

The background of the cover is a photograph showing the silhouettes of three people—a man, a child, and a woman—standing on a beach and looking out at the ocean during a sunset. The sky is filled with large, golden clouds, and the sun is low on the horizon, creating a bright glow over the water.

Reproductive Health Knowledge and Behaviour of Young Unmarried Women in Maldives

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Reproductive Health Knowledge and Behaviour of Young Unmarried Women in Maldives

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List of Abbreviations and Acronyms

ASRH – Adolescent Sexual and Reproductive Health
CDE – Commerce, Development and Environment (CDE) Pvt. Ltd
FGD – Focus Group Discussion
FPU – Family Protection Unit
GCE – General Certificate of Education
GFATM – Global Fund for AIDS, Tuberculosis and Malaria
GSHS – Global School Health Survey
HMP – Health Master Plan
ICPD – International Conference on Population and Development
IGMH – Indhira Gandhi Memorial Hospital
IPPF – International Planned Parenthood Federation
LSE – Life Skills Education
MDGs – Millenium Development Goals
MDHS – Maldives Demographic and Health Survey
MLR – Medico-legal record
MoE – Ministry of Education
MoHF – Ministry of Health and Family
NGO – Non Governmental Organisation
PGO – Prosecutor General’s Office
RH - Reproductive Health
RSHA - Reproductive and Sexual Health of Adolescents (study)
SAP – Strategic Action Plan
SRH – Sexual and Reproductive Health
UNFPA – United Nations Population Fund
UNICEF – United Nations Childrens Fund
WHLE – Women’s Health and Life Experiences
WHO – World Health Organisation
YHC – Youth Health Cafe’

Foreword

Worldwide, 1 in 10 babies are born to teenage girls and young women, and every year, an estimated 70,000 adolescents die during childbirth. Most of these deaths could be prevented.

In countries like Maldives, where minors form a fourth of the population, and where a third of population are in their reproductive years, addressing sexual and reproductive health is of vital importance. Through adolescent sexual and reproductive health education and increasing access to the reproductive health services the number of unintended pregnancies, unsafe abortions, and reproductive tract infections that increase the risk of maternal disability and death can be reduced.

Addressing the reproductive health is not only the cornerstone of achieving the United Nations Millennium Development Goal on reducing maternal mortality (MDG 5), but it is vital also when wanting to meet most of the other goals, such as eradicating extreme poverty (MDG 1), achieving universal education (MDG 2), promoting gender equality (MDG 3), reducing child mortality (MDG 4), combating HIV/AIDS (MDG 6), and ensuring environmental sustainability (MDG 7).

This study highlights the challenges that adolescents face in accessing reproductive health services and being able to make informed reproductive health choices, including how to avoid unintended pregnancies.

The study provides insights to inform policy and to plan interventions on adolescent sexual and reproductive health through collaborative efforts across sectors.

It is UNFPA's hope that this study will stimulate a dialogue and action on what is needed to prevent unintended pregnancies, especially among adolescents and young people in the Maldives



Ms. Lene K. Christiansen
UNFPA Country Director

INTRODUCTION

Introduction

Background and context

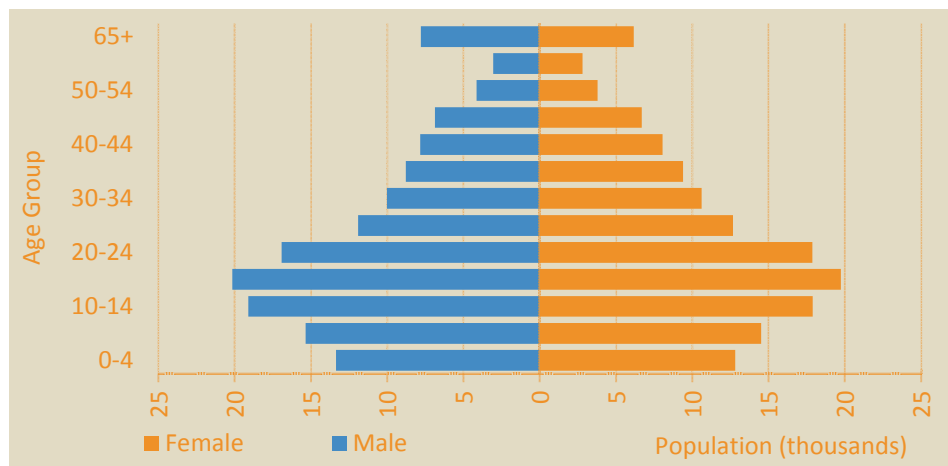
This preliminary study on sexual and reproductive health (SRH) knowledge and behaviour among young, unmarried women in the Maldives was motivated by the findings of the 2010 Statistical Analysis of the Family Protection Unit (FPU) at the Indira Gandhi Memorial Hospital (IGMH) in Malé.

FPU data showed that out of a total of 620 cases attended to by the unit during the analysis period, 121 cases were pregnancies outside marriage. Furthermore, the findings revealed that the majority of such cases were among the official youth age group of 18 – 24 years, the cohort of young people most relevant to this study. As Figure 1 shows, the adolescent and youth demographic in the Maldives is the highest and this fact adds emphasis to the need to explore the problematic SRH behavioural trend observed in the FPU statistics, among young unmarried women. According to the 2006 census, 31.9 percent of the Maldivian population was young people, constituting

51.1 percent female and 48.9 percent male.¹

The issue of pregnancy outside marriage has not been studied in the Maldives to date. This is understandable considering the social taboo attached to the subject in a society where religious and social norms inhibit the discussion of this issue. Pregnancy outside marriage is a punishable offence by law in the Muslim context of the Maldives. Efforts have been made in the past by UNFPA to impart SRH knowledge to women and families with a view to improve women’s reproductive health, well-being and their reproductive rights. However, such efforts are generally poorly received and progress is slow in this area. Examples

Figure 1: Population pyramid of Maldives, 2006



Source : Department of National Planning, 2010

of education efforts can be seen in UNFPA supported projects such as the Life Skills Education (LSE) and Youth Health Café (YHC) initiatives with relevant government

1 Data source - Department of National Planning



ministries². Nevertheless, these initiatives have been beset with operational and implementation challenges which have

² UNFPA CP4 Evaluation (2008-2010), October 2010

impeded their success.

The Research

Objectives

The research focuses on the subject of SRH knowledge and behaviour among young unmarried women in the Maldives. A key objective of the research is to explore whether the level of knowledge correlates to the prevalence of pregnancy outside marriage among young women in Maldives, a phenomena observed in the FPU statistics. A further objective of the research is to provide evidence based knowledge on this public health and youth health issue, to support the National Youth Health Strategy which is currently being developed.

The study aims to identify gaps in the provision of RH information and services for young women and consider how these can be addressed. It will also focus on the socio-cultural context of SRH information and service provision and how this affects SRH knowledge, behaviour and decision-making among young people. An important objective is to identify the causal factors which lead to negative social outcomes, such as pregnancy outside marriage.

Scope and limitations

The scope of the research is limited, being geographically confined only to Malé. Also, due to the socio-cultural sensitivity of the research subject, the sample was limited to young people who have reached the age of

majority. Therefore, despite the relevance of the adolescent age group to this enquiry, the focus of the study is limited to a sample of women above the age of eighteen.

Methodology

This study is based on a process of qualitative enquiry. Bearing in mind that no research has been conducted to date which focuses on the issue of pregnancy outside marriage among young women, this is a preliminary study. Therefore, a comprehensive literature review was conducted to gather any available relevant information. The primary data was sought through Focus Group Discussions (FGDs) and in-depth interviews with women of reproductive age above eighteen. Although adolescents are an important and relevant target audience for this study, the limited scope of the study prevented their inclusion.

To convene focus groups, a key source of support was non-governmental organisations actively working on social issues. In addition, a youth audience was sought through a faculty of the Maldives College of Higher Education. Due to the highly sensitive nature of the research subject, in-depth interviews were also sought through various professionals mostly with connections to the health and social care provision sector and related areas. Attempts were made to use snowballing to generate interview subjects through the FGDs. Nevertheless, this proved to be ineffective, SRH behavior and outcomes have social and cultural consequences and are perceived as a very private matter to individuals. Lack of patient confidentiality is a serious issue in the health service sector area in the Maldives. These realities, compounded by the close-knit and extended nature of family and community connections made sourcing

interviewees a key challenge.

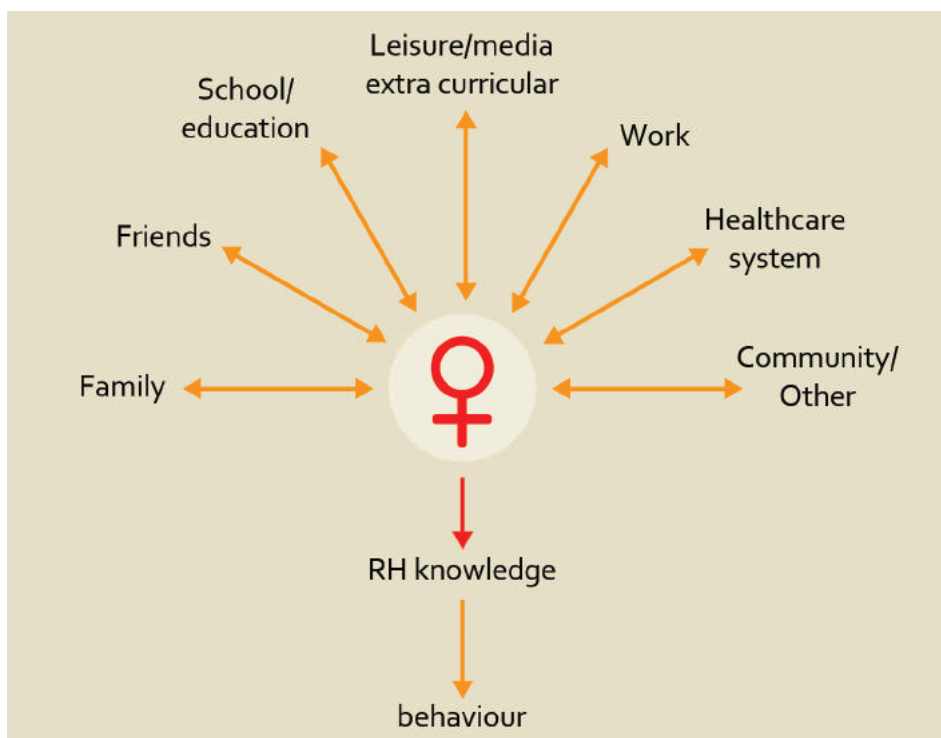
In order to obtain peripheral and related information to enhance the general understanding of the topic, several additional individual conversations and interviews were conducted to inform the study. Some quantitative data was gathered in order to inform the research. In this respect, available data was sought from both the IGMH and the MoHF which were considered relevant and important to the study. In addition, attention was given to studying a small number of case records at both the FPU and the Prosecutor General's Office.

Focus Group Discussions (FGDs)

A total of three FGDs were conducted consisting 27 participants. FGD-1 consisted of a youth group of eight participants between the ages of 18 and 22. This group included seven young women and one young man. FGD-2 consisted of a mixture of ten young and older participants ranging between 19 and 48, the majority of whom were in their twenties and thirties. FGD-3 consisted of an older group of nine participants between 44 and 62 years. While the majority of participants were from Malé, some came from the atolls and shared their experience from their islands of origin. Due to the difficulties experienced in convening FGDs within the limited time-frame, the decision was made to remove the age limitation to women over 18 years. The rationale for this was because the youth experiences, knowledge and perceptions of older persons would also help fulfill the study purpose.

Each focus group was provided a brief introductory presentation about the research and its objectives, Each group was asked

Figure 2: In-depth interview structure



six questions which were intended to guide and generate productive discussions and these were used flexibly to keep discussions generally centered on the topic of RH (see Appendix 1).

In-depth Interviews

The interview structure was designed using a subject centered approach to help generate discussion about the individual's experience of receiving RH knowledge which affected her RH decision-making and behavior. The purpose of the interview structure was to help interviewees to consider which channels and sources of RH information were available to them as they developed through adolescence. Further, it was designed to help interviewees to discuss the extent to which these sources influenced and/or guided their RH decision-making.

Two of the interview subjects did not want their conversations recorded, which

was a challenge experienced in conducting in-depth interviews. This however, was a reflection of the sensitivity of the subject being discussed. These interviews were documented immediately afterwards to ensure that the quality of information provided was not compromised

Altogether, three interviews were obtained and these

were conducted within home environments in which interviewees were comfortable. The interviews were conducted in a mix of English and Dhivehi, as was comfortable to use. Each interviewee was provided a brief introduction to the research. Interviewees agreed to participate and contribute towards the research voluntarily by signing an informed consent form (see Appendix 2). In order to guide the discussion, an interview structure was shared with subjects (see figure 2). The duration of each interview was approximately one and a half to two hours.

Validation

The study findings were shared and discussed with relevant stakeholders at a half day workshop to validate the study findings.

Ethical considerations

Due to the very sensitive nature of the enquiries being made, one of the most

important ethical considerations when conducting the study was to ensure confidentiality and anonymity of participants. In this regard, respondents at FGDs were not required to identify or introduce themselves. In all FGDs, attention was given to include only those aged above eighteen, in compliance with the agreed research ethics guidelines. Informed consent was obtained from interview subjects and all participation was voluntary.

SEXUAL AND REPRODUCTIVE

HEALTH BEHAVIOUR

AND MALDIVIAN YOUTH

Sexual and Reproductive Health Behaviour and Maldivian Youth

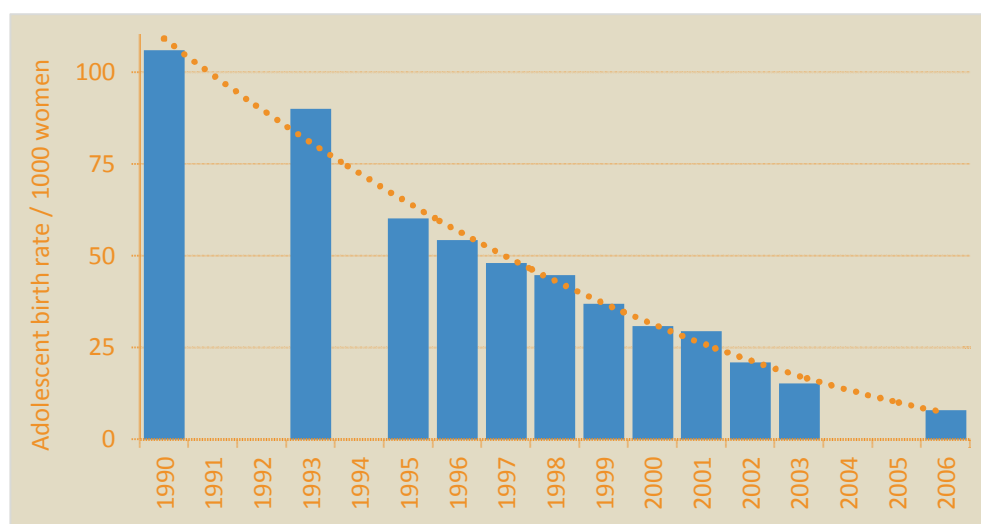
Youth fertility dynamics

As late as the mid 1990s, the average age of marriage in the Maldives was 16 years and a majority of young people became adolescent parents.³ According to 1995 national

statistics, 19 percent of the Maldivian population was among the 15-19 age group and 14 percent of this cohort were reported to have been married.⁴ Nevertheless, development has been rapid in the Maldives and increased access to secondary education as well as economic development has affected the fertility dynamics among young people quite dramatically over the years. Since 1990, the adolescent birth rate has

been declining steadily, as evident in Figure 2. Marriage among the 15-19 year age group had declined from 14 percent in 1995, to 3 percent in 2000. However, statistics for 2000 show that among females of the 15-19 year cohort, 28 percent were married as opposed to 3.6 percent among males of the same cohort.⁵

Figure 3: Adolescent Birth Rate



Source : Data source : UN Stats – Millennium Indicators 2009, <http://mdgs.un.org/unsd/mdg/Data.aspx>

statistics, 19 percent of the Maldivian population was among the 15-19 age group and 14 percent of this cohort were reported to have been married.⁴ Nevertheless, development has been rapid in the Maldives and increased access to secondary education as well as economic development has affected the fertility dynamics among young people quite dramatically over the years. Since 1990, the adolescent birth rate has

The age at first marriage among females is somewhat lower than among males and the 2003 RSHA study raised concerns about the continued prevalence of teen pregnancies, although by 2001, pregnancy among the 10-14 year age group had dropped to zero for the first time.⁶

The minimum age of marriage in the Maldives was set to 18 years by law through the passage of the Family Act in 2000, prior to which, children as young as 13 could and

3 Health Master Plan, 1996-2005 : 23

4 Ibid

5 Study on Reproductive and Sexual Health of Adolescents, 2003:18, (hereafter referred to as the 2003 RSHA study)

6 Ibid : 20 (this is the first year there was no record of pregnancy among this age group).

did get married as an accepted practice.⁷ Therefore, early marriage and sexual initiation among Maldivian adolescents, particularly among females, could be described as the social and cultural norm until relatively recently. The developments in the last fifteen years however, have had a major impact on the SRH behaviour and consequent fertility trends among young Maldivians. According to the most recently published figures of the 2009 Maldives Demographic and Health Survey (MDHS), the median age at first marriage in the Maldives is 19 years.⁸

It is reported in the Maldives National Report to the International Conference on Population and Development (ICPD) in 1994, that the concept of child spacing was first introduced to the Maldives in 1984 and “access to contraceptive facilities” had been “very limited” up until 1990.⁹ The introduction of the idea of child spacing and family planning, and the provision and availability of contraceptive commodities are closely linked to culturally accepted beliefs of pregnancy and childbearing to occur strictly within marriage. Therefore, as the 2003 RSHA study explains, “marriage determines largely the onset of access to sexual and reproductive health services” in the Maldives.¹⁰ From the government policy and institutional practice perspective, this continues to be the case today.

In the above socio-cultural and developmental context, the age of marriage has drastically increased in the Maldives while concurrently, institutionalised SRH services and commodity supplies continue to

be available solely to married couples. The underlying assumption here is that sexual intimacy does not or should not occur until marriage, which is consistent with socially held views, underpinned by long held religious beliefs. Nevertheless, there is ample evidence to show that this situation is inconsistent with the social realities of youth sexual behaviour.

Prevalence of youth sexual behavior outside marriage

The earliest available nationwide RH research in the Maldives is the RH Baseline Survey of 1999, which made tentative enquiries about adolescent sexual knowledge and behaviour. The information obtained on actual adolescent sexual behaviour by this research is anecdotal. However, focus group consultations revealed that adolescent boys and girls reported using contraceptives prior to marriage, indicating premarital sexual initiation. Additionally, it is noteworthy that a 15 year old unmarried pregnant girl was among the participants of one of the focus groups conducted for that research.¹¹

Subsequent research also indicates the prevalence of sexual behaviour among unmarried youth in the Maldives. The 2004 RH Survey reported that youth focus group participants expressed their view that “Maldivian youth is generally sexually active before marriage”.¹² Survey findings about unmarried youth revealed that “two thirds of those who had had sex said their first sexual intercourse was before the age of 18 years”,

7 Note : discretion to marry children under 18 is provided to the Registrar of Marriages in the Family Act 2000, as per Islamic shari’ah

8 2009 MDHS : 69

9 GOM National Report for the ICPD, 1994:17

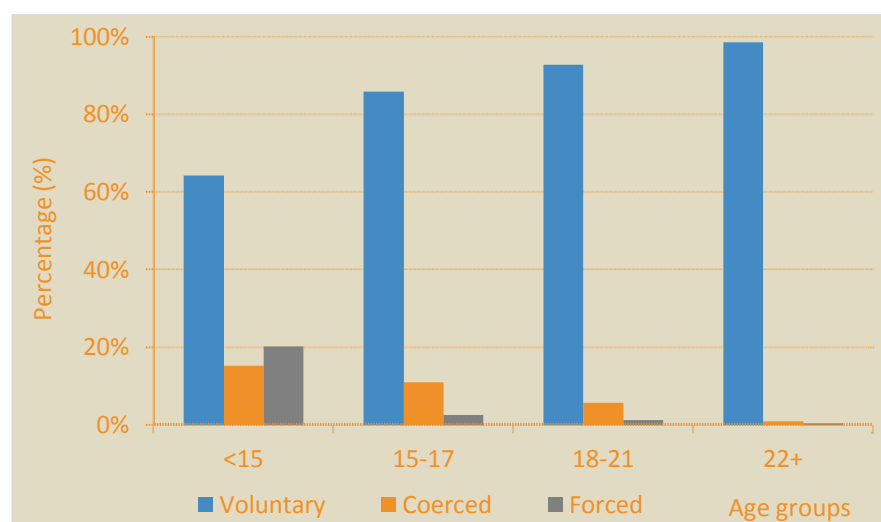
10 2003 RSHA:19

11 RH Baseline Survey, 1999:50

12 RH Survey, 2004:32

indicating premarital sexual initiation.¹³ Among consulted opinion leaders, over half of the respondents “agreed that unmarried youth were sexually active on their islands”.¹⁴ The survey also reported finding about some 26 instances of pregnancy among consulted unmarried youth.¹⁵ There was also a perception among young people that if pregnancy happens outside marriage,

Figure 4: Nature of first sexual experience



Source: The Maldives Study on Women’s Health and Life Experiences, 2007, Table 7.5, pg.57

“usually the boy takes responsibility” removing the need for an abortion.¹⁶ This suggests that while young people are sexually active prior to marriage, they also consider marriage as a potential route to avoid the consequences of out of wedlock pregnancy.

There is also indirect evidence of the prevalence of sexual behaviour outside marriage among Maldivian youth. The 2007 study on Women’s Health and Life Experiences (WHLE) sought to understand

13 Ibid : 33

14 Ibid : 34

15 Ibid (26 yes responses when unmarried youth were asked if they had ever been pregnant or fathered a child)

16 Ibid:32

the prevalence of gender based violence in the Maldives and the data provided in Figure 3 relates to a sample of 1270 respondents. The majority of 18-21 year olds (92 percent), reported their first sexual experience as “wanted” or voluntary as did 85 percent of 15-17 year olds. Although coercion and force feature strongly in these findings, especially among children below the age of 15, the

prevalence of consensual sexual behaviour among these young people is notable. The marital status of respondents in this data is not specified. However, considering that the minimum age of marriage is 18, in addition to the findings of research noted previously, it is highly unlikely that the majority of these respondents had their first sexual experience within marriage.¹⁷

The 2007 WHLE study further made enquiries to establish the prevalence of sexual abuse of girls under the age of 18, conducting interviews with 220 respondents below 18. Among these, 109 respondents constituting 50 percent of the sample “reported that they were in an intimate relationship”. The report also noted that the “majority of girls under 18 years have not yet entered into significant live-in relationships” indicating that respondents were unmarried.¹⁸ In the Maldives, marital relationships are customarily live-in relationships. These findings, albeit indirectly, provide strong evidence that unmarried adolescents and

17 WHLE, 2007:56-57

18 Ibid:54

youth initiate sexual activity at an early age in Maldivian society, regardless of socially accepted norms.

The Biological and Behavioural Survey (BBS) conducted in 2008 also provided alarming evidence of youth sexual risk behaviour involving significant numbers of young female sex workers. A key finding of the report is the prevalence of “unprotected sex with multiple partners” among the high risk groups, among which are adolescents in the 15-17 year age group and older youth.¹⁹ The 2008 study on the Socio-Cultural Factors and Unsafe Abortions in the Maldives provided qualitative research findings on the prevalence of pregnancy and unsafe abortion among unmarried youth. According to the study, “abortions were more common among unmarried youths than among married couples”.²⁰ The 2009 MDHS found that from a sample of 1198 youth respondents, 39 percent responded yes when asked if any of their unmarried friends had told them that they had initiated sexual activity. Furthermore, youth perception also shows that 90 percent agreed to the statement that it is more common now for “couples to initiate sexual intercourse before marriage”.²¹

The research findings cited above provide a substantial evidence base on the prevalence of sexual behaviour among unmarried adolescents and youth, which make up a significant and important demographic in the Maldives. Moreover, these findings also highlight the multiple issues connected to high risk, unsafe and unprotected sexual behaviours and practices, which

undoubtedly contribute to the public health burden of the country. Issues stemming from the prevalence of sexual behaviour among unmarried youth include a complex mix of health, social and legal consequences, primarily connected to the occurrence of pregnancy outside marriage.

Prevalence of pregnancy outside marriage

It is evident from the research findings discussed so far that pregnancy outside marriage occurs in the Maldives, as reported by both the RH Baseline Survey of 1999 and the follow-up RH Survey of 2004. Several other subsequent research documents help to highlight the prevalence of this issue. These behaviours occur despite existing social belief systems which consider sexual behaviour outside marriage as unacceptable and pregnancy outside marriage as socially taboo. In fact, these behaviours directly conflict with received social and religious norms and values in Maldivian society. Pregnancy outside marriage is in fact, a criminal offence with serious legal and social consequences. Nevertheless, it has to be acknowledged that sexual activity is a consistent social reality in the daily lives of Maldivian youth, regardless of such societal expectations.

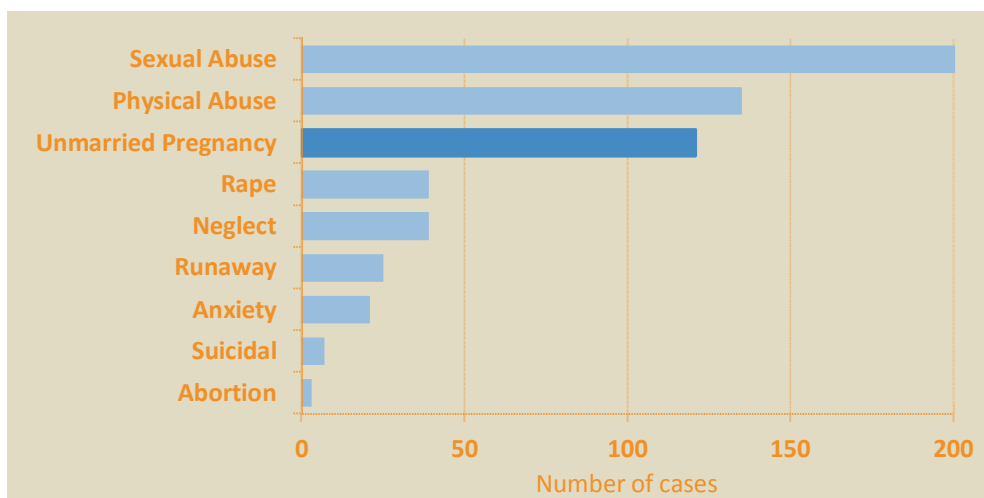
The clearest evidence available about the prevalence of pregnancy outside marriage among Maldivian youth emerged from the statistical analysis of the data generated by the FPU at IGMH as noted in chapter 1. As Figure 4 shows, pregnancy outside marriage featured as the third most common issue

19 Biological and Behavioural Survey, 2008:4

20 Socio-cultural Factors and Unsafe Abortions in Maldives, 2008 : 2

21 2009 MDHS youth questionnaire unpublished data provided by MoHF

Figure 5: Family Protection Unit cases, by type



Source: A Statistical Analysis of the FPU, IGMH, August 2010

among patients attended to by the FPU since it opened in 2005. It is important to note that 68 percent of these cases involved young women between the ages of 15-24. Additionally, FPU case records help to provide a snapshot of the circumstances which bring young people to the unit. They help to show the family and life situations which surround many cases of out of wedlock youth pregnancy (see Appendix 3).

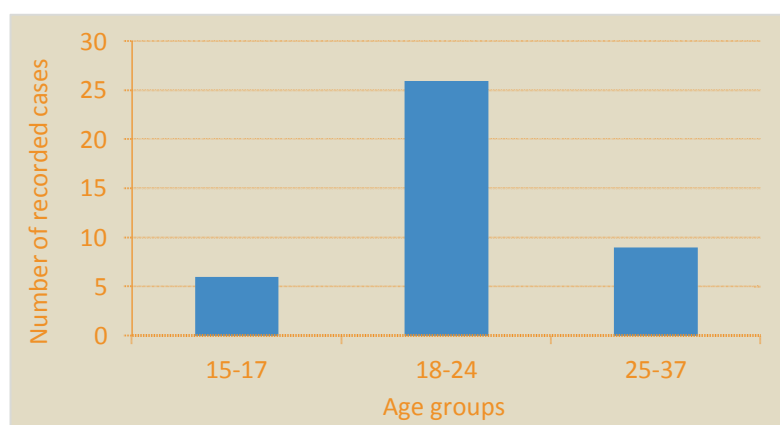
The prevalence of pregnancy outside marriage among young women is also clearly evident from medico-legal records (MLRs) at the IGMH. Although MLRs are legally valid documents, it must be noted that the quality of record taking in MLRs is often sketchy and weak. Nevertheless, these are considered a valid source of information due to the authority and importance attached to their content. As Figure 5 shows, over a period of almost one year, 41 suspected and established cases of out of wedlock pregnancies

were recorded among which, the majority of cases involved young women between the ages of 18-24 years. As some of these cases appear to relate to sexual abuse and cases of rape which result in pregnancy, the issue of sexual abuse merits much closer and thorough

investigation, which is outside the scope of this study. The issue of pregnancy due to sexual abuse of young children with disabilities is a further disturbing social reality which is raised by medical practitioners consulted for this research. This is an issue which requires particular attention and investigation by relevant state authorities.

FGDs conducted in Malé for this study

Figure 6: Medico-legal Records, cases by age group



MLR for suspected and established cases of pregnancy outside marriage: 20 Jan to 11 Dec 2010

Source: IGMH records

Box 1

Story of a young girl who wanted to abort following pregnancy outside marriage

I know about someone who wanted an abortion after getting pregnant. She got pregnant the year after finishing school.

She told me she tried very hard to induce abortion even by herself ... she was just trying different things to try to abort ... and on her boyfriend's suggestion, she put panadol in a bottle of coke and drank that as well but it didn't happen – and because nothing worked she told her mother, by which time she was two months into the pregnancy. Her mother also wanted her to abort, so they went out of the country.

When they went abroad to get the abortion, they were told that she did not have enough blood [anaemic] and that she could not have the abortion. They [abortion service provider] said that they could do it but there was no guarantee – on the one hand she could go into a coma and on the other, she could die – so they did not recommend it. So she came back home.

FGD participant (18 to 22 age group)

revealed that participants consider pregnancy outside marriage to be a serious social issue. Yet, it is also evident from the case studies conducted for this research, that pregnancy outside marriage is a common occurrence among young people. All the participants in two of the focus groups personally knew of one or more cases of pregnancy outside marriage. Two of the three interview subjects for this research reported personally knowing about multiple cases of pregnancy outside marriage among their peers. Available research

documentation and the findings of this study confirm the occurrence and prevalence of adolescent and youth pregnancy outside marriage in the Maldives. This fact can neither be disputed, nor ignored.

The domestic socio-cultural context, i.e., the social and legal implications connected to out of wedlock pregnancy creates an intricate link between pregnancy outside marriage and abortion. Consequently unsafe abortion is a key issue among young Maldivian women who become pregnant outside the bonds of marriage.

Prevalence of unsafe abortion due to pregnancy outside marriage

The only research study conducted to date on the issue of unsafe abortions in the Maldives was produced in 2008 by the International Planned Parenthood Federation (IPPF). This qualitative study found that abortion is more common among unmarried youth than it is among married couples.²² The study also reported the alarming perception among consulted persons that abortion is “a risk free procedure” which is viewed as a “safe alternative to contraception”.²³ It is clear from this report that abortion is frequently sought by young unmarried Maldivian women as a solution to out of wedlock

²² Socio-cultural Factors and Unsafe Abortions in Maldives, 2008 : 2

²³ Ibid : 3

pregnancy.

A somewhat blasé attitude towards abortion is evident from the IPPF abortion study also, which reported a respondent who described obtaining an abortion as “a weekend affair”. According to this informant, “you go on leave on Friday ... obtain [an] abortion during [the] weekend and come back - for work on Monday, so no one would come to know, such an easy task nowadays”.²⁴ Such views indicate the prevalence and carefree attitude towards this serious health matter. A very similar abortion seeking weekend trip abroad is reported by Fatima, one of the interview subjects of this research, although the actual situation is not as anxiety free as the above anecdote conveys (see Appendix 5). A medical practitioner consulted for this study also informed that some patients request for abortions at private clinics in Malé, despite its illegality. Some of the reasons for such requests include economic hardship and concern about existing personal health issues. According to the informant, the marital status of many such patients is not always clear.

It was noted by several professionals consulted that establishing the extent of the prevalence of unsafe abortion among Maldivians would be particularly difficult, if not impossible. This is because frequently, Maldivians seek abortion in neighbouring India or Sri Lanka, a point reiterated in the IPPF abortion study.²⁵ Furthermore, such abortions take place in facilities that may operate outside the legal system. Therefore, these so-called “clinics” are unlikely to either document patient statistics, or cooperate with any research effort for obvious reasons. An abortion procedure experienced in such a “clinic” abroad is vividly described by Aisha,

24 Ibid : 27-28

25 Ibid : 43

who was interviewed for this study (see Appendix 5).

There is ample anecdotal evidence to suggest that abortion is the most common option taken by young women who fall pregnant outside marriage. It is important to note that this route is taken despite the fact that abortion is illegal in the country, indicating the desperateness of such situations.²⁶ Aisha’s story is strong testimony showing the depth of such desperation. Consultations with FGD participants for this research also support the above assertion about the prevalence of abortion seeking behaviour among unmarried young women. One young participant reported having heard of the case of a student who had had three abortions by the time she had got to grade 9. Another young participant reported personally knowing about two of her friends who had had abortions to terminate out of wedlock pregnancies, assisted by one of the girls’ sister. In one of these cases, the reason for choosing abortion was because the girl was not yet 18 and was unable to get married.²⁷ Another young FGD participant noted that when she was in school, she heard there were 8 cases of student pregnancy, of which two went on to give birth and the remaining six underwent induced abortions “using their own methods.” She added that “when the total school population is 400 students, 8 is a high figure I think.” Another young participant related the story of her friend who became pregnant outside marriage and sought an abortion abroad (see Box 1).

The three case studies of this research provide insights into the prevalence of

26 Abortion is illegal in the Maldives, unless medically recommended or to save a woman’s life.

27 Minimum age of marriage in the Maldives is 18, under the Family Act 2000

abortion as a solution to out of wedlock pregnancy among young unmarried women. Among the three interviewees who contributed to this study, a total of six abortion experiences were reported. In five of the six cases, the age at which the experience occurred was from mid-teens to early twenties. Of the six abortions, two were within marriage, one of which was medically recommended and conducted in safe conditions abroad. Four of the abortion experiences were in unsafe conditions without appropriate medical expertise, care or supervision. Two of these were in illegal “clinics” abroad and the other two were injection induced abortions by non-medical personnel in medically unsupervised and therefore, unsafe conditions in Malé. One of the interviewees reported knowing about someone who provided such abortions as a business in Malé. She further reported personally knowing five peers who have all had abortions, one of whom has had three abortions. One interviewee reported assisting a school friend who induced abortion in Malé using injections. In several instances, FGD participants also related stories where young unmarried women used home remedies and/or injections in Malé, or sought induced abortions abroad.

Box 2

Abortion carried out by an unskilled service provider

“When the strip on the pregnancy test turned pink, 23-year-old Mustafa asked his girlfriend to marry him. Not because he wanted to, but because he believed it was the right thing to do. She said no.

Aminath, who was 19, replied she was too young to have a child. And so, he told her he would “fix it”.

A few days later, Mustafa learned of a man who charged Rf2,000 (US\$155) to perform an abortion. Reassured by two friends who had used him, he set up an appointment in Male’.

“The man gave her three injections and said that within one to four hours, she would start to bleed and it would be very painful and it would be like giving birth,” says Mustafa, his frail voice quivering.

“At this point I was having serious doubts about this guy. He wasn’t a doctor... he was boasting about his abortion activities and the number of girls he had done this to. He said at one point it was almost one every night. The way he said it was without a trace of compassion.”

Mustafa’s description of what followed is harrowing: Aminath was carried back and forth to the toilet, she threw up twice and was writhing in agony. Four hours later, she began to bleed. ”

Source :

Abortion in the Maldives : the untold story, M Omid, Minivan News, 07 January 2010
<http://minivannews.com/society/abortion-in-the-maldives-the-untold-story-2191>

Many young women do not have the means to access abortion services abroad. They then turn to a variety of “home remedies” which they hope will induce abortion. The IPPF abortion study provides a list of

abortion methods reported to be used in Malé. These include “home remedies” such as panadol dissolved in coke and eating raw pineapple. Aisha, who contributed to this research, used both these methods unsuccessfully to induce abortion (see Appendix 5). Such methods are also evident in the story provided in Box 1 above, related by a young FGD participant. As noted previously, the use of injections to induce abortion was a common method reported by interview subjects for this research. However, anecdotal evidence provided by a gynaecologist suggests that abortion injections are becoming less common now although patients inform of the availability of other medical treatments for pregnancy, such as Misoprostol. This medication is allegedly available in the black market for Mrf3000 to Mrf4000 and is considered a very effective medical treatment to terminate pregnancy. The findings of this research show that abortions are available in the Maldives and are commonly known about. It is known about among young women, among medical practitioners and among members of the general public as well. This is perhaps why they seek abortion services from medical clinics despite its illegal status in the country.

Anecdotal evidence from medical practitioners suggest that people who previously worked in the health sector, such as health workers and pharmacists are actively involved in facilitating and administering illegal induced abortions in Malé. Additionally, medical practitioners suspect that agents of abortion providers abroad are among specialist doctors who regularly visit private health clinics in Malé. The IPPF abortion study supports such assertions, which reports the involvement of health workers in illegal abortion service provision. Furthermore, it informs about

the existence of “brokers” who assist women seeking abortions abroad.²⁸ One of the interview subjects of this research reported using the services of a pharmacist to facilitate and administer her abortion injections (see Appendix 5). There is ample evidence to suggest the practice and prevalence of illegal abortions in unsafe conditions in Malé. Additionally, the findings of this research suggest that a significant market for this illegal service is among vulnerable young women who find themselves pregnant outside marriage, which is a desperate situation for many.

A media report published in January 2010 by Minivan News, an online newspaper, provided an exposé about the prevalence of illegal and unsafe abortions among young women in the Maldives (see Box 2 and Appendix 4). The article by Ms Omidi was the first of its kind in Maldivian media history and brought this socially taboo subject to an open public forum. As the online comments to this article suggest, the prevalence of abortion among Maldivian women can be described as a public secret.²⁹ As one commentator interestingly posted, “the Thursday afternoon flight to Colombo is nicknamed the ‘bandu dhonna flight’ or the abortion flight”. The comment further stated that “[a]bortion is common and often sponsored by a rich guy to his concubines, who usually travels to India or Sri Lanka to do it”.³⁰

Conversations with a youth psycho-social support counsellor revealed that abortion

28 Socio-cultural Factors and Unsafe Abortions in Maldives, 2008 : 27, 29

29 Abortion in the Maldives, Minivan News, 07 January 2010

<http://minivannews.com/society/abortion-in-the-maldives-the-untold-story-2191> (Accessed : Dec 2010)

30 Ibid (comment by Ahmed Azim on Sat, 9th Jan 2010, 09.45am)



- ▶ A young boy wooing a girl. It is customary for girls and boys to engage in relationships at a very young age although intimate relations are regarded taboo and non-existent.

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seeking in other countries, among young Maldivian women is a well known fact. Nevertheless, young people do not tend to present with mental health issues in connection with abortion specifically, although patients use third-party references to discuss such issues. According to the counselor, although abortion is not discussed directly, anxiety issues of friends or acquaintances are discussed which convey post-abortion guilt, anxiety or fear. As the IPPF report noted, “some women are reported to experience moral and religious regret and counseling avenues available for them were also found to be low”³¹ The shared experiences of interviewees for this research shows that young women who

undergo abortions cope with the physical and mental health impact by themselves. This is also underpinned by the secrecy surrounding abortion and the fear and shame of exposure to family and friends alike.

An additional observation reported by informants of this study is abortion related infertility. One informant reported knowing about people who had induced abortion due to pregnancy outside marriage and had become infertile as a result of the abortion. Another source also raised the same issue suggesting the perception among some people that infertility is an emerging issue related to induced abortion among young women. Although the serious physical and mental health issues related to unsafe induced abortions is a very important area

31 Socio-cultural Factors and Unsafe Abortions in Maldives, 2008:3-4

which merits exploration, it is beyond the scope of this study.

There is convincing qualitative evidence which shows the prevalence of illegal abortion practices in the Maldives among young unmarried women. Many of the findings of the IPPF unsafe abortion study and this study are consistent, confirming the prevalence of the issue. Further, the findings of this study also show that premarital sexual initiation is common among Maldivian youth. A consequence of this is the prevalence of unplanned and unwanted pregnancy outside marriage, which invariably leads desperate young women to seek abortion in unsafe conditions either abroad or in Malé. Information obtained from the variety of sources consulted for this study, including FGD participants and interview subjects, as well as medical practitioners confirm the existing research on the prevalence of this issue. The occurrence and prevalence of unsafe abortion due to pregnancy outside marriage among young women in the Maldives is therefore, indisputable.

SEXUAL AND REPRODUCTIVE

HEALTH KNOWLEDGE

AND MALDIVIAN YOUTH

Sexual and Reproductive Health Knowledge and Maldivian Youth

Sexual and reproductive health knowledge and attitude among unmarried youth

The subject of sexuality and reproduction are socio-culturally uncomfortable topics for open discussion in the Maldives. As the RH Baseline Survey of 1999 noted, “shyness or social pressure” may affect the willingness of young people to disclose such knowledge.³² However, the survey found that adolescents had some knowledge of contraceptives, had favourable views about family planning and had some knowledge about STDs. The survey found that never married respondents were “only half as likely to be aware of at least one modern method of contraception compared with respondents who have ever been married”.³³ While social discomfort was a perceived deterrent to disclosing knowledge, the observation that youth respondents were sexually active was noted by the survey report, suggesting an interesting social incongruity.

The 2004 RH Survey found that 48 percent of both males and females reported speaking to their friends about SRH matters and 46 percent reported speaking to no-one.³⁴

It is not customary in the Maldives for young people to receive SRH information at home. As an FGD participant noted, “I don’t think [SRH] information is explained in any household, especially in the islands”. Furthermore, participants observed that there was a social perception that talking about SRH matters would remove the “shyness” between parents and children. Clearly, this does not contribute to an empowering home environment for young people on SRH matters. The 2009 MDHS youth questionnaire responses confirm that among the list of sources young people ever consulted on SRH matters, friends are the most consulted and parents the least consulted.³⁵ The 2009 MDHS also reported that 25 percent of women and 22 percent of men “had not talked about reproductive health and sexuality with anyone”. Mostly, both women and men talked to their peers, with 57 percent of women speaking to female friends and 66 percent of men speaking to male friends. According to the survey, teachers are also among those consulted to a lesser extent and health service providers are the least consulted on RH matters by young people.³⁶ These realities are very clear from the information shared by interviewees for this research, none of whom had supportive home environments in SRH terms, as they grew up.

While the primary source of SRH

32 RH Baseline Survey, 1999:22

33 Ibid

34 Reproductive Health Survey, 2004 : 28

35 2009 MDHS youth questionnaire data from the MoHF (unpublished)

36 2009 MDHS : 186-187

“ More than half the respondents to the 2009 DHS youth questionnaire data did not know that a woman could get pregnant following first sexual intercourse. ”

Maldives Demographic and Health Survey, Ministry of Health and Family/WHO/UNFPA/UNICEF, ICF Macro

information for young people is reported to be friends, other sources include various media including TV, radio, printed media as well as the internet to a lesser extent. However, the quality of such information is viewed to be problematic. For instance, FGD discussions for this research showed that participants disapproved of the way some media messages handled SRH information. While they were critical about a recent HIV/AIDS prevention advert which promoted the use of condoms, they did agree that the protection message was clear. However, participants felt that the advert promoted promiscuity among youth. One participant expressed her opinion that the protection message was necessary because youth sexual behaviour is a reality that will persist, regardless of societal disapproval. Therefore, she believed it was preferable they used condoms rather than risk their health. This is an unusual and notable comment, providing a very realistic perception and acknowledging the social reality of the prevalence of sexual activity among youth.

Available findings from the 2004 RH Survey and the 2009 MDHS showed the internet to be one of the least used sources of SRH information among young people. Contrary

to this, FGD participants reported the internet to be one of the most popular such sources for young people. However, they also observed that the internet may not be the most appropriate or valid source of SRH information to young people. Overall, it is evident from existing research and consultations for this study, that the quality and reliability of available SRH information to young people is weak.

It is therefore not surprising that basic SRH information, such as knowledge about the female fertile period, is generally very low among Maldivian youth. When asked about the latter by the 1999 RH Baseline Survey, only 10 percent of youth respondents gave the correct answer and in the 2004 RH Survey, 16 percent replied correctly.³⁷ The 2009 MDHS found that over half of both male and female never-married respondents aged 15-24 did not know when the most fertile period is, in a woman's menstrual cycle. In fact, only 16 percent of women and 11 percent of men responded correctly to this question.³⁸ Among the 15-19 year male cohort, only 8 percent had correct knowledge

37 RH Baseline Survey, 1999:25, Reproductive Health Survey, 2004 : 31

38 2009 MDHS : 182-183

of a woman's fertile period. There seem to be little difference between the 1999 figure and the 2009 statistics on youth knowledge of the female fertile period. This provides an indication of the extent to which youth awareness on SRH basics has progressed over the last decade. Unpublished data from the MDHS survey also shows that the majority (58 percent) of youth respondents did not know that a woman could get pregnant following first sexual intercourse.³⁹

Available information on youth knowledge of contraceptives and their use is somewhat inconsistent. The recent 2009 MDHS reports that contraceptive knowledge is high among never-married young people, with more than 90 percent having heard of one family planning method. The report states that on average, never married young people knew of 5.5 contraceptive methods.⁴⁰ Nevertheless, unpublished data from the MDHS youth questionnaire responses show that the majority of youth are unsure which contraceptive method may be the most effective (see Appendix 6). An interview subject for this research informed that the traditional withdrawal method was used due to the unavailability of modern contraceptives to unmarried youth (see Appendix 5, Case Study 3). However, knowledge of traditional methods is considered to be low among young people, although the fourth most common youth response on the best contraceptive method in the 2009 MDHS is rhythm method (see Appendix 6). A health practitioner consulted for this research also observed that despite its high failure rate, natural or traditional methods are frequently used by women.

There appears to be a belief among some

young people that contraceptives such as condoms interfere with sexual pleasure, a view noted in the RH survey which reported that 45 percent of sexually active youth "never used a condom". The common reason for this was reported to be their dislike of condoms.⁴¹ This perception was expressed by an interview subject for this study, who noted her belief and acceptance that boys did not like condoms, justifying her practice of unprotected sex, risking pregnancy to please the male partner (see Appendix 5, Case Study 2). There is reason to believe that despite knowledge of contraceptive methods, some young people appear to not fully understand the importance of contraception for self protection when engaging in sexual behaviour. A medical practitioner consulted for this research also observed the poor level of SRH knowledge among young patients who present with SRH issues, including STDs. The same source also reported the poor attitude towards contraception by young women who seek to terminate pregnancy, who are unable to provide an answer when asked why contraception was not used.

HIV/AIDS knowledge among young people are considered very high in the Maldives, with the 2009 MDHS reporting that 96 percent of never-married youth of both sexes have heard of AIDS.⁴² However, the 2008 BBS observed that despite the 65 – 80 percent of survey respondents who were aware of HIV transmission prevention methods, "condom use is extremely low among all groups".⁴³ Furthermore, the survey reported that "among sexually active youth in Male' and Laamu, more

39 2009 MDHS youth questionnaire data from the MoHF (unpublished)

40 2009 MDHS : 183

41 RH Survey, 2004 : xiv

42 2009 MDHS : 188

43 Biological and Behavioural Survey, 2008 : 5

than 90% engage in unprotected sex.”⁴⁴ The BBS further reported the widespread belief among young people that they will not get HIV, among which, about 3 to 6 percent reportedly believed that “religion alone would protect them from HIV”.⁴⁵ The 2008 IPPF abortion study also reported the perception among study participants that contraceptive use is “cumbersome”, leading the author to stress the importance of raising awareness among unmarried youth that abortion is not a safe alternative to contraception.⁴⁶ Available research therefore suggests that there is a significant disparity between knowledge of contraceptive methods and their use among Maldivian youth, indicating a poor level of awareness and understanding of the importance of contraceptive protection. Misconceptions about contraception and their uses seem common among youth, further suggesting the poor level of knowledge and understanding about the relevance and importance of protective sexual behaviours.

The extent of SRH information and knowledge of contraception and their use among unmarried young people in the Maldives, despite the favourable nature of available official statistics, can be considered weak. It is clear that the primary source of SRH information for young people is their peers. It is also evident that there is a serious mutual social discomfort between youngsters and adults to discuss SRH matters. Consequently, the home environment is neither supportive nor conducive to the development of SRH knowledge among young adults leaving youth to depend on peers for support.

44 Ibid : 56

45 Ibid : 4

46 Socio-cultural Factors and Unsafe Abortions in Maldives, 2008 : 43

Perhaps as a result, the linkage between youth knowledge of contraceptives and their use for self protection is weak. Available research and the findings of this study indicate that superficial contraceptive knowledge per se does not lead to protective sexual practices among unmarried young people. The superficiality of the knowledge youth seem to have about contraception may perhaps underpin the many misconceptions and unhealthy attitudes towards sexual health risk behaviours, such as low contraceptive use and abortion seeking, particularly among unmarried youth.

Sexual and reproductive health information and education available to unmarried youth

It has already been established that adolescents and unmarried youth encounter significant social barriers to seeking meaningful SRH information at home. Other possible avenues of information available to young people include the school, extra-curricular Life Skills Education (LSE) conducted in and out of school, youth projects, healthcare facilities and providers as well as premarital counselling. The findings of the 2009 MDHS survey show that 92 percent of youth respondents believed that human sexuality and reproduction should be taught at school, indicating the perception among youth of the importance of the subject.⁴⁷ This section will therefore look at the availability of SRH information to young

47 2009 MDHS youth questionnaire data from the MoHF (unpublished)

relating to SRH. In the Islam syllabus revised in 2009, this information primarily focuses on topics related to hygiene and cleanliness and cleansing requirements from a religious perspective. In the grade 8 Islam syllabus, topics covered in one lesson include an explanation of what menstruation is, “how to understand menstrual blood” as well as the duration of a menstrual period (see Appendix 7). This lesson describes four types of menstrual blood, namely black, red, yellow and murky (“a colour in between black and white and dirty water”).⁵¹ The grade 8 Islam text also provides an explicit description of sexual intercourse in Dhivehi (see Appendix 7). The above outlines the extent of SRH information coverage in the Islam curriculum content in school education to young people. It has to be said that this level of information and depth of knowledge on SRH is unlikely to be of benefit to adolescents and young adults. Furthermore, in this approach to information provision, supportive and relevant information is lacking. It is questionable whether such information will be absorbed in the most meaningful and productive way by young people, to achieve positive health outcomes. The fact that existing limited SRH information was removed from the primary science text in 2003 and the content of the Islam curriculum remains is indicative of the weakness of the quality of SRH education in Maldivian schools. Furthermore, it suggests a regression of the education system, undermining the importance of scientific knowledge to the development and protection of the health of future generations.

The Cambridge (UK) biology syllabus taught from grade 8 and above, as an optional subject within the science stream, contains a

51 Grade 8 Islam textbook, 2009, EDC, MoE

more meaningful SRH knowledge base (see Appendix 8). This includes the following topics:

- Diagrammatic understanding of the male and female human reproductive system
- Menstrual cycle including fertile period
- Menstrual cycle and the role of hormones
- Birth control and contraceptive methods
- Pregnancy and diet
- Syphilis and HIV/AIDS plus prevention methods

However, secondary school biology is studied by a minority of the school population. According to information available from the Department of Public Examinations (DPE), approximately 20 percent of the entire school population in the country took the biology subject exams in 2009 and 2010 (see Appendix 9). This shows that the majority of school students receive no meaningful SRH information or education in the Maldives.

As a biology student, an interview subject for this study informed that SRH lessons in the biology class was quite an event in her school experience. She informed that students who study biology become “informal peer educators” for those who do not study the subject, as the latter seek this information from their peers who studied the subject. This is consistent with the findings presented elsewhere in this report that the primary source of SRH information for youth is their peers. There is clearly a need among students to have this type of information although within the school curriculum, it is limited to only those who study biology at secondary school. It is evident that the current school curriculum is not designed to support the SRH knowledge and information needs of young people.

The extra-curricular LSE syllabus, which was developed within a UNFPA supported programme which ran from 2003 to 2010 provides some ASRH content to students who receive LSE through their schools. Despite a long running project to incorporate LSE within the schools system, this initiative has not been particularly successful in the Maldives. LSE provision primarily remains in a few schools in Malé and is not available in the large majority of schools in the country.⁵² Furthermore, LSE provision is left to the discretion of individual schools and has no mandatory remit within the schools system. Therefore, LSE recipients make up a small minority of the student population.

According to consulted LSE instructors in some Malé schools, the ASRH content within the LSE syllabus is inadequate and untimely to support the ASRH needs of adolescents. For instance, most girls reach puberty at the age of 9 to 11. However, they receive information about menstruation through the LSE package 2 in grade 8 at the age of 13 plus, long after they experience menarche. The LSE package one provided in grade 6 and 7 touches on puberty but does not contain meaningful ASRH content. Instructors inform of the need to provide ASRH information to students much earlier, in grades 4 and 5. Currently, it is evident that the ASRH content within the LSE packages are



- ▶ Mother and son enjoying a leisurely stroll. In the Maldivian culture, parental nurturing rarely encompasses meaningful and age-appropriate SRH information to their developing child.

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52 UNFPA CP4 Evaluation (2008-2010), October 2010 : 34

inadequate to adolescent needs. Instructors are well aware that some students are sexually active and that the risk of pregnancy exists among students. They also know that pregnancy does occur among students and are familiar with the issue of pregnancy outside marriage, which leads to abortion and related health consequences.

The LSE package 4 syllabus is delivered to

Box 3

Privacy denied upon request

I went to see the doctor and the translator was someone I knew and I requested the doctor for privacy. But the doctor said that the translator was there to assist and [the doctor] could not work when the assistant leaves. So I had to ignore my embarrassment and continue with the consultation.

It is not possible to maintain privacy or confidentiality.

FGD participants views (18 to 22 age group)

out of school youth through the Youth Health Café (YHC) project under the UNFPA programme noted previously, which provides SRH information to young adults. However the YHC project has also seen limited success in educating young people on SRH matters due to a variety of issues including socio-cultural barriers to SRH information provision.⁵³ The YHC continues to operate with a small number of volunteers offering peer education and LSE training.⁵⁴ However, it does not have the resources and capacity to reach and educate significant numbers of young people on SRH matters.

53 UNFPA CP4 Evaluation (2008-2010), October 2010 : 36-37

54 Personal communication with YHC Programme Officer (June 2011)

According to informants, the Reproductive Health (RH) Centre at the IGMH ran an adolescent health clinic although it stopped providing this service long since. The IGMH website continues to carry information about this service although it is no longer available (see Appendix 10).⁵⁵ Several informants consider the RH Centre as an environment unsuited for young people to access SRH information. Nevertheless, given the serious resource limitation in the healthcare system, the utilisation of existing resources would be prudent. It is evident from discussions with senior staff at IGMH that there is a willingness to reinstate the adolescent health clinic. However, this is a management decision that has to come from the newly privatised and corporatized health care system to which this facility belongs.

The premarital awareness course conducted by the Family Court to all newly marrying couples in Malé is another medium through which young people used to receive SRH information. This course began in August 2007 and contained a session on SRH information, which is no longer available.⁵⁶ According to the Registrar of Marriages at the Family Court, the SRH component of this course ceased to be included two years ago due to lack of availability of resource personnel.⁵⁷ Such long standing and consistent capacity limitations indicate that the will to educate young people on SRH matters does not really exist within the established institutions in the Maldives.

55 IGMH website : <http://mhsc.com.mv/en/?p=44> (Accessed : May and June 2011)

56 Participation to observe the premarital awareness course for this research, 16 April 2011.

57 Personal communication – Registrar of Marriages, Family Court (May 2011)

It is possible to conclude that for youth in the Maldives, meaningful and productive ASRH and SRH information is not available in the home, the school or anywhere else so long as they remain unmarried. Even after marriage, the perception is that this information is usually sought when a woman becomes pregnant. The available information within school is less than adequate to serve the ASRH needs of young people to support them through adolescence and young adulthood. There is no out of school support system either, with the reach and capacity of the only such programme, the YHC, being limited and weak. The premarital awareness course provides no RH awareness and preparation for young people embarking on the reproductive phase of their lives. Therefore, unmarried youth are very much left to their own devices to manage their SRH information needs. FGD participants consulted for this study confirm that young people do not receive SRH information and are unable to use such information to make SRH decisions affecting themselves. As one FGD participant noted, “most of the time [young women] do not know what the best age to become pregnant is, and there is no-one to discuss such things. Most of the time, when a girl gets married, she is not prepared for pregnancy and it comes as a shock. They do not become pregnant because they want to, but because it just happens. Perhaps it’s because they have not received such information.” According to another young participant, “a young person may get RH information if there is someone studying nursing living in their home or there is a doctor, or if they have a very educated family with friends who are doctors”, suggesting that the average person does not have access to information.

Given the situation of the absence of

adequate, appropriate and necessary SRH information and education to young people, the need to understand SRH service availability to young people perhaps does not need to be considered. However, for the sake of completion, the discussion will now consider the availability of SRH services to unmarried young people in the Maldives.

Sexual and reproductive health information and services available to unmarried youth

All available information support the fact that there are no SRH information or service providers available to adolescents or unmarried young people in the Maldives, in a meaningful, productive, supportive and sustainable manner. The home environment is not supportive of SRH development needs and the school environment is equally lacking in meaningful and tangible support to adolescents and young adults on SRH matters.

As the 2003 RSHA study informed, “marriage determines largely the onset of access to sexual and reproductive health services” in the Maldives.⁵⁸ Until then, young people are left to their own devices to learn and understand SRH matters. As an interview subject for this research informed, until she went to grade 6 and met a fellow student who was both knowledgeable and experienced in sexual matters, she thought a baby came out of a woman’s bottom. Her SRH knowledge from peers improved to the

58 RSHA, 2003 : 19

extent that when she became sexually active a few years later, she observed that “[w]e knew of pregnancy prevention methods but did not have access to contraceptives. If we managed to get a condom, we would use it. As for pills, we didn’t think about it because they were not available” (see Appendix 5, Case Study 3). However, as Aisha’s story testifies, after she went through her abortion experience, she went to great lengths to obtain contraceptives, at one point using her boyfriend’s married sister’s pill prescription to obtain contraceptive pills. It is worthy of note that although she studied biology, much of her SRH knowledge and the contraceptives she obtained came from peers and friends. It is possible that today as before, young people use a variety of “unofficial” means to source contraceptives (as they do to seek abortions). This is perhaps to be expected in a society where SRH or RH support services are unavailable to young people through official, established, institutionalised and supportive education or health services.

In the Maldives, RH services are available to married couples who seek family planning services or pregnancy and maternal health care services through established health service facilities. The RH Centre at the IGMH in Malé is one of the longest established health service facilities which provide RH services. As noted earlier, although the centre ran an adolescent health clinic sometime in the past, this is no longer operational. Additionally, the RH Centre was not viewed by consulted participants of this study as a viable source of SRH support to unmarried youth. One young FGD participant observed her view that, “I don’t think most people would know that such a place exists!”.

The findings of this study show that

there is a perception among consulted individuals that healthcare providers are not an attractive source of SRH information due to lack of privacy and confidentiality. Both young and older FGD participants shared their view that in general, health practitioners cannot be trusted or confided in about personal and private matters such as sexual health issues. This is due in part because of the less than private environment in which healthcare has to be sought and on the other, due to the close knit nature of communities where people know each other personally. One young participant related an unpleasant personal experience of a doctor’s consultation on a private health matter (see Box 3). Such experiences help to explain the type of findings such as that of the 2008 BBS, which showed that despite the availability of health clinics, most survey respondents chose to either self-medicate or “do nothing about STI symptoms”.⁵⁹

The lack of availability of SRH information, education and services arguably contribute to the serious shortcomings in SRH knowledge, attitudes and behavior among unmarried young people in the Maldives and their less than healthy attitude towards their sexual health. Additionally, the lack of youth access to contraceptives, which can be described as non-existent, perhaps explains young peoples’ dismissive attitude towards contraceptive use. As discussed, contraceptives are not available to unmarried youth in the Maldives through reliable and established sources, in a meaningful and supportive manner. In fact, it is not officially recognized that young people are sexually active in the Maldives and there is ample evidence in official documents to suggest that there is no official recognition of the occurrence of unsafe abortion among unmarried young women. As the 2009

⁵⁹ Biological and Behavioural Survey, 2008 : 5

MDHS recently reported, 95 percent of women between 15-19 “are not sexually active” and the 15-19 ever married age cohort “have never given birth”.⁶⁰ The report went so far as to say that “pregnancies among teenagers in Maldives are rare”.⁶¹ These statistics appear wholly inconsistent with existing quantitative and qualitative research as well as the findings of this research.

The issue of SRH service provision to unmarried young people will be a highly controversial issue in the socio-cultural and religious context of the Maldives. It is indeed a controversial issue in less conservative societies in the world. There are no tried and tested, hard and fast rules on how to handle the difficult social issue of youth SRH. However, the current approach in the Maldives of complete denial of the issue is arguably unproductive and fails to serve the most significant and precious demographic group of the population, the country’s youth. The current situation also has a series of health, social and legal consequences which duty bearers can ill afford to ignore.

60 2009 MDHS : 70, 47

61 2009 MDHS : 51

CONSEQUENCES OF

PREGNANCY

OUTSIDE MARRIAGE

Consequences of Pregnancy Outside Marriage

Health, social and legal consequences of pregnancy outside marriage

As discussed previously, there is clear evidence to show that unmarried youth are sexually active in the Maldives and pregnancy outside marriage is also prevalent among this youth demographic. One of the serious health consequences of pregnancy outside marriage in the Maldivian context is the prevalence of unsafe abortion. According to the World Health Organization, the global prevalence of unsafe abortions is significant, with an estimated 42 million pregnancies being voluntarily induced and terminated annually. Of these, nearly half are estimated to be illegal, “often performed by unskilled providers or in unhygienic conditions, or both.”⁶² Moreover, the WHO reports that 98 percent of unsafe abortions occur in developing countries. The Maldives is not immune from this phenomenon.

As the 2008 IPPF unsafe abortion study shows, abortion is more common among unmarried youth in the Maldives than it is among married couples. The findings of this study provide insights into the extent of abortion seeking behaviour among young unmarried women. Young FGD participants of this study spoke candidly about friends who had sought abortions following out

of wedlock pregnancy. Consulted health practitioners inform about abortion seeking behaviour among patients and knowing from them about the availability of illegal abortion services. Among the three interview subjects consulted for this study, a total of six abortion experiences were reported, the majority of them having been sought in unsafe conditions without appropriate medical supervision (see Appendix 5).

One of the interviewees who had two induced abortions following out of wedlock pregnancy used injections administered by non-medical personnel, in the absence of any medical supervision. She reported bleeding for three months following one of her abortion experiences. Another interviewee spoke of the physical and psychological trauma of an unsafe abortion experience which still affects her today, many years after the experience. The physical and psychological health impact of unsafe induced abortions among unmarried young women in the Maldives is not known. Available evidence shows that young people do not access established health services in such situations and support services are not available to them. Furthermore, the situation is exacerbated by the fact that the prevalence of unsafe abortion is not recognised or acknowledged by the relevant authorities, leading to the lack of availability of health services to young people in need of such services. To date, the IPPF unsafe abortion study, which is the only study of its kind, remains unacknowledged by the health

62 Unsafe Abortion, WHO, 2007:1

Box 4

Story of discrimination against children born outside marriage

I know of a child like that and he is a good child even though his parents were like that. And he wanted to marry someone from a good family and they [the girl's family] disapproved, but now they have somehow got married and even have two children but still, the mother-in-law still does not speak to him. Imagine how long ago it happened and it wasn't something he had anything to do with, and he is really good, but what a stain it is [on him] ... and his mother-in-law refuses to speak to him at all

FGD participants (44 to 62 age group)

authorities in the Maldives (see Appendix 4).⁶³

In the Islamic socio-religious context of the Maldives, sex outside marriage is prohibited and criminalised through the legal system. Therefore, pregnancy outside marriage is a criminal offence carrying punitive social and legal punishments. Abortion is illegal in the Maldives unless medically recommended or to save the life of the woman. This status quo has a profound impact on the health seeking behaviour of unmarried young women, who turn to illegal and unsafe abortion service providers risking their health and even life, in the process. FPU case notes show that teenage maternal deaths have occurred following attempted self-induced abortion in out of wedlock situations. Existing documentation confirm that maternal deaths occur in out of wedlock

63 Abortion in the Maldives, Minivan News, 07 January 2010
<http://minivannews.com/society/abortion-in-the-maldives-the-untold-story-2191> (Accessed : Dec 2010)

pregnancy cases due to self-induced abortions.⁶⁴

There are several motivating factors which drive the above noted risk behaviours among unmarried youth. For a student, out of wedlock pregnancy will result in expulsion from school and the potential loss of future self development and life opportunities. The social stigma attached to pregnancy outside marriage is also significant to both the woman involved and the child born in such circumstances, as FGD participants clearly highlighted.

According to one participant, despite the fact that a child born out of wedlock cannot be blamed, “even

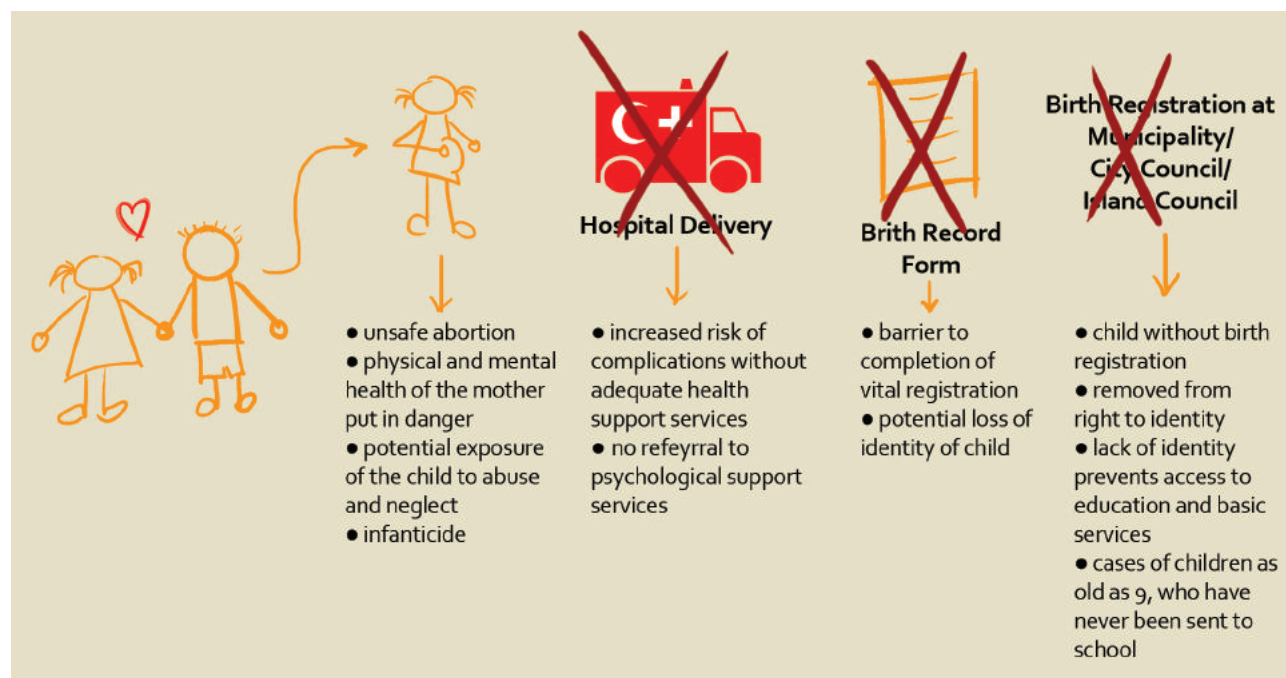
I would tend to see that child in a

different light”. Participants shared stories explaining the long lasting impact of social labelling and marginalisation out of wedlock pregnancy can carry in Maldivian society, as evident from the story in Box 4. Social labelling and ostracisation is a reality in Maldivian society, specifically for the woman and also children born outside marriage. Such a child is both socially and legally labelled “illegitimate” (see Appendix 12).

According to Maldivian law, a woman who becomes pregnant outside marriage is punished according to Islamic shari'a, for the crime of ziney or adultery. This involves the legal sentence of 100 lashes and house arrest for the duration of one year. Although the punishment for a man is similar involving 100 lashes and one year's banishment, sentencing is based entirely on admission of guilt (see Appendix 11). In the Maldives, paternity testing is not used as admissible evidence in court and the opportunity for

64 Maternal Mortality Synthesis Report 2003-2007:23

Figure 7: Possible unintended social and health consequences of pregnancy outside marriage, when the system is avoided.



men to deny guilt makes male accountability in out of wedlock pregnancy cases something of a farce. Consequently, there is a serious gender disparity in the punishment for ziney cases. According to 2006 statistics produced by the Department of Judicial Administration, from a total of 184 people sentenced to lashing or flogging, 146 were women constituting nearly 80 percent of the cases.⁶⁵ The punitive, non-rehabilitative and discriminatory realities of the Maldivian legal system motivate the desperate measures taken by young unmarried women who become pregnant outside marriage. As one of the interview subjects for this study informed, “my boyfriend and I knew at the time that we could not have a child because I was in school, and I would be put under house arrest and I knew I had so much to lose. My whole future was at stake and it

just was not an option. Keeping a baby was not an option.” (see Appendix 5, Case Study 3). Ironically, the kindest option available to a vulnerable young woman of limited economic means in this situation is to put her life at risk, at the hands of an illegal abortion service provider. As an FGD participant said, even when parents support their unmarried pregnant child’s abortion, “they are doing it for the sake of the child – they will not want the child to come to any harm”. In the perceptions and actions of both young people and old, the social and legal harm clearly overrides the personal and private harm abortion potentially causes to the health and future well being of unmarried young Maldivians.

The role of policy makers, state authorities and duty bearers are an important element which has to be considered, given the above social realities.

65 Omid M, Minivan News, July 2009 <http://minivannews.com/society/amnesty-calls-for-moratorium-on-flogging-1371> (Accessed : August 2010)

THE POLICY ENVIRONMENT

ON YOUTH SEXUAL AND

REPRODUCTIVE HEALTH

The Policy Environment on Youth Sexual and Reproductive Health

Health Sector

Youth SRH is a cross-cutting issue, influenced by many areas of government administration and public service provision, including education, health and social care provision, youth development, as well as law enforcement. The change in government in 2008 brought many changes to existing national level policies on planning and development. Nevertheless, international commitments to national development remain within the government's focus and policy agenda.

The Maldives is party to the milestone International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994, and its consequent Programme of Action.⁶⁶ The government's efforts to educate students and youth on population issues including the "implications of high fertility and high rate of population growth for the quality of life and well-being of all Maldivians" was observed in the national report to the ICPD.⁶⁷ Therefore, policies relating to youth SRH issues could perhaps be expected to be guided by the ICPD principles and the declaration of the conference. The Maldives continue to be committed to achieving the Millennium Development Goals (MDGs) of the UN system by 2015, recently reporting the full achievement of MDG5. Maternal mortality

rate and the fertility indicator of adolescent birth rate are reportedly achieved. One of the targets of MDG5 relevant to this study is Target 5B which is "universal access to reproductive health", which the government considers to have been fully achieved in the Maldives.⁶⁸ The findings of this study provide ample proof that this is in fact, not an accurate depiction of the situation.

As noted earlier, official statistics report that 95 percent of 15-19 year old women are not sexually active in the Maldives with teenage pregnancies reported to be rare.⁶⁹ This is in stark contrast to the available statistics of the FPU case record analysis which shows a significant prevalence of adolescent and youth out of wedlock pregnancy. This is also inconsistent with the findings of available existing research, dating from 1999 to the more recent 2008 IPPF unsafe abortion study. The lack of acknowledgement of the prevalence of adolescent and youth pregnancy and unsafe abortion practices by the authorities is evident in the government's failure to recognise the IPPF study. The January 2010 media article on abortion reported a health ministry official stating that the absence of statistics made it difficult to understand the issue of abortion.⁷⁰ However no efforts have been made since

66 GOM National Report for the ICPD, 1994:17

67 Ibid : 18

68 Millennium Development Goals, Maldives Country Report, 2010:16

69 2009 MDHS : 68-70, 51

70 Abortion in the Maldives : the untold story, Minivan News, 07 January 2010

<http://minivannews.com/society/abortion-in-the-maldives-the-untold-story-2191> (Accessed : Dec 2010)

to study the issue. The aim of the recently reviewed Health Master Plan 2006-2015 is to protect the health of the population. However, it does not acknowledge that youth pregnancy and unsafe abortion are public health issues in the Maldives, nor does the entire document contain the word abortion.



► A young girl receiving SRH information at a hospital. Social barriers exist for youth to access sexual and reproductive health services through skilled healthcare professionals.

Giacomo Pirazzi

The RH Strategy of 2008-2010 outlined a thematic area which aimed at “protecting the reproductive rights and reproductive health of the vulnerable youth and adolescents”. The overall goal of this strategy was to “protect and improve sexual and reproductive health of adolescents and young adults”.⁷¹ Ministry of Health and Family (MoHF) officials inform that the implementation of this strategy is currently under evaluation. Available information suggests that no substantial adolescent SRH programmes were implemented under this strategy to protect the health of young people.⁷²

As noted previously, the 2003 RSHA study observed that marriage determines access to SRH, RH and contraceptive services to young people in the Maldives. This remains very much the case today as there are no government policies which supports or facilitates access to reproductive health services to unmarried youth. From a health policy perspective, various documents suggest the government’s positive attitude towards its international commitments and the achievement of development indicators. However, the situation on the ground in terms of youth SRH information and service provision has no correlation to the government’s reported achievements.

Education Sector

On the issue of adolescent and youth SRH information and education provision, the education sector does not appear to have played a significant role to date. The findings of this study show that despite

71 National RH Strategy 2008-2010:19, 29

72 Personal communication, CCHDC, MoHF

the favourable aim of the school health programme developed in 1986 to empower students with knowledge and skills to protect their health, this has not been addressed from an SRH perspective. Available information suggests that the school health programme was not effective, with its implementation being weak and fraught with limitations and challenges over the years.⁷³

The removal of existing SRH information from the primary school syllabus in 2003 is indicative of the weak policy position of the education establishment in this area. Furthermore, the challenges to progress experienced by the UNFPA LSE programme over its seven year duration, helps to highlight the limitations of the education establishment to support ASRH in schools.⁷⁴ The continued barriers to incorporating meaningful ASRH content within the LSE curriculum suggest inherent problems within the schools system in appreciating the importance and relevance of this topic.

The fact that LSE remains an extra-curricular subject not available to the large majority of the school population provides evidence to suggest that empowering students to

“ Promote healthy lifestyles among students, by providing them with knowledge and skills that will enable them to take responsible decisions to protect their own health and well-being. ”

School Health Policy 2011 Ministry of Education/Ministry of Health and Family 1986 - School Health Programme established

protect their health is not a priority of the sector. The recently revised school health policy informs that the aim of the current policy is to mainstream health and well-being into the education system. One of its seven objectives is to “empower students with skills and competencies that enable them to make healthy choices to prevent health problems, maintain and improve their health, and adopt healthy behaviours.”⁷⁵ This objective of the new policy is similar to the aim of the school health programme of two decades ago. While this helps to convey the static nature of the school health initiative within the schools system in the Maldives, there is no confirmation within the newly revised health policy that SRH will feature within its remit. Health and well being is expected to be developed as a separate subject in the revised school

73 School Health Policy, January 2011, MoE/MoHF

74 UNFPA CP4 Evaluation (2008-2010), October 2010

75 School Health Policy, January 2011 : 15

curriculum. It is yet to be confirmed whether SRH will be included within the content of this newly proposed curriculum subject.⁷⁶

Overall, neither the health sector, nor the education sector has adequate policies in place to support the provision of ASRH and SRH information, education and services to support young people. The non-recognition of the issue of youth pregnancy and unsafe abortion by the health authorities is as a problematic, as is the failure of the authorities to act on the findings of existing research. The resistance to creating a supportive ASRH information provision environment within schools by the education establishment suggests the reluctance within the policy environment to address the issue. It is therefore possible to conclude that the socio-cultural context of the Maldives presents a powerful barrier to empowering young people to protect and preserve their sexual and reproductive health and future well-being. A culture of reluctance prevails among duty bearers on the issue of adolescent and youth SRH in the Maldives.

Youth Sector

Despite the high youth demographic in the Maldives, the level of attention given to youth development can be described as poor in the Maldives. In 2003, a National Youth Policy was produced by the then

76 Ibid : 12-14



- Youth Challenge 2004. Instead of occasional LSE awareness programmes for youth, there is a strong need for youth-friendly and accessible programmes that promote sexual and reproductive health and education and provide these services to youth in need.

Ministry of Youth and Sports.⁷⁷ The overall vision of this policy was to achieve full youth participation in the development of the country. Within its objectives, the youth policy outlined a section on promoting healthy lifestyles among youth, which involved the production of a Youth Health Strategy. According to youth ministry officials consulted, most of the planned programmes under this policy were

77 Maldives National Youth Policy, 2003, Ministry of Youth and Sports

implemented.⁷⁸ However, nearly eight years down the line, the proposed Youth Health Strategy has yet to be produced.⁷⁹

The out-of-school LSE programme for youth, supported by the UNFPA funded project from 2003-2010 called the Youth Health Café (YHC) was established under the supervision of the youth ministry. However, it had not expanded significantly out of Malé although some of its volunteers visit islands to conduct occasional LSE awareness programmes. A component part of the LSE curriculum for out-of-school youth contains youth SRH awareness and education.

Currently, the YHC project is supported by a small group of committed volunteers. The YHC made unsuccessful attempts at the end of 2010 before the end of the donor funded project, to establish a youth health clinic, which was a complete failure according to consulted individuals who participated in the exercise. Therefore, SRH and RH education to out-of-school young people via the YHC LSE programme has not achieved meaningful results for the nation's youth. In fact, the outlook for youth development in the area of health promotion and SRH and RH education and service provision remains dismal in the Maldives.

78 Personal communication, Youth Development Section, Ministry of Human Resources, Youth and Sport

79 UNFPA CP4 Evaluation (2008-2010), October 2010

CONCLUSION

Conclusion

This qualitative enquiry into the topic of SRH knowledge and behaviour among young unmarried women in the Maldives provides an insight into the situation of unmarried youth SRH and well-being.

This study was motivated by the findings of the FPU statistics which showed a high prevalence of out of wedlock pregnancies which were being reported to IGMH in Malé. Within its limited remit, this study has attempted to understand why this is occurring. The literature review conducted for this study found that there is a significant, documented evidence base showing high prevalence of sexual behaviour among young unmarried youth in the Maldives dating back to 1999. Furthermore, significant developmental changes have occurred in the country in the last two decades, resulting in a substantial shift in youth fertility dynamics within a very short timeframe. However, there have been no productive policy interventions to address the issue of SRH when the average age of marriage for women had risen from 16 to 19 in approximately sixteen years. The significant development of setting the minimum age of marriage to 18 by law in 2000 further heralded the need to address SRH needs of a population with a steadily increasing age of marriage. However, this situation remained unaddressed despite the findings of several research efforts which highlighted the necessity to address the gaps in adolescent and youth SRH information and service provision.

Focus group consultations conducted for

this study showed that there is a deep social discomfort about discussing the topics of ASRH and SRH with unmarried youth within Maldivian society. This arguably results in the lack of attention given to this topic by all duty bearers, including parents, the education system as well as the healthcare system. Despite the conservative Islamic religious context of the Maldives, many social contradictions exist. Although pregnancy outside marriage is socially taboo and criminalised by law, the prevalence of sexual behaviour among young people leads directly to the prevalence of out of wedlock pregnancy. There is a dearth of ASRH and SRH information, education and service provision for unmarried youth. The upshot of this is the consequence of unsafe abortion which is found to be particularly prevalent among unmarried young women. The serious physical and social health impact of this is not known as the issue of illegal, unsafe abortion remains unacknowledged by state authorities. This status quo persists, despite available research confirming the prevalence of illegal and unsafe abortion seeking behaviour among unmarried youth both within and outside the country.

One of the key findings of this study is the insights received from in-depth interviews which show the seriousness of the situation of the prevalence of unsafe abortions. A total of six abortions were experienced by the three interview subjects consulted for this study, the majority of which were in unsafe conditions. This indicates the prevalence of this serious SRH risk behaviour among unmarried young women. However, their

behaviour can be explained by the fact that these vulnerable young women were motivated to avoid the punitive social and legal consequences which potentially had negative repercussions for their future life opportunities. There may also be linkages to potential unintended consequences to out of wedlock pregnancy, such as mental health issues which may result in the occurrence of infanticide. The policy environment which should support the health and well-being of young people is fraught with shortcomings. Therefore, the situation of young unmarried women remains precarious and unstable, when it comes to their SRH, physical and mental well-being.

RECOMMENDATIONS

Recommendations

The following are suggestions and ideas to various stakeholders on how some of the issues observed from this study, could be addressed. However it is crucial to note that the most important positive changes can be brought about by those working from within the various sectors. Only they have intimate knowledge of the difficulties and barriers to progress they encounter, at both professional and personal levels. Anything approaching positive change, to address the culture of reluctance to inform and educate young people on RH matters will only come with a genuine desire to support young people. It is unlikely that any beneficial change that improves the physical and mental well being of young people can occur as long as the political and policy level will to protect and preserve the health of young people continue to remain weak.

Education sector

- Research school-based, age and culturally appropriate ASRH and SRH education in other Muslim contexts, as well as other countries, to draw knowledge on beneficial practices and amend existing policy and practice to support the SRH health and wellbeing of young people
- Strengthen the School Health Policy to incorporate ASRH information and education provision as a priority area of student developmental health, with a view to empowering young people to make SRH decisions to protect and preserve their physical and mental health
- Strengthen the core curriculum to provide age appropriate SRH information to all students
- Improve the ASRH content in the LSE syllabus to ensure that students receive age appropriate, timely and meaningful SRH information that they can apply in practice to protect their health
- Lower the age of teaching LSE package one to grade 4, to provide timely ASRH knowledge to students in a manner appropriate to their age
- Review and strengthen the Islam syllabus for both primary and secondary students, to ensure that SRH related information is consistent with and complements scientific knowledge on SRH that students receive in the biology subject
- Educate and train teachers by incorporating ASRH education into teacher training courses and professional development training packages
- Support parental awareness on ASRH and educate parents on the importance of addressing the SRH needs of the developing child at home
- Facilitate access to information and a supportive learning environment for school and university students to learn and develop their SRH knowledge
- Accommodate school libraries as a productive learning environment with

appropriate learning materials where students can access health information that can empower them to self-educate and improve their ASRH and SRH knowledge

- Incorporate age appropriate SRH components in the child friendly schools indicators (supported by UNICEF)
- Collaborate with relevant UN agencies, government stakeholders, NGOs and the media to produce programmes that will address the serious ASRH and SRH information gaps to adolescents and youth, both in and out of school

Health sector

- Incorporate ASRH and SRH awareness as a public health priority within relevant policies, especially targeted to adolescents and youth
- Strengthen the Health Master Plan to include SRH goals that seek to protect the reproductive health of young people, outlining implementable interventions that can be monitored with relevant indicators to measure progress
- Review the national RH Strategy 2008-2010, to ensure that thematic area 5 relating to adolescent and youth health is pursued and programmes are implemented to address youth SRH at national level
- Recognise and review available research evidence on the prevalence of unsafe abortion, especially among young people, and devise meaningful and productive national level strategies and policies to address this public health issue

- Establish a baseline on the prevalence of unsafe abortion in the Maldives
- Establish adolescent and youth friendly SRH information provision services for unmarried young people, through confidential, community based, professional health care facilities
- Conduct productive youth health awareness programmes at community and outreach level to inform and educate young people on SRH and the health risks of unsafe induced abortion
- Collaborate with relevant UN agencies, government stakeholders, NGOs and the media to produce public health promotion programmes relating to ASRH and SRH, with a view to addressing the serious RH information gaps in Maldivian society
- Support the Family Court to provide SRH education provision through the mandatory premarital awareness course for newly marrying couples

Youth education and development sector

- Consult and engage with youth groups to establish SRH information and awareness needs of young people and establish effective methodologies for delivering SRH information in the Maldivian cultural context
- Collaborate with relevant UN agencies, government stakeholders, NGOs and the media to produce youth peer education programmes relating to SRH, with a view to addressing the serious RH information gaps, consequent misconceptions and harmful practices



- ▶ Commitment and will for positive change is required from all stakeholders to break the culture of reluctance to inform and educate young people on RH matters

Shaaheena Ali

prevalent among youth

- Support youth NGOs and CBOs to promote SRH education and awareness among their members and the communities they serve
- Support the Family Court to provide SRH education provision through the mandatory premarital awareness course for newly marrying couples

Law enforcement sector

- Review sentencing practices in cases of pregnancy outside marriage to assess the extent to which gender discrimination

against women occur, and revise such practices to support just, equitable and non-discriminatory judicial practices which comply with constitutional rights

- Review the currently punitive judicial practice of dissolving an existing marriage if a child is born within a gestation timeframe that is inconsistent with the duration of marriage, to avoid fragmenting family units. This could be revised, for example, by setting an acceptable time-frame of birth within 6 months of marriage, which is shari'a compliant and practiced in other Muslim countries.

- Review the current judicial position of non-acceptance of paternity testing in cases of pregnancy outside marriage which facilitates male unaccountability, and revise this practice to permit DNA evidence to confirm paternity thereby ensuring equal responsibility of both parties in caring for the child born under such circumstances, and equitable justice to both
- The Family Court should consult with relevant health service providers to reinstate the SRH component in the premarital awareness programme and enhance the teaching method currently used to provide meaningful RH education to newly marrying couples

of socially sensitive issues such as youth SRH behaviour and pregnancy outside marriage. However, it has to be recognised that the Maldivian media is in its infancy and is currently not equipped to do all this. Nevertheless, the potential role of the media to support SRH education in a culturally sensitive and appropriate manner is significant. As observed by respondents who participated in this study, the media could be a key player in public awareness raising on RH issues.

Given media capacity constraints, sensitisation and education of media personnel is also an important aspect which has to be considered by stakeholders to improve youth RH knowledge. A lot of

media personnel are also very young. The provision of support to sensitise and educate young media personnel may have potential benefits to help facilitate a youth culture in communities which would consider SRH as an important general health concern for young people.

Further, relevant stakeholders should use the media as an important tool to address RH related social issues. UNFPA has engaged with the media in the past to promote family planning and as noted in the 1994 national ICPD report, media was used to increase public awareness on population and development issues and family planning

“ Attempts will be made to present news, information and programmes aimed to maintain the health of the society. ”

Maldives Media Code of Ethics, Maldives Media Council

Role of the media

The media sector has a potentially key role to play in youth education by reporting responsibly and sensitively on social issues affecting youth. The media must ensure stakeholder accountability and pay particular attention to ethical handling

matters nearly twenty years ago.^{80,81}

A revival of these approaches in public health awareness raising is perhaps necessary, to address youth RH issues that have such debilitating and destructive negative impacts on young lives. An important method to consider is peer education, as the evidence is clear that young people confide in other young people on RH matters. A supportive environment must be created to facilitate peer education and use media as a tool to reach the larger community. Successful examples of such youth driven initiatives are available from other countries.^{82,83} A multi-sectoral and collaborative effort, involving education, health, youth, the legal sector, UN agencies, NGOs and CBOs, is essential to make a meaningful socio-cultural impact in Maldivian society to protect and preserve the reproductive health and well being of young people.

80 UNFPA CP4 Evaluation (2008-2010), October 2010: 30-31

81 GOM National Report for the ICPD, 1994:18

82 Voices of Youth, UNICEF Nepal, <http://unicef.org.np/voy/freedom-express> (Accessed : May 2011)

83 Saathi Sanga Manka Kura, Nepal, <http://ssmk.org> (Accessed : May 2011)

APPENDICES

Appendix 1

List of FGD questions

- 1) Do young women receive adequate education on reproductive health?
- 2) Do young women use health information to make decisions about their health?
- 3) Do young women have adequate access to RH information and services ?
- 4) To what extent do young women use RH knowledge to make decisions about their own health ?
- 5) At what age do you think young women become sexually active in your community ?
- 6) Is pregnancy outside marriage an issue in your community ?

FGD participant background data collection note

UNFPA Research (RH knowledge and behaviour of young unmarried women)			
Focus Group Discussion - date :		venue :	
<p>٠٠</p>			
✓			
✓			
✓			
✓			

Participation in the discussion is voluntary.
All information provided will be treated as confidential.

٠٠

Session conducted by :
 Humaida Abdulghafoor, Research Consultant

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Appendix 2

Informed consent form for in-depth interviews

Research Title :

Research on reproductive health knowledge and behaviour of young, unmarried women in Maldives.

Purpose of the research :

The purpose of this research is to improve available knowledge and obtain qualitative information on reproductive health knowledge and behaviour of young women in the Maldives. The findings of the research will help to inform and guide policy, specifically the Youth Health Strategy.

Research approved on 06 December 2010 by the :

Ethics Review Committee, Decision Support Division, Ministry of Health & Family, Maldives

Participant Consent Form

Participation in this research is entirely voluntary.

Participants are not required to answer any questions they do not wish to answer.

Participants may withdraw from the research at any point.

All information provided will be treated as strictly confidential, including the identity of the volunteer.

Once the research and its associated report(s) are fully completed, all raw information will be destroyed as per the ethical guidelines followed by the research.

I agree to the above terms of voluntary participation in this research.

Participant Name : _____

Contact number : _____

Signature : _____

Date : _____

Name/signature of researcher and date :

Humaida Abdulghafoor _____

UNFPA Project : Reproductive Health, Output 1

Project Code : MDV4R11A

Researcher : Humaida Abdulghafoor (Humay)

Initial planned research period : 21 October to 20 December 2010

Extended from : 01 February to 01 May 2011



Appendix 3

Family Protection Unit case notes - snapshots

Year 2010

Age : 20

Pregnant by : “boyfriend” – first meeting following telephone relationship (rape)

Family situation : intact / supportive

Other information :

arrived in Malé from island for higher education - studies discontinued – case not reported to authorities due to fear and shame

Age : 21

Pregnant by : boyfriend

Family situation : intact / supportive

Age : 17

Pregnant by : info unavailable

Family situation : living with grandmother in island

Other information :

ran away from island, admitted unconscious to ER, 3 months pregnant – suspected of having taken some medication - died day after admission

Age : 17

Pregnant by : info unavailable

Family situation : living in island with family

Other information :

admitted to ER, had been taking Actifed – up to 85 tablets - 9 months pregnant - at school – now left

Age : 17

Pregnant by : boyfriend

Family situation : parents supportive

Year 2009

Age : 17

Pregnant by : boyfriend

Family situation : supporting family after unexpected death of father.

Other information :

Renting in Malé.

Pre-term birth in toilet at home.

Age : 17

Pregnant by : not known – unwilling to talk

Family situation : parents supportive

Appendix 4

Abortion in the Maldives: The Untold Story

By Maryam Omid | January 7th, 2010

Reproduced with permission from Minivan News (online), May 2011

When the strip on the pregnancy test turned pink, 23-year-old Mustafa asked his girlfriend to marry him. Not because he wanted to, but because he believed it was the right thing to do.

She said no.

Aminath, who was 19, replied she was too young to have a child. And so, he told her he would “fix it”.

A few days later, Mustafa learned of a man who charged Rf2,000 (US\$155) to perform an abortion. Reassured by two friends who had used him, he set up an appointment in Male’.

“The man gave her three injections and said that within one to four hours, she would start to bleed and it would be very painful and it would be like giving birth,” says Mustafa, his frail voice quivering.

“At this point I was having serious doubts about this guy. He wasn’t a doctor... he was boasting about his abortion activities and the number of girls he had done this to. He said at one point it was almost one every night. The way he said it was without a trace of compassion.”

Mustafa’s description of what followed is harrowing: Aminath was carried back and forth to the toilet, she threw up twice and was writhing in agony. Four hours later, she began to bleed.

As a Muslim country, abortion is illegal in the Maldives except to save a mother’s life, or if a child suffers from a congenital defect such as thalassemia. But anecdotal evidence points overwhelmingly to a high rate of abortion.

“I can count seven of my friends, three girls and four boys. The story was the same,” says Mustafa.

Statistical Vacuum

There is scant information available on abortion in the Maldives. No research on the subject has ever been commissioned. But, says Fathimath, 40, a social researcher on youth and women, other statistics indicated that abortion was prevalent.

She points to the discrepancy between the decline in the fertility rate and the low rate of contraceptive use – an estimated 39 per cent – which raised important questions that remained unanswered.

Halfway through the conversation, Fathimath says she herself has terminated two pregnancies. The first time she was 20 and a newlywed. She had been given the opportunity to study in the UK and felt her pregnancy was ill-timed. Her second abortion was more recent: her husband had been cheating on her when she found out she was pregnant.

“At that time, I wasn’t emotionally capable of having a child,” says Fathimath, who had both of her abortions abroad.

The only tidbit of official information that exists comes from the Reproductive Health Survey conducted in 2004. The survey found that despite the absence of reliable data, it was likely that unsafe abortions could be a cause for concern. Three years later, an unofficial report by the International Planned Parenthood Federation (IPPF) reached a similar conclusion.

Interviews with four demographically-diverse focus groups revealed that induced abortions were common among women and girls in Male’ with most ostensibly taking place in unsafe circumstances.

But, the IPPF never obtained government permission to carry out the study and because of the qualitative nature of its research, its findings were never acknowledged or made public, says Fathimath.

The report found that the stigma of having a child out of wedlock compels women and girls to opt for abortions. Two focus groups of unmarried boys and girls asserted that abortion was widespread. Some said they knew of girls as young as 12 who had undergone abortions and each knew at least one person who had terminated a pregnancy.

The discussions further revealed that while abortion was more common a

Taboo

Using the information gleaned from the focus groups, IPPF concluded that widespread premarital and extramarital sex, high rates of divorce and remarriage (including sex between marriages), and poor access and practice of contraception could lead to a high number of unwanted pregnancies.

All four groups said that despite being illegal, sex outside of marriage was commonplace, especially among young people. Nor was it uncommon for married men to have affairs with unmarried girls.

But disturbingly, the focus groups said that couples preferred not to use contraception. Among the reasons offered included a reluctance to use condoms.

For some, the IPPF discovered, having an abortion was itself a form of contraception. One girl said: “When abortions can be obtained without much difficulty, young people do not want to use contraceptives as those take away the pleasure.”

Under the form of sharia law practiced in the Maldives, both sex before marriage

and adultery are offences punishable by flogging. But attitudes towards sex reveal a discrepancy. While it is acknowledged in private that both take place, social norms and cultural attitudes restrict public discussions on the subject. As a result, students are not taught about contraception at school as for many this would be tantamount to condoning sex outside of marriage.

Government Policy

Nazeera Najeeb, head of the population division in the health ministry, stressed that it was difficult to grasp the extent of the problem in the absence of official statistics.

“Without that it’s difficult to say exactly what’s happening,” she says.

The health ministry has plans to conduct research into abortion in the Maldives and educate the public about the health risks involved, she says.

“We are trying to create awareness on the disadvantages. At present we are trying to develop some mass media programmes.”

The list of potential health complications associated with unsafe abortion rolled off by Nazeera makes for grim reading: reproductive health infections, infertility, septicaemia, shock and even death.

While students could not be taught about contraception at school, they could be alerted to the dangers of unsafe abortion, she said. In addition, the health ministry could redouble its efforts to promote contraception among married couples.

For Velazinee, however, as long as the government continues to shy away from the sensitive issues that surround abortion, couples will continue to find themselves in the same quandary.

As with the drug epidemic, only government policies that addressed the real picture would help break the taboo, and thus, move the country towards finding a solution, she says. Until a shift in policy-making occurred, she adds, society will continue to be marked by a dualism: a public facade that does not reflect the private sphere.

“We gear policy to the normative standards of being a 100 per cent Muslim country rather than the reality. The government doesn’t want to publicise the availability of contraception for fear the move will be misinterpreted. They don’t want to acknowledge these issues, but the reality is that these things happen.”

The names of all those who have spoken about their personal experiences involving abortion have been changed.

<http://minivannews.com/society/abortion-in-the-maldives-the-untold-story-2191>
Accessed : 06 December 2010

Appendix 5

Note : The names used to identify case study subjects are fictitious to preserve the anonymity of participants in compliance with the ethical standards observed in this study.

Case Study 1: Fatima's story

My mother died when I was about 15 or 16 years old. I come from a big family and I am one of ten children. In my family, my mother and father quarrelled frequently. It was a very dysfunctional home environment. I once had a dream that my mother was going to die and oddly, it did not make me particularly unhappy. Maybe I felt that this would mean there would be no more fighting in the house. I remember my older sister telling my mother to stop having children, but I think my mother believed that children were given by God and she had no part to play in it.

I felt neglected at home. I did not receive any RH information at home from my parents and I could not ask for any information from my mother. When I started my periods, I did not tell my mother. Actually, it did not occur to me to even ask her. I was not prepared for it.

When I was about 16, two of my older siblings were charged with some offence and banished to other islands. So this made me the eldest in the house and I became the head of the household. My father was around, but he was always at work. I had no idea what was happening. There was no discipline in our house. We all did whatever we wanted. At this stage, I stopped going to school. I had repeated one class several times so I was a little old for my class at the time. So I dropped out of school and did not

finish school.

Around this time, I had my first boyfriend. I had no guidance on these things from anyone. Like I said, my father was at work mostly. I ended up having intimate relations with my boyfriend mainly to please him. And then soon after, he left to study abroad. So I was exposed to intimate relations at this stage. Later on, when I was in my early twenties, I had another boyfriend and became pregnant. So I told him about it and he arranged to take me to a neighbouring country. I remember asking my sister, if I could go with him because he was going on an office trip.

Actually, 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. Anyway, I went abroad with my boyfriend without informing anyone at home, except my sister. I packed a backpack with a few clothes in it and sneaked out of the house and took the ferry to the airport. We were careful not to take the same ferry, in case someone noticed, so we met up at the airport. Actually, while at the airport, a friend of one of my siblings saw me checking in for the flight. I was really nervous in case I got stopped at some point. But anyway, I managed to get on the flight and leave.

When we landed at our destination, we went and stayed in a hotel that night. Next day, my boyfriend took me to a kind of “nursing

home” in a suburban area of the city. At this place, they gave me a general anaesthetic and carried out the abortion procedure. When I woke up, it was all done. But I remember being very annoyed because there was blood on my skirt. So that was it. The same day, we flew back to Malé and when I got home, news had reached my family.

My sister had heard some story and suspected that I may have had an abortion. So I rushed to the bathroom and threw the sanitary pad I was wearing onto the house roof to hide any evidence, in case she insisted on checking up on me!! I was very worried. Also, I had a high fever when I arrived but I continued to take the medicine the abortion clinic gave me, and after a few days, I was fine. The news had got to my father and he talked to me and asked if the rumours were true. He was very disappointed. I told him they were not true.

I got married to this boyfriend sometime afterwards. He was very experienced in relationships as he had already been married and divorced a few times. Actually, I was not a very studious person and I did not participate much in class or socialise with other schoolmates. I was very quiet in class. But I loved books so I would read anything. The kind of books I was able to get were mostly romance fiction novels and I learnt whatever I learnt from those books. I got an opportunity to join a health related course after I had turned thirty. Things were not going well with my marriage and attending classes gave me an opportunity to leave the house. When I started doing this course, I began to understand all the experiences I have had in my life and began to learn about RH. It occurred to me that I had just waded through life and numbed myself to the realities and experiences of it. Up till then, the only place I got RH related information

was like in movies and even then, things like kissing. Whatever information I got until then was from romance fiction books!!

As things worked out, I had to have a second abortion after my marriage for medical reasons, on the advice of doctors. Now, I know a great deal more about RH than I ever did and I am telling you my story because I think it is very important for young people to know such information. I want to help because I don't want others to have the same experience as myself.

Case Study 2: Reesha's story

In my family, there were eight children. We lived with our mother on our island and our father was often away from the island with his work. I was the eldest so I had a lot of responsibility at home. I always wanted to leave the family and I did not like living on the island. My mother used to shout at us a lot and she never explained things calmly to us. We all went to school, except for one of us who became ill and stopped going to school. One of my siblings dropped out of school and went astray. The rest of us went to school. In grade 6, I had to repeat the school year. My mother just sent us to school, but was never interested in our schoolwork or anything.

I didn't enjoy primary school because I was bullied as I was well built for my age. It was difficult because I had started to grow in places, as I was bigger built. I also hated it when school teachers practiced favouritism towards children of the richer families. But I began to enjoy school when I got to secondary school. I had my first boyfriend in grade 6 and my classmates also had boyfriends. They shared information and experiences about intimate relations with boyfriends. It was in grade 8 that a classmate talked to me about having intimate relations with a boy.

My parents were very protective and did not allow us to go out and about. But I knew of several neighbourhood friends who used to receive money from older men. I think it could be for sexual favours, but I don't know what kind of things they did. It could just be stroking elderly granddads or something like that. They were clever and knew how to get money from the old people, but I think they did it because they did not have any money and they were poor. Maybe they could not

get money any other way. But we were not poor. We used to get new clothes and lots of stuff other kids did not get.

I did not receive any RH information from my mother. I was very uncomfortable when I reached puberty and my body started changing because I had a healthier build than the others. I got to know things about periods from things I saw at home. For example, I used to see sanitary pads in the house and also in the dustbin. I noticed how my mother used to hide sanitary pads under her towel when going for a shower. I had no curiosity to ask too many questions, but I observed these things. I got lots of information from my friends. It was when I was in grade 7 that I learnt how children are conceived and born. We used to have this teacher who explained things to us. But you see, I did arts so I did not have a lot of information about reproduction from school. When I was in grade 10, I had a health problem and with the support of a friend's sister who was a nurse, I went on my own to see a doctor. The doctor explained that I had a urine infection. Until then, I didn't know such things happened.

The family health worker used to visit our house to see my mother. She would bring medicines and I learnt that they were family planning medicine. I was not such a studious person and I did not read much. I used to borrow books from the library because the picture on the cover looked nice. We had no TV at home and we were not allowed to go and watch TV in other houses. But our home was not a peaceful place. You see, my mother had me when she was just thirteen I think, so she did not know much about child care. She didn't get good care from my grandmother either, so now I understand that it's not her fault that she didn't know how to look after us.

When I was in grade 8, I liked to do art. And when I finished grade 10, I went to a nearby island to do a two month handicraft course. I used to watch people on TV doing handicraft work and always wanted to do that. But then, I saw an advert for a handicraft course in Malé. I wanted this so much that I removed the advert from the wall in case another applicant might be successful and I did not get the opportunity. My parents did not want me to apply for the course and did not help me at all, but I tried really hard and managed to send off the application and got a placement. I got a lot of grief from my parents because they just didn't want me to leave the island. But this was my chance to get away. I didn't want to get married. I just wanted to be independent.

When I was in Malé doing my course, I met a really good boy who was very supportive towards me but he was ten years older than me. I wanted to marry him but my parents did not approve so the relationship ended. I was living at a relative's house in Malé, and they don't take much notice of what I did or where I went or how I lived. Anyway, I met this other guy and that was when I got pregnant. I was about twenty-two at the time. You see, if you are with someone, you have to do things they want you to do. That's how I used to think at that time. He was good looking but I must say that I did not really trust him. I had intimate relations because I did not have the guts to say no. It was not frequent, maybe once every two months or so. But I didn't use any protection or contraception and would wait anxiously for my periods to arrive. Every time, I was worried and anxious I might get pregnant. It became normal to do this, and became like a habit. You know, boys don't like condoms and I believed that. We used the withdrawal method. When I got pregnant, I knew about it even before I tested

because I felt very happy and I would dream in my sleep that I had a child. I told a friend and had a test done and found out I was pregnant. When I told my boyfriend, he did not believe me. 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. So I did not want to discuss this with him again.

I had heard stories of how sometimes, boyfriends inform the police when girls get pregnant and how girls might even get stopped at the airport if they try to leave the country to get an abortion. I didn't want that to happen to me because it would be so shameful. But 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. So he had that experience. I didn't see a doctor or anything. This person came to the house one evening and gave me three injections. Each injection was given about one hour apart. I went through a lot of pain. I found out I was pregnant about two weeks into the pregnancy. It took about a month to organise the injections. So by the time I had the abortion, I think I was about two months pregnant. I knew about the risks of doing it. But my friend was very supportive and helped me through it.

About two years later, I had my second pregnancy, while I was having a relationship with quite a rich boyfriend. He was into drugs and alcohol and stuff, but he had a lot of money. But I became pregnant not by him but by someone else. But he knew it wasn't him. After trying some time, he agreed to give me money to have an abortion. So I rented a day room in a guest house and my

boyfriend arranged to have a pharmacist to come and give me the injections. This time, I asked a relative to be with me during the abortion. I could not ask my friend from last time. After the abortion, I had bleeding for three months. You see, when the situation happens, the most important thing is to get a solution. But the thing is, after the event, it's easy to get back to old habits. This kind of thing becomes a part of life and there is also a need to have intimate relations with someone to feel good, to feel that I belong with someone.

I don't talk to people about these experiences because I don't want people to know. Only one or two close friends know about these things. If I had a choice, I would not have asked my relative to stay with me when I had the second abortion. These are very secret things because I don't want to get a bad name. I don't want my parents to know because it would be shameful. 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 eventually and I got pregnant soon afterwards. I did not want to start a family so soon because of various reasons, like financial reasons and personal reasons. I wanted to develop myself more before I had a child. It was too early in the marriage and we had not settled yet. So I decided to have an abortion. It is not our choice, but certain things happen. Maybe these things happen because we do not have good values, despite being Muslim. Our own selves are pushing us towards doing these things. We know having sex outside marriage is not a good thing. But we do it to feel wanted and to feel a sense of belonging.

Case Study 3: Aisha's story

When I was in school, I remember being really naïve. In grade 6, when I was about twelve years old, I used to think that babies came out of a woman's bottom. But one day, an older classmate who was a repeating student I think, explained to me that there was another opening besides the urethra and the anus. When I went to grade 8, I chose the science stream. So in biology lessons, I learnt about scientific information about the human reproductive system and also menstruation.

One of my classmates was sexually active even in grade 6. She would explain to us what happens in sex and what sperm looked like so we probed her to find out more and learnt that she was speaking about her personal experiences. I had no such experience at that time but when I got to grade 8, I learnt how reproduction worked. By this time, I also knew there was such a thing as a fertile period and that you could count dates to identify that period. I also knew if ejaculation does not happen inside the body, or the reference used then was "not to out" during this time, pregnancy can be avoided. I knew about the existence of condoms but I had never seen one, and I knew about pills. I learnt about pills because my sister was prescribed them due to a medical condition. So I knew how it worked and I mostly learned these things from speaking to friends and older cousins, from the information they shared from their experiences.

Those who took biology in school learnt about reproduction so other friends who didn't study biology would come to us to find information. When I was in school there was no internet, no cell phones and the public library did not have such information

so we just talked among peers about these things. The students taking commerce didn't know any of this information so they would always come to us. I remember when reproduction classes were being taught, there would be this buzz of activity with other students coming to find out whether we have had a class and what was taught that day and what had we learnt and so on. When I look back, I realise that science stream students were informal peer educators for the commerce stream students on RH. Perhaps it's different now but that was the way it was when I was in school. I know that in primary school, they did not teach anything on reproduction. I remember one of my classmates had her period in grade 4, (around nine years old), which was really early and she didn't know what was happening to her. Most of us got our period when we were in grade 7 or 8.

I didn't learn much about SRH at home. Definitely nothing from my father! When my older sister reached puberty, my mother sat us down and explained to us about menstruation. So when I had my periods, it did not come as a surprise although I did not know anything about reproduction at that time. Although my mother explained that periods happened every month and so on, there was no connection made about that and sex or pregnancy. But when I was in grade 10, I still remember the day my mother gave me and my sister a talk about sex and it made us both really embarrassed and uncomfortable. But my mother is a really sensible person and she explained some things and said that we had to be careful about our behaviour because pregnancy can happen. We both had boyfriends at the time and she said that she knew that when boys and girls got together, it is not to study religion. But she did not tell us any details like you see in the movies, such as what a

condom is and how to use it or anything like that. She told us that if we needed anything or had any questions, we can always come to her. But she's our mum so how could we go and talk to her about things like that?

We used to go to older cousins who showed us what a condom looked like and explained to us how it is used so we knew that such things existed. They also told us to be very careful but even with them, it was not possible to go and talk about our personal experiences because we were so much younger. When I eventually had my first sexual experience, I did not even tell my close friends. You'd think they would be the first people I would tell, but I hid this fact for a long time because I felt uncomfortable about sharing it in case no-one else had done it and I might get labelled ... you know how the social attitudes are around these things.

Meeting up with boyfriends was really hard for most of us when we were in school. Finding privacy was a huge issue among my peers. Boyfriends were not allowed to come to our houses to spend time alone with us, so maybe most girls found such opportunities in public places, maybe even among some bushes. My experience was different because my boyfriend had his own place. Other friends may have sneaked off while out for tuition or something to spend some time together at a friend's house. I think that even though it was socially frowned upon, the thinking among young people, especially among close friends was that having intimate relations was okay because everyone was doing it. But between groups of friends, it was a different story. There was finger pointing, teasing, name-calling and even bullying between groups. They would call each other names such as "slutty", "badi" or "kaalhu" which were very demeaning. I remember a friend once

said to me that everyone was doing it, so regardless of what someone else said, it was not important to abstain from it because everyone was doing it. So there was an understanding within groups that it was happening although between groups, some kind of effort at policing it was going on.

I think that among the boys too, there was concern about the risk of pregnancy. They also wanted to avoid it but the most common contraceptive method used was withdrawal. I think girls were aware of other methods but I am not sure how well informed the boys were. At the time, we didn't really discuss such things with boys. It is possible that we were all resigned to the fact that such things were not available to us. So when young people were sexually active, I think it was a combination of risking it and not thinking about it. Some probably thought that it would be okay just this once and chose not to think about it too much. I don't know what the boys thought but among the girls, I think this was the view.

By the time I was in grade 10, I knew about contraceptives but I didn't know how to get them. Actually, you couldn't get them. No girl would dare to go into a pharmacy to buy a contraceptive because it would be too embarrassing. We heard rumours that you had to have a marriage certificate to buy condoms. Actually I think that was the case then. Only married couples could buy them. At school, we heard about random cases of students getting pregnant all the time, from other schools as well. It wasn't so common but perhaps once or twice a year, you would hear about someone being expelled from our school but it never happened to a close friend of mine.

As I said, my boyfriend was several years older than me, which was one of the reasons

why I could not tell my friends about my sexual debut because most of my friends were going out with boys of a similar age to them. I was quite surprised at myself when I first gave in to intimate relations because I was quite a strong person. I had had a previous boyfriend also, who was not able to persuade me to do what I was not ready to do. Initially, I refused to engage in intimate relations for some time because I felt I was not ready and I was too young and perhaps I was also thinking from a religious point of view. But eventually, I gave in and I did feel pressured to oblige. But once I started, it was different and I thought it was okay.

At that time, our main preoccupation was about the possibility of getting pregnant and we did not give a thought to STIs because we didn't know about them. Although we were concerned about the possibility of pregnancy and we thought withdrawal was an effective contraceptive method, we both knew that there was a very small risk that pre-ejaculation could cause pregnancy. We were also using the counting method. In my head, I thought there was a very small chance. We knew of pregnancy prevention methods but did not have access to contraceptives. If we managed to get a condom, we would use it. As for pills, we didn't think about it because they were not available. And when I was about seventeen, the small chance happened and I became pregnant.

I found out because I missed my period. Two days passed, and then three, and then a week and because this had never happened to me before, I thought I had to do something about it. I was still in school. So with great difficulty, I managed to get a pregnancy test kit, which a married friend of my boyfriend helped to buy, and did the test which showed positive. I could not believe

it so three weeks later, I re-tested. A month passed after that and another. I was getting really desperate and the only thing I could do was to try home remedies to terminate the pregnancy. My boyfriend and I knew at the time that we could not have a child because I was in school, and I would be put under house arrest and I knew I had so much to lose. My whole future was at stake and it just was not an option. Keeping a baby was not an option. Telling my mother was also not an option so between us we had to do something. Those days, they used to say that eating unripe pineapple can help to induce abortion. My parents didn't notice and I used to go to his place to eat unripe pineapple, and to this day I can't eat pineapple! I also took Disprin dissolved in coke, which was another home remedy and we waited and waited for my period to arrive. It just did not happen. I was trying to do whatever I could to induce abortion, including riding my bike and exercising. We were both scared and traumatised by the whole thing and didn't know what to do.

By the third month, we were really desperate. My sister knew about the problem and she was also trying to help. But we were all so young and had no money so what could she do to help? I remember we were at our wits end by this time. And then it so happened that my friend's family was going abroad to a neighbouring country and they invited me to join them. My boyfriend also thought it was an opportunity to find a solution abroad and he joined too. He said it would not take too long and we could just go off together and have it done. It took a lot to convince my parents to let me go and my father was really angry and completely disapproved of it. My mother was more understanding. Even if both of them were against it, I had no choice but to go, because they would be even madder if they found out my situation. So

I went on that trip. My father was so angry with me he refused to speak to me for several months afterwards.

So 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 but we used to hear all the time how people got abortions in that country. So about two days before our trip ended, we eventually found a clinic by asking a local man. When we got there, they said that it was not possible to induce abortion at this stage, although they would do a check-up. 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. I knew enough at that time to understand that this was not a legal operation. It still gives me nightmares just thinking of the place.

So I went in for a check-up behind this curtain, and the doctor had told my boyfriend that an abortion procedure was not possible but he will do a check-up and my boyfriend should wait outside. 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. My boyfriend was outside thinking this was just a check-up and he didn't know what was happening. 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. I asked if he started already and he just said yes. The pain was excruciating. It was the most agonising ten or twenty minutes although it felt like an hour. I thought I was dying. It was such a painful thing and as I said, because I was so far into my pregnancy, I could see all the stuff they were taking out of me. It was traumatising to see all that stuff, along with all the pain I was having. Eventually

they finished and the doctor said “Ok, done. Leave”. They had not even put me in a gown. They had simply pulled down my pants. And then I began to throw up. They got angry with me for vomiting, and I made my way to the bathroom crying and someone came along and gave me a sanitary pad, which I used. As I walked out vomiting, I was trying to clean it up and on my way out, I saw another woman holding her sides, also vomiting, making her way out and I realised there were all these women coming in and out and this clinic was that kind of an operation. I went out to my boyfriend crying and he looked really anxious not knowing what was happening. He asked me what had happened and the doctor had said it was a check-up. I told him it’s finished so let’s go.

My boyfriend later told me that while I was inside, they asked him to pay and he thought he was paying for the check-up because it was really cheap. It was about 1500 rupees, but personally, I don’t think it was worth even that. It was a female nurse and a male doctor who conducted the procedure and they were just chatting among themselves. When I told them about the pain, they just told me “five minutes”. I am not exaggerating, but it was really traumatising and I still remember it. I remember thinking they can’t do this, they can’t just do it without asking me ... he said he was just checking, but in the end we were relieved so we could not complain either. My boyfriend had no idea what was happening but at the counter, he was given a pack of medicines without any information. He was simply told to get them. He wanted to come in after a while, he said, but they would not allow him in saying that I would be out in a moment. But of course, I was inside crying and trying to tidy myself up. There was no check-up afterwards, or scans or anything to see how things were and when I think about

it now, I realise how much was wrong with the whole thing. How did they know if my insides were ok or not?

I didn’t realise at the time, but much later on I realised that I should have had some scans and things done because how do I know what kind of damage has happened to me as a result of it, like internal bleeding or something? But at the time, it did not even occur to me to go and see a doctor. We returned to Malé two days later and it took about a week for the bleeding to stop, which was like a period and after that, I had no further pain. Physically, I experienced some changes after the abortion.

After this experience, we went to great lengths to get contraceptives. For example, I used a boyfriend’s sister’s pill prescription to get pills for myself. Because I was not married, I could not go to the doctor’s to get a pill prescription. After that experience, it was really scary. We rarely managed to get condoms and we had such difficulty getting pills. We just did not have access to contraceptives.

About my health, I didn’t think about going to see a doctor. I didn’t know about things like PAP smears or pelvic examinations or anything. I just knew the basics. But when I later went to university abroad, I learnt about the existence of all kinds of women’s health related matters. So then I realised I should have myself checked out in case I had contracted some kind of infection from being exposed to that experience in that dingy place. How do I know if the equipment they used was sterilised or not? I saw someone else go into that clinic straight after me and it was only much later that I realised what a big deal it was. I think about how all these Maldivians are constantly going to these places for abortions. Because of the information available to me while at

university, I went and did all the tests.

Although my boyfriend and I are no longer together, we are still in touch. After all these years, he is still affected by that experience. When we speak on the phone occasionally, he would tell me that he remembers it and how much it still upsets him about the way it happened. He found the whole thing very uncomfortable. Usually, men may not understand this but it is perhaps because he saw the state I was in when I came out of that place that he is affected by it. With all the vomiting and everything, he helped to clean me up afterwards when we got to the hotel.

Mentally, I had a mixture of emotions because it was such a harrowing experience. My sister could not handle hearing about it because she is very squeamish, and the things that disturbed me were the images of the things they were removing from inside me. I had seen all that so I needed to talk to someone but she could not listen to all that. I understood her discomfort, because some people can even pass out at the sight of blood. I could not talk about it with my boyfriend because it made him feel so guilty, so it was a difficult situation. Even to this day, it is still very difficult. But I have coped with it in different ways. At university, I went to the women's centre and joined support groups and although I did not receive immediate help after the experience, I feel like I have managed to let go of it now. I am sure there are many people who had not had that opportunity. At university, it's not like in Malé, and no one knows you and you can trust people. Here, you might go to a support group and find your next door neighbour there.

I think I had a pretty good family support system and I am sure that even if my parents

had got to know about my situation, they would have helped me, although I don't think they would have chosen the option to abort. I really don't know but at the time, I felt that that would have been their advice. For me, having a child was not an option. I have not told my parents about it still.

Not long after my own experience, I was helping a school friend who underwent an abortion in Malé. I must have been about eighteen then. It was induced through injections and I was there, holding her hand. When she had the injections, she got simultaneous vomiting and diarrhoea. That's what happens. After that, I used to hear a lot about people getting pregnant. It was as though everyone was getting pregnant at the same time. When I think about it, we were all in a similar age group and everyone was out there doing the same thing. When I think of my own circle of friends around that time, everyone except a handful were sexually active.

Nowadays, fear of becoming pregnant is the last of my concerns. But when I look back, there are many emotional aspects connected to that experience and I feel that it was a really bad thing to do. I was not ready for that and it was a huge responsibility, even though the choice was mine. But clearly, I was not mature enough to handle something like that. I wish it did not happen like that. Now, I can handle the responsibility but then, I was not ready for it. Abortion is not a method of preventing pregnancy.

I remember thinking that my boyfriend, being much older, would be responsible and he would not do something bad to me. I trusted him because of our emotional connection and believed that because he loved me, he would do me no harm. We knew that what we were doing exposed

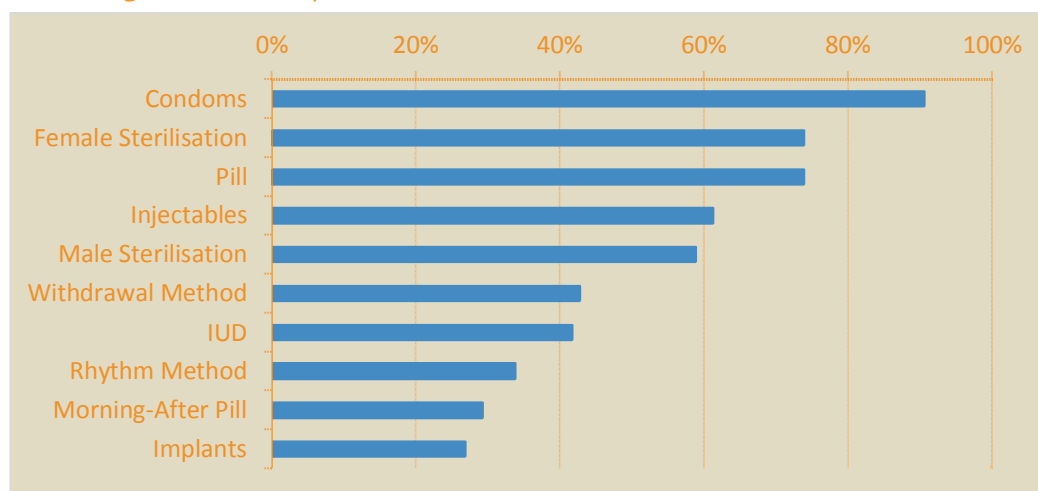
us to a small chance of getting pregnant, and thought that small chance would not happen to me. Like my peers, I feel that it is really important to have information available to young people, because we believe that even at a young age, you can make them responsible for things and although abortion is a choice, it is possible to prevent it. I wish we had that when we were younger. Now, anyone can walk into a pharmacy and buy a condom, regardless of what kind of looks people give.

Perhaps young people feel that information is power and perhaps they are getting socially less sensitive about this. It would still be difficult to do this if you are fifteen or sixteen, but now, they are becoming sexually active at thirteen, and even if they have information, they do not have access to contraceptives. In this country, a girl would still not be seen buying a contraceptive, although a boy might. But now, the younger generation of people are becoming sexually active in primary school, in grade 6 and 7 ... now these guys have done everything by grade 6. I think that young people should be given information within the school system so that it will help them to make informed RH related decisions.

Appendix 6

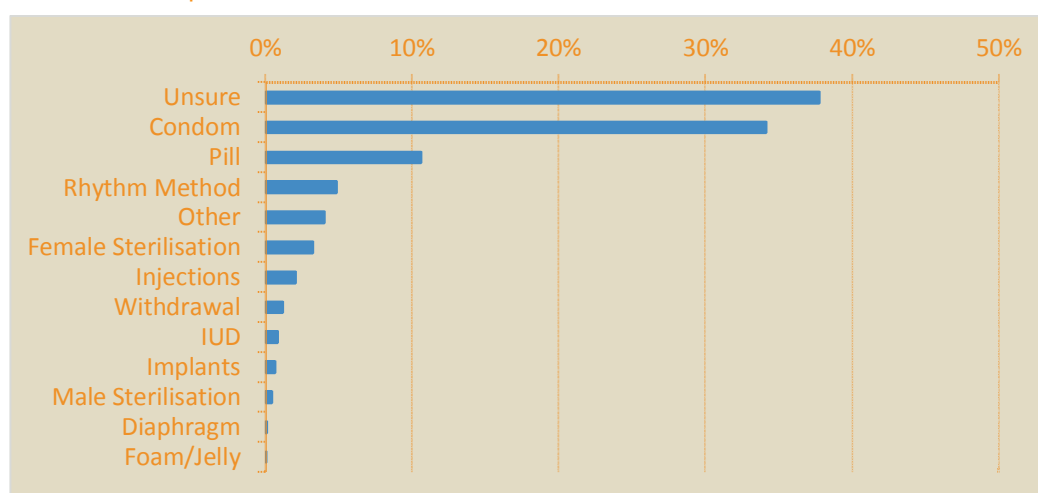
Youth knowledge of contraceptive methods Published and unpublished data, MDHS, 2009

Knowledge of contraceptive methods



Source: Adapted from 2009 MDHS, 2010:184, Table 15.6

Best contraceptive method



Source: Adapted from 2009 MDHS youth questionnaire data (unpublished)

Appendix 7

Extracts from Islam subject school texts

Menstruation

Menstruation is the monthly bleeding that comes from the private part of a healthy girl. According to scholars, menstruation begins when the child turns nine according to the lunar calendar. If blood is seen before this, it will be considered the result of some disease.

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Menstrual duration

Minimum menstrual period is 24 hours. Medium duration is 6 days and 6 nights or 7 days and 7 nights. Maximum is 15 days and 15 nights. This is what Imam Shafii has said.

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Sexual Intercourse

The meeting of the sexual organs of two people of the two sexes with sexual desire as they should

بَرَسْتُ سَهْوًا سَهْوًا سَهْوًا سَهْوًا سَهْوًا سَهْوًا سَهْوًا سَهْوًا سَهْوًا
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Source: Grade 8 Islam textbook (English translation added)

Appendix 8

Biology subject syllabus content - Cambridge (UK)

In the Maldives, reproductive health information is available to Grade 8 - 10 school children via the Cambridge Biology subject syllabus within the science subject stream.

In the content of the Cambridge Biology syllabus, the following RH information is taught.

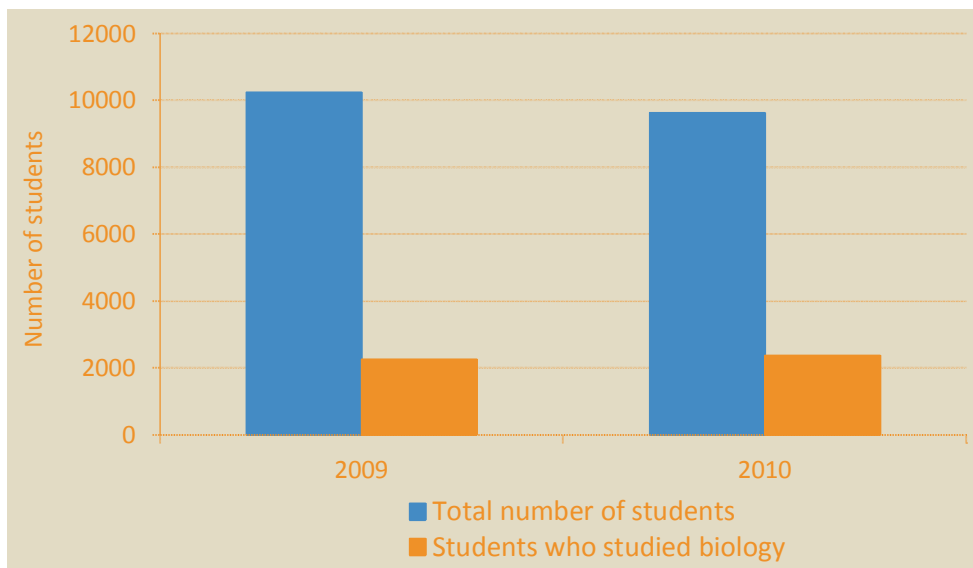
- (q) identify on diagrams of the male reproductive system and give the functions of the testes, scrotum, sperm ducts, prostate gland, urethra and penis;
- (r) identify on diagrams of the female reproductive system and give the functions of the ovaries, oviducts, uterus, cervix and vagina;
- (s) compare male and female gametes in terms of size, numbers and mobility;
- (t) describe the menstrual cycle, with reference to the alternation of menstruation and ovulation, the natural variation in its length and the fertile and infertile phases of the cycle;
- (u) explain the role of hormones in controlling the menstrual cycle (including FSH, LH, progesterone and oestrogen);
- (v) describe fertilisation and early development of the zygote simply in terms of the formation of a ball of cells that becomes implanted in the wall of the uterus;
- (w) state the function of the amniotic sac and the amniotic fluid;
- (x) describe the function of the placenta and umbilical cord in relation to exchange of dissolved nutrients, gases and excretory products (no structural details are required);
- (y) describe the special dietary needs of pregnant women;
- (z) describe the advantages of breast milk compared with bottle milk;
- (aa) describe the following methods of birth control: natural, chemical (spermicides), mechanical, hormonal and surgical;
- (bb) explain that syphilis is caused by a bacterium that is transmitted during sexual intercourse;
- (cc) describe the symptoms, signs, effects and treatment of syphilis;
- (dd) discuss the spread of human immunodeficiency virus (HIV) and methods by which it may be controlled.

Source : University of Cambridge International Examinations
© University of Cambridge International Examinations 2008
Syllabus code 5090
For examination in June and November 2011

Appendix 9

Number of students who sat biology examinations in 2009 and 2010

Students who sat GCE O'level & IGCSE exams



Source: Department of Public Examinations, April 2011

Appendix 10

Extract from IGMH Website - The Adolescent Clinic

5. The Adolescent Clinic

Purpose:

Giving information and guidance to teenagers regarding any problems which may arise due to the emotional as well as the physical changes that they are going through.

Services rendered:

Providing Medical checkups to ascertain their health condition.

If the doctor notices any problem during checkups the client will be referred to specialists for further investigation

Giving vaccines required by the adolescents such as Tetanus Toxoid, Rubella, Hepatitis B, Chicken Pox, Small Pox and Mumps.

Counselling.

Physical changes

Health problems related to adolescence

Relationships between friends and family

Sexually transmitted diseases

Reproductive health information

Significance of abstaining from psychologically induced traumatic behaviour

Essentials for maintaining a good health

6. Obtaining consultations from the various clinics

Consultation can be obtained from the various clinics only after getting an appointment from the RHC. Consultation from all the clinics is free of charge.

7. Other Services Provided by the RHC

Visiting patients admitted in the wards

Providing postnatal care to both mother and the baby, and providing guidance.

Guidance regarding breast feeding

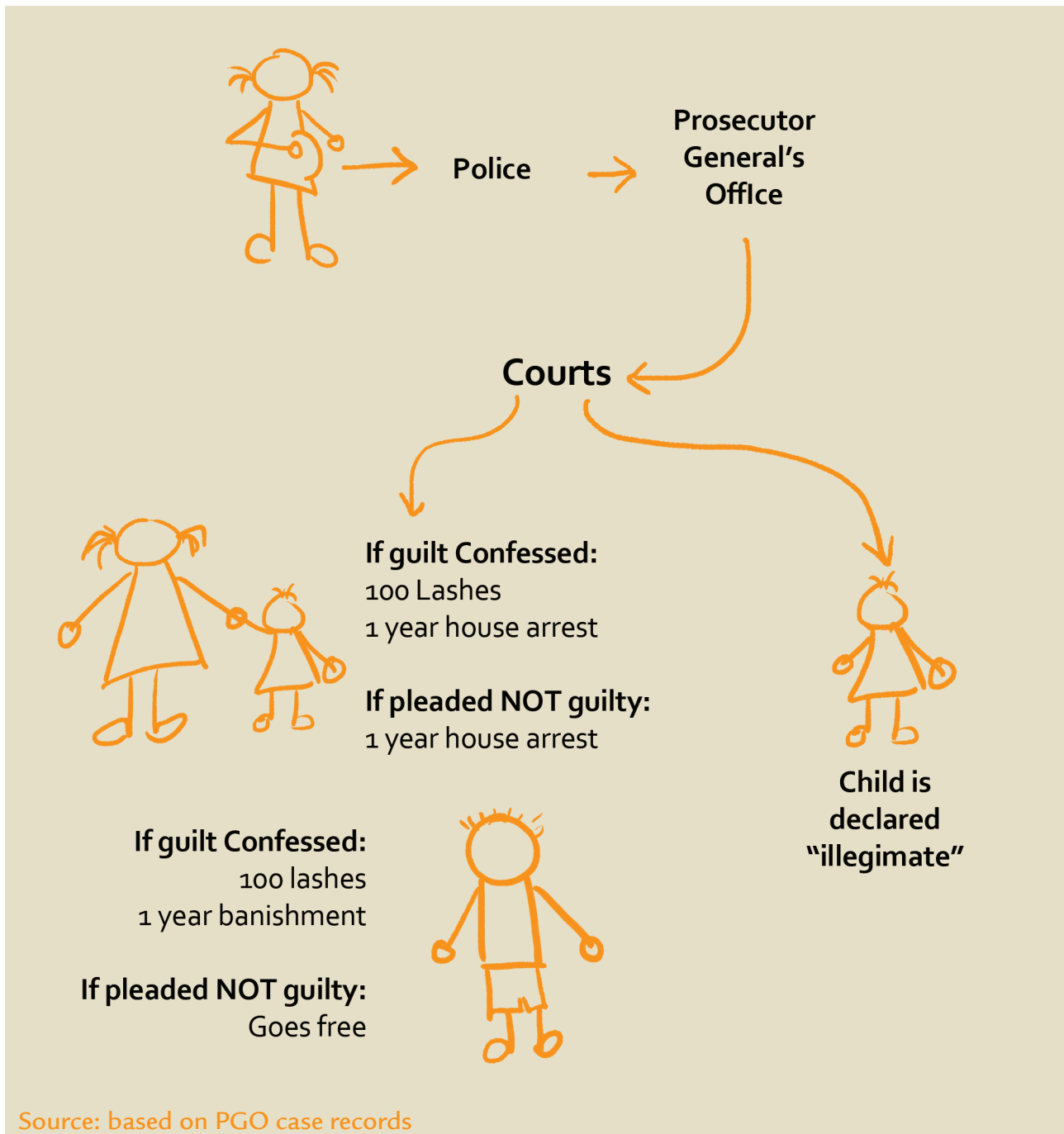
Guidance regarding child care

Providing information on how to tend to episiotomy/caesarean wounds

Source: <http://mhsc.com.mv/en/?p=44> (Accessed : May and June 2011)

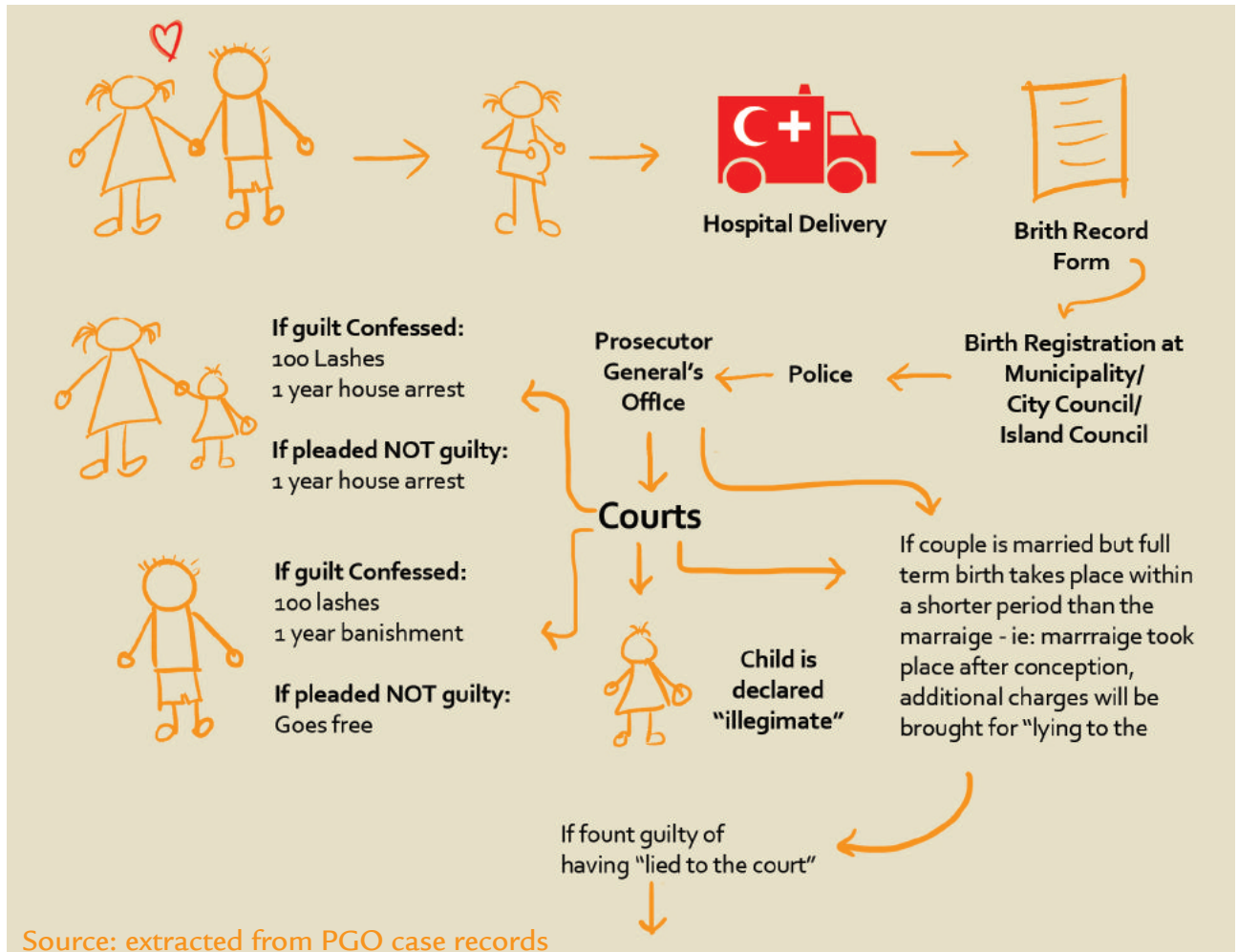
Appendix 11

Scenario of legal procedural consequence in cases of pregnancy outside marriage

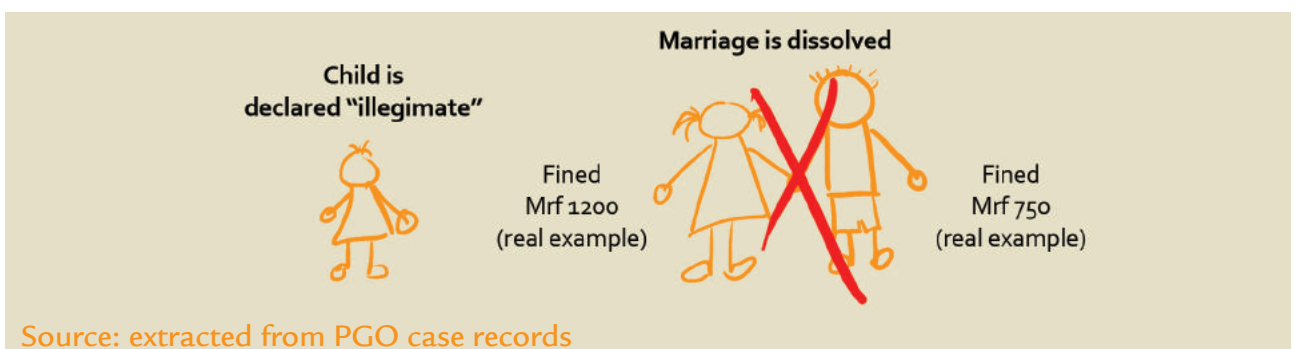


Appendix 12

The organisation of the administrative system in cases of pregnancy outside marriage



Legal repercussion when couples opt to marry once the woman falls pregnant. These punishments are in addition to the regular scenario as shown above



References

1. Biological and Behavioural Survey on HIV/AIDS, 2008, Department of Public Health, Ministry of Health, Maldives/GFATM, 2008
2. Draft Public Health Bill, submitted to Parliament on 02 September 2009 by MP Mohamed Nasheed (Kulhudhuffushi dhekunu constituency)
3. Family Act, No.4/2000
4. Family Protection Unit (FPU) : A Statistical Analysis, August 2010 ; IGMH and UNFPA (published leaflet)
5. Final Report of the Maldivian Penal Law and Sentencing Codification Project, Vol.2, Official Final Commentary (English version), Attorney General's Office/UNDP (January 2006) [submitted to Parliament in August 2007]
6. Fourth Country Programme Evaluation 2008-2010, October 2010, UNFPA
7. Greene M E (et al), In This Generation : Sexual and Reproductive Health for a Youthful World, Population Action International, 2002
8. Guidelines for Submitting Research Proposals to National Health Research Committee, Health Information and Research Unit, Ministry of Health, February 2007
9. Health Master Plan 1996 – 2005, Ministry of Health, Maldives
10. Health Master Plan 2006-2015 (Reviewed 2010), Ministry of Health and Family, 2010
11. Knowing our Rights : Women, family, laws and customs in the Muslim world [Third Edition], Women Living Under Muslim Laws, 2006
12. Mack N [et al], Qualitative Research Methods : A Data Collector's Field Guide, Family Health International/USAID, 2005
13. Maldives Demographic and Health Survey 2009, Ministry of Health and Family, Maldives/WHO/UNFPA/UNICEF, ICF Macro, 2010
14. Millennium Development Goals - Maldives Country Report 2010, Department of National Planning, Ministry of Finance and Treasury, Maldives 2010
15. National Report for the International Conference on Population and Development, 5-13 September 1994, Cairo, Egypt, Government of the Republic of Maldives

16. National Reproductive Health Strategy (2008-2010), Department of Public Health, Ministry of Health, Maldives, 2008
17. National Standards for Family Planning Services, 2005, Department of Public Health, Maldives
18. Reproductive and Sexual Health of Adolescents in the Maldives, 2003, CDE/UNFPA
19. School Health Policy 2011, Ministry of Education and Ministry of Health and Family, Maldives, January 2011
20. Thalagala N, Socio-Cultural Factors and Unsafe Abortions in the Maldives, 2008, IPPF (SARO)
21. The Maldives National Youth Policy 2003, Ministry of Youth and Sports, Maldives
22. The Maldives Study on Women's Health and Life Experiences, 2007, Ministry of Gender and Family, Maldives/UNFPA/UNICEF/WHO
23. The Reproductive Health Baseline Survey, Ministry of Health, Maldives/UNFPA, 1999
24. The Reproductive Health Survey, 2004, Ministry of Health, Maldives/UNFPA,
25. The Strategic Action Plan 2009-2013, Government of Maldives, 2009
26. Unsafe Abortion : Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003 [Fifth Edition], World Health Organisation WHO, 2007
27. Young People's Sexual and Reproductive Health in the Middle East and North Africa, 2007, Population Reference Bureau, Policy Brief

Internet sources and references:

Abandoned infant girl found in Hulhumalé, Minivan News, 27 November 2010, Minivan News, <http://minivannews.com/news-in-brief/abandoned-infant-girl-found-in-hulhumale-13755> (Accessed : 21 May 2011)

ICPD Programme of Action 1994
<http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm>
(Accessed : 18 March 2011)

Merrett N, Premature baby found in coast milk tin on Villingili, 21 May 2011, Minivan News, <http://minivannews.com/society/premature-baby-found-in-coast-milk-tin-on-villingili-20440> (Accessed : 21 May 2011)

Nazeer A, Dead baby found in swimming area, 05 May 2011, Minivan News, <http://minivannews.com/society/dead-baby-found-in-swimming-area-19871> (Accessed : 08 May 2011)

Omidi M, Amnesty calls for moratorium on flogging, Minivan News, 09 July 2009
<http://minivannews.com/society/amnesty-calls-for-moratorium-on-flogging-1371>
(Accessed : 06 August 2010)

Omidi M, Abortion in the Maldives : the untold story, Minivan News, 07 January 2010
<http://minivannews.com/society/abortion-in-the-maldives-the-untold-story-2191>
(Accessed : Dec 2010)

Ortega L R, Murder of new-born baby sends mother and daughter to life in prison, Minivan News, 14 March 2010, <http://minivannews.com/society/murder-of-newborn-baby-sends-mother-and-daughter-to-life-in-prison-4498> (Accessed : 06 December 2010)

Saathi Sanga Manka Kura, Nepal, <http://ssmk.org>
(Accessed : May 2011)

Voices of Youth, UNICEF Nepal, <http://unicef.org.np/voy/freedom-express>
(Accessed : May 2011)



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