



Sexual and Reproductive Health and Rights in Maldives

Policy Brief



Introduction and scope of the issue

Maldives has a total population of 407,660 (out of which about 15% are foreign citizens), distributed in 187 administrative islands. The youth cohort (15-29 years) comprise of 31.5 % of the population. While Male', the capital island, has a population of roughly 38 percent of the total population, about 62 percent live in the islands of the Atolls. Maldives ranks at 105 out of the 188 countries in the UNDP Human Development Index.

The 2017 State of World Population report, "Worlds Apart: Reproductive Rights and Health in an Age of Inequality" identifies several forms of inequalities. As mentioned in the report, "whether a woman is able to exercise her reproductive rights depends in part on whether she lives in a city or rural area, how much education she has and whether she is affluent or poor." The Maldives is no exception. But some of the challenges Maldives face are unique. This paper focuses on inequalities faced by the people of Maldives as described by those involved at various levels of providing sexual and reproductive health (SRH) services.

The constitution of Maldives ensures right to good standard of healthcare for the people. A few acts and their respective regulations ensure adequate standards of healthcare for the population. Under the Act on Human Rights (2006), the right to health encompasses, among

other things, the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; and the provision of essential drugs and equitable distribution of all health facilities, goods and services.

The Public Health Act (2012), the Health Services Act (2015) and the Health Professionals Act (2015) ensure good standard of healthcare for the population, protection from hazardous agents for health by prevention, and by providing appropriate care of a reasonable quality. The Gender Equality Act (2016) mandates government to provide SRH information and services to all.

The government's policy of providing free health services to all, though its "Unlimited Aasandha" scheme, ensures health services are provided free of charge to all citizens of the country. This includes services that are available in the country and those which are provided by referring the patient to Aasandha empaneled hospitals abroad.

The Health Master Plan 2016-2025 outlines promotion of safe sexual and reproductive health behaviours and practices among adolescents and young adults as one of its strategic inputs. In the National Reproductive Health Strategy 2014-2018, the government recognizes that reproductive health is a crucial component of the general health.

Sexual and reproductive health (SRH) services and the commodities used in family planning are distributed through the SRH programme for married couples. This programme is run by public hospitals and health centers and some private agencies through their collaboration with the Health Protection Agency (HPA) and UNFPA. All government hospitals and health centers provide health services including SRH services and family planning services for free. A few non-governmental organizations like Society for Health Education (SHE), Journey and Open Hand and some clinics provide various combinations of the SRH services for free either through their Aasandha empanelment or through their collaboration with HPA and UNFPA.

Except for the long term methods, the family planning commodities available in the islands' health centers are not too different from those available in the atoll hospitals. Implants and Intra-uterine devices can only be provided in the atoll hospitals as specialists are employed there. Family planning commodities are dispatched to the island health centers from the atoll hospitals, based on the requests sent to the hospital. The family planning commodities are provided free of charge to married couples including foreigners working in the islands.

The government has also established the services of a pharmacy on every island. While condoms are available in these pharmacies for sale, only those in the regional hospitals keep other family planning commodities, and their stock is also limited.

Methodology & data source

Information for this paper was collected by reviewing literature, interviewing key stakeholders from the Health Protection Agency and other partners in health, observing the available services during visits to the health

facilities. These include Indira Gandhi Memorial Hospital (IGMH) RH Centre, Dhamanaveshi and the Public Health Unit of the Villingili Hospital.

Key findings Adolescent health services

Even though adolescent health services are an important segment of SRH services, they are not provided to the respective age group in a way they would feel comfortable seeking the services. Moreover, it appears that a good segment of the society still feels reluctant to educate the youngsters on SRH. The difficulties in accessing information on SRH by the adolescent population is further enhanced by the fact that the education sessions on SRH are not conducted on a regular basis and only in a few schools.

The Youth Health Strategy and the National Standards for Adolescent and Youth Friendly Health Services outlined a comprehensive strategy to address SRH by putting together multiple agencies as service providers. However, it has not been fully implemented and there is still a gap in providing adolescent friendly health services. For example, the adolescent health screening programme that was started at Dhamanaveshi in 2014 and the adolescent health services provided at IGMH Reproductive Health Centre from 2010 to 2013 are not regularly implemented. Furthermore, adolescent health services that started at Kulhudhuffushi Regional Hospital in 2015 have been recently discontinued due to a change in hospital management. A more focused approach needs to be developed to provide adolescents with the services they need in a friendly way.

Inequality due to geographical distribution of the islands

The most notable form of inequality, as mentioned by the stakeholders, is caused by the geographical distribution of the islands. Some Maldivian islands have a very small population - more than 65 percent of the islands have less than one thousand people. It is not economically feasible for the government to provide a comprehensive list of health services to such small populations. Hence the government has standardized the services and each island provides a set of services accordingly. This means that in some islands people do not have equal access to all health services, including SRH services. Due to the lack of a good referral mechanism and the scarcity of affordable transport between the islands, some islanders face difficulties in accessing services that are not available in their own island. These issues are especially noted when the weather is rough and regular transportation is suddenly disrupted.

Inequality in health service provision

Another point highlighted is that the standard and quality of services provided in the atolls and Male' are different.

For example, the protocol for managing pregnant mothers involves, amongst other things, performing antenatal ultrasound scans to assess the health of the developing fetus, including looking for anomalies at 20 weeks of pregnancy. While ultrasound scan is done by trained sonographers and radiologists in Male', the scan is done by gynecologists in most atoll hospitals. Many of the gynecologists are not trained nor certified to do scans. But, in the absence of a trained technician or a radiologist, they have little choice but to take up the job. The alternative to this is for the patient to travel to Male' to get the scan done.

Another example is in the prescription of contraceptive implants considering that trained staff are based in Male' and Hulhumale Hospitals.

A more difficult problem lies in the fact that the doctors and staff working in the islands are not regularly monitored. This allows them to work very independently and even though they are instructed to follow the national guidelines in treating patients, some are not compliant to these instructions. Moreover, doctors and other caregivers from Male' are provided with opportunities to attend training sessions and workshops to improve their professional skills, whilst on other islands hardly any such sessions are conducted. Hence standardization of services and assurance of quality become very difficult.

Income inequality between Atolls and Male'

According to the Household Income Expenditure Survey (HIES) 2009/2010 data, the average household income for Male' was MVR 28,909 and for Atolls was MVR 11,200. Average per-capita income was estimated to be MVR 4,252 in Male' and MVR 1,940 in the Atolls. This gap seems to be widening.

The service providers noted that while they acknowledged there was inequality in income distribution between the residents of Male' and the islands, to their knowledge, this probably had little impact on the uptake of services. This could be because the SRH services and commodities are free of charge to all. Other than the surgical services and specialist services, what is available in the atoll hospital is also available on the island's health centers. Nevertheless, traveling to other islands to seek services outside one's own island incurs a cost. This is especially so if they have to travel to Male' or to travel

abroad to seek the services. Therefore, it is likely that what is not available in a person's island, like a specialist consultation to fulfil an SRH need, is rarely sought for unless the issue is urgent or affecting one's general health.

Gender Inequality

Maldives ranks 106 out of the 144 countries assessed by the World Economic Forum on its 2017 Global Gender Gap Index. While this ranking is about women not being able to have equal rights as men, the stakeholders noticed that a wider variety of SRH services was available for women than for men in Maldives. For example, the RH Centre at IGMH and also at SHE offers long and short acting contraceptives for women. They also conduct systematic health screening for women and counselling services for both men and women. For men they provide condoms for protection from STIs and for prevention of pregnancies. Vasectomy as a permanent method is also offered from these places. But they do not conduct health screening of men. This is partly because men do not attend the RH center at IGMH or SHE to seek health screening services for them. And due to lack of appropriate campaigns educating men on SRH, some men do not even know that the services are available for them. This is highlighted by the fact that some men seek advice on SRH and family planning services from the urologist.

Gender inequality can also manifest as economic disadvantage for women. For example, women headed households are poorer as compared to male headed households. This could mean that access to services is limited for women; especially for those living in the islands and who are often dependent on men for travel as well as finance.

Cultural and societal norms assign different roles to men and women, and ascribe different

positions in the hierarchical ladder in society. At times this is a difficult challenge to overcome. Conservative thinking by families has also led to gender segregation. For example, some families disallow female members of the families to seek services from male doctors.

The method of family planning may be chosen by man, but with the variety of choices available for women, often the responsibility lies on women's shoulders.

Inequality for those with Disabilities

Special programmes to address the needs of the less abled population are few and more needs to be done so as to make the services available to all. For example, none of the SRH service centers have the appropriate resources to provide family planning services to hearing and speech impaired clients seeking these services. Thus the work of translation of any communication to sign language is left to those seeking the services. The relatives that accompany these patients, who play the role of their private sign language "expert" do not always feel comfortable explaining the instructions to their clients. They feel reluctant fearing they might not give the message properly, especially the counselling advice on family planning.

Conclusion

To make the SRH services more effective, focused reproductive health services should be provided to the vulnerable and marginalized groups. These include adolescents, the less abled population, women with high risk pregnancies, and others with high risk behavior.

A total fertility rate of about 2.1 children per woman is what WHO calls a Replacement-level fertility, necessary to maintain the size of a

population. With a total population of 344,0231, a total fertility rate of 2.461, an unmet need for family planning being 28.1 per cent, and 35 percent of married women using contraceptive methods in Maldives, there is generally a need for more expanded services for family planning. Equally important is a more focused and specialized programme targeted to cover the family planning needs of the vulnerable population. This is especially because evaluation of maternal mortality and also “near-miss” cases of the past few years have indicated where the SRH programme could have intervened to change the outcome.

While some services try to capture those that belong to a few marginalized populations, others are provided for all. This leaves some from vulnerable populations without proper means of accessing the services. For example, as a service of the HIV and STI Programme, attempts are made to reach out to those with high risk behaviour. But the efforts of the programme are limited, and are mostly focused on those living in Male’.

At times inhibitions lay down by the culture and societal norms also prevent access to services. For example, though a variety of family planning methods are available with the Public Health Units of the Atoll Hospitals and island health centers, some are hesitant to seek those services. This is due to the small nature of the community, the staff responsible for providing the service is often known to the service seeker and they feel shy to seek the service.

Also pregnant teenagers and those pregnant out of wedlock do not seem to seek the services as they should. This could be due to the established societal and cultural norms which do not accept these pregnancies very well. At times such pregnancies have resorted to illegal methods to abort the fetus and ended up in greater misery.

If SRH services are made available to the marginalized populations in a client-centered manner to these populations, service seeking behaviour will be likely to change and service uptake by them should improve. The government is encouraged to look into various options to ensure universal access to quality SRH services.

Recommendations

Based on the above observations, a few policy recommendations can be made.

1. Standardize sexual and reproductive health services and assure the quality of services at all levels.

This can be ensured by strict adherence to national guidelines by service providers. Regular monitoring of SRH services provided at the health facilities will help standardization of care and quality assurance of the services.

2. Establish a good referral mechanism.

In the absence of a good transport mechanism between the islands, it becomes very difficult for the islanders to seek the services they need from outside their islands. However, a good referral mechanism can overcome this challenge.

3. Educate the community on the type of reproductive health services they could seek.

This should include educating them on the points of availability of these services.

The services available at various levels of the health facilities can be mapped and made known to the islanders. This will enable them to decide where to seek their desired services from if proper information and basic family planning counselling can be given in their own island.

4. Provide reproductive health services tailored to specific populations.

Identify the vulnerable population by information collected from the service providers and public and target SRH services to these. This would also include making custom made programmes targeted to selected populations and implementing them. For example, training of staff to communicate in sign language (especially those working at facilities from which clients with hearing and speech impairment seek

services) will help communicate with these clients.

5. Foster multisector collaboration.

Lack of appropriate collaboration and poor coordination between sectors is noted. Stakeholders engaged in providing SRH services need to be brought together on the same table and a model of providing services where the sectors collaborate and coordinate has to be developed and implemented.

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