ICPD+15 and Beyond: Progress Achievements and Challenges
Maldives
1994 – 2009
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Reproductive Health
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### Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ASRH</td>
<td>Adolescent sexual reproductive health</td>
</tr>
<tr>
<td>CBO</td>
<td>Community based organization</td>
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<tr>
<td>CEDAW</td>
<td>Convention on the elimination of all forms of against women</td>
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<tr>
<td>CPR</td>
<td>Contraceptive prevalence rate</td>
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<td>DHS</td>
<td>Demographic health survey</td>
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<td>FLPR</td>
<td>Female labour participation rate</td>
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<td>FPU</td>
<td>Family Protection Unit</td>
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<td>GBV</td>
<td>Gender-based violence</td>
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<td>GDI</td>
<td>Gender development index</td>
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<td>GDP</td>
<td>Gross domestic product</td>
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<td>ICPD</td>
<td>International conference on population and development</td>
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<td>IGMH</td>
<td>Indira Gandhi memorial hospital</td>
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<td>LFP</td>
<td>Labour force participation</td>
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<td>MDG</td>
<td>Millennium development goals</td>
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<td>MMR</td>
<td>Maternal mortality rate</td>
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<tr>
<td>NGO</td>
<td>Non-governmental organization</td>
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<tr>
<td>NPD</td>
<td>National planning department</td>
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<tr>
<td>PoA</td>
<td>Programme of Action</td>
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<tr>
<td>PPP</td>
<td>Public private partnership/purchasing power parity</td>
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<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RTI</td>
<td>Reproductive tract infections</td>
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<tr>
<td>SAARC</td>
<td>South Asian Association for Regional Corporation</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
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<td>TFR</td>
<td>Total fertility rate</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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</table>
ICPD International Conference on Population and Development

The 1994 International Conference on Population and Development (ICPD) in Cairo was a milestone in the history of population and development. At the conference, the world agreed that population is not about number, but about people. Implicit in this rights-based approach is the idea that every person counts. The conference also made it clear that empowerment of women is not simply an end in itself, but also a step towards eradicating poverty and stabilizing population growth. Reproductive health and rights are cornerstones of women’s empowerment.

At the conference, 179 countries adopted a 20–year Programme of Action (PoA) which focused on individual needs and rights, rather than focusing on achieving demographic targets. The concrete goals of the ICPD include, providing universal education; reducing infant, child and maternal mortality; ensuring universal access by 2015 to reproductive health care, including family planning, assisted childbirth and prevention of sexually transmitted infections including HIV.

The ICPD PoA is fully aligned with the Millennium Development Goals (MDGs) and the two sets of commitments are mutually reinforcing and overlapping. The ICPD PoA set out a broad and comprehensive vision of developments which included many elements not covered in the eight MDGs, where the ICPD PoA addresses the complex interrelationships between, population distribution, sustainable development, climate change, urbanization, migration, gender equality, data collection and analysis.
Executive Summary

This report provides an assessment of the progress made during the past fifteen years by the Maldives in implementing the Programme of Action adopted at the International Conference on Population and Development (ICPD), held in Cairo in 1994. The report highlights the key issues, gaps and challenges that lie ahead, and provides directions for future course of action. It draws from in-depth situation analyses prepared by national and international consultants on the areas of population and development, reproductive health and rights and gender equality and empowerment of women.

Population and Development

The Maldives has made significant gains during the past fifteen years in strengthening the incorporation of population issues in policy development and planning, achieved through collection and analysis of data, building national capacity through training and creating a better understanding of population and development issues among planners. More recently, significant organizational and institutional restructuring and changes in systems and functions have taken place with the election of the new government, in 2008. Some key change includes, the transfer of planning functions to the Office of the President under a National Planning Council chaired by the President, and the reorganization of the former Ministry of National Development Planning to Department of National Planning within the Ministry of Finance and Treasury. These would have considerable impact on the implementation of policies on population and development as well as on the achievement of the ICPD and MDG goals.

Today, Maldives is at a critical juncture, with dramatic increases in population by specific functional age groups, with young people constituting the largest cohort of the population, hence characterized by a rapidly expanding labour force and a declining dependency ratio. These current trends, provides a unique and timely opportunity to make expansions in education and skills, where the large cohort of young people with marketable skills could add significantly to the growth in GDP. Failure to technically educate and utilize these resources will not only result in unemployment and slower economic growth, but would also have long term implications for health and social welfare. Additionally there is high unemployment of women, (discussed further later in this report), which has negative impacts on overall progress of the nation.

Future action to address the concerns within the area of population and development especially emerging issues would include:

- Adequately addressing the needs and concerns of the large adolescent and youth population and of women of all ages in terms of employment, education, recreation and reproductive and sexual health needs
- Strengthening the planning, processing and analysis of data, particularly of the 2011 census with wider representation of the population such as the large foreign migrant population.
- Investing in the disaggregation, quality and analysis of data to guide the development of policies and programmes.
- Building national capacities on population and development through a comprehensive capacity development plan.
• Active evidenced based advocacy on population trends and emerging population concerns to clear misconceptions and to develop and implement informed polices and interventions.

Reproductive Health and Reproductive Rights
Access to basic health services is nearly universal in the Maldives. Consolidating the on-going gains made in the last decade, Maldives has made significant progress in improving access to maternal and child health, family planning services and skilled attendance at birth. As a result, there have been marked reductions in infant mortality, maternal mortality and fertility; hence Maldives is making considerable headway in achieving the related ICPD and MDG Goals.

Despite these achievements, there is still much to be achieved in improving the demand and supply of reproductive health services and in improving the health seeking behaviour particularly of the large adolescent population. Much remains to be done in improving contraceptive prevalence, reducing the unmet need for contraception and reducing maternal morbidity. Levels of anaemia and malnutrition among pregnant women continue to be high; knowledge of RTI/STIs and prevention and in particular the methods of prevention continue to be limited; availability of services for other elements of RH care such as infertility management and treatment of reproductive organ cancers are still inadequate. Meeting the RH need of men, adolescent and unmarried youth are some of the key challenges for the future, which require innovative, and more target oriented actions.

Future actions to address reproductive health concerns would include:
• Strengthening the availability and accessibility to safe, modern and affordable methods of contraceptives, with increased promotion of condom use through innovative social marketing strategies with private sector involvement.
• Improving the quality of reproductive health services by strengthening management, better monitoring and supervision, human resource development and establishing and increasing the utilization of guidelines and protocols.
• Further research and analysis on the causes of anaemia, RTIs and reproductive organ malignancies with greater awareness raising on prevention.
• Greater promotion of safe sexual and reproductive health knowledge and behaviours particularly among adolescents and youth with reinvigoration of current interventions to be more targeted and results driven, particularly the life skills programme for in school youth.
• An institutionalised health sector response to address reproductive health implications of gender based violence

Gender Equality and Women’s Empowerment
Maldives, under a new democratic government, has committed strongly to gender equality and gender mainstreaming. The Constitution of the Republic of Maldives (2008) guarantees to all persons the same rights and freedoms, and upholds the principles of equality and non-discrimination. President Mohamed Nasheed’s statement on the occasion of International Women’s Day (2009) outlined Government policy and
provided a comprehensive vision of women’s empowerment and promotion of gender equality through gender mainstreaming.

The Maldives has signed key international instruments committing itself to gender equality and women’s empowerment. It has made significant progress towards achieving the Millennium Development Goals, but faces challenges in achieving MDG Goal 3 of promoting gender equality and empowering women by 2010.

There is no institutional discrimination along gender lines in access to education. Gender parity has been achieved in the literacy rates, enrollment, and attainment in primary and secondary levels though disparity still exists in tertiary education. Cultural, religious and societal restrictions in mobility continue to limit participation of women in paid employment and men continue to have almost twice as much presence in the labor force than women. The number of women in senior decision making positions is minimal.

High female unemployment, low political participation, gender based violence, high divorce rate and male migration leading to almost 47 percent female headed households, are major issues experienced by women of Maldives, both in Male and in the Atolls. Conservative interpretation of Sharia on child custody, polygamy and divorce create further gender based constraints for women.

No systematic integration of gender in the government planning, budgeting and monitoring has been carried out successfully as yet. Recognizing the need for focused efforts for gender equality, the Government has approved a Gender Equality Policy and Gender Architecture Framework to ensure systematic gender mainstreaming by all government structures and for substantive work on issues of discrimination against women.

Future actions to address gender equality concerns would include:

- Operationalise the political commitments of the new Government on Gender Equality and Women’s Empowerment
- Violence against women and girls needs to be addressed with severity through policy reform, improved capacity for prevention and response. Provision of services and care for survivors of violence needs to be strengthened
- Male partnership and male involvement in changing notions of masculinity for prevention of violence and for emphasizing the caring and supportive role men can and do play within marriages and the family.
- Improve understanding of the underlying causes of gender inequality, and women’s empowerment particularly on low political participation of women, through research and analysis to strengthen interventions.
- Awareness raising and guidance for secondary school girls and boys, particularly in terms of career choices in order to overcome stereotyping in careers and address socio-cultures attitudes towards women and their roles in society.
Partnerships
The number of registered NGOs/CBOs is high - more than 700, but those who are active, especially in the area of population, RH and Gender are only a handful. The Government’s experience in working with NGOs/CBOs also showed a degree of frustration for the promised outputs almost always been delayed, or never delivered. Although there is a high expectation to work with NGOs/CBOs, the government and donors are expected to first invest in their capacity building both in technical and managerial skills in order to nurture a sustainable, productive partnership. NGOs/CBOs outside Male’, and Youth NGOs will need special strengthening to promote their democratic participation in policy making, advocacy and self-empowerment.

Collaboration with private sector in the provision of services and information through PPP is the key policy of the current government. In the area of RH, potential area of collaboration is provision of contraceptives and promotion of male involvement through social marketing. It will have to be ensured that both private sector and civil society develop gender and inclusion sensitive ways of working in the sector they contribute to.
1. Situation Analysis

The Republic of Maldives, an Indian Ocean archipelago consisting of 1190 islands, is spread over an area of 90,000 sq km and has an exclusive Economic Zone covering 900,000 sq. km of the sea. The total land area of the Maldives is 298 sq km and only 200 out of 1,190 islands are inhabited. The Maldives gained independence from Britain in 1965 and became a Republic on 11 November, 1968. All Maldivians follow the Islamic faith and speak Divehi, the national language.

The Maldives has achieved rapid economic growth during the past quarter century and has recovered from the devastating effects of the 2004 Tsunami and has remained resilient amid the adverse consequences of the 2008 global financial crisis. Maldives has also made rapid progress in reducing mortality, fertility and population growth and is committed to the implementation of the ICPD PoA adopted at Cairo in 1994. According to the national MDG report (2007) the Maldives has achieved many of the Millennium Development Goals, which includes a number of ICPD Goals. Maldives is also poised to achieve other MDGs except the Goal 3 on gender and Goal 7 on environment. The new multi-party government of the Maldives which came into power in November 2008 has recently adopted a “Strategic Action Plan 2009-2013” which would impact population and health outcomes and gender equality and, therefore, must take into account future population trends and their inter-linkages with development, which are described in the sections that follow.

1.1 Population Trends and Prospects

Population growth
The latest population and housing census, conducted during March 2006, enumerated 298,968 Maldivians living in Maldives and outside of Maldives on the census date and projections indicate that the Maldivian population is likely to have increased to 314,542 by 1 July 2009.

Data given in Table 1 indicate that the population of Maldives increased from 180,088 in 1985 to 298,968 in 2006 and that during this twenty-one year period the rate of growth of Maldivian population declined rapidly from 3.4 percent during 1985-1990 to 1.7 percent during 2000-2006

Table 1: Trends in population growth 1985 – 2006

1 Though the population census was conducted on a de facto basis, it did not collect information from registered workers with work permits living in Maldives at the time of the census, though they were counted during the listing operation. Registered workers with work permits alone number 70,075 in 2007, which is 18.7 percent of the total population(including foreign workers) living in Maldives and about 38.0 percent of those employed. If undocumented workers and dependants of foreign workers are included total population and its growth as well as the percentage of foreigners in the total population and among workers would be correspondingly higher.

2 The scenario will be quite different, and the rate of growth higher particularly for recent periods, if migrant workers and their dependants are included in the total population as there has been a very rapid increase in their number during recent years. The exclusion of the migrant workers and their dependants from the population would also impact many other issues discussed in the paper. It will have some impact on the estimation of GDP and the demand for services as they contribute significantly to production and the utilization of services. However, for want of data and for other reasons described later on in the paper, the analysis and interpretation contained in the report is limited to the trends and patterns of the Maldivian population.
The high rate of population growth that averaged 3.0 percent or more during the quarter century before 1990 was due mainly to the decline in mortality. The significant decline in the rate of growth since 1995 is brought about by the rapid decline in fertility resulting from factors that are described in detail in the discussion below.

Reliable estimates of fertility and mortality for recent years are not readily available and available estimates are based on the information on births and deaths collected by the Ministry of Health and Family during the registration of these events and from the 2006 census. These are subject to varying types of error which were neither fully evaluated nor accounted for in deriving the estimates.

### Mortality

It is evident from the service statistics by the Ministry of Health and Family that there have been significant improvements in health services and that Maldives has achieved universal access to basic health services despite the difficulties posed by geography, the small population size and distance of some of the island communities. This and the improvements in female education, the availability of safe water and sanitation facilities have contributed significantly to improvements in health and reductions in mortality.

Available estimates suggest that life expectancy has increased to 71.7 for males and 72.7 for females in 2005 and that the increase in female life expectancy is greater than that of males. A large part of the increase in life expectancy is brought about by the decline in mortality during infancy and early childhood. Significant reduction in maternal mortality has also been achieved during recent years (See Table 2). Thus, the Maldives has achieved the ICPD goals relating to infant and early childhood mortality to below 35 and 45 per 1,000 live births respectively; and has reduced maternal mortality by more than half the 1990 levels well in advance of the year 2015.

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3 The recently conducted Demographic and Health Survey (DHS), results of which are expected to be available soon, will yield more reliable estimates of a number of population and health indicators.
Table 2: Trends in selected mortality indicators by sex*

<table>
<thead>
<tr>
<th>Year</th>
<th>Infant Mortality Rate(Male/atolls)</th>
<th>Under Five Mortality Rate</th>
<th>Maternal Mortality Rate</th>
<th>Male/Female Life expectancy(2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>47/63</td>
<td>--</td>
<td>330</td>
<td>59.5/62.2</td>
</tr>
<tr>
<td>1990</td>
<td>35/33</td>
<td>48.0</td>
<td>500</td>
<td>58(Both sexes)</td>
</tr>
<tr>
<td>2000</td>
<td>17/23</td>
<td>51.0</td>
<td>143(2001)</td>
<td>70.7/72.2</td>
</tr>
</tbody>
</table>

*These figures are compiled from various sources which among themselves are inconsistent. However, they reflect the general trend.

Fertility

Estimates also suggest that Maldivian population has undergone significant decline in fertility since 1980 and the decline has been very rapid since 1990. Total fertility rate (TFR), i.e. the average number of children born to women during their reproductive life under prevailing patterns of age specific fertility, which averaged around 6-7 until 1990 has declined rapidly and according to the 2006 census it has reached 2.1 which is at replacement level.

Maldives has all the preconditions for rapid fertility decline, with good health services infrastructure, rapidly declining infant and child mortality, improved education of women, increasing participation of women in the labour force, including in paid employment, and improved access to and availability of modern methods of contraception. However, such a rapid reduction is unprecedented and the results of the recent DHS (2009) will provide important insights into the trends and patterns of fertility and their underlying determinants. Yet, there is clear evidence to indicate that fertility declined significantly since the 1990’s due to a number of reasons.

Table 3: Selected indicators of fertility and family planning*

<table>
<thead>
<tr>
<th>Year</th>
<th>Total fertility rate</th>
<th>Contraceptive prevalence rate, modern methods</th>
<th>Teenage fertility rate</th>
<th>Mean age at marriage, female</th>
</tr>
</thead>
<tbody>
<tr>
<td>1985</td>
<td>6.2</td>
<td>Around 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1990</td>
<td>6.4</td>
<td>15(1991)</td>
<td>0.284</td>
<td>19.1</td>
</tr>
<tr>
<td>2000</td>
<td>2.8-3.1**</td>
<td>32 (1999)</td>
<td>0.067</td>
<td>21.8</td>
</tr>
<tr>
<td>2006</td>
<td>2.1-26**</td>
<td>34 (2004)</td>
<td>0.154</td>
<td>23.1</td>
</tr>
</tbody>
</table>

*These estimates are also compiled from various sources, at average number of children ever born to women in the age group 15-19. **WHO statistical information system, 2009, cited in PPP for better health and family services in the Maldives, 2009

These include, increase in the mean age of marriage particularly for females, increase in the contraceptive prevalence rate as highlighted in Table 3; spousal separation for long periods of time due to male migration and the time lost in marital union occurring as a result of frequent divorce and subsequent remarriage. Abortion, although illegal, anecdotal evidence suggests to be prevalent among unmarried youth and married women, reflecting the high unmet need for contraception.

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4 Results from the DHS will provide much more insight into other factors such as adolescent sterility, infertility, post partum infecundity etc that could contribute to the fertility dynamics.
Age-structure transition
In the Maldives the age structure transition is occurring very rapidly, mainly as a consequence of unprecedented decline in fertility since the 1990’s as can be seen from Table 4.

Table 4: Percent of population by broad age groups

<table>
<thead>
<tr>
<th>Year/Age groups</th>
<th>1990</th>
<th>2000</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-15</td>
<td>46.9</td>
<td>40.8</td>
<td>31.4</td>
</tr>
<tr>
<td>15-64</td>
<td>50.6</td>
<td>55.4</td>
<td>63.3</td>
</tr>
<tr>
<td>65+</td>
<td>2.5</td>
<td>3.8</td>
<td>5.3</td>
</tr>
<tr>
<td>Total</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: 2006, Population and Housing Census

For example percent of population below age 15 which was 46.9 in 1990 has declined to 31.4 in 2006. Most of this decline is reflected in the increase in the working age population, 15-64 years of age as children of 1990 have moved up in age are now in the prime working ages of 15-30. Currently, therefore, two out of three Maldivians are in the working age and a large share of them are in the prime working age. Thus, while in 1990, there was one dependent for every one in the working age today there are two in the working age for one dependant. However, as discussed later in the report unemployment in the prime working ages is very high and is a matter of serious concern.

Population distribution and internal migration:
Distribution of Maldivian population by atolls indicate that during the period 1977-1985 the proportion of population living in Male doubled from 13 to 26 percent and remained around the same level, 27.4 percent, till 1995. Between 2000 and 2006, however, the share of Male has increased to 34.7 percent. While Male’s population increased by 35 percent during 2000-2006 total population living in outer atolls remained nearly the same, with some atolls registering significant losses and others making modest gains. Internal migration from outer atolls to Male accounts for the differences in the rates of growth between Male and outer atolls, and migration towards Male from outer atolls has increased significantly after 2000 in response to the growing disparities in opportunities between Male and the atolls.

The twin emphasis of the new ‘Strategic Action Plan’ to improve nation-wide transport network and promote regional development is also intended to alleviate the pressure on Male and to bring about the voluntary movement of the population in some islands.

International migration
The number of Maldivians living abroad is relatively few. However, as noted earlier, more than 70,000 registered migrant workers were living in Maldives in 2007. It is also recognized that an unknown number of undocumented workers, believed to be about 30,000 are also living in Maldives. Majority of the foreign workers are engaged in

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5 Age structure transition, together with continuing natural increase and migration (internal and international), will have important impact for the future development of Maldives as discussed in the later part of the paper.
unskilled and semi skilled occupations and are disproportionately concentrated in the capital, making Male (area 2 sq km) one of the densely populated (approx. 70-80,000 persons per sq km) areas.

As mentioned earlier migrant workers, documented and undocumented, and their family members are not counted in the national population and housing censuses, hence their contribution to the national economy is not fully accounted and nor are their needs fully planned for in national policies and programmes.

**Emerging trends**

Projections based on the population of 2006 indicate that the Maldivian population will continue to increase, as fertility declines moderately and remains below replacement level, and reach 401,000 by 2025 and to 461,000 by 2045\(^6\). In other words there will be an increase of 100,000 persons in the Maldivian population, or an increase by one third, within the next 20 years.

Age structure, as discussed earlier, will continue to change. The changes in population by functional age groups as reflected by the population projections are shown in Table 5.

**Table 5: Trends in population (in thousands) by functional age groups**

<table>
<thead>
<tr>
<th>Age group/year</th>
<th>2006</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-14</td>
<td>68.4</td>
<td>58.8</td>
<td>56.0</td>
<td>63.4</td>
<td>69.5</td>
</tr>
<tr>
<td>15-19</td>
<td>40.8</td>
<td>38.9</td>
<td>31.8</td>
<td>26.6</td>
<td>29.3</td>
</tr>
<tr>
<td>20-29</td>
<td>60.7</td>
<td>73.8</td>
<td>79.0</td>
<td>70.5</td>
<td>58.3</td>
</tr>
<tr>
<td>30-54</td>
<td>77.9</td>
<td>90.5</td>
<td>110.5</td>
<td>134.4</td>
<td>154.6</td>
</tr>
<tr>
<td>55-64</td>
<td>11.7</td>
<td>12.7</td>
<td>19.0</td>
<td>26.6</td>
<td>31.3</td>
</tr>
<tr>
<td>65+</td>
<td>14.2</td>
<td>15.5</td>
<td>16.7</td>
<td>18.3</td>
<td>24.6</td>
</tr>
</tbody>
</table>

Source: 2006, Population and Housing Census

The projected trends in population by specific functional age groups are quite dramatic. First, population in the primary and early secondary years will continue its decline until 2015, after which it will increase, as a result of the “echo effect”—an increase in the number of births in the coming years due to the large cohort of women who are entering the reproductive ages. Second, population in the late secondary ages will decline significantly in the next fifteen years.

Third, during the same period, population in the working age groups, 20-64, will increase significantly and will reach 244,200 or 61 percent of the total population. Finally, population in the older ages will continue to increase in number, and their share in the total population will increase moderately to 6.2 percent in 2025. It is, therefore, necessary to take into account the implications of emerging age structure dynamics, internal and international migration, discussed in the preceding sections and their implications are taken into account in implementing the “Strategic Action Plan.

\(^6\) Total population of Maldives, including foreign workers and their dependants, would be higher if they are included in the projections.
1.2 Economic and social context

Economic growth
Maldives has recorded a high rate of economic growth during the past quarter century and as a result the real GDP per capita has increased to US$2,830 in 2009\(^7\). Rapid growth of the tourism sector has played a central role in maintaining the high rate of growth. As noted in the introduction, Maldives has also recovered from the devastating effects of the 2004 Tsunami. However, there are concerns that the global economic crisis that began in 2007 and the price volatility of food and fuel could have significant effects on the economy. Maldives is also facing key challenges to contain public expenditure and to reduce fiscal deficits that have increased significantly during recent years. Maldivian economy is heavily dependant on tourism and fisheries which together account for 40 percent of GDP. Maldives, therefore, is exposed to high degree of vulnerability due to external shocks. Its economy is also vulnerable to environment and climate change due to the fragility of its ecosystem.

Poverty and malnutrition
According to the Vulnerability and Poverty Assessment of 2005, poverty in Maldives has declined rapidly since 1997 and that by 2005 absolute poverty (using the poverty line of US$1 per day (PPP)) has been eliminated\(^8\). The 2007 national MDG report indicates that even when a higher poverty line is applied significant reductions in poverty has been achieved during the period 1997 – 2004. For example, if US$3 per day in PPP terms is applied percentage of population living below this poverty line has declined from 19 in 1997 to 3 in 2004. Despite the very low levels of poverty malnutrition among children 0-3 years of age is relatively high and the prevalence of underweight and stunting is 21 and 17 percent respectively.

Employment and Unemployment
The characteristic feature of the labour market and employment in the Maldives is the heavy reliance on foreign workers amidst high and rising employment among the Maldivian population, particularly among women and youth. As noted earlier, there are about 70,000 registered foreign workers and an unknown number, believed to be of the order of 30,000, undocumented workers, which together account for 43.7 percent of the total number of persons employed in the country. The rapid increase in foreign workers is due to a number of reasons which include, among other factors, mis-match between the supply and demand for labour with specific skills, (eg. teachers), and the unwillingness of Maldivian workers in entering unskilled and semi-skilled occupations such as those demanded by the construction sector.

Unemployment is high in the Maldives. According to the 2006 census it is around 14 percent of the labour force (employed and unemployed). Unemployment rates are much higher among women and youth; the rates are as high as 40 percent among young

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\(^7\)UNICEF Regional Office for South Asia (2009), The Social Sector in the Maldives: An Overview and Policy Ideas for Reform, Kathmandu, Nepal.

women and 20 percent among young men. It is to be recalled that Maldives currently has a high proportion of the population in the early working ages (20-29).

Furthermore, the Government’s plan to reduce public sector employment will also have its impact, at least in the short term, on unemployment. Another notable feature is the increasing participation of women in the labour market during recent years. While labour force participation continues to be much higher among men, participation of women in the labour force has been increasing over time. For example, it is estimated that 53 percent of women above 15 years of age in 2006 are in the labour force (working or seeing work) as compared to 45.3 percent in 2000. Finally, employment in the public sector, in particular the Government, accounts for one-fourth of the labour force and employment in Government has increased at the rate of 8 percent per year during the last decade.

**Education**

Maldives has made significant progress in expanding educational opportunities and has achieved education related MDGs. It has achieved universal primary education and near universal literacy. It has reduced gender disparity in school enrolment. Enrolment in lower and higher secondary is still low, 64.6 and 7.2 percent respectively. Enrolment of girls is higher at the lower and higher secondary levels than boys (70.7 percent vs 58.8 percent at lower secondary and 7.8 percent and 6.7 percent at higher secondary respectively). As noted earlier, education system, however, in the Maldives is not adapted to the needs of the labour market in terms of equipping them with the required skills.

**1.3 Gender Equality and Women’s Empowerment**

The Maldives has signed key international instruments committing itself to gender equality and women’s empowerment. The new Government has made strong political commitments. Maldives, with a Gender Development Index (GDI) of 0.767 and Gender Empowerment Measure (GEM) of 0.430 is ranked highest in all of South Asia (ranked 77 for GDI and 90 for GEM10 (HDR, 2009) indicating overall improvement in certain indicators for women. Men and women have relatively equal access to education, health services, employment and equal pay. It has also made significant progress towards achieving the Millennium Development Goals, but faces challenges in achieving MDG Goal 3 of promoting gender equality and empowering women by 2010. High female unemployment, low political participation, sexual and other forms of violence, fragmented family structures with a high divorce rate and male migration leading to almost 47 percent female headed households, are major issues experienced by women in the Maldives. High levels of female unemployment is an issue as women have minimal job opportunities in the key sectors of tourism and fisheries, have limited skills for new potential areas of economic growth and have a high care burden. With strong social norms about what is permissible for women and with increasing social control over their mobility, their opportunities may shrink further.

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9 It should be noted, however, that part of this increase is due to the adoption of new concepts and questions in the 2006 census designed to better capture women’s economic activity.

10 Sri Lanka, the closest, is ranked 83 for GDI and 98 for GEM. GDI ranks of other South Asian countries are: Bhutan: 113, India: 114, Nepal: 119, Bangladesh: 123, Pakistan: 124, Afghanistan: 154. GEM ranks are: of Nepal: 83, Pakistan: 99 and Bangladesh: 108. GEM is not available for Bhutan, India and Afghanistan.
Findings from different studies reveal that, adolescents and youth in the Maldives are exposed to a variety of behaviours that puts them at risk for unplanned pregnancies, unsafe abortions as well as STIs including HIV/AIDS. Several studies have highlighted that adolescents and young people are very vulnerable. These emerging problems are a cause of concern for the Government, NGOs and society at large in the Maldives at present.

The government has recently raised concerns regarding the danger of conservatism and the need for immediate attention to confront its growth. While there is no hard evidence, the increasing conservatism is indicated by rising practices of home-based religious education and banning of children (specially of girls to go to school; no social permission to women to seek medical care from male doctors). Influences of conservative doctrine may well hamper recent positive trends such as increasing age of marriage, decreasing fertility and maternal mortality and could severely impact women’s mobility and autonomy, unless timely action is taken.

Increasing personal insecurity (especially in Male) with gang wars is creating barriers to women’s and girls’ mobility and progress. Women are forced to protect their children, especially daughters, by accompanying them to school and any other outings to protect them from abuse. This constrains women from taking on any professional responsibilities and restricts girls from higher level education which necessitates travel.

1.4 Environment and climate change

The fragile nature of the ecosystem and the fact that the 1,200 coral reef islands lie only one meter above the sea level makes Maldives highly vulnerable to environment and climate change. Maldives continually faces increasing exposure to weather events such as sea swells that affected the country in 2007. Warming of the ocean due to increasing CO2 emissions will threaten the prized coral-reef system, which will exacerbate the human impacts from fishing, construction, tourism and pollution. In the long run sea level rise could make Maldives uninhabitable11.

The new Government is committed to make Maldives carbon neutral by shifting away from the use of fossil fuels for its energy needs. It has also taken an active advocacy role ahead of the Copenhagen Summit (December 2009) for the developed countries and fast growing economies of China, India, Brazil etc to take concrete action to reduce CO2 emissions. However, while climate change and sea level rise continue to threaten Maldives there are immediate concerns and factors that affect the environment and sustainable development of Maldives. These concerns include, among others, solid waste management, strengthening safe water and sanitation, containing pollution and mitigation of the negative impacts of climate change on its citizens, especially women whose historic disadvantages make them highly vulnerable to climate change.

Increasing population and its concentration in Male, coupled with increasing consumption of durable and consumption goods, is rapidly deteriorating its pristine environment. This results from inadequate planning for the collection and disposal of solid wastes, including those that are not bio-degradable. Rapid increase in motor-bikes and cars makes Male over-crowded and high in environmental pollution. Fresh water supply in Maldives is limited to a few months through rain water harvesting as fresh water tables are already depleted in all islands. Fresh water, therefore, is supplied through desalination of sea water, a facility that has been established in most atolls/islands.
2 Progress in the Implementation of the ICPD Programme of Action

2.1 Population and Development

Age-structure and economic growth
Today, Maldives is at a critical juncture, and is characterized by a rapidly expanding labour force—resulting from the high cohort of births of the 1980’s—and an economy that has been growing at a rapid rate, notwithstanding the recent declines in the rate of growth of GDP due to the global financial crisis and the fiscal problems identified earlier. Maldives has already entered a phase, a window of opportunity, when the dependency ratios (ratio of those below age 15 and over 65 to those in the working ages) are at its lowest. This period, lasting about 30 years, provides a unique and timely opportunity to expand secondary education, improve quality and make it relevant for employment in the emerging labour market. This large cohort of young people, with marketable skills could add significantly to the rate of growth of GDP. Failure to educate and utilize this reservoir of resources in a gender sensitive manner results not only in high unemployment and consequent loss to GDP but also will have long term implications for health and social welfare.

Migration and economic growth
Dependence on foreign workers, particularly for those with marketable skills, will continue, as the new Government starts implementing the “Strategic Action Plan”, unless immediate steps are taken to train those entering secondary school and those who report as unemployed. Migration of unskilled and semi-skilled workers is likely to increase as the demand for construction workers will remain high as the Government pursues its plans of decentralization and building infrastructure, including housing, in the provincial centres.

Population ageing and development
Population ageing, defined as the process by which an increasing proportion of the population will belong to older ages, is inevitable. Projections indicate that the pace of this process will be moderate until 2025, but will accelerate thereafter. It should be noted that the new Government has instituted a scheme to provide MRF 2,000 per month to all persons above age 65 from the Government’s coffers. As the number of older persons increase this will consume a significant part of the national budget. It will be necessary, therefore, to plan for the social security and other needs, in particular their health needs, of older persons through sustaining robust economic growth and establishing appropriate mechanisms for savings and investment.

Inequality and poverty
Maldives has achieved the goal of eradicating poverty. However, inequalities in income and access to services, particularly between Male and the atolls is a matter of concern. Regionalization and the creation of provincial centres, if proved successful, will attract investment and create employment contributing to reduction in the inequality between Male and the provinces. This might also help to bridge the gap in the access to services, including health services and education. Internal migration, in particular, migration to
the new provincial centers, including from Male, could be helpful in bridging the inequality.

**Education**
As discussed earlier, the decline in the number of children in the secondary school ages, provides a “window” to increase enrolment in secondary schools, and in improving the quality of education at all levels. Special emphasis needs to be placed in job oriented training that will reduce unemployment among the youth and also reduce dependence on foreign labour in selected occupations.

**Health including Reproductive Health**
Projections indicate that the number of women in the reproductive ages will remain high for some years as the current cohort of youth pass through these years. It was also seen that that the unmet need for family planning remains high and that access to information and services for young people is limited and not reflected in the estimate of unmet need. Therefore, continued growth of population—both through natural increase and migration, and the high proportion of population in the reproductive ages will require continued emphasis and investment in health, including reproductive health and family planning.

**Impacts on other sectors**
Most other sectors will also be impacted by the continued growth of population and its distribution across various atolls and Male. Demand for housing and transport will increase, and the “Strategic Action Plan” accords priority to establish a nation wide transportation system and provide affordable housing in the context of decentralization and greater participation of the private sector. Demand for food, water and for consumer durables will increase more rapidly with population growth and increases in the levels of income.

**Population trends, environment and climate change**
Projected increase of the Maldivian population and the prospects of continued increase in foreign workers and increased consumption will continue to affect the environment through increased carbon emissions and solid waste, unless measures are taken to address the deteriorating situation. It will also put pressure on water supply and sanitation requirements.

**Institutional Framework for Population and Development**
Maldives has made good progress in using population and development data in formulating the development agenda within the past fifteen years. In addition, to the data provided by the census and civil registration information, more specific surveys have been conducted with assistance from development partners. UNFPA has been a key partner in training and building the national capacities. For instance UNFPA has been providing assistance to strengthen the census to account for women’s work and ownership of property, as well as gender analysis of the data of 2000 and 2006 Census. The instrument for the collection of census data has been made more gender sensitive to give visibility to women’s work and to measure their access to assets and resources. Technically this made it possible to estimate the market value of home production. This is a major breakthrough in enabling the conventional System of National Accounts of
Maldives to include many non-market activities performed within the household such as processing activities, water collection, and the repair and construction of houses for one’s own use.

Activities undertaken for human resource development were mainly training programmes – long term fellowship programmes for Master’s in population and gender studies; the introduction of a certificate level course on population, gender and reproductive health at the College of Higher Education; the incorporation of population, RH and gender topics into regular training curricula for government officials at the College of High Education; and short term trainings and workshops within the project activities. While the strategy chosen for human resource development is quite sound in that it aimed at long term as well as short term development of capacity in gender, population and reproductive health, its effectiveness at the operational level is hard to determine because of the difficulty of retaining people trained under the project, unknown degree of application of the skills learned, and difficulty to assess the appropriateness of the content of the training.

With the decentralization as the new government’s policy, capacity building at the local level to collect, analyze the local information, and use it for policy-making, is becoming ever crucial. DNP has been conducting training workshops in the regions to disseminate and how to use gender-sensitive data in their planning. TOT on data collection, statistical data analysis and report writing skills Workshop was organized by joint funding from UNFPA and UNICEF in November 2009.

UNFPA and other UN agencies are also funding the first ever DHS since 2007. The preliminary results will be made available in December 2009. DHS will shed light on many RH behaviors and RH rights issues that were not able to capture in the existing surveys, therefore would enable further in-depth studies in the future.

2.2 Reproductive Health and Reproductive Rights

Reproductive health policies and programmes
A number of strategic plans have been developed to address reproductive health issues in the country. In 2005, the first National Reproductive Health Strategy was formulated from 2005 to 2007. This strategy addressed seven thematic areas that included safe motherhood, family planning, ASRH, RTI/STI and HIV/AIDS, GBV, male involvement, and RH morbidities. The Strategy was fully implemented in 2007; however its impact has not been assessed. A new RH Strategy has been formulated from 2008 to 2010, which draws on from the previous strategy with the same seven thematic areas, with implementation currently underway. Its impact and outcomes are yet to be seen with the development of a comprehensive monitoring and evaluation plan.

The National Strategic Plan on HIV/AIDS (2007 to 2011) outlines eight strategic directions that include, prevention, targeted interventions to high risk groups, capacity building and preparation for an epidemic, sustainability of the current low prevalence, treatment and care for people living with AIDS, safe practices in the workplace and building an adequate information system to monitor the disease trends. Overall, the Strategic Plan is quite comprehensive and efforts need to be put to implement the Plan.
Also it is important that monitoring and evaluation of the implementation be further strengthened and the process is initiated well before the Plan comes to an end.

The current government’s Manifesto outlines five core areas in its promises, one being affordable and quality healthcare for all. With the introduction of the “Strategic Action Plan”, sectoral strategic plans are being developed to address the issues to align to them to the promises. The marked differences in the new strategies are in governance and privatization. Decentralised governance and increased private public partnerships and privatization of health care. These strategies are sound in increasing the efficiency of health facilities. However, in some cases it can be argued that operational costs will increase and may lead to accessibility issues. For instance purchase of consumables and other necessities of the institutions will become more expensive due to less volume if decentralized hence increasing costs. Privatization will increase costs even further. Thus, it is imperative that financing mechanisms be build concurrently so that the public will have access to care. It is also necessary to ensure that preventive services, which would be a major component of RH services to be covered by national insurance mechanisms.

Although Maldives has achieved a number of strides in improving the reproductive health status of the population, there are number of areas that future policies and programmes need to focus on. The current policies have its strength on taking the rights based approach to reproductive health and health in general. One key area of importance is that of human resources development. It is imperative that gaps in the workforce are identified and more emphasis is put forth to address this issue. Especially, for better maternal and RH care at the peripheral level, local expertise will be the key to successful programme implementation and better outcomes of the interventions.

Another key area of programme alignment should be RH in emergency situations. At present no programmes are specifically targeted to people affected by disaster situations. With lessons learnt from the 2004 Tsunami, temporary shelters could be taken into account to ensure that programmes are designed in a way that it can easily be adapted to such situations. Unfortunately there aren’t any research findings on the needs of these populations in the local context. However, anecdotal evidence suggests that there was a small “baby boom” within the temporary shelters during the past 4 years.

**Access to care**

The Reproductive health situation of the Maldives, has been consistently improving over the past 2-3 decades with increasing access and quality of reproductive health and family planning services. The maternal mortality ratio (MMR) has decline considerably and currently stands at 45.7 per 100,000 live births (VRS, 2008), while contraceptive prevelance rate (CPR) is 34% (RH Survey, 2004). With increased awareness and health promotion efforts, over 90% (Health Statistics, 2007) of births take place at a health facility and 94.8% of births are attended by skilled health personnel (Health Statistics, 2007). Table 6 shows the number of deliveries by place of occurrence.
Table 6: Place of Delivery 2004 – 2006

<table>
<thead>
<tr>
<th>Place of Delivery</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>IGMH</td>
<td>1828</td>
<td>2036</td>
<td>2163</td>
</tr>
<tr>
<td>Hulhumale' Hosp</td>
<td>3</td>
<td>26</td>
<td>50</td>
</tr>
<tr>
<td>ADK Hosp</td>
<td>312</td>
<td>391</td>
<td>511</td>
</tr>
<tr>
<td>Regional Hosps</td>
<td>1226</td>
<td>1274</td>
<td>1445</td>
</tr>
<tr>
<td>Atoll Hosps</td>
<td>866</td>
<td>1093</td>
<td>1045</td>
</tr>
<tr>
<td>Health Centres</td>
<td>453</td>
<td>366</td>
<td>422</td>
</tr>
<tr>
<td>Health Posts</td>
<td>22</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Home</td>
<td>525</td>
<td>334</td>
<td>203</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>27</td>
<td>15</td>
</tr>
<tr>
<td>Not stated</td>
<td>5</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>TOTAL</td>
<td>5267</td>
<td>5583</td>
<td>5886</td>
</tr>
</tbody>
</table>

Source: 2006, Population and Housing Census

Although the Ministry of Health and Family classification of health facilities indicates that all levels of health care facilities have maternal health clinics and care provided, emergency obstetric care remains a challenge, due to the island geography of the country and the difficulties and costs of transport. Proper emergency obstetric care is available starting from grade 1 hospitals, which are mainly at atoll level (Health Services Categorization, 2008). However, anecdotal evidence suggests that these hospitals also have limitations with regard to the sophistication of the services and the skills of the available professionals. It is imperative to note that high investments are not a feasible option for small hospitals of this nature and hence it is much more cost effective and safe to identify potential high risks early and facilitate access to higher centers on a timely manner.

It is evident that emergency obstetric care needs greater improvement. For instance, according to the Maternal Mortality Synthesis Report (2008), 38.1% of the maternal deaths were successfully transferred to higher centers with better emergency obstetric care while 19% died in transit and another 19% were advised for transfer but the condition deteriorated to a level a transfer would not have been successful. Despite these facts, as indicated above, investment and improving emergency obstetric care at lower levels of the health system will remain a major challenge and efforts need to be taken to prevent mothers from reaching such a state by ensuring early recognition, intervention and facilitation of services.

In an attempt to encourage, and facilitate high risk mothers who get referred to higher centers, a pilot initiative on maternity waiting homes was introduced in the early to mid 1990s in Meemu Atoll. The utilization of this facility was low that the sustainability of it became a major issue and eventually this service had to be discontinued. However, the evidence is not documented and hence such innovative ideas can still be initiated with more community consultations and community participation.

The health sector is currently facing a process of realignment to the change in government a year ago. There are many aspects of these changes that need to be addressed in relation to access to care. Firstly, the merging of Ministries of Health and Gender has a number of positive aspects. For instance the ownership of family
protection services that house abuse and rape victims for continued care could be better utilized with more cooperative support from the health facilities at the atoll and island level. However, this system of acute care and community care needs to be further synchronized and strategies need to be put in place to do so. The challenge though for this establishment is the possible changes in the management of health care facilities. Decentralization, private public partnerships and full privatization would have an impact on the current systems in place. Careful study and implementation is crucial to ensure that currently established programmes, especially the referral chains are continuously implemented and sustained despite these possible institutional developments.

The advantages of this system could include better development of decentralized services through provincial initiatives including specialized care development in the RH area. For instance, in Male’ currently there is a development by a private party that focuses only on women and children. The scope of developing this area is huge and may have a good impact at provincial levels thus bringing in more specialized personnel and equipment to community level facilities.

**Contraceptive Prevalence and Unmet Need**

The contraceptive prevalence rate in the Maldives continues to be low. Although access to contraception is not very difficult, there are many causative factors for the low rates. The CPR for modern methods stood at 32% in 1999 (RH Survey, 1999) and in 2004 this figure stood almost the same at 34% (RH Survey, 2004). A set of data is available for CPR using modern temporary methods from 1991 to 2004. These indicate that the rate is even lower and there has not been a significant change during the 1999 to 2004 period. Chart 1 shows the trend in CPR over these years.

The most common type of contraception used by the population is the contraceptive pill with 13% both in 1999 and 2004 (RH Survey, 2004). It is important to note that the prevalence of pills have not changed during this period, the reason for which is not known, although the condom use went up from 6% in 1999 to 9% in 2004 (RH Survey, 2004). However, these prevalence are again in married couples and do not reflect the real situation of the country. The main reason for using contraception was reported as not wanting more children at 42% (RH Survey, 2004), which is expected since the target population was, married women. In 2004, (RH Survey) it was shown that about 30% of women who used contraception discontinued due to a number of reasons. The most prevalent were side effects corresponding to 24%, which is a reduction from 34% in 1999 (RH Survey, 1999). However, 22% said that they discontinued for no specific reason, which is an increase from 10% in 1999 (RH Survey, 1999, 2000). More needs to be done to
understand the dynamics of contraceptive discontinuation in the country. In depth research on this matter will help device future directions.

Reliable figures are available only for unmet need among married women and men. Among married women between 15 to 49 years, the unmet need for contraception is 42% in 1999 (RH Survey, 1999) signifying a reduction to 37% in 2004 (RH Survey, 2004). For men under 50 years the unmet need is 36% (RH Survey, 2004). Furthermore, among the 21 maternal deaths during 2003 to 2007, 67% of the mothers had an unmet need for contraception. However, it is plausible to say that this may not be a true reflection of the unmet need for contraception due to design issues in the questionnaire.

Reproductive Health Commodity Security
Currently the national RH Programme procure the following commodities with UNFPA assistance and government contribution:
- Depo-Provera Injection
- Oral contraceptives
- Norplant
- Intrauterine devices
- Condoms

Government contributions towards procurement of RH commodities has gradually increased towards an exit strategy from donor dependence; with US$1,000 contributed in 2005 to US$20,000 by 2009 (CCHDC, 2009). During this period, the national programme has also increased its capacity in commodity forecasting and distribution. However, the efficiency of RH commodity forecasting needs to be improved in order to ensure timely and continuous availability of contraceptives under the RH programme. This current gradual exit strategy implemented by the government holds the key to future sustainability of the programme. In doing so, the national programme should also look at implementing new strategies such as social marketing.

Emergency Contraception
Emergency contraception was introduced in Maldives through the National Reproductive Health Strategy (2005 to 2007). With continued resistance against emergency contraception, it was introduced in a very limited manner with emergency contraception made available for victims of rape and abuse under doctor’s advice. Evidence suggests that a black market for emergency contraceptives has emerged as a result, with Indian brands advertised through cable television being available at very high costs in the country. Given the delayed and misuse of emergency contraceptives could further increase the number of unwanted pregnancies. The new RH Strategy (2008 to 2010) has included an action to make emergency contraception available at pharmacy level, implications of which are yet to be seen.

Maternal Mortality
By 2007, Maldives achieved the MDG5 target for reducing maternal mortality by two thirds. Baseline data for MMR in 1990 was not reliable and is estimated at about 500 per 100,000 live births and hence cannot be used as a baseline. However, taking more reliable data from 1997, where the MMR was 258.7 per 100,000 live births, the MDG target would be to reduced to 64.68 per 100,000 live births by 2015. This statement, however, is made with caution since the MMR in Maldives can fluctuate quite significantly due the small denominator (number of live births) and a single death could
change the scenario. It is expected that there will be a fluctuation in the MMR and the challenge is to reduce the number of maternal deaths and maintain this fluctuation below the MDG5 threshold. Maldives also could look at the possibility of publishing a moving average for MMR or simple use number of deaths as an indicator. Chart 2 shows the trend in MMR from 1997 to 2007.

Among the maternal deaths that occurred during the above period, 52% were due to direct causes and 48% due to indirect causes (Maternal Mortality Synthesis Report [MMSR], 2008). The most common direct cause of the deaths were post partum haemorrhage contributing to 64% of all direct deaths and the most common indirect cause of the deaths were multi organ failure and anaemia contributing to 30% and 20% of deaths respectively (MMSR, 2008).

It is imperative to note that 48% of the deaths occurred in women falling to the high-risk age group of above 35 years (MMSR, 2008). According to the Maternal Mortality Synthesis Report (2008), 90% of the 21 maternal deaths that occurred between 2003 and 2007 were preventable. It is thus important that the RH programme targeted activities at these age groups in reducing maternal mortality.

Antenatal Care
Antenatal care coverage is high in the Maldives. In 1999, 62% of women reported that they had at least four visits during the last pregnancy (RH Survey, 1999) which rose to 91% by 2004 (RH Survey, 2004,) indicating increased awareness, availability and access to antenatal care services in the country. Furthermore 70% of pregnant mothers were seen by a gynaecologist in their last antenatal care visit (RH Survey, 2004) while the 2007 micronutrient survey showed that 89.4% of pregnant mothers were seen by a gynaecologist. Chart 3 shows the trend in antenatal care for the years 1999 and 2004. Since, there is almost universal antenatal care available, it is now important to address the quality and the extent of care provided. National policies should be focused on developing proper protocols for antenatal checkups and also to extend these services beyond doctor consultations to include physical exercise and preparation for delivery activities. These protocols could be specific to the level of services provided in the delivery hierarchy of the health system.
**Postnatal care**

Postnatal care is an area where further research needs to be undertaken and services strengthened. It can be said that there is a need for proper postnatal care programmes around the country. At present there is little evidence that postnatal care is encouraged and sought by mothers. In 2004, 60% of mothers reported that they had contact with a health care provider within six weeks of delivery and only 49% reported that they were advised on postnatal issues such as the need for family planning (RH Survey, 2004).

**Skilled Attendance at Birth**

Efforts to improve services to ensure better delivery of maternal health care has lead to very high proportion of births being attended to by skilled professionals. Statistics show that by 2006, 61.5% of deliveries were attended by doctors and almost 25% by staff nurses and a further 8% by nurses (Health Statistics, 2007). A limitation of this stratification of data is that the skills of these professionals in relation to maternal health, specifically midwifery is not clear. It is imperative that in future data be presented in ways that provide more detailed information in this regard. In addition to this, there is a concern of the significant prevalence of TBA attended deliveries. It is also seen that there is no significant reduction in such deliveries either. It is important that more work is done to address these issues with solid evidence of the implications of such births. According to the Maternal Death Synthesis Report, two complicated home deliveries attended by TBA resulted in deaths due to delays in reaching emergency care (2008). Also, there is evidence that religious beliefs are a reason for home births and this issue needs to be addressed. Table 7 shows the proportion of professionals attending births from 2004 to 2006.

<table>
<thead>
<tr>
<th>Attending professional</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>55.42%</td>
<td>64.36%</td>
<td>61.52%</td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>19.50%</td>
<td>17.75%</td>
<td>24.60%</td>
</tr>
<tr>
<td>Nurse</td>
<td>10.18%</td>
<td>9.44%</td>
<td>8.10%</td>
</tr>
<tr>
<td>CHW</td>
<td>1.42%</td>
<td>0.36%</td>
<td>0.61%</td>
</tr>
<tr>
<td>FHW</td>
<td>0.38%</td>
<td>0.38%</td>
<td>0.49%</td>
</tr>
<tr>
<td>TBA</td>
<td>12.87%</td>
<td>7.29%</td>
<td>8.06%</td>
</tr>
<tr>
<td>Other</td>
<td>0.27%</td>
<td>0.18%</td>
<td>0.02%</td>
</tr>
<tr>
<td>Not stated</td>
<td>0.34%</td>
<td>0.28%</td>
<td>0.29%</td>
</tr>
</tbody>
</table>

Source: 2006, Population and Housing Census

In order to achieve the targets of the Skilled Birth Attendance Policy of the Ministry of Health and Family that has targets set for 2007, 2010 and 2015. The Policy is comprehensive in the strategies that need to be implemented. However, there is no evidence that the document is an officially endorsed document that has been put into use. It is imperative that this policy be reviewed with regard to target dates and implemented quickly. Also the policy should put more emphasis on assessing the impact of its implementation. The current monitoring and supervision strategy of the policy is not adequate for this function.
Mode of delivery
As can been in Table 6, 90% (Health Statistics, 2007) of births take place at a health facility. The national rate for caesarean deliveries stand at 27.8% and the rate of vaginal deliveries stand at 66.2% (Health Statistics, 2007). In 2006, 3% deliveries were assisted vaginal vacuum, 1% assisted vaginal forceps and 1% breech and in a further 0.9% of the deliveries the mode is unknown (Health Statistics 2007).

Anaemia
There is a high prevalence of anaemia among women in the Maldives. The Multiple Indicator Cluster Survey (2002) showed that 51% of women are anaemic and 55% of pregnant women are anaemic. Perhaps anaemia is the most common morbidity among women of reproductive age. In addition to this, in 80% of the mother who died during 2003 to 2007 had anaemia. Chart 4 shows anaemia status of women by age group (MICS II, 2002).

It is important though that care providers are ensuring that pregnant women are given iron supplementation during pregnancy. It is reported that 87% of women took iron supplementation during their last pregnancy in 2004 (RH Survey, 2004) compared to 50% in 1999 (RH Survey, 1999). According to the Maternal Death Synthesis Report (2008), anaemia contributed to 20% of maternal deaths between 2003 and 2007. Also anaemia is quoted as the most prevalent risk factor with 60% of mothers who died during the above period (MMSR, 2008).

The high prevalence of anaemia reflects poor nutritional status of women of reproductive health age group in the Maldives. More programmes need to focus on this area and further research is needed to identify the exact causes of anaemia among women in the Maldives.

Nutritional status
Apart from the high anaemia prevalence, it is seen that in Maldives about 23% of women of reproductive age group have chronic energy deficiency syndrome (MICS II, 2002). This syndrome is higher among women in the 15 to 19 year age group with about 50% and another 33% in the 20 to 24 year age group (MICS II, 2002). This indicates that nutrition deficiency is higher in the age group where pregnancies are also higher and hence can be said to indicate higher risk pregnancies in these age groups. There is also evidence of vitamin A deficiency among mothers who had a child less than five years and pregnant mothers. MICS II (2002) indicates that 11% of women have difficulty seeing in daylight and another 6% of women suffer night blindness. During their last pregnancies, 5% of women had difficulty seeing in daylight and the same percent of women suffered night blindness. More research needs to be done on the nutrition status of women in the reproductive health age group to identify potential reproductive health risks due to nutritional deficiencies in order to target programmes to overcome these issues.
**Abortion**
No statistics are available on abortions. However, anecdotal evidence suggests that there is a significant rate of abortions in the country. Many of these abortions occur abroad and skilled personnel do not attend those that occur in the country. These abortions are not limited to pregnancies out of marriage but even in married couples when they have a pregnancy that is not planned, many have to resort to this choice since no such services are available due to legal and religious restrictions. The Maternal Death Synthesis Report (2003 - 2007) indicates that two mothers tried to conceal their pregnancy and ended up with as a maternal death during the five years, which indirectly indicates that this mother could have attempted an abortion in an unsafe environment.

**Reproductive tract infections**
Little information is known about the extent of reproductive tract infections in the country. There is no data to present a national prevalence of any reproductive tract infections. An institution based reproductive tract infection survey was conducted in 2001 and this survey indicated that Candida is the most prevalent with about 12% (RTI Survey, 2001). Again, more studies, better reporting mechanisms and record keeping are required for RTI’s is the country.

**Reproductive Cancers**
Reproductive health cancers are also an area of concern. Once again there is no evidence as to the extent of this problem in the country. It is imperative that a RH cancer register is developed. To look at it in a more holistic manner, it can be said that a national cancer registry need to be established. In the late 90’s Ministry of Health embarked on some preliminary works of developing a cancer register but so far it has not properly materialised in the country.

Furthermore, cancer prevention programmes are also virtually non-existent. Breast cancer, cervical and prostate cancer screening programmes are not established and not even advocated much in the country. Though the Maldives has had a significantly successful RH programme in place, this is one area that the programme should start to focus in future. Initial steps could include retrospective studies to determine the extent of the issue and develop a register of current cancer patients. This could then be strengthened to identify the incidence and include them to ensure a reliable set of data is available for programme planning and implementation.

**Infertility**
Infertility is an area that has not been addressed well in the country. Perhaps it is perceived to have a low prevalence and also has some stigma around it. Anecdotal evidence suggests that there is an increasing incidence of infertility in the country. Though there are no official records of the extent of this problem, it is imperative that this area also starts to get addressed through the reproductive health programmes of the country.

**Health sector response to violence against women and girls**
A key initiative to address violence against women and girls through the health sector has been the establishment of the The Family Protection Unit (FPU) at the Indira Ghandhi Memorial Hospital as a collaborative effort between the Ministry of Gender
An evaluation of the FPU noted that the establishment of the FPU was a milestone and represents the first Maldivian model of integrated care for abused women and children, offering services for physical, sexual and emotional violence within health services. Being the main hospital providing healthcare to people in Male’, IGHM may also serve as the first point of contact for most people who experienced GBV or child abuse.

Being strategically placed at IGHM, the FPU certainly enhances the opportunity for abused women and children to receive good quality care and counselling. However, some challenges remain to its full implementation. There are two counsellors appointed to the FPU who are on call for 24 hours and a few committed doctors who help in the administration of the FPU. However, there is no official designated FPU coordinator. Local ‘champions’ are needed for the establishment of such services, but the long-term sustainability of the FPU can only be ensured if a formal institutionalization is in place, with a designated coordinator.

The FPU is an important pilot project and hence it is essential to further strengthen the FPU capacity and its linkages to other stakeholders in order to strengthen services for victims of GBV with its replication at Atoll and island level. While the FPU is increasingly known in IGMH and in the wider community, there is a need to strengthen ownership by IGMH of the FPU and publicise its services to the wider community

**STIs and HIV/AIDS**

There is no official prevalence rate for HIV/AIDS in the Maldives. Given the low prevalence, it may not be necessary to calculate such a rate at this point in time. HIV screening has been conducted routinely as a precautionary measure to identify incidence. Also HIV screening is done for pregnant women and for all blood transfusion in the Maldives. In year 2008, 261,175 people were screened for HIV and one national was found positive while 15 expatriates were also found positive (MOHF, 2009). Since 1991, a total of 14 locals and 235 expatriates have been found positive for HIV (MOHF, 2009). Though Maldives is a low prevalent country, there are many risk factors that are prone to a wider spread of the disease. Injecting drug users, sex work by both locals and expatriate, the expatriate and local population who live away from families are all potential risk factors.

According to the Biological and Behavioural Survey (2008), a number of vulnerable populations were identified, including female sex workers, men having sex with men and injecting drug users. However, the results of this survey cannot be generalized as it does not provide a representative sample of the whole country. Further, the Comprehensive Audience Analysis for HIV prevention (2009) indicates that these populations need to be addressed through targeted programmes. However, implementing targeted programmes will pose a challenge given the stereotypical views that exist in society.

The prevalence of STIs is also not well known in the country. It is regarded that STI prevalence is high in the local population. The BBS Survey (2008) identified cases of Syphilis, Hepatitis B and Hepatitis C among the survey population. The Ministry of
Health and Family reports that in 2008 no cases of Syphilis was identified among 1548 antenatal screens and only 1 case was identified among 1755 generally screened cases (MOHF, 2009). Although there is a reporting system established for reporting STI’s, more work needs to be done to strengthen the system and routinely compile and analyse the reported data.

Adolescent Sexual and Reproductive Health
Adolescent Sexual and Reproductive health is an area of concern in the Maldives especially given the large adolescent/youth population. According to the Audience Analysis and youth representatives from regions, rape, child abuse, group sex are observed in their communities with very low condom use. Young people, especially outside Male’, do not have access to information and services on sexual and reproductive health including STI/HIV prevention. Thus, youth empowerment to choose safer behaviours and reach out to their peers with the correct message should be encouraged.

Life skills education (LSE) programmes for in-school and out of school adolescents and youth were introduced largely through UNFPA support and mostly focused on the schools in Male’. A comprehensive life skills package was developed in partnership with Ministry of Education and with the consultancy support from Society for Health Education. A number of facilitators drawing from girl guides and NGOs were trained on a continuous basis and their services utilised for introducing LSE at primary schools. Despite achievements made in the face of numerous challenges, the programmes are faltering and have not managed to build and take root. Therefore, sustainability and continuity remains a challenge.

The key findings of the May 2009 review of the impact of the Youth Health Café (YHC) which was set up with UNFPA support are mixed. The (YHC) is a timely and a culturally appropriate initiative to provide services to the adolescents/youth. Although there is awareness among the youth and to a lesser extent adolescents in schools of the existence of the YHC, there is limited knowledge about the services offered by YHC. YHC needs to be incorporated into the system as a permanent service delivery point of the Ministry of Human Resources, Youth and Sports. The inadequacy of proper staff positions to provide the services, high turnover of staff, insufficient networking and coordination with relevant agencies, discontinuity of initiatives and lack of medium to long term planning are issues also influencing its effective functioning and that need to be addressed.

2.3 Gender Equality and Women’s Empowerment

National and International Policy Commitments
Maldives, under a new democratic government, has committed strongly to gender equality and gender mainstreaming. The Constitution of the Republic of Maldives (2008) guarantees to all persons the same rights and freedoms, and upholds the principles of equality and non-discrimination. President Mohamed Nasheed’s statement on the

12 Article 17(a) of the Constitution stipulates non-discrimination of any kind, such as discrimination based on “race, national origin, colour, sex, age, mental or physical disability, political or other opinion, property, birth or other status, or native island,” Article 17(b) provides a legal basis for Temporary Special Measures or Affirmative Action.
occasion of International Women’s Day (2009) outlined Government policy and provided a comprehensive vision of women’s empowerment and promotion of gender equality through gender mainstreaming. The Strategic Action Plan of Government of Maldives (November 2009) presents a sectoral plan on gender which aims to “ensure that equality of women and men are upheld, women and girls enjoy fundamental rights and freedoms on an equitable basis”. Gender is also identified as one of the cross-cutting issues in all the other sectors.

The Maldives ratified the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) in 1993. It also acceded to the Optional Protocol to the CEDAW on 13 March 2006. The government participated in landmark international conferences which called for gender equality and women’s empowerment such as the ICPD and the Fourth World Conference on Women. The Maldives is party to the Beijing Platform for Action, the Commonwealth Plan of Action Gender and Development; the SAARC Plan of Action on the Girl Child; and the SAARC Convention on Preventing and Combating Trafficking in Women and Children for Prostitution. The government together with its development partners have launched and implemented programmes to strengthen its national machinery for women for women’s advancement and to promote gender equality and women’s rights. While significant gains and achievements were made through programmes for the economic and political empowerment of women, raising awareness on legal rights, advocacy through the media for gender equality challenges remain.

**Social Indicators, Labour Force Participation and Employment**

The 2007 MDG Country Progress Report notes gender parity in primary education with 100 percent net enrolment of both girls and boys and more female enrolment in lower secondary and higher secondary levels of education. Both male and female literacy rates are above 90 percent, in Male` as well as in Atolls.

In tertiary education, a significant gender disparity still exists, though the disparity has significantly narrowed. There are more men with tertiary education qualifications than women. In 1990, there were 177 males who had degree level qualifications and only 42 women. In 2006, there were 1,498 males holding tertiary qualifications compared to 874 females. With increased access to tertiary education opportunities, the gender gap is predicted to narrow further.

There is a need to undertake policy analysis on the introduction of gender preference in allocation of scholarships. Even where tertiary education opportunities are available in the country, women who have to juggle work, family and a household may find it too demanding to continue higher education. Furthermore, women continue to be largely confined to stereotypical ‘caring’ roles such as teaching and healthcare. There is a need for greater efforts to encourage more women into other work areas traditionally dominated by men.

The sex-ratio (males per females) has reduced to 103, indicating an improvement in women’s survival chances. Fertility has declined significantly along all age groups both in Male` and Atolls in the last 10 years. Despite cultural norms which favour early marriage, socio-economic changes including better educational opportunities,
urbanization and migration have considerably altered the trend of early marriage which are now in late twenties for both women and men. Recent achievements include the removal on the bar on women Head of State under the new Constitution ratified in August 2007 as well as the appointment for the first time of three female judges/magistrate in June 2007 (Review of Family Law, 2009).

Prevailing traditional and socio-cultural norms and attitudes, limit women’s active participation in economic, political and religious leadership. Women have a much higher unemployment rate than men (nearly 24 percent compared to 4.5 percent for men) and fewer women actually participate in the labour market. Of the economically inactive women, largest proportion, 37 percent (and above 70% in the age group 20-49) are inactive due to the unequal gender division of labour and demands of house work and child care. Women spend approximately 6-8 hours daily on house work as compared to 3-4 hours by men. Stereotypical gender roles place 72 percent women workers in the education sector and 68 percent in the health and social work, primarily as mid and lower level functionaries. Women dominate the informal sector with almost 90 percent working as self-employed home-based workers, increasing their vulnerability. Approximately 64 percent of the workers in agriculture and forestry and manufacturing sectors are women, though only 23 percent among skilled agricultural and fishery workers are women (Census 2006).

Female headed households
The country has one of the highest rates of female-headed households (47%) in the world with more than half due to migration of spouses for work and one sixth as a result of being widowed or divorced (MDG Report, 2007). Female household heads are especially vulnerable to poverty and have a much higher unemployment rate (15 %) than male household heads (4%) (Census 2006). Men, as primary bread-winners in the patriarchal social structures, have difficulties in finding job opportunities in their home islands, and are forced to work on other islands, leaving women to cope with the full burden of households.

Marriages and divorce
Maldives presents one of the highest divorce rates with available data indicating an average of one third of marriages ending in divorce. A larger proportion of women are divorced (6 %) and widowed (5.1%) compared to men (3.5% and 1.7% respectively). Divorced women and their children face additional economic and social vulnerabilities with limited choices to improve their situation apart from remarrying. Consequently, Maldivian women have, on average, four marriages by the time they reach 50 years of age (MDG Report, 2007). The high divorce rates bear complex direct and indirect consequences on children and youth including vulnerability to sexual abuse, juvenile delinquency and substance abuse. An additional challenge for divorced women and their children are equitable child custody and property rights.

Political Participation and Voice
Participation of women in political and public life persists in being poor. A higher proportion of economically active men (8% of male labor force) work as legislators, politicians, senior managers etc, compared to women (only 2% of female labor force), (Census 2006). The new Majlis, constituted in May 2009, saw women in only 5 out of a
total of 77 seats. Atoll chiefs and island chiefs form the leadership in outer atolls and women’s role in these positions have so far been very limited. Women’s appointment to other political postings, diplomatic posts, and at the executive decision making level of government too remains limited.

The relatively low proportion of seats held by women in national parliament and other decision making bodies, is indicative of the challenges they continue to face in a traditional male dominated society. Raising the required finances for campaigns, balancing the demands of family, home life and motherhood with the huge demands of a political life remain daunting for women.

**Gender-Based Violence**

A major challenge to achieving the Millennium Development Goal 3 is the extensive violence experienced by women and girls in the country. Violence against women and girls, which is a major form of gender-based violence (GBV) and discrimination bears multiple and often lifelong consequences on girls and women with severe costs to families and the State. Patriarchal structures and systems and socio-cultural norms and practices and women’s subordinate status, sanction this male impunity of violence against women and girls. Findings from a recent survey indicate that one in three women (36.6%) aged 15-49 reported to have experienced at least one form of physical and/or sexual violence in their lifetime (WHO Multi-Country Study, 2007). The majority of violence was perpetrated by a male intimate partner challenging the assumption that the home is a place of safety and refuge for women. Generally the levels of intimate partner violence were higher in the atolls (particularly in the central and southern regions) than in Male’. Of working women in the Central region, 51 percent reported experiencing verbal violence and 7 percent of employed women reported sexual harassment at work by another employee or their boss.

Childhood sexual abuse (sexual abuse before the age of 15) was found to be relatively common in the Maldives. At the national level, 12 % of women aged 15-49 had been sexually abused before the age of 15. In Male’ the rate was significantly higher at 16.3%. The data shows that girls are at greatest risk of sexual abuse by male family members and male acquaintances.

The most commonly mentioned perpetrators of physical violence were male family members, in particular the father or step-father. In contrast, the most commonly mentioned perpetrators in sexual violence were male acquaintances (such as family friend, work colleague) and strangers. Generally the levels of intimate partner violence were higher in the atolls (particularly in the central and southern regions) than in Male’. Women who have been separated or divorced generally reported a higher life-time prevalence of physical or sexual violence by an intimate partner than currently married women. Also, women with higher levels of education reported lower life-time prevalence of intimate partner violence than those who had not attended school or only had primary level education. Younger women also seem to be at greater risk of partner violence with larger proportion of partnered women aged 25-29 reporting violence in the past 12 months than older women. Approximately 10% of women reported that their first sexual experience was either coerced or forced and the younger the girl at
first sexual encounter, the more likely it was that sex was forced. Women who had experienced physical and/or sexual partner violence were significantly more likely to have ever contemplated suicide than women who had not experienced abuse. Data indicates that violence is often considered a ‘private’ matter, lying out of the realm of public debate and exploration. Such factors have helped gender-based violence remain largely hidden and undocumented in the Maldives. Socialisation processes, shame and self-blame have reinforced this secrecy. This has made it difficult to assess the extent of the problem or develop effective prevention strategies and support services for the victims.

**Family Law Act**
The Family Law Act (2001) is the first law which specifically relates to gender relations, marriage and family life. It has some positive provisions such as eighteen years as the minimum age of marriage for both men and women, pre-nuptials agreement, concept of dower and divorce only by court's order. But prejudices within the judiciary and judicial interpretations reproduce and reinforce gender inequalities within family and society. Pre-nuptial agreements, often used by Muslim women in other Islamic states to create a platform of equality within marriage and to address issues that may emerge at its dissolution, had not been a practice in the Maldives. Though the law facilitates it, the concept is not promoted by the Court and is scarcely used. Few women who initiate divorce proceedings for any of the reasons specified in the Family Act get a divorce, due to the impossibility of providing evidence required by the Court. The courts rarely grant above the minimum prescribed sums for child support despite the provision for the judge to raise child support commensurate to the father’s income and/or to ensure the child the same socio-economic benefits as s/he is accustomed to (Review of Family Law, 2009).

**Gender and the Legal Framework**
The legal framework is based on *Shari'ah* law, where men are the head of household and the main provider with greater rights in terms of accessing divorce and polygamy. While obedience and care is expected from the wife, men are given the responsibility of providing for and maintaining his wife/wives and children. In a *Shari’ah*-based court of law, a woman’s word does not carry the same weight as a man’s. In cases of sexual offense, it is a man’s word against a woman’s. Violence against women and girls is a serious and growing concern receiving limited response by the legal system, with recent government reports estimating that one in three Maldivian women aged 15-29 had experienced some form of physical or sexual violence at least once in their lifetime (as cited above). The rules of inheritance favour men, as they are defined in terms of the person’s relationship to the deceased, and assume that men will provide maintenance for women automatically. For women, marriage to a non-Muslim is completely ruled out following Islamic *Shari’ah* principles, making it mandatory for any non-Muslim wishing to marry a Maldivian woman to first convert to Islam, and be accepted by concerned authorities as a Muslim prior to marriage. Abortion and homosexuality are also illegal.

The MDP-Alliance Manifesto, the main policy document of the Government, addresses the family as a “unit” with no reference to a rights based approach of individuals rights and duty bearers and analysis of the different gender and power relations within the
family. This, together with the existing practices with regard to family, places women at a disadvantage in their engagement with the State and Law.

Gender Mainstreaming in Structures and Systems
National Women’s Machineries, later called “Gender Ministries” have been part of the government architecture since 1979. These mechanisms have gone through a number of changes in their positioning within the Government structure. The lead agency was the gender and development section of the Ministry of Gender, Family Development and Social Security which had oversight and monitoring responsibilities. Recently the Ministry was dissolved and the Department for Gender and Family Protection Services mandated with the responsibility of gender. The new Strategic Action Plan of the Government has created a new gender architecture. A technical team with an advisor on Gender Equality will be located in the President’s Office and a Deputy Minister as focal person in each ministry/department. This new machinery with location of responsibilities at different levels is expected to be more effective for both mainstreaming gender and addressing women’s empowerment.

No systematic integration of gender in the government planning, budgeting and monitoring has been put in place at present. The Department of National Planning has initiated efforts on gender responsive budgeting through the initial training of its staff. The process for the formation of a Gender Responsive Budget Committee facilitated by Department of National Planning, is ongoing. Systems for monitoring and regular reporting providing disaggregated information and analysis are absent.

Maldives is a member of the SAARC Gender database which has been set up as a joint initiative of the seven member countries: Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka. But appropriate and institutionalised use of this database is still to become routine.

Previous efforts on addressing gender
Gender as a cross-cutting issue was well recognized in the planning process in the Maldives. The 7th National Development Plan (2006 – 2010) has given a specific focus on gender issues and the Ministry of Planning and National Development had taken a lead role in ensuring gender issues were well integrated into the NDP including in sectoral policies and plans. The United Nations Development Framework 2007-2010 also identified gender as a priority area of UN system support in the Maldives. Under the previous government a National Policy on Gender had been formulated and came into effect on 5th April 2006. The National Gender Policy focused on gender mainstreaming for the effective inclusion of gender concerns in all policies, programmes and projects, empowerment of women to ensure the participation of women in the political, social and economic spheres.

The policy also focused on advocacy and gender sensitization, combating gender-based violence and implementation of the CEDAW. The National Gender Policy also focused on collecting sex-disaggregated data and analyzing them from a gender perspective, legal review and reform with a focus on Gender in the Criminal Justice System, and establishing a decentralized social protection service for women.
Protection services, including counselling and social work were then provided by the Child and Family Protection Services and the Family and Community Development section undertook the implementation of the international instruments such as the CEDAW, CRC, Commonwealth Plan of Action, Declaration etc including advocacy. The Planning, Monitoring and Research Section undertook research with regards to children, women and families, monitors and reports on the implementation of these instruments in addition to policy planning and implementation.

Similarly a project was initiated to establish Social Protection Services Centres to provide decentralized social services for children, women and families in the atolls. It was expected that the whole project for all the atolls would be completed by 2009. Family and Child Protection Centres were set up in all 20 atolls under the previous administration and are currently functioning. However, there is limited information regarding the quality and level of services being provided. These centres are facing severe constraints due to limited financial and human resources.

Existing GBV Services and Protection of Women and Adolescents
The Health Master Plan (2006 – 2015) and the National Reproductive Health Strategy (2008 – 2010) state the importance of integrating GBV care into health services. It is widely recognized that provision of services and care for victims of violence needs to be greatly strengthened and that it is an urgent priority in improving the reproductive and sexual health services for women and young people. In conjunction there is a need to introduce a legislative framework to provide access to justice, and effective remedies and to empower women taking a holistic approach. Two important legislations - Sexual Harassment Bill and Domestic Violence Bill are under discussion.

A Joint UN Programme on Strengthening Response to Prevention and Elimination of Gender-Based Violence against Women and Children in the Maldives has been launched and in currently under implementation. The Ministry of Health and Family is the main focal ministry for implementation of this programme.

The main aims of the Joint Programme are to raise the understanding of CEDAW among key stakeholder including parliamentarians and the judiciary and law enforcement agencies. The sensitization of health care providers to GBV is noted in particular. The programme also focuses on strengthening the capacity to collect quality, reliable data to create public awareness on violence against women as an infringement of human rights. It further aims to enact legislation on domestic violence and all forms of sexual abuse including sexual harassment.

UNICEF is supporting initiatives on acquiring critically needed data on child protection issues in the Maldives. UNICEF is also working with several partners to develop and implement a national, coordinated child protection database that will keep records of all child protection data in the country as well as ensure that children are referred appropriately throughout a protection system.
3 Challenges and Future Course of Action

3.1 Population and Development

Moving Towards Equity and Social Justice

Government of the Maldives has recently adopted “Strategic Action Plan” covering the five year period 2009-2013 to fulfill the five key pledges by the ruling party which are: (i) establish a nationwide transportation system, (ii) ensure affordable living costs, (iii) provide affordable housing, (iv) provide affordable and quality health care for all, and (v) prevent narcotic abuse and trafficking. This plan replaced the 7th National Development Plan (2006-2010), the framework with which the UNDAF and the UNFPA Country Programme were aligned to. The Plan consists of 31 Sector Plans, contains a set of goals and polices geared to the fulfillment of the above pledges and demonstrates the commitment of the new Government to promote democracy and good governance; social justice and social protection; human rights; gender equality; and environmental sustainability. Decentralization and public-private partnerships are key elements of implementing the “Strategic Action Plan”.

Major institutional/organizational changes as well as changes in systems and functions are also being made towards implementing these policies. For example, the former Ministry of National Development Planning has been made a Department of Planning within the Ministry of Finance and Treasury. The Department of Statistics currently functions within the Department of National Planning. The planning functions have been transferred to the Office of the President under a National Planning Council which is chaired by the President.

Likewise, major changes are also expected in the organization and delivery of health services. Key elements of this change are decentralization and private sector participation. It is expected that provincial corporations will be created to plan and deliver health services in the respective provinces with the Ministry of Health and Family functioning as a normative and regulatory body. The new initiative also includes the provision of universal health insurance. Without adequate safeguards this could adversely impact public health service and preventive care, and the system of monitoring.

It is in this evolving context of reform and organizational restructuring that the following priorities and recommendations are made. These recommendations also take into account the need to continually monitor progress and identify issues and concerns related to population and development in the context of emerging trends described in the preceding sections.

Data and information

Major source of data in Maldives is the Population and Housing Census conducted normally every five years, the latest one being conducted in 2006, one year later due to the 2004 Tsunami. Other sources include the data collected through the registration of births and deaths and service statistics collected by the Ministry of Health, and other administrative statistics such as the registration of foreign workers, statistics on
educational enrolment etc. Special purpose surveys such as the RH survey (2004) and the more recent DHS also provide valuable information.

Within next few years the initiatives such as decentralization, national transport network etc under the new “Strategic Action Plan” will begin to have its impact and needs to be monitored. Therefore, organization and conduct of census in 2011 should be supported by all development partners with UNFPA providing technical support for the planning, processing and analysis of the data.

In regard to the next census, it is also to be recommended that foreign workers (registered as well as undocumented) and their dependants are covered by the census, and detailed statistics regarding this large segment of the population and the workforce can be published separately for use in planning and policy.

**Research and analysis**

Good quality research and analysis on population and development is lacking in Maldives. The situation is further worsened by the departure of many who received advance training on population to take up other positions.

However, it is important to ensure that the data that become available are properly evaluated and analyzed in time, and the results including their implications for policies and programmes are disseminated widely. It is also necessary to examine the implications of population trends for various sectors periodically.

In addition, there are a number of areas that require collection of data through specially designed surveys. An important research area is migration (both foreign workers and their dependants, as well as internal migration of Maldivians) and its multi-faced impact on their own welfare; impact on their families, including on women who become heads of households when their husbands migrate; and the contribution that they are making to their community and society. Additionally an assessment and analysis of women migrant workers and their vulnerability to sexual abuse and the social implications of high number of male migrants is necessary.

**Advocacy**

Results of analysis and research on important issues of population and its impact on development should be used for advocacy purposes. Active evidence based advocacy is important to clear misconceptions regarding population trends and how they contribute to or hinder development, in order to develop and implement informed policies. Advocacy to further advance the empowerment of women, to expeditiously address the needs of youth through skills training and improved access to health including reproductive health services, and to create better understanding of migration and its impacts are other important areas. Advocacy along with the support for strengthening disaggregated data systems, research and analysis, should, therefore, be an important component that UNFPA, with its comparative advantage should support.

**Capacity development including institutional strengthening**

National capacity for the above mentioned activities is limited in Maldives and is recognized as an important constraint for implementing the Strategic Action Plan.
Support for training and skill development in the area of population and development should, therefore, be a priority for UNFPA in the coming years.

The National Planning Council is the apex body responsible for development and UNFPA should support the secretariat of the Council to build its capacity to monitor the trends in population, analyze their implications for development and advocate at the level of the National Population Council on issues related to population and development including those mentioned above.

Once the institutional arrangements for collecting and analyzing the data and for providing technical support to the National Population Council are finalized it is necessary to ascertain the needs for capacity development in the new institutions and develop a capacity development plan. The plan could then form the framework for UNFPA support in the coming years for capacity development on population and development and related advocacy.

The capacity development plan could include the organization of in country short-term courses on population and development and on specialized topics with external technical support. These can be organized in conjunction with one or more of the activities relating to data gathering, research and analysis.

The Maldives has achieved remarkable progress and has achieved many of the ICPD Goals and MDGs, though there are still issues that remain to be addressed, as discussed in the preceding sections. Planning towards equity and justice in line with the Strategic Action Plan must, therefore, take into account the opportunities and challenges posed by the emerging demographic dynamics and their implications for development.

**Environment, Disaster Risk Reduction and Climate Change**

Another important research area, in line with the theme of the 2009 State of World Population Report, is how population dynamics, reproductive health and gender contribute to climate change mitigation and adaptation measures, sustainable environmental management and disaster risk reduction strategies. Research findings need to be part of advocacy and capacity building strategies with policy makers and relevant national counterparts and civil society.

There is a need to recognize the increased vulnerability of women to impacts of climate change due to existing inequitable gender relations which burdens them with care responsibilities, constrains their mobility, limits their influence in decisions and decreases their access to resources in all policy decisions and interventions. It is essential to build on their understanding of local knowledge systems and strengthen their skills and capacities, acknowledging and promoting their capacities to stabilize consumption in households and community (credit, access to markets, social security mechanisms). Strengthening of women’s voice and ability to influence decisions, ensuring their representation in all decision-making bodies regarding climate change and protecting them against violence resulting from climate change issues (e.g. increased domestic violence due to male trauma with loss of livelihoods, high migration etc) is necessary.
3.2 Reproductive Health and Reproductive Rights

Strengthening Services and Capacity Building

While significant progress has been made in the availability, accessibility and utilization of basic reproductive health services and contraceptives over the last fifteen years, a number of challenges remain, particularly in improving the quality of RH services and in addressing the unmet need for family planning.

The need for improvement in the quality of RH services is urgent. Strengthening the skills of service providers particularly in the islands, improving antenatal and postnatal care through training using new protocols to focus on skilled areas identified through a functional analysis, and through follow-up supervision on counseling, are important in improving the quality of services. Continued advocacy for ensuring midwifery training for nurses and community health workers is also required. This is necessary in order to ensure that births even in most remote islands are attended by skilled birth attendants and that health care workers have the necessary skills and knowledge to handle emergency cases.

Accessibility and availability to RH services currently only include maternal and child health services and family planning for women who are pregnant or have a recent delivery. Thus, there is a strong need to introduce other RH service components in a comprehensive manner. Ensuring the supply of RH commodities, development of guidelines and protocols, training of service providers, improvements in logistics and information systems, human resource development, strengthening of programme management coupled with effective behavioural change communication strategies are critical in this regard. Special emphasis as highlighted earlier in the report needs to be placed in improving emergency obstetric care by early detections and improving outreach services in the islands and atolls.

At the same time, availability and accessibility to safe and affordable methods of contraceptives needs to be strengthened with innovative social marketing and promotion strategies. This is more compelling given the prevalence of unsafe abortions and the large adolescent population. The current gradual exit strategy for contraceptive commodities being implemented by the government holds the key to future sustainability of the programme. In doing so, the national programme should also look at implementing new strategies like social marketing, particularly with outreach services to adolescence and youth and a universal social insurance scheme to ensure that the poorer sections of the population are covered.

Such interventions need to be synchronized with efforts to promote safe sexual and reproductive health behaviour. Interventions to strengthen in particular the prevention of STIs including HIV/AIDS needs to be reinvigorated. In this regard, life skills programmes in schools also need to be strengthened. It is recommended that methods of retaining and utilizing quality life skills facilitators be worked out and implemented by the Ministry of Education.

In addressing gender-based violence through the health sector, the response to victims of GBV needs to be strengthened and expanded to serve the island population, in
collaboration with the related gender and health units of the Ministry of Health and Family. The capacity of the Family Planning unit needs to be strengthened including its linkages to other stakeholders in order to strengthen services for victims of GBV. This model should also be replicated at atoll and island level.

**Advocacy and Awareness Raising**

The awareness on the rights of men, women and young people to reproductive health information and services is still limited in the Maldives. Thus, the need for advocacy in the promotion of reproductive rights is paramount. In particular, given the inequalities between men and women in reproductive health related decision-making, the active engagement of men in family and child care needs must be promoted through carefully designed behaviour change communication strategies, and should be complemented by information on reproductive health information and services for men.

Focus should also be placed on the promotion of condom use as a method of protection against STIs, HIV/AIDS and unwanted pregnancies. At the same time, targeted interventions to raise awareness and promote safe sex is required for populations vulnerable to STIs and HIV/AIDs.

**Research and Analysis**

There are a number of areas where research and analysis is required for targeted interventions, one of them being anaemia among pregnant women – a significant problem contributing towards maternal deaths. Research and analysis on the causes of anaemia are needed to strengthen remedial actions together with strengthening of ongoing efforts for proper nutrition and eating habits. There is also an urgent need for research on reproductive organ malignancies and infertility. This needs to go hand in hand with improving facilities for the diagnosis of reproductive organ malignancies and management of infertility. Further research is also required to address the low contraceptive prevalence rate for modern methods of contraception. Since discontinuation and unmet need is a major issue affecting contraceptive prevalence rate, analysis of the underlying reasons are necessary.

### 3.3 Gender Equality and Women’s Empowerment

**Strengthening Services and Capacity Building**

The operationalisation of political commitments and implementation of strategic action plan will require a dedicated effort. The national gender architecture is to be established under the responsibility of the President’s Office. It will execute the Gender Equality Policy in coordination with the Gender Focal Points in all sectoral ministries. Capacity building of the technical team in the President’s Office and the Department of Gender and Family Protection Services to develop the expertise for gender analysis, gender-responsive planning budgeting and evaluation in all sectoral ministries is a top priority. The ability to develop guidelines, provide technical assistance, respond on gender issues of different sectors will need a process-oriented approach to capacity building with a combination of class-room, on-the-job and mentoring processes. While gender budgeting has been under discussion, substantive work has not happened as yet. Skills and systems for gender budgeting will need to be developed and applied.
Capacity building will also be necessary for the implementation of the strategic action plan on gender. New concepts of affirmative action, gender sensitive monitoring and evaluation will require in-depth understanding for application. Information management systems routinely capturing disaggregated information regarding progress on gender issues will need to be established and people trained in their use. To strengthen capacity to collect quality, reliable data, as discussed in the population and development section is also essential.

Capacity has to be strengthened for strong action against violence against women and girls. Strong political commitment of the government against violence against women and girls and sexual abuse and violence of children is a pre-requisite for effective transformation in the situation. Provision of services and care for victims of violence against women and child abuse needs to be greatly strengthened. The limited use of formal services clearly reflects the limited availability of such services in the Maldives, particularly outside of Male’ and the fear of consequences to their own and their children’s safety.

Skills for women to have higher employment opportunities and for political participation needs to be increased. These can only be achieved through well-designed and integrated packages which recognize the gender-based constraints of women and their ability to develop if provided appropriate opportunities.

Capacity also is required to review and revise school textbooks and teaching materials, to disseminate information on CEDAW through the educational system, to ensure human rights education have a gender perspective aimed at changing existing stereotypical views and attitudes towards women’s and men’s role in the family and society.

**Advocacy and Awareness Raising**

Evidence based advocacy is necessary to increase recognition of gender differentiated realities and their implications on progress of women. Policy and institutional recognition is required that with high divorce rates and male migration, many single women in female-headed households continue to bear the brunt of high work-burdens. Policies must recognize these gender specific issues and create an enabling environment for their equitable progress. These factors impact employment opportunities of women and affect their ability to become independent, impact their access to health services and for participation in decision making forums.

Dissemination of positive Government policies, the new “Strategic Action Plan” on gender, the new gender architecture and the responsibilities it places on the different ministries to the public in general and to women in particular is required for them to be informed and to demand accountability from the service providers.

Sustained discourse and social dialogues are necessary on the negative impacts of violence against women and girls, of growing conservatism and its implication for women’s and girls human rights and on the positive results of higher male contribution to household management and child care. Advocacy work with the Ministry of Islamic Affairs, other religious leaders, parliamentarians, judiciary, Government and civil society
to ensure support for women's rights and gender equality should also be strengthened in this regard. It is also important to raise awareness of CEDAW among decision-makers and parliamentarians in general, to implement training for parliamentarians, the judiciary and public officials, including law enforcement personnel and health-service providers to ensure they are sensitized to all forms of violence against women and can provide support.

Male participation for reduction in violence against women and girls is essential. There is need to actively engage men and boys and male policy makers as partners and agents for change with tailored interventions and messages on gender equality and zero tolerance for violence against women and girls

Public education and mobilization campaigns by and for men opposed to violence against women and girls, in collaboration with women’s groups, explicitly targeting male notions and masculinity that perpetuate violence against women and girls need to be launched widely.

**Research and Analysis**

Understanding of the link between International Human Rights Instruments guaranteeing women’s rights and Sharia’h Law is an area for research, analysis and debate. There is a need for further efforts to reform the Family Law by re-reading the Shari‘ah based on the spirit of equality espoused by Islam in order to ensure gender equality and to further women’s rights within marriage, in accessing divorce, child custody and child support and access to the marital home.

Further research and understanding for the reasons behind the low political participation of women is required in order to strengthen interventions, which should be followed by awareness and advocacy for encouraging more women into the political and public sphere and having their viewpoints and voices to be heard.
### Statistics

#### Population

<table>
<thead>
<tr>
<th>Data</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population in thousands:</td>
<td>2006</td>
</tr>
<tr>
<td>Male</td>
<td>151,459</td>
</tr>
<tr>
<td>Female</td>
<td>147,509</td>
</tr>
<tr>
<td>Economically active population (Maldivian)</td>
<td>128,836</td>
</tr>
<tr>
<td>Population Growth Rate (2000 – 2006)</td>
<td>1.69</td>
</tr>
<tr>
<td>Crude birth rate per 100,000 population</td>
<td>22</td>
</tr>
<tr>
<td>Life expectancy at birth:</td>
<td>2007</td>
</tr>
<tr>
<td>Male</td>
<td>72.3</td>
</tr>
<tr>
<td>Female</td>
<td>73.7</td>
</tr>
<tr>
<td>Under 5 mortality rate per 100,000 population</td>
<td>14</td>
</tr>
<tr>
<td>Maternal mortality ratio per 100,000 live births</td>
<td>0.43</td>
</tr>
<tr>
<td>Infant mortality rate per 1,000 live births</td>
<td>11</td>
</tr>
<tr>
<td>Population 60 years and over, percent</td>
<td>6.5</td>
</tr>
</tbody>
</table>

#### Socio-Economic & Education

<table>
<thead>
<tr>
<th>Data</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population below $1/day</td>
<td>2004</td>
</tr>
<tr>
<td>Literacy rate:</td>
<td>2006</td>
</tr>
<tr>
<td>Male</td>
<td>98.4</td>
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<tr>
<td>Female</td>
<td>98.1</td>
</tr>
<tr>
<td>Primary school enrolment, gross % of school age population</td>
<td>109</td>
</tr>
<tr>
<td>Secondary school enrolment, gross % of school age population</td>
<td>129</td>
</tr>
<tr>
<td>Real GDP per capita (USD)</td>
<td>2009</td>
</tr>
<tr>
<td>Public expenditure as percentage of national budget</td>
<td>13</td>
</tr>
</tbody>
</table>

#### Reproductive Health/ASRH

<table>
<thead>
<tr>
<th>Data</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Fertility Rate per women 15 -49</td>
<td>2006</td>
</tr>
<tr>
<td>Deliveries attended by skilled attendants %</td>
<td>2004</td>
</tr>
<tr>
<td>Contraceptive prevalence rate for women 15 -49, modern methods</td>
<td>2004</td>
</tr>
<tr>
<td>Contraceptive prevalence rate for women 15 -49, any method</td>
<td>2004</td>
</tr>
<tr>
<td>Unmet need for family planning, spacing/limiting: Male</td>
<td>2004</td>
</tr>
<tr>
<td>Female</td>
<td>2004</td>
</tr>
<tr>
<td>Percentage of caesarean sections</td>
<td>2007</td>
</tr>
<tr>
<td>Proportion of population 15 – 24 %</td>
<td>25</td>
</tr>
<tr>
<td>Mean age at marriage: Male</td>
<td>2006</td>
</tr>
<tr>
<td>Female</td>
<td>2006</td>
</tr>
<tr>
<td>HIV/ AIDs cases reported Male</td>
<td>2008</td>
</tr>
<tr>
<td>Female</td>
<td>2008</td>
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</table>

#### Gender Equality

<table>
<thead>
<tr>
<th>Data</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labour force participation rate, 15-64: Male</td>
<td>2006</td>
</tr>
<tr>
<td>Female</td>
<td>2006</td>
</tr>
<tr>
<td>Female headed households %</td>
<td>2006</td>
</tr>
<tr>
<td>Percentage of women in informal sector</td>
<td>2006</td>
</tr>
<tr>
<td>No. of seats in parliament: Male</td>
<td>2009</td>
</tr>
<tr>
<td>Female</td>
<td>2009</td>
</tr>
<tr>
<td>No. of cabinet ministers: Male</td>
<td>2009</td>
</tr>
<tr>
<td>Female</td>
<td>2009</td>
</tr>
<tr>
<td>No. of state ministers: Male</td>
<td>2009</td>
</tr>
<tr>
<td>Female</td>
<td>2009</td>
</tr>
<tr>
<td>Percentage of women employed in health sector</td>
<td>2006</td>
</tr>
</tbody>
</table>

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13 ▲ – MDG indicator, ● – ICPD goal, statistics are obtained from various sources, including the census, RH survey and the presidents office. Cases of HIV are the cumulative total up to 2008.
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