

COUNTRY PROFILE

COUNTRY PROFILE ON UNIVERSAL ACCESS TO SEXUAL AND REPRODUCTIVE HEALTH SERVICES: MALDIVES



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1. Introduction

Maldives is a small, South Asian island nation that consist of 1190 coral islands, out of which only about 16 percent of the islands are inhabited (Department of National Planning, 2012; Fulhu, 2014). These islands form in to 26 natural clusters that are known as atolls (Ministry of Health and Gender, 2014). For administrative purposes, these natural clusters of islands in Maldives are grouped into 20 atolls (Department of National Planning, 2012; Figure 1; Fulhu, 2014; Ministry of Health and Gender, 2014). .

In Maldives, there are no designated urban and rural areas within these atolls (Ministry of Health and Family & ICF Macro, 2010). However, the classification of urban and rural utilised in the Maldives Demographic and Health Survey 2009 will be used in some parts of the discussions, especially when discussing about the findings of 2009 Maldives Demographic and Health Survey , to consider the residential households of Male' (the capital island of Maldives) as urban and the rest of the residential households in Kaafu atoll and the other 19 atolls of Maldives will be classified as rural (Ministry of Health and Family & ICF Macro, 2010).

Furthermore, Maldives has a population of 341,256 people (Table 1) and the population of Maldives consists of 1.5 per cent more males than females (Table 1). The population of Maldives has been increasing annually from 2006 to 2014 at an annual growth rate of 1.56 (Table 1). In addition to this, at 2013, the life expectancy at birth for a Maldivian male and female is 72.97 years and 74.66 years, respectively (Table 2). Maldives is also ranked globally among the top 6 countries which had made the most significant increases in life expectancy from 1990 to 2012 (World Health Organization [WHO], 2015a).

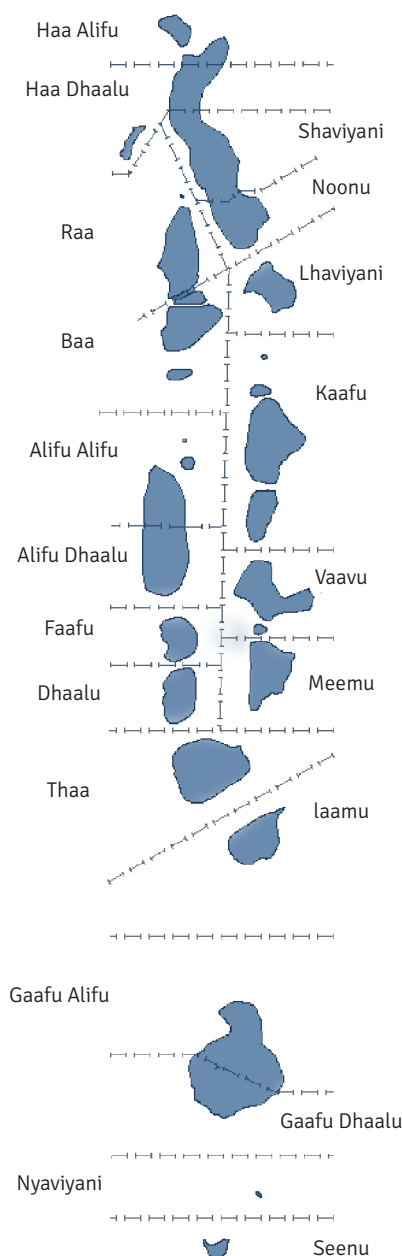


Figure 1. Map of Maldives.

The life expectancy at birth for men and women in 2013 are 73.0 and 74.7 years old, respectively. (National Bureau of Statistics, 2015)

Table 1. Population of Maldives by locality 2006 and 2014

Census 2006			Census 2018			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.

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.

In addition to this, in relation to the Maldives' expenditure on health, the health expenditure as a percentage of national budget had declined from 11.3 percent in the year 2004 to 3.1 percent in the year 2011 (Figure 2). Furthermore, about a three-fold decline had been observed for the public health expenditure as a percentage of total Gross Domestic Product (GDP) between the years 2004 to 2011 (Figure 3). Peak values for both the health expenditure as a percentage of national budget and the public health expenditure as a percentage

of total GDP was observed for the years 2008 and 2009 (Figure 2; Figure 3). A reason for such peaks could be due to high dependency on expensive expatriate work force for health that need to be deployed to several islands within the country due to its geographical isolation from one another, coupled with the establishment of health insurance initiatives such as *Madhana* program for the first time in the Maldives during August 2008 (Nagpal, 2011).

Figure 2-Health Expenditure as a % of National Budget: 2004 to 2011

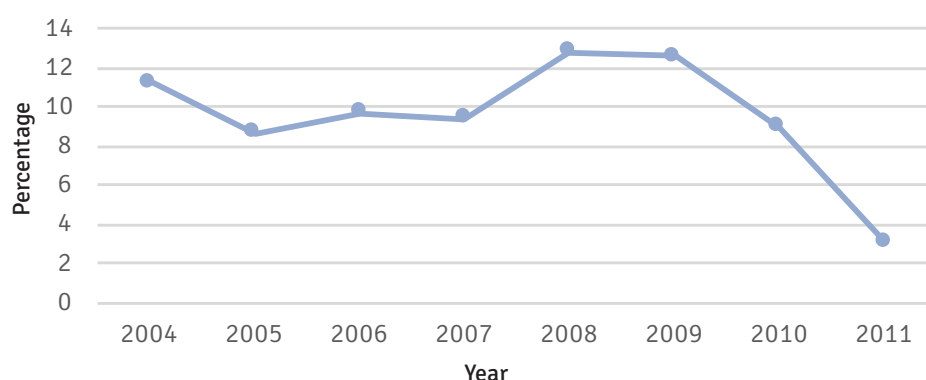


Figure 2. Health Expenditure as a % of national budget: 2004 to 2011. Adapted from Maldives National Health Accounts 2011, by World Health Organization and Ministry of Health, 2014a, Copyright (2014) by World Health Organization.

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

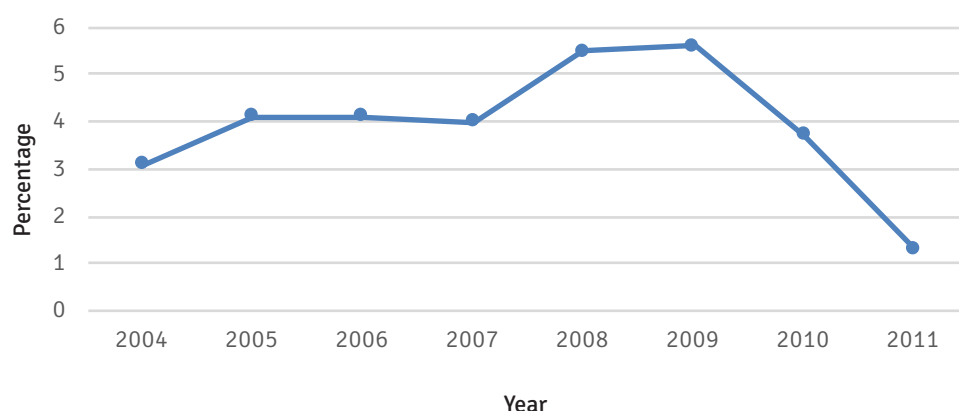


Figure 3. Public Health Expenditure as a % of total GDP: 2014 to 2011. Adapted from Maldives National Health Accounts 2011, by World Health Organization and Ministry of Health, 2014a, Copyright (2014) by World Health Organization

Moreover, in the year 2011, the Total Expenditure on Health (THE) as a proportion of GDP was 9.2 percent and the out of pocket expenditure as a percentage of THE was 49.4 percent (World Health Organization [WHO] & Ministry of Health, 2014a). On the other hand, the general government expenditure on health as a percentage of THE was 44.0 percent (WHO & Ministry of Health, 2014a). This indicates that the out of pocket expenditure is higher than that of the government expenditure. Although, this could have implications on people's access to health care services, it is important to note that the subsequent years that followed brought significant changes to the health insurance scheme in the Maldives which lead to the establishment of the first universal health insurance scheme in the name of "Aasandha" in January 2012 (Nagpal & Radaelli, 2013). This insurance scheme was revised again during the current presidency in the name of 'Husnuvaa Asandha' in order to make this scheme as a health insurance scheme for all citizens without a ceiling protection limit (The President's Office, 2014). As the only and also the most recent Maldives National Health Accounts Survey was conducted prior to 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 Maldivian context.

Apart from this, Maldives had signed 7 out of the 9 major International Conventions and 5 Optional Protocols related to the provision of human rights as follows:

- 1 International Convention on the Elimination of All Forms of Racial Discrimination [CERD],

- 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 [CAT],
- 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 [ICESCR] and
- 12 Convention on the Rights of Persons with Disabilities

Although, Maldives had signed these conventions and protocols, it is important to note that the government of Maldives had made several reservations on a number of provisions under ICCPR, CRC and CEDAW (Government of Maldives, 2008). For instance, in relation to the Maldives government's commitment to CEDAW (1979), Maldives had made reservations on Article 16, indicating that Islamic Sharia Law is an important governance factor within a country which has a constitution based on Sharia Law and

hence, the Sharia Law take precedence over the Article stated in the convention (Thanenthiran, Racherla, & Jahanath, 2013). Therefore, it is vital to understand the interplay of Sharia Law and its influence on Sexual and Reproductive Health [SRH] services available within Maldives. A better understanding of this interplay would likely ease the planning, implementation and the uptake of new SRH services within the country.

Maldives. Furthermore, at present, a Maldivian woman who is at the beginning of her childbearing years would give birth to 2.26 children by the end of her childbearing years (Figure 4)

The Total Expenditure on Health (THE) as a proportion of GDP was 9.2 percent and the out of pocket expenditure as a percentage of THE was 49.4 percent (World Health Organization [WHO] & Ministry of Health, 2014a)

2. The status of sexual and reproductive health services in Maldives

In the year 2013, a comprehensive set of 17 indicators measuring the extent of universal access to SRH were developed by Ravindran for Asian-Pacific Resource and Research Centre for Women (ARROW). These indicators were developed after several exhaustive discussions and the build-up of consensus among the participants of the Strategic SRH and Rights indicators' workshop held in Malaysia from 21st to 22nd August 2013 (Ravindran, 2013).

Hence, in order to measure the extent of universal access to SRH services in Maldives, the following 15 of Ravindran (2013)'s strategic indicators were evaluated for Maldives and their findings and its implications has been discussed thoroughly in the subsequent sections:

1. Contraception Prevalence Rate
2. Total Fertility Rate
3. Unmet need for contraception
4. Maternal Mortality Ratio
5. Proportion of births attended by skilled birth attendants
6. Availability of basic emergency obstetric care and comprehensive emergency obstetric care
7. Coverage of post-partum / postnatal care within 48 hours of delivery by a skilled health provider
8. Antenatal care coverage
9. Perinatal Mortality Ratio
10. Infant Mortality Rate
11. Adolescent birth rate
12. Availability and range of adolescent sexual and reproductive health services
13. HIV prevalence and burden
14. Availability of services for HIV and AIDS
15. Availability of sexual and reproductive health services at different levels of care.

The remaining two strategic indicators (i.e. Government expenditure on health and out-of-pocket expenditure as proportion of total health expenditure) have already been discussed in the introductory section. Therefore these two indicators will not be discussed any further in this profile.

Contraception

This section will cover 3 of Ravindran (2013)'s strategic indicators for universal access to SRH. These 3 indicators are contraceptive prevalence rate, total fertility rate and unmet need for contraception. These indicators are also key indicators pertaining to contraception and are used, coupled with other important indicators for contraception such as male use of contraception, to monitor the extent to which individuals and couples are able to freely decide the number and spacing of their children and have access to a range of safe and effective contraceptive methods as envisioned in the International Conference on Population and Development [ICPD] Programme of Action (United Nations, 2014).

Firstly, in the year 1984, Maldives had a population growth rate of 3.2 percent per year (World Health Organization South-East Asia Region Office [WHO

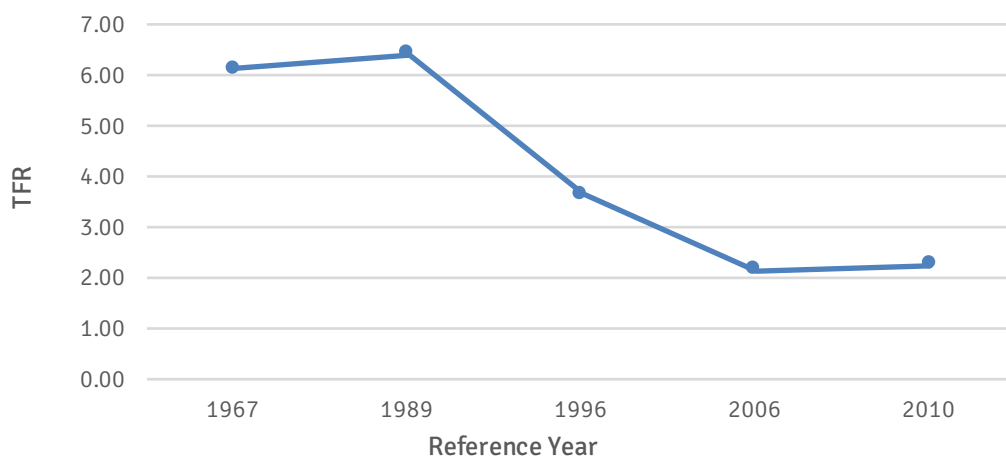
SEARO], 1988). Such high population growth rate was recognised by the Government of Maldives at that time as an impediment to economic development of the Maldives and the government cited that such rapid population growth rates “... will stretch severely all the natural resources and slow down the provision of social services” required for the economic development of the Maldives (WHO SEARO, 1988). This concern further backed up with the belief that better spacing of children will reduce the high levels of Maternal Mortality Rates (11.9/1000) and Infant Mortality Rates (120.7/1000 live births) observed within the Maldives during the early 1980s, lead to the development of the 1984 Child-Spacing Programme (WHO SEARO, 1988). This was the first programme with a focus on contraception implemented within Maldives (WHO SEARO, 1988).

To complement this programme and to ease the implementation of such a programme in a community where such measures were considered both novice and controversial issues at that time

period, a Child-Spacing Policy was enacted in the late 1980s to legalise the use of natural methods, barrier methods, pills, injectables and IUDs for the first time in the Maldives (WHO SEARO, 1988). It is important to note that both the formulation of the Child-Spacing Programme and the Child-Spacing Policy were influenced by religious perceptions. As a result, the target population for the Child-Spacing Programme and the policy were restricted to married couples (WHO SEARO, 1988), thus limiting the access to such services by unmarried men and women.

Despite this, the 3-fold decline in the Total Fertility Rate (TFR) observed within the Maldives during the two decades that followed (Figure 4), gives weight to the argument that the Child-Spacing Programme and the Child-Spacing policy had contributed positively in reducing the TFR of Maldives. Furthermore, at present, a Maldivian woman who is at the beginning of her childbearing years would give birth to 2.26 children by the end of her childbearing years (Figure 4)

Figure 4: TFR of the Maldives between the years 1967- 2010



Reference Year is referred to the mid point of each time period. Example: the year 1967 corresponds to the mid point of 1966 to 1975

Figure 4. TFR of the Maldives between the years 1967-2010. Adapted from World Fertility Data 2012 by United Nations, Department of Economic and Social Affairs, Population Division, 2013, Retrieved from <http://www.un.org/> Copyright (2013) by United Nations.

In addition to this, based on the Figure 5 below, it is evident that there are significant differences in the fertility rates when the Maldivian women living in the urban residents of the Maldives were compared with their rural counterparts. Both the TFR and most of the Age Specific Fertility Rates (ASFRs) tend to be higher for the Maldivian women residing in the rural areas (Figure 5). Similarly, the highest peak for the ASFR was observed at a younger age group (20-24 years) for the rural areas when

compared to the urban areas (25-29 years) (Figure 5). Apart from this, sub group analysis of the survey respondents were compared in terms of their location (urban, rural), education level and wealth in the 2009 Maldives Demographic and Health Survey. The results showed that the median age at which women living in rural areas started childbearing were 2.5 years earlier than women living in urban areas (Ministry of Health and Family & ICF Macro, 2010).

Figure 5- A Comparison of the Fertility Trends of Maldivians Residing in Urban and Rural Areas - 2009 DHS survey results

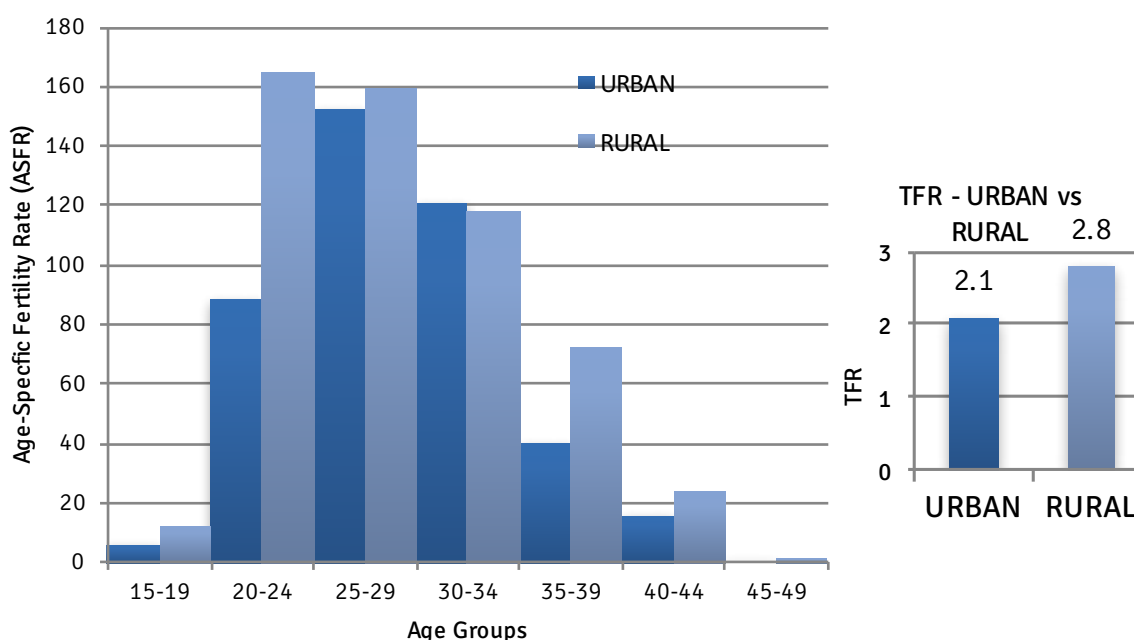


Figure 5. A comparison of the fertility trends of Maldivians residing in urban and rural areas-2009 DHS survey results. Adapted from Maldives Demographic and Health Survey, by Ministry of Health and Family and ICF Macro, 2010, USA: ICF Macro. Copyright (2010) by ICF Macro & Ministry of Health and Family.

Furthermore, the median age of first birth for women with no education were 5.8 years lower than women with some secondary education and women in the poorest households tends to give birth to their first child 2.4 years earlier than women living in the wealthiest household (Ministry of Health and Family & ICF Macro, 2010). Hence, this showed that women living in rural areas, women with lower education levels and women representing to poorer households tend to give birth earlier than their respective counterparts. There was no attempt made in the 2009 Maldives Demographic and Health Survey to delineate the reasons why women representing rural areas, poorer household and lower education levels tend to start childbearing earlier than their respective counterparts. However, it is likely that these women tend to settle down and hence start childbearing at a young age due to missed opportunities for education, contraceptives, and career development. This is supported by United Nations Development Programme [UNDP] (2014)'s statement that "the practice of early marriage tends to continue when the social and economic options of young women are limited" (p.64). Hence, this can be an area which needs to be further analysed in the future.

Moving on to the discussion about the utilisation of contraceptives in Maldives, upon analysis of the Knowledge, Attitude and Practice (KAP) gaps, 7 in 10 Maldives Demographic and Health

survey respondents knew at least one method of contraception (Ministry of Health and Family & ICF Macro, 2010). This segregates to more than 90 percent of these survey respondents being aware of male condoms, OCPs, female sterilization and injectables and 80 percent being aware of IUDs and male sterilization and 71 percent having heard about implants (Ministry of Health and Family & ICF Macro, 2010). The least known method among the survey respondents (29 per cent) was emergency contraceptive pills. A reason for this could be that emergency contraceptive pills was only introduced in 2007 (Ministry of Health and Family & ICF Macro, 2010), indicating that more time was needed for information relating to these pills to be disseminated within the Maldivians.

Maldives' total fertility rate increased to 2.46 in 2014, from 2.20 in 2006 (National Bureau of Statistics, 2016)

Table 3. Current Contraceptive Use Among Current Married Women Aged 15-49 Years

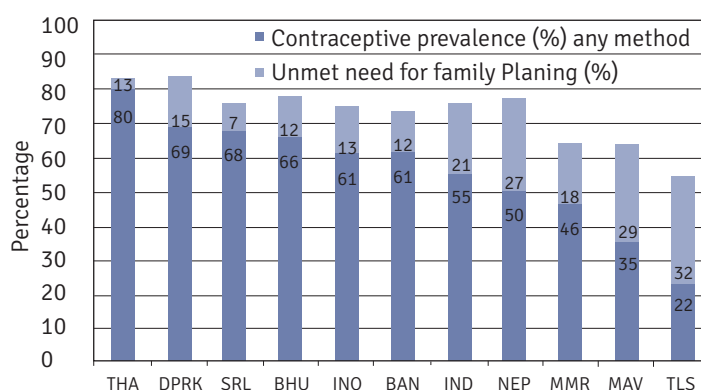
Types of method used	Percentage
Any method	34.7
MODERN METHOD	
Any modern method	27.0
Female sterilization	10.1
Male sterilization	0.5
Pill	4.6
IUD	0.8
Injectables	1.2
Implants	0.5
Male condom	9.3
TRADITIONAL METHOD	
Any traditional method	7.8
Rhythm	3.4
Withdrawal	4.2
Folk method	0.1
Not currently using	65.3

Note: Adapted from “Maldives Demographic and Health Survey 2009” By Ministry of Health and Family & ICF Macro, 2010, Copyright 2015 by Ministry of Health and Family and ICF Macro.

The Table 3 above summarizes current contraceptive prevalence rate among married women aged 15-49 years. According to this table, current contraceptive prevalence rate in Maldives

for any method is 34.7 percent and for any modern method is 27.0 percent. Maldives have the second lowest contraceptive prevalence rate across South-East Asia region (Figure 6)

Figure 6. Contraceptive prevalence and unmet need for family planning in SEAR countries, 2011/12.



Source:
1. UN, Population Division, World contraceptive Use 2012
2. WHO/ Searo, MDG broucher and analytical Kit 2012

Note:
Reference year of data for contraceptive prevalence: 2011/12(BAN), 2011(NEP), 2010(BHU), 2009(MMR, TLS), 2009 (MAV,THA), 2007/09 (IND), 2008/07(SRL), 2002(DPRK)

Reference year of data for Unmet need for family planning:
2011/12(BAN), 2011(NEP), 2010(BHU, DPRK), 2009/10(TLS), 2009 (MAV), 2007/08(IND), 2007(INO, MMR), 2008/07(SLR), 2006(THA)

Figure 6. Contraceptive prevalence and unmet need for family planning in SEAR countries, 2011/12. Reprinted from Health situation and trend assessment-proportion of demand for family planning satisfied (met need for contraception) by World Health Organization Regional Office for South-East Asia, 2015, Retrieved from <http://www.searo.who.int/>. Copyright (2015) by World Health Organization Regional Office for South-East Asia.

Furthermore, in accordance with Table 3, the most common types of contraceptive methods utilized in Maldives are female sterilization (10.1 percent) and male condoms (9.3 percent) while male sterilization and implants being the least common methods of modern contraceptives used among currently married women.

Apart from this, Maldives also have the second highest unmet need for contraception within South-East Asia Region (Figure 6). According to the findings of Maldives Demographic and Health Survey 2009, the total unmet need for contraception among currently married women in Maldives is 28.1 percent, out of which, 15 percent of women were in need of contraception or family planning because they wanted to space the next birth and the remaining 13.1 percent of women were in need of contraception because they wanted to limit the number of births (Ministry of Health and Family & ICF Macro, 2010). The findings of this survey also showed that the level of unmet need tends to decrease with increasing age while women residing in rural areas of the country tends to show a slightly higher unmet need for contraceptives when compared to their urban dwelling counterparts (Ministry of Health and Family & ICF Macro, 2010).

It is important to note that the data for these measures were only collected from married women and no information has been collected from women with unmet need regarding the attitudes and views of their spouses related to their use of contraceptives. However, upon closer analysis of reason for not using contraceptives and reasons for discontinuation of contraceptive use, a small proportion of women who discontinued any method of contraceptives (1.6 percent) and 5.5 percent of women who do not intend to use contraceptives in the future had quoted that their spouse's disapproval as their reason for discontinuing and not intending to use contraceptives, respectively (Ministry of Health and Family & ICF Macro, 2010). Additionally, accessibility and availability did not seem to play a significant role in the women's decision to discontinuing any method of contraceptive use (0.2 percent) and not intending to use contraceptives in the future (0.1 percent) (Ministry of Health and Family & ICF Macro, 2010).

While these findings of the Maldives Demographic and Health Survey 2009 indicated that the reasons for discontinuation or reasons for not using contraceptives has little to do with their husband/partner's disapproval and access to contraceptives (Ministry of Health and Family & ICF Macro,

2010), the findings of a qualitative study conducted by United Nations Population Fund in Maldives [UNFPA Maldives] (2011) indicated that male's disapproval to use condom as it interferes with 'sexual pleasure' was one of the main reasons for engaging in risky sexual behaviours by some of the participants of this study. This also highlights the importance of engaging men in alleviating risky sexual behaviours among these age groups.

This study also found that there were barriers to effective utilization of contraceptive services by unmarried women due to reasons such as fear of getting penalized and also not being aware that such services can be accessed by unmarried people. It also showed that some of the unmarried women who accessed such services were subjected to some level of discrimination from the service providers (UNFPA Maldives, 2011).

Moving back to the findings of the Maldives Demographic and Health Survey 2009, a further 10.4 percent of women discontinued contraceptive use due to side effects mainly during the use of injectables (41.6 percent) and pills (18.8 percent) while another 6.8 percent of women discontinued the use of contraceptives due to health concerns (Ministry of Health and Family & ICF Macro, 2010). Health concerns (12.0 percent) and "fear of side effects" (5.5 percent) were also significant factors affecting women's decision for not intending to use contraceptives in the future (Ministry of Health and Family & ICF Macro, 2010).

On the contrary, 13.8 percent of women had to discontinue contraceptive use due to method failure mostly during the use of traditional methods of contraceptives such as withdrawal (30.7 percent) and periodic abstinence (21.5 percent) (Ministry of Health and Family & ICF Macro, 2010). Furthermore, a large proportion of Maldives Demographic and Health Survey 2009 respondents who are not using contraceptives across all age groups, all education levels, all regions (including urban and rural areas) and all wealth quintiles had claimed that they had not discussed family planning with an outreach worker or at a health facility within the past one year (range= 79.8 percent to 87.5 percent) (Ministry of Health and Family & ICF Macro, 2010). This could have implications on women's decision and need to use contraceptives. Contact with family planning and outreach workers can also assist in identifying adequate contraceptive methods and also learn how to use them appropriately, thus, decreasing the number of unintended pregnancies (The ACQUIRE project, 2008).

However, it is unclear whether these factors (i.e. disapproval by husband/partner, accessibility/availability issues, health concerns, side effects/fear of side effects, method failure and disengagement in discussions with relevant professionals regarding contraceptive use) are directly contributing to the unmet need for contraceptive use among married women. Maldives Demographic and Health Survey 2009 had also not explicitly explored this association. Nevertheless, generation of such information can assist in underpinning the underlying reasons for the poor uptake of contraceptive use within the Maldivian married women. Similarly, as the findings of the UNFPA Maldives (2011) study suggested that male partner's disapproval and availability and accessibility issues could have an impact on the unmet need for contraceptive use especially among unmarried sexually active men and women, it is vital to obtain information regarding reasons for unmet need for contraceptive use from unmarried women, men, the youth and other high-risk population groups which had not been covered during the 2009 Maldives Demographic and Health Survey as well.

Maternal health

This section will explore key indicators relating to maternal health including Maternal Mortality Ratios (MMR), availability of emergency obstetric care and comprehensive emergency obstetric care, antenatal care coverage, proportion of birth attended by skilled birth attendants and coverage of post-partum / postnatal care within 48 hours of delivery by a skilled health provider. These indicators have also been identified by Ravindran (2013) as key strategic indicators for assessing the level of access to sexual and reproductive health within a community.

There has been a considerable reduction observed for the MMRs over the past decades (i.e. between the years 1990 to 2012). For instance, the MMR had declined from 500 per 100,000 live births in the year 1990 (Ministry of Health, 2013) to 13 per 100,000 live births in the year 2012 (Figure 7; Ministry of Health, 2013). Furthermore, a reason for the fluctuations in MMR observed in Figure 7 below can be because the MMR figures can increase significantly even with a single maternal death due to the small population of the country (Department of National Planning, 2010). Nevertheless, even with these fluctuations, Maldives has already achieved the Millennium Development Goal [MDG] 5, Target 5A: "reduce by three-quarters, between 1990 and 2015, the Maternal Mortality Ratio" (Department of National Planning, 2010). Maldives is also listed among the 19 countries which had achieved MDG5 by 2013 with a 93 percent decline in MMR (World Health Organization [WHO] 2014).

Figure 7: MMRs of the Maldives: 2001- 2012

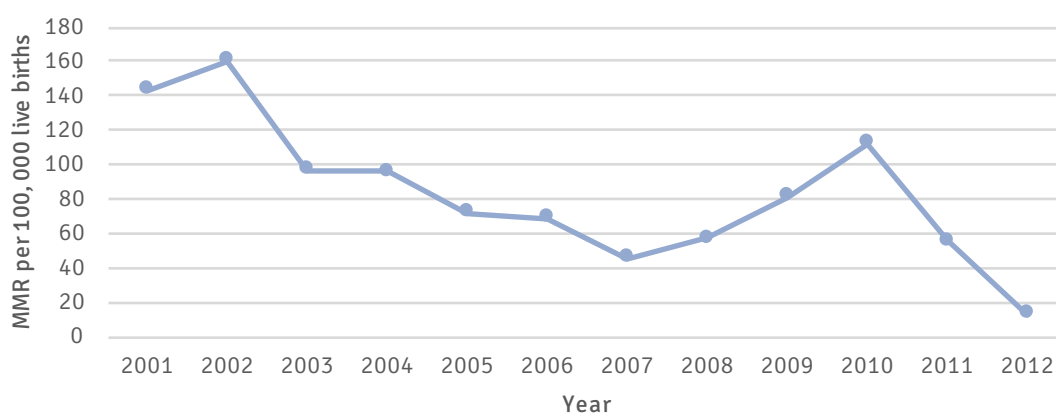


Figure 7. MMRs of the Maldives: 2001-2012. Adapted from Maldives Health Statistics 2013, by Ministry of Health 2014a, Retrieved from <http://www.health.gov.mv/>. Copyright (2014) by Ministry of Health.

Department of National Planning (2010) highlights the availability of obstetric care services at all atoll levels leading to increased access to skilled attendants such as doctors and nurses during delivery as one of the main contributing factors for Maldives in successfully achieving MDG5. Efforts have also been made by the government to strengthen the provision of emergency obstetric care services at all atoll levels during the past years (Ministry of Health and Gender, 2014).

However, the unique geography and the widely dispersed population of the Maldives continues to impose logistical challenges such as lack of proper transportation services which can accommodate for high risk pregnant women during their referral and transfer from an island which does not have adequate emergency obstetric care service to the island which has the atoll level emergency obstetric care facility (Department of National Planning, 2012). This is a concern since 19 percent of maternal deaths had occurred during transit to better health care facilities (“Maternal Mortality Synthesis Report”, 2008, as cited in Department of National Planning, 2012). Hence, there is a need to lobby for better transportation routes for easier access to services by people living in islands without emergency obstetric care services. An easier transportation route is also likely to strengthen the linkages between family planning services and other reproductive health services within the Maldives.

The “Maternal Mortality Synthesis Report” (2008, as cited in Department of National Planning, 2012) had also emphasized that 64% of the maternal deaths had occurred due to direct causes such as post-partum haemorrhage and 20% of these deaths were due to anaemia (Department of National Planning, 2012). Hence, it is essential to advocate for implementing programmes aimed at preventing maternal deaths from anaemia and post-partum haemorrhage especially since the poor nutritional status of women in Maldives has been documented as a probable contributing factor for the prevalence of anaemia among pregnant Maldivian women (Department of National Planning, 2010).

In addition to this, the need for sustaining educational programmes on good nutrition during early childhood and pregnancy were also identified from the focus group discussions held during the “2012 Maldives operational review of the progress towards achieving the ICPD goals” (Department of National Planning, 2012). These discussions also highlighted the importance of establishing maternity homes in the atolls and developing one island in the atoll as a maternity hub in order to provide better quality services closer to the population as a means of reducing the number of preventable deaths among these population groups

(Department of National Planning, 2012). Upon recognition of this need, the Ministry of Health is currently undertaking a project with the assistance from international donors to set up “Maternity Waiting Homes” where pregnant women who are residing in an island with limited obstetric care can travel and wait in an island which has sufficient obstetric care. Hence, it is recommended to monitor the effectiveness of this project in preventing or reducing the number of maternal deaths that especially occur during transfers to emergency obstetric care facilities and to duplicate such initiatives across the country.

Apart from this, although, WHO guidelines are adapted to Maldives and all standard international guidelines are being followed, there is still a need to strengthen the implementation of these guidelines within Maldives (Department of National Planning, 2012).

Furthermore, Maldives have a high Antenatal Care [ANC] coverage as supported by the findings of the Maldives Demographic and Health Survey 2009. The findings of this survey showed that 90 percent of women had made their first ANC with as recommended during their 1st trimester of pregnancy (Ministry of Health and Family & ICF Macro, 2010). Furthermore, 85 percent of the women had made 4 or more ANC visits during their pregnancy and only a small proportion of women (1%) had not made any ANC visits during their pregnancy (Ministry of Health and Family & ICF Macro, 2010). Among these women who had made ANC visits, 99 percent of these women received ANC services from a skilled provider such as gynaecologist, other doctors, nurse, midwife, or community/family health care worker at least once during their ANC visits (Ministry of Health and Family & ICF Macro, 2010).

In addition to this, the findings of the Maldives Demographic and Health Survey 2009 also showed that 95 percent of births that had occurred 5 years prior to the survey had been assisted by skilled attendants such as gynaecologist, other doctors, nurse, midwife or community/family health worker (Ministry of Health and Family & ICF Macro, 2010). Place of residence, mother’s education level and level of mother’s wealth seemed to have an impact on the use of skilled birth attendants during delivery. For instance, a higher percentage of urban women had received skilled attendance during birth (99 percent) when compared to their rural counterparts (93 percent) (Ministry of Health and Family & ICF Macro, 2010). Women with some level of education also shows a higher proportion of deliveries attended by a skilled attendant (92 to 99 percent) when compared to women with no formal education (85 percent) (Ministry of Health

and Family & ICF Macro, 2010). The percentage of births attended by a gynaecologist also increases with mother's level of education and wealth status (Ministry of Health and Family & ICF Macro, 2010). Hence, this may indicate a need for targeted interventions for rural women, women with little or no education and women with lower wealth status in order to close the gap in utilisation of skilled birth attendants during delivery when compared to their respective counterparts.

In relation to the use of Postnatal Care (PNC), the findings of the Maldives Demographic and Health Survey 2009 showed that 67 percent of women received PNC with 48 hours of delivery (Ministry of Health and Family & ICF Macro, 2010). This could have an implication on the health of the mother and the child as most neonatal and maternal deaths are likely to occur during the first 2 days of delivery (Ministry of Health & ICF Macro, 2010). 24 percent of the respondents were also not aware about the appropriate timing of PNC. Age of Mother, level of education and wealth status of mother also influenced the PNC seeking behaviour as PNC visits tends to increase with

decreasing age and increasing education level and wealth status (Ministry of Health and Family & ICF Macro, 2010). Hence, in order to further improve the health of the mothers and children (especially neonates), it is important to target women with lower education, lower wealth status and older pregnant mothers in order to increase their utilisation of PNC services.

Perinatal Mortality Rate (PMR)

In accordance with the Figure 8 below, the total perinatal mortality rate had halved from 28 perinatal deaths per 1000 live births in the year 2001 to 13 perinatal deaths per 1000 live births in the year 2012. The data in the Figure 8 also indicates that up to the year 2007, the perinatal mortality rates were recorded at a higher rate among atolls when compared to Male'. This might be due to reasons such as diversity of the level of health care available in different islands.

Figure 8: Maldives Perinatal Death Rate: 2001-2012

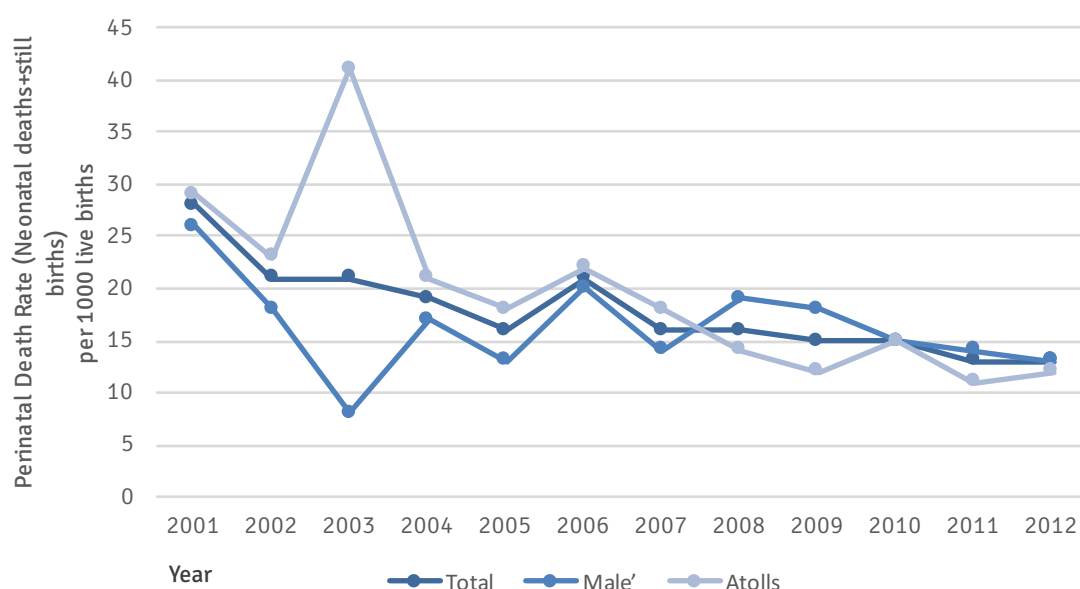


Figure 8. Maldives Perinatal Death Rate 2001-2012. Adapted from Maldives Health Statistics 2012, by Ministry of Health 2013, Retrieved from <http://www.health.gov.mv/>. Copyright (2013) by Ministry of Health & Maldives Health Statistics 2013, by Ministry of Health 2014a. Retrieved from <http://www.health.gov.mv/>. Copyright (2014) by Ministry of Health.

However, since 2008 the perinatal mortality rates recorded at atolls had been slightly lower or almost equal to the perinatal mortality rates observed in the capital city of Maldives (Figure 8). Perinatal mortality rate is regarded as a vital indicator to measure the state of delivery services available in a particular community, including both the quality

and effectiveness of these services and the uptake of these services within a community (Ministry of Health and Family & ICF Macro, 2010). It is also an important indicator to measure the overall quality of obstetric and paediatric care available in a community (WHO, 2006). Hence, it could be argued that the closing of the gap between

the perinatal mortality rates of the atolls when compared to Male' could indicate that the level of utilization of appropriate delivery services had increased within atolls and/or the quality of delivery services as well as other relevant obstetric care and paediatric care services available within these atolls had also improved during the past decade.

Furthermore, the Maldives Demographic and Health Survey 2009 indicated that the highest perinatal mortality figures were observed among births to the female survey respondents who had given birth before the age of 20 years (47 deaths per 1000 live births), while it was lowest among births to the female survey respondents aged 20 to 29 years (14 deaths per 1000 live births) (Ministry of Health and Family & ICF Macro, 2010). Apart from this, first pregnancies had the highest rates of perinatal mortality (21 deaths per 1000 live births) when compared to subsequent pregnancies and perinatal mortality rates were higher for births to urban women (22 per 1000 live births) when compared to births to rural women (17 deaths per 1000 live births). However, there was no clear pattern in the relationship between perinatal mortality and education and/or household wealth observed from the 2009 Maldives Demographic and Health Survey (Ministry of Health and Family & ICF Macro, 2010). Nevertheless, targeted interventions could be developed and implemented for first time pregnant women and pregnant women who are giving birth before the age of 20 in order to

further decrease the perinatal mortality rates across the country.

It is also important to note that there are some discrepancy on the definition of perinatal mortality used in the series of Maldives Health Statistics publications when compared with the definition used by Maldives Demographic and Health Survey 2009 and the definition utilized in the World Health Organization's report of Country, Regional and Global Estimates of Neonatal and Perinatal Mortality. The Maldives Health Statistics publications defines perinatal mortality as the total number of neonatal deaths and stillbirths per 1000 live births (Ministry of Health, 2014a), while Maldives Demographic and Health Survey 2009 defines perinatal mortality as the sum of early neonatal deaths and still births per 1000 pregnancies of 7 plus month of duration (Ministry of Health and Family & ICF Macro, 2010). On the other hand, World Health Organization (2006) defines perinatal mortality as the sum of early neonatal deaths and still births per 1000 births (inclusive of live births and stillbirths). Hence, it is important to minimize such discrepancies in order to make data comparison with other countries and other reports/surveys more feasible. Minimizing such discrepancies will also assist in enhancing the reliability and validity of using these measures as an effective indicator to assess the accessibility and quality of obstetric (including delivery) care and paediatric care services available within a community.

Infant Mortality Rate

Figure 9: IMR of Maldives: 2002-2012

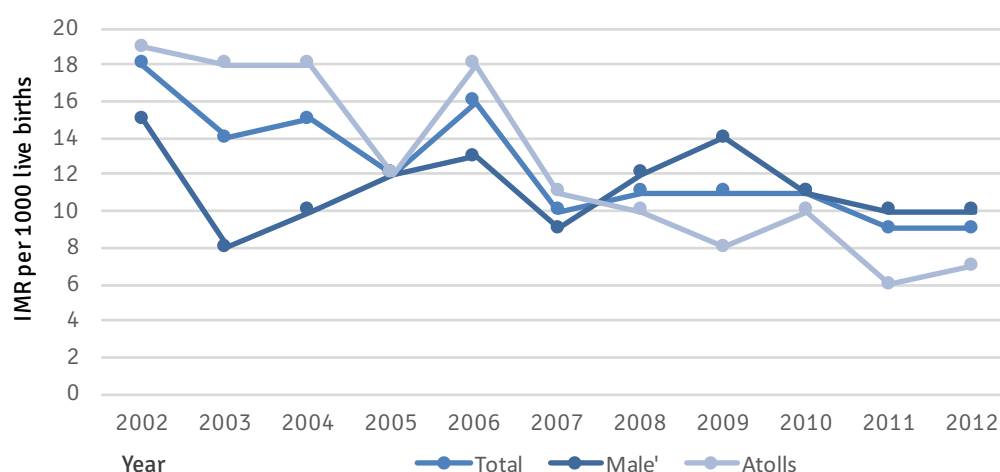


Figure 9. IMR of Maldives. Adapted from Maldives Health Statistics 2013, by Ministry of Health 2014a, Retrieved from <http://www.health.gov.mv/>. Copyright (2014) by Ministry of Health.

The Figure 9 above gives weight to the argument that over the past decade, Maldives had shown significant progress in decreasing the Infant Mortality Rate (IMR). For instance, the IMR value of 9 deaths per 1000 live births observed in the year 2012 was half the value of IMR recorded a decade ago (Figure 9). There is also not much difference observed for IMRs between Male' and Atolls over the past 6 years and in most of these years Atolls performed slightly better than Male' in terms of achieving lower IMRs (Figure 9). Furthermore, Maldives had already achieved the MDG target of reducing the under 5 Mortality Rate (which included IMRs and Child Mortality Rates) to 16 per 1000 live births by the end of 2015 (Ministry of Health and Gender, 2014). This had also made Maldives the second best country in South Asia in terms of achieving significant improvements on child mortality rates (Department of National Planning, 2010).

Although neonatal death rate had declined over the past decade from 11 deaths per 1000 live births in the year 2002 to 5.92 deaths per 1000 live births in the year 2012 (Ministry of Health, 2014a), about 2 in 3 infant deaths are still attributable to neonatal deaths (Ministry of Health and Gender, 2014). Hence, the key challenges for further reductions in IMR lie with identifying ways to reduce neonatal death rate (Ministry of Health and Gender, 2014). As majority of these neonatal deaths (75%) had occurred during the first week of birth, there is a need for better neonatal intensive care or resuscitation methods to be established within Male' and other atolls as a vital measure to prevent neonatal deaths that are caused due to premature births and babies born with congenital anomalies (Ministry of Health and Gender, 2014). Furthermore, Department of National Planning (2010) had identified that malnutrition is still a significant issue within Maldives. Hence, there is also a need to improve the nutritional status of infants and children in order to reduce infant and child mortality rates of the country.

As 75% of neonatal deaths occurred during the first week of birth, there is a need to strengthen neonatal intensive care or resuscitation methods across the Maldives including in Male' and Atolls (Ministry of Health and Gender, 2014).

Adolescent and young people's sexual and reproductive health

The period of adolescence is defined by World Health Organization as the passage of human growth and development that happens in between childhood and adulthood (i.e. from the ages 10 to 19 years) (World Health Organization, 2015b). On the other hand, young people and youth are used interchangeably by United Nations Secretariat to define 15-24 year olds (United Nations Department of Economic and Social Affairs [UNDESA], 2013). However, some UN entities such as WHO and UNFPA had often utilized the term "young people" to refer to the age-group that comprises both adolescents and youths (i.e. from ages 10 to 24 years) (UNDESA, 2013). This age-group attributes to an important population group within Maldives since it is estimated that about 52% percent of the Maldives population falls below 25 years (National Bureau of Statistics, 2015b). Hence, this section will explore the key indicators governing the access to sexual and reproductive health services by 10-24 year olds of the Maldives. These indicators will include SRH behaviours of the adolescents and young people, adolescent birth rates and/or out-of-wedlock pregnancies and unsafe abortions due to such pregnancies, the SRH knowledge among this population group, the availability of a range of sexual and reproductive health services for the adolescent and young people within the community and barriers to effective utilization of sexual and reproductive health services by the adolescents and young people within Maldives.

There is evidence in the current literature regarding the existence of premarital sexual activity among the youth population of the Maldives. For instance, the Reproductive Health Survey conducted in 2004 had indicated that about 62 percent of youths who had engaged in sexual activity had informed that their first sexual intercourse had happened before the age of 18 years (UNFPA Maldives and CIET International, 2004). UNFPA Maldives (2011) had argued that this could be an indication that these sexual activities had happened outside of marriage since the legal marital age in Maldives is 18 years. In addition to this, premarital sexual activity was observed among 11.6 percent of 18-24 year old youths of 2009 Maldives Demographic and Health Survey respondents (Ministry of Health and Family & ICF Macro, 2010). The findings of the Biological and Behavioural Survey on HIV and AIDS conducted by United Nations Development Programme [UNDP] in 2008 had also shown that almost 50 percent of its' youth survey respondents were sexually active and out of which about 75 percent of these participants were not married.

Similarly, there is evidence in the current literature regarding unwanted pregnancies occurring outside of marriage among youth population of the Maldives. One of the most heavily cited evidence regarding such incidences is the findings from the “Statistical Analysis of the Family Protection Unit at Indira Gandhi Memorial Hospital” (2010, as cited in UNFPA Maldives, 2011). This analysis showed that 19.35 percent of the 620 documented cases from 2005 until the analysis period were pregnancies that had occurred outside of marriage and significant proportion of these cases had occurred among young women aged 18-24 years.

UNFPA Maldives (2011) had also expressed concern that adolescent and unmarried young people’s pregnancy rate and unsafe abortion rate is

also likely to be significant within Maldives. This is reiterated in the findings of the Baseline Survey conducted by Society for Health Education in 2013 which also indicated that there is evidence for pregnancies and unsafe abortion practices among adolescents and unmarried young people who had got pregnant due to cases of rape and incest. Some of these accounts that has been taken from extracts of case study findings presented in UNFPA Maldives (2011)’s report and Society for Health Education (2013)’s Baseline Survey are summarized in Box 1 below.

Box 1: Extracts of case studies about adolescent and unmarried young people’s pregnancies and unsafe abortion

Note: Names of the participants had been changed in the original sources to maintain confidentiality

Extracts	Source
<p>“...when I was in my early twenties... became pregnant. So I told him [boyfriend]...he arranged to take me to a neighbouring 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...”</p>	<p>Case Study 1: Fatima’s Story from UNFPA Maldives (2011, p. 57-58)</p>
<p>“...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.”</p>	<p>Case Study 3: Aisha’s Story from UNFPA Maldives (2011, p. 63-65)</p>

“....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 baby was 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... So I 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”....”

11 year old Fathimath was always a chubby child so no one realized she was pregnant until she went in to labour...Her uncle started sexually abusing her before she had reached her menarche... Her uncle's assaults finally stopped at one point but were soon replaced by a family friend... As she was threatened not to tell anyone she hid these incidents from her mother...Fathimath...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.... 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 enroll 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.

Aminath was 14 years old when her stepfather first started sexually abusing her... Her mother was aware of it but did not take any action to stop her stepfather...she started missing her periods and realized that she was pregnant.... She started avoiding school until she stopped going altogether....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...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... 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... awoke to the sound of people searching her home...someone... reported ... authorities that she has given birth... Aminath was taken in by the authorities and currently lives under the state care in an orphanage.

Case Study 3: Aisha's Story from UNFPA Maldives (2011, p. 63-65)

Case study 2 from Society for Health Education (2013, p.22-23).

Case study 3 from Society for Health Education (2013, p.23).

Despite evidence suggesting the existence of pre-marital sexual activity among adolescents and young people as well some level of pregnancies and unsafe abortions occurring among this population group, a large proportion (25 percent of young women and 22 percent of young men) of 2009 Maldives Demographic and Health Survey respondents had never talked to anyone regarding reproductive health and sexuality issues (Ministry of Health & ICF Macro, 2010). A lack of knowledge about fertility period and its role in determining the chances of pregnancy was also observed among these respondents. However, a significant proportion of men and women (93% and 94%) were aware of contraceptive methods. Nevertheless, as discussed previously there are some challenges faced by young unmarried women in effective utilisation of contraceptives such as male partner's disapproval and availability and accessibility issues to SRH services due to fear of being stigmatized or prosecuted (UNFPA Maldives, 2011).

On the contrary, the government of Maldives had commenced several interventions to setup youth/adolescent friendly health services within the past years (El-Saharty, Ohno, Sarker, Secci, & Nagpal, 2014). Some of these initiatives include the implementation of Youth Health Strategy, the Standards and Service package for Adolescent Friendly Health Services and life skills education program in schools (El-Saharty, et al., 2014). The National Reproductive Health Strategy 2014-2018 had also been formulated in 2014 and this also has goals and activities targeted at enhancing access to Adolescent Sexual and Reproductive Health Services within Maldives (Ministry of Health, 2014b). However, the provision of services such as psychosocial counselling, contraception, HIV/STI prevention and treatment and maternal health care for adolescents within the primary, secondary and tertiary health care structure of the Maldives is still likely to be faced with challenges due to the sensitivity of the issue arising from the cultural and religious controversies present within the Maldives. This reflects the importance of developing health promotion programs that are aimed at creating attitudinal changes and increasing the awareness of the general population in regards to adolescent and young people's SRHRs and its consequences on the adolescents and young people's Sexual Reproductive Health

3. The status of sexuality education curricula in the Maldives

There is no evidence in the current literature regarding the availability of Comprehensive Sexuality Education in the Maldives. The only health related education with some level of sexuality health information that is currently being provided in schools is related to life skill education and this was also included in the 100-day road map pledged by the current government in the year 2014 (UNFPA Maldives, 2014). The new curriculum framework developed by National Institute of Education (2015) also includes aspects of health and wellbeing. However, little emphasis was made under health and wellbeing on the provision of comprehensive sexuality education in this curriculum framework. Most of the focus of the health and wellbeing section of this curriculum framework was on areas such as nutrition, physical activity and mental wellbeing (National Institute of Education, 2015).

Given that a large proportion of adolescence and young adult years are likely to be spent in schools and evidence suggest that some of the young adults of the Maldives do engage in premarital sexual activities and do have a lack of correct knowledge regarding important measures (Ministry of Health and Family & ICF Macro, 2010; UNFPA Maldives, 2011), it is important to provide comprehensive sexuality education among these population groups.

Among the respondents to the youth questionnaire of the 2009 Demographic Health Survey, 25 percent of young women and 22 percent of young men had never talked to anyone regarding reproductive health and sexuality issues (Ministry of Health & ICF Macro, 2010).

HIV and AIDS

This section will discuss about the major indicators that could be used to evaluate the accessibility to HIV and AIDS services within Maldives. These indicators will include HIV prevalence and burden and availability of services for HIV and AIDS. These two indicators have also been identified by Ravindran (2013) as important indicators measuring a community's access to Sexual and Reproductive Health services.

Prevalence and burden

Ever since, the first case of HIV was reported in Maldives in 1991 (Health Protection Agency, Communicable Disease Division, 2013; National HIV/AIDS Council, Ministry of Health & the UN Theme Group on HIV/AIDS, 2006; UNDP, 2012), Maldives has been able to maintain a relatively low prevalence of less than 0.1 percent of HIV cases (Health Protection Agency, Communicable Disease Division, 2013). This prevalence rate has also been recognized as one of the lowest estimated HIV prevalence in South and West Asia region (UNDP, 2012).

Nevertheless, from 1991 to 2013, 19 Maldivians (16 males and 3 females) has been reported to be HIV-positive (Health Protection Agency, Communicable Disease Division, 2013). A further 332 HIV-positive cases has been identified among expatriates residing in the Maldives (Health Protection Agency, Communicable Disease Division, 2013). All of these cases were identified via case reporting and in most of these cases the patients had reported that they had acquired HIV infection via heterosexual transmission (Health Protection Agency, Communicable Disease Division, 2013).

Additionally, in 2013, there were 7 people (6 Maldivians and 1 expatriate worker) living with HIV in the Maldives (Health Protection Agency, Communicable Disease Division, 2013). 5 out of the 6 Maldivians and the only expatriate worker living in Maldives with HIV are receiving Anti-Retroviral Treatment as part of the free of charge lifelong care and Anti-Retroviral Treatment service which is provided by the Government of the Maldives to all HIV-positive patients (Health Protection Agency, Communicable Disease Division 2013).

Furthermore, in contrast to most of the countries,

Maldives has initiated its national response to HIV and AIDS even before the first case of HIV was reported in Maldives (UNDP, 2012). For instance, the Government of Maldives built the infrastructure for a National AIDS program and this program was launched in 1987 as the lead agency to monitor and coordinate the national multi-sectoral response to AIDS (UNDP, 2012). A National AIDS Council comprising of representatives from different relevant sectors were also established with the role to serve as a multi-sectoral advisory body to the National AIDS Program (UNDP, 2012).

Moreover, as of 2006, in accordance with the Maldives Strategic Plan for Prevention and Control of HIV/AIDS (2002-2006), testing facilities for HIV has been made available at all 54 blood transfusion services located outside of Male in 6 regional hospitals, 10 Atoll hospitals and 38 health centres (National HIV/AIDS Council, Ministry of Health & the UN Theme Group on HIV/AIDS, 2006). Within Male, HIV testing facilities are available from IGM Hospital, National Thalassemia Center (Now a part of Maldives Blood Services) and two private hospitals (National HIV/AIDS Council, Ministry of Health & the UN Theme Group on HIV/AIDS, 2006). Furthermore, as of 2011, 8 Voluntary Counselling and Testing (VCT) centers have been established in IGM Hospital, Villimale' Hospital and in 6 regional hospitals (National AIDS Programme, Ministry of Health and Family, 2011). Additionally, by the end of 2012, 3 VCT centers has been established within Non-Governmental Organizations known as Journey, Society for Health Education (both NGOs are located in Male') and Open Hand (located in Fuahmulak island) (UNDP, 2012). These centers do cater for the most at risk populations and vulnerable populations within Maldives (UNDP, 2012).

It is important to note that, voluntary, informed and confidential HIV testing with written consent is recommended for Maldives under National AIDS Policy (Center for Community Health and Disease Control, Ministry of Health and Family, 2009). However, findings from 2010 UNGASS Country Progress Report of Maldives had indicated that the uptake of VCT services is not popular within Maldives (National AIDS Programme, Ministry of Health and Family, & UNAIDS, 2010). This is a concern since the results of 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) had indicated that the HIV epidemic in Maldives is characterized by low overall prevalence of HIV but with high vulnerability and risk and hence, Maldives has been identified as

a country with high epidemic potential for HIV. This is supported by the findings of the following surveys and reports that had attempted to explore the risk factors that make Maldives vulnerable for HIV:

1. “Situational analysis on HIV/AIDS in the Maldives” (National HIV/AIDS Council, Ministry of Health & the UN Theme Group on HIV/AIDS, 2006):

The key risk factors identified in this report are:

- The population of Maldives consists of a significant proportion of young people who have low levels of knowledge on HIV transmission and their access to accurate and reliable information on HIV and youth friendly services are limited,
- Increasing drug use amongst young people coupled with an increasing use of injecting drugs,
- Low levels of condom use and limited access to condoms,
- Increasing prevalence of HIV among expatriate workers,
- Presence of sex workers within the country and increasing access to sex workers within the country,
- Increased inter-country travels by Maldivians to neighbouring countries with higher prevalence of HIV,
- A high number of blood transfusion due to high prevalence of transfusion dependant diseases such as Thalassaemia,
- Globalization leading to political, social and cultural changes due to increased access to other countries and views via satellite and internet which have a tendency to influence the sexual behaviour of young people.

2. “2008 Biological and Behavioural Survey (BBS) on HIV and AIDS” (The Global Fund supported programme in the Maldives, 2008):

The key findings of this survey are summarized below:

- **Risk among resort workers:** 1 out of 484 resort workers tested during this survey was positive for HIV. This was combined with a Syphilis prevalence of 1.2 percent. Syphilis is known as an ulcerative Sexually Transmitted Infection (STI) that significantly increases the risk for contracting and transmitting HIV.
- **Presence of STIs:** Apart from the syphilis prevalence among resort workers, other types of STIs were detected among the different risk groups sampled in this survey. 0.8 – 6.0 percent of Hepatitis B prevalence was found among high risk groups (resort workers: 2 %, Men who have sex with Men [MSM]: 6% in Addu and 1% in Male’, seafarers: 4%, migrant construction

workers: 2%, Injecting Drug Users [IDUs]: 0.8% in Addu).

- **Presence of Hepatitis C:** Among IDUs residing in two sites sampled for this survey (i.e. Male’ and Addu), Hepatitis C prevalence of 0.7 % and 0.8% was detected among IDUs in Male’ and Addu, respectively. The presence of Hepatitis C among IDUs indicates that sharing of needles and syringes are likely to be practiced among IDUs and this is a concern since sharing of needles is regarded as the “most efficient way” in which HIV virus can be transmitted among this population group.
- **Overlapping of risk populations and low self-perceived risk for HIV among these population groups:** Unprotected sex with multiple partners among high risk groups are common. Significant percentage of IDUs in Male (31%) and Addu (23%) share unsterile needles and syringes. Risk behaviours such as buying and selling of sex, sex with non-regular partners, pre-marital sex, group sex and injection of drugs were found among 15-17 year olds and the older youth respondents of this survey. Although risk behaviours were common, the majority of respondents from the key populations sampled believed that they will not acquire HIV indicating a low self-perceived risk for HIV among these population groups.
- **Knowledge and practice gaps including poor health seeking behaviour:** 65-80 percent of the survey respondents were aware of the ways to prevent HIV transmission. However, extremely low condom use was found among all the population groups sampled in this survey. Most of the respondents also preferred self-medication or does not take any steps regarding their symptoms of STIs indicating poor health-seeking behaviour despite the availability of health clinics at different levels of care within the Maldives.
- **Limited access to prevention programmes:** Apart from seafarers, MSM and FSW (Female Sex Workers) residing in Male’, a low percentage of respondents (< 40%) were reached by HIV prevention programs in the past one year prior to the survey. Low uptake of VCT services were also observed which could be due to the low knowledge about the availability of HIV testing places (only less than 50 percent of respondents were able to identify a place from which they could have an HIV test). Less than 40 percent of respondents were reached by condom distribution during the past one year prior to the survey. Additionally, the access to clean needles and syringes through programmes were limited to only less than 15 percent of the IDUs who responded to the survey.

Apart from the two studies discussed above, findings from other studies also give evidence to the presence of risk factors for HIV transmission within Maldives. For instance, a sub-sample of youth in the “2004 Reproductive Health Survey” showed that 14% of males and 5% of females under the age of 18 who were surveyed admitted to having been sexually active and out of which, 45% of those who were sexually active had never used condoms (UNFPA and CIET, 2004). Additionally, only 41.5 percent of women from the 7000 who were surveyed as part of the “2009 Maldives Demographic Health Survey” had “comprehensive knowledge” about HIV (Ministry of Health and Family & ICF Macro, 2010). The presence of such multi-faceted risk factors that cross-cut different high risk population groups within Maldives is a concern since even one positive HIV case among these groups could easily trigger an HIV epidemic due to the close networking present among these groups. This is supported by 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) which had emphasized that the most likely trigger for an HIV epidemic in Maldives is via IDUs as sharing of contaminated needles is one of the most efficient way in which HIV can be transmitted coupled with the significantly large number of drug users within Maldives. Furthermore, evidence of how HIV epidemics were spread in other Asian countries also highlights that injecting drug use had often triggered such epidemics in these countries and this could happen to Maldives as well (“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). Hence, there is a need to strengthen the targeted interventions for IDUs and other overlapping risk groups within Maldives. There is also a need to develop and implement programs offering a comprehensive set of services that includes outreach education, STI screening and treatment, condom distribution and distribution of clean needles and syringes in partnership with government and non-government organizations as recommended by The Global Fund supported programme in the Maldives (2008).

Availability of sexual and reproductive health services at different levels of care

a. Availability of SRH services, primary, secondary and tertiary level

At present, at least the basic SRH services are available from all level of care within the Maldives health system. Government of Maldives’ has been committed to increasing the availability to family planning services ever since a policy to implement programs in family planning in Maldives was adopted in 1986 and by 1990 these programs had reached all islands (Ministry of Health and Family & ICF Macro, 2010). Furthermore, Health Protection Agency’s National Reproductive Health Unit is responsible for catering to the needs of all family planning methods offered by health facilities and NGO’s upon request. Contraceptives such as oral contraceptive pills, injectables, and male condoms are available in all levels of government health facilities while, IUD insertion and removal are performed in all hospitals and all contraceptive methods offered by government health facilities are provided free of charge (Ministry of Health and Family & ICF Macro, 2010). Apart from this, gynaecological and maternal health care, HIV/STI prevention and treatment services are provided by the government health facilities free of charge (Ministry of Health and Family & ICF Macro, 2010). In addition to this, contraceptives, SRH and HIV related services (e.g: Voluntary Counselling and Testing) are provided free of charge at NGOs such as Society for Health Education as well (Ministry of Health and Family & ICF Macro, 2010).

Although, SRH services are readily available from all levels of care within Maldives, there is evidence from current literature that indicates that certain key population groups are facing challenges in accessing these services. For instance, as mentioned earlier in other relevant sections, there is evidence that suggest that access to these services by unmarried women, adolescents and other key population groups are hindered due to factors such as fear of being penalized for an illegal sexual offence (UNFPA Maldives, 2011), legal restriction to gynaecological check-ups by unmarried women and legal restrictions to contraceptives by unmarried women and men (Franklin, 2009). Fear of being stigmatized and having to face some level of discrimination by the health care service providers are also key barriers to accessing these services by youths and other key population groups (UNFPA Maldives, 2011). Additionally, although, some types of contraceptives such as condoms

can be purchased from private pharmacies, they are expensive without a doctor's prescription (i.e. not eligible for the government health insurance scheme) hence, this imposes accessibility issues for some of the young people, key affected population groups such as FSWs and MSMs that wish to practice safer sexual behaviours. These issues indicate that there is a need to implement strategies and programs in order to increase accessibility and uptake of the available SRH services at different levels of care by different sub or key population groups within the Maldives.

4. Recommendations

For the government:

- Improve the nutritional status of women who are in their reproductive age group by developing and implementing evidence based interventions such as promoting the use of folic acid among women who are in their reproductive age group.
- Include SRH in the educational framework or in the national curriculum in a more comprehensive manner so that the most age appropriate and accurate information can be given to a large population.
- Review guidelines, protocols and standards for pre-pregnancy health care, basic MNH services, emergency obstetric care and sick newborn care for all levels of care as suggested by National Reproductive Health Survey 2014-2018 draft (Ministry of Health, 2014).
- Find innovative and evidence based means to easy transportation routes and mechanisms for easier access to services by people living in islands with limited access to obstetric care.
- Strengthen the linkages between FP services and other RH services.
- Strengthen implementation of WHO guidelines and all standard international guidelines that are being followed in the Maldives.
- Expand reproductive health services to include pre-pregnancy counselling, information sessions on different topics, pregnancy exercise classes and birth coaching
- Strengthen neonatal intensive care or resuscitation methods as a vital measure to prevent neonatal deaths that are caused due to premature births, babies born with congenital anomalies such as congenital heart defects and neural tube defects.
- Work towards creating an enabling environment by increasing the awareness of the

general population in regards to adolescent and young people's SRHRs and its consequences on the adolescents and young people's Sexual Reproductive Health.

For NGOs and the civil society:

- Advocate for easy transportation routes for easier access to services by people living in the outer regions/ islands of the Maldives.
- Advocate to include components of Comprehensive Sexuality Education in to the life skill modules of Ministry of Education.
- Advocate for the integration of SRH and HIV in service provision as one entity
- Advocate to create an enabling environment to promote access to health service by key affected population groups and vulnerable groups.
- Develop and implement interventions targeted for the key affected populations focusing on their SRH needs.

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About SHE

Society for Health Education (SHE) is a non-governmental organization that is proactive in identifying and addressing the crucial health and social concerns of the Maldives. It was founded in 1988 by four women with the mission to enhance the quality of life of Maldivian families. Keeping in line with the society's mission, it embraces the following mandate:

- Strive to improve the quality of life of the Maldivian people.
- Harness the expertise of national professionals, on a voluntary basis for development programmes.
- Endeavour to raise awareness on health and social issues.

Today, SHE is one of the largest, most vibrant NGOs in the Maldives which addresses issues concerning Thalassaemia, Counselling and Psychosocial Support, Sexual and Reproductive Health (SRH) and Health Education.

SHE's programmes and activities encompass campaigns, events, training, research and advocacy efforts towards the empowerment of women, advancement of women's rights and building resistance against violence, discrimination and injustice. SHE brings the collective expertise, experience and engagement of its members, volunteers and staff, in partnership with government organizations, UN agencies, civil society and private sector, in order to fulfill gender and rights issues in Maldives.

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