth and migrant workers. Expatriate workers applying for a work permit are required to undergo a medical screening process, which includes selected communicable diseases, including HIV. In 2014, 7242 expatriates were tested and 6 among them were tested positive for HIV, who were not granted permit to stay. As of this reporting cycle in 2016, 30,001 expatriates underwent pre-employment screening among which 18 of them tested positive.[1]

In 2014, nearly 25,000 HIV tests were carried out- a slight drop from 2013, which saw 35,754 tests being done. In order to increase the uptake of HIV testing services, the NSP states that 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). Thus far, in 2016, only 803 people underwent self-referred testing for HIV and none tested positive.[2]

B. Care, Treatment and Support

Antiretroviral services are being delivered from one center, Indira Gandhi Memorial Hospital in Male'. People testing positive for HIV are immediately enrolled in the national treatment programme, and a treating physician assigned to every client, who will look after the client, ensuring regular checkups, dispensing the ARV drugs and

[1] National Strategic Plan for the Prevention and Control of HIV/AIDS 2014-2018 (Health Protection Agency, 2013)
[2] NAP records (retrieved March 2016)

follow-up. The National Programme facilitates psychosocial support, and if required legal support as well. Patients on treatment, who are living away from the ART center, are asked to identify a family member who will collect the drugs from the ART center and deliver the drugs to the client. This practice has been ongoing and functional ever since the ARV programme was established, and reported in previous reporting cycles. The NSP 2014-2018 notes a commitment to focus on taboo, denial and stigma of risk behaviors and people living with HIV in the next wave of advocacy, information and education activities.

C. Knowledge and Behavior Change

As the second rounds for the BBS as well as the nationally representative Demographic and Health Survey (DHS) have not been conducted, the knowledge and behavior change data remains unchanged from previous reports. Notable findings from these studies are provided below:

The 2009 DHS showed that overall only 41.5% of the women surveyed had 'comprehensive knowledge' about HIV, meaning that they knew consistent use of a condom during sexual intercourse and/or having just one uninfected faithful partner can reduce the chance of getting HIV, as well as rejecting the two most common misconceptions about HIV.[1] 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.'[2]

Despite high reported knowledge, high-risk behaviors for STI and HIV transmission continue to occur. The BBS 2008 reports that nearly all (98%) FSW in Addu and 88% in Male' reported unsafe sex with a client in the past 7 days; 100% and 80% reported unsafe sex with a regular partner in the past 7 days, indicating a clear potential pathway for HIV into sexual networks in which monetary exchange plays a role. MSM in Addu and Male' used condoms consistently in 21% and 36% of their encounters with men and in only 2% and 17% of their sexual encounters with women, respectively. Regarding sexual networking, IDU, similar to MSM, have a wide- ranging sexual network. In Addu and Male', 97% and 90% of IDU had sex in the past 12 months. 65% and 74% had a regular sex partner (of whom only 1% and 2% were also injecting); 54% and 55% had a non-regular partner, 52% and 38% bought sex; 4% and 16% sold sex; 2% of male IDU sold sex to another man in both locations and 1% and 2% of IDU reported consensual sex with another man. Importantly, 59% of IDU reported unsafe sex in the past 12 months.[3]

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[1] The HIV and AIDS Situation: Related Policy and Programmatic Responses of the Maldives (Ministry of Health, 2011)

[2] National Strategic Plan for the Prevention and Control of HIV/AIDS 2014-2018 (Health Protection Agency, 2013)

[3] 2008 Biological and Behavioral Survey on HIV/AIDS (UNDP, 2008)

IV. Best practices

Two achievements are notable as best practices. First is the engagement of two NGOs in providing VCT services, which ensures availability of such services independent of the health sector.[1] Secondly, the Guidelines for the Prevention of Mother to Child Transmission (PMTCT) of HIV integrate PMTCT into the mainstream health system via Reproductive Health Services.[1] Establishing these guidelines and training health personnel has contributed to the Maldives being on the road to achieving elimination of Mother-to-Child syphilis and HIV transmission.

V. Major challenges and remedial actions

As with preceding years, one main challenge that persists is the limited number of civil society partners available to support the state-run National AIDS Programme. This limits opportunities to tap into communities and networks to implement target interventions for KAPs.

The second main challenge is the widening funding gap. The transitions from Lower-Income Country to an Upper Middle-Income Country as well as from MDGs to SDGs combine with continued low prevalence to make it challenging for Maldives to be eligible to access funding mechanisms such as the Global Fund. This scenario is also linked with challenges in justifying state funding and priorities. Potential ways of alleviating this resource gap include regional partnership for cross-border issues as well as country participation in consultations to lobby for differentiative consideration- that is, to be considered for funding assistance based on more than country income status and low prevalence.

VI. Support from the country's development partners

The NAP acknowledges continued technical support from WHO Maldives, nominal support from UNICEF Maldives, and notes potential partnership with International Organization for Migration (IOM) Maldives for support on migrant health interventions.

VII. Monitoring and evaluation environment

The monitoring and evaluation mechanisms are dependent upon timely and strategic information systems providing changes and responses to the epidemic in the country. As evidenced by the continued reliance on BBS 2008 and other dated figures, the current M&E system continues to be characterized as weak, and in need of assistance in

[1] Guidelines for the Prevention of Mother to Child Transmission (PMTCT) of HIV (Health Protection Agency, 2013)

strengthening capacity for M&E activities.[1] The NSP 2014-2018 notes the following weaknesses and challenges in particular:[2]

- HIV in Maldives is mostly likely to be concentrated among populations at high risk of infection and is different from other countries that may reflect predominantly generalized heterosexual epidemic.
- 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.
- Monitoring and evaluation of responses to the epidemic needs strengthening, specially, targeted interventions, strategic information systems to measure progress these are yet to be in place.
- Protocols for ensuring efficient flow of information from periphery to center and then back to periphery needs strengthening.
- Statistical modeling to better understand trends in HIV prevalence in Key Populations at risk is yet to be carried out; this can be a follow-up activity of IBBS 2016, and it is essential that more data is available to conduct modeling and this underscores the importance of strengthening surveillance systems as well as the collection of routine data.

[1] The HIV and AIDS Situation: Related Policy and Programmatic Responses of the Maldives (Ministry of Health, 2011)

[2] National Strategic Plan for the Prevention and Control of HIV/AIDS 2014-2018 (Health Protection Agency, 2013)