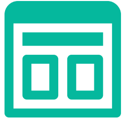
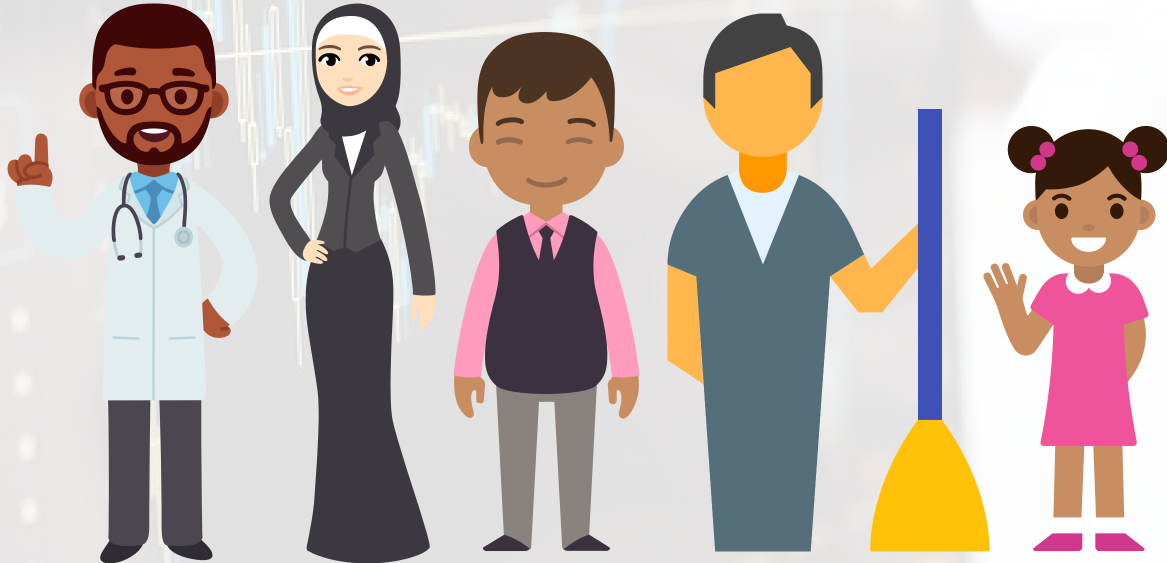


QUALITATIVE REPORT

Socio-Economic Impact of COVID-19 in the Maldives



SOCIAL SECTOR EXPERIENCES DURING THE COVID-19 PANDEMIC'S LOCKDOWN IN THE MALDIVES

In partnership with

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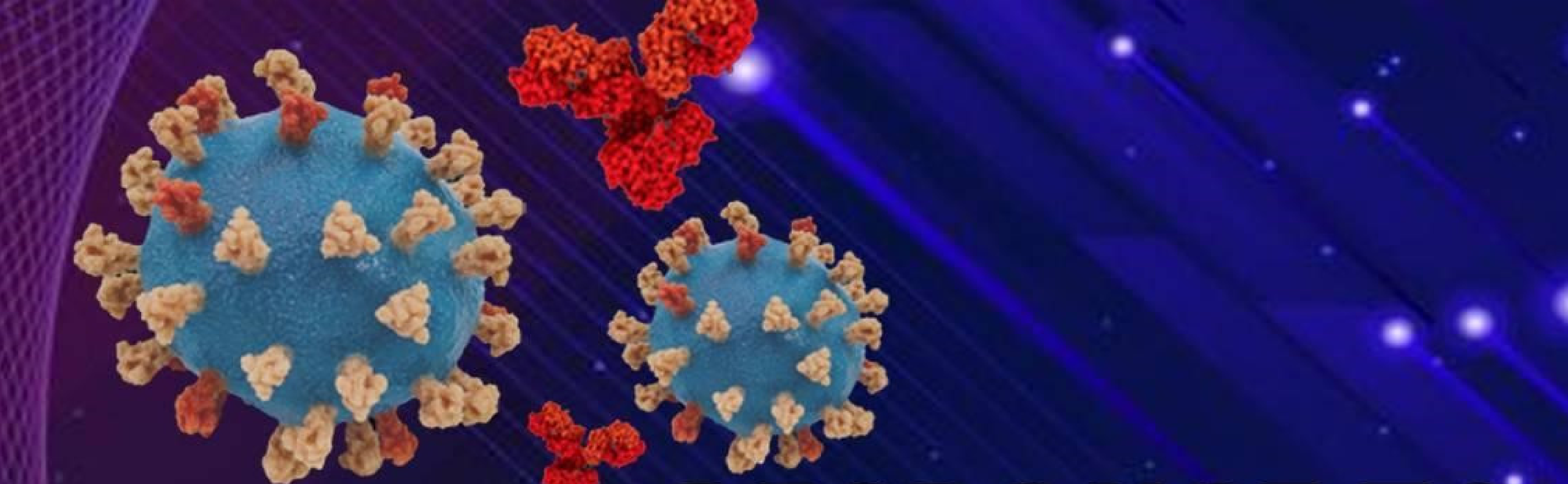


INTRODUCTION

Social protection and continuity of social services are essential aspects in any crisis situation. However, during pandemic situations protection and provision of services are extremely challenging. This report draws on the experiences of government agencies and civil society organisations engaged in serving the vulnerable populations during the time of lockdown during April – June 2020.

METHODS

The study is part of a broader research examining the socio-economic aspects of COVID-19 in the Maldives, approved by National Health Research Council (NHRC/2020/006) and registered at the Maldives National University. The report draws on twelve in-depth interviews with key informants of stakeholder institution of the government and auxiliary bodies, and civil society organisations (see appendix for the institutions from which the key informants were drawn).

This report focuses on experiences of the social sectors during the lockdown in the early stages of the pandemic, assuring basic needs and equal rights, protection of vulnerable groups, services for drug users, continuity of education and non-COVID-19 health care. Care and services for persons with disabilities has been published separately on the disability sector and not included in this report.

FINDINGS:OVERVIEW

Three themes emerged from the experiences of social sector: (1) Unprepared, (2) Outside the response and (3) Community support. These encompass aspects of planning and coordination, vulnerability, stigma, community support and volunteering. (Figure 1 presents the threads that emerged in the analysis and Table 1 summarises the clusters for each theme).

1. UNPREPARED

The main threads that emerged in relation to the theme of 'Unprepared' were that sectors were not ready for the crises that surfaced in the pandemic and there was no contingency for sustaining the basic commodities for survival and no systemic preparation for the response. The response of the Emergency Operations Centre (EOC) was viewed solely as a health response. Even with the activation of the National Emergency Operations Centre, the emergency management structures proposed in the national emergency operations plan was not activated, rather new structures were put in place that evolved as the response progressed. This resulted in a number of issues, in the coordination, information flow and decision making.

While some sectors such as education sector had emergency plans, those also fell short of the response needs of the pandemic. Social services sector was particularly unprepared having to institute ad-hoc interventions, mobilise resources and set operational processes. A number of government agencies were providing relief and social support to the vulnerable segments of the population they have a mandate to serve. Given the situation, the sectors were reacting and planning response in real time and mostly in isolation within their sectors. This resulted in some duplication of efforts by the government agencies each with their own operational processes which was not clear to other agencies. Despite the shortcomings on efficiency, all the agencies tried to work together and the response continued to improve efficiency to some extent.

Figure 1: Word map of the textual analysis

The centralized nature of the government administration was a huge challenge in operationalising the response in the Atolls. The Atolls had limited knowledge and skills in responding to the emergency and with the concentration of services in Male' there was no contingency for the Atoll population. The lack of capacity and resources in the Atolls can be said to be one of the policy considerations in enforcement of significant travel restrictions to the Atolls to keep the islands free from COVID-19.

Table 1: Themes and clusters

Themes	clusters
Unprepared	Not ready, plans inadequate for the crisis
	No contingency resources
	Coordination unclear and chaotic
	Realtime planning of operations
	Roles, responsibilities, communication flow not clear
	Centralised – reliance on Male'
Outside the response	Social services not part of emergency operations
	Competing for resources – local and international
	Technology and innovations
Community support	Volunteers
	CSOs providing professional support
	Community resources
	Supporting victims of Stigma and discrimination

2. OUTSIDE THE RESPONSE

The second theme was working ‘outside the core response’. Social protection and provision of social services and basic needs were not seen as an integral part of the core emergency operations. There was a narrow interpretation of the pandemic as a health emergency and other social risks and emerging social crisis were overlooked. It was noted that essential services were defined narrowly to utilities, there was no determination of what the essential social services were and how to proceed in delivering those during the crisis. With the emergence of the crisis for shelter and relief and need for protection of populations at risk of exploitation, abuse and neglect, separate coordination structures were established under the purview of the social council and economic council. While these mechanisms responded to the social crisis, the detachment form the emergency operations centre created problems in coordination, misinformation and duplications as noted above.

Furthermore, the social sectors responded on their own, mobilising their internal resources and social networks, rather than as part of the emergency operations centre. This resulted in sectors competing for resources, both human, financial, and other community resources. Sectors individually approached locally resident donors/multilateral partners and opened relief funds for donations and materials for relief and other social support.

Social issues included those related to the provision of shelter, food, water, and hygiene items; protection of vulnerable groups, children, elderly, victims of abuse, discrimination and stigma, provision of social protection; drug rehabilitation services; education service; and non-covi-19 healthcare. These are discussed in the next section of this report.

3. COMMUNITY SUPPORT

The third theme from the experience was the ‘community support’. Several people fell victim to the stigma and panic, with local and foreign temporary residents and drug users in Male’ being evicted from their place of lodging. The response received overwhelming support from the community despite the fear and panic of the pandemic. Large number of volunteers, in addition to those of the Maldives Red Crescent, worked at the emergency response centre, in the front line and working from home.

Parallelly, a number of professionals of Civil Society Organisations (CSOs) provided support to the community and continued to support the vulnerable population segments such as persons with disability, single mothers, drug users, migrants and elderly in providing social support to families and peers. Community resources were mobilised by businesses and private citizens providing material support in terms of relief items, operational resources such as vehicles, computers, data packages to support the operations and provision of social services.

FINDINGS: SOCIAL ISSUES AND SERVICE EXPERIENCES

The findings on the main social issues and experiences of the social service providers are discussed below.

Basic Needs: Food and Water, Shelter and Hygiene

With the detection of COVID-19 cases in the community and the lockdown, concerns were raised for protection of the vulnerable groups. However, protection of rights and ensuring equal treatment was not seen as a core component of the pandemic response, and was not included in the National Emergency Operation Centre function. However, the social protection and provision of relief functions were established under oversight of Social Council at the president's office; Social committee chaired by the Vice President and a Lockdown Management Committee chaired by the Minister of economic development.

> *"spoke with the NEOC responsible people about the social issues, but was told that social services and protection, particularly for those victims of abuse and discrimination are not part of the operations... that we have to deal with it ourselves". KI-social protection and social services*

Shelter and survival were at the forefront of the social protection response. Shelter and relief work were largely focussed on Male' area, as in addition to the difficulties of lockdown, there was community transmission of COVID-19 in the greater Male' area. Schools were converted to shelter centres for migrant populations, some managed by the Ministry of Gender Family and Social Services (MoGFSS) and others managed by the Male' city council. In addition, shelter was provided at government sponsored guesthouses to families from Atolls stranded in Male' and those evicted from rental households. Temporary shelters were put up in Gulheefalhu for migrants to decongest their living conditions.

Maldives Red Crescent along with a number CSOs worked in provision of relief; food, water and hygiene packs with support from private businesses and government institutions. With the support MRC provided close to 400,000 meals to people in need in Male' area.

> *"we had too many people to reach, and our volunteers were not enough to prepare food and also deliver the food and other basic items to those needing relief, especially the migrants. We discussed with NEOC if they could get support from a caterer who can cook and we do the delivering and get a place to store the relief items" KI-Maldives Red Crescent*

While social committee focussed on provision of relief, lockdown committee worked to endure availability of basic items to the population, not only in Male' area, but also in the Atolls. State Trading Organisation (STO) ensured stockpile of staples and delivery to each Atoll. With Male' area under lockdown, provision of essential supplies to the Atolls were challenging, particularly with large number of labourers and workers involved in transport and logistics being placed under quarantine with exposure to COVID-19. The national defence force played a significant role in provision of supplies to the Atolls and import to Male' in collaboration with Male city council and the institutions managing ports.

> *"We noted an increase in usage of basic food supplies much earlier than we expected. Usually we start seeing stock depleting close to Ramadan, but this time we started seeing in February. We were also following the global situation with the pandemic, so we decided to stockpile earlier on and placed orders for contingency. This allowed us to be fairly confident of the food supply, but we had problems later with the disruption of the supply chain globally. So government decided to use chartered flights to get the basic goods in the country and negotiated with neighbouring countries". KI -State Trading Organisation*

In parallel, Ministry of Fisheries Marine Resources and Agriculture (MoFMRA) strategically started working on possibilities of quick return local food production initiatives. Some of the programmes included distribution of high yielding seedling/crops appropriate to the local environment to those interested in farming, coupled with allocation of land for farming in the islands and establishment of the National Agro Corporation to facilitate farm to market distribution and longterm sustainability of local food security.

> *“we only produce 3-5% of the food we consume in the country. the main problem is transport. With the lockdown and travel restrictions, this was the biggest problem. How can we distribute the produce form local farmers... Lockdown was during Ramadan and lot of islands already had their produce and they were worried about selling the produce... we expedited establishment of the Agro National Corporation to buy their produce... so we feel that farmers did not think much negative impact because of the lockdown”. KI -Agriculture sector*

> *“we observed that a lot of people who lost jobs from resorts that went to the islands started farming. We used the opportunity to expedite import substitution initiative and it was very well received and we are hoping this continues.... from a food security point of view there was a silver lining to the sector because of the pandemic”. KI -Agriculture sector*

Similar to agriculture, fisheries sector continued to function for the local food production, with fishery factories continuing to buy and process fish from fishermen. The main challenge for the fisheries were those related to narrow product base which limited the scope of storage.

> *“the economic packages helped continuing the fisheries, It was not affected that much... fishermen had decreased their catch with the closure of the EU market, but EU market opened earlier than we expected. Those doing reef fishing were more affected with the closure of resorts. they lost their market.... We observed that some fishermen were quite smart... some switched to pole and line and from bodukanneli (yellow fin) fishing to kalhubilamas (skipjack) as the export markets closed”. KI -Fisheries sector*

Protection of vulnerable groups

Children

With increasing covid-19 positive cases, issues related to child rights emerged as the response policy was to provide quarantine and isolation at state provided facilities. This led to issues of separation of children and dependents from their carerers with subsequent risks to their safety and welfare. With these issues, standard protocols were developed in moving dependents to isolation and quarantine, allowing carerers to accompany dependents with informed consent of risks of exposure to the disease agent.

> *"we tried to coordinated with NEOC with the issues of protection when children had to be taken to isolation facilities. At the start there was no operational protocol to follow if a child gets positive, but parents are negative. We asked questions we asked questions like who would accompany the child, will they be looked after by the Operations, we were worried about how will they assure safety both of the care provider and of the child if something happened. With these questions raised, protocols were developed to follow when sending dependents to quarantine and isolation". KI-Social protection and social services*

Victims of abuse

The reports of domestic violence and neglect to the authorities were noted to be low during the lockdown. However, stakeholders note that, this may not be a true reflection since family protection services were not functioning during the lockdown. Surveys conducted during the lockdown noted that the people who responded to have known cases of domestic violence was similar to pre-lock down levels. Thus, it is likely that these vulnerable populations were not able to access the services and protection during the lockdown. A number of reports of child abuse surfaced soon after ease of lock down that support the proposition that these vulnerable people were left behind.

> *"We had a lot of reports of abuse, soon after the lockdown was lifted. You can see from the reports to us and from the Police, We were not able to reach them and they were stuck at home with the perpetrators. At first we thought with other family members also staying at home, such incidents decreased, but sadly it was not so". KI-Social protection and social services*

Victims of discrimination and stigma

The lockdown resulted in stigma and discrimination for those who were responding or exposed to the disease with some people being evicted from their rental households. MoGFSS designated certain guesthouses as shelters for the locals who got evicted and provided relief for about 500 people over the one and half months of lockdown. Psychosocial support hotline 1,425 was established at HEOC lead by Maldives Red Crescent and established links with psychiatrists at the National Centre for Mental Health. During the lockdown 3,040 people were reached through the hotline and provided psychosocial first aid.

Elderly and persons with disability

Protection of elderly was at the centre stage of the pandemic and some stakeholders believed that undue focus on elderly protection increased psychological stress and anxiety among the elderly and their families. Mechanisms were set in place to identify elderly and other vulnerable groups and establish a callout system to identify social needs of those families with elderly population. This function is supported by multiple stakeholders including health, gender and family, girl guides and volunteers. While some appreciated the effort, others were not so receptive to such calls and saw as infringement of their privacy.

> *"We call anyone tagged as needing care in the outbreak system, including contacts and positives. We call them alternate days even if they are at home or at an isolation facility. Most people appreciate that we call. We don't provide any service but just "hallubalaalanee" and ask if they have any needs. But we also come across people telling us not to call, saying that they are okay and get angry when we call again. So for those we wait for a few days before calling again, we are afraid they may need help and there's not one to help". KI-Emergency Operations*

Efforts to reach out to younger persons with disabilities were however not adequately addressed and no systemic mechanism was established within the emergency operations or outside of the operations. A separate report on disability sector experiences is published describing the situation during the pandemic.

Foreign migrants

Foreign migrants (immigrants) were a large segment of the population in need of protection. Majority of the people infected and exposed to the disease at the start of the epidemic were migrants and had to be isolated and quarantined in Male' area. In addition, numerous migrants lacked shelter and means of survival and were without legal documents. As noted above government set up temporary shelters for foreign migrants at schools and later in established facilities at Gulheefalhu and Hulhumale to decongest their housing situation and also to provide shelter for those homeless. Close to 15,000 migrants were supported with shelter and relief during the lockdown. The government also issued a moratorium on legal action and facilitated shelter, relief and health care without fees. Despite these efforts, 4 (four) migrants were brought dead to health facilities in Male', whose cause of death were not covid-19. At the same time, government facilitated a number of repatriations, particularly Bangladeshi migrants, to their home country and revived the regularisation programme as a opportunity for the undocumented workers to get employed legally.

> *"we tired to integrate the regularisation programme as we responded to the foreign migrants in need during the lockdown. We manged to arrange for safe accommodation for those who had COVID19 and close contacts after they were released form quarantine and isolation and match them with employers. Some of the foreign migrants who were willing were repatriated... we repatriated over 10,000 foreign migrants". KI- Male' Lockdown committee*

Social protection benefits

Provision of monetary benefits to vulnerable groups such as benefits for single mothers, persons with disability and elderly continued for those previously registered without disruption since the beneficiary mechanisms were through banking. However, new registrations were disrupted during this period and even after the lockdown was lifted, as the public services continued to function at a limited scale.

> *"our social protection benefit schemes are provided through the banking system, so we did not have any problems in continuing those. But we don't have information if the recipients were able to actually use them with the lockdown and difficulties in going to the ATMs". KI – Social Protection*

Similarly, basic pension scheme continued its operations without much disruption and the Pensions office planned and created a reserve for a possible unexpected large number of pay out with the pandemic. The main areas of concern in the pensions were with regard to the timely information on deaths, retirements, unemployment and other income benefits that have relevance to the pension schemes. It was noted that with large number of people losing jobs, the emerging income support and unemployment benefits schemes had no mechanism to link the information to the pension scheme. The disconnect between all the socio-economic benefit schemes were noted to be a huge challenge that increases administrative cost and does not allow for monitoring impact of these on the social protection and the ultimate goal of poverty reduction.

> *"the disconnect between the system is the main gap. If we can find a way to connect the schemes, verification of induvial status and assessment will be so much efficient and we will be able to monitor effectiveness of all the special protection pillars together". KI – Social Protection*

Drug rehabilitation services

Drug users were one of the vulnerable groups left behind in the pandemic planning, and had to be attended to, outside the pandemic operations. Lock down resulted in disruption of rehabilitation and detoxification services. This resulted in a number of clients coming out on the streets, breaching lockdown rules, often with withdrawal symptoms. National Drug Authority (NDA) indicated that although they had anticipated possible increase of cases with withdrawal and overdose cases, they were not fully prepared for the sudden lockdown. Services at the Himmafushi Rehabilitation Centre continued with existing clients, but new client entry to the centre was suspended temporarily. The absence of a remand centre for drug user offenders was a huge gap. The setup to cater for people with drug users came a few weeks later, with a temporary detoxification set up at the national football stadium (galolhu dhandu) that provided services to around 350 drug users. However limited coordination with relevant institutions including policy makers, health and enforcement services were a deterrent to operationalise the required services effectively.

> *“we were able to set up galohu dhandu as the temporary detox and community treatment centre with the support of youth ministry. But we had some problem in coordination with Gender ministry and to within a week of starting at galolhu dhandu we were asked to relocate to Imaaduddin school saying it was a bigger place. But it was a difficult place to manage security and we had people released from corrections mix with other clients and people from the community were throwing drug pieces over the school wall to the clients. We spend only one night there and met with VP and decision was taken to moved back to galolhu dhandu”. KI – Drug rehabilitation*

Furthermore, by law, drug users need to sign in and sign out to maintain their community treatment programme and avoid criminal penalty. A hotline 1410 was activated, and alternate processes were set up and agreed with the stakeholders, to ensure these processes deliver continuation of the client's community rehabilitation programme, including process for monitoring through urine testing. Detailed SOPs were prepared for internal use for online rehabilitation sessions, outpatient and inpatient care. The CSOs working with the NDA played a significant role in providing outreach service and bridging to care for the clients in Male area. Similarly, there was good collaboration with centre for mental health in providing multidisciplinary care.

> *"We had a lot of help form Journey and their volunteers, police did not have enough human resources to help us, so Journey helped us a lot supporting security, manning hotline and coordinating finding clients and getting them to the temporary set up" KI – Drug rehabilitation*

Continuation of the community programme with urine monitoring, lack of psychiatrists and nurses to attend to the cases of withdrawal, non-availability of medicines for treating withdrawal and detoxification were the main challenges during lockdown.

> *"the main deterrent for usage in the community treatment was urine testing but its disruption during lockdown will have a significant impact on the programme, we have yet to see. Some clients are stuck on the islands and with the travel restrictions they can't come. Health facilities are reluctant and don't have any set up to provide any of these services. Going forward we need to have a mechanism where health facilities can be used to provide detox services" KI – Drug rehabilitation*

> *"medicines for providing detox were not available in the country, either at STO nor in any of the institutions. We had only 14000 tablets of Benzo. We still haven't received controlled drug for detox for various reasons related to regulatory and global supply chin disruption. We are managing with what we have, it is not optimal, but we have no choice". KI – Drug rehabilitation*

Managing covid-19 patients who are drug users proved to be extremely challenging, in terms of keeping them in isolation. Several instances occurred where patients, fled from the facility or disrupted the work at the isolation ward requiring further security, psychological and social interventions. NDA coordinated with the HEOC in providing multidisciplinary care and therapy for those infected with COVID-19 and were isolated at the facility.

> *"we were not able to manage covid-19 patients who are drug users. The facilities did not have much security and because of drug withdrawals, the patients had behavioural problems and disturbs other patients. There were patients that left the covid-19 facility and come back once they get a top up. We had no way of determining who their contacts were and at risk of infection". KI – Health care*

It was noted that there was no shortage of supply of addictive substances, and local supply continued with a drop in unit cost. With clients that fled from facilities often returned with their addiction needs fulfilled.

> *"Although there was concern for supply of basic food items, drug supply did not get affected. We estimated about five to six months' supply in the country from the information form clients, police and volunteers. Also the prices went down, a heroin piece of MVR 100 -120 went down to 50. We feel that with the disruption of transport the suppliers were trying to distribute their stock they have in the island quickly". KI – Drug rehabilitation*

The learning that emerged from the experience points to the need for more flexible treatment regimens and use of technology and online platforms for some aspects of treatment monitoring.

> *"We noticed that some clients waiting to go to the rehab centre does not need full treatment programme as it is now, for some a shorter treatment is possible. We also learned to use online administrative processes that we should continue even after the pandemic. Now we have emergency operations procedures, essential list of contingencies that can be used in any such emergency, even if not a pandemic" KI – Drug rehabilitation*

Education Services: Schooling and Higher Education

Education sector can be said to have better preparedness to respond to emergencies, however, not to the extent to continue teaching in a situation of a complete lockdown for an extended period of time. However, some initiatives such as the 'digital school' proved to be extremely useful in this situation as a number of schools had provided their students with digital devices under this programme and there were some primary concepts discussed among the education professionals on distance teaching and learning. While this is so, it was soon realised there were inadequate preparation for delivery of curriculum through distance modes and issues with internet connectivity and cost of internet made it difficult to implement a digital education programme across the country.

> *"We had some tablets handed over to students when they went on break just before the public health emergency declaration. So, we tried to use online, but students' teachers and parents were new to this and it was very challenging for everyone. Everyone was working on their own time, some at night, some early morning..., it was tough, very tough. Despite the efforts and we feel that engagement of students was very poor". KI – Education*

> *"We even tried to reach the students that have special education needs and even had a list of about 175 students to check where they were and how they were doing. Principals were sked to call and check on the status of their SEN students. But teachers had to use their own phones and this also became an issue. It is a gap that we need to address, we need official designated numbers. Also, we had no monitoring mechanism for this, so it didn't really work". KI – Education*

The school systems were however quick to innovate and a tele-class programme was initiated to be telecasted through the public service media (PSM) television channels.

> *"WE had no choice but to prepare for tele classes, we started recording programmes but had to stop with the lockdown. Since education was not defined as essential service, it was difficult to get the teachers to go and record these. Stopping the tele classes in between was not good for the students, but we were not able to record the programmes during the lockdown at the speed we wanted". KI – Education*

With the closure of schools, despite the attempts to teach and provide learning opportunities for children, a number of problems emerged, not only in terms of learning outcomes, but also in the behaviour of children. Some of these issues were directly related to learning outcomes in terms of numeracy and literacy, partly due to the supervision and support arrangements within the family. The situation called for the parents or a family member to be the classroom support person to assist the children in maintaining their focus and clarifying their questions.

Other social issues were also observed among behaviour of children, including some children becoming highly dependent on the digital devices and using the devices for social networking that were not always safe. Other observations noted include, children becoming more indrawn and quieter and reluctant to interact with others including the teachers and their peers.

> *"in the Atolls, although schools were closed but children were doing other things going to the sea and on the road. So they got into a lot of mischief. Also with the access to online devices the students start using social media and chatting with people. Parents realise this much later and they take the devices away... this makes the child angry and runway form home and get a device form someone... Even in Male we even have a case like that and ended really bad with the child falling to victim to sexual abuse". KI – Education*

Some positive experiences were also noted in the school system, in the use of technology. This was a seen a huge learning experience and it was noted that it built teacher skills in the use of online tools, but also identified gaps such as assessing the extent of learning and support needs of students that are disadvantaged and lagging behind. Teacher skills building interventions were started to get the teachers ready to support students with trainings in psychosocial first aid and improving WASH facilities and infection prevention interventions in the schools.

In term of online teaching similar experiences to general education were reported in the higher education sector and it was noted that, while a number of colleges and universities were already using hybrid means of delivering their classes, this was not adequate to respond to the need. Furthermore, it was observed that private higher education institutions were quicker to adopt online modes of teaching than public institutions, and were able to resume teaching.

The hardest hit was the technical and vocational education and training (TVET) which required physical attendance. Even before the pandemic the TVET sector was not adequately equipped with up-to-date technology even for hybrid teaching and learning.

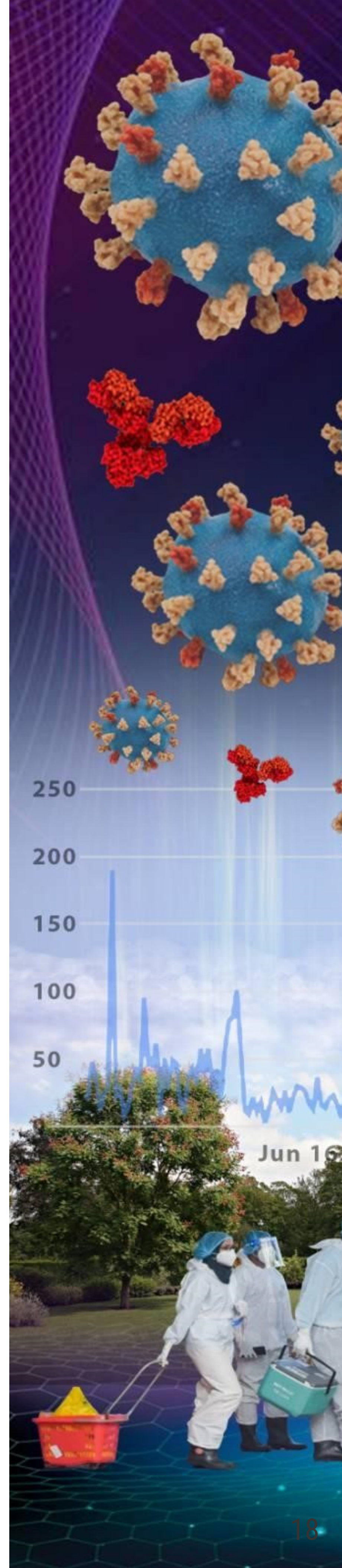
> *"Only one or two institutions were ready for full online teaching. Connectivity was a major problem and most of the colleges did not have the server capacity and also hardware. But most of all the lecturers were not skilled to teach online. They needed training and use of online tools". KI – Higher Education*

The online teaching was taken up positively by the higher education institutions. Some colleges noted the silver lining in this, the opportunity to extent the courses to with the Atolls and get a bigger student enrolment. Online teaching however has implications for accreditation of such courses as they will not fit with the current accreditation standards.

> *"The colleges were ready to take on the challenge and even invest in the online teaching mode. We have given temporary approval to continue teaching online but our concern is quality. We are working now with MQA to develop online e-learning teaching guideline and requirements for accreditation of the courses". KI – Higher Education*

One of the response activities in the Ministry of Higher Education was to ensure financial security and safety of students abroad on government funded schemes and scholarships. In addition, private students abroad were a major challenge for the higher education Ministry.

> *"It took a while for us to get ourselves together. we were not prepared at all. Since local higher education institutions functions independently, our main focus at the Ministry was to attend to students abroad on loans and scholarships. We had to make sure they continued to get the money. Some students were stranded, had to move out of hostels and were trying to come back. We are talking about thousands of students. There were private students also in this situation. We were trying to get in touch with all of them, but we don't even know how many were there. Even with lockdown, we had a few of staff working on this throughout the early days to make sure the students had money and some way of shelter, coordinating with the embassies". KI – Higher Education*



Health Care Services: Non COVID-19 Healthcare

The government had anticipated possible need to scale down the regular healthcare during the lockdown, but the planning was not adequate to the healthcare needs of the population. Challenges were observed in the referral system, including the linkages with Aasandha that finances the referral and healthcare costs. The fact that the health system is developed in a manner with high dependence on Male' for specialty care, meant that with lock down and associated travel restrictions to Male' made some services being not available to the population, particularly those living in the Atolls. This resulted in delayed access to health care for those in the atolls, but also emergence of alternative pathways.

It was observed that some basic health care services were disrupted such as those of maternal health services, with people unaware and unsure of where they could go to seek services and some foetal deaths were reported due to such delays. Ministry of Health quickly reacted to this and started a programme to reach out to the pregnant women through phone and teleconsultation and assessment providing guidance on care and places for referral. Transport in healthcare is one of the main expenditures in health care. Aasandha responded in the lockdown situation by making changes to the operational procedures required to be completed for covering transport cost of referral.

> *"We had two stillbirths during the lockdown period. It can be attributed to delay in care, both at patients end and at health facilities. Unlike the past, we didn't have an update list of high risk pregnancies in the islands and could not reach out to them on time. We also did not give people clear instructions on where to go in case of emergency and need for check-up". KI – Health care*

The second challenge was the continuation of care for those with chronic illnesses and bed-bound patients. The health system only had a registry of elderly requiring homebased care, but had no registries of those with long term illnesses. The system responded to this challenge by establishing mobile medical response teams in the Male' area where there was local transmission and advising the public to call the emergency operations centre for those in need for services. Private health care clinics were urged to provide online consultations and refilled prescriptions already issued.

> *"From Maldives Medical Association, we volunteered to help in the provision of outreach medical care for those in need and had a set up within HEOC as mobile medical response team – MMRT. A few nurses also joined the team. We had a lot of calls for medical attendance, even at night. It was like running an ER but mostly on tele with standby field team. A lot for renewing prescriptions for those with chronic diseases. Out process included a phone triage and if required phone consultation by a specialist and if required we visited the home physically in full PPE. We had to attend physically when there is a need for physical examination and taking biological samples for laboratory tests". KI – Health care*

This required significant use of online tools and adjustments of Aasandha operational procedures in the coverage of prescription medicines by accepting refill of prescriptions from pharmacies that were not empaneled and providing them opportunity to register for empaneling. The pharmacies responded with registering with Aasandha and instituting home delivery mechanisms of prescribed medicines. Until this system established, the State Trading Organisation's medical supplies department responded with the staff located in the emergency operations in Male', filling prescriptions and delivering medicines to the patients home.

> *"We had selected staff working at the Aasandha office throughout the lockdown. We changed the protocol and accepted photos of prescriptions if signed and stamped by registered medical practitioners. Soon we were able to open the Aasandha portal to all the pharmacies and they started using the portal to issue the medicines". KI – Aasandha*

The continued access to healthcare services for patients for chronic disease in Male' area was possible with extensive coordination of volunteer health care professionals, public and private health care facilities and pharmacies as well as Aasandha. However, some patient groups such as cancer patients and surgical patients that required hospital-based care were not able to get timely care, and experienced pain and suffering and worsening of disease condition.

> *"Most of the Aasandha cover during the lockdown was for emergency referrals and evaluations. With the lockdown, the regular transport between Atolls were disrupted. It was extremely difficult to get any transport provider to provide service during this time. We had a lot of difficulty in setting operational process for the evacuations. We relied on MNDF and Maldivian for the emergency referrals. It was expensive and operationally challenging. We learned a lot in this and can plan better for next time". KI – Aasandha*

Attempts were made to provide emergency health care even at the time of lockdown and community transmission of COVID-19 in Male'. Specific operational protocols were established at the public and private hospitals to screen for possible cases of COVID-19 to determine pathways of care. This however, delays in the provision of emergency care resulted in complications and added morbidity to those that attended emergency care at the main referral hospital. Some of the respondents felt that the processes established were not considerate of the patients' health needs despite the hospitals having adequate PPE to protect health care workers. Some perceived this created the fear of the disease even among health care workers.

> *"PPE was one of the priorities supplies we had stockpiled. Male' area hospitals collaborating in the response were provided with adequate PPE stock and plans were made to provide emergency care with PPE. But even at IGMH there were a lot of delay in providing emergency care.... They would keep the patient unattended until the COVID-19 results become available. This was not the protocol". KI – Health care*

Some of the essential health care services such as childhood immunisation and provision of directly observed treatment for patients of tuberculosis and thalassaemia also suffered delay in care during the lockdown, particularly in Male' with the community transmission and associated restrictions. Attempts were made to catch up on these services with scheduled appointments and appears to have succeeded without much problems in the short term.

> *"since we have list of children to be immunised, Dhamanaveshi and Hulhumale hospital public health unit and Villimale hospital started calling parents and giving appointments. Atolls were also instructed to restart vaccination at the same time. We had about a month's delay in the childhood vaccinations". KI – Health care*

DISCUSSION

The perception that a pandemic is largely a health concern is misleading that limit adequate preparedness for the social and economic response. The need to integrate social and economic risks in the risk assessment and response interventions has been noted after previous pandemic, the most recent H1N1 pandemic (Jonas, 2013) The interim international guidance documents were also largely on health response, and had several gaps, which continued to be revised to address continuity of essential services and reduce social and economic impact (Nicoll et al., 2020; WHO, 2020). In the Maldives, COVID-19 pandemic response started with a narrow focus as a health problem and the response remained largely a health response despite the realisation of social and economic risks that required interventions across all sectors, service delivery and social and economic life.

This narrow risk perception of the pandemic left gaps in the preparedness and response operations leading to inefficiencies in the response operations and delays in reaching the most vulnerable and hard to reach population. As the social and economic risks escalated, the national emergency response structures emerged and evolved, some integrated into the functions of the Emergency Operations Centre (EOC), but some structures operated separate from the EOC. While one may argue that this may not be the best practice, given the country's geo-political context, this was perhaps the best fit for the country. The flexibility and responsiveness of the pandemic coordination mechanism with the mechanism for contact and daily communications between responding agencies have been identified as critical for timely and effective response (Kunicova, 2020). Improvements in the risk communication systems within the government, multi-agency coordination with independent institutions and non-government agencies, and transparent public communication in response to societal concerns are needed in the response and have been recommended from other country experiences (Hu & Qiu, 2020).

However, it must be noted that the pandemic experience in other countries also have identified gaps particularly in ensuring equity and addressing social protection issues and providing social services (Evans, Lindauer, & Farrell 2020; Heimer, Neil & Vlahoy, 2020). Existing structural injustice that sidelines vulnerable and minority population groups have been suggested to be the main reason for emergence of inequalities in pandemic response (DeBruin, Liaschenko & Marshall, 2020). In such contexts, the application of fair procedures and neutral decision making in a pandemic situation fall short of producing the desired social justice, leaving behind the most in need. Hence the pandemic response requires consideration of ethical and moral values with community engagement to implement policies and interventions of affirmative actions for specific vulnerable population groups.

In a pandemic situation, community engagement is critical, to reach and meet the needs of all segments of the society, particularly the vulnerable groups. In the Maldives, significant community engagement was observed in the pandemic response. The positive experience identified by the key informants were the benevolence of the society in the response and willingness of volunteers, government and business institutions as well as civil society organisation to support the pandemic response efforts. Materials, donations, time, expertise, and skills were forthcoming for the emergency response from the community. The management of the community support however was observed to be an experience that need improvement.

Communication with the community support groups and civil society organisations have been identified as the core intervention to maximise support (Hu & Qui, 2020). The delay in community engagement and gaps in communication with community support groups and civil society organisations created gaps in coordination of response and provision of services to some segments of the population.

The contingency for food security and essential commodities were observed to be inadequate, given the high dependency on import for these items. The pandemic triggered fast tracking of structural and policy interventions to enable national production of food and storage with the import substitution policy and establishment of the National Agro Corporation (FAO, 2020). It is important that these initiatives remain at the forefront of public policy and explore alternative options for the country to be more resilient in food security (Abdulgafoor, 2020; Hilmy, 2020). Sustained investments for national food security will be a critical step in the country preparedness for future pandemics and other national emergencies.

The population level interventions for pandemic control (such as movement control, work from home, school closures) has brought to the forefront, the gaps in social protection for vulnerable groups. The problem of domestic violence, sexual abuse, child abuse, neglect and discrimination has surfaced not only in the Maldives, but in a number of countries (Bradbury-Jones & Isham, Buttell & Ferreira 2020; Xue, et al., 2020).

The problem of abuse is now being referred to as the “hidden pandemic” during the COVID-19 pandemic that was inadequately addressed across societies (Evans, Lindauer, & Farrell 2020). Previous experiences and research have shown that emergency situations can escalate domestic violence, and with movement restrictions during a pandemic further increases the risk as there is less scrutiny and consequence in the face of limited access to services and enforcement (Bradbury-Jones & Isham, 2020). In Maldives, analysis of reported cases has shown an increase in the instances of gender-based violence during the pandemic (Institute of Research and Development, 2021). In preparation for continued movement restrictions and building resilience, it is recommended to address the determinants of domestic violence in parallel to increasing social workers in service and easier access to social protection services including simplified reporting mechanism for the victims.

While the country has a number of social protection programmes, there is a disconnect between them that resulted in poorer people becoming victims of discrimination and eviction from households. The focus of social protection in the country appears to be on provision of financial benefits, however, the pandemic highlighted gaps in access to housing and sustainable income. Migrants, both internal and foreign, were observed to be the most vulnerable groups during the lockdown, followed by people with substance use disorders. It is important that recovery efforts take a transformative approach to build resilience of the society to provide social protection for the vulnerable segments (Summerton, 2020). Social protection require a focus on ensuring basic standard of housing both for locals and foreign migrants and coordinate social protection policies and interventions tying in the financial schemes with provision of goods and services.

Services for the people with substance use disorders were one of the essential services noted to be severely disrupted. Similar experiences were reported in other countries with de-addiction and rehabilitation services that were not accessible to the target population (Heimer, Neil & Vlahoy, 2020). While other countries provided take-home detox kits, homebased treatment with online support (Dunlop et al., 2020), in the Maldives, additional challenges were encountered due to the legal requirements in operations of the treatment programmes that required physical attendance. The lessons indicate the need for preparedness in a number of areas for service expansion, contingency stock and the provision of alternative approaches to continue treatment in emergency situations such as pandemics. The recovery efforts need to further study and explore the appropriateness of current service and treatment approaches and improvements required to ensure sustainability of the services during emergencies and build resilience of the support groups and families of people with substance use disorders.

Education sector can be said to have some level of preparedness and in sustaining educational services, mainly due to the initiative for emergency preparedness and integration of digital technology in teaching and learning. However, preparation was incomplete to fully transition to digital technologies and there were significant gaps in skills for online teaching and learning, and student support during classes.

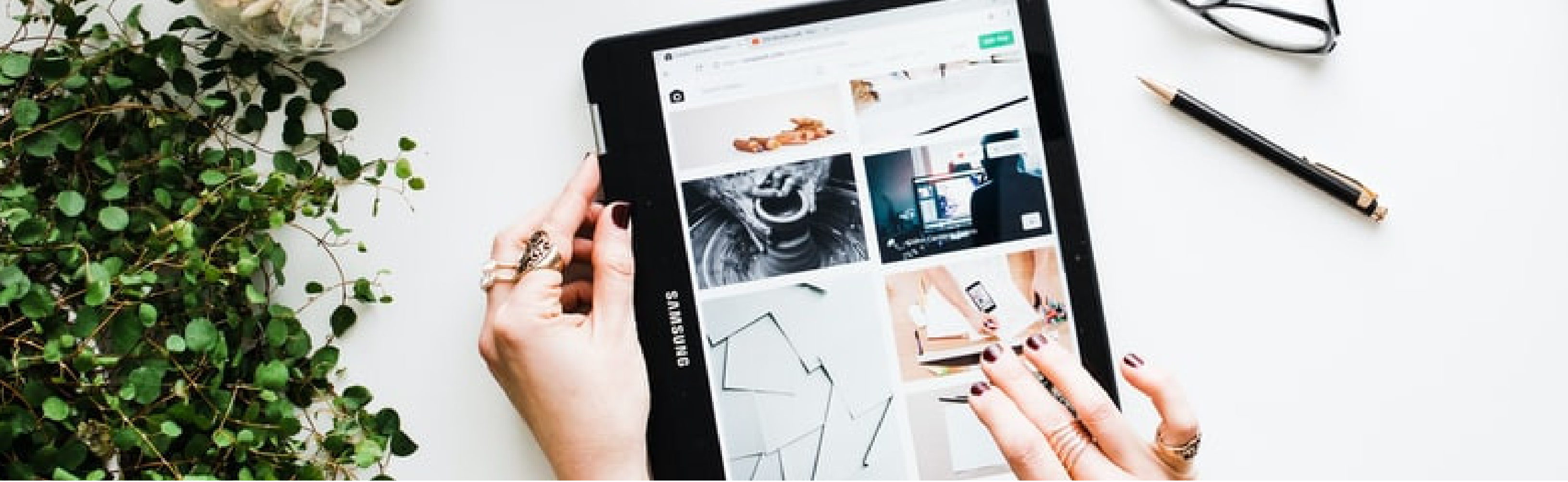
Pedagogy used for face-to-face learning is not practical for online learning both in general and higher education. Though a range of pedagogy is available for online and distance learning, there is no one size fits all pedagogy for online learning, and teachers require proper professional development and training to orient themselves towards their students (Doucet et al., 2020). It has been noted in other settings that teachers as learners with a fixed mindset, find it difficult to adapt and adjust, whereas the learners with a growth mindset quickly adapt to a new learning environment (Pokhrel & Chhetri, 2020). Despite these challenges some positive experiences that emerged include, increased participation of parents in the child's education and interaction with teachers. However, it is anticipated that students returning to school will have greater variability in academic and social skills and many students can be expected to be behind academically (Kuhfeld et al., 2020). These effects and long-term impact on students' academic performance of the pandemic and alternate teaching and learning pedagogy needs further study and exploration for schools to take appropriate actions to support students as they return.

Furthermore, it was noted that students exhibited behavioural and psychosocial changes that affected their learning (Petrie, 2020). This observation is not limited to Maldives, with more students taking online classes and spending more time on virtual platforms, with unstructured time spent online, has exposed children to harmful content and vulnerable to online exploitation and cyberbullying (Kuhfeld et al., 2020).

School routines are important coping mechanisms for adolescent and young people for maintaining social and psychological wellbeing such closures mean a lack of access to the resources they usually have through schools (Lee, 2020). Further research is needed on the mental health and psychosocial impact of school closure on students of different age groups to enable establishment of appropriate support programmes.

Healthcare services most affected were those of referral and specialty care. The lockdown disrupted the referral mechanism to Male' where specialty services are established. However, health system was not prepared adequately for operating contingency referral processes. While attempts were made to maintain emergency services, the absence of referral mechanisms resulted in delays in access to care for those in the Atolls. Furthermore, essential services such as childhood vaccination, access to family planning services were suspended during the first half of the lockdown (UNFPA Maldives, 2020). Although there were no reports on increased mortality from non-covid19 causes, the effects of these service disruptions are yet to be seen in the service coverage and morbidity. In the event of a pandemic, it is required to prioritise essential health services that if discontinued have serious negative health impacts on individual patients and population health such as maternal and child health, highly infectious communicable diseases such as tuberculosis and chronic conditions such as cancer (Blanchet et al., 2020).

Primary health care (PHC)is aimed at building community resilience for health and responding to epidemics and public health emergencies. However, it was observed that pandemic response in many countries haves not integrated the PHC approach in the response, especially when movement restrictions have decreased access to health care (Blanchet et al., 2020). In the Maldives, this has been attributed to the limited priority given to sustaining capacity for primary health care in the health systems, partly due to different understanding of policy makers and on the concepts of PHC. In a number of countries PHC response focussed on provision of outpatient care at PHC centres, acute care at hospitals, infection prevention and control measures for primary health care workers (Halcomb et al.., 2020; Lim & Wong, 2020). Goodyear-Smith (2020) notes that what is effective in reducing is how PHC is mobilised in the response operations. This is an important aspect that needs further research in the Maldives, particularly to explore the extent to which the health system aligns with PHC concept and how the PHC was used during the response.



CONCLUSION

The social sectors were unprepared to respond to the pandemic and almost all the sectors were detached from the core emergency response and responded separately. This resulted in several gaps and inefficiency in the response, particularly when responding to the needs of the vulnerable segments of the population. Pandemic risk assessment and response planning lacked a focus on ensuring continuity of essential social services for the most vulnerable and were left behind at the outset which resulted in delay in the provision of social protection. It is important that the critical gaps and experiences are further studied and the recovery efforts adequately addresses the social impacts of the pandemic, to prevent long term impact on social development and sustainable development goals of the Maldives.

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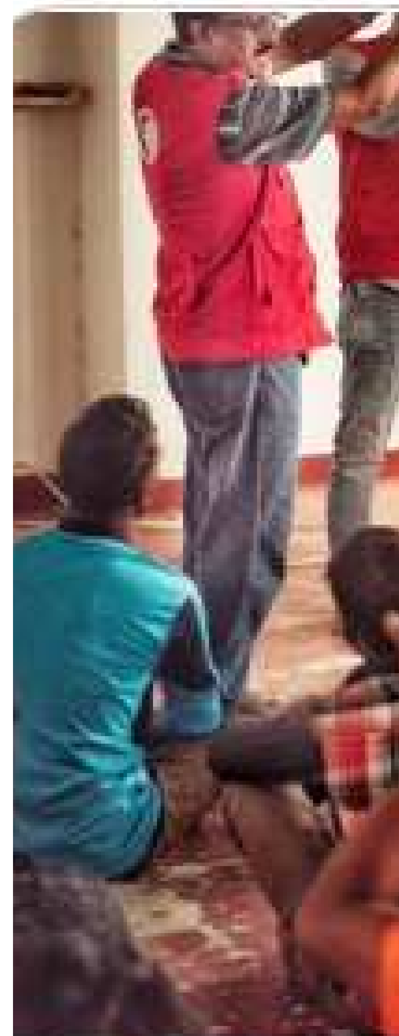

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SECTORS FROM WHICH KEY INFORMANT INTERVIEWS

National Emergency Operations Centre

Lockdown Committee

Maldives Red crescent

Food production and supply sector

Social protection services

Drug rehabilitation services

Education and higher education services

Health services including health care financing

Disability services

Civil society organisations

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