This is the report on Reproductive and Sexual Health of Adolescents in the Maldives submitted by Commerce, Development and Environment Private Limited to UNRC under the terms of the Special Services Agreement dated 23 December 2002. The opinions expressed herein are those of the authors and do not necessarily reflect the views of the UNFPA.

Research Team

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ARH	Adolescent Reproductive Health
CCE	Centre for Continuing Education
CDE	Commerce, Development and Environment Private Limited
DPH	Department of Public Health
EDC	Education Development Centre
GER	Gross Enrolment Ratio
HIV	Human Immunodeficiency Virus
NER	Net Enrolment Ratio
NGO	Non Governmental Organisation
ILO	International Labour Organisation
IMR	Infant Mortality Rate
MHAHE	Ministry of Home Affairs, Housing and Environment
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Rate
MOE	Ministry of Education
MOH	Ministry of Health
MPND	Ministry of Planning and National Development
Rf	Maldivian Rufiya
NCB	Narcotics Control Board
NDP	National Development Plan
O/L	Ordinary Level
SHE	Society for Health Education
STDs	Sexually Transmitted Diseases
STIs	Sexually Transmitted Infections
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNRC	United Nations Resident Co-ordinator
VPA	Vulnerability and Poverty Assessment
WHO	World Health Organisation

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PART I

1. Introduction

Aims and Objectives

This report on Reproductive and Sexual Health of Adolescents in the Maldives is the result of an important study initiated and funded by the United Nations Population Fund (UNFPA) field office in Male', Maldives. The aim of the study is to provide information useful for programming strategies to promote reproductive and sexual health among adolescents in the Maldives.

The roots of many problems in adulthood can be found in adolescence. The main purpose of the background study is to obtain information relating to the situation on Adolescent Sexual and Reproductive Health to inform the UNFPA Adolescent Sexual and Reproductive Health (ASRH) project. The study findings would assist UNFPA in further strengthening and expanding the project according to the changing needs of adolescent girls and boys in the Maldives.

The specific objectives of the study are:

1) To undertake primary/field research and analysis of secondary data sources to identify as far as possible,

   sub group of adolescents (eg: out of school, migrant, etc)
   extent of knowledge on reproductive and sexual health issues amongst adolescents
   attitudes related to reproductive and sexual health issues amongst adolescents
   reproductive and sexual behaviour of adolescents and its determinants
   where and how to reach adolescents
   where and how adolescents are currently accessing reproductive health information and services
   reproductive health policies and plans targeted at adolescents
   reproductive health programs services available to adolescents
   partners working in the field of adolescent sexual and reproductive health.

2) To map ongoing work in the area of Adolescent Sexual and Reproductive Health particularly Life Skills education programmes.

3) To identify gaps in information necessary to design and implement successful Reproductive Health programs targeted at adolescents.

This research was undertaken in Male', the capital of the Maldives. Almost half of the adolescent population of the Maldives lives in Male' and nearby resorts. It is acknowledged that significant differences may be there in the knowledge and attitudes of adolescents living in Male' compared to that of the population in the islands.

Focus group discussions

The sampling frame comprised unmarried adolescent boys and girls living in Male'. The age group 10-14 was considered early adolescents while age group of 15-19 years was considered as late adolescents.

Focus group interviews were conducted with a representative sample of adolescents, belonging to early adolescent male students, early adolescent female students, late adolescent Male' male students, late adolescent Male' female students, late adolescent migrant student males, late adolescent migrant student females and late adolescent male office workers and late adolescent female office workers.

The participants in the six student adolescent groups were selected in the following manner. Eight schools were asked to send students to hold focus groups with students. The schools asked to send students were Ameeniya School, Dharumavantha School, Imaduddin School, Ghiyasuddin School, Madhrasathul Ameer Ahmed, Galolhu Madhrasa, Maafannu Madhrasa and Center for Higher Secondary Education. Supervisors from each school were asked to identify students whom he/she thought would be interested in participating in the focus group interviews.

A common set of questions was developed by the research team. A common framework for the process as well as a common set of questions to use in the focus group discussions were developed by the research team. The questions and process were discussed with UNFPA technical staff prior to the focus group discussions and based on the feedback improvements were made to the questions as well as the process.

Two additional focus groups were organised to collect and describe the perceptions of working adolescents about sexual health information and services. These late adolescents were selected from five different offices.

The following number of adolescents participated in these focus groups:

Student migrant males: 8

Student migrant females: 9

Student Male' males: 7

Student Male' females: 8

Early adolescent males: 8

Early adolescent females: 7

Working adolescent males: 6

Working adolescent females: 9

The discussions in the focus groups were transcribed and coded in a standard format appropriate to focus group discussions. The reports of each focus group were written independently by the researchers.

Contactable married adolescents are an important group for assessing the impact of the program on reproductive health. The initial design of focus group discussions was to target at married adolescents as well. However because of the relatively few number of adolescent age marriages in Male' it was not possible to draw a representative sample of this population. Effort was made to receive a list of married adolescents from the concerned agencies, however it proved impractical to draw a simple random sample of married adolescents from the population resident in Male. It was decided that the targeting of selected married adolescents would lead to selection bias in sampling and may affect the results.

It is assumed that there would be a significant adolescent out-of-school non-working population. However, because of the difficulty in reaching this population and drawing a random sample, this group of adolescents was not included in the study.

The samples of school going adolescents were drawn from pre-selected schools and there is a possibility that there may be significant differences in the need for sexual health and reproductive health information expressed depending on the level of sexual education in the pre-selected schools.

As there was no baseline data on knowledge, attitudes and behaviour for comparison from previous studies the researchers did not have the advantage of designing the questionnaire and selecting the groups to control for bias. As participation in the program was voluntary, there may have been a self-selection bias towards more educated, more vocal and more outgoing adolescents. It is also highly likely that the pre-selected schools nominated the active leading boys and girls in the schools. There may also be a gap between professed and actual behaviour. Every effort was made to control for confounding factors and to elicit actual behaviours.

Key informant interviews

The following are the key government and non-governmental organizations consulted for the purposes of this study:

Ministry of Education (MOE)
Ministry of Health (MOH)
Department of Public Health
Ministry of Planning and National Development
Ministry of Women's Affairs and Social Security
Ministry of Youth and Sports
Unit for the Rights of Children
Girl Guides Association
Boys Scout Association
Society for Health Education
FASHAN
Ameeniya School
Majeediya School
Dharumavantha School
Galolhu Madhrasa

The following United Nations agencies were consulted:

UNFPA
WHO
UNICEF
UNDP

Content of the report

Following the introduction in Part I, a demographic and socio-economic profile of adolescents and young people is presented in Part II. The following elements are covered in the profile:

Definition of adolescence and young
Legal milestone ages
Growth and distribution of adolescents and young people
Age at marriage
Reproductive health
Family life
Education
Labour force participation
Income

Special needs
Health
Delinquency and crime

The demographic and socio-economic profile of adolescents and young people is drawn out from the report to the UNCR by the authors.

Part III of the report presents the reproductive health policies, plans, programs, services targeted at adolescents in the Maldives and identifies the partners working in the area. The policies, programs, and services of the different agencies and organizations are reported together because they share the responsibility to promote adolescent sexual and reproductive health. The results in Part III are presented under five broad areas:

1. Reproductive health policies and plans targeted at adolescents.
2. Reproductive health programs and services available to adolescents.
3. Partners working in the field of adolescent sexual and reproductive health.
4. Ongoing work in the area of adolescent sexual and reproductive health and life skills.
5. Identification of key gaps in information necessary to design and implement successful Reproductive Health programs targeted at adolescents.

Part IV of the report contains the results of the focus group interviews with student adolescents and working adolescents. The questions in the focus groups asked adolescents to give their views on the nature and quality of existing services and programs to promote sexual and reproductive health.
Part V contains the main findings and recommendations.

PART II

2. Definition of Adolescence and Young People

Adolescence is a distinct and dynamic phase of development in the life of an individual. It is a period of transition from childhood to adulthood and is characterised by spurts of physical, mental, emotional and social development. During this period, known as adolescence, individuals move toward physical and psychological maturity and economic independence, and acquire their adult identity.

There are three basic definitions of adolescence. According to the biological definition, adolescence begins with the condition of being or in the period of becoming first capable of reproducing sexually.

The psychological definition of adolescence emphasizes the period of time when certain development tasks or changes take place in the behaviour or cognitive development (or both) of the individual.

The sociological definition stresses on the idea of adolescence as a transitional period from the dependent state of childhood to a self-sufficient state of adulthood (DMC 2002).

The World Health Organisation considers “adolescence” to be the period between 10 and 19 years of age. For the purpose of the International Youth Year, the United Nations has defined “youth” as encompassing the age range 15-24.

As there is a period of overlap in the definitions of adolescence and youth, for the purposes of this study reference is made to the 10-19 year age group as adolescents and 20-24 year age as young people. Additionally, where there are analytical implications, the adolescent age group is subdivided into early adolescents (10-14 year age group) and late adolescents (15-19 year age group).

3. Legal Milestone Ages

The Maldives is a party to the United Nations Convention on the Rights of the Child and the Government is working on the review of laws and regulations in relation to the provisions in the Convention. The Citizen's Majlis enacted the Children's Act (Law 9/91) on 24 November 1991 and this Act has introduced several legal milestone ages that fall under the adolescence period. The Constitution and several other laws of the Maldives also have legal milestone ages that are highly significant for the adolescents and young people.

The following are some of the legal milestone ages for adolescents and young people in the Maldives.

10 years	Issuance of Identity Card
12 years	Entitlement limit for child fare on transport services (Children's Act)
14 years	Minimum legal age for paid employment (Children's Act)
16 years	Eligible to enter into legal contracts (Contract Act 04/91)
18 years	Protection limit as a child (Children's Act)
18 years	Minimum age for marriage (Family Law)
18 years	Eligible to obtain Driving License (Land transport Act)
21 years	Right to vote (Constitution)
21 years	Eligible to become a founder member of parties, clubs and societies
25 years	Qualifies to become a Member of Parliament

In 2002, an amendment was made to the Children's Act (Law 9/91) by the Citizen's Majlis stipulating that children under the age of 18 have legal protection as a child. With the entry into force of this amendment, the President's Office has decreed all the concerned Government agencies to revise the existing regulations on legal ages to conform to the amendment.

The Ministry of Youth and Sports, who have been considering youth to be persons in the 16-35 years age group has now changed the definition of youth to persons in the 18-35 years age to conform with the amendment to the Children's Act. Several other Ministries are also in the process of bringing the necessary changes to their regulations and procedures. A new labour law is expected to be considered by the Citizen's Majlis in 2003 and it is anticipated that the labour law would introduce provisions on the minimum legal age of employment and conditions of employment.

At the moment it is very clear which agencies of the Government are responsible for enforcing the provisions on the rights of the children. What is not clear is which agencies of the Government are responsible to provide programmes and services to adolescents particularly, adolescents in the 16-18 year age group.

4. Growth and Distribution of Adolescents and Young People

Composition of adolescents and young people

According to the Census 2000, the adolescent population (ages 10-19) comprised 27.53 % (74,355) of the Maldives total population of 270,101 (Table 1). The 20-24 years age cohort numbered 23,514 and comprised 8.7% of the total population. In total, adolescents and young people comprised 36.23 % of the total population.

There were an estimated 36, 868 adolescent girls and 37,487 adolescent boys in the Maldives in the year 2000. Adolescent boys comprised 13.88 % and adolescent girls comprised about 13.65 % of the total population of the Maldives.

With regard to the young people (ages 20-24), in 2000, the young females comprised 4.4% of the total population of the Maldives while young males comprised 4.3% of the total population. Out of the 23,514 young people in the age cohort 20-24, there are 11,894 females and 11,620 males.

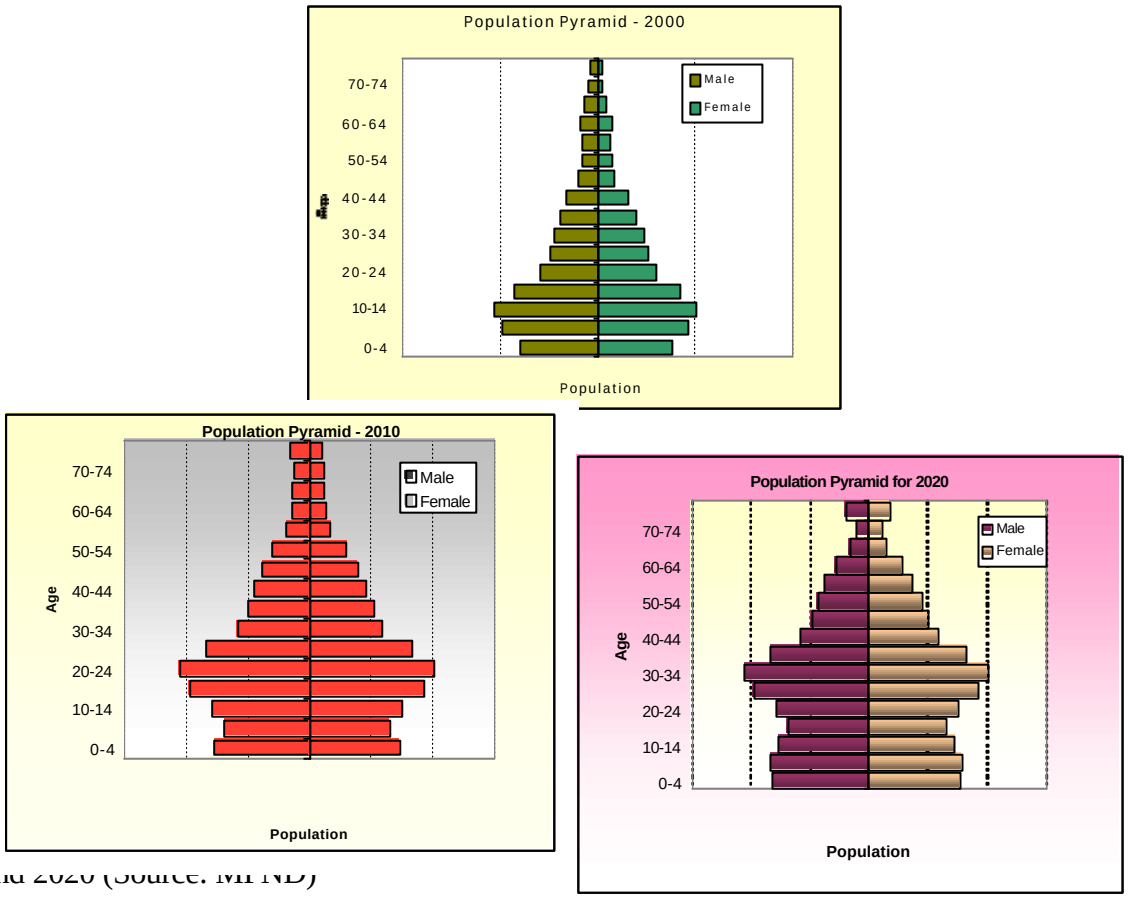
Table 1: Adolescent population and young people by age and sex – 2000

	Population			%			Cumulative %		
Locality	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Republic	270101								
Total 10-24	97869	49107	48762	36.23	18.18	18.05			
10	8460	4286	4174	3.13	1.59	1.55	3.13	1.59	1.55
11	8280	4210	4070	3.07	1.56	1.51	6.20	3.15	3.05
12	7784	4000	3784	2.88	1.48	1.40	9.08	4.63	4.45
13	7872	3985	3887	2.91	1.48	1.44	11.99	6.10	5.89
14	8693	4416	4277	3.22	1.63	1.58	15.21	7.74	7.48
15	7825	3960	3865	2.90	1.47	1.43	18.11	9.20	8.91
16	6656	3300	3356	2.46	1.22	1.24	20.57	10.42	10.15
17	6578	3272	3306	2.44	1.21	1.22	23.01	11.64	11.37
18	6327	3087	3240	2.34	1.14	1.20	25.35	12.78	12.57
19	5880	2971	2909	2.18	1.10	1.08	27.53	13.88	13.65
20	5383	2692	2691	1.99	1.00	1.00	29.52	14.88	14.65
21	4424	2164	2260	1.64	0.80	0.84	31.16	15.68	15.48
22	4398	2162	2236	1.63	0.80	0.83	32.79	16.48	16.31
23	4843	2390	2453	1.79	0.88	0.91	34.58	17.36	17.22
24	4466	2212	2254	1.65	0.82	0.83	36.23	18.18	18.05

Source: Census 2000.

Growth and projections

The number of adolescents grew from 60,775 (24.82% of the total population) in 1995 to 74,355 (27.53% of the total population) in 2000. The number of young people grew from 21,021 (8.58%) in 1995 to 23,514 (8.7%) in 2000. The total population of adolescents and young people grew from 33.41% in 1995 to 36.23% in 2000. Figure 1 shows the likely population structures in 2010 and 2020 compared to the 2000 population pyramid.



and 2020 (Source: MPND)

According to data provided by the Ministry of Planning and National Development, it is estimated that the adolescent population would reach a peak of 80,091 in 2004 (27.67% of the total population) and start declining in 2005. The projected adolescent population for 2005, 2010, and 2020 would be 79,612 (27.1% of the total population), 68,962 (21.67%), and 56,619 (15.37%) respectively. The projections clearly show that the five year period from 2000-2005 is a critical period to make policy interventions for the health, safety and education of the adolescents.

The number of young people (age group 20-24) is projected to be 33,513 (11.40%) in 2005. The population in this age group is likely to reach the peak in 2011 with a population of 41,543 (12.85%) and then decline to 30,723 (8.34%) by the year 2020.

Distribution of adolescents and young people

Table 2 and Figure 2 show the distribution of adolescent population across the atolls and Male'. The number of adolescents and young people living in Male' and Male' Atoll is significant in the context of the distribution of the total population. While Male' is home to 27.42% of the total population of the Maldives, 28.96% of the adolescent population and a disproportionate 38.86% of the young people live in Male'. The islands of Male' atoll including the tourist resorts in the atoll host 8.70% of the young people compared to its distribution of 4.98% of the total population. The proportion of young people living in Male' atoll (8.70%) is almost twice that of the highly populated Addu Atoll (4.38%) and South Thiladhunmathi (4.42%). Male' together with the resorts and islands in Male' Atoll host 47.56% of the young people (20-24 year age group) in the country.

Table 2: Adolescent population & young people by locality 2000

	Population (10-19)	Population (20-24)	% (10-19)	% (20-24)
Male'	21535	9138	28.96	38.86
North Thiladhunmathi (Haa Alif)	3805	806	5.12	3.43
South Thilandhunmathi (Haa Dhaal)	4593	1040	6.18	4.42
North Miladhunmadulu (Shaviyani)	3097	810	4.17	3.44
South Miladhunmadulu (Noonu)	2948	624	3.96	2.65
North Maalhosmadulu (Raa)	3876	958	5.21	4.07
South Maalhosmadulu (Baa)	2740	693	3.69	2.95
Faadhippolhu (Lhaviyani)	2594	710	3.49	3.02
Male' Atoll (Kaafu)	3034	2045	4.08	8.70
North Ari Atoll (Alif Alif)	1304	602	1.75	2.56
South Ari Atoll (Alif Dhaal)	2077	822	2.79	3.50
Felidhu Atoll (Vaavu)	416	166	0.56	0.71
Mulaku Atoll (Meemu)	1330	333	1.79	1.42
North Nilandhe Atoll (Faafu)	1098	235	1.48	1.00
South Nilandhe Atoll (Dhaalu)	1320	365	1.78	1.55
Kolhumadhulu (Thaa)	2673	604	3.59	2.57
Hadhdhumathi (Laamu)	3233	816	4.35	3.47
North Huvadhu Atoll (Gaaf Alif)	2054	554	2.76	2.36
South Huvadhu Atoll (Gaaf Dhaal)	3196	665	4.30	2.83
Fuvahmulah (Gnaviyani)	2307	498	3.10	2.12
Addu Atoll (Seenu)	5125	1030	6.89	4.38

Source: Census 2000

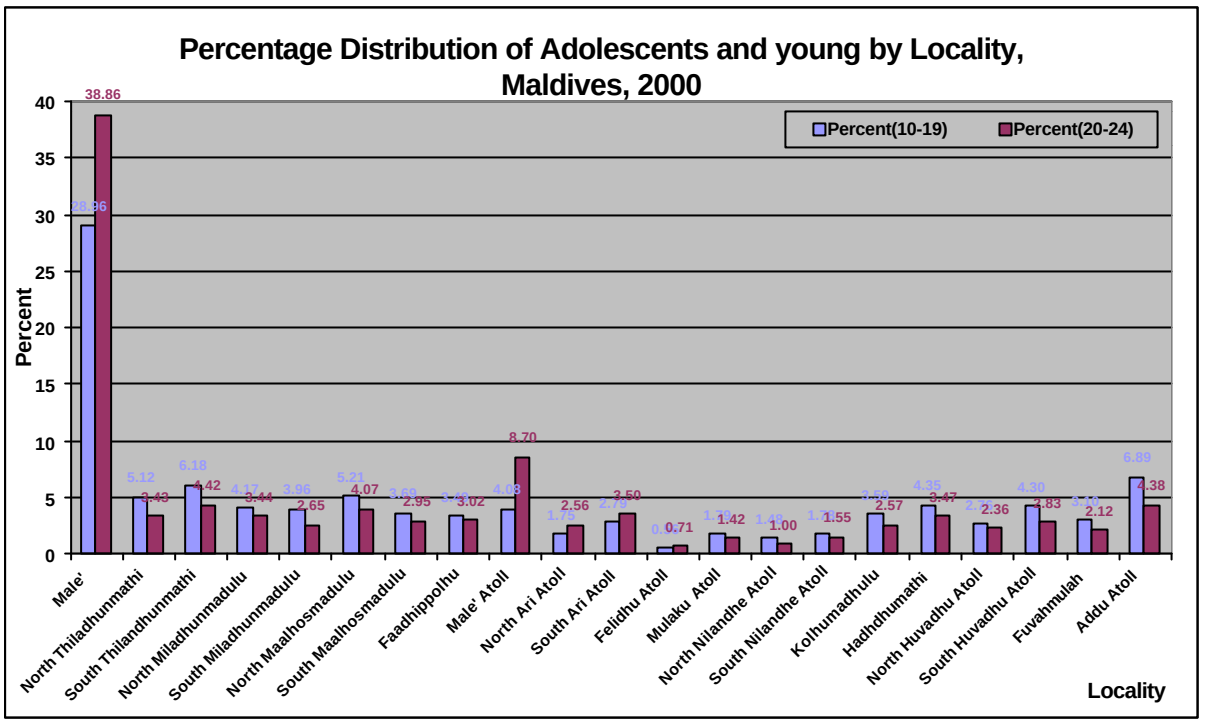


Figure 2: Percentage distribution of adolescents and young people by locality

Sex ratio

Table 3 shows the sex ratios (boys to girls) of the 0 – 24 years age population from the Censuses 1985, 1995 and 2000. The Analytical Report of the Census 2000 identifies that the observed pattern of the sex ratios of the population across age groups in the Maldives shows serious deviation from normal expectations (MPND 2002).

Countries with reliable demographic data report sex ratio at birth of around 105 to 106 male births for every 100 female births, with a narrow band of variability (Poston *et al.* 2001). This excess number of males is normally offset in the following age cohorts by the differential mortality rates (Carey and Lopreato 1995).

In most populations, female infants have a lower mortality than their male counterparts, an outcome that is attributed to biological and genetic factors. The female advantage also operates beyond infancy, although at some point during early childhood, environmental rather than biological factors begin to have a greater influence in determining sex differentials in mortality. As a large proportion of mortality under age five is concentrated in the first year of life when mortality due to endogenous causes prevails, the sex differential of under-five mortality generally favours girls (Carey and Lopreato 1995).
In all three census years the sex ratio was higher than 100 for the 0-4, 5-9 and 10-14 age groups and less than 100 at ages 15-24. At 0-4 age group, the sex

ratio is expected to be high, as there would be an excess number of males, primarily because at birth more male babies are born.

Table 3: Sex ratio of the adolescent population

Age Groups	1985	1995	2000
0-4	102	107	103
5-9	104	105	104
10-14	110	104	103
15-19	99	98	99
20-24	98	90	98

Source: Analytical Report – Population and Housing Census of the Maldives 2000,

5. Age at Marriage

The estimated singulate mean age at marriage has increased for both sexes during the last decade. The mean age at first marriage among women in the Maldives increased from 19.11 in 1990 to 21.80 in the year 2000, while mean age at first marriage for males increased from 23.69 in 1990 to 25.60 in 2000 (Table 4).

The age at marriage for women is still low compared to men and there is a 3.8 year difference between male and female mean age at first marriage in the year 2000.

Table 4: Mean Ages at Marriage by Sex 1990 - 2000

Sex	1985	1990	2000
Republic			
Male	22.51	23.69	25.57
Female	17.99	19.11	21.77
Male'			
Male	23.79	24.92	26.35
Female	19.64	21.13	23.29

Source: Analytical Report – Population and Housing Census of the Maldives 2000,

Improved access to secondary education and more employment opportunities appears to have had a positive influence on age at marriage. This observation is supported by the fact that the singulate mean age at marriage in Male', where there are more opportunities for secondary education and employment, is found to be higher than that of the national average, both for females and males. The singulate mean age at marriage for females in Male' is estimated to be 23.29 years and for males in Male' it is 26.35 years.

The Census 2000 data also indicates that the percentage of people marrying during the adolescent years has fallen sharply in the Maldives. Teenage marriage, declined from 14% of the 15-19 year age group in 1995 to 3% in 2000. However, teenage marriages are still prevalent at a significant level among the female population. 28.22 % of the 19 year old females were married in 2000 compared to 3.64% of males in the same age. 2.75% of the 19 year old females have also experienced a divorce by the year 2000 (Table 5). Of the 20-24 year young age cohort, 58.22% of the females were married relative to 22.74% of the males in the same age cohort. 5.36% of the female population in this age cohort have gone through the experience of a divorce compared to 1.98% of the male population (Table 6).

Though the number of marriages at adolescence is steadily declining, the high percentage of married female adolescents is an area that needs attention. It is likely that among married female adolescents autonomous decision making is very low in relation to RH issues. In addition to the psychological immaturity of an adolescent bride, very often her body is not prepared to accommodate the early onset of childbearing (Mehta *et al.* 1999).

Table 5: Adolescent population by marital status, Maldives, 2000.

Locality	Married (%)			Married (N)			Divorced (%)			Divorced (N)		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
Republic												
Total	2.78	0.57	5.03	2070	214	1856	0.24	0.03	0.46	182	11	171
10	0.00	0.00	0.00	0	0	0	0.00	0.00	0.00	0	0	0
11	0.00	0.00	0.00	0	0	0	0.00	0.00	0.00	0	0	0
12	0.19	0.13	0.26	15	5	10	0.00	0.00	0.00	0	0	0
13	0.14	0.15	0.13	11	6	5	0.00	0.00	0.00	0	0	0
14	0.21	0.11	0.30	18	5	13	0.00	0.00	0.00	0	0	0
15	0.32	0.20	0.44	25	8	17	0.03	0.00	0.05	2	0	2
16	1.82	0.42	3.19	121	14	107	0.12	0.00	0.24	8	0	8
17	4.80	0.73	8.83	316	24	292	0.43	0.00	0.85	28	0	28
18	10.04	1.43	18.24	635	44	591	0.89	0.10	1.64	56	3	53
19	15.80	3.64	28.22	929	108	821	1.50	0.27	2.75	88	8	80

Source: Census 2000.

Table 6: Young population by marital status, Maldives, 2000.

Locality	Married (%)			Married (N)			Divorced (%)			Divorced (N)		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
	40.69	22.74	58.22	9567	2642	6925	3.69	1.98	5.36	867	230	637
20	24.43	8.21	40.65	1315	221	1094	2.19	0.85	3.53	118	23	95
21	31.71	12.85	49.78	1403	278	1125	2.78	1.25	4.25	123	27	96
22	42.04	22.62	60.82	1849	489	1360	4.12	2.36	5.81	181	51	130
23	50.90	31.76	69.55	2465	759	1706	4.54	2.72	6.32	220	65	155
24	56.76	40.46	72.76	2535	895	1640	5.04	2.89	7.14	225	64	161

Source: Census 2000.

Since there is a trend towards increasing age at marriage for both sexes this has a significant implication for the sexual and reproductive health policy of the Government. It needs to be recognised that adolescence is becoming an extended period before marriage, raising issues about premarital sexuality and relationships with the opposite sex.

With the introduction of the Family Law raising the legal age of marriage to 18, there has been a profound impact on the age of marriage. In the Maldives marriage determines largely the onset of access to sexual and reproductive health services, and thus increasing age at marriage has to be considered carefully by the planners and providers of sexual and reproductive health services.

6. Reproductive Health

Pregnancy

Birth registration data (Table 7) indicates that 10% of all live births in 2001 were attributed to women aged 15-19. It is also noteworthy that 41% of all live births are attributed to the 15-24 years age group. Teenage pregnancies are dangerous to the mothers as well as the children. Risk of maternal mortality has been estimated to be two to four times higher for adolescent mothers than for mothers in their twenties. Infant mortality is estimated to be 30% higher among children born to adolescent mothers than those born to mothers in their twenties (NPFDB 1998).

Table 7: Number of live births by age of mother

	1998			1999			2000			2001		
	N	%	Cm%	N	%	Cm%	N	%	Cm%	N	%	Cm%
Total	5687			5226	100		5314	100		4882		
10 – 14	12	0	0	2	0	0	6	0	0	0	0	0
15 – 19	675	12	12	588	11	11	497	9	9	506	10	10
20 – 24	1783	31	43	1582	30	42	1729	33	42	1498	31	41
25 – 29	1483	26	70	1364	26	68	1426	27	69	1335	27	68
30 – 34	942	17	86	971	19	86	938	18	86	897	18	87
35 – 39	582	10	96	545	10	97	541	10	97	497	10	97
40 – 44	187	3	100	147	3	99	155	3	100	133	3	100
45 – 49	22	0	100	27	1	100	21	0	100	14	0	100
50 – 54	1	0	100	0	0	100	1	0	100	2	0	100
Not Stated	0	0	100	0	0	100	0	0	100	0	0	100

Source: Ministry of Health – Maldives Health Report 2002

The Census 2000 data shows that 2.65% of the adolescent female population (10-19) had given birth to at least one child by 2000. From the 20-24 age cohort 24.72% had given birth to one child and 14.6% had given birth to two children. Census data also reveals that 8.1% of the 19 year age population and 4.5% of the 18 year old population had given birth in the year preceding the Census 2000. In the 20-24 years age cohort 10-14% had given birth to a baby in the year preceding the census 2000.

The birth registration data (Table 7) showed that there were no births to early adolescent mothers (10-14 years of age) for the first time in 2001. These results appear to show that the numbers of women who were at high risk from early child bearing is decreasing.

Maternal deaths

According to the data provided by Ministry of Health, out of the 34 maternal deaths that occurred in the Maldives from 1998-2001, 4 (11.8%) deaths were at 15-19 years of age and 7 (20.6%) deaths occurred in the 20-24 age group.

Knowledge, Attitude and Behaviour

Knowledge and access to information and services on how to prevent unwanted and too-early pregnancies is limited. Knowledge about care needed during pregnancy, lactation for health of mother and child, and access to prenatal-postnatal services is still limited as well. According to the Reproductive Health Baseline Survey (1999), when respondents were asked when during the menstrual cycle a woman is most likely to conceive; 34% could not give an answer, 53% think a woman is most likely to conceive a few days after the purity bath following periods and only 11% said a woman is most likely to conceive in the middle time between two periods (MoH 2000).

According to the main findings of the Reproductive Health Baseline Survey, adolescent boys and girls know about modern methods of contraception. Adolescent boys mentioned the pill and condoms while girls mentioned condoms only. The information about contraception was received from the media (especially radio) and from friends more than from sources such as teachers and health workers. According to the Survey, most groups of boys and girls had high levels of knowledge of HIV/AIDS but knowledge on the symptoms and methods of transmission of other STDs was low.

The Health Master Plan claims that unsafe sexual relations in adolescents are increasing in the country, exposing them to too early and unwanted pregnancies, induced abortions in hazardous conditions, and STDs, including HIV infection. The Health Master Plan also refers to deaths due to unsafe abortions based on unofficial information from the community. The Master Plan uses the number of adolescents who get sentenced for pre-marital sex as an indication that adolescents are sexually active and reports 1995 data on sentences for offences related to sex outside marriage (MoH 1998).

There is a total lack of qualitative and quantitative information on actual adolescent's sexual behaviour. At the end of 2002 FASHAN undertook a UNESCAP sponsored Rapid Situation Assessment of Drug Abuse in the Maldives. It was reported that the Rapid Situation Assessment has quantitative information on adolescent sexual behaviour. Section E of the questionnaire used for the rapid assessment was focused on sexual behaviour, Section F on HIV/AIDS knowledge and Section G on STDs. The questions asked from respondents include age and context of first intercourse, number and type of sexual partners, risk taking sexual behaviour, use of

contraceptives, testing for HIV/AIDS, and specific questions on sexually transmitted diseases.

The results of the survey has been analysed by FASHAN and a draft report of the Rapid Situation Assessment has been submitted to the concerned national authorities and UN agencies. All the concerned officials expressed that the report was very comprehensive and the report would be made available once the Rapid Situation Assessment is finalised.

Practice of contraception and family planning

Although many adolescents and young people have some knowledge of contraceptive methods, current contraceptive use among late adolescents is low. 87% of respondents up to 30 years of age know at least one modern method of contraception and 77% of those never married know of at least one modern method. Yet, among the late adolescent females, only 33% reported to have ever used a contraceptive method and 56% of the 21-30 years age group have used a contraceptive method. Nearly half of respondents in the Reproductive Health Baseline Survey do not know any side effects of contraceptives. Among the mix of contraceptive methods, 13% used pills, 10% used female sterilization, and 6% used condoms. 58% used no contraceptives and 9% relied on traditional methods (MoH 2000).

Sexual abuse

According to the Police records, the number of cases investigated and number of arrests related to sexual abuse of children is on the increase. While a total of 36 arrests were made on sexual abuse charges in 1998, the number of arrests on sexual abuse charges in the first 11 months of 2002 stood at 82.

Since 2000, the Unit for the Rights of the Children maintains a database of all cases reported to the Unit. Data is collected and maintained under 8 broad problem areas with coding for specific problems. The specific problems of sexual abuse and incest fall under the broad problem area of child abuse. Table 8 shows the number of child abuse cases reported since 2000 and the number of sexual abuse cases is of alarming proportions in a closely knit society such as the Maldives.

Table 8: Child abuse cases reported to URC

Year	Physical abuse		Sexual abuse		Psychological abuse		Neglect	
	Male	Female	Male	Female	Male	Female	Male	Female
2000	7	7	7	46	-	1	-	-
2001	12	1	1	30	-	-	4	7
2002	12	14	6	28	1	-	12	6

Total	**31**	**22**	**14**	**104**	**1**	**1**	**16**	**13**
	53		**118**		**2**		**29**	

Source: URC Database

Significant initiatives have been taken to guarantee child protection and child rights in the Maldives. The rules on investigation, adjudication and sentencing with respect to child related offences has been strengthened. An urgent need exists for support services for children and families. There is no emergency shelter to accommodate children who are victims of abuse and neglect. Nor is there a permanent children's shelter for the girls, while there has existed such a facility for boys since 1979.

HIV/AIDS and STDs

The Reproductive Health Baseline Survey (MoH 2001) shows knowledge of HIV/AIDS is high among both boys and girls. They are aware of how HIV/AIDS is transmitted and their knowledge is generally accurate. The Survey also showed that most of the adolescent boys and girls know how STDs are transmitted.

The AIDS situation in the Maldives is under control and only one national has been found HIV positive since 2000. The cumulative total of HIV positive cases since the beginning of the screening program in 1991 is 12. Six of the positive cases among nationals have died. None of the cases were in the adolescent or young age group (MoH 2001).

According to the Health Report 2001, Syphillis screening has been part of the medical checkups in the Maldives since the early 1980s. The results show very low incidence. The RTI/STI survey 2002 of the Maldives presents for the first time quantitative information on the incidence and prevalence of other STDs and STIs. The baseline prevalence of RTIs and sero prevalence of treponemal antibodies are given as T. vaginalis (1.2%), Candida (11.5%), C trachomatis (2.9%), N gonorrhoea (4.3%), Treponemal/antibody seroreactivity (0.9%), HSV 2 (3.4%) and Hepatitis B (1.3%) (MoH 2002).

7. Family Life

Families make a major contribution to the health and well being of individuals across their lifespan, from conception to old age. Supportive, nurturing family environments provide the foundation for the development of competence, self-esteem and well-regulated behaviour. In addition, there is a range of family factors that may impact adversely on the development, health and well being of adolescents and young people (Fergusson *et al.* 1990). The literature on parental divorce, for example, indicates that family conflict (both prior to and after divorce), parent–child relationships, financial hardship, and parental psychological distress and substance abuse have a

greater impact on adolescent developmental health outcomes than the divorce transition itself (Pryor and Rodgers 2001; Rodgers and Pryor 1998).

This study provides a snapshot of the current family life of adolescents in the Maldives with reference to Census 2000 (Figure 3). The data obtained includes the proportions of children living in different family types. However, there is no data on the stability of families over time, and the transitions such as separation, divorce, remarriage and re-divorce.

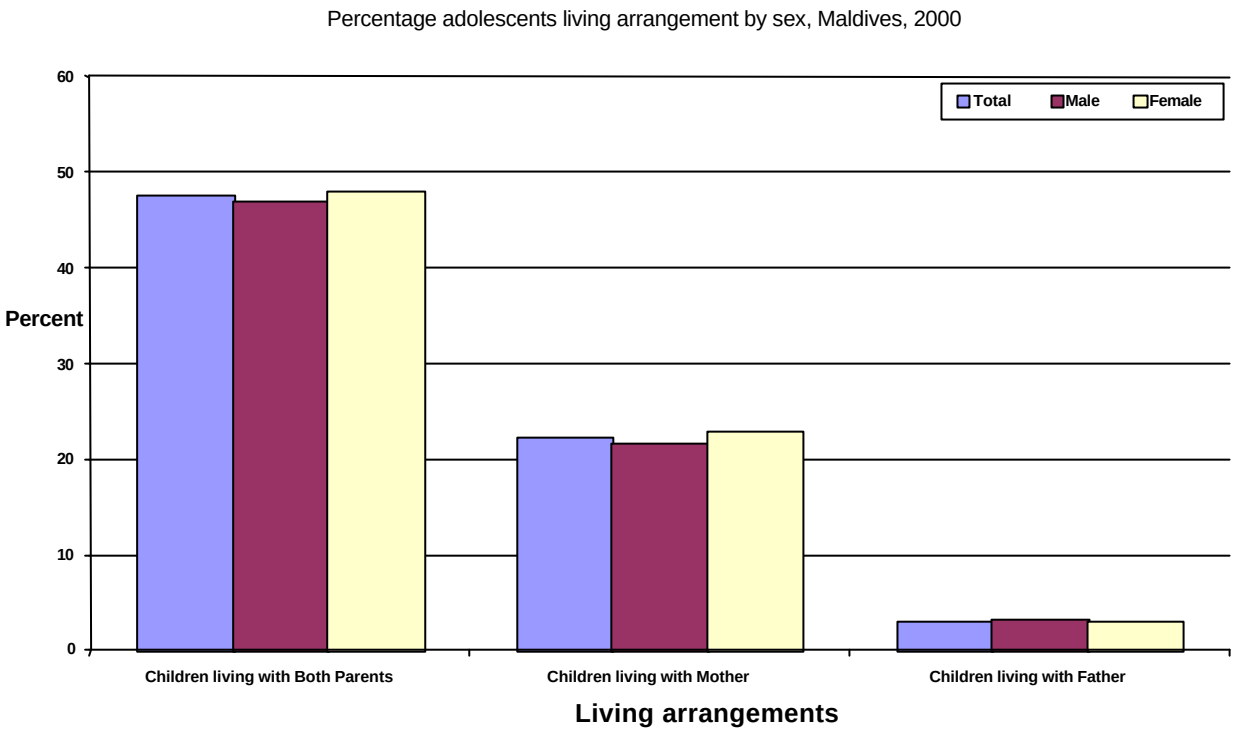


Figure 3: Family life of adolescents (Source: Census 2000)

Only 47.47% of the children belonging to the 10-14 year age cohort live with both parents. 22.15% live with mother only, 3.02% live with father only and 27.36% do not live with a natural parent. In the 15-19 years age cohort, 38.75% of children live with both parents, 17.75% live with mother only and 3.26% live with father only (Table 9). 40.24% of the late adolescent population do not live with a natural parent.

The Multiple Indicator Cluster Survey – MICS 2 (MoH 2001) also provides information on the family status of children in the Maldives. MICS 2 findings are based on investigation of a sample of 1062 households covering a population of 7468. According to the MICS 2 living status of children with natural parents differs by age of child. Approximately 84 % of children aged 0-4 live with parents as compared to 82 % in the 5-9 age group and 72 % in the 10-14 age group. In all 5 % of children were found to be not living with a natural parent. Slightly more female children were not living with their

natural parents as compared to male children. On the other hand the percentage of children not living with a natural parent increases from 1 % in the 0-4 age group to 3 % in the 5-9 age group and 10 % in the age group 10-14. In the absence of one parent, a large proportion of children were living with their mothers as compared to fathers.

Table 9: Adolescents living with parents, mother, father by age and sex, Maldives, 2000

	Children living with Both Parents			Children living with Mother			Children living with Father		
Locality	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**	**Total**	**Male**	**Female**
Republic	47.47	46.97	47.98	22.15	21.50	22.81	3.02	3.12	2.91
Total of 10-14	54.53	54.90	54.15	25.71	25.58	25.85	2.82	2.96	2.67
10	59.33	58.96	59.70	27.96	28.35	27.55	2.38	2.33	2.42
11	57.61	57.15	58.08	27.00	26.91	27.10	2.92	3.09	2.75
12	54.89	55.78	53.96	26.08	25.88	26.29	2.67	2.95	2.38
13	52.48	53.58	51.35	24.36	24.14	24.59	3.14	2.99	3.29
14	48.48	49.23	47.70	23.19	22.67	23.73	2.98	3.42	2.53
Total of 15-19	38.75	36.98	40.51	17.75	16.37	19.12	3.26	3.32	3.20
15	46.56	46.04	47.09	20.74	20.78	20.70	3.32	3.61	3.03
16	42.41	41.03	43.77	19.50	19.15	19.85	3.62	3.64	3.61
17	38.63	36.89	40.35	17.36	14.85	19.84	3.28	3.27	3.30
18	33.27	30.09	36.30	15.79	13.61	17.87	2.84	2.95	2.75
19	30.24	27.67	32.86	14.32	11.92	16.78	3.20	3.03	3.37

Source: Census 2000.

8. Education

The majority of the adolescent population is in school (Figure 4) and in March 2002 there were a total of 106,220 students enrolled in school (Table 10). The best opportunity to reach adolescents is thus presented by the school system.

The Ministry of Education has student enrolment data of all schools in the country taken in March of each year and publishes this data in the annual Education Statistics (MoE 2002). There are three categories of schools in the Maldives: government, community and private schools. Formal schooling is preceded by 2 years of pre-primary education in lower and upper kindergarten. Primary education begins at the age of 6, at which children enter a 7 year cycle starting in Grade 1 and ending in Grade 7. Secondary education in the Maldives consists of Grade 8-10 (lower secondary) and 11 – 12 (higher secondary).

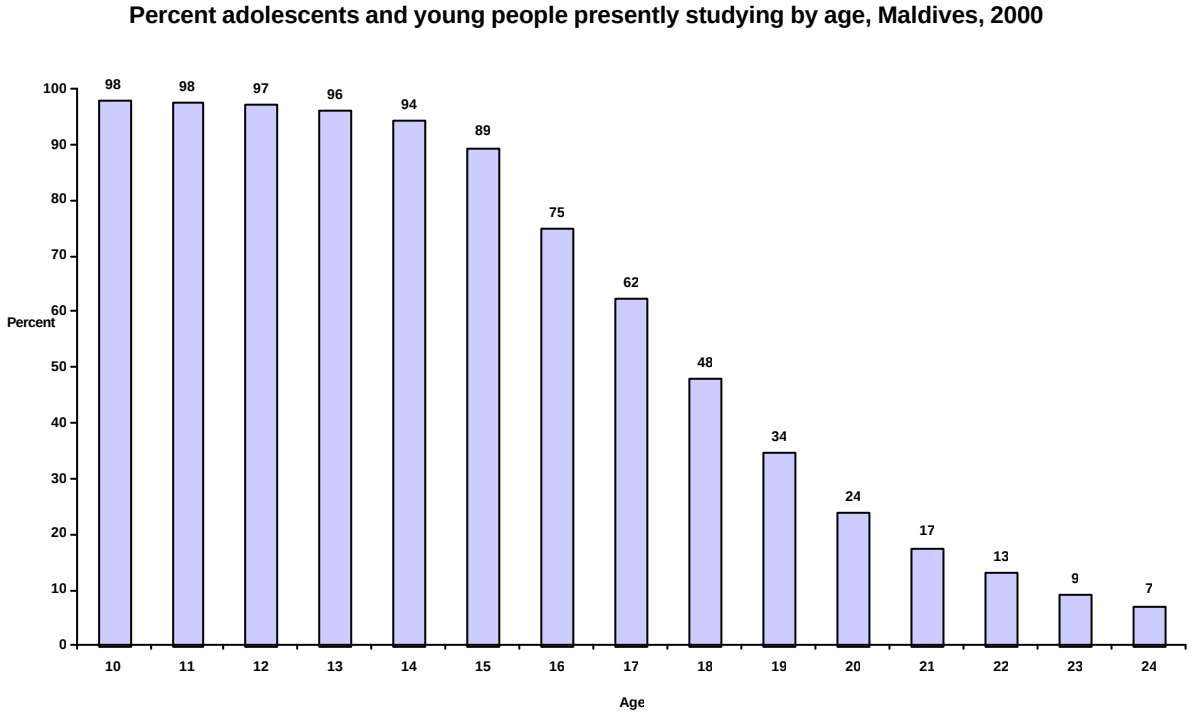


Figure 4: Age profile of adolescents & young people presently studying (Source: Census 2000)

Table 10: Number of schools and enrolment trends by level, 2002

Level	Number of schools	Number enrolled

Pre-primary	154	12,886
Primary	230	68,242
Lower Secondary	96	23,903
Higher Secondary	4	1,131
Special Classes	1	58
Total	485	106,220

Source: Education Statistics, 2002, Ministry of Education.

Provision of education is a major challenge in the Maldives as 46.5% of the population is under 15 years of age and distributed across 200 islands. Yet, universal access to primary education was achieved in 2000 and Table 11 shows the gross and net enrolment ratios by level of education. The Gross Enrolment Ratio expresses total enrolment in a level of education, irrespective of age, as a percentage of the eligible official school age population in a year. The Net Enrolment Ratio shows the enrolment in level of education of the official school age group as a percentage of the corresponding population.

Almost all children start primary school and the number of adolescents completing primary grades is increasing rapidly. Net enrolment ratio for the first seven years of basic primary level education in 2002 stands at over 99 percent and trends in enrolment at the primary school level demonstrate almost complete gender parity (Table 11).

Those who complete primary school hope to continue to secondary and the expansion of the secondary school system has been given due priority. Yet, as of 2001, approximately 2,950 boys (39.8%) and 2,891 girls (38.1%) terminated their education at the end of Grade 7. The net enrolment ratio shows a drastic decline from 100.9 at primary level to 44.2 at secondary level. The net enrolment ratio of male adolescents at secondary level of education (40.3) is lower than the enrolment ratio of female adolescents (48.3).

Table 11: Gross and net enrolment ratio

Level/Age Group	Enrolment			Gross Enrolment Ratio			Net Enrolment Ratio		
	Female	Male	Both Sexes	Female	Male	Both Sexes	Female	Male	Both Sexes
Primary level (Gr.1-7) Age 6-12	32801	35441	68242	125.7	129.9	127.8	100.4	101.4	100.9
Lower Secondary level (Gr. 8-10) Age 13-15	12656	11247	23903	102.4	87.4	94.7	48.3	40.3	44.2
Higher Secondary level (Gr. 11-12) Age 16-17	504	627	1131	6.6	8	7.3	1.8	1.5	1.6

Source: Education Statistics, 2002, Ministry of Education.

Not only is the enrolment at secondary level far from satisfactory, the achievement at completion of secondary level also falls short of expectations. According to the Asian Development Bank sponsored Post Secondary Education Study undertaken in 2002, of the 4,468 boys and 4,689 girls

admitted to secondary school approximately 79% will eventually take the Cambridge "O" level examination which is a minimum requisite for admission to the majority of tertiary education programmes. The ADB study team also estimates the number of boys and girls in the 15 to 19 year cohort who are likely to pass Cambridge "O" level English by 2006 to be a mere 3,289. That is 8% out of a total of 41,089. For the remaining 37,800 youth who will not pass "O" level English there are few employment-oriented education or training options available.

Analysis of the 2000 Census data reveals that 1.57% of the adolescent population (10-19 years of age) and 2.28% of the 20-24 age cohorts have never attended a school in their life. Figure 5 shows the distribution of these children who have never attended school by atoll. This could be because existing education programmes are beyond the reach of adolescents and young people with special needs. According to Census 2000, 1.8% (1801) of the adolescent and young population are reported to suffer from serious disabilities. At the moment only 58 students with special needs have access to special education classes.

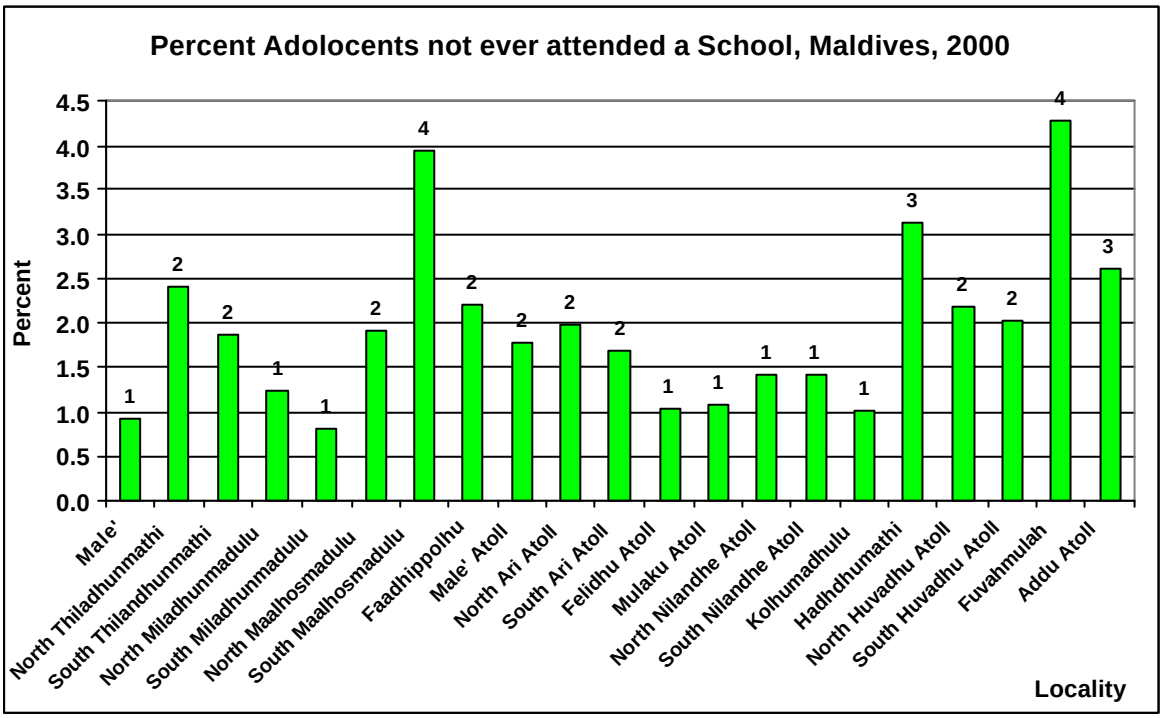


Figure 5: Percent adolescents who have never attended school (Source: Census 2000)

9. Labour Force Participation

Labour force participation refers to an individuals' decision whether or not to participate in the labour force (Ehrenberg and Smith 1997). The standard measure of labour force participation is the labour force participation rate, which is calculated by expressing the number of persons in the total labour force as a percentage of the working age population (ILO, KILM 2002). The total labour force consists of the employed and the unemployed while the working age population is the population above a certain age, prescribed for the measurement of economic characteristics (ILO, KILM 2002). Whereas the definitions of working age population and labour force differ across countries, in the Maldives the labour force refers to those over 15 years of age who are either employed, actively seeking work or expecting a recall from a layoff. Overall, labour force participation rate indicates the extent of an economy's working age population that is economically active (ILO, KILM 2002).

In the absence of employment surveys in the Maldives, census provides the most comprehensive data on the labour force participation of adolescents and young people. Labour market data of the Maldives are also available from the following sources:

Job Matching Service (MHREL)
Tracer studies on Employment Status of GCE O/L candidates (MHREL)
Large Establishments Survey (MPND)
Small Establishments Survey (MPND)
Household Income and Expenditure Survey (MPND)
Survey of Resorts and Hotels (Ministry of Tourism)
Register of Permanent Government Employees (The President's Office)

According to Census 2000, the labour force in the country totalled 87,070 or 54.8% of the working age population, defined as 15 years of age and over (Table 12). Of the labour force, 98% are employed. Approximately 32% of those employed work in Male', while 68% are working in the Atolls.

Table 12: Labour force participation rates, 1985 to 2000.

Census year	Total population	15+ population	Labour Force 15+	LFP Rate
1985	180,088	98,728	51,433	52.1
1990	213,215	112,561	55,745	49.5
1995	244,814	130,670	67,042	51.3
2000	270,101	158,897	87,070	54.8

Economically active

Figure 6 shows the percentage of economically active adolescents. The labour force participation rate for late adolescent population is 23.46%. This is expected because of low enrolment ratios at secondary level. 2.23% of 12-14 years age group is also economically active. This could be due to number of adolescents dropping out of school or terminating education at primary level.

The labour force participation rate is higher for male adolescents than female adolescents. Males start entering the labour force around 15-19 years of age, and the sex specific activity rate shows that the male late adolescent labour force participation rate is 28%. Females also start entering the labour force at late adolescent stage; however, their labour force participation rate is 19% compared to the 28% of late adolescent males. This difference in labour force participation rate can be attributed to the combined effects of higher net enrolment of girls at secondary level of education, higher teenage female marriages as well as late adolescent pregnancies.

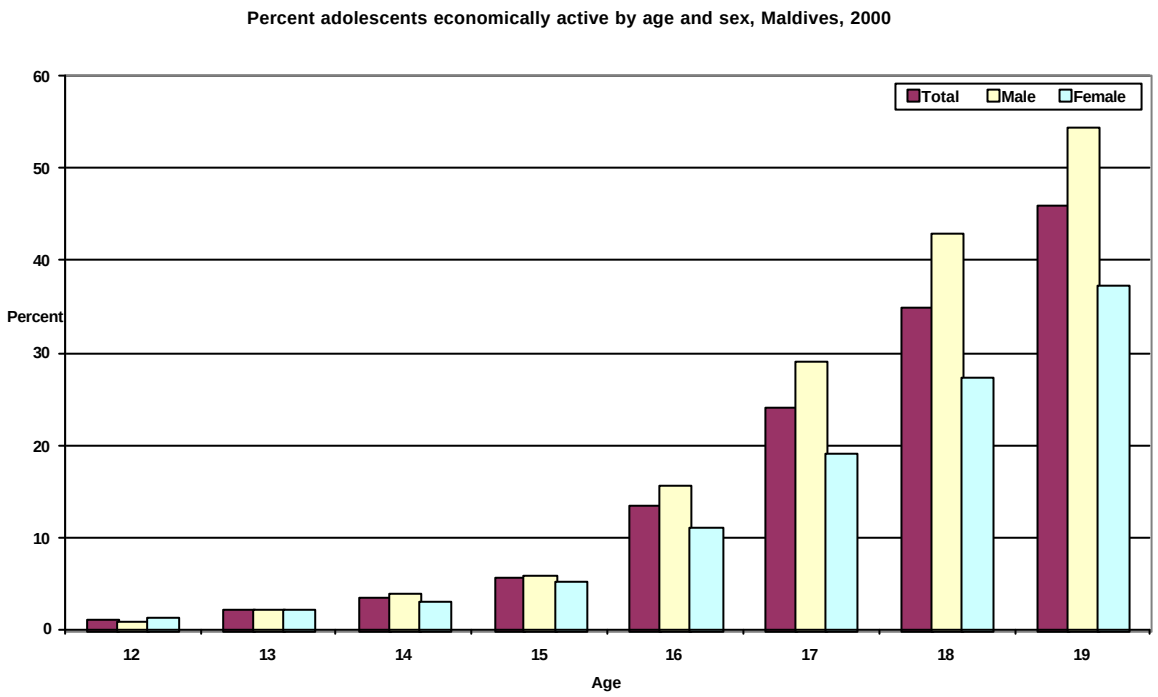


Figure 6: Percentage of adolescents economically active by age and sex

At ages 20-24 years (Figure 7), males remain economically active with a labour force participation rate of 76.8% while the female labour force participation rate for the young women is only 45.6%. Out of the 11,620 young males, 8,927 were economically active where as of the 11,894 young females only 5,429 were economically active. The gender disparity in labour force participation rate is very severe (Figures 7 and 8) among the young peoples and urgent policy measures are needed to address the disparity.

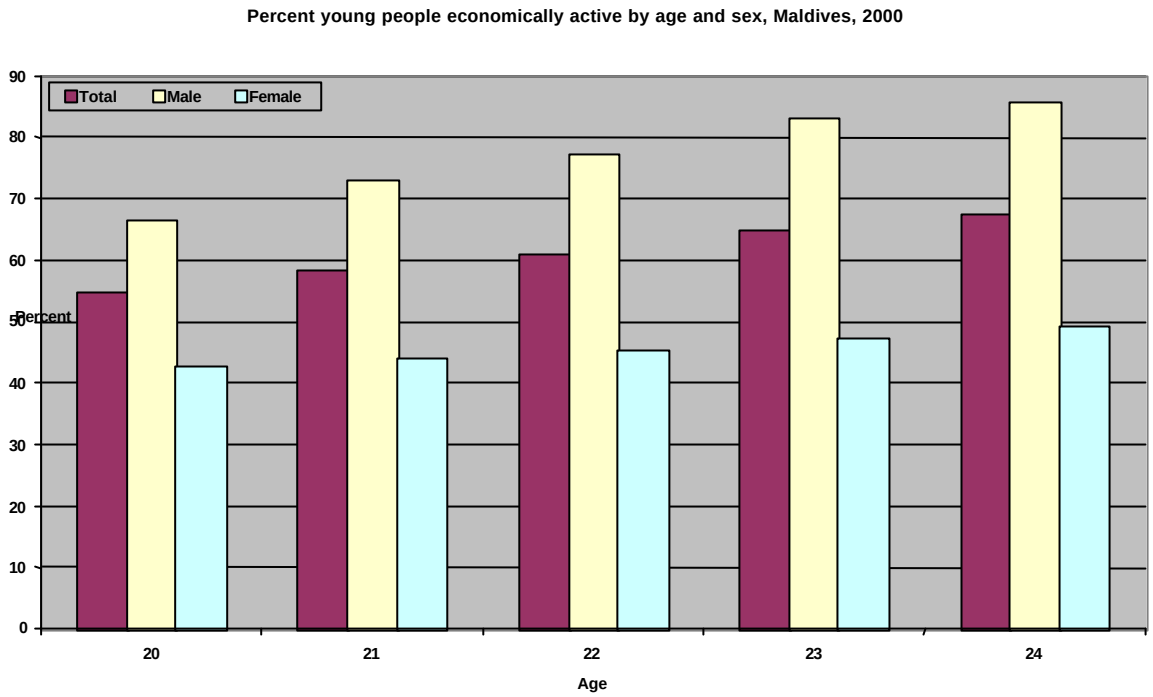


Figure 7: Percentage young economically active by age and sex (source: Census 2000)

Employed population

Figure 8 shows the percentage of adolescents and young people employed by age and sex. The employed person's percentage also shows the significant difference in employment between males and females in the 20-24 age group.

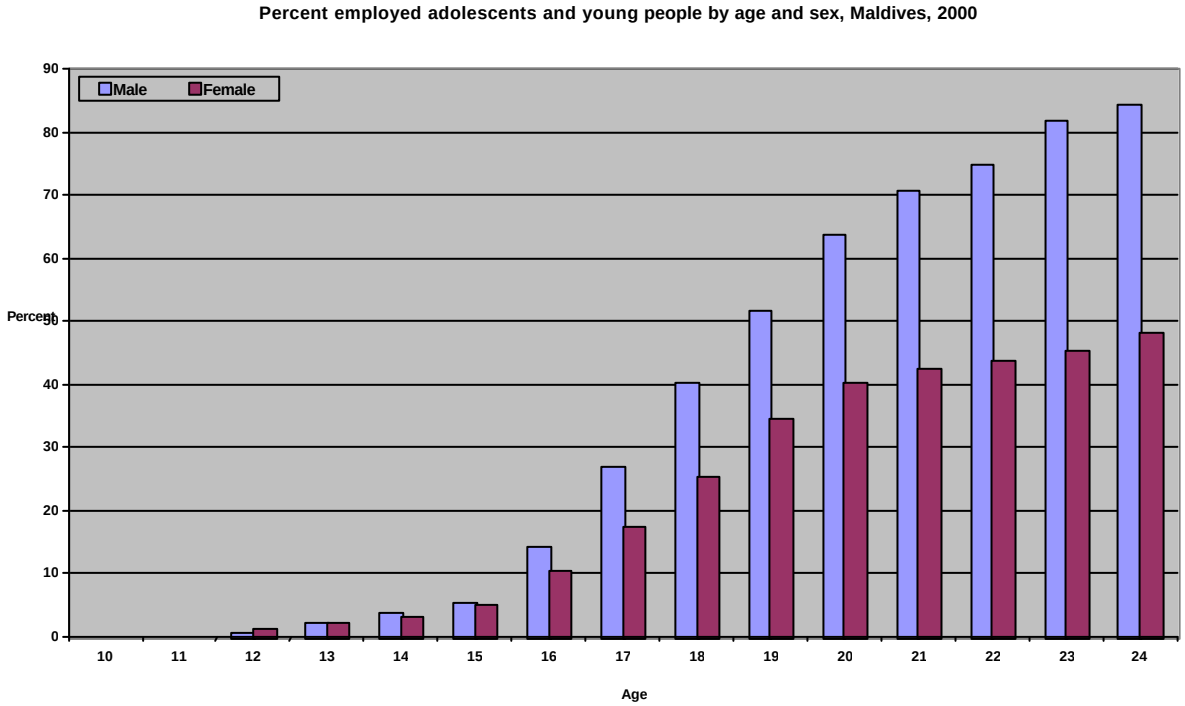


Figure 8: Percentage of adolescents and young people employed by age and sex

Unemployed population

Figure 9 shows the percentage of unemployed adolescents and young population by age and sex for 2000. It is significant that there were more unemployed females than unemployed males in the ages 23 and 24.

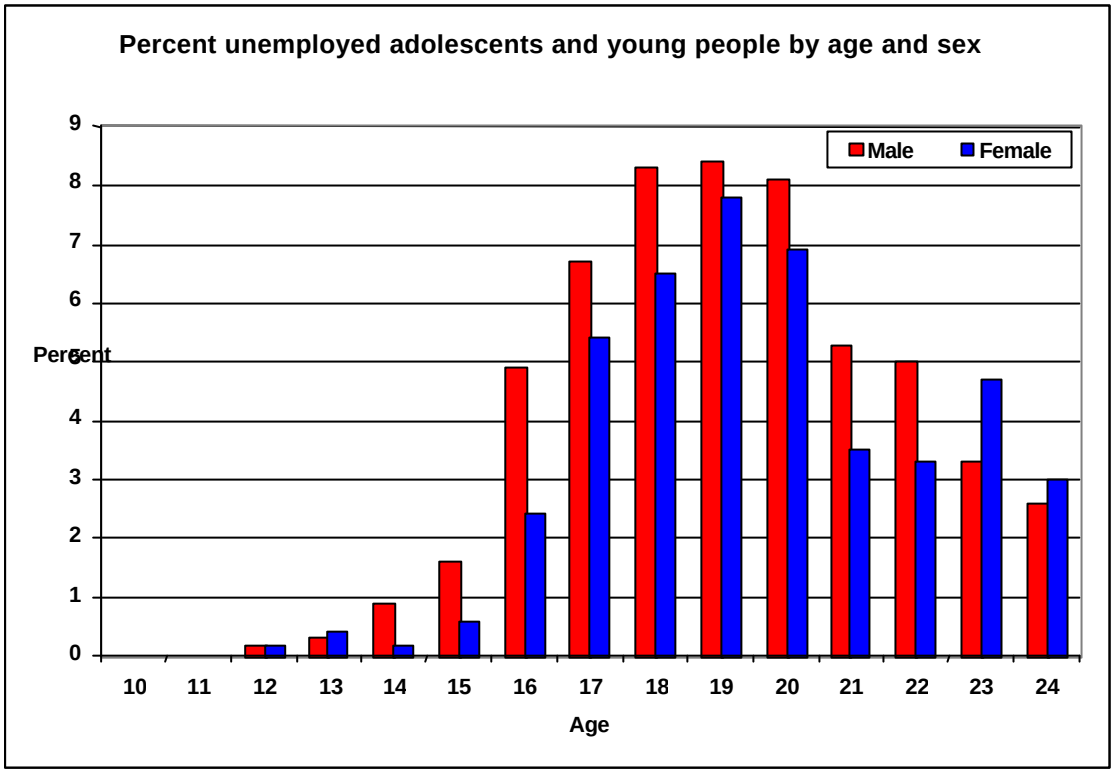


Figure 9: Percentage unemployed adolescents and young people by age and sex, 2000.

Employment by industry

Looking at the industrial classification of the employed adolescent population (10-19 years age), nearly one third of employed adolescents were engaged in the hotel and restaurants industry (30%) during Census 2000 (Figure 10). The second highest percentages of adolescents were engaged in community, social services (27%). This category includes education, health, public administration and other community and personal services. Over half of the total employed adolescents are engaged in these two industries. Other industries with significant adolescent employment include manufacturing (11%), transport, storage and communication (10%), fishing (8%) and whole sale, retail trade (7%).

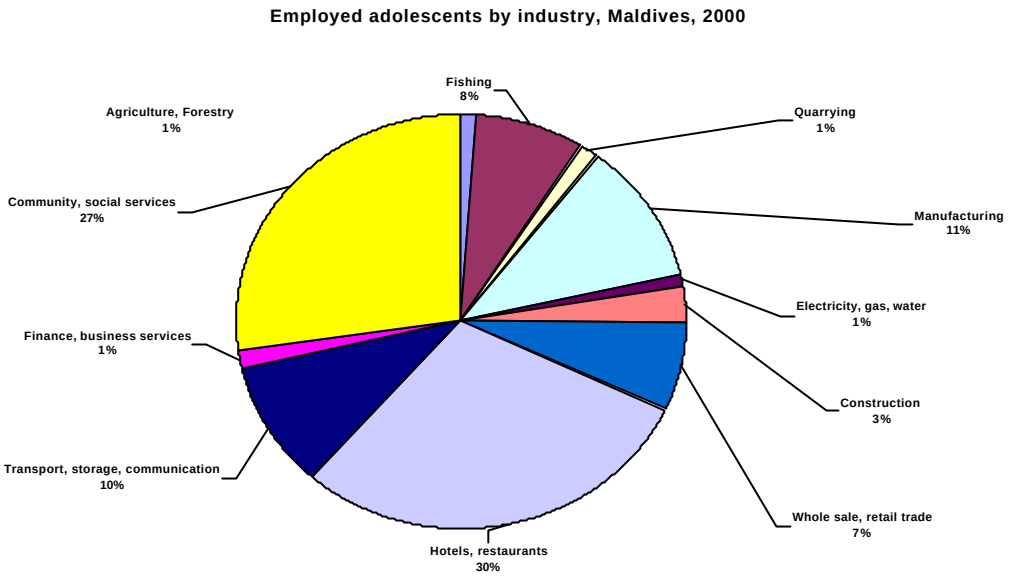


Figure 10: Employed adolescents by industry (Source: Census 2000)

The employed young people by selected industrial categories (Figure 11) shows that community and social services (33%) and hotel and restaurants (22%) are the two industries where over half of the employed young people were engaged during the Census 2000. Other industries where a significant percentage of young peoples were engaged are transport, storage and communication (12%), manufacturing (10%) and whole sale, retail trade (8%). Only 6% of the young people were engaged in fishing.

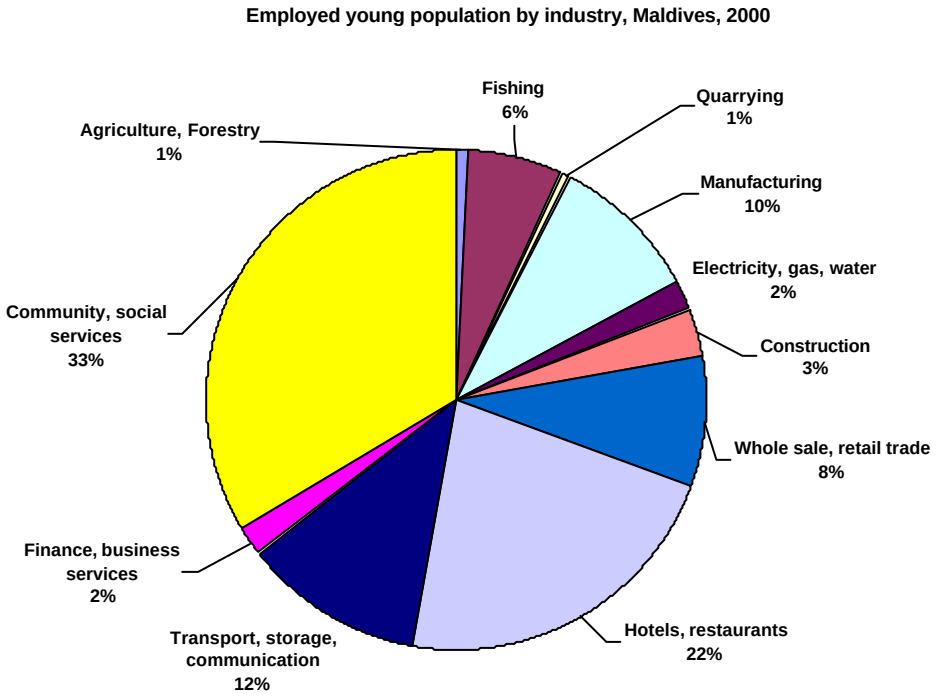


Figure 11: Employed young population by industry, 2000 (Source: Census 2000).

Employment by occupation

Looking at the occupational classification of the employed adolescent population presented in figure 12, service workers and shop and market sales workers is the occupation where the highest percentage of adolescents were engaged during the Census 2000 week. The second and third highest percentages of adolescents were engaged in the occupational categories of plant and machine operators and assemblers and professionals respectively.

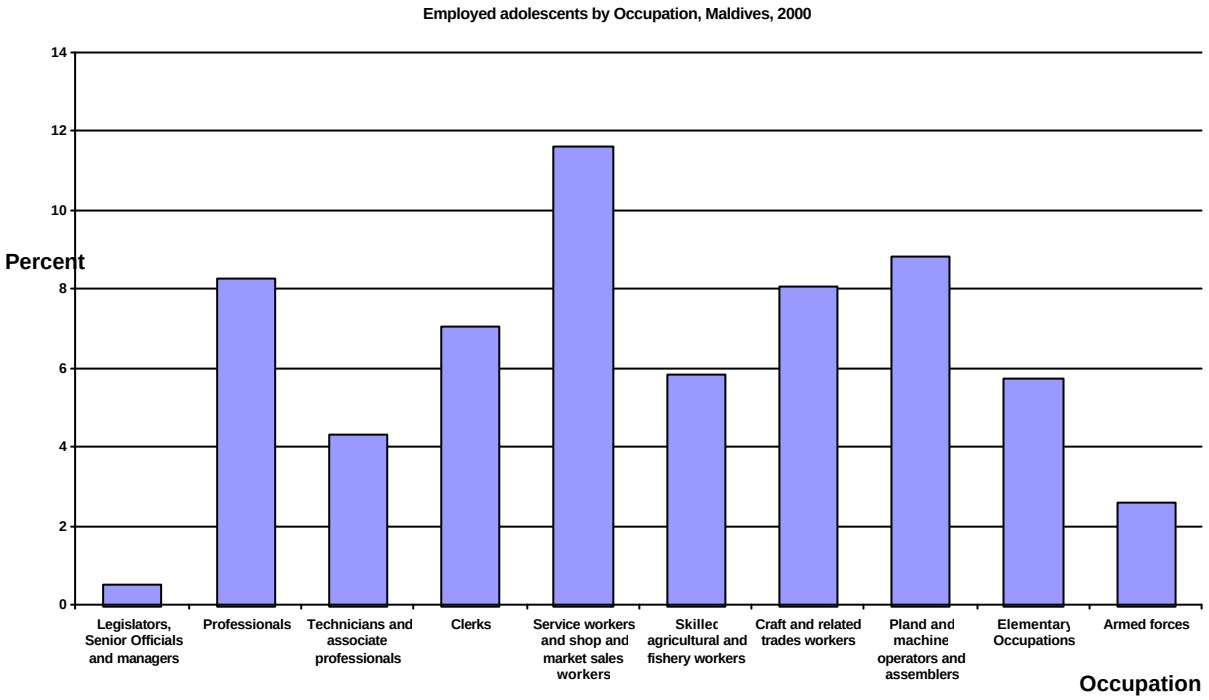


Figure 12: Employed adolescents by occupation

Out of the total employed young people, similar to the adolescent population the highest percentage was employed in the occupational category of service workers and shop and market sales workers (Figure 13). Unlike the adolescent population the second highest percentages of employed young people were in professional occupations and the third and fourth highest percentages were engaged in craft and related trades workers category, and clerks category respectively.

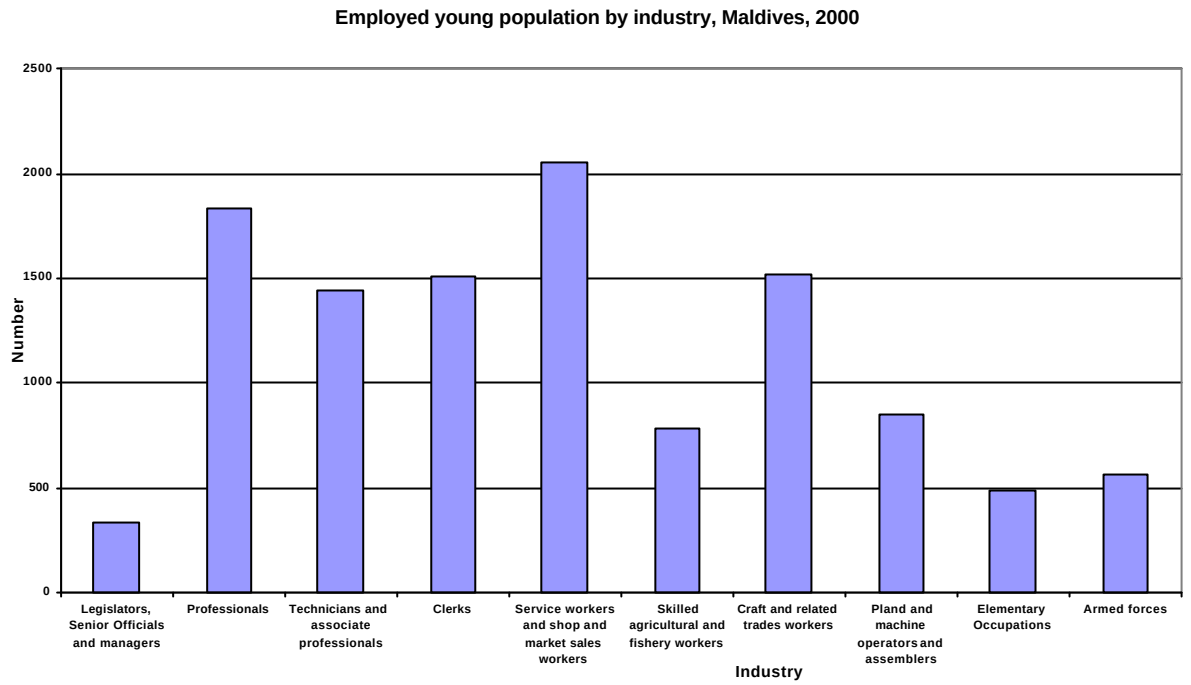


Figure 13: Employed young population by occupation

Not economically active population

Figure 14 shows the percentage of economically inactive adolescents and young people by age and sex.

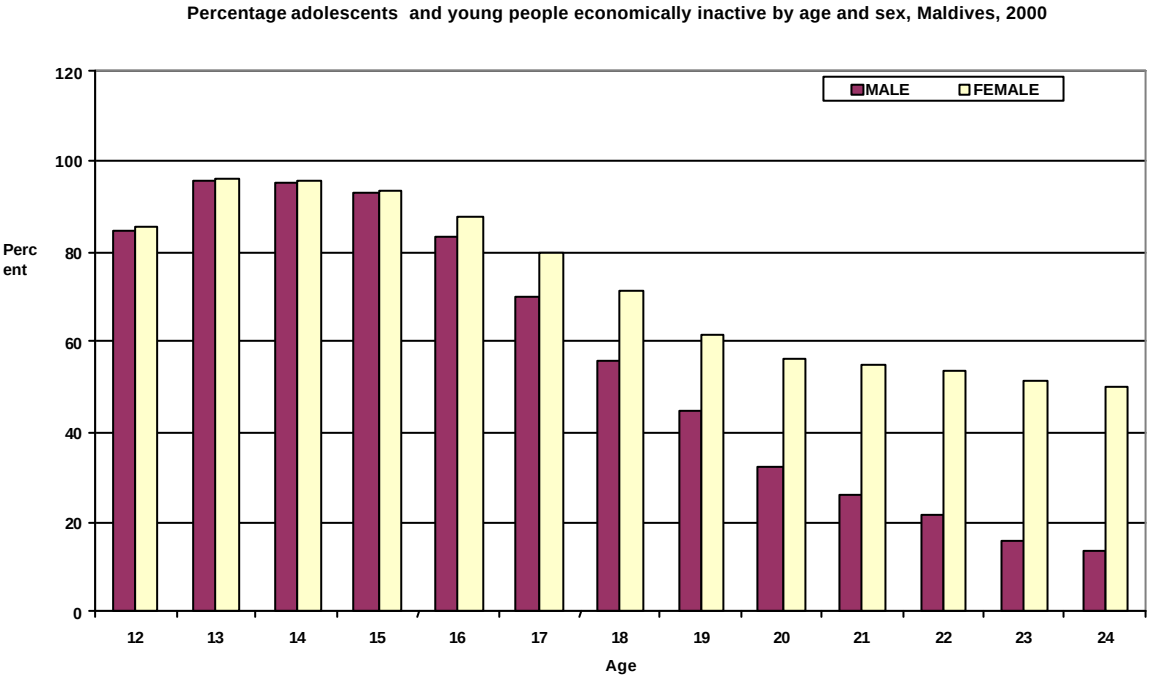


Figure 14: Percentage of adolescents and young people economically inactive by age and sex

Of the 33,266 late adolescent population, 25,057 adolescents were not economically active. Of the 25,057 economically inactive late adolescents 20,325 (81%) stated that they were going to school or attending training; 1,155 (4.6%) said they do not want to do any work; 769 (3.0%) were discouraged workers unable to get any type of work and 702 (2.8%) reported they had housework and family responsibilities.

Out of the 23,514 young people (20-24 years of age) 8,889 are not economically active. Of the 8,889 economically inactive young people 2,628 (29.56%) said they were going to school or attending training; 2,608 (29.34%) said they had housework and family responsibilities, 874 (9.8%) were discouraged workers unable to get any type of work; 694 (7.8%) do not want to do any work and 598 (6.7%) were not able to find work at the current place of residence.

The main finding from the labour force participation of adolescents and young people is the considerable gap between male and female labour force participation rates. While there has been a significant increase in overall female labour participation from 15% in 1985 to 19% in 1990, 28% in 1995 and 37% in 2000, the labour force participation rate of females is still as low as half that for males. In the late adolescent age group female labour force participation rate is 19% compared to 28.0% for males. Among the young peoples (20-24 years of age) female labour force participation rate is 45.6% compared to 76.8% for males.

Given this gender disparity in the labour force participation rates of adolescents and young population, what need to be studied are the possible causes of low female labour participation within these age groups.

The gap in labour force participation is evident enough in the context of the dominance of male Maldivians and expatriates in tourism. Though about one third of adolescents and young people have found employment in the tourism industry there are only tens of Maldivian females working in the resorts. Highest female employment is in the community and social services sector (29%), followed by manufacturing (23.5%).

In order to accurately determine the percentage of young women who are economically active, the informal sector needs to be carefully studied as well. The informal sector is defined by the United Nations, Department of Economic and Social Affairs,. Statistics Division as a group of production units which form part of the household sector as household enterprises or, unincorporated enterprises owned by households.

According to ILO, the informal sector plays an important role in generating employment for women (ILO 2003). Women are usually found to concentrate or even dominate the informal sector. Thus if the employment of adolescent and young women in the informal sector is not accounted for in measuring employment of women, the labour force participation of these women would

be underestimated. In this context, it is likely that the questionnaire used in the Census 2000 did not adequately account for adolescent and young female participation in the informal sector.

The probability of women being economically active varies to a great extent with their marital status and maternal responsibilities. In an analysis of the influence of marital status of women on labour force participation based on Census 2000 data, Shahudha (2002) shows that labour force participation rates of married women were lowest in almost all age groups, especially in the earlier years of their married life, when they have to care for their young children. Thus, given that in 2000, 28.22 % of the 19 year old women and 58.22 % of the 20 to 24 year old women were married relative to 3.64% and 22.74% of males respectively, it can be said that the marital status of these women could be a significant contributing factor to their relatively low labour force participation rates. Moreover, in 2000, 33% of the live births were within the 20 to 24 age group women. In sharp contrast, female labour force participation rate is highest for the divorced and widowed women (43.0%) reflective of the need to work in order to support themselves and their children in the absence of their spouses. It is also interesting to note that on the contrary, labour force participation rate of married men is highest (87.7%) relative to single men (50.0%) and divorced men (66.0%).

Furthermore, in developing countries labour force participation decisions of married women are determined by both economic factors and non-economic factors (Moosa 2002). Economic factors that can affect a married woman's decision to participate in the labour force include own wage income, husband's wage income and non-labour income. Non-economic factors include educational, institutional and cultural barriers (ILO, KILM 2002).

In terms of the household production models, with higher relative earnings of women, married women's participation increases due to the positive substitution effect of an own wage income rise. Additionally, an increase in women's earnings might also strengthen their bargaining power in household decision making. On the other hand increase in the relative earnings of men suggests a negative income effect on the participation of married women (Moosa 2002).

Non-economic factors are known to play an equally important role as economic factors in determining the labour force participation behaviour of married women (Moosa 2002). One such factor that has been widely debated about in economic literature is the effect of childcare on the labour force participation of married women. The age of the youngest child, the number of children and child spacing affects the time that can be allocated to market work. A second important factor is household production, which can be both time consuming and physically demanding for married women, especially for

those with children. A third factor is the socio-cultural norms that discourage married women's participation in the labour force.

Based on the significant percentage of married late adolescent and young women, these economic and non economic factors can be examined in the context of late adolescent and young married women in Maldives.

In the Maldives, available information suggests that prevailing non-economic factors affect the labour force participation decisions of married women more than the economic factors. There are laws and regulations, gender biases and socio-cultural obstacles that at the same time both facilitate and hinder married women's participation in the labour force. Under the Constitution of the Maldives, qualified women have employment opportunities equal to men and they are paid equally for the same job and enjoy the same benefits. Thus in this case not only does the legal framework provide an incentive for women to participate in the labour force but by enabling equal earnings between men and women under the same conditions of employment, such laws diminish economic factors such as income discrimination that hinder the participation of women in the labour force.

Another important non-economic factor facilitating the married women's participation in the labour force is the changing attitudes of men towards women's employment outside of home. A recent UNDP study also shows that there are large numbers of women in the atolls who are willing to work and their desire to work is supported by their husbands (UNDP 1998). While acknowledging the progress being made, it is just as important to note that there still exist a number of gender biases, socio-cultural obstacles and institutional structures that hinder women's participation in the labour market. Such gender biases and socio-cultural obstacles include the limited access women have to technology (especially in the atolls), childcare and family obligations and the stereotypical attitudes of society that lead to occupational segregation, thereby restricting women's participation in other employment generating industries such as tourism. Institutional structures that hinder women's participation in the labour force could include the school shift system, inflexible work hours, maternity leave etc.

While the effect that these non-economic factors can have on the labour force participation of married adolescent and young women is clear, studies have not been undertaken to investigate the interplay of these factors and their effect on women's labour force participation decisions. In Census 2000, 37% of the economically inactive females reported that they did not work due to difficulties in taking care of their children and doing household work (Shahudha 2002). A few studies have also highlighted the cultural practices that inhibit women's actual employment (Razee 2000, Maumoon 2000). They include early marriages, early motherhood and corresponding household duties. According to the senior officials of the Ministry of Women's Affairs and Social Security there is also the content of socialisation that instils

subordination which has become so ingrained that women generally believe that they are less capable than their male counterpart. In contrast, the young Maldivian men have not been constrained by similar gendered notions and the increasing demand for labour accompanying economic growth has allowed young men freer access to employment opportunities.

Hence, there is a significant need to study the labour force participation of young females in the Maldives in the context of human capital, marital status and motherhood. It should examine the women specific factors in each context that affect their decision whether or not to participate in the labour force. In investigating and identifying these factors, such a study should also identify the policy directions and goals that need to be put in place in order to fully reap the economic and social gains from the participation of young women in the development process of the country.

Among the recent initiatives that have direct relevance on the labour force participation of adolescents and young people the Youth Employment Survey and the new Labour Law are noteworthy. The Ministry of Youth and Sports has initiated a Youth Employment Survey and it is expected that the results of the Survey would be published in mid 2003. This Survey is aimed at finding the causes for youth unemployment in the Maldives and would provide additional insight into constraints the youth have in finding suitable employment.

A new Labour Law is pending with Parliament and is expected to be considered in 2003. It is hoped that under the framework of the new labour law, provisions would be introduced that would allow married females and mothers to actively participate in the labour force of Maldives. It is also expected that the new labour law would consider the minimum paid employment age of 14 years.

10. Income

In the absence of reliable studies and surveys to assess the income levels of adolescents and young people, only very rough estimates of income can be made. Though Census 2000 has data available on income it is subject to significant errors associated with over-declared income from self-employment (where turnover is reported instead of profit), seasonal variation and under-reporting of income.

Studies that provide data on income obtained from household surveys in which random samples of households are interviewed using structured questionnaire provide better information on income levels. The Vulnerability and Poverty Assessment (VPA) is such a study conducted in the Maldives in 1998 by the MPND/UNDP. The VPA uses consumption as a proxy to income (UNDP 1998) and is the most reliable data set on income levels in the country. However, the usefulness of the VPA for this study is limited because VPA does not provide income data by specific age groups.

The VPA study estimated Maldives' poor based on the theory of poverty dominance (May 2001) and used three poverty lines: a very low poverty line, a relatively high poverty line, and a poverty line drawn somewhere in between. The results were the following: 13% of Maldivians are under the poverty line ofRf 7.5 income per person per day (the lowest line); 22% are under the poverty line of Rf 10 income per person per day (the medium line); and 42% are under the poverty line of Rf 15 income per person per day. In dollar terms, about 42% of the population subsist on a per capita income US$1.3 per day or less, 22% on a per capita income of US$0.85 per day and 13% on an income of US$0.6 per day or less (UNDP 1998).

The VPA estimated the average level of per capita household income in Maldives is about Rf 24 (equivalent to approximately US $2) per person per day. Incomes in Male' are higher than in the other islands; with average income per person per day in Malé estimated at Rf 35 compared with the Rf 20 average in the other atolls.

According to the Census 2000 data set 85.78% of adolescents earned less than Rf 500 per month and 5.8% earned in the range Rf 500-2000 per month (Figure 16).

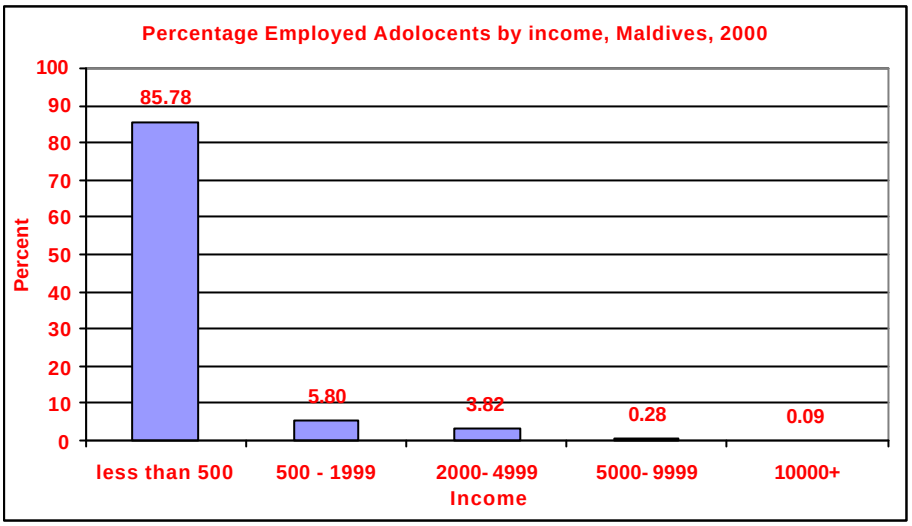


Figure 16: Revealed incomes of employed adolescents (Source: Census 2000)

In the 20-24 years of age category, 28.89% earned a monthly income in the range of Rf 2000-4999; 19.63% earned in the range of Rf 500-1999 while 44.96% earned a monthly income of less than Rf 500 (Figure 17).

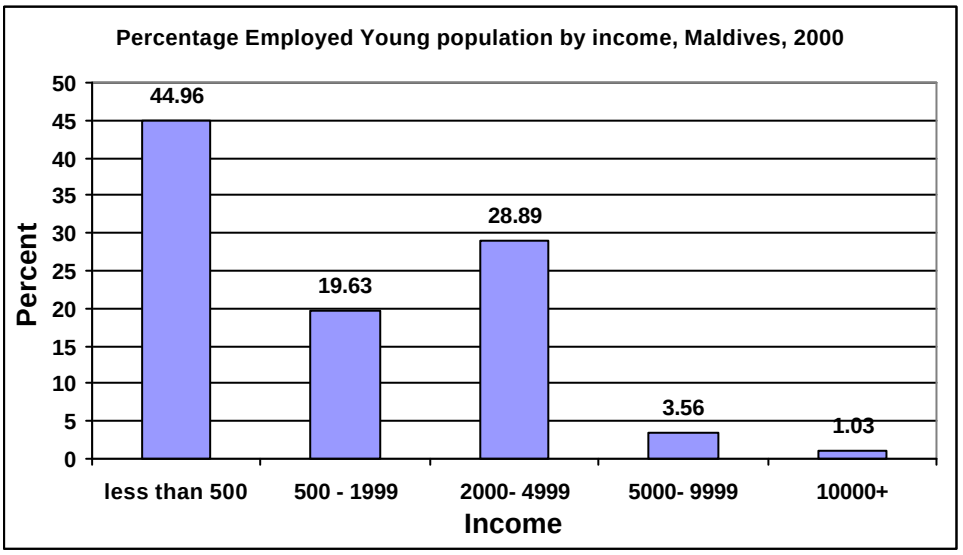


Figure 17: Revealed incomes of young population aged 20-24

The revealed income figures are not a good approximation of income earned and therefore the above figures have to be treated with caution. There is a need to undertake household surveys to determine income levels by specific age groups using various proxies and controls to avoid the problems of direct questions on income.

11. Special Needs

The prevalence of disabilities among adolescents is studied from the census data. 1.8% of the adolescent and young population in the Maldives suffer from serious disabilities. Out of the 1801 adolescents and young people with disabilities 29.09% (524) had a mental disorder while 23.21% (418) reported speech disorders (Figure 18). Mental health problems are associated with a range of other adverse outcomes, including continuing behavioural and emotional problems, relationship difficulties, impaired educational and occupational outcomes, and engagement in criminal activities. At a societal level, these problems are associated with significant costs through demands on health, mental health, special education, justice, and welfare services.

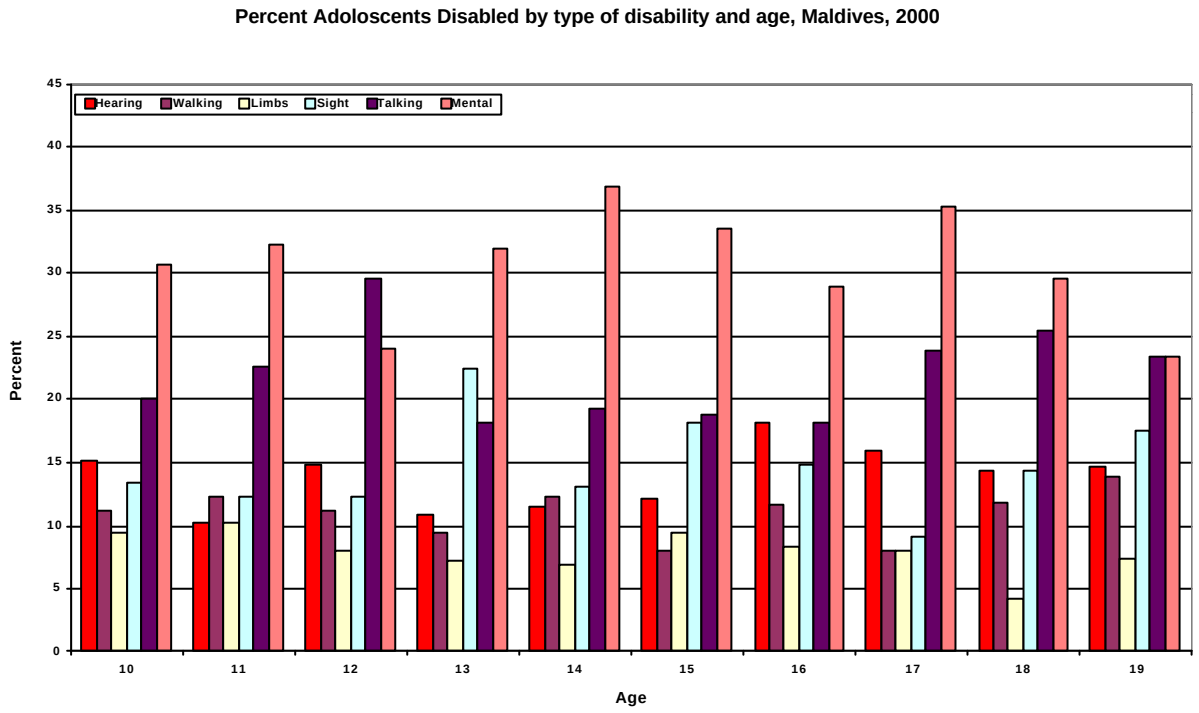


Figure 18: Adolescents (percent) disabled by type of disability and age (Source: Census 2000)

According to a press interview given by the Ministry of Women's Affairs and Social Security, a survey on children with special needs has been completed in February 2003 and the results of this survey are likely to help fill some of the glaring gaps in qualitative and quantitative information on persons with special needs.

The Ministry of Health has also contracted Commerce, Development and Environment Private Limited to undertake an analysis of the data on mental health in the country and results are expected by mid 2003.

12. Health

Age specific mortality

The age specific mortality rate of the population by age groups shows that in the Maldives the mortality rate of the adolescent and young population is high (Table 13). However, no reliable information is available on the causes of mortality. There is thus a need to undertake studies on the causes of mortality among the adolescent population and young people. Such a study should address accidents, occupational health and risky behaviours the adolescents and young people may be engaged in the Maldives. It is anticipated that the results of the "Occupational and Other Injuries" study commissioned by the Ministry of Health will be available in mid 2003 and will provide important information on accidents and occupational health related incidents in the Maldives.

Table 12: Age specific mortality rate per ten thousand population, 1999-2001

	1999	M	F	**2000**	M	F	**2001**	M	F
0-4	33	34	32	51	54	49	42	43	41
5 - 9	6	6	7	4	4	4	4	4	4
10 - 14	5	6	4	4	4	3	3	4	2
15 - 19	6	8	4	3	3	3	4	7	1
20 - 24	9	13	5	6	8	4	8	10	5
25 - 29	5	5	5	6	7	5	8	6	9
30 - 34	10	11	9	6	9	2	9	10	7
35 - 39	15	8	21	11	11	11	12	11	12
40 - 44	15	16	14	19	14	24	22	21	23
45 - 49	38	30	46	31	43	17	28	30	26
50 - 54	62	70	54	80	72	89	79	86	71
55 - 59	106	127	83	140	166	112	96	111	81
60 - 64	218	239	191	182	172	194	182	194	168
65 - 69	282	308	246	327	374	265	284	265	309
70+	736	687	810	613	658	544	751	736	775

Source: Ministry of Health – Maldives Health Report 2002

Thalassaemia

Thalassaemia, an inherited haematological disorder is one of the most serious health concerns of the adolescent and young population. The Maldives has one of the highest known incidences of thalassaemia anywhere in the world. The Society for Health Education estimates that one in every six Maldivians is a thalassaemia carrier. It is also estimated that about 60-70 children are born every year with the disease though only about 1/6th of the cases are diangnosed. In 1988, there were 55 children with thalassaemia major under

treatment in the then Central Hospital. This number has increased to 431 by the end of 2000.

Anaemia

Low nutrition levels and anaemia in adolescent girls are serious health issues that need urgent attention (MHAHE 2002). Nutritional deprivation, increased iron demand for adolescent growth, excessive menstrual losses of iron and early/frequent pregnancies aggravate and exacerbate pre-existing anaemia and its effects. Most girls are likely to be unaware of their increased nutritional needs for growth (especially increasing their food intake to meet calorie demands of pubertal growth), resulting in girls who are underweight and of short stature.

The Multiple Indicator Cluster Survey (MICS 2) 2001 found that 57% of adolescent girls are anaemic. Iron deficiency anaemia is an outcome of nutritional deficiency of iron, folate, vitamin B12 or some other nutrients. This is one of the leading health problems among growing children as well as menstruating and pregnant women. Anaemia may have detrimental health effects on the health of women and children, and may become an underlying cause of maternal mortality and perinatal mortality. Severity of anaemia is classified as mild anaemia (10.0 – 10.9 g/dl for pregnant women and 10.0 – 11.9 g/dl for non-pregnant women), moderate anaemia (7.0 – 9.9 g/dl), and severe anaemia (less than 7.0 g/dl). More than 57% of the late adolescent females were found to be anaemic with 43.6% having mild anaemia, 13.0% moderate anaemia and 0.6% severe anaemia. Among the young women (20-24 years age group) 51.1% were found to be anaemic with 42.8% having mild anaemia, 8.0% moderate anaemia and 0.3% severe anaemia.

Height and weight

MICS 2 also assessed the nutritional status of women using height and weight data. The cut-off point for height, below which a woman can be identified as nutritionally at risk, varies among populations, but it is usually considered to be in the range of 140-150 centimetres (4 feet 7 inches to 4 feet 11 inches). MICS 2 found the mean height for women in the Maldives to be 150cm. The mean height varies between 146 and 151cm for women in different population groups. In Maldives 11.4 % of the 15-19 year old females are under 145 cm in height and 11.1% of the 20-24 year old females have a height under 145 cm. The geographical differentials are significant with Male' having only 10% of women who are below 145cm where as the southern region has 36%.

Chronic energy deficiency is usually measured using the Body Mass Index, defined as the weight in kilograms divided by the height in meters squared (kg/m^2). Chronic energy deficiency is indicated by a BMI of less than 18.5.

The mean BMI of the late adolescent girls is 19.4 and 49.6% of late adolescent girls had a BMI of less than 18.5. Among the young women (aged 20-24 years) the mean BMI is 20.9 and 32.9% of young women had a BMI of less than 18.5.

13. Delinquency and Crime

Crime

There appears to be a general belief that the adolescent and young population account for a disproportionate amount of serious and violent crime in comparison to adults. To briefly examine the hypothesis of growing criminality among today's adolescents and young people, this study analyses the crime rates in the Maldives. Data sources for this analysis were Department of Corrections who provided data on persons sentenced by age (Table 14); Ministry of Defence and National Security who have presented statistics of arrestees by age and offence (Table 15). Narcotics Control Board provided data on their clients in different status grouped by age (Table 16).

If today's generation of adolescents and young people have higher criminal propensities, their crime rates should be higher than youth crime rates of previous years. In addition, if adolescents and young people are responsible for a disproportionate percentage of crime, their arrest rates should be higher than adult groups.

Table 14: Persons sentenced by age and year

Persons sentenced by age (numbers), 1990 – 1999

Age and Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
All Ages	872	1001	936	1042	1044	1171	1098	1278	1661	1663
Under 19	233	253	233	236	206	269	277	359	616	603
20 – 29	429	437	403	485	418	485	452	543	573	605
30 – 39	110	193	170	226	255	257	215	237	319	312
40 – 49	56	69	65	70	85	86	77	73	94	82
50 & over	44	49	65	25	80	74	77	66	59	61

Persons sentenced by age (percentages), 1990 – 1999

Age and Year	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999
All Ages (Number)	872	1001	936	1042	1044	1171	1098	1278	1661	1663
Under 19	27	25	25	23	20	23	25	28	37	36
20 – 29	49	44	43	47	40	41	41	42	34	36
30 – 39	13	19	18	22	24	22	20	19	19	19
40 – 49	6	7	7	7	8	7	7	6	6	5
50 & over	5	5	7	2	8	6	7	5	4	4

Source: Statistical Year Book 2001

Table 15: Arrestees by age group and type of crime

	1998		1999		2000		2001		2002	
Total Arrests	***3025***		***2880***		***2619***		***2958***		***2955***	
AGE 10 – 14										
	1998	%	1999	%	2000	%	2001	%	2002	%
Theft	52	46.8	59	39.1	53	42.4	64	61.0	60	50.8
Assault	17	15.3	14	9.3	10	8	4	3.8	16	13.6
Drugs	8	7.2	6	4.0	1	0.8	0	0	1	0.8
Sexual Offences	5	4.5	11	7.3	6	4.8	12	11.4	6	5.1
Traffic Violation	5	4.5	5	3.3	10	8	3	2.9	1	0.8
Others	24	21.6	56	37.1	45	36	22	21.0	34	28.8
TOTAL	111	100	151	100	125	100	105	100	118	100
% of total arrests	3.7%		5.2%		4.8%		3.5%		4.0%	
AGE 15 – 19										
	1998	%	1999	%	2000	%	2001	%	2002	%
Theft	232	20.8	227	22.8	158	20.8	287	28.9	315	32.8
Assault	124	11.1	127	12.7	72	9.5	102	10.3	188	19.6
Drugs	123	11.0	69	6.9	82	10.8	56	5.6	72	7.5
Sexual Offences	79	7.1	38	3.8	46	6.0	86	8.7	76	7.9
Traffic Violation	270	24.2	252	25.3	177	23.3	182	18.3	29	3.0
Others	287	25.7	284	28.5	226	29.7	281	28.3	279	29.1
TOTAL (15 – 19)	1115	100	997	100	761	100	994	100	959	100
% of total arrests	36.9%		34.6%		29.1%		33.6%		32.4%	
AGE 20 - 24										
	1998	%	1999	%	2000	%	2001	%	2002	%
Theft	107	14.5	70	11.4	72	12.5	109	15.8	148	21.2
Assault	73	9.9	61	9.9	59	10.2	87	12.6	104	14.9
Drugs	134	18.1	93	15.1	92	16.0	105	15.2	149	21.4
Sexual Offences	40	5.4	42	6.8	48	8.3	59	8.5	69	9.9
Traffic Violation	148	20.0	164	26.7	127	22.0	132	19.1	26	3.7
Others	238	32.2	184	30.0	178	30.9	200	28.9	201	28.8
TOTAL (20 -24)	740	100	614	100	576	100	692	100	697	100
% of total arrests	24.5%		21.3%		22.0%		23.4%		23.6%	

Source: Police Headquarters – Ministry of Defence and National Security

It is not possible to draw any major conclusions from the available data as the arrestees' statistics and data on persons sentenced are muddled by repeat and multiple offenders and these data need to be filtered before analysis can be undertaken. The sentenced and arrestee statistics show that a significant proportion of the arrestees and sentenced persons belong to the late adolescent population. 30 – 35% of all arrests are made in the 15-19 years group. Among the early adolescent population (10-14 years) over half of arrestees are on theft related offences. In the late adolescent population (15-19 years of age) 30% of arrests are on theft and another 30% on traffic violations. However, among the young people (20-24) drug related arrests account for 20% of all arrests and this is significant.

According to experts who have studied the crime profile of the Maldives one of the most significant observation is that the majority of the criminals have all had their first offence at the ages 10-14. Most of these were petty offences.

The experts also reveal that 76% of criminals are repeat or multiple offenders. The experts are of the view that close to 70% of the criminals in jail could be under 30 years of age and about 80% of those in jail may be sentenced on drugs offences. These findings reveal the severity of the problem facing the adolescent and young population. The sentence for drug related crimes are in the range of 20-25 years and if the young offenders with petty crimes turn to drug related offences, they are subject to spending their prime productive age at jail or under other forms of sentencing.

Substance abuse

Official recognition of substance abuse as a problem came in 1977 when a person was arrested with 350 grams of hashish and 3 others were found smoking hashish. Available statistics indicate that substance abuse situation in the country is worsening. Table 16 shows the different clients of NCB at the end of 2002.

Table 16: Different clients of NCB by age by end of 2002

COMMUNITY				
Age	MALE	%	FEMALE	%
10 and 14	1	0.9	0	0
15 and 19	29	26.6	4	57.1
20 and 24	35	32.1	2	28.6
Others	44	40.4	1	14.3
TOTAL	109	100	7	100
HOUSE ARREST				
Age	MALE	%	FEMALE	%
10 and 14	0	0	0	0
15 and 19	1	1.5	12	100
20 and 24	27	39.7	0	0
Others	40	58.8	0	0
TOTAL	68	100	12	100
DRC - REHAB				
Age	MALE	%	FEMALE	%
10 and 14	0	0	0	0
15 and 19	24	33.8	0	0
20 and 24	23	32.4	0	0
Others	24	33.8	1	100
TOTAL	71	100	1	100

Source: Narcotics Control Board

According to professionals and experts working in this field, it is likely that a profile of drug abusers would show that most of them are late adolescents or young people residing in Male'. It is also likely that many of them would be school leavers or drop outs and children who have been subject to abuse.

Recently, FASHAN has completed a Rapid Situation Assessment of Drug Abuse in the Maldives and the results of this Assessment would provide much needed quantitative information on the scale of the problem as well as

the profile of abusers and the implications for policies and programs on adolescents and young people.

One of the critical issues identified by the concerned Government officials and NGOs in relation to substance abuse is the lack of adequate rehabilitative facilities to meet the existing need. At the end of 2002 only 125 places were available in the Drugs Rehabilitation Centre and the Narcotics Control Board had to keep 200 clients under house arrest as there were no places available.

PART III

14. Reproductive Health Policies and Plans

One key finding may be important in situating these results. Adolescent sexual and reproductive health is a new program area for many of the agencies. According to most of the officials the policies and programs are not only new but their sustainability is also questionable as most of the programs are donor funded and there is significant uncertainty over the future of donor assistance.

Adolescent Health Strategy and Action Plan

The Ministry of Health and Department of Public Health reported that an Adolescent Health Strategy and Action Plan zero draft is now ready. The Adolescent Health Strategy and Action Plan is based on expert advice presented by Dr. Dev Nair. Two seminars have been held on 21 October 2002 and 25 October 2002 to consult relevant government agencies and non governmental organizations on the draft Adolescent Health Strategy. It was not possible to review the draft Strategy and Action Plan for the purposes of this study as the draft is not yet available.

The Health Master Plan

The Health Master Plan 1996 – 2005 (MoH 1998) has specific policies, goals, objectives and strategies to ensure the reproductive health and well-being of adolescents. In the Health Master Plan, the Government recognises the vulnerability of adolescents to various health ailments and the importance of addressing the special needs of adolescents. According to the Health Master Plan, the Government will give priority to the identification of the specific health needs of the adolescents and provide services that are sensitive to their specific needs. The Ministry of Health is to collaborate with the Ministry of Education to ensure that the adolescents receive adequate information and education on health issues such as nutrition and exercise, reproductive health, risks of teenage pregnancies, thalassaemia, smoking and substance abuse, so that they will have the information and skills to enable them to take responsibility for themselves and their family's health.

The Health Master Plan calls for family planning and reproductive health services as well as services for the prevention of sexually transmitted diseases to be made available in a manner that attracts adolescents and young people to seek those services.

Among the specific objectives to ensure the health and well-being of adolescents in the Health Master Plan are:

- to provide all adolescents in school with health information required to protect themselves from ill health;

- to reduce the number of adolescents who take up smoking;

- to reduce the number of adolescents who start up substance abuse;

- to reduce the number of adolescents who get married before they are 20 years of age;

- to ensure that no adolescent will be infected with HIV through sexual transmission.

Three strategies are prescribed in the Health Master Plan for adolescents' health and they are:

"Empowerment of adolescents and women. Adolescents and women need to be empowered so that they have control of their reproductive health and have the ability to lead a healthy life. In this respect, women and adolescents need to be given opportunities to participate in the planning and implementation as well as evaluation of projects and programmes that affect their health. They also need to be provided with an environment and conditions that support and reinforce changes in lifestyle.

Information, education and communication: Adolescents need to be provided with easy access to information especially with respect to sexual issues, including sexually transmitted diseases, smoking, substance abuse, nutrition, exercise, reproductive health, thalassaemia and responsible parenthood. Specific projects need to be designed for out of school youth. Projects designed for education of adolescents, whether they be for in or out of school adolescents, must be designed in a way that actively involves the adolescents, so that behaviour change is more possible. Such projects should be planned with the participation of adolescents. IEC activities could be implemented in the form of special campaigns that actively involve adolescents at all stages – planning through to the evaluation of the project.

Accessibility to quality health services: Adolescents are often hesitant to seek services, even if they are easily available, especially since they are at the development stage where they believe they are immune to diseases. Hence, services need to be attractive and sensitive to adolescents and ensure their privacy. Services provided should also include counselling services for adolescents aimed at ensuring their mental and physical well being."

The Ministry of Health also reported that they have written policy goals for HIV prevention and STD prevention, and that the policy goals are directly relevant to adolescent health.

National Youth Policy

The Ministry of Youth reported that they have written policy goals for Youth in the Maldives and the National Policy on Youth is ready for publication. The National Policy on Youth has policies and strategies to promote sexual and reproductive health of the youth. Strategy 7.6 in the National Youth Policy is on promotion of good health and healthy lifestyles among youth. This policy area covers promotion of sexual health, family planning, and increasing awareness on STDs and HIV / AIDS.

National Population Policy

The National Population Policy has been prepared by the Population Programme Coordination Committee under the guidance of the Ministry of Planning and National Development. Due attention is given to sexual health and reproductive health in the National Population Policy. Strategies that have direct relevance for adolescent sexual and reproductive health in the draft National Population Policy include:

- Integrate population education issues into the secondary school curriculum;
- Strengthen programmes to develop life skills amongst adolescent / youth;
- Strengthen Information Education Communication (IEC) and Advocacy to reduce teenage pregnancies.
- Create awareness on the importance of better reproductive health / family planning, and the risks of early marriage and pregnancies.
- Ensure the provision of adequate health care, including educational programmes on family planning and population for all adolescents / young people.
- Inculcate ethical, social and cultural values in adolescents and youth through integrating relevant messages and activities into the school curricula and non-formal education programmes.
- Provide population education to targeted influential groups and youth.
- Provide population education in secondary schools to educate boys and girls on risk behaviour, dangers associated with adolescent pregnancies, and to prepare them for responsible parenthood.

Officials of the Ministry of Education reported that they do not at the moment have written policies or explicit action plans on sexual and reproductive health education for students. However, the Ministry of Education has been implementing a Population Education Programme and School Health Programme concurrently and activities have been implemented under these two programmes to increase the awareness of adolescents on sexual and reproductive health. At present these two programmes are going through an important phase where the Ministry of Education is considering how these two programmes can be integrated to bring better results. The MOE is also about to launch a pilot project for ASRH and Life Skills.

The schools informed that they do not have any written goals for sexual and reproductive health education. Some schools reported that the school mission statement includes the healthy, social development of the students. The schools welcome and participate in adolescent sexual and reproductive health related programmes implemented by government agencies as well as non-governmental organisations.

None of the Government organizations had explicit action plans on adolescent sexual and reproductive health with targets, responsibilities and measurable outcomes. However, the biannual Work Plan 2002-2003 of the Office of the WHO in the Maldives includes funding for an adolescent health work plan with targets and measurable outcomes. The main two outcomes of the work plan number MAC CAH 001 are 1) an integrated adolescent health strategy and 2) school teachers and parents trained in life skills education and adolescent health issues. The WHO HIV/AIDS Work Plan also has as an outcome, training of selected peer educators on adolescent sexual health and high risk behaviour and development of relevant IEC materials. The Department of Public Health is responsible for the implementation of the WHO plans and the identified development partners are UNICEF, UNFPA, Ministry of Women's Affairs and Social Security, Ministry of Youth and Sports, Ministry of Education and FASHAN.

15. Reproductive Health Programs & Services

Population Education Programme

The Ministry of Education has been implementing the Population Education Program since 1984 and the fourth phase of the programme was completed in 2002. In the fourth phase, one of the outputs was to cater for the sexual and reproductive health needs of in-school and out-of-school adolescents. Though there were significant constraints in achieving the output a number of successful activities that targeted adolescents' sexual and reproductive health were implemented. These include a workshop on reproductive health, smoking, substance abuse and other issues and a peer education programme on adolescent reproductive health and gender. According to the Final Project Report of the Population Education Project (MDV/98/PO3) a Handbook on Adolescent Reproductive Health has also been developed to target out-of-school-adolescents.

The Education Development Centre has also organised workshops to consider how adolescent sexual and reproductive health information can be incorporated into the O' level curriculum, the types of supplementary material that would be required and the subjects that are relevant. The identification of co-curricular activities, formulation of guidelines and implementation of some of these activities are reported to have contributed towards the setting up of a co-curricular base for disseminating selected information.

School Health Programme

A School Health Programme was started in 1986 by the Ministry of Education. With continuing support from the Ministry of Health and its departments, the School Health Programme has focused on medical screening of children and follow up; health education and awareness for students; and provision of health information for the teachers and to parents. At present the School Health Program is limited by scope of activities and geographical outreach. Activities are presently carried out in Male' schools only and the Ministry of Education is considering options to extend the programme to the atolls. One of the primary strategies of the School Health Programme is to establish a School Environment that will promote healthy well being. The provision of information and educational materials on adolescent health and disease prevention especially AIDS/STD prevention and provision of access to counselling services in the area of reproductive health and HIV/AIDS prevention are two of the key activities under this strategy.

Minimum Standards of Service and Instructional Time

The Ministry of Health and the Ministry of Education were asked questions about the nature of and level of standards for adolescent sexual and reproductive health promotion and education set by the Health and Education ministries.

Respondents from Ministry of Education reported that there are no clear standards for mandatory instruction or mandated required instruction on adolescent sexual and reproductive health.

The Ministry of Education officials and school officials were asked if they stipulated time and/or grade levels for instruction about adolescent sexual and reproductive health including STDS and HIV/AIDS. The Ministry of Education has not stipulated nor recommended time allocations for instruction on adolescent sexual and reproductive health. None of the schools have stipulated instructional time or grade levels for sexual and reproductive health education as well.

When school officials were asked to describe the amount of time that their students received in sexual and reproductive health instruction, the answers varied considerably. Moreover, school principals were often unable to estimate how much time was allocated to such education as it depended on the teachers who teach Biology and Islam. It was impossible for most school principals to estimate the time and reach because the co-curricular programs were not regular and not scheduled in the school academic programme.

Ministry of Education and schools reported that they do not have specifically defined the qualifications required to teach adolescent sexual and reproductive health issues. The Ministry of Education identified lack of trained teachers as one of the most significant obstacles in incorporating adolescent sexual and reproductive health into the existing education programmes in schools. The Ministry of Education also reported that they have not defined the qualifications to become a counsellor at a school.

The Department of Public Health has published minimum standards for family planning services, sexual and reproductive health information as well as guidelines for medical officers and midwives. Among the publications of the Department of Public Health, the National Guidelines and Minimum Medical Standards for Family Planning Services, Clinical Reproductive Health Guidelines for Medical Officers and Midwives as well as IEC Guidelines for Community Health Workers and Family Health Workers are noteworthy. Whilst these materials have the potential to benefit adolescents, they do not specifically focus on adolescents and are not adolescent reader friendly.

Support for Teachers – In-service

Our questioning of the direct support provided for teaching sexual and reproductive health education began by asking Education and Health respondents if they funded or organized teacher in-service training. The responses indicate that this type of support is present but not available on a regular basis.

Department of Public Health indicated that they will soon be conducting training workshops for teachers and school health assistants on life skills education and adolescent issues. These Workshops will be conducted in Male', Seenu Atoll and Haa Dhaal Atoll. 25 participants will be invited to each workshop and it is anticipated that in-service training would be provided to a total of 75 teachers and or school health assistants by the end of these three workshops. Each workshop is scheduled to run for 4 full days.

One difficulty identified for in-service training by the Department of Public Health and a leading NGO is the busy schedule of teachers throughout the academic year.

The schools interviewed did not report any of their teachers having received in-service training related to adolescent sexual and reproductive health.

Teaching and Awareness Materials

A key policy issue for the Education Ministry is the authorization or recommendation of teaching and learning materials. These materials are often a source of controversy in sexual and reproductive health education. The Educational Development Centre has developed for Grades 11 and 12 a Population Education Handbook for teachers. Chapter 3 of the teachers' handbook is on the reproductive health of adolescents. The Educational Development Centre has also developed a Population Educations Students' Handbook for secondary schools. Chapters 6 and 7 of the Students' Handbook are dedicated to reproductive health and adolescent reproductive health. It was also reported that apart from these two handbooks there are at present no other authorized materials to be used in schools system.

The Education Development Centre has undertaken the very difficult but critical task of producing an authorised teaching and awareness material on sexual and reproductive health. This is a highly commendable effort as it is very difficult in many countries of the world to have authorized material on sexual and reproductive health which is a source of much controversy. However, the two handbooks have not been published yet and neither of the books has been introduced to the school system. In the absence of any other authorized material, students are getting access to different kinds of unreliable information and keeping in mind that the relevance of the content would decline with time the need for quick action on the handbooks cannot be more pronounced. Therefore it is highly recommended that these two books be published as soon as possible and introduced to the school system.

Department of Public Health (DPH) has developed IEC Guidelines for Community Health Workers and Family Health Workers. The Department of Public Health has also developed a number of booklets and leaflets for free distribution that covers sexual and reproductive health. Though DPH has a good resource material for distribution in the form of booklets and leaflets at present none of the material is adolescent specific. It is also noted that some of the material are not very reader friendly and in order to make it suitable to adolescents extra efforts are needed in selecting the content as well as choosing the presentation styles to make it adolescent friendly.

FASHAN has reported that they have developed a training module for teachers and parents on adolescent behaviour and that the workbooks and materials are ready. The contents of the training module include: reasons for student misbehaviour; central ideas on discipline; starting the year right; classroom rules; points to consider when developing rules; tips for starting the year right; effective teaching; effective teachers; maintaining a good environment; classroom survival; characteristics of good teaching; teachers response styles; effective classroom management; motivation; developing self-esteem; ideas to build student self-esteem; discipline and classroom

management; ways to deal with various behaviours; and positive language. FASHAN also reported that this module is yet to be used.

The Society for Health Education (SHE) has produced a number of radio programmes relevant to adolescent sexual and reproductive health. SHE also has a regular publication KULUNU which is written on different themes and one issue of KULUNU was dedicated to adolescence. SHE has produced a number of flip charts on health education, which are used for the regular IEC sessions conducted by SHE for Grade 10 students. SHE has also produced a number of relevant leaflets.

Counselling Service

One government agency, two non governmental organizations and the Government schools in Male' reported that they provide regular counselling service. Though it was possible to get information on the areas of counselling age specific data is not available yet.

Ministry of Youth and Sports provides regular counselling sessions at the Youth Center from 4-6 in the afternoon and 8-10 in the evenings, except on Fridays. Qualified counsellors (7 females and 3 males) provide help on different kinds of issues and according to the statistics, 17.9% of counselling is provided on interpersonal relations, 17.9% on sexual abuse and 5.1% on family issues. At present messages are taken during outside hours of service and the Ministry of Youth and Sports identified the need to have a 24 hour hotline service. Ministry of Youth and Sports reported that counselling is well received by the youth and that they plan to expand the present service hours.

Ministry of Youth and Sports has also conducted the first round of a nine month training course on counselling and 10 counsellors were trained. The training was conducted by three consultants who take counselling sessions at the Youth Center. The second round of the training course is planned for 2003.

The Ministry of Youth and Sports is also considering the placement of qualified counsellors at the 5 regional Youth and Sports Centers.

The Society for Health Education (SHE) also has a highly successful counselling program running for a significant period of time. SHE employs counsellors with tertiary qualifications from overseas universities and offers telephone counselling as well as face-to- face counselling at specially designated counselling rooms in the SHE building. The following table summarises the areas of counselling that SHE has provided. The counsellors at SHE report that though family issues and relationship issues are identified on initial contact, a significant number of cases handled have sexual health and sexual abuse as underlying factors.

Table 17: Summary of counselling cases 2001-2002

COUNSELLING PROBLEMS	Registered Clients				Telephone Counselling			
	2001	%	2002	%	2001	%	2002	%
Relationship Difficulties	9	10	7	6.1	65	23.9	70	20
Depression	7	7.8	9	7.8	14	5.1	11	3.1
Anxiety	9	10	7	6.1	10	3.7	15	4.3
Marital Issues	12	13.3	22	19.1	33	12.1	52	14.9
Family Issues	7	7.8	14	12.2	21	7.7	33	9.4
Grief Counselling	1	1.1	0	0	1	0.4	0	0
Drug Related Problems	0	0	2	1.7	4	1.5	2	0.6
Sexual Problems	2	2.2	1	0.9	15	5.5	17	4.9
Family Planning/Pregnancy	2	2.2	2	1.7	31	11.4	25	7.1
Thalassaemia counselling	0	0	6	5.2	10	3.7	19	5.4
Health Related Problems	0	0	1	0.9	8	2.9	13	3.7
Domestic Violence	1	1.1	0	0	0	0.0	0	0
Learning Difficulties	2	2.2	8	7.0	5	1.8	4	1.1
Psychological Problems	4	4.4	1	0.9	9	3.3	6	1.7
Behaviour Problems	27	30	25	21.7	33	12.1	57	16.3
Sex Abuse	1	1.1	2	1.7	3	1.1	13	3.7
Other Problems/Difficulties	6	6.7	8	7.0	10	3.7	13	3.7
TOTAL	90	100	115	100.0	272	100.0	350	100

Source: Society for Health Education

FASHAN provides counselling services but mainly to young people referred to FASHAN by the Narcotics Control Board. FASHAN's scope of counselling also includes service provided to the parents of drug users and other young children. FASHAN's counselling records also show that a significant number of cases receive counselling on relationships, divorce and adolescent behaviour.

Majeediya School and Ameeniya School employ a staff counsellor. The Principal of Majeediya School reported that counselling is not well received by the boys of Majeediya due to the perception that counselling is associated with "wrong doings". One of the underlying reasons for this perception is that at present counselling is on a referral basis. Teachers and supervisors refer students to the counsellors and students do not feel comfortable with this process.

However, in the focus group discussion, the girls of Ameeniya indicated that the presence of a staff counsellor in their school is a good initiative and that the girls have "friendly chats" with the counsellor.

Clinic Service

The SHE Clinic is the only non hospital based clinic from where adolescents can get high standard sexual and reproductive health services in a private and highly confidential setting. The SHE Clinic is open from morning till late evening. In the adolescent focus group meetings some groups of adolescents, particularly Male' students and working adolescents indicated they feel shy to visit the SHE clinic and services because of the "image" it carries. On the other hand migrant adolescent expressed high regard for the SHE clinic and other SHE services and their keenness to avail of the services.

Awareness Activities

Ministry of Youth and Sports reported that they implement a number of programmes that are relevant to adolescent sexual and reproductive health awareness every year. They include the Advanced Certificate Course in Youth Work (09 months full time), Youth Counsellor's Training Course (04 months) Life Skills Workshops (04 workshops in last two years), Youth Camps (once a year), Healthy Lifestyles Workshops, and Youth Challenge (2-3 day fair). Youth Ministry has planned to hold 3 Healthy Life Styles Workshops in 03 zones in 2003 to celebrate the National Youth Day. Youth Ministry identified that workshop style is too infrequent to reach the adolescents and is considering how to run a sustained continuing programme. Youth Ministry also identified transport costs as a major barrier to reaching the adolescents in the atolls.

DPH has implemented life skills and risky behaviour related training workshops in August and September 2002. DPH was also asked if they have contact with these trained participants through electronic communications networks or other means to facilitate exchanges of ideas and information. It was found that DPH would like to have such a mechanism but it is not there at the moment.

16. Building Partnerships

The majority of the adolescent population is in school and therefore presents the opportunity to receive sexual and reproductive health information from school-based health programs. Thus the two main partners ought to be the Ministry of Education and Ministry of Health.

Ministry of Education has links to all the islands in the Maldives through the school system as well as the non-formal education system and must be considered a priority partner. Within the Ministry the Population Education Programme and the School Health Program would have direct responsibility to oversee the implementation of activities while the Education Development Center (EDC) and Center for Continuing Education (CCE) are two of the operational arms of the Education Ministry that would have useful roles to play in adolescent sexual and reproductive health education.

The Ministry of Health has clear mandate to promote adolescent sexual and reproductive health in the country and the goals, objectives and strategies to be followed are clearly stated in the present Health Master Plan. The main operational arm of the Ministry of Health that is likely to implement adolescent sexual and reproductive health programs is the Department of Public Health. Thus the Ministry of Health and the Department of Public Health should be considered as important partners in delivering adolescent sexual and reproductive health programs and services.

The National Youth Policy has specific strategies to promote youth sexual and reproductive health and the Ministry of Youth and Sports incorporates adolescent sexual and reproductive health in most of the activities they conduct. The Ministry of Youth and Sports and the youth networks comprising of the various clubs and societies represent a significant existing network that can be used to reach the adolescents of Maldives.

The Ministry of Planning and National Development is mandated to develop and implement the National Population Policy. The Population Policy has several strategies that are adolescent sexual and reproductive health targeted, and it is likely that with the official launching of the National Population Policy, the Ministry of Planning and National Development would seek the cooperation of relevant Ministries and departments of the government to implement those strategies. With the additional mandate for resource allocation for development programs and projects the MPND would be an important partner in the adolescent sexual and reproductive health area.

The Girl Guide Association and Boy Scout Association are also identified as excellent networks of adolescents in the Maldives. There are about 2000 members of the Guide Association in Male' and 2500 members in the atolls.

The Girl Guide Association reported that adolescent health has been introduced in the Guide Handbook and that guide activities can be used to reach adolescents. The Scout Association reported that there are 2000 scouts in Male' and about 1,900 scouts in the atolls. Scout Association has so far not undertaken any activities related to adolescent sexual and reproductive health.

Among the non-governmental organisations Society for Health Education (SHE) has been very active in the area of sexual and reproductive health promotion. FASHAN also implements important activities that are directly relevant to adolescent health. SHE and FASHAN have already established themselves as highly recognised national level NGOs with sustainable programs and projects and already proven excellent partners. Care Society with their particular focus on children with special needs would also be an important partner.

17. Ongoing Activities

The Population Education Programme and the School Health Programme of the Ministry of Education are two ongoing programs with an established history. At present the two programs are entering a phase of high significance with the Ministry of Education carefully considering how these two programs can be integrated and implemented to complement each other. This is an opportune time to consider how specific adolescent sexual and reproductive health promotion goals and targets can be incorporated in these two programmes.

This study has also found that youth-oriented awareness campaigns are successfully being used by the Ministry of Youth and Sports and the Ministry of Health to raise awareness on health issues and that the adolescent community receives such events well. We also found that such campaigns are often coordinated with the delivery of information and counselling services, and with co-operation from schools. Specific health awareness campaigns such as AIDS Week can be coupled to Youth Awareness Activities as far as possible. The Youth awareness campaign organisers identified the difficulty in acquiring resources for such campaigns. One possible way forward that concerned agencies can consider is to pool the resources available for development and production of awareness materials and to develop high quality adolescent and youth friendly materials that can be used by the Ministries of Education, Youth and Health. Private sponsorship could also be sought for the production of such materials. The Youth Awareness activities are planned well ahead and delivered on a regular basis with friendly and healthy cooperation among concerned agencies and officials.

Society for Health Education (SHE) reported that they conduct regular Multi Purpose Health Trips to get access to “hard to reach” groups in the islands. SHE also organises school visits to Male’ schools on a regular basis, and offers counselling services from morning till late evening. The SHE clinic is also a well recognised non-hospital based clinic. These activities of SHE are regular, continuing and ongoing work in the area of adolescent sexual and reproductive health and life skills.

FASHAN’s Peer Group is also an ongoing programme with good potential. At present, peer groups’ works with adolescents on awareness raising and education mainly on drug issues. Since drug issues are closely linked to adolescent sexual and reproductive health issues and most adolescents get sexual and reproductive health information from their own peers, the sustainability of peer education for sexual and reproductive health needs to be explored.

Most agencies and organisations reported that they made efforts to ensure that guidance counsellors, teachers, parents and students were aware of the available sexual health services in their communities. However, most of the services appear ad hoc at the moment and innovative and far reaching methods need to be identified to publicize the available services.

18. Data and Information

Data on adolescent sexual and reproductive health issues is very scanty. Many of the experts and professionals interviewed expressed concern over the misconceptions, neglect of the real situation, moral judgements and stereotyping linked to adolescent sexual and reproductive health. Some of the experts identified a total lack of understanding of what sexual and reproductive health entails, as awareness raising on sexual and reproductive health was too concentrated on HIV/AIDS alone, rather than providing a comprehensive picture.

The Annual Health Reports published by the Ministry of Health does not have sexual and reproductive health knowledge, attitudes and behaviours of adolescents.

The Health Master Plan identifies that the health problems in the adolescent age group are related to sexual health and other lifestyle related conditions such as substance abuse, smoking and sexually transmitted diseases. The Health Master Plan also states that reproductive health problems arise from early marriage and early child bearing, putting both the mother and the infant at risk. Additionally, the Health Master Plan claims that unsafe sexual relations in adolescents are increasing in the country, exposing them to too early and unwanted pregnancies, induced abortions in hazardous conditions, and sexually transmitted diseases, including HIV infection. The Health Master Plan also refers to deaths due to unsafe abortions based on unofficial information from the community. The Master Plan uses the number of adolescents who get sentenced for pre-marital sex as an indication that adolescents are sexually active and reports 1995 data on sentences for offences related to sex outside marriage.

Ministries and other agencies were specifically asked about sources of information on adolescent sexual and reproductive health. They were also asked if they funded quantitative or qualitative studies on adolescent sexual health behaviours that would help to guide the development of adolescent sexual and reproductive health services. The Ministries referred to the Reproductive Health Baseline Survey and the results of the Multiple Indicator Cluster Survey as possible sources of information. It was also revealed that presently a study on client attitudes and utilisation of reproductive health services offered at IGMH is been undertaken by Commerce, Development and Environment Private Limited.

The Reproductive Health Baseline Survey of 1999 was funded under the UNFPA Country Program for 1998-2002. The aim of the Reproductive Health Baseline Survey was to provide information about behavioural, attitudinal

and knowledge characteristics of the population, including men and women of different ages, and their access to and use of health services available. The survey included focus group discussions with adolescents in Male' and the islands. According to the main findings of the survey, adolescent boys and girls know about modern methods of contraception. Adolescent boys mentioned the pill and condoms while girls mentioned condoms only. The adolescents received information about contraception from the media (especially radio) and from friends, more than from sources such as teachers and health workers. According to the Survey, knowledge of HIV/AIDS is high among both boys and girls but knowledge of other STDs was low among most groups of boys and girls.

The Multiple Indicator Cluster Survey of 2001 was undertaken to assess the situation of children and to monitor the progress made through the intervention programmes. The MICS 2 covered a wide area of issues such as nutrition, children suffering from diarrhoea, salt iodisation, pre-natal care and care during delivery, anaemia among women, child labour, general living arrangement of children and birth registration. Since MICS relates only to issues of children under 5 years of age, the survey does not address adolescent sexual and reproductive health issues.

There is a total lack of qualitative and quantitative information on adolescents' actual sexual behaviour, knowledge, views and needs. At the end of 2002 FASHAN undertook a UNESCAP sponsored Rapid Situation Assessment of Drug Abuse in the Maldives. It was reported that the Rapid Situation Assessment has policy relevant and useful information on adolescent sexual behaviour. Section E of the questionnaire used for the rapid assessment was focused on sexual behaviour, Section F on HIV/AIDS knowledge and Section G on STDs. The questions asked from respondents include age and context of first intercourse, number and type of sexual partners, risk taking sexual behaviour, use of contraceptives, testing for HIV/AIDS, and specific questions on sexually transmitted diseases.

The results of the survey has been analysed by FASHAN and a draft report of the Rapid Situation Assessment has been submitted to the concerned national authorities and UN agencies. The Study Team made verbal requests to FASHAN, concerned Government agencies and UN agencies to provide a copy of the draft report for review and reference. All the concerned officials expressed that the report is very comprehensive and the report would be made available once the Rapid Situation Assessment is finalised.

There are three major areas of data and information that was identified as key gaps through the key informant interviews, focus group discussions and the consultation held on the first draft of this study report. These three gaps are related to data and information on adolescents, parents, and teachers.

The first major gap is the lack of knowledge regarding adolescents' sexual development, behaviours, relationships and attitudes. At present there is no credible information available in the Maldives on adolescents sexual health, behaviours and attitudes. Adolescents themselves have seldom been asked what their reproductive health concerns and needs are: it is often assumed that adults – whether they are parents, health workers or policy makers – know what the adolescent reproductive health needs and concerns are and what is best for them. Religious obligations and social norms prohibit unmarried adolescents to be sexually active, and if they are, it is frowned upon and in the case of girls, it results in serious name-calling, stereotyping and repercussions from the social environment. As one official clearly stated "we first need to know what the problem is and what the concerns and issues are before we start putting money into an adolescent sexual and reproductive health program".

The way forward in this is to break the barriers and to undertake research to obtain information regarding adolescents' sexual behaviour patterns, opinions, reactions, justifications and explanations. The research should explore and understand the underlying processes that lead to specific behaviour outcomes among specific individuals in specific contexts.

The Safe Passages to Adulthood programme developed in 1999 by the UK Government's Department for International Development (DfID) for UNDP/UNFPA/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction identify different thematic blocks of information that would inform the design of culturally appropriate and acceptable health and education services. They include 1) adolescents knowledge and sources of information regarding relationships, sex and contraception with emphasis placed on the role of parents and elders as well as the education system and the media in informing young people about sexual health matters; 2) relationships and sexual development up to and including a full account of the contexts of first intercourse; 3) insight into the development of sexuality and factors shaping this development including parental attitudes, peer pressure and cultural norms; 4) understand that many adolescents may be sexually inexperienced and investigate the reasons why a respondent has yet to experience first intercourse and how they feel about , and others view, on their current status; 5) investigate subsequent sexual behaviour to describe feelings and relationships since first intercourse; 6) explore risk taking behaviour, perceptions of risk and vulnerability as well as the mechanisms employed to avoid risk; and 6) focus on the knowledge, attitudes and usage of the sexual and reproductive health services provided to adolescents (DfID 2000).

The second major gap identified is on parents' knowledge and attitudes. In the key informant interviews and the focus group discussions parents were considered to be an appropriate and important channel for providing sexual and reproductive health education to adolescents. It was perceived by several

key informants that parents often lack accurate information on the subject or do not know how to communicate with their sons and daughters on such a sensitive topic. The young adolescents in the focus groups also indicated that most of the parents have real difficulties in communicating with them on sexual and reproductive health issues.

Clearly, parents have a role as the primary educator of adolescents and parents can have a strong influence on the nature of the relationships formed by adolescents as they grow and become sexually active. Some of the key informants expressed concern that family-based discussions cannot always deal effectively with all sexual and reproductive health topics and that therefore the schools ought to be the most reliable and objective source of sexual and reproductive health information. In the same context, key informants also expressed concern about not knowing the perception of parents on sexuality education and the possible controversies involved in giving sexuality education at schools. There is thus an urgent need to understand the perceptions of parents on sexual and reproductive health education and on preventative sexual health services for adolescents. Some of the questions that need answers in this regard are whether parents want their children to receive sexual and reproductive health education and if yes at what age and how comprehensive and at what scope. This need is immediate and at the consultation held to discuss the draft report of this study, the participants requested that a focus group discussion of parents be included in the scope of this study if time and resources permit.

The third gap in information is on teachers' knowledge and attitudes. In the key informant interviews concerns were raised that some of the teachers who are teaching on sexual and reproductive health are not trained teachers and many teachers may not have an appropriate level of health education to provide accurate information to adolescents. In the focus group discussions, adolescents also noted that they find teachers to be uncomfortable in discussing some of the sexual and reproductive health topics. Consequently reliable data and information is required on the role, responsibilities, attitudes and knowledge of teachers on sexual and reproductive health education. Such information is critical as the majority of adolescents are in school and have direct contact five days a week with their teachers.

PART IV

19. Focus Group Discussion Results

This section of the report summarises the results of eight focus group interviews with student adolescents and working adolescents. The focus groups were designed to identify:

Where and how to reach adolescents?
Attitudes and knowledge regarding sexual and reproductive health policies and programmes
Where and how adolescents are currently accessing sexual and reproductive health information and services?

The questions in the focus groups asked adolescents to give their views on the nature and quality of existing services and programs to promote sexual and reproductive health. Direct quotes from the focus groups with students are used to illustrate or emphasize certain results.

Subgroups of Adolescents

For the purposes of this study, the scope of the adolescent population was limited to the adolescents living in Male'. The following are the subgroups of adolescents identified through key informant interviews and review of relevant literature:

Early adolescent males
Early adolescent females
Late adolescent Male' male students
Late adolescent Male' female students
Late adolescent migrant male students
Late adolescent migrant female students
Late adolescent working males
Late adolescent working females
Married adolescent males
Married adolescent females
Non-school attending non-working adolescent males
Non-school attending non-working adolescent females

Out of these identified 12 subgroups of adolescents in Male', focus group discussions were held with the first eight subgroups. It was found impractical to hold focus group discussions with married adolescents because of the very few number of married adolescents living in Male'. Non-school attending non-working adolescents are an important sub-group however it was found

very difficult to arrange a focus group discussion with a representative sample of this sub-group.

These focus groups were intended to gather voices to accompany and illustrate the other information that were colleted within the study. The findings reported here provide insight into what adolescents think about sexual and reproductive health information and services. Adolescents welcomed the focus group discussion and participated openly and actively. They were keen to participate and shared their thoughts freely.

Those who participated in these focus groups were not selected in a truly random manner. Consequently, their views should not necessarily be seen as representative of all adolescents in the schools, Male' or the nation as a whole. As well, since there were difficulties encountered in recruiting school leavers as well as male employed adolescents, this suggests that these results should be interpreted with caution.

However, the amount of congruence in the findings of these eight focus groups suggests that the issues identified here are of considerable importance in this analysis of policies, programs and services related to adolescent sexual and reproductive health. The findings of the focus group discussions are reported below. The discussion of these findings is combined with the discussion of the other study results in the final chapter of this report.

School Education and Counselling

Adolescents said that sexual and reproductive health education is a very important part of their schooling. In the opinion of the adolescents who participated in the focus group, sexual health education should be offered in lower secondary schools and higher secondary schools.

Students said that they wanted sexual health education to include a broad understanding of the nature of sexuality that includes physical, social and emotional elements. Most students reported that the present education they receive is through Biology and are too physical and biological in nature. They reported that sexual health education they receive is limited to topics such as anatomy, pregnancy and HIV / AIDS.

Students in all of the focus groups were not satisfied with the sexual health education that they had received in schools. They found that the content was only what is found in the biology textbooks, and no other resources or teaching activities were used. Students in all focus groups said that teaching materials and resources used in schools were not of a high standard.

Students also did not rate very highly the teachers who teach sexual and reproductive health related topics. Students said that teachers often appeared to be uncomfortable in discussing and teaching about certain topics related to sexuality.

Students reported that there have been very limited focus on sexually transmitted disease. Students indicated they wanted more information about these diseases. Students identified that the sexual health education be holistic in nature and also deal extensively with relationships and dating pressures.

"Nothing about us, it is lesson and lesson."

"What we learn is anatomy, pregnancy and HIV alone."

"Just physical aspects, technical stuff, nothing emotional."

Students wanted more emphasis to be placed on topics such as sexual abuse, dating risks, STDs, self examination for sexual health problems and relationship related issues.

Students of Ameeniya school regarded the school counseling program as a good initiative and they welcomed the opportunity to have "friendly chats".

Students also informed that the commerce and arts stream students have hardly any access to sexual and reproductive health information from school. The only access these students have is through the subject of Islam and different teachers of Islam have very different attitudes to the topics they teach.

Four critical issues can be identified in terms of adolescents accessing sexual and reproductive health information from the school system. First, the commerce and arts stream students have minimal access to sexual and reproductive health information from the school system. Secondly the students are finding that there is a lack of good material apart from what is available in the Biology Text Books. Thirdly, the school teachers are not properly trained to answer the kind of questions that adolescents have on their sexual and reproductive health. Fourthly, there is a need to change the image of counselling in schools as well as the present process and procedures for counselling service.

Parents and Friends

Students in all focus groups said that they do not discuss sexuality with parents and found that objective and effective discussions with parents is almost nil. Some female students said that they discuss menstruation related aspects with parents.

"I can't imagine my parents discussing it".

"I wouldn't tell my parent because I am scared to face the anger".

"I know that my parents are very close to me and they would help, but there is no way in the world that I would discuss sexual health with them."

One respondent stated "Teenage is like hell for girls from parent side."

Students also noted that, very often, the first source of information about sexuality was from their friends and that whatever resources friends have are shared commonly.

Many respondents identified boyfriend / girl friend as a reliable discussion partner. Boys thought girls knew more and girls believe that boys know more. But they are not sure where there friends get information from.

Adolescents expressed difficulty in communicating with parents on sexual and reproductive health matters. However, parents clearly have the role as the primary educator of adolescents and parents are the most appropriate and important channel for providing sexual and reproductive health. High priority needs to be given to address parenting skills in the context of the new information age their kids are growing up.

Friends remain the first source of information on sexuality and adolescents expressed that they believed their friend know more than them about sexual and reproductive health issues. However, in the absence of thorough research on the knowledge of adolescents on sexual and reproductive health it is extremely difficult to determine the kind of information that is being exchanged among adolescents. Internet, romantic novels and movies appears to be the key primary sources of information.

Media

Adolescents in all focus groups reported that they also learn about sexuality from the media; television, magazines, and adult movies. However, most students did not view these other sources as being as reliable as the school.

Students groups, particularly the student male Male' group, noted that the media is putting pressure on youth to be sexually active. They indicated that information presented in magazines, TV and the internet is often of a "tempting" nature and they wanted schools to discuss and study the media's role and influence on sexual behaviour.

Practically all the adolescents who participated in the focus groups indicated having read Monday Times. Monday Times is no longer published. The female adolescents also read Udhares, Huvaas, and Manas. Dhunthari is the favourite magazine of early adolescents.

The international magazines male adolescents read are Readers Digest, New Scientist, National Geographic and Cosmopolitan. “We read Cosmo for information and read it when our mother or sisters bring them home”.

The international magazine female adolescents read are Femina, Cosmo, Readers Digest and News Week.

There is an urgent need for both early adolescent and late adolescent targeted English language magazines in the Maldives. Concerned agencies may encourage publishers and Newsgroups such as Haveeru News Service by undertaking market studies and making public the information. There also appears to be a significant need and potential market for sexual and reproductive health information in the form of popular books what can be considered the equivalent of culturally and socially sensitive love making guides in the Dhivehi language.

Radio and TV

Hardly any adolescents who participated in the focus groups listened to the radio and the main reason for not listening is not having the time. Early adolescent boys and girls reported that the only program they listen to is the children’s favourite “Eba Ulhey – Miba Ulhey” programme.

The adolescents who participated in the focus groups do not listen to any of the education programmes broadcast on radio and they reported that sometimes they hear the radio while attending to other matters and the programmes they recall hearing most often are “Baajjaveri Hedhuneh” and the “Madhaha Program” on Fridays. The adolescents also reported that the only programme they make an effort to listen on radio is the “Keerithi Rasoolaage Siyarathu” broadcast in Ramazan.

A significant finding of the focus group discussion is the declining role of TVM in the life of adolescents. The adolescents who participated in the discussion indicated that the only programmes they watch regularly on local TV are “TVM News” and “Heyanbo”. All the adolescents who participated in the focus groups watch “Heyanbo” regularly. The migrant adolescents also indicated that they do watch educational programmes “Fehivina”, “Vinavi” and Dhivehi Music programmes such as “Dhivehinnaai Music” and “Avaamendhuru”.

It can be clearly seen that TVM is being replaced by the cable TV channels. Star Movies, HBO, Channel V, MTV, Star World, Cartoon Network, ESPN, Star Sports and Ten Sports are the favourite channels of the adolescent boys while adolescent girls watch Sony TV, Star Plus, Star Movies, National Geographic and Zee Network channels more often.

Kasaoti, Kusum, Kutumb, Heena, Kiyoun Hoathaahey Piyar appear as the most favourite TV programmes of the majority of the female adolescents. The late adolescent females who attend the Government schools also indicated Friends, Malcolm in the Middle, X-Files, Roswell and Dark Angel as favourites.

The adolescent boys mostly watch movies, music and sports on TV. They also indicated the science and education channels such as National Geographic and Discovery Channel as highly entertaining.

The role of Radio as a medium to reach the adolescents in Male' is minimal. However, it is likely that radio would still play an important role in the life of adolescents in the islands. Clearly the role of local TV on the life of adolescents has declined with the introduction of cable TV in Male'. With the present level of popularity of both Hollywood and Bollywood and sports channels it would be very difficult for educational TV to compete at the peak viewing hours.

Internet Use

The focus group interviews examined adolescents' use of and attitudes toward accessing sexual health information through the Internet.

Practically all working adolescents used the internet 3-5 times a week, mainly at office or at home.

Migrant male students indicated that 90% have not used internet and those who get access to internet do so once a month, either at the National Library, Dhiraagu Cyber Café or at Icon Game Station.

Migrant female students indicated they do not get access to internet at all.

Male' male and female students said that they all use internet, either at home, school, or cybercafes and most used the internet 5-7 times a week.

All the respondents who have used the internet said that they have obtained information about relationships, dating and sex from the internet. Both sexes

of the adolescent working group and Male' students identified internet as the most valuable source of information on sexual health.

The respondents suggested there be online chat sessions with doctors on teenage health issues and that such sessions be advertised through popular media. For such a chatline to become successful, the students suggested ensuring total anonymity and in a high internet security mode facilitated by Dhiraagu.

The respondents also identified the existing high cost of internet use as a barrier and suggested that more computer and internet facilities to be provided in the National Library, Youth Center and the Schools. At present internet is available on 08 terminals in the National Library and 04 terminals at the Youth Center. The adolescents suggested introducing simple booking schemes for the computers in these places as the computers are on very high user demand.

The Principals of the Government Schools in Male' indicated that they are working to provide unlimited access to internet in their schools trhough Dhiraagu Lease Lines and it is likely that internet would become highly accessible in these schools soon. In such a situation, Internet can serve as a useful supplement to existing health care services and more research on this topic is necessary to help educators determine how to present Internet based health information.

Considering the respondents' perception of the worth, trustworthiness, usefulness, and relevance of sexual health information on the Internet, it can be said with confidence that those adolescents who have access to the internet value this medium highly than all other mediums.

PART V

20. Findings and Suggested Policy Directions

This study has reported on the status of policies, plans and programmes in sexual and reproductive health in the Maldives relating to adolescents. The major findings we have highlighted in this section of the report are not an exhaustive treatment of the information that we analysed for this study. Some will find that these findings are not new to them. People who work with and in the areas related to adolescents will find their recent experiences reflected in many of these data.

What is new about this study is the breadth and scope of the investigation. We looked into existing data that has yet not been analyzed and presented to policy makers. We also reached to sub groups of adolescents that have not been investigated as a target subgroup. We listened to the adolescents and presented their voice as accurately as is possible. This report also began by underlining that even our own surveys had limitations and constraints including choice of subgroups as well as the participants in subgroups. Yet, the findings of this study highlight the need and justification clearly. It identifies problems and suggests possible solutions. The adolescents indicated that sexual and reproductive health information and services is needed by them and key informants agreed with this need to help the new group of adolescents to make a safe and sound transition into adulthood. The Maldivian adolescents expressed their disappointment that they are not benefiting much from the existing sources of information and services. The adolescents have suggested ways they believe would improve the results of the present efforts.

To assist in the deliberations of decision makers at both the Government and the UN agencies, we have outlined here our major findings and consequential recommendations.

Observation 1:

Over a quarter of the population are adolescents. The adolescents and young people together represent 36.23% of the population. The focus groups discussions showed that the adolescents need sexual and reproductive health information and services. The key informants agreed that this need be considered at policy and program level.

Consequentially: we conclude that sustained support and new financing for the implementation of adolescent sexual and reproductive health programs is justified.

Observation 2:

The adolescent population would peak in 2004 and start declining in 2005.

Consequentially: we conclude that the need for adolescent sexual and reproductive health is immediate and policies and programs need urgent implementation.

Observation 3:

Male' and islands in the vicinity of Male' host 47.5% of the young people and Male' is home to almost 30% of the adolescent population.

Consequentially: we suggest that proportionate funding be allocated for programs in Male'.

Observation 4:

There is a significant trend towards increasing age at marriage from 17.99 years in 1985 to 21.77 for females and from 22.51 to 25.57 for males.

Consequentially: we highlight the need to recognize this significant achievement and consider the policy implications that go along with the achievement. Adolescence is becoming an extended period before marriage raising issues about premarital sexuality, dating and relationships.

Observation 5:

There is a total lack of qualitative and quantitative information on actual sexual behaviour of adolescents. Without quantitative and qualitative information on attitudes and behaviour culturally appropriate and acceptable sexual and reproductive health information and services cannot be provided. Our observation is that the adolescents are receptive to questions on their sexual attitudes and behaviour.

Consequentially: we recommend to undertake research to obtain information regarding adolescents sexual behaviour patterns, opinions, reactions, justifications and explanations. We suggest utilization of tried and tested culturally appropriate methodology. One such methodology is the Safe Passages to Adulthood, developed by the UK Government's Department of International Development for UNDP/UNFPA/WHO/World Bank Special Programme for Research, Development and Research Training in Human Reproduction.

Observation 6:

The majority of the adolescent population is in school and there were a total of 106,220 students enrolled in 2002.

Consequentially: we find that the best opportunity to reach adolescents and deliver successful sexual and reproductive health programs is presented by the school system. Thus the lead partner in adolescent sexual and reproductive health should be the Ministry of Education and the School Health Programme of the Education Ministry with full support of Ministry of Health.

Observation 7:

The gender disparity in labour force participation rates is glaring and 37% of the not economically active females reported they did not work due to difficulties in taking care of their children and doing housework.

Consequentially: we suggest that such information be reached out to adolescents as well as policy makers so that culturally and socially acceptable cost effective child care schemes can be developed.

Observation 8:

There are adequate written policies and strategies on adolescent sexual and reproductive health. However, there is a total lack of explicit action plans with specific targets, outcomes partners, roles and responsibilities.

Consequentially: we conclude that next step is likely to be development of explicit action plans.

Observation 9:

A key policy issue for the Ministry of Education is the authorization or recommendation of teaching and learning materials. The Educational Development Center has developed a set of authorized material for schools.

Consequentially: we suggest that the material be published as soon as possible and disseminated to the school system.

Observation 10:

Subgroups within the adolescent population have distinct characters and face distinct issues and constraints. Adolescent migrant females are identified as particularly vulnerable and they are subject to higher levels of physical and emotional abuse and least well-served by school health education and preventive services.

Consequentially: we recommend that due priority be given to adolescent migrants in Male', particularly the female adolescent migrants. We suggest the schools as the best means to reach female adolescent migrants. We also

suggest the National Library as an avenue to reach the adolescent male migrants.

Observation 11:

Even among the student adolescent subgroups there are significant differences in access to sexual and reproductive health information. Clearly the commerce and arts stream students are at a disadvantage.

Consequentially: we suggest that more attention be given to students from these streams. However all students need adequate ASRH information, guidance and Life Skills Education.

Observation 12:

The present adolescent population is living in the new information age and Cable TV and Internet plays a significant role in the life of present adolescent group. There is a significant need for high quality reliable information on sexual and reproductive health information for adolescents in this information age. One of the significant finding of the focus group discussions is the declining role of radio and local TV on the life of adolescents. The adolescents hardly listen to the radio and the only popular local TV program regularly watched by adolescents is *Heyanbo.* The adolescents totally disregarded radio and local TV as mediums to reach them. Practically all the adolescents spend time watching the channels on the cable networks and while male preference is for music, movies and sports channels the overwhelming female demand is for Indian regular drama series telecast on Sony, Star Plus and Zee Network.

A significant proportion of the adolescents, particularly the female population read and they read the Dhivehi magazines as well. The adolescents identified the need for a local teenage magazine and also identified that there is a market for foreign published teenage magazines in the Maldives.

The overwhelming demand as the most valuable source of adolescent health information to the non-migrant adolescent population is identified to be the internet, preferably through the portal of Dhiraagu. The respondents also called for well publicised chat sessions with recognised doctors in a highly private, confidential and secure setting.

The main route to reach the migrant population in Male' is through the school system for females and the National Library for the males.

Consequentially: we suggest that due attention be given to sustained information provision through the most suitable channels and means.

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