COUNTRY PROFILE

COUNTRY PROFILE ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE RIGHTS:

MALDIVES

Sida

arrow
asian-pacific resource & research centre for women

1. Introduction

Located in the Indian Ocean, Maldives, the smallest Asian country, is an archipelago of 1190 coral islands that are grouped into 26 natural clusters (known as atolls) (Central Intelligence Agency [CIA], 2013). These natural clusters are classified into 20 atolls for administrative purposes (Department of National Planning, 2012; Figure 1; Fulhu 2014; Ministry of Health and Gender, 2014).

Figure 1. MAP OF MALDIVES

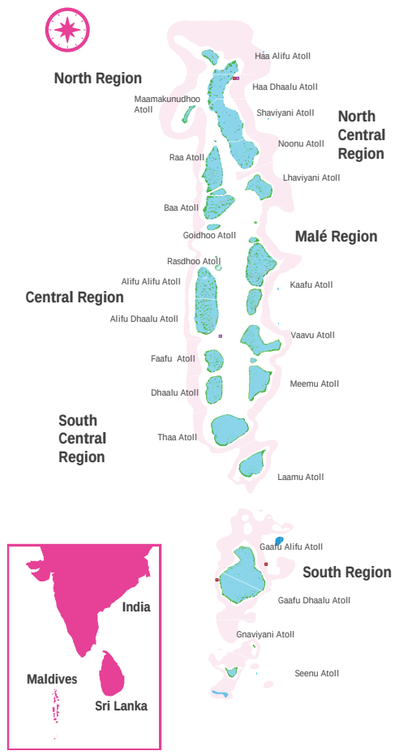

Figure 1. Map of Maldives. Adapted from Maldives Demographic and Health Survey 2009, by Ministry of Health and Family and ICF Macro, 2010, Copyright (2010) by Ministry of Health and Family and ICF Macro.

There are no officially designated urban and rural areas within Maldives (Ministry of Health and Family & ICF Macro, 2010). However, for data consistency, the classification of urban and rural used in the Maldives Demographic and Healthy Survey 2009 [MDHS 2009] will be utilised in some parts of this profile, especially when citing the findings of MDHS 2009. On this note, the residential households of the capital island of Maldives (Male') will be considered as urban and all the other residential households in the remaining islands will be considered as rural (Ministry of Health and Family & ICF Macro, 2010).

Although, Maldives has 1190 islands, only 16 percent of these islands are inhabited (Department of National Planning, 2012; Fulhu 2014). Additionally, the Census 2014 preliminary results indicate that the current population of Maldives is 341,256 with slightly more males (50.66%) than females (49.24%) (Table 1). An average annual population growth rate of 1.56 was also observed from 2006 to 2014 (Table 1).

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Table 1. POPULATION OF MALDIVES BY LOCALITY- 2006 AND 2014

Census 2006			Census 2014			Inter--censal average annual growth rate 2006-2014
Male	Female	Total	Male	Female	Total	
151,459 (50.66%)	147,509 (49.34%)	298,968 (100%)	173,172 (50.75%)	168,084 (49.25%)	341,256 (100%)	1.56

Note: Adapted from "Population and housing census 2014_revises_04 March 2015," by the National Bureau of Statistics, 2015a. Copyright 2015 by National Bureau of Statistics.

Furthermore, with life expectancy at birth figures exceeding 70 years for both Maldivian males and females in 2013 (Table 2), Maldives is ranked among the top 6 countries which had made the most notable increase in life expectancy at birth between the years 1990 and 2012 (World Health Organization [WHO], 2015a).

TABLE 2- 2013 LIFE EXPECTANCY AT BIRTH (YEARS)

Male	Female
72.97	74.66

Note: Adapted from "Statistical Yearbook of Maldives 2014," by the National Bureau of Statistics, 2015b. Copyright 2015 by National Bureau of Statistics.

Apart from this, based on the findings of the 2011 National Health Accounts Survey [NHA 2011, the Maldives health expenditure as a percentage of national budget had decreased from 11.3 percent to 3.1 percent between the years 2004 and 2011 (Figure 2).

Similarly , about a three-fold decline had been observed for the public health expenditure as a percentage of total Gross Domestic Product [GDP] from 2004 (3.1%) to 2011 (1.3%) (Figure 3).

The figures for the health expenditure as a percentage of national budget and the public health expenditure as a percentage of total GDP were highest during 2008 and 2009 (Figure 2; Figure 3). A reason for such increase during these two years could be due to high dependency on expatriate workforce for health that needs to be deployed to various islands across Maldives, coupled with the establishment of the public health insurance initiatives such as Madhana program for the first time in the Maldives in 2008 (Nagpal, 2011).

Figure 2. Health Expenditure as a % of national budget : 2004 to 2011

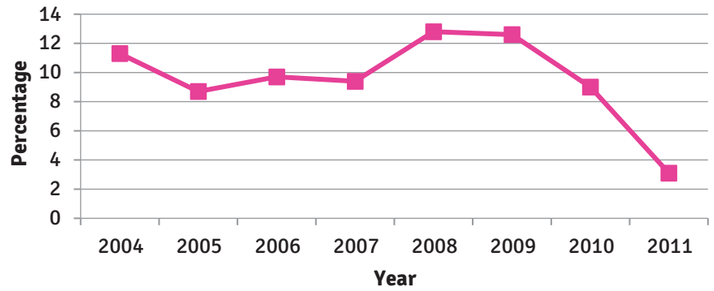

Figure 2. Health Expenditure as a % of national budget: 2004 to 2011. Adapted from Maldives National Health Accounts 2011, by World Health Organization and Ministry of Health, 2014, Copyright (2014) by World Health Organization.

Figure 3. Public Health Expenditure as a % of total GDP: 2004 to 2011

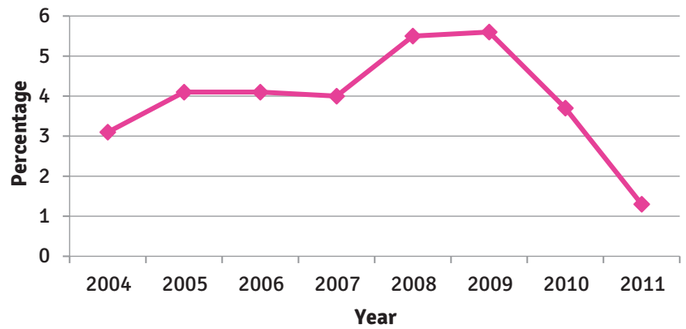

Figure 3. Public Health Expenditure as a % of total GDP: 2014 to 2011. Adapted from Maldives National Health Accounts 2011, by World Health Organization and Ministry of Health, 2014, Copyright (2014) by World Health Organization

Other health expenditure figures which were measured in NHA 2011 include the total expenditure on health [THE] as a percentage of GDP (9.2 percent), the general government expenditure on health as a percentage of THE (49.4 percent) and the out of pocket expenditure on health as a percentage of THE (44.0 percent) (WHO & Ministry of Health, 2014). These figures show that the out of pocket expenditure is higher than that of the government expenditure. This could have implications on people's access to health care services. However, it is important to note that significant changes to the health insurance scheme had occurred during the past few years in the Maldives. This had led to the establishment of the first universal health insurance scheme in the name of "Asandha" in January 2012 (Nagpal & Radaelli, 2013). This insurance scheme was further revised during the current presidency in the name of 'Husnuvaa Asandha", making this scheme as a health insurance scheme for all citizens without a ceiling protection limit (The President's Office, 2014). Since, the only and also the most recent Maldives National Health Accounts Survey was conducted before the establishment of a universal health insurance scheme in Maldives, it is yet to be explored whether such an initiation had an impact on the out of pocket expenditure on health and other expenditure measures related to health within Maldives.

Aside from this, Maldives became a member of United Nations in the year 1965 and since 1978 Maldives had begun engaging in international policy discussions which strengthened Maldives link with donor institutions (Department of National Planning, 2012). Maldives also became a member of Commonwealth of Nations and a founder member of South Asian Association for Regional Cooperation [SAARC] during 1980s (Department of National Planning, 2012). Maldives engagement in such regional and international entities had also facilitated Maldives in signing several important international human rights instruments. For instance, Maldives had signed 7 out of the 9 major International Conventions and 5 Optional Protocols related to civil and political rights, economic and cultural rights, torture, non-discrimination, gender discrimination and the rights of children (Government of Maldives, 2008). The only two International Convention that Maldives had not acceded to date is the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and International Convention for the Protection of All Persons from Enforced Disappearance. The main International Protocols and treaties that Maldives is a part of are:

1. International Convention on the Elimination of All Forms of Racial Discrimination,
2. Convention on the Elimination of All Forms of Discrimination against Women [CEDAW],
3. Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women,
4. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,
5. Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment,
6. Convention on the Rights of the Child [CRC],
7. Optional Protocol to the Convention on the Rights of the Child on the Involvement of Children in Armed Conflict,
8. Optional Protocol to the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography,
9. International Covenant on Civil and Political Rights [ICCPR],
10. Second Optional Protocol of the International Covenant on Civil and Political Rights,
11. International Covenant on Economic, Social and Cultural Rights, and
12. Convention on the Rights of Persons with Disabilities

Maldives engagement in such regional and international entities had also facilitated Maldives in signing several important international human rights instruments.

Despite the fact that Maldives had signed the aforementioned treaties and protocols, it is noteworthy that the government of Maldives had entered several reservations to a number of provisions under ICCPR, CRC and CEDAW (Government of Maldives, 2008). For example, Maldives had made reservations on Article 16 of CEDAW as this article contradicts with Islamic Sharia (Law) (Thanenthiran, Racherla, & Jahanath, 2013). This highlights the significance of Islamic Sharia as a governance factor within Maldives, especially since Maldives' constitution is based on Islamic Sharia (Thenthiran, Racherla, & Jahanath, 2013).

Hence, it is important to understand the interplay of Islamic Sharia and its influence on the access to sexual and reproductive health and rights within Maldives. It is also equally important to evaluate the extent of universal access to Sexual Reproductive Rights (SRR) available within Maldives as a significant proportion of its population belongs to the reproductive age group (Department of National Planning, 2010).

Hence, the aim of this policy brief is to provide an overview of the situation of sexual and reproductive rights within Maldives and to give recommendations to relevant stakeholders based on the findings of this policy brief.

I. The Sexual and Reproductive Rights in Maldives

In order to evaluate the extent of universal access to sexual and reproductive rights in Maldives, the key indicators mentioned in the Asian-Pacific Resource and Research Center For Women [ARROW]'s publication "An Advocate' Guide: Strategic Indicators for Universal Access to Sexual and Reproductive Health and Rights" will be used. These indicators has been compiled after a series of discussions with key stakeholders and the build-up of consensus among relevant stakeholders who participated in the strategic sexual and reproductive health and rights indicator's workshop held in Malaysia from 21st to 23rd August 2013 (Ravindran, 2013). Hence, this section will assess these indicators in the following order:

1. Policies on sexual and reproductive health,
2. Grounds under which abortion is legal,
3. HIV and AIDS policies,
4. Policy on adolescent sexual and reproductive health services,
5. Difference between median age at marriage and legal minimum age at marriage,
6. Extent of gender-based violence,
7. Legislation related to gender-based violence,
8. Legislation and policies on sexual orientation,
9. Legislation and policies on gender identities and,
10. Grievance redress mechanisms for sexual and reproductive health services

This section will end with recommendations for relevant stakeholders based on the findings from this evaluation.

1. Policies on sexual and reproductive health

To date, there is no integrated sexual and reproductive health policy or strategy in the Maldives. However, in 2014 the Ministry of Health with support from WHO and the United Nations Population Fund (UNFPA) had formulated the third National Reproductive Health Strategy developed for the period of 2014 – 2018 (United Nations Population Fund in Maldives [UNFPA Maldives], 2014). Currently, the implementation of this strategy is on-going by the relevant authorities. The key components of this strategy include family planning, maternal and new born health, prevention of unsafe abortion, prevention and management of Sexually Transmitted Infections (STIs) including HIV and promoting sexual health (Ministry of Health, 2014a). Other reproductive health issues specific to the current Maldivian context which are also being addressed in this strategy include gender-based violence, cervical cancer, strengthening the provision of appropriate reproductive health services in emergency situations, infertility and reproductive health needs of specific groups such as the youth, men and the elderly (Ministry of Health, 2014a).

Some of the planned activities and outputs in the implementation plan of the National Reproductive Strategy 2014-2018 do address universal access to sexual and reproductive health for key affected populations and most at risk populations. It also addresses the need to incorporate sexuality education and family life education in to the existing school curriculum. However, the fact that this strategy is a "Reproductive Health" strategy rather than a "Sexual and Reproductive Health" strategy implies that more weight is likely to be given to reproductive aspects of wellbeing. This is even reiterated in the goal of this strategy which is "..to achieve universal access to reproductive health – towards achieving the right of the individual and couples to protect their reproductive health and to take responsibility for their reproductive functions – and to maintain maternal mortality ratio at lower than 50 per 100 000 live births (or less than 4 maternal deaths/year, nation-wide) and perinatal mortality rate at lower than 10 per 1000 total births by 2018" (Ministry of Health, 2014a, p.23). This may mask the successful implementation of the objectives of this strategy which has a focus on sexual health in addition to reproductive health considering the challenges of implementation such as lack of human resources and poor inter-sectoral collaborations which are commonly faced during implementation of health related activities in the Maldives (Department of National Planning, 2010, 2012). Hence, there is a need to strengthen inter-sectoral collaboration, increase human resources and build capacity for the timely implementation of the activities leading to the successful achievement of the objectives and goals of this strategy.

Aside from the National Reproductive Health strategy 2014-2018, some of the main strategies that are currently being implemented in the Maldives by international agencies include WHO country cooperation strategy for the Maldives for the period of 2013 – 2017 (WHO, 2013) and the United Nations Development Assistance Framework for Maldives from 2011 to 2015 (United Nations Systems in the Maldives [UN Maldives], 2010). Both of these strategies along with the draft National Reproductive Health Strategy 2014-2018 had mostly addressed reproductive health issues with a preventive approach rather than a right based approach. This would greatly affect the sexual and reproductive health rights of the most vulnerable sub populations within the Maldivian communities.

In addition to the aforementioned strategies, there are few legislations enacted and policies and plans formulated in Maldives that are relevant to sexual and reproductive health. These include:

Hence, there is a need to strengthen inter-sectoral collaboration, increase human resources and build capacity for the timely implementation of the activities leading to the successful achievement of the objectives and goals of this strategy.

Population Policy of the Maldives 2004 (Ministry of Planning and National Development 2005):

- One component of this policy statement includes reproductive health and emphasizes on the rights of the individuals and couples to decide voluntarily and responsibly the number and spacing of their children. This policy also describes reproductive health as a state of complete physical, mental, social wellbeing in couples, having freedom to decide the number and spacing of their children. However, this policy had missed addressing the sexual health component especially related to key affected population groups and most at risk population groups.

The Public Health Protection Act 2012 (Maldives):

- While this act includes the protection of public from communicable diseases, non-communicable diseases and lifestyle related diseases, emergency preparedness etc, this act had failed to address the sexual and reproductive health issues of the public. Nonetheless, this act could be used as a strong tool to advocate for the development of sexual and reproductive health policies and strategies as sexual and reproductive health does fall under the protection of public health. However, it is also vital to advocate for the amendment of this act in order to include sexual and reproductive health component as this would enable the provision of increased political strength and support to this issue.

Proposed Maldives Health Master Plan 2016-2025 (Ministry of Health, 2014b):

- One of the strategic focus areas of the proposed Health Master Plan for the next 10 years includes public health protection. Some of the strategic directions under public health include "provision of a healthy start in life through effective reproductive, maternal and child health services", "enabling healthy behaviours, safe sexual and reproductive health practices among adolescents and young adults", "strengthen health promotion and health education customized to the target audience". Once this Health Master Plan 2016-2025 gets enforced, these three strategic directions could be used as a basis for advocating and implementing programs that enable universal access to sexual and reproductive health and rights for the Maldivian community.

In addition to these, other policies, plans and legislations that could assist in building political basis for advocating for the sexual and reproductive health and rights within Maldives include:

- The Anti-torture Act 2013 (Maldives)
- The Disability Act 2012 (Maldives)
- The Domestic Violence Prevention Act 2012 (Maldives)
- The Sexual Harassment Prevention Act 2014 (Maldives)
- The Sexual Offence Act 2014 (Maldives): This act both gives protection to some of the sexual and reproductive health and rights for Maldives such as protection from rape including marital rape (under certain circumstances) and sexual abuse while it hinders some of the sexual and reproductive health and rights especially of the most vulnerable sub populations within Maldives.

Overall, there are a series of strategies, plans, polices and legislations within Maldives which could be used together to advocate for the formulation of a comprehensive and integrated sexual and reproductive health policy/strategy within Maldives. However, it is important to note that unmarried men and women, marginalised groups and migrants have needs that are currently inadequately addressed in these strategies, plans, policies and legislations within Maldives.

Furthermore, some of the notable gaps or challenges to timely implementation of the present strategies include the need to orient the laws for the general public and relevant organizations, key organizations that are important to implement these laws and policies need to be sensitized to vital issues identified in these laws and policies, the need to strengthen a well-coordinated multi-sectorial response as well as the need to build capacity which is required for effective implementation of these laws and policies. Hence, these implementation gaps are needed to be addressed in order to continue efforts for promoting and implementing sexual and reproductive health and rights of Maldivians and foreigners residing in Maldives.

2. Grounds under which abortion is legal

Until recently, induced abortion has only been legal in Maldives under the ground of therapeutic reasons (i.e. in order to either preserve the health of a pregnant woman or to save the life of a pregnant woman) (United Nations [UN], 2013). This is likely to impose challenges to accessing safe abortion services by vulnerable populations such as those who had become pregnant due to cases of rape and incest. For instance, the case studies presented in the Box 1 below taken from a baseline survey conducted by Society for Health Education in 2013 shows that pregnancy is common among victims of rape and incest. In most cases, these victims are minors who not only had lost their right to make decisions on their sexual and reproductive health, but their right to access the required reproductive and health services has also been undermined. This may have increased their risk for complicated pregnancy outcomes. For example, in both case studies reported in Box 1, although the delivery had taken place in two different circumstances (a home delivery versus a delivery at a health facility which is likely to be assisted by a skilled birth attendant), both of their babies died within 24 hours of delivery. This could be an outcome of not being able to access the appropriate ANC services during their pregnancy due to various societal reasons. On the other hand, the case studies also highlights that the impact of such pregnancies goes beyond the abuse of the victim's sexual and reproductive health and rights but it has a broader impact on their right to live a normal life similar to other children of their age. For instance, both the girls in the case studies had lost their right to education. One had to stop going to school while the other was expelled from school and all other schools in her island refused to enrol her despite the fact that she was only an 11 year old, her perpetrators had already been reported and her family had sought assistance from relevant authorities. This is a concern as this impacts the Millennium Development Goal 2 (Achieve universal access to primary education) and 3 (Promote gender equality and empower women) (Millennium Project, 2006).

Box 1: Case studies taken from Society for Health Education (2013)'s baseline survey (Note: All names has been changed to maintain privacy and confidentiality in the original source of these case studies)

Case study 1:
11 year old Fathimath was always a chubby child so no one realized she was pregnant until she went in to labour. Fathimath lived in her island with her family in their house of three rooms. She was the youngest of her siblings and shared her room with her mother, three brothers and an uncle. Her uncle started sexually abusing her before she had reached her menarche. As they lived in the same room her uncle got many opportunities to force himself on her and have sexual intercourse.
Her uncle's assaults finally stopped at one point but were soon replaced by a family friend. As a frequent visitor to the house the family friend knew when he could find Fathimath alone to have sexual intercourse with her. As she was threatened not to tell anyone she hid these incidents from her mother who became suspicious and questioned about her strange behaviour.
Fathimath finally realized that she might be pregnant when she missed her period for several months consecutively and felt something move inside her belly. She managed to hide her pregnancy from her family members until one day she felt the intense pain of labour. Her family took her to the hospital thinking she was having gastric problems. The attending doctor examined her and diagnosed that she was pregnant and in labour. Fathimath had a normal delivery and was later shifted to the regional hospital for further services. However, her baby died within 24 hours of delivery.
Currently, Fathimath lives with her parents in her island, both her uncle and the family friend were reported to the Police for sexually abusing her. However, she was expelled from her school after the incident and the other schools in her island would not enrol her as student. Her family has sought help from the appropriate authorities but so far Fathimath remains at home and has already lost one year of her education.

Case Study 2:
Aminath was 14 years old when her stepfather first started sexually abusing her. She lived in her island with her mother, stepfather and three half siblings. Her parents slept in one room, her siblings shared one room together and she had her own room to herself. However, after she turned 14 her stepfather started entering her room and having sexual intercourse with her against her will. Her mother was aware of it but did not take any action to stop her stepfather.
Soon after the sexual assaults began, she started missing her periods and realized that she was pregnant. Other people in the island also became suspicious of her appearance and behaviour, and rumours about her pregnancy began to circulate. She started avoiding school until she stopped going altogether. Her friends called to question her about the rumour which she denied.
It all culminated in the night of her labour when she started experiencing the intense pain from the contractions. She was not aware that she was in labour and accepted the many medicinal foods and drinks her mother procured to ease her pain. She was unable to sleep through the night and finally at dawn her mother took her to the bathroom and asked her to sit on the toilet seat where she proceeded to deliver her baby. Aminath was barely conscious throughout the delivery. She recalls her mother cleaning her and then falling on to the blood soaked mattress. She also remembers her father shouting to her mother that the baby was dead before she lost consciousness. She finally awoke to the sound of people searching her home as someone had reported to the authorities that she has given birth.
Following the incident, Aminath was taken in by the authorities and currently lives under the state care in an orphanage.

Upon recognizing such challenges, numerous advocacy work initiated by a local Non-Governmental Organization known as Society for Health Education, in the year 2013 (Fikry and Ismail, 2013) along with Ministry of Health's contributions assisted in paving a road leading to abortion being discussed both in the political and religious spheres. The fruit of these deliberations was the release of a fatwa (Islamic Ruling) on 11th December 2013 by the Government's council of religious scholars known as the Islamic Fiqh Academy. This fatwa gave guidance on the grounds on which abortion can be legal within an Islamic context as follows:

1 - "Under the circumstance where a mahram (kin with whom marriage is unlawful)man commits forceful adultery with his kin – the termination of the consequent fetus within 120 days of gestation;
2 - Under the circumstance where a non mahram (a person with whom marriage is lawful) man commits forceful adultery with a woman – the termination of the consequent fetus within 120 days of gestation;
3 - Under the circumstance where a man commits forceful adultery with a physically weak or under aged girl – the termination of the consequent fetus within 120 days of gestation;
4 - Under the circumstance where in a lawful marriage, the conceived fetus is believed to be a thalassemic major, sickle cell major or the fetus is believed to be physically or mentally deformed at the time of its birth and that it will not be cured by any means – the termination of the fetus within 120 days of gestation;
5 - Under the circumstance where the life of a pregnant woman is in danger – the termination of the fetus or administration of an induced abortion even after 120 days of gestation" (Islamic Figh Academy, Ministry of Islamic Affairs, 2013, p.1).

As a result of this fatwa and the advocacy efforts by various stakeholders, amendments were made to the penal code of Maldives in the year 2014. It expanded the legal grounds under which abortion is legal within Maldives to the circumstances and conditions as stated in the fatwa (The Penal Code, 2014 (Maldives)). This shows that carefully targeted interventions including sensitizing programs directed towards key stakeholders could actually lead to making significant changes to both political and religious perception for even highly controversial and sensitive issues. It also shows the notable influence of religious stakeholders in governing and shaping the political directions within Maldives. Hence, in this regard, the events that lead to the development of the fatwa and the changes that made to the penal code could be used as examples for shaping and making interventions to build momentum for the discussion of highly sensitive topics with both religious and political stakeholders.

In short, the last two years were marked as years that lead to huge changes to the legality of abortion within Maldives. However, these changes still do not permit abortion under economic and social reasons aside from rape or incest cases (The Penal Code, 2014 (Maldives)). Rape has been defined in both The Penal Code of 2014 and Domestic Violence Prevention Act 2012 (Maldives) to go beyond vaginal penetration by stating that it would be considered rape if one's genital organ is inserted to another's genital organ or any other organ without the permission of the latter person involved. While, the definition of rape is mostly focused on rape between unmarried men and women, it does address marital rape under specified conditions (i.e. during divorce process that has been initiated in court, when both spouses are living separately under a mutual agreement, when one spouse is aware that he/she has a sexually transmitted disease and engages in sexual behaviour with the intention of passing the disease to his/her partner) (The Penal Code, 2014 (Maldives)).

In addition to this, the circumstance under which abortion can be performed if the foetus is detected to have impairment is only if the parents were married at the time of conception (The Penal Code, 2014 (Maldives)). Therefore, this excludes pregnancies in unmarried couples or pregnancies for unmarried women. Abortion is also not legal in Maldives for economic or social reasons or on the basis of a request from the expecting mother (unless the mother's circumstance fits one of the circumstances as specified in the fatwa) (The Penal Code, 2014 (Maldives)).This has resulted in a lot of cases of women availing themselves with risky and unsafe abortion methods. For instance, the excerpts of case studies presented in Box 2 below taken from UNFPA Maldives (2011) gives evidence to the fact that unwanted pregnancies which subsequently lead to unsafe abortion practices does occur within Maldives.

Box 2: Case study excerpts taken from UNFPA Maldives (2011)
Note: All names has been changed to maintain privacy and confidentiality in the original source of these case studies

Excerpt 1
"....when I was in my early twenties... became pregnant. So I told him [boyfriend]...he arranged to take me to a neighboring country... before the trip, I was given some medicine by my boyfriend who said it would help me start having my period again. So I took it, but nothing happened. .I went abroad with my boyfriend...my boyfriend took me to a kind of "nursing home" in a suburban area of the city... they gave me a general anaesthetic and carried out the abortion procedure. When I woke up, it was all done..."

Excerpt 2:
"....when I got pregnant...I was about twenty- two...I didn't use any protection or contraception... Every time, I was worried and anxious I might get pregnant... It became normal to do this... like a habit. You know, boys don't like condoms and I believed that.... When I told my boyfriend...He said that I was trying to trap him and that I had just picked up some guy off the street and now want to put the blame on him.... I wanted to have an abortion. So I went to a friend for help and she gave me the money to have an abortion. With her help, I found someone who did abortions. It wasn't a health worker or anything. It was someone who had experience of helping to induce an abortion for his own girlfriend quite recently... I didn't see a doctor or anything. This person came to the house one evening and gave me three injections... I went through a lot of pain...by the time I had the abortion, I think I was about two months pregnant. I knew about the risks of doing it...About two years later, I had my second pregnancy, while I was having a relationship with quite a rich boyfriend...But I became pregnant not by him but by someone else...I rented a day room in a guest house and my boyfriend arranged to have a pharmacist to come and give me the injections... After the abortion, I had bleeding for three months...I know of other people from my island who now live in Malé who have had similar experiences... I know about someone who does induced abortions as a business...I know about five friends who have had abortions and one of them has done it three times...I got married...got pregnant... I did not want to start a family so soon...So I decided to have an abortion."

Excerpt 3
"....and when I was about seventeen.... I became pregnant...I found out because I missed my period....I was still in school....A month passed after that and another....the only thing I could do was to try home remedies to terminate the pregnancy....My whole future was at stake .... Keeping a babywas not an option...My parents didn't notice and I used to go to his [boyfriend] place to eat unripe pineapple....I also took Disprin dissolved in coke.... It just did not happen. I was trying to do whatever I could to induce abortion, including riding my bike and exercising... And then...my friend's family was going abroad...they invited me to join them....I went on that trip....by this time, I was four months pregnant and way past aborting. We went to some hospitals and were told that they did not do abortions... we eventually found a clinic...When we got there, they said that it was not possible to induce abortion at this stage...When I walked into the clinic, I thought to myself this was not what I had in mind. It was a dingy place and I was concerned about the sterility of the place...SoI went in for a check-up behind this curtain...I didn't really know what he meant by checking, so when I went in, he put me up on the bed onto stirrups and he started the procedure... They did not give me an anaesthetic or even a painkiller but started pumping from a vacuum, and he just said "five minutes" to me... The pain was excruciating...I thought I was dying.. Eventually they finished and the doctor said "Ok, done. Leave"...."

The above excerpts taken from UNFPA Maldives (2011) case studies also shows that most of the young women who are able to afford to go abroad to perform an abortion does resort to that option. While some does access safe abortion services (such as Excerpt 1 in Box 2), others have utilised services which are likely to be providing unsafe abortion services (Example: Excerpt 3 in Box 2).

On the contrary, women who are not able to afford to go abroad to utilise abortion services are severely restricted to seeking safe abortion services due to legal barriers and hence, these women had resorted to utilising unsafe abortion options such as the use of injections as observed in Excerpt 2 in Box 2.

Apart from this, there is also a need to create

awareness among the population about the circumstances under which abortion is permissible within Maldives. As improved understanding of this topic within the country would facilitate better accessibility to such services for those who are most in need.

...from early years of the global AIDS epidemic, Maldives has taken a preventative approach rather than enabling an environment in which the people who have acquired the infection could live a safe life enjoying all the benefits offered by the community regardless of their HIV status.

3. Policies on HIV and AIDS

At present there are no specific laws or legislations that inhibit arbitrary discrimination on the basis of HIV and AIDS status of an individual within Maldives. This is reflected on the UNAIDS report published in 2010 which criticised Maldives for the absence of legislations and regulations that provide protection for people living with HIV and AIDS from discrimination.

One reason for this could be due to the consistent low prevalence and incidence of HIV and AIDS in the Maldives (Health Protection Agency, Communicable Disease Division, 2013). Hence, from early years of the global AIDS epidemic, Maldives has taken a preventative approach rather than enabling an environment in which the people who have acquired the infection could live a safe life enjoying all the benefits offered by the community regardless of their HIV status. As a result, the first comprehensive AIDS control program was established in the year 1987 with the objective of hampering the spread of HIV and AIDS in the Maldives (Franklin, 2009; United Nations Development Programme [UNDP] 2012). This program is still an ongoing program and is currently being coordinated by the Health Protection Agency under the guidance from the National AIDS council that consists of multiple stakeholder representatives (includes ministries, NGOS, etc) (Franklin, 2009; UNDP, 2012). This program had broadened over the past few decades to allow universal access to HIV and AIDS treatment, management, care and psychological support for those who are in need of such services as part of the free of charge service provided to all HIV positive patients by the Government of Maldives (Health Protection Agency, Communicable Disease Division, 2013). These efforts had resulted in Maldives achieving the HIV and AIDS related targets of the Millennium Development Goal 6 (Combat HIV and AIDS, Malaria and other diseases) (Department of National Planning, 2010).

However, the "2009 Joint mid-term review of the national response to HIV in the Maldives" (as cited in National AIDS Programme, Ministry of Health and Family, & UNAIDS, 2010) and The World Bank (2012) had expressed concern that even though Maldives has a low overall prevalence of HIV, Maldives is still classified as a country with high epidemic potential for HIV due to the presence of high vulnerability and risk for HIV transmission and acquisition. This is supported by evidence from the current literature which had shown that there are multi-faceted risk factors for the transmission of HIV and AIDS present within the Maldivian community. Some of these risk factors include the presence of unsafe sex among unmarried adults, adolescents and young adults, key affected populations and most at risk populations and increasing prevalence of injecting drug use with some evidence of needle sharing as well as the overlapping of risk factors among most at risk population groups (The Global Fund supported programme in the Maldives, 2008; National HIV/AIDS Council, Ministry of Health & the UN Theme Group on HIV/AIDS, 2006).

This issue could be further exacerbated by lack of non-discriminatory laws and regulations that protects vulnerable sub populations and enables these subpopulations from effective utilisation of support services including treatment, care and even preventive measures for communicable diseases such as HIV and AIDS (UNAIDS, 2010). Furthermore, The Penal Code 2014 (Maldives) criminalizes sex work, drug use and having same sex sexual activities without any grounds of exception as such acts are deemed to be against the principles of Islamic Sharia.

This is supported by evidence from the current literature which had shown that there are multi-faceted risk factors for the transmission of HIV and AIDS present within the Maldivian community.

In contrast, upon recognition of the threat of a potential epidemic of HIV and AIDS for the Maldivian community, the recent years had brought changes to how the HIV and AIDS situation is being managed in the Maldives. The government and some NGOs have initiated harm reduction programs such as voluntary counselling and testing in order to promote confidential, anonymous and non-discriminatory testing for HIV and AIDS (UNDP, 2012). A behaviour change communication strategy was also developed in 2009 with the assistance from global fund in order to address risky behaviours among selected vulnerable population groups (Franklin, 2009). However, there is still a need to hasten support and sustain effective and efficient implementation of such initiatives within Maldives.

4. Policies on Adolescent Sexual and Reproductive Health Services

To date, there is no specific adolescent and reproductive health policy or strategy in the Maldives. However, the National Reproductive Health Strategy 2014-2018, the draft Health Master Plan 2016-2025 and the Behaviour Communication Strategy formulated in 2009 gives strategic directions for actions regarding the Adolescent Sexual and Reproductive Health issues (Ministry of Health, 2014a; Ministry of Health, 2014b; Franklin, 2009). A closer analysis of these strategies and plan shows that aside from the Behaviour Communication Strategy, the remaining strategy and plan had emphasized more on the provision of school based awareness and sexuality education programs with collaboration with the Ministry of Education's school health program. While, this can be regarded as an effective strategy, it does not cover vulnerable adolescent groups such as school dropouts.

... the remaining strategy and plan had emphasized more on the provision of school based awareness and sexuality education programs with collaboration with the Ministry of Education's school health program.

In addition to this, improving the provision of youth friendly health services (including sexual and reproductive health services of the adolescents) has been discussed in the National Reproductive Health Strategy 2014-2018 and in the draft Health Master Plan 2016-2025. However, specific details about the types of services that will be provided under these youth friendly health services are not covered in the National Reproductive Health strategy 2014-2018 and the draft Health Master Plan 2016-2025 (For example: Is it advocating for the availability of condoms to the youth via these services?, Will these services be available to the adolescent regardless of the marital status?, Do these services require guardian or parental consent for accessing services for adolescents or does it permit minors to give informed decision on their own behalf?). Therefore, more detailed strategic directions are necessary especially due to the sensitivity of the topic in the Maldives.

On the contrary, the Behaviour Change Communication Strategy did recommend advocating for policy changes that will ensure protection of the sexual health of the youth inclusive of STI check-ups for unmarried women (Franklin, 2009). This strategy also raised concern that some of the current policies in place pose a barrier to universal access to the adolescent sexual and reproductive health services. These include:

- Unmarried women cannot legally obtain contraceptives even though now contraceptives are offered over the counter from pharmacies and,
- Pregnant school age girls lose their right to attend schools whether or not they have given birth (Franklin, 2009).

Apart from this, The Penal Code 2014 (Maldives) and The Sexual Offence Act 2014 (Maldives) criminalizes voluntary premarital sexual activities and even the possession of a barrier device such as condoms among unmarried men and women. This might hinder the effective utilisation of adolescent sexual and reproductive health services especially due to fear of being punished or stigmatized. Upon considering the fact that about 1 in 4 Maldivians at present fall under youths (15-25 year olds) and this proportion is projected to increase in the coming years, there is a need to amend policies that poses barriers to effective utilization of adolescent and youth friendly sexual and reproductive health services (Ministry of Health, 2014b). There is also a need to strengthen a multi-sectoral collaboration and response to the provision of Adolescent Sexual and Reproductive Health Services as these services tends to crosscut the responsibilities of multiple agencies such as Ministry of Youth and Sports, Ministry of Health, Ministry of Education, Ministry of Law and Gender and even the Ministry of Islamic Affairs.

4.1. Difference between Median Age at Marriage and Legal Minimum Age at Marriage

The Table 3 below summarizes the median age at first marriage statistics which is available from the two rounds of reproductive health surveys which had been conducted in Maldives in the years 1999 and 2004. These statistics have been compared with the legal minimum age at marriage which has been specified as 18 years in the law on family of the Maldives (Ministry of Gender and Family, 2007). This has been done in order to evaluate the difference between median age at marriage and legal minimum age at marriage during these years.

Table 3: Time trend analysis of the difference between median age at marriage and legal minimum age at marriage between 1999 and 2004.

Population group: female respondents aged 15-49 years	1999			2004		
	Median Age at first marriage	Legal Minimum age at marriage	Difference (Median Age at first marriage – legal minimum age at marriage	Median Age at first marriage	Legal Minimum age at marriage	Difference (Median Age at first marriage – legal minimum age at marriage
All women	17 years	18 years	**-1 year**	18 years	18 years	0 years
Women with primary and above education	18 years	18 years	0 year	19 years	18 years	1 year
Women with none or non-formal education	16 years	18 years	**-2 years**	17 years	18 years	**-1 year**
Women aged up to 30 years	18 years	18 years	0 year	19 years	18 years	1 year
Women aged above 30 years	17 years	18 years	**-1 year**	17 years	18 years	**-1 year**

Note: 1999 statistics adapted from "Reproductive Health Baseline Survey," by CIET international, 1999. Copyright 1999 by CIET international and Ministry.
2004 statistics adapted from "Reproductive Health Survey 2004," by Ministry of Health & CIET International, 2004. Copyright 2004 by Ministry of Health CIET international .

The above Table 3 shows that the difference between median age at first marriage and the legal minimum age at marriage had increased when 1999 Reproductive Health Survey figures are compared with 2004's Reproductive Health Survey figures. Apart from this, the difference in median age at first marriage and legal minimum age at marriage for women with higher level of education (primary and above education) and younger women (aged up to 30 years) tends to be higher when compared to women with none or non-formal education and older women (aged above 30 years), respectively.

Additionally, even though, the findings of median age at marriage statistics of 2009 MDHS cannot be compared with the reproductive health surveys conducted in 1999 and 2004 due to difference in age bracket of female survey respondents from which these statistics has been obtained in the relevant surveys, the 2009 MDHS survey had also shown a clear trend indicating that increased level of education attainment tends to increase the gap between median age at first marriage and legal minimum age at marriage. Apart from this, the difference between the median age at first marriage and the legal minimum age at marriage also tends to increase with higher wealth quintile and place of residence (Urban verses rural) (Table 4). As current global evidence suggest that scarcity of social and economic options (especially of women) tends to favour the practice of early marriage (United Nations Development Program, 2014), there is a need to investigate the reasons for the low performing sub groups of women within Maldives, as although with no solid evidence it is argued that poverty, lack of employment and education opportunities could be one of the reasons for this difference between these age groups. Hence, further research into this area is necessary in order to plan and implement interventions especially if the rights of these women are undermined due to such reasons..

Table 4: Difference between median age at marriage and legal minimum age at marriage – 2009 MDHS 25- 49 year old female survey respondents.

Population group –aged 25-49 years	Median Age at first marriage	Legal Minimum age at marriage	Difference
All women	19 years	18 years	1 year
Urban women	20.4 years	18 years	2.4 years
Rural women	18.5 years	18 years	0.5 years
Women living in Male' region	20.4 years	18 years	2.4 years
Women living in central region	17.7 years	18 years	**-0.3 years**
Women with no formal education	17.0 years	18 years	**-1 year**
Women with more than secondary education	23.8 years	18 years	5.8 years
Women with lowest wealth quantile	18.2 years	18 years	0.2 years
Women with highest wealth quantile	21.1 years	18 years	3.1 years

Note: Adapted from "Maldives Demographic and Health Survey 2009," by the Ministry of Health and Family & ICF Macro, 2010. Copyright 2010 by Ministry of Health and Family & ICF Macro

4.2. Gender based violence

4.3. Extent of Gender-based violence

To date, the only study which has measured the extent of gender-based violence in the Maldives is the "Women's Health and Life Experience Survey" which was conducted between 2004- 2006 in the Maldives (Ministry of Gender and Family, 2007). The findings of this survey showed that about 1 in 3 (34.6 percent) of Maldivian females aged 15-49 years have experienced some level of physical or sexual violence during their lifetime (Ministry of Gender and Family 2007). Out of these women, about 1 in 5 women (19.5 percent) had experienced physical and/or sexual violence in the form of intimate partner violence during their lifetime and about 1 in 8 women (13.2 percent) had been a victim of physical and/or sexual violence from a non-intimate partner such as family members, work colleagues and strangers since the age of 15 years (Ministry of Gender and Family, 2007). A cumulative 28.4 percent resulting in more than 1 in 4 women had also experienced physical and/or sexual violence by both intimate and non-intimate partners since the age 15 years (Ministry of Gender and Family, 2007). Apart from this, 1 in 8 (12.2 percent) women who had ever experienced sexual and/or physical violence have reportedly been abused sexually during childhood (Ministry of Gender and Family, 2007).

Experience of gender based violence within the Maldivian population goes beyond physical and sexual violence. For instance, approximately 29 percent of women aged 15-49 years who had ever been involved in a relationship had experienced emotional abuse from an intimate partner during their lifetime (Ministry of Gender and Family, 2007). The highest prevalence of such abuse was reported from central and southern regions of Maldives (Ministry of Gender and Family, 2007).

In terms of the severity of such intimate partner violence experienced by women aged 15-49 years in the Maldives, women were largely subjected to more severe forms of physical violence such as kicking, choking or burning (Ministry of Gender and Family, 2006). This is a concern since such forms of physical violence extends to women even during their pregnancies with 6 percent of women who had been pregnant during their lifetime had reported experiencing physical and/or sexual violence out of which 41 percent of such women had been kicked or punched in their abdomen during their pregnancies (Ministry of Law and Gender, 2014). This had resulted increased prevalence of complicated pregnancy outcomes such as miscarriage, stillbirth

and abortion among such women who had been abused physically and/or sexually during their pregnancy (Ministry of Law and Gender, 2014).

Women with little or no formal education, women who had been separated or divorced and younger women (mostly aged 25-29) had higher rates of lifetime prevalence of physical and/or sexual violence (Ministry of Law and Gender, 2007). Apart from this, when the capital island of Maldives (i.e. Male') was compared with other atolls, it is evident that the atolls had reported higher level of intimate partner violence (Ministry of Law and Gender, 2007). Ministry of Law and Gender (2007) had argued that this finding is consistent with other countries which had conducted similar studies as part of the WHO Multi-Country study indicating that intimate partner violence is commonly higher in rural areas when compared to urban areas. However non partner violence was more common among Male' region when compared to other atolls (Ministry of Law and Gender, 2007). This could be facilitated by reasons such as overcrowding leading to sharing of small rooms with family members who eventually become perpetrators as observed in the following case study in Box 3.

Box 3: A Case Study taken from Society for Health Education (2013)'s baseline survey
Note: Note: All names has been changed to maintain privacy and confidentiality in the original source of these case studies

Hawwa lived with her parents and her many siblings in their island. Due to the limited number of rooms in her house she usually slept with her family members in one room. The sexual abuse from her father started when she was six years old. She would wake up every night to her father removing her clothes and touching her genitals. It soon advanced to penetrative sexual intercourse which hurt her intensely and caused her to bleed.

This continued for years even after they moved to Male'. In Male' her parents lived in a separate room while she slept with her siblings. However, her parents had an argument one night and her mother moved in to her room. Her father took her and her 15 year old sister to his room where they slept together in one bed for several weeks. During this period her father sexually abused her regularly and she woke up several nights to find him sexually abusing her sister as well, which her sister denied. After they moved to Male', her father bought a computer and made Hawwa watch pornographic movies stating that he wanted to do the acts depicted in the movie with her. All the while, her mother suspected their father was sexually abusing Hawwa, and finally caught him in the act one night. Despite many arguments that followed Hawwa's mother did not do anything for fear of not being able to provide for her financially when her husband was prosecuted. Finally, when Hawwa was 10 her mother reported the matter of Hawwa's father sexually abusing her and her elder sister to the Police and her father was prosecuted. Additionally, following the submission of the case to the Maldives Police Service, the investigating officers received other reports stating that the elder sister had gotten pregnant and was taken abroad for abortion. However, due to the lack of evidence no action was taken regarding this.

On this note, rape and forced sex during incest cases also seemed to be a significant issue with 467 sexual offences being recorded in the Maldives Police Services in 2014 (Maldives Police Service, 2014). Crime statistics report published by Maldives Police Service in 2012 also showed high number of child sexual abuse cases for 2011 (79 cases) and 2012 (82 cases) (Maldives Police Service, 2012).

Upon recognizing such issues, The Domestic Violence Prevention Act 2012 (Maldives) was enacted which prohibits any acts or form of domestic violence, thus providing some level of protection for women who are experiencing both intimate and non-intimate partner violence (Ministry of Health, 2014a). However, as gender-based violence goes beyond domestic violence, there is a need to develop and implement legislations and plans to protect the rights of men, women and children from gender-based violence. There is also a need to develop studies to investigate the different forms of violence being experienced by men and boys as there is currently no study in Maldives that had captured the extent of gender based violence among males. Hence, their rights should not be neglected during the formulation of interventions and strategies to combat GBV.

1.1. Legislation related to gender-based violence

The Domestic Violence Prevention Act 2012 (Maldives) is the legislation enacted in Maldives that addresses intimate partner violence. This act is comprehensive and addresses physical, sexual and emotional abuse (inclusive of controlling behaviors). On the other hand, The Sexual Offences Act 2014 (Maldives) addresses rape and incest cases. However, as mentioned in earlier sections, both of these acts fall short in addressing sexual violence occurring within marriages unless a divorce case has been lodged, both partners are living separately or one of the partner who have a sexually transmitted disease engages in forced sexual activities with his/her spouse with the intention of spreading the disease to the partner (The Sexual Offence Act, 2014 (Maldives)). Hence, some of the sexual rights of married men and women are still neglected under these acts. Nevertheless, as the burden of proof seemed to lie on the alleged perpetrator as witness accounts, forensic evidence, medical assessments and even the victim's statement could be used against the perpetrator as evidence of rape, this could be an added advantage for ensuring timely persecution of the perpetrators (The Sexual Offence Act, 2014 (Maldives)).

Aside from this, Maldives had recently enacted The Sexual Harassment Prevention Act 2014 (Maldives). This act addresses workplace sexual harassment. Although, the Human Rights Commission of the Maldives is given the statutory provision of making regulations related to this act, each organization including the health sector has an obligation to set up and establish a "complaint submission committee" in the Human Resource section to review, evaluate and take action against any Sexual Harassment case The Sexual Offence Act, 2014 (Maldives)).

Some other relevant laws that prevent violence against women include The Disability Act 2012 (Maldives) which criminalizes the rape of a person with disability. Furthermore, it should be noted that there is currently no specific legislation relating to female genital mutilation.

5. Legislation and policies on sexual orientation

Under The Sexual Offence Act 2014 (Maldives) same-sex sexual activities even between consenting adults are illegal and are subjected to a punishment of 7 – 10 years' of incarceration. There is also no legal prohibition of discrimination in employment on the basis of sexual orientation. Furthermore, as the penalty for same-sex sexual activities is imprisonment, the person responsible is likely to lose their job even if no workplace discrimination is evident. There is also no specific clause or article in the current constitution of the Maldives that prohibits discrimination based on sexual orientation. In addition to this, there is also no law prohibiting incitement of hatred on the basis of sexual orientation in Maldives.

... as the burden of proof seemed to lie on the alleged perpetrator as witness accounts, forensic evidence, medical assessments and even the victim's statement could be used against the perpetrator as evidence of rape, this could be an added advantage for ensuring timely persecution of the perpetrators...

5.1. Legislation and policies on gender identities

Although, there is currently no law criminalizing "cross-dressing" or other activities of trans or gender-variant people within Maldives, the prohibition of same-sex sexual activities in The Sexual Offence Act 2014 (Maldives) is indicative that such behaviors are not part of the acceptable norm of the community. Religious beliefs also contradicts "cross dressing" and other activities relating to Trans or gender variant people. While there are many unisex names used in the Maldivian community, the assignment of a defined female name to a male individual and vice versa is not permitted during registration procedures. There is also no legal ground in which one's gender can be changed. Furthermore, there is no legislation or policy in place prohibiting discrimination in employment based on gender identity within Maldives. There is also no law prohibiting incitement to hatred on the basis of gender identity and prohibition on discrimination based on gender identity. There is no evidence suggesting that asylum can be granted on grounds of discrimination based on gender identity authorized by law or policy and gender reassignment treatment/ surgery or body modifications are not available in Maldives.

Grievance redresses mechanisms for sexual and reproductive health services

Currently there are no evident grievance redress mechanisms for Sexual and Reproductive Health services in Maldives. This could be a result of the absence of an integrated sexual and reproductive health policy as usually grievance and redress mechanisms are covered in a specific act itself (e.g.: tribunal hearing as part of The Sexual Harassment Prevention Act 2014 (Maldives). Hence, there is a need to build momentum for enactment of a specific policy addressing Sexual and Reproductive Health issues in order to ensure that the voice of all the relevant groups within the population (especially the most vulnerable groups) could be heard and their concerns addressed both at facility level and at government level.

6. Recommendations

For the Government:

1. Ensure timely implementation of all strategies relevant to the Sexual and Reproductive Health of the Maldivians and those residing in the Maldives
2. Establish an integrated National Sexual and Reproductive Health strategy.
3. Collaborate with relevant ministries, government agencies and other stakeholders such as NGOS to strengthen the multi-sectorial response to the Sexual and Reproductive Health issues of the population.
4. Enact polices which prohibit discrimination on the grounds of HIV and AIDS status, Revise the currently implemented RH policies to reflect SRH and HIV
5. Amendment of Public Health Act to include sexual reproductive health
6. Conduct awareness raising campaigns for the public on SRR
7. Strengthen the delivery of SRR information in the education system
8. Strengthen the delivery of SRR information and facilities in the health sector
9. Conduct a study on SRR in the Maldives to assess the current situation

For NGOs and civil society:

1. Refer to documented best practices in the country to duplicate these initiatives and efforts.
2. Strengthen collaboration between all relevant stakeholders (including government and other NGOs) for the timely implementation of strategies and policies relevant to sexual and reproductive health.
3. Explore ways in which sensitive issues concerning the sexual and reproductive health and rights of the most vulnerable populations can be brought in to the political and religious spheres.
4. Lobby to revise public health act to include SRH
5. Advocate for the rights of key affected population and vulnerable groups (including youth) in terms of accessing the required health care services
6. Conduct awareness raising and information sharing activities for the general public

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