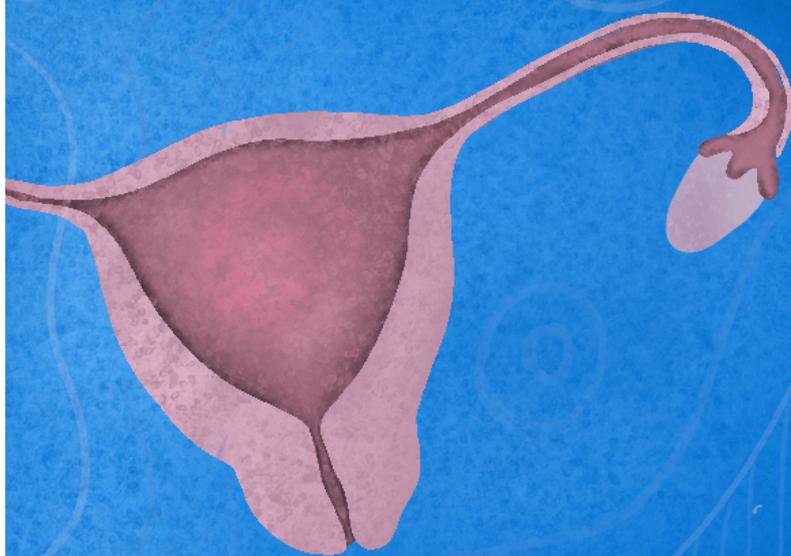


QUALITATIVE ASSESSMENT ON CHALLENGES TO ACCESS SRH INFORMATION AND SERVICES AMONG YOUNG PEOPLE IN THE MALDIVES WITH A FOCUS ON UNPLANNED TEENAGE PREGNANCY



Ensuring rights and
choices for all

HUMAIDA ABDULGHAFOOR
National Consultant for UNFPA Maldives 2020

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ABBREVIATIONS

CSE	Comprehensive Sexuality Education
D&C	Dilation & Curettage
DHS	Demographic And Health Survey
EC Pill	Emergency Contraceptive Pill
ESQID	Education, Supervision And Quality Improvement Division
FGM	Female Genital Mutilation
FPA	Family Protection Authority
FPU	Family Protection Unit
GBV	Gender-Based Violence
GSHS	Global Student-Based School Health Survey
HPA	Health Protection Agency
HPV	Human Papilloma Virus
IGMH	Indhira Gandhi Memorial Hospital
MMR	Maternal Mortality Rate
MNYC	Maldives National Youth Council
MoGFSS	Ministry Of Gender, Family & Social Services
MoNPI	Ministry Of National Planning & Infrastructure
NIE	National Institute Of Education
OOP	Out-Of-Pocket
SDG	Sustainable Development Goals
SHE	Society For Health Education
SHS	School Health Section
SRH	Sexual And Reproductive Health
SRH/R	Sexual And Reproductive Health And Rights
STI/RTI	Sexually Transmitted Infection/Reproductive Tract Infections
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

INTRODUCTION

Background & Country Context

The Maldives is an area of 115,300 square kilometres of primarily ocean, with 188 dispersed inhabited small island communities among a total of nearly 1190 small islands in the Indian Ocean. The Maldives has a population of 512,038 in total which includes a national population of 366,176 and an expatriate population of 145,862, the latter being predominantly male.^{1,2} According to a youth analysis of the Census 2014, the “number of individuals aged 15 to 34 had increased from 121,000 in 2000 to 136,000 in 2014, representing around 40 per cent of the Maldivian resident population (about an equal number of 68,000 young men and young women).”³ Among the inhabited islands, 123 consist of small communities of less than 1000 residents, while 63 islands have a resident population of between 1,000 – 10,000 with just 2 islands having populations above 10,000, which includes the capital Male’ which hosts 38% of the total population.⁴ In this geographical context with the centralized urban hub of greater Male’ and the widely dispersed small island communities, the Maldives faces specific challenges to provide healthcare and other public services equitably across the country.

The health sector in the country is administered through a tiered system with a healthcare service centre established in every inhabited island. Regionally, there are secondary level service hospitals and in the capital Male’ City, the main public health tertiary level service provider is Indhira Gandhi Memorial Hospital (IGMH). There are two private hospitals in the urban centre of Greater Male’ as well as several private clinics providing a range of specialized curative healthcare services, including alternative/traditional medicine clinics. The government established a universal health coverage scheme in 2014, called Husnuvaa Aasandha providing free healthcare for Maldivian nationals, which is currently available for Maldivians living in India and Sri Lanka as well.^{5,6}

The Maldives has achieved significant developmental gains in key health indicators over the past four decades, with life expectancy at 75 years for women and 73 years for men, as per 2016 figures.⁷ Maldives achieved the MDG goal 5A on maternal health indicators, although the MDG goal 5B on universal access to SRH has not been achieved.⁸ The national total fertility rate (TFR) has been declining and stood at 2.5 in 2009 further lowering to 2.1 in 2016/2017, with a trend of higher TFR in rural areas compared to the urban centre Male’.⁹ The population of women in the reproductive age group 15-49 is reported to be 112,000 in 2019.¹⁰ According to the latest DHS 2016-2017, “[n]inety-nine percent of women in the Maldives receive antenatal care from a skilled provider, mostly a gynaecologist”, 95% of births are delivered in a health facility with 100% of births assisted by a skilled service provider.¹¹ These indicators are reported to have remained stable since 2009. The DHS surveys in both 2009 and 2016-2017 are consistent in their findings that teenage pregnancy in the Maldives is uncommon, reporting that “only 2 % have begun childbearing” among the 15-19 years cohort.¹² Nevertheless,

- 1 Statistical Pocketbook of Maldives 2019, National Bureau of Statistics, Ministry of National Planning & Infrastructure, 2019
- 2 Thematic Analysis on Youth in the Maldives based on 2014 Population and Housing Census data, Andreas D, UNFPA, 2017
- 3 Ibid:15
- 4 Population & Housing Census 2014, Statistical Release 1, National Bureau of Statistics, Ministry of National Planning & Infrastructure, 2014
- 5 Note : husnuvaa means ‘unlimited’ in the local language, Dhivehi
- 6 Husnuvaa Aasandha - Scheme Overview, Aasandha, <https://aasandha.mv/en/scheme/overview> (accessed : 30 Dec 2019)
- 7 Statistical Pocketbook of Maldives 2019, National Bureau of Statistics, Ministry of National Planning & Infrastructure, 2019
- 8 Joint-submission to the UPR 2015, Society for Health Education/Sexual Rights Initiative, UPR 22nd Session, May 2015
- 9 Maldives Demographic & Health Survey 2016-2017, Ministry of Health, Maldives
- 10 Maldives : Using Data to Inform FP Prioritisation (draft), UNFPA Maldives, [undated]
- 11 Maldives Demographic & Health Survey 2016-2017, Ministry of Health, Maldives (pg.115)
- 12 Maldives Demographic & Health Survey 2009, Ministry of Health, Maldives (pg.51), and Maldives Demographic & Health Survey 2016-2017, Ministry of Health, Maldives (pg.67)

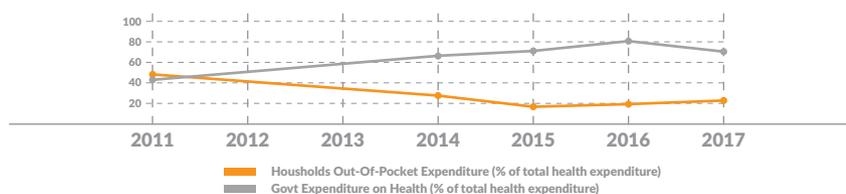
these quantitative indicators sit uncomfortably with qualitative findings based on the lived experiences of adolescents and young people and the persistent service gaps on SRH to adolescents and youth in the Maldives.

Maldives has been producing National Health Accounts since 2011, with subsequent reports produced in 2014 and for the years 2015-2017. According to the Ministry of Finance, out-of-pocket (OOP) health expenditure has reduced dramatically from 50% in 2011 to 29.5% in 2014.¹³ Data available from the latest National Health Accounts 2015-2017 shows the improvements in OOP over recent years, as provided in Figure 1 below. While the two trendlines show a significant and consistent correlation of reducing OOP with rising government expenditure, it is notable that due to the centralized tertiary level healthcare provision, those living out of Male' face significant OOP costs due to travel and accommodation which are generally not covered by government healthcare. Moreover, the healthcare services available in the atolls outside the urban centre are often inadequate and limited, with referral to IGMH being a normative practice for most diagnostic medical needs. The situation is exacerbated given the curative model of health service in the Maldives. These realities have a serious impact on service access for many, particularly the most vulnerable and economically disadvantaged. Youth friendly SRH information and service provision is a particularly poorly served area. Available policy literature shows that none of the youth health initiatives in the Maldives have been successful for various reasons.^{14,15} The 2016-2025 Health Master Plan reported that "the services of the adolescent health clinic [at IGMH] are under-utilized as the service environment is stigmatizing to young people and has ceased to function."¹⁶ While expenditure on SRH is not identified in the most recent national accounts, the 2011 report informs that USD 3.0 per capita is spent on maternal and child health, family planning and counselling which constitute 0.5% of total government health expenditure.¹⁷ The available data does not provide information on the range of SRH expenses, and in the country context, is entirely silent on abortion services. A 2012 rights study by the Human Rights Commission of the Maldives informed that "a quarter of women and 15.9% of men knew someone who had had an illegal abortion", which indicates the significance of the issue of unplanned pregnancy and abortion in the Maldives.¹⁸

FIGURE 1

HEALTH EXPENDITURE TREND, MALDIVES 2011 TO 2017

Data Source : Maldives National Health Accounts, 2015 -2017, Ministry of Health, Maldives (pg25)



13 Launching of the National Health Accounts 2014, 27 October 2018, Ministry of Finance, <http://www.finance.gov.mv/media/news/launching-of-the-national-health-accounts-2014> (accessed : 30 Dec 2019)

14 Sexual and Reproductive Health and Rights in Maldives, Policy Brief, UNFPA, 2017

15 Health Master Plan 2016-2025, Ministry of Health, Maldives

16 Ibid:27

17 Maldives National Health Accounts, 2011, Ministry of Health, Maldives (pg.34)

Objectives of the research

Several concerns surrounding access to SRH motivate this research, as specified in the Terms of Reference for the assignment. These include concerns about the instability of the Maternal Mortality Rate (MMR) in the Maldives context, the decline of the Contraceptive Prevalence Rate (CPR) and the socio-cultural taboo surrounding the topic of Comprehensive Sexuality Education (CSE) in a context where access to SRH information and services are 'formally' available to young people after marriage. A primary concern of this assignment is the observation that significant numbers of girls are being deprived of formal schooling due to unplanned pregnancy while at school, and as such, it is the intention of this research to document case studies of young people with this life experience.

A key purpose of this research is also to understand the root causes of gender inequality and the factors that influence Maldivian girls and young women, specifically in rural contexts where increased levels of vulnerability and disadvantage exists to access SRH information and services. As such, this research will use a qualitative methodological approach to examine structural gender-based discrimination impacting the study subjects in both urban and rural contexts, where feasible.

IN SUMMARY, THE OBJECTIVES OF THIS RAPID QUALITATIVE ASSESSMENT ARE TO ESTABLISH

A) *lived experiences of young people affected by the existing structural and socio-cultural challenges and barriers to access SRH information and services*

B) *lived experience of seeking help when experiencing gender-based violence (GBV) in the same context*

Methodology

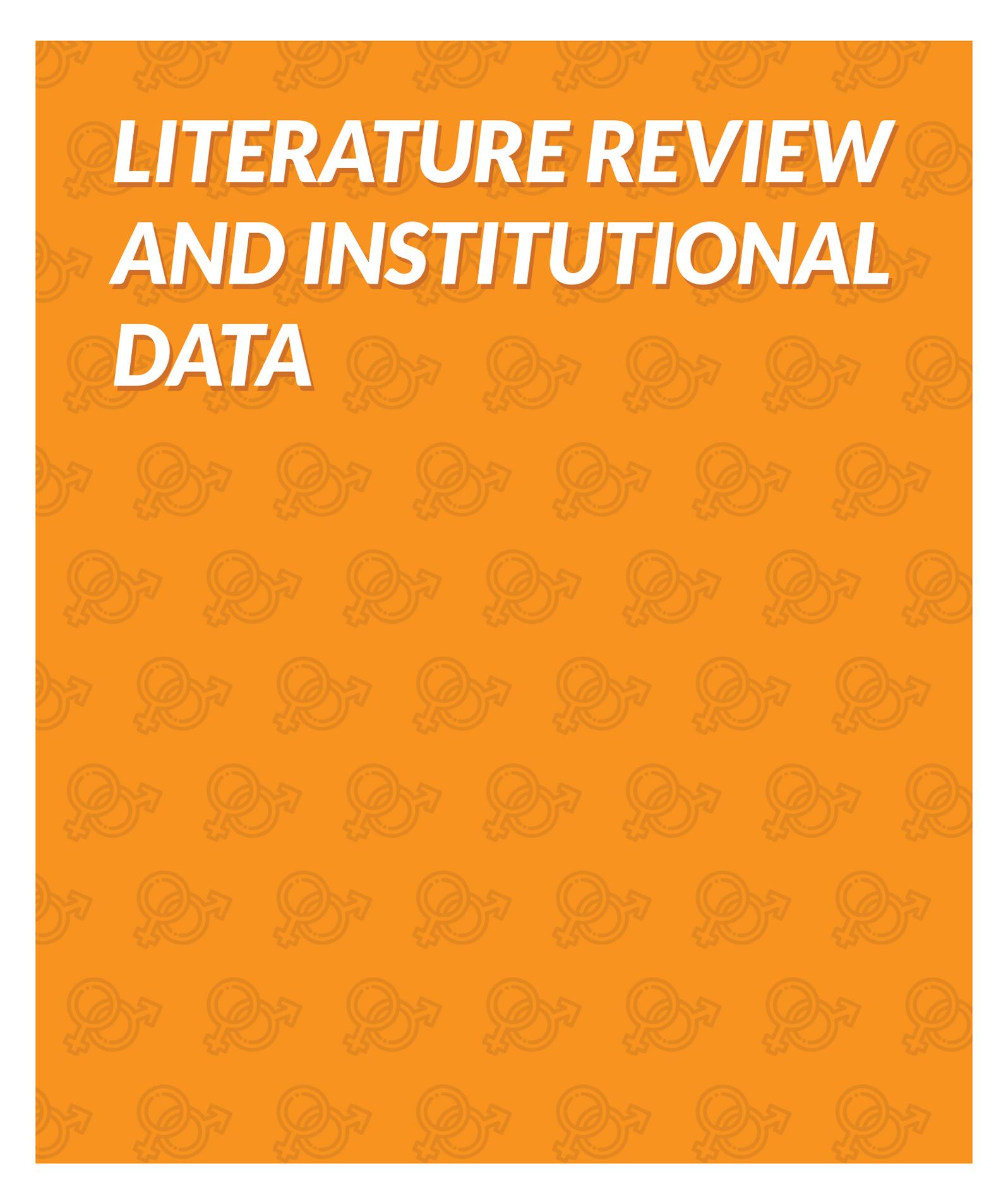
A qualitative methodology was used to gather information for this rapid assessment to document lived experiences of young people. A rapid review of existing literature that covers the specific area that interests this study was conducted. Due to the acute time constraints and the timing of the exercise which coincided with annual holidays, a purposive sampling method was used to reach key informants. Specific, trustworthy official and unofficial gatekeepers were approached to access study subjects to gather primary data, such as the Ministry of Gender, Family and Social Services (MoGFSS) and related networks including civil society and health service providers. Key informant interviews were conducted with specific stakeholders to obtain insights, as listed in Appendix 1. While efforts were made to obtain primary data on the target group of the research, much of the data was obtained from secondary sources. A flexible data gathering strategy was used to adapt to some of the observed challenges and limitations, given the sensitivity of the subject.

Efforts to obtain primary data through in-depth interviews with study subjects was not successful, which was anticipated given the existing research constraints, including time constraints, timing of the research coinciding with end of the year holidays in the Maldives, combined with the fact that the subject is extremely sensitive with hesitancy of subjects to trust gatekeepers as well. Therefore, case studies were documented from open-ended conversations with social workers, conducted in their workplace. Case workers filtered specific cases that fit the target group, primarily on the experience of unplanned pregnancy among adolescents and young people, specifically subjects that had experienced pregnancy while attending school. Ethical considerations were observed as a high priority given the target group, the sensitivity of the topic as well as the importance of observing confidentiality. In this regard, a confidentiality agreement was signed between the MoGFSS and the researcher.

Limitations and significance of the study

The primary limitation of this inquiry is the short time-frame available to conduct the research, especially in the rural context. However, this was addressed in the research method by using a purposive sampling method and a very focused approach to data collection using specific key informants that are knowledgeable in the subject area within the government and non-government sectors. While attempts were made to obtain primary data, efforts to reach interview subjects were not successful. As such, the alternative option to source relevant data from case notes from the MoGFSS was chosen. Therefore, the case notes and case accounts shared by consulted stakeholders provide direct insights to the lived experiences and realities of life of target subjects, which is the best possible available information in the circumstances.

It was envisaged that the findings of this inquiry will generate new information on a cohort of vulnerable young people whose SRH life experiences have not been studied to date in the Maldives. Therefore, this research will be significant in its objective to capture some of the closest to source and credible accounts of lived experiences of a very vulnerable group of young people in the Maldives, given the vision of the sustainable development goals (SDGs) to 'leave no one behind'.



LITERATURE REVIEW AND INSTITUTIONAL DATA

LITERATURE REVIEW AND INSTITUTIONAL DATA

As observed in the introduction, there is a body of information in terms of national level surveys and occasional small scale studies by researchers and students exploring the issue of SRH/R among adolescents and young people in the Maldives. However, in-depth qualitative assessments to gain broader contextual understanding and documentation of specific challenges to access SRH information and services among this demographic remain scarce. This review will present findings from existing national surveys, reports and strategies and provide recent institutional data on relevant indicators to adolescent and youth SRH that are pertinent to this inquiry.

National surveys and quantitative data on adolescent and youth SRH indicators

The World Health Organisation defines adolescents as individuals in the 10-19 years age group and youth as those in the 15-24 years age group, and young people as those aged 10-24 years.¹⁹ In Maldives, youth and young people are counted from an older and wider age range, with the latest Census in 2014 showing that young people aged 18-34 years represent 35% of the population while the 15-24 cohort is 20%.²⁰ The Census also showed that 60% of women in the Maldives are of reproductive age.²¹ Each of these facts indicate the relevance of prioritising SRH information and service provision in the country.

According to the latest Demographic and Health Survey (DHS, 2016-2017), 69% of women and 55% of men are in a marital union and the median age at first marriage is 20.9 years among women and 24.7 years among men, indicating that women marry four years earlier than men.²² The DHS also reported that among a sample of men and women between the ages of 25-49 years, the “median age at first sexual intercourse” among Maldivian women is 20.7 years and 23.1 years among men.²³ Moreover, the survey found that 21% of women in the sample have had sexual intercourse before the age of 18, while “only 13% of men have had sex before age 18”.²⁴ By the age of 20, 43% of women are reported to have had sexual intercourse while this figure stood at 25% for men, suggesting that a significantly higher number of young women have sexual initiation/experience during adolescent and teen years. The findings showing sexual initiation among women occurring much earlier than men could be driven by early marriage or indicates the prevalence of both consensual and non-consensual premarital sexual initiation. Both scenarios have significant consequences for the overall SRH health and wellbeing of young people.

In the last two surveys, the DHS has consistently showed that teenage pregnancy is “rare” and low in the Maldives with 2% adolescents reported to have begun childbearing, among whom 0.6% at age 17 years, 0.7% at 18 years and 6.5% at 19 years.²⁵ Research on sexual initiation among young people has observed that “involuntary intercourse” may be a factor influencing the accuracy of such

18 The “Rights” Side of Life, HRCM / UNDP, 2011 (pg.30,38)

19 WHO South East Asia website, <https://www.who.int/southeastasia/health-topics/adolescent-health> (accessed : 31 Dec 2019)

20 Thematic Analysis of Youth in the Maldives, UNFPA Maldives, 2017

21 *ibid*

22 Maldives Demographic & Health Survey 2016-2017, Ministry of Health, Maldives (pg.59)

23 *Ibid*:57

24 *ibid*

25 Maldives Demographic & Health Survey 2009, Ministry of Health, Maldives, p.51 ; Maldives Demographic & Health Survey 2016-2017, Ministry of Health, Maldives, p.67

data, and “misreporting is more likely when an individual’s experience includes nonconsensual sex.”²⁶ In this context, it is concerning that data available from the Ministry of Education shows that between 2017 and September 2019, twenty one school students were recorded to have become pregnant. In addition to the disruption to the child’s education and health impacts, the prevailing religious, cultural and legal context where out-of-wedlock pregnancy is criminalised and heavily socially stigmatised, this is especially problematic.^{27,28} Moreover, data available from the Global Student-based School Health Survey (GSHS) provided later in this report highlight other compounding factors (see page 21).

In terms of reproductive health knowledge, contraceptive uptake and use of family planning, existing data indicates the puzzling inconsistency that contraceptive use is lower among women with higher levels of education in the Maldives, than among those with lower education levels.²⁹ Also, contraceptive use has declined significantly since 2009. The DHS 2016-2017 reported findings on knowledge of key SRH information among women. It found that only 18% of women between 15-49 years had knowledge of their fertile period, and this number is low among adolescents at 14% and is highest among youth between 25-29 years at 22% (see Images 1&2). Considering near universal school enrollment in the Maldives, the level of SRH knowledge is evidently poor, the reasons for which will be discussed elsewhere in this report, especially in connection to the poverty of SRH content delivered in the school curriculum.

IMAGE 1

HEALTH EXPENDITURE TREND, MALDIVES 2011 TO 2017

Data Source : DHS 2016-2017, Table 7.7, screenshot

Table 7.7 Knowledge of fertile period by age

Percentage of women age 15-49 with correct knowledge of the fertile period during the ovulatory cycle, according to age, Maldives DHS 2016-17

Age	Percentage with correct knowledge of the fertile period	Number of women
15-19	14.1	1,099
20-24	19.1	1,223
25-29	22.6	1,379
30-34	17.7	1,372
35-39	19.6	1,044
40-44	17.9	845
45-49	11.8	737
Total	18.0	7,699

Note: Correct knowledge of the fertile period is defined as “halfway between two menstrual periods.”

26 Gender Differences in the Timing of First Intercourse: Data from 14 Countries, Singh S, et al, *International Family Planning Perspectives*, Vol. 26, Number 1, March 2000

27 Data obtained from the Ministry of Education, September 2019 (UNFPA Maldives communications)

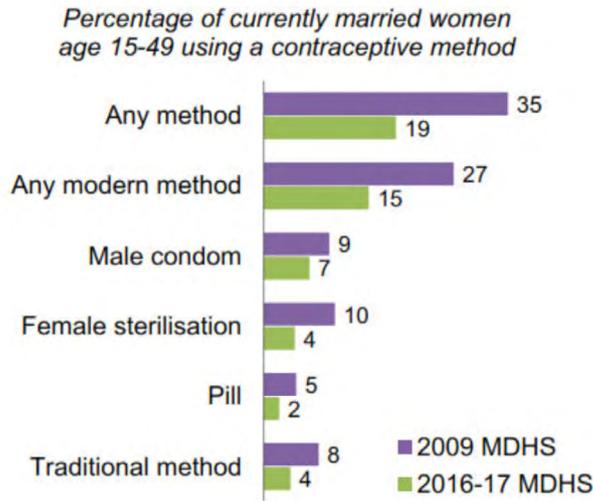
28 Universal Periodic Review of Maldives, 22nd Session, Joint-submission SHE/SRI, May 2015

29 Joint-submission to the UPR 2015, Society for Health Education/Sexual Rights Initiative, UPR 22nd Session, May 2015

IMAGE 2

TRENDS IN CONTRACEPTIVE USE SHOWING DECLINE OF UPTAKE OF ALL METHODS SINCE 2019

Data Source : DHS 2016-2017, Table 7.2, screenshot



Gender-based and domestic violence, marital control and spousal violence are areas of specific concern in the context of SRH, with available data showing that 1 in 5 women experience intimate partner violence in the Maldives.^{30,31,32} Existing literature on the issue of access to SRH information and services, particularly for young people in the Maldives indicate inconsistencies between the quantitative data obtained through national surveys such as the DHS noted above, and in-depth qualitative data involving the documentation of lived experiences.^{33,34}

30 Maldives Study on Women's Health and Life Experiences, Ministry of Gender, 2007

31 Efficiency of Sexual and Reproductive Health Spending in Maldives, Abegunde D, UNFPA, April 2016

32 Maldives Demographic & Health Survey 2016-2017, Ministry of Health, Maldives

33 Sexual Health Policies and Youth : A case study of the Maldives, Shaffa Hameed, Doctoral Thesis for London School of Economics, June 2012

34 Reproductive Health Knowledge and Behaviour of Young Unmarried Women in the Maldives, UNFPA Maldives, 2011

INSIGHTS FROM EXISTING QUALITATIVE DATA

In the Maldives socio-cultural context, data on sexual behaviours generated from self-reported quantitative surveys is considered unreliable, being even perceived as implausible. For instance, the low response rate of 12% in urban areas in the 2004 baseline Reproductive Health Survey is a case in point, as well as the subsequent DHS 2009 which found that “only 11.6% of youth aged 18-24 years ... had engaged in premarital sex”.³⁵ According to Hameed, a qualitative inquiry conducted in 2009 found that a range of stakeholders including “policymakers, service providers and youth ... found [the DHS] figure a gross underestimation.”³⁶ As noted previously in this report, the DHS 2009 also found that teenage pregnancy in Maldives “is rare”, a finding inconsistent with the insights obtained from a qualitative inquiry into the lived experience of SRH behaviour among unmarried young women.³⁷ Moreover, it is a well recognised fact that the prevalence of abortion is not documented or officially recorded for policy purposes, nor acknowledged despite the availability of relevant research on the issue.³⁸

Many factors contribute to challenge data accuracy on SRH behaviour including existing socio-cultural paradoxes, such as the fact that while extra-marital sexual activity is criminalised and pregnancy out of wedlock is socially taboo, an expectation exists that young men will be sexually active outside marriage. A policy expectation exists that religious abstinence would be the normative practice among young people, although qualitative findings indicate that “religious sensitivity cited and assumed in policies ... were not reflected in young people’s narratives.”³⁹ In fact, young people report being less concerned about the religious dimension of extra-marital sexual activity than the social and family repercussions of the consequences of such behaviour. According to Hameed, “Most young people interviewed expect to be disowned or kicked out of their homes if they were found to be sexually active or pregnant outside of marriage. They were very conscious of how their behaviour reflects on their family, creating added pressure for youth to conceal illicit sexual activities, even at the expense of their own health.”⁴⁰ The following account of how an out of wedlock pregnancy was managed by a woman provided in that research is worthy of note.

“ [...] when she got pregnant while in school, she wrapped her [stomach] in cloth and later ... her mother and them... well, she delivered in the bathroom and the baby... when they found her the baby had died they say ... I don't know if the baby was killed ... There's no facility like that on this island, I mean you can't get pills like that but I guess you could drink something like bleach but ... she wrapped herself in cloth until she gave birth ...” (R14, married, female, rural)”⁴¹

A consequence of the prevailing situation is the occurrence of cases of infanticide, which in recent years has been visible in media reports. As observed in a 2014 article, “Several cases of infanticide were reported in the media in recent years, including several new born babies and prematurely born infants abandoned in parks, buried in secluded places, or thrown into the sea.”⁴²

35 To be young, unmarried, rural and female : intersections of sexual and reproductive health and rights in the Maldives, Shaffa Hameed, RHM Journal, 2018:pg.62

36 *ibid*

37 Reproductive Health Knowledge and Behaviour of Young Unmarried Women in the Maldives, UNFPA Maldives, 2011:pg.29

38 *ibid*

39 To be young, unmarried, rural and female : intersections of sexual and reproductive health and rights in the Maldives, Shaffa Hameed, RHM Journal, 2018:pg.62

40 *Ibid:66*

41 *Ibid*

42 Dead infant found in Malé lagoon, Minivan News (Archives), 14 April 2014, <https://minivannewsarchive.com/tag/infanticide> (accessed : 10 Jan 2020)

INSTITUTIONAL DATA AND ANALYSIS

Ministry of Gender, Family and Social Services (MoGFSS)

The prevalence of child sexual abuse and violence is a serious concern in the Maldives, with available data showing a steady increase of reported cases in recent years. Data obtained from the MoGFSS shows that sexual violence and abuse reporting against the girl child is in stark contrast to that for boys (see Figure 2). There is a notable increase of reported cases of sexual crimes against children in 2019 compared to the previous two years. The reasons for this can only be adequately assessed through further study of the cases. However, the notable increase can also be an indicator of public confidence in reporting to the authorities given the more stable political situation in the country compared to previous years. It is also notable that there is a significant increase in reported cases of child rape, which is exclusively of the girl child (see Figure 3). This data covering a period of just over three years shows no reported cases of boy child rape. This difference raises questions whether rape is a crime perpetrated exclusively against girls or whether there is a culture of non-reporting of boy child rape. Additionally, given the general lack of confidence in institutions in the Maldives, the available data raises many questions about the prevalence of non-reporting. This will be impossible to estimate given the wide variety of challenges to access social protection services, including quality of services as well as socio-

FIGURE 2

REPORTED CASES OF CHILD SEXUAL VIOLENCE / ABUSE BY SEX AND YEAR

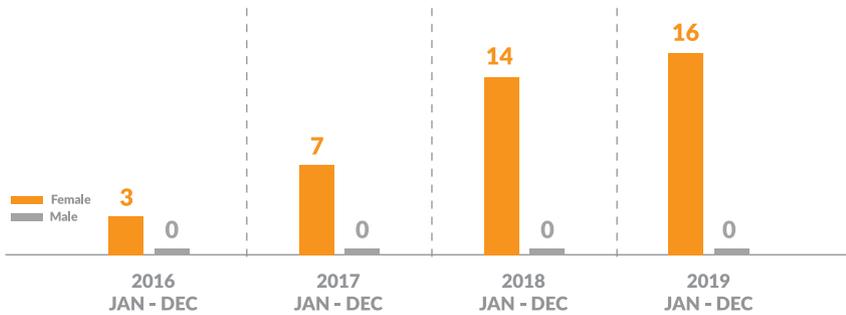
Note : Data from 2016 and 2019 are for part of the year

Data Source : Ministry of Gender , Family and Social Services, December 2019



FIGURE 3
REPORTED CASES OF CHILD RAPE BY SEX AND YEAR

Note : Data from 2016 and 2019 are for part of the year
Data Source : Ministry of Gender , Family and Social Services, December 2019



cultural, geographic and economic challenges, especially in rural contexts. The available data on child sexual abuse shows a significant increase of reported cases in 2017 (see Figure 4 below) which has since been declining. This data does not support the suggestion above, about improved confidence in the social protection service providers as a possible explanation of increased reporting. Once again, there is a very notable disparity between the reported number of cases of abuse against the girl and boy child, showing a clear difference showing the extent of sexual abuse against the girl child (see Figure 4). There is a need to

FIGURE 4
NUMBER OF REPORTED CASES OF CHILD SEXUAL ABUSE, BY SEX AND YEAR

Note : Data from 2016 and 2019 are for part of the year
Data Source : Ministry of Gender , Family and Social Services, December 2019

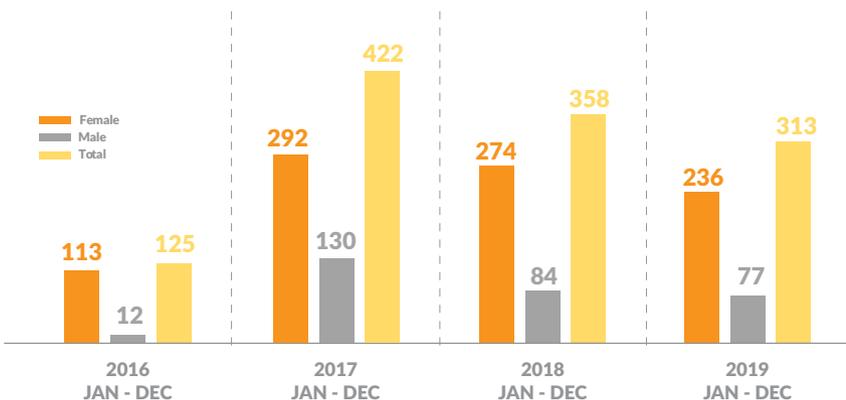
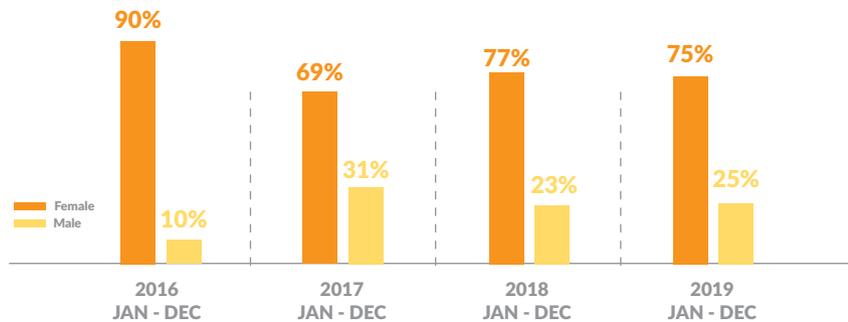


FIGURE 5**% REPORTED CASES OF CHILD SEXUAL ABUSE, BY SEX AND YEAR****Note : Data from 2016 and 2019 are for part of the year****Data Source : Ministry of Gender , Family and Social Services, December 2019**

do further analysis of this data to achieve greater clarity on these dynamics.

For the purposes of this assessment, the reported prevalence of sexual violence against children is an important indicator for duty bearers to strengthen SRH information and services to facilitate the empowerment of children through education. Equipping children to defend their physical and mental wellbeing by providing them with age-appropriate information and knowledge through formal and non-formal means is critical to support their active engagement to prevent or seek protection as appropriate. Concurrently, there is an acute need to strengthen social protection services across the country through greater investment to improve existing services and significantly develop human resource capacity of the national social protection service system.

Family Protection Authority (FPA)

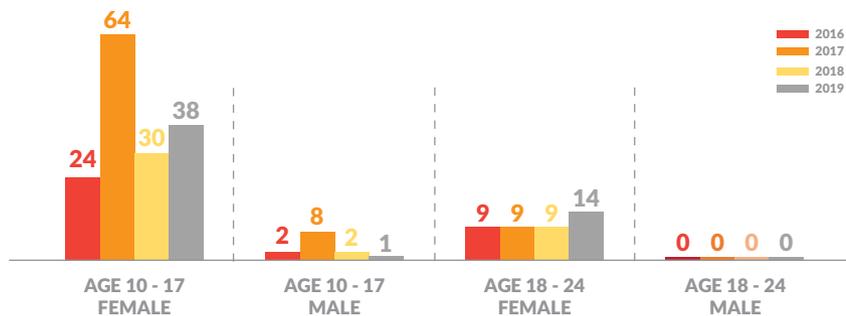
The FPA is the semi-autonomous legal entity created by the Domestic Violence Protection Act (2012) to ensure implementation of that law. As such, the FPA compiles disaggregated data on all reported cases of domestic violence as specified in the law. Figure 6 below shows the age group and sex disaggregated data of cases of sexual abuse reported to the FPA between January 2016 and 18 December 2019. The data shows a stark discrepancy between the number of cases of sexual violence against the girl child and boys among adolescents (age 10-17) and youth (age 18-24). The fact that reported cases of sexual abuse among female 18-24 year age group is higher than the reported cases of the male 10-17 age group is notable. Furthermore, the zero reporting of male 18-24 age group is particularly significant. In the absence of further inquiry, which is beyond the scope of this research, it is not possible to determine the cause of these massive gender-based discrepancies in reported cases of sexual abuse and violence. It is possible that in the patriarchal socio-cultural context, male youth do not report

abuse due to perceived ‘weakness’ and loss of sense of masculine pride to defend oneself. This in turn is likely to result in significant family wellbeing and mental health consequences, especially in the prevailing situation where support and rehabilitation services are negligible or non-existent, especially in rural contexts.

FIGURE 6

ADOLESCENT AND YOUTH SEXUAL ABUSE CASES REPORTED TO THE FPA, BY AGE GROUP, SEX AND YEAR

Note : Data from 2016 and 2019 are for part of the year
Data Source : Family Protection Authority, December 2019



Health Protection Agency (HPA)

The HPA is a legal body created under the Public Health Protection Act 7/2012 and was established on 01 January 2013.⁴³ The HPA is positioned under the direct oversight of the Minister of Health and carries a broad mandate to ensure public health protection in a variety of areas. The HPA website outlines core areas of its work which include the component of reproductive health.⁴⁴ However, the content on the website refers to obsolete policy documents indicating that the information is dated. Inquiries were made at the HPA for the purpose of this research. The HPA has not run programmatic interventions on reproductive health in its short history. However, the agency maintains records of contraceptive commodities distributed through the public health system to establish user rates.

Notably, from March-May 2019, HPA successfully implemented the first phase of a nationwide immunization campaign to vaccinate adolescent girls in the 10-14 year cohort, against the Human Papilloma Virus (HPV).^{45,46} The campaign is a collaborative activity involving the Ministry of Health (MoH), HPA, WHO, UNICEF, IGMH, ADK Hospital (private) and Cancer Society of Maldives.^{47,48} While the campaign leaflet informed that the “immunization programme offers HPV vaccine for adolescent boys and girls at 10 years of age”, available information suggests the campaign targeted girls only (see Image 3). According to HPA, the first phase achieved nationwide HPV vaccination coverage of 90% while the second phase to deliver the second dose of the 2-dose vaccine had begun in October 2019. The coverage results are not yet available although a high reach is anticipated.

43 HPA Facebook page, https://www.facebook.com/pg/HealthProtectionAgencyMaldives/about/?ref=page_internal (accessed : 31 Dec 2019)

44 HPA website, <http://hpa.gov.mv/English/content/?page=RH&id=332> (accessed : 31 Dec 2019)

45 HPV vaccination campaign launched, Maldives Independent, 22 March 2019, <https://maldivesindependent.com/society/hpv-vaccination-campaign-launched-144492> (accessed : 01 Jan 2020)

46 Campaign video spot on social media available on Twitter : https://twitter.com/HPA_MV/status/1108595803717697536 (accessed : 01 Jan 2020)

47 HPA campaign leaflet - “Human Papilloma Virus vaccine” (undated)

48 HPA on Twitter announcing the launch of the HPV vaccination campaign, 21 March 2019, https://twitter.com/HPA_MV/status/1108590613664944130 (accessed : 01 Jan 2020)

IMAGE 3

HPA VACCINATION CAMPAIGN ANNOUNCEMENT, 7 JULY 2019, HPA

Data Source : HPA on Twitter



IMAGE 4

HPA VACCINATION CAMPAIGN VIDEO SPOT TWEET

Data Source : HPA on Twitter



The HPV campaign shows HPA's capacity to implement collaborative public health campaigns within a relatively short time-frame, to deliver public health outputs at national scale. Therefore, the potential to execute SRH information campaigns by the agency is not beyond the realms of possibility despite prevailing challenges. In the Maldives context, "vaccine hesitancy" and rejection linked to global trends of misinformation, confusion as well as religious beliefs is a recognised phenomenon, following the observation of unusual trends in childhood vaccination uptake in the country. An overview of this issue is outlined in a related local news article which reported the DHS 2016-2017 finding that "based on the vaccination cards and information provided by mothers in the survey, it was found that 77 percent of children under two years received all basic vaccines (a drastic drop from 93 percent in 2009), whereas 8 percent did not receive any vaccines."^{49,50} The fact that a successful public health campaign relating to an adolescent SRH issue can be collaboratively executed provides a window of opportunity to explore the feasibility of using these channels of implementation on equally significant other SRH concerns. The involvement of the HPA is critical to the meaningful public health awareness on adolescent SRH concerns central to this research.

Ministry of Education, School Health Section (SHS)

The SHS of the Ministry of Education (MoE) functions within the broader umbrella of the Education, Supervision and Quality Improvement Division (ESQID) and implements the school health policy prepared by the MoE in collaboration with the MoH.⁵¹ The Maldives first adopted the concept of health promoting schools in December 2004, with the development of the Health Promoting Schools Policy by the MoE and the MoH, in collaboration with WHO and UNICEF.⁵² Prior to that, Maldives had a School Health Programme dating back to 1986 under which, focus was given to the "medical screening of children, health education and awareness" among other health promotion interventions, within "core curricular and co-curricular activities".⁵³

The latest available School Health Policy dates back to 2011 which, according to the SHS, is currently under review. Notably, in its assigned 'success criteria' for schools aiming to achieve the status of a health promoting school, the 2004 policy referred to the inclusion of "sexual health" information "relevant to their age" as a lower level criteria (see Image 5).⁵⁴ However, the 2011 policy document observed there were many challenges to the implementation of the 2004 initiative, notably that the "School health programme [was] still considered to be secondary to teaching by school heads and senior management".⁵⁵ Other observed issues inhibiting policy implementation include competing priorities for students' time, lack of relevant teaching materials, deficiencies within the curriculum as well as the lack of relevant knowledge of health related concepts among school health focal points (see Appendix 2).⁵⁶ Furthermore, a notable deterrent was the lack of support from the health service provider. This latter concern indicates challenges to inter-departmental collaboration across line ministries on children's health issues which demand the attention of high level policy makers. A notable positive

49 Vaccines: a viral controversy and a vital discussion, Jalyl R.A. The Edition, 19 May 2019, <https://edition.mv/report/10625> (accessed : 01 Jan 2020)

50 20 children checked upon in operation against extremism, Maldives Independent, 22 December 2019, <https://maldivesindependent.com/society/20-children-checked-upon-in-operation-against-extremism-149722> (accessed : 01 Jan 2020)

51 School Health Policy 2011, Ministry of Education & Ministry of Health and Family, January 2011

52 Health Promoting Schools Policy, December 2004, Ministry of Education/Ministry of Health

53 *Ibid*:pg.01

54 *Ibid*:pg.10

55 School Health Policy 2011, Ministry of Education & Ministry of Health and Family, January 2011

56 *ibid*

observation was the collaboration between “leading teachers and school health assistants/focal points and counsellors” to deliver curricular health topics jointly.⁵⁷ The few available positives shed some light to the potential avenues available for capacity building interventions, and insights on best practice to target advocacy for effective outcomes.

IMAGE 5

TEXT FROM HEALTH PROMOTING SCHOOLS POLICY , 2004 (PG10)

Maldives Health Promoting Schools Initiative Success Criteria			
The following are the criteria for schools participating in the Health Promoting Schools programme. A school can aim for one level at a time or achieve targets in more than one level at one go. However, the lower level criteria need to be achieved either before or at the same time while aiming for the higher ones.			
	BRONZE	SILVER	GOLD
SCHOOL HEALTH EDUCATION	<ul style="list-style-type: none"> ▶ sufficient time (min. 1h) each week is allocated to health in the overall curriculum ▶ students gain a basic understanding, relevant to their age, of nutrition; disease prevention and hygiene; physical activity; safety; emotional health; oral health; sexual health; tobacco and other substance abuse; and environmental health issues 	<ul style="list-style-type: none"> ▶ the school's health education advocates teaching and learning methodologies that encourage students to work together and places an emphasis on active student participation ▶ the school provides opportunities for extra-curricular activities such as nutrition programmes or celebration of World Health Day 	<ul style="list-style-type: none"> ▶ students have opportunities to learn and practise life skills in problem solving, decision-making, effective communication, interpersonal skills, coping with stress and critical thinking ▶ opportunities are provided for teachers, school health assistants and parents to attend training and education programmes in health areas

The 2011 policy referred to the integration of health and wellbeing into the national school curriculum and the policy decision to develop health and wellbeing as a separate subject from key stage 2 onwards.⁵⁸ The policy envisaged the new subject to “cover areas on health protection and promotion of healthy practices and behaviours covering hygiene, nutrition, *reproductive health*, mental and psychosocial health, tobacco and drug use prevention, physical education as well as prevention of disease, injury and disability” (italics added).⁵⁹ It is notable that the policy language had changed from “sexual health” in 2004 to “reproductive health” in 2011. Additionally, the policy approach also changed from an introduction to a more comprehensive curricular integration of health topics. The key stage 2 subject on Health and Physical Education in the national curriculum was developed in 2014 by the National Institute of Education (NIE).⁶⁰

Inquiries at the SHS for this research suggests that key informants are satisfied with the curricular content of SRH topics and its integration across key stages, with the assurance that the current curriculum’s SRH integration is possibly the

⁵⁷ *ibid*

⁵⁸ *In the Maldives, key stage 2 includes grades 4, 5 and 6 of the age cohort 9-11 years*

⁵⁹ *School Health Policy 2011, Ministry of Education & Ministry of Health and Family, January 2011;pg.12*

⁶⁰ *Health and Physical Education in the National Curriculum : Key stage 2 (Grade 4, 5 & 6), National Curriculum, National Institute of Education, Maldives, 2014 [also re-published in 2015]*

best of its kind in the South Asia region. However, the biggest challenge observed by informants is the inadequacy of teacher training and development to deliver the SRH content in the national curriculum. As proof of the level of discomfort among teachers, the following anecdote was shared by informants. At a teacher's conference, an Islam teacher put this question to mothers in the audience : if you tell your son to go and say his prayers and he turns and asks why you have not said your prayers, how will you explain the situation to them? The religious context in this scenario is that a woman cannot perform prayer during her menstrual period. None of the teachers in the audience provided a response to this question, which informants said, indicated the acute level of discomfort to engage in SRH topics even within the family. According to informants, teachers become vilified by parents when efforts are made to discuss SRH content within the classroom, citing instances where parents lodge complaints against teachers for showing images of human anatomy in the classroom. Therefore, the perception is that SRH is "still seen as a taboo subject" within society. The SHS collaborated with UNICEF around 2014, producing a leaflet entitled "Growing Up Well for Girls" and "Growing Up Well For Boys" for distribution in schools, covering subjects of hygiene and puberty (see images 6 below).

IMAGE 6

SCHOOL HEALTH SECTION LEAFLETS, "GROWING UP WELL" FOR GIRLS AND BOYS, MINISTRY OF EDUCATION/UNICEF (UNDATED,CIRCA 2014)



The leaflets provide answers to an array of questions on puberty, such as “what will happen to girls in puberty” and on menstruation such as “will I know when my period is going to start”? The leaflet for girls includes information on tips for management of personal hygiene and grooming such as “how to use a pad” and “shaving tips” (see Appendix 3 for a list of topics and questions in the leaflets). The leaflet for boys covers similar aspects on personal hygiene and grooming. Both leaflets cover some nutrition information, how to manage acne and pimples as well as a paragraph on body image. Neither touch upon anything beyond puberty and menstruation and includes no information on any aspect of sexuality, reproductive health, human anatomy or physiology depicting reproductive organs. A third leaflet produced by the SHS is entitled “Purification in Islam” covering religious practice in connection with menstruation and the “discharge of fluids from reproductive organs” (see Appendix 3).

Although some key informants for this research expressed satisfaction with the SRH content integration in the current curriculum at various key stages, other available information suggest a different situation. In 2017, UNFPA Maldives provided technical assistance to the NIE to undertake a mapping exercise and develop a self-learning tool for teachers, to effectively integrate and deliver UNESCO standard SRH content through the national curriculum.⁶¹ The subsequent report of the activity observed that “Key stage 1 and 2 text books have sufficient integration of topics such as relationship and values, attitudes and skills. However, the key stage 3 text books cover only fifty percent of the content depth for these two topics.”⁶² In addition, although the key stage 3 (12-13 year cohort) curriculum addressed human development to some extent, the finding was that “sexual behavior and sexual and reproductive health are not addressed.”⁶³ It is notable that the key stage 2 curriculum includes language on teaching children about bodily changes in adolescence. Under the heading “Growth, Development and Health Awareness”, the text of the syllabus reads : “This strand will help to prepare the child for bodily changes that occur in pre-adolescence and adolescence. The child will be able [to] identify its external body parts, and changes that occur in the body due to growth. It will also help the child to recognize the differences between males and females. The child will also be able to recognize and deal with feelings of sexuality.”⁶⁴ The mapping exercise did not dwell on key stages 4 and 5 which are critical years for adolescent SRH educational need. However, it made recommendations to address gaps in the lower stages by including deficient content in the earlier years into the key stage 4 & 5 syllabus, the status of which is unclear and beyond the scope of this activity to pursue.⁶⁵

A 2018 research paper on adolescent access to SRH information in the Maldives provides a compact graphical table showing the significant gaps in the school curriculum on SRH content across key stages 1, 2 and 3 (see Appendix 4). The table used the original mapping data from the technical report of 2017. This colour coded table provides at a glance the limited content captured in the curriculum and the near complete absence of coverage of the key thematic areas on sexual behaviour and sexual reproductive health in the curriculum. A cursory glance along

61 *Technical Support for Integrating Reproductive Health Education in the Maldives National Curriculum Rollout Process*, Institute of Research & Development for UNFPA Maldives, December 2017

62 *ibid*

63 *Ibid*;pg.6

64 *Health and Physical Education in the National Curriculum : Key stage 2 (Grade 4, 5 & 6)*, National Curriculum, National Institute of Education, Maldives, 2015;pg.7

65 *Technical Support for Integrating Reproductive Health Education in the Maldives National Curriculum Rollout Process*, Institute of Research & Development for UNFPA Maldives, December 2017;p.06

each column representing each key stage shows the extent of ‘missing’ content indicating the level of adoption of the UNESCO standards of SRH education in the curriculum to date. The national curriculum’s SRH integration activity to reach the end goal of providing CSE in Maldivian schools is clearly at a developmental stage of work in progress.

The 2011 policy reviewed the implementation of the 2004 school health policy, providing insights into the situation over a decade ago. A status update on the performance of the 2011 policy will be available on completion of the current review process. This will shed light into more recent dynamics and provide policy level direction which will help to inform possible interventions to support the school health programme today. What is clear from the current status is that the school health policy is yet to address adolescent SRH education delivery to align with both the current curriculum as well as the present political commitments of the government to adopt CSE (see image 7 below). Both of these are relatively recent developments, which are points of entry for potential programmatic interventions on adolescent SRH education delivery. Maldives could draw lessons from other Muslim countries that have successfully adopted SRH curricular content.⁶⁶

The change of government in November 2018 and possible changes to policy priorities within the MoE may have affected the progress of the initiative to integrate SRH into the curriculum. Informal inquiry with a secondary school teacher in Male’ suggests that previous efforts to accelerate SRH education to key stage 4 and 5 students have somewhat waned over the last year.⁶⁷ This indicates a current policy disconnect with previous efforts to maintain gains in this area. On a positive note however, the recent high level commitments made by the Minister of National Planning and Infrastructure (MoNPI) at the ICPD+25 Nairobi Summit in Nairobi, Kenya in November 2019, provide reason to suggest that political will does exist to “provide age and gender appropriate reproductive health services to adolescents and young people” in the Maldives (see Image 7 below). In addition, commitments made by the Maldives National Youth Council (MNYC) to initiate “proper youth engagement” in SRH is also a positive development although the MNYC will require the support of a variety of stakeholders including donor agencies to achieve this ambitious goal (see Appendix 5 for the text of this commitment).

⁶⁶ "Do adolescent girls have adequate knowledge to make healthy and informed life choices?", Shafeega F, in *Research Papers on the Situation of Women in Maldives*, UNFPA Maldives/UN Women/British High Commission in Sri Lanka, 2018:121

⁶⁷ Personal communication with a secondary school teacher.

IMAGE 7

HIGH LEVEL SRH COMMITMENTS MADE AT THE ICPD+25 NAIROBI SUMMIT BY THE MALDIVIAN GOVERNMENT IN NOVEMBER 2019

Data Source :

31 October 2019

COMMITMENT TITLE:

Strengthen reproductive health policies and programmes to address ASRH, RH cancers, and better access to reproductive health commodities

COMMITMENT DESCRIPTION:

Action 1: Provide age and gender appropriate reproductive health services to adolescents and young people including migrant workers on a continuous basis

Action 2: Conduct regular training programmes at health facilities to implement Reproductive, Maternal, New born, Child and Adolescent Health (RMNCAH)

Action 3: Provide easy access to reproductive health commodities and technologies through health facilities, NGOs

Mode of engagement:

- Programmatic action
Hamessing the demographic dividend through investing in adolescents' and youth's education, employment opportunities and health, including family planning and sexual and reproductive health and services.

COMMITMENT TO BE ACTIONED IN:

Maldives

SUBMITTED FROM:

Maldives

The 2018 research on adolescent access to SRH observed there is “very little professional development in the area of” CSE in the Maldives, especially for primary school teachers.⁶⁸ Furthermore, teacher training is conducted “as a one-off block” which is ineffective “because it does not provide continuous support to teachers” and also “goes against a body of research that suggests that classroom teachers are the best people to deal with CSE.”^{67,70} This helps to explain the information provided by key informants that teacher discomfort to impart SRH information in the classroom setting is one of the biggest barriers to SRH education in Maldivian schools. In this context where school-based, age appropriate SRH education is not available, young people are deprived of basic health education that will equip them to make informed decisions about personal health matters and SRH wellbeing. The situation increases their vulnerability to sexual abuse and exploitation in a context where child sexual abuse has resulted in a host of legislation against offenders although implementation of laws remains extremely weak.

Society for Health Education (SHE) NGO

SHE is the longest serving non-governmental entity in the Maldives working in the area of SRH information and service delivery to the public. The SRH Programme at SHE provides client friendly and confidential services in this socio-culturally sensitive area of healthcare in the Maldives, providing a range of services including gynaecological consultations to contraceptive counselling and commodities.^{71,72} In 2018, the Family Planning Centre at SHE “provided 2736 SRH consultation services through specialized doctors” including “918 HIV & AIDS consultation[s], 747 STI/RTI consultation[s], 877 gynecological consultations and 89 pediatric consultations”.⁷³ SHE also provides emergency contraceptive (EC) pills which is an important service in the Maldives context where unmarried young people are excluded from access to contraceptive commodities through formal healthcare providers. While SHE is primarily based in Male’ with no presence in the atolls, access to SHE is available to those in the greater Male’ area or to those who can travel to Male’ for service. SHE conducts outreach camps, school visits and field travel to provide their services in the atolls, although this depends on the vagaries of programme funding. Data available from SHE shows a significant increase of clients seeking SRH services as evident in Figure 7 below. Of particular interest is the significant increase in the uptake of EC pills over the past few years, which can be interpreted to indicate a serious unmet need for contraception, its safe and sustained use as well as access to SRH information and services to maintain healthy reproductive behaviours (see Figure 8). Data available from SHE shows the consistent increase in the number of EC pills issued to clients. In 2018, SHE provided 452 EC consultations, which include the number of clients that obtained comprehensive information on all emergency contraception methods, and the number of clients who opted for that service (see Figure 8).

68 “Do adolescent girls have adequate knowledge to make healthy and informed life choices?”, Shafeega F, in *Research Papers on the Situation of Women in Maldives*, UNFPA Maldives/UN Women/British High Commission in Sri Lanka, 2018

69 *ibid*

70 *International technical guidance on sexuality education: an evidence informed approach*, UNESCO/UNAIDS/UNFPA/ UNICEF/UN Women/WHO, 2018:12

71 SRH Programme, SHE, <https://www.she.org.mv/programs/SRH> (accessed : 02 Jan 2020)

72 Annual Report 2018, SHE

73 *Ibid*:pg.28 ; [STI/RTI - sexually transmitted infection/ reproductive tract infections]

FIGURE 7

SRH CLIENTS WHO OBTAINED SERVICES FROM SHE IN 2017 & 2018 BY SEX

Note : Data from 2016 and 2019 are for part of the year
Data Source : Annual Reports 2017 & 2018, SHE

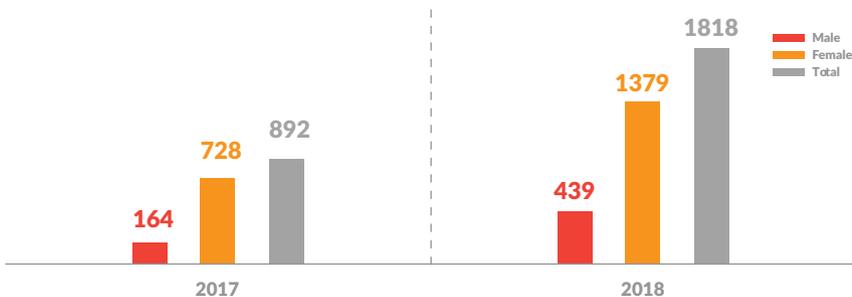
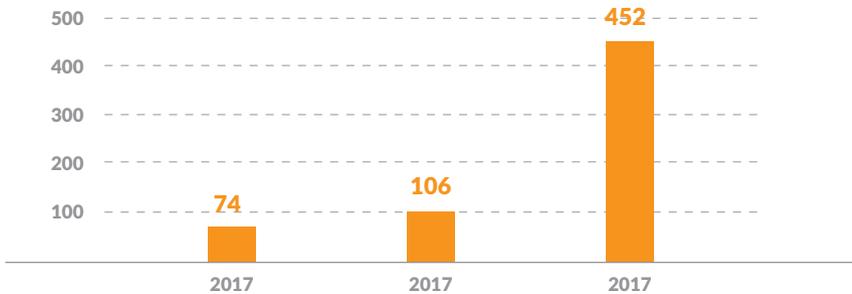


FIGURE 8

EC PILLS ISSUED BY SHE FROM 2016 - 2018* TOTAL NUMBER

Note : The 2018 figure refers to “EC CONSULTATION” when comprehensive information on all emergency methods are provided + when a client opts for a method
Data Source : Annual Reports 2016, 2017 & 2018, SHE



Other available data

Despite the celebrated achievement of MDG goal 5A on maternal health by the Maldives, the failure to achieve MDG goal 5B on universal access to SRH information and services continues to undermine the maternal health gains, especially for the country’s youth and the most vulnerable within that demographic. Comprehensive collection, collation and analysis of data in some areas of maternal health and pregnancy is not conducted in the Maldives, as evident from the absence of abortion related data identified by existing research. The reluctance to recognise the prevalence of unsafe abortion by public health authorities is a serious gap in the health service system of the Maldives.⁷⁴ The first abortion study conducted in the Maldives in 2008 observed that “abortions were more common among unmarried youths than among married couples” in the Maldives.⁷⁵ The continuing exclusion of unmarried young people from access to

74 Reproductive Health Knowledge and Behaviour of Young Unmarried Women in the Maldives, UNFPA Maldives, 2011:pg.10

75 ibid

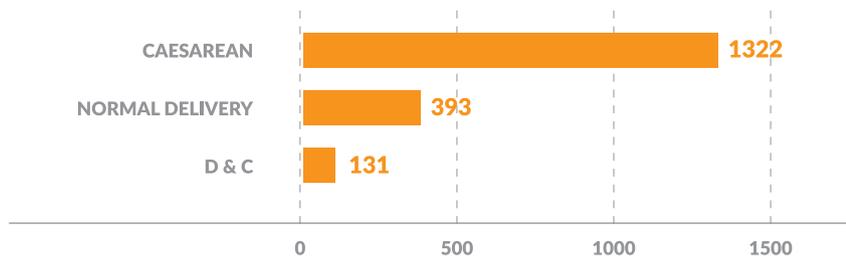
SRH information and services through normative policy and practice facilitating contraceptive access to married couples only, maintains the status quo. Recent research on adolescent access to SRH observed that there is “no data available for the prevalence of abortion in the Maldives. The statistics on abortion and abortion related services are also not collected by the public sector nor the private sector health care facilities for any age cohorts.”⁷⁶ Anecdotal evidence shows that in cases where a woman experiences out of wedlock pregnancy and seeks contraception thereafter, contraceptive services are denied by health services, which is a situation that directly undermines the wellbeing of women, particularly the most vulnerable.

Therefore, the following institutional data, for the 12 months of 2018 obtained by UNFPA Maldives for this research, provides a glimpse into an area of acute data poverty. The data presented in Figure 9 below helps to provide some perspective on the prevalence of Dilation and Curettage (D&C) procedures obtained at healthcare emergency-centres (or E-centres), against data on normal deliveries and caesarians. In the age group 16-35 years over the course of one year, the data shows 72% of cases in the data-set to have delivered a child through caesarian section as opposed to 21% who had births through normal delivery. Notably, 7% of patients in this data set underwent D&C procedure. In this data-set, only 5 cases are documented among the 16-17 year age group for caesarian births, with none recorded in this group for D&C or normal delivery. Given the available literature and qualitative insights that indicate prevalence of pre-marital sexual activity and unsafe abortion, the absence of cases in the adolescent age group in this data-set is telling. The significantly high prevalence of caesarean deliveries is another notable issue in this data-set, which is beyond the scope of this study to dwell upon.

FIGURE 9

**NUMBER OF PREGNANCY RELATED PROCEDURES AT E-CENTER BY TYPE
JAN -DEC 2018, FOR WOMEN AGED 16 -35 YEARS**

Data Source : UNFPA Maldives



The data available in this data-set for the age group 36 years and above is also noteworthy, which is presented in Figure 10 below. In this data-set, 52% of cases underwent caesarian section, 22% had normal delivery and 26% underwent a D&C procedure. The high percentage of D&C cases is indicative of issues that should be of public health concern. The fact that this procedure is more prevalent

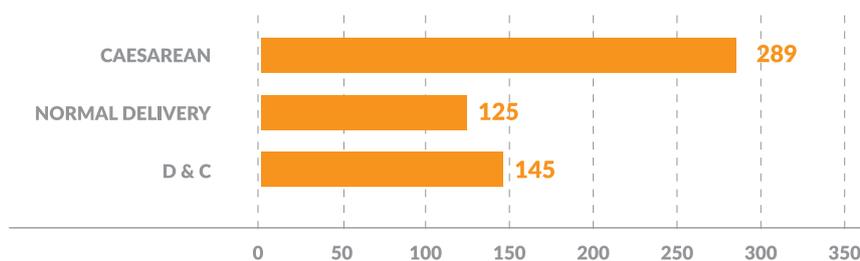
⁷⁶ Do adolescent girls have adequate knowledge to make healthy and informed life choices?; Shafeega F, in Research Papers on the Situation of Women in Maldives, UNFPA Maldives/UN Women/British High Commission in Sri Lanka, 2018:pg.125

than normal births raises questions about the situation of women's reproductive health in the Maldives. The data is inadequate to make assumptions about the purpose of D&C, although it does provide an insight into the significance of its prevalence. Therefore, such data require further scrutiny and research by public health authorities to understand the possible reasons behind these significant numbers and the high prevalence rates.

FIGURE 10

NUMBER OF PREGNANCY RELATED PROCEDURES AT E-CENTER BY TYPE JAN -DEC 2018, FOR WOMEN AGED 36 YEARS AND ABOVE

Data Source : UNFPA Maldives



Other factors of relevance to this discussion include the high unmet need for contraception in the country context, the inconsistencies surrounding education level, contraceptive knowledge and behaviour as well as the high prevalence of female sterilisation as a contraceptive choice. The DHS 2016-2017 found that “the most widely used contraceptive method is the condom, followed by female sterilisation, withdrawal, and the pill”, while the use of all methods have declined from 2009 levels.⁷⁷ Additionally, DHS 2016-2017 informs that “[o]f all births in the past 5 years and current pregnancies, 77% were wanted at the time of conception, 16% were mistimed, and 7% were unwanted.”⁷⁸ However, the DHS arguably does not capture the situation of the most vulnerable, particularly those in the youth demographic.

The GSHS was conducted in the Maldives in 2009 and 2014. A narrative report of the 2009 survey is available although there is no similar report for the 2014 survey. The GSHS collects data for a wide range of indicators including on student diet, alcohol and substance abuse, school bullying, parental care, physical injury, sexual abuse, HIV/AIDS awareness, violence and mental health. The GSHS is a self-reported survey with a student sample from grades 8 to 12 in the age cohort 13-17 years.⁷⁹ A sample of relevant available indicators to this research, from the 2009 and 2014 GSHS are provided in Appendix 6 of this report.

The 2009 GSHS showed that nearly half of boys and girls were aware that abstinence can protect them from HIV/AIDS, and a similar percentage reported knowing “how to tell someone that they do not want to have sexual intercourse with them”.⁸⁰ The survey also reveals extremely concerning data on student health

77 Maldives Demographic & Health Survey 2016-2017, Ministry of Health, Maldives, pg.89

78 Ibid,pg.79

79 Global School-based Student Health Survey (Male' & Atolls) 2014, 2014 Fact Sheet, Maldives, Ministry of Education/ World Health Organisation

80 Global School-based Student Health Survey, 2009, GSHS Country Report, Maldives, Ministry of Education/ World Health Organisation, 2009:p.28

and wellbeing, including that 16.1% girls and 17.8% boys reported being “forced to have sexual intercourse”, showing this experience is reported to be slightly higher among boys than girls. This is particularly noteworthy given the fact that available data from the MoGFSS provided earlier in this report (see Figure 3) shows the complete absence of boy child rape reporting. The 2009 GSHS also found that 22.2% girls and 21.9% boys reported making “a plan about how they would attempt suicide”, while the 2014 GSHS data shows 10.8% girls and 14.9% boys had “attempted suicide” one or more times in the 12 months prior to the survey.⁸¹ It is clearly evident that significant numbers of adolescents and young people in Maldivian schools are very vulnerable. The situation requires duty bearers to respond robustly and meaningfully to the above discussed findings from a wide range of different data sources, providing clear insights into the SRH and other vulnerabilities young people experience.

RELEVANT EMERGING ISSUES

Maldives has a history of child marriage facilitated by its family law, due to its Islamic culture and belief system, while also adopting the age of majority as 18 years.⁸² Maldives became party to the Convention on the Rights of the Child in 1991, which precedes the enactment of the family law. According to an analysis of Census 2014, “census data shows that 95 percent of [Maldivian] children have never been married. However, child marriages take place in the country, although the numbers are few, with only 0.60 percent of the children (106 children aged 15-17) being married at the time of the Census.”⁸³ Marriage to minors was facilitated at the discretion of the Family Court, until a Supreme Court decision as late as 2016, which ruled that the Supreme Court’s direct approval would be required in such cases, along with the additional requirement for a case assessment by the Ministry of Gender and Family.⁸⁴ While these developments had the effect of halting marriage to minors, the enactment of the Child Rights Protection Act in 2019 now sets the legal age of consent for marriage at 18 years, without exception.⁸⁵

Despite these progressive institutional and legal developments, the Maldives has been undergoing significant social change influenced by ultra-conservative and radical religious views and ideologies for nearly two decades. In 2010, alarm was raised by the Family Court about the issue of out of court and unregistered “private marriages” by persons reportedly rejecting the Maldivian State and its courts as being inconsistent with Islamic Shari’ah.⁸⁶ It is in this context that the very recent events revealed the issue of unregistered child marriages taking place in the Maldives which has raised intense public concern. The issue arose in November 2019 following a reported crime incident where one of the accused was also “alleged to have been married out of court to a 13-year-old girl”, who was also reportedly pregnant.⁸⁷ One subsequent report informs that the “Maldives Police Service revealed that three child marriages were reported in 2014 while another incident was brought to attention in 2015 after an underage ‘bride’ became pregnant.”⁸⁸

81 *ibid*

82 Family Act 2000

83 *Children of Maldives: Analysis of Children of the Maldives from Census 2014*, National Bureau of Statistic, Ministry of Finance & Treasury/UNICEF, pg.18

84 *Supreme court approval required for underage marriage*, Maldives Independent, 21 September 2016, <https://maldivesindependent.com/society/supreme-court-approval-required-for-underage-marriage-126645> (accessed : 10 Jan 2020)

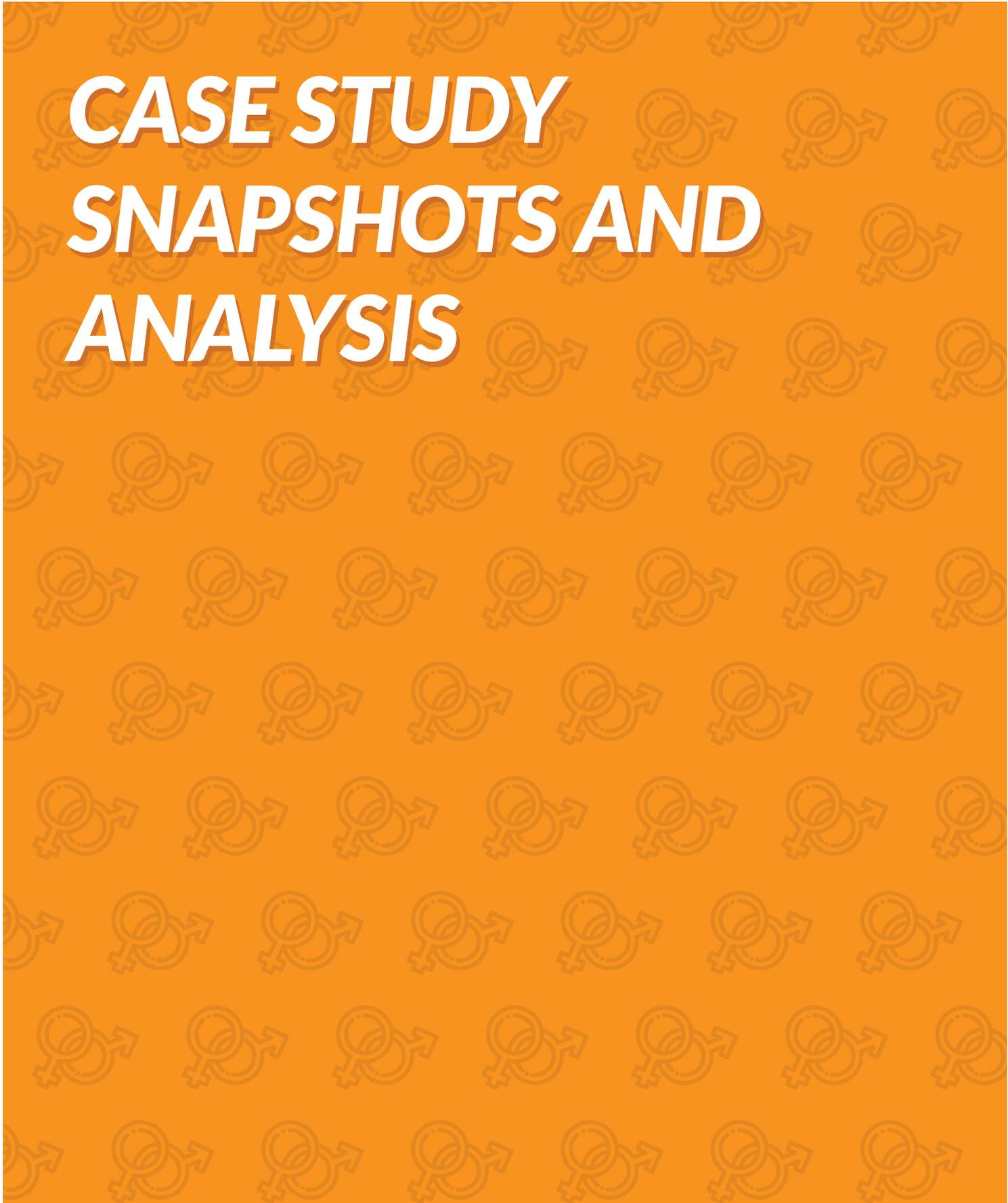
85 *President signs bills on Child Rights Protection and Juvenile Justice into law*, 20 Nov 2019, President’s Office, Press Release Ref. 2019-900, <https://presidency.gov.mv/Press/Article/22631> (accessed : 10 Jan 2020)

86 *Unregistered marriages leave children unable to inherit, warns Family Court*, Minivan News Archives, 12 April 2010, <https://minivannewsarchive.com/society/unregistered-marriages-leave-children-unable-to-inherit-warns-family-court-5744> (accessed : 10 Jan 2020)

87 *Authorities unaware of 13-year-old’s alleged marriage*, Maldives Independent, 25 November 2019, <https://maldivesindependent.com/society/authorities-unaware-of-13-year-olds-alleged-marriage-149463> (accessed : 10 Jan 2020)

88 *Child Marriage in Maldives: Holding perpetrators and enablers accountable*, The Edition, 11 December 2019, <https://edition.mv/report/13894> (accessed : 20 Jan 2020)

CASE STUDY SNAPSHOTS AND ANALYSIS



CASE STUDY SNAPSHOTS

The following case studies were documented by conducting open ended conversations with case workers at the MoGFSS. Cases were taken from different locations, and the cases relate to subjects from urban, semi-urban and rural settings across the Maldives. The cases are presented in simple point form to provide a snapshot of the family situation, access to education and general lived experiences of the young person involved in the case. A variety of factors contribute to the increased vulnerability and exposure to harm experienced by the subjects of these case studies. They also highlight systemic and structural limitations, including societal, cultural, economic, environmental and governance aspects.

CASE 01 | AGE 15+

SITUATION : Unplanned pregnancy / urban setting

BACKGROUND – FAMILY & EDUCATION

- *Initially, the child came to the attention of the social services due to school absenteeism and reported parental negligence.*
- *With divorced parents and a single working mother, the child's school attendance suffered with regular absenteeism.*
- *The family consisted of 6 siblings, the child in question being the youngest, who was placed in the care of a grandmother by the mother. The family had moved from a rural to urban location and the children grew up in the latter.*
- *The unplanned pregnancy at 15 is reported to have happened due to intimate relationship with a "boyfriend". No details of the partner are available.*
- *The child received ante-natal care and maternal healthcare access through formal healthcare channels. Social services facilitated and monitored the case, providing assistance to arrange birth registration for the newborn.*
- *Supportive family environment with older siblings willing to provide economic assistance to care for both the teenage mother and her child.*

OTHER OBSERVATIONS

The services provided do not include any SRH information or access to information and services to prevent repetition of unplanned pregnancy in the future.

CASE 02 | AGE 21+

SITUATION : Unplanned pregnancy / urban setting

BACKGROUND – FAMILY & EDUCATION

- *Case presented to social services through a third party reporting that the young person had become pregnant following abuse within the family by a family member.*
- *The young person was in higher education and reported having an intimate relationship with a “boyfriend” indicating consensual relations.*
- *Family environment with supportive siblings and parents.*
- *Pregnancy disrupted education.*
- *Other details of the case indicate lack of SRH knowledge by young person.*

OTHER OBSERVATIONS

The legal system will take criminal action against the young person due to having a child out of wedlock which is a criminal offence. This will result in social stigmatisation and marginalisation of both the mother and child, as well as the family. The likelihood of these repercussions affecting the child is also significant, as outlined in existing research.⁹⁷

CASE 03 | AGE 16+

SITUATION : Unplanned pregnancy / urban setting

BACKGROUND – FAMILY & EDUCATION

- *The child in question had a history of exposure to sexual abuse within the family and community.*
- *There’s a history of drug abuse within the family environment.*
- *The cases of multiple siblings in this family are also lodged with the social services, with another sibling taken into State care at one point along with the child of this case.*
- *The child has history of sexual abuse by stepfather and was reportedly exposed to prostitution.*
- *No specific details available on the education situation.*

OTHER OBSERVATIONS

A situation of extensive family dysfunction and breakdown, resulting in multiple social issues impacting the young person and siblings within the family, with criminal negligence of children by family/caregivers.

⁹⁷ Reproductive Health Knowledge and Behaviour of Young Unmarried Women in the Maldives, UNFPA Maldives, 2011

⁹⁸ Note : In October 2019, a review of the Single Parent

CASE 04 | AGE 12+ TO 17+

SITUATION : unplanned multiple pregnancies / rural + urban settings

BACKGROUND – FAMILY & EDUCATION

- *Family situation extremely vulnerable due to parent with disabilities.*
- *The child's mother had married multiple times with children from multiple partners.*
- *The child suffered a history of sexual abuse, starting at age below 10, by a 70+ year old man, within the family environment.*
- *The child experienced multiple incidents of abuse by much older men, including from within the family and the community.*
- *The child had family members with a record of drug abuse.*

OTHER OBSERVATIONS

Extremely complex case with multiple vulnerabilities and family issues from which a child could not remove herself. The social services system is ill-equipped to attend to such cases which are exacerbated by such systemic limitations. Child protection systems appear to have failed to conduct investigations required to establish perpetrators and remove the threats to the child from her environment. Out of wedlock pregnancy which conflicts with the law appears to have brought the child to the attention of social protection services. However, multiple pregnancies as a minor indicates a complete failure of the social protection system to prevent repetition of the issue and safeguard the child.

CASE 05 | AGE 16+

SITUATION : unplanned pregnancy / rural

BACKGROUND – FAMILY & EDUCATION

- *The child's case was referred to social services through island level health service providers.*
- *Parents divorced, with two older siblings.*
- *The child has a history of family violence by the father, including during mother's pregnancy.*
- *History of physical and sexual abuse by the father, since before reaching age 10.*
- *With supportive mother and siblings, the child was later in a stable family environment.*

- *With intervention by social services, her education continued through both formal and informal routes, after the disruption to education due to pregnancy.*

OTHER OBSERVATIONS

Social protection services are ill-equipped to prevent occurrence and escalation of family violence and abuse. Island level services are unable to identify and cater to increased vulnerabilities within families, particularly the risk of children being exposed to SRH and other physical and psychological harm.

CASE 06 | AGE 14+

SITUATION : unplanned pregnancy / urban

BACKGROUND – FAMILY & EDUCATION

- *Case referred to social protection services following presentation at FPU/IGMH.*
- *Information indicates this is a case of “stranger” rape, following an attack in a public place*
- *Child was allowed to continue schooling but had to discontinue following complaints to the school by other parents. Disruption to education due to attitudes of re-victimisation within the external environment.*
- *Supportive parent and family environment.*

OTHER OBSERVATIONS

Several service provision gaps observed in terms of preventing the situation from deteriorating further. Limited case information on the timing of reporting in relation to the assault incidence, pregnancy and extent of support services provided.

Social stigma and societal attitudes prevented continuation of education for child victims, further subjected to victim-blaming at a community and societal level. Social protection services have a duty of care to provide increased awareness within school community and ensure continuity of education to the child. However, such due diligence and interventions to support victims may not be possible for under-resourced systems.

No information about perpetrator or level of case investigation by the authorities.

CASE 07 | AGE 16+**SITUATION** : unplanned pregnancy / urban**BACKGROUND – FAMILY & EDUCATION**

- Family situation with a mother with mental health condition.
- More than 10 siblings from multiple marriages, with several children born out of wedlock including the child in this case.
- History of neglect, physical and sexual abuse experienced by the child in the case
- The child was suspected of being groomed by a much older man who also allegedly had intimate relations with the child's mother, on whom the family depended financially.
- The child had the experience of marriage to a much older man of age 50+

OTHER OBSERVATIONS

Multiple vulnerabilities, poverty and lack of support services exacerbate the situation of extremely vulnerable families with no support system or networks to address the issues which result in increased family dysfunction. The case indicates complexity of family dysfunction impacting the child, but also that social protection systems are weak and inadequate to provide protection to such families and children.

CASE 08 | AGE 16+**SITUATION** : unplanned pregnancy / rural + urban migration**BACKGROUND – FAMILY & EDUCATION**

- The case referred to social protection services following presentation at FPU/IGMH.
- Family situation with the father serving a prison sentence for sexually abusing his children.
- Multiple siblings from the same parents.
- Drug abuse in the family by some of the siblings and some reported to have records for being in conflict with the law.
- The child's education affected, with school absenteeism reported to be common among her siblings too, although other forms of behavioural difficulties are notably not observed by the social services.
- The child in this case eventually dropped out of school.

- The children of this family were left at times with friends, as well as grandparents that work. The grandparents are reported to leave the children unattended at times when they go to work.
- The family situation resulted in displacement of the child in the case, with further friendship developed with a man with a record of child sexual abuse and conservative religious views.

OTHER OBSERVATIONS

High level of family dysfunction and vulnerability, with no support system to prevent escalation of child poverty and continued exposure to SRH and other harm within the community.

CASE 09 | AGE 15+

SITUATION : unplanned pregnancy / rural

BACKGROUND – FAMILY & EDUCATION

- The case presented in the broader context of a case of suicide of a male school student.
- The girl in this case presented at the island health centre, and connections were made by the authorities, between the suicide case and the pregnancy.
- Both young people were attending school.
- The girl child in the case had a stable family situation with both parents supportive.
- Social protection service were involved in the case after the first trimester had passed.
- Continuation of education was provided separately through evening classes when the case was identified, which was considered in the best interest of the child in the circumstances of the case.
- The child in this case successfully completed higher secondary schooling.

OTHER OBSERVATIONS

Anecdotal information that the option of abortion was sought, although this was not available due to various challenges, including the rural situation. Social protection services and other authorities appear to have provided meaningful support services in this case, which is interesting considering the rural context. This suggests that in some instances, support services can be provided even with limited resources. It also indicates support services may be dependent on individuals in the system rather than the effectiveness of the system itself.

CASE 10 | AGE 15+**SITUATION** : unplanned pregnancy / semi-urban**BACKGROUND – FAMILY & EDUCATION**

- The child's case was already lodged with social protection services in a case of "parental negligence" prior to the unplanned pregnancy issue.
- Family situation of the case is socially and economically vulnerable and difficult, with a single mother and multiple siblings, primarily dependent on the State's single parent allowance cash transfer [which is a token and insufficient amount].^{98,99}
- Parent supportive to the young person and her baby.
- Young person dropped out of school completely following pregnancy and declined the support of the authorities to continue schooling.

OTHER OBSERVATIONS

Extremely vulnerable family situation with multiple siblings and single parent. Social services appear to be unable to intervene or provide support to prevent deterioration of the family situation. Poverty and complicating factors such as negative social attitudes towards such vulnerability impacts the wellbeing of the whole family unit.

The ten cases presented here provide limited but helpful insights to understand the lived realities of young people in extremely vulnerable situations within the family and community, who experienced the life-changing situation of becoming pregnant without intending to do so. In most of the cases, poverty and complex family dysfunctions are common themes, with notably weak social protection services available to the majority of cases. In some cases, failures of the protection services may have aggravated the situation. However, the underlying reality is that young people are not adequately informed, prepared or supported by duty bearers, including the family, school and other caregivers to take care of themselves and their SRH needs as they develop from adolescence to young adulthood. The cases also highlight that it is the most vulnerable members of society that are caught up in the situations observed in these cases.

Some of the cases appear to be from families that are extremely marginalized, socially ostracised and even re-victimized by elements within the larger community. There is a phenomenon in the small island communities of the Maldives where vulnerable women are targeted, often by influential members of the community, for sexual exploitation. This leads to a cycle of exploitation of generations of the same family. Some of the cases documented here may very well be from such families, which can be considered the most vulnerable in the community, in every way. Therefore, the onus should be on the social protection services as duty bearers, to take additional measures to support such families to break the cycle of exploitation and social violence they are subjected to as a normative

Allowance was initiated by the government.

99 President reviews Single Parent Allowance Programme with Cabinet recommendations, The President's Office, 15 October 2019, <https://presidency.gov.mv/Press/Article/22442> (accessed : 23 January 2020)

behaviour within the community. There is a need for policy level recognition of such circumstances in order for social protection services to provide necessary support to prevent the cycle of violence it perpetuates.

It can also be observed from the cases that in several instances, unplanned pregnancy was the result of consensual sexual intimacy. The absence of policy level recognition cannot alter basic facts about adolescence, human development, sexuality and sexual behaviour. It is therefore incumbent upon policy-makers as duty bearers to address the acute gaps in SRH information, education, counselling and other support services for adolescents and young people, to limit individual suffering as well as the social and economic burden on the State to provide protection services.

In the Maldives, social protection services across all sectors consistently fail to provide protection for the most vulnerable citizens and in this context, it is incumbent upon the authorities to act in the public interest by initiating robust policy level changes. Critical cases that have received public attention in recent years include the death of three year old Ibtihhaal Mohammed whose mother was charged with his murder and imprisoned, as well as the case of Ziyada Naeem, who died from her injuries after being allegedly raped by her estranged husband.^{100,101,102} In the latter case, the husband was acquitted despite the overwhelming evidence available, according to the authorities.^{103,104} It would be a worthwhile exercise to analyse the two cases to assess the gendered and discriminatory structural dynamics that resulted in the sentences in the two cases. However, case law is not available in the Maldives to assist scrutiny of the court system and sentencing regimes and such an analysis is beyond the scope of this report. Notably, the court hearing where Ziyada Naeem's husband was acquitted was closed to the public limiting media scrutiny of the case, which is not an uncommon practice in the Maldives.¹⁰⁵ Another notable example is the failure of the authorities to act on the case of an elderly man accused of sexually abusing four sisters in the same family.¹⁰⁶ The failures of law enforcement authorities to adequately deal with perpetrators and the general perception of systemic inefficiency and ineffectiveness are observed from serious cases of persistent abuse which reach the media, as evident from the range of reported cases. In January 2020, public protests took place outside the MoGFSS in Male' following the reported rape of a two year old girl, allegedly by her father, grandfather and great-grandfather.¹⁰⁷ Since the recent media exposure in December 2019 of unregistered child marriage cases involving radicalised groups in the rural island of Maduvvari in Raa Atoll, and the child rape case igniting public protest, a host of cases of child sexual abuse has been emerging.^{108,109,110,111} A report by the Auditor General on the case management of abused children found serious gaps in service delivery, with significant delays in providing critical healthcare support. The prevailing systemic gaps across law enforcement and social protection service systems are explained from the extent of institutional failure observable from reported cases. In such a system, it is important to be mindful that significant under-reporting and non-reporting is likely to be the prevailing norm. Given the gravity of the failures of

100 State negligence investigated in death of Rakeedhoo child, Minivan News - Archives, 29 January 2015, <https://minivannewsarchive.com/society/state-negligence-investigated-in-death-of-rakeedhoo-child-92438> (accessed : 23 Jan 2020)

101 After Ibtihhaal, Maldives Independent, 30 March 2018, <https://maldivesindependent.com/feature-comment/after-ibtihhaal-136923> (accessed : 22 Jan 2020)

102 Husband charged over abused woman's death, Edition.mv, 23 August 2016, <https://edition.mv/news/775> (accessed : 22 Jan 2020)

103 Husband acquitted over death of rape victim, Maldives Independent, 22 March 2019, <https://maldivesindependent.com/crime-2/husband-acquitted-over-death-of-rape-victim-144494> (accessed : 22 Jan 2020)

104 Court accused of discounting evidence of death caused by marital rape, Maldives Independent, 25 March 2019, <https://maldivesindependent.com/crime-2/court-accused-of-discounting-evidence-of-death-caused-by-marital-rape-144562> (accessed : 22 Jan 2020)

105 Husband acquitted over death of rape victim, Maldives Independent, 22 March 2019, <https://maldivesindependent.com/crime-2/husband-acquitted-over-death-of-rape-victim-144494> (accessed : 22 Jan 2020)

106 Court drops charges against elderly man accused of sexually abusing 4 sisters, Edition.mv, <https://edition.mv/news/6764> (accessed : 22 Jan 2020)

107 Outraged citizens protest against rape, demand immediate action, Edition.mv, 17 January 2020, <https://edition.mv/news/14490> (accessed : 22 Jan 2020)

108 Rape victim taken under state care, Maldives Independent, 03 December 2019, <https://maldivesindependent.com/politics/rape-victim-taken-under-state-care-149586> (accessed : 23 Jan 2020)

109 Another elderly man arrested over child sexual abuse, Edition.mv, 20 January 2020, <https://edition.mv/news/14530> (accessed : 22 Jan 2020)

110 Fuvahmulah man arrested for 'marrying' 15-year-old, Edition.mv, 22 January 2020, <https://edition.mv/news/14571> (accessed : 23 Jan 2020)

111 Police arrest 73-year-old for sexual abuse of toddler, Edition.mv, 22 January 2020, <https://edition.mv/news/14578> (accessed : 23 Jan 2020)

the social protection systems, it is absolutely necessary for duty bearers to invest in changes aimed at preventing the exposure of adolescents and young people to the vulnerability of uninformed decisions which put their future stability at risk.

Information gathered for this research shows that adolescents and young people in the Maldives are experiencing significant mental health issues, with a high prevalence rate of suicidal thoughts among school children. It is notable from one of the cases documented here that one young person took his life during a situation where he was associated with an unplanned pregnancy. While details of the case are anecdotal, available research confirms the depth of concern young people have about social stigma and ostracisation attached to out of wedlock pregnancy, especially in small communities. As Hameed observed in her research, “most young people interviewed expect to be disowned or kicked out of their homes if they were found to be sexually active or pregnant outside of marriage. They were very conscious of how their behaviour reflects on their family, creating added pressure for youth to conceal illicit sexual activities, even at the expense of their own health.”¹¹³ The pressure on young people caught up in such situations is not just on the pregnant partner. Consultations with some service providers indicate that in most of the cases of suspected unplanned pregnancy, it is generally a young man who seeks information and services on behalf of their partner. Therefore, it is evident that the pressure for boys to find solutions to support their intimate partner is significant, especially in hostile environments where healthcare support services are denied due to their unmarried status.

A further point to highlight from the documented cases is the freedom perpetrators of child sexual abuse have in the Maldives context. In one instance, it was indicated that the unplanned pregnancy was the result of a predatory action of a married man who wanted to “test his fertility”. Such chilling accounts of calculated abuse against vulnerable young people by much older men become normalized in conditions of impunity for perpetrators. It is not uncommon in the Maldives for perpetrators of child sexual abuse to escape accountability, as evident from the types of cases that are dismissed by the courts.¹¹⁴

A concluding point to observe from the cases do not relate directly to the cases, but to the quality of social protection services available in the Maldives. It is evident that there is an acute lack of technical and professional human resource capacity within the social protection infrastructure to manage the volume and type of cases happening in the Maldives. While it is beyond the scope of this research to delve into the limitations of the social protection services, it is clear that investment in capacity building for social service case workers along with policy level changes to facilitate service delivery is urgently needed. A holistic systemic approach to service delivery involving a multitude of stakeholders will be necessary to deliver results to both protect and prevent young people from falling into cycles of vulnerability, suffering, despair and life-long dysfunction.

112 Medical treatment delayed for abused children: Audit, Edition. mv, 20 January 2020, <https://edition.mv/news/14551> (accessed : 22 Jan 2020)

113 To be young, unmarried, rural and female : intersections of sexual and reproductive health and rights in the Maldives, Shaffa Hameed, RHM Journal, 2018

114 Court drops charges against elderly man accused of sexually abusing 4 sisters, The Edition, 7 August 2018, <https://edition.mv/news/6764> (accessed : 12 Jan 2020)

Following the news reports which alerted the authorities to investigate the case of unregistered child marriage in Raa Atoll Maduvvari mentioned earlier, the President is reported to have established a “task force to investigate the case”.¹¹⁵ The Gender and Human Rights Committee of the People’s Majlis (parliament) also began their own investigations to assess the case and “the Parliament issued an official announcement ... for public information on child marriages, unapproved by a court.”¹¹⁶ The issue of out of court marriages in Maldives has been a concern raised by the Family Court in 2010 and 2014.^{117,118} Notably, systemic gaps cannot be addressed through ad-hoc and reactionary responses by the oversight institutions. The existing legal framework is adequate to strengthen public services and child protection services, arguably even prior to the recent ratification of a new Child Protection Act in 2019.¹¹⁹ In order to leave no one behind, what is required is the consistent investment in budgetary resources, human resource development and training to establish a functional social protection system that is feasible to implement and sustain in the socio-cultural and geographic realities of the Maldives.

115 President Solih assembles task force to investigate child “bride” case, *Edition.mv*, 28 November 2019, <https://edition.mv/news/13657> (accessed : 23 Jan 2020)

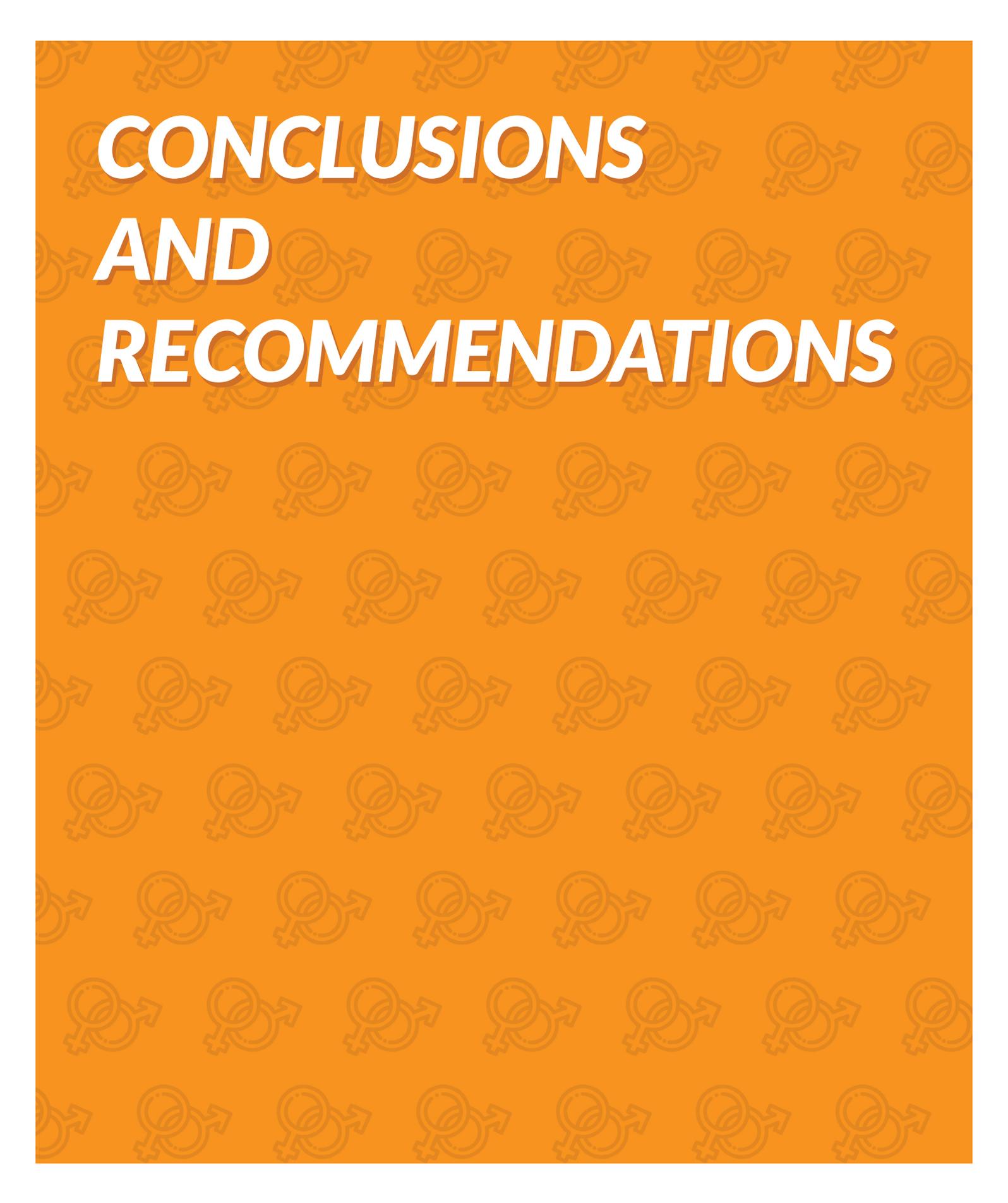
116 *ibid*

117 *Unregistered marriages leave children unable to inherit, warns Family Court*, *Minivan News - Archives*, 12 April 2010, <https://minivannewsarchive.com/society/unregistered-marriages-leave-children-unable-to-inherit-warns-family-court-5744> (accessed : 23 Jan 2020)

118 *Fatwas against registering marriages a huge challenge: Family Court chief judge*, *Minivan News - Archives*, 27 April 2014, <https://minivannewsarchive.com/politics/fatwas-against-registering-marriages-a-huge-challenge-family-court-chief-judge-83630> (accessed : 23 Jan 2020)

119 *President ratifies landmark child protection laws*, *Maldives Independent*, 21 November 2019, <https://maldivesindependent.com/society/president-ratifies-landmark-child-protection-laws-149361> (accessed : 23 Jan 2020)

CONCLUSIONS AND RECOMMENDATIONS

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CONCLUSIONS

This qualitative research effort aimed to get an understanding of the lived experience of young people in the Maldives, affected by prevailing structural and socio-cultural barriers to access SRH information and services and their experience of gender-based violence in the same context. While efforts were made to get first-hand primary data from affected individuals, various limitations and constraints made it necessary to depend largely on available secondary data to inform the research. However, existing literature and data as well as key informant consultations provided useful insights on key issues impacting the life situation of vulnerable young people from an SRH/R perspective.

There is a significant disconnect between the findings of quantitative national surveys and the findings from available qualitative research on young people's experiences in accessing SRH information and services in the Maldives. While the DHS consistently finds teenage pregnancy and premarital sexual initiation among adolescents to be negligible, qualitative findings inform otherwise. The upshot of this is the absence of policy level recognition of the multiple issues this presents, especially considering the high youth demographic in the country, with 60% of women currently in the reproductive age cohort. The consequences of the policy level hesitancy to address SRH/R issues are evident from the findings from available institutional data presented in this report. Data from the MoE shows the prevalence of teenage pregnancy in schools, which has significant negative impacts on the life situation of a child with disruptions to education and loss of socialising environment of schooling. This is besides the negative impacts of potentially life-long societal stigmatisation and ostracisation that out-of-wedlock pregnancy carries in the Maldives.

Data from the MoGFSS, the FPA as well as the GSHS show the prevalence of sexual abuse and violence against children, adolescents and young people. While these are reported cases to the authorities, the data dynamics indicate complete non-reporting in some instances, which raises questions. Although the GSHS shows a slightly higher reporting of forced sexual intercourse among boys, data available from the MoGFSS indicate no reporting of rape among boys and young men. Non-reporting of sexual violence is also notable among boys and young men from the data available from the FPA. Is non-reporting due to lack of trust in the authorities? Is it due to socio-cultural factors that inhibit boys from seeking assistance when their bodily integrity is violated? Further inquiry into these areas is required to understand these inconsistencies. What is clear from the available data is the significant prevalence of exposure to SRH harm in the Maldives among vulnerable young people.

Consultations with key stakeholders in education, health and the non-governmental sector shows a dearth of SRH/R information and service provision to adolescents and young people. The HPA has no programmatic history of SRH interventions to raise public awareness on adolescent and youth SRH concerns,

although the agency recently embarked on a vaccination campaign to immunize adolescent girls against HPV. Efforts to integrate CSE into the school curriculum are reported to be satisfactory according to some key informants although others disagree. Available research also shows that this remains quite inadequate. A UNFPA Maldives commissioned mapping exercise of SRH integration in the curriculum shows significant gaps across key stages 1-3. It is also evident that there is inadequate teacher training and development to deliver the curricular content on SRH through CSE, and the resultant teacher hesitancy to deliver this part of the curriculum is compounded by alleged parental hostility toward the subject. Data available from SHE presented in this report can be taken as an important proxy indicator on the unmet need for SRH/R information and services among young people in general, but SHE is based in Male' with limited outreach activities in the atolls. All these indications show that vulnerable adolescents and young people are both poorly-served or completely unserved by the existing service systems, by education, health and other sectors.

The disparate nature of the data gathered for this research does not enable comparative analysis or help to generate a comprehensive and holistic picture of the multiple gaps in service systems that are failing young people. Some data are useful proxy indicators which can be used to identify linkages to related issues. For instance, the data available from E-centres which show the prevalence of D&C helps to raise questions about the significance of this procedure in the general context of the existing gaps in SRH service provision. As noted elsewhere in this report, access to abortion remains in a policy blind-spot as a problematic issue left unaddressed in the Maldives. Even with the above mentioned limitations, what is very clear from the findings of this research is that in every sector, the service gaps and shortcomings are quite evident. Efforts have been made here to bring together relevant, credible, recent and available data to assess the current situation impacting young people's access to SRH/R information, education and services which affect their lived realities.

Information obtained from the 10 case studies presented in this report show the lived realities of adolescent girls who endured the consequences of the absence of SRH/R information, education and support services. As the analysis of the case studies show, both consensual and non-consensual sexual experience led to adolescent and/or youth unplanned pregnancy, which had significant repercussions exposing young people to extreme forms of vulnerability and harm. It is interesting to note that it is not only one partner in such a relationship that suffers consequences, as observed in the case where the boyfriend of one young pregnant girl is alleged to have committed suicide. This anecdotal insight taken in light of another anecdote that young men are the primary health seekers for emergency contraception indicates the challenge faced by both boys and girls in such situations. The inability to access services due to lack of means and resources is itself a vulnerability young people do not choose.

It is evident from the case studies that although the education and social

protection services facilitated access to curricular education in some form, in all but a very few cases, this was completely disrupted, which will have both short and long term implications. In some cases, the young person refused continuing education due to personal and environmental factors such as societal attitudes which prevented continuation of school. Notably, while some cases spiraled into multiple unplanned pregnancies and serious vulnerabilities and exposure to further harm, in other cases, extended family support in tandem with social service support helped to stabilize the young person's life situation in a supportive family setting. This is the outcome of luck more than policy-based system design and intervention. The availability of social protection services is somewhat arbitrary, dependent on many factors including the quality of social service infrastructure and service personnel. It was also evident that the social protection services are extremely weak and stretched with capacity limitations which impact service delivery in multiple ways. There seem to be no support services provided to adolescents and young people to improve their SRH knowledge, while under the supervision of a social worker.

Recent developments relating to the exposure by mainstream media and acknowledged by government authorities about the incidence of unregistered child-marriage among radicalised groups adds a further dimension to the discussion on adolescent vulnerability and access to SRH information and services in the Maldives. The situation poses particular challenges to policy and programme interventions and highlights significant public service delivery gaps. Nevertheless, the government's ICPD+25 Nairobi Summit commitments in 2019 to adopt CSE and strengthen SRH education in the Maldives provide an entry point to increase programme interventions towards Maldives' SDG commitment to 'leave no one behind'.

RECOMMENDATIONS

Based on some of the observations and findings of this inquiry, the following recommendations are made to UNFPA Maldives for potential programmatic interventions across sectors that may help improve the situation of access to adolescent SRH information and services in Maldives.

Education sector

1) The MoE is currently reviewing the 2011 school health policy which presents opportunities for collaboration, particularly in the context of the government's commitments at the Nairobi Summit.

UNFPA could engage with MoE and other relevant stakeholders to provide technical support to include SRH/R and CSE as key components of school health policy narrative, with appropriate language that provide clarity for meaningful and practical implementation.

2) Research shows that "CSE programmes should be delivered by well-trained and

supported teachers in school settings" (UNESCO, 2018; Shafeega, 2018), and the current situation provides opportunities to strengthen support to MoE and the NIE for teacher training and development.

UNFPA could expand technical support services to increase teacher training on CSE, with a focus on including leading teachers, school health counsellors and even supportive parents as key focal points to deliver curricular content on SRH, in light of previous positive reports on this approach.

3) The policy recommendations on improving curricular content and delivery on SRH/R provided in the research paper by Fathimath Shafeega in 2018 are reiterated in this set of sectoral recommendations.¹²⁰

Health sector

4) The HPA in collaboration with multiple stakeholders successfully executed the initial phase of a national awareness campaign on HPV immunization among adolescent girls. While the complete success of this is yet to be known, the modality suggests potential for other activities involving public health awareness on SRH/R issues for young people.

UNFPA could explore the possibility of SRH/R advocacy campaigns with HPA to raise public health concerns affecting adolescents and youth, in collaboration with allies such as MNYC and SHE, to achieve Nairobi Summit commitments.

Social protection services

5) There is an acute and urgent need to improve the human resource capacity and professional knowledge of social workers. There may be value in UNFPA's programmatic intervention to facilitate SRH/R knowledge building among social workers to equip them with life skills tools that could guide/facilitate preventive care among vulnerable young people under their care.

UNFPA could facilitate SRH/R awareness training for social workers to improve their knowledge and capacity to support adolescents and young people under their care on matters affecting SRH/R.

General recommendation comment

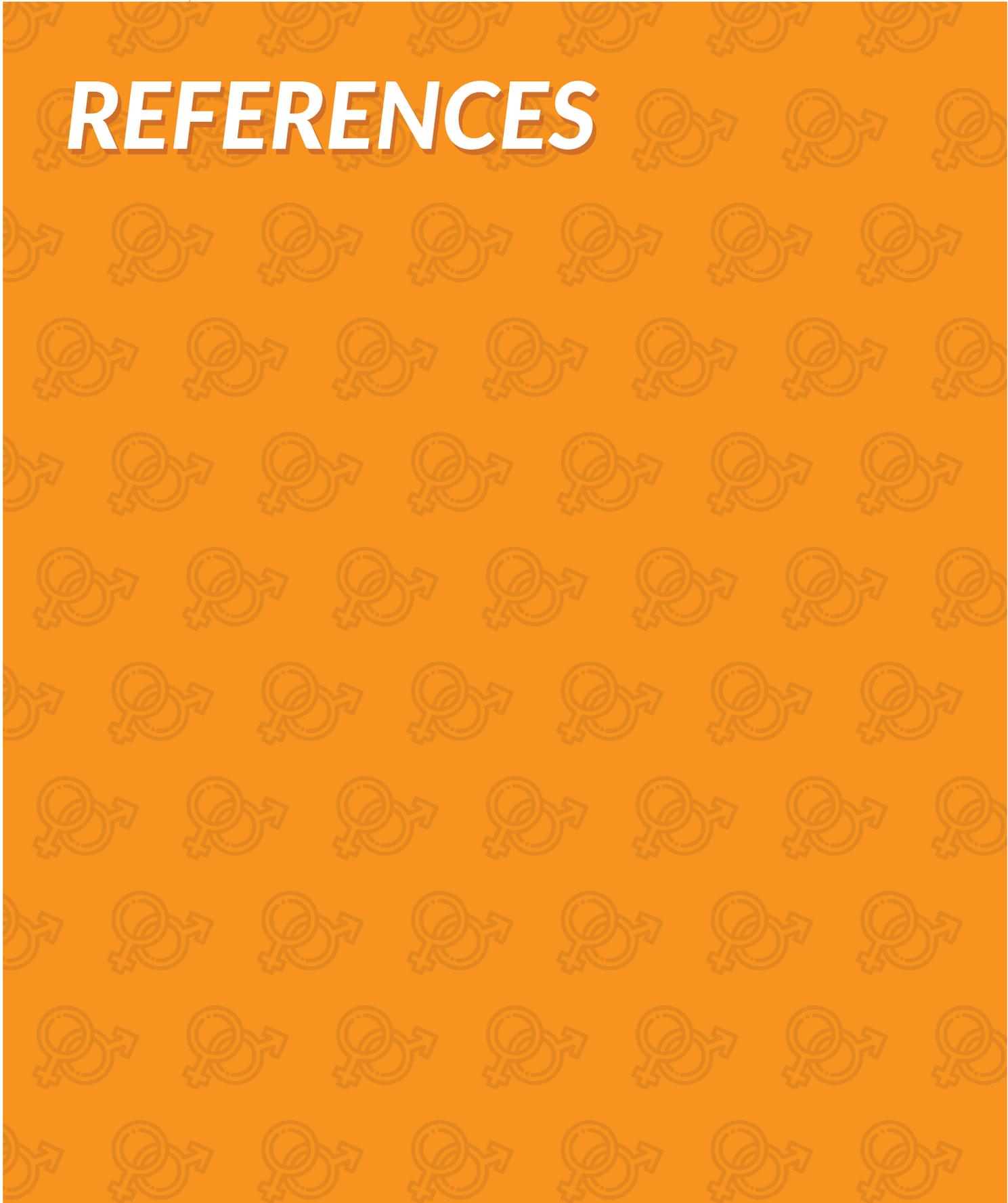
6) There is a need to conduct further qualitative research to get clearer understandings of many of the issues affecting young people's SRH life experiences that are not captured in national survey data. There is also a need to advocate for quantitative data enrichment and coherence to ensure their reliability and useability, on issues relating to SRH/R among young people specifically, and in general.

7) The Domestic Violence Prevention Act 2012 requires cross-sectoral interventions to implement the provisions of the law, to protect, prevent and

¹²⁰ "Do adolescent girls have adequate knowledge to make healthy and informed life choices?" in Research Papers on the Situation of Women in Maldives, UNFPA Maldives/UN Women/British High Commission in Sri Lanka, 2018:138

rehabilitate victims and perpetrators of violence. The intent and structure of the law indicates the necessity for cross-sectoral collaboration to achieve the provisions of the law. Therefore, it is recommended that stakeholders fully adopt the modality of cross-sectoral collaboration to address the multi-dimensional issues affecting the most vulnerable that are being left behind due to systemic gaps and weaknesses resulting from the absence of such coordination and cooperation.

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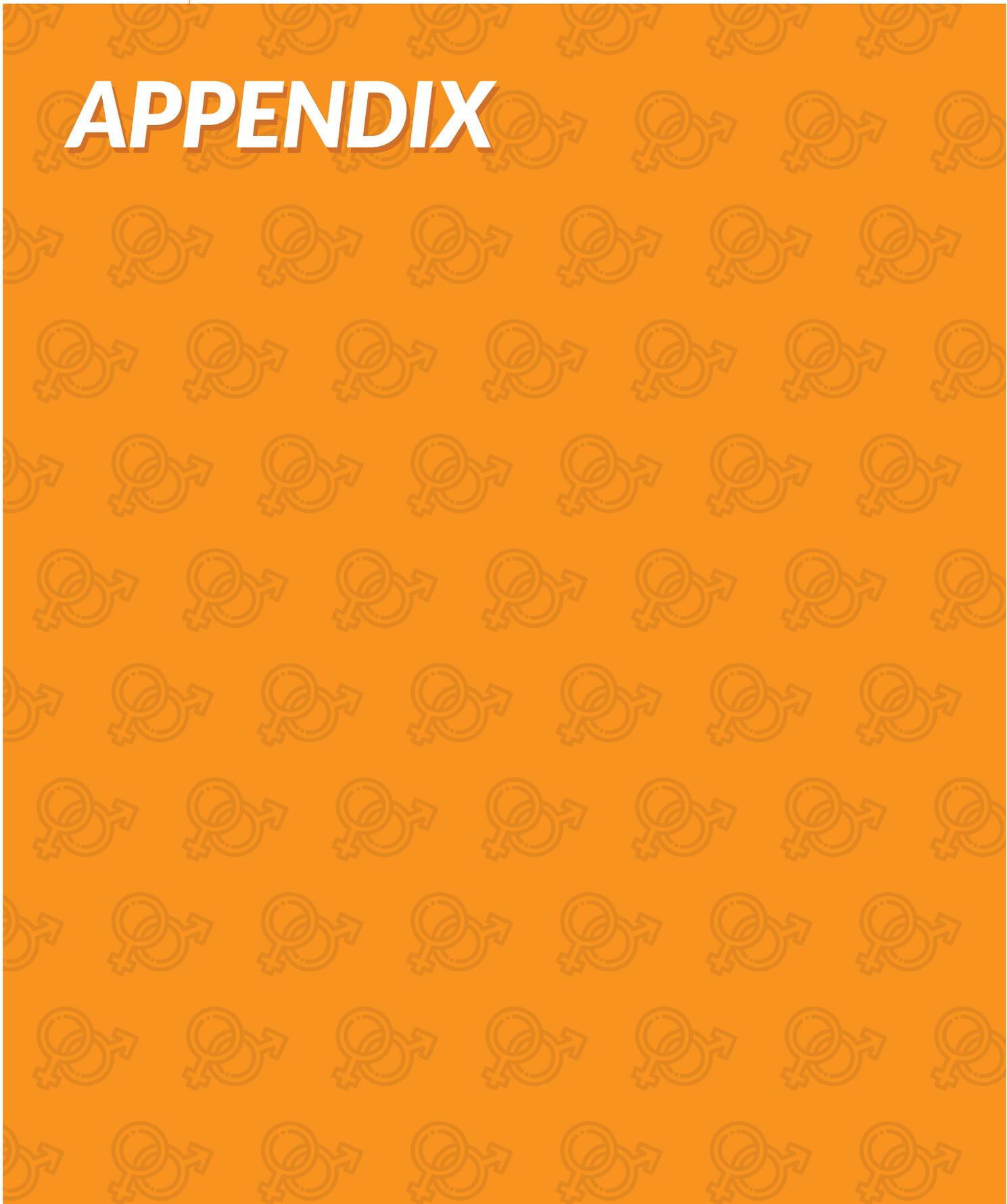
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APPENDIX



APPENDIX 1

List of institutions for key informant consultations and proposed points for inquiry.

	<i>Key informants at</i>	<i>Inquiries relating to ...</i>
1	School Health Division ESQID, Ministry of Education	<ul style="list-style-type: none"> - school health policy on SRH/R - extent/depth of SRH/R coverage in the curricula - scope of coverage/implementation - teacher education/training on subject area - content implementation and monitoring - other possible indicators and available information/data
2	Health Protection Agency (HPA)	<ul style="list-style-type: none"> - mandate and origins - programme(s) on SRH/R public awareness, conducted by the agency - extent of programmatic reach - other related activities
3	Society for Health Education (SHE) SRH Programme	<ul style="list-style-type: none"> - SRH/R programme overview - extent of programmatic reach to adolescent/youth cohort - spaces, channels used to reach target groups - extent of reach and challenges experienced - data on target populations reached
4	Ministry of Gender, Family and Social Services, Social Service Department	<ul style="list-style-type: none"> - observation of SRH/R issues in social protection cases - types of cases and data availability - other related available information
5	Family Legal Clinic (FLC)	<ul style="list-style-type: none"> - case types overview - establish observation on instances of SRH/R denial in cases attended by the FLC - linkage of SRH/R and GBV in case observations [specifically in target group]

APPENDIX 2

Verbatim extract from the School Health Policy 2011 on strengths and weaknesses in the implementation of the Health Promoting School Policy 2004.

Some of the deterrents identified by the implementers include:

- Competing educational priorities in the school for students' time.
- School health programme still considered to be secondary to teaching by school heads and senior management.
- Little involvement of the school health assistant or health focal point in delivering the health topics in the curriculum.
- Inadequate teaching materials and IEC materials on health topics.
- Lack of support from local health service providers.
- Minimum health and counselling infrastructure in schools.
- Current public health issues of student population not covered in the curriculum and the content in the curriculum being outdated
- Lack of an in-service training programme to bring all school health focal points (who come from different health back grounds such as nursing, PHC) to same level of understanding of concepts.

Some positive experiences include:

- Implementation of school health education activities by scheduling of adequate time during school session and as extra activities was facilitated when the head and senior management were sensitized to the concepts of health promoting schools.
- Good Coordination between leading teachers and school health assistants/focal points and counsellors, enabled them to deliver health topics of the curriculum jointly.
- Effective utilization of parents who are health professionals to conduct health education and screening programmes.

Informal liaison with national public health programme level staff in the health sector facilitated timely technical support and resource materials.

APPENDIX 3

List of topics covered in the leaflets produced by SHS for both girls and boys separately (see image 6)

Growing Up Well for Girls (List of headings in the leaflet – in order of presentation in the leaflet)	Growing Up Well for Boys (List of headings in the leaflet - not in order of presentation)
How Can I Help?	How Can I Help?
Puberty - What will happen to girls during puberty?	Puberty - What will happen to boys during puberty? - Why are most of the girls taller than the boys already?
Menstruation : - Will I know when my period is going to start? - What is discharge? - When is my period going to start? - How much blood will I lose? - How long will my first period be? - Will other people know I am having my periods? - What do I do if I get blood on my clothes?	
TIPS [about sanitary pads preparedness & access]	
Personal Hygiene & Grooming	Personal Hygiene and Grooming - When should I shave?
How to Use a Pad	
Taking Care of Yourself [nutrition information]	Taking Care of Yourself [nutrition information]
Do you Worry About How You Look?	Do you Worry About How You Look?
How Can I prevent Acne and Pimples?	How Can I prevent Acne and Pimples?
Tips to Better Manage Pimples & Acne	Tips to Better Manage Pimples & Acne
Shaving Tips	Shaving Tips
Myth Busters	

Sample pages from separate "Growing Up Well" leaflets for girls and boys + leaflet on ritual purification

For Boys

PUBERTY

Puberty is a series of changes that your body goes through as you grow into a young man. You start to produce hormones which will change your body and it can also affect your emotions. It can be difficult to get used to it but everyone must go through it including girls while they grow into young women. The changes are different for boys and girls and it should be respected. For boys, puberty usually happens between 10 and 18 years of age. Some might start puberty earlier or later. This is normal. Each person's body will grow and change when it is ready. All of us are different so our bodies change differently too. Here are some of the common changes you can expect during puberty.

What will happen to boys during puberty?

- You will grow taller, bigger and may get more muscular.
- Your voice changes and gets deeper. It might be difficult to control at first but it will settle down soon.
- You develop facial hair.
- Your underarms and private area grow hair.
- Sweat and oil glands become more active and you may get pimples and sweat more.
- Your body odour changes.
- Your reproductive system matures.
- Your penis and testicles get bigger and may feel itchy and uncomfortable.
- You may experience mood changes.

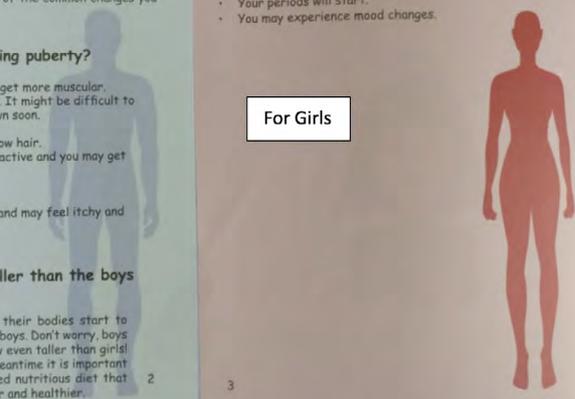
Why are most of the girls taller than the boys already?

Girls get a head start on puberty as their bodies start to change and grow a bit earlier than most boys. Don't worry, boys will usually catch up and some may grow even taller than girls! You just need to wait and see. In the meantime it is important that you keep active and eat a balanced nutritious diet that will help your body grow taller, stronger and healthier.

For Girls

What will happen to girls during puberty?

- You will grow taller and gain some weight.
- Your breasts start to grow and hips widen.
- Your muscles get stronger.
- Your underarms and private area grow hair.
- Sweat and oil glands become more active and you may get pimples and sweat more.
- Your body odour changes.
- Your reproductive system matures and you may get vaginal discharge.
- Your periods will start.
- You may experience mood changes.



For Girls

SHAVING TIPS

Hair will grow on different parts of your body. It is always better to keep them short or shave them. If you want to shave, it is really up to you to decide when you want to start shaving.

- Before shaving, you should wash your hands properly.
- Rinse your razor to make sure it is clean.
- It is important to wash the surface of the skin before shaving, so you don't get a rash from shaving. This is particularly important if you have sensitive skin.
- You can use a mild soap to wash your skin.
- Hair in different parts of the body grows in different directions. You should shave in the direction your hair is growing. Shaving in opposite direction can give a rash, redness or razor burn!
- Rinse your razor every few strokes to make sure it doesn't get clogged.
- When you are done, wash your skin surface.
- Make sure you rinse and dry the razor, and store it safely.
- You must renew the blade of your razor or get a new razor if it becomes blunt or if it develops a stain to make sure you don't end up with a rash, redness and blotches.
- You may get some cuts and nicks. You just have to be careful and make sure it doesn't happen every time!
- Also, you must never share razors/shavers with others.



For Boys

SHAVING TIPS

- There are all sorts of razors available these days. You can buy razors and shaving gel or cream at lots of shops, supermarkets and some pharmacies. Some people prefer using electric shavers.
- First, you should wash your hands properly.
- Rinse your razor to make sure it is clean.
- It is important to wash your face before shaving, so you don't get a rash from shaving. This is particularly important if you have sensitive skin.
- You can use a mild soap or a gentle face wash to wash your face.
- Hair in different parts of the face grows in different directions. You should shave in the direction your hair is growing. Shaving in opposite direction can give a rash, redness or razor burn!
- Rinse your razor every few strokes to make sure it doesn't get clogged.
- When you are done, give your face a nice wash!
- Make sure you rinse and dry the razor, and store it safely.
- You must renew the blade of your razor or get a new razor if it becomes blunt or if it develops a stain to make sure you don't end up with a rash, redness and blotches.
- Expect to get some cut and nicks. You just have to be careful and make sure it doesn't happen every time.
- Also, you must never share razors/shavers with others.



5 Why not talk to a parent or trusted adult to get some tips. You can even get a shaving lesson from someone who has done it before!

<p>MYTH BUSTER</p> <p>For Girls</p> <p>"You lose a lot of blood"</p> <p>Nop. You only lose 3-4 tablespoons of blood at first. Even once periods get more regular as you grow up, you still lose a very limited amount of blood every time.</p> <p>"It is a disease or sickness"</p> <p>They could not be more wrong! Periods are part of the functions of normal female reproductive system. Having your period means you are growing up healthy and well!</p> <p>"Menstrual blood is not regular blood"</p> <p>Menstrual blood is regular blood. Just because it flows from the vagina does not make it abnormal. In fact, vaginas are a normal part of the female body, and having your period means you are growing up healthy. Also, did you know it has no odor at all? Whatever smell comes after blood is exposed to air. Now, there is a cool fact for you!</p> <p>"You should not wash your hair or cut your nails during your periods"</p> <p>Wrong again. You should continue good hygiene practices as any other time of the month. You would probably need to wash your hair daily and trim your nails at least once a week.</p> <p>13</p>	<p>TIPS TO BETTER MANAGE PIMPLES & ACNE</p> <ul style="list-style-type: none"> • Keep your hands clean and finger nails trimmed and clean. • Washing your skin is important to remove excess oil and dead skin cells which can clog your pores. Washing too much can actually damage your skin by over-drying or irritating existing pimples. • If you've been exercising, doing a sport, doing active work or if the heat is just so terrible that you are sweating too much, you should wash your face and other acne-prone areas of your body as soon as possible. • If you use skin products, choose products that are non-comedogenic (meaning they don't clog pores). • Be careful with hair styling products and keep them away from the face. A lot of these products contain oils that can make your acne worse! • If you get acne on your body (e.g. back or thighs), avoid wearing tight clothes. They can rub against the pimples and irritate it more. Never pop, prick or squeeze pimples. This can actually push pus or an infection deeper inside causing more redness, swelling, and worse - scarring, which may be there forever! • Don't be embarrassed to get help. If your acne is really bothering you, you should speak to a trusted adult. Doctors can recommend special creams or gels and medicines for your acne and can help you manage your acne better. • If you are taking prescription medication for acne, you must complete your medication as the doctor advised (unless the doctor tells you to stop it before that). When your skin starts to look better, you might feel like you don't need the medicine anymore, but there is a chance that you might get a breakout if you stop too early. • Here is some good news - acne usually gets a lot better as you get older! • A well balanced nutritious diet and physical activity can keep your body and skin fit and healthy. <p>For Boys</p> <p>7</p>
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PURIFICATION IN ISLAM

Adolescence is a time when we go through a lot of physical, mental and social changes. Our bodies start going through the physical changes of puberty. What we enjoy doing during our free time may not be the same as when we were a little younger, and even how we speak to others and act around other people may change a bit. These are all normal things that happen to all girls and boys during puberty. Everyone grows at their own pace, and all these physical and emotional changes may not be exactly the same for all of us. Sometimes, trusted grown-ups such as your mother or father or an older sibling, may talk to you about some of the changes that you may be going through during puberty.

This factsheet summarises some of the very important hygiene lessons that all Muslims need to learn and practice as we grow up healthy and well.

If you want to read more about the changes that girls and boys go through during puberty, "Growing up well for girls" and "Growing up well for boys" contain lots of useful information on growing up well!

ARE THERE ANY SPECIAL HYGIENE REQUIREMENTS FOR MUSLIMS?

Yes. As we grow up and our bodies go through puberty, where our reproductive system matures, there are special hygiene and cleanliness requirements we should all learn about and practice in our life.

WHEN ARE WE REQUIRED TO PERFORM SPECIAL CLEANSING PRACTICES?

AFTER MENSTRUATION (PERIODS)

When menstrual bleeding stops. If your periods are irregular and lengthy, you can cleanse yourself after stops bleeding and return to performing usual prayers.

AFTER DISCHARGE OF FLUIDS FROM REPRODUCTIVE ORGANS

Discharge of reproductive fluids may occur during sleep or in other circumstances for both males and females. You should observe for any wetness on your clothes or underpants. If there is any discharge, you need to cleanse yourself appropriately.

APPENDIX 4

Screenshot of the SRH content mapping table presented in the paper by Fathimath Shafeega in 2018 entitled “Do adolescent girls have adequate knowledge to make healthy and informed life choices?” in Research Papers on the Situation of Women in Maldives, UNFPA Maldives/UN Women/British High Commission in Sri Lanka, 2018. [Note: highlights in yellow, and green underline under columns KS1, 2 & 3 added for emphasis.]

Figure 1- Mapping exercise for SRHR integration across the curriculum
Source: UNFPA, 2017.

KEY THEMES	TOPICS	KS 1	KS 2	KS3
1. RELATIONSHIPS	1.1 Families	YES	YES	YES
	1.2 Friendship, love and romantic relationship	YES	YES	SOME
	1.3 Tolerance and respect	NO	<u>MOST</u>	NO
	1.4 Long-term commitment, marriage and parenting	NO	NO	NO
2. VALUES, ATTITUDES AND SKILLS	2.1 Values, attitudes and sources of sexual learning	YES	SOME	SOME
	2.2 Norms and peer influence on sexual behaviour	YES	YES	SOME
	2.3 Decision-making	YES	YES	SOME
	2.4 Communication, refusal and negotiation skills	YES	<u>MOST</u>	<u>MOST</u>
	2.5 Finding help and support	YES	YES	SOME
3. CULTURE, SOCIETY AND HUMAN RIGHTS	3.1 Sexuality, culture and human rights	NO	SOME	SOME
	3.2 Sexuality and the media	SOME	NO	SOME
	3.3 The social construction of Gender	NO	SOME	<u>MOST</u>
	3.4 Gender-based violence including sexual abuse, exploitation and harmful practices	SOME	SOME	<u>MOST</u>
4. HUMAN DEVELOPMENT	4.1 Sexual reproductive anatomy and physiology	SOME	SOME	NO
	4.2 Reproduction	NO	NO	NO
	4.3 Puberty	NO	SOME	YES
	4.4 Body Image	YES	SOME	<u>MOST</u>
	4.5 Privacy and bodily integrity	<u>MOST</u>	SOME	YES
5. SEXUAL BEHAVIOUR	5.1 Sex, sexuality and the sexual life cycle	SOME	NO	NO
	5.2 Sexual behaviour and sexual response	NO	NO	NO
6. SEXUAL AND REPRODUCTIVE HEALTH	6.1 Pregnancy prevention	NO	NO	NO
	6.2 Understanding, recognising and reducing the risk of STIs including HIV	YES	NO	NO
	6.3 HIV and AIDS stigma, care, treatment and support	NO	NO	NO

DO ADOLESCENT GIRLS HAVE ADEQUATE KNOWLEDGE TO MAKE HEALTHY AND INFORMED LIFE CHOICES?

APPENDIX 5

Screenshot of the commitment made by the Maldives National Youth Council at the ICPD+25 Nairobi Summit in Nairobi, Kenya, November 2019.

31 October 2019

COMMITMENT TITLE:

Ensuring proper youth engagement in Sexual Reproductive Health.

To be actioned in : Maldives

COMMITMENT DESCRIPTION:

Council will collaborate with relevant government authorities and other key stakeholders to ensure proper facilities and inclusive access for young people to obtain required knowledge, information and services on SRH&R through youth health care within next 5 years

COMMITMENT CATEGORY:

(4) Access for all adolescents and youth, especially girls, to comprehensive and age-responsive information, education and adolescent-friendly comprehensive, quality and timely services to be able to make free and informed decisions and choices about their sexuality and reproductive lives, to adequately protect themselves from unintended pregnancies, all forms of sexual and gender-based violence and harmful practices, sexually transmitted infections, including HIV/AIDS, to facilitate a safe transition into adulthood.

Mode of engagement:

- Programmatic action

SUBMITTED BY:
Maldives National Youth Council

Source : <https://www.nairobisummiticpd.org/commitments> (accessed : 03 Jan 2020)

APPENDIX 6

Selected indicators from the Global Student-based School Health Survey (GSHS),
Ministry of Education/WHO, 2009 and 2014

Selected indicators		2009 GSHS			2014 GSHS		
		Girls	Boys	Total	Girls	Boys	Total
Believed people can protect themselves from HIV infections or AIDS by not having sexual intercourse	Male'	59.7%	53.9%	56.9%	*	*	*
	Atolls	41.1%	44.2%	42.4%	*	*	*
	Maldives	46.9%	47.1%	46.8%	*	*	*
Knew how to tell someone that they do not want to have sexual intercourse with them	Male'	62.8%	58.5%	60.8%	*	*	*
	Atolls	45.4%	44.9%	45.0%	*	*	*
	Maldives	50.9%	48.9%	49.8%	*	*	*
Were physically forced to have sexual intercourse when they did not want to	Male'	11.7%	10.8%	11.2%	*	*	*
	Atolls	18.1%	20.8%	19.5%	*	*	*
	Maldives	16.1%	17.8%	17.0%	*	*	*
Made a plan about how they would attempt suicide during the past 12 months	Male'	20.1%	15.6%	18.1%	*	*	*
	Atolls	23.1%	24.7%	24.0%	*	*	*
	Maldives	22.2%	21.9%	22.2%	19.6%	16.6%	18.5%
Percentage of high school students who attempted suicide (one or more times during the 12 months before the survey)	Male'	*	*	*	*	*	*
	Atolls	*	*	*	*	*	*
	Maldives	*	*	*	10.8%	14.9%	13.2%

* data not available



Ensuring rights and
choices for all

UNFPA Maldives Country Office

3rd Floor, Shinetree Building,
Boduthakurufaanu
Magu, Maafannu, Male' 20184,
Republic of Maldives

Tel: (960) 3316940
Fax: (960) 3317936
Email: maldives.office@unfpa.org
Web: maldives.unfpa.org



@UNFPAMaldives