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The Status of Family Planning and Reproductive Health in the Republic of Maldives

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Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
APRO	Asia Pacific Regional Office, UNFPA
BBS	Biological and Behavioral Survey
CCHDC	Centre for Community Health and Disease Control
CEmOC	Comprehensive Emergency Obstetric Care
CHWs	Community Health Workers
CPR	Contraceptive Prevalence Rate
CSW	Commercial Sex Workers
DHS	Demographic Health Survey
DPH	Department of Public Health
ENT	Ear Nose Throat
EPI	Expanded Programme on Immunization
FHW	Family Health Worker
FP	Family Planning
FPU	Family Protection Unit
FSW	Female Sex Worker
GBV	Gender Based Violence
GDP	Gross Domestic Product
GF	Global Fund
GFATM	Global Fund against HIV/AIDS, TB, Malaria
GSHS	Global School Based Students Health Survey
HC	Health Centers
HIS	Institute of Health Science
HIV	Human Immunodeficiency Virus
I/NGO	International/ Non-governmental Organization
ICOMP	International Council on Management of Population Programmes
ICPD	International Conference on Population and Development
IEC	Information, Education and Communication
IGMH	Indhira Gandhi Memorial Hospital
IMR	Infant Mortality Rate
IUDs	Intra-Uterine Devices
KAP	Knowledge, Attitude and Practice

LSE	Life Skill Education
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDP	Maldives Democratic Party
MHP	Master Health Plan
MMR	Maternal Mortality Rate
MOHF	Ministry of Health and Family
MPND	Ministry of Planning and National Development
MoYS	Ministry of Youth and Sports
MSM	Men having Sex with Men
MTP	Mid-term Plan
MWSA	Maldives Water and Sanitation Authority
NAC	National HIV/AIDS Center
NTC	National Thalassemia Center
PHC	Primary Health Care
PPP	Public Private Partnership
Rf	Rufiyaa
RH	Reproductive Health
RTI	Reproductive Tract Infection
SAP	Strategic Action Plan
SHE	Society for Health and Education
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TBA	Traditional Birth Attendants
TFR	Total Fertility Rate
UN	United Nations
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNV	United Nations Volunteers
VDRL	Venereal Disease Research Laboratory
VHI	Voluntary Health Insurance Scheme
WHO	World Health Organization
YHC	Youth Health Café

Executive Summary

This paper presents the status of family planning (FP) in the context of improving access to reproductive health services in the republic of the Maldives. Methodology adopted while preparing the paper include extensive desk review as well as interaction with key stakeholders-government, donors/development partners and NGOs that the author has undertaken during a visit to Male`, the capital city of Maldives.

Available evidence suggests that Maldives has been in the forefront of recognizing the population problems and policies and programmes were designed to address the issues. During the period from mid-70s to 2000, Maldives enjoyed a period of relative stability and growth which helped it to prioritize investment in social development. Health and education facilities were expanded across the country – including hard-to- reach islands. Rapid expansion of health facilities in the framework of primary health care and upgrading the facilities by equipping them with needed infrastructure, skilled service providers and accessories contributed to improve access to health. As a result, Maldives experienced a rapid decline in fertility and mortality and its life expectancy at birth increased significantly. With a total fertility rate of 2.5 per woman (Ministry of Health and Family, 2009a), IMR of 11/1000 live births, MMR of 57 per 100000 live births and life expectancy at birth of 73 years in 2008 (Ministry of Health and Family, 2009b), Maldives is well ahead of many of the South Asian countries and has entered the era of "Demographic Dividend". Maldives claims to have already achieved the MDG goal of universal primary education, IMR and MMR and is on track to achieve other MDGs except the goal on environment which is difficult to attain, given the geographical constraints.

Maldives' health delivery system draws upon the concept of primary health care where other services such as RH and FP have been integrated in an incremental approach. The primary reasons for Maldives' successes are: provision of accessible services, with special emphasis on atoll populations; awareness creation on high risk pregnancies; continuity of antenatal and post natal care, ensuring 4 antenatal visits for each pregnancy; and deliveries attended by skilled personnel. For example, 2006 statistics indicated that 54 % of deliveries were conducted by doctors, 39 % by staff nurses, 8% by nurses, and only around 3% by TBAs (many of whom were trained).

The history of FP programmes in Maldives dates back to the launching of the child spacing project with the support of WHO/UNDP/UNFPA in the mid-80s. UNFPA has been continuously supporting the country to improve access to reproductive health (RH) services including FP in the country. Three methods of modern contraceptives-condoms, pills and injectables are available in all the health facilities and other methods are available at higher levels of health facilities.

The highest ever CPR recorded for Maldives has been 42% in 2004 which has declined to 34% in 2009. CPR of modern methods in 2004 was 34% which declined to 27% in 2009. Except for condoms, all other methods showed a declined rate. Traditionally, the contributions of traditional methods such as abstinence and rhythm have been relatively high in the CPR of Maldives.

Among the modern methods, four methods: female sterilization, condoms, oral pills and injectables dominate the method mix. Except for condoms and female sterilization, all methods have shown a decline in use in 2009 compared to 1999 and 2004. Maldives has experienced a rapid fertility decline even in the context of a relatively low CPR. This is an area of further research to examine other correlates of the decline including abortion, high mobility of people, STI/RTI and other RH morbidities. Abortion is illegal in Maldives.

Under an 'exit plan' agreed with UNFPA, the Government of Maldives has undertaken the full responsibility of funding the procurement of contraceptives since 2009. Logistic management services have been strengthened to ensure regular supply and minimize stock-outs in service delivery points.

While there have been no systematic studies, declining fertility, changing attitude of policy and programme managers on population issues, priority on Tsunami reconstruction and the changed political context could be some of the reasons for reversal in the CPR in the country. Further investigation is needed in this area.

Due to demographic transition, Maldives' adolescent youth population has bulged. Studies have documented evidence that adolescent and youth in Maldives are sexually active and indulge in risky behavior including drug abuse and unsafe sex. Access to RH services including contraceptives to unmarried adolescent youth is not officially promoted. As a result, adolescents find it difficult to access condoms and other RH services. Attempts of the NGOs to provide services to adolescents and youth have been less than satisfactory.

Change of the government in 2008 ushered a new era of democratic governance in the country. The new government has come up with several policies and programmes. Some of the policies advocated are corporatization of the health services, public-private partnership, insurance schemes and decentralization. At present, the government is spending 90% on health expenditure. There is fear that some of the policies options of the new government may not be women, children and adolescent RH friendly and the gains made by Maldives may not be sustained. The operationalization of these policies and programme has yet to happen. Once these policies and programmes are in place, its implications on health services will be felt.

The paper concludes with some recommendations such as repackaging of population and development messages in the context of demographic transition and focusing on emerging issues capitalizing on the government's recognition of RH rights. It further recommends socio-cultural research to understand reproductive behavior of men, women and adolescents in the society, improving method mix and male participation in FP. A multi-sectoral approach for the promotion of adolescent sexual and reproductive health services is necessary, including evidence-based advocacy and lobbying at all levels.

The Status of Family Planning and Reproductive Health in the Republic of Maldives, 2010

"It (the Population Policy of Maldives) supports reproductive rights of individuals and couples to decide freely and responsibly the number and spacing of their children and create an environment for cost effective provision of information and services that would enable them to make informed choices to achieve their reproductive intentions".

Population Policy of the Maldives, Working Draft, 2004 (MPND, 2005, p.8).

1. Aim of the Report

The aim of this report is to compile, review and analyze the status of family planning (FP) in the Republic of Maldives during the last three decades on the internationally and nationally agreed targets and achievements, progress towards meeting the targets of the International Conference on Population and Development (ICPD) and Millennium Development Goals (MDGs). Based on the review and analyses, the report presents recommendations on how to reposition the national FP programme in the Maldives and the way forward. It needs to be noted that the study is being prepared at a time when Maldives is in transition; politically and socially. The political changes that brought the new democratically elected President to power has yet to stabilize, as stalemate between the Parliament and the President's office, continued to linger for more than two months at the time of reporting.

2. Methodology

A variety of methods and materials have been used in preparing the report. This consists of both desk review and visit to Male', the capital of Maldives, to interact with key stakeholders and collect other necessary information to assist in the preparation of the report. Available information was collected and compiled for desk review. The reviewed documents included review of key government policy and programme documents, policy statements and progress reports of the government on socio-economic and demographic indicators, MDGs and Human Development Report. For better understanding of the situation, the author visited Maldives from 25 September to 4 October, 2010. During the period, he met and interacted with a wide spectrum of people representing various constituencies. These included meeting with the State Minister of Health, officiating permanent Secretary of Health and Director General of Centre for Community Health and Disease Control (CCHDC), and other key government officials, UN Country Team members and NGO representatives. A list of persons met is shown in Annex 1.

3. Past Achievements in FP/RH

3.1 What the Programme Achieved in 30 Years

Population trends: According to the 2006 census, population of the country was about 300,000 spreading over 198 inhabited islands. Like other developing countries, Maldives also experienced period of sluggish and rapid population growth. During the first half of the 20th century, population growth was to a large extent balanced by both high levels of fertility and mortality with an estimated population growth rate of around 1 % per annum (Chaudhury, 1996 and MPND, 2002). However, as indicated by the global historical trends, population started to grow more rapidly in and around the mid-50s as high mortality began to decline due to improvements in health conditions triggered by advances in medicine and availability of medicines. Population of Maldives was estimated to be around 100,000 in 1966, the year it gained independence. Maldives seems to have official census undertaking in 1977, scientific estimate of population growth rates were available only after that.

Table 1 below shows the population trends in Maldives covering almost a century. Maldives experienced both high fertility, high mortality regimes until mid-1980s and experienced rapid decline in the subsequent years, characteristics similar to other countries experiencing socio-economic and demographic transition. A population growth rate during the inter-censual period 2001-2006 has been 1.69 %.

Table 1: Census year, Population, Sex ratio and Average Annual Growth Rate, Maldives

Census Year	Total Population	Sex Ratio	Average Annual growth rate
1911	72,237	119	-
1977	142,832	111	-
1985	180, 088	108	3.20
1990	213,215	105	3.43
1995	244,814	104	2.73
2000	270,101	103	1.96
2006	298,968	103	1.69

(Source: MPND, 2007: Maldives, Population and Housing Census 2006)

Various data indicate that fertility of Maldives began to decline since the early 1990s (MPND, 2002) and this decline has been rapid in recent years (Niyaaz, 2002; Naseem et al., 2004). Fertility analyses of recent censuses indicate that Maldives has experienced one of the most rapid fertility transitions in the region. The 1990 and 1995 censuses reported total fertility rates of 6.4 and 5.7 children per woman. Total fertility estimates for the 2000 and 2006 stand at 2.8 and 2.1 respectively.

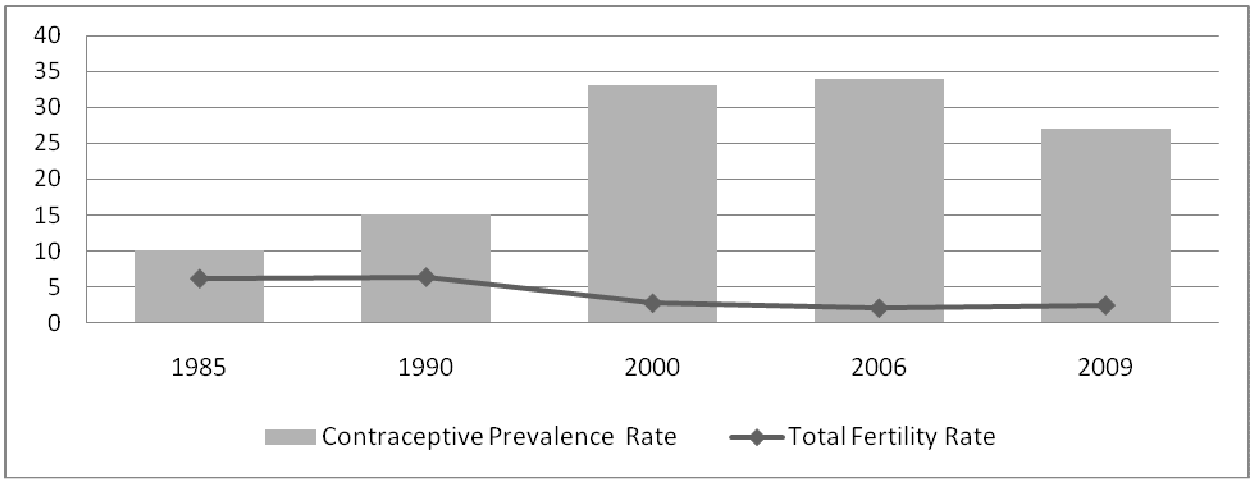

Fig 1: Selected indicators of Fertility and Family Planning- Modern Methods (ICPD+15), Country Report (Annex 2 Table A.1)

(Source: Country Report, Maldives: ICPD+15 and Beyond: Progress Achievements and Challenges, 1994-2009. Government of Maldives and UNFPA, 2009)

Contraceptive prevalence rate (CPR) shows a steady increase over 1985-2006 (Fig 1). Before the official launching of the child spacing project which formally introduced FP services in the country, the total CPR (inclusive of traditional and modern methods) was estimated around 10% which increased to 42% in 1999 to 39% in 2004 and declined to 35% in 2009. However, more scientific data on CPR began to be available only from 1999 survey which indicated a CPR of 33% for the modern methods. The corresponding data in 2004 RH survey was 34% and the first ever demographic survey conducted in Maldives in 2009 recorded a CPR of 27% for the modern methods.

Given the small size of the population, mortality estimates often lack consistency in estimates of demographic parameters. However, because Maldives conducts census every five years, the reliability of data cannot be questioned. Commensurate to the decline in the fertility, mortality has declined significantly during the reviewed period contributing to the increase in life expectancy at birth. Table 2 shows the decline in IMR, under- 5 mortality and MMR over the years. As per the data, Maldives seems to have already achieved MDG goal of reducing the MMR and infant and child mortality at the aggregate level.

Table 2: Trends in Mortality, Various Indicators, 1990-2009

Year	Infant Mortality	Under 5 Mortality	Maternal Mortality	Life Expectancy
1990	35	48	500	58 Both sexes
1995-2000	35	44	143 (2001)	70.7/72.2(M/F)
2000-2004	32	38	69 (2006)	71.7/72.7 (M/F)
2004-2009	14	17	43 (2008)	

(Source: Country Report, Maldives: ICPD+15 and Beyond: Progress Achievements and Challenges, 1994-2009. Government of Maldives and UNFPA, 2009)

As a result of declining fertility and mortality, the population age structure in Maldives has changed significantly even though, it is still relatively young. Changing age structure is depicted in Fig. 2 and population pyramid in Fig. 3. The percentage of population aged 0-15 in 1990 to the total population was around 47% which has declined to 31% in 2006.

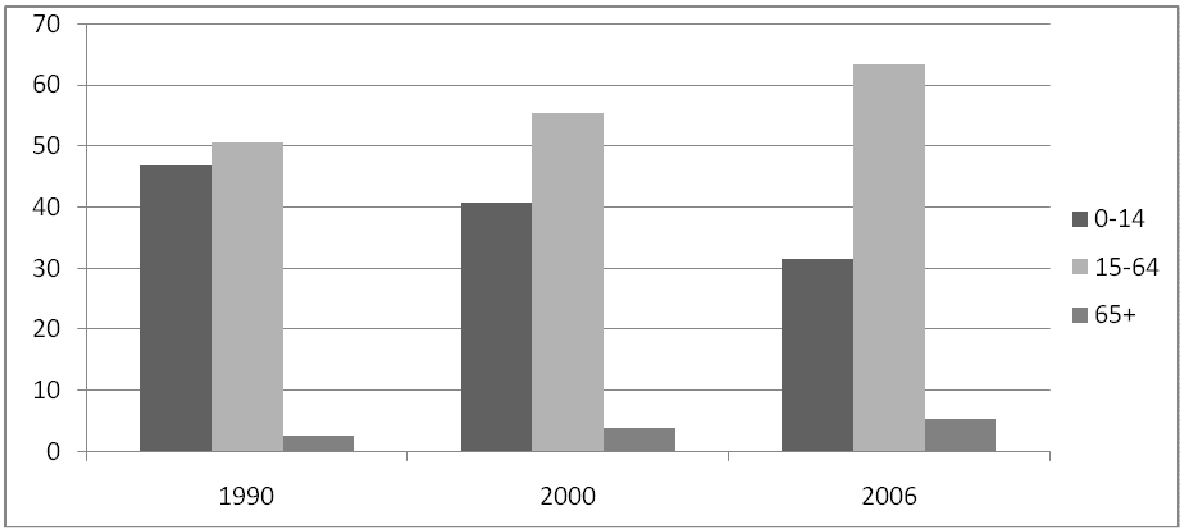

Fig. 2: Changing Age Structure of Maldivian Population (Annex 2 Table A.2)
(Source:MPND, 2007: Population and Housing Census, 2006.

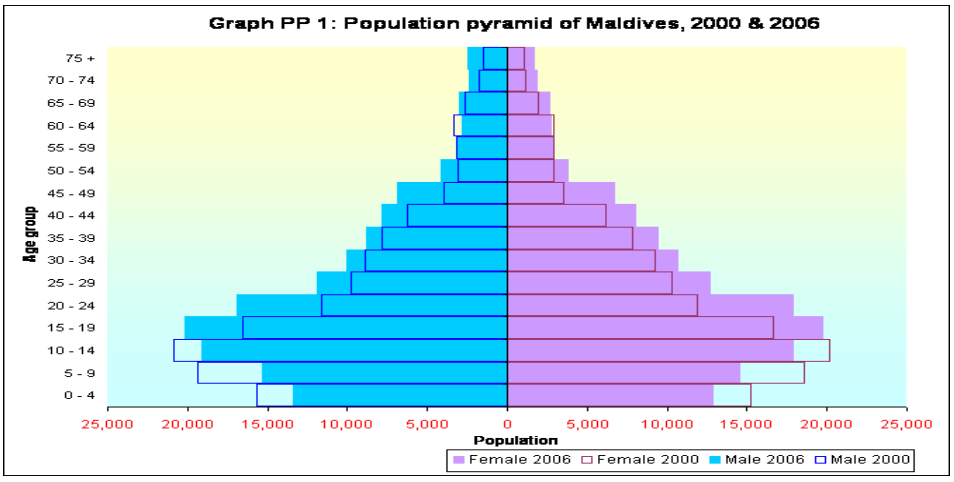

Fig. 3: Population pyramid of Maldives, 2000 & 2006
Source: MPND, 2007: Population and Housing Census, 2006.

This decline in younger age population bulged the working age population and Maldives has entered into the era of what is popularly known as 'Demographic Dividend'. This is a window of opportunity at which the dependency ratio (number of dependents per working age population) tends to be lowest in its

demographic transition and the country can really benefit from it by utilizing the working age population for economic development. The period is expected to last for about a generation (30 years or so). If the country fails to benefit from this window of opportunity, once again the dependency ratio is likely to be imbalanced and working age population will decline resulting in higher dependency ratio. Maldives has achieved this stage because of its successes in promoting socio-economic development, by investing more in improving access to health and education.

3.2 The Secrets of Success

Relative to the spread of the small islands (1200) forming the archipelago, the number of inhabited islands is around 198. A number of socio-economic and political factors have contributed to Maldives' success. The small size of the population, generous donor support, opportunity provided by the tourism sector and fisheries industry fueled the revenue needed for investing in people. Maldives enjoyed an economic growth during the 1980s and early 1990s – GDP growth rate hovering around 10 % per annum, reaching a height of 11.4% in 1990 (MPND, 2003). The prolonged high rates of GDP enabled the government to invest more in social development - investing in human capital - education and health of people and improving services for them.

A notable feature of the Republic's national development plans has been the public expenditure on health and education which has far exceeded the population growth rate. For many years, Maldives' development plans continued to allocate more than 24% of all public expenditure on health and education well in excess of the 20% recommended by the World Summit on Social Development. No gender disparity exists in primary education and net enrolment ratios are higher for girls at the secondary school level whereas the gap in tertiary education is narrowing—girls are catching up. With the expansion of school facilities, expenditure on education has also increased tremendously. The expenditure on education rose from US$19 million in 1995 to US$169.4 million in 2009, an increase of almost nine fold (UNCT, 2010). In the past, government also focused on adult education through religious leaders and school teachers. These achievements have played an important role in explaining near-universal literacy rates among the 15-25 years old and gender-parity in literacy.

As with the case for education, there has been rapid expansion of health facilities. Government made a policy of expanding health facilities to all islands. Islands without health facilities were targeted for outreach activities conducted either by the centre or by the atoll health facilities. It has achieved near-universal coverage for diseases under the expanded programme of immunization (EPI), contributing to

child survival. With increased child survival prospect, women are bearing fewer children, thus improving their health.

The expansion of health facilities, especially availability of a specialist medical practitioner such as gynecologist for obstetric care and services and nurses at regional hospitals and atoll hospitals significantly reduced travel time to seek medical care and more importantly, expenses to pay for commuting to health care facilities.

Likewise, effectiveness in promoting the primary health care (PHC) approach advocated by the Alma Ata Conference has been identified as one of the critical elements of success. The reasons for these successes were primarily the adoption practices which were designed according to exemplary PHC principles and strategies: provision of accessible services, with special emphasis on atoll populations; awareness creation on high-risk pregnancies; continuity of antenatal and post natal care, ensuring four antenatal visits for each pregnancy; and deliveries attended by skilled personnel. For example, 2006 statistics indicated that 54 % of deliveries were conducted by doctors, 39 % by staff nurses, 8% by nurses, and only around 3% by TBAs, many of whom were trained (WHO and DPH, 2008).

Other elements of success were implementation of periodic development plans well supported by sectoral policies and strategies (e.g. Health Master Plans, National Reproductive Health Strategies, Youth Policy) which strengthened Maldives' institutional capability to deliver services in planned and incremental way. As early as 1999, Maldives had developed a national population policy which was formalized in 2004 (MPND, 2005).

4. Current Issues in the National FP Programme

In order to better understand the issues, it is pertinent to know how health services in general and FP services in particular is planned, organized and delivered in the Maldives. This is followed by evolution of FP programme and current status and issues in RH and FP in the country. The country's Health Plan of 1980 is considered as the foundation of the health planning and development in the country. The second stage of the long term planning was the formulation of the Perspective Plan for the country which ended in 2005. Ministry of Health (now Ministry of Health and Family) formulates annual development plans and programmes.

4.1 Delivery of Health Services in Maldives

Maldives' health services are organized as a four tier hierarchical structure. At the lowest level of service delivery, island level health facilities known as Health Centres (HC) are operational. At this level there

are at least two grades of the facilities depending upon the size of population it serves. Some of the facilities have a medical doctor since 2007, community health workers (CHWs) and nurses in addition to other administrative staff. Islands with lower population base have only CHWs and *Foolhumaas* (Traditional Birth Attendants, TBAs). At the atoll level, which usually consists of more than two islands, Health Centers upgraded to atoll level hospitals are operational. There are around 19 Atoll level hospitals in the country. Since 1993, they have been staffed with medical doctors and CHWs. As per the policy of the government articulated in the Master Health Plan, MHP (1996-2005), these facilities have been upgraded to provide in-patient treatment and labour room facilities for deliveries. They have now been staffed with other medical service providers such as a pediatrician, gynecologist, and nurse-cum-midwives. Some of them also provide comprehensive emergency obstetrics care services (CEmOC).

At the third level, there are Regional Hospitals that cater to three to five atolls. There are six regional hospitals in total to provide secondary level curative care, including surgical and outreach services to all atolls. In addition, they are also staffed to provide ear, nose and throat (ENT) services and have programme for vector borne diseases. The Hulumale Hospital is another health facility which caters to the capital Male' population and also functions as a regional hospital.

At the national level, Indhira Gandhi Memorial Hospital (IGMH) in Male' serves as the tertiary care facility. The referral system works with a hierarchy ascending from family health workers (FHWs) in islands to specialists in IGMH. The establishment of public health unit within the health facility is characteristic of Maldives' effort to combine both preventive and curative services to promote preventive aspects of health. Abdul Rahman Dhon Kaleyfan hospital in Male', a private sector facility also serves as the referral and tertiary facility. See Annex 3 for RH services provided by various tiers of health facilities.

The Ministry of Health and Family is the policy making body of the Health Ministry. After the democratic changes, the former Department of Public Health (DPH) has been renamed as Center for Community Health and Diseases Control (CCHDC), which looks after the programmatic side of the primary health care in the country. The National Thalassaemia Center (NTC), Maldives Water and Sanitation Authority (MWSA) and Institute of Health Sciences (HIS) are other para-statal organizations involved in one or the other way in health service delivery.

Within the CCHDC, the Population Health Section is responsible for the planning, distribution and management of FP services in the country. The supply unit within this section is responsible for the

logistics management of the RH commodities, mostly FP methods. There is a policy of maintaining a stock for six months at the regional and atoll level facilities and three months at the health facilities at the island level. The health centre in-charge at island level and primary health unit in-charge in the atoll and regional health facilities submit the regular requisitions for contraceptives to Population Health Section which is then forwarded to the Supply Unit for distribution. Based on the request made for additional supply of commodities, the Supply Unit sends the requested quantities to the respective service delivery points. Over the years, UNFPA has assisted the strengthening of the logistics management information system by providing training to the staff in the management of the system to ensure un-interrupted supply of commodities at each level of service delivery. The government has now fully undertaken the responsibility of funding the contraceptives.

4.2 The Evolution of Family Planning Services in Maldives

Maldives did not have an official FP programme until 1984. Planned efforts to reduce infant, child and maternal mortality got some headway between 1984-89 (Government of Maldives, 1994). During the period, the Government entered into a contract with UNFPA/UNDP/WHO to promote child spacing programme to increase the intervals in successive births with the aim of improving maternal and child health. In the early days of the programme implementation, distribution of contraceptives was limited and there were no policies and procedures for its promotion and distribution. In 1987, Maldives formulated a policy and procedure for procurement and distribution of contraceptives, provision of contraceptive services, counseling to potential acceptors and monitoring of both supplies and services. The methods selected by the government for child spacing included natural methods, hormonal and the barriers methods, for example, pills and IUDs. Male and female sterilization were permitted only on medical grounds and at the voluntary request of the couple. Given that all island level health posts were not equipped with trained medical personnel, it was also decided that contraceptive methods be distributed only at the atoll level health facility. The protocol required that the contraceptives be given to couples only by medical doctors or Community Health Workers (CHWs). However, in 1990, realizing that limiting the availability of contraceptives at the atoll level facility hindered access to contraceptives to a large majority of island population, it was decided that contraceptives be made available at islands level also. For that purpose, 57 FHWs were upgraded by providing them training on contraceptives and were positioned in more populated islands of the country (Didi, 1991; Government of Maldives, 1994; Thongthai and Didi, 1996). This helped in wider awareness and gradual increase in the CPR in the country.

The first ever Knowledge, Attitude and Practice (KAP) survey on FP carried out in December 1990, with financial assistance from UNFPA and WHO, helped to evaluate the success of the FP interventions, to

improve service delivery and launch specific information, education and communication (IEC) programmes for promoting the use of FP. The survey also provided important policy-programme relevant information to improve the quality and access to primary health care/RH services in the country.

In 1990, realizing the limited capacity of the Government to expand FP and child spacing services, UNFPA supported an NGO, Society for Health Education (SHE) under a project titled, "Development of Effective Child Spacing Mechanisms in Selected Regions and Atolls" which helped in raising public awareness on population growth, the importance of FP, small family size and use of FP services for child spacing (UNFPA, 1997). The project ensured community participation in health care of the mother and child and promoted the concept of volunteerism in the country. It also helped to strengthen national capacity in the field of IEC, a backbone for the success of any public health intervention. UNFPA support to the NGO was also a realization that Government alone cannot shoulder the burden of all round development and NGOs and civil societies should collaborate to reach out where the government has failed to do so (Didi, 1991 and Didi and Thongthai 1996).

Training of service providers (*Foolhamaas*, FHWs and CHWs) together with island leaders, through mobile health trainings at atoll levels on importance of family health, prevention and promotion of reproduction (fertility/infertility), motivation and counseling of couples, and contribution of local elites (island, atoll leaders) in promoting women and child health contributed significantly in strengthening the PHC services of the government. Although the focus was on FHWs and CHWs, the project also strengthened the capacity and skill of medical officers and medical supervisors. Provision of international consultants, health personnel such as nurse-cum-midwives and several other technical backstopping support including UNVs, filled the human resource gap in health service delivery. Similarly, the provision of equipments, boats and supplies (contraceptives) strengthened the national capacity to attend to the emerging needs. The boats were not only utilized for UNFPA-supported activities but it also helped increase the mobility of health care providers within island and atolls (Didi and Thongthai, 1996).

Khaleel (2001) argued that the main aim of introducing and integrating the FP programme within the MCH services was among the top priority areas to provide better services for pre- and post-natal care as well as child health. He further identified that IEC activities on population issues along with the benefits of child spacing were critical elements in Maldives' FP successes. He noted that the IEC strategies played a pivotal role in motivating couples to accept FP as a means to limit their family size. For instance, radio, TV and other mass media such as local newspapers and print materials and interpersonal communication networks among community leaders were used to disseminate information on FP issues. Training/orientation regarding RH/FP programmes was introduced for atoll chiefs, department heads and

religious leaders. Other relevant activities included the training of community volunteers, such as teachers, women's groups, island development committee members and youths as motivators and agents of change.

4.3 Trends in Method Mix

Despite remarkable success of the FP programme in the Maldives, not all modern contraceptive methods are promoted and available to the Maldivian population. CPR of modern methods was 33%, 34% and 27% in 1999, 2004 and 2009 respectively for which data are available from comparative national surveys (see Table 3). Even when the CPR was highest at 42% in 1999, the contribution of the traditional methods was the highest (about 9%). The use of modern methods improved only slightly from 33% in 1999 to 34% in 2004 as per the RH survey of 2004. During the 2004 period, the contribution of the traditional method declined to 5% while the total CPR (inclusive of traditional method) stood at 39%. Users of traditional methods are split almost equally between periodic abstinence (3 %) and withdrawal (4 %).

Table 3: Trends in Contraceptive Method Mix, 1999-2009

Methods	**1999**	**2004**	**2009**
Modern Methods	33.0	34.0	27.0
Traditional	9.0	5.0	7.8
Total Users	42.0	39.0	34.7

(Source: Ministry of Health, Republic of Maldives, UNFPA, CIET International, *Reproductive Health Survey 2004, Male'*, Maldives, 2004, Decision Support Division, Ministry of Health and Family, Demographic Health Survey, 2009, Preliminary Results).

Pills and female sterilization has remained the backbone of modern contraceptive used in the country. Oral pills has remained one of the most popular methods of contraception in the Maldives during the 1999-2004 period, accounting for 13% to the CPR in both the surveys in 1999 and 2004 respectively. The other modern contraceptive methods which remained constant during 1999-2004 were injectables (3%) and male sterilization (1%). However, during the 2004-2009 periods, there has been a significant shift in method mix. For example, the use of pills declined from 13% in 1999 and 2004 to 4.6% in 2009, injectables declined from 3% in 1999 and 2004 to 1.2% in 2009 and male sterilization declined from 1% in 1999 and 2004 to 0.5% in 2009.

In 1999, female sterilization contributed about 10% to the CPR which declined to 7% in 2004 and again increased to 10.1% in 2009. Male condom is the only contraceptive method which shows some consistency of increase across the successive survey periods. The use of male condom increased from

around 6% in 1999 to 9% in 2004 and to 9.3% in 2009. The use of IUCD was about 1% in 1999 which doubled to 2% in 2004 and again declined to 0.8% in 2009.

Historically, Maldives FP programmes offered limited choices of methods. Government was always sensitive to societal norms. Despite limited choices of methods offered, the rapid decline in fertility and mortality proved that its FP programmes have been successful. However, the government could not maintain the momentum of the FP programmes due to political reform process initiated in the country since the mid-2005 as well as due to the priority on rehabilitation and reconstructions after the Tsunami.

Abortion is illegal in Maldives and is not considered as a method of FP. Although data on abortions are difficult to obtain, partly because people are not willing to discuss openly due to religious reasons, the RH Survey 2004 and Biological and Behavioral Survey 2008 data from the Family Protection Unit of IGMH have pointed that unwanted pregnancies and voluntary abortions do happen in the islands and in Male'.

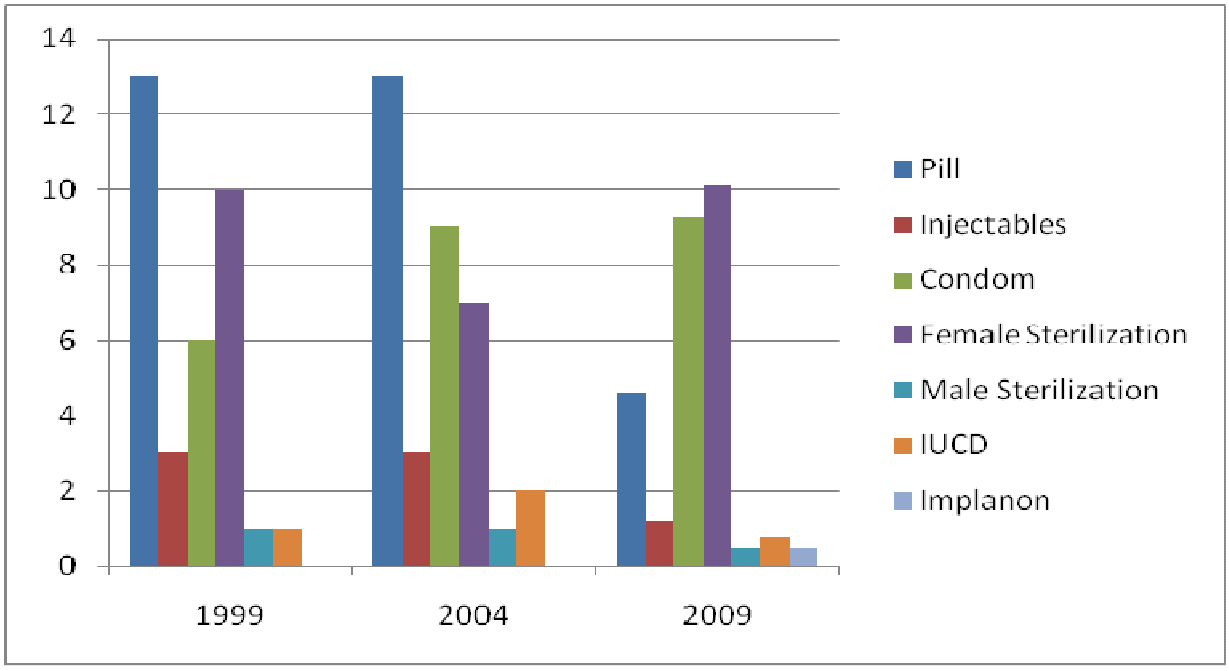

Fig. 4: Trend of Modern Contraceptive Method Mix

Source: (Annexed on Table A.3)

However, the recently concluded DHS survey, 2009 presents a different picture and shifting preferences of the users. Overall, total CPR has declined to 34.7% in which the contribution of modern methods is only 27%, a decline of almost 21% between 2004-2009. Except for increased use of female sterilization from 7% in 2004 to 10% in 2009, and a small increase in condom use, all other modern methods showed a significant decline, the most noticeable being for the oral pills. The use of oral pills declined from around 13% in 2004 to 4.6% in 2009, a decline of almost two-thirds. During the period, the government

introduced Implanon and it contributed about 0.5% to the total CPR from modern methods. Maldives' Master Health Plan, 2006-15 aimed at increasing the CPR by 50% in 2010 and to 65% by 2015 to meet the ICPD and MDG goal (Ministry of Health, 2006). However, its progress towards attaining that goal has remained weak despite appreciable decline in the TFR.

There are social and cultural barriers to promotion and acceptance of contraceptives in the country. Like many other countries in the region, Maldives offered "cafeteria approach" for promotion of contraceptives, its impact has been limited due to socio-cultural and geographical barriers. Ajmal (2003) considers that some of the contraceptive methods such as condom have been put under Schedule 3 of the drugs which means that it must be sold by a pharmacist with a prescription. Treatment of condom in Schedule 3 of the drugs poses a barrier for accessing it as and when needed by sexually active people. Government has also failed to push methods such as IUCD and Implanon in massive scale due to lack of trained service providers. In summary, method mix has remained very weak in Maldives and desires much to be improved.

Unlike other countries in the region, Maldives' demographic transition is unique. It has achieved a rapid fertility decline without commensurate increase in the CPR. Likewise, contraceptive use behavior in Maldives is quite different from the commonly observed patterns elsewhere. For example, contraceptive prevalence in the Maldives decreased with increasing education, (e.g. use of modern methods declined from 36% among women with no education to 21% among women with more than secondary education). Most of the differential is due to the higher reliance on female sterilization among women with no education. Interestingly, while pill use declined with increasing education, condom use increased with increasing education. Unlike many other countries, the differences in contraceptive prevalence by wealth status or urban-rural residence are also not substantial (MOHF-MDHS, 2009).

4.4 Adolescent sexual and reproductive health and access to contraceptives

Maldives does not have an explicit policy on access to contraceptives among adolescents, youth and unmarried couples/individuals. As a result, a large number of adolescents do not have access to FP services despite the evidence of increased sexual activity and risky behavior of this group.

Several surveys and reports showed increased vulnerability of Maldivian adolescents and youths to risky behaviors (Narcotics Control Board, 2003; Ministry of Youth and Sports, 2005; UNDP, and MOH, 2008; SAP, 2009). A rapid situation assessment of drug abuse in Maldives (Narcotics Control Board, 2003) reported that by age 21, 75% of youth have had at least one sexual experience. Many of the adolescents and youth sexual encounters were without condom use making them the most at risk group for rapid transmission of HIV/AIDS. A situational analysis of the adolescents (Ministry of Youth and Sports,

2005) showed that only about 40% of adolescents were with their parents and almost 27% of adolescents aged 10-14 were not with their biological parents with possible impacts in proper grooming and limited opportunities for development of the adolescents. The same study noted that 14% of males and 5% of females under the age of 18 admitted being sexually active and many of them did not use condoms. Access to condoms for unmarried adolescents remains a barrier. A study found that even though IGMH is distributing free condoms, many potential users did not obtain it from there but rather bought it from the pharmacists for confidentiality and brand availability (Ajmal, 2003). The same study noted that of the total buyers, only 6% were adolescents, which the pharmacists themselves acknowledged that this is under-reporting of the buyers by them.

Maldives conducted the first ever Demographic and Health Survey in 2008/09. Preliminary results of the survey indicate that knowledge (heard) of HIV/AIDS is almost universal among the Maldivian population (MOHF, 2009). More significantly, after the receipt of the first ever support from the Global Fund for HIV/AIDS, a first biological and behavioral survey (BBS) was conducted among the five most-at-risk groups (Seafarers, Men having sex with men (MSM), adolescent youths, commercial sex workers (CSWs) and injecting drug users (IDUs)) which showed that Maldivian youths are vulnerable to HIV/AIDS. The report noted that unprotected sex with multiple partners is prevalent among the high risk groups and that the sharing of unsteriled needle and syringes is common among IDUs (31% in Male', 23% in Addu). This study also found risky behaviors among the 15-17 year olds and the older youth, including buying and selling of sex, sex with non-regular partners, pre-marital sex, group sex and injecting drugs. However, these behaviors are not consistent with the self-perception of risk. The majority of respondents believed they would not get HIV. Some 3-6% believed that religion alone will protect them from HIV (UNDP and MOH, 2008). Youths seeking counseling services are increasing[1] but the services are limited mainly to Male'. In 2009, Maldives participated in the Global School Based Student Health Survey (GSHS), which substantiated some of the findings by various surveys and studies cited above. The survey found that alcohol use among school students was 6.7% (9.1% male and 4.2% for female) and 66% of them having experienced it before they were aged 14 years (Education Development Centre and WHO, 2009).

To address sexual and reproductive health (SRH) care needs of the adolescents, UNFPA has been supporting integration of population and more importantly life skill education (LSE) activities in the school curricula. However, its attempt on LSE has remained modest and mostly limited to Male' area. The LSE modules and training are very much appreciated but due to lack of support it has not been able

[1] Personal interaction with Dr. Mausooma of SHE.

to reach out to the most vulnerable population groups, especially adolescents and youth, and out-of-school children.

To fill-in some of the gaps in SRH services for adolescents and youths, more importantly out-of-school youths, UNFPA and WHO joined hands to establish Youth Health Café (YHC) in Male', which many believed was a step forward in creating a conducive environment for improving adolescents' access to SRH services. However, it could not get the momentum going for several reasons. One of the primary reasons is ownership of the programme. Institutionally, YHC is housed and run by the Ministry of Youth and Sports but services are to be provided and coordinated by the Ministry of Health and Family. Lack of sectoral coordination between the agencies is the other reason. Given the prevailing socio-political situation, all parties consensus and coordination to improve SRH of adolescents and youths is critically important.

Likewise, UNFPA also partnered with WHO and UNICEF to improve access to services for the gender based violence (GBV) victims and established Family Protection Unit (FPU) within the IGMH. The unit is under the supervision of a well trained gynecologist. A closer examination of cases treated and referred to FPU provides sufficient evidence that sexual abuse of children is increasing, so is the case of teenage pregnancy and GBV against women and children. This is evidenced by the fact that one in three women in Maldives were reported to be victims of GBV (Ministry of Gender and Family, 2007). Despite the potential of FPU to serve as the nodal agency, lack of coordination among several agencies—the Ministry of Health and Family, child protection section, police and other welfare agencies has hampered the smooth functioning of the unit.

4.5 Promotion of Condom as a means of Dual Protection

Despite critical evidence for promoting condoms as a means of 'dual protection', government response has been lukewarm. It still has to formulate a policy on dual protection and integrate this in the RH commodity. Maldives' successive attempts to secure Global Fund (GF) support culminated in support for HIV/AIDS programme with UNDP as the principal recipient in 2006. Under the programme, a series of exploratory and behavior research activities have been carried out targeting the most at risk groups. It has also been supporting syndromatic treatment of RTI and STIs in the country. Table 4 below depicts STIs services provided under the GF supported HIV/AIDS programme—STI is seemingly a major RH problem and a hidden disease in the country.

Table 4: Services Provided to STIs Patients through Global Fund Supported HIV/AIDS Projects

Description	By P1 - August 2009		By June 2010	
	Target	Achieved	Target	Achieved

Number of health care providers trained in diagnosis and clinical management of STIs	248	253	261	316
Number of STI cases treated at health care facilities	200	1619	1,702	2,587

Source: UNDP/GF, 2010, Data given by UNDP/GF Programme Manager

4.6 The NGO Sector

The NGO sector in Maldives has been historically weak. Before the advent of the multiparty democracy, in 2008, only two to three national NGOs of importance were in existence. SHE (Society for Health and Education) has remained in the forefront of population activities in the country. UNFPA supported SHE to assist government in reaching out to the marginalized community. SHE runs counseling centers for adolescents, mainly pre-marital youths offering them counseling and referral services but not free access to contraceptives. SHE is also running some youth related activities under the GF-supported HIV/AIDS programme. Apart from the counseling support, SHE also runs a FP clinic. SHE does not provide free access to contraceptives to unmarried adolescents but it provides emergency contraceptives to victims of sexual violence in consultation with guardians of the victim.

There are few other NGOs such as Journey, Maanfa-center of elderly population, Mothers against Drugs which are becoming popular in the country. Journey is closely associated with drug abuse and rehabilitation of drug-addicts and has played a critical role in the GF activities.

NGO Capacity and Needs Assessment, a collaborative exercise of the Rajje Foundation, Australian Government and UNDP noted that there is little understanding of and support for meaningfully involving NGOs and civil society by some government institutions. There exists unexplored opportunities for productive and mutually beneficial linkages between the Government of Maldives, NGOs, private sector, I/NGOs and civil societies. The existing Associations Act and its regulations need to be revised to improve participation by independent and diverse civil society actors. The report further noted that the capacity of NGOs are low due to low level of funding and inadequate human resources that are managed mostly by volunteers.

4.7 International Support

Maldives has received generous support from international development partners and agencies, such as WHO, UNICEF and UNFPA in promoting health care services in the country. While WHO was actively engaged since early 1960s, UNFPA came relatively late to the scene but contributed significantly in promoting FP and RH services. UNFPA has been the only agency supporting Maldives in the RH commodities including FP services and its logistics management system. Under an exit strategy agreed with the Government, UNFPA has gradually reduced its share in the procurement of RH commodities while the government's share has been increasing. As a result, by 2010, Maldives' government has taken

the ownership of procuring the contraceptives through its own internal resources and UNFPA is no longer investing in FP procurement even though it is still assisting the government in its international procurement and quality control.

Maldives drafted the first National HIV/AIDS Policy in 1996 with WHO support. This policy was further revised and updated in 2004 to address the emerging issues including the findings from the youth and drug surveys (Ministry of Health, 2006). The HIV/AIDS policy aims to control and limit the transmission of HIV/AIDS through focusing on IEC, while taking measures to maintain confidentiality and eliminate discrimination. Maldives has also started receiving support from the Global Fund against HIV/AIDS, Malaria and Tuberculosis (GFATM). The Biological and Behavioral Survey (BBS) conducted under the GFATM fund has helped to establish a scientific database on some of the most at risk groups such as FSWs, MSM, youths, IDUs and seafarers.

5. Understanding the Current Situation

Maldives' demographics is unique in many sense. Within a short period of time, Maldives experienced a rapid decline both in birth and death rates and increased life expectancy at birth. These improvements were felt across all regions and administrative units and had important implications in reducing the TFR, IMR and child mortality and MMR in the country. As a result, Maldives has already achieved some of the ICPD goals and most of the MDGs. However, Maldives also faces challenges in sustaining and consolidating the gains it has made.

One of the implications of the demographic transition is the changes in the age and sex structure of the population. Maldives' population is youthful and it has already entered the era of demographic window of opportunity where there is more working age group population than the dependents, making it potentially the most productive period in national history. But this also meant that there is high level of unemployment among educated youths. Because of early sexual activity and lack of safe sexual behavior, coupled with increasing drug and substance abuse, Maldives is vulnerable to rapid transmission of HIV/AIDS in the country if further preventive measures are not taken. For example, a situation analysis of HIV/AIDS study estimated that by 2015, without intervention, Maldives has as many 5,780 HIV cases, but, with intervention, the HIV cases may be limited to 292 cases (NAC, et al, 2006).

There are some disturbing signs as well. After a steep decline in TFR in 2006, the latest DHS conducted in 2009 shows that fertility has actually increased during the 2006-2009 period from 2.1 in 2006 to 2.5 in 2009. This increase in TFR is accompanied by a decrease in the CPR, especially of modern methods.

Factors which are contributing to such reversal trends in the country are matters of serious concern and need to be watched and addressed carefully.

One of the main reasons has been shifts in government priorities in policies and programmes. Maldives is one of the countries that conducts census every five years, which allows government to review its policies and programmes based on new socio-demographic indicators. Once the government realized that population is undergoing rapid demographic change (especially after the 2000 census), the focus of the programme shifted to other areas and at all levels. Public health workers in the government departments acknowledged this shift and agreed that government was not aggressively pursuing and implementing FP agenda as before. Because government allocates resources based on population figures, with the decline in number of school-going children, community people in the islands feel that government may close the school or merge it to the neighboring island school. This is also likely to happen to health facilities. Hence, this encourages the island community to be pro-natalist and shun the use of FP services.

In view of the constraints posed by geography on national development, government introduced population consolidation policy aiming at reducing the sparsely populated islands by merging them with nearby islands and establishing regional centers. However, the lack of clarity on what really consolidation entails and the way it was handled has created some negative impact on FP programmes. Island communities, especially the elites and leaders see that the government is targeting their community for consolidation. They propagate that if they continue using FP and do not bear more children, the community would be the first target for moving to another island for consolidation and would have to face more difficulties.

The UN country team, in its country situation analysis towards preparation of the next cycle of support, recognizes the increase in Islamic fundamentalism as a critical factor that will have important bearings in Maldives' future development (UNCT, 2010). Islamic fanatics are using FP in their propaganda and are saying that the use of FP is against Islam and discourage people to use it. This is beginning to influence the attitude and behavior of the service providers and they are not encouraged to promote it.

Despite relatively good socio-economic indicators, violence against women is very high- one in three women have experienced violence in their life time (Ministry of Gender and Family, 2007) in the . Maldives also has one of the highest percentages of women who are heads of household. This puts additional burden on women as they have to take on the role of a man as head of the family as well.

Of critical importance are the new government policies and programmes. The National Strategic Action Plan (SAP): National Framework for Development, 2009-15 will serve as the principal planning

document of the government in the delivery of the government pledges and programmes outlined in the Maldives Democratic Party (MDP) alliance manifesto. The five pledges include: a) developing a nationwide transport network that would allow for people and commerce to move without hindrance throughout the whole country; b) providing affordable housing to all citizens; c) ensuring reasonable and affordable healthcare to all citizens; d) bringing down the costs of the most basic goods and services; and e) eliminating the rampant traffic and abuse of narcotic drugs currently prevalent in the country. The Strategic Action Plan of the government is to-date the most comprehensive planning document. A number of policy frameworks are proposed under each sector. Under the health sector, the following policy statements are articulated:

- Strengthen health promotion, protection and advocacy for healthy public policies
- Provide access to affordable, equitable and quality health services for all Maldivians including provision of universal health insurance
- Build a competent, professional health service workforce
- Build a culture of evidence based decision making within the health system
- Establish and enforce appropriate quality assurance and regulatory framework for patients
- Enhance the response of health systems in emergencies

The Ministry of Health and Family in its mission statement mentions that it aims to establish systems for health, well-being and social protection of its people, provision of affordable, accessible and quality health care services and drug rehabilitation services and strengthen mechanisms for protecting the rights of its children, women, persons with disabilities and elderly and sustain the quality of health care and social protection services. One of the pillars of SAP is “affordable and quality health care for all”. Among others its strategies include strengthening the motherhood and RH programmes including age sex appropriate ASRH, cancers, GBV and provisions of RH commodities and universal health insurance for all.

It has formulated a new Health Master Plan. A New RH Strategy, 2008-10 is also operational. As per the SAP, government plans to strengthen public-private partnership (PPP) and entrusts the operation of health facilities to the corporations. It also aims at promoting decentralization and giving greater control to the people. Accordingly, it has already formed two corporations for the IGMH and Addu hospital. However, there is no clear policy on how the corporatization of the health facilities will help to achieve the pledges made under the SAP. Likewise, the government has also brought an ambitious health insurance scheme known as Madhana to cover all Maldivians. Except for voluntary health insurance scheme (VHI) which is patronized by semi-government entities, Madhana is the only insurance scheme that promises to cover all

Maldivians. In 2011, "Madhana Plus" is likely to be introduced to provide subsidies for international treatment. The Government also plans to subsidize insurance premium for those who earn less than Rufiyaa (rf) 21/day (about 100,000 persons estimated to earn less than 21 rf/day) which will entail recurring financial burden of US$ 200 million in the current financial crisis situation (Ministry of Health and WHO, 2009). Another study (Chamara, 2009) on inequality in health services in the Maldives recognizes the gains made by the country and noted that even though health services outside Male' is pro-poor, inequality lies in providing special services and care. Cost of travel to seek higher level of services is very high and significant inequality lies in obtaining medicines when needed. The government policies such as the ones mentioned above have wider implications for delivery of health services. Maldives' current success in development is brought by investing in building social capital and health and education of the people. Public expenditure on health and education is highest and the public sector finances 90% of health expenditure in the country. This may not be the case in the future. Vulnerable groups such as women, adolescents and youths and people living in the outer islands would then be deprived of the much needed health services.

6. Recommendations

Repackaging of Population and Development Issues. Although Maldives has made significant gains in achieving MDG goal in MMR and IMR, it has yet to achieve ICPD goal on improving universal access to RH services especially amongst adolescents and youths. Likewise, CPR of 27% for modern methods with a seemingly high unmet need estimated to be around 33% (the new DHS data is yet to be analysed) clearly demonstrates the need for promotion of SRH rights and services in the country, hence the refocus on FP services. UNFPA and RH advocates must repackage the programme and its messages capitalizing on the recognition of reproductive rights by the government. Emerging data must be analysed to create evidence to advocate for continued relevancy of promoting RH for improving the quality of Maldivian men, women and adolescents. Innovative approaches must be identified and worked out to suit the changing preferences of people.

Conduct Qualitative and Socio-cultural Research. There are critical gaps in understanding the underpinning factors of demographic transition and Maldives' success in improving socio-economic condition. Relatively, low CPR of 39% and decline in TFR in the magnitude of 2.1 in 2006 demands lot more than what we know of the Maldivian society's RH behavior. What is contributing to this phenomenon? There are several unanswered questions. Is it abortion, or high mobility of men or secondary sterility, or high prevalence of RTI/STI or a combination of these factors which is contributing to such a situation in Maldives? Abortion is illegal in the country. But abortion is believed to be carried

out both within the country and outside. An in depth, socio-cultural perspective to help understand the situation is clearly called for.

Improving Contraceptive Method Mix. Contraceptive method mix has remained weak in Maldives. Future programme effort has to be directed at improving the method mix. For this purpose training of service providers on use of the method and counseling is critically important. Given the rise of the Islamic fundamental elements in the country, it is likely that there will be stronger opposition to some methods than other, for example male sterilization. RH and population programme has to be developed and designed to reflect the sensitiveness of these issues, changing priorities and test of the community at large and service providers. Maldives FP effort in the past has been successful on stressing the importance of spacing methods to have the desired number of children couples want. Learning from the past experience, similar programmatic efforts should be directed utilizing the changed context to promote SRH and reproductive rights of individuals informing them on choices of methods and its efficacy. Male involvement in FP should be promoted more effectively. Such effort should also target the capacity building of FP service providers by developing their skill on service provision of which counseling to the client is an integral part.

Advocacy and Lobbying. There are new actors in population and development in the country. There is a new parliament (Peoples Mujliis), many of them are young and restless. Islamic party is the coalition partner and Supreme Council of Islamic Affairs has a big say in shaping the opinions, values and behavior of the people. Utilizing the opportunity provided by the SAP and Maldives' international commitments, new advocacy materials has to be prepared for specific target groups at all levels. Tailor-made exposure visits of the key actors in relevant countries (Iran, Pakistan, Bangladesh, Malaysia and Indonesia) to places of importance on SRH should be targeted. GF has successfully utilized the Council to the benefit of the HIV/AIDS programme. Population and RH programmes can also benefit from such interventions. These advocacy materials must be grounded and be evidence-based. Much of these evidences will have to come from various socio-economic research proposed above while the DHS and BBS will provide further evidence on some of the issues. Advocacy tools and materials based on these should be developed and used to inform and lobby for relevant policy and programmatic changes.

Addressing Adolescent and Youths SRH Needs. Maldives' adolescent and youth population is sexually active and restless. A number of socio-cultural factors – high divorce rate, high unemployment, lack of access to RH services and information have further compounded the situation. Youth related problems have worsened in densely populated places such as Male' and Addu. Lack of space and opportunity for sports and other recreation drives adolescents to other avenues of action. Youths are being reported to be

used by all political parties for various purposes. Developing schools, educational curricula that values labour and teaches life skill education and is employment oriented is needed along with SRH information and services. A multi-sectoral response to address adolescent RH and development needs should be prioritized. Evaluation of the FPU and YHC and its recommendations should be used to create a new model of service provision for improving access to adolescent and youth. Private sector, civil societies and NGOs should be encouraged and strengthened to promote sexual and reproductive information and services to adolescent to protect them from risky sexual behavior.

Communication and Behavior Change. Despite universal knowledge of FP devices and HIV/AIDS, use of the methods is nominal both for meeting the unmet need and protection from risky sexual behavior. The focus of future RH and population programme should be identifying the communication messages to change the behavior of the people, more importantly adolescent and youths. Peer education and role models could be used to influence the outcome. Building upon the increasing evidence from various surveys and studies, multiple media sources both electronic and print should be engaged and encouraged to disseminate these messages to reach out to a wider spectrum of adolescent, youths and their families.

Addressing Gender Disparities and Gender-based Violence. Maldives is less likely to achieve the MDG in reducing gender disparity and reducing violence against women. As a liberal Muslim state in the past, Maldivian women enjoyed relative freedom and improved socio-economic status. But women in Maldives also suffer from GBV. Addressing gender-based violence requires multi-pronged approach at all levels. New Government's SAP has some good elements to promote gender equality and empower women. Development partners must continue to build on past achievements and not lose sight on this.

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Annexes

Annex 1: Acknowledgement and List of Persons Met

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Dr. Mausooma Kamaluddin, Director of Sexual and Reproductive Health, Society for Health and Education (SHE)

Annex 2: Tables

Table A.1: Selected indicators of Fertility and Family Planning

Year	Total Fertility Rate	Contraceptive Prevalence Rate for Modern Methods
1985	6.2	10
1990	6.4	15 (1991)
2000	2.8	33 (1999)
2006	2.1	34 (2004)
2009	2.5	27

(Source: Country Report, Maldives: ICPD+15 and Beyond: Progress Achievements and Challenges, 1994-2009. Government of Maldives and UNFPA, 2009)

Table A.2: Changing Age Structure of Maldivian Population

Age group	1990	2000	2006
0-14	46.9	40.8	31.4
15-64	50.6	55.4	63.3
65_{+}	2.5	3.8	5.3
Total	100.0	100.0	100.0

(Source: Population and Housing Census, 2006, Ministry of Planning and National Development, 2007)

Table A.3: Trend of Modern Contraceptive Method Mix, 1999-2009

Methods	1999	2004	2009
Pill	13.0	13.0	4.6
Injectables	3.0	3.0	1.2
Condom	6.0	9.0	9.3
Female Sterilization	10.0	7.0	10.1
Male Sterilization	1.0	1.0	0.5
IUCD	1.0	2.0	0.8
Implanon	-	-	0.5
Diaphragm	-	0.0	0
Norplant	-	0.0	0

(Source: Reproductive Health Survey, 2004, Table 23, p. 15. Ministry of Health and CIET international. Maldives and Maldives Demographic Health Survey, 2009, Preliminary Report, Table 5, p 11. Ministry of Health and Family, Maldives and ICF Macro, USA)

Table A.4: Maternal Mortality Ratio per 100,000 live births for Maldives, 1999-2008

Year	Number of deaths	MMR per 100,000 live births
1999	6	115
2000	4	75
2001	7	143
2002	8	160
2003	5	97
2004	5	96
2005	4	72
2006	4	69
2007	3	46
2008	4	57

(Source: Maldives Health Statistics, 2009. Table 19, p. 30, Ministry of Health and Family)

Table A.7: Maternal Care Indicators

(Percentage of women age 15-49 who had a live birth in the five years preceding the survey who received antenatal care from a health professional for the last live birth and whose last live birth was protected against neonatal tetanus, and among all live births in the five years before the survey, percentage delivered by a health professional and percentage delivered in a health facility, by background characteristics, Maldives 2009)

Background characteristic	Percentage with antenatal care from a health professional[1]	Percentage whose last live birth was protected against neonatal tetanus[2]	Number of women	Percentage delivered by a health professional[1]	Percentage delivered in a health facility	Number of births
Age at birth						
<20	100.0	77.6	111	92.5	92.3	165
20-34	99.5	81.7	2,682	95.9	95.9	3,148
35+	98.3	77.1	397	92.9	90.8	423
Residence						
Urban (Malé)	99.6	83.5	964	99.2	97.9	1,123
Rural	99.2	79.9	2,227	93.7	94.0	2,613
Region						
Malé	99.6	83.5	964	99.2	97.9	1,123
North	99.1	78.0	489	92.4	94.3	578
North Central	98.4	78.5	466	89.7	90.3	539
Central	99.2	75.6	293	90.1	91.8	343
South Central	99.4	78.7	390	97.6	97.8	453
South	99.8	85.6	589	97.3	95.2	700
Atoll						
Malé	99.6	83.5	964	99.2	97.9	1,123
Haa Alif	97.7	71.8	132	92.6	94.7	160
Haa Dhaal	99.5	86.6	210	90.3	94.0	253
Shaviyani	100.0	71.4	147	95.4	94.3	165
Noonu	99.3	84.3	133	90.0	91.2	151
Raa	97.3	82.7	153	84.4	86.8	174
Baa	97.8	62.6	107	93.3	89.8	124
Lhaviyani	100.0	82.6	73	94.3	96.0	89
Kaafu	98.7	74.3	114	87.7	92.3	130
Alif Alif	99.4	85.4	70	83.3	83.0	84
Alif Dhaal	99.5	69.2	98	97.0	96.9	116
Vaavu	100.0	86.4	11	95.1	97.6	12
Meemu	100.0	94.9	58	100.0	100.0	66
Faafu	97.7	92.3	51	94.5	96.0	61
Dhaalu	100.0	84.7	53	95.6	95.2	62
Thaa	98.7	66.4	98	97.4	98.0	111
Lhaamu	100.0	72.9	129	98.8	98.3	153

Gaaf Alif	100.0	78.7	107	94.6	95.2	131
Gaaf Dhaal	100.0	85.4	122	99.1	95.5	148
Gnaviyani	99.0	72.2	98	99.2	98.3	108
Seenu	100.0	93.5	263	96.9	94.0	314
Education						
No education	97.3	77.8	396	86.1	86.8	449
Primary	99.1	76.0	1,143	93.2	94.2	1,368
Secondary	100.0	84.5	1,456	99.1	98.1	1,703
More than secondary	100.0	94.3	156	99.4	95.2	173
Certificate	(100.0)	(79.2)	39	98.8	98.8	43
Wealth index quintile						
Poorest	98.6	76.3	595	90.0	90.5	709
Poorer	99.0	79.7	677	93.4	93.6	802
Middle	99.4	81.8	677	95.6	96.3	783
Richer	100.0	81.7	643	98.9	98.2	756
Richest	99.6	85.5	599	99.3	97.2	686
Total	99.3	81.0	3,190	95.4	95.1	3,736

(Source: Ministry of Health and Family, 2009a. Maldives Demographic and Health Survey, Preliminary Report. Ministry of Health and Family and ICF Macro.

Note: Figures in parentheses are based on 25-49 unweighted cases

[1] Doctor, nurse, midwife, or auxiliary midwife

[2] Includes mothers with two injections during the pregnancy of the last live birth, or two or more injections (the last within 3 years of the last live birth), or three or more injections (the last within 5 years of the last live birth), or four or more injections (the last within ten years of the last live birth), or five or more injections prior to the last live birth

Table A.5: Current Use of Contraception

(Percent distribution of currently married women age 15-49 by contraceptive method currently used, according to background characteristics, Maldives 2009)

Background characteristics	Any method	Any modern method	Female sterilization	Male sterilization	Pill	IUD	Injectables	Implants	Male condom	Any traditional method	Periodic abstinence	Withdrawal	Folk method	Not currently using	Total	No. of women
Age																
15-19	15.0	9.6	0.0	0.0	1.6	0.0	1.2	0.0	6.8	5.4	0.7	4.7	0.0	85.0	100.0	111
20-24	23.2	16.8	0.1	0.0	3.5	0.4	1.0	0.6	11.3	6.4	1.8	4.6	0.0	76.8	100.0	1,188
25-29	30.0	20.8	1.3	0.0	4.1	1.2	2.0	0.7	11.6	9.2	3.7	5.4	0.2	70.0	100.0	1,446
30-34	35.1	26.5	6.4	0.2	7.1	1.2	1.0	0.6	10.1	8.6	4.1	4.2	0.2	64.9	100.0	1,193
35-39	44.0	35.1	17.3	0.7	5.2	0.8	1.5	0.0	9.5	8.9	4.9	4.0	0.0	56.0	100.0	1,065
40-44	45.3	38.4	24.2	1.2	5.3	0.9	0.6	0.7	5.5	7.0	3.1	3.8	0.1	54.7	100.0	884
45-49	39.7	34.8	26.1	1.7	2.0	0.3	0.8	0.0	3.9	4.9	3.2	1.7	0.0	60.3	100.0	612
Residence																
Urban (Malé)	33.6	25.6	10.1	0.4	1.8	1.4	0.7	1.2	10.1	8.0	4.7	3.1	0.2	66.4	100.0	2,122
Rural	35.3	27.6	10.1	0.5	6.0	0.6	1.5	0.1	8.9	7.6	2.8	4.8	0.0	64.7	100.0	4,378
Region																
Malé	33.6	25.6	10.1	0.4	1.8	1.4	0.7	1.2	10.1	8.0	4.7	3.1	0.2	66.4	100.0	2,122
North	39.4	28.2	5.7	0.3	6.5	0.9	2.4	0.0	12.5	11.2	4.5	6.7	0.0	60.6	100.0	1,009
North Central	37.4	28.3	10.3	0.1	7.5	0.3	1.9	0.1	8.0	9.2	3.3	5.8	0.0	62.6	100.0	967
Central	42.0	33.1	13.7	1.5	5.4	0.4	0.7	0.1	11.4	8.9	2.6	6.1	0.2	58.0	100.0	563
South Central	31.7	25.0	8.6	0.6	6.9	0.5	0.9	0.1	7.4	6.7	2.2	4.5	0.0	68.3	100.0	789
South	28.4	25.5	13.2	0.5	3.9	0.5	1.1	0.3	6.0	3.0	1.3	1.5	0.1	71.6	100.0	1,051
Atoll																
Malé	33.6	25.6	10.1	0.4	1.8	1.4	0.7	1.2	10.1	8.0	4.7	3.1	0.2	66.4	100.0	2,122
Haa Alif	42.7	27.5	7.0	0.4	6.3	0.7	4.9	0.0	8.2	15.3	9.6	5.7	0.0	57.3	100.0	302
Haa Dhaal	41.3	28.5	4.2	0.4	5.1	1.3	1.6	0.0	15.9	12.8	3.3	9.5	0.0	58.7	100.0	414

Shaviyani	33.2	28.6	6.3	0.0	8.7	0.6	0.8	0.0	12.1	4.6	0.9	3.6	0.0	66.8	100.0	292
Noonu	43.4	33.3	10.4	0.3	12.5	0.0	1.7	0.0	8.5	10.1	3.3	6.7	0.0	56.6	100.0	268
Raa	37.8	24.2	9.3	0.0	5.6	0.7	2.0	0.0	6.6	13.6	4.1	9.4	0.0	62.2	100.0	313
Baa	29.9	25.2	11.8	0.3	2.7	0.3	1.7	0.3	8.1	4.7	2.0	2.7	0.0	70.1	100.0	216
Lhaviyani	36.8	31.4	10.2	0.0	9.3	0.0	2.3	0.0	9.7	5.3	3.6	1.7	0.0	63.2	100.0	171
Kaafu	42.6	33.6	13.3	0.6	7.0	0.3	0.7	0.0	11.8	9.0	3.2	5.8	0.0	57.4	100.0	231
Alif Alif	37.1	28.9	11.1	3.0	4.9	0.0	0.4	0.0	9.5	8.2	1.8	6.3	0.0	62.9	100.0	125
Alif Dhaal	44.8	35.3	16.0	1.6	3.7	0.8	0.9	0.3	12.1	9.5	2.4	6.6	0.5	55.2	100.0	183
Vaavu	39.4	33.3	13.4	0.4	6.2	0.0	0.0	0.0	13.3	6.1	2.7	3.5	0.0	60.6	100.0	23
Meemu	47.3	31.5	9.8	1.1	10.2	0.0	0.9	0.7	8.9	15.8	1.9	13.8	0.0	52.7	100.0	125
Faafu	42.7	24.0	8.7	2.2	3.7	0.0	1.0	0.0	8.4	18.7	3.5	15.2	0.0	57.3	100.0	93
Dhaalu	32.8	29.4	13.5	0.0	6.7	0.0	0.7	0.0	8.4	3.4	3.1	0.3	0.0	67.2	100.0	108
Thaa	23.2	20.4	9.4	0.4	4.8	0.4	0.4	0.0	5.0	2.8	2.5	0.3	0.0	76.8	100.0	197
Lhaamu	26.3	23.9	5.3	0.4	8.1	1.4	1.3	0.0	7.5	2.4	1.3	1.1	0.0	73.7	100.0	265
Gaaf Alif	23.3	21.7	11.5	0.4	4.0	0.0	1.1	0.0	4.7	1.5	0.4	1.1	0.0	76.7	100.0	177
Gaaf Dhaal	42.5	33.8	15.6	0.5	6.1	0.5	2.2	1.2	7.6	8.6	3.5	5.2	0.0	57.5	100.0	241
Gnaviyani	21.2	19.0	10.4	0.8	1.9	2.1	0.3	0.0	3.5	2.3	0.9	0.9	0.5	78.8	100.0	190
Seenu	25.9	25.2	13.7	0.4	3.5	0.0	0.8	0.0	6.8	0.8	0.8	0.0	0.0	74.1	100.0	443
Education																
No education	43.6	36.2	21.5	1.3	5.8	0.6	1.0	0.2	5.7	7.4	3.7	3.7	0.1	56.4	100.0	1,488
Primary	36.9	29.2	12.0	0.5	5.5	0.8	1.5	0.6	8.4	7.6	3.1	4.5	0.0	63.1	100.0	2,216
Secondary	27.3	19.6	2.3	0.0	3.5	1.0	1.0	0.5	11.2	7.7	3.4	4.2	0.2	72.7	100.0	2,409
More than sec0ndary	32.7	21.2	1.7	0.0	2.1	0.8	0.5	0.7	15.4	11.5	5.7	5.8	0.0	67.3	100.0	316
Certificate	42.6	39.1	10.3	0.0	2.4	0.0	5.8	1.2	19.4	3.4	0.0	3.4	0.0	57.4	100.0	72
Living children																
0	12.9	7.5	0.0	0.0	0.7	0.0	0.0	0.0	6.8	5.4	2.1	3.3	0.0	87.1	100.0	946
1-2	29.2	20.5	1.6	0.1	3.9	0.9	1.2	0.7	12.2	8.6	4.2	4.3	0.2	70.8	100.0	2,908
3-4	44.4	35.8	15.8	0.6	8.0	1.5	1.7	0.4	7.7	8.6	3.6	5.0	0.0	55.6	100.0	1,486
5+	54.2	47.8	32.0	1.6	5.4	0.6	1.6	0.4	6.2	6.3	2.4	3.8	0.1	45.8	100.0	1,160

Wealth index quintile																
Poorest	36.9	29.1	10.7	0.4	7.1	0.4	2.5	0.1	7.9	7.8	2.8	4.9	0.0	63.1	100.0	1,167
Poorer	35.4	27.0	9.3	0.7	6.6	0.5	1.2	0.1	8.7	8.4	2.6	5.7	0.1	64.6	100.0	1,278
Middle	34.3	27.4	10.5	0.3	5.3	0.7	1.2	0.5	8.8	7.0	2.8	4.2	0.0	65.7	100.0	1,363
Richer	33.4	25.6	10.9	0.5	3.0	0.8	0.8	0.4	9.2	7.8	4.2	3.5	0.0	66.6	100.0	1,311
Richest	33.9	26.0	9.0	0.4	1.7	1.7	0.6	1.2	11.5	7.9	4.6	3.0	0.3	66.1	100.0	1,381
Total	34.7	27.0	10.1	0.5	4.6	0.8	1.2	0.5	9.3	7.8	3.4	4.2	0.1	65.3	100.0	6,500

Source: Ministry of Health and Family, 2009a. Maldives Demographic and Health Survey, Preliminary Report. Ministry of Health and Family and ICF Macro.

Note: If more than one method is used, only the most effective method is considered in this tabulation.

Table A.6: Fertility Preference by No. of Living Children

(Percent distribution of currently married women age 15-49 by desire for children, according to number of living children, Maldives 2009)

Desire for children	Number of living children[1]							Total
	0	1	2	3	4	5	6+	
Have another soon[2]	75.4	22.9	11.2	4.2	3.5	1.7	0.1	17.8
Have another later[3]	16.5	50.6	21.7	10.7	2.4	2.2	0.3	21.5
Have another, undecided when	5.6	8.1	4.0	2.9	1.0	0.5	0.1	4.1
Undecided	1.0	7.2	14.2	9.9	5.7	1.2	0.9	7.1
Want no more	0.5	10.2	43.8	57.3	65.1	67.1	57.2	37.2
Sterilized[4]	0.0	0.2	3.4	13.3	20.0	24.5	38.6	10.5
Declare infecund	0.8	0.2	1.1	0.8	1.0	1.5	1.7	0.9
Missing	0.1	0.6	0.6	0.9	1.4	1.3	1.0	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of women	730	1,683	1,371	954	591	443	728	6,500

Source: Ministry of Health and Family, 2009a. Maldives Demographic and Health Survey, Preliminary Report. Ministry of Health and Family and ICF Macro.

[1] Includes current pregnancy, [2] Wants next birth within 2 years
[3] Wants to delay next birth for 2 or more years , [4] Includes both male and female sterilization

Annex 3: Reproductive Health Services Provided by Health Facilities

Health Post

Basic Family Planning Services

- 3 temporary/modern methods (Male Condom, Contraceptive Pills and Depoprovera)
- Counseling

Maternal and Neonatal Care

- Antenatal Care
- Urine test for albumin and sugar
- Hemoglobin
- Post-partum Care

RTI / STI

- Syndromic Treatment
- Counseling
- Referral

Health Centre

Basic Family Planning Services

- 3 temporary/modern methods (Male Condom, Contraceptive Pills and Depoprovera)
- Counseling

Maternal and Neonatal Care (Basic Emergency Obstetric Care)

- Antenatal Care
- Urine test for albumin and sugar
- Hemoglobin
- Conducting normal delivery
- Blood transfusion
- HIV screening
- VDRL screening
- Hepatitis B screening
- Post-partum Care

RTI / STI

- Syndromic Treatment
- Counseling
- Referral

Atoll Hospital

Basic Family Planning Services

- 4 temporary/modern methods (Male Condom, Contraceptive Pills, Depoprovera and IUCD)
- Sterilization (Vasectomy and Tuballigation)
- Counseling

Maternal and Neonatal Care (Emergency Obstetric Care)

- Antenatal Care
- Urine test for albumin and sugar
- Hemoglobin
- Ultrasound scanning
- Cesarean Section
- Blood transfusion
- HIV screening
- VDRL screening
- Hepatitis B screening
- Post-partum Care

RTI / STI

- Syndromic Treatment
- Urine analysis
- Culture
- Counseling
- Referral

Regional Hospital

Basic Family Planning Services

- 4 temporary/modern methods (Male Condom, Contraceptive Pills, Depoprovera and IUCD)
- Sterilization (Vasectomy and Tuballigation)
- Counseling

Maternal and Neonatal Care (Emergency Obstetric Care)

- Antenatal Care
- Urine test for albumin and sugar
- Hemoglobin
- Ultrasound scanning
- Cesarean Section
- Blood transfusion
- HIV screening
- VDRL screening
- Hepatitis B screening
- Post-partum Care

RTI / STI

- Syndromic Treatment
- Urine analysis
- Culture
- Counseling
- Referral